Preliminary Report

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

Chief Psychiatrist of South Australia

December 2018

Government of South Australia
SA Health

For more information

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ISBN

Dr Chris McGowan
Chief Executive
Department for Health and Wellbeing

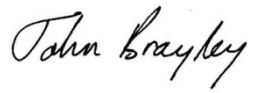
Dear Chief Executive

Please find attached a preliminary report of work undertaken within the Office of Chief Psychiatrist to respond to recommendations made by Independent Commissioner Against Corruption, in his report on Oakden.

This contains work responding to recommendations directed at the Chief Psychiatrist, Chief Executive and Minister.

A final report of the implementation will be provided to the Chief Executive by 30 June 2019.

Yours sincerely



Dr John Brayley
Chief Psychiatrist

31 December 2018

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

Foreword

The Office of the Chief Psychiatrist was asked to lead the response to the ICAC Commissioners Oakden Recommendations, on behalf of the Department for Health and Wellbeing. This work has involved researching and reviewing material related to recommendations directed at the Chief Psychiatrist and the Chief Executive of SA Health. Our team has also worked with other relevant Branches in the Department the Quality Information Performance Branch, related to safety, quality and reporting recommendations Infrastructure related to the condition of infrastructure and the Allied and Scientific Health Office related to the adequacy of allied health staffing in services. Consultation has also occurred with the Principal Community Visitor and the Local Health Networks.

A number of recommendations have already been partly implemented. Regular unannounced Chief Psychiatrist inspections are underway using staff from our Mental Health Safety and Quality team, and a new standard for these inspections prepared and subject to consultation. Estimates of future resource requirements for full roll out are have been prepared and are included in this report.

The Principal Community Visitor has also increased the number of unannounced inspections undertaken. The Minister has engaged Julian Gardner, an eminent legal practitioner and inaugural Public Advocate in Victoria in response to the Commissioner's recommendation that the Minister cause a review to be undertaken on the training and education of Visitors.

The OCP's ICAC Implementation Team of Ben Sunstrom, Michele Burman, and Paul Roberts has conducted its own review of Local Health Network mental health governance and accountability, and identified the need for explicit references to *Mental Health Act 2009* responsibilities, in key management documents, and clarity in the varied structures related to reporting and responsibility.

It became apparent in this work that the *Mental Health Act 2009* itself may need reform to deliver better accountability and governance. While on one hand the responsibilities related to compulsory care are stated in details, and the Act does have objects and principles outline broader responsibilities for delivering safe and high quality services, upholding rights and the prevention of harm – principles that apply to all those involved in administering the Act; on the other hand the Act is not explicit on how the responsibilities that emanates from these principles flows down to clinical , leaders, administrators, and front line staff and does not expand on the broader role of the Chief Executive in the delivery of clinical care, in the same way that the *Health Care Act 2008* does generally. This will be considered further as the final report is developed, in particular whether responsibilities should be expanded in the Act, or explicit reference made in the *Mental Health Act 2009* for the requirement to adhere to *Health Care Act 2008* obligations. It should also be noted that more than one person may have a similar duties and obligations related to patient care, and the system can break down if any one individual does not uphold that duty.

While much of the content of this report has led to actions, or will be followed on by future plans, some elements, such as those related to possible legislative change, will require further and wider discussions with key parties.

I wish to thank the team that has undertaken the review, and key executive in the Department who have provided feedback on the issues and plans in this paper prior to its presentation to yourself.

John Brayley
Chief Psychiatrist

Executive Summary

This Preliminary 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, Quality Information Performance Branch, Southern Adelaide Local Health Network, and the Women's and Children's Health Network.

This Preliminary Report will outline the ICAC Report recommendations, the topics considered, the work undertaken so far, the work yet to be done and will propose actions to address matters, where possible. This Report will also be used to prompt discussion, seek feedback and carry out consultation on ICAC Report recommendations, matters considered and actions proposed, to better inform the Final Report.

The Final Report is expected to be complete in June 2019.

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

A review has commenced of the clinical governance arrangements for mental health services in South Australia, and will consider 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.* The Final Report will propose actions to make the governance of mental health service and the *Mental Health Act 2009* consistent across South Australia. The Final Report will also provide a discussion, and possible proposed actions, relating to the interaction and overlap between the *Health Care Act 2008* and the *Mental Health Act 2009.*

Recommendation 2 – Mental Health Roles and Responsibilities

A review has been undertaken of the roles and responsibilities of Local Health Network staff regarding clinical care and *Mental Health Act 2009* functions and has 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.* It is proposed that: reference to the Act as a general responsibility is made in the role descriptions of all LHN staff, the role descriptions of relevant non-clinical staff should reference the Act as a key function, the role descriptions for mental health service clinicians should reference the Act in both key functions and essential criteria, and reporting lines for the Act should be included on organisational charts.

Recommendation 3 – Communication of Governance and Responsibilities

A review has been 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. It is proposed that the Office of the Chief Psychiatrist develop material for the Local Health Networks to publish and promote. The Final Report will provide discussion and possible proposed actions for a structured campaign for communication, infographics and media.

Recommendation 4 – Local Health Network Training

A review has commenced of the training systems and resources available to Local Health Network staff for the Safety Learning System, obligations and procedures under legislation

and policy, work currently underway on training systems, and the *Mental Health Act 2009* and mental health clinical practice. The Final Report will provide discussion, and proposed actions, for these matters.

Recommendation 5 – Chief Psychiatrist Inspections

The Office of the Chief Psychiatrist has commenced a more frequent inspection regime and has developed version 1 of a Chief Psychiatrist Standard – Inspections; the Office will consult on both before the Final Report. A review has been undertaken of the history of Chief Psychiatrist inspections, the enhanced inspection regime so far, and the options for inspection regime models going forward . It is proposed that the Chief Executive and the Minister nominate a preferred enhanced inspection regime – annual, biennial or triennial. The Final Report will also provide discussion and proposed actions relating to options for legislative change for inspections and a comparison with the other inspection and investigation regimes operating in South Australia.

Recommendation 6 – Community Visitor Scheme Inspections

The Community Visitor Scheme has commenced carrying out more unannounced visits and inspections. A review is underway 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. That review will be undertaken by Mr Julian Gardner, former Public Advocate of Victoria, in collaboration with the Principal Community Visitor. The Final Report will provide discussion, and proposed actions, for these matters.

Recommendation 7 – Community Visitor Training and Qualifications

A review has commenced 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. That review will be undertaken by Mr Julian Gardner, former Public Advocate of Victoria, in collaboration with the Principal Community Visitor. The Final Report will provide discussion, and proposed actions, for these matters.

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 Chief Executive Officers 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;* the differences between the role of a regulator and the operator of a service; and options available for enhancing positive obligations for the Chief Psychiatrist and others. It is proposed that: a designated officer or authority in the Department (not the Chief Psychiatrist) be responsible for prosecution of offences under the *Mental Health Act 2009,* compliance with the *Mental Health Act 2009* should be explicit in contracts and service level agreements with the Chief Executive Officers of Local Health Networks, the separation of regulator and operator functions should be made clear in the developing SA Health governance changes, the Chief Psychiatrist must have Standards relating to certain matters, and it should be an explicit condition of facility determination under the Act by the Chief Psychiatrist that failure to adhere to those Standards can result in revocation of a facility's determination. In addition, some optional proposed actions for the consideration of the Chief Executive and Minister include: a function for the Chief Psychiatrist to ensure/promote compliance with the Act, a function for the Chief Executive to also be responsible for the standard of mental health care, and legislation options for multiple officers to be responsible, within their powers and role, for the same legislative functions.

Recommendation 8b – Resources of the Office of the Chief Psychiatrist and other Agencies

A review is underway of the staffing and other resources necessary for the Office of the Chief Psychiatrist, and the Allied and Scientific Health Office, Community Visitor Scheme, Infrastructure Directorate, Local Health Networks, and Quality Information Performance Branch, to carry out existing and proposed powers, functions and responsibilities. The Final Report will provide discussion and options for staffing and other resources.

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. It is proposed that: the Local Health Networks, the Infrastructure Directorate, the Quality Information Performance Branch and the Office of the Chief Psychiatrist collaborate to develop additional assessment criteria; develop a Strategic Asset Management Framework, a register for assessment findings and responses, and a Project Plan; and commence the review of facilities in two phases, focussing in the first instance on facilities with *Mental Health Act 2009* determinations and then in the second phase reviewing other specialist mental health services.

Recommendation 10 – Implementation of the Chief Psychiatrist Oakden Report

The Office for the Ageing is coordinating, in collaboration with other branches of the Department for Health and Wellbeing, and the Local Health Networks, the implementation of the findings of the Chief Psychiatrist Oakden Report, the Oakden Report Response Plan Oversight Committee and the SCOPE SA Steering Committee.

Recommendation 11 – Consumer Advisors

The Quality Information Performance Branch has commenced a project to review consumer advisor: roles and responsibilities in general and mental health settings, roles and responsibilities in other jurisdictions, training to manage complaints, systems and processes for the reporting and escalation of complaints, line management and supervision, independence and options available for enhancing training, independence and reporting. The project is expected to be complete in June 2019 and the project report will inform the Final Report.

Recommendation 12 – Review of Restrictive Practice

A review has commenced of the use of restraint and seclusion in mental health settings and of the current policy guideline and standards. The review of the use of restrictive practice will be completed in early 2019, with an updated policy guideline and standard suite to be published by June 2019.

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 Discussion Paper of that review is available in Appendix 13.1. It is proposed that the Paper be submitted to the Department, the Local Health Networks and the Workforce Working Group of the Mental Health Service Plan to inform planning and service design.

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 commitment to addressing all recommendations.

The Chief Executive of SA Health in May 2018 requested that the Chief Psychiatrist and Director of Mental Health Strategy 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 this Preliminary Report which outlines a number of proposed actions as well as the work required to further implement the remaining recommendations.

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 Introduction

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 includes:

- **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.

An important component of a functioning clinical governance system is a committee structure which can assist in reviewing incidents, accreditation reports, key performance indicators, and setting policy direction for continuous improvement.

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.

Preliminary Work

1.2 Clinical Governance

Terms of Reference for the current clinical governance committees have been provided by each of the five Local Health Networks as well as committee structures. A review has commenced on each of these to determine if administration of the *Mental Health Act 2009* is currently covered within the Terms of Reference.

Contact will be made with other jurisdictions to determine how their mental health legislation is linked to their clinical governance structures. This will assist in weighing up whether it is better to include administration of the Act in general health clinical governance structures, just mental health clinical governance structures or both.

Consideration will need to be given to requesting a sample of copies of agendas, minutes and action lists from the Local Health Networks. While the Terms of Reference will assist in determining the scope of what is discussed, the membership and frequency of the meeting it will not provide a total picture of the effectiveness of the committee. The minutes and action lists will assist in providing information on what is documented as discussed at the meeting, what is minuted as an action and how actions are followed up.

1.3 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.

A review of the interaction and overlap between the Acts will be provided in the Final Report and will inform the final discussion and proposed actions in section 8.7 of this report.

Proposed Actions

To be provided in the Final Report.

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

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.

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 Mangers 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 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 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 current 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.

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 2.2** 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 positons 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 see **Appendix 2.1**, they were not included in the total figures in the Check List for the respective LHN.

Findings

Part One – Organisational Structures

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.

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. While it likely accurately depicts the various reporting lines, the amount of detail included made it difficult to read.

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 their main structure 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

Part Two – 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 an essential criteria.

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.

Responsibilities of staff in non-clinical roles within mental health services

The clinical governance framework does not define clinical governance responsibilities for staff in administration or other support roles in clinical mental health services.

The National Safety and Quality Health Service (NSQHS) Standards – Standard 1: Governance for Safety and Quality in Health Service Organisations 1st edition provides the following role definition for the non-clinical workforce

The role of the **non-clinical workforce** is important to the delivery of quality health care. This group may include administrative, clerical, cleaning, catering and other critical clinical support staff or volunteers. By actively participating in organisational processes – including the development and implementation of safety systems, improvement initiatives and related training – this group can help to identify and address the limitations of safety systems. A key role for the non-clinical workforce is to notify clinicians when they have concerns about a patient's condition.

The *Mental Health Act 2009* does assign responsibilities for the administration of the Mental Health Act 2009 through the delegation of a power from the Director of a Treatment Centre to staff of a Treatment Centre.

In Part 1 (3) – Interpretation of the Act, staff of a Treatment Centre is defined as follows:

Staff of a treatment centre, means the director of the centre, or any person performing duties involved in the administration or operations of the centre, whether under a contract of employment or some other contractual arrangements

While this issue is outside of the scope of the recommendations of the ICAC report, consideration will need to be made on including a statement on the Act administration to role descriptions for non-clinical staff that are located in either a Treatment Centre or Hospital setting.

Preliminary Work

The Final Report will contain a discussion about the benefits and draw-backs of different mental health system governance models, including sole psychiatric leads, co-direction between a psychiatrist and another profession, and multi-disciplinary management, with a contrast between service governance and Act governance. Similarly, how the different mental health system governance models should work with safety quality risk systems, Local Health Network systems and the new Boards will be explored.

Proposed Actions

Proposed Action One

It is proposed that the role descriptions of all staff of a Local Health Network:

- Should 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
- That consideration should be given to explicitly mentioning the general powers and functions of the Minister and Chief Executive that are routinely carried out by clinical, administrative and management staff.

Proposed Action Two

It is proposed that the role descriptions of all clinical staff of a mental health service of a Local Health Network should have:

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

Proposed Action Three

It is proposed that consideration should be given to adding a text box to organisation charts for Mental Health Services outlining the reporting line for *Mental Health Act 2009* administration.

Proposed Action Four

It is proposed that the role descriptions of relevant non-clinical staff should 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).

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

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.

Findings

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 (SSMS) 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.

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 so are not able to make any findings on these.

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 is not currently possible to provide any findings on other modes of communication due to the limited numbers of examples provided. It will be proposed that a small information section is drafted by the Office of the Chief Psychiatrist for inclusion on LHN intranet sites on overall responsibility for staff of mental health services for the administration of the Act. This section could refer staff to the Chief Psychiatrist website for further information. It will also be proposed that a fact sheet on administration of the *Mental Health Act 2009* responsibilities be drafted and distributed to staff within the Local Health Networks.

Preliminary Work

Structured Campaign for Communication, Infographics and Media

The Final Report will provide discussion and possible proposed actions for the establishment of a dedicated ASO6 Senior Project Officer to manage a structured ongoing campaign for communication, infographics, and media (including social media) about mental health services and the *Mental Health Act 2009*, to consumers and carers, the public, general health services, mental health services, other Government departments and agencies, non-government organisations and statutory officers. That position could be placed in the Office of the Chief Psychiatrist or in the nascent Wellbeing SA.

Proposed Actions

Proposed Action Five

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

Proposed Action Six

The Office of the Chief Psychiatrist develops 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.

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 the Safety Learning System.
- 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 Quality Risk training content.
- System, facility and service-culture barriers to staff use of 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 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.

Preliminary Work

Discussion of and proposed actions relating to the matters for consideration outlined above will be provided in the Final Report.

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 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.*

5.2 Outline of Enhanced Inspection Regime

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.

Table 5.2 – Use of Inspections Powers in 2018

Matter	Unannounced	Announced	Total
Jan to Mar	6	-	6
Apr to Jun	2	2	4
Jul to Sep	8	5	13
Total Jan to Sep	16	7	23

For the July to September quarter, the OCP temporarily employed an additional 2.0 FTE clinical and safety and quality officers from unexpected internal savings. The additional two staff worked with the staff of the 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 addition, the Deputy Chief Executive SA Health committed an extra $800,000 to the Office of the Chief Psychiatrist in August 2018 to address increased workload, which included a Senior Inspections Officer, at the ASO7 / RN3 / AHP3 level, which has enabled the Office to temporarily 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. See section 8b of this report for more information.

The Office of the Chief Psychiatrist will monitor inspection findings, recommendations made, and service improvement outcomes, as outlined in the *Chief Psychiatrist Standard – Inspections* (see section 5.4 of this report below and appendix 5.1), to determine if the enhanced inspection regime is driving service improvement and health outcomes for consumers and carers.

5.3 Comparison with other Inspection and Investigation Regimes

To be developed. The Final Report will compare and contrast the different inspection and investigation regimes that occur in South Australian facilities that provide mental health services, to provide an overall perspective of the legislative and standards regimes currently in use, a discussion of what matters are relevant to each regime, and a discussion of where the Chief Psychiatrist and Community Visitor Scheme regimes fit in the total regime framework. That comparison will include the following inspection and investigation regimes:

- Accreditation audits against the National Safety and Quality Health Service Standards – Australian Health Service Safety and Quality Accreditation Scheme.
- Accreditation of aged care facilities – Australian Aged Care Quality Agency.
- Analysis of adverse incidents (Part 8, *Health Care Act 2008*) – Local Health Networks.
- Complaints reviews and investigations – Health and Community Services Complaints Commission.
- Complaints reviews and investigations – Local Health Networks.
- Incident reviews and investigations – Local Health Networks.
- Investigation of suspected abuse of vulnerable adults – Adult Safeguarding Unit, Department for Health and Wellbeing.
- New or refurbished health facilities inspections – Quality Information Performance, Department for Health and Wellbeing.
- Review of programs for people with mental incapacity – Public Advocate.
- Safety Quality Risk audits – Local Health Networks and Department for Health and Wellbeing.
- Visits and inspections – Community Visitor Scheme.

The powers of investigation of the Ombudsman and the Independent Commissioner Against Corruption will not be reviewed as they are purposefully broad, to enable review of the functions of the whole of Government.

5.4 Chief Psychiatrist Standard – Inspections

The Office of the Chief Psychiatrist has drafted a *Chief Psychiatrist Standard – Inspections* to provide clarity, certainty and guidelines for the use of inspection powers. The Standard 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 Standard 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 Standard. See Appendix 5.1 for the full Chief Psychiatrist Standard and Appendix 5.2 for a listing of sites and services slated for inspection.

5.5 Options for Legislative Changes

To be developed, to be informed by the work underway in sections 5.3 and 6.3. The Final Report will discuss the possibility and appropriateness of options for amendments to the *Mental Health Act 2009* to require the Chief Psychiatrist to carry out inspections in certain circumstances and to report the findings of certain inspections to the Chief Executive or the Minister.

5.6 Options for Inspection Regime Models

Each inspection takes one week in total for two Full Time Equivalent officers to complete. The time required is of course spread over several weeks and includes preparation, inspection, analysis, reporting and follow up as described in **Table 5.3**.

Assumptions in the calculations are as follows:

- Each inspection takes 1 week of effort in total (distributed over 1 to 4 weeks).
- Each inspection requires 2 Full Time Equivalent Officers, though up to half a dozen different officers with different expertise may be involved in each inspection.
- There are only 44 weeks available for inspection work each year (4 are removed by public holidays and other immediate work, and 4 are removed because of annual leave).
- There are 103 separate units/sites that require inspection (see Appendix 5.2), with about 26 (25%) usually requiring a follow up inspection. Allowing for a couple of inspection requests from the Chief Executive or the Minister, the total inspections per regime cycle would be 130.

The existing Safety, Quality and Risk Team, if they were to continue to contribute 0.6 FTE to inspections under the parameters described above, would be able to complete one regime cycle every 4.9 years. However, that is not possible as the Team already has a workload over the capacity of the incumbent 3.0 FTE staff, including: complaints, coronials, incidents, investigations, mental health safety and quality policy, and statewide mental health safety quality risk committees, data analysis and reporting.

Table 5.3 – Outline of Inspection Processes

Stage	Actions
Preparation	• Collate and analyse existing documentation for site: complaints, incidents, other inspection reports, workplace instructions. • Logistics for inspection team availability and travel.
Inspection	• Visit site, inspect all areas and equipment. • Engage with consumers, carers and staff. • Review casenotes. • Liaise with managers at inspection completion.
Analysis	• Document inspections findings. • Analyse findings against: complaints, incidents, other inspection reports, workplace instructions. • Compare to legislation, policy and best practice requirements.
Reporting	• Draft report with findings, analysis and recommendations. • Consult with health service regarding errors of fact, progress so far on actions and existing mechanisms that could address findings. • Final report submitted to health service.
Follow up	• Register report and recommendations in OCP database. • Refer relevant recommendations to other service improvement processes or agencies. • Follow up with health service or other agency regarding progress at relevant intervals. • Close off recommendations when complete. • Report inspections quarterly to the Minister and yearly in the Annual Report of the Chief Psychiatrist.

Table 5.4 below provides calculations for three options: annual, biennial and triennial inspection regimes cycles. For example, the annual inspection regime option is based on all 130 inspections required being undertaken in the 44 weeks available for work in a year, requiring 5.9 FTE. The inspection team required, described below the table, would be composed of full-time and part-time staff, to enable access to the full range of expertise required.

Table 5.4 – Staffing and Timeframes for Inspection Regime Options

Calculations	Annual	Biennial	Triennial
Inspections / sites	130	130	130
Work weeks available	44	88	132
Staff required	5.9 FTE	3.0 FTE	2.0 FTE

Option 1 – Annual Inspection Cycle

Main Team

- 2.0 FTE RN3/AHP3/SW3 Senior Clinician
- 1.5 FTE ASO7 Senior Safety and Quality / Project Officer
- 1.0 FTE ASO3 Project / Admin Support Officer
- 0.5 FTE Consultant Psychiatrist
- 0.2 FTE Consumer Consultant
- 0.2 FTE Carer Consultant
- 0.1 FTE Chief Psychiatrist

Additional Team as required

- 0.1 FTE Interstate Expert Consultant (as required)
- 0.1 FTE Other OCP staff (as required)

Option 2 – Biennial Inspection Cycle

Main Team

- 1.0 FTE RN3/AHP3/SW3 Senior Clinician
- 1.0 FTE ASO7 Senior Safety and Quality / Project Officer
- 1.0 FTE ASO3 Project / Admin Support Officer

Additional Team as required

- 0.1 FTE Consultant Psychiatrist
- 0.1 FTE Consumer Consultant
- 0.1 FTE Carer Consultant
- 0.1 FTE Chief Psychiatrist
- 0.1 FTE Interstate Expert Consultant (as required)
- 0.1 FTE Other OCP staff (as required)

Option 3 – Triennial Inspection Cycle

Main Team

- 1.0 FTE RN3/AHP3/SW3 Senior Clinician
- 0.5 FTE ASO7 Senior Safety and Quality / Project Officer
- 0.5 FTE ASO3 Project / Admin Support Officer

Additional Team as required

- 0.1 FTE Consultant Psychiatrist
- 0.1 FTE Consumer Consultant
- 0.1 FTE Carer Consultant
- 0.1 FTE Chief Psychiatrist
- 0.1 FTE Interstate Expert Consultant (as required)
- 0.1 FTE Other OCP staff (as required)

Option one, while creating a faster inspection cycle and getting to every mental health service every year, would require a large additional staffing resource and would generate a large additional volume of work for the OCP, the Local Health Networks, the Department and the Minister, which may not be able to be addressed within the year.

Option two would create a reasonable biennial timeframe for all mental health services to be inspected, a 2-year timeframe for Local Health Network responses and service improvement, and would create a small dedicated full-time team able to support the in-kind expert contributions of the staff of the OCP and the Local Health Networks.

Option three would create an inspection regime cycle that could be synchronised with the triennial accreditation of health services against the National Safety and Quality Health Service Standards. However, this option does not build expertise in a dedicated full-time team and is more reliant on the part-time in-kind contributions of the staff of the OCP and the Local Health Networks.

On balance, the Office of the Chief Psychiatrist recommends option 2, to strike a balance between frequency of inspection, resources required, building expertise and work generated. However, it is acknowledged that the pecuniary constraints effecting the Department for Health and Wellbeing and the Government of South Australia must also be considered.

5.7 Commencement of New Inspection Regime

The commencement of a new inspection regime will create additional work for the Local Health Networks, the Department for Health and Wellbeing (in particular the Quality Information Performance Branch and the Infrastructure Directorate) and the other programs and regimes the Office of the Chief Psychiatrist might refer matters to, such as the Community Visitor Scheme or the accreditation auditors of the Australian Health Service Safety and Quality

Accreditation Scheme. The current reform of the Local Health Network governance to a Board structure, and the reform of the Department to include Wellness SA and a Commissioner for Innovation and Excellence in Health Care, are both major change activities that will significantly impact on the capacity of the system and each organisation to carry out additional work. To appropriately support the system, the Department and the Local Health Networks to manage an increased inspection regime, and the consequent work, will require an initial investment above that required by the ongoing regime.

The work required to establish an enhanced inspection regime would include: developing/adapting systems to manage recommendations and actions taken, training staff and managers, supporting staff and managers to address individual recommendations, support staff and managers to address systemic recommendations, developing/adapting queueing systems for work and training, working with existing safety, quality and risk systems, and developing/adapting referral mechanisms to external agencies.

Option four – That the initial phase of the enhanced inspection regime should be supported by additional resources in the Office of the Chief Psychiatrist as outlined below:

- Option 1 – Annual Inspections: The initial phase of the enhanced regime would take place over 2 years, to enable the proposed 5.9 FTE to carry out all the development, training and support work required, before the ongoing annual regime commences.
- Option 2 – Biennial Inspections: The initial phase of the enhanced regime would take place over 2 years, and would require 5.9 FTE as described in section 5.6 above, which would reduce to 3.0 FTE after the initial phase.
- Option 3 – Triennial Inspections: The initial phase of the enhanced regime would take place over 3 years and would require 3.0 FTE as described in section 5.6 above, which would reduce to 2.0 FTE after the initial phase.

Option five – That the enhanced inspection regime should be developed and implemented over a longer period of time within the current FTE of the Department and the Local Health Networks.

The Office of the Chief Psychiatrist recommends option four so that, whatever inspection regime model is chosen (from one to three), the regime is supported for the initial phase to build the capacity of the systems and staff of the Local Health Networks, the Department and external agencies to manage the increased workload through a period of significant organisational change.

Proposed Actions

Proposed Action Seven
It is proposed that the Chief Psychiatrist continue to carry out an enhanced inspection regime, to periodically inspect all mental health facilities and conduct unannounced inspections as required.

Proposed Action Eight
It is proposed that the Chief Executive SA Health and the Minister for Health and Wellbeing nominate a preferred inspection regime model.

Proposed Action Nine
It is proposed that the Chief Executive SA Health and the Minister for Health and Wellbeing nominate a preferred model for the resources to support the commencement of the enhanced inspection regime.

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.

Discussion

6.1 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.

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 Gazetted 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.

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.

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

6.2 Outline of Enhanced Visit and Inspection Regime

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 50% of the required bi-monthly visits to mental health facilities as announced inspections, and 50% as unannounced inspections. The CVS will monitor the issues found, concerns raised with health services, and resolution of those concerns over the coming 18 months to contrast the effectives of the previous and current visit regime.

Preliminary Work

6.3 Comparison with the Visit and Inspection Regimes of Other Jurisdictions

The Office of the Chief Psychiatrist has engaged Mr Julian Gardner AO, former Victorian Public Advocate who also established the Community Visitor Scheme in that State, to conduct a review of the Community Visitor Scheme regarding ICAC recommendations 6 and 7, and propose actions in relation to:

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

Mr Gardner will provide a report to the Office of the Chief Psychiatrist in early 2019, which will then become an appendix of the Final Report and inform the final discussion and proposed actions for items 5.3, 6.3, 6.5, and 7.4.

In addition, WestWood Spice is carrying out a National Review of Community Visitor Schemes on behalf of the NDIS Quality and Safeguarding Framework, with a report due in December 2018. The discussion and findings of that report may also inform the Final Report.

6.4 Comparison with the Other South Australian Inspections Regimes

To be developed. This matter will be explored fully in section 5.3 of the Final Report.

6.5 Differences between a Community Visitor Scheme versus other Inspection Regimes

To be developed, to be informed by work underway in sections 5.3 and 6.3. In the Final Report this discussion section will describe the conceptual and practical differences between a community-based regime such as the Community Visitor Scheme, with a focus of inspection against the reasonable expectations of the general community, and a clinical- or legislation-based regime, such as Chief Psychiatrist inspections or accreditation audits for the National Safety and Quality Health Service Standards, with a focus of inspection against defined standards and legislation.

6.6 Options for Reporting and Responding

To be developed, to be informed by the work underway in sections 5.3 and 6.3. In the Final Report this section will explore possible legislative, standards or policy options for the communication of, and responsibility for, findings and recommendations of the Community Visitor Scheme provided to the Local Health Networks and the Chief Psychiatrist.

Proposed Actions

To be developed for publication in the Final Report. This recommendation is directed at the Principal Community Visitor, who will determine final actions in response.

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.

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.

7.2 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.

7.3 Qualifications of Current Community Visitors

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

7.4 Comparison with the Qualification and Training Requirements of other Jurisdictions

An initial review of the Community Visitor Schemes, and equivalent schemes, of other Australian jurisdictions is summarised in **Table 7.2**. That review indicates that 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 7.2 – Qualifications Required and Training Regimes of other Jurisdictions

State	Qualifications	Training Regimes
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.	Annual training day. Support to attend regular training both in the ACT and NSW.
NSW	One CV in each panel (of two) required to be a medical practitioner or a suitably qualified clinical person	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	Panel consist of three with two from a legal or medical profession	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	No formal qualifications	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	No formal qualifications	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	No formal qualifications	Comprehensive induction, stream specific & report writing training and attend regular other training on topical issues (optional)
WA	No formal qualifications	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.

The initial review also indicates that there is considerable consistency with training and support provided to Community Visitors. 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.

A full discussion of these matters is yet to be developed, based on the review in Mr Julian Gardner's report. See section 6.3.

7.5 Options for Qualifications and Training Requirements

To be developed, to be informed by Mr Julian Gardner's report (see section 6.3) and the exploration of the differences between a community visitor scheme and a clinical or legislation inspection scheme to be made in section 6.5.

Proposed Actions

To be developed for publication in the Final Report, based on Mr Julian Gardner's report.

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.
- Differences between the role of a regulator and an operator of services.
- 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

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 of non-compliance, or, for more significant matters, writing formally to a Chief Executive Officer or making a report to AHPRA.

In summary, the existing powers, functions, and statutory nature of the role empower the Chief Psychiatrist with an adequate obligation to promote compliance with the Act. If greater clarity and certainty is required however, it is proposed that an obligation similar to subsection 90(1)(a) of the *Mental Health Act 2009* be added, requiring the Chief Psychiatrist to promote compliance with the Act.

See report section 8.7 for additional options.

8.2 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 and are usually considered as part of an individual's claim against SA Health. 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 Ageing, who is not the Chief Psychiatrist, be responsible for the prosecution of offences under the *Mental Health Act 2009.*

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.

8.3 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.

Ultimate responsibility to ensure the appropriate standard of patient care and service delivery sits with the Chief Executive of SA Health, as per section 7(1)(c) of the *Health Care Act 2008*. This responsibility is inclusive of the standard of mental health care and is discussed in more detail in report section 8.4 below.

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, to provide effective connected, but by necessity different, responsibilities for both the regulator and operator of mental health services for the standard of care provided. For more information about the role of a regulator versus that of an operator, see report section 8.6 below.

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.

See report section 8.7 for additional options.

8.4 Current Obligations of the Minister and Chief Executives

There are a number of current positive obligations relating to Act compliance and the standard of health care that are the responsibility of the Minister, the Chief Executive of SA Health, and the Chief Executive Officers of the Local Health Networks. These positive obligations are part of legislation, policy, service contracts and service level agreements, as outlined in **Table 8.1** below:

In summary, in relation to the standard of health care, the Minister is responsible for providing facilities and services, and education and training; the Chief Executive and Chief Executive Officers are responsible for ensuring the standard of health care, that health care addresses the needs of the community, legislative compliance and policy compliance; and the Chief Psychiatrist for promoting the continuous improvement of mental health services. The obligations of the Minister and Chief Executive come from legislation and the obligations of the Chief Executive Officers come from policy and contract. Together, this suite of positive obligations addresses the issue relating to the standard of mental health care at a number of levels. However, if greater clarity and certainty is required, it is propsed that an obligation similar to subsection 7(1)(c) of the *Health Care Act 2008* is placed in the *Mental Health Act 2009* (requiring the Chief Executive to ensure the standard of mental health care) be made.

The issue relating to a positive obligation for Act compliance is not addressed in as many ways, instead being attended to by inference in the CEO Executive Service Contract, the Service Level Agreement and the Role Description that the Chief Executive Officers of Local Health Networks are bound by. It is proposed that a requirement for compliance with the *Mental Health Act 2009* be introduced explicitly into the Executive Service Contracts and Service Level Agreements of the Chief Executive Officers of the Local Health Networks.

8.5 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 8.2** below for a summary of those powers or **Appendix 8.1** for a more detailed listing.

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

Current positive obligations of the Minister
Source and Responsibility
Mental Health Act 2009, sections 86(b) and 86(f) • Develop/promote a strong and viable treatment and care system, and a full range of services and facilities for people with mental illness. • Develop/promote education and training, and accountability systems, for mental health services.
Current positive obligations for the Chief Executive of SA Health
Source and Responsibility
Health Care Act 2008, sections 7, 30, 33 and 63 to 75 • Ensure appropriate standards of patient care and service delivery. • Responsible for the administration of incorporated hospitals. • An incorporated hospital must be administered and managed to address the health needs of the community. • Part 7 – Quality, improvement and research. • Part 8 – Analysis of adverse incidents.
Current positive obligations for the LHN Chief Executive Officers
Source and Responsibility
SAES CEO Executive Service Contract Part 5 – Duties • Carry out the RD, in accordance with the Executive Performance, the SAES Charter, the SAES Executive Competency Framework and all relevant legislative requirements. Schedule 3 • Within the areas under the control of the Executive, ensuring the observance of Government requirements and the objectives, values, principles and standards in, or made under, the Act. Specific Performance Criteria, Key accountability 6 – Legislative requirements • Obligations under the *Work Health and Safety Act 2012* and WorkCover Standards, *Public Finance and Audit Act 1987*, *Health Care Act 2008*, *Public Sector Act 2009* and *Public Sector (Honesty and Accountability) Act 1995* satisfied.
Service Level Agreement 8 Regulatory and Legislative Framework • The LHN, as an incorporated hospital under the *Health Care Act 2008*, is responsible for the planning and delivery of purchased health services and ensuring compliance with the legislation as it applies to the LHN. 9 Local Health Network Accountabilities • The LHN must comply with all legislation applicable to the LHN, including the *Health Care Act 2008*; Corporate and Clinical Governance Requirements • The LHN CEO is to have structures and processes in place to fulfil statutory obligations and to ensure good corporate and clinical governance, as outlined in *Health Care Act 2008*, relevant South Australian legislation and regulations, and SA Health policies.
Role Description • The CEO is responsible for ensuring the LHN effectively performs its statutory functions and for ensuring that the LHN provides accessible, integrated, safe, quality healthcare.

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.

Table 8.2 – 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	-

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. When compared to other jurisdictions, it is not proposed that the Chief Psychiatrist requires additional powers or functions.

8.6 Role of a Regulator versus an Operator of a Service

A regulatory authority is a public official or government agency responsible for exercising autonomous authority over some area of human activity or service. Regulatory authorities are commonly established to enforce safety and standards, and protect consumers in sectors where there is a lack of effective choice or competition. Regulatory authorities have statutory authority for carrying out their role, which can include making regulations and standards, monitoring and overseeing activity, and conducting audits and inspections. Regulatory authorities are often also involved with the licensing of and conditions imposed on operators.

An operator of a service is the official or body responsible for the management, performance, decision making, organisation, delivery, finance, human resources, planning and infrastructure required for a service to function. An operator can conduct the business of the service as they deem appropriate, within the framework of regulation, capacity and budget they operate under.

The separation of the role of the regulator and the operator of a service is based on ethics, best business practice and the protection of the public, and leads to greater accountability, transparency and public confidence. The separation of the roles also promotes probity and reduces conflicts of interest, allowing both the regulator and the operator to better carry out their functions without perceived or actual impropriety.

In South Australia, the Local Health Networks are the operators of mental health services and the Chief Psychiatrist is the regulator. The Department for Health and Wellbeing has a broader regulator function regarding general health safety and quality, policy and contracting, which also effect mental health services. It is proposed that the regulator and operator functions for mental health services remain separate in South Australia, and that this be taken into consideration with the development and implementation of the Health Service Boards and the Commissioner of Service Excellence.

8.7 Other Options Available

Language

While the Chief Psychiatrist's powers and functions are described in an adequate way from a legislative point of view, greater clarity and certainty for the public and the Parliament may be created by the use of stronger, more positive language. While strengthening the language may not necessarily increase the potency, applicability or effectiveness of a particular power or function, it may enhance understanding and thus also compliance. If stronger language is deemed appropriate, the provisions drafted should take into consideration the existing powers of other individuals and agencies, and the differing roles of a regulator and an operator, to ensure a sound matrix of responsibility between individuals, statutory officers and health services.

If greater clarity and certainly is required, it is proposed that the language of section 90(1)(a) be changed from "promote" the continuous improvement to "ensure", or a similar more positive legislative term.

Alternatively, it is possible for different officers to have the same functions and powers, and for each to be responsible for carrying them out in accordance with their role and position. 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, both the Chief Executive of SA Health and the Chief Psychiatrist could 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 position, capacity, and functions and powers. Section 1.3 of this Report has more information, for further development in the Final Report.

Chief Psychiatrist Standards and Compliance

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 sections 90(2) and 90(3) of the *Mental Health Act 2009* be amended to require the Chief Psychiatrist to issue Standards relating to:

- Administration of and compliance with the Act
- Electro-Convulsive Therapy
- Inspections
- Restrictive Practice
- Rights of Consumers and Carers
- Treatment and Care Plans

The Act further refines 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.

The connection of Standards and the determination of a place as a facility under the Act would provide the Chief Psychiatrist with a mechanism to both promote compliance with the Act and to promote the standard of mental health care, without introducing new powers or displacing the powers currently ascribed to other individuals, statutory positions or health services.

It is proposed that sections 96, 97 and 97A of the *Mental Health Act 2009* be amended to provide that if a facility does not comply with the requirements of a Chief Psychiatrist Standard, that facility may be subject to conditions or limitations set by the Chief Psychiatrist, or may have its determination as a facility under the Act revoked.

Summary

While the Chief Psychiatrist's powers and functions are adequate, from a legislative point of view, for ensuring compliance with the Act and the standard of mental health care, that adequacy may not be apparent to the public or to the Parliament, as it is an emergent quality drawn from the many provisions of the Act and the statutory nature of the position. To provide greater clarity and certainty for the public and the Parliament, it may be necessary to introduce amendments to strengthen the language of some powers and functions. Proposed actions made for these matters have been phrased as "if greater clarity and certainty is required" and are optional considerations for the Minister and the Chief Executive. The remaining proposed actions are more straight-forward and have been made to address issues identified during the review of the powers and functions of the Chief Psychiatrist.

Proposed Actions

Proposed Action Ten
If greater clarity and certainty is required for the responsibility of the Chief Psychiatrist for ensuring compliance with the Act, it is proposed that an obligation similar to subsection 90(1)(a) of the *Mental Health Act 2009* be added, requiring the Chief Psychiatrist to ensure compliance with the Act.

Proposed Action Eleven
It is proposed that a designated officer or authority in the Department for Health and Ageing, who is not the Chief Psychiatrist, be responsible for the prosecution of offences under the *Mental Health Act 2009.*

Proposed Action Twelve
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.

Proposed Action Thirteen
If greater clarity and certainty is required for the responsibility of the Chief Executive to ensure the standard of mental health care, it is proposed that an obligation similar to subsection 7(1)(c) of the *Health Care Act 2008* should be added to the *Mental Health Act 2009* to ensure standards of mental health care and service delivery.

Proposed Action Fourteen
It is proposed that a requirement for compliance with the *Mental Health Act 2009* be introduced explicitly into the Executive Service Contracts and Service Level Agreements of the Chief Executive Officers of the Local Health Networks, and to the equivalent future contracts and agreements with Health Service Boards.

Proposed Action Fifteen
It is proposed that the regulator and operator functions for mental health services remain separate in South Australia, and that this be taken into consideration with the future development and implementation of the Health Service Boards and the Commissioner of Service Excellence.

Proposed Action Sixteen
If greater clarity and certainly is required for positive obligations for the Chief Psychiatrist, it is proposed that:

- The language of section 90(1)(a) be changed from "promote" the continuous improvement to "ensure", or a similar more positive legislative term, or

- The option for the Chief Executive and the Chief Psychiatrist to have the same power, as per section 16 of the *Work Health and Safety Act 2012,* be explored.

Proposed Action Seventeen
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 relating to:

- Administration of and compliance with the Act
- Electro-Convulsive Therapy
- Inspections
- Restrictive Practice
- Rights of Consumers and Carers
- Treatment and Care Plans

Proposed Action Eighteen
It is proposed that sections 96, 97 and 97A of the *Mental Health Act 2009* be amended to provide that if a facility does not comply with the requirements of a Chief Psychiatrist Standard, that facility may be subject to conditions or limitations set by the Chief Psychiatrist, or may have its determination as a facility under the Act revoked.

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 to carry out existing powers, functions and responsibilities relating to:
    - Administration of and compliance with the Act.
    - Inspections.
    - Safety and Quality, and Service Improvement.
    - National, State and Departmental Functions.
    - Strategy and Planning.
- 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.
- Staff and other resources necessary for the Allied and Scientific Health Office, Community Visitor Scheme, Infrastructure Directorate, Local Health Networks, and Quality Information Performance Branch to carry out proposed powers, functions and responsibilities proposed in this report.

Preliminary Work

Initial Increased Resourcing

From July 2018 the Office of the Chief Psychiatrist employed extra staff from unexpected internal savings to carry out additional work identified in the first half of the year, namely 2.0 FTE clinical and safety and quality officers to carry out inspections (preparation, visits, reporting and follow up) and 1.0 FTE clinical planning officer to work with the staff of the Mental Health Strategy Team, the South Australian Mental Health Commission and the broader mental health sector to draft the Mental Health Services Plan.

In addition, the Deputy Chief Executive SA Health committed an extra $800,000 to the Office of the Chief Psychiatrist in August 2018 to address increased workload, comprising:

- SAES1 Director Mental Health Policy, Planning and Safety.
- ASO7 Senior Accountability and Compliance Officer.
- ASO7/RN3/AHP3 Senior Inspections Officer.
- ASO7 Senior Clinical Planning Officer.
- And 0.3 FTE Senior Clinical Lead to carry out inspections and reviews as required.

Establishment of and recruitment to those positions is underway.

Possible ICAC Report Resourcing

Discussion and proposed actions for recommendation 8b of the ICAC Report will be provided in the Final Report of the Chief Psychiatrist. The work undertaken so far in this Preliminary Report indicates that there may be staff and resource implications for the Office of the Chief Psychiatrist for proposed actions relating to:

- Recommendation 5 – Increase the use of inspections by the Chief Psychiatrist.
- Recommendation 8 – Possible change to powers and functions of the Chief Psychiatrist.

In addition, the work undertaken in this Preliminary Report indicates that there may be staff and resource implications for other agencies for proposed actions relating to:

- Recommendation 4 – Train staff in SLS use, mandatory reporting and SA Health policy and procedure.
- Recommendation 6 – Increase the use of inspections by the Community Visitor Scheme.
- Recommendation 7 – Possible changes to the training and qualifications of Community Visitors.
- Recommendation 9 – Review the condition and fitness for purpose of mental health facilities.
- Recommendation 10 – Implement reform of Older Persons Mental Health Services based on the Oakden-related recommendations of the Chief Psychiatrist and the Oakden Report Response Plan Oversight Committee.
- Recommendation 11 – Train and support Consumer Advisors.

See the relevant sections of this report for more information.

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

The Chief Psychiatrist's Oakden Report considered the condition of the infrastructure at the Oakden facility as one of the causes of the poor standard of care provided. The review stated: *The substandard quality of the infrastructure is likely to have led to considerable difficulty providing appropriate management of the most severe challenging behaviours of Dementia. Furthermore, the infrastructure has led to low morale and frustration among staff and led to some visitors becoming distressed by the environment in which their loved one has to reside*.

In response to recommendation 9 of the ICAC Oakden Report it is proposed that the Local Health Networks, the Infrastructure Directorate and the Office of the Chief Psychiatrist carry out a review of the condition and fitness for purpose of mental health facilities in South Australia. That review will be informed by the matters discussed below in sections 9.1 to 9.6 of this Report. A Project Plan for the review can be found in **Appendix 9.3**.

9.1 Current Facility Responsibilities and Governance

The Local Health Networks are responsible for monitoring 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 that LHNs allocated budget.

All maintenance works, both rolling / scheduled and emergency / unscheduled is undertaken by approved contractors from 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.
- Delivering property and security services across SA Health.

- Managing the delivery of biomedical engineering services.

The Quality Information and Performance (QIP) Branch, 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.
- Chief Psychiatrist inspection.
- Community Visitor Scheme visit and inspection.
- Infrastructure Directorate review of capital works.
- Local Health Network maintenance review.
- 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.

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

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.

However, work underway by the Local Health Networks, the Infrastructure Directorate, the QIP Branch and the Office of the Chief Psychiatrist may indicate other criteria that facilities should be assessed against. It is proposed that these agencies collaborate to determine if there are any other criteria that the condition and fitness for purpose of mental health facilities should be assessed against.

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 not possible to continually upgrade each facility to meet all new and emerging treatment modalities, as the incurred costs and interruptions to clinical care would not be acceptable.

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, and current best practice, and make recommendations for future service provision based on adapting the existing facility and best practice to provide a contemporary clinical service with good outcomes, which may result in a service that is different to one 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. See **Appendix 9.1** for a complete listing.

In addition, there a 45 other community specialist mental health services sites that may require a facility condition inspection. See **Appendix 9.2** for a complete listing.

It is proposed that the review of the condition of mental health facilities be undertaken in two phases, the first examining the condition of facilities that have had *Mental Health Act 2009*

determinations and the second examining the condition of the remaining specialist mental health services.

9.6 Strategic Asset Management Framework

In response to recommendation 9 the South Australian Government 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.

It is proposed that the Infrastructure Directorate develop 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).

The Infrastructure Directorate has commenced working on the Framework, which is expected to be complete in February 2019.

Proposed Actions

Proposed Action Nineteen

It is proposed that the Local Health Networks, the Infrastructure Directorate and the Office of the Chief Psychiatrist carry out a review of the condition and fitness for purpose of mental health facilities in South Australia.

Proposed Action Twenty

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 the NSQHS Standards. For existing non-new services, mental health facilities should be assessed against the NSQHS Standards.

Proposed Action Twenty One

It is proposed that the Local Health Networks, the Infrastructure Directorate, the QIP Branch and the Office of the Chief Psychiatrist determine if there are any other criteria that the condition and fitness for purpose of mental health facilities should be assessed against.

Proposed Action Twenty Two

It is proposed that the review of the condition of mental health facilities be undertaken in two phases, the first examining the condition of facilities that have had *Mental Health Act 2009* determinations and the second examining the condition of the remaining specialist mental health services.

Proposed Action Twenty Three

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, and current best practice, and make recommendations for future service provision based on adapting the existing facility and best practice to provide a contemporary clinical service with good outcomes, which may result in a service that is different to one delivered in a contemporary facility.

Proposed Action Twenty Four
It is proposed that the Infrastructure Directorate develop 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).

Proposed Action Twenty Five
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.

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 Oakden the Implementation Plan and associated governance structure to continue the work required for the implementation of the recommendations from the Oakden Oversight Committee.

Discussion

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.

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

In response to the Oversight Committee Report, an implementation plan has been developed. The plan will be overseen by the establishment of a Steering Committee. The Steering Committee will include membership from the Department for Health and Wellbeing, and Local Health Networks.

Executive leads from the Department for Health and Wellbeing who will be responsible for leading the implementation work across the recommendations have been assigned as follows:

- Sites, Structures and Facilities – Executive Director, Infrastructure
- Policy and Practice - Chief Psychiatrist and Executive Director, Quality, Information and Performance

- Aged Care Performance and Governance – Executive Director, Quality Information and Performance and Executive Director, Policy and Governance

Importantly, it is proposed that the new service be called Specialised Care for Older People SA (SCOPE SA), to forge a clear break with the stigma attached to the Oakden Older Persons Mental Health Service.

The Office for the Ageing will provide project support to the Steering Committee with a progress report on implementation due in June 2019

Proposed Actions

Proposed Action Twenty Six

It is proposed that the Office for the Ageing, Department for Health and Wellbeing executive leads and the Local Health Networks continue to collaborate to implement the findings of the Chief Psychiatrist Oakden Report, the Oakden Report Response Plan Oversight Committee and the SCOPE SA Steering Committee.

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.

Preliminary Work

The Quality Information and Performance Branch, Department for Health and Wellbeing, will undertake a project to review this recommendation and other matters, with a report expected in June 2019.

The project will be a collaboration between QIP, the Health Consumers Alliance, the Health and Community Services Complaints Commissioner and the Local Health Networks, to consider and make recommendations regarding a number of consumer feedback and participation matters, including:

- Matters for consideration as outlined above.
- A review of the Consumer Feedback Management Policy Directive, Policy Guideline and Toolkit 2015.
- Communication strategies for keeping Consumer Advisors up to date with policy and process developments.
- Community of Practice options available for Consumer Advisors across the State.
- Comparison of generic versus specialised Consumer Advisors.
- Compliance with Standard 2 – Partnering with Consumers – of the National Safety and Quality Health Service Standards.
- Current training available and future training requirements.
- Impacts of the disestablishment of the Health Consumers Alliance.
- Impacts of the establishment of 10 new governing boards and the focus of consumer engagement shifting to Local Health Networks.
- Inclusion into the Service Level Agreements with Local Health Networks.
- Purpose and history of the Consumer Advisor role.

Proposed Actions

Proposed Action Twenty Seven

It is proposed that the QIP Branch considers the matters raised by the ICAC Report as a part of their total review of Consumer Feedback and Participation positions, systems and policies.

Proposed Action Twenty Eight

It is proposed that the QIP Branch 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 *Health Care Act 2008* and the *Mental Health Act 2009.*

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.
- Broad review of the use of restrictive practice in mental health services in the last 4 years.
- Detailed review of the use of restraint in mental health services.
- Detailed review of the use of seclusion in mental health services.

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 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.

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.
- Minimising Restrictive Practices in Health Care Policy Directive 2015 + Toolkit.
- National Safety and Quality Health Service Standards 2017 (2nd edition).
- National Standards for Mental Health Services 2010.
- Preventing and Responding to Challenging Behaviour Policy Directive 2015.
- 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.

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 Policy Guideline and Standards 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.

That review will incorporate:

- 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 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 will examine restrictive practice in SA and around Australia, be informed by recommendations of the Independent Commissioner Against Corruption (ICAC) report of the investigation into possible maladministration at the Oakden Older Persons Mental Health Service, take into account the submissions received through the policy consultation process and make recommendations for practice change to be embedded in the revised policy documents.

A Point Prevalence Survey in Restrictive Practices was conducted in 2018 by the Local Health Networks, which will inform the review of the use of restrictive practice and the redrafting of the policy and standard suite.

Two half day workshops, one for consumers and carers and one for health service staff, took place in December 2018 as part of the consultation process.

Once feedback and information provided at the workshops has been collated, drafting will be deferred until the detailed review of the use of restraint and of seclusion has been completed in the first quarter of 2019, when final drafting will take place, incorporating up-to-date data and feedback from the sector, of the policy and standard suite.

It is expected that new standards will be robust and will be modelled on international best practice where jurisdictions have dramatically reduced the use of restrictive practices in their quest to eliminate their use where possible.

12.4 Broad Review of the Use of Restrictive Practice over the Last 4 Years

The state wide use of restrictive practice in mental health services (as can be seen in **Table 12.1**) for 2017-18 has decreased significantly from 4447 to 1804 total events, a drop of 59%, This decrease is thought to be due to the closure of Oakden Older Persons Mental Health Services and renewed understanding and compliance with the contemporary use of restrictive practice.

There has been a 97% decrease in overall mechanical restraint incidents for 2017-18 compared to the previous financial year. The use of chemical restraint has also decreased by 27%, with the incidence of physical restraint decreasing by 47%.

In contrast, state-wide seclusion incidents increased by 27% in the 2017-18 financial year compared to the previous financial year.

Table 12.1 – Restrictive Practice Event by Type

Type of Event	2014-15		2015-16		2016-17		2017-18	
	No	%	No	%	No	%	No	%
Restraint – chemical	649	14.5	523	14.6	343	7.7	252	14.0
Restraint – mechanical	2550	57.2	2057	57.2	2745	61.7	88	4.9
Restraint – physical	509	11.4	607	16.9	357	8.0	189	10.5
Seclusion	753	16.9	409	11.4	1002	22.5	1275	70.7
Total	**4461**	**100**	**3597**	**100**	**4447**	**100**	**1804**	**100**

It should also be noted that there were an additional 365 seclusion events at James Nash House, the Forensic Mental Health Service, during 2017-18 caused by the use of lockdown every night, whereby patients are confined to their rooms. (This practice also reflects the aged 1980s design of the main James Nash House building which will need to be addressed, so that routine seclusion overnight does not occur.)

12.5 Review of Restraint

A detailed review of the use of restraint has commenced and the results of that review, and any proposed actions that may arise, will be published in the Final Report.

12.6 Review of Seclusion

A detailed review of the use of seclusion has commenced and the results of that review, and any proposed actions that may arise, will be published in the Final Report.

Proposed Actions

Proposed Action Twenty Nine

It is proposed that the review of the Restraint and Seclusion in Mental Health Services Policy Guideline, Toolkit and Chief Psychiatrist Standards be completed in early 2019, with an updated policy and standard suite to be published by June 2019.

Proposed Action Thirty

It is proposed that any required consequential changes to Departmental restrictive practice policy be referred to the Quality Information and Performance Branch for inclusion in the next update of those documents.

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 undertook the review of this recommendation and drafted the *Independent Commissioner Against Corruption: Allied Health Professional Staffing in Mental Health Discussion Paper.* For the full paper see **Appendix 13.1**. In summary, the Discussion Paper found:

- Allied health professionals were mostly employed at junior levels.
- Allied health professionals were mostly employed as 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.

Proposed Actions

Proposed Action Thirty One

It is proposed that the Workforce Working Group of the Mental Health Service Plan considers the content and findings of the Discussion Paper and incorporates them into the Service Plan and subsequent action and implementation plans.

Appendix One – Summary of Proposed Actions

Proposed Action No	Description
One	It is proposed that the role descriptions of all staff of a Local Health Network: • Should 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 • That consideration should be given to explicitly mentioning the general powers and functions of the Minister and Chief Executive that are routinely carried out by clinical, administrative and management staff.
Two	It is proposed that the role descriptions of all clinical staff of a mental health service of a Local Health Network should 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	It is proposed that consideration should be given to adding a text box to organisation charts for Mental Health Services outlining the reporting line for *Mental Health Act 2009* administration.
Four	It is proposed that the role descriptions of relevant non-clinical staff should 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 to develop the wording for a short section on the administration of the MH Act that will be added to Local Health Network intranet sites
Six	The Office of the Chief Psychiatrist develops 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.
Seven	It is proposed that the Chief Psychiatrist continue to carry out an enhanced inspection regime, to periodically inspect all mental health facilities and conduct unannounced inspections as required.
Eight	It is proposed that the Chief Executive SA Health and the Minister for Health and Wellbeing nominate a preferred inspection regime model.
Nine	It is proposed that the Chief Executive SA Health and the Minister for Health and Wellbeing nominate a preferred model for the resources to support the commencement of the enhanced inspection regime.
Ten	If greater clarity and certainty is required for the responsibility of the Chief Psychiatrist for ensuring compliance with the Act, it is proposed that an obligation similar to subsection 90(1)(a) of the *Mental Health Act 2009* be added, requiring the Chief Psychiatrist to ensure compliance with the Act.
Eleven	It is proposed that a designated officer or authority in the Department for Health and Ageing, who is not the Chief Psychiatrist, be responsible for the prosecution of offences under the *Mental Health Act 2009.*
Twelve	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.

Thirteen	If greater clarity and certainty is required for the responsibility of the Chief Executive to ensure the standard of mental health care, it is proposed that an obligation similar to subsection 7(1)(c) of the *Health Care Act 2008* should be added to the *Mental Health Act 2009* to ensure standards of mental health care and service delivery.
Fourteen	It is proposed that a requirement for compliance with the *Mental Health Act 2009* be introduced explicitly into the Executive Service Contracts and Service Level Agreements of the Chief Executive Officers of the Local Health Networks, and to the equivalent future contracts and agreements with Health Service Boards.
Fifteen	It is proposed that the regulator and operator functions for mental health services remain separate in South Australia, and that this be taken into consideration with the future development and implementation of the Health Service Boards and the Commissioner of Service Excellence.
Sixteen	If greater clarity and certainly is required for positive obligations for the Chief Psychiatrist, it is proposed that: • The language of section 90(1)(a) be changed from "promote" the continuous improvement to "ensure", or a similar more positive legislative term, or • The option for the Chief Executive and the Chief Psychiatrist to have the same power, as per section 16 of the *Work Health and Safety Act 2012,* be explored.
Seventeen	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 relating to: • Administration of and compliance with the Act • Electro-Convulsive Therapy • Inspections • Restrictive Practice • Rights of Consumers and Carers • Treatment and Care Plans
Eighteen	It is proposed that sections 96, 97 and 97A of the *Mental Health Act 2009* be amended to provide that if a facility does not comply with the requirements of a Chief Psychiatrist Standard, that facility may be subject to conditions or limitations set by the Chief Psychiatrist, or may have its determination as a facility under the Act revoked.
Nineteen	It is proposed that the Local Health Networks, the Infrastructure Directorate and the Office of the Chief Psychiatrist carry out a review of the condition and fitness for purpose of mental health facilities in South Australia.
Twenty	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 the NSQHS Standards. For existing non-new services, mental health facilities should be assessed against the NSQHS Standards.
Twenty One	It is proposed that the Local Health Networks, the Infrastructure Directorate, the QIP Branch and the Office of the Chief Psychiatrist determine if there are any other criteria that the condition and fitness for purpose of mental health facilities should be assessed against.
Twenty Two	It is proposed that the review of the condition of mental health facilities be undertaken in two phases, the first examining the condition of facilities

	that have had *Mental Health Act 2009* determinations and the second examining the condition of the remaining specialist mental health services.
Twenty Three	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, and current best practice, and make recommendations for future service provision based on adapting the existing facility and best practice to provide a contemporary clinical service with good outcomes, which may result in a service that is different to one delivered in a contemporary facility.
Twenty Four	It is proposed that the Infrastructure Directorate develop 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).
Twenty Five	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.
Twenty Six	It is proposed that the Office for the Ageing, Department for Health and Wellbeing executive leads and the Local Health Networks continue to collaborate to implement the findings of the Chief Psychiatrist Oakden Report, the Oakden Report Response Plan Oversight Committee and the SCOPE SA Steering Committee.
Twenty Seven	It is proposed that the QIP Branch considers the matters raised by the ICAC Report as a part of their total review of Consumer Feedback and Participation positions, systems and policies.
Twenty Eight	It is proposed that the QIP Branch 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 *Health Care Act 2008* and the *Mental Health Act 2009.*
Twenty Nine	It is proposed that the review of the Restraint and Seclusion in Mental Health Services Policy Guideline, Toolkit and Chief Psychiatrist Standards be completed in early 2019, with an updated policy and standard suite to be published by June 2019.
Thirty	It is proposed that any required consequential changes to Departmental restrictive practice policy be referred to the Quality Information and Performance Branch for inclusion in the next update of those documents.
Thirty One	It is recommended that the Workforce Working Group of the Mental Health Service Plan considers the content and findings of the Discussion Paper and incorporates them into the Service Plan and subsequent action and implementation plans.