The Annual Report

of the Chief Psychiatrist of South Australia

2010-11

Government of South Australia

SA Health

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Government of South Australia
SA Health

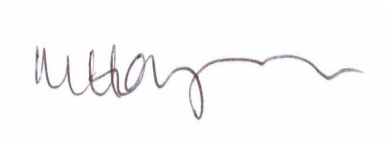
Hon John Hill MP
Minister for Health
Minister for Mental Health and Substance Abuse

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 Office of the Chief Psychiatrist for the financial year ending 30 June 2011, in compliance with the Department of Premier and Cabinet Circular on Annual Reporting requirements.

Yours sincerely



Dr Margaret Honeyman QSO
Chief Psychiatrist
Director Mental Health Policy
30 September 2011

Foreword

It is with great pleasure that I present the first annual report of the Chief Psychiatrist. 2010-11 has been a landmark year, with the commencement of the *Mental Health Act 2009,* the establishment of the Office of the Chief Psychiatrist (OCP) and the introduction of the Community Visitor Scheme to further protect the rights of people with a mental illness who are admitted to South Australian treatment centres.

South Australia is currently undertaking an extensive program of mental health reform to improve facilities and service delivery, enhance collaborative partnerships and increase the involvement of consumers and their families. The reforms have been driven by Mental Health Operations and the Health Regions working together. The role of the Chief Psychiatrist supports these reforms by working with stakeholders to continually improve the delivery of mental health services, monitoring the treatment of patients and the administration of the Act and providing advice to the Minister.

In our first year, our key priorities have been the implementation of the Mental Health Act 2009 and the introduction of the Community Visitor Scheme. Both were complex initiatives that required significant change to practices and systems across health and other sectors. There were many challenges, but these were overcome through the understanding and collaboration of stakeholder groups and agencies.

One of the highlights of this year has been the establishment of effective working relationships between the Office of the Chief Psychiatrist and mental health services, emergency services, other government agencies, non-government organisations and community groups, as well as consumers and carers. This has been an important part of the reform's progress and I would like to thank individuals and agencies for their hard work over the last year. In particular, I acknowledge the dedication and teamwork shown by the members of the OCP.

I would also like to congratulate Mr Maurice Corcoran on his appointment as the Principal Community Visitor.

This report provides an opportunity to reflect on activity and progress to date, as well as areas that require further change and improvement.

This has been an exciting year for mental health and the Office of the Chief Psychiatrist and I look forward to seeing further progress in the year to come.

Dr Margaret Honeyman
Chief Psychiatrist

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Acknowledgements

The Office of the Chief Psychiatrist (OCP) 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 of activity within South Australian mental health services.

The OCP would like to specifically acknowledge the data, advice and support of the: Adelaide Metropolitan Mental Health Directorate (SA Health), Australian Bureau of Statistics, Coroner's Court of South Australia, Country Health SA, General Practice SA, Guardianship Board of South Australia, Health System Information and Performance Branch (SA Health), Mental Health Client Information and Applications Team (SA Health), Mental Health Operations Branch (SA Health), Ramsay Health Care SA, Royal Flying Doctor Service, Safety and Quality Directorate (SA Health), 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 2011 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 OCP and other SA mental health services are contained in the Department of Health Annual Report 2010-11.

Data Caveat

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

Where possible explanatory narrative has been added but nevertheless interpretation requires to be informed by context.

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 Part 12 section 92 of the Act to present an annual report to the Minister by 30 September each year.

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 South Australian 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 2007, 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 Office of the Chief Psychiatrist

The OCP has a number of functions either mandated under, or caused by the implementation of, the Act. In addition, the OCP has subsumed all of the functions formerly provided by the Mental Health Policy Unit and the position of Chief Adviser in Psychiatry. A summarised description of all responsibilities is provided below, grouped into functional areas.

1.3.1 Mandated Responsibilities and Powers

The Chief Psychiatrist has a number of mandated responsibilities and powers, including to:

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

1.3.2 Safety and Quality

The OCP works in partnership with SA Health and mental and general health services to improve the safety and quality of services through: implementing policy and standards; monitoring the organisation and delivery of services; monitoring and providing advice regarding incidents and complaints; assisting with the review of incidents or processes; and; undertaking safety and quality projects.

1.3.3 Policy

The OCP has taken over the responsibilities of the former Mental Health Policy Unit which encompasses both national and state policy development and implementation. This currently includes the Fourth National Mental Health Plan, the South Australian Mental Health and Wellbeing Policy 2010-2015, the South Australian Emergency Services Mental Health Memorandum of Understanding 2010 and the Aboriginal Mental Health Action Plan 2011.

1.3.4 Advice and Liaison

The OCP provides advice and liaison regarding the interpretation and use of the Act, cross-border arrangements, the interpretation and use of the Mental Health and Emergency Services Memorandum of Understanding, policy, standards, incidents, inquests, complaints, information sharing and Ministerial and Parliamentary matters. The OCP also collaborates with other parts of SA Health and external agencies and individuals to resolve complex cases and system issues.

1.3.5 Education and Training

The OCP provides education, training and related resource material regarding National and State legislation, policies, standards and practice guidelines to mental and general health services, emergency services, non-government organisations and community groups.

1.3.6 GP PASA

The OCP provides the call centre service for the General Practitioner Psychiatrist Advice – South Australian (GP PASA 291) service. GP PASA 291 is a service facilitating GP referrals for one-off assessment and management plans by private psychiatrists, provided under MBS item 291.

1.4 Annual Report Road-map

This is the inaugural Annual Report of the Chief Psychiatrist, as required by section 92 of the Act. The Act mandates the reporting of patient demographics, mental health legal orders and cross-border arrangements, and requires the monitoring of the treatment of voluntary and involuntary patients, the use of restraint and seclusion, and the administration of the Act.

In addition to the legislated content, this report describes the activities of the Office of the Chief Psychiatrist and the broader activity and reform agenda of mental health services in South Australia.

By describing the mental health system, the reform agenda, the demographics of patients and the use of the Act together, this report provides a comprehensive picture of mental health services and the people who used those services in 2010-11.

A number of abbreviations and acronyms are used in this report. Please see the glossary for definitions and more detail.

The report will improve the community's understanding of the mental health system and will enhance service development and planning by mental health services and partner agencies.

2. South Australia's Mental Health System

2.1 Mental Health Services

Mental Health Services in South Australia in 2010-11 were delivered by SA Health, the Adelaide Health Service, the Children, Youth and Women's Health Service, Country Health SA, non-government and not-for-profit organisations, private hospitals and private health practitioners (the organisational structure of public health services in 2011-12 has changed with the introduction of to Local Health Networks in accordance with COAG agreements).

Public mental health services are delivered to metropolitan and country people in three age-specialised service streams: children and adolescents; adults; and; older people.

Mental health services delivered or funded by SA Health comprise the graduated levels of care recommended by the Social Inclusion Board's *Stepping Up* Report. These include:

- **Emergency Departments** – emergency assessment, treatment and referral services for people who have, either voluntarily or involuntarily, presented with mental illness.
- **Acute Inpatient Units** – inpatient services for people diagnosed with a serious mental illness who require short term intensive management of their health and safety.
- **Intermediate Care Centres** – services for people who are unwell but don't need acute inpatient admission, encompassing comprehensive assessment and treatment tailored to the consumer's needs, and collaborative approaches in preparing individuals for transition back to the community or to avoid an inpatient admission.
- **Community Rehabilitation Centres** – community based residential rehabilitation services, which support recovery by providing an active therapeutic environment with intensive rehabilitation and life skills development, and integration into community life.
- **Supported Accommodation** – accommodation with specialist treatment and support provided by mental health services, psychosocial treatment and support provided by non-government organisations, and tenancy support provided by not-for-profit housing organisations or Housing SA, including the Housing and Accommodation Support Partnership (HASP), Supported Social Housing (SSH) and other programs.
- **Community Mental Health Services** – a range of specialist services provided to people in the community, including acute crisis intervention, mobile assertive care and continuing care.
- **Non-Government Services** – a range of psychosocial rehabilitation support, peer support and information, and respite services provided to people in their own homes in the community.

Many people receive mental health treatment and support through their General Practitioner, private psychiatrists and psychologists, and private hospital inpatient and outpatient services.

In addition, Forensic Mental Health Services provide specialist treatment and support to people who have been found mentally incompetent to have committed an offence or mentally unfit to stand trial, and Prison Health Services provide specialist treatment and support to prisoners and offenders who may have a mental illness.

2.2 Mental Health Act 2009

The *Mental Health Bill 2009* was passed by State Parliament on 3 June 2009 and was assented to by the Governor in Executive Council on 11 June 2009. It was enacted on 1 July 2010.

The Act provides South Australia with an improved legislative framework 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 underpin 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.
- Create more appropriate and effective processes for engagement between consumers and service providers, including transport and orders for community treatment and detention and treatment.
- 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:

- 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.
- Specially trained mental health clinicians, called Authorised Health Professionals, can make Level 1 Community Treatment Orders (CTOs) and Detention and Treatment Orders (DTOs) – 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.
- Improved 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.

- 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.
- The establishment of Limited Treatment Centres (LTCs) in country South Australia where people on Level 1 DTOs can be detained for up to 7 days, receiving care and treatment closer to their homes and families rather than travelling to Adelaide.
- Enhanced cross-border arrangements so that people with mental illness who become unwell in their non-home state can more quickly get the care and treatment they need.
- The establishment of the position of Chief Psychiatrist to monitor the treatment of patients, the standard of psychiatric care provided in South Australia, the use of orders and prescribed treatments, and the administration of the Act.

2.3 Mental Health Emergency Services Memorandum of Understanding

People who have a mental illness or who exhibit behaviours of community concern may require a response by multiple agencies, including SA Health, SAAS, RDFS and South Australian Police (SAPOL), to ensure safe transport and timely access to assessment and treatment services.

The 2010 Mental Health and Emergency Services Memorandum of Understanding (MHESMoU) was updated from the previous 2006 memorandum in the context of the *Mental Health Act 2009* and establishes an agreed framework for agencies involved in the management of such situations.

The MHESMoU commits the signatory parties to work cooperatively to provide a safe and coordinated system of assessment, care and transport, and defines the roles and accountabilities of each agency.

3. System and Mandatory Reporting

3.1 Mental Health Services

3.1.1 Summary of Facilities

Table 3.1.1 provides a summary of acute, sub-acute and supported accommodation services provided in South Australia during 2010-11. As the reform progresses some services will undergo changes and new facilities will commence providing services.

Table 3.1.1 – Acute, sub-acute and supported accommodation services

Service type	Ward / Program	Health Service
Acute child & youth	Boylan	Womens and Childrens Hospital
Acute adult	1G	Lyell McEwin Health Service
	4G, 5H, 5J, 5K	Flinders Medical Centre
	C3	Royal Adelaide Hospital
	Cedars	Glenside Campus
	Cramond	Queen Elizabeth Hospital
	Helen Mayo	Glenside Campus
	Morier	Noarlunga Health Service
	Rural and Remote	Glenside Campus
	Ward 17	Repatriation General Hospital
	Woodleigh	Modbury Hospital
Acute older	Ward 18	Repatriation General Hospital
	1H	Lyell McEwin Health Service
	Rosewood	Glenside Campus
Forensic	Aldgate, Birdwood, Clare	James Nash House
	Grove Closed	Glenside Campus
Adult extended	The Birches, Glen Transition	Glenside Campus
Older extended	Clements, Makk, McLeay	Oakden Campus
Intermediate care	Country	CHSA
	East	Glenside Campus
	South	Noarlunga Health Service
Community Rehabilitation Centres	Elpida	Central LHN
	Trevor Parry	Southern LHN
	Wondakka	Northern LHN
Supported accommodation	HASP	Metropolitan area
	Supported Social Housing	Metro and country
	Other programs	Metro and country

Source: HIP, CBIS and CARS.

The majority of mental health services are delivered outside of bed-based facilities and programs, namely by community mental health services, psychosocial support and other services provided by non-government organisations, and primary health care provided by General Practitioners and others.

3.1.2 Summary of Service Provision

Many consumers access several service types over the course of their journey of recovery and the numbers of patients outlined in Tables 3.1.2 and 3.1.3 are not cumulative.

Table 3.1.2 depicts the 2010-11 volume of services provided for public and private inpatient, intermediate care, community recovery, community mental health and psychosocial support services.

Table 3.1.2 – Service use across the levels of care

Service	Occasions of service	No	%
Public hospital inpatient services	Total separations	388,246	100
	Separations with principal diagnosis as mental health	16,307	4.2
	Separations from mental health wards	7,676	1.98
Private hospital inpatient	Mental health separations	1170	-
ICC	Total patients	172	-
CRC	Total patients	167	-
CMHS	Total contacts	558,750	-
	Total consumers	31,401	-
IPRSS	Total psychosocial support hours	111,540	-
	Total consumers	1,246	-

Source: HIP, CBIS and CARS.

Table 3.1.3 depicts the volume of emergency services provided through metropolitan emergency departments, SAAS, SA Police and the RFDS. Although people with mental illness make up only a small percentage of the individuals receiving emergency services, the complexity of some cases can amplify the time taken and collaboration by different agencies required to provide a service.

Table 3.1.3 – Emergency service use

Service	Occasions of service	No	%
Metropolitan EDs	Total presentations	383,992	100
	Mental health presentations	11,220	2.92
	Drug and alcohol presentations	4,302	1.12
SAAS	Total SAAS events	307,000	100
	Mental health events	4,605	1.5
SA Police	Total metropolitan taskings 2009-10	310,260	100
	Mental health taskings 2009-10	3,187	1.03
RFDS	Total transfers	5,958	100
	Mental health transfers	307	5.1

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

Many people receive an emergency community mental health response through Assessment and Crisis Intervention Service (ACIS) teams, which provide emergency assessment, intervention and follow-up services.

3.2 Patient Demographics

3.2.1 Gender

The South Australian population is split almost evenly between women (50.6%) and men (49.4%). **Source: ABS (31010DO002_201006, June 2010).**

Tables 3.2.1 and 3.2.2 show the gender of people receiving the range of public community and inpatient services, except supported accommodation and IPRSS for which data is unavailable.

Table 3.2.1 – Gender in community services

Program	ICC	CRC	CMHS	All CTOs
Female	23.8	45.5	48.2	35.9
Male	76.2	54.5	51.8	64.1

Source: HIP and CBIS.

Table 3.2.2 – Gender in inpatient services

Program type	CAMHS acute	Adult acute	Older acute	PICU	Forensic acute	Forensic extended	Adult extended	Older extended	All DTOs
Female	69	51	61	23	19	19	21	34	44.3
Male	31	49	39	77	81	81	79	66	55.7

Source: HIP and CBIS.

Community mental health services and adult acute inpatient services show gender trends in line with the general population. People in CRCs and on DTOs show a slight bias towards males at around 55%. Service types with strong biases towards females are older acute (61%), and CAMHS acute (69%). Data from the Adelaide Clinic private hospital shows that 65.8% of their services were provided to female clients. The remainder have strong biases towards males, including CTOs (64.1%), adult extended inpatient services (66%), ICCs (76.2%), PICUs (77%) and Forensic (81%).

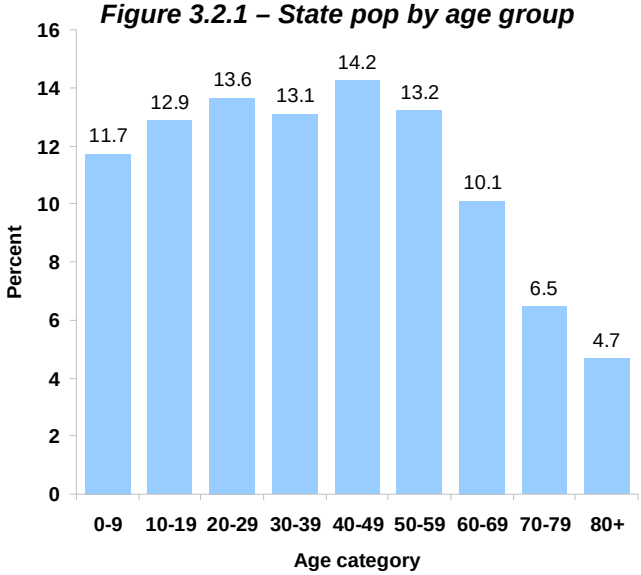
3.2.2 Age

The population of South Australia has a reasonably even distribution across age categories (within 3.5%) from 0-9 years of age up to 50-59, with a decrease thereafter at a declining rate, as per Figure 3.2.1.

Tables 3.2.3 and 3.2.4 show the age of people receiving the range of public community mental health and inpatient mental health services respectively.

At the broadest level, total service provision matches population levels except for children and young adolescents.

Figure 3.2.1 – State pop by age group



Source: ABS 2006, SLA Projections, 3235.4.55.001.

Table 3.2.3 – State population and community services by age group

	SA Pop	%	CMHS	%	CRC	%	ICC	%
0-9	192073	11.7	2611	8.3	-	-	-	-
10-19	211103	12.9	6255	19.9	2	1.2	5	2.9
20-29	223807	13.6	4888	15.6	35	21.0	69	40.1
30-39	214500	13.1	5364	17.1	49	29.3	55	32.0
40-49	233786	14.2	4991	15.9	33	19.8	34	19.8
50-59	217264	13.2	3345	10.7	33	19.8	8	4.7
60-69	165793	10.1	1771	5.6	14	8.4	1	0.6
70-79	106144	6.5	1117	3.6	1	0.6	-	-
80+	76713	4.7	1025	3.3	-	-	-	-
Total	1641184	100	31367	100	167	100	172	100

Source: CBIS, HIP and ABS (2006, SLA Projections, 3235.4.55.001).

Table 3.2.4 – Inpatient services by age group

	CAMHS	%	Adult	%	Older	%	PICU	%	Frnsic	%	Total	%
00-14	103	25	113	1.9	-	-	-	-	-	-	216	2.8
15-24	309	75	701	11.8	-	-	67	13.6	18	13.4	1095	14.3
25-34	-	-	1264	21.2	-	-	166	33.6	52	38.8	1482	19.3
35-44	-	-	1441	24.2	-	-	132	26.7	37	27.6	1610	21.0
45-54	-	-	1132	19.0	3	0.4	90	18.2	21	15.7	1246	16.2
55-64	-	-	780	13.1	18	2.7	35	7.1	5	3.7	838	10.9
65-74	-	-	282	4.7	276	40.8	4	0.8	1	0.7	563	7.3
75-84	-	-	163	2.7	288	42.6	-	-	-	-	451	5.9
85+	-	-	84	1.4	91	13.5	-	-	-	-	175	2.3
Total	412	100	5960	100	676	100	494	100	134	100	7676	100

Source: HIP.

Note that the age categories used for community services and inpatient services are different.

In addition to the age breakdown within specific services shown in Tables 3.2.3 and 3.2.4, Figures 3.2.2 and 3.2.3 display totals for inpatient services and community services. From these it can be seen that both peak for adults in their 20s, 30s and 40s, and that community services have another higher peak for young people in their teens. These peaks match the age groups that have higher onset rates and greater acuity of mental illness.

Figure 3.2.2 – Inpatient services by age

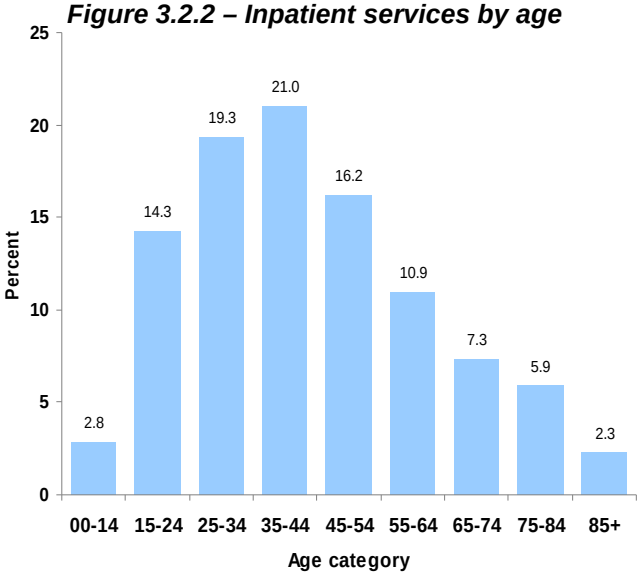
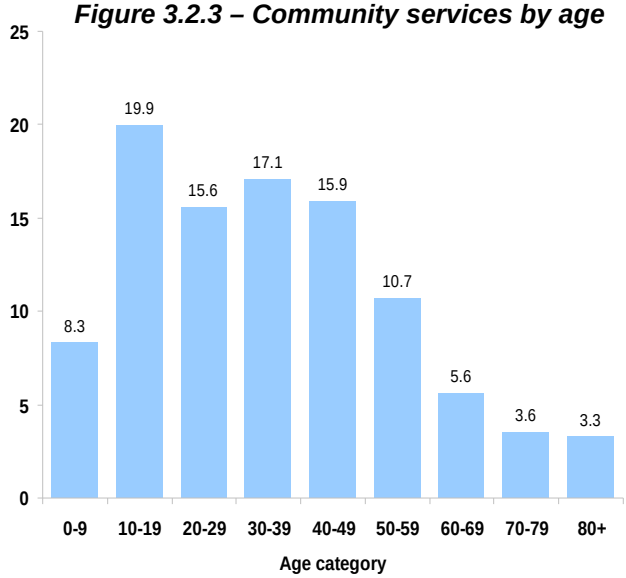


Figure 3.2.3 – Community services by age



Source: HIP and CBIS.

3.2.3 Aboriginality

Tables 3.2.5 and 3.2.6 display the Aboriginality of people receiving the range of community and inpatient mental health services. The percent of people who identify as Aboriginal or Torres Strait Islander in each service type should be contrasted against the 1.7% of the South Australian population who identify as Indigenous (ABS 2006, ATSI Population Characteristics, 4713.0).

Table 3.2.5 – Aboriginality in community services

Program	ICC	CRC	CMHS	Spp Accom	IPRSS	All CTOs
Number	11	4	1940	7	63	92
Percent	6.4	2.4	6.2	4.27	5.06	10.0

Source: HIP, CBIS and CARS.

Table 3.2.6 – Aboriginality in inpatient services

Program type	CAMHS acute	Adult acute	Older acute	PICU	Forensic acute	Forensic extended	Adult extended	Older extended	All DTOs
Number	22	395	7	76	19	21	11	4	266
Percent	5.3	6.7	1.1	15	26	34	33	6.3	5.5

Source: HIP and CBIS.

Aboriginal people average around 5 to 6% of consumers in the majority of services.

Aboriginal people make up only 2.4% of the consumers in community rehabilitation centres (this may be because Aboriginal people prefer to return to their own homes and communities) and only 1.1% of consumers in older acute services, which may be because of reduced life expectancy.

Aboriginal people make up 10% of the consumers on CTOs (which may be because CTOs are a more effective and appropriate means of delivering treatment to Aboriginal people) and 15% of people in psychiatric intensive care, which may be because of delays in accessing assessment and treatment.

Aboriginal people comprise 26% of forensic acute consumers and 34% of forensic extended consumers, the former matching the 20-23% of South Australian prisoners who are Aboriginal. The causes of the over-representation of Indigenous Australians in prisoner and offender populations are beyond the scope of this report.

3.2.4 Cultural and Linguistic Diversity

Table 3.2.7 displays the CALD status of people across a range of inpatient and community services.

Table 3.2.7 – CALD status by service type

Program	Inpatient	DTO	ICC	CRC	CTO	CMHS	Spp Acc	IPRSS
Number	784	547	-	-	89	2229	9	1246
Percent	10.2	11.4	-	-	9.7	7.1	5.5	3.37

Source: HIP, CBIS and CARS.

CALD status has been estimated from country of birth information where an individual was born in a non-English speaking country. In addition, 12 people (1.3%) on a CTO required an interpreter and 98 people (2.0%) on a DTO required an interpreter. Information regarding the use of interpreters in other services is not available.

In broad terms, the percentage of people identified as CALD decreases with the lessening acuity of the mental health service provided. This may mean that CALD people use other supports and health services, such as extended families and GPs, when they can and when they are less acutely unwell.

3.2.5 Residence

Table 3.2.8 displays the South Australian population and the people receiving public community and inpatient services by the six metropolitan and three country mental health service regions. The metropolitan regions comprise: Eastern, Inner Southern, Northern, North East, Southern and Western, and the country regions comprise: Inner Rural, North Western and Riverland South East. This information has been compiled from residential postcode data.

Table 3.2.8 – SA population, community services and inpatient services by region

	SA Population		Community services		Inpatient services	
Region	Number	Percent	Number	Percent	Number	Percent
Inner Rural	245,932	15.0	5151	16.4	823	10.7
Western	235,932	14.3	4684	14.9	1230	16.0
Eastern	209,980	12.8	2998	9.5	1046	13.6
Northern	197,580	12.0	4123	13.1	987	12.9
Inner Southern	189,468	11.5	2504	8.0	1020	13.3
North East	177,647	10.8	2859	9.1	1030	13.4
Southern	166,958	10.2	3308	10.5	861	11.2
North Western	116,642	7.1	3163	10.1	244	3.2
Riverland South East	101,799	6.2	2031	6.5	238	3.1
Unknown	-	-	445	1.4	71	0.9
Interstate	-	-	135	0.4	66	0.9
Overseas	-	-	-	-	60	0.8
Total	1,641,184	100	31,401	100	7676	100

Source: CBIS, HIP and ABS (2006, SLA Projections, 3235.4.55.001).

Figure 3.2.4 shows in which regions the South Australian population lives, ordered from most populated to least.

Figures 3.2.5 and 3.2.6 show community patients and inpatients by region, in the same order.

Community patients are under-represented in the Eastern and Inner Southern regions, and over-represented in the North Western region.

Inpatients are under-represented in the Inner Rural, North Western and Riverland South East regions, and over-represented in the North East.

Figure 3.2.4 – Population by region

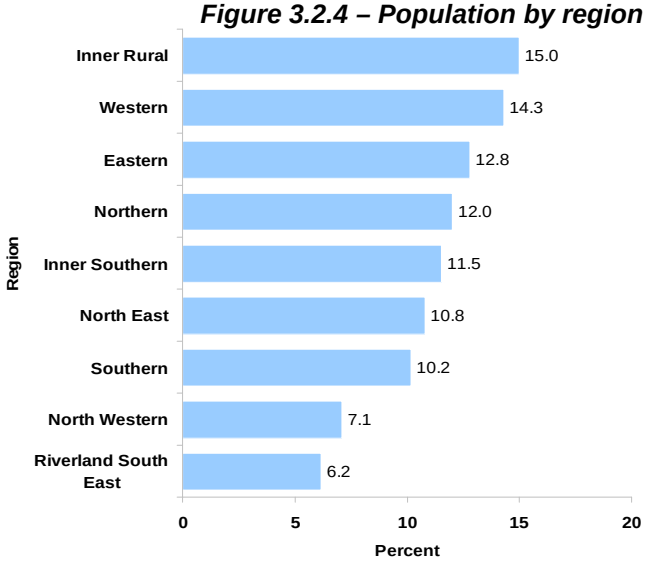


Figure 3.2.5 – Community patients by region

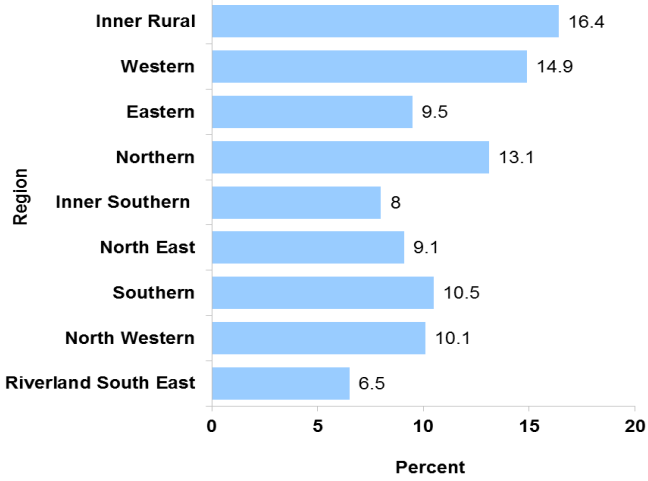
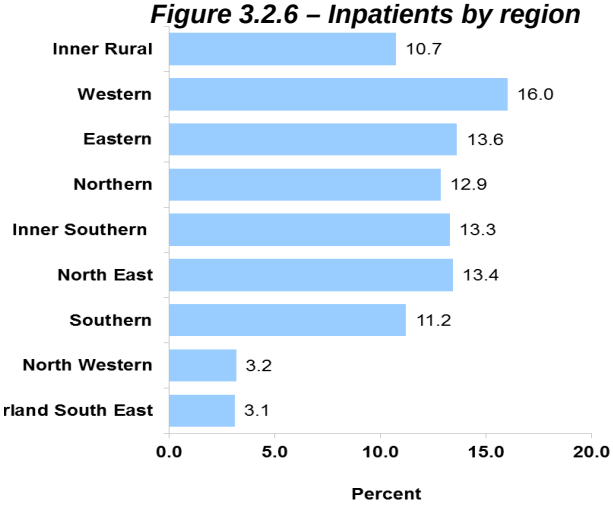


Figure 3.2.6 – Inpatients by region



3.3 Mental Health Legal Orders

During 2010-11 there were a total of 8071 mental health legal orders active, 7098 (87.9%) of which were made under the *Mental Health Act 2009* and 973 (12.1%) of which were made under the *Mental Health Act 1993* and transitioned to the new Act when it came into force on 1 July 2010. Table 3.3.1 summarises these orders.

Table 3.3.1 – Active orders

	Mental Health Act 2009		*Mental Health Act 1993*		All Orders	
Order type	Number	Percent	Number	Percent	Number	Percent
CTO1	192	2.7	-	-	192	2.4
CTO2	772	10.9	913	93.8	1685	20.9
All CTOs	964	13.6	913	93.8	1877	23.3
DTO1	4493	64.3	-	-	4493	55.7
DTO2	1552	21.9	-	-	1552	19.2
DTO3	89	1.3	60	6.2	149	1.8
All DTOs	6134	86.4	60	6.2	6194	76.7
Total	**7098**	**100**	**973**	**100**	**8071**	**100**

Source: CBIS and GSB.

Analysis of mental health legal orders from this point on is based solely on 2009 Act orders, as the CBIS and GSB databases are not comparable.

As previously discussed in the patient demographics section, people on CTOs had a gender profile of females 35.9% and males 64.1%, and people on DTOs had a gender profile of female 44.3% and male 55.7%.

In addition, 10% of people on CTOs identified as Indigenous and 5.5% of people on DTOs identified as Indigenous. 9.7% of people on CTOs were identified as CALD and 11.4% of people on DTOs were identified as CALD.

Table 3.3.2 shows the different orders types across the age categories.

Figure 3.3.2 – Age of people on orders

	CTO1		CTO2		DTO1		DTO2		DTO3	
Age	No	%	No	%	No	%	No	%	No	%
0-9	-	-	-	-	1	0.0	-	-	-	-
10-19	5	2.7	7	1.0	178	5.2	24	1.8	2	2.5
20-29	43	23.0	130	17.7	698	20.3	252	19.4	14	17.3
30-39	59	31.6	232	31.6	791	23.1	276	21.2	15	18.5
40-49	40	21.4	177	24.1	735	21.4	261	20.1	7	8.6
50-59	22	11.8	106	14.4	495	14.4	205	15.8	14	17.3
60-69	9	4.8	45	6.1	258	7.5	128	9.8	15	18.5
70-79	8	4.3	30	4.1	145	4.2	89	6.8	7	8.6
80+	1	0.5	7	1.0	129	3.8	66	5.1	7	8.6
Total	187	100	734	100	3430	100	1301	100	81	100

Source: CBIS.

The DTO1 made for a child was for a 9-year old child in situational crisis in the country, who was transported to the Women's and Children's Hospital, where the DTO1 was revoked. The child was settled and then discharged to multi-agency community care, including CAMHS and Families SA.

As can be seen from Figures 3.3.1 and 3.3.2 , the use of CTOs peaks for people in their 30s, with lesser peaks for people in their 40s, 20s and 50s, whereas the use of DTOs is similar for people across their 20s, 30s and 40s, with a lesser peak for people in their 50s.

Figure 3.3.1 – CTOs by age

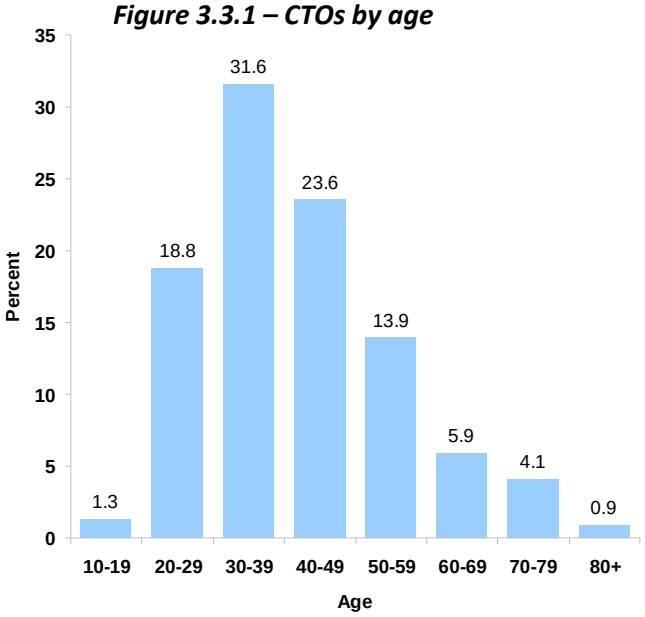
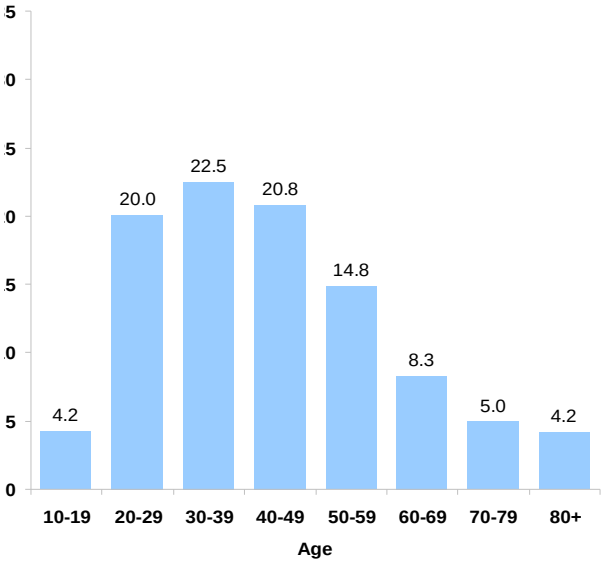


Figure 3.3.2 – DTOs by age



Source: CBIS.

3.3.1 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.

Making the Order

Of the 192 CTO1s made during 2010-11, 97 (50.5%) were made by psychiatrists, 77 (40.1%) by GPs, 9 (4.7%) by authorised health professionals and 9 (4.7%) by an "unknown" clinician. The data and database system issues that caused the "unknown" error have been corrected and will not influence future data and reporting.

Multiple Orders

There were 192 CTO1s made for 187 consumers, with 182 people (97.3%) having one CTO1 placed on them and 5 people (2.7%) having two CTO1s.

Order Outcome

Table 6.1.3 shows the outcomes of the CTO1s made.

Table 3.3.3 – CTO1 outcomes

Outcome	Number	Percent
Revoked at 24-hour review	14	7.3
Subsequently revoked	10	5.2
Revoked or quashed by the GSB	-	-
Went for intended duration	168	87.5
Total CTO1s made	192	100

Source: CBIS.

Duration

Of those CTO1s not revoked at the 24-hour review stage, 78.6% went for 28 days (the maximum allowed under the Act), with a minor peak of 8.3% lasting for around 7 days.

3.3.2 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 772 CTO2s made for 734 consumers, with the overwhelming majority (98.5%) having only one CTO2.

Order Outcome

CTO2s can be revoked by the Guardianship Board on appeal by the patient or application by a health professional or other person with a proper interest in the welfare of the patient. CTO2s can also be revoked by the District Court. Due to data system issues it is not possible to describe how many CTO2s were subsequently revoked by the Board or the Court.

Duration

CTO2s had a range of durations, from 20 days to 365 days, with 689 (89.6%) going for a year and a minor cluster of 33 (4.3%) going for 6 months.

3.3.3 Level 1 Detention and Treatment Orders

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

Making the Order

Of the 4493 DTO1s made during 2010-11, 3213 (71.5%) were made by medical practitioners, 801 (17.8%) were made by "other", 295 (6.6%) were made by private psychiatrists, and 184 (4.1%) were made by authorised health professionals. The data system issues that resulted in the "other" classification for 17.8% of DTO1s have now been resolved.

* Detail of where medical practitioners were when they made a DTO1 is available as indicative information only. Data from April 2011 suggests that 35.7% of medical practitioner DTO1s were made in metropolitan hospital emergency departments, 25% were made in an unspecified part of metropolitan hospitals, 19% were made in acute mental health wards in metropolitan hospitals, 9.5% were made in country hospitals, 6% were made in community mental health service settings and the remaining 4.8% were made in a variety of settings, including prison, nursing homes, GP clinics and the Magill Training Centre.

Multiple Orders

Of the 3430 people on DTO1s, 79.6% had one DTO1 in place during the period, 14.3% had two DTO2s and the remaining 6.1% had three, four, five, six or seventeen DTO1s. For some people, multiple orders indicate the acuity or episodic nature of their illness, and for other people multiple orders represent the difficulties of a process working across many different information technology and administrative systems. The seventeen-order individual made multiple presentations at Emergency Departments across metropolitan Adelaide, with 15 of the orders revoked at the 24-hour review stage. The OCP is working with metropolitan mental health services on improving case-management and cross-agency collaboration for this individual.

Order Outcome
Table 3.3.4 shows the outcomes of DTO1s made during the year.

Table 3.3.4 – DTO1 outcomes

Outcome	Number	Percent
DTO1s made	4493	100
Revoked at 24-hour review	1464	32.6
Subsequently revoked	394	8.8
Revoked or quashed by the GSB	1	0.0
Went for intended duration	2634	58.6

Source: CBIS.

Duration
Table 3.3.5 shows DTO1 duration. Most DTO1s went for the full 7 days (42.3%), with the next most common duration being 1 day (32.5%). Durations from 2 to 6 days show a small steady increase.

Table 3.3.5 – DTO1 durations

	1 day	2 days	3 days	4 days	5 days	6 days	7 days	Total
Number	1462	122	123	161	291	433	1902	4493
Percent	32.5	2.7	2.7	3.6	6.5	9.6	42.3	100

Source: CBIS.

3.3.4 Level 2 Detention and Treatment Orders
Level 2 DTOs can last for up to 42 days and can be made by a psychiatrist or authorised medical practitioner for a patient who is on a DTO1 and requires continuing care and treatment.

Multiple Orders
Of the 1301 people on DTO2s, 84.5% had one DTO2, 13.3% had two DTO2s and the remaining 2.4% had three, four or five DTO2s made during the year.

Order Outcomes
Table 3.3.6 displays the outcomes of DTO2s made during the year.

Table 3.3.6 – DTO2 outcomes

Outcome	Number	Percent
DTO2s made	1552	100
Subsequently revoked	668	43.1
Revoked or quashed by the GSB	1	0.1
Went for intended duration	883	56.9

Source: CBIS.

Duration
DTO2s had a range of durations, from 1 day to 42 days, with peaks at 1 week (10%), 11 days (9.2%), 2 weeks (8%), 3 weeks (6.9%), 4 weeks (4.4%), 5 weeks (3.7%) and the majority at 6 weeks (32.1%).

3.3.5 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

Of the 81 people on a DTO3, 91% had one DTO3 and the remaining 9% had two DTO3s.

Order Outcomes

DTO3s can be revoked by the Guardianship Board on appeal by the patient or application by a health professional or other person with a proper interest in the welfare of the patient. DTO3s can also be revoked by the District Court. Due to data system issues it is not possible to describe how many DTO3 were subsequently revoked by the Board or the Court.

Duration

DTO3s had a range of durations, from 11 days to 365 days, with peaks at 1 month (4.6%), 2 months (8%), 3 months (26.4%), 6 months (13.8%) and 12 months (23%), with the remaining 24.2% of DTO3s having durations scattered between 11 and 365 days.

3.3.6 Places of Detention

Table 3.3.7 displays the approved treatment centres authorised by the Minister to provide involuntary care and treatment and lists bed numbers and inpatient separations for each.

Table 3.3.7 – ATCs, beds and separations

	Beds		Separations	
Approved Treatment Centre	**Number**	**Percent**	**Number**	**Percent**
Adelaide Clinic	62	11.5	1170	13.2
Flinders Medical Centre	40	7.4	1059	12.0
Glenside Campus	153	28.4	1425	16.1
James Nash House	30	5.6	128	1.4
Lyell McEwin Health Service	50	9.3	936	10.6
Modbury Public Hospital	20	3.7	601	6.8
Noarlunga Health Service	20	3.7	545	6.2
Oakden Services for Older People	55	10.2	49	0.6
Royal Adelaide Hospital	16	3.0	842	9.5
Repatriation General Hospital	49	9.1	781	8.8
The Queen Elizabeth Hospital	31	5.8	879	9.9
Women's and Children's Hospital	12	2.2	431	4.9
Total	**538**	**100**	**8846**	**100**

Source: HIP

Bed numbers include Psychiatrist Intensive Care Unit (PICU), acute and extended care mental health beds across the age spectrum and separations represent the number of discharges from those mental health beds.

Glenside, James Nash House and especially Oakden have fewer separations than their bed numbers would suggest, which may be caused by the extended care beds at these sites and individuals remaining inpatients for much longer periods of time. In contrast, FMC, RAH and TQEH have more separations than their bed numbers would suggest, which may be because more people are detained to those sites in the first instance before being transferred to an ATC closer to their homes and support networks.

There were 8,846 inpatient admissions and 6,194 DTOs during 2010-11, indicating that around 70% of all inpatients in mental health wards were involuntary admissions.

3.4 Restraint and Seclusion

All public ATCs report restraint and seclusion events in mental health wards into a statewide database. Of the total 7676 public mental health admissions in 2010-11, only 331 (4.3%) consumers underwent restraint or seclusion.

Gender

Table 3.4.1 shows the gender of the consumer in each restraint and seclusion event. While overall the gender balance is even, within the age-specific services differences emerge: in child and youth services 88.9% of events are for females, in adult services 62.8% are for males and in older services 56.3% are for females. These rates are broadly consistent with the rates of people receiving inpatient care in each age-specific service except for general adult wards, which only have a gender bias towards males of 51%.

Table 3.4.1 – Restraint and seclusion events by gender

	Child & youth		Adult		Older		Total	
	No	%	No	%	No	%	No	%
Female	104	88.9	296	37.2	838	56.3	1238	51.6
Male	13	11.1	498	62.8	650	43.7	1161	48.4
Total	117	100	794	100	1488	100	2399	100

Source: Restraint and seclusion database.

Age

Table 3.4.2 shows the age of the consumer in each restraint and seclusion event.

Table 3.4.2 – Restraint and seclusion events by age

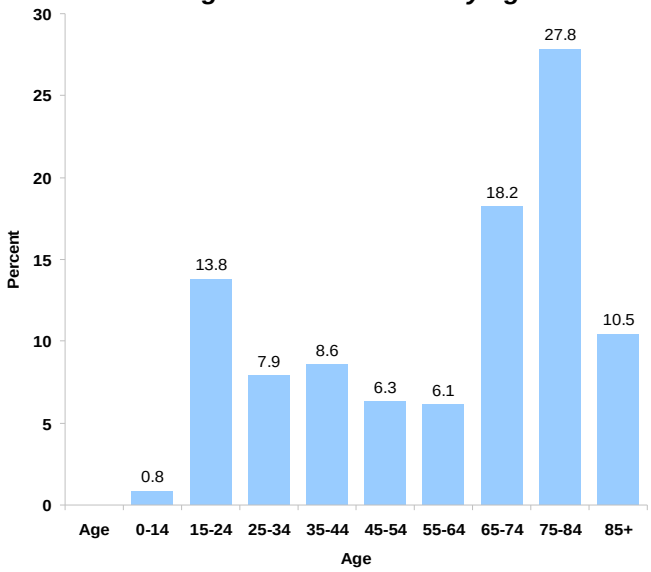
	Child & youth		Adult		Older		Total	
	No	%	No	%	No	%	No	%
0 - 14	17	14.2	3	0.4	-	-	20	0.8
15 - 24	103	85.8	227	28.6	-	-	330	13.8
25 – 34	-	-	189	23.8	-	-	189	7.9
35 - 44		-	206	25.9	-	-	206	8.6
45 - 54	-	-	114	14.3	38	2.6	152	6.3
55 - 64	-	-	55	6.9	92	6.2	147	6.1
65 - 74	-	-	1	0.1	436	29.4	437	18.2
75 - 84	-	-	-	-	667	44.9	667	27.8
85+	-	-	-	-	251	16.9	251	10.5
Total	120	100	795	100	1484	100	2399	100

Source: Restraint and seclusion database.

When compared with Figure 3.4.1 it can be seen that restraint and seclusion occurs at a steady rate for people in their 30s, 40s and 50s, with smaller peaks for people over 85 and people in their teens and early 20s, and much larger peaks for people in their 60s, 70s and 80s.

These peaks may indicate consumers in stages of life less able to manage impulses and emotions, co-morbid dementia and/or frailty, or requiring assisted care.

Figure 3.4.1 – Events by age



Aboriginality and CALD Status

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

Duration

Table 3.4.3 and Figures 3.4.2 and 3.4.3 show the duration of restraint and seclusion events, ranging from under 1 hour to over 12 hours.

Table 3.4.3 – Duration of restraint and seclusion events by age-specific service

	Child & youth		Adult		Older		Total	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
<1	44	35.6	83	10.4	225	15.2	352	14.7
1-2	34	28.0	161	20.2	316	21.4	512	21.4
2-3	3	2.5	139	17.3	265	18.0	407	17.0
3-4	1	0.8	131	16.4	153	10.4	285	11.9
4-5	-	0.0	94	11.7	88	6.0	182	7.6
5-6	-	0.0	27	3.4	43	2.9	70	2.9
6-7	-	0.0	24	3.0	31	2.1	55	2.3
7-8	4	3.4	43	5.3	31	2.1	78	3.3
8-9	21	16.9	23	2.9	36	2.5	80	3.3
9-10	14	11.0	16	2.0	50	3.4	79	3.3
10-11	1	0.8	10	1.3	54	3.7	66	2.7
11-12	-	0.0	10	1.3	101	6.8	111	4.6
12+	1	0.8	39	4.8	81	5.5	121	5.0
Total	123	100	800	100	1476	100	2399	100

Source: Restraint and seclusion database.

The duration of events across adult and older people's services have similar distributions, with older services peaking at less than two hours and then dropping away, and adult services having a clumped distribution of up to five hours. This may indicate a difference in the time the consumers in each service type take to settle, or a difference in causal symptoms.

Figure 3.4.2 – Event duration in adult services

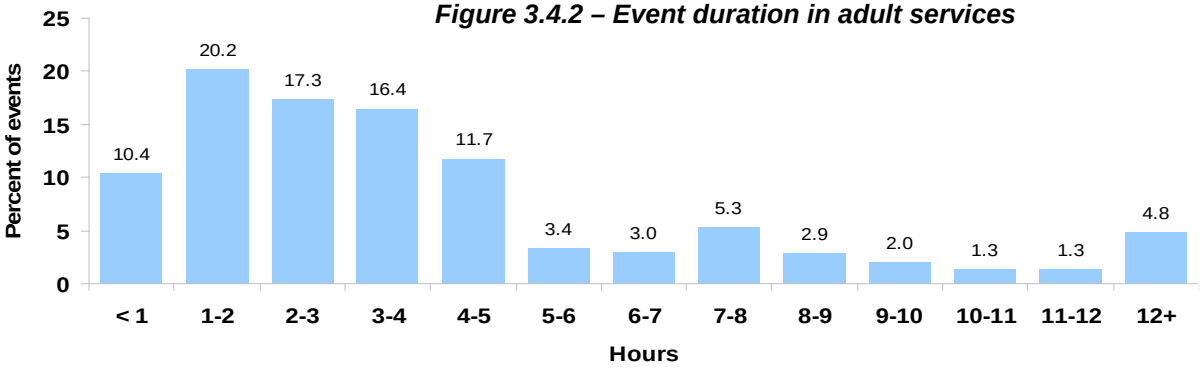
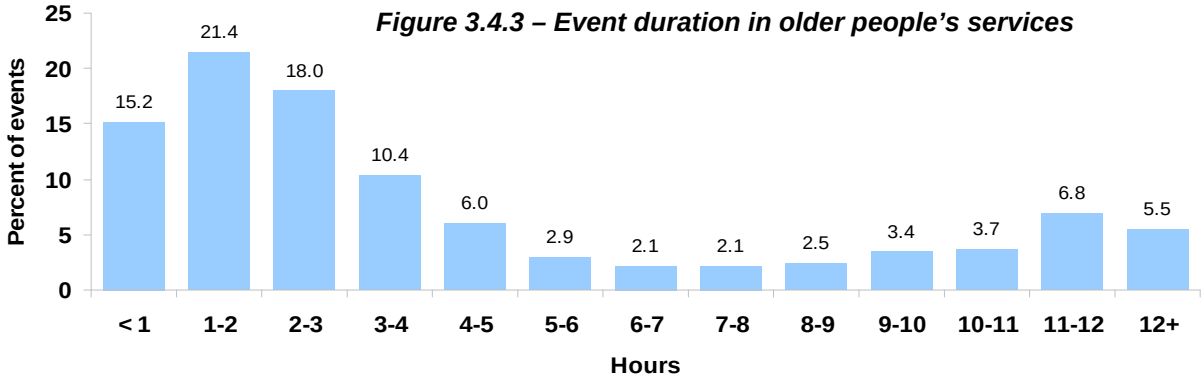


Figure 3.4.3 – Event duration in older people's services



Reason for Event

Table 3.4.4 shows the reasons for restraint or seclusion events in the three age service streams. Most events had multiple causal factors.

Table 3.4.4 – Reason for restraint or seclusion event

Service	Reason for Event	Percent
Child and youth services	Self harm	56
	Property damage	43
	Other	41
	Aggression to others	36
Adult services	Aggression to others	74
	Self harm	42
	Property damage	35
	Other	32
Older people's services	Self harm	77
	Aggression to others	35
	Other	17
	Property damage	9

Source: Restraint and seclusion database.

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, South Australian data against these items are summarised in Tables 3.4.5 and 3.4.6, for each of the age-specific inpatient services. Table 3.4.5 displays the rate of restraint and seclusion per 1000 bed days and the numbers of inpatients physically restrained only. Table 3.4.6 depicts the number of consumers with restraint or seclusion events in each age-specific service, and those consumers with two or more events, with events lasting more than four hours and events with major complications.

Table 3.4.5 – ACHS Items

Rate of restraint and seclusion per 1000 bed days				
Service	**Physical**	**Mechanical**	**Seclusion**	**Total**
Child and youth	-	-	27.4	27.4
Adult	0.2	0.8	8.7	9.7
Older people	0.5	54.8	0.0	55.3

ACHS 5.7 – Inpatients physically restrained only (under-reported)	
Service	**Number**
Child and youth	-
Adult	16
Older people	12
Total	28

Source: Restraint and seclusion database.

Table 3.4.6 – ACHS Items

Service type	Consumers	ACHS 5.2		ACHS 5.3		ACHS 5.5	
		2 or more events		> 4 hours		Complications	
	No	No	%	No	%	No	%
Child & youth	18	5	27.8	1	5.6	1	5.6
Adult	226	93	41.2	65	28.8	36	15.9
Older	87	72	82.8	37	42.5	51	58.6
Total	331	170	51.4	103	31.1	88	26.6

Source: Restraint and seclusion database.

3.5 Prescribed Treatments

The Act requires the control and monitoring of prescribed psychiatric treatments, comprising Electro-Convulsive Therapy (ECT), neurosurgery for mental illness and any other prescribed treatment made by regulation. The only prescribed psychiatric treatment practised in South Australia is ECT.

Electro-Convulsive Therapy

ECT is a psychiatric treatment for severe mental illness, prescribed in particular circumstances, for example:

- When there has been a persistent mental illness and other treatments have been ineffective or only partially effective.
- When an individual is unable to function as a result of their illness.
- When an individual's life is in danger due to not eating or drinking or otherwise refusing to accept life sustaining treatment.

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) has guidelines for ECT which are due for review by an expert panel. The current guidelines are available on the College website at: http://www.ranzcp.org/policy-advocacy/therapeutics-and-interventions.html. The South Australian Branch of the RANZCP has an ECT subcommittee which ensures training and accreditation of psychiatrists and registrars in the administration of treatment. They also have practice guidelines which will be revised in alignment with the RANZCP guidelines.

It is most commonly used to treat the symptoms of depression, although there is evidence that it can also be effective in treating the symptoms of mania, catatonia, schizophrenia and other serious mental illnesses. ECT is a procedure that is performed under a general anaesthetic, where controlled seizures are induced. It requires the completion of a patient consent form and in cases where this cannot be obtained the *Mental Health Act 2009* is referred to for processes on administering ECT with the consent of the Guardianship Board.

The Act provides requirements for consent to ECT. These specify under what circumstances a person can be prescribed ECT and the maximum number and length of treatments.

Use of ECT in 2010-2011

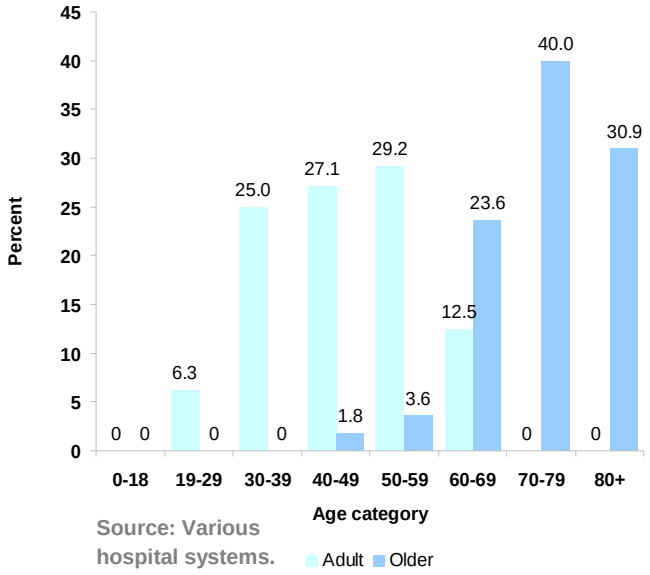
While every service that administers ECT keeps records, there has not been any standard way of collecting data to this point. This is being addressed, but at the time of this report the data was not standardised so no benchmarking was possible.

A total of 6393 ECT treatments were given in the 2010-2011 period. Of these, 3749 (58.6%) treatments were provided by public mental health services and 2644 (41.4%) by private psychiatric hospitals.

Age

The ages of people receiving ECT in one adult acute setting and in one older acute setting is shown in Figure 3.5.1. (Age was one of the data elements not routinely collected across sites.) This information is indicative only and suggests that people from their 20s to their 80s receive ECT, with peaks for people in their 60s and 70s. Better data collection and more analysis are required in this area.

Figure 3.5.1 – ECT by age category



Source: Various hospital systems.

Diagnoses

For the four services from which diagnostic information was received, 85% of all ECT treatments were given for a diagnosis of depression. Due to the differences in how this diagnostic information was collected by services, 'depression' diagnoses include major depressive disorder, depression with psychotic features and suicidal ideation.

This was followed by bipolar disorder (5.7%) and schizoaffective disorder (5.5%) although the numbers for these were significantly lower. The remaining 3.8% were treated for conditions specified as 'other'.

ECT Type

ECT is provided in three general service settings: inpatient/acute, maintenance and outpatient. Inpatient/acute refers to ECT provided during an admission when someone is acutely unwell, maintenance refers to ECT that is regularly scheduled to keep a person well, and outpatient ECT is provided as required when a person begins to feel unwell and attends their health service for preventative treatment.

Of the three public mental health services that recorded this data, 68.7% of ECT treatments were provided as inpatient/acute, 19.7% as maintenance and 11.6% as outpatient.

ECT Consent

The Act requires ECT to be consented to by the patient, the Guardianship Board or, in the case of an emergency, by the treating psychiatrist. ECT was consented to by the patient in 5095 (79.7%) treatments, by the GSB in approximately 1150 (18.0%) treatments and by a psychiatrist in 148 (2.3%) treatments.

3.6 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 2010-11 there were:

- Two instances of the use of s71, where a person detained to a treatment centre in another state was transferred to an Approved Treatment Centre in South Australia to continue their care and treatment.
- Five 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, in order that they may continue their care and treatment.

In addition, the OCP provided regular advice to South Australian and interstate treatment teams regarding cross-border arrangements.

4. Priority Groups Activity

4.1 Consumer Participation

Consumer participation in mental health services is profoundly important. To achieve true mental health reform, ensure service quality and improve outcomes it is essential that mental health services be fully informed by the experience and needs of people in our community who experience mental illness (Social Inclusion Board, 2007). The application of lived expertise to mental service development and delivery will ensure that services are meaningful, responsive and effective to the people they serve.

Consumer participation refers to individual participation opportunities to provide meaningful input into our own care and treatment, as well as feedback into the development and delivery of mental health services. Opportunities to engage in all forms of participation are essential as consumers hold vital experiential knowledge that can inform mental health services about what works and what doesn't from a lived-experience perspective. SA Health is committed to consumer expertise being utilised in mental health services, and currently there are many positive examples where consumer expertise is being utilised across South Australian mental health services and include:

At an individual level through active consumer input and engagement in the development of individual mental health care plans, in collaboration with service providers.

At a service delivery and operational level:

- Engaging consumer expertise in document development and review.
- Engaging consumer expertise in reform projects development and implementation.
- Employment and training of Peer Specialists in public and non-government services.
- Consumer Advisory mechanisms in government, non-government and private sectors including, but not limited to, advisory groups and consumer representatives.
- Regional participation frameworks.

At a strategic policy and planning level:

- SA Health Consumer and Community Participation Policy that identifies consumer engagement as a necessary part of the work and responsibility of all of SA Health.
- Dedicated consumer consultant position in the Mental Health Unit.
- Consumer Consultant membership of the State-wide Mental Health Executive.
- Dedicated Experts by Experience positions in Country Health SA.
- Consumer representation on the State-wide Mental Health Clinical Network.
- Consumer expertise and advice through Mental Health Unit Consumer Reference Group.
- Consumer representation in service model development, policy direction, project planning and decision making steering committees through the Mental Health Unit Consumer Reference Group and other consumer participation and advisory mechanisms

These provide a welcome and necessary foundation and there is much scope to broaden the processes and practices in which consumers are engaged in mental health services in SA. To build on this positive beginning the Consumer and Carer Consultants in the Mental Health Unit are developing a Consumer and Carer Engagement Strategy which will be developed in collaboration with key stakeholders. It is intended that this strategy will articulate best practice in consumer and carer participation and its application at all levels of mental health service delivery and will involve extensive lived experience expertise in its development and implementation.

4.2 Carer Participation

Carers play a critical role in supporting people who experience a mental illness.

The importance of recognising and including carers is clearly described in the National Standards for Mental Health Services, the South Australian *Carer's Recognition Act 2007* and the Social Inclusion Board's *Stepping Up* report.

SA Health is committed to ensuring that consumer, carer and family participation guides the planning, development, delivery and evaluation of its mental health services. Engagement of carers has been supported in a number of ways, including:

- The role of the Carer Consultant, who is based at the SA Health Mental Health Unit, whose role it is to advocate for the role of carers in mental health service and policy development. The Carer Consultant is a member of the Mental Health Consumer and Carer National Register and the National Consumer and Carer Workforce Group.
- The Carer Consultant convenes the monthly SA Mental Health Unit Carer Advisory Group which provides input and feedback on SA Health's mental health service delivery, initiatives and reviews at a strategic policy and planning level via:
  - Community Mental Health Implementation Reference Group
  - Statewide Supported Accommodation Program Management Committee
  - Returning Home Program Management Committee
  - Intermediate Care Centre Core Planning Group
  - IPRSS Program Management Committee
  - Statewide Mental Health Clinical Network
  - Mental Health Nurses Advisory Group
  - Rehabilitation and Recovery Core Planning Group
  - Dr Margaret Tobin Awards Organising Committee
  - TheMHS Carer Forum Organising Committee.

Carers are involved at service delivery and operational level via:

- Employment of Carer Consultants in acute inpatient settings and the non-government sector.
- Carer Advisory mechanisms in non-government and private sectors, including, but not limited to, advisory groups and carer representatives.
- Regional participation frameworks such as Country Cafes.
- Carer Advisory Groups in both metropolitan and regional areas.

Carers across SA appreciated the opportunity to attend various *Mental Health Act 2009* workshops delivered by the Mental Health Unit.

Carers have also contributed to the development of a course delivered by SA Mental Health Training Centre entitled, Carers – One of Your Primary Resources, which was well received by SA Health clinicians and NGO staff.

The Carer Consultant and the Consumer Consultant are currently developing a Participation Framework which will support SA Health mental health services enhance consumer and carer participation at all levels of mental health service delivery.

4.3 Aboriginal and Torres Strait Islander People

State-wide Aboriginal Mental Health Consultation Summary Report

A key recommendation of the Social Inclusion Board's '*Stepping Up: A Social Inclusion Action Plan for Mental Health Reform 2007-2012'* was to address mental health concerns of Aboriginal people in South Australia. From this recommendation, an extensive consultation process into Aboriginal mental health was undertaken, resulting in the publication of the 'Summary Report: Statewide Aboriginal Mental Health Consultation (July 2010)'.The consultative process included an extensive state-wide consultation visiting 17 locations throughout South Australia, with 328 people consulted, of whom 259 were of Aboriginal descent.

The report documents the perceptions, beliefs and concerns of mental health and wellbeing issues and makes 13 recommendations addressing concerns of mental health services and programs for Aboriginal consumers.

As a result, the OCP and Mental Health Operations developed an Aboriginal Mental Health Action Plan that will guide Aboriginal mental health reform in South Australia. This compliments the Principal Aboriginal Mental Health Advisor position that is co-funded by the OCP and Mental Health Operations, which works across SA Health, the health regions and partner agencies to improve mental health services for Aboriginal people.

Ongoing Engagement

A number of key activities which underpin the action plan aim to improve mental health outcomes and services for Aboriginal people across all jurisdictions. Currently underway are a number of activities including the:

- Establishment of an Aboriginal Mental Health Leadership Group that will oversee the progress of the action plan.
- Development of a culturally appropriate communications strategy to raise mental health awareness across the Aboriginal community.
- Development and delivery of health promotion and prevention education and information programs for communities and professionals.

The OCP will continue to make inroads in improving outcomes of mental health and wellbeing concerns, by working with Aboriginal communities, key stakeholders and building new partnerships and networks that will guide the changes necessary within mental health services and system of care.

4.4 Culturally and Linguistically Diverse People

The OCP has been represented on the committee developing a SA Health framework to develop services for Culturally and Linguistically Diverse (CALD) communities. A mental health strategy is required to complement this framework.

CALD communities within themselves are very diverse, encompassing a wide range of past experiences, including voluntary immigration, refugees and asylum seekers, illegal immigrants and survivors of torture and trauma. They come from a very wide range of cultural, linguistic, religious and spiritual backgrounds. As a consequence their mental health needs require specific consideration

In Australia approximately 45% of all people will experience a mental health problem at some point during their lives, making mental health a priority health area for the community in general, including for CALD communities. Although the prevalence of mental health problems for CALD communities is reported to be comparable to that of the broader population, people with CALD backgrounds are less likely to access and use mental health services making service underutilisation an issue. In addition, some people with CALD backgrounds have an increased prevalence of risks for mental health problems related to their migration and settlement experiences, English language proficiency, health literacy and cultural beliefs. Refugees and humanitarian entrants are one population group for which mental health issues are a particular concern due to the complexity and trauma associated with the refugee experience.

Mental health services for people with CALD backgrounds need to take account of the person's background, cultural beliefs, family situation, employment and housing, and other health conditions. SA Health has developed *South Australia's Mental Health and Wellbeing Policy 2010-15*. This policy aims, amongst other things, to ensure that all population groups are able to access mental health services that meet their needs on a non-discriminatory basis, irrespective of their cultural background. CALD communities are identified in the policy as one of the population groups for which specialised service responses are needed.

Work on the CALD mental health strategy will proceed in 2011-2012 in tandem with the consortium of Mental Health in Multicultural Australia (MHiMA). The consortium includes the Queensland Transcultural Mental Health Centre, the University of Melbourne Centre for International Mental Health, the Victorian Transcultural Psychiatry Unit and the University of South Australia.

4.5 Veterans

The OCP has been represented on the Committee developing a framework for Veteran Health including Mental Health. It is anticipated that this document will be complete in late 2011.

Currently there is a diverse age range within the veteran population, from veterans of conflicts from last century now in their eighties and nineties, through to young veterans from recent and current conflicts. Mental health requirements of veterans are also diverse, being those common to any population group but importantly there are specific needs for those conditions associated with exposure to theatres of war such as Post Traumatic Stress Disorder

There has been a recent increase in the numbers of serving Australian Defence Force members based in South Australia with the relocation of the Army's 7th Royal Australian Regiment (7RAR) Battle Group from the Northern Territory to the Edinburgh Defence Precinct in the northern metropolitan area of Adelaide. The relocation of families with the 7RAR is anticipated to impact on local public health services.

The framework when completed will describe a range of services currently available and/or requiring further development to complement the historically important role of the Repatriation General Hospital.

5. Community Awareness and Promotion Activity

South Australia has significantly invested in promoting psychological wellbeing and building mental health literacy in the population. The *Stepping Up* Report clearly identifies the need for additional action to combat stigma and discrimination.

5.1 Specific Programmes

SA Health provides, funds and works in partnership with a number of community awareness and promotion services and programmes, including:

- Exploring the development of an across government action plan for workplaces that promote and protect psychological wellbeing.
- "Mental Health First Aid" Training to build communities equipped to cope with and be involved in supporting people with a mental illness.
- Building psychological wellbeing outcomes into service planning for six new Community Mental Health Centres and the GP Shared Care Program.
- The SQUARE and ASIST suicide awareness and prevention training programs to equip communities and clinicians with information, knowledge and skills.

A range of mental health initiatives target young people, including:

- "Healthy Young Minds" which aims to improve and expand child and adolescent mental health services in high demand areas.
- The "Headroom" Project that aims to promote positive mental health for children and young people.
- Research funded under the SA Health Strategic Health Research Program, (SHRP) to assist us to better understand the relationship between psychological distress and the social determinants of health including education, income, employment, and other risk factors.

A further initiative is under development to increase awareness and understanding of mental illness and associated issues amongst South Australians and increase community acceptance and inclusion of people living with a mental illness and to increase positive representation of mental health issues by the South Australian media

5.2 Mental Health Practitioner's Guide to Sharing Consumer Information

The *Mental Health Act 2009* contains confidentiality and disclosure of information provisions that enable service providers and others administering the Act to share information in a more flexible way that was previously permitted, if the sharing is reasonably required for the treatment, care or rehabilitation of the consumer. These provisions, which can be found in section 106, were aimed at overcoming the barriers identified by the Bidmeade review regarding the sharing of information. The provisions also mirror those found in section 93 of the *Health Care Act 2008*.

The purpose of the Mental Health Practitioner's Guide to Sharing Consumer Information is to support service providers working in the mental health sector by discussing the circumstances in which disclosing a consumer's personal information may be appropriate under the *Mental Health Act 2009* and the *Health Care Act 2008*, as well as providing a step-by-step guide to professional practice in information sharing. The Guide applies to mental health practitioners and others engaged in the administration of the *Mental Health Act 2009* and the *Health Care Act 2008*, including:

- SA Health employees working in adult mental health, child and adolescent mental health, primary health, community health services or the South Australian Ambulance Service.
- Health professionals engaged by an incorporated hospital on a fee for service basis.

- Employees of non-government organisations contracted to provide services on behalf of SA health.
- Persons appointed as Community Visitors under section 50 of the *Mental Health Act 2009*.

The Mental Health Practitioner's Guide to Sharing Consumer Information was developed in 2010-11 and will be rolled out to mental health services, partner agencies and community groups during 2011-12.

5.3 beyondblue

beyondblue is a national, independent, not-for-profit organisation working to address issues associated with depression and anxiety in Australia. Established in 2000 by the Commonwealth and Victorian Governments, the bipartisan initiative is in its third five-year term to 2015 and is currently supported by the Commonwealth and all State and Territory Governments. SA Health has co-funded *beyondblue* since 2001 and participates in its management, program development and service delivery.

beyondblue provides information, education, resources and a number of telephone, internet and face-to-face services for individuals and agencies about depression and anxiety. *beyondblue* also lobbies government and industry, carries out research and works in collaboration with a range of government agencies, non-government organisations, business groups and community groups to enhance the lives of people living with depression and anxiety. The priorities for 2011 and beyond include: community awareness and destigmatisation, consumer and carer participation, prevention and early intervention, primary care and targeted research.

5.4 Destigmatisation Campaign

During 2010-11 SA Health developed a television and print destigmatisation campaign for roll-out in 2011-12.

5.5 Mental Health Week

This occurs annually in October and during the week a range of different activities and displays are held to promote mental health awareness and information about services and programmes. Mental Health Week is a collaborative partnership by consumer groups, carer groups, non-government organizations, public mental health services and interested individuals to enhance awareness and participation. Displays and events were held in most mental health services. The OCP and Mental Health Operations Branch did a stall in the mall and a number of other events.

5.6 The Margaret Tobin Awards

The Dr Margaret Tobin Awards for Excellence in Mental Health were established in 2004 to acknowledge the contribution made by the late Dr Tobin to mental health reform in South Australia. The Awards publicly recognise and celebrate the achievements of people and organisations who have made an outstanding contribution to mental health services in South Australia, showcase achievements in the mental health sector, inspire others to achieve excellence in providing mental health services, and encourage others in promoting positive mental health.

The Dr Margaret Tobin Awards categories and winners for Mental Health Week in October 2010 were:

- *Category One:* Excellence in leadership and commitment to mental health reform. Winner: Ms Zhila Javidi.
- *Category Two:* Excellence in promoting an understanding of mental health in the community. Winner: Carer Support – The Mental Health Team.
- *Category Three:* Excellence in the provision of services to people with a mental illness who are most in need or most at risk. Winner: Helping Hand Aged Care – Mental Health Team.
- *Category Four:* Media Award – Excellence in promoting positive mental health by reporting mental illness and mental health in a balanced and respectful way. Winner: The Guardian Messenger.
- *Category Five:* Aboriginal Award – Excellence in the provision of mental health services for those most in need or most at risk. Joint Winners: Jenny Evertt and Bobbi Sawyer.
- *Category Six:* Consumer/Carer/Volunteer Award – Person who has made an outstanding contribution to improvements for people with or at risk of developing a mental illness. Winner: Dave Tapley.

6. Mental Health Reform Activity

6.1 Stepping Up Reforms

The governance of public mental health services in 2010-11 comprised the Mental Health Operations Branch and Office of the Chief Psychiatrist Branch of central SA Health, the Adelaide Health Service, Country Health SA and the Children, Youth and Women's Health Service. The branches and regional services worked together in collaboration to develop and implement the reform agenda, and to operate and monitor ongoing service delivery.

The Stepping Up Reforms were driven by the Mental Health Operations Branch and the health regions working together, with input from the OCP.

Acute Inpatient Facilities

Work continued on the:

- Redevelopment of the Glenside Campus to provide a new 129-bed mental health and substance abuse facility, which will be completed in late 2012.
- Development of a new 20-bed older persons acute unit at TQEH.
- Planning and development of 10 Limited Treatment Centre beds in the Hub Hospitals in Berri, Mount Gambier, Port Lincoln and Whyalla.

Intermediate Care

New 15-bed facilities at Noarlunga and Glenside began operating in 2010-11, to complement the existing 15 intermediate care places across Kangaroo Island, Mount Gambier, Port Augusta and Port Lincoln.

Community Rehabilitation Centres

Rehabilitation services were provided to consumers at the Elpida, Trevor Parry and Wondakka community rehabilitation centres as part of the stepped system of care.

Supported Accommodation

Supported accommodation expanded during 2010-11 from the previously existing 128 beds. The new HASP program, which will provide 77 houses for people who require more intensive support, had 24 properties completed and the tenants moved in and receiving support. The SSH program, which will provide 262 houses for people who require less intensive support, had 230 properties completed and the tenants moved in and receiving support.

Community Mental Health Services

The first of six new community mental health centres commenced operation in May 2011. The centre, located at Marion Domain was developed as part of the State Aquatic Centre and GP Plus Health Care Centre development and will provide the full range of community based mental health services from a single location for consumers in the inner southern suburbs.

Construction commenced in March 2011 on the second centre located at Tranmere which will provide services to residents of the Eastern suburbs. Planning has also commenced for the development of the northern community mental health centre to be located at Salisbury.

Non-Government Organisation Services

A review of non-government organisation services was carried out in 2010-11 to evaluate the outcomes for consumers and the effectiveness of service delivery, and it will be used in service planning and development.

6.2 Other Reforms

Mental Health Services for Older People

The key elements of the Older Persons Mental Health Service reforms that have been advanced in the last year include:

- Transition of older people in the Aged Extended Care Wards on Glenside Campus to more appropriate places in the non-government Residential Aged Care Facility sector.
- Continuing work towards the completion of a new 20-bed aged acute unit at the Queen Elizabeth Hospital in December 2012.
- Development of new and expanded community team sites for the Northern and Western Community Teams and the renovation and expansion of the Southern Team site. All of these sites are scheduled to be completed in 2011-12 with a new and expanded Eastern Community Team site to be completed by June 2012.

Specific Reform Programmes

- An Early Psychosis Intervention Service (EPIS) has commenced operation and is already enabling an enhanced level of service response to young people experiencing a serious mental health issue.
- A review and report of the Weight Disorder service has been completed and a new model of care for a state wide service described. Funding has been allocated to develop the recommendations and an implementation working group is being formed.
- The redevelopment of the forensic facility at James Nash House with a budget of $19 million for refurbishment and the relocation of 10 beds from Glenside during 2012.
- Five Mental Health Nurse Practitioners have been recruited and are practicing in a variety of country locations. Two of the remaining three positions are to commence from June 2011.
- A “whole of country” Older Person mental health service model for Country SA continued to be developed during 2010-2011. The model includes the recruitment of eight dedicated specialist clinicians integrated within the local mental health teams and increased Psychiatrist time.
- Throughout 2010-2011 Country Health SA continued to hold regular Consumer Forums and Local Café meetings to gather information to inform service planning. CHSA Mental Health Services have appointed two Experts by Experience Development Officers. The role of the development officers includes communicating with existing carer and consumer groups around the State and ensuring consumer and carer issues have a mechanism to be addressed by CHSA.
- A Nurse Practitioner Candidate (NPC) Framework has been developed and endorsed by CHSA Mental Health Executive. Eight Nurse Practitioners have now been recruited. All candidates are expected to complete their training and achieve status as Nurse Practitioners over the next three years.

Council of Australian Governments

In March 2011 the Council of Australian Governments announced funding for South Australia for the implementation of mental health sub acute initiatives which will deliver 159 beds or bed equivalents across six projects. The six mental health projects are:

- Community Rehabilitation Centres in country SA
- Crisis Respite Facilities
- Crisis Respite in the Home
- Forensic Step Down Facility
- Supported Accommodation
- Youth Subacute Facility

Information and Communication Technology

South Australian mental health (and general health) services currently use an array of different systems to capture and record their activity.

SA Health is developing a statewide electronic health (eHealth) system that will comprise one health record for each patient across all public hospitals and community services.

The new Enterprise Patient Administration System (EPAS) will improve clinical work practices across all SA public healthcare facilities and will support the provision of better integrated care. This will be achieved by allowing timely electronic access to clinical information across multiple sites.

After significant input from over 300 administrative, technical and clinical staff across SA Health, the Allscripts software system was chosen. EPAS will be designed by our clinicians for our clinicians.

Audio Visual Conferencing

The Act enables the use of video-conferencing technology to facilitate clinical assessment and for making, confirming, extending, reviewing or revoking mental health orders.

The implementation of improved audio-visual capabilities across an increased number of regional sites is being co-funded in partnership with the Federal Government. The first stage of the project, referred to as the Digital Telehealth Network Project, was completed in 2010 with the installation of 18 cameras and screens, and bandwidth upgrades enabling high quality video-conferencing between the following regional centres and the Regional and Remote hub at Glenside Campus. Sites include:

- Adelaide Hills Health Service, Mount Barker
- Berri Campus, Riverland Regional Hospital
- Booleroo Centre District Hospital and Health Service
- Keith Hospital
- Kingscote Hospital, Kangaroo Island
- Kingston Soldiers' Memorial Hospital
- Mount Gambier Community Health Service
- Murray Bridge Hospital Soldiers' Memorial Room
- Port Lincoln Regional Health Service
- Port Pirie Hospital and Mental Health Services
- Quorn Health Services
- Roxby Downs Health Service
- Umuwa Health Service, APY Lands
- Whyalla Hospital and Health Service
- Yorke Peninsula Mental Health Service (Minlaton)

And the following three metropolitan sites:

- Repatriation General Hospital
- Rural and Remote Mental Health Services, Glenside Campus
- Country Health SA Mental Health Service, Adelaide

The audio-visual technology has been extremely well used for conducting assessments and general psychiatric reviews. Although there have been a only a few Level One Treatment orders reviewed and/or confirmed by this mechanism to date, the infrastructure, policy and procedures are now in place to allow the use of videoconferencing to review orders. This supports early intervention and management closer to home and has avoided transfer to Adelaide for some consumers.

7. Office of the Chief Psychiatrist Activity

7.1 Mental Health Act

7.1.1 Implementation

The implementation of the Act was a year-long project undertaken in 2009-10 by the then Mental Health Policy Unit (now OCP), in collaboration with the Health Regions, the Guardianship Board and a number of other agencies and stakeholders.

The OCP produced publications and training resources, carried out education and training, developed formal instruments, established processes and systems, enhanced and established collaborative partnerships, and provided advice during the implementation.

In addition, the clinicians, officers, health services, government agencies and non-government organisations effected by the changes to the Act, as well as many consumers, carers and families, considered the changes that they needed to make in their professional and personal lives to meet the new provisions, instruments and processes of the Act.

7.1.2 Administration

During the first year of the administration of the Act the OCP carried out a number of actions to continue or enhance its functioning.

Advice and Liaison

The OCP provided advice and liaison regarding the interpretation and use of the Act to numerous agencies and individuals over the course of the year.

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 DTOs – to be reviewed by a psychiatrist within 24 hours – to ensure that consumers get immediate access to the treatment and care they need.

During the implementation of the Act, 110 mental health clinicians undertook two-day training and were authorised by the Minister to be AHPs. During 2010-11, 35 more staff were trained and authorised to be AHPs, making a total of 145, representing 8.5% of the total mental health workforce of 1700. This is consistent with the proportions of staff in similar roles in other jurisdictions. Prior to the implementation of the Act there were some concerns about the number of AHPs and the use of the role. These concerns did not eventuate.

The OCP also delivered refresher training for all 145 AHPs during 2010-11, to keep them up-to-date with issues and solutions, share learnings and maintain currency of authorisation.

Authorised Medical Practitioners

Authorised Medical Practitioners are senior psychiatric registrars or foreign-trained psychiatrists who receive specific South Australian Psychiatric Training Committee (SAPTC) training and are authorised by the Minister to have the powers of a psychiatrist for the purposes of carrying out the Act.

Eight people undertook the SAPTC AMP training during 2010-11 but health services did not request that any be authorised while they monitored the administration of the Act and what need there might be for the AMP role.

Community Visitor Scheme

Part 8, Division 2 of the *Mental Health Act 2009* establishes a Community Visitor Scheme (CVS) in South Australia. The purpose of the CVS is to provide further protection of the rights of people with a mental illness who are admitted to treatment centres in South Australia. To this end, the CVS provides an opportunity for community visitors to visit treatment centres and other incorporated or private hospitals to inspect premises and consult with consumers and staff to ensure that people with serious mental illness are receiving appropriate care and treatment.

The OCP took lead responsibility for planning and implementing the scheme and undertook the:

- Development of publications, policy, procedures and systems to support the scheme's operations.
- Development of a two day initial training session for potential Community Visitors.
- Education and training for consumers, carers, mental health services and other agencies about the scheme.
- Establishment and recruitment of a CVS Coordinator and Administration and Information Officer.
- Establishment of a governance structure, including an Advisory Committee to provide support and advice to the Principal Community Visitor.
- Recruitment and appointment by the Governor of South Australia's first Principal Community Visitor.
- Recruitment and appointment by the Governor of the first Community Visitors.

The Principal Community Visitor has now taken carriage of the scheme and works from an independent office in the CBD with the staff and volunteers of the scheme.

Cross Border Arrangements

Civil cross-border agreements

South Australia has current civil Memoranda of Agreement with Victoria and New South Wales. These agreements were made pursuant to the Mental Health Regulations 1995 under the *Mental Health Act 1993* and will continue to have effect until replaced by revised agreements in accordance with the provisions of the *Mental Health Act 2009*. The current agreements make provision for interstate involuntary admissions, planned transfers of involuntary inpatients, and the apprehension and return of involuntary inpatients that are absent without leave. They do not extend to Community Treatment Orders.

South Australia has also signed a Memorandum of Agreement with the Northern Territory pursuant to the Mental Health Regulations 1995 under the *Mental Health Act 1993*, however this agreement is currently not operational as the Northern Territory has not yet declared the *Mental Health Act 2009* (SA) a corresponding law.

The *Mental Health Act 2009* has extensive provisions for cross-border agreements and the recognition of orders, including Community Treatment Orders. A revised Memorandum of Agreement between South Australia and Victoria, made pursuant to the provisions of the Act, is being finalised. South Australia is currently liaising with the Northern Territory, the Australian Capital Territory, New South Wales and Queensland to negotiate similar Memoranda of Agreement with those jurisdictions.

Forensic cross-border agreements

The *Criminal Law Consolidation Act 1935* (CLCA), which is committed to the Attorney-General, provides for the custody, supervision and care of persons found either mentally incompetent to have committed an offence or mentally unfit to stand trial (forensic patients).

However, there is currently a very limited legislative base upon which to enter into forensic cross-border agreements.

Under Action 24 of the *Fourth National Mental Health Plan*, all Australian jurisdictions have committed to review and, where necessary, amend relevant legislation to support cross border agreements and transfers of people under forensic orders. To this end, the Attorney-General's Department has proposed to conduct a review of Division 4 of Part 8A of the CLCA, including provision for the interstate transfer of supervisees. The OCP, as a key stakeholder, has contributed to this work, and will continue to contribute to it .

Education and Training
From early 2010 to June 2011, a total of 3222 people attended information and education sessions regarding the Act. Sessions range 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, Royal Flying Doctor Service, Drug and Alcohol Services SA, Guardianship Board of SA, Office of the Public Advocate, Department of Correctional Services and non-government organisations.

Forms and Statements of Rights
The OCP monitored the use of the forms and statements of rights required by the Act, collated feedback and suggestions, and redrafted the statement of rights which were authorised by the Minister. The OCP will submit redrafted forms for the Minister's consideration in 2011-12.

Mental Health Emergency Services Memorandum of Understanding 2010
The MHESMoU 2010 was developed by the Mental Health Operations Branch under the guidance of the MHESMoU Steering Committee in early 2010. In mid-2010 the OCP worked with the signatory agencies to develop training content and resources, which it then rolled out to mental health services and other agencies and groups.

During 2010-11 the OCP provided information and education sessions regarding the MHESMoU to over 600 staff, including: mental health services, emergency departments, general health services, older persons mental health services, child and adolescent mental health services, SA Ambulance Service, SA Police and the Royal Flying Doctor Service.

The OCP also provided advice and liaison regarding the implementation of the MHESMoU and the resolution of complex cases and issues.

Mental Health Legal Orders
The OCP acknowledged and entered into the CBIS data system the 7098 orders made during 2010-11, and provided advice and liaison for non-compliance and other issues.

7.1.3 Review
It was anticipated that the implementation of the new legislation would raise a number of issues that needed to be reviewed on an ongoing basis. A Mental Health Act User group was established to ensure that issues arising from the implementation and operation of the Act are identified and resolved. This includes but is not limited to:

- Administration, implementation and operation of the Act
- Communications
- Community Visitor Scheme
- Data, systems, evaluation and reporting
- Education and training

- Instruments to carry the Act into effect
- People and groups empowered to carry the Act into effect
- Regulations
- Stakeholder collaboration

Membership of the User Group includes representatives from the following groups and agencies: consumers, carers, the Local Health Networks, Guardianship Board, Office of the Chief Psychiatrist, Legal and Governance Unit and Office of the Public Advocate.

The group meets quarterly and will continue to review issues as they arise.

7.2 Other Functions

Clinical Advice and Liaison
The OCP provides clinical advice, liaison and support to individual clinicians and services as required, with a focus during 2010-11 on the Act, the CVS, ECT, restraint and seclusion, risk assessment, suicide prevention and the new National Standards.

GP PASA
The OCP processed 750 GP PASA calls during 2010-11, averaging around 60 a month.

Ministerial and Parliamentary Functions
The OCP drafted and provided advice for Ministerial briefings and responses, parliamentary briefing notes, parliamentary questions, parliamentary estimates and Chief Executive briefings and responses.

National and State Policy
The Chief Psychiatrist and other OCP staff participated in national and state policy development and implementation with the following groups:

- Aboriginal Mental Health Action Plan Steering Committee
- *Beyondblue* Board
- Fourth National Mental Health Plan Implementation and Working Groups
- Framework for Veteran's Healthcare Advisory Group
- MHESMoU Steering Committee
- National Mental Health Standing Committee
- National Safety and Quality Partnership Subcommittee
- National Suicide Prevention Working Group
- Royal Australian and New Zealand College of Psychiatrists (SA Branch)
- SA Health Mental Health Executive
- SA Health Strategic Framework for CALD Communities Advisory Group
- SA Medicine Safety Advisory Group
- SA Medicines Advisory Committee
- SA Restraint and Seclusion Steering Committee

7.3 Complaints, Incidents, Inquests, Inspections and Reviews

7.3.1 Complaints

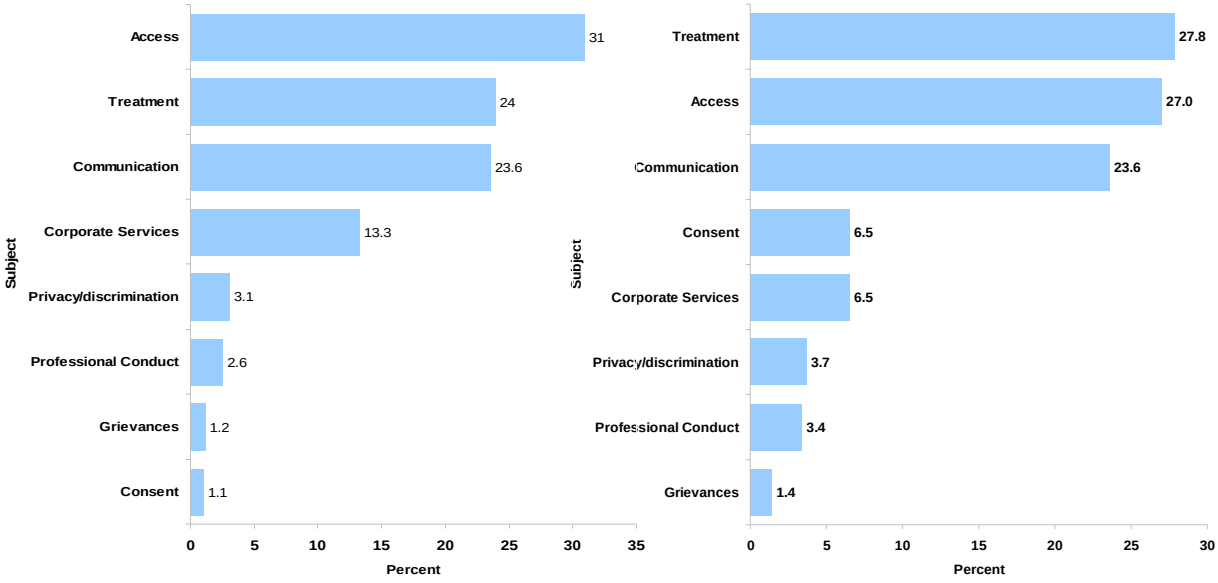
SA Health believes consumer feedback and complaints provide an opportunity to observe the quality of health care from the perspective of consumers and their carers. Consumer feedback and complaints also provide information that, when used effectively, can assist in directing improvement in the quality of services.

All complaints received by SA Health are addressed through the SA Health Consumer Feedback and Complaints Management Policy Directive, which follows national standards for complaint handling and reporting.

SA Health received 4827 complaints during 2010-11, with 352 (7.3%) concerning mental health services.

Feedback and complaints received are categorised into nine main subject areas and then further categorised into sub categories. Figures 7.3.1 and 7.3.2 below show the complaints received by all of SA Health and by mental health services.

Figures 7.3.1 and 7.3.2 – SA Health and mental health complaints by subject



Source: SA Health Safety Learning System

Access, treatment and communication were the subjects most commonly complained about in general health and mental health. A break down of the top three categories for mental health reveals complaints relating to treatment to be most common. These complaints relate to wrong/inappropriate treatment, inadequate treatment and medication. Access complaints were related to service availability, discharge or transfer arrangements, and refusal to admit or treat. Communication complaints were related to inadequate information, attitude and wrong/misleading information.

Of all complaints received by SA Health, 81.8% of complainants were satisfied or partially satisfied by the outcome. Of the mental health complaints received, 73.7% of complainants were satisfied or partially satisfied by the outcome. The difference in satisfaction rates may be largely attributable to many mental health complainants receiving their treatment involuntarily.

7.3.2 Incidents

SA Health has a vigorous system for the prevention, reporting and management of incidents which may cause harm to a patient or to a staff member. The detail of that system and the incidents themselves are contained in the annual Patient Safety Report.

In 2010-11 there were a total of 18,208 incidents reported across SA Health (including near misses, those where no harm was caused and those that caused harm), of which 1,109 (6.1%) were reported for mental health services.

7.3.3 Inquests

In 2010-11 the Coroner carried out 27 inquests, of which 11 (37%) had a mental health aspect or required investigation and response by mental health services. Of the 11 inquests, 5 were for people who had died by suicide and 6 were for people who had died from physical illness.

It should be noted that the 11 events occurred on average 2.3 years before the inquests were held and that mental health services had already implemented changes to address most of the issues which were subsequently the subject of recommendations from the Coroner.

The significant recommendations identified in the inquests were:

- Improved adequacy and access to medical assessment.
- Improved communication between mental health services and families / carers.
- Improved communication between services.
- Improved nursing observations.
- Improved risk assessment.

Specific actions undertaken after the events to address issues include:

- Development and implementation of an Extreme Heat response for people with mental illness.
- Development and implementation of a Physical Health monitoring and management program for people receiving mental health services.
- Development and implementation of improved risk assessment processes and records.

Actions undertaken in 2010-11 to address the themes and issues include:

- Development and implementation of the 2010 Mental Health and Emergency Services Memorandum of Understanding.
- Implementation of the new provisions in the *Mental Health Act 2009* for improved communication with and participation of carers and families.
- Development of the South Australian Suicide Prevention Strategy.

7.3.4 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 2010-11.

7.3.5 Reviews

As part of the Safety and Quality agenda there was a review of the circumstances of deaths from suicide and other causes of mental health consumers in the community between 2007 and 2009. The review had a very comprehensive analysis of a wide range of factors and made a number of recommendations with respect to communications and practice

improvement and a group is currently working together to ensure implementation of the recommendations

Any adverse event occurring within a health service is allocated a code to prioritise severity and an investigation conducted to determine the cause and identify any remedies required to prevent a repeat episode. These investigations may be a paper or desktop review or a fuller investigation interviewing relevant individuals. The intention is that the investigations be conducted with transparency and open disclosure in accordance with the National Open Disclosure Standard.

In 2010-11, the review process has included the use of external reviewers on three occasions, either from another part of the service or from interstate. This has enabled an objective examination of the situation, with the opportunity for reflective practice and learning, as well as the identification of any systemic issues requiring improvement. This includes recommendations for clinical practice issues and system performance issues. The quality improvement cycle should include future audit to ensure recommendations have been implemented effectively. In general, issues most frequently identified include communications between patient and/ or family or carer and health provider, between agencies, between clinical teams e.g. at clinical handover, and shortcomings in discharge planning.

7.4 Safety and Quality

7.4.1 Standards

National Standards
The National Standards for Mental Health Services (the Standards) were reviewed in 2006 in consultation with services, consumers and carers. This was in response to many changes in the provision of mental healthcare since the Standards were introduced in 1996. There has been an overall increase in service provision, expansion of non-government organisations and private sectors and an increase in the role of primary care. The 2010 Standards were approved by the Commonwealth late in 2010, and the OCP developed a strategy for implementing the Standards in 2011 throughout a range of mental health services.

Implementation
'Standards Packs' were provided to community services, inpatient units, non-government organisations and private services. The Packs consisted of copies of the Standards and relevant Implementation Guidelines with posters for display. In addition, training sessions were offered to services regarding the new Standards and how they apply to specific settings. Further information and training resources were made available through the OCP website. At the time of reporting a total of 13 services, both inpatient and community had received training (86 clinicians).

Timeline
The materials and training sessions will continue to be rolled-out throughout 2011. At the time of publication, services in the North, West, Central and Country areas have received training and 'Standards Packs'. Private mental health services and non-government organisations that provide services to those with mental health problems and/or mental illness were also provided with 'Standards Packs' and given the opportunity to have a training session.

Standards Issued by the Chief Psychiatrist
The Chief Psychiatrist may, with the approval of the Minister, issue standards that are to be observed in the care or treatment of patients. This power is provided by s90(3) of the Act, which states:
(3) Any standards issued by the Chief Psychiatrist under this section will be—
(a) binding on any hospital that is an incorporated hospital under the *Health Care Act 2008*; and
(b) binding as a condition of the licence in force in respect of any private hospital premises under Part 10 of the *Health Care Act 2008*

No standards were set in 2010-11 under this provision but work has commenced to ensure access to medical records for solicitors representing patients in proceedings under the Act.

7.4.2 Physical Health Monitoring
The Act requires that there should be regular medical examination of every patient's mental and physical health.

It is known that the life expectancy of those with serious mental illness is approximately 10 years less than the general population. This is due to a combination of factors, some unknown effect of the psychiatric disorder, unhealthy diet, and smoking, lack of exercise and some of the effects of some psychotropic mediation which can cause weight gain.

Although some people may be in shared care arrangements between specialist psychiatric service and primary care, many mental health consumers do not use the services of a general practitioner or are unable to afford the gap fee.

The OCP has collaborated with, and encouraged the regional services, in their development of metabolic health screening programmes to monitor and refer consumers for appropriate treatment of physical illness.

7.4.3 Heat Directive
Over a period of three consecutive years there had been a rise in the rate of mortality culminating in eight deaths of mental health consumers (January 2009) during extreme heat temperature conditions. A sustainable way to reduce the number of deaths was required.

A joint project between the Emergency Management Unit, Mental Health Services, State Emergency Services and the Bureau of Meteorology was undertaken and Extreme Heat Protocols and Policy were developed. Those mental health consumers identified as at risk during periods of extreme heat were closely monitored during these periods by mental health staff and Australian Red Cross call centre.

The extreme heat response is based on the Adelaide forecast for temperature over the following 7 days and triggered by State Emergency Services (SES) alerts. The levels of alerts and response comprised:

Heat Status	Action Required
Moderate	No action
High	All MH consumers assessed for vulnerability – intensive contacts begin day 3 of 7 consecutive days of high heat
Extreme	Intensive contacts begin day 1 of extreme heat for all consumers assessed as vulnerable

After implementation of the Heat Policy Directive in mid-2010, there were no reported deaths during the 2010-11 periods of extreme heat. The project won the South Australian Health – Improving Patient Safety Award and has been presented at various forums both nationally and internationally.

7.4.4 Clozapine Review

Clozapine is an antipsychotic drug with specific efficacy in treatment resistant psychosis, however, it is associated with a number of side effects that are of concern. There are strict protocols to be observed when it is being administered, as set by the Therapeutic Guidelines Authority. The OCP began a review of Clozapine use in South Australia with the Office of the Chief Pharmacist, the Clozapine Focus Group, the Clozapine Working Group and mental health services. The review is expected to be completed in 2011-12.

7.4.5 Research

Using a broad definition of research, the OCP is involved in many aspects of investigation which is then used to formulate direction. The OCP is frequently guided by the experience of other jurisdictions and share learnings with the other Offices of Chief Psychiatrists. This includes a review of how a Community Visitor Scheme operates elsewhere, how authorised health professionals or equivalent receive training and the content of that training.

The OCP have conducted literature reviews on suicide prevention, metabolic monitoring, clozapine administration and numerous other topics.

The OCP have been engaged as co-sponsors of specific research topics for example thresholds for Intervention in applications for community treatment orders, a prospective study of clinical handovers, a qualitative retrospective study of the precipitants for suicide, and the review of deaths in the community.

The OCP wishes to support and sponsor further research particularly in the field of quality, safety and the protection of rights.

7.5 Restraint and Seclusion

7.5.1 Introduction

Following the reforms of the 1990s which focussed on the mainstreaming and de-institutionalisation of mental health services, the reforms of the 2000s focussed on recovery, building more consumer-focussed services, and improving the rights and liberty of people using mental health services. One aspect of this reform was the acknowledgement that the use of restraint and seclusion did not always conform to the principles of the new service paradigm.

To this end, the National Mental Health Seclusion and Restraint Project was established in 2007 to reduce, and where possible eliminate, the use of restraint and seclusion. In addition, the National Standards for Mental Health Services 2010 and South Australia's Mental Health and Wellbeing Policy 2010-2015 require the reduction of the use of restraint and seclusion where possible, and the *Mental Health Act 2009* requires care and treatment to be delivered in the least restrictive way. The National Project makes the following definitions:

- Physical restraint: the hands-on immobilisation or physical restriction of a consumer.
- Mechanical restraint: the application of devices (including belts, harnesses, manacles, sheets and straps) on a consumer's body to restrict his or her movement.
- Seclusion: the confinement of the consumer at any time of the day or night alone in a room or area from which free exit is prevented.

7.5.2 South Australian Project

South Australia has engaged a project officer in the monitoring, management and reduction of restraint and seclusion since 2008, under the supervision of a steering committee, chaired by the Chief Psychiatrist. In 2010-11 the key components of the project were:

- Develop a state-wide policy and guideline.
- Develop and implement the use of restraint and seclusion reduction tools.
- Collect and report on data across the state and source.
- Develop and implement training and education for staff on reduction practices.

A draft policy was developed for consultation in 2011-12 and a suite of reduction strategies was developed and implemented within one mental health unit as a pilot.

The OCP has facilitated the training of 50 instructors across the state, with 25 remaining active and has received requests to provide more to continue to implement Non-Violent Crisis Intervention training. Over the past year a total of 1080 staff have been trained in this prevention and de-escalation program. An annual refresher process has been commenced for those trained early in 2010 and a process for the Local Health Networks to maintain a training process will be developed. This has also included training for the new staff in the southern and eastern intermediate care centres and all health staff at Marion GP Plus.

This training has also been provided to health staff working in emergency departments, country hospitals and community teams, peer workers and consumer and carer consultants. It will be made available to the community visitors of the Community Visitor Scheme in 2011-12.

7.6 Suicide Prevention

South Australian Suicide Prevention Strategy

The Government of South Australia has significant concerns about the rate of suicide in South Australia. As a result, SA Health has prioritised the strategic development and implementation of a comprehensive Suicide Prevention Strategy for South Australia. The development of the strategy is in line with the policy objectives of both *South Australia's Mental Health and Wellbeing Policy 2010 – 2015* and the *Fourth National Mental Health Plan 2009 – 2014.*

The personal circumstances and experiences that lead a person to attempt suicide are complex and varied. Many of these risk factors for suicide are outside the control of the health sector, as are many of the protective factors that strengthen individuals and protect against suicide. As a result, 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 is required.

The South Australian Suicide Prevention Strategy will seek to deliver a comprehensive, co-ordinated strategy for suicide prevention across the community, including SA Health services. As part of the development and implementation of the Suicide Strategy, SA Health will play an important role in reviewing and enhancing health services so that we can provide the best possible services to consumers and their families.

Many aspects of the development plan are now underway and the governance structure set out will provide the direction necessary for a review of current services and the development of broadly endorsed key strategic directions.

The objective of this development plan is to set out a process and timetable for the development of a comprehensive South Australian Suicide Prevention Strategy to reduce the number of suicides and attempted suicides in South Australia by:

- Increasing the effectiveness of services and support available to people at risk of suicide or who have attempted suicide.
- Influencing and addressing, as far as possible, the risk and protective factors which are known to reduce the risk of suicide, particularly for high risk groups.
- Increasing community awareness about suicide and suicide risk factors.
- Promoting a comprehensive, coordinated response to suicide prevention across a range of government and community sectors.

Strategy development

The strategic development and implementation of South Australia's Suicide Prevention Strategy will occur in a planned way inclusive of the following steps. Key milestones will define the major stages and include:

- A literature review.
- A review of South Australian suicide prevention and postvention services.
- Establishment of a governance structure.
- Community engagement and consultation.
- Development of a Model of Care for suicide prevention programs in South Australia.
- Development of the South Australian Suicide Prevention Strategy.
- Development of the implementation plan for the South Australian Suicide Prevention Strategy.

8. Looking Forward

The information contained in this first report of the Chief Psychiatrist will establish some benchmark figures for the future. In particular the greatly improved ability to track mental health legal orders will ultimately allow for reflective consideration of the application of powers under the Mental Health Act 2009 in a way not possible before.

SA Health is approximately two thirds of the way through the most comprehensive reform of mental health services to be undertaken in such a time frame in Australasia. Reform of mental health legislation is an essential adjunct to the process, emphasising as it does the least restrictive means of treatment and active collaboration between clinician and consumer in developing care plans. There is also increasing active collaborations between clinical service providers and non-government organisations providing psychosocial support services.

Annual reports provide an opportunity to inform the community at large of the extent and scope of work in our services. We invite feedback to assist us further in providing a responsive consumer-focussed range of services that will meet both population and individual needs.

Appendix I – Glossary

A		
	ACHS	Australian Council on Healthcare Standards
	ACIS	Assessment and Crisis Intervention Service
	ABS	Australian Bureau of Statistics
	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*
	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
	ATC	Approved Treatment Centre – *a place determined by the Minister under s96 of the Act to be suitable for the detention and treatment of people with mental illness*
B		
	BART	Information system used to record and report Child and Adolescent Mental Health Service activity.
C		
	CALD	Culturally and Linguistically Diverse
	CAMHS	Child and Adolescent Mental Health Services
	CBIS	Community Based Information System
	CCC	Combined Country CME (Client Management Engine) – *used to record and report adult mental health services*
	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 *–the peak intergovernmental forum in Australia, comprising the Prime Minister, State Premiers, Territory Chief Ministers of the President of the Australian Local Government Association*
	CRC	Community Rehabilitation Centre
	CTO	Community Treatment Order
	CVS	Community Visitor Scheme
	CYWHS	Children, Youth and Women's Health Service
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

F

FMC	Flinders Medical Centre

G

GH	Glenside Hospital
GP PASA	General Practitioner Psychiatrist Advice – South Australia
GSB	The Guardianship Board of South Australia - *can make Administration Orders, Guardianship Orders and Orders giving consent to treatment. The Board also hears appeals under the Mental Health Act 2009, and makes orders for compulsory detention and treatment of people with a mental illness*

H

HASP	Housing and Accommodation Support Partnership

I

ICC	Intermediate Care Centre
ICT	Information and Communication Technology
IPRSS	Individual Psychosocial Rehabilitation Support Service – *a partnership program providing one-on-one rehabilitation and support services in a person's home and local community*

J

JNH	James Nash House

K

L

LHN	Local Health Network
LMHS	Lyell McEwen Health Service
LTC	Limited Treatment Centre - *a place determined by the Minister under s97 of the Act to be suitable for the detention and treatment of people with mental illness*

M

MHA	*Mental Health Act 2009*
MHC	Mental Health Clinician
MHESMoU	Mental Health and Emergency Services Memorandum of Understanding 2010
MPH	Modbury Public Hospital
MP	Medical Practitioner

N

NGO	Non-Government Organisation
NHS	Noarlunga Health Service
NPC	Nurse Practitioner Candidate

O

OCP	Office of the Chief Psychiatrist
OSOP	Oakden Services for Older People

P		
	PAS	Patient Administration System
	PICU	Psychiatrist Intensive Care Unit
Q		
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
	SAPOL	South Australian Police
	SLA	Statistical Local Area
T		
	TQEH	The Queen Elizabeth Hospital
U		
V		
W		
	W&CH	Women's & Children's Hospital
X		
Y		
Z		

Appendix II – Bibliography

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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*
- Introduction to the Community Visitor Scheme – *Mental Health Act 2009*
- Mental Health and Emergency Services Memorandum of Understanding 2010
- Mental Health Practitioner's Guide to Sharing Consumer Information
- Plain Language Guide – *Mental Health Act 2009*
- South Australia's Mental Health and Wellbeing Policy 2010-15
- Summary Report: Statewide Aboriginal Mental Health Consultation

Information and Training Resources

- Community Visitor Scheme Presentation – 1 hour
- Information Sharing Presentation for Clinicians – 3 hours
- Information Sharing Presentation for Communities – 1 hour
- *Mental Health Act 2009* Presentation for Clinicians – 4 hours
- *Mental Health Act 2009* Presentation for Communities – 1 hour

Mental Health Act Instruments and Agreements

- Forms:
    - Administration of an episode of ECT without Patient Consent
    - Level 1 Community Treatment Order
    - Level 1 Detention and Treatment Order
    - Level 2 Detention and Treatment Order
    - Leave of Absence
    - Patient Transport Request
    - Transfer to an Interstate Treatment Centre
    - Revocation of a Community Treatment or Detention and Treatment Order
    - Transfer of a Detained Patient between Treatment Centres/Hospitals
- Statements of Rights:
    - Leave of Absence
    - Voluntary Admissions
    - Community Treatment Orders
    - Detention and Treatment Orders
- Cross Border Agreements
    - New South Wales
    - Victoria

Fact sheets

- Cross Border Agreements – Plain Language Summary
- People and Powers – *Mental Health Act 2009*
- Mental Health and Emergency Services MoU
- Information Sharing
- South Australia's Mental Health and Wellbeing Policy 2010-15

Appendix IV – 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 – 131 456
- 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/