The Review

of the Mental Health Act 2009

A Report by the Chief Psychiatrist

of South Australia

May 2014

Government of South Australia
SA Health

For more information

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Hon Jack Snelling MP
Minister for Mental Health and Substance Abuse

Dear Minister

I am pleased to submit to you *The Review of the Mental Health Act 2009* for presentation to each House of Parliament, in accordance with section 111 of the Act.

The Review provides an account of matters that have come to light in the first four years of operation of the Act and issues raised in the course of broad consultation, with particular focus on the rights of individuals and the capacity to deliver effective services.

The Review weighs these matters and issues against developments in mental health legislation, policy and best-practice across Australian jurisdictions and makes recommendations for legislative change for consideration by the Parliament of South Australia.

Yours sincerely

Dr Panayiotis Tyllis
Chief Psychiatrist
Director Mental Health Policy

23 May 2014

Foreword

Mental health legislation represents perhaps the most controversial laws that impact on public life. The capacity for health practitioners to restrict individual rights and enforce involuntary treatment under certain circumstances is questioned by many including civil libertarians, legal practitioners and patient advocates. However, such measures can be life-saving and may be the best of several difficult options for a patient or their support persons in challenging situations.

From a personal professional perspective being a psychiatrist, having powers under the Act is a responsibility that weighs heavily in each and every decision to invoke them. The ethical dilemmas that have to be reconciled in formulating the best possible action place a considerable burden on professionals tasked with providing the best mental health care to their patients.

The fundamental importance of rights-based mental health legislation is to protect and promote the rights of an individual to quality, least restrictive care, maximal autonomy and involvement of support persons, in tandem with the capacity of qualified decision-makers to have limited powers to take action in specified circumstances.

I would like to thank the people with mental illness, their families and carers, health practitioners, legal practitioners and other agencies who work tirelessly every day towards the best outcomes possible. I would like to acknowledge the individuals who have contributed their perspective on the operations of the Act since it was implemented in July 2010 and the members of the Mental Health Act User Group who have provided the breadth of expertise required to maintain the ongoing evolution of this complex area of legislation. Finally, I would like to thank the Manager and staff of the Office of the Chief Psychiatrist for the extensive work required to produce this review.

Dr Panayiotis Tyllis
Chief Psychiatrist

Contents

Introduction

Context 2
Methodology 3

Subjects of Inquiry

1. Advocacy and Appeals 4
2. Capacity and Consent 7
   - 2.1 Capacity and Consent 7
   - 2.1 Advance Care Directives 9
3. Carers 10
4. Children and Young People 11
5. Community Visitor Scheme 13
6. Confidentiality and Disclosure 15
7. Cross Border Arrangements 17
8. Definitions 18
9. Forms 20
10. Guiding Principles 23
11. Language 25
12. Officers authorised under the Act 26
13. Prescribed Psychiatric Treatment 28
    - 13.1 Electro Convulsive Therapy 28
    - 13.2 Neurosurgery for Mental Illness 30
    - 13.3 Other Prescribed Psychiatric Treatment 30
    - 13.4 Prescribed Psychiatric Treatment Panel 31
14. Restrictive Practice 33
15. Review of the Act 35
16. Rights 36
17. Section 56 and 57 39
    - 17.1 Care and Control 39
    - 17.2 Patient Transport Requests 42
18. Treatment Orders 43
    - 18.1 Community Treatment Orders 43
    - 18.2 Inpatient Treatment Orders 45
    - 18.3 Involuntary Treatment Threshold 48
    - 18.4 Leave of Absence 51
    - 18.5 Treatment for Any Illness 52
19. Treatment and Care Plans 53

Appendices

Appendix I – Bibliography 55
Appendix II – List of Contributors 56
Appendix II – List of Recommendations 57

INTRODUCTION

In 2005 a review of the existing *Mental Health Act 1993* was carried out by Ian Bidmeade and the Department of Health. The *Paving the Way – Review of Mental Health Legislation in South Australia Report* made a number of recommendations to modernise the Act and bring it up to date with contemporary evidence-based best practice in the provision of mental health services and the protection of human rights.

The Parliament of South Australia considered those recommendations in the drafting of new legislation and the *Mental Health Act 2009* commenced operation on 1 July 2010.

The objects of the Act are to ensure that people with mental illness receive a comprehensive range of services for their treatment, care and rehabilitation; that those services are recovery-oriented; that people retain their freedom, rights, dignity and self-respect as far as is consistent with their protection and the protection of others; and to confer limited powers to make orders for community treatment or inpatient treatment.

The Act provided improved rights for people with mental illness and their families, increased capacity for mental health services, greater clarity regarding treatment orders and powers, improved collaboration between mental health and emergency services, additional capacity for country people to be assessed and treated in the country, improved information sharing, the introduction of the Community Visitor Scheme, the introduction of the Chief Psychiatrist role, improved cross border arrangements and increased accountability and transparency.

Context

Section 111 of the Act requires the Minister to cause a report to be written on the operation of the Act and to be laid before each House of Parliament within 4 years of the commencement of the Act. That 4 years period ends on 30 June 2014.

The Act is based on contemporary rights, mental health and legislative practice. Prior to the beginning of the formal Review process, most feedback received was concerned with the detail and implementation of the Act and made recommendations for amendment rather than wholesale redrafting.

To this end the scope of the Review is focused on how the rights of people with mental illness, their families and carers, and the service delivery capacity of agencies, could be enhanced.

Methodology

The Office of the Chief Psychiatrist established the Mental Health Act User Group in August 2010 to monitor, evaluate and provide advice regarding the operation of the Act. The User Group comprises stakeholders who are effected by or use the Act, including people with mental illness, carers, child and adolescent mental health services, community mental health services, the Community Visitor Scheme, country mental health services, the Crown Solicitor's Office (as required), emergency departments (as required), the Guardianship Board (as required), inpatient mental health services, the Office of the Public Advocate, private mental health services, the Royal Flying Doctor Service, SA Ambulance Service and SA Police.

From 2010 the Mental Health Act User Group has maintained an Issues Register of matters concerning the operation of the Act. The Register, and any actions taken to address the matters raised, are monitored by the User Group. While a number of matters have been resolved by mental health services or the other agencies responsible, other issues were legislative in nature and have been deferred to this review.

The Review of the Act formally commenced in September 2013 with a 2-month period of public submission. In addition, targeted consultation sessions were held concurrently with a broad range of stakeholders over 3 months. Twenty three targeted consultations were held, with consumers, carers, community mental health services, emergency services, inpatient mental health services, legal practitioners, Parliamentarians, private mental health services, unions and professional bodies. A total of 45 written submissions were received.

The matters raised from the Issues Register, targeted consultations and written submissions were then collated into 3 documents: those of a legislative nature to be considered as part of the Review, those of an operational or service nature for consideration by mental health services and partner agencies, and those which concerned other legislation.

Based on the collated feedback document regarding the Act, the Office of the Chief Psychiatrist began the drafting of this Report in 2014, considering developments in international human rights, the review and commencement of mental health legislation in other Australian jurisdictions and the diverse opinions of the people of South Australia.

A workshop was convened in April 2014 inviting individuals and agencies who had participated in the review to further debate and elaborate key of issues of particular complexity and importance. The additional detail gained informed the final drafting of this work, the *Review of the Mental Health Act 2009 – A Report by the Chief Psychiatrist of South Australia.*

The Review is submitted to the Minister for presentation to both Houses of Parliament, after which it will available for the consideration of consumers, carers, mental health services, other agencies, statutory officers and the public.

All South Australians working together can then inform the further improvement of the *Mental Health Act 2009.*

1. ADVOCACY AND APPEALS

The processes of advocacy, legal representation and appeals are essential to preserve and promote the rights of people with mental illness. It should be noted that the replacement of Guardianship Board with the South Australian Civil and Administrative Tribunal will see a number of reforms in the advocacy and appeals space.

1.1 Advocacy

Matters for Consideration

- All Guardianship Board hearings, not just appeals, should have the capacity for legal representation paid for by the Minister.
- There is inequity in the capacity of patients and health practitioners to provide supporting evidence in the form of medical reports for treatment order applications and appeals.

Discussion

Legal Representation

Section 81 of the Act provides for a person to appeal against a treatment order made by a health practitioner to the Guardianship Board. Section 84 provides for the person to be represented at that appeal by a legal practitioner at no cost to the person, with the practitioner's fees paid by the Minister under a regulated scheme. The person can also have a legal representative of their own choosing.

Sections 70 and 73 of the *Guardianship and Administration Act 1993* have similar provisions for people who wish to appeal a treatment order made by the Guardianship Board to the District Court and can have legal representation paid for by the Attorney-General.

Neither Act provides for legal representation (at no cost to the person) at Guardianship Board hearings to consider applications for level 2 community treatment orders or level 3 inpatient treatment orders.

The provision for legal representation at Guardianship Board hearings to consider treatment order applications would be in line with the objects of the Act and the principle of procedural fairness. The provision of legal representation at application hearings may reduce the number of appeals against these orders, as legal matters could be resolved for the most part at the hearing rather than later at appeal. The ability to appeal against a decision of the Board would remain. Overall, the total number of occasions of legal representation would probably moderately increase, with the probable moderate increase in cost being borne by the Department for Health and Ageing.

It is recommended that legal representation at no cost to the patient be extended, from appeals to the Guardianship Board regarding treatment orders made by health practitioners, to the Guardianship Board hearings to consider applications for level 2 community treatment orders and level 3 inpatient treatment orders, for example:

> *84(1) In every appeal to the Board under this Part, and applications to the Board under section 16 and 29, the person to whom the proceedings relate is entitled to be represented by counsel in accordance with this section.*

Medical Reports

Procedural fairness requires that both parties to a proceeding should have the same representation and evidentiary rights, as relevant to the proceedings underway. For proceedings to hear applications for or appeals against treatment orders, a patient does not have access to the same resources as health practitioners for medical opinions. To address this matter, the recommendation from section 16 of this report to introduce a right for a second psychiatric opinion

would enable patients and their legal representatives to request a second medical opinion and the report produced in that process could be tendered as part of the Guardianship Board hearing.

Recommendations

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.

1.2 Hearings and Appeals Body

Matters for Consideration

> A specialist tribunal should consider mental health matters.

Discussion

The *South Australian Civil and Administrative Tribunal Act 2013* which comes into operation in July 2014 will reform hearings and appeals regarding mental health matters through the establishment of the South Australian Civil and Administrative Tribunal (SACAT), which will replace the Guardianship Board as the body independent of mental health services to make and/or review treatment orders, ECT consent and some cross-border arrangements. SACAT will also replace the diversity of other Tribunals and Review Bodies across Government.

SACAT may establish specific lists or streams of expertise for different matters, including the appointment of a Deputy President, Magistrates, Senior Members, Ordinary Members, Supplementary Members and Assessors to consider, hear and make determinations.

The commencement of SACAT will see a number of reforms to hearings, reviews and appeals which will address most of the process matters raised below in section 1.3 of this report.

It is recommended that a specific dedicated Mental Health List or Stream of SACAT be established to hear all mental health matters.

Recommendations

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

1.3 Hearings and Appeals Processes

Matters for Consideration

> Appeals against orders of the GSB should be heard de novo (from the beginning).
> Appeals are often made on the technical validity of a form, rather than whether the criteria and processes of the Act were met.
> Board membership for appeals should be more than 1 psychiatrist.
> Should hearings and appeals be able to be held via audio-visual conferencing.
> There are no limits to the number of appeals that can be made against one order, or against an order made subsequent to a previous order being revoked.

Discussion

Appeals and Form Validity

Treatment orders are sometimes appealed, and the appeal upheld, due to the technical validity of the form used, rather than whether the person met the criteria of the Act for the order and whether the health practitioner followed the correct process. This can lead to people who are acutely unwell having their order revoked by the Guardianship Board and a new order immediately made by mental health services to protect the person's health and safety. Subsection 101(1) provides that

an order, notice or instrument of the Act will be valid, despite non-compliance with a requirement of the form or contents of the document, if the intended meaning and effect are reasonably apparent. Subsection 101(2) provides that a clerical error, omission or misdescription of a person in an order, notice or instrument may be corrected by the person who wrote the document, by a psychiatrist confirming or varying the document, or by the Guardianship Board. These provisions address the issue of minor or moderate errors, by confirming the validity of the document or allowing its correction, which should only bring major errors to the consideration of the Board. It is recommended that SACAT consider the provisions of section 101 and how they may be incorporated into SACAT proceedings.

Appeals as Re-hearing or De novo

Conceptually, appeals against a decision can be made as a re-hearing, where only the evidence available and the patient's risk at the time of the making of the order should be considered, or *de novo*, or as new, where the evidence available and the patient's risk now should be considered.

The SACAT Act requires reviews of previous decisions to consider both the evidence and risk at the time the order was made and the evidence and risk at the time of the review, affording a full exploration of the rights of and risks for the person. Amendment of the Act is not required.

Audio-Visual Conferencing

Audio-visual conferencing is used from time to time for Guardianship Board hearings for people who live in country areas or for whom it would be unsafe or not practicable to move from their acute mental health setting. While a face to face hearing is preferable for all proceedings, as it is easier for all parties to communicate and understand each other, it is not always possible. To require transport to a hearing by ambulance or police, possibly under duress when a reasonable alternative is available, is not in keeping the least restrictive principle of the Act. The Act does not and should not provide any constraints to how the Guardianship Board should carry out hearings.

Board Membership

The *Guardianship and Administration Act 1993* and regulations provide for mental health Boards hearing appeals to comprise 1 or 3 members. A Court decision in 2012 found that at least one member of such Boards must be a psychiatrist. Since late 2012 all appeal hearings have been heard by Boards consisting of one psychiatrist. This may abrogate a person's rights by denying them a hearing by a Board including a legal practitioner and/or community member, and requiring the psychiatrist Board member to review the decision of another psychiatrist. The SACAT Act provides for Tribunals to be composed of up to 3 members, with those members drawn from a range of legal, professional and community backgrounds, dependent on the nature and requirements of the proceedings at hand. It is recommended that SACAT consider fairness of procedure for people with mental illness when considering the membership of Tribunals to hear mental health matters.

Multiple Appeals

The SACAT Act has specific provisions for proceedings that are frivolous, vexatious or calculated to cause delay. Amendment of the Act is not required.

Recommendations

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.

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

2. CAPACITY AND CONSENT

The criteria for actions taken under the Act are based on mental illness and risk of harm. Evolving evidence-based best practice, international human rights and the legislation of other Australian jurisdictions champion the inclusion of capacity, so that people with mental illness can be involved in decision-making for their treatment and care to the extent they are capable at any particular time.

2.1 Capacity and Consent

Matters for Consideration

- The Act provides for decisions to be made on the basis of illness and risk, not capacity.
- Patients need to participate in decisions and planning for their treatment and care to their current level of capacity.
- New capacity content of the Act should match the intent and provisions of the *Advance Care Directives Act 2013.*

Discussion

Capacity Criteria for Involuntary Treatment

See section 18 of this report.

Guiding Principle

The guiding principles of the Act require treatment and care to be as least restrictive as possible and to involve the participation of people with mental illness and their carers and families in the planning and delivery of that care as far as practicable and appropriate. The guiding principles do not currently reference a person's directions or wishes. It is recommended that a guiding principle be introduced to section 7 requiring that the directions and wishes of a person should be taken into consideration as far as reasonably practical and appropriate, using the language of the *Advanced Care Directives Act 2013* provisions, for example:

> *7(m) the directions and wishes of a person, especially those given in an advance care directive, should be taken into consideration as far as is reasonably practical and appropriate;*

Decision-Making Capacity Section

People with mental illness should be involved in decision-making for their treatment and care to the extent they are capable of, within the constraints of the Act to protect them and others from harm. Capacity may be full, partial, varying or absent and may be moderated by an advance care directive or a substitute decision-maker. A person's directions or wishes cannot deny involuntary treatment, if a health practitioner who has examined the patient has ordered it, but can, if it is safe and appropriate to do so, guide the form of that involuntary treatment.

The *Advance Care Directives Act 2013* provides a contemporary framework for capacity and substitute decision-making and the proposed additions below match the provisions of that Act, for consistency and improved understanding by all stakeholders. It is recommended that a decision-making capacity Part be introduced to the Act between Part 2 objects and guiding principles and Part 3 voluntary inpatients, with sections describing impaired decision-making capacity, substitute decision-makers and mandatory medical treatment, for example:

> *Part 2B – Decision-making capacity*
> *7B – Decision-making capacity for the purposes of this Act*
> *(1) A person is presumed to have decision-making capacity, subject to subsections (2) and (3).*
> *(2) A person will be taken to have impaired decision-making capacity in respect of a particular decision if -*
> *(a) the person is not capable of –*

(i) understanding any information that may be relevant to the decision (including information relating to consequences of making a particular decision); or
(ii) retaining such information; or
(iii) using such information in the course of making the decision; or
(iv) communicating his or her decision in any manner; or

(b) the person has satisfied any requirements in an advance care directive given by the person that sets out when he or she is to be considered to have impaired decision-making capacity (however described) in respect of a decision of the relevant kind.

(3) Determinations under subsection (2)(a) must consider that –

(a) a person will not be taken to be incapable of understanding information merely because the person is not able to understand matters of a technical or trivial nature; and
(b) a person will not be taken to be incapable of retaining information merely because the person can only retain the information for a limited time; and
(c) a person may fluctuate between having impaired decision-making capacity and full decision-making capacity; and
(d) a person's decision-making capacity will not be taken to be impaired merely because a decision made by the person results, or may result, in an adverse outcome for the person.

(4) Notwithstanding a determination under subsection (2)(a) a person may have partial or varying decision-making capacity depending on support and the complexity of the decision to be made.

7C – Substitute decision-maker

(1) A substitute decision-maker is a person who can make decisions on a person's behalf regarding health care, living arrangements and other personal matters in accordance with the Advance Care Directives Act 2013.

(2) In the absence of an advance care directive with instructions for a substitute decision-maker, a responsible person can be determined in order of preference from –

(a) a Guardian; or
(b) a substitute decision-maker nominated in a signed advance care plan; or
(c) a prescribed adult relative (with a close and continuing relationship) –
(i) a spouse or domestic partner; or
(ii) an adult related by blood, marriage or adoption; or
(iii) an adult related by Aboriginal or Torres Strait Islander kinship; or
(d) an adult friend (with a close and continuing relationship); or
(e) an adult charged with overseeing the day-to-day care of the person; or
(f) the Guardianship Board.

7D – Mandatory medical treatment

(1) Medical treatment ordered under section 56 of this Act, a community treatment order or an inpatient treatment order cannot be refused by –

(a) a person with full, partial or varying capacity; or
(b) the directions of an advance care directive; or
(c) a substitute decision-maker;

(2) Notwithstanding subsection (1) a medical practitioner must take into account the directions and wishes of a person, an advance care directive or a substitute decision-maker as far as is reasonably practical and appropriate.

Recommendations

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.

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.

2.2 Advance Care Directives

The *Advanced Care Directive Act 2013* introduces advance care directives, whereby a competent adult can make directions about health care, end of life, living arrangements, other personal matters and substitute decision-makers for the future when they may not have capacity.

Matters for Consideration

> A consequential change to the *Advanced Care Directive Act 2013* should be made to include medical treatment provided under section 56 in the definition of mandatory medical treatment in section 12 of the *Advanced Care Directive Act 2013.*

> The Act should reference the *Advanced Care Directive Act 2013*.

Discussion

Consequential Amendment

Section 12 of the *Advance Care Directives Act 2013* does not allow the inclusion of provisions in an advance care directive that are unlawful, contravene professional codes of conduct or refuse mandatory medical treatment. Mandatory medical treatment is defined as medical treatment ordered under a community treatment order or inpatient treatment order. However, this definition excludes medical treatment which may be ordered for a person subject to section 56 care and control, placing the person and the service at risk. It is recommended that treatment provided under section 56 should be included in the definition of mandatory medical treatment, for example:

> *(1) In this section –*
> *mandatory medical treatment means –*
> *(a) medical treatment ordered under a community treatment order, an inpatient treatment order or section 56 of the* Mental Health Act 2009; *or*

Referencing the *Advance Care Directives Act 2013*

The Act does not reference the *Advanced Care Directive Act 2013*, which may create confusion for patients, carers, mental health services and other agencies. It is recommended that definitions for advance care directives, advance care plans and substitute decision-makers be introduced to section 3 definitions, for example:

> *advance care directive means a legal directive made by a person regarding health care, living arrangements, other personal matters and substitute decision-makers in accordance with the* Advance Care Directives Act 2013;
>
> *advance care plan means any formal plan, for an example an Ulysses Agreement, made by a person regarding health care, living arrangements and other personal matters which must be taken into consideration as far as practicable by substitute decision-makers, carers and services;*
>
> *substitute decision-maker means a person who can make decisions on a person's behalf regarding health care, living arrangements and other personal matters in accordance with the* Advance Care Directives Act 2013;

Recommendations

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.*

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.*

3. CARERS

The Act recognises the vital role carers play in the treatment, care and support of people with mental illness, in line with the provisions of the *Carers Recognition Act 2005* and the standards and principles of the Carer's Charter.

Matter for Consideration

> Should South Australia adopt a formal carer nomination process similar to New South Wales.

Discussion

The *Mental Health Act 2007* of New South Wales makes provisions for a primary carer of a patient, including a formal nomination process and a description of who is appropriate for the role if a formal nomination has not been made. These provisions are helpful but are restricted to the processes of the *Mental Health Act 2007* alone and do not provide more broadly for carer's rights or participation in a patient's care.

The provisions of the South Australian *Carer's Recognition Act 2005, Mental Health Act 2009* and *Advance Care Directives Act 2013* provide a much broader platform for the rights, concerns and participation of carers in the lives of people with mental illness. However, the understanding and implementation of the legislation by mental health services and other agencies is inconsistent and all partners – people with mental illness, carers, mental health services, other agencies, advocates and statutory officers – must continue to pursue education in and adherence to the legislative and policy requirements for carers' rights and participation.

It is recommended that a formal primary carer process should not be included in the Act.

4. CHILDREN AND YOUNG PEOPLE

The Act recognises the special vulnerability of children and young people and makes a number of provisions to afford them additional considerations and protections.

Matters for Consideration

- The Act should have consistent provisions for defining children within the Act.
- The Act should recognise the specific needs and developmental stages of children and young people.
- The Act should articulate a much stronger statement about the protections that need to be in place for the children of adults with mental illness.
- The Act should mandate the separate treatment of children and young people from adults.
- If a child has a guardian the parents of the child may also have rights to be kept informed.

Discussion

Children of Adults with Mental Illness

Children of parents with a mental illness to which the Act applies may experience greater vulnerabilities and risks at times when the parent's capacity to manage their acute distress and mental illness may impact on parental responsibilities. The safety, welfare and rights of the child are paramount. In 2005 the Paving the Way Report highlighted the importance of children with mental illness and children at risk because of mental illness of others.

With the introduction of Advance Care Directives it is anticipated that parents and guardians will be able to make adequate provision for substitute carers in times when they are do not have the capacity to care for their children or dependants. Operationally, treatment and care planning should involve specific strategies for assisting the person to manage their health, wellbeing and parental responsibilities. When risk to children is identified reporting under the *Child Protection Act 1993* must be adhered to.

Subsection 7(1)(f) states that the rights, welfare and safety of the children and other dependants of patients should always be considered and protected as far as possible. The use of "as far as possible" is different from other sections of the Act, where "as far as practicable" is used, reinforcing the imperative to protect children and other dependents. It is recommended that the rights of the children of adults with mental illness be strengthened by the addition of "young people" as a category, for example:

> *7(1)(f) the rights, welfare and safety of children, young people and other dependents of patients should be considered and protected as far as possible;*

Decision Making Capacity

The Act qualifies the capacity of children to make decisions in section 4 (application of the Act to children) and section 42 (electro convulsive therapy) by providing that a right conferred to a person under 16 may be exercised by their parent or guardian but that the rights of a child 16 years or older remain with the child. This provision and the new decision-making provisions recommended in section 2.1 of this report allow for children to participate in decision-making to the extent they are able. It is recommended that a specific capacity section for children is not required, but that reference to the proposed decision-making capacity provisions may be needed in section 4, depending on advice from Parliamentary Counsel.

Definition

The Act defines a child in section 3 to be a person under 18 years of age. This definition matches that of the *Child Protection Act 1993* and the mental health legislation of other jurisdictions. Given the existing and proposed provisions allowing children to participate in decision making to the extent they are able (see above), it is recommended that the definition of child remain the same.

Parents to be Kept Informed

The New South Wales *Mental Health Act 2008* provides for the parents of a child to be kept informed of the use of the Act on the child, if it is safe and appropriate to do so. This balances the rights of the child and the parent in circumstances where a guardian exists. It is recommended that a similar provision be introduced to section 4, for example:

> *4(3) If a child made subject to the provisions of this Act has a parent or parents who are legally entitled to information about the child, then the parent or parents should be given copies of orders, notices and statements of rights if it is safe, appropriate and practicable to do so.*

Recognise Developmental Stages

See section 10 of this report.

Separate Treatment

Subsection 7(1)(e) of the guiding principles requires that children and young persons should be cared for and treated separately from other patients as necessary to enable the care and treatment to be tailored to their different developmental stages. This principle is worded consistently with the other principles, using “should”, rather than the definitive “must” of actions taken to make someone subject to the provisions of the Act. The inclusion of “as necessary” also provides mental health services the capacity to treat the child or young person in the environment best suited for their needs, which for some very young children might be with their mother or father and for some older teenagers be with adults. To replace “as necessary” with “must” would constrain services from adapting to the individual’s needs. It is recommended that no change be made to subsection 7(1)(e).

Recommendations

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

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.

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.

5. COMMUNITY VISITOR SCHEME

The Act introduced a community visitor scheme to conduct visits to and inspections of treatment centres, advocate for patients to promote the proper resolution of issues and refer matters of concern to the Minister, Chief Psychiatrist or mental health services.

Matters for Consideration

- Forensic mental health patients are excluded from the Scheme's scope.
- The Act should provide detailed requirements for the annual report of the Principle Community Visitor.
- The expansion of the Scheme into supported residential facilities could be facilitated through regulations to the Act.
- The term of the statutory Principal Community Visitor position is shorter than most statutory positions.
- There is no capacity for the Principal Community Visitor to conduct monthly inspections alone if a second Community Visitor is unavailable.
- Treatment centres and inpatient services are the only mental health services within scope of the Scheme.

Discussion

Facilities and Services in Scope

Section 51(1)(a) provides for community visitors to visit and inspect treatment centres. Treatment centres comprise 12 approved treatment centres in metropolitan Adelaide and 3 planned limited treatment centres in country South Australia. No community-based services or facilities are provided for, denying people receiving treatment and care from community mental health services, community rehabilitation centres or intermediate care centres the further protection of their rights that the Scheme affords. It is recommended that the constraints in section 51 and 52, which limit visits to treatment centres on a monthly basis, are amended to allow the Regulations to determine the services and facilities within scope and the timeframes for visits and inspections, for example:

> *51(1)(a) to conduct visits to and inspections of any mental health services and facilities prescribed in the Regulations;*
>
> *52(1) each mental health service and facility nominated in the Regulations must be visited and inspected regularly in accordance with the timeframes determined in the Regulations.*

Forensic Mental Health Patients

To bring forensic mental health patients within the community visitor scheme scope an amendment to the section 3 definition of a patient is required. See section 8 of this report.

Reporting

The Act requires the Principal Community Visitor to provide an Annual Report to the Minister by 30 September each year, to be laid before both Houses of Parliament. The Act does not specify the content of the report other than "on the work of the community visitors". It is recommended that greater detail be described for the report, for example:

> *54(1) The Principal Community Visitor must, on or before 30 September in every year, forward a report to the Minister on the work of the community visitors during the financial year ending on the preceding 30 June, including information on:*
> *(a) the number of visits and inspections conducted; and*
> *(b) the number of occurrences of advocacy for patients; and*
> *(c) the number of matters of concern referred to appropriate persons or bodies; and*
> *(d) the nature and themes of inspection findings, issues of advocacy and matters of referral; and*
> *(e) the outcomes of visits and inspections, advocacy and matters referred.*

Principal Community Visitor Term

Section 50(3) provides that appointment to the Principal Community Visitor position or a Community Visitor position will be for a term of 3 years and that a person cannot hold a position for more than 2 consecutive terms. Three year terms for the Principal Community Visitor position does not match the terms of similar statutory roles here or interstate, for example: Commissioner for Victim's Rights 5 years, Health and Community Services Complaints Commissioner 7 years, President of the Guardianship Board 5 years, Public Advocate 5 years, the TAS Principal Official Visitor 5 years and the WA Chief Mental Health Advocate 5 years. It is recommended that Community Visitors retain a 3 year term but that the Principal Community Visitor be extended to have 5 year terms, for example:

> *50(3A) A person will be appointed to the position of Principal Community Visitor on conditions determined by the Governor and for a term, not exceeding 5 years, specified in the instrument of appointment and, at the expiration of a term of appointment, will be eligible for reappointment.*
>
> *50(3B) A person will be appointed to the position of Community Visitor on conditions determined by the Governor and for a term, not exceeding 3 years, specified in the instrument of appointment and, at the expiration of a term of appointment, will be eligible for reappointment.*

Supported Residential Facilities

It has been suggested that the Act could be amended to facilitate the expansion of the community visitor scheme into the supported residential facilities sector. However, the inclusion of provisions relating to a sector already governed by other acts and contracts in the Act would be problematic at best. It is recommended that the inclusion of supported residential facilities in the scope of the community visitor scheme should be pursued through the amendment of the *Supported Residential Facilities Act 1992* or the drafting of a new *Community Visitor Scheme Bill.*

Visits and Inspections

The Act requires the scheduled visits and inspections that occur every month to be undertaken by 2 or more community visitors. On occasion this is impossible due to illness or the logistics of a scheduling process with many variables. It is recommended that the Principal Community Visitor have the power to conduct visits and inspections alone as required by the circumstances, for example:

> *52(2B) In respect to subsections (1) and (2) where a visit by 2 community visitors is impractical, a visit may be conducted by the Principle Community Visitor alone.*

Recommendations

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

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

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

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

6. CONFIDENTIALITY AND DISCLOSURE

Information about people with mental illness has been subject to competing paradigms over time, from not recognising individual's rights to privacy to not allowing disclosure to others involved in treatment and care. The current confidentiality and disclosure provisions are balanced and allow decisions to be made on a case by case basis.

Matters for Consideration

- Consider the findings of the *Paving the Way* Bidmeade Report.
- Section 98 requires the director of a treatment centre to keep a register of voluntary and involuntary inpatients. There are no such provisions in the *Health Care Act 2008*.
- Subsection 99(1) provides for the Minister to disclose basic information, duplicating powers under section 106.
- Subsection 99(2) requires the director of a treatment centre to give copies of orders and other documents to a patient on discharge, duplicating requirements under Parts 3, 4, 5, 8, 9 and 10.
- Subsection 106(4) permits the disclosure of information against the person's wishes if they are subject to a treatment order, abrogating that person's rights.
- The requirement for a register of mental health patients is discriminatory.

Discussion

Section 106 – Confidentiality and disclosure of information

The current confidentiality and disclosure provisions are sophisticated and balance the rights of individuals to privacy against the need to disclose information for effective service delivery and preserve safety. Section 106 requires that information is confidential unless disclosure is required: by request or consent of the person, by law, to lessen or prevent a serious threat to life or safety, or for the treatment, care or rehabilitation of the person. Disclosure of information to a relative, carer or friend is specifically allowed, if reasonably required for the person's treatment, care and rehabilitation and not contrary to the person's best interests. Information may be disclosed against a person's will if they are subject to a treatment order but only if that information is reasonably required for the person's treatment, care and rehabilitation and is not contrary to the person's best interests.

The current provisions embody the findings of the Bidmeade Report and reflect the provisions found in other Australian jurisdictions' legislation, though written more succinctly. It is recommended that section 106 remain unchanged.

Section 98 – Register of patients

Section 98 requires the director of a treatment centre to keep records relating to voluntary and involuntary inpatients. This section dates from a time when community mental health services did not exist and treatment centres were stand-alone institutions run as separate service entities from the rest of SA Health. These provisions do not include community patients. An equivalent section is not included in the *Health Care Act 2008* for medical and surgical inpatients or community patients. Record requirements for medical and surgical patients are outlined in standards and procedures only, not in legislation. It is recommended that section 98 be removed. Alternatively, if a reference to keeping records is required, a broad requirement of the Minister or Chief Executive to ensure records are kept would suffice and would match the other broad requirements of the Minister in section 86. Indeed, the provision to keep a register or maintain records could be moved to section 86. Example provisions might read:

> *86(j) to ensure records are kept relating to every person receiving mental health treatment and care, and that those records set out information that enables effective treatment and care of patients, the monitoring of mental health services and the administration of this Act;*

Section 99 – Particulars relating to admission of patients to treatment centres

Subsection 99(1) requires the Minister to provide information regarding whether a person has been a voluntary or involuntary mental health patient, and their admission and discharge dates, to any person who requests that information and has a proper interest in the matter. This subsection is a remnant from former Mental Health Acts which had a custodial rather than therapeutic nature and does not reflect current community, mental health service or legislative standards regarding rights. There are no similar requirements for the Minister to provide information about medical or surgical patients under the *Health Care Act 2008*. Information regarding mental health patients can be lawfully and appropriately disclosed using section 106 of the Act. Subsection 99(1) is unnecessary and discriminatory.

Subsection 99(2) requires the director of a treatment centre to provide a patient on discharge with a copy of any orders, certificates or authorisations on which they were admitted or treated. This provision duplicates the provisions in Parts 3, 4, 5, 8, 9 and 10, relating to statements of rights, treatment orders, transport requests and cross-border arrangements, that require the director of a treatment centre to provide information and copies of documents to patients, and carers, relatives or friends if appropriate. In addition, a patient is able to request copies of their own information through the *Freedom of Information Act 1991.* Subsection 99(2) is unnecessary.

Given the unnecessary and discriminatory nature of subsection 99(1) and the redundancy of subsection 99(2), it is recommended that section 99 be removed.

Recommendations

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

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.

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

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.

7. CROSS BORDER ARRANGEMENTS

Part 10 of the Act provides for the transfer of care of patients under community treatment orders and inpatient treatment orders between South Australia and other Australian states and territories. The provisions of this Part are particularly complex and their practical operation made even more so dependent on the clinical situation, the existence of a Ministerial Agreement with the state or territory and the requirements of that Ministerial Agreement and/or the corresponding law of the other state and territory.

Matters for Consideration

- Part 10, Arrangements between South Australia and other jurisdictions, should be streamlined.
- Section 71 provides for a person subject to an interstate inpatient treatment order to be transferred to a South Australian treatment centre and that the Act applies as if a level 1 inpatient treatment order had been made upon the time of admission. The form and notification requirements of this section should be articulated.
- Subsections 76(1)(d) and (e) provide for a person on an interstate inpatient treatment order to be taken to a South Australian treatment centre and treated as an involuntary inpatient, including being given treatment authorised by a medical practitioner who has examined the patient, pending transport to an interstate treatment centre. Time constraints are not provided.
- Subsections 77(1) and (2) provide for a South Australian authorised officer who comes across a person in another state on a South Australian inpatient treatment order in the custody of an interstate officer can only transport the patient to South Australia if there is a Ministerial agreement.
- The Act allows a number of actions only if there is a Ministerial Agreement with the state or territory in question, even though the actions may be permitted by the legislation of both jurisdictions, have bilateral psychiatric approval and be in the patient's best interests, reducing options for the patient, families, South Australian services and interstate services.
- The Police cross-border arrangements between South Australia and Western Australia may provide a good example processes to consider.

Discussion

Cross border arrangements are one of the more complicated sections of the Act and are subject to lengthy provisions, changing corresponding Law in other jurisdictions and the content of Ministerial Agreements. Given the complexity of these matters, and the changing of the landscape with new mental health legislation being commenced or considered in the Northern Territory, Victoria and Western Australia in 2013 and 2014, it is recommended that this section of the Report be deferred until late 2014, when the implications of the legislative changes in other states can be considered fully. The deferred section can then be examined with the rest of the Report and included in the further processes of consideration by the Minister, Parliament and the community.

In the meanwhile, the Office of the Chief Psychiatrist released the Cross Border Arrangements – Transferring the care of Mental Health Patients between South Australia and Other States and Territories Chief Psychiatrist Standard and Plain Language Guide in January 2014, which provides guidance for mental health services on service options and legislative requirements under the current Act.

Recommendations

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.

8. DEFINITIONS

Amendment and addition to the definitions in the Act is required to further protect the rights of people with mental illness and improve service provision capacity.

Matters for Consideration

> Consideration should be given to the definitions of the Act, including: authorised health professional, authorised medical practitioner, care and control, child, director of a treatment centre, mental illness and patient

Discussion

Authorised Health Professional

See section 12 of this report.

Authorised Medical Practitioner

See section 12 of this report.

Care and Control

See section 14 of this report.

Children and Young People

See section 4 of this report.

Director of a Treatment Centre

Section 3 defines the director of a treatment centre as the person for the time being in charge of the centre or a person duly authorised to admit patients to the centre. A director has a number of functions under the Act which are often delegated to other staff. The existing definition creates difficulty for services because although the Act recognises the director of a treatment centre, no treatment centre has such a position, requiring the Chief Executive with oversight of the treatment centre to delegate powers. To improve clarity and practicality it is recommended that all references to "director of a treatment centre" should be amended to "director of mental health services of a treatment centre" throughout the Act and that the definition of director in section 3 be amended, for example:

> *director of mental health services of a treatment centre means the person registered as a specialist Psychiatrist holding or acting in a position with lead clinical responsibility for mental health services at the treatment centre;*

Mental Illness

Section 3 of the Act defines mental illness as "any illness or disorder of the mind", qualified by Schedule 1 – certain conduct may not indicate mental illness. A number of submissions made the case that the definition of mental illness should be further refined. However, the Bidmeade Report also considered the definition of mental illness and found "a significant concern was that people in need of help might be excluded from assistance with too much definition." The report concluded "we tend to the view that the definition of mental illness should not be over prescriptive. The most significant issue is the need for intervention, wherever possible on a voluntary basis, and where some restriction is required, it is in the least restrictive form or alternative." It is recommended that no change be made to the definition of mental illness.

Patient

The Act currently defines a patient as a voluntary inpatient, a person subject to a community treatment order and a person subject to an inpatient treatment order, excluding voluntary community patients, a person subject to section 56 or 57 care and control powers, forensic mental health patients who have been ordered into the custody, supervision and care of the Minister and mental health services by a Court under the *Criminal Law Consolidation Act 1935,* and prisoners who may be receiving mental health services. These exclusions preclude those groups from the

rights and protections of the Act and create difficulties for service providers. It is recommended that these groups be included in the definition of a patient, for example:

a patient means -
(a) a voluntary community patient; or
(b) a voluntary inpatient; or
(c) a person to whom section 56 or 57 powers apply; or
(d) a person to whom a community treatment order applies; or
(e) a person to whom an inpatient treatment order applies; or
(f) a prisoner receiving voluntary or involuntary mental health treatment and care; or
(g) a person to whom a section 269O, 269U or 269X order of the Criminal Law Consolidation Act 1935 applies;

Recommendations

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.

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.

9. FORMS

The Act requires a number of forms to be used to carry the powers of the Act into effect. Each form must have its content and design approved by the Minister. The Office of the Chief Psychiatrist has worked with consumers, carers, health practitioners, legal practitioners, other agencies, record managers, statutory officers and other stakeholders to develop forms which balance the protection of individual rights against practicality of use for health and other services.

Matters for Consideration

- All forms should be simplified to reduce technical errors and concomitant legal challenges.
- All forms should have the "suburb" field changed to "suburb/town".
- All forms should have the Chief Psychiatrist and Guardianship Board fax and telephone numbers on them.
- As treatment order expiry is fixed at 2pm, the forms should all state 2pm rather than having a free text field to be filled in.
- Greater clarity is needed for the use of electronic forms and approvals to carry the Act into effect.
- Inpatient treatment order forms should include the name of the treatment centre the person is destined for.
- Notification requirements should be simplified.
- Treatment order forms should include the reason for the order.

Discussion

Expiry Time of Treatment Orders

All treatment orders expire at 2pm unless revoked at another time. It is recommended that treatment order forms should have the expiry time stated as 2pm, rather than providing a field for the health practitioner making the order to complete.

Electronic Forms

Queries have been raised regarding the validity of forms and approvals made electronically. As many agencies move towards electronic records systems this question is of particular focus, with SA Health currently implementing EPAS across metropolitan and some country hospitals. The Act provides for orders, applications and consents to be in the form approved by the Minister. To offer clarity on this matter it is recommended that the Minister approve the validity of electronic and paper versions of the forms required by the Act and that provisions are introduced to the Act, for example:

> *5B – Written and electronic documentation*
> *(1) A reference in this Act to documentation or an instrument made in writing in the form approved by the Minister includes written and electronic forms of that documentation or instrument.*
> *(2) An electronic form of a document or instrument includes forms that may be found in electronic records systems and electronic communication systems.*

General

Three general issues regarding forms have been raised: that the "suburb" field is Adelaide-centric and should be changed to "suburb/town, that the telephone and facsimile numbers for the Chief Psychiatrist and Guardianship Board should be on forms to make notifications easier and quicker, and that the forms should be simplified to enhance usability and reduce technical errors and challenges. It is recommended that the Office of the Chief Psychiatrist amend the forms and submit them to the Minister to consider for approval.

ECT Consent

See section 13.1 of this report.

Notification of Treatment Orders

See sections 18.1 and 18.2 of this report.

Reason for Treatment Orders

The current treatment order forms require the health practitioner making the order to formally acknowledge that the involuntary treatment criteria have been met: that it appears to the health practitioner that the person has a mental illness, is at risk of harm (including from the continuation or deterioration of their condition) and that there is no less restrictive means of treatment available. The forms do not require a diagnosis or a description of the person's appearance or behaviour to make an order. Though not on the forms, it is accepted clinical practice to document appearance, behaviour and possible diagnosis in a person's medical records, and to discuss the reasons for making the order with the person and their carer and family if and when it is safe and therapeutically appropriate to do so.

Diagnosis or a description of appearance or behaviour was not included when the forms were drafted: to preserve the confidentiality and dignity of the person, because a diagnosis made in the field may not be accurate though the person still needs involuntary treatment, a presentation in the community or in an emergency situation may be too complex to accurately notate on the form at the time, and the placement of a diagnosis or the person's appearance or behaviour on the form would sometimes focus the attention of consumers, carers and legal practitioners on the accuracy of those statements, rather than the requirements of the Act, which are that it appears the person has a mental illness and is at risk of harm. The focus of questioning the validity of an order should be: did the person appear to have a mental illness and be at risk, and did the health practitioner follow all the requirements of the Act regarding the order.

The countervailing arguments are that: a person should be entitled to know why their usual rights and liberty are being suspended, greater fairness of procedure is afforded by the addition of a description, and challenges to the validity of an order should be able to include such a descriptive statement as a record of events at the time the order was made.

Both points of view are valid. Most health practitioners would opt for no diagnosis or description and most legal practitioners would opt for the inclusion of a diagnosis or description. Consumers and carers have diverse opinions on this matter, with the weight slightly in favour of no inclusion. Given the balance of pros, cons and opinion, and that the current forms meet the requirements of the Act, it is recommended that treatment order forms remain the same and do not require a diagnosis or description of the appearance or behaviour of a person.

Treatment Centre Nomination for Treatment Orders

The current inpatient treatment order forms do not require the health practitioner making the order to nominate a particular treatment centre for admission. The forms were drafted in this manner to cater for the contingencies of orders being made in the community and/or in emergency situations where the treatment centre the person arrives at may not be the one originally planned for. Additionally, the Act provides for treatment in or transport to "a" treatment centre, not the "nearest" or the "nominated" treatment centre.

The opposing argument posits that nomination of a particular treatment centre is required to ensure fairness of process by providing as much information as possible, which can be used by the person and any advocates to understand what is happening and make challenges if they wish.

On balance, the introduction of such a requirement would not be consistent with the principles of the Act by focussing attention and challenges on whether the person was taken to the "correct" treatment centre (as was observed under the 1993 Act), rather than if the health practitioner was justified in making the order and what are the immediate treatment and care needs of the patient. Any such introduction would also make carrying orders into effect more difficult for health

practitioners, SA Ambulance and the SA Police as people made subject to orders would more frequently be taken to one treatment centre initially and then transferred to another. It is recommended that treatment order forms should continue to not require the nomination of a particular treatment centre.

Recommendations

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

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

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

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

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

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

10. GUIDING PRINCIPLES

Matters for Consideration

- Children and young people should have their needs and protections strengthened.
- Explicit recognition of refugees and in particular survivors of torture and trauma, as a special needs group.
- International human rights agreements Australia is a party to should be included in the guiding principles.
- Subsection 7(1)(c) should separate the requirement for treatment and care plans from the specific needs of different peer groups.
- The sexual safety of women and other vulnerable individuals in mental health facilities should be provided for in the Act.

Discussion

Children and Young People

See "Needs of Different Groups" below and section 4 of this report.

International Human Rights

See section 16 of this report.

Treatment and Care Plans

Subsection 7(1)(c) of the guiding principles currently combine the requirement that services to patients should be governed by a multi-disciplinary treatment and care plan with the requirement that services should take into account the specific age and cultural needs of the patient. This does not add clarity and undervalues of the importance of both matters. Separating the requirement for treatment and care plans and using the same language as sections 39 to 40 "the treatment and care of a patient must, as far as practicable, be governed by a treatment and care plan" would add clarity. It is recommended that treatment and care plans should have a separate provision by amending the existing subsection 7(1)(c), for example:

> *7(1)(cA) the services must, as far as practicable, be governed by comprehensive treatment and care plans that are developed in a multi-disciplinary framework in consultation with the patients (including children) and their family or other carers or supporters;*

Refugees and Survivors of Torture and Trauma

The Act does recognise the specific needs of refugees generally through subsection 7(1)(c)(iii) "services should take into the account the different cultural backgrounds of patients" and section 45 where if a patient cannot communicate in English but could communicate with an interpreter, then the health practitioner carrying out the examination should arrange for an interpreter wherever possible. See section 16 of this report regarding interpreters.

However, the specific needs of survivors of torture and trauma are not recognised, nor are the needs of people who have experienced trauma from domestic, sexual or other abuse. To this end, it is recommended that subsection 7(1)(cB) be amended as below "Needs of Different Groups" to require services to take into account any experience of trauma, whether from physical or psychological abuse, rape, experience of a disaster or other event, or experience of warfare or torture.

Sexual Safety

The Act does not currently recognise the differences experienced by women, men, intersex people and people with different gender identity in mental illness and treatment and care. It is recommended that gender and gender identity be included in the differences that must be taken into account by services when delivering care. See the proposed subsection 7(1)(cB) below.

The Act also does not make any direct provision for the sexual safety of women, people with intellectual disability, lesbian gay bisexual transgender or intersex people, or other vulnerable people. This matter is significant and it is suggested that it would be addressed through the reference already proposed for subsection 7(1)(cB) (that services must take into account the needs of gender) and the introduction of a further guiding principle based on the safety and quality principles from the *Health Care Act 2008,* for example:

7(1)(l) mental health services should meet the highest levels of quality and safety;

However, greater detail on this matter is required from a policy and best-practice perspective. The Office of the Chief Psychiatrist has consulted broadly on and is drafting a Sexual Safety in Mental Health Services Policy Guideline which will provide guidance for services on keeping individuals safe from inappropriate sexual activity, and creating sexually safe environments and processes.

Needs of Different Groups

The range of cultural, developmental and experiential needs of patients should be included in the Act to guide understanding, planning and service delivery. It is recommended that the specific needs of children, young people, adults and older people, culturally and linguistically diverse people, Aboriginal and Torres Strait Islander people, gender and gender identify, and people with experience of trauma personally, in disaster or in warfare, should be taken into account when planning or providing services, for example:

7(1)(cB) the services must take into account the cultural, developmental and experiential needs of patients, including:
(i) the developmental stages of children; and
(ii) the developmental stages of young people; and
(iii) the developmental stages of adults; and
(iv) the developmental stages of older people; and
(v) the gender or gender identity needs of people; and
(vi) the traditional beliefs and practices of Aboriginal or Torres Strait Islander people; and
(vii) the cultural and linguistic backgrounds of people; and
(viii) the needs of people with personal experience of trauma or torture, including that related to domestic, disaster or warfare circumstances.

Recommendations

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.

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.

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

11. LANGUAGE

Matters for Consideration

> Not all references to “detention” or “detained” were removed from the Act in the 2012 amendments.

> The Act could be amended to refer to “persons with mental illness” rather than “mentally ill persons” in the preamble.

> The term “patient at large” should be replaced with something less stigmatising.

Discussion

Detention

In 2012 the Act was amended and the use of “detention”, “detained” and “detain” removed to reduce stigma and promote the understanding that mental illness is a health issue not a custodial issue. Instead, the Act now provides for Inpatient Treatment Orders and involuntary treatment. Not all references to “detention” or “detained” were removed during the amendment process and it is recommended that they now should be, for example from the contents list, sections 20 and 32 and schedule 2(1),(2),(3),(5) and (6). Alternatively, schedule 2, which describes the transitional arrangements for the commencement of the Act on 1 July 2010, could be removed.

Mentally Ill Person

The preamble to the Act refers to “mentally ill persons”, which creates stigma by placing illness or disorder before an individual’s personhood and citizenship. Instead, the Act should refer to people with mental illness. It is recommended that the preamble be amended, to read:

> *An Act to make provision for the treatment, care and rehabilitation of persons with serious mental illness with the goal of bringing about their recovery as far as is possible; to confer powers to make orders for community treatment, or inpatient treatment, of such persons where required; to provide protections of the freedom and legal rights of persons with mental illness; and for other purposes.*

Patient at Large

See section 18.4 of this report.

Recommendations:

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

33. That schedule 2 should be removed.

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

12. OFFICERS AUTHORISED UNDER THE ACT

The Act establishes the powers available to individuals and classes of professionals when providing care and treatment to people with mental illness. Actions are guided by best clinical practice, duty of care, professional supervision and staff experience and skill, so that not every individual in a category will exercise all the powers available to them.

Matters for Consideration

- Authorised Health Professionals should be renamed “Authorised Mental Health Professionals” to avoid confusion with Allied Health Professionals.
- MedSTAR medical practitioners, nurses and paramedics should be classified as authorised officers.
- Officers without specialist mental health training can be classed as “Mental Health Clinicians” for the purposes of the Act.
- The Chief Psychiatrist should have the power to directly appoint Authorised Health Professionals and Authorised Medical Practitioners instead of the current delegation of power from the Minister.

Discussion

Authorised Officers

Authorised officers are defined by section 3 of the Act as mental health clinicians, ambulance officers, medical officers or flight nurses employed by the Royal Flying Doctor Service, and others prescribed by the regulations. The section 3 definition of a mental health clinician then provides for the Chief Psychiatrist to classify classes of professionals as mental health clinicians for the purposes of the Act, giving them access to the powers and responsibilities of authorised officers. There is need for additional professionals to have access to authorised officer powers to bring the objects and guiding principles of the Act into effect, including medical and nursing staff of emergency departments, medical and nursing staff of country hospitals, and medical and nursing staff of the SA Prison Health Service. The current mechanism of having to classify groups as “mental health clinicians” first to convey these powers is unnecessary and creates confusion.

It is recommended that the section 3 definitions of authorised officer and mental health clinician should be amended so that the Chief Psychiatrist can directly classify a class of professionals as authorised officers and that the definition of mental health clinician should be limited to only those with appropriate tertiary qualifications, for example:

> *authorised officer means –*
> *(a) a mental health clinician; or*
> *(b) an ambulance officer; or*
> *(c) a person employed as a medical officer or flight nurse by the Royal Flying Doctor Service etc; or*
> *(d) a person of a class prescribed by the regulations; or*
> *(e) a person of a class of persons classified by the Chief Psychiatrist as authorised officers;*
>
> *mental health clinician means a person of a class of persons with recognised qualifications in the treatment and care of people with mental illness;*

The evidentiary provisions of subsection 109(c) describe that an apparently genuine document purporting to be the classification of a class of persons by the Chief Psychiatrist as mental health clinicians will be accepted as such without evidence to the contrary. In line with the recommendations above, it is recommended that the reference to “mental health clinician” be replaced with “authorised officer”.

MedSTAR is South Australia’s single emergency medical retrieval service and is responsible for providing care to the critically ill and injured throughout the South Australia and beyond. MedSTAR

retrieval team staff, comprising medical practitioners, flight nurses and paramedics, have been classified as mental health clinicians for the purposes of the Act by the Chief Psychiatrist and thus also as authorised officers. It is recommended that MedSTAR staff and other professional groups should continue to be considered and classified by the Chief Psychiatrist to have powers under the Act, ensuring timely application, evaluation, monitoring and review of any such classifications.

Authorised Health Professionals

Authorised Health Professionals are experienced mental health clinicians who are authorised by the Chief Psychiatrist, as delegated by the Minister, to be able to make level 1 treatment orders so that patients get timely access to the treatment and care they need.

The term "authorised health professional" and its abbreviation "AHP" is similar to "allied health professional", which can cause confusion for patients, services and other agencies. To provide greater clarity it is recommended that all references to authorised health professionals in sections 3, 5, 10, 12, 21, 23, 45, 75, 94, 95, 102 and 103 should be changed to "authorised mental health professionals".

The powers to appoint and regulate authorised health professionals in sections 3, 94 and 95 reside with the Minister. Those powers are currently delegated to the Chief Psychiatrist. It is recommended, as the assessment, registration, training and review of authorised health professionals are both a clinical and an operational matter, that the powers of sections 3, 94 and 95 should be transferred from the Minister to the Chief Psychiatrist. It is further recommended that a new provision be added to section 94 to require the Chief Psychiatrist to maintain records of the registration and functioning of authorised health professionals, for example:

> *94(3) The Chief Psychiatrist must ensure records are kept of the registration and functions of authorised health professionals.*

Authorised Medical Practitioners

Authorised Medical Practitioners are senior psychiatric registrars or international psychiatric specialist medical graduates who are authorised by the Chief Psychiatrist, as delegated by the Minister, to be able to act as a psychiatrist for the purposes of the Act.

The power to appoint authorised medical practitioners in sections 3 and 93 reside with the Minister. Those powers are currently delegated to the Chief Psychiatrist. As the assessment, training, registration and review of authorised medical practitioners are both a clinical and operational matter, it is recommended that the powers of sections 3 and 93 should be transferred from the Minister to the Chief Psychiatrist. It is further recommended that a new provision be added to section 93 to require the Chief Psychiatrist to maintain records of the registration and functioning of authorised medical practitioners, following the example for 94(3) above.

Recommendations:

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

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

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

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.

13. PRESCRIBED PSYCHIATRIC TREATMENT

Prescribed psychiatric treatment is defined by the Act as electro-convulsive therapy, neurosurgery for mental illness and any other treatment declared by regulation to be prescribed psychiatric treatment. The use of prescribed treatment is strictly regulated and monitored.

13.1 Electro-Convulsive Therapy

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

Matters for Consideration

- Current limits for consent (up to 12 treatments or up to 3 months, whichever comes first) mean that patients who have less-frequent periodic ECT treatment require consent applications every 3 to 6 treatments.
- Should consent for people under 16 years of age continue to be made by a parent or guardian or by the Guardianship Board on application by a health practitioner.
- The consent to ECT form (MR82J) requirement for a witness signature is a carryover from the previous 1993 Act.
- The use of reasonable force is not explicitly allowed to carry ECT into effect.

Discussion

Children

The Act allows ECT to be provided to children and young people, given consent by the young person themselves, a parent or guardian, or the Guardianship Board. ECT is only very rarely provided to young people, with no children under 16 receiving ECT in 2012-13 and only 14 young people between 16 and 24 receiving ECT in the same year out of a total of 551 people. It has been suggested that ECT for children should not be allowed. While ECT treatment is a significant step for any patient, particularly for young people, it would not be appropriate to remove a treatment that has been demonstrated to be safe, effective and potentially life-saving from consideration by the young person, their parents and the treatment team. Removing a treatment option altogether for children and young people may reduce their right to a comprehensive and effective range of services. It is recommended that ECT remain as a – rarely used – treatment option for children and young people.

The consent provisions for ECT for children and young people enable treatment to be consented to by the young person (if 16 years or older and having decision-making capacity), by the parent or guardian (if the patient is under 16) or by the Guardianship Board (on application). This means that, in line with consent for children in general health, the decision-making cascade starts with the child, then passes to the parent or guardian and then to an independent arbiter. This enables the child to exercise their rights of self-determination wherever possible, parents to exercise their rights of guardianship and for an independent arbiter to consider all matters in extenuating circumstances. It is recommended that the ECT consent provisions remain the unchanged.

The general provisions of section 4 and the ECT provisions of subsection 42(1)(c) allow that a child who has reached 16 years of age and who is capable of making decisions may give or refuse consent to ECT on their own behalf. These provisions qualify the definition of a child in the Act (as a person under 18) by enabling self-determination for young people 16 years or older. It is recommended that young people who are 16 years or older and have decision making capacity should continue to be able to consent or refuse ECT on their own behalf.

Complex Cases

Complex ECT treatment and consent matters are currently considered by treatment sites and the Guardianship Board. It is recommended that the option for referring complex cases to the Prescribed Psychiatric Treatment Panel be added, for example:

> *42(1)(c)(iv) by the Prescribed Psychiatric Treatment Panel on application by the patient, a parent or guardian, a medical practitioner or the Board under this section.*

Consent Limits

The consent provisions of the Act allow a single consent to last for up to 3 months, or 12 ECT treatments, whichever comes first. The provisions were designed to reflect the number of treatments that have been demonstrated to have therapeutic effect for patients and to ensure consent is sought regularly and is informed by the recent health and wellbeing of the patient. Some individuals require less frequent treatment over greater periods of time and some people require more intensive courses that may exceed 12 treatments and therefore require further consent to be signed. While this causes an impost of more regular paperwork and Guardianship Board proceedings for some patients, this does not warrant amending the consent provisions. It is recommended that the consent provisions remain unchanged.

Forms

The *Consent to ElectroConvulsive Therapy* form (MR82J) requires the authorisation of a psychiatrist, the consent of the patient, or their medical agent, guardian, parent or the Guardianship Board, and the signature of a witness. In addition, the psychiatrist, the anaesthetist and the ECT nurse discuss the process, potential benefits and potential side-effects of the treatment with the patient and their carer or family. The authorisation and consent are required by the section 42 ECT provisions. The witness signature field was placed in the 2009 Act forms as it was on the forms of the 1993 Act but it is not required by the 2009 Act. It is recommended that the witness signature field of the MR82J form be removed.

Reasonable Force

The Act differentiates between the administration of prescribed treatment and other treatments that may be provided to voluntary patients or involuntary patients subject to a treatment order. For ECT that differentiation requires specific consent by or on behalf of the person for a series of treatments or formal authorisation of a single emergency treatment by a psychiatrist. Consent or emergency authorisation must be made regardless of whether the person is subject to a treatment order or not. The provisions of section 42 do not provide for the use of reasonable force to ensure compliance with consent or emergency authorisation however, if the person is subject to an inpatient treatment order, reasonable force may be used to provide treatment deemed necessary by a medical practitioner who has examined the patient, including ECT. The use of reasonable force to provide ECT treatment to a patient should be a rare event only in cases of significant risk. To make it absolutely clear that the ECT provisions do not themselves allow the use of reasonable force it is recommended that subsection 42(4) be amended, for example:

> *42(4) Consent to the administration of ECT –*
> *(a) extends to the administration of anaesthesia required for the purposes of the ECT treatment;*
> *(b) may be revoked at any time by the patient or their parent, guardian or substitute decision maker;*
> *(c) does not authorise the use of reasonable force;*

Recommendations

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

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

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

13.2 Neurosurgery for Mental Illness

Neurosurgery for mental illness is a medical procedure where surgery is carried out on the brain of the patient to reduce or prevent the symptoms of mental illness. Neurosurgery is not currently practiced in South Australia.

Matters for Consideration

- Applications for neurosurgery for mental illness should be made to a Prescribed Psychiatric Treatment Panel convened by the Chief Psychiatrist.
- Neurosurgery for mental illness should always be voluntary.
- Neurosurgery for mental illness should be removed from the Act and medical practice.

Discussion

Neurosurgery in the form of leucotomies and lobotomies was conducted rarely in the past in Australia, prior to the discovery and manufacture of effective anti-psychotic medication in the 1960s and 1970s, to manage extreme and persistent behaviour. This would be unacceptable today – ethically, legally and medically – and no return to those practices is warranted or contemplated.

However, advances in technology and in understanding of the physiology of the brain have led to the development of neurosurgical procedures that may reduce or abate the otherwise intractable and severe symptoms of mental illness for a small number of individuals. One such procedure currently being used in New South Wales and Victoria trialled is deep brain stimulation, where electrodes are implanted in a patient's brain targeting specific neural circuits to deliver a tiny electrical current from a pacemaker-like device to reduce symptoms of treatment-resistant depression and intractable severe obsessive-compulsive disorder. This procedure is only used for patients with severe and persistent mental illness which does not response to medication and other therapies, and is only carried out with the patient's consent and participation. Currently in South Australia deep brain stimulation is used to treat some patients with severe Parkinson's Disease where other therapy is ineffective or not tolerated, to alleviate symptoms and allow improved quality of life.

It is recommended that the provisions for neurosurgery for mental illness remain in the Act but that all applications for neurosurgery must be considered by a Prescribed Psychiatric Treatment Panel convened by the Chief Psychiatrist, for example replacing subsection 43(b) with:

> *43(1)(b) the neurosurgery has been authorised for treatment of the illness by the Prescribed Psychiatric Treatment Panel established under section 44B; and*

Recommendations

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

13.3 Other Prescribed Psychiatric Treatment

There are currently no other prescribed psychiatric treatments subject to regulations in South Australia. An example of one treatment that could be considered for regulation is transcranial magnetic stimulation, a non-invasive procedure where a strong magnetic field is applied over the scalp to stimulate electrophysiological changes of the conscious patient in the targeted area of the brain.

Matters for Consideration

> Section 44 allows for the introduction of regulations to mandate authorisations or consents or both for other prescribed psychiatric treatment but does not restrict the making of those regulations.

Discussion

The capacity to introduce regulations to address new treatments as they emerge is laudable but that capacity itself is not regulated in any way. It is recommended that emerging treatments that may require regulation should be submitted to a Prescribed Psychiatric Treatment Panel, convened by the Chief Psychiatrist, for consideration from an ethical, legal and medical perspective. An amendment to section 44 would enable this, for example:

44(4) The regulations must be considered by the Prescribed Psychiatric Treatment Panel.

Recommendations

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.

13.4 Prescribed Psychiatric Treatment Panel

Matters for Consideration

> A Prescribed Psychiatric Treatment Panel should consider all applications for neurosurgery for mental illness and all applications to include other prescribed psychiatric treatments in the *Mental Health Regulations*.

Discussion

The current provisions for decision making for neurosurgery for mental illness and for other prescribed psychiatric treatment do not adequately protect the rights of individuals or use an accountable ethics-based process. To address this issue, it is recommended that a Prescribed Psychiatric Treatment Panel should be convened by the Chief Psychiatrist when required, to consider applications for neurosurgery for mental illness, to make regulations to guide the use of other prescribed psychiatric treatments and to consider complex ECT cases referred to it. A new section should be introduced, for example:

44B–Prescribed Psychiatric Treatment Panel

(1) The Chief Psychiatrist may convene a Prescribed Psychiatric Treatment Panel to consider matters relating to –
(i) applications for neurosurgery for mental illness; or
(ii) the introduction or amendment of regulations relating to prescribed psychiatric treatment; or
(iii) complex ECT cases referred to the Panel.

(2) The Prescribed Psychiatric Treatment Panel will comprise members including but not restricted to –
(i) a patient; and
(ii) a carer; and
(iii) a psychiatrist; and
(iv) a neurosurgeon, if relevant; and
(v) a lawyer; and
(vi) a member of the South Australian Civil and Administrative Tribunal; and
(vii) a bioethicist.

(3) The Prescribed Psychiatric Treatment Panel may conduct proceedings as it sees fit, including receiving testimony from the patient, a carer, the treating psychiatrist or other person with a proper interest in the matter.

(4) The Prescribed Psychiatric Treatment Panel will make records of submissions and deliberations and make a recommendation to the Chief Psychiatrist to authorise or not authorise the proposed prescribed psychiatric treatment.

(5) A decision of the Prescribed Psychiatric Treatment Panel is final and further consideration of a matter will only be undertaken as a new application if additional supporting evidence is submitted.

Recommendations

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.

14. RESTRICTIVE PRACTICE

The Act allows the use of practices which restrict a person's liberty and freedom of movement when they or others are at risk of harm, and to enable services and agencies to carry the provisions and orders of the Act into effect. While necessary, these practices are a significant abrogation of rights and must be strictly controlled.

Matters for Consideration

> Definitions for care and control, reasonable force, restraint and seclusion are required to provide clarity.
> The term "mechanical body restraint" is used in way that excludes physical restraint from the same level of significance, scrutiny and reporting.
> A restrictive practice section should be introduced to guide the application of practices.
> The reference to reasonable force in section 34A should be the same as the reference in 56(3)(c).

Discussion

Definitions

Care and control, reasonable force, restrictive practice, restraint and seclusion are not defined in the Act, which can cause confusion between everyday language meanings, definitions used by other agencies, and accepted practice and use in mental health settings. The Office of the Chief Psychiatrist has undertaken significant consultation and collaboration with a broad range of stakeholders on restraint and seclusion to develop the Restraint and Seclusion Policy Guideline and Chief Psychiatrist Standards, and this work has informed the recommendations of this report. It is recommended that restrictive practices should be defined in section 3 of the Act to assist understanding and practice, for example:

Care and control means the use of vocal, social and physical presence in relation to a person to influence and manage the person;

Restrictive practice means –
(a) care and control; or
(b) reasonable force; or
(c) restraint; or
(d) seclusion;

Reasonable force means the use of force in relation to a person as reasonably required in the circumstances;

Restraint means –
(a) physical restraint means the application of bodily force to the person to restrict the person's movement;
(b) mechanical restraint means the application of a device to a person's body to restrict the person's movement;

Seclusion means the confinement of a person alone in an area from which the person cannot leave of their own volition;

Reasonable Force

The definition of reasonable force in section 34A(2), which describes the capacity of treatment centre staff to carry inpatient treatment orders into effect, is different to that in section 56(3)(c), which describes the capacity of authorised officers to use care and control for a person who has or appears to have a mental illness and be at risk of harm. The definition of reasonable force in section 56 is robust and limited to what is reasonable in the current circumstances. It is

recommended that the provisions for reasonable force in subsection 34A(2) be amended to be the same as subsection 56(3)(c), for example:

> *34A(2) Treatment centre staff may take measures for the confinement of the patient, and may restrain the person and otherwise use force in relation to the person as reasonably required in the circumstances –*

Restrictive Practice

Care and control, reasonable force, restraint and seclusion are mentioned separately in the Act, with different criteria for use, restrictions and documentation requirements. The introduction of a section that describes principles and constraints for the use of all restrictive practices would improve certainty, clarity and the understanding of rights and documentation. It is recommended that a new section be added to Part 5 Division 5, for example:

> *38B – Restrictive Practice*
> *(1) A restrictive practice may only be used in relation to a person who has or appears to have mental illness if there is no less restrictive means of ensuring –*
> *(a) the safety of the person or others; or*
> *(b) compliance with a treatment order or requirement of this Act.*
> *(2) The use of any restrictive practice may only be made in relation to a person who has or appears to have mental illness as reasonably required in the circumstances.*
> *(3) The use of any restrictive practice must be accompanied by the instigation of measures to ameliorate the need for its use.*
> *(4) For the duration of the use of restrictive practice the person's needs must be met and the person's dignity protected as far as practicable.*
> *(5) The use of any restrictive practice must cease as soon as possible.*
> *(6) Notification of the use of restrictive practice in relation to a person must be made to a guardian, medical agent, relative, carer or friend of the person as soon as it is practicable, safe and appropriate to do so.*
> *(7) The use of any restrictive practice in relation to a person must be documented in the records of the service or agency that carried out the restrictive practice.*

Restraint

The Act refers to "mechanical body restraint" in the context of the guiding principles, monitoring by the Chief Psychiatrist and documentation of the use of the practice. This reference excludes physical restraint, which is also a significant abrogation of a person's rights and should be strictly monitored and controlled. It is recommended that the use of "mechanical body restraint" in subsections 7(1)(h), 90(1)(b) and 98(2)(c) be amended to "physical or mechanical restraint".

Recommendations

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

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

47. That references to "mechanical body restraint" should be amended to "physical or mechanical restraint".

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".

15. REVIEW OF THE ACT

The Act requires the review of the operation of the Act within four years of commencement. However, this provision only allows for a once-off review and does not articulate a regular mechanism to keep the legislation relevant and effective.

Matters for Consideration

> Section 111 only requires the Act to be reviewed 4 years after commencement.

Discussion

To ensure that the mental health legislation in South Australia remains contemporary it is important to incorporate regular review and analysis. This will ensure the identification of operational and legislative improvements, give consideration to the experiences of consumers, carers and those administering the Act, determine whether the policy objectives of the Act remain valid and incorporate national and international trends in mental health law reform. It is recommended that the Act be reviewed every four years, for example:

111–Review of the Act
The Minister must, every 4 years after commencement of this Act or any provision of this Act–

Recommendations

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

16. RIGHTS

The Act provides South Australians with a legislative framework that sets out the rights of people with mental illness and assists with their recovery and participation in community life. The section 6 objects of the Act ensure that people with a mental illness retain their freedom, legal rights, dignity and self-respect as far as is consistent with the protection of the person and the community.

Matters for Consideration

- The Act should include the right to a second opinion regarding treatment and care options.
- The Act should reference the relevant United Nations conventions and protocols.
- The provisions regarding the use of interpreters should be strengthened.
- The rights of people with mental illness should be strengthened.

Discussion

International Human Rights

The United Nations has developed a number of conventions, principles and protocols regarding the protection of vulnerable people to which the Government of Australia is a signatory. It has been suggested that the Act should reference the relevant documents to enhance the rights and protections for people with mental illness. These documents include:

- Universal Declaration of Human Rights (1948).
- Convention on the Rights of the Child (1990).
- Principles for the Protection of Persons with Mental illness and for the improvement of Mental Health Care (1991).
- Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (2006).
- Convention on the Rights of Persons with Disabilities (2008).

The principles of both the *Universal Declaration of Human Rights* and the *Convention of the Rights of the Child* that are relevant to people with mental illness are incorporated in the Act, while broader application flows across State and Commonwealth legislation and policy.

The *Principles for the Protection of Persons with Mental illness and for the Improvement of Mental Health Care* contains 25 principles, further articulated as 85 rights, for people with mental illness. The Act currently addresses 80 (94.1%) of those 85 rights, with the 5 outstanding rights being addressed through this report, the *Advance Care Directives Act 2013,* and the Patient and Solicitor Access to Patient Records Chief Psychiatrist Standard.

The *Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* is the subject of collaboration by all Australian Governments. Specific legislation will be passed in all states to allow and regulate the inspection of all facilities where people may be kept involuntarily, including treatment centres, to meet the requirements of the Optional Protocol. It is not recommended that additional reference is made to the Optional Protocol in the Act.

The *Convention on the Rights of Persons with Disabilities* contains 50 articles which outline rights across all aspects of life and society for people with disabilities, including people with mental illness. The rights include accommodation, education, employment, health, justice and participation and are, for the most part, beyond the scope of the Act. However, the “universal” rights of the Convention, such as freedom, liberty, choice and the protection of vulnerable people are enshrined in the Act in section 6 objects, section 7 guiding principles and part 8 further protections for people with mental illness. When signing the Convention many countries made qualifying declarations. Australia’s declaration for the Convention was, in part:

> *Australia further declares its understanding that the Convention allows for compulsory assistance or treatment of persons, including measures taken for the treatment of mental disability, where such treatment is necessary, as a last resort and subject to safeguards;*

However, one matter from the Convention which the Act does not adequately address is the question of capacity and substitute decision-making. This will be addressed through the commencement of the *Advance Care Directives Act 2013* on 1 July 2014 and the recommended changes to the *Mental Health Act 2009* made in section 2 of this report.

Additionally, in 2013 the United Nations released the *Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*. This report has not yet made its way into convention or protocol and, for people with psychosocial disability, states that people should retain their freedom, dignity and rights as far as possible, treatment should be delivered in community settings wherever possible, involuntary community and inpatient treatment should never be carried out on the grounds of disability, and that restrictive practices should never be carried out on the grounds of disability. The Act addresses freedom, dignity and rights, and a community-focus, at the highest level as guiding principles and addresses the grounds question by always requiring the threshold of "at risk of harm" before any involuntary treatment or restrictive practice is used. The Act requires no additional content in response to the Report at this time.

It is recommended that international human rights and agreements should be recognised in the Act broadly, to allow for the development of future agreements, for example:

> *7(k) mental health services should be provided in accordance with international treaties and agreements that the Government of Australia is a signatory to, unless otherwise required by this Act or any other Act.*

Interpreters

It is essential that the rights of culturally and linguistically diverse (CALD) people are protected. The Act recognises CALD people in subsection 7(1)(c)(iii) of the guiding principles, requires that information be provided in a way that is understandable as far as practical in subsection 7(1)(j) and mandates in section 45 that health practitioners making an examination for the purposes of the Act must use an interpreter for the examination, if one is required and it is possible to make arrangements in the circumstances. The Office of the Chief Psychiatrist also provides the Statements of Rights in the languages of the 15 CALD groups that most frequently use mental health services in South Australia.

The Act sufficiently recognises the rights of CALD people. It is recommended that there be no change to provisions regarding CALD people and the use of interpreters.

Rights

Rights are articulated in section 6 objects, section 7 guiding principles, part 8 further protections for persons with mental illness and scattered throughout the Act as qualifying provisions in sections that allow involuntary treatment and care. These rights, although distributed, are significant and far-reaching. There are some issues which are not adequately addressed, such as capacity, substitute-decision making and the rights of people subject to section 56 or 57 care and control, and these and other matters are discussed in this report, see sections: 1 advocacy and appeals, 2 capacity and consent, 6 confidentiality and disclosure, 10 guiding principles, and 17 care and control.

In addition to enhancing rights throughout the Act, it has been suggested that a collation of rights in one section would assist individuals, families and services to understand and give effect to those rights. This would be best placed as the first Schedule in the Act, with the existing schedules 1 (certain conduct may not indicate mental illness) and 2 (transitional provisions) becoming schedules 2 and 3 respectively, for example:

> *Schedule 1 – Rights of people with mental illness*

Second Opinion

Health services across Australia accept the principle that a patient is entitled to seek a second opinion regarding their treatment and care. This principle holds true for mental health services but

can create difficulties for patients and services because a patient receiving involuntary treatment cannot refuse treatment. Most states address this matter through clinical best-practice and under the legislated principles of preserving the rights, dignity and freedom of people with mental illness as far as possible. Victoria has addressed the matter directly in their *Mental Health Bill 2014.*

It is recommended that a second opinion section be introduced to the Act, for example:

49B–Second Psychiatric Opinion

(1) A patient receiving involuntary care in accordance with this Act, or a guardian, parent, carer, friend or other person with a proper interest, may request a second psychiatrist opinion.

(2) A second psychiatric opinion may be sought from any psychiatrist not currently providing treatment and care to the patient.

(3) The psychiatrist providing the second opinion

(a) must examine the patient; and

(b) may consult the treating psychiatrist and other health practitioners; and

(c) may consult a guardian, parent, carer, friend or other person with a proper interest; and

(d) may examine the patient's records.

(4) The psychiatrist providing the second opinion must write a report and provide a copy to –

(a) the treating psychiatrist; and

(b) the patient, when it is safe and appropriate to do so; and

(c) the guardian, parent, carer, friend or other person with a proper interest, if it is safe and appropriate to do so .

(5) The treating psychiatrist may choose to adopt all, some or none of the recommendations of the second opinion report.

Assessment of Offenders – Consequential Amendment

Under the *Criminal Law Consolidation Act 1935* subsection 269X(1)(b) and (2)(b) the court may commit a defendant to a secure mental health facility until the conclusion of an investigation into the defendant's mental competence or fitness. Decisions under this section may be made by the court without knowledge of or preliminary evaluation of the mental state of the person, thereby not affording the same protections for the individual's rights as available in the *Mental Health Act 2009*. The *Mental Health Act 2009* is applicable to offenders held in remand and to prisoners and provides the necessary protection of the rights of individuals and considerations for the safety of others in regards to involuntary mental health assessment through the use of section 56 powers or treatment orders. This allows urgent involuntary mental health assessment and treatment to be undertaken when necessary, and voluntary assessment to occur on a non-urgent basis.

It is recommended that section 269X of the *Criminal Law Consolidation Act 1935* is unnecessary and should be removed, to be replaced with provisions similar to those in subsections 57(9) and (10) of the *Mental Health Act 2009,* whereby a person arrested or apprehended by police may be released from their custody for the purpose of medical examination or treatment, and police may request the return of the person to their custody when examination or treatment has been completed. These new provisions may be more properly in either Act.

Recommendations:

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

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

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

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).

17. SECTION 56 AND 57

17.1 Care and Control

Section 56 and section 57 empower health practitioners and police officers to take action regarding people who have or appear to have a mental illness and to be at risk of harm. Those actions may be taken to keep the person safe and to facilitate assessment or treatment.

Matters for Consideration

> The current provisions do not describe rights, timeframes, documentation, monitoring and reporting, or confirmation by a second officer.

Discussion

All Australian jurisdictions provide for the compulsory apprehension, transport and assessment of people who have or appear to have mental illness before a community treatment order or inpatient treatment order has been made. These compulsory measures allow the person and others to be kept safe while arrangements are made for an examination of the person's mental health. The compulsory measures include care and control, transport, reasonable force, administration of medication, entering premises, searching a person and their belongings and, for police, breaking and entering premises. The measures are brought to bear until a health practitioner can make an examination to determine if the criteria for a community treatment order or an inpatient treatment order are met, or what other treatment options may be appropriate.

In South Australia the compulsory measures are the section 56 and 57 powers of care and control. In other Australian jurisdictions the compulsory measures take the form of orders, with titles including Assessment Order, Detention to Enable Assessment, Emergency Examination Order, Recommendations for Assessment and Referral for Examination. For those jurisdictions, when an assessment order is made in the community, powers similar to those in section 56 and 57 can be used to apprehend and transport the person to a treatment centre.

Broadly, the South Australian provisions are simpler, more immediate, less restrictive, do not subject the person to an order, have shorter durations and are easier for health practitioners and police officers to implement, however, the provisions do not afford the same protection of the individual's rights. Rather than introduce assessment orders and unnecessary complexity, it is recommended instead that further protections for people with mental illness and greater accountability be added to the provisions.

In addition, section 56 and 57 powers can be used to carry a Patient Transport Request into effect for a person who is non-compliant with a community treatment order, is subject to a new inpatient treatment order made in the community, is at large from a treatment centre or is being transferred between treatment centres or hospitals.

Confirmation

The current provisions do not require the health practitioner or police officer placing a person under section 56 or 57 to have their decision reviewed, confirmed or revoked at the time by a second health practitioner or police officer. This enables health practitioners and police officers to take action immediately to preserve health and safety. However, the use of section 56 or 57 powers are reviewed when the person is examined by a medical practitioner or authorised health professional to determine if a treatment order is required. It is recommended that additional confirmation provisions not be introduced.

Definition

See section 14 of this report.

Documentation

The current provisions do not require the use of section 56 or 57 powers to be documented in a person's health, ambulance or police records, apart from the general requirement of section 98 for health services to document patient treatment and authorisations for that treatment. In addition, all agencies document their interactions with patients within the ambit of relevant legislation and policy as part of usual procedure. The use of these powers is a suspension of a person's rights to liberty however and mandatory minimum documentation is warranted. It is recommended that the use of section 56 or 57 powers be documented in the records of the agencies whose officers bring the powers into effect, for example:

> *56(9) An authorised officer will ensure records are kept of the use of care and control for the person including identification of the authorised officer, the time and place care and control was initiated, the reasons for the use of care and control, any subsection (3) powers exercised, the time and place care and control was ceased and the reasons for ceasing care and control.*

Monitoring and Reporting

The current provisions do not require the use of section 56 and 57 to be separately monitored and reported, instead the general requirements of section 90(1) for the Chief Psychiatrist to monitor the treatment of patients and the administration of the Act, and section 98 for health services to document the treatment of patients and the authorisations for that treatment, apply. In addition, mental health services monitor and report the treatment of patients through the safety, quality and risk mechanisms and processes that apply to all services within the treatment centre and the Local Health Network. Introducing specific monitoring and/or reporting mechanisms into section 56 and 57 would equate these powers with orders and create considerable documentation, database and communication requirements. Instead, it is suggested that the addition of mandatory documentation provisions (see above) will protect the rights of individuals by making the use of section 56 subject to the vigorous safety, quality and risk processes of SA Health, the SA Ambulance Service and the Royal Flying Doctor Service, and the use of section 57 subject to the safety, quality and risk process of SA Police. It is recommended that no additional monitoring and reporting provisions for the use of section 56 and 57 be introduced.

Rights

The current provisions do not describe specific rights for people made subject to section 56 or 57 powers, though individuals do have general rights applicable to the whole Act. People receiving voluntary and involuntary treatment have access to the general rights and those in Part 8 – further protections for persons with mental illness. These rights are communicated to people receiving treatment via a statement of rights. It would be appropriate to introduce similar rights coverage for people subject to section 56 or 57, which would be accomplished by adding them to the definition of a patient in section 3 and by mandating that they also receive a statement of rights. This statement of rights would include information about: what is care and control, what does it mean if I am under care and control, children under 16 years old, advocacy contacts, language assistance and complaints contacts, and would describe the rights of individuals in the areas of: getting a statement of rights and a copy to a support person (if appropriate), having a support person, examination and treatment, communication, interpreters, complaints and confidentiality. It is recommended that the rights of people subject to section 56 and 57 be enhanced through inclusion in the definition of a patient and by requiring a statement of rights, for example:

> *56(3B) An authorised officer who takes the person into his or her care and control must, as soon as practicable–*
>
> *(a) ensure the person is given a written statement in the form approved by the Minister (a statement of rights) informing the person of his or her legal rights.*
>
> *(b) if the person is unable to read or otherwise comprehend the statement of rights, the authorised officer must ensure that any steps that are practicable in the circumstances are taken to convey the information contained in the statement to the person.*

(c) ensure a guardian, medical agent, relative, carer or friend of the person is given a copy of the statement of rights, unless the authorised officer has reason to believe that it would be contrary to the person's best interests to do so.

56(5B) An authorised officer who ceases care and control for a person must, as soon as practicable, inform the person that care and control has ceased.

Timeframes

In South Australia the compulsory measures of section 56 and 57 continue to be exercisable as long as reasonably required to facilitate medical examination or treatment. In practice this is usually under 24 hours but does from time to time in country areas and metropolitan emergency departments extend beyond 24 hours. In other Australian jurisdictions the compulsory measures (orders) may be in place for 24 hours and may be renewed up to 2 times, for a total maximum time of 72 hours – except Queensland where these orders may last for up to 7 days.

The current provisions do not place a limit on "as long as reasonably required". To strengthen rights and accountability but not restrict the capacity of authorised officers to keep people safe, a time-limit for care and control once the person has been transported to a place for medical examination or treatment could be introduced. No time limit would be imposed for care and control during transport. It is recommended that there continue to be no fixed time limit for transport (other than what is reasonably required) but that a time limit of 4 hours be introduced for care and control once the person is at a place for assessment or treatment, for example:

56(5) The powers conferred by this section continue to be exercisable–

(a) as reasonably required to transport the person to a treatment centre or other place for the purpose of medical examination or treatment of the person; or

(b) for up to 4 hours from the time of arrival of the person at the treatment centre or other place where they have been transported for medical examination or treatment.

Recommendations

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.

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.

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

17.2 Patient Transport Requests

The Act provides for the making of patient transport requests by health practitioners to the SA Ambulance Service, SA Police or the Royal Flying Doctor Service to transport a person to a place for treatment. A patient transport request can be made if a person is non-compliant with a community treatment order, if a new inpatient treatment order has been made and the person requires transport to a treatment centre, if a person is at large from a treatment centre or if the person is being transferred between treatment centres or hospitals.

Matters for Consideration

> The current provisions do not adequately describe how authorised officers and police officers can assist each other to carry community treatment orders into effect in the least restrictive environment.

Discussion

The current provisions of section 55 for patient transport requests allow a medical practitioner or mental health clinician to request the assistance of authorised officers or police officers to transport a person who is not compliant with their community treatment order to a place for treatment. The authorised officer or police officer can then use their section 56 or 57 powers to carry out the transport. In practice this means that a person subject to a community treatment order who refuses their medication when a mental health team attends their home can also be made subject to a patient transport request, taken to a community mental health service or treatment centre, forced to take prescribed medication and then transported home again. This is not least restrictive treatment for the person, causes delays and interruptions for the person and services, and creates more work for all agencies involved. Instead it is recommended that section 55 be amended to be "patient assistance requests" and that subsection (1)(a) be amended so that a request can be made for authorised officers or police officers to attend to assist the mental health team to administer medication on the spot. If it is not safe or practicable to do so, the authorised officers or police officers can transport the person, as per the current provisions. This amendment will enable the person to stay in their own home with minimal disruption and will cause less impost on mental health services, SA Ambulance and SA Police resources, for example:

55–Issuing of patient assistance requests
(1) A patient assistance request may be issued in respect of a patient as follows:
(a) if a community treatment order applies to the patient and the patient has not complied with the requirements of the order, a medical practitioner or mental health clinician may issue the request for the purpose of:
(i) attendance by authorised officers or police officers to administer the requirements of the order; or
(ii) the patient's transport for treatment in accordance with the order;

Recommendation

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.

18. TREATMENT ORDERS

18.1 Community Treatment Orders

Matters for Consideration

- Level 1 community treatment orders are underused.
- Notification of community treatment orders is made to both the Chief Psychiatrist and the Guardianship Board, and both Offices must then acknowledge each order to the originating service.
- There are no explicit provisions for the use of reasonable force to enact a community treatment order, unlike inpatient treatment orders and s56 and s57 powers.

Discussion

Notifications

The Act requires medical practitioners and authorised health professionals who make, confirm, vary or revoke a community treatment order level 1 to notify the Chief Psychiatrist and the Guardianship Board within 1 business day. The Chief Psychiatrist and the Guardianship Board must then acknowledge receipt of each such notification within 1 business day. This means that each order, when made, confirmed, varied or revoked, is notified twice and acknowledged twice, unnecessarily duplicating paperwork and, because of the vagaries of electronic communication, resulting in 2 sets of information which are not identical. It is recommended that notification under section 11 of the making, confirming, varying or revoking of an order should be made to the Chief Psychiatrist only, within 1 business day. The Chief Psychiatrist will then subsequently acknowledge receipt of the order within 1 business day and notify the Guardianship Board of the order within 1 business day.

Reasonable Force

The Act allows for the use of reasonable force by appropriate officers to carry into effect the powers relating to inpatient treatment orders and section 56 and 57 care and control powers. Although a temporary suspension of human rights, the provisions for reasonable force enable mental health staff, emergency department staff, police officers and ambulance officers to keep a person safe while they are being assessed and treated. Without the capacity to use reasonable force, all assessment and treatment would be voluntary and the provisions of the Act would be largely moot.

The Act does not explicitly provide for the use of reasonable force to carry a community treatment order into effect. However, if a person is non-compliant with their community treatment order a patient transport request can be made, which enables an appropriate officer to use reasonable force under section 56 or 57 to transport the person to a place for treatment. While these provisions may recognise a person's rights more greatly at a time of non-compliance with their community treatment order, by not allowing reasonable force to carry out treatment in situ (if safe and possible to do so), the provisions then constrain the person's rights by allowing involuntary transport and treatment and the use of reasonable force.

In effect, the least restrictive form of involuntary treatment becomes more restrictive through the use of a patient transport request, which allows for involuntary transport, treatment and possible transport back, through all of which reasonable force may be used.

In many instances, it may be less restrictive for the person to be subject to reasonable force and involuntary treatment in the community, rather than be made subject to a patient transport request and reasonable force to carry the transport and treatment into effect. Of course, for some non-compliant individuals, reasonable force and involuntary treatment in the community will not be safe or possible and a patient transport request, transport, more assertive treatment and reasonable force will be required.

It is recommended that provisions explicitly allowing the use of reasonable force to carry community treatment orders into effect be introduced, for example:

19B – Powers relating to involuntary community patients

(1) This section applies to a patient to whom a community treatment order applies and where the patient has not complied with the requirements of that order.

(2) When it is safe and practicable to do so Authorised officers, ambulance officers and police officers may take measures for the treatment of the patient and exercise powers (including the power to use reasonable force), as reasonably required for carrying the community treatment order applying to the patient into effect and ensuring compliance with this Act.

(3) Powers under subsection (2) may be exercised for a patient who is subject to a section 55 patient assistance request.

Underuse of Level 1 Community Treatment Orders

Level 1 community treatment orders were intended to be the least restrictive involuntary treatment option but are underused. For 2012-13, there were 186 level 1 community treatment orders, 1358 level 2 community treatment orders and 4779 level 1 inpatient treatment orders, out of a total 8131 mental health treatment orders. Anecdotal feedback suggests that the underuse is caused by the requirement that all level 1 community treatment orders must be reviewed by the Guardianship Board and that 28 days is too short a time for therapeutic interventions to have effect.

There is no consistency across Australian jurisdictions for the maximum duration of community treatment orders, as per the table below. South Australia is the only state that strikes a balance by providing for shorter community treatment orders to be made by authorised health professionals or medical practitioners and longer community treatment orders to be made by a Guardianship Board or equivalent. However, all other jurisdictions have provisions that allow for an individual to be involuntarily assessed and/or treated for 3 or 7 days pending consideration for a community treatment order or inpatient treatment order.

Maximum duration of community treatment orders across Australia

State	Duration	State	Duration
NSW	12 months	SA	28 days or 12 months
NT	14 days	VIC	12 months
QLD	Until revoked	WA	3 months

Some jurisdictions provide for community treatment orders to be made in a community or inpatient setting and some only allow for community treatment orders to be made in an approved treatment centre or through a tribunal hearing.

To fully realise the least restrictive potential of the Act however, it is recommended that the automatic review of all level 1 community treatment orders by the Guardianship Board in section 15 should cease. Instead, level 1 community treatment orders should be made through the same process as level 1 inpatient treatment orders where an order, made by an authorised health professional or medical practitioner, must be confirmed or revoked by a psychiatrist within 24 hours or as soon as practicable. (Subsection 10(5) would be replaced by similar provisions to 21(5) to accomplish this.) A level 1 community treatment order can, of course, be appealed and reviewed by the Guardianship Board in those circumstances. It would appear the requirement for automatic review by the Guardianship Board is a legacy provision from the 1993 Act, where all community orders were made by the Board.

In addition, the maximum duration of 28 days, and the durations from other jurisdictions, appear to be based on administrative rather than therapeutic parameters. It is recommended that the maximum duration for level 1 community treatment orders in subsection 10(4) should be the same as for level 2 inpatient treatment orders, 42 days, to allow therapeutic interventions including medication and psychosocial treatment to have an effect and assist the person, the treating team and advocates to assess what works, what doesn't and what future treatment options might be.

Recommendations

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.)

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

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.

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.

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

18.2 Inpatient Treatment Orders

Matters for Consideration

> A number of alternative inpatient treatment order regimes were proposed, with differing levels and durations of orders.

> Notification of inpatient treatment orders is made to both the Chief Psychiatrist and the Guardianship Board, and both Offices must then acknowledge each inpatient treatment order to the originating service.

> The Act only allows the Guardianship Board to revoke level 3 inpatient treatment orders, resulting in discharge delays for some patients after sufficient recovery to return to the community.

> The Act requires a formal report when making a level 2 inpatient treatment order, to be sent to the director of the treatment centre and then to the Guardianship Board. No other order has such report requirements.

> The expiry time for inpatient treatment orders should be 5pm, not 2pm.

Discussion

Expiry

People subject to Detention Orders under the previous 1993 Act were often discharged at 12 midnight upon the expiry of their order. To remedy this in line with Bidmeade Report recommendations, the 2009 Act designates an expiry time of 2pm to allow a suitable period within business hours for the person, families and services to make arrangements for discharge, transport and other matters. It is recommended that expiry times for treatment orders remain fixed at 2pm.

Notifications

The Act requires medical practitioners and authorised health professionals who make, confirm, vary or revoke an inpatient treatment order level 1 or inpatient treatment order level 2 to notify the Chief Psychiatrist and the Guardianship Board within 1 business day. The Chief Psychiatrist and the Guardianship Board must then acknowledge receipt of each such notification within 1 business day. This means that each order, when made, confirmed, varied or revoked, is notified twice and acknowledged twice, unnecessarily duplicating paperwork and, because of the vagaries of electronic communication, resulting in 2 sets of information which are not identical. It is recommended that notification of the making, confirming, varying or revoking of an order should be

made to the Chief Psychiatrist only, within 1 business day. The Chief Psychiatrist will then acknowledge receipt of the order within 1 business day and notify the Guardianship Board of the order within 1 business day.

Order Types and Duration

There is no consistency between Australian jurisdictions for the maximum duration of inpatient treatment orders, as per the table below.

Maximum duration of inpatient treatment orders across Australia

State	Duration	State	Duration
NSW	3 months	SA	7 or 42 days, or 12 mths
NT	14 days	VIC	6 months
QLD	Until revoked	WA	21 days

South Australia is the only jurisdiction which has three levels of order of differing durations, catering for short-, medium- and long-term illness and treatment. The other states cater for entry level or short-term illness and treatment through assessment orders (titles including: Assessment Order, Detention to Enable Assessment, Emergency Examination Order, Recommendations for Assessment, Referral for Examination) for up to 72 hours (7 days for Queensland) and then for medium- and long-term illness and treatment through one-off or repeated inpatient treatment orders lasting, depending on the jurisdiction, up to 14 days, 21 days, 3 months, 6 months or until revoked.

The South Australian regime, although pluralistic, creates focus on the tension between the rights of the individual and the period of involuntary treatment required to have positive therapeutic and safety outcomes. The least restrictive principle is well articulated by such a system with different order durations for short-, medium- and long-term illness, with the additional capacity for earlier revocation or subsequent orders if a person's health should improve or become worse. It is recommended that the current provisions for level 1, level 2, and level 3 inpatient treatment order types and durations should remain unchanged.

Revocation of Level 3 Inpatient Treatment Orders

The Act allows for level 3 inpatient treatment orders, lasting for up to 12 months, to be made by the Guardianship Board on application by the Public Advocate or Director of an approved treatment centre (or employee so authorised by the director). A level 3 order can also only be revoked or varied by the Guardianship Board, on application by the patient, the Public Advocate, a health professional or a person with a proper interest in the welfare of the patient, including a guardian, medical agent, carer, relative or friend. The capacity for proper persons to apply for a revocation or variation is sound and allows for the protection of the patient's rights.

However, if a person has recovered sufficiently to resume life in the community the treating psychiatrist cannot revoke the order, causing the person to remain as an inpatient beyond when it may be therapeutically warranted while arrangements are made for a Guardianship Board hearing. Hearings can take several weeks to a month to arrange, depending on a variety of legal, clinical and administration factors. Individuals subject to a level 3 inpatient treatment order may be placed on a leave of absence to allow their placement in the community but the level 3 order remains in place. When this occurs over an extended period of time it creates an ambiguous situation for the patient and is not consistent with the principle of least restrictive treatment.

To return individuals subject to a level 3 inpatient treatment order more promptly to the community, it is recommended that the treating psychiatrist should be able to revoke the order, providing that a second independent psychiatrist who has examined the patient supports the revocation and that the treating psychiatrist submits to the Guardianship Board a report of the reasons for the revocation, supporting statements from the patient and appropriate advocates or carers, and an updated treatment and care plan describing the treatment and care that will be provided to the person in the community. For example:

29(8) A level 3 inpatient treatment order may be revoked by a psychiatrist if–

(a) the psychiatrist is satisfied that the criteria for the making of the level 3 inpatient treatment order no longer apply; and

(b) a second psychiatrist not involved in the treatment and care of the patient who has examined the patient provides a written opinion supporting the revocation; and

(c) a report outlining the reasons for the revocation is submitted to the Guardianship Board; and

(d) supporting statements from the patient and their guardian, medical agent, carer, family or friends as appropriate are submitted to the Guardianship Board; and

(e) a treatment and care plan describing the treatment and care that will be provided to the patient in the community is submitted to the Guardianship Board.

In addition, section 30 – Notification of level 3 orders – should be amended to include psychiatrist revocations must be notified to the Guardianship Board and the Chief Psychiatrist within 1 business day.

Reports when making level 2 Inpatient Treatment Orders

The Act requires the psychiatrist or authorised medical practitioner making a level 2 inpatient treatment order to write a report of their examination of the patient and the reasons for making the order, and to submit that report to the director of the treatment centre as soon as practicable. The director must then submit that report to the Guardianship Board.

No other treatment order requires a separate report to be written and submitted in this way, as all other orders require confirmation by a psychiatrist or consideration by the Guardianship Board, providing for a separate officer or agency to independently examine the person. The requirement for a report for level 2 inpatient treatment orders replaces that examination provision with a review provision, whereby the director of the treatment centre and the Guardianship Board review the reports. The review provision has been used in this way because a person made subject to a level 2 order has already been subject to a level 1 inpatient treatment order, which must be independently examined and confirmed by a psychiatrist, who cannot be the officer who made the order. However, the report is additional paperwork which does not service another clinical or legal purpose. It is proposed that the review requirement is appropriate for level 2 inpatient treatment orders but that the need for additional documentation is onerous.

It is recommended that the report requirement be amended to require the psychiatrist or authorised medical practitioner making the order to document the results of the examination and the reasons for the order in the patient's records and to submit to the director of the treatment centre, as soon as practicable, a copy of the updated treatment and care plan for the patient. The director must then submit the treatment and care plan to the Guardianship Board. The treatment and care plan must comply with the requirements of section 41. For example:

26(4) A psychiatrist or authorised medical practitioner making a level 2 inpatient treatment order must, as soon as practicable–

(a) document the results of his or her examination of the patient and of the reasons for making the order in the patient's records; and

(b) provide to the director of the treatment centre in which the patient is or is to be an involuntary inpatient a copy of the patient's treatment and care plan.

26(5) On receiving the treatment and care plan under subsection (4), the director must forward a copy of the treatment and care plan to the Board.

Recommendations

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.)

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.

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.

18.3 Involuntary Treatment Threshold

The Act requires criteria to be met before a treatment order can be made, establishing a threshold for involuntary treatment.

Matters for Consideration

> Community treatment order provisions contain a criterion that "there are facilities and services available for appropriate treatment of the illness". There are no similar criteria for inpatient treatment orders, nor are there similar criteria for the orders of other Australian jurisdictions.

> The criterion for harm does not clarify if involuntary treatment criteria apply when there is risk of harm to physical health, as well as mental health.

> The criterion for harm should be serious harm.

> The criterion for harm should include harm to social standing, employment and finances.

> The threshold criteria should match that recommended in the Bidmeade report.

> There should be a criterion requiring impaired capacity before a treatment order can be made.

Discussion

Legislation across Australia describes the criteria for making an order for involuntary treatment as seven domains: mental illness, harm or risk, treatment, least restrictive treatment, capacity, refusal and facilities. Per the domains, a treatment order can only be made if: a person has a mental illness, is at risk of harm, requires treatment, there is no less restrictive option available, the person lacks the capacity to make decisions, unreasonably refuses treatment and there are suitable facilities or services available. The criteria are summarised in the tables below.

Criteria for Involuntary Treatment across Australia – part 1

	Illness	**Harm / Risk**	**Treatment**
NSW	Mental illness or mentally disordered	Serious harm to self / others – including continuing or deteriorating condition of person	Treatment or control
NT	Mental illness	Serious harm to self / others or serious mental / physical deterioration	Treatment
QLD	Mental illness	Imminent risk of harm to self / other or serious mental / physical deterioration	Immediate treatment
SA	Mental illness	Harm to self / others – including continuation or deterioration of condition	Treatment
TAS	Mental illness	Serious harm to health / safety or safety of others	Treatment
VIC	Mental illness	Serious deterioration in mental / physical health or serious harm to person / other	Immediate treatment
WA	Mental illness	Significant risk to health / safety or significant risk of harm to person / other	Treatment
UN*	Mental illness	Serious likelihood of immediate or imminent harm to self / others, or serious deterioration in condition of person	Treatment

* Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care (1991). Recommended in the Bidmeade Report also.

Criteria for Involuntary Treatment across Australia – part 2

	Least Restrictive	Capacity	Refusal
NSW	Least restrictive treatment	-	-
NT	Least restrictive treatment	Informed consent	Unreasonably refused
QLD	Least restrictive treatment	Capacity to consent	Unreasonably refused
SA	Least restrictive treatment	-	-
TAS	Least restrictive treatment	Decision making capacity	-
VIC	Least restrictive treatment	-	-
WA	Least restrictive treatment	Capacity to make decisions	Unreasonably refused

In addition, South Australia requires a criterion of "appropriate facilities and services are available" for the making of community treatment orders.

Harm

The Act uses "harm" as the risk criterion for involuntary treatment. Harm is a deliberately broad noun that places responsibility for decisions regarding involuntary treatment with health practitioners and responsibility for challenging those decisions with patients, families, legal practitioners and the Guardianship Board. The reasons for those decisions and those challenges must be sound and demonstrable, both from the clinical and legal perspective, affording people with mental illness fairness of process and a legislative framework which both keeps them safe and protects their rights. It is recommended that the risk criterion should remain "harm".

There has been some suggestion that the risk criteria should be amended to "serious harm". While this would provide more definition, it constrains the interpretation of the Act in a way that may skew the balance of decision-making versus decision-challenging processes from "is the person at risk of harm" and "has due process been used" to "what is the definition of serious". The use of adjectives in legislation should be kept to a minimum so that focus can be kept on the appropriate use of provisions, rather than the interpretation of words. It is not recommended that the harm criterion should be further qualified by "serious".

There has also been some suggestion that the risk criteria should be amended to set the threshold for involuntary treatment to "immediate or imminent" risk of harm. Again, the use of adjectives does not necessarily improve understanding and may cause focus on definitions rather than appropriate action. In addition, the use of "immediate" or "imminent" is against the principle of least restrictive treatment whereby a person who is assessed as becoming acutely unwell in the future cannot be involuntarily treated now for a shorter period of time to lessen or prevent the acute period of illness later. Most people, families, mental health services and advocates would prefer a shorter period of treatment now to a longer period of treatment later and a longer period of being acutely unwell. It is not recommended that the harm criterion be qualified by "immediate" or "imminent". The criterion should remain as "harm" in subsection 10(1)(b), subsection 16(1)(b), subsection 21(1)(b), subsection 25(2)(b) and subsection 29(1)(b).

Continuation or Deterioration of Condition

The Act describes harm as "including harm involved in the continuation or deterioration of the person's condition", allowing health practitioners to make an order for involuntary treatment to prevent or lessen a period of acute illness. All feedback and submissions regarding this aspect of the threshold criteria were positive. It is recommended that the definition of harm to continue to include the continuation or deterioration of a person's condition, see subsection 10(1)(b), subsection 16(1)(b), subsection 21(1)(b), subsection 25(2)(b) and subsection 29(1)(b).

Harm to other than Mental Health

The criterion of harm in the Act is broad and is qualified as "harm because of the person's mental illness". While this broadness enables health practitioners to make decisions on a case by case basis to keep individuals safe, greater clarity would be provided by explicitly describing harm as "harm to mental or physical health", rather than the existing inference. The newer legislation in other jurisdictions includes a more defined description of harm. It is recommended that harm be

qualified further as harm to mental or physical health, for example subsection 10(1)(b), subsection 16(1)(b), subsection 21(1)(b), subsection 25(2)(b) and subsection 29(1)(b) should state:

> *(b) because of the mental illness, the person requires treatment for the person's own protection from harm to mental or physical health or harm involved in the continuation or deterioration of the person's condition or the protection of others from harm; and*

Some submissions suggest that the definition of harm should include harm to social status, employment and finances. While this suggestion does have some merit, as illness for some people causes actions or behaviours that directly affect these areas of their lives, it may be extending the Act beyond what its proper intent and reach should be. All of us make mistakes and bad decisions from time to time and it is outside the remit of the Act, which is necessarily concerned with mental illness and protection of rights, to regulate more broadly into people's lives. Additionally, the question of a person's capacity over time across all aspects of their life is already dealt with in the powers of guardianship and administration in the *Guardianship and Administration Act 1993* and the provisions of the *Advance Care Directives Act 2013,* which allow for individuals to plan for their future in case of reduced capacity and nominate a substitute decision maker, and for services to make an application to the Guardianship Board for assessment of a person's capacity if necessary. It is recommended that the definition of harm in the Act not include harm to social standing, employment or finances.

Capacity and Refusal

The Act is illness based legislation and does not provide for questions of capacity. However, in consideration of the *Advance Care Directives Act 2013* and the inclusion of a capacity section in the Act as proposed in section 2 of this report, it would be appropriate to include capacity as a threshold criterion for involuntary treatment. This would mean that the health practitioner or Guardianship Board, when making an order, must consider the person's capacity to make decisions regarding treatment for their mental illness as part of their overall assessment. It is recommended that capacity be added as a criterion for involuntary treatment, for example:

> *(e) the person lacks capacity to make decisions regarding treatment for their mental illness, in accordance with section [proposed 7B, see section 2 of this report] .*

Some jurisdictions link a refusal criterion to the capacity criterion, so that a treatment order can only be made if a person has a mental illness and is at risk of harm and "does not have capacity to make decisions about treatment for the mental illness or has unreasonably refused treatment". The addition of refusal to the capacity criterion through the use of "or" does not add clarity to the involuntary threshold nor does it further protect the rights of individuals, as health practitioners can ignore the question of capacity and use the unreasonable refusal provision instead. The linking of the refusal criterion to the capacity criterion reduces the importance of the person's capacity when an involuntary treatment order is being considered. This criterion does not assist health practitioners to make decisions nor does it shed light on a person's state of mind, as most people will refuse involuntary treatment most of the time. It is recommended that a refusal criterion should not be added, either as a stand-alone criterion or linked to the capacity criterion.

Facilities and Services

The Act requires a threshold criterion of "there are facilities and services available for appropriate treatment of the illness" for the making of community treatment orders. This criterion is not required for inpatient treatment orders nor is it required for community treatment orders in other jurisdictions. It would appear this criterion was put in place as a precautionary measure for transition from the previous Act where only the Guardianship Board could make community treatment orders. As well, the criterion may have been introduced to ensure services were available when the Guardianship Board considers making a level 2 community treatment order on application by the Public Advocate or family member. However, mental health services are a necessary part of these proceedings and the Guardianship Board will not make an order without a service being available to carry it into effect, making this provision unnecessary. It is recommended that this criterion be removed from subsections 10(1)(c) and 16(1)(c).

Recommendations

66. The “facilities and services” criteria should be removed from community treatment orders.

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

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

18.4 Leave of Absence

Matters for Consideration

> The Act provides for Directors of treatment centres to authorise leave of absence and for the Director to delegate that function to others. The current delegations and form do not allow appropriate or timely granting or cancelling of leave of absence.

> The use of the term “at large” for people absent without leave from a treatment centre while subject to an inpatient treatment order is stigmatising and not accurate.

Discussion

Delegations

A person subject to an inpatient treatment order can leave the treatment centre in the presence of a staff member from the treatment centre or may be given a leave of absence by the Director or a delegate. Current delegations for this function vary between treatment centres. In addition, the *Leave of Absence* (MR90H) form is not as clear as it could be. The current provisions of sections 36 to 38 regarding leaves of absence and section 100 regarding Director delegations are adequate however protocols for putting these functions into practice should be improved. The Office of the Chief Psychiatrist is working with the Legal and Governance Unit and the Local Health Networks to draft standard Instruments of Delegation for all treatment centres and will amend the MR90H form to reflect those changes.

At Large

The Act defines a person who is subject to an inpatient treatment order who is not at a treatment centre or in the care and control of an authorised officer as at large. This may be because the person left the care and control of an authorised officer outside a treatment centre, the person left a treatment centre without permission or the person did not return from a leave of absence. The phrase “at large” is stigmatising, is applied to people who have escaped from police or correctional custody and is not as accurate as “absent without leave”. It is recommended that “at large” should be replaced with “absent without leave”, for example in sections and subsections 3, 55(1)(c), 56(1)(b), 57(1)(b), 57(2), 61, 70(1), 71(1), 76(1) and (4), and 77(1) and (3).

Recommendations

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

18.5 Treatment for Any Illness

Matters for Consideration

> Inpatient Treatment Orders allow for the involuntary treatment of mental illness and any other illness authorised by a medical practitioner.

Discussion

The current provisions for the three levels of inpatient treatment order allow for the involuntary treatment of mental illness and any other illness authorised by a medical practitioner who has examined the patient. While this power is used to maintain or improve the physical health of people subject to treatment orders when they may not have full capacity to make decisions, it denies them the fundamental right to refuse treatment for a physical illness. There are a number of existing mechanisms whereby a treatment team can involuntarily treat physical illness, including section 13 of the *Consent to Medical Treatment and Palliative Care Act 1995* which enables emergency medical treatment if the person is incapable of consenting and there is imminent risk to life or health, the *Guardianship and Administration Act 1993* which provides for the appointment of a guardian and special powers to detain and treat under section 32, and the *Advance Care Directives Act 2013* provisions regarding substitute decision makers, capacity and decision making. Given these legislative options it may be redundant to also allow the treatment of any illness in the Mental Health Act.

However, in some instances physical illness may cause or contribute to mental illness and it would be unhelpful to remove the capacity to involuntarily treat all physical illness from the Act. It is recommended that the provisions for involuntary treatment be modified to allow only treatment for mental illness or physical illness causing or contributing to mental illness, and that the involuntary treatment of physical illness not related to mental illness is already and best dealt with through other legislation and processes. For example, sections 24(1), s28(1) and s31(1) should be amended to:

> *A patient to whom an inpatient treatment order applies may be given treatment for his or her mental illness, or any other illness causing or contributing to the mental illness, of a kind authorised by a medical practitioner who has examined the patient.*

Recommendations

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.

19. Treatment and Care Plans

The Act makes provisions to mandate that people subject to treatment orders and voluntary inpatients must have treatment and care plans that describe the treatment, care and rehabilitation that will be provided to the person and that those plans must be prepared and revised in consultation with the patient and a support person, if appropriate, as far as practicable.

Matters for Consideration

- Provisions including the participation of and disclosure to other services and agencies should be added.
- Treatment and care plan provisions should be strengthened and regulations should be drafted to guide content.
- Voluntary community patients are excluded from the Part 6 treatment and care plan provisions.

Discussion

The treatment and care plan provisions of the Act are designed to bring about a balance between self-determination, the experience of carers and the expertise of health practitioners by involving all in plan preparation and review. Collaboration brings about greater convergence of perspectives and options and a shared understanding of progression and recovery. In addition, these provisions reflect best-practice and articulate the requirements of both the National Standards for Mental Health Services 2010 and the National Safety and Quality Health Service Standards 2012.

The provisions are robust. However, compliance with the provisions is poor. This dearth comprises a lack of plans altogether in some instances, a lack of involvement of the patient or their carer in others, and poor quality or failure to address rehabilitation or recovery needs in others. The reasons for these circumstances are many, including the focus of many National and State initiatives and requirements on assessment and risk without concomitant focus on planning and outcomes, the constraints of the current electronic patient record systems, the restrictive confidentiality provisions of the former Act and the increasing demand on community and inpatient mental health services.

It is recommended that the Act and regulations are not amended but that patients, carers and mental health services continue to work together to improve collaborative planning and that SA Health and Local Health Network executive and statutory officers continue to monitor and advocate for improvement.

The current provisions for treatment and care plans exclude voluntary community patients, who are also excluded from the definition of a patient in section 3. Voluntary community patients make up the majority of community patients and should be included. It is recommended that section 39 be amended to mandate treatment and care plans for voluntary community patients in addition to voluntary inpatients, for example:

> *39(1) The treatment and care of a voluntary community patient or voluntary inpatient must, as far as practicable, be governed by a treatment and care plan directed towards the patient's recovery.*
> *39(2) The treatment and care plan–*
> *(a) must describe the treatment and care that will be provided to the patient and should describe any rehabilitation services and other significant services that will be provided or available to the patient; and*

The current provisions for treatment and care plans do not require the participation of other health service providers or agencies. It is recommended that that other services providers and agencies be included in sections 39, 40 and 41 by the amendment of provision (c) in each to become provision (d), and the addition of a new provision (c), for example:

(c) must, as far as practicable, be prepared and revised in consultation with other service providers and agencies which are providing treatment, care or support to the patient; and

Recommendations

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

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.

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Appendix II – List of Contributors

In addition to the information provided by people with mental illness, carers and families, health services, other agencies and statutory officers over the first 4 years of the operation of the Act, the Office of the Chief Psychiatrist would like to thank the following individuals and organisations for contributing to this Review.

Aboriginal Legal Rights Movement Inc., Aboriginal Legal Services, Angela Dobie, Australian Medical Association, Australian Nursing and Midwifery Federation, Baptist Care, Boylan Ward (CAMHS), Care Inc., Carers Australia SA, Carment Hofhuis, Cathy Lester, Chief Psychiatrist Western Australia, Children of Parents with a Mental Illness Inc., Citizens Advocacy Research & Education Inc., Club 84 (NALHN), Psychosocial Rehabilitation Program (NALHN), Community Visitor Scheme, Courtney Tasker, Crown Solicitor's Office, Department Communities and Social Inclusion, Department Education and Child Development, Disability Advocacy and Complaints Service of SA, Eastern Community Mental Health Teams (CALHN), Eastern Team (OPMHS), Forensic Community Mental Health, Forensic Step down Unit, Former SA Mental Health Carers Advisory Group, Gail Wood, Glenside Campus Cedars North West (CALHN), Glenside Campus Cedars PICU (CALHN), Guardianship Board of SA, Health and Community Services Complaints Commissioner, Health Consumer Alliance of SA Inc., Hon Ann Bressington MLC, Dr Duncan McFetridge MP, Hon Gay Thompson MP, Hon Gerry Kandelaars MLC, Hon John Dawkins MLC, Hon John Rau MP, Hon Robert Brokenshire MLC, Hon Tammy Franks MLC, Inner Rural Mental Health (CHSA), James Nash House (FMHS), Karyn O'Keefe, Kylie Harrison, Legal Services Commission, Life Without Barriers, Margaret Tobin Centre (SALHN), Margaret Wilcocks, Mental Health Carers Advisory Group, Mental Health Clinical Caucus Group (CHSA), Mental Health Coalition of SA, Mental Health Consumer Advisory Council Inc., Meridee Evans, Michael Kelly, Michael Nagy, Mission Australia, Morier Ward (SALHN), Mr R. Harvard, Multi-Cultural Communities of SA Inc., Northern Mental Health Community Team (NALHN), Office of the Public Advocate, Office of the Chief Psychiatrist Mental Health and Substance Use (SA Health), Office of the Commissioner for Equal Opportunities, Ombudsman SA, Personal Helpers and Mentors, Policy & Legislation Unit Policy Commissioning Division (SA Health), President Guardianship Board, Ramsay Group, Repatriation Hospital - Ward 18 (OPMHS), Robert Hayes, Royal Adelaide Hospital (C3 and Emergency Department) (CALHN), Royal Flying Doctor Service, SA Mental Health Carers Advisory Group, Sanctuary Carer Support Group, South Australian Ambulance Service, South Australian Police, Ward 5J/4G (SALHN), Stephanie Mitchell, Survivors of Torture and Trauma Assistance and Rehabilitation Service, Terry Udy, The Law Society of South Australia, The Mental Health Act User Group, Royal Australian and New Zealand College of Psychiatrists, The State-wide Mental Health Lived Experience Register, Veteran Community SA, Veterans' Advisory Council and Defence Communities Association, Western Community Team, (OPMHS), Woodville Intermediate Care Centre (CALHN), Youth Affairs Council of SA, Youth Think (CAMHS).

Appendix III – List of Recommendations

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.
2. SACAT should establish a specific dedicated Mental Health List or Stream, supported by officers with mental health 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.
4. SACAT should consider fairness of procedure when selecting Tribunal members to hear mental health matters.
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.
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.
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.*
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.*
9. The guiding principle for dependents of adults with mental illness should include children and young people as separate groups.
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.
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.
12. Community-based services and facilities should be included in the scope of the Community Visitor Scheme through the regulations.
13. The term of appointment to the Principal Community Visitor position should be 5 years.
14. The contents of the Annual Report of the Principal Community Visitor should be described in more detail.
15. The Principal Community Visitor should have the capacity to conduct visits and inspections of facilities alone.
16. The confidentiality and disclosure provisions of section 106 should remain unchanged.
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.
18. The requirements of section 99(1) for the Minister to provide information about patients are discriminatory and should be removed.
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.
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.

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.
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.
23. Treatment order forms should state expiry as 2pm.
24. Forms should contain the telephone and facsimile numbers of the Office of the Chief Psychiatrist.
25. Forms should specify “town/suburb” where they currently specify “suburb”.
26. Clarity should be provided regarding the use of electronic versions of forms.
27. Treatment order forms should not require a diagnosis or description of a person’s appearance or behaviour.
28. Treatment order forms should not require nomination of a particular treatment centre.
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.
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.
31. The guiding principles should require mental health services to meet the highest levels of quality and safety.
32. That all remaining references to “detention” and “detained” should be removed from the Act.
33. That schedule 2 should be removed.
34. That the preamble should be amended to refer to “persons with mental illness”.
35. The Chief Psychiatrist should be able to classify classes of professional directly as authorised officers.
36. The definition of mental health clinicians should be restricted to professionals who have undertaken recognised mental health qualifications.
37. Authorised Health Professionals should be renamed Authorised Mental Health Professionals.
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.
39. Complex ECT clinical or consent matters should be considered by a Prescribed Psychiatric Treatment Panel convened by the Chief Psychiatrist.
40. The witness signature field of the *Consent to ElectroConvulsive Therapy* (MR82J) form should be removed.
41. The ECT consent provisions should make it clear they do not allow the use of reasonable force.
42. That applications for neurosurgery for mental illness should be considered by a Prescribed Psychiatric Treatment Panel convened by the Chief Psychiatrist.
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.

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.
45. That definitions for care and control, reasonable force, restrictive practice, restraint and seclusion should be introduced to the Act.
46. That a restrictive practice section should be introduced to the Act.
47. That references to “mechanical body restraint” should be amended to “physical or mechanical restraint”.
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”.
49. That the Act should be reviewed and a report tabled in Parliament every four years.
50. That rights should be collated in a Schedule to assist understanding and compliance.
51. The right to a second psychiatrist opinion should be introduced.
52. That a provision recognising international human rights agreements should be introduced.
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).
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.
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.
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
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.
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.)
59. The requirement for all level 1 community treatment orders to be reviewed by the Guardianship Board should be removed.
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.
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.
62. New provisions explicitly allowing reasonable force to be used to carry community treatment orders into effect should be introduced.
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.)

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.
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.
66. The “facilities and services” criteria should be removed from community treatment orders.
67. The definition of harm should be amended to specify harm to mental health or physical health.
68. The threshold criteria for involuntary treatment should include a capacity criterion.
69. That the term “at large” should be replaced with “absent without leave” throughout the Act.
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.
71. That voluntary community patients should have treatment and care plans mandated by the Act.
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.