

Response to the Review of the *Mental Health Act 2009*

8th September 2010

This response answers the questions posed in this review report which is available on the following web link: <http://bit.ly/MHAct2009>

1. **Patients should have access to legal representation, at no cost to themselves, for all hearings to consider treatment order applications before the Guardianship Board.**

This recommendation is supported.

Given the significant loss of rights experienced by people placed on involuntary orders, it is only appropriate that legal representation be provided.

In supporting this recommendation, we recognise that care will need to be taken in its implementation, so that the cost of providing this representation does not become prohibitive, and that legal practitioners with knowledge and understanding of this jurisdiction are available when needed.

Currently a list of legal practitioners who undertake this work is maintained by the Office of the Public Advocate, and used by both the Guardianship Board and the District Court when arranging hearings. The Assistant Public Advocate coordinates the list. Funding for representation is provided by SA Health, and the fee for service rate of reimbursement set by the Portfolio Executive of that Department.

An expanded scheme that provides representation for treatment order matters as well as appeals could be more formally established and may use a different model.

For example one approach would be for the scheme to be managed by the Legal Services Commission. An alternative approach would be to fund an organisation to operate a Community Mental Health Legal Centre; an organisation that already operates community legal centres might take on this role. The employment of a small number of lawyers may be more economical than the current fee for service model if that was extended.

This question was also discussed by the Office of the Public Advocate's Supported Decision Making Committee. The potential value of trained non-legal advocates was noted. Currently Commonwealth funded disability advocacy agencies provide this representation to the Board, but their capacity to do this is stretched. The benefits of trained non-legal advocates should not be dismissed, as this might provide cost-effective coverage that could not be achieved with a full legal model.

A hybrid scheme could have a Community Mental Health Legal Centre employing both lawyers and trained non-legal advocates, the lawyers providing representation for appeals and for complex first level applications, and the advocates assisting in less complex matters.

People appearing before the tribunal should still be able to choose their own lawyer if they wish, with payment available as it currently is for appeals.

Our Office would wish to contribute to the planning and development of any expanded scheme.

2. **SACAT should establish a specific dedicated Mental Health List or Stream, supported by officers with mental health expertise.**

This recommendation is supported, but with the qualification that the Stream that considers mental health matters should also consider Guardianship and Administration matters, as currently occurs within the existing Guardianship Board. South Australia has effectively managed both mental health matters and guardianship matters under a single tribunal for nearly 20 years, and it is our view that the connection between these streams of work should continue, and not be separated as has historically been the case in other states.

Given that orders for guardianship, administration or mental health treatment each entail a loss of rights, it makes sense for one stream in the tribunal to oversee all such orders for a person, rather than having separation between the work of the streams.

It is our understanding that this is what SACAT will do with the establishment of the Community stream, taking over the work of the Guardianship Board. Professionals with mental health expertise have been appointed as ordinary members of SACAT.

When this matter was discussed by our OPA Supported Decision Making committee there was a strong view that SACAT should also have people with experience as consumers of mental health services, people with disability (including psychosocial disability) and carers of people with disability as members, and that panels could then be drawn from people who have legal expertise, relevant professional expertise, and community expertise.

3. **SACAT should consider the section 101 provisions confirming the validity of documents despite errors, or allowing their correction, and incorporate them into SACAT processes.**

This is supported. It is a requirement of the law that this section be considered. In the future if there is uncertainty about the meaning and intent of section 101, we would suggest that the matters be taken by the Mental Health Service to appeal to obtain further clarity of intent.

Our Office endorses the commentary by the Chief Psychiatrist that a face to face hearing is preferable for all proceedings for parties to communicate and understand with each other, and that transport under duress to attend hearings should be avoided. Prior to late 2012 appeal hearings were routinely heard face to face in metropolitan hospitals, because people were too unwell to travel to the Board's premises. Hospitals had spent some time, and we understand money, in providing appropriate rooms, facilities and equipment storage for visiting Board to convene on site. This long standing visiting service was stopped to most hospitals for budget reasons in late 2012, and replaced by videoconferencing. It is our view that this decision should be reexamined by SACAT, and hospital visits reinstated whenever possible.

4. **SACAT should consider fairness of procedure when selecting Tribunal members to hear mental health matters.**

This recommendation is strongly supported.

This Office agrees with the commentary by the Chief Psychiatrist that the current arrangement in South Australia to have single member Boards comprised only of a psychiatrist may abrogate a person's rights.

It is our expectation that SACAT will address the anomaly, as the President of SACAT will have discretion in the composition of Boards.

Our Office acknowledges the good work of the psychiatrists currently undertaking the single member Board work who have been considered to have tackled this work with respect, care and skill. Our Office's understanding however is that many of those psychiatrists have taken on this role reluctantly, because of a belief that a lawyer should be involved in chairing an Appeal hearing, and indeed one psychiatrist member refused to do this work.

The single member psychiatrist hearing was introduced in response to budget pressures. There should be adequate funding allocated for a legal practitioner to act as chair of Appeal boards, which are when possible comprised of 2-3 members with different expertise.

With respect to fairness generally we consider that SACAT in taking over smaller tribunals, will offer improved fairness, quality, independence and accountability. It is our expectation that the Community "Human Rights" stream will provide a therapeutic jurisprudence model which is best practice for tribunal work. It will be under the leadership of a senior member, but that member will also be accountable to a Supreme Court justice who is the President of SACAT. SACAT provides greater actual and perceived independence in undertaking its adjudicating roles, because as a quasi-judicial tribunal it will have a clearer separation from executive government in all aspects of its operations, than is currently the case with smaller tribunals.

5. **That a guiding principle should be introduced to the Act requiring that the directions and wishes of a person should be taken into consideration as far as reasonably practical and appropriate.**

This recommendation is supported.

It brings practice in Mental Health in line with other areas of health care where a person may have lost decision making capacity for a particular decision, but can still express a wish for example within the *Guardianship and Administration Act* and the *Advance Care Directives Act*.

6. **That a decision-making capacity Part should be introduced to the Act, with sections describing impaired decision-making capacity, substitute decision-makers and mandatory medical treatment.**

This Office strongly supports this recommendation, and commends the Office of the Chief Psychiatrist for making this recommendation, which if implemented would ensure that mental health legislation in this state is consistent with international and national best practice, and the rights of people receiving mental health care would be more closely aligned to those of people receiving physical health care..

Many psychiatrists and human rights practitioners would argue that without mental capacity criteria, mental health legislation is fundamentally discriminatory towards people with a mental illness, because it does not consider capacity whereas equivalent Guardianship legislation does.

We support the addition of these definitions as described in the report, including the requirement that there be a presumption of capacity.

Our original submission supported the introduction of capacity criteria. We make these comments about how capacity criteria might operate.

Decision making capacity and consent to treatment

A person who has decision making capacity should be able to consent, or refuse consent for any treatment.

A person who has impaired decision making capacity, to make a decision about psychiatric treatment, could have treatment involuntarily administered without consent, if the person is on a ITO or CTO, and the decision to administer the treatment is made in a way that is consistent with both the principles and specific requirements of the *Mental Health Act*.

A person who has impaired decision making capacity, to make a decision about general medical or dental treatment, could have treatment administered without consent, subject to the requirements of the *Consent to Medical Treatment and Palliative Care Act 1995* and if relevant the *Guardianship and Administration Act 1993*.

Decision making capacity and the making of orders

A decision making capacity criteria should be added to the existing criteria for a CTO and an ITO.

The addition of a criteria of impaired decision making for a CTO would require a practitioner to consider whether or not a person has impaired decision making capacity to consent to or refuse a psychiatric treatment, in addition to the existing criteria, before an order is made.

The addition of a criteria of impaired decision making for a ITO would require a practitioner to consider whether or not a person has impaired decision making capacity to accept or decline admission to hospital, in addition to the existing criteria, before an order is made.

Interface with the *Consent Act*

The *Consent Act* permits a person responsible to consent to medical treatment, including psychiatric medical treatment, if a patient has impaired decision making with respect to that decision.

Examples would include the consent by a person responsible to antipsychotic medication delivered to a person in an aged care facility who has behavioural and psychological symptoms of dementia, or the consent by a person responsible to clozapine treatment, for a younger person with psychosis who does not object to treatment, but does not have the capacity to consider the benefits and risks of treatment.

Unless a *Mental Health* order is required, mental health treatment is frequently consented to using these *Consent Act* provisions, although at times there could be a choice as to which act to use.

The *Mental Health Act 1993* had a helpful criteria for community treatment orders, that they should only be used if a person has refused or failed, or is likely to refuse or fail, to undergo treatment.

While this criteria no longer exists in the *Mental Health Act 2009*, it is still a delimiter between practitioners seeking a *Mental Health* order for a patient who is refusing treatment, where force would be used if required, as opposed to using *Consent Act* provisions to obtain substitute consent from a person responsible for the patient who is

otherwise accepting treatment, but because of impaired decision making capacity not able to consider the risks and benefits sufficiently to make an informed decision.

Supported Decision Making

Consistent with Article 12 of the UN Convention on the Rights of Persons with Disabilities, a person should be supported to exercise their capacity, if this support is required.

Supported Decision Making is a key part of the new Victorian *Mental Health Act 2014*. Rights can be upheld by encouraging people to nominate a support person, to assist with decision making if unwell, and by completing a Ulysses Agreement.

Supported Decision Making is consistent with a capacity approach in Mental Health Legislation.

Section 47 of the current act, already gives patients the right to be supported. It is our view, that following the Victorian example, more references could be made to supporters to encourage people to use nominated supporters when unwell.

Dispelling concerns about a mental capacity approach

At this point it is worth while dispelling some concerns we are aware of about the potential introduction of capacity criteria in South Australia. The first concern is that a decision making capacity criteria is onerous and difficult to assess. It is our Office's view that this is not the case.

Currently practitioners in general health need to consider decision making capacity whenever they ask a patient to consent to treatment. In complex matters they will ask psychiatrists and psychologists to provide a report, but it is not necessary to obtain a report each time a decision is to be made. Considering these 'capacity' questions:- does the person understand the relevant information; can they retain that information, use the information and communicate a decision, - should be no more complex and time consuming in mental health practice than assessing other elements of the existing legislative criteria to make an order, and in the majority of urgent and emergency situations will be relatively straightforward.

It is also important that these day to day decision making capacity assessments are not seen to more complex and onerous than they actually are.

If a decision making capacity criteria is introduced into the criteria for an ITO or a CTO then there are different standards of evidence required for an initial order which may be made by a general practitioner, and the review of the order by a psychiatrist. An initial order only require that a person **appears** to meet the existing criteria, as opposed to the higher statutory requirement that psychiatrists need to consider of being **satisfied** that criteria are met..

If a decision making capacity criteria were added to the *Mental Health Act*, then the first line practitioner would similar only need to determine if a person **appears** to have lost capacity to make a particular decision (eg to accept treatment or come into hospital), and then it will be the reviewing psychiatrist who would need to be **satisfied** that capacity is impaired.

The second concern that we are aware of is that the experience in Tasmania following the 2014 introduction of capacity based legislation in that state, could be replicated if we have capacity based legislation in South Australia. Clearly our Office is not in a position to review the anecdotal difficulties in Tasmania this year following the implementation of their legislation and their cause. However our very strong impression after informal discussion

with Tasmanian contacts is that the reported problems in that state of excessive bureaucracy in the operation of the Act, the requirement to complete large numbers of forms and send them to multiple places, and the need for frequent and multiple reviews by two different tribunals, has nothing to do with the decision making capacity criteria per se, but relates to other aspects of the Act, and how it has been operationalised. There may also be a problem of mental capacity assessments in day to day practice being seen by some as more complex than they actually are. We can learn from the Tasmanian experience but it should not deter us from implementing a fundamental principle related to capacity.

Mandatory treatment

With respect to the proposed criteria for mandatory medical treatment, we suggest that it should be clear that this only applies to mandatory psychiatric treatment. This is covered by other proposed amendments to the Act.

The proposed wording, rather than referring to an inability to refuse by a person with “full, partial or varying capacity”, We suggest that it simply refers to a person who has impaired decision making capacity to make the treatment or other decision that needs to be made at that time. This situation is no different to that of fluctuating capacity in other conditions associated with delirium, dementia or brain injury

7. **That a consequential amendment be made to the *Advance Care Directive Act 2013* so that the section 12 definition of mandatory medical treatment includes medical treatment ordered under section 56 of the *Mental Health Act 2009*.**

This amendment is supported.

We understand that this amendment is likely to have effect when decisions are made by paramedics, or other health professionals authorised to administer medication to sedate a person who is behaviourally disturbed while being transported by road or air. It would be inappropriate if a person made an Advance Care Directive that refused such treatment, when it might place others at risk. Such refusals of treatment would be binding, if such an amendment was not made.

We acknowledge that there may be situations where a consumer may wish to dispute the appropriateness of treatment given in this way either before it is administered (for example prior to transport) or afterwards. Such treatment if administered would need to be consistent with the principles of the *Mental Health Act*, and the person’s views sought prior to giving treatment when it is possible to do this. It would be expected to conform to policies, protocols and guidelines.

If a consumer were concerned subsequently, then complaint avenues available through the Ambulance service, the Health and Community Services Complaints Commissioner could be followed, and the matter could also be drawn to the attention of this Office. The availability of complaint mechanisms, should serve as a deterrence to unnecessary or inappropriate administration of medication.

Air evacuations: s56 or ITO

We are unaware what proportions of air evacuations are made under s56 or an ITO. The cases that we have been aware of from time to time, involve patients on an ITO.

Sometimes the interventions used in air evacuation are significant, up to including the administration of significant sedation, muscle relaxants and intubation and ventilation. It is our view that such patients who will receive these interventions should be assessed by a medical officer for an ITO, rather than be transferred under the medical officers s56 powers, and therefore have the full protections that patients on a *Mental Health Act* order receive.

8. **Definitions for advance care directions, advance care plans and substitute decision-makers matching those of the *Advanced Care Directive Act 2013* should be introduced into section 3 of the *Mental Health Act 2009*.**

This recommendation is strongly supported. In particular the reference to provisions in the *Advance Care Directives Act*, the *Consent Act*, and the example given of Ulysses Agreements.

However we do have some comments to make about terminology.

Mental health consent practice should be aligned to general health consent practice as much as possible.

Definitions of advance care directive and substitute decision maker should align to those in the *Advance Care Directives Act 2013*. Definitions relating to the giving of health consent should also align with those contained in the *Consent to Medical Treatment and Palliative Care Act 1995*. This should include definitions for person responsible, and prescribed relative. It is our view that the *Mental Health Act* wherever possible should refer to, rather than reproduce, the *Consent Act* definitions and provisions, as we consider that the *Consent Act* itself should be used wherever possible, rather than reproducing parallel provisions in the *Mental Health Act*.

Reiterating the core theme in our answer to the earlier question on mental capacity, wherever possible the arrangements used to obtain consent for mental health treatment, should align with those in place for consent for general medical treatment. If a person has capacity the person should give or refuse consent for a particular decision. If the person does not have capacity then mainstream mechanisms should be used wherever possible - in particular seeking out a substitute decision maker appointed by an *Advance Care Directive*, or a person responsible as defined in the *Consent Act* (guardian, then prescribed relative, then close adult friend, then adult in charge of day to day care, and then finally the Guardianship Board).

If a person has an Advance Care Directive but not appointed a substitute decision maker, then any directions the person written in their ACD must be considered as if the person were speaking these words at the time.

The routine exceptions to these arrangements in the *Mental Health Act* would only apply to consent to psychiatric treatment when a person is placed under an inpatient treatment order or community treatment order.

A further exception is the limitations imposed on prescribed psychiatric treatment, where extra protections apply in the giving of consent.

Support for Ulysses Agreements

The discussion gives the example of a Ulysses Agreement as an Advance Care Plan, and that a definition of an Advance Care Plan be included in the Act.

This questions was discussed in our OPA Supported Decision Making Committee. There was strong support for Ulysses Agreements, but a preference not to use the term Advance Care Plan, to describe an agreement. This is the position of our Office.

Initially the Advance Directive review chaired by former Health Minister, Martyn Evans had suggested that an Advance Directives Act specifically recognise Ulysses Agreements. Recommendation 35 of that review is informative

THAT the proposed Advance Directives Act

recognise Ulysses Agreements

describe a Ulysses Agreement as a flexible, advisory and signed agreement between all involved parties including the treating health professional and those close to the person

protect those who comply with the terms of a Ulysses Agreement from civil or criminal liability for actions taken in accordance with the Ulysses Agreement
THAT to be valid, a Ulysses Agreement must

be completed and signed by an adult while competent

be signed by the treating health professional and by all those designated a role in the Agreement

include a certificate signed by a second health professional that the person was competent when they signed the document, understood its terms and effect, and was not coerced

include an expiry and revision date

This recommendation was not implemented, and our understanding was that the reason for not recognising such agreements in the *Advance Care Directives Act* was that it should be possible for such information to be incorporated into an Advance Care Directive.

It is our view that this recommendation could become part of the *Mental Health Act*, using the traditional term Ulysses Agreement.

There are significant differences between an Advance Care Directive and a Ulysses Agreement in Mental Health Practice, that support having both options available. An Advance Care Directive is indeed a person's directive; it is completed by the person and witnessed. It is not an agreement with practitioners.

In contrast the Ulysses Agreement is made with treating practitioners. The descriptions in the agreement, of how care will be delivered if a person becomes unwell in the future are prepared with health professionals, and agreed to by all parties. The descriptions of how care is to be delivered can be detailed and specific. It is also seen as a flexible agreement that may change from time to time.

Because of this flexibility, and the fact that the agreements are non-binding, it is our Office's view that the suggestion by Advance Directive Committee for a second health professional to sign a document stating that the person was competent and not coerced is an excessive requirement for a document such as this that may evolve and change. However to help protect a person's rights it may be desirable for a consumer to involve a support person or advocate in preparing the agreement, or discuss it with a peer worker or consumer consultant.

The Advance Directive review also noted that a Ulysses Agreement is separate to a treatment plan required in Mental Health legislation. Such an Agreement could be added to the Treatment Plan, but it is different.

The term Advance Care Plan

We suggest that there could be potential confusion if this term is used, as defined in the Review.

The term is not defined in South Australian legislation, although it is widely used in clinical conversation, particularly as it relates to end of life care. If it were defined in the *Mental Health Act* this would be the first time that it has been given a legislative definition in South Australia.

The National Framework of Advance Care Directives describes an Advance Care Plan as ones that state preferences about health and personal care and preferred health outcomes. The Framework explains that they may be made with or for the person, and can be undertaken by a person with diminished competence, or completed by a family member or someone who knows the person well. Advance Care Plans allow preferences to be written down, when it is no longer possible to complete a formal Advance Care Directive because a person has lost capacity.

While a Ulysses Agreement, according to the national definition, is an Advance Care Plan, the latter term is broader and encompasses more.

It is our view that if a statutory plan is to be created in a Mental Health Act, it should refer directly to the Ulysses Agreement, in a form as suggested in the Advance Directive Review.

9. **The guiding principle for dependents of adults with mental illness should include children and young people as separate groups.**

This is supported.

10. **Parliamentary Counsel should consider what links are required between the guiding principles, section 4 and the proposed decision-making capacity provisions to ensure children are adequately included.**

The provisions for children consenting to treatment should be consistent with the *Consent Act* s12. This permits a child to consent who is capable of understanding the nature, consequences and risks of treatment, and the treatment is in the child's best interest.

As a further protection if a child were to consent to mental health treatment as an inpatient, a parent or guardian should be informed of this consent.

11. **That the Act should provide for the parents of a child in the care of a guardian to be kept informed of matters relating to the child if it is safe and appropriate to do so.**

The Office does not have a position on this suggestion, and would require more information to draw a conclusion. The outcome is desirable. It is not clear to us where such a provision should best sit, in either health legislation or child protection legislation or in a standards document already produced in the sector.

A general principle is that the treatment of important information about mental health care should be treated no differently to information about physical health care. Therefore if this principle is to be regulated in the *Mental Health Act*, then careful consideration should be

given to inclusion of a similar principle in the *Health Care Act*, and/or *Children's Protection Act*.

Alternatively an analysis may be needed to determine if this change needs legislative change. For example the Child Youth and Women's Health Network have produced Health Standard for Children and Young People Under the Guardianship of the Minister. There might be further elaboration on mental health care, and information for birth parents.

12. **Community-based services and facilities should be included in the scope of the Community Visitor Scheme through the regulations.**

Partially supported. Our Office supports the ease of using regulations to add additional places to visit in the future. However for the visiting that is either already established or known to be needed now we consider that the authority to visit certain designated places should remain in legislation. This makes sense to us, because the places already visited, such as ward, or recently identified for visits, such as 24 hour residential services that have taken the places of wards, could be considered "core" places to visit.

However adding a provision in the legislation to permit the Government to declare additional places to be inspected in regulations would give extra flexibility.

13. **The term of appointment to the Principal Community Visitor position should be 5 years.**

Supported.

14. **The contents of the Annual Report of the Principal Community Visitor should be described in more detail.**

Supported. The Principal Community Visitor has produced a detailed and considered Annual Report. This recommendation is consistent with the current work of this scheme, and will help ensure consistency into the future.

15. **The Principal Community Visitor should have the capacity to conduct visits and inspections of facilities alone.**

Supported. The wording of the suggested legislation refers to such visits only occurring when a two person visit is impractical. This qualification is also supported.

16. **The confidentiality and disclosure provisions of section 106 should remain unchanged.**

Supported.

17. **The requirement for a register of patients is discriminatory and should be removed or, if retained, moved and amended to become a requirement to keep records only.**

Supported. The recommendation to remove the current register is supported. Our understanding is that this is kept by institutions, and it is unlikely to have much utility at the present time.

A future option could be to consider the establishment of a statewide register for epidemiological, research and service planning purposes. It is likely that such a register could be established through regulations rather than an Act, and consultation could occur between service users, carers, planners and researchers as to what form a register should take, and how privacy protections are incorporated into the use of a register.

Well established registers have been used for many years in South Australia in cancer and in obstetrics for research, cancer service planning, monitoring pregnancy outcome data and maintaining statistics. Reporting requirements are contained in the *Health Care Regulations 2008*. In mental health research, recent 2014 publications, illustrate the benefit of registries for mental health. Researchers in Denmark have used a mental health registers to demonstrate improved outcomes and cost benefits of an assertive community treatment program. The, South London and Maudsley Health Trust have used an electronic register to examine suicide rates of people who have had contact with specialist mental health services.

We would support the removal of this provision in the *Mental Health Act*, if the register as it is now established has no current use or foreseeable use.

18. **The requirements of section 99(1) for the Minister to provide information about patients are discriminatory and should be removed.**

Supported.

19. **The requirements of section 99(2) for the director to provide copies of paperwork to patients duplicate the same requirements in other parts of the Act and should be removed.**

Supported.

20. **That the Office of the Chief Psychiatrist should draft an addendum to this Report regarding cross-border arrangements by the end of 2014 for consideration by the Minister and presentation to both Houses of Parliament.**

Supported.

21. **The definition of a patient should be amended to include: voluntary community patients, people subject to section 56 or 57 powers, prisoners receiving mental health treatment and care, and forensic mental health patients.**

Supported. This clarification will provide additional protections to these groups and is strongly supported.

22. **All references to the “director of a treatment centre” should be replaced by “director of mental health services of a treatment centre”, which should be defined as a specialist Psychiatrist with lead clinical responsibility for mental health services at the treatment centre.**

Supported.

23. **Treatment order forms should state expiry as 2pm.**

Supported.

24. **Forms should contain the telephone and facsimile numbers of the Office of the Chief Psychiatrist.**

Supported.

25. **Forms should specify “town/suburb” where they currently specify “suburb”.**

Supported.

26. **Clarity should be provided regarding the use of electronic versions of forms.**

Supported.

27. **Treatment order forms should not require a diagnosis or description of a person’s appearance or behaviour.**

Supported.

At this time there are a number of other changes that are being considered to the legislation in the current legislation review that could have greater impact in improving rights and outcomes, than a suggested change to treatment order forms. For this reason this recommendation is supported at this time.

However we leave open the contingency, at some future time, of seeking a change back to forms that contain brief reasons for decision as was the case for forms in the *SA Mental Health Act 1977* and the *Mental Health Act 1993*.

This can occur at any time, as the form of orders are approved by the Minister, so therefore a decision does not need to be made as part of the legislation review.

We previously have expressed the view that it would be desirable for the forms to contain a brief statement of the reasons for making of an order. This would link clinical presentation with legal criteria and would include, for example, brief details to confirm that the person has a mental illness, the nature of risk, and why an order in the circumstances is least restrictive.

This is consistent with what would have occurred with the former South Australian *Mental Health Act 1993* which asked the practitioner making an order to describe “The grounds on which I have formed my opinion.” Four lines were provided for a practitioner to briefly explain how the legal criteria are met based on a clinical assessment. We considered that this was an effective discipline in making an order. If the practice were adopted it would also assist consumers and carers to be given this information as per the requirements of the *Mental Health Act 2009*.

Having said this, the new Act has now operated for 4 years without a requirement for reasons to be written in this way, on the form. Our Office would still expect the reasons for making the order to be documented in the person's case record. So while we still see it desirable to document brief reasons on the form, our position is not steadfast that this is absolutely necessary. Changing back to the old system of writing reasons on forms would take some education and implementation. At this time we would consider that more benefit could be obtained by implementing some of the other recommendations of this review, as opposed to reintroducing this requirement, however this topic can be considered again at any time.

28. **Treatment order forms should not require nomination of a particular treatment centre.**

This is supported, but only insofar as it applies to the initial admission of a patient to hospital.

It is accepted that a patient may be sent to one hospital's emergency department which may not have inpatient beds, and then be transferred to a second hospital. What is written on the form can then be incorrect, and additional paperwork is then required to transfer the patient's order to the new limited treatment centre or approved treatment centre.

However once the patient is admitted to a hospital the requirements of s35 of the Act, *Transfer of involuntary inpatients*, should continue to apply, with notification of guardians and carers as per part 6 of that section.

This would include admission to short stay beds attached to emergency departments.

29. **The guiding principles should separate the requirement for treatment and care plans from the requirement to provide services that take into account the special needs of different groups.**

Our Office does not have a strong opinion on this proposal. We would support either the status quo, or the new proposal to separate the requirements.

Because treatment and care plans are the subject of a separate part of the Act (Part 6- Treatment and care plans), it could be said that there may not need to be a separate principle about the use of the treatment and care plans in addition to the specific requirement.

The current linking of the two principles suggests that the needs of each of the groups should be reflected in treatment and care plans.

If the requirements were separated as suggested, then the new principle could be specific in the ways that services and practitioners take into account the needs of patients. For example to be taken account in the planning and delivery of services, and the assessment and treatment of patients.

30. **The guiding principles should require that the special needs of different groups must be taken into account, including: children, young people, older people, gender and gender identity, Aboriginal and Torres Strait Islander people, culturally and linguistically diverse people, and people with personal experience of trauma or torture, including that related to domestic, disaster or warfare circumstances.**

Supported.

We suggest that the first four suggested areas in this amendment - the development stages of children, young people, adults and older people, could be combined from the current four points into a single point without a loss of meaning.

31. **The guiding principles should require mental health services to meet the highest levels of quality and safety.**

Supported.

32. **That all remaining references to “detention” and “detained” should be removed from the Act.**

Supported. This is consistent with the intent of the Mental (Inpatient) Amendment Bill 2012.

We would note though that the word ‘detained’ has human rights value, because in simple language it accurately describes the loss of liberty experienced by a person on an inpatient treatment order, and the obligations that the state has towards a person who is detained on this order according to international human rights instruments.

So for example in Victoria, the word detention is not used in the titles of orders, but is used elsewhere in the Act. Detention is used in the South Australian *Guardianship and Administration Act 1993*.

Nevertheless the remaining uses of the words detention and detained in the Act are inconsistent with the changes made in Schedule 1 of the 2012 Bill, and should be changed now.

This would also be an opportunity to remove references to the rescinded *Mental Health Act 1993* from other South Australian Legislation such as the *Health Care Act 2008*, and the *Guardianship and Administration Act 1993* and update these references to nominate the current Act.

33. **That schedule 2 should be removed.**

Supported

34. **That the preamble should be amended to refer to “persons with mental illness”.**

Supported.

35. **The Chief Psychiatrist should be able to classify classes of professional directly as authorised officers.**

Supported.

36. **The definition of mental health clinicians should be restricted to professionals who have undertaken recognised mental health qualifications.**

Supported.

37. **Authorised Health Professionals should be renamed Authorised Mental Health Professionals.**

Supported.

38. **The appointment of Authorised Health Professionals and Authorised Medical Practitioners should be changed from the Minister to the Chief Psychiatrist, who should be required to keep records of the registration and functioning of authorised health professionals and authorised medical practitioners.**

Supported.

39. **Complex ECT clinical or consent matters should be considered by a Prescribed Psychiatric Treatment Panel convened by the Chief Psychiatrist.**

Supported.

The Act requires both authorisation of ECT by a psychiatrist and consent for ECT by the patient, a substitute decision maker, guardian or the Guardianship Board.

This panel convened by the Chief Psychiatrist should only consider the *authorisation* of such treatment in complex situations. Consent arrangements should not change as this is a separate process, although interrelated. The person or Board giving consent may be influenced and reassured that a decision to authorise ECT has been considered by a high level panel, but that panel should not have a consenting role.

40. **The witness signature field of the *Consent to ElectroConvulsive Therapy (MR82J)* form should be removed.**

The use of a witness, in our view, should correspond to practice for consent forms in Health. On the basis that a witness of a signature is not currently required for other forms to consent for health procedures, we accept this recommendation.

41. **The ECT consent provisions should make it clear they do not allow the use of reasonable force.**

Supported.

42. **That applications for neurosurgery for mental illness should be considered by a Prescribed Psychiatric Treatment Panel convened by the Chief Psychiatrist.**

Supported. See comments about the authorisation role of such a panel in question 39.

43. **The introduction or amendment of regulations regarding other prescribed psychiatric treatments should be considered by a Prescribed Psychiatric Treatment Panel convened by the Chief Psychiatrist.**

Supported.

44. **That a Prescribed Psychiatric Treatment Panel section should be introduced to the Act, to consider applications for neurosurgery for mental illness, the introduction or amendment of regulations relating to prescribed psychiatric treatment and complex ECT cases referred to the Panel; to be convened by the Chief Psychiatrist, consisting of at least: a psychiatrist, a neurosurgeon, a lawyer, a member of the South Australian Civil and Administrative Tribunal, a bioethicist, a patient and a carer.**

Supported. The Chief Psychiatrists report should contain de-identified data on the number of matters considered, the nature of the matters and their outcome. It should also report on any recommendations related to new prescribed treatments as per question 43.

45. **That definitions for care and control, reasonable force, restrictive practice, restraint and seclusion should be introduced to the Act.**

Supported.

46. **That a restrictive practice section should be introduced to the Act.**

Supported.

To ensure consistency with national initiatives with respect to the use of restrictive practices in disability services, and restraint in aged care, there should also be a definition of chemical restraint, included in the restrictive practices section.

47. **That references to “mechanical body restraint” should be amended to “physical or mechanical restraint”.**

Supported.

48. **That the reference to reasonable force for treatment centre staff in section 34A should be amended to be “restrain the person and otherwise use force in relation to the person as reasonably required in the circumstances”.**

Supported.

49. **That the Act should be reviewed and a report tabled in Parliament every four years.**

Supported.

50. **That rights should be collated in a Schedule to assist understanding and compliance.**

Supported.

51. **The right to a second psychiatrist opinion should be introduced.**

Supported.

The proposed wording could reflect more closely the provisions in the Victorian Act. In particular the provisions could specifically describe the functions of the psychiatrist providing a second opinion in relation to both the criteria for making an order and treatment, and the response required by the treating psychiatrist after receiving the second opinion report.

The Victorian *Mental Health Act 2014* specifically refers to an assessment as to whether the criteria of an order apply (s81):

(1) The functions of a psychiatrist giving a second psychiatric opinion are—

- . (a) in relation to an entitled patient (other than a forensic patient), to assess the entitled patient and to provide an opinion as to whether the criteria for the relevant Order apply to the entitled patient; and

- . (b) in relation to an entitled patient, to review the treatment provided to the entitled patient under the relevant Order and to recommend any changes that the second opinion psychiatrist is satisfied are appropriate in the circumstances to the treatment provided under that Order.
- (2) A psychiatrist who is asked to give a second psychiatric opinion under this Division cannot override the treatment prescribed by the authorised psychiatrist.

It then provides obligations on the treating or “authorised” psychiatrist who has received the report (s85).

- (1) If a report prepared under section 84 in relation to an entitled patient (other than a forensic patient) expresses the opinion that the criteria for the relevant Order do not apply to the entitled patient, the authorised psychiatrist must—
- . (a) examine the entitled patient as soon as practicable after receiving a copy of the report; and
 - . (b) determine whether the criteria for the relevant Order apply to the entitled patient.
- (2) If the authorised psychiatrist determines under subsection (1)(b) that the criteria for an Order to which the entitled patient (other than a forensic patient) is subject do apply, the authorised psychiatrist must—
- (a) give the entitled patient the reasons for the determination; and
 - (b) advise the entitled patient that he or she has the right to apply to the Tribunal for revocation of the Order.

The Victorian Act then permits a patient to seek a further opinion from the Chief Psychiatrist if the treating psychiatrist adopts none or only some of the second opinion psychiatrists recommendations (s88).

The Chief Psychiatrist has the power to direct the treating psychiatrist, to change treatment.

This regime provides different levels of second opinion and review. If a second psychiatrist concludes that the criteria for making an order are not met, and the treating psychiatrist disagrees, then the patient could use this report as a basis of an appeal to a tribunal. If a second psychiatrist makes a treatment recommendation to which the treating psychiatrist disagrees, then the Chief Psychiatrist has authority to resolve this if approached.

Given the compulsory nature of treatment given under the *Mental Health Act*, and the inability for most of the treatments to be refused by either patient, their family or guardian it makes sense that the usual rights to second opinion that can be exercised by any patient in a health setting, be codified in legislation to ensure that this right can always be exercised and that a second opinion is responded to.

This recommendation will have resource implications, although it should be possible to estimate the demand for second opinions on their use in Victoria.

52. That a provision recognising international human rights agreements should be introduced.

Strongly supported.

53. **That section 269X of the Criminal Law Consolidation Act 1935 should be removed and substituted by provisions allowing the release and return of people from the custody of the Court to mental health services similar to subsections 57(9) and (10).**

Opposed.

It is the opinion of this Office that the Courts should have appropriate powers to commit a person into custody, other than prison, while an investigation is occurring into whether a person has been competent to commit an offence, or is fit to stand trial.

These orders protect the defendant who is in the court process who may have a mental illness or disability. If the court did not have this option, and the Court considered that the defendant should be in custody, then the Court would have no other option than to make the person a remand prisoner.

It is our view that the rights of the person are better protected through the status of being placed under s269X order, than they would be by not having this status. The benefit of this status can even apply when a hospital bed is not available, and the Court has been left with no alternative but to place the person in prison.

It is also relevant to note that a s269X order does not take away the rights of an individual with respect to their ability to consent or refuse health care, and is therefore less restrictive than a *Mental Health Act* order..

For example the s269X order permits a person to be placed in custody in hospital, but not administered treatment against a person's will. For medication to be administered involuntarily to a s269X client in hospital it is our understanding that it is necessary to also place the person under a *Mental Health Act* Inpatient Treatment Order for this treatment to be given. The person will then receive the protections of the *Mental Health Act* under that order with respect to their treatment. If the same person was placed in custody in prison under s269X because of a lack of mental health beds, then it would be necessary for the treating psychiatrists to place the person under a *Mental Health Act* Community Treatment Order to enforce involuntary treatment.

This is different to the situation that applies when proceedings have concluded and a person with mental impairment or unfitness to stand trial is placed by the Court in the custody, supervision and care of the Minister for Mental Health (s269V), a power which allows the administration of involuntary treatment.

In summary s269X perform a significant role and should be retained. As a future exercise it may be worthwhile considering adding forensic provisions of the *Mental Health Act*, to provide clearer powers to the Court to make assessment and/or treatment orders for defendants and prisoners, which might then be reviewed by a tribunal such as the South Australian Civil and Administrative Tribunal (SACAT). This would require reform of both the *Criminal Law Consolidation Act* and the *Mental Health Act*.

54. **The rights of people subject to section 56 and 57 should be enhanced through inclusion in the definition of a patient and by requiring a statement of rights.**

Supported.

55. **The use of section 56 or 57 powers should be documented in the records of the agencies whose officers bring the powers into effect.**

Supported.

56. **That a time limit of 4 hours be introduced for care and control once the person is at a place for assessment or treatment**

Supported. There should be an option to extend this period by further 4 hour blocks if required. This could be necessary for people who are transported from country areas. It is our view that it is preferable to set a timeframe of 4 hours that would be met in most circumstances, and then extend it if is required with some justification for doing so, instead of continuing the current arrangements that do not specify a time limit.

57. **Patient transport requests should become patient assistance requests with specific provision to allow authorised officers and police officers to assist with the administration of the requirements of community treatment orders, as well as transport.**

Supported.

58. **Notification of the making, confirming, varying or revoking of a community treatment order should be made to the Chief Psychiatrist only, within 1 business day. (The Chief Psychiatrist will then subsequently acknowledge receipt of the order and notify the Guardianship Board within 1 business day.)**

Supported.

59. **The requirement for all level 1 community treatment orders to be reviewed by the Guardianship Board should be removed.**

Supported.

60. **Level 1 community treatment orders should be made in the same manner as level 1 inpatient treatment orders, so that they are reviewed within 24 hours or as soon as practicable by a psychiatrist who then confirms or revokes the order.**

Supported.

61. **The maximum duration for level 1 community treatment orders should be increased to 42 days to allow therapeutic interventions time to have effect and reduce the possibility of future more restrictive treatment options.**

Not supported.

It is our view that if there is benefit in aligning the duration of Community Treatment Orders and Inpatient Treatment Orders. This could be done by reducing the duration of an Inpatient Treatment Order Level 2 from 42 days to 28 days. A person would then be reviewed by a tribunal after 35 days in hospital, after completing a 7 day level 1 order and a 28 day level 2 order.

Should however it be decided that the duration of a community order be increased to 42 days, then our Office's position would be that this can be safely done if other measures were taken at the same time to ensure that rights were upheld. For example by introducing a capacity criteria for the making of orders and access to statutory second opinion to people who disagree with the treatment. If a regular tribunal review were to occur at 42 days then it would be important that people placed on these longer orders were empowered to lodge an appeal should they disagree with an order, so as to reduce the duration of involuntary treatment, should a tribunal review on appeal be successful.

62. **New provisions explicitly allowing reasonable force to be used to carry community treatment orders into effect should be introduced.**

Not supported in its current form.

Our Office does support the part of this recommendation that is intended to make explicit current powers, but does not support an extension of these powers, which may increase the potential for either force, or the threat of force, to be relied upon in delivering mental health care.

This proposed amendment would make the use of force explicit, and permit it to be used in a consumer's home. The discussion paper explains that people can currently be taken to a place of treatment under s56 or s57 so that reasonable force can be used, but the force cannot be used in a person's home.

The evidence for the effectiveness of Community Treatment Orders is limited. In 2007 the Institute of Psychiatry, King's College London, concluded following a review of the international literature, that there was no robust evidence as yet to prove whether CTOs are beneficial or harmful to patients. A response to this conclusion was the commissioning of an English nationwide trial of CTOs based at Oxford University. The results published last year in the *Lancet* (vol 381 pages 1627 - 1633) demonstrated that there was no reduction in the readmission rate when people were randomised to either CTOs or a comparison group where people were placed on "leave" from hospital. In that community based comparison group, medication could not be given without consent but the patient could be reviewed by mental health staff and quickly readmitted if required. The mental health staff treating people in the control group, would no doubt educate patients about the benefits of treatment and encourage adherence to prescribed medication, but could not require it.

It would seem to our Office that the results of this trial is consistent with the good evidence of the benefit for people with serious mental illness regularly seeing mental health workers for rehabilitation and treatment, but as yet there is still not robust evidence for administering medication without consent.

Our Office does acknowledge that CTOs may have a life saving role for some mental health consumers, who lack insight into their illness and are at risk, but the number of consumers who need to be on an order is probably less than the number currently on orders, and that many of the people on orders would do just as well if they were to receive regular mental health visits and were assisted to take medication voluntarily without requiring compulsory treatment.

We are concerned about the extension of the use of force to a person's home. We suggest that in most cases force is not needed. It is sufficient for the person receiving treatment to know that they would be taken to a clinic and administered treatment with force if they did not comply. The clinic can be a safer environment than the home with sufficient staff available to restrain and administer treatment.

If force could be administered at the home, then there is a risk that this could become a routine occurrence because of the relative ease of doing this compared to transporting a patient.

Most places in South Australia would have a local mental health clinic, hospital or general health clinic that a person could be taken to. It is our view that this should be the routine power used - to take a person to a clinic for the administration of treatment.

Should it be considered necessary to use force in the home, then this extra authority should be considered by the Guardianship Board when it makes an order. The Board could consider the needs of people living in very remote areas far away for clinics, and in authorising and then reviewing the use of this additional power ensure that the use of force does not become routine.

63. **Notifications of the making, confirming or revoking of an inpatient treatment should be made to the Chief Psychiatrist within 1 business day. (The Chief Psychiatrist should subsequently acknowledge the receipt of that order and notify the Guardianship Board within 1 business day.)**

Supported.

64. **The reporting requirement for level 2 inpatient treatment orders should be replaced with the requirement to provide a copy of the treatment and care plan.**

Not supported.

The power to hold a person in custody for 42 days is a significant one. The intent of s26 (4) is that a psychiatrist explain in a report the reasons for making this decision, which is considered by the Director of a Treatment Centre and then can be reviewed by the Guardianship Board.

It is our Office's view that this discipline represents an important check and balance. When the new Act was prepared, it was a significant change to replace two orders in the 1993 Act (a first 21 day order reviewed by one psychiatrist and a second 21 day order reviewed by two psychiatrists) with a single 42 day order.

Formally documenting the reasons for this longer order was one of the checks and balances proposed for this longer order.

A treatment and care plan would not fulfill this function as such a plan would not indicate the clinical and legal reasons for making an order.

65. **That the treating psychiatrist may revoke a level 3 inpatient treatment order with a second supporting psychiatric opinion and provision of a report and the treatment and care plan to the Guardianship Board.**

Supported.

66. **The "facilities and services" criteria should be removed from community treatment orders.**

Supported.

67. **The definition of harm should be amended to specify harm to mental health or physical health.**

Supported.

68. **The threshold criteria for involuntary treatment should include a capacity criterion.**

Strongly supported.

69. **That the term “at large” should be replaced with “absent without leave” throughout the Act.**

Supported.

70. **The capacity to treat mental illness or any illness under an inpatient treatment order should be amended to treat mental illness or any other illness causing or contributing to the mental illness.**

Strongly supported.

71. **That voluntary community patients should have treatment and care plans mandated by the Act.**

The proposition that a voluntary community patient should have a treatment and care plan is supported. However it is not supported that this should be mandated by the Act as part of a new specific legislated provision at this time.

As noted in the discussion in the Review it is a requirement of National Mental Health Standards that consumers are involved in the development of a treatment, care and recovery plan. The *Mental Health Act 2009* already has a principle that services are governed by a treatment and care plan developed in conjunction with consumers, family, carers and supporters.

For these reasons a specific legislated requirement should be unnecessary, as improving the uptake of these plans could be part of activities to improve service quality and meet standards, as they would be in other areas of health care where plans are also used.

The Review notes difficulties in implementing the existing requirements for treatment and plans. As these implementation issues are addressed care plan use should increase. There are benefits and risks in the specific regulation of treatment and care plans in an Act. For involuntary consumers, who already have lost many rights, a comprehensive treatment and care plan is a mechanism to ensure their involvement in planning, and to document the delivery of comprehensive care. It is important that this is specifically regulated for in the Act for this reason.

The situation for voluntary consumers in Mental Health Services can be seen as similar to that of general health consumers who have a condition that needs a care plan. It should be required as part of good quality care. If a specific legislated provision was introduced before the issues raised in the Review that have limited care plan use are resolved, then the completion of the plan may become an end to itself to meet a new legislative requirement, rather than a useful component of care that will engage consumers and ensure comprehensive services are provided.

72. **That other service providers or agencies should be included in the preparation and revision of treatment and care plans as far as practicable and appropriate, and that those plans should be shared with the other service providers or agencies as appropriate.**

This is not supported.

We support the principle of mental health services working collaboratively with other providers and agencies, that underpins this suggested addition.

For this reason adding a principle rather than a care and treatment plan requirement could be an alternative.

For example a new principle could be that Mental Health Services work collaboratively with other providers and in these relationships, information is shared with those providers in accordance with the wishes of the consumer, and the requirements of legislation.

Some agencies would only need to see an extract of a care and treatment plan that it is relevant to their role, rather than receiving a full plan eg police or Housing SA.

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