The Annual Report

of the Chief Psychiatrist of South Australia

2011-12

Government of South Australia

SA Health

For more information

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Government of South Australia
SA Health

Hon John Hill MP
Minister for Mental Health and Substance Abuse

Dear Minister

In accordance with s92 of the *Mental Health Act 2009*, I am pleased to submit the Annual Report of the Chief Psychiatrist for presentation to Parliament.

This report provides an account of the functions of the *Mental Health Act 2009* and the Office of the Chief Psychiatrist and Mental Health Policy for the financial year ending 30 June 2012, in compliance with the Department of Premier and Cabinet Circular on Annual Reporting requirements.

Yours sincerely

Dr Panayiotis (Peter) Tyllis
Chief Psychiatrist
Director Mental Health Policy
30 September 2012

Foreword

Herein is the second annual report of the Chief Psychiatrist of South Australia. Continued work on the reporting requirements of the *Mental Health Act 2009* has seen strengthening of the data quality which will undoubtedly improve considerably with the introduction of a single electronic medical records system across the state (Enterprise Patient Administration System – EPAS).

Coming to the position of Chief Psychiatrist and Director of Mental Health Policy in November 2011, a key focus for me was to forge stronger links with consumers, carers, and external stakeholders and partners, as well as enhancing collaboration between mental health and other health services. My goal is to firmly establish the mental health of our community is a key consideration in health care delivery at all levels from primary to tertiary.

The information set out in this report allows us to reflect on the use of the *Mental Health Act 2009* and consider our position in regards to the objects and guiding principles. In addition, the report provides a snapshot of the activity within the Office of the Chief Psychiatrist and Mental Health Policy (OCPP). The breadth of scope of the work is evident and I would like to acknowledge the hard work and dedication of the staff in the OCPP over the past year.

The structure of the report has been kept broadly consistent with that of the inaugural report of 2010-11 to allow easier comparison. However, the OCPP welcomes feedback on any alterations that will improve the report and its utility for consumers, carers, service providers, advocates and administrators.

Dr Panayiotis Tyllis
Chief Psychiatrist

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Acknowledgements

The Office of the Chief Psychiatrist and Mental Health Policy (OCPP) would like to thank the numerous contributors to this report, both for the contribution to content but also for the work it represents in the preceding year within South Australian mental health services.

The OCPP would like to specifically acknowledge the data, advice and support of the: Australian Bureau of Statistics, Country Health SA Local Health Network, ECT Treatment Sites, Emergency Triage and Liaison Service, Data and Reporting Services branch (SA Health), Guardianship Board of South Australia, Mental Health Client Information and Application team (SA Health), Mental Health Operations branch (SA Health), Mental Health Triage, NEAMI, Ramsey Health Care SA, Royal Flying Doctor Service, South Australian Ambulance Service, South Australian Police, the staff of community and inpatient mental health services, and the consumers and carers of mental health services across the state.

Annual Reporting Requirements

The 2012 Annual Reporting Requirements of the South Australian Department of the Premier and Cabinet outlines the requirements for the content of South Australian government annual reports, within the statutory obligations of any relevant Acts.

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

Accordingly, information regarding the finances, service agreements and workforce of the OCPP and other SA mental health services are contained in the Department of Health Annual Report 2011-12.

Data Caveat

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

Care has been taken in the presentation, analysis and attribution of data so that the reader can more accurately interpret information from different datasets, services and periods.

Terminology

Many abbreviations and acronyms are used in the report. Please see the glossary in Appendix I for names and descriptions in full.

1. INTRODUCTION

The position of Chief Psychiatrist was established on 1 July 2010 by the *Mental Health Act 2009* to ensure greater accountability and the safety and quality of mental health services in South Australia. The Chief Psychiatrist is required by section 92 of the Act to present an annual report to the Minister before 30 September each year. Although the contents of the report outlined in s92 are concerned with the monitoring of involuntary treatment and consumers subject to inter-jurisdictional arrangements, the Office of the Chief Psychiatrist and Director of Mental Health Policy has broadened the scope to enable increased awareness and transparency of important developments and activity within South Australian mental health services.

1.1 National Context

Mental health policy, planning and service delivery in South Australia has been shaped and aligned to the Fourth National Mental Health Plan, the National Mental Health Policy 2008, the National Standards for Mental Health Services 2010 and the COAG National Action Plan on Mental Health 2006-11.

1.2 State Context

Mental health policy, planning and service delivery in South Australia has been shaped and aligned to the Social Inclusion Board's *Stepping Up Report*, South Australia's Strategic Plan 2011, the SA Health Strategic Plan 2008-10, the *Mental Health Act 2009* and South Australia's Mental Health and Wellbeing Policy 2010-15.

1.3 Mental Health Act 2009

The Act provides South Australia with the legislative framework required to ensure that people with serious mental illness receive a comprehensive range of services to facilitate, to the greatest extent possible, their recovery from mental illness and participation in community life. The Act more extensively underpins the rights of people with mental illness, which are further complemented by South Australia's Equal Opportunity Legislation, as amended by State Parliament on 14 July 2009 to ensure that people suffering from mental illnesses do not experience discrimination.

The broad purposes of the Act are to:

- Protect the rights and liberty of people with mental illness, and ensure that their dignity and liberty is retained as far as is consistent with their protection, the protection of the public and the proper delivery of services.
- Ensure the accessibility and delivery of specialist treatment, care, rehabilitation and support services for people with mental illness.
- Promote meaningful engagement between consumers and service providers.
- Establish greater accountability to monitor the effectiveness and quality of services and promote continuous improvement.

The guiding principles of the Act require that mental health service provision should:

- Place as few restrictions as possible on the rights and freedoms of a person with mental illness, while meeting patient and public safety and service delivery requirements.
- Be designed to bring about the best therapeutic outcomes for patients and be voluntary where possible.

- Be delivered through comprehensive treatment and care plans developed in partnership between service providers, consumers, carers and other relevant people.
- Take into account the specific needs of children and young people, of older people, and culturally and linguistically diverse people.
- Take into account the specific needs of Aboriginal and Torres Strait Islander people, including broader definitions of health, wellbeing and community.

The improved provisions of the Act include:

- ***Streamlined processes for interaction and transport of mental health consumers.*** Mental health clinicians, South Australia Ambulance Service (SAAS) and Royal Flying Doctor Service (RFDS) can engage with and transport consumers without a police presence. The interactions of all four agencies have been streamlined so that they can interact more effectively and appropriately with consumers.
- ***Broadening of powers under the Act to facilitate early intervention.*** Specially trained mental health clinicians, who are then declared Authorised Health Professionals, can make Level 1 Community Treatment Orders (CTOs) and Inpatient Treatment Orders (ITOs) – to be reviewed by a psychiatrist within 24 hours – to ensure that consumers get immediate access to the treatment and care they need to get well and keep safe.
- ***Information sharing that supports consumer recovery.*** Information sharing capacity that enables mental health services to share information with other agencies, non-government organisations and carers and families if it is reasonably required for the treatment and care of the consumer.
- ***Improved access to assessment for regional consumers.*** The capacity for psychiatrists and other mental health clinicians to assess and examine a person through audio-visual conferencing technology, allowing the assessment of rural and remote people in their own communities.
- ***Improved access to specialist mental health care and treatment as close as possible to the person's home for regional consumers.*** The establishment of Limited Treatment Centres (LTCs) in country South Australia where people on Level 1 ITOs can be treated for up to 7 days, receiving care and treatment closer to their homes and families rather than travelling to Adelaide.
- ***Reducing legislative barriers to consumer recovery and care across jurisdictions.*** Enhanced cross-border arrangements so that people with mental illness who become unwell in another state can more quickly get the care and treatment they need.
- ***Continuous improvement and enhanced monitoring in mental health care.*** The establishment of the position of Chief Psychiatrist to promote continuous improvement in the organisation and delivery of mental health services in South Australia and monitor the treatment of patients, the standard of psychiatric care, the use of orders and prescribed treatments, and the administration of the Act.

1.4 Role and functions of the Chief Psychiatrist

The Chief Psychiatrist of South Australia also functions as the Director of Mental Health Policy. The Office of the Chief Psychiatrist and Mental Health Policy (OCPP) is placed within the Division of Mental Health and Substance Abuse in the South Australian Department for Health and Ageing and has close working relationships with mental health services, general health services, non-government organisations, other government agencies, private providers, consumers and carers. The OCPP has a number of responsibilities, which can be grouped into functional portfolios.

1.4.1 Legislation

The legislative functions of the OCPP can be divided into 3 categories, those mandated by the Act, those required for the effective operation of the Act and those required by the interactions between mental health services and other laws.

Mandated Responsibilities and Powers

The legislated functions and responsibilities of Chief Psychiatrist are to:

- Acknowledge each mental health legal order confirmed, varied or revoked.
- Advise the Minister on issues relating to psychiatry.
- Classify people as mental health clinicians for the purpose of carrying out the Act.
- Conduct inspections of the premises and operations of any hospital.
- Issue standards for mental health services, with the approval of the Minister.
- Make or approve some cross-border arrangements.
- Monitor the administration of the Act and the standard of psychiatric care.
- Monitor the treatment of voluntary and involuntary patients.
- Monitor the use of restraint and seclusion.
- Present an annual report to the Minister.
- Promote the continuous improvement of the organisation and delivery of mental health services.
- Any other function assigned by any other act or by the Minister.

Administration of the Act

The OCPP undertakes the following functions in relation to the Act:

- Training, credentialing and re-credentialing of Authorised Health Professionals.
- Credentialing and re-credentialing of Authorised Medical Practitioners.
- Review and amendment of the Act.
- Development of resources to support the application of the Act.
- Oversight of consumers moving between South Australia and other jurisdictions.

Broader Legislative Framework

The OCP provides input and advice to SA Health, other departments and other jurisdictions on topics. In 2011-12 this included:

- Cross-border agreements for forensic mental health clients under the *Criminal Law Consolidation Act 1935*.
- Use of the *Consent to Medical Treatment and Palliative Care Act 1995* to assess and treat when an individual cannot consent.
- Use of s32 of the *Guardianship and Administration Act 1993* in hospital settings.

1.4.1 Policy

The OCP provides high level policy advice and development in areas of key relevance to mental health service delivery including:

- Carer Participation.
- Consumer participation.
- Development of the Pathways to Care series to replace the Emergency Demand Management policy suite.
- Development of the South Australian Mental Health Restraint and Seclusion Policy, Guideline and Toolkit.
- Implementation of the Aboriginal Mental Health Action Plan.
- Progress of the development of Youth Mental Health as a focus of service delivery through implementation of the Youth Model of Care.
- Standards for patient and solicitor access to patient records.
- Support for the development of a single statewide Child and Adolescent Mental health service.

1.4.2 Strategy

Activity has included:

- Continued work to support the implementation of the reforms outlined in the Stepping Up Report 2007-2012.
- Development of the South Australian Suicide Prevention Strategy 2012-2016 and Implementation Guide.
- Reviewing recommendations of the Statewide Mental Health Clinical Network draft report on Borderline Personality Disorder and advising on implementation.
- Working with the recently established Mental Health in Multicultural Australia consortium to maximise the benefit within this state from South Australia's involvement at a national level.

1.4.3 Safety and Quality

This is considered to be one of the key responsibilities of the OCPP and links in with the requirement mandated under the Act to promote the continuous improvement of the organisation and delivery of mental health services. Activity includes:

- Development of South Australian Electroconvulsive Therapy Guidelines, Policy and Standards.
- Establishing clear processes for reviewing and responding to adverse incidents, complaints and coroners findings that impact on mental health services at a statewide level.
- Leading and supporting the Enterprise Patient Administration System (EPAS) Mental Health Clinical Working Party to develop eHealth system requirements to support the move to electronic medical records for mental health consumers.
- Review of Clozapine use in South Australia.
- Review of the Mental Health Care Plan to address issues of utilisation and consumer acceptability.

1.4.4 Education, Training and Advice

- Administrative support and further development of GP PASA which facilitates general practitioner access to urgent psychiatric assessment.
- Advice to the Minister and CEO SA Health on complex mental health clinical scenarios.
- Coordination of SA consultation on National Framework for Recovery and National Statement of Rights and Responsibilities for mental health consumers.
- Liaison, staff development and fact sheets to support the expansion of Authorised Officer role under the Act to clinicians in emergency departments and correctional services officers.
- Redevelopment and maintenance of Mental Health presence on the SA Health website.

2. PATIENT AND SERVICE REPORTING

2.1 Patient Demographics

2.1.1 Gender

Tables 2.1.1 and 2.1.2 display the gender of people across the state, community service settings and inpatient service settings.

Table 2.1.1 – Gender in community settings

Program	SA pop	ICC	CRC	Forensic cmty	Supp Accom	CMHS	IPRSS	All CTOs
Female	50.5	48.6	29.1	16.2	47.7	48.6	42.1	33.9
Male	49.5	51.4	70.9	83.8	52.3	51.3	57.9	66.1

Source: CARS, CBIS, HIP, ABS 3235.0 Population by Age and Sex

Table 2.1.2 – Gender in inpatient settings

Program	CAMHS acute	Adult acute	Older acute	PICU	Forensic inpatient	Adult extended	Older extended	All DTOs
Female	69.7	48.2	60.2	31.5	10.3	21.4	39.1	43.4
Male	30.3	51.8	39.8	68.5	89.7	78.6	60.9	56.6

Source: CBIS, HIP

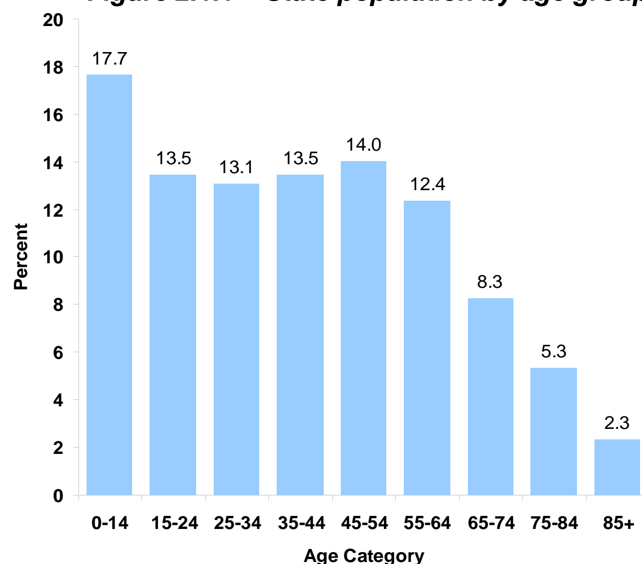
The South Australian population is distributed almost evenly between women (50.5%) and men (49.5%). Settings with similar gender divisions include ICCs, supported accommodation, CMHS and adult acute inpatient services. IPRSS had a moderate bias towards men with 57.9% of its clients being male. Settings with strong bias towards women are older acute inpatient services (60.2%) and CAMHS acute (69.7%). Settings with strong bias towards men are older extended inpatient services (60.9%), PICU (68.5%), CRCs (70.9%), adult extended inpatient services (78.6%), forensic community services (83.8%) and forensic inpatient services (89.7%). Of those people subject to orders, 56.6% of people on DTOs were male and 66.1% of people on CTOs were male.

2.1.2 Age

The population of South Australia has a reasonably even distribution across adult age categories, with a moderate peak for people under 15, a plateau of people aged from 15 to 65, and decreasing numbers of people older than 66, as per Figure 2.1.1.

Tables 2.1.3, 2.1.4 and 2.1.5 show the age of the state population and of people across a number of community and inpatient settings.

Figure 2.1.1 – State population by age group



Source: ABS 3235.0 Population by Age and Sex

Table 2.1.3 – Age in SA population and IPRSS

SA population			IPRSS*		
Age group	No	%	Age Group	No	%
0-14	289,166	17.7	0-19	25	2.2
15-24	220,898	13.5	20-29	256	22.8
25-34	214,459	13.1	30-39	303	27.0
35-44	220,633	13.5	40-49	259	23.1
45-54	229,572	14.0	50-59	132	11.8
55-64	202,918	12.4	60-69	47	4.2
65-74	135,329	8.3	70-79	61	5.4
75-84	87,219	5.3	80-89	37	3.3
85+	38,038	2.3	90+	2	0.2
Total	1,638,232	100	Total	1122	100

Source: ABS 3235.0 Population by Age and Sex, Health Outcomes International
*** Note: IPRSS data is indicative only and categorises age groups differently.**

From Tables 2.1.3, 2.1.4 and 2.1.5, and Figures 2.1.1, 2.1.2 and 2.1.3, it can be seen that most (75%) of the population was of 0-54 years of age, most IPRSS services provided to people 20-49 years old, ICC services to people aged 26-55 years, CRC services to people aged 16-45 years, CMHS to people aged 0-45 years, supported accommodation to people aged 26-55 years and CTOs made for people of 26-55 years of age.

For inpatient settings, contrasting against most (75%) of the population being from 0-54 years of age, most acute CAMHS was provided to people who were 15-24 years old, adult acute to people aged 25-54 years, older acute to people aged 65-84 years, PICU and Forensic to people aged 15-44 years and DTOs made for people of 16-55 years of age.

Table 2.1.4 – Age in community settings and on CTOs

Age Group	ICC		CRC		CMHS		Supp Accom		CTOs	
	No	%	No	%	No	%	No	%	No	%
0-15	-	-	-	-	6494	19.7	-	-	-	-
16-25	113	13.4	34	26.8	5941	18.0	12	7.9	121	7.7
26-35	198	23.5	46	36.2	5459	16.6	59	39.1	437	27.7
36-45	239	28.3	26	20.5	5444	16.5	35	23.2	465	29.5
46-55	180	21.3	16	12.6	4207	12.8	32	21.2	297	18.8
56-65	104	12.3	5	3.9	2471	7.5	11	7.3	143	9.1
66-75	10	1.2	-	-	1379	4.2	1	0.7	77	4.9
76-85	-	-	-	-	1126	3.4	-	-	31	2.0
86+	-	-	-	-	455	1.4	1	0.7	5	0.3
Total	844	100	127	100	32976	100	151	100	1576	100

Source: CARS, CBIS, HIP

Table 2.1.5 – Age in inpatient settings and on DTOs

Age Group	CAMHS		Adult acute		Older acute		PICU		Forensic		DTOs	
	No	%	No	%	No	%	No	%	No	%	No	%
0-14	97	19.2	115	1.7	-	-	-	-	-	-	29	0.4
15-24	408	80.8	946	13.6	-	-	85	18.2	24	20.7	1003	14.6
25-34	-	-	1498	21.5	-	-	134	28.7	41	35.3	1567	22.8
35-44	-	-	1654	23.8	-	-	144	30.8	30	25.9	1560	22.7
45-54	-	-	1328	19.1	2	0.3	77	16.5	14	12.1	1207	17.6
55-64	-	-	822	11.8	18	2.7	23	4.9	4	3.4	680	9.9
65-74	-	-	387	5.6	296	44.6	4	0.9	-	-	415	6.1
75-84	-	-	158	2.3	256	38.6	-	-	3	2.6	279	4.1
85+	-	-	48	0.7	91	13.7	-	-	-	-	118	1.7
Total	505	100	6956	100	467	100	467	100	116	100	6858	100

Source: CBIS, HIP

Figure 2.1.2 – CMHS by age group

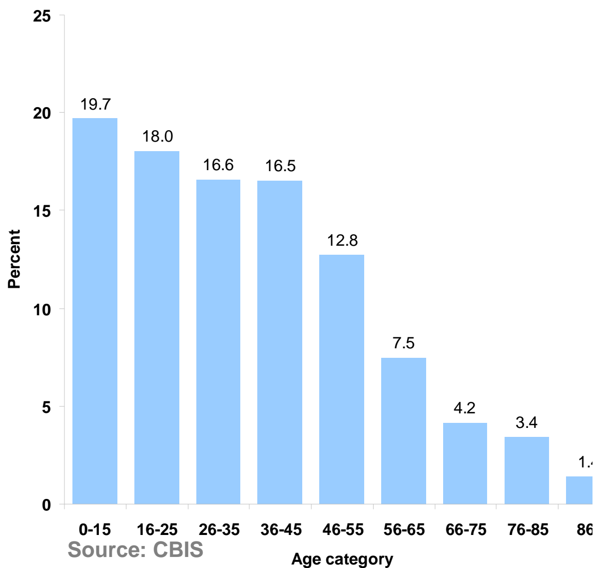
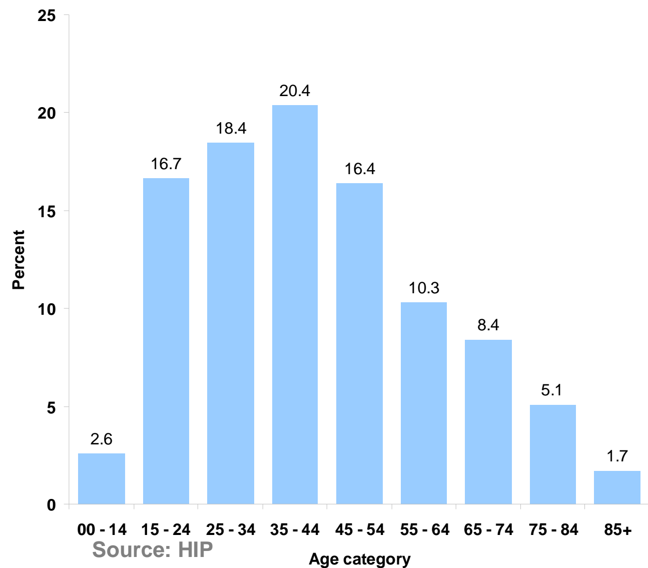


Figure 2.1.3 – Acute inpatient svcs by age group



2.1.3 Aboriginality

Tables 2.1.6 and 2.1.7 show the number of Aboriginal and Torres Strait Islander people across the state, community service settings and inpatient service settings.

Table 2.1.6 – Aboriginality in community settings

Program	SA pop	ICC	CRC	Forensic cmty	Supp Accom	CMHS	IPRSS	All CTOs
Number	30,382	31	8	20	9	2260	17	129
Percent	1.9	3.7	6.3	8.3	6.0	6.9	7.0	8.2

Source: CARS, CBIS, HIP, ABS 3235.0 Population by Age and Sex

Table 2.1.7 – Aboriginality in inpatient settings

Program	CAMHS acute	Adult acute	Older acute	PICU	Forensic inpatient	Adult extended	Older extended	All DTOs
Number	25	507	24	69	27	19	-	422
Percent	5.0	7.3	3.6	14.8	23.3	45.2	-	6.2

Source: CBIS, HIP

Aboriginal and Torres Strait Islander people make up 1.9% of the South Australian population. In contrast, they make up a greater proportion of patients in community service settings, averaging around 7%, except for ICCs at 3.7%. Similarly, Aboriginal people are over-represented in inpatient service settings, again averaging about 6% across the larger settings: CAMHS acute, adult acute, older acute and DTOs. Aboriginal people are strongly over-represented in the PICU, forensic inpatient and adult extended settings.

2.1.4 Cultural and Linguistic Diversity

Tables 2.1.8 and 2.1.9 display CALD status across the population and service settings.

Table 2.1.8 – CALD status in community settings

Program	SA pop	ICC	CRC	Forensic cmty	Supp Accom	CMHS	IPRSS	All CTOs
Number	104212	27	12	NA	12	2233	NA	187
Percent	8.6	3.2	9.4	NA	7.9	6.8	NA	11.9

Source: CARS, CBIS, HIP

Table 2.1.9 – CALD status in inpatient settings

Program	CAMHS acute	Adult acute	Older acute	PICU	Forensic inpatient	Adult extended	Older extended	All DTOs
Number	21	681	127	26	10	1	14	709
Percent	4.2	9.8	19.2	5.6	8.6	2.4	30.4	10.3

Source: CBIS, HIP

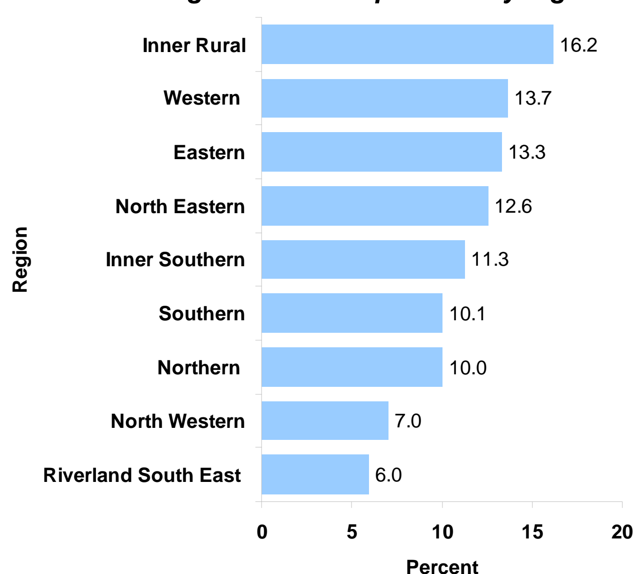
CALD status has been estimated from country of birth information, which shows that 8.6% of the SA population was born in non-main English speaking countries. The percentage of CALD people in most service settings is broadly similar to that of the general population, except for under-representation in adult extended (2.4%), ICC (3.2%), CAMHS acute (4.2%) and PICU (5.6%) settings, and over-representation in older acute (19.2%) and older extended (30.4%) settings.

2.1.5 Residence

Tables 2.1.10 and 2.1.11 and Figures 2.1.4 to 2.1.8 display the mental health regions, derived from residential postcodes, of the SA population and people receiving services across community and inpatient settings. The metropolitan regions comprise: Eastern, Inner South, Northern, North East, Southern and Western, and the country regions: Inner Rural, North Western and Riverland South East.

The regions are ordered from most populous to least. The pattern of service use across the regions does not always match the population distribution.

Figure 2.1.4 – Population by region



Source: ABS 3218.0 Regional Population Growth 2011

Table 2.1.10 – Residential region for the SA population, community services and CTOs

	SA pop		CMHS		CTOs	
Region	No	%	No	%	No	%
Inner Rural	264,587	16.2	4639	14.1	162	10.3
Western	223,893	13.7	4209	12.8	302	19.2
Eastern	217,698	13.3	3059	9.3	283	18.0
North East	205,632	12.6	3072	9.3	165	10.5
Inner South	185,000	11.3	3366	10.2	141	8.9
Southern	164,768	10.1	3410	10.3	149	9.5
Northern	163,852	10.0	4871	14.8	171	10.9
North Western	114,999	7.0	3072	9.3	77	4.9
Riverland SE	97,803	6.0	1983	6.0	68	4.3
Unknown	-	-	546	1.7	38	2.4
Interstate	-	-	411	1.2	20	1.3
Overseas	-	-	-	-	-	-
Total	1,638,232	100	32796	100	1576	100

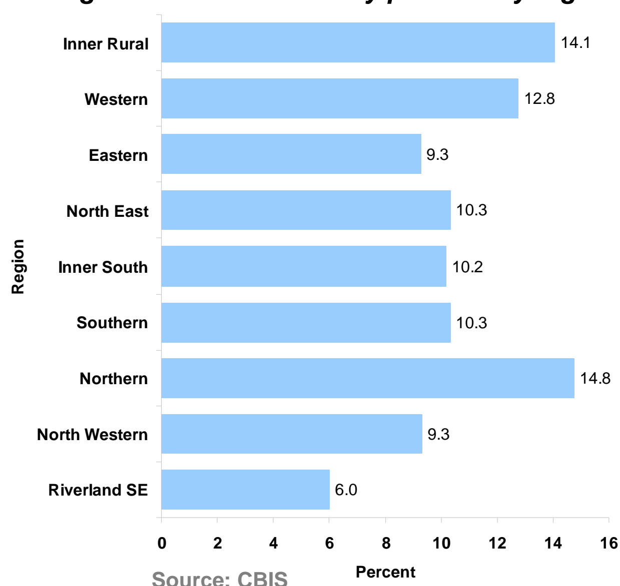
Source: CBIS, ABS 3218.0 Regional Population Growth 2011

Table 2.1.11 – Residential region for inpatient settings and DTOs

	CAMHS acute		Adult acute		Older acute		DTOs	
Region	No	%	No	%	No	%	No	%
Inner Rural	58	11.5	769	11.1	80	12.1	621	9.1
Western	69	13.7	1241	17.8	110	16.6	1283	18.7
Eastern	56	11.1	1195	17.2	94	14.2	351	5.1
North East	80	15.8	899	12.9	78	11.8	782	11.4
Inner South	57	11.3	737	10.6	102	15.4	898	13.1
Southern	54	10.7	637	9.2	77	11.6	1268	18.5
Northern	93	18.4	841	12.1	88	13.3	975	14.2
North Western	20	4.0	226	3.2	18	2.7	240	3.5
Riverland SE	13	2.6	241	3.5	7	1.1	154	2.2
Unknown	-	-	17	0.2	-	-	226	3.3
Interstate	5	1.0	153	2.2	9	1.4	60	0.9
Overseas	-	-	-	-	-	-	-	-
Total	505	100	6956	100	663	100	6858	100

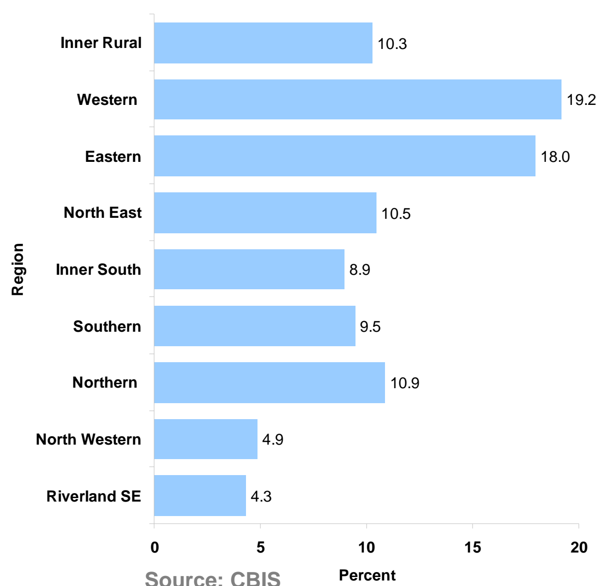
Source: CBIS, HIP

Figure 2.1.5 – Community patients by region



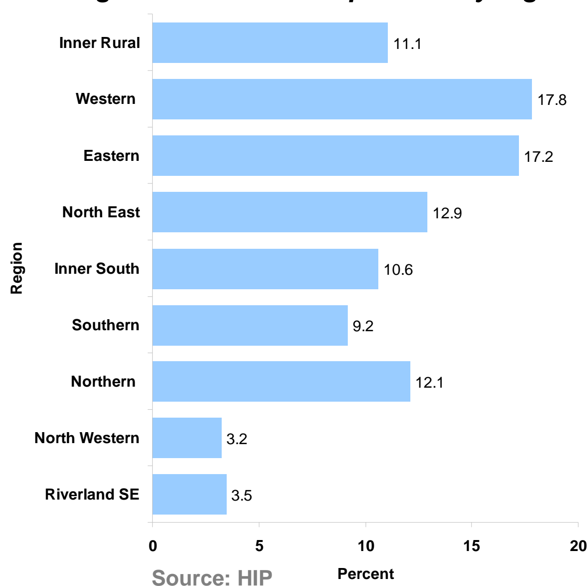
Source: CBIS

Figure 2.1.6 – CTOs by region



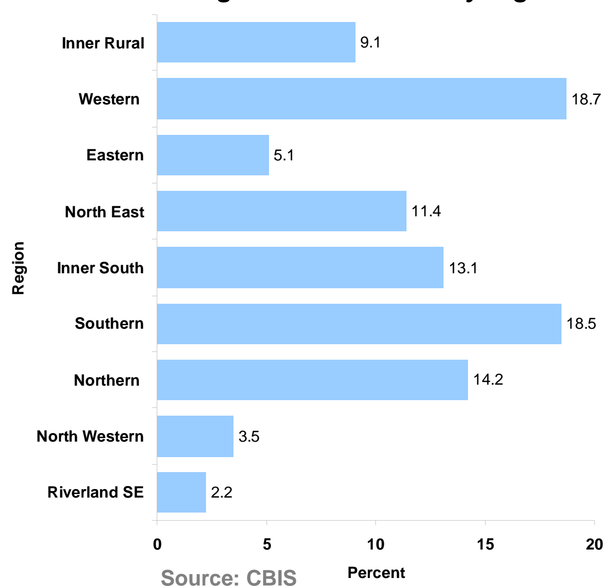
Source: CBIS

Figure 2.1.7 – Adult inpatients by region



Source: HIP

Figure 2.1.8 – DTOs by region



Source: CBIS

2.2 Mental Health Legal Orders

During 2011-12 there were 8434 mental health legal orders active. Table 2.2.1 summarises these orders and compares them to the orders active in 2010-11. The rates of order type have remained similar, except for a decrease in CTO2s from 20.9% to 16.6% and an increase in DTO1s from 55.7% to 60.0%.

Table 2.2.1 – Mental health legal orders

	Orders 2010-11		Orders 2011-12	
Order type	Number	Percent	Number	Percent
CTO1	192	2.4	172	2.0
CTO2	1685	20.9	1404	16.6
All CTOs	1877	23.3	1576	18.7
DTO1	4493	55.7	5059	60.0
DTO2	1552	19.2	1644	19.5
DTO3	149	1.8	155	1.8
All DTOs	6194	76.7	6858	81.3
Total	**8071**	**100**	**8434**	**100**

Source: CBIS

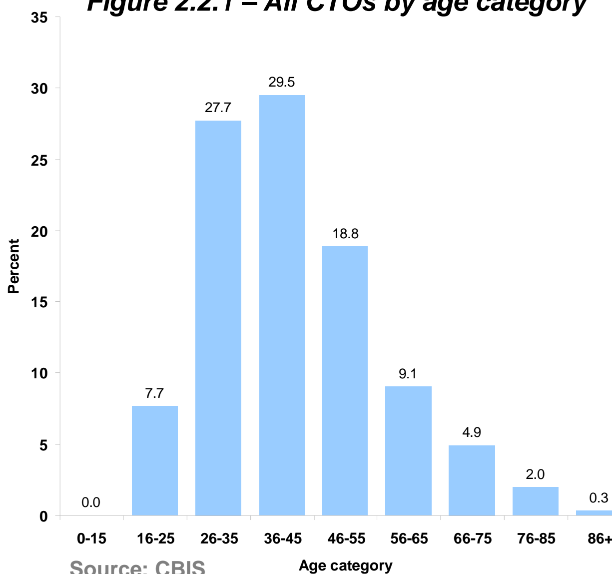
The 8434 orders active during 2011-12 affected only 4449 individuals, with 2455 people (55.2%) being subject to 1 order only and 1994 people (44.8%) being subject to 2 or more orders. More details of multiple orders are found in the sections below.

Table 2.2.2 – Age of people on orders

Age	CTO1		CTO2		DTO1		DTO2		DTO3	
Group	No	%	No	%	No	%	No	%	No	%
0-15	1	0.6	1	0.1	34	0.9	2	0.1	0	0.0
16-25	23	13.8	101	9.3	650	17.5	160	12.0	8	6.0
26-35	50	29.9	303	27.8	835	22.5	284	21.3	27	20.1
36-45	41	24.6	317	29.1	869	23.4	289	21.7	16	11.9
46-55	28	16.8	206	18.9	637	17.2	251	18.8	17	12.7
56-65	15	9.0	89	8.2	323	8.7	132	9.9	18	13.4
66-75	4	2.4	46	4.2	184	5.0	110	8.2	20	14.9
76-85	4	2.4	23	2.1	127	3.4	77	5.8	22	16.4
86+	1	0.6	2	0.2	51	1.4	29	2.2	6	4.5
Total	167	100	1088	100	3710	100	1334	100	134	100

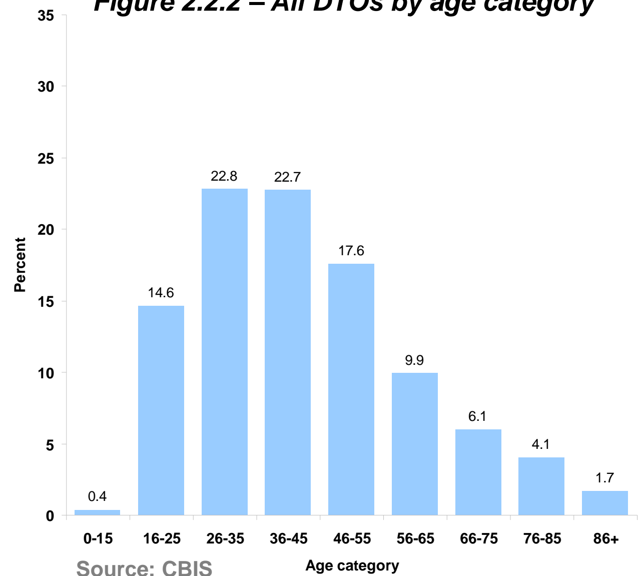
Source: CBIS

Figure 2.2.1 – All CTOs by age category



Source: CBIS

Figure 2.2.2 – All DTOs by age category



Source: CBIS

2.2.1 Level 1 Community Treatment Orders

Level 1 CTOs can last for up to 28 days and can be made by an authorised health professional or medical practitioner. A CTO1 not made by a psychiatrist or authorised medical practitioner must be reviewed by a psychiatrist within 24 hours or as soon as practicable.

Making the Order

Of the 172 CTO1s made during 2011-12, 79 (45.9%) were made by psychiatrists, 75 (43.6%) by medical practitioners, 6 (3.5%) by authorised health professionals, 3 (1.7%) by authorised medical practitioners and 9 (5.2%) were unknown due to illegible signatures on forms.

Multiple Orders

The 172 CTO1s were made for 167 people, with 162 (97.0%) having one CTO1 and 5 (3.0%) having two CTO1s.

Order Outcomes

Table 2.2.3 shows the outcomes of the CTO1s made.

Table 2.2.3 – CTO1 outcomes

Outcome	Number	Percent
Orders made	172	100
Expiry date – maximum possible	139	84.2
Expiry date – less than maximum	26	15.8
Revoked at 24-hour review	7	4.1
Subsequently revoked	11	6.4
Went for intended duration	154	89.5
Revoked or quashed by GSB	-	-

Source: CBIS

Duration

Of the 165 CTO1s not revoked at the 24-hour review stage, 79.4% went for the maximum 28 days, with a minor peak of 9.9% lasting for 6-7 days.

2.2.2 Level 2 Community Treatment Orders

Level 2 CTOs can last for up to 365 days and can be made by the Guardianship Board on application by a health professional or other person with a proper interest in the welfare of the patient.

Multiple Orders

There were 1404 CTO2s made for 1088 people, with 779 (71.6%) having one CTO2, 302 (28.8%) having two CTO2s and 7 (0.6%) having three.

Order Outcomes

Table 2.2.4 shows the outcomes of the CTO2s made.

Table 2.2.4 – CTO2 outcomes

Outcome	Number	Percent
Orders made	1404	100
Expiry date – maximum possible	1302	92.7
Expiry date – less than maximum	102	7.3
Revoked by GSB or Court	5	0.4
Went for intended duration	1399	99.6

Source: CBIS

Duration
CTO2s had a range of durations, from 3 days to 365 days, with 1298 (92.5%) going for a year and a minor cluster of 65 (4.6%) going for 6 months.

2.2.3 Level 1 Detention and Treatment Orders

Level 1 DTOs could last for up to 7 days and could be made by an authorised health professional or medical practitioner. All DTO1s must have been reviewed within 24 hours, or as soon as practicable, by a psychiatrist or authorised medical practitioner, who cannot have been the same clinician who made the order.

Making the Order
Due to issues now resolved, data for the making of DTO1s is indicative only. Of the 5059 DTO1s made in 2011-12, 90.0% were made by medical practitioners, 5.2% were made by psychiatrists, 2.6% by authorised health professionals and 2.2% by authorised medical practitioners*. (*This figure may be inaccurate as there were only 3 AMPs during 2011-12.)

DTO1s were made in the following places: 51.9% in an unspecified part of a metropolitan hospital, 27.8% in metropolitan emergency departments, 9.3% in acute mental health wards, 6.7% in country hospitals and the remaining 4.4% in varied settings including community mental health centres, people's homes, other community services, prison and GP rooms.

Multiple Orders
There were 5059 DTO1s made for 3710 people, with 2827 (76.2%) having one DTO1, 606 (16.3%) having two DTO1s, 176 (4.7%) having three DTO1s and the remaining 101 (2.7%) having four or more DTO1s.

Order Outcomes
Table 2.2.5 shows the outcomes of the DTO1s made.

Table 2.2.5 – DTO1 outcomes

Outcome	Number	Percent
Orders made	5059	100
Expiry date – maximum possible	2105	61.4
Expiry date – less than maximum	1326	38.6
Revoked at 24-hour review	1628	32.2
Subsequently revoked	562	11.1
Revoked or quashed by GSB	2	0.04
Went for intended duration	2867	56.7

Source: CBIS

Duration
Table 2.2.5 shows DTO1 duration. Most (41.6%) went for 7 days, with 32.2% being revoked at the 24-hour review stage. The remaining durations increase in proportion from 1 to 6 days.

Table2.2.5 – DTO1 durations

	24-hour revoke	1 day	2 days	3 days	4 days	5 days	6 days	7 days	Total
Number	1628	14	11	47	119	361	774	2105	5059
Percent	32.2	0.3	0.2	0.9	2.4	7.1	15.3	41.6	100

2.2.4 Level 2 Detention and Treatment Orders

Level 2 DTOs could last for up to 42 days and could be made by a psychiatrist or authorised medical practitioner for a patient that is on a DTO1.

Of the 1644 DTO2s made, 1422 (87.7%) had a preceding DTO1 registered with the OCPP.

Multiple Orders

There were 1644 DTO2s made for 1334 people, with 1099 (82.4%) having one DTO2, 182 (13.6%) having two DTO2s and the remaining 53 (4.0%) having three, four, five or six DTO2s.

Order Outcomes

Table 2.2.6 shows the outcomes of the DTO2s made.

Table 2.2.6 – DTO2 outcomes

Outcome	Number	Percent
Orders made	1644	100
Expiry – short	156	9.5
Expiry – maximum	1488	90.5
Subsequently revoked	1019	62.0
Revoked or quashed by GSB	1	0.01
Went for intended duration	624	38.0

Source: CBIS

Duration

DTO2s had a range of durations from 1 day to 42 days, with 206 (12.5%) in place for 1-7 days, 287 (17.5%) for 8-14 days, 227 (13.8%) for 15-21 days, 162 (9.9%) for 22-28 days, 117 (7.1%) for 29-35 days, 113 (6.9%) for 36-41 days and 532 (32.4%) for the maximum of 42 days.

2.2.5 Level 3 Detention and Treatment Orders

Level 3 DTOs can last for up to 365 days and can be made by the Guardianship Board on application by a health professional or other person with a proper interest in the welfare of the patient.

Multiple Orders

There were 155 DTO3s made for 134 people, with 117 (87.3%) having one DTO3, 13 (9.7%) having two DTO3s and 4 (3.0%) having three DTO3s.

Order Outcomes

Table 2.2.7 shows the outcomes of the DTO3s made.

Table 2.2.7 – DTO3 outcomes

Outcome	Number	Percent
Orders made	155	100
Expiry date – maximum possible	117	75.5
Expiry date – less than maximum	38	24.5
Revoked by GSB or Court	33	21.3
Went for intended duration	122	78.7

Source: CBIS

Duration

DTO3s had a range of durations from 7 days to 365 days, with peaks at one month (5.2%), two months (4.5%), 3 months (23.2%), 6 months (19.4%) and 12 months (21.3%), with the remaining 26.5% of DTO3s having durations scattered throughout the 365 days.

2.3 Restraint and Seclusion

The mental health services of South Australia are committed to reducing, and where possible eliminating, the use of restraint and seclusion, and only use these practices to address significant safety issues. The Act requires treatment centres to keep records of all restraint and inclusion incidents and the Chief Psychiatrist to monitor all restraint and seclusion incidents, under sections s98(2)(c) and s90(1)(b) respectively. In addition to information in the medical records of consumers, a statewide restraint and seclusion database is used by all mental health inpatient units to record incidents and work is progressing to extend this reporting to emergency departments.

In 2011-12 there were a total of 2357 incidents recorded for 637 people, with 2186 incidents for 502 people occurring in mental health inpatient settings and 171 incidents for 135 people occurring in emergency department settings. The 502 people who experienced a restraint or seclusion incident in mental health inpatient settings represent 5.7% of the total 8795 admissions to mental health wards.

South Australia is the only state collecting and analysing restraint and seclusion data from emergency departments. The improved reporting has resulted in higher numbers reported.

2.3.1 Gender

Table 2.3.1 shows the gender of the consumer in each restraint and seclusion incident. The incidence of males being restrained or secluded is double that of females being restrained or secluded. This is consistent across service settings.

Table 2.3.1 – Restraint and seclusion incidents by gender and service setting

	Child and youth acute		Adult acute		Older acute		Total	
Gender	No	%	No	%	No	%	No	%
Female	28	40.6	416	34.2	298	26.3	746	30.9
Male	41	59.4	800	65.8	833	73.7	1668	69.1
Total	69	100	1216	100	1131	100	2414	100

Source: CBIS, Restraint and seclusion database.

2.3.2 Age

Table 2.3.2 and Figure 2.3.1 show the age groupings for incidents across the three acute mental health inpatient settings of child and youth, adult and older persons.

Table 2.3.2 – Restraint and seclusion incidents by age group and service setting

	Child and youth acute		Adult acute		Older acute		Total	
Age	No	%	No	%	No	%	No	%
0 - 14	25	36.8	1	0.1	-	-	26	1.1
15 - 24	43	63.2	197	16.3	-	-	240	10.0
25 - 34	-	-	366	30.2	-	-	366	15.2
35 - 44	-	-	369	30.5	-	-	369	15.3
45 - 54	-	-	212	17.5	-	-	212	8.8
55 - 64	-	-	41	3.4	117	10.4	158	6.6
65 - 74	-	-	11	0.9	161	14.3	172	7.1
75 - 84	-	-	12	1.0	633	56.1	645	26.8
85+	-	-	2	0.2	217	19.2	219	9.1
Total	68	100	1211	100	1128	100	2407	100

Source: Restraint and seclusion database

There are peaks for adults between 25 and 44 years of age, and for older people between 75 and 84 years of age.

These peaks may indicate ages when adults are less able to control impulses and aggression, and when older people are more at risk of falls or experiencing behavioural disturbances of dementia.

Figure 2.3.1 – Restraint / seclusion by age

Source: Restraint and seclusion database

2.3.3 ATSI and CALD status

Information regarding the Indigenous status and Cultural and Linguistic Diversity of people undergoing restraint and seclusion is not available.

2.3.4 Duration

Table 2.3.3 shows the duration of restraint and seclusion incidents, ranging from under 1 hour to over 12 hours.

Table 2.3.3 – Duration of restraint and seclusion incidents

	Child and youth acute		Adult acute		Older acute		Total	
Hours	No	%	No	%	No	%	No	%
<1	49	71.0	169	13.9	74	6.5	292	12.1
1 - 2	17	24.6	194	16.0	219	19.4	430	17.8
2 - 3	1	1.4	179	14.7	197	17.4	377	15.6
3 - 4	2	2.9	164	13.5	95	8.4	261	10.8
4 - 5	-	-	95	7.8	64	5.7	159	6.6
5 - 6	-	-	42	3.5	63	5.6	105	4.3
6 - 7	-	-	42	3.5	40	3.5	82	3.4
7 - 8	-	-	49	4.0	31	2.7	80	3.3
8 - 9	-	-	37	3.0	40	3.5	77	3.2
9 - 10	-	-	16	1.3	56	5.0	72	3.0
10 - 11	-	-	25	2.1	67	5.9	92	3.8
11 - 12	-	-	52	4.3	52	4.6	104	4.3
12+	-	-	82	6.7	100	8.8	182	7.5
Unknown	-	-	70	5.8	33	2.9	103	4.3
Total	69	100	1216	100	1131	100	2416	100

Source: Restraint and seclusion database

2.3.6 Reason for event

Table 2.3.4 shows the reasons for restraint or seclusion incidents in the three acute inpatient streams combined. Most incidents had multiple causal factors.

Table 2.3.4 – Reasons for restraint or seclusion incident

Service	Reason	Percent
Child and youth	Self harm	79.7
	Aggression to others	71.0
	Property damage	24.8
	Other	7.2
Adult	Aggression to others	80.1
	Other	34.4
	Self harm	30.6
	Property damage	28.2
Older	Self harm	87.7
	Aggression to others	39.8
	Property damage	15.1
	Other	3.5

Source: Restraint and seclusion database

2.3.7 Australian Council on Healthcare Standards

The ACHS has a number of key reporting items for restraint and seclusion. For the purposes of interstate benchmarking and comparison, SA data against these items are summarised in the tables below. Table 2.3.5 displays the rate of restraint and seclusion per 1000 bed days and the numbers of inpatients physically restrained only. Table 2.3.6 depicts the number of consumers restrained or secluded, those experiencing two or more incidents, incidents lasting more than four hours and incidents resulting in major complications.

Table 2.3.5 – ACHS items

Rate of restraint and seclusion per 1000 bed days					
Service	Physical	Mechanical	Seclusion	Total	2010-11 Total
Child and youth	0	0	15.7	15.7	27.4
Adult	0.1	0.1	11.1	11.3	9.7
Older people	1.5	41.9	0	43.4	55.3

ACHS - Inpatients physically restrained only (under reported)	
Service	Number
Child and youth	0
Adult	13
Older people	4

Source: Restraint and seclusion database

Table 2.3.6 – ACHS Items

		ACHS 5.2		ACHS 5.3		ACHS 5.5	
	Consumers	2 or more events		> 4 hours		Complications	
Service type	No	No	%	No	%	No	%
Child and youth	28	9	32.1	0	0	0	0
Adult	521	191	36.7	394	32.4	5	0.4
Older people	88	65	73.9	498	44	0	0

Source: Restraint and seclusion database

For older persons there was no statistically significant change from the previous year. For adult persons the inclusion of Emergency Departments in the collection of data has made a difference, however, the amount of time spent in seclusion has decreased and the number of major complications was significantly less.

2.4 Electroconvulsive Therapy

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

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

In South Australia ECT is administered in 6 public hospitals: Flinders Medical Centre, Glenside Hospital, Lyell McEwin Health Service, Modbury Hospital, the Queen Elizabeth Hospital and the Repatriation General Hospital, and 2 private hospitals: Adelaide Clinic and Fullarton Private Hospital.

During 2011-12 733 people received a total of 5469 ECT treatments. Of these, 341 (46.5%) people were public patients and 392 (53.5%) were private patients; 3659 (66.9%) treatments were administered in public hospitals and 1810 (33.1%) treatments were administered in private hospitals.

2.4.1 Gender

Of the 341 public patients, 200 (58.7%) were female and 141 (41.3%) were male. Of the 392 private patients, 248 (63.3%) were female and 144 (36.7%) were male.

2.4.2 Age

Table 2.4.1 and Figure 2.4.1 show the age of people in public settings receiving ECT. Administration is consistent for people from 36 to 65 years of age, with a peak for people from 66 to 75.

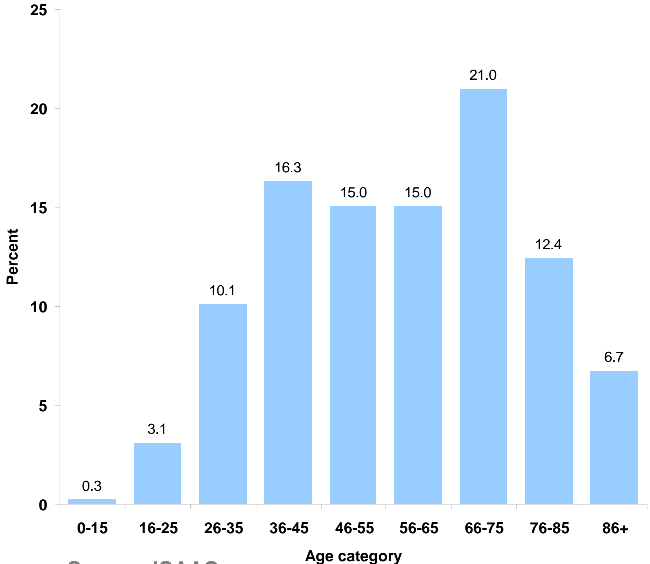
Table 2.4.1 – ECT by age category

Age	No	%
0-15	1	0.3
16-25	11	3.1
26-35	34	10.1
36-45	56	16.3
46-55	51	15.0
56-65	51	15.0
66-75	72	21.0
76-85	42	12.4
86+	23	6.7
Total	341	100

Source: ISAAC

The age of people receiving ECT in private hospitals is similar, with the bulk (78.0%) being between 31 and 70, with 4.7% from 21-30, 9.5% from 71-80 and 7.8% from 81-90.

Figure 2.4.1 – ECT by age category



Source: ISAAC

2.4.3 Aboriginality

There were 25 people of Aboriginal and Torres Strait Islander origin who received ECT in public settings, making up 7.2% of the total 341 people. This proportion is similar to the broad percentage of Aboriginal participation in mental health services across community and inpatient settings.

2.4.4 Cultural and Linguistic Diversity

There were 51 people born in non-main English speaking countries who received ECT in public settings, comprising 14.9% of the total 341 people. This proportion is higher than the 8.6% present in the general population and across most public mental health service settings for people of CALD background, other than older acute and older extended settings.

2.4.5 Diagnoses

Of the 341 public patients, 250 (73.3%) were diagnosed with depressive disorders, 30 (8.8%) with schizoaffective disorders, 17 (5.0%) with bipolar disorders and 44 (12.8%) with other conditions. Of the 392 private patients, 351 (89.4%) were diagnosed with major depression, 28 (7.0%) with psychotic depression and 14 (3.5%) with schizoaffective disorder.

2.4.6 Legal Status and Patient Type

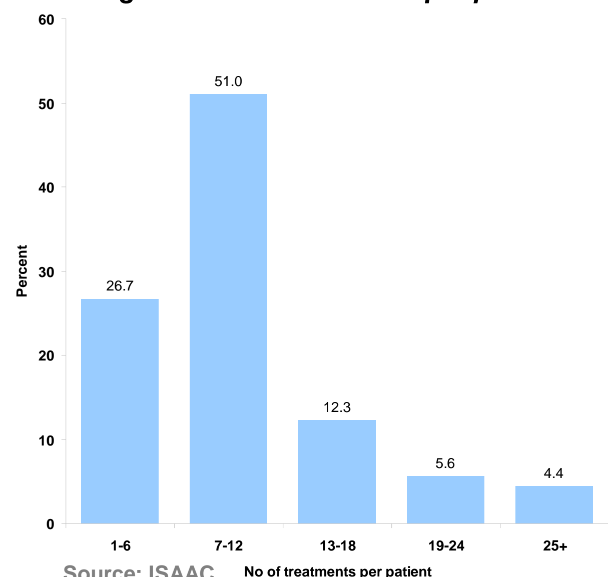
Of the 341 public patients, 270 (79.3%) were voluntary patients at the time of their ECT and 71 (20.7%) were involuntary. Of the 3659 public treatments administered, 2655 (72.8%) were delivered during inpatient stays and 994 (27.2%) as outpatient visits. Of the 1810 private treatments administered, 1428 (78.9%) were delivered during inpatient stays and 382 (21.1%) as daypatient visits.

2.4.7 Treatments per Patient

Figure 2.4.2 shows the number of treatments per patient for 2011-12 for public ECT. Of the total 341 people, 91 (26.7%) received 1-6 treatments, 174 (51.0%) received 7-12 treatments, 42 (12.3%) received 13-18 treatments, 19 (5.6%) received 19-24 treatments and 15 (4.4%) received 25 treatments.

The higher treatment numbers represent individuals who were acutely unwell and had more than one course of ECT in 12 months, and those who receive regular but less frequent ECT over time to prevent relapse.

Figure 2.4.2 – Treatments per patient



Source: ISAAC

2.5 Forensic Services

Sections 269A to 269ZB of the *Criminal Law Consolidation Act 1935* deal with mental impairment and provide for the District Court or Supreme Court of South Australia to find someone who has been charged with a criminal offence as mentally incompetent to have committed that offence and/or to be mentally unfit to stand trial. A mental impairment that may lead to mental incompetence is defined as: a mental illness, an intellectual disability or a disability or impairment of the mind caused by senility, but not intoxication.

If someone has been deemed, or found by trial, to be mentally incompetent then they are declared to be liable to supervision. Someone who is liable to supervision may be released unconditionally or may be made subject to a Supervision Order, which will have a limiting term (expiry) equal to the length of time that the Court deems appropriate if the defendant had been convicted of the offence. At any time during the limiting term the Court may vary or revoke the supervision order, on application by the Crown, the defendant, the Parole Board, the Public Advocate or any other person with a proper interest in the matter.

Someone made subject to a Supervision Order may be placed into the custody of the Minister or released on License into the community. If in the custody of the Minister, the person may be detained in facilities including James Nash House or Grove Closed or, if there is no practicable alternative, in prison.

A person released on License into the community may have a number of conditions attached to that License by the Court. The License is supervised dually by Forensic Community Mental Health Teams (who supervise mental health and treatment on behalf of the Minister) and Community Corrections (who supervise all other aspects of the License on behalf of the Parole Board), often in conjunction with the local Mental Health Team.

If a person is found to be in breach of any conditions of their License a judge or other proper court officer may issue a warrant for their arrest and return to Court, or other appropriate facility (such as James Nash House or prison) while they await a Court hearing.

Forensic Mental Health Services in South Australia comprise inpatient services at James Nash House (30 beds) and Grove Closed (10 beds), and community services for up to 250 people across 4 teams in metropolitan Adelaide in the East, South, North and West.

2.6 Cross-Border Arrangements

Part 10 of the Act makes a number of provisions for the treatment and transport of individuals between South Australia and other Australian jurisdictions.

During 2011-12 there were:

- One instance of a person on a SA CTO moving interstate and having an interstate community treatment order placed on them.
- Two instances of a person being placed under a level 1 DTO in South Australia after absconding from an inpatient treatment order interstate.
- Two instances of the use of s69, where the Chief Psychiatrist made a level 1 CTO for a person in South Australia, without examination of that person, where a CTO existed interstate, so that they may continue their care and treatment.

2.7 Services and Service Use

2.7.1 Mental Health Facilities and Services

Bed numbers will continue to change as the reform agenda progresses.

Table 2.7.1 – Approved treatment centres, beds and separations

Approved Treatment Centre	Wards	Beds*		Seps	
		No	%	No	%
Adelaide Clinic		56	10.7	1535	14.9
Flinders Medical Centre	4G, 5H, 5J, 5K	48	9.1	1031	10.0
Glenside Campus	Birches South A, Birches South B, Birches North, Cedars PICU, Cedars NW, Grove Closed, Rosewood, Rural and Remote,	124	23.6	1569	16.4
James Nash House	Aldgate, Birdwood, Clare	30	5.7	108	1.0
Lyell McEwin Health Service	1G, 1H	46	8.8	970	9.4
Modbury Hospital	Woodleigh	20	3.8	600	5.8
Noarlunga Health Service	Morier	20	3.8	554	5.4
Oakden Services for Older People	Clements, Makk, McLeay	64	12.2	46	0.4
Royal Adelaide Hospital	C3, PECU	24	4.6	1486	14.4
Repatriation General Hospital	Ward 17, Ward 18	54	10.3	707	6.8
The Queen Elizabeth Hospital	Cramond	21	4.0	880	8.5
Women's and Children's Hospital	Boylan, Helen Mayo	18	3.4	715	6.9
Total		531	100	10330	100

Source: HIP, Ramsey Health (*bed numbers as at 30 June 2012)

Table 2.7.2 – Public inpatient service settings, beds and separations

Service type	Wards	Beds*		Seps	
		No	%	No	%
CAMHS acute	Boylan	12	2.6	505	5.7
Adult acute	1G, 4G, 5H, 5K, C3, Cedars NW, Cramond, Helen Mayo, Morier, PECU, Rural and Remote, Ward 17, Woodleigh	224	47.8	7047	80.1
Older persons acute	1H, Rosewood, Ward 18	71	15.1	663	7.5
PICU	5J, Cedars PICU	18	3.8	376	4.3
Forensic inpatient	Aldgate, Birdwood, Clare, Grove Closed	40	8.5	116	1.3
Adult extended	Birches North, Birches South A, Birches South B	40	8.5	42	0.5
Older extended	Clements, Makk, McLeay	64	13.6	46	0.5
Total		469	100	8795	100

Source: HIP (*bed numbers as at 30 June 2012)

Table 2.7.3 – Community service settings, beds/places and consumers

Service setting	Location	No
Intermediate Care	Metro: Eastern, Southern & Western	45
	Country: Kangaroo Island, Port Augusta, Port Lincoln & South East (An increase of 5 from 2010-2011)	20
	Total consumers across metro and country	844
Community Rehabilitation	Elpida, Trevor Parry, Wondakka	60
	Total residents	127
Supported accommodation	Housing and Accommodation Support Program (HASP)	79
	Other supported accommodation programs	56
	Total residents across metro and country	151
Supported social housing	Metro (180) and country (61)	241
Community Mental Health	Total contacts across metro and country	587,307
	Total consumers	32,976
	Average contacts per consumer	17.8
IPRSS	Total hours across metro and country	174,139
	Total consumers	1,122
	Average hours per consumer	155.2

Source: CARS, CBIS, HIP

Tables 2.7.1, 2.7.2 and 2.7.3 from the previous page display services across inpatient and community settings by places and consumers. Inpatient services are shown by approved treatment centre and by inpatient service type. The Adelaide Clinic, RAH, TQEH and WCH, and to a lesser extent Modbury and NHS, all had a greater proportion of separations than beds, indicating higher flow of patients through their beds. Glenside, JNH, Oakden and RGH had a greater proportion of beds than separations, indicating longer length of stay patients in extended care settings.

2.7.2 Emergency Services

Table 2.7.4 shows the volume of emergency service use in metropolitan Adelaide across the various agencies and services. It should be noted that although people with mental illness make up a small proportion of emergency service contacts, presentations can be complex and may require coordination of resources and more time for an effective response.

Table 2.7.4 – Emergency service use

Service	Occasions of service	No	%
Metropolitan emergency departments	Total presentations	361,162	100
	Mental health presentations	11,738	3.3
	Drug and alcohol presentations	3,923	1.1
RFDS	Total transfers	6259	100
	Mental health transfers	365	5.8
SA Police	Total metro taskings 2009-10	310,260	100
	Mental health taskings 2009-10	3,187	1.03
SAAS	Total SAAS events 2010-11	307,000	100
	Mental health events 2010-11	4,605	1.5

Source: HIP, Royal Flying Doctor Service, SA Ambulance, SA Police

The Mental Health Triage line took 54,069 crisis and emergency assistance calls from metropolitan Adelaide in 2011-12, of which 22,572 (41.7%) were dealt with immediately, 25,360 (46.9%) resulted in further calls and referrals, and 6,137 (11.4%) dropped out before they could be answered. The Emergency Triage and Liaison Service took 12,733 calls from country SA in 2011 that required case management or referrals, with approximately another 12,000 calls requesting information or otherwise being dealt with immediately.

2.7.3 Service Use

There were a total of 406,594 separations from public hospital inpatient settings in 2011-12, with 17,446 (4.3%) of those having a principal diagnosis of mental illness and 8,795 (2.2%) being from a mental health ward.

Table 2.7.5 shows the average length of stay across the range of bedded services.

Table 2.7.5 – Average length of stay

Category	Presentation type	ALOS Hours
Metropolitan emergency department	General presentation	4.4
	Drug and alcohol presentation	6.1
	Mental health presentation	8.8
Category	**Service type**	**ALOS Days**
Public hospital inpatient services	All admissions	4.1
	Primary diagnosis as mental illness	8.9
	All mental health wards combined	24.5
Mental health inpatient stream	CAMHS acute	3.4
	Adult acute	13.5
	Older acute	38.5
	PICU	11.6
	Forensic inpatient	98.4
	Adult extended	1324
	Older extended	487
Residential stream	ICC	10.26
	CRC	113.11

Source: HIP

2.7.4 Treatment and Care Plans

Sections 39, 40 and 41 of the Act outline the requirements for treatment and care plans respectively for voluntary patients, patients to whom community treatment orders apply and patients to whom detention and treatment orders apply.

Those sections require that, as far as practicable, the care and treatment of an individual should be governed by a plan and that the plan should be prepared and revised in consultation with the patient and, if appropriate, any guardian, medical agent, relative, carer or friend who is providing support.

Table 2.7.6 displays the number of people on an order who had their treatment and care plan revised on CBIS at the time of their order.

Table 2.7.6 – Treatment and care plans on CBIS per order type

Order Type	Number	Percent
CTO1	46	26.6
CTO2	744	53.0
All CTOS	**790**	**50.1**
DTO1	784	15.5
DTO2	497	30.2
DTO3	73	47.1
All DTOs	**1354**	**19.7**
Total	**8434**	***25.4**

Source: CBIS

*Care should be taken when considering these numbers as Child and Adolescent Mental Health Services and Country Mental Health Services do not use CBIS for their care plans or other patient information, and individuals on multiple orders may not have required a revision of their treatment and care plan for each order. In addition, some treatment and care plans are documented in paper medical records rather than electronic records.

The use and effectiveness of treatment and care plans is a significant issue which will be examined by the OCPP in the coming year.

2.7.5 Missing Persons

During 2011-12 541 report were made to Police regarding people with mental illness as missing from an acute hospital setting 541 times. Of those reports, 319 (59.0%) were made for involuntary patients, 140 (25.9%) were made for voluntary patients and the legal status of 82 (15.2%) was unknown.

The 541 reports made represent 6.2% of the total 8795 admissions to mental health wards and the 319 reports for involuntary patients is 4.7% of the total 6858 DTOs in place.

Of the 319 reports made for involuntary patients, 249 (78.1%) were recorded as returned to a health service, 62 (19.4%) were unknown, 6 (1.9%) had their order expire or become revoked, and 2 (0.6%) went interstate.

3. DIVERSITY RESPONSIVENESS

The mental health services of South Australia are responsive to the needs of diverse individuals and groups in the community.

3.1 Lived Experience – Consumers and Carers

3.1.1 Participation Report

Utilising the experience of people who live with mental illness (consumers) and their families and carers is profoundly important. Their experience ensures that mental health reform is informed, shaped by; and responsive to the wishes and needs of people in our community who experience mental illness.

To this end, the OCPP has been working over the last year on a number of mechanisms to build capacity in ensuring the engagement of people with lived experience of mental illness:

- Quarterly meetings are held for consumers (the Consumer Reference Group – CRG) and carers (the Carer Advisory Group – CAG) to provide lived experience expertise and input to SA Health's mental health service delivery, policy development and evaluations.
- Members of both the CRG and CAG represent consumers and carers on management committees and working groups within the OCPP to highlight the needs and rights of consumers and carers at policy and operational levels.

3.1.2 State Register

A State Register of mental health consumers and carers has been developed and will be implemented in 2012-13 to provide a conduit for information between consumer and carer constituencies in South Australia, as well as via and through the Consumer and Carer Consultants to the Division. Four levels of participation will be available for consumers and carers providing flexible opportunities to engage:

- Receive information only.
- Receive information and provide feedback to the Mental Health and Substance Abuse Division via email.
- Receive information, provide feedback and have the opportunity to be invited to attend targeted consultations.
- Receive information, provide feedback and apply to become a representative on the Carer Advisory Group or Consumer Reference Group.

It is envisaged that through the State Register a broader strategic plan for consumer and carer participation will be developed.

3.1.3 Lived Experience Workforce

Another key area of involvement of lived experience is the burgeoning peer and carer workforce. The Lived Experience Workforce Development Project seeks to further develop the workforce in mental health services in South Australia through an established professional and identifiable staffing group. The project is exploring issues of recruiting, supporting and effectively sustaining the Lived Experience Workforce. Project officers have commenced consultations with a small number of agencies across government and non-government sectors to identify opportunities and issues for the future development of lived experience staffing positions and lived experience based services.

3.2 Aboriginal and Torres Strait Islander People

The continuing commitment of the mental health sector to delivering better services to Aboriginal and Torres Strait Islander people is guided by the Social Inclusion Board's report: *Stepping Up: A Social Inclusion Action Plan for Mental Health Reform 2007-2012, South Australia's Mental Health and Wellbeing Policy 2010-15,* the *National Standards for Mental Health Services 2010* and the *Summary Report: Statewide Aboriginal Mental Health Consultation* (2010).

Aboriginal Mental Health Action Plan

The Action Plan developed from the Summary Report and approved by Mental Health Executive prompted the following activity in 2011-12:

Aboriginal Mental Health Reference Group

A call for nominations for membership has taken place and now interviews are underway of Aboriginal and non-Aboriginal health staff. The Reference Group will report to Statewide Mental Health Executive and will be responsible for the delivery of the AMHAP within SA Health mental health services and to the Aboriginal community of South Australia. Members will actively assist in the development of processes and activities to support the plan being implemented within their jurisdictions and in keeping within specific timeframes.

Anangu Pitjantjatjara Yankunytjatjara Lands

The OCPP has worked with a number of partners and stakeholders, including the Adelaide Football Club, the South Australian National Football League, the National Perinatal Depression Initiative team, and individuals and communities of the Lands, to develop agreements, logistics and curricula for joint visits for health promotion and education for people on the APY Lands.

In June 2012 a five day field trip was undertaken by the SANFL, OCPP and the NPDI where several communities were visited and discussions with community members occurred. This initiative received positive feedback and the commitment to continue contribution to the social and emotional wellbeing education content of the program delivered by the primary organisations.

A trip during September has been organised through the Community Development Team of the Adelaide Football Club involving current AFC players and Community Development staff, staff from the OCPP and the NPDI. The outcomes of this trip will form an education, training and community awareness proposal with a view of an ongoing partnership agreement with key stakeholders.

Community Mental Health Services for Aboriginal People

The OCPP worked with the Mental Health Clinical Network to draft a questionnaire for use in 2012-13 with community mental health services, to explore what skills, knowledge and programs are available to address the particular needs of Aboriginal people, including the impacts of the stolen generation, complex loss and grief, traditional beliefs, and the effects of stronger inter-relationships among extended families and communities.

Mental Health and Emotional Wellbeing Statement of Acknowledgement

A Statement of Acknowledgement was drafted and will be released for consultation in 2012-13.

3.3 Culturally and Linguistically Diverse People

During 2011-12 the OCPP liaised with a number of key CALD stakeholders while the national Mental Health in Multicultural Australia (MHiMA) project got underway, including: Survivors of Torture and Trauma Assistance and Rehabilitation Service (STTARS), Migrant Health Service, Migrant Resource Centre of SA, Multicultural Communities Council of SA, Transcultural Mental Health Network and the Professor of Mental Health Nursing (Uni SA).

The OCPP will employ a project officer during 2012-13 to work with these stakeholders, the MHiMA project and more broadly in the health and multicultural sectors to develop a strategy and action plan to improve the participation of CALD people in mental health services and enhance the effectiveness of services delivered.

In 2011-12 the OCPP developed the South Australian Suicide Prevention Strategy and Implementation Guide 2012-2016, which identified the CALD community as a key focus group for targeted suicide prevention initiatives. While there are a number of actions in the Implementation Guide that will benefit CALD people, there are two specific actions to address CALD suicide:

- Increase the number of mental health trained interpreters and develop a sustainable bilingual mental health workforce.
- Culturally appropriate services for asylum seekers and migrants available in community and detention centres.

Also, the OCPP translated the Statements of Rights for mental health consumers into the 15 most common languages of people from CALD communities using mental health services.

3.4 Inclusive Service Planning and Development

Inclusion of Diversity

During 2011-12 the OCPP led or participated in a number of key service and strategy developments, including the: Aboriginal Mental Health Action Plan, ECT Policy Guidelines and Standards, Pathways to Care policy suite, Seclusion and Restraint Policy, South Australian Suicide Prevention Strategy and Youth Model of Care

These service and strategy initiatives were inclusive of people of diverse backgrounds, whose participation and needs will be used by the OCPP to inform planning more broadly, including: Aboriginal and Torres Strait Islander people, carers, children, consumers, culturally and linguistically diverse people, lesbian gay bisexual transgender and intersex people, men, older people, people living with alcohol or drug abuse, people bereaved by suicide, people in the criminal justice system, people with complex needs, people living with disability, people from rural and remote communities, survivors of attempted suicide, survivors of torture and trauma, women, veterans and serving members of the defence forces, and young people.

4. MENTAL HEALTH ACT

4.1 Amendments and Regulations

The OCPP worked in collaboration with the Office of the Minister for Mental Health and Substance Abuse and Parliamentary Counsel to make amendments and updated regulations for the *Mental Health Act 2009*. The OCPP met with a number of stakeholders and Members of Parliament to discuss the amendments in detail. The amendments were made to change the language of the Act that was stigmatising of people with mental illness and to clarify sections of the Act which were not as straight-forward as they could be.

The proposed changes are:

> That *Inpatient Treatment Orders* replaced what were *Detention and Treatment Orders*, without any change to function or duration.

> The words *involuntary inpatient* replaced all previous references to a detained patient or detained person.

> To clarify the provisions for an involuntary inpatient leaving hospital grounds.

> To rectify ambiguity in ECT consent provisions for minors.

> To enable a psychiatrist to correct any mistakes or omissions in a mental health legal order they are reviewing.

The *Mental Health (Inpatient) Amendment Act 2012* was considered by both Houses of Parliament in May and June 2012, assented to by the Governor on 21 June 2012. Once proclaimed by the Governor the Amended Act will become operational.

4.2 Forms and Statements of Rights

The Act amendments provided an ideal opportunity to review the Forms and Statements of Rights. The OCPP examined the feedback from the first 2 years of operation of the Act in light of the proposed amendments and drafted revised Forms and Statements that matched the future Act, improved their functionality for services and consumers, and met medical records requirements. Additional forms were created to meet the requirements of directives and standards, and to provide optional documentation which will be useful in some service settings. The full suite of 18 forms will be released later in 2012 and will be reported in the 2012-13 Annual Report.

In addition, the 4 Statements of Rights were each translated into the languages of the 15 most populous cultural groups that receive mental health services.

4.3 Emergency Services Memorandum of Understanding

During 2011-12 the OCPP chaired the Mental Health and Emergency Services Memorandum of Understanding Steering Committee and worked with members to discuss statewide system issues, and support and expand the capacity of the local cross-agency Local Liaison Groups to deal with cases and matters as they arise.

In addition, the OCPP worked with collaborating agencies to draft amendments to the MHESMoU that better reflected the provisions of the Act and which were agreed to by all signatories. The amendments are on hold however while the agencies consider revising the MHESMoU forms to better reflect the amended Act and agency needs.

4.4 Review

Section 111 of the Act requires the Minister to provide a report to Parliament on the operation of the Act within 4 years of the commencement of the Act. In addition, s90(1) requires the Chief Psychiatrist to monitor the administration of the Act and promote continuous improvement of mental health services.

To these ends, the OCPP collates feedback and submissions about the content, administration and interpretation of the Act. Some feedback can be immediately translated into action, some requires further work and consultation in the medium term and some can only be considered in the full review of the Act.

To oversee this process the OCPP convened the Mental Health Act User Group, comprising representatives of: consumers, carers, child and adolescent mental health services, community mental health services, Community Visitor Scheme, country mental health services, emergency departments, inpatient mental health services, Legal and Governance Unit, OCPP, Office of the Public Advocate, private mental health services, SA Ambulance Service and SA Police, with additional membership from other agencies and groups as required.

The User Group maintains a register of issues raised and actions taken, to inform service planning and development, and the review of the Act.

4.5 Delegations

During 2011-12 the Minister used s87 of the Act to delegate two functions to the Chief Psychiatrist; namely the powers to determine an individual as an Authorised Medical Practitioner or an Authorised Health Professional, as per s93 and s94 respectively.

In addition, the OCPP worked with mental health services across the state to develop uniform delegations for powers and functions at a service level. These general delegations will be finalised and released in 2012-13.

5. DIRECTIVES, POLICIES, STANDARDS

5.1 Authorised Officers

Authorised Officers have significant powers under s56(3) of the Act to take a person into care and control, transport, restrain, administer medication (if also authorised to do so under the *Controlled Substances Act 1984*), enter a place, search a person's clothes and assist other authorised officers. Police officers have similar powers under s57(4), with the addition of being able to break and enter a property. Authorised officers are defined by the Act to be ambulance officers, RFDS medical officers and flight nurses, and mental health clinicians. Mental health clinicians are defined by s3 of the Act to be a class of persons engaged in the treatment and care of patients *and* classified by the Chief Psychiatrist as mental health clinicians for the purposes of the Act.

During 2011-12 the Chief Psychiatrist commenced the process of classifying additional professionals as mental health clinicians, and thus also as authorised officers, for the purposes of carrying out the Act, including medical practitioners and registered nurses employed by the prison health service, experienced custodial officers as authorised by the General Manager of a prison, medical practitioners and registered nurses employed in public emergency departments, and medical practitioners and registered nurses employed in country hospitals. The complete list of current and proposed classifications and authorisations is below.

- Employees of public mental health services, comprising: Aboriginal health workers, occupational therapists, psychiatrists, psychologists, registered nurses and social workers.
- Employees of public emergency departments as authorised by the Director of an emergency department, comprising: medical practitioners and registered nurses.
- Employees of public country hospitals as authorised by the Executive Director of Country Health SA Local Health Network, comprising: medical practitioners and registered nurses (to be nominated and rolled out in a stepped process)
- Employees of the prison health service, comprising: medical practitioners and registered nurses.
- Experienced custodial officers as authorised by the General Manager of a prison. This enables prisoners who are on community treatment orders to receive treatment in prison without having to be transported to a health facility reducing the waste in resources and unnecessarily restrictive practices previously used.
- Privately employed psychiatrists.

The OCPP continues to work with emergency departments, the Department for Correctional Services and Country Health SA to implement the changes.

5.2 Electroconvulsive Therapy

There has been growing recognition of a need for standardisation of Electroconvulsive Therapy (ECT) practice in South Australia. The OCPP has embarked on leading the collaborative development and implementation of the South Australian ECT Guidelines, Policy and Standards.

5.2.1 ECT Advisory Committee

The South Australian ECT Advisory Committee was established in April 2012 to collaboratively develop the South Australian ECT clinical guidelines, policy, and standards documents.

The ECT Advisory Committee will make recommendations on strategies for system improvement, and facilitate quality improvement and risk management activities, which all aim to ensure the safe, effective and efficient delivery of ECT services to the South Australian community.

Chaired by the Chief Psychiatrist, membership includes consumers, carers, public and private sector ECT credentialed psychiatrists, specialists, RANZCP SA Branch ECT Sub-committee Chair, ECT nurses and anaesthetists. The ECT Advisory Committee is supported by the ECT Expert Reference Group with members representing SA ECT facilities clinical and management staff, as well as university, policy and project staff.

5.2.2 South Australian ECT Guidelines, Policy and Standards

The SA Health ECT Guidelines will provide a comprehensive overview of ECT in South Australia and will describe the minimum standards for the clinical application of ECT. The Guidelines will apply to all facets of care, including the indications for treatment, potential risks and strategies to minimise them, issues of consent, facilities, anaesthesia, application of the procedure, and the required quality improvement framework.

Based on the recently published NSW *ECT Minimum Standard of Practice*, the SA Guidelines will represent the professional consensus of ECT Advisory Committee and experts in the field, supported by the best clinical evidence-base available.

A separate Policy Statement and underpinning Standards documents will be derived from these Guidelines, and define the minimum, measurable standards that must be maintained by health care providers and the health care system. The suite of three documents will be released in 2012-13.

5.3 Pathways to Care

Mental Health Services in South Australia provide a range of service types to address the needs of consumers in the course of their recovery. The core work of mental health services is to support consumers in the community, ensuring that they develop self-management skills and are empowered to lead productive and fulfilling lives. What this looks like for individuals will vary considerably with some people moving in and out of services quickly, while others require input over a longer period with varying levels of intensity.

The stepped system of care provides multiple service options for consumers with the opportunity to tailor services to the consumer's needs. Consumer pathways don't follow a set linear path with some pathways stepping up and others stepping down.

The South Australia Mental Health Pathways to Care Policy Series comprises policies that enable a responsive and integrated mental health response to community needs.

The Consultation

Clinicians from all mental health settings both metropolitan and country were consulted on the various aspects of mental health services core work. There was a resounding call for more integration and responsiveness of services and the need for greater early intervention

and preventative work. Many expressed frustration that services were reactive rather than responsive.

The Policies

The focus is on ensuring consumers reach the most appropriate service type as quickly as possible and with the least number of steps, seamlessly moving to another level of care as needed. Mental health services must pre-empt and proactively arrange the transitions of care, creating the space in the system to allow this to occur expediently. Individual mental health services within South Australia are part of an integrated whole and the policies recognise the need to provide maximum flexibility for consumers to move between service areas according to their need at different times of illness severity, disability and recovery.

The policies articulate a commitment to the principles of inclusion aiming to remove barriers to care, providing welcoming environments and information to consumers and carers about their illness so they can make informed decisions. Mental health services are required to keep these pathways fluid with each service in the system managing their demand to ensure that movement can occur between service components on a daily basis.

The draft Pathways to Care policies will be released for broad consultation in 2012-13. The Specialist Policy Series will be separately released for consultation during that period. The policy series will comprise:

Pathways to Care Series

PTC 00	Overview of Pathways to Care
PTC 01	Consumer and Carer Participation
PTC 02	Access to Mental Health Services
PTC 03	Care and Treatment in Mental Health Services
PTC 04	Transfer of Care between Mental Health Services
PTC 05	Working with Other Service Providers
PTC 06	Exiting Mental Health Services
PTC 07	Re-entry to Mental Health Services
PTC 08	Transport

Specialist Policy Series

SPS 01	Seclusion and Restraint
SPS 02	Electroconvulsive Therapy
SPS 03	Physical Health
SPS 04	Perinatal Care and Treatment
SPS 05	Cross-Border Arrangements

5.4 Patient and Solicitor Access to Patient Records

During 2011-12 the OCPP worked with a number of stakeholders, including consumers, carers, the Law Society of South Australia, the Office of the Public Advocate, Ramsey Health Care SA, public mental health services and the Office of the Minister for Mental Health and Substance Abuse to draft, consult and finalise a Chief Psychiatrist standard, made under s90(2) of the Act, for *Patient and Solicitor Access to Patient Records*.

The standard is binding on all public and private hospitals and sets out uniform processes and forms for patients and solicitors to access records for people who have been subject to an order under the *Mental Health Act 2009* or *Guardianship and Administration Act 1993*.

This access ensures people who have been subject to orders can adequately prepare for appeals and other proceedings about those orders.

5.5 Restraint and Seclusion

5.5.1 Introduction

The National Mental Health Seclusion and Restraint reduction project (Beacon) was established in 2007. This project was in response to the National Safety Priorities in Mental Health, which included; the reduction and where possible, elimination of restraint and seclusion in mental health facilities. In addition, the National Standards for Mental Health Services 2010, South Australia's Mental Health and Wellbeing Policy 2010 – 2015 and the *Mental Health Act 2009* require care and treatment to be provided in the least restrictive environment in the least restrictive way.

5.5.2 South Australian Project

South Australia continues to engage a project officer in the monitoring, management and reduction of restraint and seclusion. This project began in 2008 and is overseen by a steering committee chaired by the Chief Psychiatrist. In 2011-12 the key components of the project were:

- Development of the draft state wide policy for the reduction of restraint and seclusion in mental health services which was distributed for consultation.
- Continued development of a guideline and toolkit on the reduction of restraint and seclusion.
- Implementation of restraint and seclusion reduction tools.
- Continued collection and reporting on data across the state.
- Ongoing work to embed consistent training and education in to practice for staff on reduction of restrictive practices.
- Work with the SA Health Safety and Quality Unit on extending the work of the project to address restraint and seclusion in general health settings.

In addition to the policy, the guideline will soon be distributed for consultation across the state and the final versions will include feedback and advice from staff, consumers, carers, family and governing bodies, including the Principal Community Visitor, Public Advocate and Health and Community Services Complaints Commissioner.

South Australia is the only state attempting to collect data on restraint and seclusion of mental health consumers in Emergency Departments and de-identified data is now being shared with other jurisdictions to promote a national approach to care and treatment that reduces and where possible eliminates the use of restraint and seclusion.

There are currently 35 active instructors in SA across all mental health services providing Non-violent Crisis Intervention training in prevention and de-escalation of aggression and during 2011-12 they provided 80 training sessions to 760 staff across in-patient and community settings. This training has now been adopted in a number of general health settings, in conjunction with their on-site mental health services to provide standardised, evidence based prevention and de-escalation training across a number of sites in all Local Health Networks.

Training has also been provided to consumer and carer consultants, non-government organisations working in the mental health sector, GP Plus centres and the volunteers of the Community Visitor Scheme.

5.6 South Australian Suicide Prevention Strategy

5.6.1 The Consultation

The South Australian Suicide Prevention Strategy and Implementation Guide will be released later in 2012. The development of the Strategy would not have been possible without the openness and willingness to speak out of the people and communities of our state.

The project has brought us into contact with people from all walks of life from across South Australia. Forums were held in Nuriootpa, Berri, Murray Bridge, Mt Gambier, Victor Harbor, Whyalla, Port Augusta, Wallaroo, Jamestown, Pt Lincoln, Coober Pedy and Adelaide to discover the issues affecting South Australians. Over 750 people participated and shared their journey, to progress this Strategy.

During the consultation process we found a vast amount of good work occurring in the space of suicide prevention. However, because of a lack of coordination there was a pervasive sense that little was being done.

5.6.2 The South Australian Suicide Prevention Strategy

The South Australian Suicide Prevention Strategy 2012-16 will describe a whole of community, whole of government, approach to suicide prevention that maximises the capacity of health and community services, families and communities to work together to prevent suicide.

Suicide prevention in the context of the South Australian Suicide Prevention Strategy is all encompassing of Awareness, Prevention, Intervention and Postvention.

The seven goals listed below, articulate the elements that emerged as important in preventing suicide in this state.

1. **To provide a socially inclusive community of resilient individuals and supportive environments.**
2. **To provide a sustainable, coordinated approach to service delivery, resources and information within communities to prevent suicide.**
3. **To provide targeted suicide prevention initiatives, activities and programs.**
4. **To address, as a priority, the issues that affect regional South Australians.**
5. **To provide targeted postvention activities and programs.**
6. **To improve the evidence base and understanding of suicide and suicide prevention.**
7. **To implement standards and continuous practice improvement in Suicide Prevention.**

The South Australian Suicide Prevention Strategy and Implementation Guide will identify the priorities for action, and coordinate an effective response across our state. Suicide prevention is everybody's business.

From the South Australia Suicide Prevention Strategy will be drawn specific strategies for Children and Youth, Aboriginal and Torres Strait Islander (ATSI) communities, Men and Older Persons.

6. OFFICE OF THE CHIEF PSYCHIATRIST AND MENTAL HEALTH POLICY

The OCPP also carries out a number of other roles and functions, as detailed below.

6.1 Advice and Liaison

The OCPP provides advice and liaison to clinicians and services, other agencies, consumers and families as required, with a focus during 2011-12 on the Act, Authorised Officers, information sharing, the Mental Health Emergency Services Memorandum of Understanding, restraint and seclusion, and suicide prevention.

6.2 Authorised Health Professionals

In addition to the other powers and responsibilities of a mental health clinician, Authorised Health Professionals can make Level 1 CTOs and Level 1 ITOs – to be reviewed by a psychiatrist within 24 hours – to ensure that consumers get immediate access to the treatment and care they need.

During 2011-2012, 47 mental health clinicians completed the required two-day training and were subsequently authorised by the Minister to be AHPs, making a total of 182 across the state, representing 9.3% of the total mental health workforce of approximately 1700. This is consistent with the proportions of staff in similar roles in other jurisdictions. There are currently 39 clinicians approved by their clinical directors waiting to commence AHP training. The OCP also delivered 15 half-day support sessions for AHPs with a total attendance of 207, keeping them up-to-date with issues and solutions, share learnings and maintain currency of authorisation.

6.3 Authorised Medical Practitioners

Authorised Medical Practitioners are senior psychiatric registrars or Psychiatric Specialist International Medical Graduates who receive specific training from the South Australian Psychiatric Training Committee (SAPTC) and are subsequently authorised by the Minister to have the powers of a psychiatrist for the purposes of the Act. Three medical practitioners completed the SAPTC AMP training during 2011-12 and were registered as AMP's.

6.4 Community Visitor Scheme

The OCPP provided administrative, accounting, human resource and planning support to the CVS during 2011-12, the first year of the Scheme's operation.

6.5 Cross-Border Arrangements

Civil Cross-Border Arrangements

During 2011-12 South Australia had Memorandums of Agreement with New South Wales and Victoria for the treatment, care and transport of people on orders between those jurisdictions and our own. The OCPP continues to work with these and other jurisdictions to draft Memorandums and to improve protocols and agreements.

The OCPP also provides liaison and advice to services in South Australia and other states for the options available for cross-border arrangements for individuals moving between jurisdictions.

Forensic Cross-Border Arrangements

No law in any Australian jurisdiction allows for the transfer of forensic clients between states, other than the repatriation of individuals at large to the state where they are under a supervision order. The OCPP continues to work with other jurisdictions, and with the Attorney-General's Department regarding the *Criminal Law Consolidation Act 1935,* to bring about reform in this area.

6.6 Education and Training

Authorised Officers

The OCPP provided training and resources regarding the use of authorised officer powers across a number of metropolitan and country locations, including mental health services, general health services and emergency departments.

Information Sharing

The OCPP provided education and resources regarding information sharing to 391 mental health service staff, 35 carer and consumers, and 9 non-government organisation staff, with sessions run in metropolitan and country locations.

Mental Health Act 2009

A total of 386 people attended information and education sessions regarding the Act. Sessions ranged from one hour through to two days and have been attended by: consumers, carers, inpatient and community mental health services, general practitioners, emergency departments, the SA Ambulance Service, SA Police, Department of Correctional Services and non-government organisations.

Mental Health and Emergency Services Memorandum of Understanding

The OCPP provided information and education sessions regarding the MHESMoU to 225 staff, including: mental health services, emergency departments, general health services, older persons mental health services, child and adolescent mental health services, SA Ambulance Service and SA Police.

6.7 GP PASA

General Practitioner Psychiatrist Advice – South Australia is a single point of contact telephone service for GPs seeking to make appointments for consumers with participating psychiatrists for the purpose of providing a comprehensive assessment and management plan. The OCPP processed 966 calls during the 2011-12 financial year.

6.8 Inspections

The Act gives the Chief Psychiatrist the authority to conduct inspections of the premises and operations of any facility that is an incorporated hospital under the *Health Care Act 2008*. This power was not exercised in 2011-12.

6.9 Mental Health Legal Orders

The OCPP carried out data entry, acknowledgements and trouble-shooting for the 8434 mental health legal orders made during 2011-12.

6.10 Ministerial and Parliamentary Functions

The OCPP drafted and provided advice for Ministerial briefings and responses, Cabinet submissions and comments, parliamentary briefing notes, parliamentary questions, parliamentary estimates, Chief Executive briefings and responses, Freedom of Information requests, Coronial inquests and findings, and youth and other court orders.

6.11 National and State Policy

The Chief Psychiatrist and other OCPP staff participated in national and state policy development and implementation with the following groups:

National

- National Recovery Framework for Mental Health Services
- National Safety and Quality Partnership Subcommittee
- National Suicide Prevention Working Group
- Statement of Rights and Responsibilities

State

- Aboriginal Mental Health Action Plan Steering Committee
- Borderline Personality Disorder Working Party
- Carer Advisory Group
- Clozapine Working Group
- Community Visitor Scheme Advisory Committee
- Consumer Reference Group
- Emergency Demand Management Working Group
- EPAS Clinical Advisory Group
- EPAS Mental Health Working Group
- Forensic Executive Leadership Group
- Health Services Provision to Immigration Detainees
- Medicines Advisory Committee
- Mental Health Act User Group
- Mental Health Executive
- Mental Health Executive and Union Meeting
- MHESMoU Steering Committee
- Restraint and Seclusion Steering Committee
- Royal Australian and New Zealand College of Psychiatrists (SA Branch)
- Statewide Mental Health Clinical Directors
- Statewide Mental Health Clinical Network
- Suicide Advisory Committee
- Transcultural Mental Health Network
- Youth Model of Care Steering Committee

6.12 Reviews

The OCPP participated in the formal review of the assessment, management and coordination of services for 2 individuals with chronic and complex needs and behaviours during 2011-12.

7. LOOKING FORWARD

The dynamic nature of health care delivery and ongoing progress towards implementing mental health reform will inform both the scheduled review of mental health governance and the development of integrated community-based services inclusive of all elements of the stepped model of care. The development of such a service system will deliver real outcomes for consumers by more appropriately meeting their needs and will provide clinicians with more options for care, treatment and rehabilitation, with stronger links between service elements to enhance collaboration and case management.

Ensuring the continued focus on community mental health, alternatives to hospitalisation and above all a healthcare environment that enables recovery will remain the key priorities for the Office of the Chief Psychiatrist and Mental Health Policy. These priorities will be captured in South Australia's next strategic plan for mental health. Areas requiring continued development and attention include Older Persons Mental Health Services, Forensic Mental Health Services, stigma reduction and social inclusion initiatives for people with mental illness. The implementation of a Youth service system and the formation of a single statewide Child and Adolescent Mental Health Service present considerable challenges for us.

It is anticipated that the Pathways to Care policy series will bring much-needed focus on integration across the different levels of care in the stepped system and between primary care, mental health care, NGOs and the private sector. The achievement of this aim will require sustained effort from clinicians at the service delivery level to bring to bear a customer service focus in our work with consumers, carers and other service providers.

The work of the Suicide Prevention Advisory Committee will be vital in progressing the goals set out in the South Australian Suicide Prevention Strategy. Mapping out priorities for the next 12 months and beyond will allow the setting of targets which will be reported against in the next annual report. Suicide prevention requires a whole of community response. It has been reassuring to see the level of discussion, interest and activity generated recently and the responsible use of media to open up the conversation around this sensitive issue.

Finally the OCPP would like to acknowledge people with mental illness, their carers and their families – it is your strength we draw on to drive the reform.

Appendix I – Glossary

A

ABS	Australian Bureau of Statistics
ACHS	Australian Council on Healthcare Standards
ACIS	Assessment and Crisis Intervention Service
AHP	Authorised Health Professional – *a mental health clinician who has undertaken extra training and been approved by the Minister to perform specific tasks under the Act*
ALOS	Average Length of Stay
AMP	Authorised Medical Practitioner – *a medical practitioner with extensive psychiatric experience and training who has been approved by the Minister to perform specific tasks under the Act*
AO	Authorised Officer – *mental health clinicians, ambulance officers and RFDS flight nurses*
APY Lands	Anangu Pitjantjatjara Yankunytjatjara Lands
ATSI	Aboriginal and Torres Strait Islander
ATC	Approved Treatment Centre

B

BART	Information system used to record and report CAMHS activity.

C

CAG	Carer Advisory Group
CALD	Culturally and Linguistically Diverse
CAMHS	Child and Adolescent Mental Health Services
CARS	Consumer Activity Reporting System
CBIS	Community Based Information System
CCC	Combined Country CME (Client Management Engine)
CHSA	Country Health South Australia
CLCA	Criminal Law Consolidation Act
CMHC	Community Mental Health Centre
CMHS	Community Mental Health Service
COAG	Council of Australian Governments
CRC	Community Rehabilitation Centre
CRG	Consumer Reference Group
CTO	Community Treatment Order
CVS	Community Visitor Scheme

D

DASSA	Drug and Alcohol Services of South Australia
DTO	Detention and Treatment Order

E

ECT	Electro-convulsive Therapy
ED	Emergency Department
EPAS	Enterprise Patient Administration System
EPIS	Early Psychosis Intervention Service
ETLS	Emergency Triage and Liaison Service

F

FMC	Flinders Medical Centre

G

GH	Glenside Hospital
GP	General Practitioner
GP PASA	General Practitioner Psychiatrist Advice – South Australia
GSB	The Guardianship Board of South Australia

H

	HASP	Housing and Accommodation Support Partnership
	HIP	Health Information Portal
I		
	ICC	Intermediate Care Centre
	ICT	Information and Communication Technology
	IPRSS	Individual Psychosocial Rehabilitation Support Service
	ISAAC	Integrated South Australian Activity Collection
	ITO	Inpatient Treatment Order
J		
	JNH	James Nash House
L		
	LHN	Local Health Network
	LMHS	Lyell McEwin Health Service
	LTC	Limited Treatment Centre
M		
	MHA	*Mental Health Act 2009*
	MHC	Mental Health Clinician
	MHESMoU	Mental Health and Emergency Services Memorandum of Understanding 2010
	MHiMA	Mental Health in Multicultural Australia
	MPH	Modbury Public Hospital
	MP	Medical Practitioner
N		
	NGO	Non-Government Organisation
	NHS	Noarlunga Health Service
	NPC	Nurse Practitioner Candidate
O		
	OCPP	Office of the Chief Psychiatrist and Mental Health Policy
	OSOP	Oakden Services for Older People
P		
	PAS	Patient Administration System
	PECU	Psychiatric Emergency Care Unit
	PICU	Psychiatrist Intensive Care Unit
R		
	RAH	Royal Adelaide Hospital
	RANZCP	Royal Australian and New Zealand College of Psychiatry
	RFDS	Royal Flying Doctor Service
	RGH	Repatriation General Hospital
S		
	SAAS	South Australian Ambulance Service
	SANFL	South Australian National Football League
	SAPTC	South Australian Psychiatric Training Committee
	SAPOL	South Australian Police
	SLA	Statistical Local Area
	Supp Accom	Supported Accommodation
T		
	TQEH	The Queen Elizabeth Hospital
W		
	W&CH	Women’s & Children’s Hospital

Appendix II – Bibliography

Clinician's Guide and Code of Practice – Mental Health Act 2009. Department of Health, Government of South Australia (2010).

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Mental Health Act 2009 (South Australia).

Mental Health and Emergency Services Memorandum of Understanding 2010. Department of Health, Government of South Australia (2010).

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Plain Language Guide – Mental Health Act 2009. Department of Health, Government of South Australia (2010).

South Australian Suicide Prevention Strategy 2012-16. Department for Health and Ageing, Government of South Australia (2012).

South Australia's Mental Health and Wellbeing Policy 2010-2015, Department of Health, Government of South Australia (2010)

SA Health Strategic Plan 2008-2010, Department of Health, Government of South Australia (2008).

South Australia's Strategic Plan 2007, Government of South Australia (2007).

Summary Report: Statewide Aboriginal Mental Health Consultation 2010. Department of Health, Government of South Australia (2010).

Appendix III – Publications and Resources

Current mental health publications and resources available from SA Health.

Publications

- Clinician's Guide and Code of Practice – *Mental Health Act 2009*
- Evaluation of the Returning Home Program
- Evaluation of the Individual Psychosocial Rehabilitation and Support Services (IPRSS) Program
- Introduction to the Community Visitor Scheme – *Mental Health Act 2009*
- Mental Health Practitioner's Guide to Sharing Consumer Information
- Plain Language Guide – *Mental Health Act 2009*
- Review of Deaths – June 2001 to December 2009
- South Australia's Mental Health and Wellbeing Policy 2010-15
- South Australian Suicide Prevention Strategy 2012-2016
- Summary Report: Statewide Aboriginal Mental Health Consultation 2010
- The Annual Report of the Chief Psychiatrist of South Australia 2010-11
- The Annual Report of the Chief Psychiatrist of South Australia 2011-12
- The Framework for Recovery-Oriented Rehabilitation in Mental Health Care

Information and Training Resources

- Act Amendments and Revised Forms – 1 hour presentation
- Authorised Health Professionals – 2 day training package for clinicians
- Authorised Officers – 1 hour presentation for emergency departments
- Community Visitor Scheme – 1 hour presentation
- Information Sharing – 1 hour presentation for communities
- Information Sharing – 2 hour presentation for clinicians
- *Mental Health Act 2009* – 1 hour presentation for communities
- *Mental Health Act 2009* – 2 hour presentation for clinicians
- Mental Health and Emergency Services MoU – 1 hour presentation for clinicians

Mental Health Act Instruments and Agreements

- Cross Border Agreement – New South Wales
- Cross Border Agreement – Victoria
- Mental Health and Emergency Services Memorandum of Understanding 2010

Fact sheets

- Authorised Officers – *Mental Health Act 2009*
- Cross Border Agreements – Plain Language Summary
- Information Sharing
- Making and Confirming / Revoking Level 1 Orders – *Mental Health Act 2009*
- Mental Health and Emergency Services MoU
- People and Powers – *Mental Health Act 2009*
- Prison Health Officers and Custodial Officers
- South Australia's Mental Health and Wellbeing Policy 2010-15

Appendix IV – Forms and Statements of Rights

Forms

Mandatory

- MR82J Consent to Electroconvulsive Therapy
- MR82Q Patient and Solicitor Access to Patient Records
- MR82R Undertaking not to Divulge Requested Information
- MR90B Community Treatment Order level 1
- MR90C Inpatient Treatment Order level 1
- MR90D Confirmation/Revocation of the Making of a level 1 Treatment Order
- MR90E Inpatient Treatment Order level 2
- MR90H Leave of Absence
- MR90I Administration of an Episode of Emergency ECT without Patient Consent
- MR90K Patient Transport Request
- MR90L Transfer of an Involuntary Inpatient within South Australia
- MR90M Request for Approval to Transfer to an Interstate Treatment Centre
- MR90N Transfer from Another Jurisdiction to a South Australian Treatment Centre
- MR90O Revocation of a Treatment Order

Optional

- MR82P Sharing Consumer Information Consent Form
- MR90A Care and Control Record
- MR90F Report to the Director of the Making of a level 2 Inpatient Treatment Order
- MR90S Checklist for Procedural Requirements

Statements of Rights

- Community Treatment Orders
- Inpatient Treatment Orders
- Leave of Absence
- Voluntary Admissions

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

Appendix V – South Australian Mental Health and Related Services

Appendix IV provides links to service finders and listings of mental health and related services in South Australia.

Emergency Mental Health Services

- Mental Health Telephone Triage Service – 131 465
- Lifeline – http://www.lifeline.org.au
- Suicide Call Back Service - http://www.suicidecallbackservice.org.au/
- Beyondblue – http://www.beyondblue.org.au
- Kids Help Line – http://www.kidshelp.com.au/
- Mensline Australia – http://www.mensline.org.au
- Your family doctor or general practitioner

Public Mental Health Services

- The Whitepages, under "mental health" – http://www.whitepages.com.au
- The University of Adelaide Library directory of mental health services – http://www.adelaide.edu.au/library/guide/med/menthealth/mentadd.html
- SA health services finder – http://www.hsfinder.sa.gov.au

Private Mental Health Services

- Your family doctor or general practitioner can provide treatment or refer you to a private psychologist or psychiatrist.
- The Adelaide Clinic - http://www.adelaideclinic.com.au/

Non-Government Organisation Services

- Mental Health Coalition of South Australia listing – http://www.mhcsa.org.au/

Aboriginal Health Services

- Aboriginal health services finder – http://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/health+services/aboriginal+health/aboriginal+health+services

Advocacy Services

- Community Visitor Scheme – cvs@health.sa.gov.au
- Office of the Public Advocate – http://www.opa.sa.gov.au
- Disability Advocacy and Complaints Service of SA – http://www.dacssa.org.au/
- Multicultural Advocacy Liaison Service of SA – http://www.malssa.org.au/

Complaints Services

- The Complaints Officer or Consumer Advisor of your health service
- Office of the Chief Psychiatrist – ocp@health.sa.gov.au
- Health and Community Services Complaints Commissioner – http://www.hcscc.sa.gov.au

Appeals

- Guardianship Board of South Australia – http://www.guardianshipboard.sa.gov.au/

Legal Services

- The Law Society of SA – http://www.lawsocietysa.asn.au/

Addendum – Order Appeals

This addendum contains information regarding appeals against mental health legal orders to both the Guardianship Board (GSB) and the District Court (DC) of South Australia.

The data systems of the GSB and OCPP are not compatible and the information provided in this addendum is indicative only. Work has commenced to improve data compatibility between the agencies.

Of the total 8,434 mental health legal orders made in 2011-12, 498 (5.9%) were subject to an appeal, with 433 (5.1%) being appealed to the GSB and 65 (0.8%) being appealed to the DC.

Note that a small unknown number of orders were subject to both a GSB and a DC appeal and have been counted twice in this addendum.

Appeals to the Guardianship Board

An appeal against a mental health legal order may be made to the GSB by: the person to whom the order applies; the Public Advocate; a guardian, medical agent, relative, carer or friend; or any other person who satisfies the GSB that they have a proper interest in the matter. In practice appeals regarding CTO1s, DTO1s and DTO2s are made to the GSB.

Table A1 displays the outcomes for the 433 appeals made to the GSB for the total 6,875 CTO1s, DTO1s and DTO2s made in 2011-12.

Table A1 – Guardianship Board appeals and outcomes

Outcome	Order expired before appeal	Order revoked	Appeal withdrawn	Appeal upheld	Appeal dismissed	Order varied	Total
Number	42	134	84	19	147	7	433
% of appeals	9.7	30.9	19.4	4.4	33.9	1.6	100
% of orders	0.6	1.6	1.2	0.3	2.1	0.1	6.3

Source: GSB

Appeals to the District Court

An appeal against a decision or order of the GSB may be made to the DC by: the applicant to proceedings before the GSB; the person to whom proceedings relate; the Public Advocate; any person who gave evidence or made submissions to the proceedings; or any other person who satisfies the GSB or DC that they have a proper interest in the matter. In practice appeals regarding CTO2s, DTO2s and DTO3s are made to the DC.

Table A2 displays the outcomes of the 65 appeals made to the DC for the total of 3,203 CTO2s, DTO2s and DTO3s made in 2011-12.

Table A2 – District Court appeals and outcomes

Outcome	Appeal upheld	Appeal dismissed	Remitted to the GSB	Appeal withdrawn	Total
Number	3	33	9	20	65
% of appeals	4.6	50.8	13.8	30.8	100
% of orders	0.1	1.0	0.3	0.6	2.0

Source: GSB