Final Report

Implementation of the Recommendations of the Oakden Report of the Independent Commissioner Against Corruption

Chief Psychiatrist of South Australia

May 2020

Government of South Australia
SA Health

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ISBN

Dr Chris McGowan
Chief Executive
Department for Health and Wellbeing

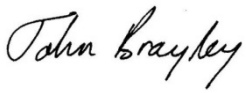
Dear Chief Executive

Please find attached the Final Report in response to the recommendations made by the Independent Commissioner Against Corruption, in his report on Oakden. This report addresses recommendations directed at the Chief Psychiatrist, Chief Executive and Minister, and builds on the Preliminary Report dated 31 December 2018. It also reports on recommendations directed at the Principal Community Visitor.

This report describes the work undertaken to date by the Office of Chief Psychiatrist, the Community Visitor Scheme, the Department for Health and Wellbeing, and the Local Health Networks; proposes actions for future and long-term work; and identifies key decision points for consideration by the Chief Executive and the Minister.

I commend this report to the attention of the Chief Executive and the Minister.

Yours sincerely



Dr John Brayley
Chief Psychiatrist

31st May 2020

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- Allied and Scientific Health Office, Department for Health and Wellbeing.
- Central Adelaide Local Health Network.
- Community Visitor Scheme.
- The former Country Health SA Local Health Network.
- Crown Solicitor's Office, Attorney-General's Department.
- Infrastructure Directorate, Department for Health and Wellbeing.
- Northern Adelaide Local Health Network.
- Office for Ageing Well, Department for Health and Wellbeing.
- Office of Parliamentary Counsel, Attorney-General's Department.
- Safety and Quality Unit, Department for Health and Wellbeing.
- Southern Adelaide Local Health Network.
- Women's and Children's Health Network.

Chief Psychiatrist Foreword

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 Office of the Chief Psychiatrist 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. This Final Report describes the ICAC recommendations, matters reviewed, actions that have been completed and those still underway, and proposes some further actions for consideration.

I would like to thank the Allied and Scientific Health Office, Community Visitor Scheme, Infrastructure Directorate and the Local Health Networks for their collaboration and contributions to this Final Report. I would also like to thank the OCP officers tasked with coordinating this work.

The ICAC recommendations raise significant issues with equally significant policy, governance and service delivery impacts. The practical implementation of actions arising from the recommendations has taken and will continue to take time and energy, as the Department for Health and Wellbeing and the Local Health Networks integrate those actions, alongside other change processes, in a measured sustainable way.

I acknowledge the change in governance arrangements for SA Health during this time, with the commencement of Governing Boards for Local Health Networks, the devolution of the Country Health SA Local Health Network into six regional Local Health Networks, changing roles for the Local Health Networks and the Department for Health and Wellbeing, and the restructure of the Department to better facilitate its role as system manager.

These changes will assist with the implementation of the ICAC recommendations going forward through improved local governance to Boards, but have necessarily been a focus for attention for health services over the last year.

A number of key recommendations have been implemented, including:

- Establishment of an enhanced unannounced and announced inspection regime by the Office of the Chief Psychiatrist, and a shift to unannounced visits by the Community Visitor Scheme.
- Establishment of enhanced collaboration, coordination and follow-up in response to issues by Office of the Chief Psychiatrist, Community Visitor Scheme, Department for Health and Wellbeing, and the Local Health Networks.
- Establishment of a statewide system to review and maintain the condition of health facilities as part of the Infrastructure Directorate's Strategic Asset Management Framework in the medium to long term, and the identification of facility concerns in Chief Psychiatrist inspections.
- Reviews of Chief Psychiatrist powers, CVS training and qualification requirements, restrictive practice, mental health governance and responsibilities, communication, and staffing and other resources necessary to carry out the recommendations.
- Publication of the Chief Psychiatrist Inspection Protocol and revised draft Chief Psychiatrist Standard – Restrictive Practice.

The scope and complexity of some of the ICAC recommendations has been so great that the review of, development of solutions for, or implementation of some matters is still underway. These pieces of work will join this Final Report as part of the suite of responses to ICAC, and comprise:

- Replacement of Oakden with a range of new services and facilities – Specialist Aged Care Service Reform, Office of the Chief Psychiatrist, Office For Ageing Well, Department for Health and Wellbeing, and the Local Health Networks. Significant progress has occurred in this area.
- Review and recommendations regarding the training available, resourcing and education and training needs of the mental health workforce – Office of the Chief Psychiatrist.
- Development of models and benchmarks for Allied Health Professionals in mental health services – the Allied and Scientific Health Office and the Office of the Chief Psychiatrist.
- Review of the physical condition of all mental health facilities –Infrastructure Directorate and Office of the Chief Psychiatrist.
- Review of consumer advisor roles and responsibilities and broader complaints processes and policies – Safety and Quality Unit and the Consumer Feedback and Complaints Management Program Board.
- Review of the Safety Learning System – Safety and Quality Unit

The ICAC Oakden Report has provided an opportunity for the South Australian mental health sector to reflect and take action. While difficult and confronting, with considerable work yet to be done, I have been heartened by the approach of stakeholders to this challenge: it has been seen as an opportunity to significantly improve standards, and accountability for those standards.

I look forward to the continued implementation of actions arising from the ICAC recommendations, the strengthening of collaborative partnerships, and the improvement of outcomes for consumers, carers and their families.

John Brayley
Chief Psychiatrist

Executive Summary

This Final Report of the Implementation of the Recommendations of the Oakden Report of the Independent Commissioner Against Corruption (ICAC) has been written by the Office of the Chief Psychiatrist at the request of the Chief Executive of SA Health. The Report has been developed with the assistance of the Allied and Scientific Health Office, Central Adelaide Local Health Network, Community Visitor Scheme, Country Health SA Local Health Network, Crown Solicitor's Office, Infrastructure Directorate, Northern Adelaide Local Health Network, Office for the Ageing, Office of Parliamentary Counsel, Safety and Quality Unit, Southern Adelaide Local Health Network, and the Women's and Children's Health Network.

This Final Report outlines the ICAC Report recommendations, the topics considered, the work completed, the work underway, the work yet to be done, describes consultation and feedback, and provides key decision points for the consideration of the Chief Executive and the Minister.

Recommendation 1 – Governance of Mental Health Services and the Mental Health Act

A review has been undertaken of the clinical governance arrangements for mental health services in South Australia, in the context of the National Model Clinical Governance Framework. The review considered current structures, the structures of other clinical specialities, the structures of mental health services in other jurisdictions, interaction and overlap with the *Health Care Act 2008,* and requirements of the *Mental Health Act 2009.* It is proposed that clinical governance committees include references to the *Mental Health Act 200*9 within their terms of reference and that consideration is given to having a regular audit process in place for monitoring the effectiveness of these committees.

Recommendation 2 – Mental Health Roles and Responsibilities

A review was undertaken of the roles and responsibilities of Local Health Network staff regarding clinical care and *Mental Health Act 2009* functions which considered current mental health service governance structures and reporting lines; the governance structures and reporting lines of other clinical specialities; role descriptions of managers, clinicians and administration staff; and the requirements of the *Mental Health Act 2009.* The Office of the Chief Psychiatrist has provided guidance to the Local Health Networks on a process to update role descriptions of staff within mental health services to include: reference to the Act as a general responsibility, reference to the Act as a key function for relevant non-clinical staff and reference to the Act as a key function and desirable criteria for mental health service clinicians in leadership roles.

Recommendation 3 – Communication of Governance and Responsibilities

A review was undertaken of the structures in place to routinely remind Local Health Network staff of their responsibilities under legislation and policy, and of the governance structure for both clinical care and the use of the Act. The Office of the Chief Psychiatrist is working with the Local Health Networks to develop material for the Local Health Networks to publish and promote on *Mental Health Act 2009* responsibilities.

Recommendation 4 – Local Health Network Training

A review was undertaken of the current system for Safety Learning System training, *Mental Health Act 2009* training and training for legislative requirements. The Office of the Chief Psychiatrist has undertaken a project to identify learning and development approaches of the individual Local Health Networks for staff in mental health services. The reviews undertaken have resulted in the establishment of a Training and Learning Steering Committee for mental health who will develop a training framework for mental health services. In addition an independent review of the Safety Learning System review will commence in January 2020 and will be conducted by an expert independent consultant versed in adverse event reporting and management, who is associated with Macquarie University NSW.

Recommendation 5 – Chief Psychiatrist Inspections

The Office of the Chief Psychiatrist has commenced an enhanced inspection regime and released a Chief Psychiatrist Inspection Protocol to inform consumers, carers, mental health services and partners about processes and procedures.

Recommendation 6 – Community Visitor Scheme Inspections

The Community Visitor Scheme has commenced carrying out more unannounced visits and inspections. Mr Julian Gardner former Public Advocate of Victoria in collaboration with the Principal Community Visitor undertook a review of the history of Scheme inspections, comparison with the regimes of Visitor Schemes in other jurisdictions, the differences between a community inspection regime and a clinical one, and options for reporting and following up on issues of concern. The combination of the CVS inspection regime from a community perspective and the OCP inspection regime from a clinical perspective, given their increased cross-referral and collaboration, is appropriate and effective.

Recommendation 7 – Community Visitor Training and Qualifications

A review has been undertaken by Mr Julian Gardner, former Public Advocate of Victoria of the current training provided to community visitors, current qualification requirements, comparison to the training and qualifications required in other jurisdictions and options for training and qualifications going forward. The review found that the Community Visitors did not require specific qualifications to carry out visits and inspections from a community perspective. The review did recommend expanding the training offered to potential Community Visitors to include information on Mental Health Service Standards.

Recommendation 8a – Chief Psychiatrist Functions

A review has been undertaken of the current obligations of the Chief Psychiatrist relating to the standard of mental health care and the administration of the Act; the obligations of the Minister, Chief Executive SA Health and the Governing Boards of the Local Health Networks; the obligations in the legislation of other jurisdictions; options for the prosecution of offences under the *Mental Health Act 2009;* and options available for enhancing positive obligations for the Chief Psychiatrist and others. It is proposed that: the Chief Psychiatrist must have Standards relating to certain matters, and that the Act determine when they must consider placing conditions or revoking gazettal – in particular if a facility has failed to adhere to either the Act or those Standards. Similar powers are proposed for placing conditions or revoking the powers of individuals who do not comply with the Act or standards. It is also proposed the *Mental Health Act 2009* be amended to make the Minister, Chief Executive, Governing Boards, Chief Executive Officers and the Chief Psychiatrist jointly responsible for ensuring the standard of mental health care and ensuring compliance with the Act, within their roles, capabilities and other powers and functions, similar to section 16 of the *Work Health and Safety Act 2012.* It is also proposed that the *Public Interest Disclosure Act 2018* be amended to make the Chief Psychiatrist a responsible officer under that Act.

Recommendation 8b – Resources of the Office of the Chief Psychiatrist

A review has been undertaken of the staffing and other resources necessary by the Office of the Chief Psychiatrist to carry out the ICAC recommendations. It is proposed that the Chief Executive and the Minister consider resourcing options for the Office of the Chief Psychiatrist to carry out existing and proposed powers, functions and responsibilities.

Recommendation 9 – Infrastructure Condition

A review has been undertaken of the current governance and responsibilities for facility maintenance, current facility review mechanisms, current standards used for determining facility condition, what facilities should be within scope of a physical review, and the development of a SA Health-wide Strategic Asset Management Framework. In the short term action is being taken based on Chief Psychiatrist inspection findings, special

inspections with facility officers and Chief Psychiatrist staff are planned. Public reporting of facility conditions is supported. Some details are provided in this report.

Recommendation 10 – Implementation of the Chief Psychiatrist Oakden Report

The Specialised Aged Care Service Reform Program has been established to plan, design and implement the work from the Oakden Oversight Committee. This program comprises a number of strategies including: the development of a neuro-behavioural unit for those with extreme behavioural and psychological symptoms of dementia (BPSD) and working in partnership with an aged care provider and the Commonwealth Government to deliver a Specialised Dementia Care Unit that will cater to the needs of people with severe and very severe dementia.

Recommendation 11 – Consumer Advisors

The Safety and Quality Unit, Department for Health and Wellbeing, has established the Consumer Feedback and Complaints Management Program Board to review the ICAC Report recommendations and complaints and consumer advisor matters more broadly. The board includes representatives from the Local Health Networks and the Health Consumers Alliance of South Australia. In addition to the matters raised by the ICAC Report, the Program Board will also undertake further work which includes reviewing the current Consumer Feedback Management Policy Directive, Policy Guideline and Toolkit, establishing communication strategies to ensure Consumer Advisors are kept up to date with policy and process developments and consider Community of Practice options available for Consumer Advisors across the state. In addition as a short term measure a Chief Psychiatrists Standard for Mental Health Complaint Management in SA Health Operated Services will be issued for consultation.

Recommendation 12 – Review of Restrictive Practice

A review of the use of restrictive practice and the Office of the Chief Psychiatrist restrictive practice policy documents has been carried out. This review has confirmed the role of the Statewide Mental Health Quality Improvement Committee and the Trauma Informed Practice Working Group in monitoring, analysing and taking action on restrictive practice issues, and caused the Office to implement a process to identify and approve all restraint devices used in incorporated public hospitals and licensed private hospitals. In addition, the Office has consulted on and revised its restrictive practice policy documents and has developed a draft Restrictive Practice in Mental Health Services Chief Psychiatrist Standard and Toolkit for trial and consultation with consumers, carers, mental health services, statutory officers and partner agencies

Recommendation 13 – Allied Health Professional Workforce

The Allied and Scientific Health Office has undertaken a review of current AHP staff totals, classification levels, employment status and professional groupings; AHP representation at executive levels and in mental health services; impacts of the National Disability Insurance Scheme and the My Aged Care programme; and the planning requirements for mental health service planning for adequate AHP staffing. The Office of the Chief Psychiatrist and the Allied and Scientific Health Office have commenced the establishment of a working party to consider, over the next 12 months, benchmarks for allied health professionals in different mental health service types and settings, structure and governance options, and training and development requirements.

Introduction

The Independent Commissioner Against Corruption, Mr Bruce Lander QC announced on 25 May 2017 that he was undertaking an investigation into possible maladministration at the Oakden Older Persons Mental Health Service. The report from that investigation was released on 28 February 2018. The report contained thirteen recommendations which included ones related to mental health clinical governance, administration of the *Mental Health Act 2009*, potential changes to powers of the Chief Psychiatrist and potential changes to the Community Visitors Scheme.

The then Government accepted all recommendations and the subsequent Government after the South Australian elections confirmed the commitment to addressing all recommendations.

The Chief Executive of SA Health in May 2018 requested that the Chief Psychiatrist lead the implementation of the recommendations on behalf of the Chief Executive. The implementation would require collaboration and input from multiple units in the Department for Health and Wellbeing as well as all five Local Health Networks.

In order to determine what was required for the implementation of each recommendation, an initial process was undertaken to tease out what matters would need to be considered. This led to the development of a memo from the Chief Executive of SA Health to each of the Chief Executive Officers of the five Local Health Networks.

The memo requested information to inform the initial implementation of the thirteen recommendations. Discussions also occurred with the Office for Professional Leadership, Infrastructure, Quality Information and Performance and Office for the Ageing on the work being undertaken in each of their units in response to the ICAC report.

This information as well as research undertaken on processes in other jurisdictions and national and state policy and key reference documents were considered and analysed to develop discussion points and proposed actions for the recommendations. This work was formed into the Preliminary Report which outlined a number of proposed actions as well as the work required to further implement the remaining recommendations.

Subsequent to the release of the Preliminary Report, further work was undertaken on the implementation. This work included consideration of the proposed actions from the preliminary report, with some actions being able to be fully implemented and closed, while others required the commencement of focussed projects, progress of these projects is included in this report. Work was also undertaken on the recommendations that had not been fully considered in the Preliminary Report to identify new proposed actions.

It should be noted that in the months subsequent to the release of the preliminary report, changes in governance for public health services have occurred. From 1 July 2019 changes to the *Health Care Act 2008* commenced which included the six regional Local Health Networks across country South Australia becoming operational and Local Health Network Governing Boards having responsibility for the governance and management of their respective LHN.

ICAC Recommendation 1 – Mental Health Clinical Governance Structures

The Chief Executive of the Department of Health and Ageing review the clinical governance and management of mental health services within the overall clinical governance of each Local Health Network to determine whether the management requirements of the *Mental Health Act 2009* fit within the overall health governance structures.

Matters for Consideration

- Current clinical governance committees and reporting structures for mental health services at the site/facility level and Local Health Network level.
- Current clinical governance committees and structures for other specialities.
- Management requirements for *Mental Health Act 2009* – are they covered by current health governance structures.
- Governance arrangements for mental health legislation in other states.
- Interaction and overlap between the *Mental Health Act 2009* and *Health Care Act 2008.*
- Pros and cons of having mental health governance arrangements separate or included in general health governance.
- Changes that may be required to imbed *Mental Health Act 2009* management into governance structures in mental health and health.

Discussion

1.1 National Model of Clinical Governance Framework

The National Model Clinical Governance Framework was developed in 2017 by the Australian Commission on Safety and Quality in Health Care. The framework is based on the National Safety and Quality Health Service Standards. It acts as a guiding document to help ensure that clinical governance systems are implemented effectively and support safer and better care for patients and consumers. The framework defines clinical governance as:

- The set of relationships and responsibilities established by a health service organisation between its state or territory department of health (for the public sector), governing body, executive, clinicians, patients, consumers and other stakeholders to ensure good clinical outcomes. It ensures that the community and health service organisations can be confident that systems are in place to deliver safe and high-quality health care, and continuously improve services.

The framework consists of five components which include:

- ***Governance, leadership and culture*** *– integrated corporate and clinical governance systems are established, and used to improve the safety and quality of health care for patients*
- ***Patient safety and quality improvement systems*** *– safety and quality systems are integrated with governance processes to actively manage and improve the safety and quality of health care for patients*
- ***Clinical performance and effectiveness*** *– the workforce has the right qualifications, skills and supervision to provide safe, high-quality health care to patients*
- ***Safe environment for the delivery of care*** *– the environment promotes safe and high-quality health care for patients*
- ***Partnering with consumers*** *– systems are designed and used to support patients, carers, families and consumers to be partners in healthcare planning, design, measurement and*

evaluation; elements of this component include – clinical governance and quality improvement systems to support partnering with consumers – partnering with patients in their own care – health literacy – partnering with consumers in organisational design and governance.

The National Model appropriately sees clinical governance as an integrated component of corporate governance. It is the Board of a clinical organisation's responsibility to see good governance. It notes that management has an operational focus, whereas governance has a strategic focus.

It is the Board that establishes the governance system. The framework then defines the roles and responsibilities of consumers and carers, clinicians and managers – discussed further in the discussion under Recommendation 2.

In this context the establishment of the Board of Governance for Local Health Networks in July 2019, provides an important new foci of strategic and organisational accountability that was not present at the time of Oakden, or at the time of finalisation of the ICAC Commissioner's report.

Therefore with respect to the effectiveness of mental health clinical governance, it will be determined by the

- New governance arrangements for the LHNs, and the level of strategic oversight and focus each LHN delivers for its mental health service.
- A range of leadership tasks in providing an improvement culture, effectively managing risk and management tasks including establishing and maintaining a committee structure which can assist in reviewing incidents, accreditation reports, key performance indicators, and setting policy direction for continuous improvement.

With respect to *Mental Health Act 2009* accountabilities within this structure it will be influenced by both the extent to which the whole LHN organisational governance attends to its mental health consumers and services, as well as the governance systems established within those services.

SA Health retains a significant role in determining quality outcomes through the performance expectations it sets, determining state-wide service policies , and its regulatory role through the Office of the Chief Psychiatrist. Ultimately the accountability for delivering quality mental health services is shared, and all parties need to uphold their responsibilities

1.2 Clinical Governance in other jurisdictions

Two interstate jurisdictions through their central health departments have developed their own clinical governance frameworks, which use the national framework as a source document.

In Victoria Safer Care Victoria was established in response to recommendations within the report 'Targeting zero, the review of hospital safety and quality assurance in Victoria' released in 2016. Subsequent to their establishment they developed the document 'Delivering high-quality healthcare – Victorian Clinical Governance Framework' which was published in 2017. The framework outlines clinical governance role and responsibilities for health service boards and Chief Executive Officers of health services.

In New South Wales, the Corporate Governance and Accountability Compendium was published in April 2019 and contains a section on Clinical Governance for public health services. The section includes an outline of clinical management structures which states:

"The successful implementation of clinical governance requires:

- the identification of clear lines of responsibility and accountability for clinical care and ensuring these are communicated throughout a public health organisation; and
- the development of strong and effective partnerships between clinicians and managers."[1]

While Mental Health Services should benefit from improvements in clinical governance generally across services, there are some different aspects of their core business and relationships (for example with extensive community based staff, and expected high levels of consumer and care co-design in service improvement) that requires specific attention.

It is also worth noting that in Western Australia has had a review into Clinical Governance in Mental Health Services. The review was established in response to recommendations made by the 2017 review of Safety and Quality in the WA Health System and the 2018 Sustainable Health Review Interim Report. The review is facilitated by the Department of Health with the scope of the review being wide ranging including current public mental health clinical governance structures, Mental Health governance agencies and consideration of current legislation. We are awaiting publication of the final review report.

1.3 LHN Governing Boards in South Australia

The establishment of LHN Governing Boards through the changes to the *Health Care Act 2008* will need to be taken into consideration when considering any actions for this recommendation. The amendments to the legislation may require a revision of current LHN clinical governance frameworks.

The *Health Care (Governance) Amendment Act 2018* made amendments to the *Health Care Act 2008*. The act was proclaimed on 2 August 2018 and came into operation on 1 July 2019

The amendments included the deletion of the previous section 33 and the substitution of a new section 33 – Governance and management arrangements. This new section included the following

33-Governance and management arrangements

(2) The functions of a governing board for an incorporated hospital include the following:

(a) to ensure effective clinical and corporate governance frameworks are established to support the maintenance and improvement of standards of patient care and services by the incorporated hospital and to approve those frameworks

1.4 Clinical Governance – Committees - State

The following work occurred before the new Board governance arrangements were in place, and focussed on existing executive and clinical committee structures that would now report through to a Board. It is recognised that these structures are evolving.

In order to assess the current committee structures in place, a request for information was sent by the Chief Executive, SA Health to each of the Local Health Network Chief Executive Officers. Terms of Reference for clinical governance committees for both mental health and the broader health system were included in the request

A review of each of the provided Terms of Reference and committee structures were undertaken to determine if administration of the *Mental Health Act 2009* is currently covered

[1] 5.21 – Clinical Management Structures – Corporate Governance and Accountability Compendium — NSW Health- April 2019

within the Terms of Reference for mental health governance committees and the broader health system.

CALHN
The Central Adelaide Local Health Network developed a clinical governance framework document based on the national framework for their LHN.

CALHN Mental Health – Quality and Governance Committee – Chair – Clinical Director – reports to CALHN Mental Health Division Performance Meeting – with the Chief Executive Officer.

Sub committees of this committee include:

- Serious Critical Incident Panel
- ECT
- Medication Safety
- Clinical Development – training and research
- Inpatient Quality Committee

The former Country Health SA LHN (CHSALHN) operating until 30 June 2019
The CHSALHN adopted the National Framework for clinical governance in setting up its clinical governance committee structure. On 1 July 2019, the six Local Health Networks across the regional areas became operational. As a part of the new governance structure a Rural Support Service has been set up. This service includes the establishment of a Chief Clinical Advisor. The Advisor will be responsible for:

- clinical leadership, will be functionally accountable to the Rural Support Service Governance Panel – will be multi classified and functions include - Quality, Risk and Safety

The new Rural and Remote Mental Health Service was established post 1 July 2019 and is hosted by the Barossa, Hills Fleurieu LHN. The Service will have an overarching clinical governance structure which will include representatives from all regional Local Health Networks. The Rural and Remote Mental Health Service will establish links with the Rural Support Service. The Rural and Remote Mental Health Service (RRMHS) has established a Memorandum of Administrative Agreement between the RRMHS – governed by the Barossa Hills, Fleurieu Local Health Network and the other five regional LHNs.

As part of this new structure, there may be changes to the clinical governance committee structure.

The previous committee structure included the CHSALHN Clinical Governance Committee – a subcommittee of the Country Health Strategic Executive Committee. Membership of this committee includes the Clinical Director – Mental Health. A process for regular reports on mental health topics is included in the Terms of Reference. While the terms of reference for this committee do not specify discussion of administration of legislation it is possible that discussion of the administration of the *Mental Health Act 2009* has occurred as part of the mental health topic discussion.

Committees established prior to the changes to six regional LHNs for mental health included the Mental Health Strategic Executive Committee. The Role and Function of this committee includes: sets standards, monitors, reports on and evaluate required targets and standards particularly in relationship to – quality, safety and risk management of all of its services.

Subcommittees that report to the Executive Committee have included the Mental Health Operations Performance Committee, Mental Health Peak Regional Operations Governance Committee, the Mental Health Work Health and Safety and Injury Management Committee

The Mental Health Clinical Governance Committee is also a subcommittee of the Mental Health Strategic Executive Committee. The agenda for this committee follows the National Safety and Quality Health Service Standards. The Mental Health Serious Incident Review Group reports to this committee. This committee's principle purpose is to undertake the review of critical incidents within the legislated timeframes and make systems improvement recommendations and monitor the implementation of recommendations

NALHN

The Northern Adelaide Local Health Network Clinical Governance Committee assists the Chief Executive Officer to discharge their responsibilities in relation to the provision of safe, high quality care. They ensure compliance with statutory laws and regulations. Membership includes the Divisional Directors of Mental Health (medicine and Nursing/midwifery). The committee reports to the NALHN Executive Performance and Risk Committee.

The mental health Divisional Governance Committee has a reporting link to the NALHN Clinical Governance Committee and the NALHN Strategic Operations Committee. Subcommittees of this committee includes adult clinical governance, Older Persons clinical governance and forensic clinical governance

SALHN

The Southern Adelaide Local Health Network has a clinical governance committee structure with the SALHN Clinical Council at the top providing oversight of a variety of sub committees. The council reports to the Chief Executive Officer (CEO). The sub committees include a governance committee for each division of the Local Health Network. Other committees that report to the council include clinical review, mortality review, FMC intensive and critical care mortality, trauma and new health technology

A review of the Terms of Reference for the Clinical Governance Council revealed the role and purpose of the committee was to provide high level clinical governance on matters relating to the delivery of safety high quality care and services for patients and their families. The Committee is to assist the CEO discharge their responsibility for effective clinical governance and safe, high quality services in accordance with the requirements of the Service Level Agreement between SALHN and SA Health. The membership of the committee includes the Mental Health Clinical Director and Co-Director. The terms of reference does not outline any link to responsibilities that the CEO or other members of the LHN may have under legislation including *Mental Health Act 2009*

Mental Health Services within SALHN also have a series of clinical governance committees that link to the LHN Clinical Governance Committee. At the top of this structure is the Clinical Governance Committee for Mental Health. The committee's purpose is to oversee the safety and quality program as it relates to Southern Mental Health and link to Southern Adelaide Local Health Network as a whole. The terms of reference does not specify responsibilities under relevant legislation.

WCHN

The Women's and Children's Health Network have a Clinical Safety and Quality Committee. The committee is responsible for setting priorities and strategic directions for the delivery of Excellence in Care; fostering a culture of safety and quality improvement and evaluating the effectiveness of the organisation's clinical governance systems that support looking; learning; and improving clinical practices in order to deliver care that is personal, connected,

safe, collaborative and right to every patient every time. Membership includes the Clinical Director of CAMHS

The CAMHS Clinical Safety and Quality Committee reports to the WCHN Clinical Safety and Quality Committee and has the same responsibilities within the Child and Adolescent Mental Health Service. The Committee has a range of deliverables which include establishing and implementing an audit and evaluation program, developing and monitoring a divisional safety, quality and risk plan and oversight of the development and monitoring of divisional procedural documents.

Other committees include the CAMHS Complex Care Review Committee which provides clinical review of cases identified by CAMHS clinicians which are supported by their Managers as being complex and identify system and process issues which arise from the case.

1.5 Clinical Governance Committees - Interstate Comparison

In addition to the review of current state governance structures, a formal request was made to interstate jurisdictions to obtain examples of clinical governance structures for mental health and the broader health system to determine what the governance arrangements are for mental health legislation in Local Hospital/Health Networks in other states.

This request resulted at the time of this report in information being provided by three jurisdictions.

Table 1.1 Jurisdictional Responses

Question	**Guidance or Direction provided by CP on how the administration of their Mental Health Act is monitored in a LHN**
Tasmania	Provides high level advice to the Secretary of the Department of Health and Clinical Leads within the Tasmanian Health Service both on ways the Mental Health Act is being administered/complied with and on mental health policy and clinical practice
New South Wales	The Chief Psychiatrist meets regularly with the Mental Health Review Tribunal but does not guide or direct the ways in which Local Health Districts monitor the administration of Mental Health Legislation.
Queensland	• CP Policies and Practice Guidelines establish accountability for the oversight of particular legislative or clinical process • OCP maintains a compliance register for the purpose of monitoring and auditing compliance with the Mental Health Act
Question	**Clinical Governance Structures – are they determined at the LHN level or guidance or direction provided by the relevant state department**
Tasmania	The Tasmanian Health Service (LHN) determines localised clinical governance structures. The Statewide Mental Health Services is represented on the Department's Clinical Executive Committee. The Chief Psychiatrist is also a member of this committee.
New South Wales	Part 5 Section 13 of the Model By-laws under the Health Services Acts sets out requirements for a range of committees including a committee that deals with quality and safety at the strategic level
Queensland	The Mental Health Alcohol and Other Drugs Branch of the Department of Health does not provide mandatory guidance to Hospital and Health Services on the establishment or management of clinical governance

	mechanisms excepting its role in the oversight and governance of the administration of the *Mental Health Act 2016* legislation
Question	**Do Local Health Network Mental Health Services have separate clinical governance committee structures or is mental health part of the overall clinical governance structure**
Tasmania	In addition to the clinical governance committees discussed under Question 2 the Statewide Mental Health Services have a Clinical Governance Framework that was released in 2018. The department is currently working on finalising a statewide 'Quality Governance Framework for Tasmania's Publically Funded Health Services' that is expected to be released in the next month
New South Wales	It varies between Local Health Districts.
Queensland	It varies between the Hospital and Health Services. In the larger metropolitan HHSs it is more likely for mental health services to have designated mental health governance committees. In smaller, regional, rural or remote HHSs it is more common for it to be incorporated into broader health clinical governance structures.

The level of guidance provided by central departments in the three jurisdictions who responded as outlined in the table above varies but where there is guidance provided it is limited to the development of policy and strategic documents. The structure of clinical governance committees also varies, often dependent on the size of the service with smaller services more likely to have one whole of health clinical governance structure and other larger services often having a separate mental health clinical governance committee structure as well as a whole of health structure.

1.6 Effectiveness of Clinical Governance Committees

While the Terms of Reference for committees assist in determining the role of the committee, their reporting structure, the membership and frequency of the meeting they do not provide a total picture of the effectiveness of the committee. Documentation on what is discussed, how actions are recorded and how actions are followed up is also important. The minutes and accompanying action lists where used would provide a complete picture of how the committee operates, how often they actually meet, what is the level of attendance at meetings and how are meeting actions documented.

It will be proposed that consideration be given by the Local Health Networks to implementing an auditing process for clinical governance committees. This process could occur on a yearly or bi-annual occurrence. The audit could select a pre-determined sample of clinical governance committees across the relevant LHN and review:

- The number of times the committee met in a twelve month period
- The rate of attendance focusing on any times there were insufficient numbers for a quorum.
- The documentation of actions, were they clearly documented and was there documentation of the outcome of the action.

This process could assist in ensuring the committees are functioning as they were intended to when they were established.

1.7 Interaction and Overlap between the *Mental Health Act 2009* and *Health Care Act 2008*

The *Health Care Act 2008* and the *Mental Health Act 2009* provide a range of different but overlapping powers and functions to the Minister, the Chief Executive and the Chief

Psychiatrist in overall health care and mental health care. Those powers and functions form a matrix of responsibility that includes broad matters such as:

- Population based planning
- Providing suitable facilities and services
- Providing care that is safe and best practice
- Protecting the rights and participation of patients, carers and families
- Providing education and training systems
- Promotion, prevention and early intervention
- Promoting research
- Monitoring
- Consultation

While there is a general understanding that the provisions of the *Health Care Act 2008* are overarching and take effect as a foundation on which the more specific provisions of the *Mental Health Act 2009* can occur*,* the lack of reference between the Acts means there are no explicit links between the powers and functions in both Acts, nor any links between the powers of the Minister, Chief Executive and Chief Psychiatrist between the Acts.

The work undertaken so far indicates that greater clarity of the powers and functions across the Acts may be required, as well as explicit links, and that both should be informed by the National Safety and Quality Health Service Standards on governance.

Overall it can be concluded that while there is variation nationally between clinical governance arrangements for mental health, there are many similarities in approach. There is an opportunity at this time with the development of LHN Boards for Mental Health clinical governance matters to be addressed.

The proposed actions below are technical recommendations for Boards and CEOs of LHNs to consider.

Proposed Actions

Proposed Action One

It is proposed that Terms of Reference for Clinical Governance Committees within Local Health Networks within mental health and at the health executive level includes within their scope specific reference to responsibilities under the following legislation, *Health Care Act 2008* and *Mental Health Act 2009*

Proposed Action Two

It is proposed that LHNs have an annual or bi-annual audit process in place for auditing clinical governance committees to ensure they are meeting regularly, working towards their terms of reference, have clear documentation of their actions, referral of actions to higher committees where required, and documentation of responses to actions.

ICAC Recommendation 2 – Mental Health Roles and Responsibilities

The Chief Executive should, with the Chief Psychiatrist and the Chief Executive Officers of the Local Health Networks, consider adopting management structures for the administration of the MHA to match those of overall mental health clinical governance structures, such that:

- the officer responsible for the clinical mental health care of a facility within a Local Health Network is also responsible for the administration of the Mental Health Act at that facility; and
- the officer responsible for overseeing all clinical mental health care within a Local Health Network has the responsibility for the administration of the Mental Health Act in that Local Health Network.

Matters for Consideration

- Current mental health organisation structures including lines of responsibility and accountability for each Local Health Network.
- Current LHN governance structures for other clinical specialty groups.
- Current role descriptions for Mental Health Staff in a management position or clinical lead position.
- Current functions of the Director of a Treatment Centre under the *Mental Health Act 2009*.
- Current Officer assigned the role of Director of a Treatment Centre in each Local Health Network.
- Current functions of other staff including non-clinical staff located at a Treatment Centre under the *Mental Health Act 2009*.
- Potential Changes required to current mental health organisation structures for each Local Health Network.
- Potential additional statements for *Mental Health Act 2009* administration to be added to role descriptions of Clinical Staff in management or clinical lead positions.
- Potential additional statement for *Mental Health Act 2009* administration to be added to role descriptions for staff of a Treatment Centre in a non-clinical role.

Discussion

2.1 Introduction

To assist with considering this recommendation, initial work was undertaken to determine existing structures and responsibilities for clinical governance and the administration of the *Mental Health Act 2009* (the Act).

Roles, Responsibilities and Structures for Clinical Governance

The National Model Clinical Governance Framework was developed in 2017 by the Australian Commission on Safety and Quality in Health Care. The framework is based on the National Safety and Quality Health Service Standards. It acts as a guiding document to help ensure that clinical governance systems are implemented effectively and support safer and better care for patients and consumers.

The Framework defines the following roles and responsibilities for clinicians and Managers of health services.

Patients and consumers - Patients and consumers participate as partners to the extent that they choose. These partnerships can be in their own care, and in organisational design and governance.

Clinicians – Clinicians work within and are supported by well-designed clinical systems to deliver safe, high quality clinical care. Clinicians are responsible for the safety and quality of their own professional practice and professional codes of conduct include requirements that align with the Clinical Governance Framework.

Managers – Managers (including clinical managers) advise and inform the governing body, and operate the organisation within the strategic and policy parameters endorsed by the governing body. They are primarily responsible for ensuring that the systems that support the delivery of care are well designed and perform well.

These definitions, along with the fact sheet – Clinical Governance for Managers and Clinical Managers, were used to help develop a checklist for determining if information contained within the provided role descriptions aligned with clinical governance responsibilities.

The National Framework document has been used as a guiding document to review and update clinical governance frameworks within each of the five Local Health Networks. The most recent being the development of a Clinical Governance Framework for the Central Adelaide Local Health Network which was endorsed in April 2018. This document replaced the previous two clinical governance documents which had been in place since 2015.

Administration of the *Mental Health Act 2009*– Responsibilities

The administration of the Act is guided by a set of guiding principles. These principles provide guidance and direction for officers using the Act, including health professionals, ambulance officers, police officers, the Chief Psychiatrist, and the South Australian Civil and Administrative Tribunal. These principles include:

- *Mental health services should be therapeutic and of the highest safety and quality and provided in the least restrictive way in the least restrictive environment;*
- *Mental health services should (subject to this Act or any other Act) be provided in accordance with international treaties and agreements to which Australia is a signatory;*
- *Mental health services should be provided on a voluntary basis as far as possible, and otherwise in the least restrictive way and in the least restrictive environment that is consistent with their efficacy and public safety, and at places as near as practicable to where the patients, or their families or other carers or supporters, reside*
- *mental health services should be governed by comprehensive treatment and care plans that are developed in a multi-disciplinary framework in consultation with the patients (including children) and their family or other carers or supporters*
- *mental health services should take into account—*

  (i) the different developmental stages of infants, children, young persons, adults and older persons; and

  (ii) the gender or gender identity, or the sexuality or sexual identity or orientation, of persons; and

  (iii) the particular needs of persons with disability; and

  (iv) in the case of persons of Aboriginal or Torres Strait Islander descent—the persons' traditional beliefs and practices and, when practicable and appropriate, involve collaboration with health workers and traditional healers from their communities; and

  (v) the cultural and linguistic backgrounds of persons;
- *amongst other principles (see Mental Health Act s7 for the full list).*

- (vi) the background, circumstances and particular needs of persons who have experienced torture or trauma
- Mental Health services and officers should provide regular medical examination of every person's mental and physical health and provide information in a way this it is understood by those to whom it is provided as far as possible; and
- Mental Health services should take into account Aboriginal and Torres Strait Islander descent, age, cultural and linguistic background and experience of torture and trauma.

The Act determines and provides functions to named classes of people (known as Officers). Of note are the functions and powers assigned to the Director of a Treatment Centre. The Director of a Treatment Centre is defined in the Act as the senior officer in charge of the mental health services of the Centre.

For the purposes of the Act a Treatment Centre can be either:

- an Approved Treatment Centre which is defined as being able to provide treatment and care to voluntary patients and to people placed on a level 1, level 2 or level 3 inpatient treatment order, or
- a Limited Treatment Centre which is defined as being able to provide treatment and care to voluntary inpatients and to people placed on a level 1 inpatient treatment order.

In the Act the Director of a Treatment Centre has assigned functions and powers that include:

- ensuring the rights of people with a mental illness are upheld including being provided with copies of the relevant statement of rights and order and notify the Community Visitor Scheme of a request for a visit.
- Providing the guardian, substitute decision maker (medical agent), relative, carer or friend a copy of the relevant statement of rights and order and notify the Community Visitor Scheme of a request for a visit.
- the admission of a person to a Treatment Centre including where appropriate the transport of a consumer to a Treatment Centre.

The Chief Psychiatrist has also delegated additional responsibilities to the Director of a Treatment Centre which include:

- for someone on a Level 1 or 2 Community Treatment Order ensuring there is a mental health clinician assigned responsibility for monitoring and reporting to the Chief Psychiatrist on the patients compliance with the Order.
- Ensuring that a person on an interstate Community Treatment Order that is being provided treatment for their mental illness in South Australia is provided with a copy of their statement of rights
- Ensuring that a person from interstate who is placed on a South Australian Community Treatment Order is provided with a copy of their statement of rights

The Director of the Treatment Centre may delegate powers under the Act to staff of a Treatment Centre to undertake certain functions under the Act. This is separate to the usual clinical delegations that occur throughout mental health services.

It should be noted that the delegation of a Director of a Treatment Centre in the Act does not exclude a hierarchy of officers "in charge" of a Treatment Centre, meaning that there could be a Local Director at a site/Treatment Centre and overall Director for all sites/Treatment Centres within a Local Health Network.

Prior to 5 June 2017, the definition of a Director of a Treatment Centre was 'the person for the time being in charge of the centre or a person duly authorised to admit patients to the centre'. This resulted in the powers of a Director of a Treatment Centre being considered to be allocated to the Chief Executive Officer of the relevant Local Health Network who then delegated the power to their Clinical Director – Mental Health. In consultation with the Chief Executive Officers and the Clinical Directors this definition was amended. This meant that from 5 June 2017 when the changes to the Act came into force the definition changed to 'the person in charge of the mental health services of a centre'. In the usual organisation structure of mental health services these powers and functions are the responsibility of the Clinical Director – Mental Health.

This responsibility along with the potential for delegation of responsibilities from the Clinical Director to staff of a treatment centre was considered when reviewing the organisation charts and role descriptions.

2.2 Process

In August 2018 a memo was sent from the Chief Executive to the Chief Executive Officers of the Local Health Networks requesting information to assist in the consideration of the recommendations from the ICAC report. This information request included the provision of organisation charts for mental health services and role descriptions for staff in a management position or clinical lead position. Information and documents were provided by all five Local Health Networks (please refer to **Appendix 5** for a full list of the documents provided)

The organisation charts were reviewed to determine if the line of reporting for mental health services for clinical governance matters and administration of the Act was specified, implied or not stated.

In order to assess the role descriptions a check list was developed to determine whether the responsibilities for clinical care and administration of the *Mental Health Act 2009* were specified. A check was also made on whether knowledge of or experience with the Act was considered either an essential or desirable criteria to undertake the position. Of the role descriptions provided four positions located in CALHN and two located in CHSALHN were for positions that did not have clinical governance responsibilities. While they were reviewed and information on them was included in the individual LHN discussion, they were not included in the total figures in the Check List for the respective LHN.

2.3 Organisational Structure

CALHN - The higher level mental health executive structure diagram did not highlight the clinical accountability or the professional reporting line. There are however, separate professional reporting structures available for nursing, allied health and medical staff. CALHN noted in a response to a final draft report in February 2020, that their new mental health structure was due to be finalised.

CHSALHN provided one overall organisational structure for mental health. The document included three boxes which outlined where the operational, clinical and professional accountability rested for each level of their structure.

For Clinical Accountability it states that it rests with:

- At Team level - Team Consultant Psychiatrist
- At Regional Level - Regional Clinical Lead Psychiatrist
- At Whole of Service Strategic level - Clinical Director

NALHN provided a current and proposed organisational structure for mental health. The structure contained seven different reporting lines.

SALHN provided a current organisational structure for mental health. The structure contained four different reporting lines. It also included a text description of the reporting structure for allied health team mangers and nursing team managers which provides some clarity to the structure.

WCHN provided a copy of the endorsed organisational structure for CAMHS. The structure provided did not specify any differences in either clinical or professional reporting lines.

Each of the Local Health Networks had a different approach to developing an organisational structure diagram for mental health. They varied from having a small amount of detail in regards to clinical and professional reporting lines to having a lot of detail. One Local Health Network had separate structure diagrams for the professional reporting lines.

None of the organisation charts provided specified a reporting line for the administration of the *Mental Health Act 2009*. The reporting line for the functions and powers allocated to the designated Director of a Treatment Centre and any delegations from the director to staff of the treatment centre were not shown. This may be due to the assumption that this occurs as part of the clinical accountability reporting line. While it is logical to have responsibilities for administration of the Act in the same reporting line as clinical accountability it may be necessary to specify that this is the case in organisational structure diagrams at least initially to ensure there is no confusion.

It may be helpful when designing future diagrammatic representations of organisational structures to include a small text box that outlines that the administration of the *Mental Health Act 2009* follows the same line as overall clinical accountability

2.4 Mental Health Leadership Role Descriptions

The review of the role descriptions provided resulted in the initial conclusion that there was a lack of consistency in role descriptions not just between Local Health Networks but also between similar positions within a Local Health Network. This was a result of role descriptions having a variety of dates for their creation and subsequent review. Role descriptions are often only reviewed when a position becomes vacant and it needs to be updated for advertising, or there is a major restructure.

Positions within mental health services can have a variety of reporting lines. These include operational, professional and clinical. The number and type can vary often dependent on what the position has been designated as and the discipline of the position's direct line manager. Professional reporting can be to the direct line manager if the position is the same discipline or to a different position sometimes outside of mental health if the line manager is of a different discipline.

Table 2.1: Role Descriptions Statements Check List

Section being Checked	No	For
Reporting Line	1a	Clinical Governance
	1b	Management of the *Mental Health Act 2009*
Primary Objectives	2a	Clinical governance responsibilities
	2b	*Mental Health Act 2009* Management responsibilities - covered
Key Result Area	3a	Clinical governance responsibilities
	3b	*Mental Health Act 2009* Management responsibilities

General Requirements	4	Was administration of the *Mental Health Act 2009* mentioned in any other section of the role description
Essential Criteria	5	Was knowledge of or experience with the *Mental Health Act 2009* considered an essential criteria
Desirable Criteria	6	Was knowledge of or experience with the *Mental Health Act 2009* considered a desirable criteria

Table 2.2: Check List – Local Health Network Aggregated Percentage

Criteria No	LHN - Percentage				
	CALHN	CHSALHN	NALHN	SALHN	WCHN
1(a)	100%	100%	100%	91.6%	100%
1(b)	-	-	-	-	-
2(a)	100%	100%	100%	95.0%	80%
2(b)	-	-	-	-	-
3(a)	100%	100%	100%	95.0%	100%
3(b)	-	13.3%	-	5.0%	-
4	22.2%	20.0%	50%	38.4%	40%
5	22.2%	6.6%	-	7.7%	-
6	-	6.6%	-	-	-

On finalising the review (**see Table 2.2 above**) it was found that of the 46 clinical role descriptions and 10 duty statements – Head of Unit provided, only one had an overarching *Mental Health Act 2009* administration statement. The Duty Statement – Head of Unit – for the Outer South in the Southern Adelaide Local Health Network contained the following:

- Have responsibility delegated by the Clinical Director for the administration of the Mental Health Act within the unit.

The two Psychiatry role descriptions provided by the Country Health SA Local Health Network (CHSALHN) have a statement about specific parts of the Act but did not take into account the broader requirements for the administration of the Act.

There were examples of role descriptions for very similar positions within the same LHN having differences in accountability statements. Team Manager Roles are often multi-classified with separate role descriptions developed for the allied health, administration and nursing streams. One example of this was for two Team Manager Role descriptions that were provided both were allied health with one having a clinical accountability to the Clinical Director while the other did not.

The essential and desirable criteria for positions were reviewed to ascertain if knowledge of or experience with the Act was considered to be either an essential or desirable criteria. It was found that it was only included in a small percentage of the total role descriptions. Knowledge of relevant legislation was often mentioned but did not specify the *Mental Health Act 2009*

It is clear that currently there are very few role descriptions that have administration of the Act included in either the primary objective or key results areas. There are also a very small number that specify having knowledge or experience with the Act as either an essential or desirable criteria. While it may have been considered that the administration of the Act was covered in other areas, including a statement on the Act administration responsibilities in role descriptions would reinforce this requirement. While including having ‘knowledge of relevant legislation’ within either essential or desirable criteria could be seen to cover the Act, due to the impact of the Act in providing mental health services it is considered that knowledge of or experience with the Act should be specified as a desirable criteria.

2.5 Issues That Have Arisen that are Outside of Scope of Recommendation 2

Mental Health Act 2009

The Act does not specify an equivalent position to a Director of a Treatment Centre for Authorised Community Mental Health Facilities. However, it may be reasonably inferred that the responsibility for the administration of the Act lies with the local manager, and then the Clinical Director – Mental Health as the Director of the associated Treatment Centre.

The Director of the Treatment Centre may delegate powers under the Act to staff of a Treatment Centre to undertake certain functions under the Act. Currently the Act does not require notification to be made of this delegation to the Chief Psychiatrist nor does it require the delegation to be published.

Both of these issues may need to be looked at further to determine if there are any changes to the Act that need to be considered as part of the next review or if the issuing of a Chief Psychiatrist Standard or direction is required.

Actions Completed

Action Completed One

The Office of the Chief Psychiatrist has communicated to the Local Health Networks on a process to amend role descriptions of all staff of a Local Health Network:

- to mention the *Mental Health Act 2009,* in addition to the *Health Care Act 2008* and the *Work Health and Safety Act 2012* etc, in the general responsibilities section, and
- to explicitly mention the general powers and functions of the Minister and Chief Executive that are routinely carried out by clinical, administrative and management staff.

Action Completed Two

The Office of the Chief Psychiatrist has communicated to the Local Health Networks to amend the role descriptions of all clinical staff of a mental health service of a Local Health Network to have:

- Knowledge and experience of the *Mental Health Act 2009* as a desirable criteria.
- Carrying out and reporting on the use of powers and functions of the *Mental Health Act 2009* as a key function.

Action Completed Three

The Office of the Chief Psychiatrist has communicated to the Local Health Networks on adding a text box to organisation charts for Mental Health Services outlining the reporting line for *Mental Health Act 2009* administration.

Action Completed Four

The Office of the Chief Psychiatrist has communicated to the Local Health Networks on a process for role descriptions of relevant non-clinical staff to have mention of carrying out and reporting on the use of the Mental Health Act 2009 as a key function (for example: ward clerks, security guards, compliance officers etc).

The implementations of the above actions by LHNs should provide for meaningful alignment of *Mental Health Act 2009* and Clinical Governance responsibilities.

A qualification of the above work, is that it was undertaken prior to the implementation of 6 regional LHNs, many of which only have small mental health services which take direction in clinical matters and safety and quality from a central unit based in the Barossa, Hills and Fleurieu Local Health Network. Governance and reporting will be specifically reviewed when each regional area is inspected.

The implementation of the above governance changes will be reviewed by the OCP in the second half of 2020 with a check on structures and role descriptions, with a particular focus on regional areas.

ICAC Recommendation 3 – Communication of Mental Health Governance Responsibilities

The Chief Executive and the Chief Executive Officers implement a structure to routinely remind staff of the management structure in place at the site/facility level and the Local Health Network level; the assignment of responsibilities at the centre; and the expectations and responsibilities imposed upon each member of staff at the centre.

Matters for Consideration

- Current structures for each Local Health Network in each designated mental health site/facility that reminds staff of their responsibilities and lines of accountability.
- Current structures includes provision of information on responsibilities under the *Mental Health Act 2009.*
- Current arrangements for communicating changes to responsibilities and lines of accountability to staff in each Local Health Network.
- Potential changes required to Local Health Network intranet sites.
- Potential changes required to communication processes for Local Health Networks.
- Potential development of factsheet on staff's responsibilities under the *Mental Health Act 2009*.

Discussion

3.1 Introduction

Communication of governance responsibilities and lines of accountability can take many forms, including internet based information, communiques, newsletters, email updates or information placed on notice boards and as standing agenda items on team and management meetings. Currently, each Local Health Network has their own intranet site which includes specific mental health pages. These sites provide the opportunity to host information that is both mandatory for staff to read or is for information only.

Communications can be sent to remind staff to check the intranet site when there has been a specific update either via an email or by placing a reminder on a site specific notice board. Staff can also be provided information through electronic newsletters or communiques, these can either be as a regular occurrence or when an important change has occurred eg a change in governance or area of responsibility. In areas where staff have limited access to email the communique or newsletter can be printed and displayed on a notice board accessible to all staff.

In August 2018 a memo was sent from the Chief Executive, SA Health to the Chief Executive Officers of the Local Health Networks requesting information to assist in the consideration of the recommendations from the ICAC report. This included information on communication strategies and methods.

3.2 Communication - LHNs

The information provided by the Local Health Networks was limited in scope in that it mainly consisted of links to their intranet sites. Only SALHN provided an example of a communique or newsletter. The information provided was reviewed to determine the amount of information on *Mental Health Act 2009* responsibilities that was available for staff and what was available on broader clinical governance responsibilities. It was not possible to assess what type of information was placed on site specific notice boards. It may be determined that a further request for information to the LHNs may be required to better asses what communications have occurred through either a communique or newsletter.

CALHN

CALHN Intranet Site – Subpage - Mental Health –

- Sub Page – Mental Health Directorate – Information on organisational changes Clinical Services Capability Commitment to Care Links to Organisational Structures Population characteristics Single Service, Multiple Site service model
    - Sub Page – Workforce – link to role description page
    - Sub Page – Communications – process for sending out communications outlines the different types of communications – bulletins and staff forums included
- Sub Page – Training and Research on Mental Health – Link to Mental Health Training – links to Mental Health Training Centre page on SA Health website Link to Orientation document (no mention of the Act) does mention attendance at an orientation session information on the Act may be provided at these sessions.
- Mental Health Resources – provides link to Office of the Chief Psychiatrist on SA Health Intranet site

A review of the above pages was undertaken. It was noted that there was no mention made on any of the Mental Health specific pages of administration of the Act. There is a search facility available where you can search for information on the Act. The resultant pages are those that are hosted on the SA Health intranet site. The orientation document that was available on the intranet site for staff commencing work with CALHN Mental Health Services was reviewed but it did not contain any information on the Act. It should be noted that an orientation session is also held for new staff which may include information on the Act.

There were no other examples provided of other communication strategies, nor anything on information that is available on notice boards at specific sites. Therefore the findings are limited to just the intranet site.

CHSALHN

CHSALHN Share Point -

Our Organisation Subpage – Mental Health Home subpage

- Administration sub Page – has link to MH Act Forms – goes to Chief Psychiatrist web site
- Clinical sub Page has links to subpages on services provided by CHSALHN Mental Health
- Communication Page – has links to Mental Health Checks, includes the notification of the amendment of the Mental Health Act coming into effect on 5 June 2017. There were no other communications in 2017-18 that provided information on the *Mental Health Act 2009*.

There were no other examples of communication strategies provided. There was no evidence provided of information attached to notice boards at specific sites so at this stage are not able to make any findings on these. Subsequent to this review, new intranet sites are being created for the six regional Local Health Networks.

NALHN

Inside NALHN intranet site – subpage Mental Health

- Provides Link to *Mental Health Act 2009* on Mental Health page listed under general information and resources – links to SA Health site
- Links section on Mental Health page includes link to Office of the Chief Psychiatrist – page on SA Health intranet site

- Rights and responsibilities subpage of the Mental Health Page– provides link to new Chief Psychiatrist web site

Besides the general information and the description of the information available on the Chief Psychiatrist Website, there is no other information on administration of the Act. There were no examples of other communication strategies given.

SALHN
Example of Communique provided outlining changes to an interim Mental Health Executive governance group including topics for discussion and site of meetings. Newsletter also contained instruction that it was to be printed and displayed on notice boards within services.

Letter of response dated 21 September 2018 outlined in Attachment 2 that accountability for the administration of the *Mental Health Act 2009* had been amended to confirm Clinical Director responsibilities for the Act administration and delegation of the responsibility to Heads of Unit at each facility. It stated that communiques had been sent out to staff informing them of this change. The example of the communique provided did not contain this information so are unable to comment on the content of the communication.

SALHN Intranet
Contains Mental Health Services subpage – subpage Clinical Resources – provides links to the following documents:

- Summary of Amendments and Powers and Responsibilities of Medical Practitioners
- Fact Sheet – Authorised Officers
- Fact Sheet – Section 56 Care and Control
- Chief Psychiatrist determination – recording of the use of Section 56 Powers

Provides information on specific sections of the *Mental Health Act 2009*. Currently there is no general information provided on the overall administration of the Act responsibilities.

WCHN
WCHN intranet site – subpage – Child and Adolescent Mental Health Service

- Subpage of CAMHS page – Mental Health Act Amendments – provides the most information of all the LHN intranet sites. Gives information on the changes that occurred in June 2017
- Provides link to Chief Psychiatrist website

While it provides a lot of information on the amendments to the Act it does not give an overview of the responsibilities for the administration of the Act within a clinical setting on an ongoing basis. There were no other examples of communication strategies provided.

Summary

It is clear from the review of LHN intranet sites that there is very limited information available on the administration of the Act. It was also clear that the content of the LHN intranet sites and the modes of communication of information on mental health vary between the LHNs.

The communication of information between LHN services, Primary Health Networks, other Commonwealth funded services, General Practitioners and the general public has also been identified as a problem which is broader than the original scope of this recommendation (see 3.3 below). The current process for communication on mental health across the state is often not coordinated and linkages between Primary Health Networks, public mental health services, other Commonwealth funded services, and the general public are variable.

The development of an information section on the Act that could be added to LHN intranet sites is currently being developed. The intranet section will refer staff to the Chief Psychiatrist website for further information. A fact sheet on administration of the *Mental Health Act 2009* responsibilities is currently being drafted to be distributed to staff within the Local Health Networks.

3.3 Further action

In part some of this work could be overseen by communication officers in LHNs or the Department.

However the review indicated that there is a need for simple information that could be

- Included on intranet sites
- Be provided to new employees as part of orientation.
- Be updated to each employee each year.

While each service has a different structure, common elements of the package would include

- An organisational structure.
- Descriptions of the roles of each service unit.
- Descriptions of the clinical governance duties of key appointees: Clinical Directors, Heads of Units, Team Leaders, Heads of Discipline. Details of names and contacts details.
- Duties and accountabilities under the *Mental Health Act 2009*.
- Key professional duties and accountabilities to persons receiving services and their families.
- Public Sector Code of Ethics
- Duties under the *Independent Commission Against Corruption Act 2012*, and the use of the *Public Interest Disclosure Act 2018*.

Actions Underway

Action Underway One

The Office of the Chief Psychiatrist is developing wording for a short section on the administration of the *Mental Health Act 2009* that will be added to Local Health Network intranet sites

Action Underway Two

The Office of the Chief Psychiatrist is developing a fact sheet outlining the overall responsibilities for the administration of the *Mental Health Act 2009* which will be distributed to staff within each Local Health Network

Proposed Actions

Proposed Action Three

The Office of the Chief Psychiatrist will audit the existence and awareness of this material in each LHN in 2020. Should material not be available and effectively disseminated a Chief Psychiatrist standard on Staff Orientation and ongoing Education on governance and personal accountabilities will be developed and disseminated under the *Mental Health Act 2009*.

ICAC Recommendation 4 – Local Health Network Training

The Chief Executive direct all staff at facilities in a Local Health Network where mental health services are being delivered to undergo training, as may be agreed by the Chief Executive, Chief Psychiatrist and Chief Executive Officers, in the use of the Safety Learning System; the reporting obligations for staff under Commonwealth and State legislation and the relevant SA Health and Local Health Network policies and procedures.

Matters for Consideration

- Current training systems and resources available to Local Health Network staff for use of the Safety Learning System for reporting and management of patient incidents and consumer complaints.
- Current training systems and resources available to Local Health Network staff regarding reporting obligations and procedures under legislation and policy.
- Current training systems and resources available to Local Health Network staff regarding the *Mental Health Act 2009* and mental health clinical practice.
- Current projects underway by the Quality Information Performance Branch to consolidate SA Health training platforms into one system and to review Safety and Quality training content.
- System, facility and service-culture barriers to staff around reporting patient incidents and consumer feedback (including complaints) into the Safety Learning System.
- Recent Departmental and Local Health Network reviews of education and training systems and resources.
- Contrast between the requirements and impacts of quality reporting versus quality assurance.
- Current training obligations for compliance with the Patient Incident Management and Open Disclosure Policy Directive, and the Consumer Feedback Policy Directive including use of the Safety Learning System, obligations under legislation and policy, the *Mental Health Act 2009*, and mental health clinical practice.
- Options for improving training access and compliance.

Discussion

4.1 Training on the Safety Learning System

The Safety Learning System (SLS) is an application that enables all SA Health services to record, manage, investigate and analyse patient and worker incidents as well as consumer feedback[2].

There has been a significant further development since the ICAC Commissioner made his recommendation.

A SA Deputy State Coroner Inquest Finding was released in 2019 regarding the Chemotherapy Under Dosing that occurred in 2014. In that matter there was a delay in SLS reporting, concerns that an SLS in one hospital may not alert clinicians in another hospital, and multiple witnesses who claimed that they had not been trained in the SLS. In short similar issues were identified in the haematology setting to those that the ICAC Commissioner identified in mental health.

[2] 1. SA Health Safety and Quality Website https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/clinical+resources/safety+and+quality/safety+learning+system/safety+learning+system

The Deputy State Coroner considered the SLS system left a lot to be desired. The second recommendation in the Findings as summarised here, was that the current Safety Learning System (SLS) be abandoned and replaced by an adverse event reporting system that would enable immediate reporting of adverse events to various senior staff roles as well as the measures taken to rectify the underlying error.

The Safety Learning System as a result of the recommendation is undergoing a whole system review to respond to the recommendation from the Coroner and also to determine any limitations the system may have. The review is being conducted by an expert independent consultant versed in adverse event reporting and management, who is associated with Macquarie University NSW.

The ICAC Commissioners recommendation has been considered below in the context of SLS; however these are also generic considerations for any adverse event monitoring system that maybe in use. Issues of education about the system and responsibility to report will be issues to attend to regardless of the software product used. The issues that affected mental health are not unique and whole of health system education is needed.

SLS is part of the overall safety and quality system. The SA Health Patient Incident Management and Open Disclosure Policy Directive[3] reflects the requirement for all health services to have established systems for safety and quality improvement that focus on the timely reporting of all incidents and near misses and take action to reduce patient harm, to meet the requirements of the National Safety and Quality Health Service Standards (Standard 1 – Clinical Governance), and also the National Code of Good Medical Practice. This Code, like other health professional Codes, requires reporting of patient incidents (adverse events and near misses), active participation in systems of incident management and quality improvement, to improve patient safety.

The SA Health Policy Directive describes the roles and responsibilities of all staff. The Policy Directive requires the CE SA Health, to ensure that resources are available to enable implementation of incident management and open disclosure including the education and training of appropriate staff.

The SA Health Policy Directive requires the Chief Executive Officer or Chief Operating Officer of Local Health Networks and statewide clinical support services to have staff training programs in place for incident reporting, different types of investigation, appropriate escalation to senior managers, review and open disclosure of patient incidents, including the use of the SLS.

All staff involved with direct provision of services to patients must be able to report a patient incident into SLS, and be able to participate in the investigation of incidents. As per the SA Health Policy Directive staff must be aware of their responsibilities in reporting incidents, and providing an appropriate open disclosure response. All SA Health employees or persons who provide health services on behalf of SA Health are to comply with this policy directive.

Advice and training for SLS can be sought from the relevant Local Health Network (LHN) SLS Administrator or Managers of Safety, Quality and Risk, and additional information is included in the SLS guides ‘How to Report a Patient Incident’ and ‘How to manage a patient incident’.

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[3] SA Health Policy Directive https://www.sahealth.sa.gov.au/wps/wcm/connect/89e269804e341fb5b45ffcc09343dd7f/corrected+Patient+Incident+management+and+OD_final+29-9-17+.pdf?MOD=AJPERES&CACHEID=ROOTWORKSPACE-89e269804e341fb5b45ffcc09343dd7f-mMHe3ft

A range of SLS resources have been developed and are readily available on the SA Health internet including the above guides, SLS topic guides on reporting restraint and seclusion, and many other topics. As new resources are developed, these are provided to SLS Administrators who then circulate these to relevant staff.

The LHN SLS Administrators are responsible for 'setting' up new managers with the appropriate access to be able to receive automated email notification of any incidents reported within their area of responsibility. At this time, new managers are provided training about their responsibility to review, investigate and take action to reduce the likelihood of recurrence.

The interactive eLearning course available to all SA Health Staff is designed for completion by all staff, and introduces incident investigation and open disclosure.

A range of resources are readily available on the SA Health website including a guide to using the policy directive, guideline and toolkit[4].

All patient incident managers must acquire the skills and knowledge they require to fulfil their roles and responsibilities in patient incident management, including open disclosure, incident classification and SAC (severity assessment classification) rating, investigation, using SLS, escalation of serious incidents, and taking action to improve safety. The managers and staff of a Safety and Quality and Risk Unit or equivalent, including the designated SLS Administrators, can provide advice to staff and executives, and have a role in staff education.

While training is provided, it was not clear from discussions with Local Health Networks on the accuracy and consistency of record keeping about who has undertaken any training on the Safety Learning System. It will be proposed that Local Health Networks review how records are kept of Safety Learning System training to ensure there is a central record of who has been trained and when they have been trained.

4.2 Mental Health Act 2009 Training

The Office of the Chief Psychiatrist has a one FTE Principal Advisor – Training and Collaboration who undertakes training on the *Mental Health Act 2009*. The training provided varies dependent on if general training is required or if it relates to an officer authorised under the Act. Training for new authorised officers or new authorised mental health professionals is provided face to face. Refresher training sessions are offered either by a face to face session or video conference.

General training on the Act is offered as requested. This training is provided to the Community Visitor Scheme, Non-Government Organisations and General Practitioners.

<u>Authorised Officers</u>

Authorised Officers have limited powers under the Act to facilitate the assessment and/or treatment of a person. Requests to become an Authorised Officer are sent to the Office of the Chief Psychiatrist from Local Health Networks as well as other government and non-government agencies. Once the Chief Psychiatrist has made a determination on the suitability to become an Authorised Officer a three hour training session is provided.

[4] SA Health Toolkit https://www.sahealth.sa.gov.au/wps/wcm/connect/6376ca804e3df0d4950bddc09343dd7f/PIM+and+OD+guides+for+Toolkit%28V3%29.pdf?MOD=AJPERES&CACHEID=ROOTWORKSPACE-6376ca804e3df0d4950bddc09343dd7f-mMAkJF

Once this training has been provided, a notice can published in the South Australian Government Gazette. Due to their limited powers, notices are published under the type of profession rather than by their name. Refresher sessions are available if requested.

Training for this group does not have a regular schedule but occurs in response to a request. Attendance sheets for each session provided are filled out and a register is maintained of who attended.

Authorised Mental Health Professionals

Authorised Mental Health Professionals are senior mental health clinicians who must undertake additional training and continuing professional development to be able to carry out the role.

Training for new AMHPs is held over two days. These sessions are scheduled to occur four times a year. Potential new AMHPs are notified of the available sessions and must attend a training session prior to them being authorised.

The AMHP is registered for a three year period. In addition to training for new AMHPs, sixteen half day refresher sessions are also scheduled per year. In order for an AMHP to retain their registration they must attend two out of the sixteen sessions available per year.

A register of all AMHPs is kept and is monitored to ensure that once authorised AMHPs attend the two refresher sessions each year. In total an AMHP must have attended six refresher sessions during their three year registration. If an AMHP has not attended two sessions in a calendar year, contact is made with them to discuss why this has occurred. There is some flexibility in that under certain circumstances an AMHP can attend three sessions in a year but an AMHP is not able to leave it to the last year and attend all of their six sessions in the one year.

If after three years a person has not attend sufficient refresher sessions they are required to attend a full day session prior their authorisation being renewed. If a person upon completion of their three year term wishes to continue as an AMHP, an application signed by their manager and the relevant clinical director is submitted to the OCP. A check is made on their attendance at required training sessions prior to the form being submitted to the Chief Psychiatrist for authorisation.

4.3 Training for Reporting Obligations under Legislation

Staff who work within the public health system have a number of reporting requirements under legislation. These include

- *Children and Young People (Safety) Act 2017*
- *Health Practitioner Regulation National Law (South Australia) Act 2010*

SA Health released the Legislative Compliance Policy Directive and Policy Guideline in 2017. The directive outlines that SA Health must provide appropriate training to all personnel regarding their legislative obligations arising in the course of their employment roles or duties.

In regards to Legislation the following Local Health Networks have information on their intranet sites:

- CALHN has Procedure and Legislation Co-ordinators. A weekly update is sent out which includes any changes to relevant legislation.
- NALHN – Consumer Engagement, Risk and Compliance Unit has a compliance area that includes compliance with legislation

- WCHN – has a Legislation page on their intranet. The page includes recent legislative updates, provides updates on changes to legislation and a legislation register tool which includes compliance with legislation.

The SA Health Orientation Manual includes a section for discussion on relevant legislation.

Local Health Networks have a number of training requirements for staff which is considered mandatory. The exact requirement depends on the discipline of the staff with nursing, allied health, medical and administration having some differences in what is considered mandatory. All staff however are required to undertake Mandatory Notification training which covers reporting requirements under the *Children and Young People (Safety) Act 2017*. Staff are required to undertake this training every three years

Local Health Networks keep records of who has completed their mandatory training. The Women's and Children's Health Network updates their records on a monthly basis and makes them available through their intranet site.

4.4 Learning and Development in Public Mental Health Services

The Office of the Chief Psychiatrist has undertaken a project to identify learning and development approaches of the individual Local Health Networks for staff in mental health services. The project identified a number of issues that included a lack of oversight at a system level of training provided and to whom it is provided and the potential for providing the same training in separate LHNs without any level of awareness that this is occurring instead of potentially combining training across multiple LHNs which may be a better use of available resources.

An outcome from the project is the agreement from the Local Health Networks to develop an education and training framework to support the identification of priorities, current and future. The work will be led by the establishment of a Learning and Development Steering committee. The committee will also monitor the effectiveness of training programs offered Membership of the committee will include representatives from Local Health Networks, nominated staff member to represent each of the professional groups, Aboriginal mental health and lived experience.

Actions Underway

Action Underway Three

The Office of the Chief Psychiatrist has commenced the process for the establishment of a Training and Learning Steering Committee. The committee will lead the development of an education and training framework as well as monitoring the effectiveness of training programs offered. Membership of the committee will include representatives from Local Health Networks, nominated staff member to represent each of the professional groups, Aboriginal mental health and lived experience.

Action Underway Four

An independent review of the Safety Learning System has commenced. The review is in response to recommendations from the State Coroner's findings into the Chemotherapy under dosing in 2014. The review is being conducted by an expert independent consultant versed in adverse event reporting and management, who is associated with Macquarie University NSW.

Proposed Actions

Proposed Action Four

It is proposed that Local Health Networks maintain a report of training on the safety learning system to ensure there is a central register in each LHN of the names of staff who have undertaken training and when this training has occurred.

ICAC Recommendation 5 – Chief Psychiatrist Inspections

The Chief Psychiatrist review the use of the statutory power conferred on the Chief Psychiatrist under section 90(4) of the Mental Health Act to conduct inspections of an incorporated hospital, with a view to the Chief Psychiatrist exercising the power to conduct unannounced visits to facilities within Local Health Networks more frequently than in the past.

Matters for Consideration

- History of Chief Psychiatrist inspections.
- Outline of enhanced inspection regime since February 2018.
- Comparison with other inspection and investigation regimes.
- Chief Psychiatrist Standard – Inspections.
- Options for legislative changes.
- Options for inspection regime models.

Discussion

5.1 Purpose of Chief Psychiatrist Inspections

The *Mental Health Act 2009* recognises that people receiving mental health care, especially involuntary mental health care, require additional systemic protections to those afforded under the *Health Care Act 2008*, which provides for all-of-health safety and quality oversight, investigations and actions. As well as additional individual protections for people receiving mental health care, the *Mental Health Act 2009* provides for additional systemic oversight, investigations and actions through Chief Psychiatrist standards, Chief Psychiatrist inspections, and Community Visitor Scheme visits, inspections and advocacy.

The Parliament of South Australia differentiated the nature of the systemic powers of the Chief Psychiatrist and the Community Visitor Scheme in the Act as, respectively, clinical and community. This differentiation is supported by the independent *Review of the Community Visitor Scheme* (Julian Gardner, March 2019), meets the expectations of the community and health services for the role and function of both statutory offices, and is supported by the Office of the Chief Psychiatrist and the Community Visitor Scheme themselves. See section 6.1 of this Report for more detail.

The purpose of the Chief Psychiatrist inspection regime is to provide independent clinical oversight and review of mental health services across the State.

5.2 History of Chief Psychiatrist Inspections

The Chief Psychiatrist position and associated powers and functions, including those of inspection, commenced on 1 July 2010. From that time until the end of 2015, inspection powers were formally invoked once, with the Chief Psychiatrist and Office of the Chief Psychiatrist staff working on reviews, investigations and facility determinations with the collaboration of Local Health Networks for all other matters where inspections powers may have been relevant.

This practice reflected the shared understanding of the time of the respective roles and responsibilities of the Chief Executive SA Health, the Chief Executive Officers of the Local Health Networks and the Chief Psychiatrist.

By 2016, that shared understanding of roles and responsibilities had evolved and a number of matters were submitted to the Chief Psychiatrist for review, and possible investigation. Those matters deemed appropriate for investigation or inspection using the Chief Psychiatrist's inspection powers are outlined in **Table 5.1**.

Table 5.1 – Use of Inspections Powers in 2016 and 2017

Year	Matter
2016	Investigation of 5 incidents relating to individual patients.
	Review of the Oakden Older Persons Mental Health Service.
2017	Investigation of 4 incidents relating to individual patients.
	Determination of the new Royal Adelaide Hospital and the Jamie Larcombe Centre as Approved Treatment Centres under the *Mental Health Act 2009.*

5.3 Enhanced Inspection Regime since February 2018

The ICAC Report of 28 February 2018 made the recommendation that the use of Chief Psychiatrist inspection powers should be re-assessed, with a view towards carrying out more unannounced inspections. Since that time the Office of the Chief Psychiatrist has embarked on a more rigorous inspection regime, as outlined in **Table 5.2**.

From January to June the OCP used existing Safety, Quality and Risk Team staff to carry out inspections. The three Safety, Quality and Risk staff were able to carry out inspections at 0.2 FTE of their time, already having a full work agenda, and undertook an average of five inspections per quarter with the assistance of staff from the broader OCP.

For the July 2018 to September 2018 quarter, the OCP temporarily employed an additional 2.0 FTE clinical safety and quality officers from unexpected internal savings in 2018-19. The additional two staff worked with the existing Safety, Quality and Risk Team and the broader OCP to increase the inspections undertaken. The extra staff resources enabled the pilot enhanced inspection regime to be fully implemented, resulting in 13 inspections for that period.

In August 2018, the Deputy Chief Executive SA Health committed an extra $800,000 to the Office of the Chief Psychiatrist to address increased workload, which included a Senior Inspections Officer, at the ASO7 / RN3 / AHP3 level, which enabled the Office to assign an additional officer to the Safety Quality and Risk team to prepare for, carry out, write up and support the Local Health Networks to respond to, inspections.

In April 2019 the Office employed an additional 1.0 FTE Senior Inspection/Investigations Officer, above existing funding allocations, to satisfy the increasing demands of inspection and investigation work.

As of early 2019 the Office, in collaboration with the Infrastructure Directorate DHW and the Local Health Networks, had identified 103 sites requiring period inspection, including 41 inpatient wards and emergency departments across 13 Approved Treatment Centres, 14 Authorised Community Mental Health Facilities and 45 additional speciality community mental health services sites. The number of sites will vary slightly over time as facilities close and others open; see the current Official Listing – Chief Psychiatrist Inspection Sites (**Appendix 3**) for an up-to-date listing. This list has been used in this report to assess workload, however it is currently being updated with respect to regional sites.

The Chief Psychiatrist may also occasionally inspect other inpatient or community services, as required.

See section 5.8 of this Report for a discussion of the options for capacity and resources for the Chief Psychiatrist inspection function, and section 8b of this Report for more information about resourcing and options raised by the ICAC Report more broadly.

Information about the 43 inspections undertaken – locations, unannounced vs announced, and recommendation themes, and examples of recommendations are reported in the Office

of the Chief Psychiatrist 18-19 Annual Report, available on the OCP website page 43 onwards).

5.4 Chief Psychiatrist Inspection Protocol

The Office of the Chief Psychiatrist has developed and released the *Chief Psychiatrist – Inspection Protocol* to provide clarity, certainty and guidelines for the use of inspection powers. The Protocol outlines:

- Legislative framework and powers.
- Inspection types, sites and teams.
- Inspection activation.
- Inspection processes.
- Inspection criteria.
- Inspection documentation, reporting and response.
- Interface with other inspections and visits.
- Implementation and monitoring.

The Protocol has been released as version 1 to provide consumers, carers, mental health services and inspections teams with guidance for the current inspection regime in place, and to facilitate reflection, discussion and feedback to the Office about what should be in version 2 of the Protocol. The Inspection Protocol is available on the Office of Chief Psychiatrist website. Along with this is the Investigations Protocol which defines matters considered for formal investigation.

5.5 Inspection Records, Reports, Responses and Follow Up

The OCP and the Safety and Quality Unit DHW have developed an Inspection Module in the state-wide Safety Learning System (SLS). SLS is an application that enables all SA Health services to record, manage, investigate and analyse patient and worker incidents as well as consumer feedback. The Inspection Module documents and supports the inspection process from end to end with the draft inspection reports through to completion of recommendations by the site inspected.

The Inspection Module enables the OCP to record inspection findings directly into SLS and produce standardised inspection reports which are provided to the service inspected. A key benefit of the Inspection Module is the ability to track inspection recommendations and the status of their completion, including a dashboard report able to identify different sites in each Local Health Network.

This innovative approach will also enable the analysis of inspection data, by both the OCP and Local Health Networks, in the future as the number of inspections and learnings captured increases. The ability to build a profile of a service by combining clinical incident data, inspection reports and client feedback and complaints shows promise and is currently being explored.

5.6 Chief Psychiatrist Investigations

The Chief Psychiatrist can also use their powers of inspection to undertake investigations of either individual consumer matters or broader system matters. During 2018-19 the powers of inspection were also delegated to clinical experts independent to SA Health to assist in the provision of specialist advice. In 2018-19 there were 7 investigations. Details are described in the 18-19 Annual Report, page 49.

In addition, the OCP:

- Provided support to CALHN in their commissioned review into Inpatient Rehabilitation Services (now complete).
- Funded the training of 12 SA Health staff from across the OCP and the LHNs in Certificate IV Government Investigations, enhancing capacity across the sector to carry out investigations using effective formal methodology.

5.7 Inspection Regime Going Forward

The Office of the Chief Psychiatrist has been carrying out an enhanced inspection regime since February 2018, with learnings informing the commencement of the more formalised regime in November 2018. The first six months of the formalised regime from November 2018 to April 2019 have provided a snapshot of capacity, resources required and timelines.

To calculate what resources are required for an enhanced inspection regime going forward, the following data have been considered:

- Inspection data - 43 inspections over one year
- There are 103 unique sites needing inspection.
- If the same FTE were to conduct inspections at the same rate (43 per year) it would take 2.4 years to inspect all unique inspection sites. This will also depend on the number of follow-up visits required for sites that have already been visited, which will increase as more sites and issues are identified
- This has required the use of existing safety and quality staff (two staff) who have been diverted from other activities, and current additional staff in the unit (three staff for inspections and investigations) need funding confirmed.
- Funding would therefore be required to maintain current additional staffing for the existing frequency of inspection (all facilities over 3 years), or if necessary increase the staffing if a more frequent review of all facilities is required.

During the this period 1.5FTE – ASO7/RN3/AHP3 have been undertaking work to assist in investigations underway. This has limited their capacity to participate in the inspection program.

It is proposed that the Chief Executive consider the maintenance of current two extra positions.

5.8 Local Health Networks – Clinical Improvement Officers

Local Health Network mental health services provide inpatient, residential and community care across the state through a number of age-streamed services delivered over multiple sites. Mental health clinicians and services have a large number of care, documentation, professional, and legislative roles and responsibilities, and as part of the processes of this report, said that they need additional capacity to effectively undertake continuous quality improvement that incorporates evolving best practice, learnings from complaints and incidents, Departmental and Office of the Chief Psychiatrist requirements, and Coronial recommendations.

In the discussions about the ICAC recommendations for additional resources to the Chief Psychiatrist's Office, LHN representatives considered they needed additional resources as well to meet extra requirements. This feedback is to be provided to the Chief Executives of Local Health Networks to be analysed on a LHN by LHN basis. It can then be considered by each LHN in the context of the workloads of existing safety and quality and risk staff, the change roles of existing managers and the need to significantly improve safety and quality outcomes. The need for adequate quality improvement capacity will also be critical in the implementation of the Mental Health Services Plan 2020-2025.

Completed Actions

Completed Action Five

The Office of the Chief Psychiatrist has commenced a more comprehensive inspection regime of mostly unannounced inspections, recruiting inspection officers in excess of current funding to meet the expectations of the ICAC recommendations, the community and Parliament.

Completed Action Six

The Office of the Chief Psychiatrist has developed and published a Chief Psychiatrist Inspections Protocol to describe the purpose of inspections, who will carry them out, what they will look at and outline the processes for preparation, inspection, reports and follow-up.

Completed Action Seven

The Office of the Chief Psychiatrist and the Safety and Quality Unit have developed a module of the Safety Learning System to document inspection findings and recommendations, which is being used by the OCP. In the future, the module will be able to be used by Local Health Networks to document the progress of actions in response to an inspection.

Proposed Actions

Proposed Action Five

It is proposed that the Chief Executive Department for Health and Wellbeing nominate a preferred inspection regime model (two yearly vs three yearly inspections) and additional resourcing options.

Proposed Action Six

It is proposed that Local Health Networks review their own resourcing needs for quality improvement in mental health services.

ICAC Recommendation 6 – Community Visitor Inspections

The Principal Community Visitor review the use of the statutory power conferred on community visitors under subsection 51(3) and section 52 of the *Mental Health Act 2009* to conduct unannounced inspections and visits of facilities within Local Health Networks and treatment centres, with a view to community visitors exercising the power to conduct unannounced inspections and visits more frequently than in the past.

Matters for Consideration

- History of Community Visitor Scheme visits and inspections.
- Outline of enhanced visit and inspection regime since February 2018.
- Comparison with the visit and inspection regimes of other jurisdictions.
- Comparison with the visit and inspection regimes of other agencies in South Australia.
- Differences between the nature and function of a community visitor scheme and a clinical or legislative inspection regime.
- Options for reporting issues of concern and agency responses.

To assist with the review of ICAC recommendations 6 and 7, and the matters for consideration in both, the Office of the Chief Psychiatrist engaged Julian Gardner AM, (former Victorian Public Advocate who also established the Community Visitor Scheme in that State), to conduct a review of the Community Visitor Scheme (CVS) and propose actions in relation to:

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

Discussion

6.1 Purpose of Community Visitor Scheme Visits and Inspections

The *Mental Health Act 2009* recognises that people receiving mental health care need additional systemic oversight, investigations and actions, and differentiates those functions as:

- Chief Psychiatrist – standards, inspections, and promoting continuous service improvement, and
- Community Visitor Scheme – visits and inspections, advocacy, and referral of matters of concern.

Building on the discussion of this in section 5.1 of this Report, Julian Gardner in his *Review of the Community Visitor Scheme* of March 2019 found that:

- *"Community visitor schemes in South Australia and in other Australian jurisdictions were established to assist in discharging the duty of the state to protect vulnerable citizens. Mental illness can adversely impact on a person's cognitive and emotional capacity,*

making them less able to protect themselves and therefore more vulnerable to abuse and neglect".

- The CVS applies 'community standards', described as "*would I be happy with the care and treatment I observe if it were for my family member and are said to provide an early warning system for the Minister"*.
- "*It is not the CVS role to conduct clinical reviews and assessments of a facility or of the treatment provided. That is the role of the Chief Psychiatrist. The clinical nature of inspections conducted by the OCP differs from but complements those by the CVS. The effectiveness of the combination of inspections is ensured by the positive level of co-operation and collaboration between the two agencies which was evident".*
- *"I am satisfied that the combination of CVS and OCP inspections is sufficiently comprehensive"*.

6.2 History of Community Visitor Scheme Visits and Inspections

From its establishment in July 2011 until 4 June 2017, the Community Visitor Scheme was required under section 52 of the Act to carry out monthly visits and inspections of all approved treatment centres and limited treatment centres, with the capacity to make those visits announced or unannounced as determined by the CVS. Section 52 also provided for the CVS to make additional visits and inspections as required.

Since 5 June 2017, after the amendment of the Act, sections 52 and 53 require the Community Visitor Scheme to visit and inspect approved treatment centres, limited treatment centres and authorised community mental health facilities every 2 months, with the capacity to make those visits announced or unannounced as determined by the CVS. Both sections also provided for the CVS to make additional visits and inspections as required.

Prior to the ICAC Report, the CVS visit and inspection regime was structured to address issues that were found during a visit, or that were reported over the phone or via email, through collaboration with the health service concerned, with follow up during the next scheduled visit.

In 2017-18, the Community Visitor Scheme made 179 visits and inspections to the 15 approved treatment centres and 14 authorised community mental health facilities that were determined via the Gazette during that period. Most visits and inspections attend multiple units within a health facility, including the different mental health wards and the emergency department. From those 179 visits and inspections, 95 issues of concern were raised with health service management for attention. Of those issues raised, 71 (75%) had been resolved by the end of 2017-18.

For more information see the *Principal Community Visitor Annual Report 2017-18*.

6.3 Enhanced Visit and Inspection Regime since February 2018

Since the release of the ICAC Report in February 2018, the CVS has explored options for, and been incrementally increasing, the number of unannounced visits conducted. Since October 2018 the CVS has undertaken 55% of the required bi-monthly visits to mental health facilities as announced inspections, and 45% as unannounced inspections.

The CVS has been reviewing the effectiveness of increased unannounced visits and inspections and feedback has been received from Community Visitors and staff in the mental health facilities as to the pros and cons of unannounced visits.

Whilst the overall the feedback from the mental health facilities has been positive in regards to the increased unannounced visits, the increase in unannounced visits has found some disadvantages including:

- Lack of availability of unit management or senior staff at the time of visit.
- Some of the CVs have felt uncomfortable with unannounced visits as they have established good working relationships over the years with staff.
- Less engagement with consumers as they may be involved in activities.
- Less engagement with carers and family members, and
- Consumers have less/no time to consider items for discussion with CVs.

The CVS has not conducted unannounced visits to Authorised Community Mental Health Facilities (i.e. non-inpatient services) as CVS visits are relatively new to these services and to ensure the greatest engagement with consumers it was decided that unannounced visits would not be helpful.

This needs to be seen in the context of the significant development and notices that have been forwarded to services prior to announced visits. Once the visit date and time has been confirmed with the service, they are sent a poster notice and requested to 'post' this up in the common areas of the unit where clients and families will see it and this specifies when the CVs are coming together with a brief explanation of role and function of the CVS.

In addition, Julian Gardner found:

- *"That since the delivery of the ICAC Report improvements have been made in the practices and procedures of the CVS and in the OCP, including in the conduct of unannounced inspections. The CVS procedures for recording and following up matters of concern have been enhanced and it is reported by the Principal Community Visitor that the responsiveness of responsible authorities with whom those concerns are raised is much improved."*
- "*I have examined the inspection protocols, the processes and the reports used in the CVS and find that they are appropriate to the role. The protocols and their documentation are complete and appropriate. They provide as much guidance as possible to enable issues to be identified and reported upon."*
- *"While there are some drawbacks in the use of unannounced visits, I am of the view that a mixture of announced and unannounced visits should be maintained. The process for resolving issues applied by the CVS is methodical, timely, has appropriate steps for the escalation of serious or urgent matters and ensures that the appropriate persons do provide a response".*

6.4 Comparison with the Visit and Inspection Regimes of Community Visitor Schemes in Other Jurisdictions

The nature, composition and role of Community Visitor Schemes across Australian jurisdictions varies in accordance with legislation and the other visit and inspection regimes that operate in that state or territory. In particular, the nature of CVS inspections across the states varies from: a review from a community perspective, to a review of compliance with policies and standards, to a review of the standard of care, depending on the vigour of the inspection regime of that jurisdiction's Public Advocate, Chief Psychiatrist or Departmental Inspectors.

In South Australia, with the Chief Psychiatrist's clinical inspection powers and the Health and Community Services Complaints Commissioner complaints investigation powers, the CVS inspections powers have been implemented as a review from a community perspective.

The Gardner review found:

- *"Community visitor schemes in South Australia and in other Australian jurisdictions were established to assist in discharging the duty of the state to protect vulnerable citizens.*

Mental illness can adversely impact on a person's cognitive and emotional capacity, making them less able to protect themselves and therefore more vulnerable to abuse and neglect".

- "*The CVS undertake independent inspections or checks on services to ensure clients are being treated with dignity and respect and those services are responsive and appropriate to client needs and clients have been provided with information about their care and support."*
- *"This is not to say that CVs in the performance of their functions, will and should consider matters that can be said to be within the compass of clinical operations. Elements of care that may be considered by CVs could include, for example, the rates of the use of seclusion, the opportunity for patients to have input into their care plans, the provision of activities, whether the facility has a welcoming atmosphere, whether the staff are accessible and some aspects of safety."*
- *"It is not the CVS role to conduct clinical reviews and assessments of a facility or of the treatment provided. That is the role of the Chief Psychiatrist. The clinical nature of inspections conducted by the OCP differs from but complements those by the CVS. The effectiveness of the combination of inspections is ensured by the positive level of co-operation and collaboration between the two agencies which was evident".*

It is proposed that the combination of the CVS inspection regime from a community perspective and the OCP inspection regime from a clinical one is appropriate and effective when compared to the inspection agencies and regimes of other jurisdictions.

6.5 Referral and Collaboration with other South Australian Regimes

There has also been a significant improvement in the collaboration and structured meetings between the CVS and other statutory bodies who have powers and functions within the mental health sector and the PCV would like to acknowledge the:

- Chief Psychiatrist,
- Health and Community Services Complaints Commissioner (HCSCC),
- Office of the Public Advocate (OPA), and
- South Australian Mental Health Commissioner.

Memorandums of Understandings (MoUs) between the CVS and the OPA and HCSCC have been revised and there is further exploration occurring in relation to the CVS being able to visit all those under the Guardianship of the Public Advocate.

Julian Gardner found that the collaboration and referrals between the CVS and the OCP relating to their inspection regime have significantly improved.

The PCV also believes that the mental health sector as a whole has reflected on the events at Oakden, the Chief Psychiatrist's Report and the ICAC Report, and is far more conscious of their responsibilities. In particular, Local Health Networks responses to the CVS visit reports, and inclusion of matters raised as continuous improvement strategies, has improved considerably.

6.6 Records, Reports, Responses and Follow Up

Since the release of the ICAC Report in February 2018, the CVS has examined and strengthened its processes in regards to communicating and following up issues of concern with the relevant agencies.

The CVS uses an Issues Tracking document to record all issues raised during visits and inspections, and all follow up and responses are documented. A monthly email with all CVS

visit reports and issues identified are then sent to each LHN Mental Health Director seeking responses to all.

The CVS has also re-established regular quarterly meetings with the Mental Health Directors of each LHN, which has enabled a greater opportunity to review the visits undertaken, issues raised and give consideration to addressing any systemic matters. The CVS can report that the responsiveness of the LHNs to issues raised has vastly improved over the past 18 months and the LHNs are treating their governance and responsibilities more seriously.

Where significant issues of concern are raised with the CVS, these are now escalated to the Chief Psychiatrist or Minister for Health and Wellbeing as soon as possible.

The CVS also ensures that meetings with Ministers, Statutory Officers and LHN management have agendas and records of meetings confirmed.

Julian Gardner found:

- That there were not any processes in place in other jurisdictions that could be adopted for the betterment of the CVS.
- *"The processes in place to meet the CVS role are appropriate. The protocols and their documentation are complete and appropriate. They provide as much guidance as possible to enable issues to be identified and reported upon."*

Resolution of Issues

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

- Any issues suitable to be raised at the time of the visit are raised with senior staff of the facility. At the same time any outstanding issues from a previous visit are followed up and any concerns about obstacles to the inspection are raised.
- If serious issues are identified CVs are required to call the CVS office immediately.
- Issues identified at the visit are reported in the written Visit Report Form. These are all entered into a Tracking Register which records details of the issue, the actions taken, and the time for follow up.
- All issues raised in Visit Report Forms are "triaged" in the CVS office. Any serious or urgent matters are brought to the attention of the PCV. A decision is then made as to whether it needs to be raised immediately with the Local Health Network, the Chief Psychiatrist or the Minister.
- All outstanding issues are reported monthly to the Director of Operations and/or Clinical Director of each Local Health Network. A response is requested in two weeks. Importantly, monitoring and updating of the Tracking Register ensures that outstanding responses are pursued. All visit reports are forwarded monthly to the Directors and also to the Unit managers.

A useful example of the effectiveness of this process for resolving issues was that in relation to the concerns raised by CVs in mid-2018 about the mix of general and mental health patients in Ward 4GP at the Flinders Medical Centre. Within a week of the visit the PCV emailed the Chief Psychiatrist detailing concerns. The Chief psychiatrist conducted an inspection six days later and made recommendations based on that visit and incident data that have been implemented.

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

- Quarterly with the Director of Operations in each of the five Local Health Networks.

- Every two months with the Chief Psychiatrist, and
- Every two to three months with the Minister.

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

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

6.7 Community Visitor Appointment

The Act requires that there be a Principal Community Visitor, and a sufficient number of Community Visitors, to carry out the legislated functions and powers of the CVS. The Act provides that a term of appointment for the PCV and the CVs cannot exceed three years but that a PCV or a CV can be re-appointed once their term has expired.

Previously, the CVs were given three year appointments, with earlier revocation should a CV need to resign or retire from the Scheme.

Since the ICAC Report however, CVs have been granted one year appointments only, pending the review of matters raised in ICAC Recommendations 6 and 7. While appropriate, this has caused some additional work which is not necessary any more.

It is proposed that, given the findings of this Final Report, the terms of appointment for Community Visitors should once again be three years.

Completed Actions

Completed Action Eight

The Community Visitor Scheme has established an inpatient visit and inspection regime with 50% of inspections carried out as unannounced, to enable the review of a service as it is operating at that point in time, and 50% of inspections carried out as announced, to enable full consumer, carer and staff participation.

Completed Action Nine

The Community Visitor Scheme has revised and strengthened its processes for resolving and referring issues that come to its attention.

Proposed Actions

Proposed Action Seven

It is proposed that the combination of the CVS inspection regime from a community perspective and the OCP inspection regime from a clinical perspective, given their increased cross-referral and collaboration, is appropriate and effective.

Proposed Action Eight

It is proposed that the terms of appointment for Community Visitors should return to be three years.

ICAC Recommendation 7 – Community Visitor Training and Qualifications

The Minister for Mental Health and Substance Abuse (the Minister) cause a review to be conducted of the Community Visitor Scheme (CVS) to determine whether the CVS should be amended to:

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

Matters for Consideration

- Current training provided to Community Visitors.
- Current qualification requirements for Community Visitors.
- Current qualifications of existing Community Visitors.
- Comparison of Community Visitor Scheme qualification requirements and training regimes from other jurisdictions.
- Options for Qualification and Training Requirements.

As described in section 6 of this Report, the Chief Psychiatrist engaged Mr Julian Gardner AM, former Public Advocate of Victoria who also established the Community Visitor Scheme of that state, to review the qualification and training needs of South Australian Community Visitors.

Discussion

7.1 Current Community Visitor Training

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

- Module One: Introduction, Overview and History of the Community Visitor Scheme
- Module Two: Role, Functions and Scope of the Community Visitor Scheme
- Module Three: CVS Visits and Inspections
- Module Four: Practical Matters for Community Visitors
- Module Five: Lived Experience
- Module Six: Mental Health
- Module Seven: Communication Strategies
- Module Eight: Disability
- Module Nine: Dual Disability and Gender Safety
- Module Ten: Cultural Competencies, and
- Module Eleven: Values Testing for Disability and Mental Health.

The training is then followed up by a minimum of two orientation visits with the Principal Community Visitor, including a contribution to the visit report for the first visit and then the drafting of the visit report for the second visit. All of the above is assessed by the recruitment and training officer and the Principal Community Visitor prior to a final interview where there is a decision made whether to proceed to appointment or not.

All new Community Visitors are partnered with more experienced and qualified Community Visitors for at least the first 12 months, and where performance issues have been identified, by the Principal Community Visitor.

Ongoing training and support is provided including regular 'Reflective Practice' sessions that enable Community Visitors to share experiences and challenges encountered during visits, ideas on what works for them and provide peer support to one another. The Scheme also supports Community Visitors to attend other relevant training that may arise from time to time. All Community Visitors are required to attend an annual performance review meeting with the Principal Community Visitor.

All training conducted by the CVS has a focus on seeking individual feedback from each participant and this is collated and analysed by the Training and Recruitment Officer.

7.2 Current Qualification Requirements for Community Visitors

There is no legislative or policy requirement for particular qualifications for Community Visitors. The Community Visitor Scheme, the Department for Human Services and the Department for Health and Wellbeing have agreed on a volunteer model for the CVS, with volunteers drawn from diverse backgrounds and qualifications, to provide a broad community perspective. To enable that broad perspective to be available, no minimum qualifications have been set for Community Visitors.

However, the selection, training, orientation and screening process for new Community Visitors is rigorous. Of the 38 people who applied to be a Community Visitor in 2017-18, only 10 were successful and were recommended for appointment by the Governor.

The Community Visitors have impressive backgrounds, skills and passion that have helped to deliver the Scheme's key outcomes at a very high level. They are aged between 25 and 82, come from a diverse range of cultural and social backgrounds, and can speak 17 languages between them. Community Visitors have achieved the qualifications listed in **Table 7.1**.

Table 7.1 – Qualifications of Community Visitors

Level of qualification	Number of Community Visitors
Bachelor - Social Work, Social Sciences, Psychology, Arts, Architecture, Civil Engineering, Economics, Law	33
Cert 4 – Mental Health, Tourism, Training & Assessment, Drug & Alcohol	18
Diploma – Social Sciences, Education, Counselling, EN, Marketing	18
Cert 2 – Community Services, Auslan, Business, Retail	8
Masters – Social Work, Law, Business Admin, Disability	8
Cert 1 – Assessment & Workplace Training, Hospitality, Counselling	6
Grad Dip – OH&S, Education, Technology	5
Bachelor Hons	4
Cert 3 – Small Business Management, Disability, Training & Assessment	3
Grad Cert – Disability, Tertiary Teaching	3
Mental Health First Aid	3
PhD	2
Senior First Aid	2
Advanced Cert - Accounting	1
Advanced Dip	1

Assoc Dip - Social Work	1
Registered Nurse	1

7.3 Review of Training Requirements

A review of training regimes for Community Visitors across jurisdictions indicates considerable consistency with training and support provided. All schemes have in place a 2-3 day training program, 2-3 orientation visits, regular collaborative training and support events, sponsorship to attend relevant training programs, and annual reviews of Community Visitor performance. See **Table 7.2** for detailed information.

Table 7.2 – Training Requirements in other Jurisdictions

State	Training Regimes
ACT	Annual training day. Support to attend regular training both in the ACT and NSW.
NSW	Two observation visits are conducted prior to a 3 day face to face training program. OVs undergo performance appraisal mid way through their first term, based on competency standards. A 2-day conference is conducted annually. OVs are required to participate fully in all training activities and annual conferences
NT	Provided an orientation checklist and required to attend a 2 part training sessions. Workplan & training plans are developed and monitored through Line Supervision for FTE staff on monthly basis
QLD	CVs are given a full induction of the role and detailed information about the Office of the Public Guardian (OPG). Required to participate in training and seminars, professional development workshops and participate in performance reviews at six month intervals.
TAS	One day initial training session followed by attendance at two or three observation visits. One day follow up training followed by mentoring for next two visits. Additional training get together meetings throughout year.
VIC	Comprehensive induction, stream specific & report writing training and attend regular other training on topical issues (optional)
WA	New Advocates have a 4 day in-house training program with some required pre-reading time in addition, must complete the 4 hour e-learning program on the Act and a 30 minute Aggression Prevention Training e-learning module. Attend at least one Tribunal hearing. Participate in orientation visits.

Julian Gardner found:

- *"The content of any training for a specific role must be directly related to the nature of that role. Clearly it is not necessary to a CV's role for them to be trained to the level at which they are capable of providing mental health care. Nor is it necessary for CVs to be trained to the level required to conduct a clinical review of the service. They do, however, need a broad understanding the most common types of mental illness, of symptoms and how the symptoms of illness may impact on interactions between visitors and patients. They also need to understand the ways in which communication with patients can be made the most effective. Training in the provisions of the MHA as they relate to involuntary treatment and the rights of patients under the MHA is also necessary. Such matters are currently provided in the training."*
- *"In conducting a visit CVs need to be able to process what they observe through the lens of an appropriate standard. What have been described as "community standards" are adequate to assess a wide range of matters. These include, for example, access to rights information, access to rights of review, cleanliness, some aspects of safety, capacity to communicate with family, ease of communication with staff, quality of food and the like. A patient's understanding of their care plan or the degree of input into it can be ascertained by skilful communication."*
- *"However, a question raised by the Commissioner's recommendation is whether CVs have sufficient knowledge of what should be expected in an appropriate level of care. What, for example, should a patient expect in terms of frequency and ease of contact*

with a consultant psychiatrist, to what extent should the nursing staff have specialist qualifications, what facilities should be available for providing different levels of sensory stimulation, what non-pharmacological therapies should be provided and so on. In essence there is a need to know what, by reference to current best clinical practice, should be the expected standards of care and treatment."

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

It is proposed that the Principal Community Visitor and the Office of the Chief Psychiatrist develop an additional training module and resource for Community Visitors regarding the standards of mental health care that should be expected in different services.

7.4 Review of Qualification Requirements

A comparison of the Community Visitor Schemes and equivalent programs of other Australian jurisdictions is summarised in **Table 7.3**. Five of the eight schemes do not require visitors to have any mental health qualifications. The other three schemes combine qualified staff (medical or legal) with visitors from a range of backgrounds and qualifications to undertake visits. Most States encourage applications from individuals with some lived experience.

Table 7.3 – Qualifications Required in other Jurisdictions

State	Qualifications
ACT	Appointees must be a legal practitioner who has not less than 5 years or a medical practitioner; or has been nominated by a body representing consumers of mental health services; or has experience and skill in the care of persons with a mental disorder or mental illness.
NSW	One CV in each panel (of two) required to be a medical practitioner or a suitably qualified clinical person
NT	Panel consist of three with two from a legal or medical profession
QLD	No formal qualifications
TAS	No formal qualifications
VIC	No formal qualifications
WA	No formal qualifications

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

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

The selection criteria for the CVs in South Australia are, in general terms, to their communication and observation skills and ability to advocate and prepare written reports.

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

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

- Attend an interview
- Participate in a two-day workshop
- Undertake a minimum of two orientation visits to facilities with the PCV and to prepare a written report after their second visit
- Participate in a final interview with the PCV and recruitment officer.

Julian Gardner found that the advantage of the CVS process is that there is ample opportunity to assess suitability during the two-day training and in practice with observations that can be made while visiting, including the capacity for report writing. These steps provide an opportunity to test the meeting of the selection criteria including knowledge of the mental health system. It is much easier to exclude applicants from appointment than it is to dismiss visitors after appointment.

Comments by the Principal Official Visitor in NSW have been high-lighted, where one of the two members of a visiting panel is a "clinical visitor", and where they stated that she would be concerned if both members of a panel were clinical visitors. She expressed the view that the combination was necessary to ensure that community standards as well as the principles in the legislation were applied.

Those interviewed in other jurisdictions shared the view that having visitors with mental health qualifications was not necessary to improve effectiveness. The WA program manager reported that problems had arisen with advocates who were clinical psychologists. However, it should be noted that the WA scheme is an advocacy program and the issue related to the model of advocacy sought to be applied there.

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

Observing and reporting on such matters does not, in Mr Gardner's view, require specialist mental health qualifications. For example, it is not the role of a CV to be critical of the use of seclusion per se. However, they may note that the rate of use of seclusion has noticeably changed or that it is outside expected standards. To report and raise concerns about such matters requires some knowledge of the system and good observational skills but does not require clinical expertise. That is the requirement of those to whom the CVs' concerns are reported.

In relation to training and qualifications, Mr Gardner's conclusions were that *"the current qualification requirements of the CVS are appropriate to the discharge of the role of the CVs"*.

Completed Actions

Completed Action Ten

A review of the training and qualifications required by Community Visitors has been carried out by Julian Gardner AM.

Actions Underway

Action Underway Five

The Community Visitor Scheme, in consultation with the Office of the Chief Psychiatrist, is developing a training session and resource on Mental Health Service Standards for Community Visitors to understand and assess the standard of mental health care in the services they visit and inspect.

Proposed Actions

Proposed Action Nine

It is proposed that Community Visitors do not require specific qualifications to carry out visits and inspections from a community perspective.

ICAC Recommendation 8a – Chief Psychiatrist Functions

The Minister cause a review to be conducted to determine whether the Mental Health Act should be amended to impose positive obligations on the Chief Psychiatrist to ensure:

- That public officers within the Local Health Networks delivering mental health services comply with their obligations under the Mental Health Act; and
- As far as practicable that an adequate standard of care is provided to persons with a mental illness who receive such care from a Local Health Network;

Matters for Consideration

- Current obligations of the Chief Psychiatrist relating to Act compliance.
- Current and possible options for arrangements for the prosecution of offences under the Act.
- Current obligations of the Chief Psychiatrist relating to the standard of mental health care.
- Current obligations relating to Act compliance and the standard of health care in the legislation of other jurisdictions.
- Current obligations of the Minister and Chief Executives relating to Act compliance and the standard of mental health care within South Australian legislation, policy and contract.
- Options available for positive obligations relating to Act compliance and the standard of mental health care.

Discussion

8.1 Chief Psychiatrist's Obligations relating to Act Compliance

The context of this section is that the statutory obligations of the Chief Psychiatrist role are regulatory functions, while the operation of services is under the governance of local health network Boards. The Department is a system manager and funder. Obligations for all parties including the Minister are defined in the *Mental Health Act 2009.*

While the Minister for Health and Wellbeing is ultimately responsible for the proper administration of the Act, every officer with powers and functions under the Act shares the responsibility in relation to their powers and functions. For example, a mental health clinician is responsible for the proper administration of their functions, such as being responsible for the care of a person subject to a Community Treatment Order, making a patient assistance request, making a patient transport request or applying to SACAT for the making of certain Treatment Orders. The Director of a Treatment Centre has many more powers and functions – relating to the rights of patients and carers, admitting patients, setting limits and conditions to communication and visitation, applying to SACAT for the making of Treatment Orders, making notifications to the Community Visitor Scheme, and granting and revoking leave – and shares a greater responsibility for the proper administration of the Act. While every officer and service with powers and functions under the Act is responsible for the proper administration of the Act, the Chief Psychiatrist has specific and significant powers and functions relating to the administration of the Act, and is responsible statewide for the provision of advice, inspections, instructions, monitoring, reports, resources, standards, support and training.

The Chief Psychiatrist does not have any positive statutory obligation to take any action for non-compliance with the Act. However, as a statutory officer, the Chief Psychiatrist must be diligent and exhibit the highest standard of conduct in the discharge of their office. Therefore, to carry out the explicit and implicit requirements of their powers and functions to monitor the administration of the Act and promote the continuous improvement of mental health services, the Chief Psychiatrist should take appropriate action relating to Act non-compliance. The form of such action will vary according to the nature of the non-compliance, and can include

providing advice, support or training to an individual or team, releasing instructions or a Standard for a broader issue to ensure compliance, or, for more significant matters, writing formally to a Chief Executive Officer or making a report to the Health and Community Services Complaints Commissioner or AHPRA.

In summary, the existing powers, functions, and statutory nature of the role empower the Chief Psychiatrist with an adequate obligation, from a legislative perspective, to promote compliance with the Act. However, if greater clarity and certainty is required by the public, health services and the Parliament, section 8.4 of this Report describes additional options.

8.2 Chief Psychiatrist's Obligations relating to the Standard of Mental Health Care

Every employee, contractor and volunteer of a health service is responsible for the standard of the mental health care they provide, as reflected in their role descriptions, policy and procedure, their professional codes of conduct and, at the broadest level, the common law principle of duty of care. In addition, each Local Health Network has identified clinical governance, safety and quality pathways, policy and procedure, and accreditation processes with systemic responsibility for the standard of mental health care. Finally, legislation assigns specific responsibility for some actions, which impact on the standard of mental health care, to specific individuals or groups, who are then responsible for those actions.

Responsibility to ensure the appropriate standard of patient care and service delivery under section 7 of the *Health Care Act 2008* was devolved from the Chief Executive of SA Health to the Governing Boards and Chief Executive Officers of the Local Health Networks on 1 July 2019. An analysis of the obligations of the Minister, the Chief Executive, the Governing Boards, the Chief Executive Officers and the Chief Psychiatrist relating to these matters can be found in section 8.3 of this Report.

Within this broader framework of responsibility, the Chief Psychiatrist has specific obligations for the standard of mental health care which come from the intersection of key powers and functions, comprising:

- Promote the continuous improvement of mental health services.
- Monitor the treatment of patients, the use of restrictive practices, the administration of the Act and the standard of mental health care.
- Issue standards for the treatment and care of patients.
- Conduct inspections of public and private hospitals.

The function to promote continuous improvement is supported by the powers to monitor, set Standards and conduct inspections, which create an effective matrix for the Chief Psychiatrist as a regulator to influence the standard of mental health care across the State.

The Chief Psychiatrist powers and functions as a regulator interface with the responsibilities of the Local Health Networks as the operators of mental health services, and the individual, system and organisation responsibilities for the standard of mental health care.

In summary, the existing powers and functions of the role empower the Chief Psychiatrist with an adequate obligation as a regulator to promote the continuous improvement of mental health care. However, section 8.4 of this Report describes additional options.

8.3 Obligations of the Minister, Chief Executive, Governing Boards and Chief Executive Officers

There are a number of current obligations relating to the standard of health care that are the responsibility of the Minister, the Chief Executive of SA Health, and the Governing Boards and

Chief Executive Officers of the Local Health Networks. These obligations are found in the *Health Care Act 2008* and the *Mental Health Act 2009*, as outlined in **Table 8.1** below. It should be noted that some of the provisions relating to the Chief Executive and Service Agreements are still at the Bill stage in Parliament and may be amended or not passed.

In summary, the Minister is responsible for establishing evaluation and review mechanisms, and accountability systems; the Chief Executive is responsible for overseeing, monitoring and promoting service improvement, developing and issuing policy, and monitoring LHN performance; Service Agreements must specify the standard of services; Governing Boards are responsible for ensuring clinical and corporate governance to maintain and improve standards of care, and manage performance against the Service Agreement; and the Chief Executive Officers must carry out Governing Board obligations on their behalf. The Chief Psychiatrist has powers to: promote continuous improvement, monitor, issue standards and conduct inspections.

Table 8.1 – Current Obligations – Act compliance and standard of mental health care

Minister *Health Care Act 2008*, subsection 6(1)(j) • Establish mechanisms to evaluate and review the policies and standards of health and health services. *Mental Health Act 2009,* subsection 86(f) • Develop/promote accountability systems for mental health services.
Chief Executive *Health Care Act 2008* (previously proposed amendments, subsections 7(1)(i), 7(1)(j) and (7(1)(k)) • Oversee, monitor and promote improvements in the safety and quality of health services • Develop and issue policies and directives • Monitor the performance of incorporated hospitals and take remedial action if targets are not met
Service Agreements Health Care Act 2008 (previously proposed amendments, subsection 28B(2)(a)) • Service agreements must specify services to be provided, including the standard of services
Governing Boards *Health Care Act 2008*, subsections 33(2)(a) and 33(2)(g) • Ensure clinical and corporate governance to maintain and improve standards of patient care and services • Manage performance against performance measures in the service agreement.
Chief Executive Officers *Health Care Act 2008*, section 33E • Carrying out the operations on behalf of and at the direction of the Governing Board.
Chief Psychiatrist *Mental Health Act 2009*, section 90 • Promote the continuous improvement of mental health services. • Monitor the treatment of patients, the use of restrictive practices, the administration of the Act and the standard of mental health care. • Issue standards for the treatment and care of patients. • Conduct inspections of public and private hospitals.

This matrix of obligations includes a range of functions at the broad all-of-health level, which are adequate from an overall system management and legislative perspective. However, apart from the Minister's power to develop accountability systems for mental health services, and the Chief Psychiatrist powers to promote continuous improvement, monitor, issue standards and conduct inspections, most functions remain at the broad level and could be specified

further, particularly considering the greater need for protections when care can be given involuntarily.

Positive obligations for ensuring compliance with the *Mental Health Act 2009* are not explicit for any person or agency, including the Minister, the Chief Executive, the Governing Boards, the Chief Executive Officers and the Chief Psychiatrist. Instead, it is the reasonable expectation of the community, sound management practice, Common Law and the Parliament that any individual or service with powers and functions under an Act will ensure compliance with that Act. However, the principles of system dynamics demonstrate that problems are more likely to arise, and more likely to be more significant, in any system where multiple parties are jointly responsible, with the risk that individual parties do not act assertively with full accountability, as evidenced by the Oakden investigations. To manage this risk, a system requires clear points of accountability and responsibility. While the lack of explicit responsibility for Act compliance may be adequate from a legislative or reasonableness perspective, the following options are proposed:

8.4 Options for more Positive Obligations

There were two approaches to introducing more positive obligations on the Chief Psychiatrist to Act regarding the standard of mental health care and compliance with the Act, described in sections 8.4.1 and 8.4.2 below.

8.4.1 Chief Psychiatrist Standards and Compliance

The first approach will consider three existing powers of the Chief Psychiatrist – to issue mandatory standards for the treatment and care of patients, to determine a place as a facility under the Act, and to vary and revoke a determination that a practitioner is an authorised medical practitioner or authorised mental health professional.

Currently, the Chief Psychiatrist may issue Standards relating to the treatment and care of patients, which are binding on public and private hospitals. While a Standard is binding, the Act does not articulate a specific obligation for a health service to carry a Standard into effect and nor does it expressly articulate any consequences for failure to comply.

There is no obligation to issue Standards, either broadly or for particular issues. Several Australian jurisdictions outline a minimum set of issues for which the Chief Psychiatrist or statutory official must make Standards, with the capacity to make additional ones as the official deems appropriate.

It is proposed that the regulations of the *Mental Health Act 2009* be amended to require the Chief Psychiatrist to issue Standards in these areas, including:

- Electro-Convulsive Therapy
- Restrictive Practices
- Rights of Consumers and Carers
- Treatment and Care Plans
- The assessment of criteria for making involuntary orders under the *Mental Health Act 2009*

In addition, the determination of key areas required by regulation to have Chief Psychiatrist Standards would not limit the Chief Psychiatrist from making other Standards as required. There have been previously or are now currently Chief Psychiatrist Standards relating to:

- Cross-Border Arrangements
- Ligature Risk Management
- Patient and Solicitor Access to Patient Records

- Restrictive Practice

Future areas being considered for Chief Psychiatrist Standards include:

- Clinical Therapy and Rehabilitation
- Models of Care
- Peer Workforce
- Trauma-Informed Practice

The Act further defines powers, functions and responsibilities through the determination of three specific types of facilities: Approved Treatment Centres, Limited Treatment Centres and Authorised Community Mental Health Facilities. Each type of facility is determined by the Chief Psychiatrist through the Government Gazette, and that determination may be subject to conditions and limitations. The Act does not describe what limitations or conditions might be, or how they might be triggered, placing their invocation at the determination of the Chief Psychiatrist.

It is proposed that regulations accompanying sections 96, 97 and 97A of the *Mental Health Act 2009* be developed to provide guidance to the Chief Psychiatrist on the circumstances where the Chief Psychiatrist **must** review the gazettal – and consider whether or not to place conditions on a gazettal or revoke a gazettal. These would include circumstances where the Chief Psychiatrist identifies systemic non-compliance with the requirements of the *Mental Health Act 2009*, non-compliance with a Chief Psychiatrist Standard, or identification of inadequate facilities or clinical systems that may affect the safety and quality of care, where the service is unable or unwilling to rectify this non-compliance. The Chief Psychiatrist must then make a decision whether or not to apply relevant conditions or limitations, or if required have the facility's determination as an authorised facility under the Act revoked.

It should be noted however that this approach would not intend to limit the current discretion of the Chief Psychiatrist to consider placing limitations on the determination of a unit for any reason related to the quality of care, not just those where the matter involves compliance with the *Mental Health Act 2009* or where specific standards are in place. This would usually reflect clinical practices and systems. This current option should remain at the discretion of the Chief Psychiatrist and it would be recommended that any new regulation explicitly refer to this discretion. Ward design, duress functioning, and problems with risk assessments are examples of issues that have led to limitations being placed on ward determinations via the Gazette. The new obligation would define the situations where the Chief Psychiatrist must formally make this decision and to document and communicate that decision – without limiting the other situations where such action may also be considered.

There is a similar opportunity to provide for positive obligations for individuals. MHA s94 provides power to the Chief Psychiatrist to gazette a person or class of persons as an authorised mental health professional. Authorised mental health professionals have the power to make a level 1 community treatment order or a level 1 inpatient treatment order. Similarly MHA s93 gives similar powers to gazette a specified medical practitioner or class of medical practitioner an authorised medical practitioner. Such practitioners have powers to review level 1 orders and make level 2 orders. For both categories the Chief Psychiatrist can by notice in the gazette, attach conditions or limitations to such a gazettal of an Authorised Mental Health Practitioner or Authorised Medical Practitioner or revoke the gazettal. Regulations could outline the circumstances where the Chief Psychiatrist **must** consider whether or not to attach conditions, limitations or revoke such powers. These circumstances would include non-compliance with the Act or a standard. It should be noted that this would not require the Chief Psychiatrist to place conditions, but would define when the Chief Psychiatrist must make a decision.

Similarly the Act and regulations gives powers to classes of individuals as authorised officers (mental health clinician, ambulance officers, Royal Flying Doctor medical officers and flight nurses), and the Act refers to powers of medical practitioners and psychiatrists as a group. Members of any of these groups automatically have powers under the *Mental Health Act 2009*, and only lose their ability to exercise their powers if they are no longer practicing as a member of those groups through either loss of employment or loss of registration. The *Mental Health Act 2009* itself could be amended to allow for conditions, limitations or revocation to be permitted for the powers of any individual who belongs to these groups, and allows for the same powers of applying conditions or revocation to be applied to individuals that can currently be applied to individuals who are individually gazetted, to be applied to individual members of the groups that have automatically had powers.

These strategies would mean that conditions or revocations could be applied by the Chief Psychiatrist if needed and this would provide for a response to non-compliance of the Act, where that non-compliance maybe significant but does not reach the higher threshold of being an offence against the Act (s102).

8.4.2 Matrix of Shared Positive Obligations

The second approach creates a matrix of shared positive obligations, by different officers and/or agencies having shared functions, and for each to be responsible for carrying them out in accordance with their role, position and other legislative powers and functions. A good example of this is in section 16 of the *Work Health and Safety Act 2012,* which provides that:

- More than one person can concurrently have the same duty,
- Each person with a duty must carry out that duty even if there are others with the same duty,
- If more than one person has the same duty, each person:
    - Retains responsibility for their own carrying out of the duty, and
    - Must discharge their duty to the extent made possible by their position and capacity.

If this approach were to be taken, the Minister, the Chief Executive, the Governing Boards, the Chief Executive Officers and the Chief Psychiatrist could all be responsible for "ensuring" the standard of mental health care and compliance with the *Mental Health Act 2009*, with each carrying out those responsibilities to the extent required by their existing position, capacity, and legislative functions and powers, as described in **Table 8.2**

Table 8.2 – Existing powers and functions

Person / Agency	Role, Capability, Powers and Functions
Minister	• Evaluation and review of policy • Evaluation and review of standards
Chief Executive	• Oversee, monitor and promote safety and quality • Develop and issue policy • Monitor hospital performance and take remedial action
Governing Boards	• Maintain and improve standards of care and services • Manage performance
Chief Executive Officers	• As per Governing Boards above
Chief Psychiatrist	• Issue standards • Conduct inspections Promote continuous improvement • Monitor the treatment of patients, use of restrictive practice, administration of the Act and standard of mental health care • Determine facilities and officers under the Act

Additionally, this approach requires a straight forward amendment of the *Mental Health Act 2009* only, rather than amending a variety of existing provisions and powers. A more straight

forward approach will reduce misinterpretation and provide more clarity and certainty for the mental health sector.

It is proposed that the *Mental Health Act 2009* be amended to make the Minister, Chief Executive, Governing Boards, Chief Executive Officers and the Chief Psychiatrist jointly responsible for ensuring the standard of mental health care and ensuring compliance with the Act, within their role, capability and other legislative powers and functions, similar to section 16 of the *Work Health and Safety Act 2012.*

8.5 Prosecution of Offences under the Act

The Act describes fifteen offences for the improper administration of the Act, thirteen of which are summary offences and two of which are minor indictable offences. As the Act does not expressly identify the officer or authority responsible for prosecuting offences, South Australian practice means that the prosecuting authority could be any relevant person or authority. Prosecutions are a very rare occurrence. Given these circumstances, it would be appropriate for the Government Investigator to carry out investigations and the Crown Solicitor's Office to conduct prosecutions, as required.

It is arguably inconsistent with the Chief Psychiatrist's other statutory powers and functions for them to prosecute offences under the Act. The prosecution of offences should sit with a designated officer or authority within the Department for Health and Wellbeing, and should be separate from the Chief Psychiatrist to ensure natural justice and freedom from real and perceived conflicts of interest.

It is proposed that a designated officer or authority in the Department for Health and Wellbeing, who is not the Chief Psychiatrist, be responsible for the prosecution of offences under the *Mental Health Act 2009.* While a decision has not been made who that officer might be, there are officers in the Department with roles in risk and standards who would be well placed to consider a referral for a decision about prosecution that may emanate from a Chief Psychiatrist investigation or inspection.

If greater clarity and certainty is required, it is proposed that the Department for Health and Wellbeing consider whether a policy is required for the prosecution of offences under the *Mental Health Act 2009* and, if so, to work with the Crown Solicitor's Office to draft one.

Of course, any criminal matters that come to the attention of the Chief Psychiatrist should be reported immediately to the South Australian Police.

8.6 Access to Documents Outside of Inspections

The Chief Psychiatrist has the power to conduct inspections of any part of a public incorporated hospital or a private licensed hospital, to request and examine any documents, and to take extracts or copies of those documents. However, the power to request and examine documents is technically restricted to when an inspection is taking place on the premises of the health service. A spirit of collaboration prevails however, and public incorporated hospitals and private licensed hospitals provide access to and copies of documentation to the Chief Psychiatrist when they are not physically present in the health service. The Chief Executive Officer of the health service can release information in accordance with section 93 of the *Health Care Act 2008.*

While this current arrangement is lawful, it is a little clumsy. It is proposed that section 90 of the *Mental Health Act 2009* be amended to provide the Chief Psychiatrist with the power to request access to and/or copies of any document while not on the premises of a health service that they could otherwise inspect.

8.7 Protections for Whistleblowers

A whistleblower, now known as a person making a public interest disclosure, may make a disclosure to a relevant authority about substantial risk to public health, safety or the environment, and about corruption, misconduct or maladministration in the public sector.
Previously, under the *Whistleblower's Protection Act 1993*, there was a view that the Chief Psychiatrist met the definition of a "reasonable and appropriate person" to whom disclosures could be made, which automatically invoked the requirement to keep the identity of the disclosing person confidential, except as necessary to refer the matter to a relevant authority and/or to investigate the matter.

Currently, under the provisions of the *Public Interest Disclosure Act 2018,* the Chief Psychiatrist is not a relevant authority for the receipt of public interest disclosures and must refer disclosures to the responsible officer of the Department for Health and Wellbeing, or the Office for Public Integrity, depending on the nature of the disclosure. Section 8 of the *Public Interest Disclosure Act 2018* provides that anyone who knows of a disclosure, in this case the Chief Psychiatrist and senior staff of the Office must keep the identity of the disclosing person confidential, except as necessary to refer the matter to a relevant authority.

The Office of the Chief Psychiatrist receives several confidential disclosures each year and is absolutely committed to ensuring that people considering making a disclosure about mental health services are protected. To this end, it is proposed that the *Public Interest Disclosure* Act be amended to formalise the obligations on the Chief Psychiatrist.

8.8 Inspections and Different Categories of Facility

The Chief Psychiatrist can conduct inspections of public incorporated hospitals and private licensed hospitals and the Community Visitor Scheme can conduct visits and inspections of Treatment Centres and Authorised Community Mental Health Facilities, in accordance with sections 90(4) and 51(1) of the *Mental Health Act 2009* respectively. Public incorporated hospitals are determined as such by a proclamation of the Governor and private hospitals are granted a licence to operate by the Minister, in accordance with sections 29 and 81 of the *Health Care Act 2008* respectively. Approved Treatment Centres, Limited Treatment Centres and Authorised Community Mental Health Facilities are determined by the Chief Psychiatrist in accordance with sections 96, 97 and 97A of the *Mental Health Act 2009* respectively.

This matrix of definitions means that the Community Visitor Scheme can only conduct visits and inspections to facilities determined by the Chief Psychiatrist to have special status under the *Mental Health Act 2009,* while the Chief Psychiatrist can conduct inspections more broadly into any public incorporated hospital or private licensed hospital.

However, as the diversity of the types of public and private mental health services has increased, to better meet the needs of people experiencing mental illness and their families, an emergent deficit in the inspection powers of the Chief Psychiatrist has become apparent, in that the Chief Psychiatrist does not have the power to inspect a private or non-government organisation community mental health service, even if that service has been determined by them to be an Authorised Community Mental Health Facility.

To address this deficit, and make allowance for the future evolution of the diversity of service and facility types, it is proposed that subsection 90(4) of the *Mental Health Act 2009* be amended so that the Chief Psychiatrist has the authority to conduct inspections of the premises and operations of any service determined by the Chief Psychiatrist as an Approved Treatment Centre, Limited Treatment Centre or Authorised Community Mental Health Facility.

8.9 Other Jurisdictions Comparison

All Australian jurisdictions have mental health legislation which furnishes health services with a range of powers and functions to provide treatment and safety to people experiencing mental illness who are at risk of harm. Those powers and functions differ between states, as does the statutory officer or executive who is responsible for them. See **Table 8.3** below for a summary of those powers.

Table 8.3 – Comparison of powers vs officer responsible vs state

Power / Function	ACT	NSW	NT
Administer the Act	Minister	Director-General	Minister + CEO +*
Ensure / promote rights	-	-	-
Ensure education / training	-	Director-General	-
Ensure facilities / services	-	Public health system	-
Ensure good treatment & care	-	Public health system	Person in Charge
Inspections / investigations	Inspector	-	CVS
Instigate inquiry	-	-	-
Intervene in individual care	-	-	-
Make reports	Chief Psychiatrist	Director-General	-
Make standards / guidelines	D-G + CP	Public health system	CEO (partial)
Monitor SQR / practice	-	-	Committee*
Monitor the Act	-	-	Chief Exec Officer
Promote continuous improvement	-	-	-

* Approved Procedures and Quality Assurance Committee

Power / Function	QLD	SA	TAS
Administer the Act	Chief Psychiatrist	Chief Psychiatrist	Chief Psychiatrist
Ensure / promote rights	Chief Psychiatrist	-	-
Ensure education / training	-	Minister	-
Ensure facilities / services	-	Minister	-
Ensure good treatment & care	Mental health svcs	-	-
Inspections / investigations	Chief Psychiatrist	Chief Psychiatrist	Inspectors
Instigate inquiry	-	-	-
Intervene in individual care	-	-	Chief Psychiatrist
Make reports	Chief Psychiatrist	Chief Psychiatrist	-
Make standards / guidelines	Chief Psychiatrist	Chief Psychiatrist	Chief Psychiatrist
Monitor SQR / practice	-	Chief Psychiatrist	-
Monitor the Act	Chief Psychiatrist	Chief Psychiatrist	-
Promote continuous improvement	-	Chief Psychiatrist	-

Power / Function	VIC	WA
Administer the Act	Secretary	Chief Psychiatrist
Ensure / promote rights	Chief Psychiatrist	-
Ensure education / training	-	-
Ensure facilities / services	Secretary	-
Ensure good treatment & care	-	-
Inspections / investigations	Chief Psychiatrist	Chief Psychiatrist
Instigate inquiry	-	Minister
Intervene in individual care	-	Chief Psychiatrist
Make reports	Chief Psychiatrist	Chief Psychiatrist
Make standards / guidelines	Secretary + CP	Chief Psychiatrist
Monitor SQR / practice	Secretary	Chief Psychiatrist
Monitor the Act	Chief Psychiatrist	-
Promote continuous improvement	Secretary + CP	-

Only one Australian jurisdiction provides for one statutory or executive officer to have responsibility for ensuring overall compliance with mental health legislation. In the Northern Territory, the Chief Executive Officer of the Department of Health has the function to “oversee the operations of this Act” and to “ensure that people are treated and cared for in accordance with the Act”. In the other Australian states, many specific powers and functions are described

using “ensure” or “must” and associated mandatory requirements, with the responsibility for each different positive obligation falling to the officer tasked with that power or function.

When considering a positive obligation for ensuring the standard of mental health care, no Australian jurisdiction legislates that responsibility to a Chief Psychiatrist or equivalent position. Rather, the legislation of three jurisdictions give that obligation to health services broadly or to the officer in charge of each hospital, and the legislation of five jurisdictions do not make any provisions at all, allocating that responsibility to health services through policy and contract.

When reviewing the positive obligations for Chief Psychiatrists across Australia, South Australia and Victoria have the most wide-ranging powers, followed by Queensland and Western Australia. Against the backdrop of differing patterns of powers and functions for Chief Psychiatrists across jurisdictions, South Australia’s Chief Psychiatrist has the greatest concentration of positive obligations for investigations, safety and quality, standards, monitoring and the administration of the Act, which are adequate from a legislative perspective. However, while local powers may compare favourably with those interstate, there are further opportunities to increase the clarity and certainty of Chief Psychiatrist obligations for the benefit of the public and health services. Section 8.4 of this Report describes these options.

Proposed Actions

Proposed Action Ten
That the *Mental Health Act 2009* place obligations on the Chief Psychiatrist to review the gazettal of a facility, where that facility does not comply with the *Mental Health Act*, with Chief Psychiatrist Standards, or where inadequate facilities may affect the safety and quality of care. A similar requirement should be legislated to review the powers of individual practitioners who do not comply with the Act or standards.

Proposed Action Eleven
It is proposed that section 90 of the *Mental Health Act 2009* be amended to provide the Chief Psychiatrist with the power to request access to and/or copies of any document while not on the premises of a health service that they could otherwise inspect.

Proposed Action Twelve
It is proposed that the *Public Interest Disclosure Act 2018* be amended to make the Chief Psychiatrist and delegates, responsible officers under this Act.

Proposed Action Thirteen
It is proposed that subsection 90(4) of the *Mental Health Act 2009* be amended so that the Chief Psychiatrist has the authority to conduct inspections of the premises and operations of any service determined by the Chief Psychiatrist as an Approved Treatment Centre, Limited Treatment Centre or Authorised Community Mental Health Facility.

Proposed Action Fourteen
It is proposed that sections 90(2) and 90(3) of the *Mental Health Act 2009* be amended to require the Chief Psychiatrist to issue Standards on specific topics.

Proposed Action Fifteen
It is proposed that the *Mental Health Act 2009* be amended to make the Minister, Chief Executive, Governing Boards, Chief Executive Officers and the Chief Psychiatrist jointly responsible for ensuring the standard of mental health care and ensuring compliance with the Act, within their roles, capabilities and other powers and functions, similar to section 16 of the *Work Health and Safety Act 2012.*

ICAC Recommendation 8b – Resources of the Office of the Chief Psychiatrist

and whether in that case the resources of the Office of the Chief Psychiatrist need to be increased; and

- if so to what extent; and
- whether the Chief Psychiatrist should be provided with further statutory powers to enable the Chief Psychiatrist to perform any such additional functions.

Matters for Consideration

- Current staff and other resources available to the Office of the Chief Psychiatrist as it relates to existing powers, functions and responsibilities for:
    - Administration of and compliance with the Act.
    - Inspections.
    - Investigations and Complaints
    - Safety and Quality, and Service Improvement.
- Staff and other resources necessary for the Office of the Chief Psychiatrist to carry out proposed powers, functions and responsibilities relating to the above areas.
- It should be noted the staffing and other resources necessary for other units and agencies to carry out proposed powers, functions and responsibilities are described elsewhere in this report, including:
    - Allied and Scientific Health Office DHW.
    - Community Visitor Scheme.
    - Infrastructure Directorate DHW.
    - Local Health Networks.

Discussion

8b.1 Current resourcing of the Office

The Office manages both statutory duties, and departmental duties related to mental health policy, planning, strategy, and quality and safety officers. The unit also operates the state's Suicide Prevention Team.

The unit as of 1 November 2019 has 26.7 full time equivalent staff. In 2018 the Office expanded with an extra injection of approximately $800,000 which has funded a second executive position, three inspection and investigation officers, a half time planning officer, and a policy officer who is responsible for the recently established prescribed psychiatric treatment panel. There is also funding for an extra 0.2 FTE psychiatrist, and 0.2 FTE Senior Clinical Advisor for older persons mental health. There are extra temporarily funded positions for older persons mental health and the National Disability Insurance Scheme, and suicide prevention. (It is expected in 20-21 that responsibility for overseeing Suicide Prevention Networks will transfer to the recently created Wellbeing SA, along with those resources).

8b.2 Inspections

The previous section on inspections considers the resources needed to support that function. This section considers other roles within the Office.

8b.3 Principal Project Officer – Older Persons Mental Health

The Department for Health and Wellbeing did not have a dedicated project officer overseeing policy and strategy for older persons mental health for many years. This was a significant gap, as most jurisdictions have skilled dedicated resources for policy, planning and strategy in older persons mental health.

Currently, the Office of the Chief Psychiatrist and the Office For Ageing Well DHW each have both employed one ASO8 Project Manager each to coordinate, manage, consult and implement the Oakden recommendations from the Chief Psychiatrist, the Oakden Report Response Plan Oversight Committee and ICAC as part of the Specialist Aged Care Service Reform Program. See section 10 of this Report for more detail about the Reform Program. Both positions are funded until 30 June 2020.

The project team coordinates their efforts, with the OCP Project Manager carrying out consultation, planning and implementation of the Reform Program in the mental health sector and the OFAW Project Manager carrying out consultation, planning and implementation of the Reform Program in the aged care sector. However, with the ongoing implementation of work in the Reform Program and as a matter of good governance specialist resources for older persons mental health should continue.

It is proposed that the Chief Executive consider resourcing options for a continued older person's mental health Project Officer in the Office of the Chief Psychiatrist and based on the current effective across unit work, a similar positions should continue in the Office For Ageing Well.

8b.4 Project Officer – Forensic Mental Health

A similar issue has occurred with forensic mental health services. Funding for a project officer in this area had been transferred to the service to fund a clinician some years ago. Specific policy and planning attention is needed to address the current poor state of infrastructure, support new facility planning and develop new services for forensic mental health patients and prisoners with a mental illness. The new Mental Health Services Plan contains a number of forensic mental health priorities in need of implementation.

8b.5 Complaints Officer

In addition to inspections, safety and quality monitoring and reporting, and quality improvement activities, the Office of the Chief Psychiatrist carries out a number of investigations each year (see section 5.6 of this Report), some of which are very complex. Investigations may arise out of an inspection, an incident, a complaint, a public interest disclosure, or at the request of the Community Visitor Scheme, the Local Health Network, the Chief Executive or the Minister.

The OCP Safety and Quality Team has been conducting investigations in addition to their other roles and functions but the number and complexity of investigations has been steadily increasing since the Chief Psychiatrist's Oakden Report of April 2017, and the Team needs additional capacity to carry out both inspections and investigations in a responsive timely way.

In addition to formal investigations, the Office of the Chief Psychiatrist responds to complaints, inquiries and requests for advice from members of the public and service providers, which is mostly managed by non-clinical legislation and project officers with other full-time roles. This function was initially intended to deal with enquiries about the Act, but deals with a wide range of service concerns. Some require extensive collaboration with Local Health Networks and other agencies, and when follow-up is required to ensure appropriate action has been taken.

It is proposed that the Chief Executive consider resourcing options for an Investigations and Complaints Officer in the Office of the Chief Psychiatrist to oversee complaint matters and provide a resource to investigations. This person would also coordinate and oversee the Authorised Consumer Adviser program described in recommendation 11.

8b.6 Possible Future Resourcing Needs

In addition to the resourcing options identified above, there may be future resourcing needs identified through the ICAC related projects underway, namely:

- Recommendation 4 – Review of training resources, systems and needs across the Local Health Networks relating to SLS use, mandatory reporting, SA Health policy and procedure, and legislation.
- Recommendation 13 – Recommendations of the OCP / ASHO Working Party to review Allied Health Professionals in mental health services.

See the relevant sections of this report for more information.

Proposed Actions

Proposed Action Sixteen

It is proposed that the Chief Executive considers resourcing options for inspections, investigations and complaints, Older Persons Mental Health and Forensic Mental Health.

ICAC Recommendation 9 – Infrastructure Condition

The Minister cause a review to be conducted for the purpose of reporting publicly on the physical condition of all facilities at which mental health services are delivered in a LHN:

- for the purpose of determining whether the physical condition of those facilities are fit for the purpose for which they are being used; and
- if not in what respects the physical condition of any facility is not fit for purpose.

Matters for Consideration

- Current responsibilities and governance for facilities.
- Current standards relevant for determining the condition and fitness for purpose of facilities.
- Determine facilities to be in scope for an infrastructure condition review.
- Develop a Strategic Asset Management Framework to outline an integrated approach for the effective management of assets and their condition.

Discussion

9.1 Current Facility Responsibilities and Governance

The Local Health Networks are responsible for managing and maintaining all facilities within their network. Each LHN has an asset manager responsible for monitoring property condition, scheduled maintenance work and unscheduled maintenance requests, in accordance with the LHNs allocated budget.

All maintenance works, both planned and unplanned are undertaken by approved contractors under the Across Government Facilities Management Arrangements (AGFMA), which is a key part of the South Australian Government's commitment to the maintenance, management and improvement of government building assets.

The Local Health Networks are also responsible for responding to or taking action against the issues raised by the Community Visitor Scheme, recommendations of audits for accreditation against the National Safety and Quality Health Service (NSQHS) Standards, and recommendations from Chief Psychiatrist inspections.

The Infrastructure Directorate, Department for Health and Wellbeing, supports the other business units of the Department and the Local Health Networks in:

- Strategic planning and evaluation of infrastructure requirements.
- Managing SA Health's capital program including delivery of major infrastructure projects.
- Providing executive leadership for SA Health's built assets and the delivery of property and security services across SA Health
- Managing the delivery of biomedical engineering services.

The Health Protection and Licensing Branch, Health Regulation and Protection Division, Department for Health and Wellbeing, is responsible for the inspection and licensing of new or majorly redeveloped private hospitals and day procedure centres.

These three components of facility responsibility and governance are not adequately connected. It is proposed that SA Health develop a Strategic Asset Management Framework to document and connect the work and responsibilities of the Local Health Networks, the Infrastructure Directorate and the QIP Branch. See section 9.6 of this Report.

9.2 Current Facility Review Mechanisms

Facility condition and fitness for purpose can currently be reviewed under:

- Accreditation audit against the NSQHS Standards.
- Audits against the Aged Care Quality Standards.
- Chief Psychiatrist inspections (enhanced regime).
- Community Visitor Scheme visits and inspections.
- Infrastructure Directorate review of capital works.
- Local Health Network maintenance reviews.
- Local Health Network review of incidents and complaints.
- Local Health Network risk audit and quality improvement activity.
- QIP Branch review of new or redeveloped private services.

It is suggested that these mechanisms are adequate but are not sufficiently connected or reported. It is proposed that SA Health develop a register for review and inspection findings related to facility condition, and capital and maintenance works undertaken, as a part of the Strategic Asset Management Framework. See section 9.6 of this Report.

9.3 Standards to Review Against

All public health services that provide physical health care and mental health care in South Australia, whether hospitals, residential care facilities or community health services, undergo accreditation against the National Safety and Quality Health Service (NSQHS) Standards. The Australian Health Service Safety and Quality Accreditation (AHSSQA) Scheme coordinates the accreditation process, and audits South Australian facilities every 3 years.

National consultation is underway on a user guide for the NSQHS Standards 2nd edition for health services providing care for people with mental health issues. The guide will provide practical examples from across Australia that demonstrate how health services can address the mental health needs of people in their care.

Any new construction of or extensions to public health facilities are overseen by the Infrastructure Directorate in accordance with the Australasian Health Facility Guidelines (AusHFG), which are an initiative of the Australasian Health Infrastructure Alliance (AHIA). The AusHFG outlines facility design principles based on best practice health care and facility efficiency. The AusHFG are mandatory for private licensed facilities and provide a starting point for public incorporated facilities.

Public health facility construction and redevelopment are also subject to the Department for Health and Wellbeing's Capital Works Policy suite, which outlines requirements and processes for capital works.

The Aged Care Quality Standards of the Aged Care Quality and Safety Commission provide additional requirements for facilities, furniture, fittings and equipment for aged care services.

It is proposed that there are adequate guidelines and standards to assess the condition of mental health facilities against. For new builds or refurbishments, mental health facilities should be assessed against AusHFG, the Capital Works Policy suite and, to a lesser degree, the NSQHS Standards. For existing non-new services, mental health facilities should be assessed against the NSQHS Standards. Where facilities will provide aged care services, the Aged Care Quality Standards should also be used.

9.4 Changing Facility Expectations

As occurs in all health care specialities, best practice in mental health service provision continually improves as the understanding of, and treatment options available for, illness evolves and develops. The evolution of best practice also impacts on the design and fit-out of

facilities, where a facility that was once innovative and cutting edge may be assessed 10 or 15 years later as being adequate only or perhaps not meeting all the requirements of contemporary service provision.

It is proposed that the review of the fitness for purpose of a mental health facility must take into consideration the design and service provision at the time it was built, current best practice, and the expectations of the latest Australian Health Facility Guidelines and make a determination as to whether or not the facility can be made fit for purpose, with appropriate renovations or decommissioned. When adapting an existing facility to provide a contemporary clinical service with good outcomes, there may be limitations on which services can be provided, and to the breadth of patient groups that can be supported, that would not be limitations if care was delivered in a contemporary facility.

Of course, the safety or condition of a facility is not subject to such considerations and must be assessed on risk alone.

9.5 Facilities in Scope for Review

In the SA Health Strategic Asset Management Information System (SAMIS) there are over 100 facilities across the state which, dependant on interpretation, may be considered as *"facilities at which mental health services are delivered"* as a person experiencing mental illness may receive initial treatment at any public health service, before referral or transfer to a facility with specialist mental health services.

However, to be more practical and relevant, a focus on those facilities which provide a specialist mental health service would be appropriate. These facilities fall into two categories:

- Those determined to be an Approved Treatment Centre, Limited Treatment Centre or Authorised Community Mental Health Facility under the *Mental Health Act 2009* by the Chief Psychiatrist, and
- Those community mental health services and teams not so determined, but which still provide a specialist mental health service.

There are 41 sites/services across 13 Approved Treatment Centres, no Limited Treatment Centres and 14 Authorised Community Mental Health Facilities, for a total of 55 services/sites determined under the Act that may require a facility condition inspection. In addition, there a 45 other community specialist mental health services sites that may require a facility condition inspection. See the Official Listing – Chief Psychiatrist Inspection Sites (**Appendix 3**) for the details.

The review of the condition of all health facilities undertaken as part of the Strategic Asset Management Framework will look at both categories of facility. The review of the condition and fitness for purpose undertaken by the Office of the Chief Psychiatrist, as part of the enhanced inspection regime outlined in section 5 of this Report, will focus first on category one facilities.

9.6 Strategic Asset Management Framework

In response to recommendation Nine SA Health has committed to the development of a state-wide Strategic Asset Management Framework for SA Health, which will require Local Health Networks to develop Strategic Asset Management Plans to provide information on physical built asset portfolio including but not limited to condition and functionality of assets to meet service delivery.

The Infrastructure Directorate has developed a Strategic Asset Management Framework for the whole of SA Health to outline responsibilities, actions, timeframes and reporting for the review and maintenance of the condition of public health service facilities (and private

facilities where appropriate), and is currently developing a Policy to activate and guide the use of the Framework.

9.7 Findings of Facility Reviews So Far

The OCP, the Local Health Networks and the Infrastructure Directorate have undertaken a number of reviews of facility condition since the ICAC Report was released.

There have been 12 inspections where significant facility-related observations and findings were made. Immediate safety concerns have either been addressed or are in the process of being addressed in a number of facilities and gazettal conditions are in place in 3 settings. Two facilities (James Nash House original building and Woodleigh House) no longer meet the needs of modern mental health service delivery and while works have commenced in both locations, these should be considered temporary solutions prior to decommissioning and rebuilding.

9.8 Public reporting

Public reporting of the review of mental health facilities will occur once completed. The only exception will be the withholding of specific details of safety risks that are yet to rectified, should such reporting draw attention to such risks.

9.9 Facility Review Project

The ICAC Report recommended a review of the condition of mental health facilities in South Australia. To ensure adequate and appropriate systems and processes for such a review, and to enable reviews to be incorporated into ongoing inspection and maintenance regimes, the Office of the Chief Psychiatrist has inspected facilities as part of the inspection regime and the Infrastructure Directorate has carried out facility condition inspections, which has informed the drafting and publication of the Chief Psychiatrist Inspection Protocol and the Strategic Asset Management Framework, and the development of electronic systems to record findings, remedial action and outcomes.

On the basis of the work to date done to date which has identified a number of problems with varying levels of outdated design, fitting or problems with maintenance, the Office of the Chief Psychiatrist and the Infrastructure Directorate will carry out combined reviews of the condition of all remaining (see section 9.7 above) inpatient and residential mental health facilities in South Australia. It is expected that these reviews will be completed by the end of June 2020, and that future facility condition reviews will be carried out as part of the usual Strategic Asset Management Framework and the Chief Psychiatrist Inspection Protocol processes.

It is proposed that the Office of the Chief Psychiatrist or the Infrastructure Directorate allocate a dedicated resource to complete this round of infrastructure inspections.

9.10 Mental Health Facility Management Officers

The Infrastructure Directorate supports the Local Health Networks and the Department in infrastructure strategic planning, capital program management, executive leadership for built assets and statewide policies and systems. The Directorate does not have the capacity to provide the ongoing advice and support to Local Health Networks necessary to manage the continuing replacement and refurbishment of mental health facilities, furnishings, fittings and equipment that occurs each year. Expertise in the design, materials, sourcing and installation of specialised mental health items is not held centrally, meaning that with the turn-over of staff in the Local Health Networks, expertise in one or two infrastructure matters is held locally for a short period only. This expertise is required in a statewide shared capacity, to enable local

learnings, and new materials, manufacturers and approaches, to be implemented statewide to improve consumer outcomes and reduce incidents.

Completed Actions

Completed Action Eleven

The Infrastructure Directorate has developed a Strategic Asset Management Framework (SAMF) for the whole of SA Health with the objective of a coordinated, overarching framework to ensure management of assets and service demands align with SA Health's plans, goals, policies and processes. The SAMF outlines responsibilities and actions for:

- Asset management activities to comply with all statutory requirements, directives, policies and service delivery requirements and demonstrate continuous improvement in asset planning, maintenance procedures and risk management.
- Effective management of infrastructure and assets ensuring they are fit-for-purpose and their physical condition kept to a standard appropriate for service delivery; and
- Local Health Networks to maintain information on the condition of assets and develop Strategic Asset Management Plans to guide the development and review of maintenance of the condition of public health service facilities.

Actions Underway

Action Underway Six

The Infrastructure Directorate is developing a Strategic Asset Management Policy. The Strategic Asset Management Policy sets the principles, approach, and expectations that govern the provision of asset management services to enable SA Health to deliver health care services in high quality infrastructure in an effective and efficient manner

Action Underway Seven

The Office of the Chief Psychiatrist and the Infrastructure Directorate will access additional capacity until March 2021 to complete combined reviews of the facility condition of those mental health inpatient and residential facilities not already reviewed to date as part of inspections.

Action Underway Eight

Future facility inspections will reference the following standards. For new builds or refurbishments, mental health facilities should be assessed against AusHFG, the Capital Works Policy suite and the NSQHS Standards. For existing services, mental health facilities will also be assessed against these standards, with gaps risk assessed based on the current role of the unit as described in its model of care. Where risk cannot be effectively mitigated, the clinical role of the unit to manage acuity will be reduced based on the physical limitation of the unit. A gazettal notice will be published describing these changes.

Action Underway Nine

The review of the fitness for purpose of a mental health facility will take into consideration the design and service provision at the time it was built, and current best practice, and make recommendations to provide a contemporary service from that facility either (i) in the existing facility on an ongoing basis with renovation and refurbishment, (ii) in the existing facility with limitations until a new facility can be established, or (iii) the closure of the facility within a determined time frame.

Proposed Actions

Proposed Action Seventeen

A public report of inspections of mental health facilities will be placed on the SA Health website by July 31 2020.

ICAC Recommendation 10 – Implementation of the Oakden Report

The six recommendations contained in the Oakden Report be implemented, to the extent that they have not already been implemented.

Matters for Consideration

- The work undertaken by the Oakden Oversight Committee and associated workgroups on the implementation of the recommendations from the Oakden Report.
- The report of the Oakden Oversight Committee and government response to fully implement its recommendations.
- The development of the Response to the Oakden Implementation Plan and associated governance structure to continue the work required for the implementation of the recommendations from the Oakden Oversight Committee.

Discussion

10.1 Introduction

The Chief Psychiatrist undertook a review into the care and treatment of consumers at the Oakden Older Persons Mental Health Service in 2016-17. The report from that review was released in April 2017 and contained six recommendations. In response to the report the then government established the Oakden Report Response Plan Oversight Committee to oversee the implementation of the recommendations. The work of the Committee and the associated expert working groups was finalised in June 2018.

10.2 Findings

The Oakden Report Response Plan Oversight Committee released The Oakden Report Response document in June 2018. The report outlined the work undertaken by the committee in implementing the recommendations from the Oakden report. The document included separate reports from the Expert working groups which provided recommendations on how to proceed with the implementation of:

- Models of Care
- Specialist Mental Health Facility
- Recommended Staffing Profiles
- Clinical Governance Framework
- Cultural Framework
- Reducing Restrictive Practices Framework

10.3 Implementation Project

The Specialised Aged Care Service Reform Program has been established to plan, design and implement the work from the Oakden Oversight Committee. This program comprises a number of strategies including:

- Development of a neuro-behavioural unit for those with extreme behavioural and psychological symptoms of dementia (BPSD).
- Creating a partnership between SA Health, an aged care provider and the Commonwealth Government, to deliver a Specialised Dementia Care Unit that will cater to the needs of people with severe and very severe dementia.
- Creating a Dementia Friendly Community at the Repat Health Precinct.
- The development of in-reach services into Residential Aged Care Facilities to support the care of people with dementia care as well as those with enduring mental illness.

- Working collaboratively with the aged care sector to develop a community of practice to support high quality, person-centred care for people with dementia.

Updates on the progress of the project are available on the SA Health Website. These are issued on a six monthly basis with the most recent update published in June 2019.
https://www.sahealth.sa.gov.au/wps/wcm/connect/Public+Content/SA+Health+Internet/About+us/Reviews+and+consultation/Specialised+Aged+Care+Service+Reform+Program/

A timeline of progress is shown on the next page.

Completed Actions

Completed Action Eleven
The Specialist Aged Care Service Reform Steering Committee has been established to drive and guide reform and collaboration, with membership comprising:

- Central Adelaide Local Health Network.
- Country and Regional Local Health Networks.
- Infrastructure Directorate DHW.
- Northern Adelaide Local Health Network.
- Office for Ageing Well DHW.
- Office of the Chief Psychiatrist DHW.
- Safety and Quality Unit DHW.
- Southern Adelaide Local Health Network.

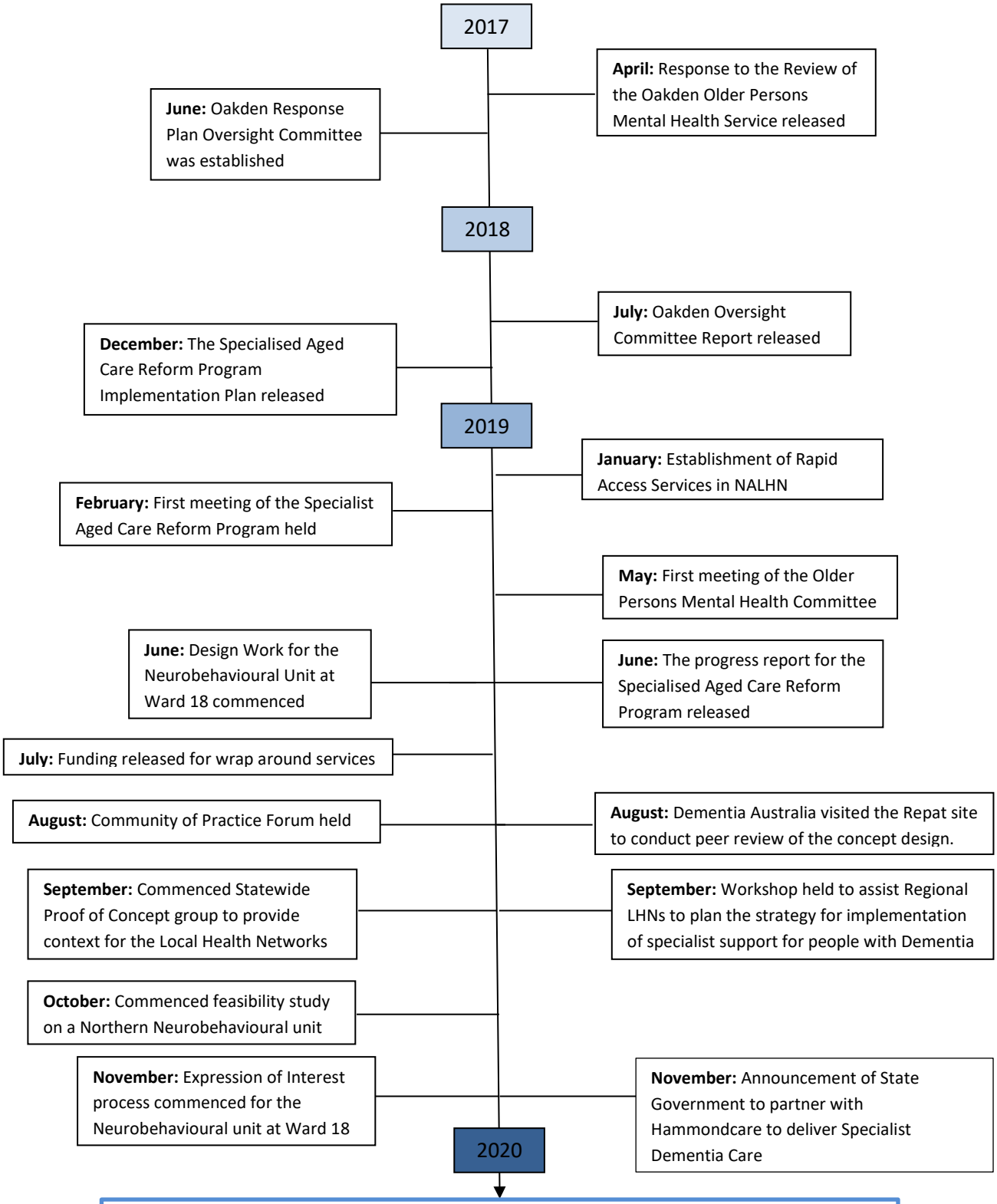
Subcommittees have also been established to carry out specific tasks, namely the Older Persons Mental Health Service Committee (to develop a model of care) and the Infrastructure Committee (to manage all aspects of refurbishment and construction works).

Completed Action Twelve
The Rapid Access Service, a multi-disciplinary team that can inreach into nursing homes to provide treatment in situ and assist with the transition of patients from hospital to nursing home, was successfully piloted in the Southern Adelaide Local Health Network and subsequently implemented in the Northern Adelaide Local Health Network. Expansion of the service into the Central and Country Local Health Networks is now commencing.

Actions Underway

Action Underway Ten
Refurbishment of Ward 18 at the Repat Health Precinct to become a Neuro-Behavioural Unit is underway. This space will be converted into an 18 bed facility, with a focus on becoming as home-like as possible, in order to support the care of people with extreme symptoms of dementia, including the conversion of some bedrooms into therapy and living spaces and the creation of a therapeutic garden. The refurbishment is expected to be completed by mid-2020.

Action Underway Eleven
Options for a co-located Specialised Dementia Care Unit, which will cater to the needs of people with severe and very severe dementia, are being explored. The Dementia Care Unit will provide 18 beds of specialist dementia care and form part of a larger facility providing at least 42 additional beds of cottage style accommodation. (Further work required is described in the Oakden Report Response Plan Oversight Committee report and in the Mental Health Services Plan 2020-2025.)



Priorities for 2020:

- Enduring Mental Illness – Development of a service plan to inform the care of older people with enduring mental illness.
- Dementia Friendly Site - Engagement in planning to develop a dementia friendly community at the Repat Health Precinct.

  Evaluation Framework - Commencement of work to evaluate the Program.

ICAC Recommendation 11 – Consumer Advisors

The Chief Executive review the role of Consumer Advisors to determine whether:

- The duties and responsibilities of Consumer Advisors, so far as they relate to facilities at which mental health services are provided, are appropriate;
- Consumer Advisors require further training to assess the significance of complaints made about those facilities or services;
- Consumer Advisors should be required to report complaints in respect of facilities to particular persons or committees; and
- Steps can be taken to ensure Consumer Advisors are independent of particular facilities.

Matters for Consideration

- Current roles and responsibilities of Consumer Advisor positions across the State.
- Current roles and responsibilities of Consumer Advisors relating to mental health services.
- Comparison with similar positions in other jurisdictions.
- Current training required and provided for managing and responding to complaints.
- Current systems and processes for the reporting and escalation of complaints.
- Current line management and supervision of Consumer Advisors.
- Current policy and practice to ensure the independence of Consumer Advisors.
- Options available for enhancing training, independence and reporting.

Discussion

11.1 Consumer Feedback and Complaints Management Program Board

The Safety and Quality Unit, Department for Health and Wellbeing, has established the Consumer Feedback and Complaints Management Program Board.

The role of the Board is specifically to oversee the state coordination and aspects of monitoring of the whole of health strategy which supports standardisation across SA Health in regard to consumer feedback and complaints management and linked to quality improvement including:

- Education and training requirements
- Monitoring:
  - Key performance indicators
  - Measuring consumer experience, including complaints management, patient rights and engagement and open disclosure
  - Compliance to SA Health policies for partnering with consumers and consumer feedback
- Compliance with Standard 2 – Partnering with Consumers of the National Safety and Quality Health Service Standards

Additionally, the Program Board is responsible to review the ICAC Report recommendations noted above and include goals within the Framework providing LHNs with key actions to implement a local sustainable consumer feedback and complaints management process. The goals will be in line with SA Health principles, values and responsibilities.

The Program Board comprises:

- Central Adelaide Local Health Network.
- Country Health SA Local Health Network.

- Health and Community Services Complaints Commission.
- Health Consumers Alliance of South Australia.
- Northern Adelaide Local Health Network.
- Office of the Chief Psychiatrist DHW.
- Safety and Quality Unit DHW.
- Southern Adelaide Local Health Network.
- Women's and Children's Health Network.

SA Health has contracted Health Consumers Alliance SA to develop the Framework in consultation with the Program Board.

The Framework will include actions for LHNs to measure their consumer feedback and complaints management system to ensure that the ICAC recommendations are met across mental health and the whole of SA Health.

The Framework will:

- Identify and map roles and responsibilities of Consumer Advisors, so far as they relate to facilities at which mental health services are provided, are appropriate;
- Include specific actions for LHNs to comply with in regard to the ICAC recommendation 11 (as noted above) including steps to ensure consumer advisors are independent of particular mental health facilities
- Identify a consistent name for Consumer Feedback Services
- Review current structure/resources and reporting mechanisms
- Review Job and Person requirements for staff
- Identify alignment with safety and quality unit mechanisms
- Identify governance structures and reporting mechanisms including reporting to Executive/Directorate meetings
- Response to complaints re seriousness level
- Identify knowledge needs/gaps for training consumer advisor/complaints roles) ie complaints management, consumer engagement and quality management

This Board will be provided a copy of the Statewide Consumer Feedback and Complaints Strategic Framework with a full review of the role of Consumer Advisors, which was foreshadowed in the preliminary report. As noted above, the Framework will be published separately.

The following can be confirmed from deliberations so far:

- There has been significant variation in the operation of Consumer Advisors across local health networks and services and these roles have not functioned as consistently and possibly as effectively as they might. This is not a reflection on the incumbents of these positions. This issue extends beyond mental health services.
- A significant issue has been the close link between Consumer Advisors to operational mental health services in the past that may contribute to a defensive posture related to complaints when the complaint officer is closely aligned with service providers. The transfer of all Consumer Advisors to report outside of mental health (to the local health network's quality and safety section and hence through to either the Director of Clinical Governance or Executive Director of Medical Services) is seen as critical in ensuring the complaint resolution, and service improvement, is the focus of the Consumer Advisor role.

- Consumer Advisors and those who respond to complaints have had their awareness of the significance of their roles heightened by the Oakden ICAC report. While this is positive and beneficial, longer lasting changes are needed.

11.2 Chief Psychiatrist Standard

On reflection it is considered that Departmental and Local Health Network actions will provide for robust complaint management in the medium to long term but that a short-term solution is still required to manage potential risks for the understanding, management, referral and follow-up of complaints about mental health services and/or the *Mental Health Act 2009*.

For this reason the Chief Psychiatrist will issue by September 2020 a draft Chief Psychiatrist Standard 'Mental Health Complaint Management in SA Health Operated Services' for consultation. The standard will be issued using the powers of section 90(2) of the *Mental Health Act 2009* and will be binding on public incorporated hospitals. The standard will support the Chief Psychiatrist's functions described in section 90(1) to promote continuous improvement in the organisation and delivery of mental health services in South Australia, and to monitor the administration of the Act and the standard of mental health care provided in South Australia.

The standard will operate for up to for three years initially. Its operation will be reviewed when the Consumer Feedback Program Board delivers it findings, when statewide changes are made to Consumer Advisor roles and functions and, if necessary, at three years to determine if it is still required when the systemic changes are implemented.

The proposed standard will contain the following:

- Create the new designation of an Authorised Mental Health Consumer Advisor.
- All complaints made about Mental Health services will need to be assessed, investigated or resolved by a Consumer Advisor, who has been determined to be an Authroised Mental Health Consumer Advisor or by a health service Consumer Advisor under the direction of an Authorised Mental Health Consumer Advisor.
- All complaint responses will consider the object and principles of the Act and seek to ensure compliance with the *Mental Health Act 2009*. This is in addition to the existing requirements to uphold the Health and Community Service Complaints Commissioner's Charter for Consumers of the South Australian Public Health System.

Consumer advisors designated as Authorised Mental Health Consumer Advisors will be authorised by the Chief Psychiatrist when the following criteria have been met:

- The Authorised Mental Health Consumer Advisor will be expected to have completed education relevant to mental health consumer and advisor work, and the rights of mental health consumers and carers.
- The LHN Executive Director, accountable for the work of the Authorised Mental Health Consumer Advisor, attests that the Advisor has the necessary skills to receive, assess and investigate complaints, and will be provided support and expert supervision when required.

The education program to be coordinated by the Office of the Chief Psychiatrist will provide:

- Education on the obligations of consumer advisors to ensure that the *Mental Health Act 2009* is complied with, and critical areas that may arise in complaint investigations that might indicate failure to comply with the Act.
- An overview of human rights effecting people receiving mental health care in South Australia, including those derived from the *Mental Health Act 2009, Carer's Recognition*

Act 2005 and international treaties and agreements to which Australia is a signatory, including the UN Principles of Persons with Mental Illness and the Improvement of Mental Health Care, the UN Convention of the Rights of Persons with Disabilities and, as it is implemented, the Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment.

- Education from people with lived experience on responding to consumers and carers who complain.
- Education on upholding the rights of people who may have a decision making incapacity to complain
- An overview on how to conduct a complaint investigation and standards of proof. (This is not intended to substitute for other government investigation training that an Advisor may choose to complete).

Authorised Mental Health Consumer Advisors will be expected to lodge with the Chief Psychiatrist annually.

- Details of numbers of mental health complaints managed, classified by content.
- An analysis of issues raised in complaints, to whom they have been escalated, and whether or not the matters have been resolved.

Preparation for this program commenced in March 2020.

It should be noted that this standard is intended to supplement and fortify existing consumer advisor and complaints mechanisms and does not substitute for the policy oversight of the Safety and Quality Unit, DHW for consumer advisor or complaint matters, for the ultimate accountability of the Governing Boards of Local Health Networks, or the statutory role of the Health and Community Services Complaints Commissioner for complaints management.

Reporting to the Office of the Chief Psychiatrist is not intended to replace other reporting, simply to ensure that the Standard is met and to assist the Chief Psychiatrist to be aware of system issues that have emerged from complaint investigations and to know whether or not these have been addressed.

While consumer advisors are no longer based in mental health divisions, which is a strength to avoid conflicts of interest, this new Authorised mental health consumer advisor strategy will ensure that advisors have specific *Mental Health Act 2009* and rights based knowledge relevant to the sector

Completed Actions

Completed Action Thirteen

Each of the Local Health Networks have reviewed and where necessary restructured their reporting line for their Consumer Advisors including where relevant Mental Health Consumer Advisors to the relevant Safety and Quality teams.

Actions Underway

Actions Underway Twelve

The Safety and Quality Unit DHW has established the Consumer Feedback and Complaints Management Program Board, which is reviewing the ICAC Report recommendations and establishing a Statewide Consumer Feedback and Complaints Strategic Framework..

Actions Underway Thirteen

The Safety and Quality Unit, DHW in collaboration with Health Consumers Alliance SA and the Program Board, is drafting the Statewide Consumer Feedback and Complaints Management Strategic Framework, expected to be finished by late-2020. The Framework

will provide findings, discussion and recommendations and will join this Final Report as part of the suite of documents describing the implementation of the ICAC recommendations.

Actions Underway Fourteen
The Office of the Chief Psychiatrist has commenced consulting on the contents of a Mental Health Complaint Management Chief Psychiatrist Standard that will create the designation of Authorised Mental Health Consumer Advisor, that can be given to people working as Consumer Advisors who meet the requirements for this designation.

Proposed Actions

Proposed Action Eighteen
It is proposed that the Project Board consider specific changes, namely that:

- Consistent with the current practice post Oakden, as a matter of ongoing policy, all Consumer Advisor positions should report to the executive with responsibility for clinical governance for the whole of the service or Local Health Network they are employed in.
- The Consumer Advisor's duties should principally be for the resolution of complaints on behalf of consumers and carers and secondarily for the safety and quality of the service more generally.
- Consumer Advisor role descriptions should include reference to the relevant provisions of the *Mental Health Act 2009,* the *Health Care Act 2008* and the *Health and Community Services Complaints Act 2004.*

ICAC Recommendation 12 – Restrictive Practices

The Chief Psychiatrist and the Chief Executive review the use of restrictive practices within each Local Health Network with a view to the Chief Psychiatrist exercising power under section 90 of the *Mental Health Act 2009* to issue new standards in relation to the use of restrictive practices and making the observance of those standards mandatory.

Matters for Consideration

- Current standards, policies and plans.
- Review of Chief Psychiatrist policy guideline and standards.
- Review of the use of restrictive practice in mental health services in the last 4 years.
- Review of the restraint devices currently in use.

Discussion

12.1 Introduction

A restrictive practice is an intervention which restricts or removes an individual's freedom of movement. Restrictive practice is used only as a last resort to protect the safety of the individual, or of others, and can take the form 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 use of restrictive practice is a suspension of an individual's usual freedoms and rights and, as such, is subject to greater concern and expectation from the public and Parliament, and is subsequently governed by a vigorous evidence-based regime of standard, policy and procedure, and monitoring and reporting. The use of restrictive practice in mental health services is additionally governed by the subsection 90(1)(b) requirement of the *Mental Health Act 2009* for monitoring by the Chief Psychiatrist. Within (non mental) health services there is use of restraint for people with a mental illness and for other conditions such as intoxication and dementia. The use of seclusion is limited to mental health treatment centres where there are purpose designed facilities.

12.2 Current Standards, Policies and Plans

There is a comprehensive range of standards, policies and plans that require the use of restrictive practice to be minimised and, where possible eliminated, in mental health services, including:

- Mental Health Services Pathways to Care Policy Directive + Policy Guideline 2014.
- National Safety and Quality Health Service Standards 2017 (2nd edition)
- National Standards for Mental Health Services 2010.
- Restraint and Seclusion Application and Observation Requirements Chief Psychiatrist Standard 2015.
- Restraint and Seclusion in Mental Health Services Policy Guideline 2015 + Toolkit.
- Restraint and Seclusion Recording and Reporting Chief Psychiatrist Standard 2015.
- The Fifth National Mental Health and Suicide Prevention Plan 2017.

There are overarching standards and policies that require the use of restrictive practice to be minimised and, where possible eliminated across all SA Health services. The SA Health policies have been undergoing a process of review in 2019. These include:

- Minimising Restrictive Practices in Health Care Policy Directive 2015 and Toolkit.
- Preventing and Responding to Challenging Behaviour Policy Directive 2015 and toolkit.
- National Safety and Quality Health Service Standards 2017 (2nd edition) Standards 1,2 and 5.

To date the review process has included a statewide point prevalence survey of restraint, and subject matter expert review of all elements of these policies and toolkit. The intent is have close alignment between the reporting and other requirements of these and the Chief Psychiatrist Standard to simplify operationalisation in settings that provide care for people restrained under the Mental Health Act and other Acts.

The National Safety and Quality Health Service Standards require health services to have clinical governance systems in place, and to perform ongoing work such as clinical audits and quality improvement, in order to meet the requirements at periodic assessment. All SA Health services that have undergone recent assessment have met these criteria.

Those standards, policies and plans are sound but, as with all matters of clinical practice, need periodic review and updating, and ongoing reinforcement for inclusion in every day practice. The ICAC Report requirement for a review of the Chief Psychiatrist Standard is timely.

12.3 Review of the Chief Psychiatrist Policy Guideline and Standards

In February 2018, a review was commenced of the:

- Restraint and Seclusion in Mental Health Services Policy Guideline 2015 + Toolkit.
- Restraint and Seclusion Application and Observation Requirements Chief Psychiatrist Standard 2015.
- Restraint and Seclusion Recording and Reporting Chief Psychiatrist Standard 2015.

The review has incorporated:

- 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.
- Current interstate and international best practice.
- Use of restraint and seclusion in South Australian mental health services.
- Observations of the Office of the Chief Psychiatrist.
- Relevant state and national standards, policies and plans.
- Findings of complaints, incidents and investigations.
- Findings of the Ombudsman and the Coroner.
- Findings of the Independent Commissioner Against Corruption.

The review of the policy documents found that the 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 has revised its restrictive practice policy documents and has developed a draft Restrictive Practice in Mental Health Services Chief

Psychiatrist Standard and Toolkit for trial and consultation with consumers, carers, mental health services, statutory officers and partner agencies.

12.4 Key elements of the new Chief Psychiatrist Standard

A copy of the current draft of the Standard is available on the Chief Psychiatrist website. It requires mental health services to undertake a range of mandatory actions to prevent restraint and seclusion, to follow practices designed to prevent patients being traumatised, or mitigating the impact of trauma, and has strict requirements for when practices can be used, how they are authorised, and their review. There will be significant new obligations on services related to the review and monitoring of patients in seclusion and how this is carried out.

Staff will be supported with training and a revised toolkit of resources. The aim will be to achieve international best practice in this area, and the new Standard is based on policy and guidelines from the UK and Pennsylvania (a pioneer in restraint and seclusion reduction).

Significantly the Standard will apply every time restraint and seclusion is authorised under the *Mental Health Act 2009* regardless of location, and will extend these initiatives to patients with a mental illness who are being cared for in emergency departments and general wards, and thus confirm the intent of the SA Health Minimising Restrictive Practices in Health Care policy directive.

This sets a rigorous standard to eliminate, where possible, the use of restraints and seclusion. Such actions can both protect consumers from trauma, and reduce the risk of injury to staff through prevention of incidents.

12.5 Review of the Use of Restrictive Practice in Mental Health services

The state wide use of restraint in mental health services decreased significantly (as can be seen in **Table 12.1**) in 2017-18, from 4447 to 2211 total events, a drop of 50% however there has been an increase in the use of seclusion.

The decrease in restraint is not only due to the closure of Oakden Older Persons Mental Health Services but also a renewed understanding of and compliance with the contemporary use of restrictive practices. The overall decrease in events should be considered in the context of an increased focus on the importance of reporting – anecdotally, fidelity to reporting requirements has improved, whilst event numbers have decreased.

There was a 97% decrease in overall mechanical restraint incidents for 2017-18 compared to the previous financial year with the incidence of physical restraint decreasing by 10%. Compared to the 2017-18 financial year, for 2018-19 there was a further 52% decrease in mechanical restraint, and a 3% decrease in physical restraint. However it should be noted that this data reports only on mental health settings, and does not include restraints in emergency departments, other inpatient settings or ambulance.

In contrast to the improvement in restraint, state-wide seclusion incidents increased by 58% in the 2017-18 financial year compared to the previous financial year, and a 2.3% increase in 2018-19. Work to address this has coincided with a review of the levels of use of restrictive practice by the Safety and Quality team of the Office of the Chief Psychiatrist; this increase was more pronounced in some units than others, with feedback given to those services. A progress overview of the review is contained in **Appendix Four**. Since these actions, there has been an improvement in monthly reporting with the numbers of seclusion events declining. The need to address this increase had also been a focus of discussions in regular Trauma Informed Practice committee meetings.

The implementation of the new Standard, supported by quality improvement actions in response to the States' Mental Health Services

It should also be noted that there are an additional several hundred seclusion events each year at James Nash House, the Forensic Mental Health Service, caused by the use of lockdown on many nights, whereby patients are confined to their rooms. For 2018-19, lockdown seclusion occurred 286 times. (This practice also reflects the aged 1980s design of the main James Nash House building which is currently being partially addressed through changes to door hardware, so that routine seclusion overnight does not occur.)

12.6 Restraint Devices

Incorporated public hospitals and licensed private hospitals use a variety of restraint devices to apply restrictive practices to people experiencing mental illness. As a part of the review of the use of restrictive practice and to move towards statewide consistency, the Chief Psychiatrist in June 2019 commenced a process to identify and approve all existing and future restraint devices.

Devices have been systematically reviewed in a process that considers both the device and the clinical situations that it might be used (as per the new Standard). This is expected to reduce the number of devices in use, and support restraint reduction work. The panels reviewing the devices will include people with a clinical background as well as people with a lived experience of mental illness

Completed Actions

Completed Action Fourteen

The Office of the Chief Psychiatrist has consulted on and revised its restrictive practice policy documents and has developed a draft Restrictive Practice in Mental Health Services Chief Psychiatrist Standard and Toolkit for trial and consultation with consumers, carers, mental health services, statutory officers and partner agencies.

Completed Action Fifteen

The Office of the Chief Psychiatrist has reviewed the use of restrictive practices in mental health services across the state. The Office of the Chief Psychiatrist and the Local Health Networks will continue to monitor, analyse and take action on restrictive practice through the existing ongoing Statewide Mental Health Quality Improvement Committee and the Trauma Informed Practice Working Group.

Completed Action Sixteen

The Office of the Chief Psychiatrist has implemented a process to identify and approve all restraint devices used by incorporated public hospitals and licensed private hospitals for people experiencing mental illness.

The list of approved devices will be used to guide practice by services applying mechanical restraint to people for whom the *Mental Health Act* is not applicable

ICAC Recommendation 13 – Allied Health Professionals

The Chief Executive, in conjunction with the Chief Executive Officers, review the level and nature of allied health staff support at facilities at which mental health services are provided by a Local Health Network for the purpose of determining whether there are adequate allied health staff to provide the necessary support at such facilities.

Matters for Consideration

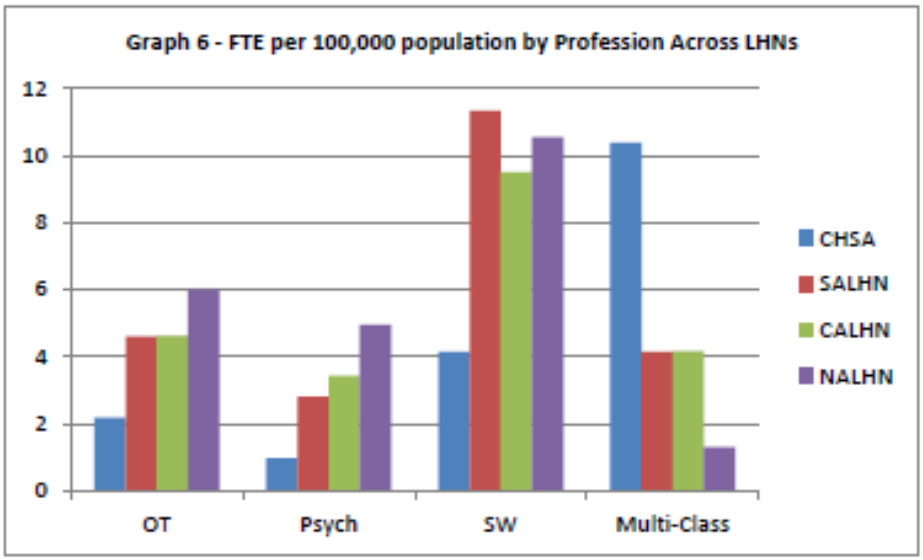
- Current allied health professional staff totals, classification levels and breakdown of full-time, part-time and temporary contract staff.
- Numbers of, and role scope for, each professional group.
- Impacts of allied health professional representation at executive levels, senior allied health professional positions in mental health services and multi-class positions.
- Impacts of the National Disability Insurance Scheme and My Aged Care programme processes and lack of allied health professionals in the broader non-government organisation sector, on public health employed allied health professionals.
- Requirement for mental health models of care and the Mental Health Services Plan to describe appropriate numbers, levels and professional mix of allied health professionals in future service design, planning and implementation.

Discussion

The Allied and Scientific Health Office (ASHO) undertook the review of this recommendation and drafted the *Independent Commissioner Against Corruption: Allied Health Professional Staffing in Mental Health Discussion Paper.* This paper is attached to this report. In summary, the Discussion Paper found:

- Allied health professionals were mostly employed at junior levels and mostly part-time.
- Allied health professionals, particularly at the more junior levels, were mostly employed on temporary contracts.
- Allied health professional positions were often multi-class positions filled by various professions.
- Allied health profession positions were not usually funded for backfill during staff leave or vacancies, directly impacting service provision and continuity.
- There is a paucity of allied health professionals in executive positions.
- There is no consistency for the numbers or professions of allied health professionals employed in mental health services, either within or between Local Health Networks.
- There has been no service-wide strategic planning for the impacts on public health employed allied health professionals from the National Disability Insurance Scheme, My Aged Care and the broader non-government organisation sector.

The following graph from the ASHO Report illustrates the overall nature of this problem.



Source: SA Health Workforce Data Analysis, combination Chris 21 and Payroll information July 2018. Verified by LHN Allied Health Departments September 2018, calculated against 2017 Census population data for MHS catchments provided by Office of the Chief Psychiatrist October 2018.

The analysis by ASHO recommends

- Dedicated Allied Health positions as members of Executive teams
- Increased senior clinical roles
- Identified backfill and succession planning
- Supported integrated care models where all professional input is valued
- Continued supported training

Observations made on Chief Psychiatrist inspections confirm variability across the system. There have been instances of significant gaps in different units, which has been either specific to an allied health discipline, or in community teams been a part of a more general problem in backfilling vacancies for both nursing and allied health. There have also been structural problems in community teams where allied health staff have been employed but social workers and occupational therapists have been limited in their ability to undertake discipline specific assessments and therapies, as opposed to general case management.

For example, occupational therapists in community teams can have as little as 1 day a week to undertaken discipline specific tasks, with the remaining 4 days spent on mental health worker coordination roles. Gaps in occupational therapy have been particularly evident and, while psychologists appear to be more readily able to undertake discipline specific work than other allied health professionals, units can vary in their access to psychologists and neuropsychologists, and access to specific therapies. Social work staff in community teams can also report being limited in their use of social work interventions given the demands of generic case management. There have been noticeable improvements in pharmacy staffing and time allocated in inpatient units in recent years, driven by concerns about medication safety.

In conclusion the review required by this recommendation has been completed by ASHO, and observations confirmed on inspections. This responds to the ICAC recommendation, and confirms that issues related to allied health staffing extend across the mental health system, there is a need to take definitive action. The next phase will require a benchmarking exercise which ASHO and the OCP will undertake. While there is agreement about gaps in allied health, benchmarks have not been resolved, and these should be available to determine staffing.

Benchmarking will take two forms: first benchmarking the specific number of professionals in each team to that will give the appropriate balance of interdisciplinary skills to multidisciplinary skills, and second the need for discipline specific supervision and leadership so that the number of allied health leaders will increase – a specific issue identified by the ASHO review.

While benchmarks can provide a guideline, ultimately access to specific allied health assessments and interventions can be considered on a case by case basis for each of the professions – in this case social work, occupational therapy, psychology, pharmacy and in some settings speech pathology (eg child and adolescent services), physiotherapy (eg older persons services), dietetics and music and art therapists. This can be readily determined by case-note auditing.

A benchmarking exercise will not only consider the total number of people employed, but the tasks they undertake during their workday – in particular maximise the benefit from existing staffing when balancing the time spent on general case coordination work with discipline specific work. This issue has also arisen in the consultation on the mental health services plan. All professions, allied health, nursing and to some extent medicine can spend time undertaking generic coordination and logistic tasks, time that potentially could be better spent providing skilled assessments and interventions based on professional skills. Structural reform emanating from the plan is expected to allow existing resources to be better used to increase access to professional skills and therapies from all professionals as well as systemically involving peer workers in teams.

While benchmarking and allied health leadership can address these structural problems in the medium to long term, additional protections are needed in the short term to ensure that consumers are receiving sufficient allied health interventions required for their recovery. For this reason, as a short term measure while this work is underway, access to allied health will be considered at each Chief Psychiatrist inspection of community mental health teams and inpatient services, with evidence sought when auditing clients notes that they can access necessary assessments and interventions (eg evidence of an appropriate level of allied health involvement). In addition there will be targeted inspections that engage senior allied health staff with delegated powers to join inspection teams. The model has already been used effectively with pharmacists joining the OCP team.

It is evident that progress in this structural change will take some years, and it is proposed that although this is the final ICAC Implementation Report, that yearly updates on this work will be made through the Chief Psychiatrist Annual Report.

Actions Underway

Action Underway Fifteen

The Office of the Chief Psychiatrist and the Allied and Scientific Health Office have commenced the establishment of a working party to consider, over the next 12 months, benchmarks for allied health professionals in different mental health service types and settings, structure and governance options, and training and development requirements.

Action Underway Sixteen

Chief Psychiatrist inspections of community teams and inpatient units now include the review of access to allied health treatment in case note reviews , and include targeted allied health audits involving senior allied staff co-opted to inspection teams to ensure that consumers are receiving the necessary assessments and therapies that would be expected for their condition in a reasonable timeframe.

Where units evidently have insufficient allied health staff, or evidence of lack of access to Allied Health care conditions will be placed on the gazettal of those units either requiring that these interventions are provided (which will then be audited) or in more severe cases restricting services capacity to take on consumers due to inadequate resourcing.

Appendix One – Summary of Actions

Completed Actions

Completed Action No	Description
One	The Office of the Chief Psychiatrist has communicated to the Local Health Networks on a process to amend role descriptions of all staff of a Local Health Network: • to mention the *Mental Health Act 2009,* in addition to the *Health Care Act 2008* and the *Work Health and Safety Act 2012* etc, in the general responsibilities section, and • to explicitly mention the general powers and functions of the Minister and Chief Executive that are routinely carried out by clinical, administrative and management staff.
Two	The Office of the Chief Psychiatrist has communicated to the Local Health Networks to amend the role descriptions of all clinical staff of a mental health service of a Local Health Network to have: • Knowledge and experience of the *Mental Health Act 2009* as an essential criteria. • Carrying out and reporting on the use of powers and functions of the *Mental Health Act 2009* as a key function.
Three	The Office of the Chief Psychiatrist has communicated to the Local Health Networks on adding a text box to organisation charts for Mental Health Services outlining the reporting line for *Mental Health Act 2009* administration.
Four	The Office of the Chief Psychiatrist has communicated to the Local Health Networks on a process for role descriptions of relevant non-clinical staff to have mention carrying out and reporting on the use of the Mental Health Act 2009 as a key function (for example: ward clerks, security guards, compliance officers etc).
Five	The Office of the Chief Psychiatrist has commenced a more comprehensive inspection regime of mostly unannounced inspections, recruiting inspection officers in excess of current funding to meet the expectations of the ICAC recommendations, the community and Parliament.
Six	The Office of the Chief Psychiatrist has developed and published a Chief Psychiatrist Inspections Protocol to describe the purpose of inspections, who will carry them out, what they will look at and outline the processes for preparation, inspection, reports and follow-up.
Seven	The Office of the Chief Psychiatrist and the Safety and Quality Unit have developed a module of the Safety Learning System to document inspection findings and recommendations, which is being used by the OCP. In the future, the module will be able to be used by Local Health Networks to document the progress of actions in response to an inspection.

Eight	The Community Visitor Scheme has established an inpatient visit and inspection regime with 50% of inspections carried out as unannounced, to enable the review of a service as it is operating at that point in time, and 50% of inspections carried out as announced, to enable full consumer, carer and staff participation.
Nine	The Community Visitor Scheme has revised and strengthened its processes for resolving and referring issues that come to its attention.
Ten	A review of the training and qualifications required by Community Visitors has been carried out by Julian Gardner AM.
Eleven	The Specialist Aged Care Service Reform Steering Committee has been established to drive and guide reform and collaboration, with membership comprising: • Central Adelaide Local Health Network. • Country Health SA Local Health Network. • Infrastructure Directorate DHW. • Northern Adelaide Local Health Network. • Office for Ageing Well DHW. • Office of the Chief Psychiatrist DHW. • Safety and Quality Unit DHW. • Southern Adelaide Local Health Network. Subcommittees have also been established to carry out specific tasks, namely the Older Persons Mental Health Service Committee (to develop a model of care) and the Infrastructure Committee (to manage all aspects of refurbishment and construction works).
Twelve	The Rapid Access Service, a multi-disciplinary team that can inreach into nursing homes to provide treatment in situ and assist with the transition of patients from hospital to nursing home, was successfully piloted in the Southern Adelaide Local Health Network and subsequently implemented in the Northern Adelaide Local Health Network. Expansion of the service into the Central and Country Local Health Networks is now commencing.
Thirteen	Each of the Local Health Networks have reviewed and where necessary restructured their reporting line for their Consumer Advisors including where relevant Mental Health Consumer Advisors to the relevant Safety and Quality teams.
Fourteen	The Office of the Chief Psychiatrist has consulted on and revised its restrictive practice policy documents and has developed a draft Restrictive Practice in Mental Health Services Chief Psychiatrist Standard and Toolkit for trial and consultation with consumers, carers, mental health services, statutory officers and partner agencies.
Fifteen	The Office of the Chief Psychiatrist has reviewed the use of restrictive practices in mental health services across the state. The Office of the

	Chief Psychiatrist and the Local Health Networks will continue to monitor, analyse and take action on restrictive practice through the existing ongoing Statewide Mental Health Quality Improvement Committee and the Trauma Informed Practice Working Group.
Sixteen	The Office of the Chief Psychiatrist has implemented a process to identify and approve all restraint devices used by incorporated public hospitals and licensed private hospitals for people experiencing mental illness.

Actions Underway

Action Underway No	Description
One	The Office of the Chief Psychiatrist is developing wording for a short section on the administration of the MH Act that will be added to Local Health Network intranet sites
Two	The Office of the Chief Psychiatrist is developing a fact sheet outlining the overall responsibilities for the administration of the *Mental Health Act 2009* which will be distributed to staff within each Local Health Network
Three	The Office of the Chief Psychiatrist has commenced the process for the establishment of a Training and Learning Steering Committee. The committee will lead the development of a education and training framework as well as monitoring the effectiveness of training programs offered. Membership of the committee will include representatives from Local Health Networks, nominated staff member to represent each of the professional categories, Aboriginal mental health and lived experience.
Four	An independent review of the Safety Learning has commenced. The review is in response to recommendations from the State Coroner's findings into the Chemotherapy under dosing in 2014. The review is being conducted by an expert independent consultant versed in adverse event reporting and management, who is associated with Macquarie University NSW.
Five	The Community Visitor Scheme, in consultation with the Office of the Chief Psychiatrist, is developing a training session and resource on Mental Health Service Standards for Community Visitors to understand and assess the standard of mental health care in the services they visit and inspect
Six	The Infrastructure Directorate is developing a Strategic Asset Management Policy. The Strategic Asset Management Policy sets the principles, approach, and expectations that govern the provision of asset management services to enable SA Health to deliver health care services in high quality infrastructure in an effective and efficient manner
Seven	The Office of the Chief Psychiatrist and the Infrastructure Directorate will access additional capacity until March 2021 to complete combined

	reviews of the facility condition of those mental health inpatient and residential facilities not already reviewed to date as part of inspections.
Eight	Future facility inspections will reference the following standards. For new builds or refurbishments, mental health facilities should be assessed against AusHFG, the Capital Works Policy suite and the NSQHS Standards. For existing services, mental health facilities will also be assessed against these standards, with gaps risk assessed based on the current role of the unit as described in its model of care. Where risk cannot be effectively mitigated, the clinical role of the unit to manage acuity will be reduced based on the physical limitation of the unit. A gazettal notice will be published describing these changes.
Nine	The review of the fitness for purpose of a mental health facility will take into consideration the design and service provision at the time it was built, and current best practice, and make recommendations to provide a contemporary service from that facility either (i) in the existing facility on an ongoing basis with renovation and refurbishment, (ii) in the existing facility with limitations until a new facility can be established, or (iii) the closure of the facility within a determined time frame.
Ten	Refurbishment of Ward 18 at the Repat Health Precinct to become a Neuro-Behavioural Unit is underway. This space will be converted into an 18 bed facility, with a focus on becoming as home-like as possible, in order to support the care of people with extreme symptoms of dementia, including the conversion of some bedrooms into therapy and living spaces and the creation of a therapeutic garden. The refurbishment is expected to be completed by mid-2020.
Eleven	Options for a co-located Specialised Dementia Care Unit, which will cater to the needs of people with severe and very severe dementia, are being explored. The Dementia Care Unit will provide 18 beds of specialist dementia care and form part of a larger facility providing at least 42 additional beds of cottage style accommodation. (Further work required is described in the Oakden Report Response Plan Oversight Committee report and in the Mental Health Services Plan 2020-2025.)
Twelve	The Safety and Quality Unit DHW has established the Consumer Feedback and Complaints Management Program Board which is reviewing the ICAC Report recommendations and other matters relating to complaints and the consumer advisor role.
Thirteen	The Safety and Quality Unit, DHW in collaboration with Health Consumers Alliance SA and the Program Board, is drafting the Statewide Consumer Feedback and Complaints Management Strategic Framework, expected to be finished by late 2020. The Framework will provide findings, discussion and recommendations and will join this Final Report as part of the suite of documents describing the implementation of the ICAC recommendations.
Fourteen	The Office of the Chief Psychiatrist has commenced consulting on the contents of a Mental Health Complaint Management Chief Psychiatrist Standard that will create the designation of Authorised Mental Health

	Consumer Advisor, that can be given to people working as Consumer Advisors who meet the requirements for this designation
Fifteen	The Office of the Chief Psychiatrist and the Allied and Scientific Health Office have commenced the establishment of a working party to consider, over the next 12 months, benchmarks for allied health professionals in different mental health service types and settings, structure and governance options, and training and development requirements.
Sixteen	Chief Psychiatrist inspections of community teams and inpatient units now include the review of access to allied health treatment in case note reviews , and include targeted allied health audits involving senior allied staff co-opted to inspection teams to ensure that consumers are receiving the necessary assessments and therapies that would be expected for their condition in a reasonable timeframe.

Proposed Actions

Proposed Action No	**Description**
One	It is proposed that Terms of Reference for Clinical Governance Committees within Local Health Networks within mental health and at the health executive level includes within their scope specific reference to responsibilities under the following legislation, *Health Care Act 2008* and *Mental Health Act 2009*
Two	It is proposed that LHNs have an annual or bi-annual audit process in place for auditing clinical governance committees to ensure they are meeting regularly, working towards their terms of reference, have clear documentation of their actions, referral of actions to higher committees where required, and documentation of responses to actions.
Three	The Office of the Chief Psychiatrist will audit the existence and awareness of this material in each LHN in 2020. Should material not be available and effectively disseminated a Chief Psychiatrist standard on Staff Orientation and ongoing Education on governance and personal accountabilities will be developed and disseminated under the *Mental Health Act 2009*.
Four	It is proposed that Local Health Networks maintain a report of training on the safety learning system to ensure there is a central register in each LHN of the names of staff who have undertaken training and when this training has occurred.
Five	It is proposed that the Chief Executive Department for Health and Wellbeing nominate a preferred inspection regime model (two yearly vs three yearly inspections) and additional resourcing options.
Six	It is proposed that Local Health Networks review their own resourcing needs for quality improvement in mental health services.
Seven	It is proposed that the combination of the CVS inspection regime from a community perspective and the OCP inspection regime from a clinical

	perspective, given their increased cross-referral and collaboration, is appropriate and effective.
Eight	It is proposed that the terms of appointment for Community Visitors should return to be three years.
Nine	It is proposed that Community Visitors do not require specific qualifications to carry out visits and inspections from a community perspective
Ten	That the *Mental Health Act 2009* place obligations on the Chief Psychiatrist to review the gazettal of a facility, where that facility does not comply with the *Mental Health Act*, with Chief Psychiatrist Standards, or where inadequate facilities may affect the safety and quality of care. A similar requirement should be legislated to review the powers of individual practitioners who do not comply with the Act or standards.
Eleven	It is proposed that section 90 of the *Mental Health Act 2009* be amended to provide the Chief Psychiatrist with the power to request access to and/or copies of any document while not on the premises of a health service that they could otherwise inspect.
Twelve	It is proposed that the *Public Interest Disclosure Act 2018* be amended to make the Chief Psychiatrist and delegates, responsible officers under this Act.
Thirteen	It is proposed that subsection 90(4) of the *Mental Health Act 2009* be amended so that the Chief Psychiatrist has the authority to conduct inspections of the premises and operations of any service determined by the Chief Psychiatrist as an Approved Treatment Centre, Limited Treatment Centre or Authorised Community Mental Health Facility.
Fourteen	It is proposed that sections 90(2) and 90(3) of the *Mental Health Act 2009* be amended to require the Chief Psychiatrist to issue Standards on specific topics.
Fifteen	It is proposed that the *Mental Health Act 2009* be amended to make the Minister, Chief Executive, Governing Boards, Chief Executive Officers and the Chief Psychiatrist jointly responsible for ensuring the standard of mental health care and ensuring compliance with the Act, within their roles, capabilities and other powers and functions, similar to section 16 of the *Work Health and Safety Act 2012.*
Sixteen	It is proposed that the Chief Executive consider resourcing options for inspections, investigations and complaints, Older Persons Mental Health and Forensic Mental Health.
Seventeen	A public report of inspections of mental health facilities will be placed on the SA Health website by July 31 2020.
Eighteen	It is proposed that the Project Board consider specific changes, namely that: • All Consumer Advisor positions should report to the executive with responsibility for clinical governance for the whole of the service or Local Health Network they are employed in.

	• The Consumer Advisor's duties should principally be for the resolution of complaints on behalf of consumers and carers, and secondarily for the safety and quality of the service more generally. • Consumer Advisor role descriptions should include reference to the relevant provisions of the *Mental Health Act 2009,* the *Health Care Act 2008* and the *Health and Community Services Complaints Act 2004.*

Appendix Two – Associated Documents

Documents accompanying this Final Report as part of the suite responding to the ICAC Recommendations:

- Chief Psychiatrist Inspection Protocol. OCP, Feb 2019.
- Chief Psychiatrist Memo – Interim Approval Existing Restraint Devices. OCP, June 2019.
- Official Listing – Chief Psychiatrist Inspection Sites. OCP, August 2019.
- Report – Allied Health Professional Staffing in Mental Health. ASHO, November 2018.
- Report – Review of the Community Visitor Scheme. J Gardner, March 2019.
- Draft Standard – Eliminating Restraint

Appendix Three – Chief Psychiatrist Inspection Sites

Approved Treatment Centres

Inpatient Site/Service	Facility	LHN
Riverland IMHU	Berri Health Service	CHSALHN
18V Ward	Flinders Medical Centre	SALHN
4GP Ward – Eating Disorders		
5H Ward, Margaret Tobin Centre		
5J Ward, Margaret Tobin Centre		
5K Ward, Margaret Tobin Centre		
Emergency Department		
Short Stay Unit		
Aldgate Ward	James Nash House	NALHN
Birdwood Ward		
Clare Ward		
Ken O'Brien Centre		
Jamie Larcome Centre	Glenside Campus	SALHN
Eastern Acute	Glenside Health Service	CALHN
Eastern PICU		CALHN
Helen Mayo House		WCHN
Inpatient Rehabilitation Closed		CALHN
Inpatient Rehabilitation Open		CALHN
Rural and Remote Ward		CHSALHN
1G Ward Closed	Lyell McEwin Health Service	NALHN
1G Ward Open		
1H Ward		
Emergency Department		
Mental Health Assessment Unit		
Short Stay Unit		
Emergency Department	Modbury Hospital	NALHN
Woodleigh House		
Mt Gambier IMHU	Mt Gambier Health Service	CHSALHN
Emergency Department	Noarlunga Health Service	SALHN
Morier Ward Closed		
Morier Ward Open		
Cramond Ward Closed	Queen Elizabeth Hospital	CALHN
Cramond Ward Open		
Emergency Department		
Ward South East – HDU		
2G Ward	Royal Adelaide Hospital	CALHN
Emergency Department		
Whyalla IMHU	Whyalla Health Service	CHSALHN
Adolescent Ward	Women's and Children's Hospital	WCHN
Boylan Ward		
Paediatric Emergency Department		

Authorised Community Mental Health Facilities

Community Site/Service	LHN
Adaire Clinic – Noarlunga Community Mental Health Service	SALHN
Ashton House – Community Forensic Mental Health Service	NALHN
Eastern/Tranmere Community Mental Health Centre	CALHN
Elpida House – Community Rehabilitation Centre	CALHN
Inner South/Marion Community Mental Health Centre	SALHN
North Eastern/Modbury Community Mental Health Centre	NALHN

Northern/Salisbury Community Mental Health Centre	NALHN
Northern/Salisbury Older Persons Mental Health Service	NALHN
Southern/Edwardstown Older Persons Mental Health Service	SALHN
Southern/Noarlunga Intermediate Care Centre	SALHN
Trevor Parry Centre – Community Rehabilitation Centre	SALHN
Western/Queenstown Intermediate Care Centre	CALHN
Western/Woodville Community Mental Health Centre	CALHN
Wondakka – Community Rehabilitation Centre	NALHN

Other Community Mental Health Facilities

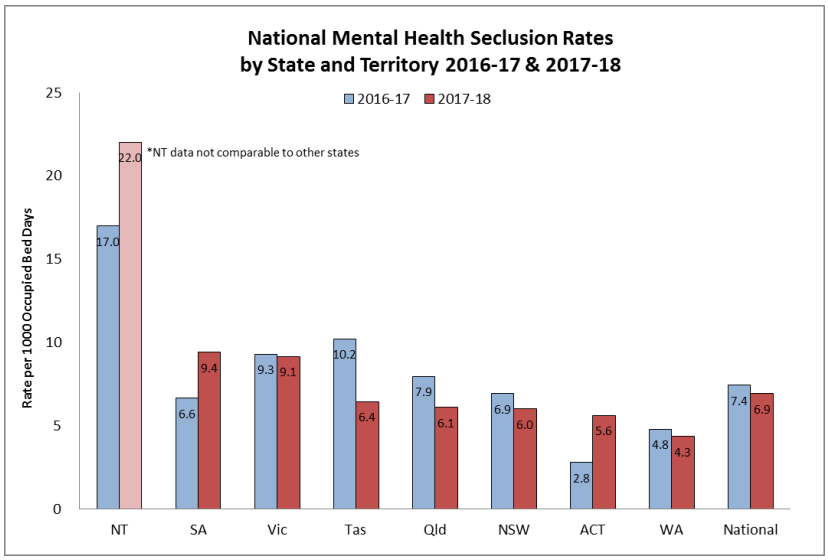
Community Site/Service	**LHN**
Berri – Community Mental Health Team	CHSALHN
Ceduna – Community Mental Health Team	CHSALHN
Centre for Treatment of Anxiety and Depression – Mile End	CALHN
Clare – Community Mental Health Team	CHSALHN
Club 84 – Northern Day Programs	NALHN
Eastern/St Morris Older Persons Mental Health Service	CALHN
Northern Metropolitan Community CAMHS	WCHN
Emergency Triage and Liaison Service	CHSALHN
Gawler/Barossa – Community Mental Health Team	CHSALHN
Kadina – Community Mental Health Team	CHSALHN
Kingscote – Community Mental Health Team	CHSALHN
Lower North Community CAMHS – Clare	WCHN
Southern Metropolitan Community CAMHS	WCHN
Mental Health Triage	CALHN
Minlaton – Community Mental Health Team	CHSALHN
Mount Barker – Community Mental Health Team	CHSALHN
Mount Barker Community CAMHS	WCHN
Mount Gambier – Community Mental Health Team	CHSALHN
Mt Gambier and Limestone Coast Community CAMHS	WCHN
Murray Bridge – Community Mental Health Team	CHSALHN
Murray Bridge Community CAMHS	WCHN
Owenia House – Community Service	NALHN
CAMHS Central Metropolitan – Eastern Team	WCHN
CAMHS Central Metropolitan – Western Team	WCHN
Port Augusta – Community Mental Health Team	CHSALHN
Port Augusta Community CAMHS	WCHN
Port Lincoln – Community Mental Health Team	CHSALHN
Port Lincoln Community CAMHS	WCHN
Port Pirie – Community Mental Health Team	CHSALHN
Port Pirie Community CAMHS	WCHN
Riverland Community CAMHS	WCHN
The Gully – North Eastern Day Programs	NALHN
Victor Harbor – Community Mental Health Team	CHSALHN
Western Rehabilitation and Activity Centre	CALHN
Western/Kidman Park Older Persons Mental Health Service	CALHN
Whyalla – Community Mental Health Team	CHSALHN
Whyalla Community CAMHS	WCHN
Yorke Peninsula Community CAMHS	WCHN

Appendix Four – South Australian Mental Health Seclusion Review – Progress Overview 2018-19

Introduction

The Office of the Chief Psychiatrist (OCP) conducted a targeted review in response to an increase in South Australian acute mental health consumer seclusion rates in the 2017/2018 financial year.

Rate of Seclusion Events, Acute Mental Health Services, by State and Territory by Financial Year



Source data: AIHW MH 2019 Report Seclusion and restraint data.xlsx > Tab: Seclusion data _S&T

As reflected in the above table, the SA Seclusion rate increased from 6.6 in 2016/17 to 9.4 in 2017/18.

The OCP Seclusion review examined possible contributing factors for this increase and recommended strategies to reduce seclusion events.

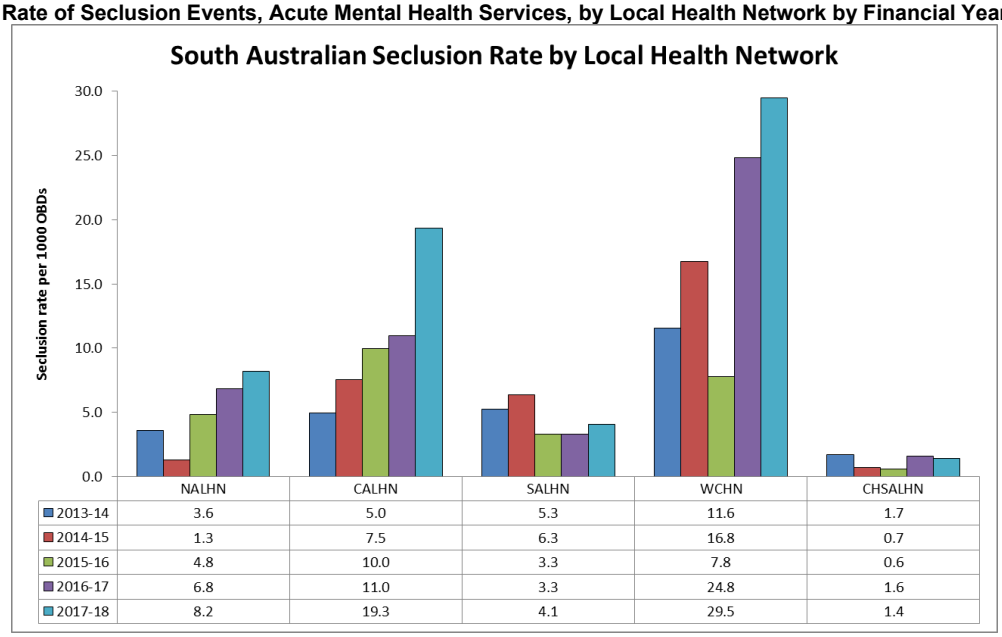
Background

In 2008, the National Association of State Mental Health Program Directors published Six Core Strategies to Reduce Seclusion and Restraint Use. These strategies were developed through extensive literature reviews and dialogues with experts who have successfully reduced the use of restrictive practices in a variety of mental health settings for children and adults across the United States and internationally. These evidence based strategies were first introduced to SA Health staff throughout the implementation of the National Mental Health Seclusion and Restraint Project (2007–2009), also known as the Beacon Project.

Discussion

The OCP review assessed seclusion data at a number of levels. The below table reflects Seclusion Rate by Local Health Network.

Rate of Seclusion Events, Acute Mental Health Services, by Local Health Network by Financial Year



	NALHN	CALHN	SALHN	WCHN	CHSALHN
2013-14	3.6	5.0	5.3	11.6	1.7
2014-15	1.3	7.5	6.3	16.8	0.7
2015-16	4.8	10.0	3.3	7.8	0.6
2016-17	6.8	11.0	3.3	24.8	1.6
2017-18	8.2	19.3	4.1	29.5	1.4

Source data: Request SA SECREST data 2018_Response_v1.xlsx > Tab: S&R Raw Data

The OCP review also considered a wide range of data pertaining to:

- Seclusion Rates for individual units
- Seclusion Event Time of Day
- Seclusion Event Duration
- Seclusion Rates by Target Population (General, Child and adolescent, older persons, forensic)
- Primary Condition Underpinning the Need for Seclusion
- Reason for Applying Seclusion
- Seclusion Rates vs Average Length of Stay
- Seclusion Rates in the context of comparative closed/secure unit data (including staff injuries, number of beds, consumer separations and average length of stay)
- Seclusion Rates vs Valid Inpatient Admission Health of the Nation Outcome Scales (HoNOS) Scores
- Seclusion Rates vs Primary Diagnosis of Consumers
- Contextual Illicit Drug Consumption data for South Australia
- Seclusion Reporting Variances (by mental health staff vs security staff)
- The impact of challenging behaviour incidents on mental health staff

The OCP Seclusion review also involved informal interviews with multi-disciplinary mental health staff from a number of services throughout SA Health. These interviews demonstrated that implementation of the Six Core Strategies was inconsistent across the state.

Findings

It was noted that the elevated seclusion rate for the Women's and Children's Health Network (WCHN) can be attributed to several individual complex consumers. WCHN continue to actively review and implement seclusion reduction strategies.

Since meeting with staff members as a part of this review, it was noted that general awareness of the Six Core Strategies has improved and action has been undertaken to

implement local seclusion reduction initiatives. This has subsequently resulted in a slight decrease in the SA state-wide seclusion rate for the 2018/19 financial year. Preliminary analysis of data suggests that the state-wide seclusion rate for South Australia in 2018/19 will be 9.1, which is a drop from 9.4 in 2017/18.

It is expected that the Central Adelaide Local Health Network (CALHN) Inpatient Rehabilitation Services (IRS) review will also be a contributing factor in the ongoing reduction of seclusion events in future.

Recommendations

1. It is recommended that consideration be given to a coordinated state-wide roll out of the Safewards model[5].
2. It is recommended that consideration be given to the development and implementation of a state-wide Sensory Modulation education program.

[5] Safewards is a model of care designed to reduce conflict (aggression, rule breaking) and containment (coerced medications, restraint and seclusion) in acute adult mental health inpatient units. The Safewards program model proposes that conflict within a ward can arise when a consumer is faced with situations that increase their emotional distress or 'flash points'. The Safewards approach focusses on what staff can do before the consumer reaches a flashpoint by being aware of potential triggers and determining the best method to reduce the impact or best containment method for the situation.

Appendix Five – Reference Material

Letter – Implementation of ICAC Recommendations, SALHN, September 2018
Memo regarding Recommendations Implementation Plan, CALHN,
National Model Clinical Governance Framework, Australian Commission on Safety And Quality, 2017
National Safety and Quality Health Service (NSQHS) Standards - Standard 1: Governance for Safety and Quality in Health Service Organisations
Plain Language Guide Mental Health Act 2009, Office of the Chief Psychiatrist, 2017
Mental Health Act 2009
Response to Implementation of ICAC Recommendations, CHSALHN,

Recommendation One
CAMHS Clinical Governance Framework Structure, WCHN
CAMHS Clinical Safety and Quality Committee, Terms of Reference, WCHN, June 2018
CAMHS Complex Care Review Committee, Terms of Reference, WCHN, December 2015
Clinical Council, Terms of Reference, SALHN, July 2017
Clinical Governance Arrangements, CALHN
Clinical Governance Framework, CALHN, April 2018
Clinical Performance Committee, Terms of Reference, WCHN, February 2018
Clinical Safety and Quality Committee, Terms of Reference, WCHN, February 2018
Clinical Safety and Quality Reporting Structure, WCHN, July 2017
Committee Structure Governance Structure including Reporting, WCHN, February 2018
Community Mental Health Governance Committee, Terms of Reference, SALHN, 2018
Corporate Governance and Accountability Compendium, NSW Health, April 2019
Delivering high-quality healthcare – Victorian clinical governance framework, Safer Care Victoria, June 2017
Division of Mental Health, Committee Chart, NALHN, 2018
Memorandum of Administrative Agreement between Rural and Remote Mental Health Service as governed by the Barossa Hills Fleurieu Local Health Network and the five other Regional Health Networks
Mental Health Clinical Governance Committee, Terms of Reference, CHSALHN, March 2018
Mental Health Governance Committee, Terms of Reference, SALHN, September 2018
Mental Health Governance Structure, CHSALHN, October 2017
Mental Health Innovation and Service Development Committee, Terms of Reference, CHSALHN, March 2018
Mental Health Integrated Clinical and Corporate Governance Committee Structure, SALHN
Mental Health Integrated Governance Committee Structure, SALHN
Mental Health Mortality and Morbidity Committee, Terms of Reference, SALHN
Mental Health Operations Performance Committee, Terms of Reference, CHSALHN, December 2017
Mental Health Project Governance Committee, Terms of Reference, CHSALHN, December 2017
Mental Health Serious Incident Review Group, Terms of Reference, CHSALHN, Draft, February 2016
Mental Health Strategic Executive Committee, Terms of Reference, CHSALHN, February 2017
Overview of CALHN Mental Health Services
Operations Executive Committee, Terms of Reference, WCHN, February 2017
Procedure Governance Committee, Terms of Reference, WCHN, November 2017
Southern Mental Health, Clinical Governance Committee, Terms of Reference, SALHN, 2013

Terms of Reference for a Review of the Clinical Governance of Public Mental Health Services in Western Australia, Department of Health, Government of Western Australia, 2018

Recommendation Two

Organisation Structure – Aboriginal Health, CHSALHN
Organisation Structure – Allied Health Professional Structure, CALHN
Organisation Structure - Allied Health, Spiritual Care, Complex and Sub-Acute Care Directorate, WCHN
Organisation Structure – Chief Operating Officer, WCHN
Organisation Structure – Child and Adolescent Mental Health Service, WCHN, November 2017
Organisation Structure, Child and Family Health Service, WCHN, April 2018
Organisation Structure, Consultation– Child and Adolescent Mental Health Service, WCHN, February 2017
Organisation Structure – Corporate Services Operational Structure, CALHN
Organisation Structure – Corporate Services, WCHN
Organisation Structure – Eastern Services Operational Structure, CALHN
Organisation Structure – Finance, WCHN
Organisation Structure – Medical Professional Structure, CALHN
Organisation Structure – Medical Services, WCHN
Organisation Structure – Medical Services and Clinical Planning, CHSALHN
Organisation Structure - Mental Health Directorate Executive Structure, CALHN
Organisation Structure – Mental Health Service, CHSALHN, 3 January 2018
Organisation Structure – Nursing and Midwifery, WCHN
Organisation Structure - Nursing & Midwifery Services, Quality, Risk and Safety Directorate, CHSALHN, September 2018
Organisation Structure – Older Persons Mental Health Services Operational Structure, CALHN
Organisation Structure – People and Culture, WCHN
Organisation Structure – Proposed – Mental Health Services, SALHN, 2018
Organisation Structure – Western Services Operational Structure, CALHN
Organisation Structure – Women's and Children's Health Network
Role Description, Advanced Nurse Manger - Mental Health RN4, CHSALHN
Role Description, Advanced Clinical Lead Occupational Therapist – Mental Health AHP4, CHSALHN
Role Description, Advanced Clinical Lead Psychology – Mental Health AHP4, CHSALHN
Role Description, Advanced Clinical Lead Social Work – Mental Health AHP4, CHSALHN
Role Description, Advanced Divisional/Stream Nursing and/or Midwifery Director - Mental Health RN, SALHN, 2018
Role Description, Business Manager – Mental Health, CALHN, 2015
Role Description, CAMHS Clinical Director, WCHN, 2015
Role Description CAMHS Director Strategic Operations, WCHN, 2014
Role Description CAMHS Manager Operations Acute and Statewide Nursing Director, WCHN, 2017
Role Description CAMHS Community Services Operations Manager AHP, WCHN, 2017
Role Description, Clinical Director – Central Mental Health Directorate, CALHN, 2013
Role Description, Clinical Director, Mental Health (Medical), CHSALHN
Role Description, Clinical Lead - Mental Health MD2, CHSALHN
Role Description, Clinical Director (Head of Unit) – Forensic Services, Mental Health Services NALHN, undated
Role Description, Co-Director – Operations – Mental Health RN, SALHN, undated
Role Description, Consultant Psychiatrist – Mental Health, SALHN, undated
Role Description, Director, Mental Health Strategy and Operations, CHSALHN
Role Description, Director, Mental Health Strategy and Operations, NALHN, undated

Role Description, Divisional Director – Medical, Mental Health Services, NALHN, 2018
Role Description, Interim Allied Health Director - Mental Health Services, SALHN, 2016
Role Description, Manager Business Operations, Mental Health Directorate, CALHN, 2018
Role Description, Manager Clinical and Corporate Information, Mental Health Directorate, CALHN, 2018
Role Description, Manger Engagement, Mental Health Directorate, CALHN, 2018
Role Description, Manager Strategy and Projects, CHSALHN
Role Description, Network Clinical Director – Mental Health, SALHN, 2018
Role Description, Nurse Unit Manager – Margaret Tobin Centre, SALHN, 2017
Role Description, Nursing and/or Midwifery Service Director – Forensic Mental Health, NALHN, 2018
Role Description, Nursing and/or Midwifery Service Director – Mental Health Services, NALHN, 2018
Role Description, Nursing and or Midwifery Service Director – Older Persons Mental Health, NALHN, 2018
Role Description, Nursing Co-Director – Mental Health Services, CALHN, undated
Role Description, Nursing Director – Clinical Practice, Mental Health Directorate, CALHN, undated
Role Description, Principal Clinical Psychologist, Mental Health Directorate, CALHN, 2018
Role Description, Principal Clinical Psychologist – Mental Health, SALHN, undated
Role Description, Principal Occupational Therapist – Mental Health Services, SALHN, undated
Role Description, Principal Social Worker – Mental Health Services, SALHN, 2016
Role Description, Regional Manager – Mental Health AHP, CHSALHN
Role Description, Regional Manager – Mental Health ASO8, CHSALHN
Role Description, Regional Manager –Mental Health RN4, CHSALHN
Role Description, Senior Business Manager – Mental Health, SALHN, 2017
Role Description, Senior Manager Acute Services/Director of Nursing RN, CHSALHN
Role Description, Senior Manager Community Services Mental Health AHP, CHSALHN
Role Description, Senior Manager Community Services Mental Health RN, CHSALHN
Role Description, Service Improvement Lead ASO, CHSALHN
Role Description, Service Manager, RN5.3, Mental Health Directorate, CALHN, undated
Role Description, Service Manager, AHP5, Mental Health Directorate, CALHN, 2018
Role Description, Team Leader – Eastern Clinical Psychosocial Rehabilitation Program AHP4, Mental Health Directorate, CALHN, 2018
Role Description, Team Leader – Mental Health AHP 3, CHSALHN
Role Description, Team Leader – Mental Health RN3, CHSALHN
Role Description, Team Manager (Advance Nurse Unit Manager) – Jamie Larcombe Centre, SALHN, 2018
Role Description, Team Manager, Elpida House, AHP4, Mental Health Directorate, CALHN, 2018
Role Description, Team Manager – Inpatient Rehabilitation Services AHP4, Mental Health Directorate, CALHN, 2018
Role Description, Statewide and Speciality Services Nursing Director – Mental Health RN, SALHN, 2018
Role Duty Statement Boylan Medical Unit Head – Example only, WCHN, undated
Role Duty Statement, Head of Unit – Emergency Mental Health/MH Short Stay Unit, SALHN, 2017
Role Duty Statement, Head of Unit - Inner South Carramar Community Mental Health Team, SALHN, 2016
Role Duty Statement – Head of Unit - Inner South Community Mental Health /Youth Mental Health Services, SALHN, 2018
Role Duty Statement, Head of Unit - Inner South Marion Community Mental Health Team, SALHN, 2016

Role Duty Statement – Head of Unit - Mental Health Acute Inpatient Services FMC, SALHN, undated
Role Duty Statement – Head of Unit - Older Persons Mental Health Services, SALHN, undated
Role Duty Statement – Head of Unit - Outer South Mental Health, SALHN, undated
Role Duty Statement, Head of Unit - Psychological Therapy Services, FMC, SALHN, 2018
Role Duty Statement, Head of Unit - Veterans Mental Health Services, SALHN, undated

Recommendation Three
CALHN Intranet Site – CALHN Mental Health
CHSALHN Intranet Site -
NALHN Intranet Site – NALHN Mental Health
SALHN Intranet Site – SALHN Mental Health Services
WCH Intranet Site – CAMHS

Recommendation Eight
CEO Executive Service Contract, Department for Health and Wellbeing.
CEO Role Description, Department for Health and Wellbeing.
Health Care Act 2008, South Australia.
Mental Health Act 2007, New South Wales.
Mental Health Act 2009, South Australia.
Mental Health Act 2013, Tasmania.
Mental Health Act 2014, Victoria.
Mental Health Act 2014, Western Australia.
Mental Health Act 2015, Australian Capital Territory
Mental Health Act 2016, Queensland.
Mental Health and Related Services Act 2018, Northern Territory.
Mental Health Compulsory Assessment and Treatment Act 1995, New Zealand.
Oakden – a shameful chapter in South Australia's History, 2018. Independent Commissioner Against Corruption, South Australia.
Service Level Agreement, Department for Health and Wellbeing.

Recommendation Nine
Accreditation Policy Directive, SA Health, 2012
Australasian Health Facility Guidelines, (AusHFG), 2016
Australasian Health Infrastructure Alliance. The guidelines include - *Health Planning Unit (HPU 131) Mental Health – Overarching Guideline*[1], a new guideline that describes the generic planning and design requirements to be considered when planning mental health inpatient units (HPUs). Note: HPUs are currently being reviewed and this work will be completed by the end of 2018.
Australian Commission on Safety and Quality in Health Care
https://www.safetyandquality.gov.au/
Australian Health Service Safety and Quality Accreditation (AHSSQA) Scheme
Australian Institute of Health and Welfare https://www.aihw.gov.au/
Capital Works Benefits Evaluation Policy Guideline, SA Health, 2018
Capital Works Implementation Policy Guideline, SA Health, 2018
Capital Works Implementation Review Policy Guideline, SA Health, 2018
Capital Works Planning Policy Guideline, SA Health, 2018
Capital Works Policy Directive 2018, SA Health, 2018
Health Care Act 2008

https://www.safetyandquality.gov.au/our-work/assessment-to-the-nsqhs-standards/australian-health-service-safety-and-quality-accreditation-scheme/
Mental Health Act 2009
National Safety and Quality Health Service (NSQHS) Standards (Second Edition), 2018
National Safety and Quality Health Service Standards user guide for health services providing care for people with mental health issues, 2018
National Standards for Mental Health Services, 2010
Oakden – a shameful chapter in South Australia's History, 2018. Independent Commissioner Against Corruption, South Australia.

Recommendation Twelve
Annual Report of the Chief Psychiatrist of South Australia 2017-18
Australian Commission on Safety and Quality in Health Care
Australian Health Service Safety and Quality Accreditation (AHSSQA) Scheme
Australian Institute of Health and Welfare
Health Care Act 2008
Mental Health Act 2009
National Mental Health Commission – Monitoring and Reporting Framework on Mental Health
National Safety and Quality Health Service (NSQHS) Standards (Second Edition)
National Safety and Quality Health Service Standards user guide for health services providing care for people with mental health issues
National Standards for Mental Health Services 2010
SA Health - Minimising Restrictive Practices in Health Care Policy Directive
SA Health - Restraint and Seclusion in Mental Health Services Policy Guideline
Suicide Prevention