Office of the Public Advocate
Feedback to the Review of the Operation of the *Mental Health Act 2009*
15th November 2013

We wish to provide the following comments

1. Review Process

The Mental Health Unit has given the community and the sector a broad remit to make submissions on any aspect of the Act.

We see that there would be benefit in having a second step in consultation.

If clear proposals come out of the first round of consultation, it could be helpful for those proposals to be then put to stakeholders, with specific questions to allow the widest discussion about ideas that might lead to legislative reform.

It would also be helpful for data to be presented. While South Australian data is presented in some detail in the Chief Psychiatrist's Annual Report to Parliament, to make conclusions about the use of our Act it would be necessary to see data comparing the use of similar orders across other jurisdictions.

We hear a broad concern in the sector that coercion is overused at times where active engagement and assertive but voluntary follow-up of consumers could be used instead. In this context data could assist by comparing the rate of orders in each jurisdiction, the percentage of clients detained in hospital, and the percentage of continuing clients of community teams who are under a CTO as opposed to receiving voluntary care. Duration of orders and outcomes of appeals are other useful comparators.

2. The United Nations Convention on the Rights of Persons with Disabilies (UNCRPD)

Australia's ratification of the Optional Protocol of the UNCRPD in July 2008, is the most significant change that occurred since the parameters for a new Mental Health Act were outlined by Ian Bidmeade in his Paving the Way report of 2005, and the core elements of the Act were planned and drafted in the following two years.

The UNCRPD as a binding instrument, and as a modern document, is more significant and relevant than the UN Mental Health Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care of 1991, which has underpinned the approach to our existing legislation.

In particular, as Australia and other countries have worked on the implementation of the UNCRPD there has been a greater focus on the issue of mental capacity. Article 12 of the UNCRPD gives persons with disabilities (including psychiatric disabilities) the right to recognition as persons before the law, and the right to enjoy legal capacity with others in all aspects of their lives. People are to be supported in exercising their legal capacity.

There is no doubt that the expectations of Article 12, and also the expectations of Article 17 which gives people the right to respect for physical and mental/integrity on an equal basis with others, can be triggers for substantive legislative reform. In some jurisdictions this has accompanied debates about replacing 'harm' criteria with 'capacity' criteria which is probably beyond the scope of the current limited review.

However a simple modification of existing legislation could lead to better outcomes for consumers and the community, and better uphold rights. This could be a stepping stone to further capacity based reform of legislation in the future that cements a capacity based approach.

Such an approach needs to be based on an assumption of capacity, and the requirement that people are supported to make their own decisions before it is determined that a service provider should make decisions for them.

Why mental health legislation should refer to mental capacity

The current criteria for making an order refer to the existence of an illness, and the risk of harm to self or others amongst other criteria, but not capacity.

When a person is placed on an ITO or a CTO the practitioner or the Guardianship Board in essence act as the substitute decision maker for that person, with respect to decisions about whether or not to come into hospital, to take medication etc.

Yet most people who are unwell and who are under an order will retain the capacity to make many decisions. While a person who is very unwell may not have the capacity to decide to come into hospital, and is admitted involuntarily, the person may still have the capacity to decide which therapies and group programs to participate in and to plan follow up care on discharge. A person who is required to take medication by virtue of a CTO, and is therefore legally unable to refuse treatment, may still have a capacity to decide between alternative specific drugs based on the different side effects profiles, and the person's own values and priorities.

A common report we hear now is that people are not sufficiently involved in their treatment planning and decision making. We suggest a new focus on decision making capacity and supported decision making would force a rethink of this. The capacity of people to make more decisions would be respected, and support offered when required.

Specific changes

There are two changes we would suggest. They could be implemented together, or one or other of the proposals could be implemented.

The first is a change in the criteria for putting an involuntary order in place.

The current structure, based on the 1991 UN Principles, could be retained.

However in addition, a new criteria could be added that requires a loss of decision making capacity to put an order in place So for example a person could only be started on an ITO if

the person no longer has the mental capacity to make that decision to either consent to or refuse admission to hospital. Similarly a person could only be started on a CTO or have a CTO renewed, if the person has lost the capacity to give informed consent or refusal to treatment, or has not regained it with treatment.

A second change would be to consider capacity when psychiatric treatment is provided to a person in hospital who is detained on an ITO. If a person has capacity to consent or refuse treatment, then consenting or refusing to treatment would be the person's decision. If the person does not have capacity to make such a decision, only then would a consultant psychiatrist be able to consent on the person's behalf.

This is analogous to the limitations on the power of health guardians to consent to treatment under the provisions of the *Guardianship and Administration Act 1993*. A guardian can only consent or refuse consent for a particular decision if the person does not have capacity to make that specific decision.

In keeping with modern legislation a person should not be regarded as unable to make a specific decision, if reasonable attempts to assist and support the person to make that decision have not been made.

Supported Decision Making

The *Mental Health Act 2009* was visionary in that it legislated for support to be available to people under orders, even before supported decision making became a current focus of improving rights.

This requirement is codified in MHA s47. It is our view that this section could be strengthened with specific reference to decision making and requirement that support arrangements be considered for all involuntary patients. It should always be the person's decision whether to bring in a family member or friend to assist them as a third party, but the option of bringing in such a third person should be a routine question.

The implementation of supported decision making could be informed by the stepped model of supported and substitute decision making put forward by the Supported Decision Making project based at the Office of the Public Advocate, based on UNCRPD Articles 12 and 5. In this model, it is an obligation of treating staff to assist a person make a decision, by whatever practical means available. This is a 'reasonable accommodation' to a person's psychiatric disability. This may require time, clear explanations and repeat discussions. If this assistance is not sufficient the service should ask the person if a third person could be involved.

To reiterate, mental health services should seek to support a person's capacity, and psychiatrists only give substitute consent to treatment when a person cannot make such a decision even with support.

Consent for Physical Treatment

In keeping with the above, it is incongruous that psychiatrists can provide consent to medical, surgical, dental and other non-mental health treatments, to people who are under a Mental Health Act order.

It is our experience that psychiatrists are generally uncomfortable taking on this role when consent for significant procedures is required and will seek to have a guardian appointment.

We can see benefits though in removing this requirement, and it would be consistent with a capacity based approach.

It is probable that for most health decisions, where judgment about health matters is not affected by a person's psychiatric illness, that patients themselves would be able to consent to treatment.

3. Reviewing the frequency of Mental Health Act Orders

As suggested above it would be useful to consider ITO and CTO rates that are calculated on a denominator of the total population in the community, and ITO and CTO numbers as percentages based of the total numbers of admissions (for ITOs) and the total number of clients receiving continuing community treatment (for CTOs). This could be compared with jurisdictions in Australia or overseas.

Other jurisdictions seek to set a high threshold for commencing involuntary treatment as a way of encouraging voluntary treatment wherever possible. The use of coercive orders should not become an alternative to offering an assertive but voluntary engagement with consumers.

To this extent the wider 'lower threshold' criteria incorporated in the SA Act, put into place with the intention of giving practitioners the power to make orders in more situations, should be seen as experimental. If there is no evidence, in either a quantitative or qualitative review to support any benefit to these wider criteria, then SA should revert to the core wording recommended by the UN and Ian Bidmeade in his review. The current criteria have the word 'serious' deleted from the original UN text, which could be reinstated.

This change would be further supported, if it should be the case that use of orders is high in SA compared to other jurisdictions, where other least restrictive alternatives could be implemented, and there is no difference in outcomes.

4. Reviewing the length of Mental Health Act Orders

In implementing the 2009 Act, the previous first 21 day order, and second 21 day order, was replaced by a 42 day order.

This was a practical initiative, because psychiatrists advised that this longer time was necessary to treat most patients.

However the average length of stay of most inpatient mental health units is 14 days. The median length of stay can be 9 days or even less.

The impact of the 42 day order, we suggest should be subject to careful review. Orders should be under a continuous review by clinicians, to be revoked at any point, when a person's condition no longer meets criteria. Therefore in theory the 42 day maximum length

should not matter, because at any time during the 42 day period if a person no longer meets the criteria for an order, it should be revoked. Is this happening?

A rights based approach would seek to limit the duration of coercive detention and treatment on one hand, while on the other increasing access to voluntary services that seek to engage with a person at the earliest opportunity.

Therefore the change to 42 day orders in the 2009 Act should be scrutinised through a review of both quantitative and qualitative data.

If the duration of this order is not clearly benefiting patients then alternatives should be considered. One option would be to return to the first and second 21 day order. A better option would be to reduce the length of orders from 42 days to 28 days. At 28 days the person would need to be reviewed by SACAT. This is the current proposal in place in Victoria. It ensures earlier legal review of more detention orders for involuntary treatment.

5. Providing information to consumers and carers

The forms for ITOs and CTOs should once again have a few lines for clinicians to indicate the reasons why an order is being made.

This would then be provided to consumer and carer. There are already provisions for the clinician not to give the form to a carer, if this is not in the interests of a consumer.

This could be a requirement of the Act, or could simply be reviewed by the Minister.

6. Continue with the current definition of mental illness

Our Office does not see a reason at this time to either restrict or expand the definition of mental illness in the Act. During the operation of the *Mental Health Act 1993*, and the *Mental Health Act 2009*, mental health and Guardianship and Administration legislation have worked side by side. The definition of mental illness should continue to include organic mental illnesses - for example behavioural and psychological symptoms of dementia which are routinely assessed and treated by mental health services for older people, and delirium secondary to medical conditions.

7. Therapeutic jurisprudence: video conferencing and appeal processes

The *Mental Health Act 2009*, authorized for the first time, examinations of the patient by practitioners using audio-visual conferencing, when it is not practical in the circumstances for an in person examination.

The Act could also provide guidance on the use of a audio-visual conferencing for tribunal hearings. While this Office sees benefit in using video links for rural consumers, people who might otherwise need to travel significant distances to a hearing, this equipment is now also used for videoconferencing to metropolitan hospitals. The change from in person visits to video hearings was introduced as a cost saving measure in December 2012. Our Office believes that consumers who traditionally were provided an in person hearing in the past, should continue to receive this service. It would be helpful if the MHA could be specific on its expectations in this area.

Similarly when the Act was written, the sector would only ever have thought that Appeals would be heard by a Board chaired by a lawyer, as this has been standard practice in this and other jurisdictions. Appeals are now heard by a psychiatrist sitting alone – once again a cost saving measure. It remains the position of this Office that a legally qualified Board member should chair such Appeal. This could be considered as part of the MHA review.

8. Submission to the YourOPA website

Members of the public submitted ideas on rights to the YourOPA website. Some referred to the operation of the Mental Health Act, and suggested changes.

While we do not necessarily agree to all of the proposed reforms submitted, each submission raises a significant issue. If these issues are not addressed through legislative change, then some may require a training response.

Copies of these submissions to our Website are attached. We hope they assist the review.

Summary of comments and recommendations from the Office of the Public Advocate

The addition of a capacity criteria to the existing criteria for making an ITO or a CTO.

If a person is on an ITO a psychiatrist can only consent for a particular psychiatric treatment if the person does not have capacity to make that decision for that particular treatment.

If a person is on an ITO a psychiatrist would no longer be permitted to consent for medical, surgical, dental or other non-mental health treatment. If a person does not have the capacity to consent to treatment this task would be done by a relative or guardian.

The frequency of use of Mental Health Act orders should be reviewed in comparison to other jurisdictions. If the threshold for orders is too low, it should return to the internationally recognised requirement of a ‘serious’ risk, rather than just ‘risk’ as is now the case.

The duration of ITOs should be reviewed, in particular the impact of the 42 day order started in this Act. If there is no evidence of benefit of the 42 day duration, we should revert to a shorter duration of order – such as an order that requires tribunal review after 28 days (the current Victorian proposal).

Consumers and carers should be given brief written reasons as to why they have been placed on an ITO or a CTO. This could be included in the Act, or simply reviewed by the Minister to issue new forms.

The Act should give guidance on the use of video conferencing to the tribunal as well as to practitioners. The effect should be that consumers who traditionally could participate in an in-person appeal, as opposed to video hearing, should continue to receive one – reversing the change made in December 2012 that decreased the availability of in person hearings.

The Act should give guidance on the composition of tribunals hearing Appeals. Our view is that legal practitioners should chair such hearings.

At this point our Office would not recommend a change to the definition of mental illness as used in the Act.

We consider that these changes would increase the participation of consumers in decisions about their own health care, and are in keeping with the current objects and guiding principles of the Act.

Also the amendments suggested, while significant in impact, would legislatively involve either small additions, changes or deletions, to current sections in the Act rather than substantial changes.

Comment from Your OPA website

Evaluation of the CTO process in South Australia

by Dregege on October 31, 2013 at 03:55PM

Australia's soaring use of community treatment orders (CTOs) has been condemned as a breach of human rights by a leading medical ethicist. (Dr Chris Ryan) who states "I think it's deeply concerning and a breach of human rights. It's not reasonable to continue legislation where people with capacity are being compelled to take treatment they don't want," Whether we are supporting young men or the elderly the increased use of CTO's appears to be quite extraordinary in South Australia and has started to look like more a form of social control than the least restrictive medical intervention it is often purported to be. Is it possible that it's not only the rights of those who are in effect 'legally coerced' into the CTO programme that are being eroded, but that growing evidence seems to suggest that in many cases this method of treatment is not only ineffectual but can be seen as detrimental to the recovery process of the individual?
Why the contribution is important

To address the usage of CTOs in South Australia, their efficacy as a process and the irights of the individual who is subjected to an order is extremely important as increasingly more people find themselves subject to a CTO order.

For many of our clients CTO's have become a regular fact of life, one client stated that he 'doesn't know what normal life is like ' as he had been on a CTO for over 10 years, is this really the only way to ensure that this man received the comprehensive treated he needed? It is hard not to believe that words like 'control, threats and punitive measures, have taken the place of 'mental health care' and support. In respect to the way decisions are made noncompliance seems to be one of the reasons given for clients not adhering to appropriate plans.

There are many situations where 'appropriate plans' in reality don't come to fruition, contrary to what mental health services argue. Secondly, many clients have discussed the issues around the type of medication they are forced to take and the deleterious side effects they have on their lives, side effects such as lethargy, erectile dysfunction, at what point are patients going to be listened to when they cry out and state that they have had enough of the awful medication and lack of freedom that many of us take for granted? Thirdly there is the whole question of human rights, many others in society have the clear right to refuse medication if they so wish without having legitimised forced treatment compelling them to take medication they do not want.

It does appear that there is a view that CTO's have to be administered in such numbers because of a perception that those with mental illness are in effect dangerous, (to themselves or society in general) even though there are many reports stating that as a group people with mental illness are actually less dangerous than the general population (see Arboleda-Florey, Holley & Crisanti, 1996; Monahan & Arnold,1996)

Having attended numerous CTO hearings it is markedly clear that the enforced treatment on patients by CTO orders can have a detrimental impact on the relationship between patients and therapeutic professionals. At the very juncture in someone's life when they need to have relationships of trust, the imposed nature of a CTO can often set the patient against the

therapeutic staff (and indeed the patients if they have been part of the process) as the imposed order is put in place. This process can in effect be seen as having more custodial overtones rather than a process based on the therapeutic needs of the client. It is I believe time for the mental health services to

If the Care Quality Commission of Great Britain concludes that CTO orders had contributed to an increase in the number of mental health patients being detained because patients were being kept on them for long periods, and Professor Tom Burns, (the psychiatrist who originally advised the British government on CTOs), has also come to the conclusion they are ineffective and unnecessary it highlights the importance of SA to investigate, (like many other countries are doing already) the validity and efficacy of the CTO solution and whether the Human rights of those people subjected to CTO treatment are, in effect, being violated.

Comment from Your OPA website

Should powers to make Mental Health Orders be limited?

by Annabell60 on October 08, 2013 at 06:16PM

Currently Orders placed on people experiencing an episode of Mental illness can be made by a variety of Health Professionals. These come under the Mental Health Act as a prescribed class. I question whether an Occupational Therapist has the required skill set and training to deny a person of their libety and consent.

Surely such a decission should only be able to be made by Psychiatrist with significant work experiene, Senior Mental Health Nurses with relevant 5 year work history in the Mental Health sector, and the same for psychologists, and senior Social Workers.
Why the contribution is important

Denying a person of their freedom is a serious matter and should be a last resort and only suitably qualified and experience professionals should have the capabiliy of putting a person on a 24 hour order.

This should be confirmed by a psychiatrist.

Powers to make Orders should be limited with the exception of Rural Areas where Staff with mental health knowledge can be thin on the ground. Dentention periods should still be limited and Orders confirmed by a Psychiatis

Comment from Your OPA website

Definition of Mental Illness in SA Mental Health Act

by Annabell60 on September 29, 2013 at 08:27PM

Expanding the definition for mental illness in the Menta Health Act to reflect the spectrum of disorders people can experience. To recognise that due to life's circumstances people can experience short term intense feelings that result in severve emotional distress and can result in a person taking their life as they can at the time see any other option.

Currently the Act does not recognise emotional distress but allows for people to bre treated without consent for a physical illness, this should only occur in extreme emergency situtions when a very real risk of loss of life could result if treatment was withheld.

There are degrees of mental illness, not everyone has the same experience, the MH Act is a one size fits all.

A person who is experincing severe emotional distress may only need to be kept in a safe environment, the opportunity to talk about their problems and a few good nights sleep in order for them to regain control.

Mental Illness tat an cause a person inablity to ope with everyday functioning and require to be taken out of situations that may be ontriubting to their distress for a short period.

Serious mental illness for those who experience either serious episondes of distress which could lead to them causing physical or emotion harm to themselves or others.
Why the contribution is important

The impotance of changing the current definition is to both enable those who experience serve emotional distress but in itself is not a diagnosable ilness, eg, grief through loss, behavioural disorders which are currently turned away from ED departments. A person should not be left in a state of severe distress.

In contrast a person who experience a period of emotional distress due to circumstances in their life should not be subject to Orders of a period loger than 7 days.

Having your freedom and consent removed is distressing in itself, control and responsibility should be reinstated at the first possible instance. Currently this is not the pratice with people remaining on 42 day orders until the day of discharge.

Comment from Your OPA website

Mental Health, mental capacity, supported decision making

by Annabell60 on September 29, 2013 at 08:15AM

The reognition that people with even the severest forms of mental illness still have their own wants and needs and to make their own decisions relating to care and treatment.

Through the use of supported deision making people can express what their needs are and what they want or what treatment and services not only suit them but enhnve their quality of life.

Currently, The Mental Health Act makes the presumption of every one under an Order has "no capacity" in my experience this is very rarely the case.
Why the contribution is important

The importance is to change culture and cinical practice and to recognise that with support people are able to make their own decisions in relating to "their life, wants, needs and best interest" as opposed to others making decisions for them. This is a powerless, degrading position to be in, and does not recognises each individuals "unique individual self worth" as in the Convention of Human Rights 1948"

Comment from Your OPA website

Mental Health Legal Issues, and legislated rights

by Annabell60 on September 27, 2013 at 08:18AM

Protections of Rights under the SA Mental Health Act, Is there need for a Judical Review? Why the contribution is important

People under the Mental Health Act have legislated rights.

The Minister for Mental Health & Substance Aubse, he has the responsibility of the Mental Health Act

The Cheif Psychiatist's role is to ensure the Menal Health Act is Administered and people's rights are observed. The Mental Health Act is legislated law by the SA Parliament.

This he has failed to do so, evidence is in documents in the public domain

The Cheif Executive Officer also has responsibilities, under the Public Sector Act he has failed to observe also records in the public domain.

The Principal Community Visitor also has legislated requirements to fulfill and has met these obligations to a degree, this is a protection built into the Act, but he has failed to ensure that the Cheif Psychiatrist administers the Act according to law.

The Guardianship Board (legal arm, a tribunal an Administrative Court, has failed as a people s a presiding tribunal to ensure Natural Justice occurs. The Guardianship Board is overseen by the President, another he.

The Public Advoctes role is to protect the fights of vulnerable people, has he, is he, in respect of the above fulfilled his role?.

The Australian Constitution of 1901 over arches all Australian Law

The Australian Constitution was written late 1890's by: British, wealthy, influencial, middle aged, male protestant, educated landowners.

If you refer to the above are there any her roles? Or are the his roles supported by her roles? Are there any his roles which do not have qualifications after their name, or is it a presumption that "indeed" a person requires formal qualifiations, where is the voice of the community member, to be a member of parliament, to govern formal qualifiations are not a requirement.

The wording of the Australian Constitution gives Australain Ccitizens the "right to appeal" decissions made by a court or tribunal. Principle of Natural Justice are accepted at tribunal.

However, Australian Law, based on British Law is adverserial, based on points of law, either it happened or did not happen "without reasonable doubt"

The Australian Constitution by the wording also gives Australian Citizen's the right to review government and government departments in the Higher Court, the right of Judicial Review.

I raise the question of the need for a Judical Review as the above Government Officials and Departments are not fulfilling their legal obligations in Legislated Law?

I am however a her and a Community Member who is raising questions that have arisen because I talk to the actual people who lives are affected by these decission makers, 50% are her and I read documents in the public domain.

What would I know?

The answers and where the evidence can be found to support the statements I have made.

Perhaps I am a Rosie, the tired seamstress on the bus. Ask he Public Advocate?