Report 18

February 2023



South Australian Law Reform Institute

Review of the *Mental Health Act 2009* (SA)

The **South Australian Law Reform Institute** was established in December 2010 by agreement between the Attorney-General of South Australia, the University of Adelaide and the Law Society of South Australia. It is based at the University of Adelaide Law School.

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This Final Report has been prepared in accordance with the Terms of Reference provided by the State Government.

Acknowledgement of Country:

SALRI acknowledges and respects Aboriginal people as the State's first people and recognises their traditional relationship with Country. We acknowledge that the spiritual, social, cultural and economic practices of Aboriginal people come from their traditional lands and waters, and that the cultural and heritage beliefs, languages and laws are still of importance today. The University of Adelaide, where SALRI is based, stands on Kaurna land.

THE UNIVERSITY of ADELAIDE

Government of South Australia
Attorney-General's Department

THE LAW SOCIETY OF SOUTH AUSTRALIA

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Glossary and Notes on Terminology

The following key terms and abbreviations are used in this Report:

AAS Act	*Ageing and Adult Safeguarding Act 1995* (SA).
Aboriginal people	SALRI recognises the diversity of Aboriginal people living throughout South Australia. SALRI has used the term 'Aboriginal' in this report to include all people of Aboriginal and Torres Strait Islander descent who are living in South Australia. This approach is consistent with the *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021).[1]
ACCHS	Aboriginal Community Controlled Health Services.
ACD Act	*Advance Care Directives Act 2013* (SA).
ACD	Advance Care Directive.
ALRC	Australian Law Reform Commission.
ARAS	Aged Rights Advocacy Service.
Authorised officer	This may be: • A mental health clinician • An ambulance officer • A medical officer or flight nurse of the Royal Flying Doctor Service • An officer of a class approved by the Chief Psychiatrist • An officer of a class approved in the regulations.[2]
BHFLHN	Barossa Hills Fleurieu Local Health Network.
CALD	Culturally and Linguistically Diverse.
CALHN	Central Adelaide Local Health Network.
CAMHS	Child and Adolescent Mental Health Services.
Capacity Assessment	A test or process used to determine whether a person has decision-making capacity to make a decision. This may be undertaken by a legal practitioner. A clinical capacity assessment may be undertaken by a psychiatrist, geriatrician, general practitioner, neuropsychologist or psychologist.[3]
Carer	A person who provides ongoing care or assistance to a person with mental illness, as defined in the *Carers Recognition Act 2005*; the term includes a person who was a carer of another before interruption of the provision of care due to the other's illness.[4] Carers can also be a guardian, substitute decision maker (medical agent), relative or friend of a person with mental illness.[5] As raised by Carer and Community support in its submission to SALRI, carer is defined by the ABS as 'a person who provides any informal assistance (help or

[1] *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021) vol 5, iii, 474.

[2] Office of the Chief Psychiatrist, *Mental Health Act 2009 Plain Language Guide* (July 2017) 12. See also *Mental Health Act 2009* (SA) s 56.

[3] See also Sylvia Villios et al, *Valuable Instrument or the Single Most Abused Legal Document in our Judicial System? A Review of the Role and Operation of Powers of Enduring Attorney in South Australia* (South Australian Law Reform Institute, 2020) 121–75.

[4] *Mental Health Act 2009* (SA) s 3.

[5] Office of the Chief Psychiatrist, *Mental Health Act 2009 Plain Language Guide* (July 2017) 12.

	supervision) to people with disability or older people (aged 65 years and over)'.[6] This is distinct from the care provided by an individual or agency on a paid basis.[7]
Care and control	An authorised officer (such as a medical practitioner or paramedic) and police officers have the power to take over care and control of a person with a mental illness, who is at risk to themselves and others. This person may be under an involuntary treatment order, waiting for transfer to a treatment centre or has failed to comply with a condition of their order. As part of exercising this power, an authorised officer or police officer may transport a person to a particular place, restrain a person using reasonable force or medication, enter a place or search and take harmful items. These powers may be used to assist and manage the treatment of a person.[8] There are differences in the powers exercisable by each. Unlike an authorised officer, a police officer *cannot* administer a drug/medication. Further, an authorised officer *cannot* use reasonable force to break into a place, although a police officer may do so.
Chief Psychiatrist	'A senior psychiatrist appointed by the Governor.'[9] The Chief Psychiatrist holds a variety of functions under the *Mental Health Act 2009* (SA).
CMTPC Act	*Consent to Medical Treatment and Palliative Care Act 1995* (SA).
Informed or Valid Consent	Informed or valid consent is given by a person if the person: • Has capacity to give informed consent; and • Has been given adequate information to enable the person to make an informed decision; and • Has been given a reasonable opportunity to decide whether or not to consent; and • Has given consent freely without undue pressure or coercion by any other person; and • has not withdrawn their consent or indicated their intention to withdraw their consent.[10]
Consumer	People who identify as having a living or lived experience of mental illness or psychological distress, irrespective of whether they have a formal diagnosis, who have used mental health services and/or received treatment.[11] This term is preferred to 'patient'.[12]
CRPD	United Nations *Convention on the Rights of Persons with Disabilities*.

[6] Australian Bureau of Statistics, *Disability, Ageing and Carers, Australia: Summary of Findings* (Catalogue No 4430.0, 24 October 2019).

[7] However, in consultation many parties used the term to refer to both.

[8] See *Mental Health Act 2009* (SA) ss 56–57.

[9] Office of the Chief Psychiatrist, *Mental Health Act 2009 Plain Language Guide* (July 2017) 12.

[10] *Mental Health and Wellbeing Act 2022* (Vic) s 86.

[11] *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021) vol 1, xiv.

[12] The term 'consumer' is used, as far as practicable, by SALRI to describe people who use or have used mental health services. Where the term 'patient' is used in this Report in a direct quotation from a consultation response or article, it is retained as such (though strictly SALRI is referring to a 'consumer'). SALRI acknowledges that there are other terms which can be used to describe these experiences and recognise that there is no single universally accepted term and the language in this area is contested and that persons with lived experience of mental illness may adopt different language to describe their experiences.

CTO	A Community Treatment Order is a legal order which requires a person living with a mental illness in the community to receive treatment without consent, at a particular place and at regular intervals.
Culturally appropriate	'An approach to policy, intervention, service delivery and intergroup interaction that is based on the positive acceptance of the cultural values and expectations of Aboriginal people.'[13] Culturally appropriate care is important for people from a broad range of cultures, including culturally and linguistically diverse individuals.
CVS	Community Visitor Scheme.
Decision-making Capacity[14]	Decision-making capacity refers to an adult's ability to make a decision for themselves. Generally, when a person has capacity to make a particular decision they can: • understand the relevant information involved; • retain this information; • use this information in the process of making a decision (weigh up the consequences) and; • communicate the decision (by any means).[15]
Depot	A special preparation of medication, which is given by injection. The medication is slowly released into the body over a number of weeks.[16]
Disability Royal Commission	*Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability.*
Diagnostic and Statistical Manual of Mental Disorders 5 TR (DSM-5-TR)	'The authoritative guide to the diagnosis of mental disorders for health care professionals around the world. Clinicians use DSM to accurately and consistently diagnose disorders affecting mood, personality, identity, cognition, and more. The manual does not address treatment, including use of medications.'[17]
Drug and alcohol use	Schedule 1 of the *MHA* lists certain conduct that do not indicate a person has a mental illness. According to this Schedule, nothing prevents, in relation to a person who takes or has taken alcohol or any other drug, the serious or permanent physiological, biochemical or psychological effects of drug taking from being regarded as an indication that a person is suffering from mental illness.[18]

[13] Patricia Dudgeon, Helen Milroy and Roz Walker (eds), *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing* (Department of the Prime Minister and Cabinet, Canberra, 2nd ed, 2014) 544.

[14] See also *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021) vol 5, 474–500.

[15] New South Wales, *Legislative Council General Purpose Standing Committee No 2, Elder Abuse in NSW* (Parliamentary Paper No 44, June 2016) 11 [2.25]. See also *Ageing and Adult Safeguarding Act 1995* (SA) s 5.

[16] Royal College of Psychiatrists UK, *Depot Medication* (April 2018) <https://www.rcpsych.ac.uk/mental-health/treatments-and-wellbeing/depot-medication>. See also *TSC v Department of Health and Wellbeing* [2021] SASCA 93, [11].

[17] American Psychiatric Association, *From Planning to Publication: Developing DSM-5-TR Factsheet* (2022).

[18] *Mental Health Act 2009* (SA) Sch 1. The intersection of drug and alcohol addiction and mental health was a recurring theme raised in SALRI's consultation. The use of illicit drugs, in particular methamphetamines, was identified as a pervasive issue in SALRI's regional consultation. Consultation with clinicians revealed the complexity and nuances associated with drug and/or alcohol use and mental illness. It was noted it may take time to determine whether a person is self-medicating to mask an underlying mental illness or whether drug and/or alcohol addiction has caused a mental illness. Consultation also identified the importance of collaboration between mental health and drug and alcohol services (namely, DASSA). See Ian Munro and Karen-Leigh Edward, 'Mental Illness and Substance Use: an Australian Perspective (2008) 17(4) *International Journal of Mental Health Nursing* 255. Similar issues arise in the criminal law context, pertaining to the intersection between intoxication and the defence of mental

Dual diagnosis	A person with more than one diagnosis. For example, a mental illness and intellectual disability.
ECT	Electroconvulsive therapy is a highly specialised medical procedure where measured small electric currents are passed through the brain, intentionally triggering a brief seizure. ECT is done under full general anaesthetic with a muscle relaxant. ECT is performed by a qualified multidisciplinary team that includes a psychiatrist and an anaesthetist. ECT is only used in specific circumstances, most commonly to treat major depression and sometimes other severe mental illness such as acute mania, catatonia and schizophrenia.[19]
ED	Emergency Department.
EFNLHN	Eyre and Far North Local Health Network.
Family Violence	'Violent or threatening behaviour, or any other form of behaviour, that coerces or controls a family member or causes that family member to be fearful.'[20]
FUNLHN	Flinders and Upper North Local Health Network.
Fluctuating Capacity	An individual's decision-making capacity is fluid and not fixed or static, and may fluctuate over time, with temporary periods of impaired decision-making capacity.[21]
HCSCC	Health and Community Services Complaints Commissioner.

impairment (previously called insanity). See further Michelle Lawrence and Simon Verdun-Jones, 'Blurred Lines of Intoxication and Insanity: an Examination of the Treatment at Law of Accused Persons found to have Committed Criminal Acts while in States of Substance-Associated Psychosis where Intoxication was Voluntary' (2015) 93(3) *Canadian Bar Review* 571; *R v Delany* [2022] SASC 125; Question of Law Reserved (No 1 of 2021) [2021] SASCA 148. 'From early in this century the increasing frequency of drug abuse disorders, particularly addiction to methamphetamine and other mind-altering drugs, amongst sufferers of major psychiatric illnesses (referred to as comorbidity) raised questions about the appropriateness of applying Part 8A of the *CLCA* when they offended…the moral opprobrium attached to drug use which is commonly viewed as voluntary, irresponsible and hedonistic behaviour. However, it is the experience of judges, lawyers and psychiatrists that drug use is, as often, a crude attempt by the psychiatrically ill at self-medication. It is also well understood that major psychotic illnesses often deprive sufferers from the insight necessary to appreciate the importance of taking prescribed medication': at [19]–[20].

[19] Office of the Chief Psychiatrist, *Annual Report 2021-22* (17 November 2022) 24.

[20] This was the definition adopted by the ALRC and NSWLRC in their 2010 *Family Violence: A National Legal Response* Report. The Report continued: 'Such behaviour may include but is not limited to:
(a) physical violence;
(b) sexual assault and other sexually abusive behaviour;
(c) economic abuse:
(d) emotional or psychological abuse;
(e) stalking;
(f) kidnapping or deprivation of liberty;
(g) damage to property, irrespective of whether the victim owns the property;
(h) causing injury or death to an animal irrespective of whether the victims owns the animal; and
(i) behaviour by the person using the violence that causes a child to be exposed to the effects of behaviour referred to in (a)–(h) above': Australian Law Reform Commission and NSW Law Reform Commission, *Family Violence: A National Legal Response* (ALRC Report No 114, NSWLRC Report No 128, October 2010) Recommendation 5. In some situations, the attributes of elder abuse can be compared to those of domestic violence between partners: see Rosslyn Monro, 'Elder Abuse and Legal Remedies – Practical Realities?' (Spring 2002) 81 *Reform* 42.

[21] The recognition of fluctuating capacity (and the presumption of capacity) are particularly important. Various factors may cause fluctuating capacity, such as neurological/neurocognitive disorders (dementia and acquired brain injury), medical co-morbidities (delirium) and medication use. The inclusion and acknowledgment of 'fluctuating capacity' has been a recurring theme raised in SALRI's past and present consultations. Various parties also spoke in favour of practical guidance as to the definition of capacity in the *Mental Health Act 2009* (SA) – see Part 3 Decision-making Capacity and Supported Decision-making. Support was also expressed for the way in which the *Mental Health Act 2009* (SA) recognises the concept of fluctuating capacity and a presumption of capacity.

HRCRC	Office of the Chief Psychiatrist Human Rights and Coercion Reduction Committee.
ICC	Intermediate Care Centre.
International Classification of Diseases 11th Revision (ICD-11)	Developed by the World Health Organisation. 'ICD–11 is the international standard for systematic recording, reporting, analysis, interpretation and comparison of mortality and morbidity data. This 11th revision is the result of an unprecedented collaboration with clinicians, statisticians, classification and IT experts from around the world, making it useable by these groups, as well as by coders.'[22]
ITO	An Inpatient Treatment Order is a legal order which requires a person with a mental illness to receive treatment without their consent.[23]
LCLHN	Limestone Coast Local Health Network.
LEAG	Office of the Chief Psychiatrist Lived Experience Advisory Group.
LELAN	Lived Experience Leadership and Advocacy Network.
Lived experience	People with lived experience identify either as someone who is living with (or has lived with) mental illness or psychological distress, or someone who is caring for or otherwise supporting (or has cared for or otherwise supported) a person who is living with (or has lived with) mental illness or psychological distress. People with lived experience are sometimes referred to as 'consumers' or 'carers'.[24] People with lived experience are referred to by SALRI as 'consumers' (but are sometimes called 'carers'). SALRI acknowledges that the experiences of consumers and carers are different.[25]
LGBTIQ	Lesbian, Gay, Bisexual, Transgender, Intersex and Queer. SALRI notes there are many terms and acronyms used to refer to people from these communities and uses LGBTIQ for consistency, including with its previous reports.[26]
MCCSA	Multicultural Communities Council of South Australia.
MHCs	Mental Health Commissioners.
Mental Illness	Any illness or disorder of the mind.[27] Schedule 1 *MHA* lists certain conduct that do not indicate a person has a mental illness. For example, political, religious or philosophical views, sexual preference or orientation, immoral or illegal conduct, antisocial behaviour, developmental disability, cultural, economic or social status.[28]
Mental Wellbeing	A state of wellbeing in which a person realises their own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to their community.[29]
NALHN	Northern Adelaide Local Health Network.

[22] World Health Organisation, *ICD-11 Fact Sheet* <https://icd.who.int/en/docs/icd11factsheet_en.pdf>.

[23] *Mental Health Act 2009* (SA) Div 2.

[24] *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021) vol 1, xv.

[25] Ibid.

[26] The Western Australian Parliamentary Report provided a summary of the issues facing LGBTIQ people in the elder abuse context: see Legislative Council Select Committee into Elder Abuse, *'I Never Thought It Would Happen To Me': When Trust is Broken* (Parliament of Western Australia, September 2018) 37–8 [3.49]–[3.55].

[27] See *Mental Health Act 2009* (SA) s 3, Sch 1. Note, *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021): the Victorian Royal Commission recognises the Victorian Mental Illness Awareness Council Declaration released on 1 November 2019. The declaration notes that people with lived experience can have varying ways of understanding the experiences that are often called 'mental illness'. It acknowledges that mental illness can be described using terms such as 'neurodiversity', 'emotional distress', 'trauma' and 'mental health challenges'.

[28] *Mental Health Act 2009* (SA) Sch 1.

[29] *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021) vol 1, xiv.

NDIS	National Disability Insurance Scheme.
OCP	Office of the Chief Psychiatrist.
OPA	Office of the Public Advocate.
OPMHLG	Office of the Chief Psychiatrist Older Persons Mental Health Leadership Group.
Patient	A person to whom an inpatient treatment order applies, or to whom s 56 (care and control) applies or a person with a mental illness who is liable to a supervision order under Part 8A of the *Criminal Law Consolidation Act 1935* (SA).
PCV	Principal Community Visitor.
PICU	Psychiatric Intensive Care Unit.
PPTP	Prescribed Psychiatric Treatment Panel.
RANZCP	Royal Australian and New Zealand College of Psychiatrists.
Restrictive Practices	A restrictive practice takes a variety of forms and aims to limit a person's freedom to move. There are four types: 1. Chemical: using medication without consent. 2. Mechanical: using a device, such as a lap belt, bed rails, a princess chair, clothing or low bed. 3. Physical: using physical force with your hands or body or placing a person in a particular position which limits movement. 4. Seclusion: placing a person in a room on their own, without a way to leave.[30]
RMCLHN	Riverland Mallee Coorong Local Health Network.
RRMHS	Rural and Remote Mental Health Service.
SAAS	SA Ambulance Service.
SACAT	*South Australian Civil and Administrative Tribunal.*
SACID	South Australian Council on Intellectual Disability.
SALHN	Southern Adelaide Local Health Network.
SALRI	South Australian Law Reform Institute.
SAPOL	South Australia Police.
SEWB	Social and Emotional Wellbeing is 'being resilient, being and feeling culturally safe and connected, having and realising aspirations, and being satisfied with life.'[31]
Shared Decision-making	Refers to skills and practices exercised by a clinician in order to engage in a collaborative decision-making process.[32]
Substitute Decision-Making	Where '(i) legal capacity is removed from a person, even if this is in respect of a single decision; (ii) a substitute decision-maker can be appointed by someone other than the person concerned, and this can be done against his or her will or (iii) any decision made by a substitute decision-maker is based on what is believed to be in

[30] See Office of the Chief Psychiatrist South Australia, *Annual Report of the Chief Psychiatrist of South Australia 2020-21* (Report, 18 November 2021) 25. See also Aged Care Quality and Safety Commission, *Overview of Restrictive Practices* <https://www.agedcarequality.gov.au/sites/default/files/media/overview-of-restrictive-practices_0.pdf>.

[31] *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021) vol 1, xv.

[32] Soumitra Pathare and Laura Shields, 'Supported Decision-Making for Persons with Mental Illness: a Review' (2012) 34(2) *Public Health Reviews* 1, 4.

	the objective 'best interests' of the person concerned, as opposed to being based on the person's own will and preferences.'[33]
Supported Decision-Making	'Comprises various support options which give primacy to a person's will and preferences and respect human rights norms. It should provide protection for all rights, including those related to autonomy … and rights related to freedom from abuse and ill-treatment (right to life, right to physical integrity, etc.)'[34]
UMHCC	Urgent Mental Health Care Centre.
Victorian Royal Commission	Royal Commission into Victoria's Mental Health System.
VAD Act	*Voluntary Assisted Dying Act 2021* (SA).
WCHN	Women's and Children's Health Network.
WHO	World Health Organisation.
YNLHN	Yorke and Northern Local Health Network.

Notes on Terminology

SALRI notes that much of the language used in this Report may be contentious, problematic or difficult to define. SALRI acknowledges that some terms do not command universal acceptance. The terms used have been selected based on current legislation and practice whether in South Australia or elsewhere.[35] In addition to the glossary, SALRI offers the following explanation for the use of certain terms:

Mental illness

Mental illness retains a broad definition under the *MHA*. Schedule 1 contains a list of factors constituting 'certain conduct', which do not indicate the presence of a mental illness.[36] The diagnosis of a mental illness relies on the expertise of the treating clinician, who adopts specific approaches or

[33] Committee on the Rights of Persons with Disabilities, *General Comment No 1 Article 12: Equal Recognition Before The Law*, 11th sess, UN Doc CRPD/C/GC/1 (11 April 2014) [27].

[34] Committee on the Rights of Persons with Disabilities, *General Comment No 1 Article 12: Equal Recognition Before The Law*, 11th sess, UN Doc CRPD/C/GC/1 (11 April 2014) [29].

[35] See *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021). See further at: Royal Commission into Victoria's Mental Health System, *Final Report Available Now* <http://rcvmhs.archive.royalcommission.vic.gov.au/>.

[36] SALRI's consultations in previous references with aged care groups have raised whether 'dementia' should be classified as a mental illness. Dementia is an umbrella term for the various syndromes that cause a gradual decline in brain function over time, resulting in progressive 'impairments in memory, language and perception, as well as […] attention, emotion regulation and decision-making' capacity. Therefore, although individuals with dementia more commonly fall under guardianship, they *may* fall under the definition of 'mental illness' and hence the *Mental Health Act 2009* (SA) may apply. In an ageing population, it is increasingly important that dementia is considered in the mental health context, most notably regarding fluctuating capacity and capacity assessment: Cameron Stewart, 'Health Law Reporter: Supported Decision-Making for people living with Dementia: An Examination of four Australian Guardianship Laws' (20210322) 28(2) *Journal of Law and Medicine* 389; United Nations, *Handbook for Parliamentarians – From Exclusion to Equality: Realising the Rights of Persons with Disabilities* (United Nations Department of Economic and Social Affairs, Office of the United Nations High Commissioner for Human Rights and Inter-Parliamentary Union, 2007) Ch 6. 'There may be times when a person with dementia comes within the definitions of a "mentally ill" or "mentally disordered" person. In these circumstances they come under the *Mental Health Act* and can be scheduled, transported to, admitted and treated as an involuntary patient (like any other person of any age)': Health Education and Training, *NSW Mental Health Act (2007)* NSW Government <https://www.heti.nsw.gov.au/education-and-training/courses-and-programs/nsw-mental-health-act-2007>.

cognitive tools. In addition, the Diagnostic and Statistical Manual of Mental Disorders 5 TR (DSM-5-TR) and International Classification of Diseases 11th Revision (ICD-11) are diagnostic guides used by a clinician in their diagnosis of a consumer. Currently, the *MHA* captures neurocognitive disorders – colloquially known as a 'dementia'. This may refer to Behavioural and Psychological Symptoms of Dementia ('BPSD), Parkinson's Disease, Lewy-Body Dementia, Alzheimer's Disease, Fronto-temporal dementia and more.[37]

'Consumer' or 'Patient'

There is no present universally agreed upon language for those seeking or needing mental health treatment, and labels commonly used include consumer, patient, client, and service user.[38] These labels can be stigmatising or empowering. SALRI, for consistency with the new Victorian Act,[39] the Office of the Chief Psychiatrist and consumer groups, has used the term 'consumer' for a person seeking treatment in a voluntary or involuntary capacity in the community.[40] Further, the term 'consumer' denotes assumptions of rationality and ability to make autonomous choices, rather than be a passive recipient of 'expert' attention.[41] However, SALRI acknowledges that the term 'consumer' does not command universal acceptance.[42]

In this Report, the term 'patient' refers to a person who has been admitted to an inpatient treatment unit of a hospital or authorised treatment centre.

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[37] See *Mental Health Act 2009* (SA) s 3.

[38] Melanie Fischer et al, 'Patient, Client, Consumer, or Service User? An Empirical Investigation into the Impact of Labels on Stigmatising Attitudes' (2020) 43(3) *Psychiatric Rehabilitation Journal* 197.

[39] *Mental Health and Wellbeing Act 2022* (Vic) s 3.

[40] SALRI notes the term 'consumer' is used, as far as practicable, in this Report. Where the term 'patient' is used in this Report in a direct quotation from a consultation response or article, it is retained as such (though strictly SALRI is referring to a 'consumer'). SALRI acknowledges there are other terms which can be used to describe these experiences and recognises there is no single universally accepted term and that persons with lived experience of mental illness may adopt different language to describe their experiences.

[41] See generally Ruth McDonald et al, 'Governing the Ethical Consumer: Identity, Choice and the Primary Care Medical Encounter' (2007) 29(3) *Sociology of Health and Illness* 430.

[42] Mark Upton, G Harm Boer and Alastair Neale, 'Patients or Clients? – a Hospital Survey' (1994) 18 *Psychiatric Bulletin* 142; Verinder Sharma et al, 'Preferred Terms for Users of Mental Health Services among Service Providers and Recipients' (2000) 51(20 *Psychiatric Services* 203; Geoff Dickens and Marco Picchioni, 'A Systematic Review of the Terms used to Refer to People who use Mental Health Services: User Perspectives' (2012) 58(2) *International Journal of Social Psychiatry* 115; Daniel Costa et al, 'Patient, Client, Consumer, Survivor or other Alternatives? A Scoping Review of Preferred Terms for Labelling Individuals who access Healthcare across Settings' (2019) 9 *BMJ Open* 1; Henry Nasrallah, 'We are Physicians, not Providers, and we Treat Patients, not Clients!' (2020) 19(2) *Current Psychiatry* 5; Andrea Lyon and Sheila Mortimer-Jones, 'Terminology Preferences in Mental Health' (2020) 41(6) *Issues in Mental Health Nursing* 515 (this last study found the terms 'individual' and 'person with lived experience' were identified as the preferred terms and the term 'consumer' was one of the least preferred terms, suggesting that the use of this term, which is in regular use in Australia, should be reconsidered).

One study revealed a preference for 'patient'. Geoff Dickens, Amanda Lange and Marco Picchioni, "Labelling People who are Resident in a Secure Forensic Mental Health Service: User Views'(2011) 22(6) *Journal of Forensic Psychiatry and Psychology* 885. This study of 100 randomly selected individuals resident in three secure mental health hospitals found 'patient' was the preferred term of 42% of respondents; 'client' (20%), 'service user' (17%) and 'consumer' (2%) were less popular. Preferences did not vary by gender, age, diagnosis, legal status, ethnicity, security level or length of stay. The study found that on the basis of preference alone, there is no case for rejection of the term 'patient' in secure mental health service provider communication and literature.

Supported decision-making and substitute decision-making

Supported decision-making should be distinguished from substitute decision-making. Supported decision-making refers to decisions made *by* a consumer *with* support. In contrast, substitute decision-making refers to decisions made *for* (or on behalf of) consumers. The Committee on the Rights of Persons with Disabilities described the supported decision-making regime as one which:

> … comprises various support options which give primacy to a person's will and preferences and respect human rights norms. It should provide protection for all rights, including those related to autonomy … and rights related to freedom from abuse and ill-treatment (right to life, right to physical integrity, etc.)[43]

It is described as a 'less restrictive alternative',[44] as opposed to substitute decision-making. Pursuant to Article 3(1) *CRPD*, '[r]espect for inherent dignity, individual autonomy including the *freedom to make one's own choices*, and independence of persons' is a fundamental principle of the Convention.[45] Persons with disabilities (which includes consumers under the *MHA*) have the international human right to 'enjoy legal capacity on an equal basis with others in all aspects of life'.[46] Further, Art 12(3) requires that State Parties should take 'appropriate measures to provide access' to supports enabling a person to exercise legal capacity.[47] These measures should promote a person with or without impaired decision-making capacity to exercise autonomy, with any supports required.

Supported decision-making is not only encouraged but has been interpreted as vital by the UN Committee on the Rights of Persons with Disabilities to comply with the *CRPD*, combined with the elimination of substitute decision-making. It is noted Australia does not view substitute decision-making as inherently inconsistent with the *CRPD*, and, in Australia's view, it allows 'for fully supported or substituted decision-making arrangements, only where such arrangements are necessary, as a last resort and subject to safeguards'.[48]

Supported decision-making can take various forms in legislation, policy and practice, however underlying all of these is the necessary respect for the consumer's 'rights, will and preferences' and the provision of support to help make a decision autonomously.

The *MHA,* as SALRI was often reminded in consultation, is underpinned by a supported decision-making model. Efforts to transform the *MHA* into a more 'rights-based' instrument are important in establishing the legal framework for a supported decision-making model.[49]

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[43] Committee on the Rights of Persons with Disabilities, *General Comment No 1 Article 12: Equal Recognition Before The Law*, 11th sess, UN Doc CRPD/C/GC/1 (11 April 2014) [29].

[44] See Matthé Scholten et al, 'Combining Supported Decision-Making with Competence Assessment: A Way to Protect Persons with Impaired Decision-Making Capacity against Undue Influence' (2021) 21(11) *American Journal of Bioethics* 45.

[45] *Convention on the Rights of Persons with Disabilities*, UN GAOR 61st sess, plen mtg 76, Agenda Item 67(b), UN Doc RES A/61/106 (3 May 2008, adopted 24 January 2007) art 3(1) (emphasis added).

[46] Ibid art 12.

[47] Ibid art 12(3).

[48] See Australia's interpretative announcement: United Nations Treaty Collection, *Chapter IV: Human Rights - Convention on the Rights of Persons with Disabilities* (New York, 13 December 2006); *Convention on the Rights of Persons with Disabilities*, UN GAOR 61st sess, plen mtg 76, Agenda Item 67(b), UN Doc RES A/61/106 (3 May 2008, adopted 24 January 2007). See further Part 2 Background and Context to South Australia's Mental Health Laws.

[49] For a discussion on supported decision-making, see Part 3 Decision-making Capacity and Supported Decision-making. SALRI notes the helpful submission of Dr Susan Peukert.

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Executive Summary

> Mental ill-health affects all Australians, either directly or through our families, colleagues, friends and loved ones. It does not discriminate. But Australia's mental health system has not kept pace with our needs… Mental illness remains stigmatised and while social views of mental illness have improved they still trail well behind our knowledge of how mental health affects people's lives. This stigma creates barriers to individuals seeking care and can reduce the effectiveness of that care. Australia's mental health system (and the professions charged with assisting people) need to be stigma free and consumers empowered to have a say in their own treatment without being deprived of the information they need to make those decisions.[50]

This observation from the Productivity Commission provides the context to SALRI's present important review of the operation of South Australia's mental health laws.

On 17 February 2022, the South Australian Law Reform Institute (SALRI) was formally requested by the Hon Josh Teague MP, the Minister for Planning and Local Government (exercising the powers and functions of the Attorney-General), to undertake an independent legislative review of the operation of the *Mental Health Act 2009* (SA) ('*MHA*') under s 111 of the Act. This review was confirmed after the 2022 State election by the Hon Chris Picton MP, the Minister for Health and Wellbeing. Minister Picton additionally asked SALRI to consider the impact, if any, of the *MHA* on the delivery of mental health services.[51]

Following this review, SALRI was required to provide a Final Report to the Minister examining the operation of the law and making any recommendations for possible changes to law and practice. According to its Terms of Reference, SALRI was not to examine the provision or delivery of mental health services. SALRI acknowledges that, as was often pointed out in consultation, there are very real issues and needs in this area. However, issues beyond the scope of this review cannot be addressed in our recommendations. Rather, SALRI has made a number of suggestions in addition to the formal recommendations.

The following formal Terms of Reference were provided to SALRI:

1. Consult with relevant stakeholders, experts, persons with lived experience of mental illness, and other interested community groups and members, and to consider best practice from other Australian (and, if appropriate, international) jurisdictions in relation to the best practice, rights-supportive approach to mental health laws.

2. Make recommendations on best practice and appropriate legislative changes as a result of these investigations, with a view to replacing (if required) or reforming South Australia's mental health legislation to better meet the objectives of the Act.

3. In particular, examine the following matters:

[50] Productivity Commission, *Mental Health: Inquiry Report* (No 95) (2014) vol 1, 4–6.

[51] This additional Term of Reference raises operational and resourcing issues that, in part, are specifically beyond SALRI's review and where there was inconsistency no recommendations could be made by SALRI. However, these barriers have been addressed within the Report and in suggestions made outside of the formal recommendations.

3.1. Whether the operation of the Act unreasonably erodes patient rights to refuse treatment, or rights to access alternative, non-pharmacological approaches to treatment.

3.2. Consider the findings of the Royal Commission into Victoria's Mental Health System, insofar as those findings are relevant to South Australia's mental health legislation, including the role of positive rights and objectives that promote community-wide good mental health, a focus on recovery-oriented practice, and accountability mechanism for decision-makers.

3.3. Consider the operation of the 'decision-making capacity criterion' for involuntary treatment orders under the Act, and its definition in s 5A, and in doing so consider:

3.3.1. Whether a best-practice, rights-based approach requires the prioritisation of this criterion and a legislated supported decision-making model;

3.3.2. Whether consumers, carers and mental health professionals require legislative clarification concerning the assessment of impaired decision- making capacity, with reference to the decisions in *PBU & NJE v Mental Health Tribunal* [2018] VSC 564 and *TSC v Department for Health and Wellbeing* [2021] SASCA 93.

3.3.3. The findings and Recommendation 4 of the Deputy State Coroner Anthony Schapel dated 4 November 2021 regarding the death of Theo Nicholas Papageorgio, which relates to the impact of legislative criteria and suicide prevention.[52]

3.4. In the context of a discussion around shifting the focus of the Act towards encouraging good mental health and wellbeing, consider whether the role of Mental Health Commissioners should be statutory under the MH Act.

3.5. Consider improvements that could be made to the operation of the Act, including to address the issues identified [by the Office of the Chief Psychiatrist]. These issues have been identified following internal consultation in the Office of the Chief Psychiatrist and preliminary external consultation with a limited number of stakeholders. While many are administrative matters concerning the current operation of the Act, several are substantive legal or rights-impacting issues. They may be grouped into the following categories: (1) human rights protections, (2) involuntary treatment orders and care and control powers, (3) Consumer representation, (4) Electroconvulsive Therapy, (5) Prescribed Psychiatric Treatment Panel, (6) Functions of the Chief Psychiatrist and Community Visitor Scheme, and (7) Miscellaneous other issues.

The *MHA* provides a framework for the delivery of mental health services in South Australia. Mental health law can significantly affect the rights of consumers,[53] particularly in the context of involuntary treatment. As such, the law must be examined through the lens of a changing legal landscape, whereby international human rights law, principles and frameworks have shifted to a supported decision-making model over the past, now outdated, substitute decision-making model. This shift places greater emphasis on the need to safeguard decision-making capacity, autonomy and self-determination.[54]

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[52] *Inquest into the Death of Theo Nickolas Papageorgiou* [2021] SACorC 13 (Coroner's Court of South Australia, Deputy State Coroner Schapel, 4 November 2021). SALRI, consistent with the approach of the Deputy Coroner, refers in this Report to Mr Papageorgiou as 'Theo'. SALRI is grateful for the valuable input of Theo's parents to this reference.

[53] SALRI, in accordance with modern practice, will use the term 'consumers' in preference to past terms such as 'patients'.

[54] See generally the voluminous work of the Victorian Royal Commission into Victoria's Mental Health System: *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021). See further at: Royal Commission into

The aim of this review is to ensure South Australia remains at the forefront of mental health reform. Consequently, the review has examined the legal, human rights and other issues raised, as well as the operation of the *MHA*. This enabled SALRI to identify any shortcomings of the law, areas for reform and potential changes to present law and practice to resolve any issue(s) identified.

SALRI's new Term of Reference focussed on the *MHA*'s guiding principles and accountability mechanisms. Specifically, to consider the impact, if any, of the *MHA* on the delivery of mental health services. A focus on the guiding principles and accountability was largely borne out of the recent Victorian Royal Commission. The intended changes to the Victorian law aimed to strengthen the objectives and principles, support access to care and treatment which is rights-based and enforce accountability mechanisms and monitoring arrangements. This was recommended in response to the lack of clear accountability mechanisms ensuring mental health principles are translated into practice. In order to address this new Term of Reference, SALRI examined how these principles can be operationalised in practice; whether their translation into practice impacts a consumer's access to mental health services, and if so, how this may be improved; and accountability mechanisms to monitor compliance with the principles and enforce consequences for non-compliance.

Although access to services, resourcing and quality of mental health services fell outside the scope of the current review, it was raised throughout SALRI's consultation when seeking views relating to this Term of Reference. Access to services is primarily a resourcing issue, which has been noted as beyond the scope of the SALRI review. In the absence of adequate resourcing, it is not possible to ensure effective, best-practice treatment for each person. In pursuing the goal of providing 'the highest attainable standard of health', it is critical that mental health services receive the funding necessary to provide accessible health services, including those focussed on early interventions that can cease or slow the progression of a mental illness that may otherwise result in a need for a more restrictive intervention, such as compulsory treatment.

SALRI submitted an Interim Report to the Minister of Health, outlining progress in the context of this review, SALRI's work to date and future plans.[55]

SALRI's consultation was comprehensive and adopted a flexible and multi-faceted approach. There were various means for interested parties and individuals to share their views with SALRI in relation to this review. SALRI had a focus on consultation with consumers and their families, regional and rural communities and Aboriginal communities. There was extensive interest and input by various means, from a wide range of parties and perspectives including consumers, medical and mental health practitioners, the Chief Psychiatrist, NGOs, legal practitioners, consumer groups, disability groups, service providers, Aboriginal Elders and Aboriginal health services, professional bodies, government and non-government bodies, office holders, experts and members of the community.

SALRI held eight focus groups in Adelaide with various organisations, including consumers (Lived Experience Leadership and Advocacy Network and Aspire Recovery Connection), disability (Purple Orange, Our Voice SA and the South Australian Council on Intellectual Disability) and Culturally and Linguistically Diverse communities (Multicultural Communities Council of South Australia). SALRI also held seven roundtable discussions in Adelaide, attended by over 60 professionals (including

Victoria's Mental Health System, *Final Report Available Now* <http://rcvmhs.archive.royalcommission.vic.gov.au/>.

[55] South Australia, *Parliamentary Debates*, Legislative Council, 31 May 2022, 327.

medical specialists, psychologists, nurses, social workers, disability advocacy workers, NGO workers and Government representatives, Office of the Chief Psychiatrist, SAPOL, Office of the Public Advocate, Legal Services Commission, SA Ambulance Service, Commissioner for Children and Young People and more).

SALRI has a focus on consultation with regional and rural communities. As part of its consultation, SALRI visited Port Pirie, Port Augusta, Whyalla, Berri, Mount Gambier, Port Lincoln and Naracoorte, engaging with a wide range of parties and held 19 Roundtables. SALRI also has a focus on honest and respectful consultation with Aboriginal communities. As part of this review, SALRI spoke to a number of Elders and members of community, Aboriginal Health Services and practitioners working closely with Aboriginal communities.

SALRI also held a number of consultation sessions, including private meetings with parties in Adelaide and regional centres. SALRI received a total of 149 submissions by various means[56] and 76 contributors to the public YourSAy site (open forum and survey). SALRI also held 42 individual meetings, held in person or online. Finally, SALRI attended a site visit to the electroconvulsive therapy suite at The Queen Elizabeth Hospital and the South Australian Section of Electroconvulsive Therapy and Neurostimulation (RANZCP), Neurostimulation Retreat in October 2022.

SALRI also took part in several media interviews in both Adelaide and regionally.

The survey responses and extensive input to SALRI's consultation has greatly informed and assisted in the formulation and findings of this review.

Many issues and concerns of resourcing, operation and culture in the provision of mental health services were raised in SALRI's consultation by many parties.

A number of parties in consultation referred to the landmark Victorian Royal Commission.[57] Though the voluminous work of the Royal Commission was a valuable resource for SALRI,[58] the scope of the Royal Commission was far ranging and involved a review of the entire mental health system in Victoria. While SALRI was not requested to undertake such a comprehensive assessment, legislative reviews such as the present still provide a valuable opportunity to determine whether the law remains fit for purpose and effective in meeting its objectives.

The challenges affecting South Australia's mental health system are by no means unique. The Victorian Royal Commission found:

> The present system is not designed or equipped to support the diverse needs of people living with mental illness or psychological distress, families, carers and supporters, let alone to cope with unforeseen pressures that may arise. The 2019-20 severe bushfire season and the COVID-19 pandemic shone further light on the pressures on the mental health system. Due to system constraints, services are often inaccessible at the times when they would make the most difference, and the system largely operates in crisis mode – that is, it tends to react to mental health crises rather than preventing them. The system is complex and fragmented and, for those who do

[56] These submissions ranged from technical comments to comprehensive submissions up to 88 pages.

[57] The Victorian Royal Commission released seven comprehensive volumes. See *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021).

[58] The new landmark Victorian *Mental Health and Wellbeing Act 2022* (Vic) (based on the Royal Commission's findings), which will come into force on 1 September 2023 was also a valuable resource. The *MHWA* is a major Act, totalling some 652 pages. It cannot be simply transplanted in a South Australian context.

> manage to get into it, difficult to navigate. People experience enormous frustration and distress when trying to identify the right mental health services for themselves or someone else.[59]

SALRI notes at an international level, 'persons with disabilities have a right to respect for his or her physical and mental integrity on an equal basis with others'.[60] Mental health laws which authorise compulsory treatment, including restrictive practices such as seclusion and restraint,[61] have often been viewed at an international human rights level, notably Article 12 of the UN *Convention on the Rights of Persons with Disabilities* ('*CRPD*'), as inconsistent with this right.[62] There is considerable debate as to the correctness, effects and implications of these international human rights principles and their binding (or lack of) effect.[63] Australia also has issued an interpretative declaration in respect of Article 12, to the effect that it views the *CRPD* as allowing 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'.[64] 'There are differing views about the effect of this declaration, particularly in relation to the role of substitute decision-making, which prompt a reconsideration of its retention.'[65] SALRI has, however, proceeded in accordance with this declaration.[66] This aligns with the approach of the Australian Law Reform Commission ('ALRC'), which also recognises that a substitute decision-making model and involuntary treatment in relation to persons with mental illness are permissible, as a last resort with suitable safeguards.[67]

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[59] *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021) vol 1, 2.

[60] *Convention on the Rights of Persons with Disabilities*, UN GAOR 61st sess, plen mtg 76, Agenda Item 67(b), UN Doc RES A/61/106 (3 May 2008, adopted 24 January 2007) art 17.

[61] For further discussion, see Part 8 Restrictive Practices and Control Powers.

[62] Sascha Callaghan and Christopher James Ryan, 'Rising to the Human Rights Challenge in Compulsory Treatment – New Approaches to Mental Health Law in Australia' (2012) 46 *Australian and New Zealand Journal of Psychiatry* 61; Sascha Callaghan and Christopher Ryan, 'An Evolving Revolution: Evaluating Australia's Compliance with the Convention on the Rights of Persons with Disabilities in Mental Health Law' (2016) 39(2) *University of New South Wales Law Journal* 596.

[63] Sascha Callaghan and Christopher James Ryan, 'Rising to the Human Rights Challenge in Compulsory Treatment – New Approaches to Mental Health law in Australia' (2012) 46 *Australian and New Zealand Journal of Psychiatry* 61; John Dawson, 'A Realistic Approach to Assessing Mental Health Laws' Compliance with the UNCRPD' (2015) 40 *International Journal of Law and Psychiatry* 70; Sascha Callaghan and Christopher Ryan, 'An Evolving Revolution: Evaluating Australia's Compliance with the Convention on the Rights of Persons with Disabilities in Mental Health Law' (2016) 39(2) *University of New South Wales Law Journal* 596; Neeraj Gill et al, 'Measuring the Impact of Revised Mental Health Legislation on Human Rights in Queensland, Australia. (2020) *International Journal of Law and Psychiatry* 73.

[64] United Nations Treaty Collection, *Chapter IV: Human Rights - Convention on the Rights of Persons with Disabilities* (New York, 13 December 2006). Although the Committee on the Rights of Persons with Disabilities has recommended that this interpretative declaration be reviewed and withdrawn, to date this has not been done. See further Part 2 Background and Context to South Australia's Mental Health Laws.

[65] Australian Law Reform Commission, *Equality, Capacity and Disability in Commonwealth Laws* (Final Report, November 2014) [2.19].

[66] This approach is also favoured by the ALRC, other law reform bodies and academic commentators. See generally Sascha Callaghan and Christopher James Ryan, 'Rising to the Human Rights Challenge in Compulsory Treatment – New Approaches to Mental Health law in Australia' (2012) 46 *Australian and New Zealand Journal of Psychiatry* 61; John Dawson, 'A Realistic Approach to Assessing Mental Health Laws' Compliance with the UNCRPD' (2015) 40 *International Journal of Law and Psychiatry* 70; Sascha Callaghan and Christopher Ryan, 'An Evolving Revolution: Evaluating Australia's Compliance with the Convention on the Rights of Persons with Disabilities in Mental Health Law' (2016) 39(2) *University of New South Wales Law Journal* 596; Neeraj Gill et al, 'Measuring the Impact of Revised Mental Health Legislation on Human Rights in Queensland, Australia. (2020) *International Journal of Law and Psychiatry* 73.

[67] See Australian Law Reform Commission, *Equality, Capacity and Disability in Commonwealth Laws* (Final Report, November 2014) 53–62 [2.78]–[2.116].

The history of mental health law demonstrates a perpetual struggle to legislate with respect to persons with lived experience of mental illness.[68] In particular, the involuntary treatment of mental illness[69] has remained 'the most consistently debated issue' in mental health law.[70] The implications of involuntary treatment (whether an Inpatient Treatment Order or Community Treatment Order[71]) are profound. It significantly impacts upon not only consumers,[72] but also their families, friends, medical practitioners and health care workers.[73] This impact is perhaps most prevalent in the area of suicide prevention.[74]

Mental health laws have traditionally provided for treatment based on a number of criteria, including the presence of a mental illness and the risk of harm to oneself or others. Mental health laws have increasingly shifted the focus of the grounds for involuntary detention and treatment, from the risk of harm to a person's capacity to consent to treatment.[75] There is now also a strong focus that involuntary treatment should be a last resort, with no alternative less restrictive means of ensuring treatment. The *MHA* adopts these approaches.

The Victorian Royal Commission was a key impetus in shifting the focus of mental health law and practice to a more holistic approach, concerning wellbeing and prevention, as opposed to an acute treatment approach. This has found legislative recognition in Victoria with the new landmark *Mental Health and Wellbeing Act 2022*, which resets the legislative foundations for the mental health and wellbeing system. This is consistent with the general themes raised in SALRI's consultation, to transform the *MHA* into a more holistic 'rights-based' instrument and shift away from a 'crisis Act' to a 'wellbeing and prevention Act'.

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[68] Judith Laing, 'Rights versus Risk - Reform of the Mental Health Act 1983' (2000) 8(2) *Medical Law Review* 210, 211; Bernadette McSherry, 'Mental Health Laws: Where to from Here' (2014) 40(1) *Monash University Law Review* 175, 177; Justice Michael Kirby, 'Mental Health Law Reform: The "Second Wave"' (1981) 1(8) *Medical Journal of Australia* 421, 421.

[69] The term 'mental illness' is used in this Report, consistent with the terminology of the *Mental Health Act 2009* (SA).

[70] Lisa Brophy and Fiona McDermott, 'What's Driving Involuntary Treatment in the Community? The Social, Policy, Legal and Ethical Context' (2003) 11(Supplementary) *Australian Psychiatry* 84; Melissa Floyd, 'Involuntary Mental Health Treatment: The Mental Health Consumer as Expert' (2013) 24(3) *Journal of Human Services* 187.

[71] The treatment most commonly administered under a CTO is a periodic depot injection of psychiatric medication. See Edwina Light, 'Rates of use of community treatment orders in Australia' (2019) 64 *International Journal of Law and Psychiatry* 83, 84. Psychiatric medication is often accompanied by severe side effects. For example, side effects associated with anti-psychotic medication may include akathisia (an inability to remain still), weight gain, cardiovascular and metabolic side effects, and tardive dyskinesia (an involuntary neurological movement disorder). See Cherrie Galletly et al, 'Royal Australian and New Zealand College of Psychiatrists Clinical Practice Guidelines for the Management of Schizophrenia and Related Disorders' (2016) 50(5) *Australian and New Zealand Journal of Psychiatry* 1, 33; South Australia, *Parliamentary Debates*, Legislative Council, 30 April 2009 2202–3. These medication side-effects were often raised by consumers to SALRI.

[72] Sam Boyle, Tamara Walsh and Lucinda Nelson, 'A Study into the Operation of the Queensland Mental Health Review Tribunal' (2021) 29(1) *Medical Law Review* 106, 106–7. While the *Mental Health Act* uses the term 'patient', contemporary terminology prefers 'consumer'. See also Glossary.

[73] United Kingdom Department of Health, *Report of the Expert Committee: Review of the Mental Health Act 1983* (1999), 19; George Szmukler and Brendan Kelly, 'We Should Replace Conventional Mental Health Law with Capacity-Based Law' (2016) 209(6) *British Journal of Psychiatry* 449, 452; Marie Nicolini, Joris Vandenberghe and Chris Gastmans, 'Substance Use Disorder and Compulsory Commitment to Care: a Care-Ethical Decision-Making Framework' (2018) 32(3) *Scandinavian Journal of Caring Sciences* 1237, 1240.

[74] The importance of suicide prevention within mental health treatment approaches was highlighted by many parties in SALRI's consultation, notably the Hon John Dawkins, a longstanding advocate in this area. Suicide prevention is a priority for State, Territory and Commonwealth Governments, with significant efforts and resources being allocated. See, for example, Australian Government, *Vision 2030: Blueprint for Mental Health and Suicide Prevention* (March 2020); South Australian Government, *Mental Health Services Plan 2020-2025* (November 2019).

[75] This shift was also reflected in the Victorian Royal Commission's findings.

The new Victorian Act reaffirms the central role in any contemporary mental health law, as far as is practicable, of a supported decision-making model. This was a strong theme in SALRI's consultation, including the need to explicitly endorse a supported decision-making model within the *MHA*. The importance of mechanisms to enforce accountability under the *MHA* were often raised to SALRI.

The role and application of decision-making capacity to refuse treatment under the *MHA* was another recurring theme in SALRI's research and consultation. There has been a recent shift toward 'capacity-based' mental health laws, consistent with international human rights law.[76] This means that the decision-making capacity of a person is now one of the statutory criteria which must be satisfied (following a clinical capacity assessment) prior to the making of an involuntary treatment order.[77] The law imposes four criteria that must be met for a treatment order to be made under the *MHA*. The inclusion of the impaired decision-making capacity criterion has been 'controversial',[78] with the South Australian Coroner's Court recommending in 2021 that it be removed as a statutory requirement when making treatment orders, in an attempt to prevent the suicide of people with mental illness.[79]

SALRI recognises that decision-making capacity is a complex construct, drawing upon various disciplines including the law, medicine, psychology and neuropsychology. It is a recurring theme in SALRI's previous references. The legislative definition of decision-making capacity must retain a degree of ambiguity, most notably in relation to its assessment. SALRI acknowledges that the assessment of decision-making capacity varies according to specific professions and disciplines. As a result, a definition which is too prescriptive would place limitations on a practitioner's ability to exercise clinical judgment and discretion. Indeed, it is an area whereby trust and reliance must be placed upon the clinical acumen and expertise of practitioners undertaking capacity assessments. This been previously raised to SALRI by many parties in consultation.

The role and use of coercive practices and reasonable force under the *MHA* in relation to persons with mental illness unsurprisingly proved recurring themes in SALRI's research and consultation. Various views reflecting diverse perspectives were expressed. SALRI recognises the need to ensure the safety of consumers, mental health practitioners and the community in this context.

The role and operation of both ITOs and CTOs for the involuntary treatment of persons with mental illness were prominent themes in SALRI's research and consultation, with a variety of differing views

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[76] Judith Laing, 'Rights versus Risk - Reform of the *Mental Health Act 1983*' (2000) 8(2) *Medical Law Review* 210, 220; George Szmukler and Brendan Kelly, 'We Should Replace Conventional Mental Health Law with Capacity-Based Law' (2016) 209(6) *British Journal of Psychiatry* 449, 450.

[77] This approach also emerges in international human rights law. The United Nations Committee has 'recommended that Australia: repeal all legislation that authorizes medical intervention without the free and informed consent of the persons with disabilities concerned, committal of individuals to detention in mental health facilities, or imposition of compulsory treatment, either in institutions or in the community, by means of Community Treatment Orders': Committee on the Rights of Persons with Disabilities, *Concluding Observations on the Initial Report of Australia*, 10th sess, 118th mtg, UN Doc CRPD/C/AUS/CO/1 (21 October 2013) [34]. See further Part 2 Background and Context to South Australia's Mental Health Laws.

[78] Melissa Floyd, 'Involuntary Mental Health Treatment: The Mental Health Consumer as Expert' (2013) 24(3) *Journal of Human Services* 187; Robert Trestman, 'Committed: The Battle over Involuntary Psychiatric Care' (2017) 45(4) *Journal of the American Academy of Psychiatry and the Law* 513; Office of the Chief Psychiatrist, *The Review of the Mental Health Act 2009 - A Report by the Chief Psychiatrist of South Australia* (SA Health, 23 May 2014) 48.

[79] *Inquest into the Death of Theo Nikolas Papageorgiou* (2021) 09/2020 (0176/2016) SACC (Schapel, Deputy State Coroner) [16.10].

expressed. The apparent prevalence of CTOs[80] and ITOs in South Australia, especially for Aboriginal and Culturally and Linguistically Diverse ('CALD') communities, was also a notable issue in SALRI's research and consultation. Many parties expressed their concern in relation to this issue, though others disagreed (often arguing that a CTO is preferable to an ITO).

The use of emergency Electroconvulsive Therapy ('ECT') under the *MHA* – indicating a lack of voluntary consent, was also raised in SALRI's research and consultation, with various views and concerns expressed. SALRI acknowledges the historical and ongoing community perception and stigma towards ECT, some of which still argue it is contentious.[81] However, many studies highlight that modern ECT is valid, effective and a recognised treatment for mental illness performed by specialised staff.[82] The value of ECT extends to individuals who lack decision-making capacity.[83]

SALRI reiterates that many issues of resourcing, operation and culture were raised in its consultation by parties of diverse perspectives. These longstanding issues include acute problems in access for regional, rural, remote and Aboriginal communities; lack of funding and available services; bed access; hospital Key Performance Indicators; cultural and operational concerns and onerous administrative and bureaucratic requirements. These considerations all impact the effective provision and delivery of mental health services in South Australia. Despite this, several of SALRI's recommendations have direct implications for the barriers that exist regarding the provision of mental health services. However, many of these barriers are beyond the scope of this review.[84] SALRI has raised several proposed suggestions which draw attention to operational or practical measures for future consideration.

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[80] Edwina Light et al, 'Community Treatment Orders in Australia: Rates and Patterns of Use' (2012) 20(6) *Australasian Psychiatry* 478; Edwina Light, 'Rates of Use of Community Treatment Orders in Australia' (2019) 69(4) *International Journal of Law and Psychiatry* 83.

[81] See, for example, Thomas Cryzyk, 'Electroconvulsive Therapy: why it is still Controversial (2012) 16(7) *Mental Health Practice* 22. 'Electroconvulsive therapy (ECT) is a procedure that has been used in the treatment of mental illness for over 60 years. Despite its continued use it remains a controversial treatment, with questions concerning its efficacy being raised not only by mental health professionals, but also service users themselves': V Challiner and L Griffiths, 'Electroconvulsive Therapy: a Review of the Literature' (2000) 7(3) *Psychiatric and Mental Health Nursing* 191. The historical abuses associated with ECT are notable. See Steven Jenkusky, 'Public Perceptions of Electroconvulsive Therapy: A Historic Review' (1992) 10(2) *Jefferson Journal of Psychiatry* 2; Merrilyn Walton, 'Deep Sleep Therapy and Chelmsford Private Hospital: Have we Learnt Anything?' (2013) 21(3) *Australasian Psychiatry* 206.

[82] See, for example, Gerda Gomez, 'Electroconvulsive Therapy: Present and Future' (2004) 25(5) *Issues in Mental Health Nursing* 473; Tyler Kaster, Zafiris Daskalakis and Daniel Blumberger, 'Clinical Effectiveness and Cognitive Impact of Electroconvulsive Therapy for Schizophrenia: A Large Retrospective Study' (2017) 78(4) *Journal of Clinical Psychiatry* 353; Sohag Sanghani et al, 'Electroconvulsive Therapy in Schizophrenia: a Review of Recent Literature' (2018) 31(3) *Current Opinion in Psychiatry* 213; Sandee Grover et al, 'ECT in Schizophrenia: a Review of the Evidence' (2018) 31(3) *Acta Neuropsychiatrica* 115; Peter Giacobbe et al, 'Improvements in Health-Related Quality of Life With Electroconvulsive Therapy: a Meta-Analysis' (2018) 34(2) *Journal of ECT* 87; Marilyne Landry et al, 'Current Practices of Electroconvulsive Therapy in Mental Disorders: a Systematic Review and Meta-Analysis of Short and Long-Term Cognitive Effects' (2021) 37(2) *Journal of ECT* 119; Tyler Laster et al, 'Risk of Serious Medical Events in Patients with Depression Treated with Electroconvulsive Therapy: a Propensity Score Matched, Retrospective Cohort Study' (2021) 8 *Lancet Psychiatry* 686.

[83] Pern-Chern Tor et al, 'Outcomes in Patients with and without Capacity in Electroconvulsive Therapy' (2020) 266 *Journal of Affective Disorders* 151. This study concluded: 'ECT is a safe and effective treatment for schizophrenia, bipolar mania and depression, and may provide similar or greater benefits in patients lacking capacity to consent, compared to those with capacity. These results support the provision of a framework for substitute decision making in the patients' best interests for ECT in patients unable to provide their own consent': at 151.

[84] SALRI reiterates that the provision and delivery of these services under the *Mental Health Act 2009* (SA) are beyond the scope of this review.

The use of South Australian Police (SAPOL) in mental health has also been identified as problematic in various respects (including by SAPOL). Consumers, families and carers have noted the involvement of police can be 'confronting and upsetting'.[85] The Victorian Royal Commission advocated that '…wherever possible, emergency services' responses to people experiencing time-critical mental health crises [should be] led by health professionals rather than police.'[86] The rationale is that '[p]olice will be involved only where necessary to protect people's safety'.[87] SALRI supports this approach and the implementation of a co-response model, which may be further complemented by the deployment of a specialised workforce. The utility of a specialised workforce was reinforced to SALRI, notably, the need for specialist mental health training to appropriately respond to mental health crises.

A recurring issue raised to SALRI was the multiplicity of services and agencies, with varying purposes. This leads to difficulty for consumers and their families in knowing where to go and navigating what is often seen as a complex and fragmented system. Indeed, even service providers, mental health and health practitioners remarked on the complexity of the system. These themes are not unique to South Australia.[88] This lack of coordination is 'particularly challenging' for people whose needs span more than one sector such as those living with dual disability – 'that is, a co-occurring mental illness and acquired or neurodevelopmental disability (such as autism spectrum disorder or traumatic brain injury) … [they] struggle to connect with services from two divergent systems.'[89]

SALRI reiterates that there is no universal solution to resolve the complex and multi-faceted issues facing South Australia's mental health system. Although the delivery and provision of mental health services is outside the scope of this review, reform of the *MHA* needs to be seen in the wider context. Reform of the *MHA*, whilst important, is not a complete solution. Changes in practice, policy and culture must also accompany legislative reforms.

Based on its comprehensive consultation, multi-disciplinary research and its Terms of Reference, SALRI's findings and recommendations can be summarised as follows:

1. That updated language and terminology be utilised, including current medical definitions and understanding of best practice.

2. That clarity be given for the use of the *MHA* for prevention as well as treatment, in accordance with guiding principles and at all times, respecting the autonomy of the individual.

3. The guiding principles in the *MHA* should be retained, but re-structured to provide greater clarity and emphasis on mental health, wellbeing and prevention, with specific regard to the *Mental Health and Wellbeing Act 2022* (Vic).

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[85] *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021) vol 4, 371.

[86] Ibid vol 5, 237.

[87] Ibid 85.

[88] Ibid vol 4, 180, quoting South West Healthcare, *Submission to the RCVMHS: SUB.0002.0029.0138*, 2019, 48.

[89] *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021) vol 4, 180. As one party told the Royal Commission: "The people working in the disability sector are reluctant to work with someone who has a mental health issue as the needs are too complex. The people in the mental health sector are reluctant to work with people with a disability as the behaviour is seen as stemming from the intellectual disability, not the mental health issue. Therefore no one wants to work with these people and the police end up dealing with the issue. NDIS seems to have made this increasingly difficult as service providers are more able to choose which clients they are going to work with': at 180.

4. That where a person lacks decision-making capacity, supported decision-making should be preferred over substitute decision-making as far as is practicable.

5. That the authority of directives relating to mental health treatment, including psychiatric medication and electroconvulsive therapy, contained within a valid Advance Care Directive should be strengthened. Provided a person has decision-making capacity at the time in which the Advance Care Directive is made, any directive should, as far as is practicable, be effective and binding, consistent with the law and practice in other areas of health care. SALRI recognises this may require consequential amendments to the *Advance Care Directives Act 2013* (SA), in particular s 12.

6. That the powers under the *MHA* be utilised for persons with a mental illness, whilst acknowledging that unresolved issues arise for people with drug and/or alcohol addiction, older persons, children and adolescents. The current framework under the *MHA* does not arguably address these cohorts adequately. This requires further future consideration.

7. An enhanced focus in the *MHA* of the need for explicit recognition of supported decision-making, including the use of Advance Care Directives.[90]

8. That the criteria for the imposition of an involuntary treatment order, including the 'impaired decision-making capacity' criterion be retained.[91]

9. That the risk criterion for the making of an Inpatient Treatment Order or Community Treatment Order should be the risk of 'serious harm' as opposed to 'harm'.[92]

10. That the present structure of Inpatient Treatment Orders be retained, but the levels of Community Treatment Orders should be removed and replaced by a single universal order with regular prescribed reviews.

11. That the *MHA* include a power allowing authorised mental health professionals and authorised officers to use 'reasonable force' in the administration and enforcement of a Community Treatment Order where there is non-compliance.

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[90] This reflects the views of many parties in consultation. See also Olga Pandos and Bernadette Richards, 'Lost in Translation: Overcoming Practical Barriers in the Operation of Advance Care Directives and Enduring Powers of Attorney in South Australia' (2022) 43(1) *Adelaide Law Review* 271.

[91] SALRI notes concerns relating to the operation of the impaired decision-making capacity criterion in the making of a CTO or ITO where there are issues of potential serious harm to the consumer or others arise. The level of risk is a separate criterion, reflecting a clinician's risk assessment. See further *Inquest into the Death of Theo Nikolas Papageorgiou* (2021) 09/2020 (0176/2016) SACC (Schapel, Deputy State Coroner); Toni Wharehoka, 'Disability Rights and Compulsory Psychiatric Treatment: the Case for a Balanced Approach under the Mental Health (Compulsory Assessment and Treatment) Act 1992' (2021) *Victoria University Wellington Law Review* 221.

[92] SALRI supports the ACT definition of 'serious harm'. Sections 58(2) and 66(2) of the *Mental Health Act 2015* (ACT) provides the relevant tribunal may make the counterpart of an ITO or CTO if it 'believes on reasonable grounds that, because of the mental illness, the person is doing, or is likely to do, serious harm to themself or someone else; or is suffering, or is likely to suffer, serious mental or physical deterioration'.

12. That a Forensic Community Treatment Order be introduced, to enhance effectiveness, accountability, consistency and follow up for service delivery and treatment. This will attempt to address operational gaps in the delivery and management of forensic mental health consumers. The concurrent use of the *MHA* and the *Criminal Law Consolidation Act* requires further consideration.

13. That the *MHA* authorise the use of reasonable restrictive practices in the provision of emergency Electroconvulsive Therapy and that it be clearly regulated.[93]

14. There are legitimate concerns in relation to the use of powers by South Australia Police under the *MHA*.[94] However, the role of police is inevitable and necessary in some circumstances and as such, their existing powers in the *MHA* should be retained. These powers should be exercised within a co-response model, with a specialised workforce empowered under the *MHA*. The rationale is that ideally '[p]olice will be involved only where necessary to protect people's safety'.[95]

15. The use of reasonable force provisions in the *MHA* for authorised officers (who have undertaken suitable training) and police should be retained, recognising the need to ensure the safety of consumers, mental health practitioners and community.[96]

16. The provision under the *MHA* of legal representation for consumers should be extended to the original jurisdiction of the South Australian Civil and Administrative Tribunal under the *MHA*. However, such provision should not be extended to interested third parties.[97]

17. There are various bodies with oversight and regulatory functions under the *MHA* which overlap and cause complexity. There is a need for statutory clarity in the respective roles and functions of these bodies, including the Office of the Chief Psychiatrist, the Mental Health Commissioner(s), the Health and Community Services Complaints Commissioner and the Community Visitor Scheme.

18. There are concerns and barriers pertaining to the implementation and operationalisation of the guiding principles in practice and whether their translation into practice impacts a consumer's access to mental health services. There are three facets to a mechanism which

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[93] SALRI notes that such amendments to allow the use of reasonable restrictive practices to facilitate emergency ECT under the *Mental Health Act 2009* (SA) will prevent the need to rely on s 32 of the *Guardianship and Administration Act 1993* (SA).

[94] These reservations are held also by SAPOL. SAPOL's present duties under the *Mental Health Act 2009* (SA) place a major demand on police resources. A co-response model has policy (especially for consumers), practical and resourcing benefits.

[95] *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021) vol 5, 85.

[96] See generally *Mental Health Act 2009* (SA) s 56.

[97] The present legal representation scheme for consumers under the *Mental Health Act 2009* (SA) before SACAT is provided by the Legal Services Commission. SALRI notes that there is a need for further consideration of advice and advocacy for consumers, carers and family members in proceedings under the *Mental Health Act 2009* (SA) outside the existing scheme. Representation is not necessarily limited to legal practitioners appearing before SACAT and can include others such as trained law students (as in Tasmania) or legally trained advocates. There are parties such as consumer groups, disability groups and the three South Australian Law Schools that could usefully assist in the provision of such advice or advocacy.

enforces the guiding principles in practice. An appointed body or bodies must be vested with the responsibility to develop standards by which the guiding principles are to be operationalised. The aim of this is to define the intended measurable outcome and determine how to operationally define the principles. Subsequently, there must be an appropriate body or bodies to monitor and enforce compliance with the guiding principles, according to their agreed definition in practice. Finally, the most appropriate cause of action to address non-compliance with the guiding principles must be considered.

19. The role of the Mental Health Commissioner presently lacks any statutory foundation[98] and should be inserted as a new Division in the *MHA*, having particular regard to their function, constitution, appointment and removal.

20. The Community Visitor Scheme, which was commended by a number of parties in consultation for their advocacy role, should be retained (subject to clarification of their role having an advocacy focus, not on clinical or technical issues, as well as oversight by the Principal Community Visitor and/or Mental Health Commissioner.) However, their wide inspection powers[99] conferred under Part 10 of the *Health Care Act 2008* (SA) should be removed and vested in the new Mental Health Commissioner and at the Commissioner's discretion as to how such powers can be exercised. Any new Community Visitor appointment and tenure should be at the discretion of the relevant Minister, in consultation with the Mental Health Commissioner and/or the Principal Community Visitor. This must be subject to appropriate training and oversight.[100]

21. The apparent prevalence in South Australia of Community Treatment Orders is notable, especially the over-representation of Aboriginal and CALD consumers. As part of this review, SALRI is unable to resolve whether this is a cause for concern. SALRI notes there are indicators which merit further examination (which involve the use and analysis of empirical data) to examine the implications of orders.[101]

22. Noting the particular issues and implications for mental health in Aboriginal communities,[102] suitable and culturally appropriate measures should be adopted to further promote Aboriginal mental health, with culturally responsive and appropriate services (including effective, culturally-informed alternatives to involuntary treatment) to facilitate a Social and Emotional Wellbeing model. Any such measures should be devised and progressed in close consultation with Aboriginal communities.

23. Initial and ongoing specialist mental health training for police and authorised officers is required in effectively dealing with persons with a mental illness.

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[98] See also Stephanie Richards, *Full-Time Mental Health Commissioner to be appointed in SA* (15 December 2022) In Daily <https://indaily.com.au/news/2022/12/15/full-time-mental-health-commissioner-to-be-appointed-in-sa/>.

[99] See *Mental Health Act 2009* (SA) s 51(3)(b). These powers currently include access to sensitive private medical records potentially without a patient's consent or subsequent knowledge.

[100] SALRI proposes that the terms and tenure of existing Community Visitors should remain as is under the *Mental Health Act 2009* (SA).

[101] Such further consideration would require the interrogation and use of detailed empirical demographic data which is outside the scope of SALRI's present review.

[102] In particular, the historical and ongoing effects of colonisation resulting in intergenerational trauma.

24. Various technical and incidental changes to clarify and improve the operation of present law and practice.

SALRI acknowledges the assistance of the South Australian Department of Health and Wellbeing in providing funding for this project. In addition, SALRI also acknowledges the valuable assistance of Dr John Brayley and the Office of the Chief Psychiatrist.

SALRI would like to acknowledge Jack and Poppy Papageorgiou, the parents of Theo Papageorgiou, who passed away in January 2016. SALRI sincerely thanks them both for their support and assistance during this review. Upon meeting Jack and Poppy, we were in admiration of their incredible strength and resilience. We learned from them that Theo was a kind-hearted, warm person. A great friend, wonderful son and brother. SALRI would like to extend its deepest condolences to Jack, Poppy and their family.

SALRI expresses particular appreciation to Evelyn Varcoe and Beth Turner for their support and assistance during this review.

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SALRI also thanks OpenBook Howden for its assistance with the publication of this Report.

SALRI would finally like to thank the many parties who generously contributed in various ways to this important review. In the preparation of this Report, SALRI had careful regard to all views expressed during consultation. SALRI is grateful for the time and valuable contributions of survey respondents, attendees and interested parties who responded, made submissions or otherwise contributed to this Report. SALRI has heard many powerful accounts in its consultation of the experiences of consumers and their families under the *Mental Health Act 2009* (SA). Many of these accounts dealt with personal experiences and SALRI sincerely thanks all parties who shared their experiences.

Recommendations and Suggestions

General

RECOMMENDATION 1

SALRI recommends that the title of the *Mental Health Act 2009* (SA) should be amended to the *Mental Health and Wellbeing Act* (SA).

RECOMMENDATION 2

SALRI recommends that a review of the Mental Health Act 2009 (SA) is to commence within five years.

RECOMMENDATION 3

SALRI recommends that SA Health should undertake steps to ensure access to patient records across Local Health Networks can occur promptly and without technical delay.

RECOMMENDATION 4

SALRI recommends that all references to 'patient' in the *Mental Health Act 2009* (SA) should be amended to 'consumer', except in the circumstances where a person is admitted to a treatment centre, such as a hospital. SALRI further recommends that the term 'voluntary community patient' in the *Mental Health Act 2009* (SA) should be amended to 'voluntary community consumer'.

RECOMMENDATION 5

SALRI recommends that a definition of 'consumer' should be added to s 3 of the *Mental Health Act 2009* (SA), with reference to the definition in s 3 of the *Mental Health and Wellbeing Act 2022* (Vic).[103]

[103] Section 3 provides: 'consumer' means a person who—

(a) has received mental health and wellbeing services from a mental health and wellbeing service provider; or

(b) is receiving mental health and wellbeing services from a mental health and wellbeing service provider; or

(c) was assessed by an authorised psychiatrist and was not provided with treatment; or

(d) sought or is seeking mental health and wellbeing services from a mental health and wellbeing service provider and was not or is not provided with those services.'

RECOMMENDATION 6

SALRI recommends that the definition of a 'mental health and wellbeing service' should be added to s 3 of the *Mental Health Act 2009* (SA), with reference to the definition in s 3 of the *Mental Health and Wellbeing Act 2022* (Vic).[104]

RECOMMENDATION 7

SALRI recommends that the statutory objects contained in s 6 of the *Mental Health Act 2009* (SA) should be amended to provide a greater focus on the promotion of wellbeing and prevention strategies, to help facilitate a shift from a crisis focused approach in the Act to one of wellbeing.

RECOMMENDATION 8

SALRI recommends that, noting the often complex intersection between mental illness and the use and effects of alcohol and/or drugs,[105] the definition of a 'mental illness' in s 3 of the *Mental Health Act 2009* (SA) should incorporate Schedule 1 (list of certain conduct that does not indicate mental illness) and in particular, the use of drugs and alcohol should be prioritised, as provision (a) under Schedule 1.

RECOMMENDATION 9

SALRI recommends that the definition of 'child' in s 3 of the *Mental Health Act 2009* (SA) should be retained as a person under 18 years of age and this should be consistent throughout the Act (see ss 4, 47(5)).

[104] Section 3 provides: 'mental health and wellbeing service' means a professional service—

(a) performed for the primary purpose of—

(i) improving or supporting a person's mental health and wellbeing; or

(ii) assessing, or providing treatment, care or support to, a person for mental illness or psychological distress; or

(iii) providing care or support to a person who is a family member, carer, or supporter, of a person with mental illness or psychological distress; or

(b) that is prescribed to be a mental health and wellbeing service—

but does not include—

(c) a non-legal mental health advocacy service; or

(d) a prescribed professional service.'

[105] See also *Question of Law Reserved (No 1 of 2021)* [2021] SASCA 148.

RECOMMENDATION 10

SALRI recommends that the definition of consent in s 3 of the *Mental Health Act 2009* (SA) should be amended to 'valid consent', with reference to the definition of 'informed consent' in s 86 of the *Mental Health and Wellbeing Act 2022* (Vic).[106]

RECOMMENDATION 11

SALRI recommends that a separate review should be conducted into the use of the *Mental Health Act 2009* (SA) for:

i. Persons with drug and/or alcohol addiction; and
ii. Older persons, especially those with a cognitive impairment or neurocognitive disorder; and
iii. Children and adolescents.[107]

Decision-making Capacity and Supported Decision-making

RECOMMENDATION 12

SALRI recommends that the current definition of 'decision-making capacity' in s 5A(2) of the *Mental Health Act 2009* (SA) should be retained and s 5A(3) should be amended to endorse a supported decision-making framework, giving consideration to s 8(1)(c) and (d) of the *Mental Health Act 2015* (ACT) to provide that:

a. A person who does not have decision-making capacity should[108] be supported to make decisions about the person's treatment, care or support to the best of the person's ability;

b. A person must not be treated as not having decision-making capacity unless all practicable steps to assist the person to make decisions have been taken.

RECOMMENDATION 13

SALRI recommends that the most suitable department or agency, in consultation with relevant interested parties (such as consumer groups and the RANZCP) should draft a capacity assessment Toolkit or Guidelines in South Australia, to be utilised as a non-legislative, educative tool for any interested member of the community or medical or other health practitioner. The Toolkit or Guidelines should be concise, written in plain English and in easily accessible formats (such as Easy Read and videos) to all members of the community and should be made available in various translated languages.

[106] Section 86 gives a comprehensive definition.

[107] The role and application of the *Mental Health Act 2009* (SA) to these three groups was often raised as problematic in SALRI's consultation. Although beyond the scope of the present review, SALRI considers further examination of the role and application of the *Mental Health Act 2009* (SA) to these three groups is appropriate.

[108] SALRI supports the term 'should' – which places less limitations on the operation of the provision.

RECOMMENDATION 14

SALRI further recommends that any Toolkit or Guidelines developed should specifically address the following:

a. Implications of capacity and its assessment for Aboriginal communities and Culturally and Linguistically Diverse communities, noting that such communities should be consulted to facilitate a process of co-design.

b. Provide clarity and explanations relating to impaired decision-making capacity in the context of mental health.

RECOMMENDATION 15

SALRI recommends that the 'impaired decision-making capacity' criterion contained in relation to the grounds for a Community Treatment Order or Inpatient Treatment Order in ss 10(1)(c), 16(1)(c), 21(1)(ba), 25(2)(ba) and 29(1)(ba) of the *Mental Health Act 2009* (SA) should be retained.[109]

RECOMMENDATION 16

SALRI recommends that measures to enforce accountability following a clinical capacity assessment, particularly in the making of a treatment order, such as providing written reasons, should be considered further and, where appropriate, implemented.

RECOMMENDATION 17

SALRI recommends that directives relating to mental health treatment (including specific psychiatric medication and electroconvulsive therapy) contained within a valid Advance Care Directive made pursuant to the *Advance Care Directives Act 2013* (SA) should, as far as practicable, be effective and binding, consistent with the law and practice in other areas of health care, with any necessary consequential amendments to the *Advance Care Directives Act 2013* (SA) to be made to achieve this aim.

Aboriginal Mental Health

RECOMMENDATION 18

SALRI recommends that appropriate measures to promote Aboriginal mental health and culturally responsive and appropriate services (including effective, culturally-informed alternatives to involuntary treatment) are considered and progressed. SALRI further recommends that measures to implement a Social and Emotional Wellbeing model, with Ngangkari Healers, Aboriginal Liaison Officers and Social and Emotional Wellbeing Officers within the *Mental Health Act 2009* (SA) should be examined. In addition, SALRI recommends that consideration should be given to resourcing and funding of these measures and positions within Local Health Networks, to achieve an integrated mental health service, capable of offering culturally appropriate and responsive supports.

[109] SALRI notes the recommendation of the Deputy Coroner in *Inquest into the Death of Theo Nikolas Papageorgiou* (2021) 09/2020 (0176/2016) SACC (Schapel, Deputy State Coroner) that impaired decision-making capacity should be removed as a criterion for the making of a CTO or ITO. SALRI acknowledges the validity of the Coroner's proposal, but with respect does not agree with it. No real support was expressed for such a change in consultation.

RECOMMENDATION 19

SALRI recommends that s 47 of the *Mental Health Act 2009* (SA) should be amended to recognise culturally appropriate responsibilities through family, kinship, and community structures to allow for cultural considerations in which individuals are allowed to provide support under the Act.

Inpatient Treatment Orders

RECOMMENDATION 20

SALRI recommends that the term 'appropriate' in relation to 'the person has impaired decision-making capacity relating to *appropriate* treatment of the person's mental illness', contained in ss 10(1)(c), 16(1)(c), 21(1)(ba), 25(2)(ba) and 29(1)(ba) of the *Mental Health Act 2009* (SA) should be removed.

RECOMMENDATION 21

SALRI recommends that the *Mental Health Act 2009* (SA) should be amended to include 'serious harm' as a threshold criterion for the imposition of an Inpatient Treatment Order.[110]

RECOMMENDATION 22

SALRI recommends that the existing three Levels of Inpatient Treatment Orders in the *Mental Health Act 2009* (SA) should be retained.

RECOMMENDATION 23

SALRI recommends that further research, analysis and interrogation of data concerning the general use and effectiveness of Inpatient Treatment Orders is required, including the disproportionately high prevalence of Inpatient Treatment Orders in South Australia for Aboriginal people and Culturally and Linguistically Diverse people.[111] SALRI further recommends that such findings should be reported in the Chief Psychiatrist's Annual Report under s 92(1)(a) of the *Mental Health Act 2009* (SA).

RECOMMENDATION 24

SALRI recommends that the definition of 'treatment' in ss 24(1), 28(1) and 31(1) of the *Mental Health Act 2009* (SA) should be amended to the treatment of mental illness that may be 'causing, contributing *or connected to'* the person's mental illness.[112]

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[110] SALRI prefers the ACT definition of 'serious harm'. Section 58(2) of the *Mental Health Act 2015* (ACT) provides the relevant tribunal may make the counterpart of an Inpatient Treatment Order if it 'believes on reasonable grounds that, because of the mental illness, the person is doing, or is likely to do, serious harm to themself or someone else; or is suffering, or is likely to suffer, serious mental or physical deterioration'.

[111] This question raises involved issues that are beyond the scope of SALRI's review and also requires empirical data and analysis.

[112] The Office of the Public Advocate recommended the inclusion of 'connected to'. A similar approach was also suggested by the Office of the Chief Psychiatrist. A common example provided to SALRI in consultation with medical practitioners was administering a blood test to monitor Clozapine levels and whether this fell within the current definition of 'treatment'.

RECOMMENDATION 25

SALRI recommends that the Office of the Chief Psychiatrist consider the publication of, or amendments to, existing standards or directives clarifying and offering consistency regarding the definition of the term 'treatment', pursuant to s 90(2) of the *Mental Health Act 2009* (SA).[113]

RECOMMENDATION 26

SALRI recommends that the *Mental Health Act 2009* (SA) should be amended to clarify the scope of s 56 to ensure this power is reasonably used to facilitate an assessment within a timely manner. SALRI further recommends that reference to an 'assessment' should be added within ss 56(3)(c) and (d) of the *Mental Health Act 2009* (SA).[114]

RECOMMENDATION 27

SALRI recommends that the relevant Minister advancing amendments to the *Mental Health Act 2009* (SA) should include specific provisions to safeguard children subject to an Inpatient Treatment Order.

RECOMMENDATION 28

SALRI recommends that the current use of force provisions in the *Mental Health Act 2009* (SA) should be retained, whilst recommending for these to be used as a last resort, with the employment of suitable de-escalation techniques.[115]

Community Treatment Orders

RECOMMENDATION 29

SALRI recommends that the *Mental Health Act 2009* (SA) should be amended to include 'serious harm' as a threshold criterion for the imposition of a Community Treatment Order.[116]

[113] SALRI acknowledges that this is largely a clinical matter, requiring clinical judgment on behalf of the medical practitioner. However, SALRI heard of inconsistencies in approach across different hospitals.

[114] For example, s 56(3)(d) of the *Mental Health Act 2009* (SA) could be amended to (d) the authorised officer may restrain the person by means of the administration of a drug or an assessment for a treatment order when that is reasonably required in the circumstances.

[115] SALRI notes that it is important to ensure the safety of the consumer, patient, staff and others. The use of force should only be a 'last resort' and undertaken by suitably trained officers.

[116] SALRI prefers the ACT definition of 'serious harm'. Section 66(2) of the *Mental Health Act 2015* (ACT) provides the relevant tribunal may make the counterpart of a CTO if it 'believes on reasonable grounds that, because of the mental illness, the person is doing, or is likely to do, serious harm to themself or someone else; or is suffering, or is likely to suffer, serious mental or physical deterioration'.

RECOMMENDATION 30

SALRI recommends that the *Mental Health Act 2009* (SA) should be amended to ensure that Directors of Mental Health Services hold the duty to ensure that a mental health clinician is appointed for each consumer on a Community Treatment Order to ensure monitoring and compliance, rather than the Chief Psychiatrist.

RECOMMENDATION 31

SALRI recommends that the *Mental Health Act 2009* (SA) should be amended to provide that the present two Community Treatment Order levels are removed in favour of a single universal Community Treatment Order, which could be made by medical practitioners or authorised mental health professionals and subject to automatic reviews by a body or tribunal such as the South Australian Civil and Administrative Tribunal. In particular, SALRI proposes the following review periods:

i. Within 4–6 weeks of its making.
ii. Upon six months of its imposition, and annually thereafter.
iii. Each time another Community Treatment Order is made.
iv. Each time a Community Treatment Order is varied.[117]

RECOMMENDATION 32

SALRI recommends that non-compliance with a Community Treatment Order should be explicitly addressed in the *Mental Health Act 2009* (SA). This provision could include matters such as:

i. Conduct which constitutes non-compliance;
ii. Responsibilities of medical practitioners and authorised mental health professionals in attempting to obtain compliance;
iii. Records of non-compliance to be kept by medical practitioners and authorised mental health professionals;
iv. Notice of non-compliance, including possible consequences, is reasonably attempted to be given to consumers.

RECOMMENDATION 33

SALRI recommends that the *Mental Health Act 2009* (SA) should include a power allowing authorised mental health professionals and authorised officers to use 'reasonable force' in the administration and enforcement of a Community Treatment Order where there is non-compliance.[118]

[117] SALRI reiterates in this context that ss 11–12 of the *Mental Health Act 2009* (SA) are pivotal to ensure that consumers and relevant persons (such as carers, substitute decision-makers, and representatives/advocates (including legal representatives)) are notified each time a Community Treatment Order is made, varied, revoked, or expires.

[118] SALRI notes that it is important to ensure the safety of the consumer, patient, staff and others. The use of force should only be a 'last resort' and undertaken by suitably trained officers.

RECOMMENDATION 34

SALRI recommends that the *Mental Health Act 2009* (SA) should be amended to include specific provisions regarding the application of Community Treatment Orders to children.

RECOMMENDATION 35

SALRI recommends that further research, analysis and interrogation of data concerning the general use and effectiveness of Community Treatment Orders is required, including the disproportionately high prevalence of Community Treatment Orders in South Australia for Aboriginal people and Culturally and Linguistically Diverse people.[119] SALRI further recommends that such findings should be reported in the Chief Psychiatrist's Annual Report under s 92(1)(a) *Mental Health Act 2009* (SA).

RECOMMENDATION 36

SALRI recommends that consideration should be given to the introduction of a Forensic Community Treatment Order, with reference to the NSW model which has greater oversight and review than a Community Treatment Order under the current *Mental Health Act 2009* (SA).

Electroconvulsive Therapy

RECOMMENDATION 37

SALRI recommends that s 42(4)(b) of the *Mental Health Act 2009* (SA) should be amended to authorise the use of reasonable restrictive practices to facilitate the provision of emergency Electroconvulsive Therapy ('ECT').[120] In addition, SALRI recommends that consideration should be given to the inclusion of explanatory notes providing a description of the circumstances when emergency ECT can be used, with appropriate safeguards and reporting procedures, including, but not limited to:

a. The use of restrictive practices to facilitate ECT should occur only when there is a clear clinical harm to the person if they do not receive ECT and all reasonable alternatives to facilitate or carry out ECT without any coercion have been attempted.
b. Coercive practices to facilitate or carry out ECT should not occur when the person has provided valid consent.
c. Coercive practices should only occur when ECT is being provided as an emergency treatment:
    i. Under emergency consent provisions; or
    ii. The South Australian Civil and Administrative Tribunal provides authorisation; or
    iii. A substitute decision-maker or guardian provides substitute consent.
d. Any use of restrictive practices must be documented in the case record and reported to the Office of the Chief Psychiatrist.

[119] This question raises involved issues that are beyond the scope of SALRI's review and also requires empirical data and analysis.

[120] SALRI notes that amendments to authorise the use of reasonable restrictive practices to facilitate emergency ECT under *Mental Health Act 2009* (SA) may avoid the need to rely on s 32 of the *Guardianship and Administration Act 1993* (SA).

i. Reports of such cases should be reported in the Chief Psychiatrist's Annual Report under s 92(1)(a) of the *Mental Health Act 2009* (SA).

RECOMMENDATION 38

SALRI recommends that the s 41C of the *Mental Health Act 2009* (SA) identifying the review triggers of the Prescribed Psychiatric Treatment Panel should be amended, to enable the Panel to review a 'complex case'. SALRI further recommends that the term 'complex case' should be defined, in consultation with the Panel, the Chief Psychiatrist and other relevant interested parties.[121]

RECOMMENDATION 39

SALRI recommends that membership of a neurosurgeon on the Prescribed Psychiatric Treatment Panel be retained, however, the requirement for them to attend a meeting should be subject to the requirements of the case.

RECOMMENDATION 40

SALRI recommends that consideration should be given to allowing the Prescribed Psychiatric Treatment Panel to invite specialist input from relevant persons, such as an Aboriginal, Culturally and Linguistically Diverse or LGBTIQ representative, where a case so requires.

Restrictive Practice and Control Powers

RECOMMENDATION 41

SALRI recommends that the care and control powers and the use of force provisions in s 56 (authorised officers) and s 57 (police) of the *Mental Health Act 2009* (SA) should be retained.

RECOMMENDATION 42

SALRI recommends that authorised officers and the South Australia Police undertake ongoing training in de-escalation techniques to avoid the use of force wherever practicable.

Role of South Australia Police

RECOMMENDATION 43

SALRI recommends that the role and powers of the South Australia Police in s 57 of the *Mental Health Act 2009* (SA) should be retained.

[121] In their submission to SALRI, the Panel identified a number of cases which may constitute a 'complex case', such as any use of restraint or restrictive practices, cases featuring clinically complex treatment-resistance, cases featuring clinically complex comorbidities and the use of ECT on children and young people aged under 18. It is noted that this would require cooperation with ECT clinical coordinators and treating psychiatrists, to ensure a referral constitutes a 'complex case'.

RECOMMENDATION 44

SALRI recommends the continued operation and evaluation of the co-responder model in South Australia to underpin the operation of the *Mental Health Act 2009* (SA)[122] and further consideration should be given to the development of a specialised mental health workforce to facilitate the operation of a co-response model.

RECOMMENDATION 45

SALRI further recommends the involvement of mental health clinicians and professionals and appropriately trained police officers in mental health for crisis intervention.

RECOMMENDATION 46

SALRI recommends that South Australia Police provide appropriate initial and ongoing specialist mental health training for police officers.[123]

RECOMMENDATION 47

SALRI recommends that, where a person has committed an offence, and is in police custody and requires treatment, the *Mental Health Act 2009* (SA) should be amended to allow authorised mental health professionals and authorised officers to use reasonable force to 'hold' a person until police arrive.

South Australian Civil and Administrative Tribunal and Legal Representation

RECOMMENDATION 48

SALRI recommends that s 84 of the *Mental Health Act 2009* (SA) should be amended to provide for an extension of the present legal representation scheme to consumers in all proceedings under the Act in the South Australian Civil and Administrative Tribunal.[124]

RECOMMENDATION 49

SALRI recommends that s 84 of the *Mental Health Act 2009* (SA) should remain and not be amended in respect to interested parties and therefore the present legal representation scheme should not be extended to interested parties pursuing an appeal of a treatment order under the *Mental Health Act 2009* (SA) in the South Australian Civil and Administrative Tribunal.

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[122] Such a model received wide support in SALRI's consultation from SAPOL, consumer groups and health practitioners. Such a model has sound policy, operational and resourcing benefits.

[123] SALRI notes that certain training in this context is already provided to SAPOL officers at different ranks.

[124] Currently the legal representation scheme provided by the Legal Services Commission of South Australia only provides representation for consumers pursuing an appeal not in the first instance or primary proceedings.

The Community Visitor Scheme and Mental Health Commissioners

RECOMMENDATION 50

SALRI recommends that the Office of the Chief Psychiatrist should establish a Child and Adolescent Mental Health Committee.[125]

RECOMMENDATION 51

SALRI recommends that greater clarity is necessary in the *Mental Health Act 2009* (SA) as to the respective roles and functions of key agencies, notably the Office of the Chief Psychiatrist, the Mental Health Commissioner(s),[126] the Community Visitor Scheme and the Health and Community Services Complaints Commissioner.[127]

RECOMMENDATION 52

SALRI notes that particular clarity is necessary as to the role and functions of the Mental Health Commissioner(s) and therefore recommends that the role, functions, constitution, appointment and removal of the Mental Health Commissioner should be added as a new standalone Division in the *Mental Health Act 2009* (SA).

RECOMMENDATION 53

SALRI recommends that the present roles and functions of the Community Visitors in Part 9 of the *Mental Health Act 2009* (SA) should be retained (though subject to the direction of the Mental Health Commissioner), but the present powers of inspection held by Community Visitors under Part 10 of the *Health Care Act 2008* (SA)) should be removed and transferred to the new statutory Mental Health Commissioner.[128]

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[125] SALRI notes that the OCP has various Committees, but not one with a focus on child and adolescent mental health.

[126] Stephanie Richards, *Full-Time Mental Health Commissioner to be appointed in SA* (15 December 2022) In Daily <https://indaily.com.au/news/2022/12/15/full-time-mental-health-commissioner-to-be-appointed-in-sa/>.

[127] SALRI notes that there is a degree of overlap between the functions of these bodies which then creates unnecessary confusion and complexity, especially for consumers as well as the community.

[128] See *Mental Health Act 2009* (SA) s 51(3()(b). SALRI notes that the Community Visitors under the *Mental Health Act 2009* (SA) possess various powers, several of which are of a significant and sensitive nature. For example, the power to inspect private medical records is largely a clinical matter, better addressed by the Chief Psychiatrist or the Mental Health Commissioner and subject to any rights of privacy or confidentiality held by the consumer. SALRI notes the Community Visitor Scheme remains a helpful and useful service to offer advocacy to consumers.

RECOMMENDATION 54

SALRI recommends that the role of the Community Visitors should solely focus on providing advocacy services to consumers and patients, and appropriate measures should be taken, including any consequential amendments to the *Mental Health Act 2009* (SA), to standardise the role and function of Community Visitors.[129]

RECOMMENDATION 55

SALRI recommends that the future appointment of Community Visitors, their functions and tenure be made by the relevant Minister, in consultation with the Mental Health Commissioner and/or the Principal Community Visitor. The role and tenure of a Community Visitor should be subject to initial and ongoing appropriate training and oversight.

Guiding Principles and Accountability Mechanisms

RECOMMENDATION 56

SALRI recommends that the phrase contained within s 7(1) of the *Mental Health Act 2009* (SA) 'are to be guided' should be replaced with assertive positive rights-based language 'is to be actively considered'.

RECOMMENDATION 57

SALRI recommends that a Statement of Recognition, with regard to the National Strategic Framework[130] and s 13 of the *Mental Health and Wellbeing Act 2022* (Vic) should be included as a guiding principle under the *Mental Health Act 2009* (SA).

RECOMMENDATION 58

SALRI recommends that the guiding principles under s 7 of the *Mental Health Act 2009* (SA) should be retained but restructured to provide greater clarity and emphasis on mental health, wellbeing and prevention, with specific regard to the *Mental Health and Wellbeing Act 2022* (Vic).[131]

[129] SALRI notes the *Mental Health Act 2009* (SA) currently identifies one of the CVS' role is 'to act as advocates for consumers or patients to promote the proper resolution of issues relating to the care, treatment or control of patients, including issues raised by a guardian, medical agent, relative, carer or friend of a patient or any person who is providing support to a patient under the *Mental Health Act 2009* (SA).'

[130] This refers to: Department of the Prime Minister and Cabinet, *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017-2023* (2017).

[131] SALRI specifically recommends that dignity of risk should be inserted as a guiding principle within the *Mental Health Act 2009* (SA).

RECOMMENDATION 59

SALRI recommends that the Office of the Chief Psychiatrist should convene a working group, with input and consultation from relevant interested parties such as the Mental Health Commissioner, Health and Community Services Complaints Commissioner, Principal Community Visitor and Office of the Public Advocate, to identify and develop standards by which the guiding principles are to be operationalised. SALRI further recommends that this working group may invite other parties, such as experts,[132] consumers, Aboriginal, Culturally and Linguistically Diverse and LGBTIQ representatives, to engage in the development of appropriate standards.

RECOMMENDATION 60

SALRI recommends that such standards should allow the Office of the Chief Psychiatrist to monitor compliance with the guiding principles and determine appropriate responses or recourse for non-compliance.[133] SALRI further recommends that, in consultation with the working group, a duty to monitor compliance and address non-compliance, may be delegated (if agreed) to the most appropriate party to avoid conflict of interests. In addition, SALRI recommends that the Office of the Chief Psychiatrist, in their role to promote the continuous improvement of organisation and delivery of mental health services, focus on the operationalisation of particular guiding principles each year, with progress to be reported in the Chief Psychiatrist's Annual Report under s 92(1)(a) of the *Mental Health Act 2009* (SA).

RECOMMENDATION 61

SALRI recommends that the incidental or technical amendments to clarify the operation of the *Mental Health Act 2009* (SA) or elsewhere as set out in Appendix 3 should be made.

Suggestions

SUGGESTION 1 (General)

SALRI suggests that further review and investigation into alternatives to the Emergency Department in public hospitals should be explored for mental health-related attendances.

SUGGESTION 2 (General)

SALRI suggests that further review and investigation into the allocation of resourcing, staffing, infrastructure and funding of Community Mental Health Teams is explored.

[132] Such parties could include the Commissioner for Aboriginal Children and Young People and the Commissioner for Children and Young People.

[133] This may take the form of a public notice identifying the party who has failed to comply and measures to address, improve and resolve non-compliance.

SUGGESTION 3 (General)

SALRI suggests that further review and investigation into the resourcing, staffing (including staff retention and resident specialists), infrastructure and funding of regional, rural and remote mental health services is explored.

SUGGESTION 4 (Decision-making Capacity and Supported Decision-making)

SALRI suggests that the definition of 'decision-making capacity' as appears in the *Mental Health Act 2009* (SA) be used across all South Australian legislation for consistency. Any amendments should be made to relevant pieces of legislation to provide this consistency.

SUGGESTION 5 (Decision-making Capacity & Supported Decision-making)

SALRI suggests that Conversation Cards or a wallet-sized information card should be available for consumers, in particular persons with a disability, such as an intellectual disability.

SUGGESTION 6 (Aboriginal Mental Health)

SALRI suggests that consideration be given to implementing a notification system, as observed between Pangula Mannamurna Aboriginal Corporation and the Local Health Network, requiring notification of an Aboriginal consumer to the relevant Aboriginal Community Controlled Health Service.

SUGGESTION 7 (Inpatient Treatment Orders)

SALRI suggests that the *Mental Health Act 2009* (SA) be amended to clarify s 56 to ensure this power is used reasonably to facilitate an assessment within a timely manner.

SALRI further recommends that reference to an 'assessment' could be inserted within sections 56(3)(c) and (d) *Mental Health Act 2009* (SA).[134]

SUGGESTION 8 (General)

SALRI suggests that further review should be undertaken into the use of the *Mental Health Act 2009* (SA) for consumers in prison.[135]

SUGGESTION 9 (General)

SALRI suggests that further review into the concurrent operation and practices involving the *Mental Health Act 2009* (SA) and *Criminal Law Consolidation Act 1935* (SA) be undertaken.

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[134] For example, s 56(3)(d) could be amended to (d) the authorised officer may restrain the person by means of the administration of a drug or an assessment for a treatment order when that is reasonably required in the circumstances.

[135] SALRI was told that prisons are not covered by any Community Mental Health Team. Health care is delivered by Prison Health, which is a primary care service and supported by consultation liaison psychiatric clinics. This raises issues in relation to care planning, enforcement of treatment in the community and issues in communication pertaining to an existing CTO for a person entering prison or upon their release.

SUGGESTION 10 (South Australian Civil and Administrative Tribunal and Legal Representation)

SALRI suggests that consideration could be given by the South Australian Civil and Administrative Tribunal to establishing a specific mental health stream.

SUGGESTION 11 (South Australian Civil and Administrative Tribunal and Legal Representation)

SALRI suggests that the State Government, in consultation with interested parties including the Legal Services Commission, the Law Society of South Australia, the Clinical Legal Education programs at the three Adelaide Law Schools and consumer and disability groups, should consider the provision of advice and advocacy[136] for consumers, carers, family members in connection to matters under the *Mental Health Act 2009* (SA), which is separate to the existing Legal Services Commission scheme for the provision of legal representation for consumers at the South Australian Civil and Administrative Tribunal.

[136] Advocacy in this context encompasses both legal representation and non-legal support and advocacy in a legal setting.

Part 1– Introduction

1.1 The South Australian Law Reform Institute

1.1.1 The South Australian Law Reform Institute ('SALRI') is an independent, non-partisan law reform body based at the University of Adelaide Law School. SALRI conducts inquiries or references into various areas of the law. It is assisted by an expert Advisory Board. The subject of a reference is determined by the SALRI Advisory Board and at the request of other parties such as the South Australian Attorney-General or the Law Society of South Australia. SALRI conducts extensive multidisciplinary research and looks at similar law and practice and its operation in other jurisdictions (both in Australia[137] and overseas). SALRI consults widely with interested parties, experts and the community. Based on the work and research undertaken during an inquiry, SALRI makes recommendations about appropriate changes to law and practice to the Attorney-General, so that the State Government and South Australian Parliament can make informed decisions about any appropriate changes. SALRI's recommendations do not necessarily become law. Rather, any decision on accepting and implementing any of SALRI's recommendations is entirely for the Government and South Australian Parliament. SALRI is not an advocacy group or academic thinktank.[138] Impartiality and independence are two of the central principles guiding SALRI's work.[139]

1.1.2 When undertaking its work, SALRI has a number of objectives. These include: to identify law reform options that would modernise the law, resolve any problems in the law, consolidate areas of overlapping law, remove unnecessary laws, or, where desirable, bring South Australian law into line with the law of other States and Territories. Under its guiding objectives, SALRI is required to consider the case for uniform laws where desirable[140] or practicable.[141]

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[137] SALRI examines the legal frameworks and practices in other Australian jurisdictions. Pursuant to the Terms of Reference for this project, there was a particular focus on the laws and practice in Victoria and the findings of the Victorian Royal Commission.

[138] See further David Plater and John Williams, 'The South Australian Law Reform Institute a Decade On: "May You Continue Well Into the Future"' (2022) 43(1) *Adelaide Law Review* 37.

[139] See further ibid 37.

[140] A component committee of the Standing Council commissioned a national project on model mental health legislation, which was completed in 1994. This project prompted review of mental health laws in every state and territory in Australia in the late 1990s: Australian Law Reform Commission, *Equality, Capacity and Disability in Commonwealth Laws* (Discussion Paper 81, May 2014) [10.75]. The ALRC, for example, raised that 'as definitions of capacity and approaches to assessing capacity vary across jurisdictions, the ALRC considers it may be useful to develop a national, or nationally consistent, approach to capacity': Australian Law Reform Commission, *Equality, Capacity and Disability In Commonwealth Laws* (Issues Paper 44, November 2014) 38 [105]. See also at: 39 Q 4; The ALRC has encouraged consistent laws across Australian jurisdictions regarding supported decision-making reflecting certain central principles. See Australian Law Reform Commission, *Equality, Capacity and Disability in Commonwealth Laws* (Final Report, November 2014) rec 10–1, 24 [1.4], 28 [1.30], 65 [3.9] 273–288; Bruce Alston, 'Towards Supported Decision-Making: Article 12 of the Convention on the Rights of Persons with Disabilities and Guardianship Law Reform' (2017) 35(2) *Disability, Rights and Law Reform in Australia* 20.

[141] One theme that SALRI heard was the confusion and intersection of the roles of the States and Commonwealth. This also emerged before the Victorian Royal Commission. See *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021) vol 4, 173–194. Bill Buckingham, the Director of Buckingham Consulting, giving evidence in a personal capacity, told the Royal Commission that the blurring of traditional boundaries has led to a 'spaghetti bowl of complexity and confusion about who does what': at 175. Mr Buckingham added that the 'merging of roles, between the Commonwealth and State governments is not being done in a deliberate way and is relatively uncoordinated. There are many areas of mental health service delivery where it is essentially a toss of the coin whether a project is funded by the Commonwealth or a state/territory government. Generally, the answer to that question will depend on where you live': at 175. Tim Marney, the Principal of Nous Group and former

1.1.3 SALRI was established in December 2010 under an agreement between the Attorney-General of South Australia, the University of Adelaide and the Law Society of South Australia.[142] SALRI is based on the Alberta law reform model, which is also used in Tasmania,[143] and is linked to the Law Reform elective course at the University of Adelaide. The work undertaken by the Law Reform class during this course is a valuable contribution and informs and supports SALRI's work.

1.1.4 A central premise of law reform is to promote the clarity, comprehension and accessibility of the law. This has particular application in relation to the *MHA*. SALRI adopts the view of Kirby J in this context; that law reform exists to promote 'the right of citizens … to have the most modern, well-informed, efficient system of law that the state can reasonably provide.'[144] SALRI has sought to follow this approach in this review. This approach has clear benefits in the context of the *MHA*, especially for consumers, carers, family members and practitioners.

1.2 Terms of Reference

1.2.1 On 17 February 2022, SALRI was formally requested by the Hon Josh Teague MP, the Minister for Planning and Local Government (exercising the powers and functions of the Attorney-General), to undertake an independent legislative review of the operation of the *MHA*.

1.2.2 An independent review is required under s 111 of the *MHA*.[145] Following this review, SALRI must provide a written Final Report to the State Government, making recommendations for any appropriate changes to law and practice. An Interim Report, outlining the work completed to date, was presented to the Minister for Health and Wellbeing and tabled in Parliament on 31 May 2022.[146]

1.2.3 The aim of the review is to ensure South Australia remains at the forefront of mental health reform. Consequently, the review examined the legal, human rights and other issues raised as well as the operation of the *MHA*. This was to enable SALRI to identify any shortcomings of the law, areas for reform and potential changes to present law and practice to resolve any issue(s) identified.

1.2.4 The following formal Terms of Reference were provided to SALRI:

1. Consult with relevant stakeholders, experts, persons with lived experience of mental illness, and other interested community groups and members, and to consider best practice from other Australian (and, if appropriate, international) jurisdictions in relation to the best practice, rights-supportive approach to mental health laws.

Western Australian Mental Health Commissioner similarly told the Royal Commission in a personal capacity: 'you have too many people playing in the same sandpit. Boundaries between Commonwealth, State and [non-government organisations'] responsibilities are fluid in the mental health space, in many instances targeting [the] same cohort of individuals and largely to deliver the same intended outcomes': at 175.

[142] SALRI can be seen as the successor to the Law Reform Committee of South Australia which operated between 1968 and 1987. During its operation, the Law Reform Committee produced a remarkable output of 106 reports. See Adelaide Law School, *South Australian Law Reform Institute* <https://law.adelaide.edu.au/research/south-australian-law-reform-institute>.

[143] Kate Warner, 'Institutional Architecture' in Brian Opeskin and David Weisbrot (eds), *The Promise of Law Reform* (Federation Press, 2005) 55, 62–4, 68.

[144] Michael Kirby, 'Changing Fashions and Enduring Values in Law Reform' (Presented at Conference on Law Reform on Hong Kong: Does it Need Reform?, University of Hong Kong, 17 September 2011).

[145] *Mental Health Act 2009* (SA) s 111.

[146] Olga Pandos et al, *Review of the Mental Health Act 2009 (SA): Interim Report* (South Australian Law Reform Institute, Adelaide, 2022). See South Australia, *Parliamentary Debates*, Legislative Council, 31 May 2022, 327.

2. Make recommendations on best practice and appropriate legislative changes as a result of these investigations, with a view to replacing (if required) or reforming South Australia's mental health legislation to better meet the objectives of the Act.

3. In particular, examine the following matters:

3.1. whether the operation of the Act unreasonably erodes patient rights to refuse treatment, or rights to access alternative, non-pharmacological approaches to treatment.

3.2. Consider the findings of the Royal Commission into Victoria's Mental Health System, insofar as those findings are relevant to South Australia's mental health legislation, including the role of positive rights and objectives that promote community-wide good mental health, a focus on recovery-oriented practice, and accountability mechanism for decision-makers.

3.3. Consider the operation of the "decision-making capacity criterion" for involuntary treatment orders under the Act, and its definition in s 5A, and in doing so consider:

3.3.1. Whether a best-practice, rights-based approach requires the prioritisation of this criterion and a legislated supported decision-making model;

3.3.2. Whether consumers, carers and mental health professionals require legislative clarification concerning the assessment of impaired decision- making capacity, with reference to the decisions in *PBU & NJE v Mental Health Tribunal* [2018] VSC 564[147] and *TSC v Department for Health and Wellbeing* [2021] SASCA 93.[148]

3.3.3. The findings and Recommendation 4 of the Deputy State Coroner Anthony Schapel dated 4 November 2021 regarding the death of Theo Nicholas Papageorgio, which relates to the impact of legislative criteria and suicide prevention.[149]

3.4. In the context of a discussion around shifting the focus of the Act towards encouraging good mental health and wellbeing, consider whether the role of Mental Health Commissioners should be statutory under the *MH Act*.

3.5. Consider improvements that could be made to the operation of the Act, including to address the issues identified [by the Office of the Chief Psychiatrist].[150] These issues have been identified following internal consultation in the Office of the Chief Psychiatrist and preliminary external consultation with a limited number of stakeholders. While many are administrative matters concerning the current operation of the Act, several are substantive legal or rights-impacting issues. They may be grouped into the following categories: (1) human rights protections, (2) involuntary treatment orders and care and control powers, (3) Consumer representation, (4) Electroconvulsive Therapy, (5) Prescribed Psychiatric Treatment Panel, (6) Functions of the Chief Psychiatrist and Community Visitor Scheme, and (7) Miscellaneous other issues.

1.2.5 This review was confirmed after the 2022 State election by the Hon Chris Picton MP, the Minister for Health and Wellbeing. Minister Picton additionally asked SALRI to consider the impact,

[147] See Appendix 1.

[148] See Appendix 2.

[149] *Inquest into the Death of Theo Nikolas Papageorgiou* (2021) 09/2020 (0176/2016) SACC (Schapel, Deputy State Coroner).

[150] See Appendix 3. SALRI has addressed a number of technical or incidental items raised by the Chief Psychiatrist in this table with SALRI's responses.

if any, of the *MHA* on the delivery of mental health services.[151] In order to address this new Term of Reference, SALRI examined how these principles can be operationalised in practice; whether their translation into practice impacts a consumer's access to mental health services, and if so, how this may be improved; and accountability mechanisms to monitor compliance with the principles and enforce consequences for non-compliance. A focus on the guiding principles and accountability was largely borne out of the recent Victorian Royal Commission. The intended changes to the Victorian law aimed to strengthen the objectives and principles, support access to care and treatment which is rights-based and enforce accountability mechanisms and monitoring arrangements. This was recommended in response to the lack of clear accountability mechanisms ensuring mental health principles are translated into practice.

1.2.6 Following this review, SALRI was required to provide a Final Report to the Minister examining the operation of the law and making any recommendations for possible changes to law and practice. According to its Terms of Reference, SALRI was not to examine the provision or delivery of mental health services. SALRI acknowledges that, as it was repeatedly advised in consultation by consumers, service providers, NGOs and health practitioners, there are very real issues and needs in this area (as demonstrated, for example, by a recent Report of the Auditor[152]).[153] However, issues beyond the scope of this review cannot be addressed in our recommendations. Rather, SALRI has made a number of suggestions in addition to the formal recommendations.

[151] This additional Term of Reference raises operational and resourcing issues that, in part, are specifically beyond SALRI's review and where there was inconsistency, no recommendations could be made by SALRI. However, these barriers have been addressed within the Report and in suggestions made outside of the formal recommendations.

[152] The Auditor concluded that there are key planning, monitoring and reporting processes in South Australia for the provision of access to mental health services that were not operating effectively. Due to these gaps, SA Health was not able to demonstrate how well it is performing in providing the public with access to the most appropriate mental health services, at the right time.

[153] See, for example, Michael Musker, *There's a Mental Health Emergency happening in South Australia. We need a Radical Overhaul* (15 April 2021) The Conversation <https://theconversation.com/theres-a-mental-health-emergency-happening-in-south-australia-we-need-a-radical-overhaul-158961>; Jemma Chapman, *"Completely Broke Me": Three Days of Mental Health Crisis in an Emergency Department* (27 May 2021) In Daily, <https://indaily.com.au/news/2021/05/27/completely-broke-me-three-days-of-mental-health-crisis-in-an-emergency-department/>; Stephanie Richards, *SA ED Wait Times for Mental Health Patients Branded "Worst in World"* (18 June 2021) In Daily <https://indaily.com.au/news/2021/06/18/sa-ed-wait-times-for-mental-health-patients-branded-worst-in-world/>; Jemma Chapman, "Needs to improve": SA Mental Health Gaps Exposed (7 September 2022) In Daily <https://indaily.com.au/news/2022/09/07/needs-to-improve-sa-mental-health-gaps-exposed/>; Jemma Chapman, *'Inhumane': ED Wait Time Blowout for Mental Health Patients* (15 October 2021) In Daily <https://indaily.com.au/news/2021/10/15/inhumane-ed-wait-time-blowout-for-mental-health-patients/>; Yun Song et al, 'Missing in Action: the Right to the Highest Attainable Standard of Mental Health Care' (2022) 16 (26) *International Journal of Mental Health Systems* 26; Philip Morris, 'The Australian Mental Health Crisis: A System Failure in Need of Treatment' (2006) 14(3) *Australian Psychiatry* 332.

1.2.7 There are particular issues and needs in the delivery of mental health services to regional, rural and remote communities,[154] as well as Aboriginal communities.[155]

1.2.8 A number of parties in consultation referred to the Victorian Royal Commission.[156] Though the voluminous work of the Royal Commission was a valuable resource for SALRI,[157] the scope of the Royal Commission was far ranging and involved a review of the entire mental health system. In contrast, it must be emphasised this is a more limited statutory review of the operation of the *MHA*, that excludes the delivery or provision of mental health services. While SALRI was not requested to undertake such a comprehensive assessment, legislative reviews such as the present still provide a valuable opportunity to determine whether the law remains fit for purpose and effective in meeting its objectives.

1.3 Consultation Approach

1.3.1 SALRI is committed to an impartial, inclusive and accessible consultation process with the South Australian community and all interested parties, including but not confined to the legal profession.[158] SALRI is especially committed to honest and respectful consultation with Aboriginal

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[154] See, for example, Health Performance Council of South Australia, *Mental Health in Rural and Remote South Australian Communities* (2013); Tom Tilley, *Mental Health Crisis "Devastating" Mt Gambier* (19 August 2010) ABC News <https://www.abc.net.au/news/2010-08-19/mental-health-crisis-devastating-mt-gambier/950416>; Matt Stephens, Victor Petrovic, and Sam Bradbrook, *Coroner Highlights Riverland Mental Health Shortfalls in Ruling on 27yo's preventable Death* (25 November 221) ABC News <https://www.abc.net.au/news/2021-11-25/theo-papageorgiou-inquest-finds-death-preventable/100630914>; Catherine Heuzenroeder, *Riverland Mental Health Recruitment Challenge* (29 November 2012) ABC Local <https://www.abc.net.au/local/stories/2012/11/29/3643924.htm>; Grace Whiteside, *Psychiatry Body Calls for Urgent Support for Mount Gambier as Intervention Order Remains* (14 Aril 2022) ABC News <https://www.abc.net.au/news/2022-04-14/mount-gambier-hospital-mental-health-election-promise/100987458>; Grace Whiteside and Selina Green, *Chief Psychiatrist places gazettal condition on South East Mental Health Service* (6 August 2021) ABC News <https://www.abc.net.au/news/2021-08-06/mt-gambier-health-service-gazettal-condition/100355224>.

[155] See, for example, Jacqueline Lynch, *Aboriginal Health Experts want more done to Tackle Suicide of Young people in the Kimberley* (10 October 2021) ABC News <https://www.abc.net.au/news/2021-10-10/mental-health-kimberley/100525368>; Rhiannon Shine et al, *Cluster of Kimberley Child Suicides Blamed by Coroner on "Tragic Intergenerational Trauma"* (7 February 2019) ABC News <https://www.abc.net.au/news/2019-02-07/kimberley-child-suicides-blamed-on-inter-generational-trauma/10783016>; Zalika Rizmal, *Victoria's Aboriginal Mental Health Services "lagging behind", Royal Commission Hears* (16 July 2019) ABC News <https://www.abc.net.au/news/2019-07-16/mental-health-royal-commission-hears-from-indigenous-victorians/11312244>; John Stewart and Brigid Andersen, *Indigenous People with Mental Health Issues "on a train" to jail: UNSW Study* (2 November 2015) ABC News <https://www.abc.net.au/news/2015-11-02/indigenous-people-mental-health-issues/6904838>; Helen Merkell, *Big Gaps Identified in Aboriginal Mental Health Services on NSW Mid North Coast* (1 February 2017) ABC News <https://www.abc.net.au/news/2017-02-01/big-gaps-identified-in-aboriginal-mental-health-services/8226570>; Leah MacLennan, *More Mental Health Staff to be sent to APY Lands following Critical Report, Concerns about no on-country Service* (8 December 2021) ABC News <https://www.abc.net.au/news/2021-12-08/more-mental-health-staff-for-apy-lands-following-report/100683918>; Patrick Martin, *First Nations Elders Dismayed about FIFO Mental Health Model Planned for South Australia's APY Lands* (3 November 2022) ABC News <https://www.abc.net.au/news/2022-11-03/aboriginal-children-without-mental-health-workers-in-communities/101556026>.

[156] See *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021) vol 1–5.

[157] The new landmark Victorian *Mental Health and Wellbeing Act 2022* (Vic) (based on the Royal Commission's findings) which will come into force on 1 September 2023, was also a valuable resource. The *MHWA* is a major Act, totalling some 652 pages. It cannot be simply transplanted in a South Australian context.

[158] Michael Kirby, 'Are We There Yet' in Brian Opeskin and David Weisbrot (eds), *The Promise of Law Reform* (Federation Press, 2005) 433, 436. See further Sarah Moulds, 'Community Engagement in the Age of Modern Law Reform: Perspectives from Adelaide' (2017) 38(2) *Adelaide Law Review* 441.

communities.[159] In addition, SALRI is also committed to an active and inclusive consultation process with regional, rural and remote communities[160] and Culturally and Linguistically Diverse communities. Such consultation is pivotal in any examination of the *MHA*, given the particular issues and implications that arise for regional, rural[161] and remote communities and Aboriginal[162] communities.

1.3.2 Such wide and inclusive consultation is integral to modern law reform.[163] As Neil Rees has observed:

> Effective community consultation is one of the most important, difficult and time-consuming activities of law reform agencies … community participation has two major purposes: to gain responses and feedback and to promote a sense of public 'ownership' over the process of law reform … consultation often brings an issue to the attention of the public and creates an expectation that the government will do something about the matter.[164]

1.3.3 SALRI's consultation for this review was comprehensive and adopted a flexible and multi-faceted consultation approach. SALRI:

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[159] See also Law Council of Australia, *The Justice Project: Aboriginal and Torres Strait Australians Final Report* (August 2018) 7–10. SALRI is committed to 'honest and respectful consultation' with Aboriginal communities. There are regular criticisms of token or perfunctory consultation with Aboriginal communities. See Melinda Miller, 'Consultation with Aboriginal and Torres Strait Islander People in Early Childhood Education: The Impact of Colonial Discourses' (2015) 42(5) *Australian Educational Researcher* 549, 553; Kylie Lingard, 'The Impact of the Law on Consultation Practices and Purpose: A Case Study of Aboriginal Cultural Heritage Consultations in NSW' (2012) (1) *International Journal of Rural Law and Policy* 1; Janet Hunt, Australian Institute for Family Studies, *Engaging with Indigenous Australia: Exploring the Conditions for Effective Relationships with Aboriginal and Torres Strait Islander Communities - Issues Paper No 5* (Australian Institute for Family Studies, 2013) 30.

[160] This theme has widely emerged in past and present SALRI references, notably by the Hon Geoff Brock MP, Minister for Local Government and the Member for Stuart and Alan Zubrinich, Port Pirie Councillor, and the erudite Dr Mark 'Matt' Giancaspro of Port Pirie and the Adelaide Law School.

[161] See also *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021) vol 5, 341, 346, 367–8. 'The Commission valued the contribution and voices of rural and regional Victorians, and hearing about the unique challenges and opportunities these communities face. The Commission visited specific communities and connected with services, community leaders and people with lived experience, supporting its commitment to rural and regional perspectives… These [regional] consultations helped the Commission to understand the mental health needs and experiences of the mental health system from people living in rural and regional communities, and how these differ between large regional centres, smaller country towns and dispersed rural farming communities': at vol 5, 346.

[162] See, for example, Aidan Curtis, 'Elders meet with SALRI on how the Law can Better Include Aboriginal Communities', *The Transcontinental* (Port Augusta) (online, 25 May 2022) <https://www.transcontinental.com.au/story/7753043/elders-have-their-say-on-law-reform/>. See also *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021) vol 5, 349–50. The Royal Commission stressed the importance of engagement with Aboriginal communities. Jill Gallagher AO, CEO of Victorian Aboriginal Community Controlled Health Organisation (VACCHO), said of the linked *Balit Durn Durn* report: 'For the first time in history, Aboriginal leaders, organisations, people, families, carers, and communities were given the opportunity to have their voices and experiences included in a redesign of the mental health system through the Royal Commission into Victoria's Mental Health System.' This report explores the power of Aboriginal culture. It outlines ways to build strength, resilience, connectedness and identity in Aboriginal people and communities to create essential pathways for fostering positive mental health and wellbeing': at 350.

[163] Roslyn Atkinson, 'Law Reform and Community Participation' in Brian Opeskin and David Weisbrot (eds), *The Promise of Law Reform* (Federation Press, 2005) 160; David Plater and John Williams, 'The South Australian Law Reform Institute a Decade On: "May You Continue Well Into the Future"' (2022) 43(1) *Adelaide Law Review* 37; Sarah Moulds, 'Community Engagement in the Age of Modern Law Reform: Perspectives from Adelaide' (2017) 38(2) *Adelaide Law Review* 441.

[164] Neil Rees, 'The Birth and Rebirth of Law Reform Agencies' (Presented at Australasian Law Reform Agencies Conference, Vanuatu, 10–12 September 2008).

a. Liaised closely with the Office of the Chief Psychiatrist;

b. Undertook initial consultation and research;

c. Identified the key issues raised in the review (guided by the Terms of Reference);

d. Prepared eight single page plain English Fact Sheets on each issue, with one to three consultation questions per Fact Sheet;

e. Prepared two additional Fact Sheets – one on the background of SALRI and the Terms of Reference and one providing a summary list of all consultation questions;

f. Adapted Fact Sheets and information for different audiences, including Easy Read;

g. Prepared a short promotional video to promote interest and input introducing SALRI, providing a summary of the review and how to contribute;

h. Created a summary of the review, a survey and an open forum on the YourSAy online platform (the Fact Sheets and promotional video were also made available on this site);

i. Organised consultation (including YourSAy) to open on Tuesday 19 April and close on Friday 29 July (14 weeks);

j. Hosted seven roundtable discussions (by theme/professional discipline) – invite only;

k. Held eight focus groups in Adelaide with various organisations, including consumers, persons with a disability and Culturally and Linguistically Diverse communities;

l. Prepared and disseminated a media release to promote SALRI's review (published by the Media Office at the University of Adelaide);

m. Arranged five regional trips within South Australia for consultation, to Port Pirie, Port Augusta, Mount Gambier/Naracoorte, Whyalla, Berri and Port Lincoln;

n. Consulted with the Office of the Chief Psychiatrist's Lived Experience Advisory Group and the Principal Aboriginal Mental Health Advisor; and

o. Prepared a consultation spreadsheet identifying relevant parties to contact.

1.3.4 As part of the consultation process, SALRI contacted a wide range of consumer and community groups, medical, mental health and other health practitioners, legal practitioners, consumer advocates, aged rights advocates, peak bodies, professional bodies, affected agencies, experts in the area and potential interested parties. These parties were invited to participate in consultation or provide their comments. Parties included the South Australian Bar Association,[165] the Law Society of South Australia, Local Health Networks, the Legal Services Commission, the South Australian Crown Solicitor, the Police Commissioner,[166] the Minister for Human Services (the Hon Nat Cook), the crossbench, the Opposition, Aboriginal Legal Rights Movement, the Commissioner for Aboriginal Engagement, Uniting Communities, Uniting Country, AMA(SA), Purple Orange, the Chief Psychiatrist

[165] The South Australian Bar Association did not make a submission, but SALRI was much assisted by Stephen McDonald SC, the Bar Association's representative on the SALRI Advisory Board.

[166] The police have a vital and often difficult role in enforcing the *Mental Health Act 2009* (SA). SALRI acknowledges the particularly helpful contribution of SAPOL to this review. See Part 9 Role of Police.

(Dr John Brayley), the Hon Geoff Brock (Minister for Local Government and the Member for Sturt), Flinders University and the University of South Australia.

1.3.5 SALRI has liaised with the Office of the Chief Psychiatrist throughout this review and acknowledges the helpful input of Dr John Brayley and his Office.

1.3.6 SALRI received a total of 149 submissions by various means and 76 contributors to the public YourSAy site (open forum and survey). SALRI also held 42 individual meetings, held in person or online. Finally, SALRI attended a site visit to the electroconvulsive therapy suite at The Queen Elizabeth Hospital and the South Australian Section of Electroconvulsive Therapy and Neurostimulation (RANZCP) Neurostimulation Retreat in October 2022.

1.3.7 The survey responses and extensive input to SALRI's consultation has greatly informed and assisted in the formulation and findings of this review.

1.3.8 SALRI typically follows a multi-faceted consultation approach and adapts its approach as required. This is particularly notable in SALRI's consultation with Aboriginal communities. SALRI met individually with Aboriginal Elders and members of Aboriginal communities and agencies, also travelling regionally to various locations. SALRI acknowledges the importance of culturally appropriate and sensitive engagement and fosters a culturally aware environment to undertake its consultation. SALRI expresses particular appreciation to Evelyn Varcoe and Beth Turner for their support and assistance during this review.[167]

1.3.9 As part of its consultation, SALRI travelled to various locations in regional South Australia to engage with the community and relevant parties.[168] These visits provided SALRI with the valuable opportunity to engage with a wide range of relevant parties, including consumers, health practitioners, service providers, NGOs, Aboriginal Elders, Aboriginal health agencies and other interested parties and individuals. This enabled SALRI to gain insight into the implications or issues experienced by individuals living and/or working in regional and rural South Australia, as well as by Aboriginal communities.

1.3.10 SALRI also took part in various Adelaide and regional media interviews.

1.3.11 There were various means for interested parties and individuals to share their views with SALRI in relation to this review.

1.3.12 SALRI had a focus in its consultation, as encouraged by the Office of the Chief Psychiatrist,[169] on the views and perspectives of consumers and people with a lived experience. The central role of lived experience in systems change is highlighted in literature.[170] This is most clearly described by Professor Jeffrey Braithwaite and colleagues, who argue that placing the patient (or

[167] SALRI also acknowledges the input of David Campbell, an experienced practitioner working with Aboriginal and other communities.

[168] See also [1.3.21].

[169] There was a request from the Office of the Chief Psychiatrist, consistent with SALRI's own practices, for a flexible, active and inclusive consultation process, notably with consumers and consumer groups.

[170] Peter Jones, 'Systemic Design Principles for Complex Social Systems' (2014) 1 *Social Systems and Design* 91, 103; Jeffrey Braithwaite, Russell Mannion and others, 'Accomplishing Reform: Successful Case Studies Drawn from the Health Systems of 60 Countries' (2017) 29(6) *International Journal for Quality in Health Care* 880, 883.

consumer) and their experience and wellbeing at the heart of system reform, is the 'most crucial' lesson of successful healthcare reform in recent times.[171] The Victorian Royal Commission:

> … adopted specific and tailored engagement approaches to promote the voices of people with lived experience. These included holding dedicated consumer and family, carer and supporter 'human-centred design' focus groups and establishing a Consumer Foundations Working Group to provide the Commission with further consumer perspectives across its work program. Human-centred design involves putting the user at the heart of the design process to support citizen-centric decision making and create health policy solutions that better serve the community.[172]

1.3.13 SALRI prepared eleven Fact Sheets, reflecting its Terms of Reference (of which nine discussed a key issue raised in this review):

- Background (about SALRI and the Terms of Reference);
- Capacity and Supported Decision-making;
- Inpatient Treatment Orders;
- Community Treatment Orders;
- Restrictive Practice and Control Powers;
- Electroconvulsive Therapy;
- The South Australian Civil and Administrative Tribunal and Legal Representation;
- The Role of South Australia Police;
- Guiding Principles and Accountability Mechanisms
- Other Issues (addresses outstanding issues that are not raised in detail by the preceding Fact Sheets, such as the Community Visitor Scheme and Mental Health Commissioners); and
- Summary List of Consultation Questions.

1.3.14 Each issue was identified in accordance with the Terms of Reference and in consultation with the Office of the Chief Psychiatrist.

1.3.15 Each substantive Fact Sheet contained one to three consultation questions, which guided SALRI's roundtable discussions and formed the basis of the survey available on YourSAy. The data and comments received during consultation have formed a valuable and integral part of SALRI's Final Report. It also informed SALRI's recommendations for changes to present law and/or practice. SALRI is grateful for the many parties who contributed to this review.

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[171] The Victorian Royal Commission also 'adopted specific and tailored engagement approaches to promote the voices of people with lived experience. These included holding dedicated consumer and family, carer and supporter 'human-centred design' focus groups and establishing a Consumer Foundations Working Group to provide the Commission with further consumer perspectives across its work program. Human-centred design involves putting the user at the heart of the design process to support citizen-centric decision making and create health policy solutions that better serve the community': *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021) vol 1, 66.

[172] Ibid.

1.3.16 SALRI also prepared a promotional video to outline the scope of the review and to encourage community participation.[173]

1.3.17 On 1 March 2022, SALRI received confirmation from the Attorney-General's Department to use the YourSAy site to help conduct its consultation. The YourSAy platform was prepared, containing:

- An overview of the review and SALRI's Terms of Reference;
- The nine Fact Sheets concerning the key issues raised within the review (excluding the Summary List of Consultation Questions);
- SALRI's promotional video and a script of the video;
- A survey consisting of SALRI's consultation questions;
- An open forum, in which members of the public may provide a comment about their experience in dealing with the *MHA*;
- SALRI's contact details and website;
- Frequently asked questions; and
- The lifecycle of the project (open, closed and under review and consultation outcome).

1.3.18 The YourSAy platform acts as a conduit between SALRI and the community. It provides an opportunity for the wider community to contribute and express their views on the relevant issues and questions to be examined in this review. SALRI is aware of the limitations associated with the use of YourSAy, most notably, it requires a level of computer, reading and writing literacy and access to a computer with an internet connection.[174] SALRI's experience over several past references has shown the importance of diverse consultation across a number of avenues (survey, fact sheet or video) and through various methods (community forum, private meeting, roundtable discussion or focus group). In addition, SALRI adapts its consultation approach to cater to specific groups or consultees, to ensure meaningful input and engagement.

Aboriginal Communities

1.3.19 SALRI is committed to an active and inclusive consultation process with Aboriginal communities.[175] Consultation with Aboriginal communities may take a different approach. Over the years, SALRI has built a rapport with a number of Aboriginal Elders, community members and organisations, both in metropolitan and regional South Australia. This is a product of ongoing discussions and visits to different communities. A SALRI visit generally occurs at the beginning of a project to ascertain initial views and identify key issues, towards the end of a project to receive feedback

[173] See the SALRI community video at: The University of Adelaide – Future Students, *Review of the Mental Health Act 2009* (16 August 2022) <https://www.youtube.com/watch?v=tvgh9ClnrzI>.

[174] This may well be an issue in regional, remote and rural locations.

[175] Aidan Curtis, 'Elders meet with SALRI on how the Law can Better Include Aboriginal Communities', *The Transcontinental* (Port Augusta) (online, 25 May 2022) <https://www.transcontinental.com.au/story/7753043/elders-have-their-say-on-law-reform/>.

on recommendations (based on consultation) and upon the completion of a project to provide a copy of the finalised report.

Culturally and Linguistically Diverse Communities

1.3.20 SALRI is committed to meaningful engagement with Culturally and Linguistically Diverse ('CALD') communities, most notably, through the Multicultural Communities Council of South Australia. For example, a community forum with members was facilitated by SALRI. This provides a valuable opportunity to consult members of CALD communities. Such a discussion in a safe environment enables SALRI to better understand particular issues or concerns facing members of CALD communities.

Disability Sector and Community

1.3.21 SALRI has close links with the disability sector and community – this includes organisations such as Purple Orange, Our Voice SA, the South Australian Council on Intellectual Disability and persons with a disability. In previous projects undertaken by SALRI, focus groups or community forums have been organised. For this review, SALRI co-facilitated four focus groups.

1.3.22 SALRI's engagement with Aboriginal communities, CALD communities and people with a disability reflects the ways in which modern consultation can be adapted to enhance meaningful engagement.

Regional Consultation

1.3.23 As part of this review, SALRI held the following five regional trips:

Date	Location
19 – 20 May 2022	Clare, Port Pirie and Port Augusta
27 May 2022	Berri
3 June 2022	Whyalla
16 – 17 June 2022	Port Lincoln
22 – 23 June 2022	Naracoorte and Mount Gambier

Roundtable Discussions

1.3.24 SALRI held seven Roundtable discussions with a wide range of interested parties and individuals and relevant agencies and both Government and non-Government bodies. These sessions were by invitation only.[176] At the commencement of each session, attendees were reminded that SALRI adopts the Chatham House Rule (individual attributable views expressed cannot and will not be repeated outside the session).[177] These sessions discussed this review with a focus on the most relevant

[176] It was not possible for SALRI to meet every interested individual in person. There were various means for interested parties and individuals to share their views with SALRI in relation to this review.

[177] Sometimes attendees will meet SALRI separately, outside a roundtable and agree or ask that their individual views are publicly attributable to them in any Report.

consultation questions. Agreement was often reached at these sessions between attendees on many of the issues. SALRI prepared detailed minutes of each Roundtable discussion. These minutes may be referred to in SALRI's Report, especially if agreement was reached on a particular question.

1.3.25 Roundtables are arranged according to a particular theme (such as industry or practice) or professional discipline (such as legal or medical). These discussions allow targeted consultation, enabling SALRI to focus on particular issues raised within a theme or professional discipline. Each Roundtable discussion was two hours in duration and was hosted at the University of Adelaide.[178]

1.3.26 The following Roundtables were held as part of this review (by theme/professional discipline):

- Medical Specialist
- Psychology/Neuropsychology
- Nursing and Social Work
- Disability Advocacy
- Mental Health NGOs
- Government/Peak Body
- Consumers and Carers
- Regional/Community

1.3.27 The Roundtables were held in late May and June 2022. In light of the ongoing COVID-19 situation, measures to offer remote participation were arranged, where required.[179]

1.3.28 SALRI conducted a number of media interviews with radio and television stations and newspapers in Adelaide, Berri, Port Pirie, Whyalla, Port Augusta, Port Lincoln and Mount Gambier.

1.3.29 In the preparation of this Report, SALRI had careful regard to all the various views expressed to it. SALRI is grateful for the valuable contributions of all survey respondents, attendees and interested parties who contributed to this Report. SALRI has also had regard to the various reviews of law and practice in this area, especially the voluminous work of the Victorian Royal Commission.

1.3.30 SALRI acknowledges the helpful contribution of the students from the Law Reform class at the University of Adelaide Law School. SALRI acknowledges the financial support of the State Government to enable SALRI to undertake this review.

1.3.31 SALRI finally wishes to express its appreciation to the many consumers, medical, mental health and other health practitioners, Aboriginal Elders, consumer and community groups, interested parties, experts and members of the community, who have generously contributed in various ways. Their views and comments have been carefully taken into account and SALRI is grateful for their time and input.

[178] SALRI has previously held community forums at venues external to the University of Adelaide. For example, a forum was arranged and undertaken at the offices of the Multicultural Communities Council of SA.

[179] It is important to note that the consultation process needed to be flexible and adaptable, especially with the ongoing COVID-19 situation.

Part 2 – Background and Context to South Australia's Mental Health Laws

2.1 Background

2.1.1 The *Mental Health Act 2009* (SA) ('*MHA*') governs the provision of mental health services and treatment in South Australia. The *MHA* commenced operation on 1 July 2010. The *MHA* was perceived as a landmark Act which 'provid[ed] a contemporary framework for the provision of mental health services and is central to the reforms currently underway in the mental health system'.[180] Mental health laws can significantly affect the rights of consumers, particularly in the context of involuntary treatment. As such, the law should be examined through the lens of a changing legal landscape, whereby international human rights law, principles and frameworks have shifted to a supported decision-making model over the previous, now outdated, substitute decision-making model. This shift places greater emphasis on the need to safeguard decision-making capacity, autonomy and self-determination.

2.1.2 Legislative and other good intentions are not necessarily sufficient. As the Victorian Royal Commission found on Victoria's mental health system:

> Despite the goodwill and commitment of many people who work in the [mental health] system, it is hampered by historical and structural challenges that have emerged and persisted over several decades. Underinvestment, poor system planning, limited accountability and disregard for consumers' preferences have ensured good mental health and wellbeing remain a low priority across government and the community. Stigma and discrimination have entrenched this. The implications for people living with mental illness or psychological distress, families, carers and supporters are stark. An undersupply of community-based services has contributed to an over-reliance on crisis responses and medication. Many people cannot access suitable services, and even when they can, services are difficult to navigate and often do not meet their needs. People are told they are not 'sick enough' to access specialist services. Human rights are breached unjustifiably through excessive use of coercive practices. Families, carers and supporters feel ignored by the system. Suicide continues to have a profound impact across communities. People expect compassion and kindness from the system, but it can traumatise and retraumatise those it seeks to support.[181]

2.1.3 The challenges facing South Australia's mental health system are similarly complex and multi-faceted.

2.1.4 The history of mental health law demonstrates a perpetual struggle to legislate in regard to persons with lived experience of mental illness.[182] In particular, the involuntary treatment of mental illness has remained 'the most consistently debated issue' in mental health law.[183] Involuntary treatment

[180] South Australia, *Parliamentary Debates*, House of Assembly, 3 June 2009, 3004 (Jane Lomax-Smith).

[181] *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021) vol 1, ix-x.

[182] Judith Laing, 'Rights versus Risk - Reform of the Mental Health Act 1983' (2000) 8(2) *Medical Law Review* 210, 211; Bernadette McSherry, 'Mental Health Laws: Where to from Here' (2014) 40(1) *Monash University Law Review* 175, 177; Justice Michael Kirby, 'Mental Health Law Reform: The "Second Wave"' (1981) 1(8) *Medical Journal of Australia* 421.

[183] Lisa Brophy and Fiona McDermott, 'What's Driving Involuntary Treatment in the Community? The Social, Policy, Legal and Ethical Context' (2003) 11(Supplementary) *Australian Psychiatry* 84; Melissa Floyd, 'Involuntary Mental Health Treatment: The Mental Health Consumer as Expert' (2013) 24(3) *Journal of Human Services* 187.

significantly impacts upon not only consumers (under both CTOs[184] and ITOs[185]), but also their families, carers, friends, medical practitioners and health care workers.[186] This impact is none the more prevalent than in the area of suicide prevention.[187]

2.1.5 Despite various advances over recent years, as the Productivity Commission observes:

> Mental illness is stigmatised. Social views of mental illness have improved, but still trail a long way behind our knowledge of how mental illness affects people's lives. This stigma creates barriers to individuals seeking care and can reduce the effectiveness of that care. Australia's mental health system (and the professions charged with assisting people) need to be stigma-free, empowering individuals who seek care. Australia's current mental health system is not comprehensive… Australia's mental health system does not empower those who need it. People with mental illness often have little say in their own treatment and are deprived of the information and other resources that they need to manage and make decisions about their own care. Providers of clinical and community services too often deliver what they think consumers need, sometimes based on ill-informed assumptions about the decision-making capacity of the consumer and sometimes based just on the symptoms presented to them rather than a holistic view of the individual… Put simply, Australia's mental health system is not 'person-centred'. It should be.[188]

2.1.6 The appropriateness of the involuntary detention and treatment of people with a mental illness, if they present a risk of harm, either to themselves or to others was traditionally rarely

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[184] Consumers and consumer groups and others highlighted to SALRI both the emotional and physical effects of CTOs, notably the marked effects of certain medications on consumers. The treatment most commonly administered under a CTO is a periodic depot injection of psychiatric medication. See Edwina Light, 'Rates of use of community treatment orders in Australia' (2019) 64 *International Journal of Law and Psychiatry* 83, 84. Psychiatric medication is often accompanied by severe side effects. For example, side effects associated with anti-psychotic medication may include akathisia (an inability to remain still), weight gain, cardiovascular and metabolic side effects, and tardive dyskinesia (an involuntary neurological movement disorder). See Cherrie Galletly et al, 'Royal Australian and New Zealand College of Psychiatrists Clinical Practice Guidelines for the Management of Schizophrenia and Related Disorders' (2016) 50(5) *Australian and New Zealand Journal of Psychiatry* 1, 33; South Australia, *Parliamentary Debates*, Legislative Council, 30 April 2009 2202–3. These side-effects were often raised by consumers to SALRI as to the effects of medication.

[185] See, for example, Susanne Jaeger et al, 'Long-Term Effects of Involuntary Hospitalization on Medication Adherence, Treatment Engagement and Perception of Coercion' (2013) *Social Psychiatry and Psychiatric Epidemiology* 1787; Olav Nyttingnes, Torleif Ruud and Jorun Rugkåsa, '"It's Unbelievably Humiliating": Patients' Expressions of Negative Effects of Coercion in Mental Health Care' (2016) 49(A) *International Journal of Law and Psychiatry* 147; Rebecca Murphy et al, '"Service Users" Experiences of Involuntary Hospital Admission Under the Mental Health Act 2001 in the Republic of Ireland' (2017) 68 *Psychiatric Services* 1127; 'International research has documented that service users who are detained involuntarily express concerns about violations of their autonomy, human rights, personal integrity, and self-efficacy. Although positive experiences and person-centered care have been reported by service users, the pervasive narrative is one of fear, distress, and loss; service users report feeling disempowered, coerced, disconnected from decision-making processes, and traumatised by their experience': at 1127–8. See further Part 5 Inpatient Treatment Orders.

[186] United Kingdom Department of Health, *Report of the Expert Committee: Review of the Mental Health Act 1983* (Report, 1999) 19; George Szmukler and Brendan Kelly, 'We Should Replace Conventional Mental Health Law with Capacity-Based Law' (2016) 209(6) *British Journal of Psychiatry* 449, 452; Marie Nicolini, Joris Vandenberghe and Chris Gastmans, 'Substance Use Disorder and Compulsory Commitment to Care: a Care-Ethical Decision-Making Framework' (2018) 32(3) *Scandinavian Journal of Caring Sciences* 1237, 1240.

[187] The links between mental illness and suicide and the need to include suicide prevention under mental health treatment approaches were raised by many parties in SALRI's consultation, notably the Hon John Dawkins, a longstanding advocate in this area. Suicide prevention is a priority for State, Territory and Commonwealth governments, with significant efforts and resources being allocated to the issue. See, for example, Australian Government, *Vision 2030: Blueprint for Mental Health and Suicide Prevention* (March 2020); South Australian Government, *Mental Health Services Plan 2020-2025* (November 2019); *Suicide Prevention Act 2021* (SA).

[188] Productivity Commission, *Mental Health Inquiry Report*, No 95 (June 2020) vol 1, 4–6. See also at: 21–2, 39, 67 rec 8; vol 2, 153–4, 353–398.

questioned. The need for protection seemed apparent. The combination of a diagnosis of a mental illness and the risk to self or others has been the justification for involuntary detention, and usually treatment, for centuries.[189] However, this premise was increasingly questioned and challenged, especially, but not exclusively, when considering international human rights principles.[190]

2.1.7 Such concerns over South Australia's mental health laws are not new.[191] The law predating the 2009 *MHA* was seen as problematic in various respects,[192] such as:

- The need to reflect changing community attitudes to mental illness';[193]
- Concern over harsh involuntary treatment;[194]
- Insufficient focus on consumers' rights;[195]
- The nature of risk assessment;[196]
- A perceived paternalistic substitute decision-making model based on a 'best interests' approach;
- The need for a supported decision-making approach;

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[189] George Szmukler, 'Involuntary Detention and Treatment: Are We Edging Toward a "Paradigm Shift"?' (2020) 46(2) *Schizophrenia Bulletin* 231.

[190] Ibid.

[191] TS George, 'Commitment and Discharge of the Mentally Ill in South Australia (1972) 4(2) *Adelaide Law Review* 330. 'Many unjustified commitments, in my opinion, do occur. This is because the criteria on which commitment is based are exceedingly broad in scope and vague in definition. Moreover, the safeguards provided by the *Mental Health Act* are patently inadequate': at 330. See also Alan Leaver, 'Recent Reform of South Australian Mental Health Legislation: "Third Wave" or "First Wave Revisited?"' (1995-1997) 1(1) *Flinders Journal of Law Reform* 40. The concern at the revelations at Oakden also prompted renewed recent concerns. See Yvette Maker and Bernadette McSherry, 'Regulating Restraint Use in Mental Health and Aged Care Settings: Lessons from the Oakden Scandal' (2019) 44(1) *Alternative Law Journal* 29.

[192] Alan Leaver, 'Recent Reform of South Australian Mental Health Legislation: "Third Wave" or "First Wave Revisited?"' (1995-1997) 1(1) *Flinders Journal of Law Reform* 40; Bernadette McSherry, 'Mental Health Laws: Where to From Here?' (2014) 40(1) *Monash University Law Review* 175.

[193] South Australia, *Parliamentary Debates*, House of Assembly, 18 February 2009, 1610 (Liz Penfold).

[194] Ibid 1605 (Dr McFetridge); South Australia, *Parliamentary Debate*, Legislative Council, 29 April 2009, 2134–2141 (Ann Bressington); South Australia, *Parliamentary Debates, Legislative Council*, 29 April 2009, 2141–2143 (David Winderlich). 'A commonly-held belief is that locking up and forcibly drugging people diagnosed with mental illness is in their best interests as well as society's as a whole. The truth is far different. Rather than protecting the public from harm, public safety is decreased. Rather than helping psychiatric respondents, many are greatly harmed. The evidence on this is clear': South Australia, *Parliamentary Debates*, Legislative Council, 29 April 2009, 2135 (Ann Bressington).

[195] South Australia, *Parliamentary Debates*, Legislative Council, 4 June 2008, 3098 (Gail Gago); South Australia, *Parliamentary Debates*, Legislative Council, 29 April 2009, 2142 (David Winderlich).

[196] South Australia, *Parliamentary Debates*, Legislative Council, 4 June 2008, 3099 (Gail Gago); South Australia, *Parliamentary Debates*, Legislative Council, 29 April 2009, 2134–41 (Ann Bressington). Research shows that the risk of serious violence or suicide by persons with mental illness is actually 'very low': Sascha Callaghan and Christopher Ryan, 'Is there a Future for Involuntary Treatment in Rights Based Mental Health Law?' (2015) 21(5) *Psychiatry, Psychology and Law* 747, 751. See also Matthew Large, et al., 'Risk Factors for Suicide Within a Year of Discharge from Rights-Holder 763 Psychiatric Hospitals: A Systematic Meta-Analysis' (2011) 45 *Australian and New Zealand Journal of Psychiatry* 61; Douglas Mossman, 'The Imperfection of Protection through Detection and Intervention: Lessons from Three Decades of Research on the Psychiatric Assessment of Violence Risk' (2009) 30 *Journal of Legal Medicine* 10; Jay Singh et al., 'Structured Assessment of Violence Risk in Schizophrenia and other Psychiatric Disorders: A Systematic Review of the Validity, Reliability, and Item Content of 10 Available Instruments' (2011) 37 *Schizophrenia Bulletin* 899.

- The grounds and prevalence of involuntary inpatient treatment;[197]
- The need to ensure involuntary treatment is the least restrictive means of administering appropriate treatment of the person's illness;[198] and
- Erosion of a consumer's autonomy.

2.1.8 These central principles have their legislative origin in South Australia in the Mental Health Bill 2008 (SA). This Bill drew upon a well-received and 'thorough review' of the mental health laws in South Australia undertaken by Ian Bidmeade, a legal policy officer and solicitor.[199] In 2005, the Government released Mr Bidmeade's review, *Paving the Way*.[200] This review proposed a number of changes to modernise the law and improve responses to people with mental illness, including 'greater emphasis on community care, not just hospital or institutional care'.[201] This review formed much of the basis of the 2009 *MHA*.

2.1.9 The Bill was introduced to the South Australian Parliament on 4 June 2008 (and reintroduced on 12 November 2008) to replace the previous *Mental Health Act 1993* (SA).[202] The Bill provided that restrictive practices should be used only as a 'last resort for safety reasons and not as a punishment or for the convenience of others'.[203] Additionally, mental health services should be provided on a voluntary basis as far as possible, and in the least restrictive way and environment, that is consistent with their efficacy and public safety.

2.1.10 The new Act had ambitious aims as the then Minister for Mental Health and Substance Abuse explained:

> A world-class mental health system depends on an effective legislative framework to ensure that society can fulfil its obligations to care for individuals with serious mental illness. There is an expectation in the community and an obligation on the part of the government that, where a person is unable to make an informed decision about their mental health and welfare and they are vulnerable or pose a risk to others, intervention can take place to ensure they obtain the assessment, treatment and care that is necessary. The *Mental Health Bill 2008* is designed to replace the *Mental Health Act 1993* and provide a contemporary framework for the provision of services to people with serious mental illness who are either unwilling or unable to consent to their own treatment… The *Mental Health Bill 2008* incorporates provisions which bring South Australia into line with contemporary approaches to the management of serious mental health issues and

[197] South Australia, *Parliamentary Debates*, Legislative Council, 4 June 2008, 3100 (Gail Gago); South Australia, *Parliamentary Debates*, House of Assembly, 5 February 2009, 1450–3 (Vickie Chapman); South Australia, *Parliamentary Debates*, Legislative Council, 29 April 2009, 2134–41 (Ann Bressington), 2141–3 (David Winderlich).

[198] South Australia, *Parliamentary Debates*, Legislative Council, 4 June 2008, 3099 (Gail Gago); South Australia, *Parliamentary Debate*, Legislative Council, 29 April 2009, 2147 (Gail Gago).

[199] South Australia, *Parliamentary Debates*, Legislative Council, 26 March 2009, 1782 (Carmen Zollo).

[200] Ian Bidmeade, *Paving the Way, Review of Mental Legislation in South Australia Report* (April 2005).

[201] South Australia, *Parliamentary Debates*, House of Assembly, 12 November 2008, 885 (Jane Lomax-Smith).

[202] South Australia, *Parliamentary Debates*, Legislative Council, 4 June 2008, 3096–118 (Gail Gago); South Australia, *Parliamentary Debates*, House of Assembly, 12 November 2008, 884–907 (Jane Lomax-Smith).

[203] *Mental Health Act 2009* (SA) s 7. See also South Australia, *Parliamentary Debates*, House of Assembly, 12 November 2008, 884–5 (Jane Lomax-Smith).

includes innovations designed to assist people to obtain assistance in a manner which aims to minimise the extent to which their freedom is curtailed and to protect their rights.[204]

2.1.11 The then Minister for Mental Health and Substance Abuse elaborated as to the Bill's aims:

> The Mental Health Bill is the basis for a number of very important reforms to the mental health system and it is vital that we progress this agenda. The Mental Health Bill provides a contemporary framework for the provision of mental health services and is central to the reforms currently underway in the mental health system. It will enable people in rural and regional South Australia to be admitted to and treated in limited treatment centres. It will enable medical practitioners and authorised health professionals to be able to consider community treatment orders as a first option in treatment. It will also enable South Australia to have a Chief Psychiatrist with the necessary powers to ensure that the mental health system is both accountable and transparent in its functioning.[205]

2.1.12 The 2009 Bill received all party support,[206] though various concerns were raised as to the delivery of mental health services,[207] notably in a regional context,[208] the use of coercive powers to treat mental health,[209] and, in particular, the need for a Community Visitor Scheme[210] (which was seen as 'a

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[204] South Australia, *Parliamentary Debates*, Legislative Council, 4 June 2008, 3096–7 (Gail Gago). See also South Australia, *Parliamentary Debates*, House of Assembly, 12 November 2008, 884–5 (Jane Lomax-Smith).

[205] South Australia, *Parliamentary Debates*, House of Assembly, 3 June 2009, 3004 (Jane Lomax-Smith).

[206] See South Australia, *Parliamentary Debates*, House of Assembly, 5 February 2009, 1448–61; South Australia, *Parliamentary Debates*, House of Assembly, 18 February 2009, 1560–71, 1597–1600, 1600–34; South Australia, *Parliamentary Debates*, Legislative Council, 3 March 2009, 1462–66; South Australia, *Parliamentary Debates*, Legislative Council 24 March 2009, 1643–6; South Australia, *Parliamentary Debates*, Legislative Council, 26 March 2009, 1782–5; South Australia, *Parliamentary Debates*, Legislative Council, 29 April 2009, 2134–52; South Australia, *Parliamentary Debates*, House of Assembly, 2 June 2009, 2845–9; South Australia, *Parliamentary Debates*, Legislative Council, 2 June 2009, 2433–6.

[207] South Australia, *Parliamentary Debates*, House of Assembly, 6 February 2009, 1560–71, 1597–1600, 1600–02 (Vickie Chapman).

[208] South Australia, *Parliamentary Debates*, House of Assembly, 18 February 2009, 1611–3 (Liz Penfold); South Australia, *Parliamentary Debates*, House of Assembly, 18 February 2009, 1617–8 (Adrian Pederick).

[208] South Australia, *Parliamentary Debates*, House of Assembly, 18 February 2009, 1611–3 (Liz Penfold); South Australia, *Parliamentary Debates*, House of Assembly, 18 February 2009, 1617–8 (Adrian Pederick); South Australia, *Parliamentary Debates*, House of Assembly, 18 February 2009, 1618–9 (Lyn Breuer). 'I want to pay tribute to staff in regional areas who deal with mental health issues. They are a small band, but they do incredible work against all odds. The fact of the matter is, and I think this is still currently the case, that there is not one resident psychiatrist in country South Australia, rural South Australia, not one resident psychiatrist. Everywhere is visited by psychiatrists but not by any who live locally. You may find that you see a psychiatrist one week and then, three weeks later, you see a completely different one, so it is difficult to bond with them. The service is not terribly satisfactory, and it is very difficult for people. There are limited numbers of psychologists in our regional areas, although a few of the bigger centres have some who are often connected with the education department. However, there are very few resident psychologists in country regions, mainly because you cannot get them to go out there… We have mental health nurses who work in isolated conditions with very little back-up support or places where they can download and talk to their peers about any issues and problems, but they do an incredible job. Generally, they are trained psychiatric or mental health nurses, although sometimes they are GPs, nursing staff or whatever. It is very difficult for them, so I think they deserve the highest accolade we can give them because they work in far more difficult situations and circumstances than their Adelaide counterparts. I think it is important for us, as country members, to pay tribute to them': at 1619 (Lyn Breuer).

[209] South Australia, *Parliamentary Debates*, House of Assembly, 5 February 2009, 1450–3 (Vickie Chapman); South Australia, *Parliamentary Debates*, Legislative Council, 29 April 2009, 2134–41 (Ann Bressington), 2141–3 (David Winderlich).

[210] South Australia, *Parliamentary Debates*, House of Assembly, 5 February 2009, 1450–52 (Vickie Chapman); South Australia, *Parliamentary Debates*, House of Assembly, 18 February 2009, 1621–4; South Australia, *Parliamentary Debates*, Legislative Council, 3 March 2009, 1465 (Michelle Lensink); South Australia, *Parliamentary Debates*, Legislative Council, 26 March 2009, 1784–5 (Robert Lawson RFD KC); South Australia, *Parliamentary Debates*,

valuable way of both engaging the community to support mentally ill people and ensuring the accountability of the professionals and the systems that care for the mentally ill'.[211]

2.1.13 The 2009 Act remains largely unchanged. However, various amendments were made in 2015,[212] most notably to insert impaired decision-making capacity as one of the criterions in the imposition of a CTO or an ITO.[213]

2.1.14 Significant international developments moving toward a social, as opposed to a medical model of disability and a supported decision-making approach. The protection of human rights for persons with disability was also part of the rationale of the 2009 *MHA*. The *CRPD* reflects a 'social' model of disability.[214] The premise of involuntary treatment or detention for persons with mental illness raises issues with various views under human rights principles.[215] International human rights principles, especially the *CRPD*, has led to a shift from a substitute to supported decision-making model,[216] the

Legislative Council, 24 March 2009, 1645–6 (Mark Parnell). See further Part 11 The Community Visitor Scheme and Mental Health Commissioners.

[211] South Australia, *Parliamentary Debates*, Legislative Council, 29 April 2009, 2142 (David Winderlich). The Hon Michelle Lensink MLC also said: 'a community visitors scheme, which was a key recommendation of Ian Bidmeade's review *Paving the Way*. We suspect that the government's decision to omit it was likely taken because of resource implications and also because the government is not keen on introducing consumer advocates within acute settings. However, I think that all health professions working within the health system would be largely supportive of a community visitors scheme. I am told that some form of community visitors scheme operates within every jurisdiction in Australia, except South Australia. We feel it is very important that people with a mental illness, who are some of the most vulnerable people in our community, have some form of advocacy. They may be estranged from family and they may not have many close friends, and we believe it is very important that they have someone who is able to provide some assistance to them and some form of advocacy': South Australia, *Parliamentary Debates*, Legislative Council, 3 March 2009, 1465. See further Part 11 The Community Visitor Scheme and Mental Health Commissioners.

[212] *Mental Health (Review) Amendment Act 2016* (SA).

[213] South Australia, *Parliamentary Debates*, House of Assembly, 2 December 2015, 3924–5. The inclusion of impaired decision-making capacity as one of the criterions in the imposition of a CTO or an ITO under the *Mental Health Act 2009* (SA) was considered as part of this review. SALRI favoured the retention of the present approach. See further Part 3 Decision-making Capacity and Supported Decision-making.

[214] Sascha Callaghan and Christopher Ryan, 'Is there a Future for Involuntary Treatment in Rights Based Mental Health Law?' (2015) 21(5) *Psychiatry, Psychology and Law* 747; Australian Law Reform Commission, *Equality, Disability and Capacity in Commonwealth Laws* (Final Report, November 2014) 38 [2.11]–[2.12].

[215] See, for example, Michael Dunn et al, 'Constructing and Reconstructing "Best Interests": An Interpretive Examination of Substitute Decision-making under the Mental Capacity Act 2005' (2007) 29 *Journal of Social Welfare and Family Law* 117; Sascha Callaghan and Christopher James Ryan, 'Rising to the Human Rights Challenge in Compulsory Treatment: New Approaches to Mental Health Law in Australia' (2012) 46 *Australian and New Zealand Journal of Psychiatry* 61; Geneva Richardson, 'Mental Disabilities and the Law: From Substitute to Supported Decision-Making?' (2012) 65 *Current Legal Problems* 333; Bernadette McSherry, 'Mental Health Laws: Where to From Here?' (2014) 40(1) *Monash University Law Review* 175; George Szmukler, Rowena Daw and Felicity Callard, 'Mental Health Law and the UN Convention on the Rights of Persons with Disabilities' (2014) 37(3) *International Journal of Law and Psychiatry* 245; John Dawson, 'A Realistic Approach to Assessing Mental Health Laws' Compliance with the UNCRPD (2015) 40 *International Journal of Law and Psychiatry* 70; Sascha Callaghan and Christopher Ryan, 'Is there a Future for Involuntary Treatment in Rights Based Mental Health Law?' (2015) 21(5) *Psychiatry, Psychology and Law* 747; Sascha Callaghan and Christopher Ryan, 'An Evolving Revolution: Evaluating Australia's Compliance with the Convention on the Rights of Persons with Disabilities in Mental Health Law' (2016) 39(2) *University of New South Wales Law Journal* 596; George Szmukler, 'Involuntary Detention and Treatment: Are We Edging Toward a "Paradigm Shift"?' (2020) 46(2) *Schizophrenia Bulletin* 231; Neeraj Gill et al, 'Measuring the Impact of Revised Mental Health Legislation on Human Rights in Queensland, Australia' (2020) *International Journal of Law and Psychiatry* 73; Toni Wharehoka, 'Disability Rights and Compulsory Psychiatric Treatment: the Case for a Balanced Approach under the Mental Health (Compulsory Assessment and Treatment) Act 1992' (2021) *Victoria University Wellington Law Review* 221.

[216] See further Terry Carney, 'Supported Decision-Making for People with Cognitive Impairments: An Australian Perspective?' (2015) 4 *Laws* 37.

erosion of the paternalistic 'best interests' approach and a focus on consumer autonomy. This has resulted in a 'paradigm shift',[217] especially in the approach to involuntary treatment and detention for persons with mental illness.[218] This shift in focus is hardly surprising, but conflicting interests will arise. As one Australian study observes:

> From a human rights perspective, taking away a person's rights to refuse treatment is one of the most serious actions that can be taken against an individual and represents a serious intrusion into a person's liberty and physical integrity. Involuntary mental health admissions can also compromise consumers' autonomy and control. Yet people with a serious mental illness may also need involuntary treatment or admission to protect them or the community from harm.[219]

2.1.15 Indeed, law and practice in this area have a difficult balance to achieve:

> The tension law makers must grapple with exists between two poles. On the one hand, treatment without consent, particularly in the face of a present objection to it, is clearly invasive and restricts the person's liberty. On the other hand, however, treatment without consent can be facilitative, in that it may provide access to urgent or beneficial treatment in circumstances where it otherwise could not be given because valid consent cannot be obtained. This tension gives rise to the following questions: is involuntary treatment ever permissible in a rights-based mental health system? Is it ever actually necessary and if so under what circumstances?[220]

2.1.16 The underlying commitment to consumer and patient autonomy under common law, the *MHA* and international human rights principles has coincided with developments in medical law. These protect the right of adults with decision-making capacity to make treatment decisions, even if considered irrational or causing serious harm to the consumer.[221] Despite these developments, the proposition was not generally applied to persons with a mental illness. Australia's mental health laws have traditionally permitted involuntary detention and psychiatric treatment of persons with mental illness if it is deemed necessary to prevent harm to either the person or others. In such circumstances, usual ordinary common law rights to refuse medical treatment are overridden, and treatment can be applied without reference to the preferences of the person concerned.[222] Such laws have become increasingly contested and are now arguably at odds with modern understandings of disability and the terms of the *CRPD*.[223] Australia has now moved to the policy as embodied in the 'least restrictive alternative' principle and recently reinforced by measures. These measures include a statutory presumption of decision-making capacity and a higher legislative threshold for involuntary treatment

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[217] Bruce Alston, 'Towards Supported Decision-Making: Article 12 of the Convention on the Rights of Persons with Disabilities and Guardianship Law Reform' (2017) 35(2) *Disability, Rights and Law Reform in Australia 2*0; Bernadette McSherry, 'Mental Health Laws: Where to From Here?' (2014) 40(1) *Monash University Law Review* 175.

[218] Sascha Callaghan and Christopher Ryan, 'An Evolving Revolution: Evaluating Australia's Compliance with the Convention on the Rights of Persons with Disabilities in Mental Health Law' (2016) 39(2) *University of New South Wales Law Journal* 596; George Szmukler, 'Involuntary Detention and Treatment: Are We Edging Toward a "Paradigm Shift"?' (2020) 46(2) *Schizophrenia Bulletin* 231.

[219] Marianne Wyder, Robert Bland and David Crompton, 'The Importance of Safety, Agency and Control during Involuntary Mental Health Admissions' (2016) 25(4) *Journal of Mental Health* 338.

[220] Sascha Callaghan and Christopher Ryan, 'Is there a Future for Involuntary Treatment in Rights Based Mental Health Law?' (2015) 21(5) *Psychiatry, Psychology and Law* 747, 753.

[221] Emma Cave, 'The Ill-Informed: Consent to Medical Treatment and The Therapeutic Exception' (2017) 46(2) *Common Law World Review* 140.

[222] Christopher Ryan, 'One Flu Over the Cuckoo's Nest: Comparing Legislated Coercive Treatment for Mental Illness with that for other Illness' (2011) 8 *Journal of Bioethical Inquiry* 87.

[223] Sascha Callaghan and Christopher Ryan, 'Is there a Future for Involuntary Treatment in Rights Based Mental Health Law?' (2015) 21(5) *Psychiatry, Psychology and Law* 747

or restrictive practices.[224] These principles all find expression in the 2009 South Australian *MHA*. The significance of the 'paradigm shift'[225] in the *MHA*, reflecting both domestic and international developments, cannot be underestimated.[226]

2.1.17 The importance of approaching law reform with a human rights framework has been previously raised by SALRI[227] (and other bodies).[228] The extensive jurisprudence under treaties such as *International Covenant on Civil and Political Rights* ('ICCPR') and especially the *CRPD*[229] is significant. Australia has signed and ratified a number of international conventions and agreements that are relevant to this review,[230] including the rights to children,[231] persons with disability, and Aboriginal people.[232]

2.1.18 There is no binding international treaty or instrument specifically established for the protection of persons with mental illness.[233] The United Nations *Principles for the Protection of Persons with Mental Illness* are relevant,[234] but such international instruments are also non-binding.[235]

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[224] Chris Maylea, Piers Gooding and Vrinda Edan, *Literature Review: Protection of Rights in Mental Health Law* (Mental Health Commission of Western Australia, 2021) 10.

[225] Bruce Alston, 'Towards Supported Decision-Making: Article 12 of the Convention on the Rights of Persons with Disabilities and Guardianship Law Reform' (2017) 35(2) *Disability, Rights and Law Reform in Australia* 20; Bernadette McSherry, 'Mental Health Laws: Where to From Here?' (2014) 40(1) *Monash University Law Review* 175.

[226] Though there is a valid argument that the intentions behind the *Mental Health Act 2009* (SA) remain to be fully realised. See also Tim Foley and Christopher Ryan, 'The Frequency of References to Decision-Making Capacity in Reports to the NSW Mental Health Review Tribunal Did Not Change after Legislative Reforms That Promoted Them' (2020) 28(2) *Australasian Psychiatry* 171; Chris Maylea, 'Victoria, Australia, is Getting a New Mental Health and Wellbeing Bill' (2022) *Journal of Bioethical Inquiry* (forthcoming).

[227] South Australian Law Reform Institute, *Discrimination on the Grounds of Sexual Orientation, Gender, Gender Identity and Intersex Status in South Australian Legislation* (Audit Paper, September 2015) 35–6; South Australian Law Reform Institute, *'Lawful Discrimination': Exceptions under the Equal Opportunity Act 1984 (SA) to Unlawful Discrimination on the Grounds of Gender Identity, Sexual Orientation and Intersex Status* (June 2016) 23–32.

[228] *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021) vol 1, 20, 141, 150, 154–5, 181, 627. The Terms of Reference, for example, of the Disability Royal Commission acknowledge the international obligation to take 'appropriate legislative, administrative and other measures' to comply with the Convention: Disability Royal Commission (Letters Patent, April 2019) 1. The Disability Royal Commission notes 'we seek to translate the human rights recognised in the *CRPD* into practicable and sustainable policies and practices that will promote the right of people with disability to live free from violence, abuse, neglect and exploitation': Commonwealth of Australia, Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Interim Report* (October 2020) xi. See also at: 10–11, 96, 342–3.

[229] *Convention on the Rights of Persons with Disabilities*, UN GAOR 61st sess, plen mtg 76, Agenda Item 67(b), UN Doc RES A/61/106 (3 May 2008, adopted 24 January 2007) preamble, art 1, art 3.

[230] See *Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, GA Res 39/46 39th sess, UNTS 85 1465 (26 June 1987, adopted 10 December 1984). This Convention may also be relevant, as there have been suggestions that the use of restrictive practices with respect to persons with disability might contravene this Convention.

[231] *Convention on the Rights of the Child*, GA Res 44/25, UNTS 3 1577 (2 September 1990, adopted 20 November 1989).

[232] *Declaration on the Rights of Indigenous Peoples*, GA Res 61/295, 61st sess, UN Doc A/RES/61/295 (13 September 2007).

[233] *Mabo v Queensland (No 2)* (1992) 175 CLR 1, 42; *Minister for Immigration and Ethnic Affairs v Teoh* (1995) 183 CLR 273, 288.

[234] *Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care*, GA Res 46/119 (17 September 1991).

[235] *Attorney-General for Canada v Attorney-General for Ontario* [1937] AC 326*; Bradley v Commonwealth* (1973) 128 CLR 557, 582 (Barwick CJ and Gibbs J), 593 (Stephen J), *Minister for Immigration and Ethnic Affairs v Teoh* (1995) 183 CLR 273, 287 (Mason CJ and Deane J, Gaudron J concurring), 370 (Toohey J), 384 (McHugh J); 286–8; *Kioa v West* (1985) 159 CLR 550, 570 (Gibbs CJ).

2.1.19 This human rights framework, notably the *CRPD*, has informed SALRI's current Report. SALRI, in particular, notes that the s 7(1)(ac) of the *MHA* provides as a guiding principle that 'mental health services should (subject to this Act or any other Act) be provided in accordance with international treaties and agreements to which Australia is a signatory'.[236]

2.1.20 The application and implications of international human rights law on the operation of the *MHA* were regular themes in SALRI consultation.[237] The *CRPD* was a prominent aspect although the premise that an individual with a mental illness should be regarded as having a disability is questioned.[238]

2.1.21 The respect for individual autonomy is integral to the *CRPD*. Autonomy should not only be seen as involving a sphere of non-interference, but also in terms of considering what supports are needed for a person to exercise their autonomy and decision-making ability.[239]

2.1.22 The importance of an individual's autonomy was often presented to SALRI, citing international human rights jurisprudence. 'The notion of personal autonomy is an important principle underlying the interpretation of Article 8 [the right to privacy and family life, home and correspondence under the European Convention on Human Rights].'[240] The European Court of Human Rights has noted that 'the ability to conduct one's life in a manner of one's own choosing may also include the opportunity to pursue activities perceived to be of a physically or morally harmful or dangerous nature for the individual concerned.'[241] However, even for those adopting a human rights approach, this is a nuanced and complex question.[242] As the European Court of Human Rights has acknowledged:

> [T]he need for domestic authorities to reach, in each particular case, a balance between the respect for the dignity and self-determination of the individual and the need to protect the individual and safeguard his or her interests, especially under the circumstances where his or her individual qualities or situation places the person in a particularly vulnerable position.[243]

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[236] See also, *Administrative Decisions (Effect of International Instruments) Act 1995* (SA).

[237] Human rights principles were raised by parties in various contexts, such as in reinforcing the need for legislative endorsement of a supported decision-making model in the *Mental Health Act 2009* (SA), opposing or at least qualifying a need for involuntary treatment (notably involuntary ECT), or as allowing involuntary treatment in certain circumstances.

[238] There is a valid argument that some persons who have recently experienced a first episode of mental illness, and those who have experienced a single or short-term infrequent episodes may either not be captured by the *CRPD* definition or may not identify within the language of disability. 'Whether all people with a 'mental illness' are appropriately considered as having a 'disability' is a moot question,' Sascha Callaghan and Christopher Ryan, 'Is there a Future for Involuntary Treatment in Rights Based Mental Health Law?' (2015) 21(5) *Psychiatry, Psychology and Law* 747, See also George Szmukler, Rowena Daw and Felicity Callard, 'Mental Health Law and the UN Convention on the Rights of Persons with Disabilities' (2014) 37(3) *International Journal of Law and Psychiatry* 245.

[239] Jonathan Herring, *Vulnerable Adults and the Law* (Oxford University Press, 2016) 34–5. This was a factor often raised in consultation, such as by LELAN, Mind Australia and Dr Susan Peukert.

[240] *Goodwin v United Kingdom* [2002] ECHR 588, [90]. See also *Pretty v United Kingdom* [2002] ECHR 427 [61], [66]; *Evans v United Kingdom* [2007] ECHR 264 [71].

[241] *Pretty v United Kingdom* [2002] ECHR 427 [62].

[242] See further European Court of Human Rights, *Guide on Article 8 of the European Convention on Human Rights: Right to Respect for Private and Family Life, Home and Correspondence* (31 August 2021) 30–1.

[243] *AMV v Finland* [2017] ECHR 273 [90].

2.1.23 The European Court of Human Rights has recognised the entitlement of States to administer involuntary treatment to persons with mental illness where 'the medical necessity has been convincingly shown to exist'.[244]

2.1.24 A number of parties in SALRI's consultation, consistent with international commentary, raised the *CPRD*, especially Article 12, in relation to this review. Article 12 of the *CRPD* reaffirms the State's obligation to recognise individuals with disability as being equal to individuals without disability under law.[245] This Article has proved the most contentious when it comes to implementation, especially in a mental health context.[246] 'There is a strong view among some in the human rights community that Article 12(2) prohibits all substitute decision-making for people with mental illness, and that Articles 14 and 17 specifically prohibit involuntary detention and psychiatric treatment .'[247]

2.1.25 The Office of the United Nations High Commissioner for Human Rights[248] and the United Nations Committee on the Rights of Persons with Disabilities[249] have indicated that there is no place for non-consented treatment based on mental illness within the *CRPD*. It has also been suggested that non-consented treatment will contravene the *CRPD*, even when a person lacks decision-making capacity.[250] It is asserted that involuntary detention and/or treatment as outcomes of substitute decision-making are impermissible, even where there is a risk to the consumer. It has also been suggested that non-consented treatment will contravene the *CRPD*, even when a person lacks decision-making capacity.[251] 'Involuntary treatment is out.'[252] This is a radical departure from the existing

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[244] *Herczegfalvy v Austria* (1992) 15 EHRR 437, [82].

[245] *Convention on the Rights of Persons with Disabilities*, UN GAOR 61st sess, plen mtg 76, Agenda Item 67(b), UN Doc RES A/61/106 (3 May 2008, adopted 24 January 2007) art 12.

[246] Michael Bach and Lana Kezner, *A New Paradigm for Protecting Autonomy and the Right to Legal Capacity* (Law Commission of Ontario, October 2010) 29.

[247] Sascha Callaghan and Christopher Ryan, 'Is there a Future for Involuntary Treatment in Rights Based Mental Health Law?' (2015) 21(5) *Psychiatry, Psychology and Law* 747, 748. See also George Szmukler, 'Involuntary Detention and Treatment: Are We Edging Toward a "Paradigm Shift"?' (2020) 46(2) *Schizophrenia Bulletin* 231.

[248] Office of the United Nations High Commissioner for Human Rights, *Annual Report of the United Nations High Commissioner for Human Rights and Reports of the Office of the High Commissioner and the Secretary General: Thematic Study by the Office of the United Nations High Commissioner for Human Rights on enhancing awareness and understanding of the Convention on the Rights of Persons with Disabilities*, Human Rights Council, 10th Sess, UN Doc A/HRC/10/48 (2009).

[249] Committee on the Rights of Persons with Disabilities, *Concluding observations of the Committee on the Rights of Persons with Disabilities on the report of Tunisia*, CRPD/C/TUN/CO/1 (13 May 2011); Committee on the Rights of Persons with Disabilities, *Concluding observations on the initial report of Spain*, CRPD/C/ESP/CO/1 (19 October 2011).

[250] Committee on the Rights of Persons with Disabilities, *Draft General comment on Article 12 of the Convention – Equal Recognition before the Law* (2013) [3].

[251] Committee on the Rights of Persons With Disabilities, *General Comment No 1, Article 12: Equal Recognition before the Law*, 11th Sess, 31 (March –11 April 2014) [7], [9], [12].

[252] Sascha Callaghan and Christopher Ryan, 'Is there a Future for Involuntary Treatment in Rights Based Mental Health Law?' (2015) 21(5) *Psychiatry, Psychology and Law* 747, 748. See also Tina Minkowitz, 'United Nations Convention on the Rights of Persons with Disabilities and the Right to be Free from Nonconsensual Psychiatric Interventions' (2007) 34(2) *Syracuse Journal of International Law and Commerce* 405; Peter Bartlett, 'The United Nations Convention on the Rights of Persons with Disabilities and Mental Health Law' (2012) 75 *Modern Law Review* 752; Dainius Puras and Piers Gooding, 'Mental Health and Human Rights in the 21st Century' (2019) 18(1) *World Psychiatry* 42; Eilionóir Flynn, 'The Rejection of Capacity Assessments in Favour of Respect for Will and Preferences: The Radical Promise of the UN Convention on the Rights of Persons with Disabilities' (2019) 18(1) *World Psychiatry* 50.

common law which permits treatment to be given without consent where a person lacks decision-making capacity.[253]

2.1.26 The World Health Organisation, as a number of parties in consultation reminded SALRI, has also advocated for involuntary treatment to be avoided, or at the very least kept to the barest minimum.[254]

2.1.27 The UN Committee on the Rights of Persons with Disabilities ('the Committee') has made plain that States should develop laws and policies to 'replace regimes of substitute decision-making by supported decision-making'[255] and has also repeatedly expressed concern about involuntary treatment. In 2013, the Committee said:

> … informed consent of the persons with disabilities concerned, committal of individuals to detention in mental health facilities, or imposition of compulsory treatment, either in institutions or in the community, by means of Community Treatment Orders.[256]

2.1.28 The Committee's General Comment No. 1 ('the Comment') argued substituted decision-making models are discriminatory and unacceptable.[257] Further, the Comment advocates for abolishing substituted decision-making,[258] which centres on 'best interest' assessments, and recommends supported decision-making approaches, which centre on the individual's 'will and preference'.[259]

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[253] See *Secretary, Department of Health and Community Services v JWB and SMB* (1992) 175 CLR 218; *Hunter v A* [2009] NSWSC 761, [31]–[32] (McDougall J).

[254] World Health Organization, *Guidance on Community Mental Health Services* (2021) viii, 6–8, 187. 'Although challenging, it is important for countries to set goals and propose steps to eliminate practices that restrict the right to legal capacity, such as involuntary admission and treatment, and to replace these with practices that align with people's will and preferences, ensuring that their informed consent to mental health care is always sought and that the right to refuse admission and treatment is also respected. This can be achieved in services where people are provided with accurate, comprehensive and accessible information about their care and support for making decisions. One method of supported decision-making that can be implemented involves the appointment, by the person concerned, of a trusted person or network of people who can provide support in weighing up different options and decisions. The trusted person or group can also help in communicating these decisions and choices to mental health staff or others. If, despite significant efforts, it is not possible to determine a person's will and preference, then decisions are based on the best interpretation of their will and preferences. Supported decision-making cannot be imposed on anyone as a condition to having their decisions respected': at 6–7.

[255] Committee on the Rights of Persons with Disabilities, *Concluding observations of the Committee on the Rights of Persons with Disabilities on the report of Tunisia*, CRPD/C/TUN/CO/1 (13 May 2011) [23]; Committee on the Rights of Persons with Disabilities, *Concluding observations on the initial report of Spain*, CRPD/C/ESP/CO/1 (19 October 2011) [34]; Committee on the Rights of Persons with Disabilities, *Concluding observations on the initial report of Peru,* CRPD/C/PER/1 (20 April 2012) [25]. The suggestions are deliberately left broad however, and it is not clear whether 'supported decision making' might include some forms of carefully designed substituted decision-making.

[256] Committee on the Rights of Persons with Disabilities, *Concluding Observations on the Initial Report of Australia*, 10th sess, 118th mtg, UN Doc CRPD/C/AUS/CO/1 (21 October 2013) 5 [34].

[257] Committee on the Rights of Persons with Disabilities, *General Comment No 1,* UN Doc CRPD/C/GC/1 (19 May 2014) [7].

[258] Ibid.

[259] Ibid [26].

2.1.29 The Committee continues to be committed to the notion of universal legal capacity,[260] and wholly rejects substituted decision-making in all forms, including in guardianship legislation and in 'mental health laws that permit forced treatment'.[261]

2.1.30 The Comment states that legal capacity is a universal attribute and should not be denied based on someone's mental or decision-making capacity.[262] The State should provide ways to help support people with diminished mental or decision-making capacity to exercise their legal agency.[263] This support 'should never amount to substituted decision-making'.[264] Any decisions that need to be made to intervene in an individual's exercise of their legal capacity, should never be made in the 'best interests' relating to a person.[265] Instead, third parties should attempt to interpret their 'will and preference' as far as possible.[266] It concludes by stating that all policies which 'allow or perpetrate forced treatment' should be abolished, as they contravene this inherent right.[267] Treatment decisions should only be made with the prior and informed consent of the individual.[268] General Comments are not binding on State parties, but are authoritative and can be a 'powerful influence on domestic policy debates'.[269]

2.1.31 In the Australian context, the Committee recommended that:

> Australia should repeal all legislation that authorises medical interventions without free and informed consent of the persons with disabilities concerned, and legal provisions that authorize commitment of individuals to detention in mental health services, or the imposition of compulsory treatment either in institutions or in the community via Community Treatment Orders (CTOs).[270]

2.1.32 The Committee also recommended that Australia 'review the interpretative declarations on [Articles] 12, 17 and 18 in order to withdraw them'.[271] This recommendation was repeated by the Committee in 2019.[272]

2.1.33 This recommendation was made with reference to the Australian Government's interpretive declaration, published at the time of signing the *CRPD*. This declaration noted the *CRPD* permits substituted decision-making 'where such arrangements are necessary, as a last resort and subject to safeguards', and that the Convention 'allows for compulsory assistance or treatment of

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[260] This is the idea that legal capacity is a 'universal human attribute' and can never be lost because of functional impairment: see Committee on the Rights of Persons with Disabilities, *General Comment No 1,* UN Doc CRPD/C/GC/1 (19 May 2014) 2 [8], 4 [15], 6 [25].

[261] Ibid 2 [7].

[262] Ibid [8].

[263] Ibid [12].

[264] Ibid [16].

[265] Ibid [17].

[266] Ibid.

[267] Committee on the Rights of Persons with Disabilities, *General Comment No. 1*, UN Doc CRPD/C/GC/1 (19 May 2014) [42].

[268] Ibid.

[269] Terry Carney, 'Supported Decision-Making for People with Cognitive Impairments: An Australian Perspective?' (2015) 4 *Laws* 37, 44.

[270] Committee on the Rights of Persons with Disabilities, *Concluding Observations on the Initial Report of Australia*, 10th sess, 118th mtg, UN Doc CRPD/C/AUS/CO/1 (21 October 2013) [34].

[271] Ibid [8].

[272] Ibid; Committee on the Rights of Persons with Disabilities, *Concluding Observations on the Initial Report of Australia*, 10th sess, 511th mtg, UN Doc CRPD/C/AUS/CO/2–3 (20 September 2019).

persons, including measures taken for the treatment of mental disability', where such treatment is necessary as a last resort.[273]

2.1.34 Australia has maintained the positions adopted by these interpretative declarations and retained substitute decision-making and compulsory treatment in guardianship laws, as well as mental health laws.[274]

2.1.35 Other advocates hold similar views to the Committee.[275] For example, in 2014, Bernadette McSherry called for the abolition of mental health (and guardianship) laws in the light of the *CRPD*, asserting that Australia's interpretive declaration is inconsistent with recent pronouncements by the Committee, such that it does not preclude the exploration of law reform options that provide an alternative framework to involuntary detention and treatment. McSherry argued that, in light of the ethos of the *CRPD*, the focus for mental health laws into the future should be on positive rights such as 'the right to the enjoyment of the highest attainable standard of health' as set out in Article 25, rather than continuing the current focus on involuntary detention and treatment.[276]

2.1.36 However, Article 12 has met with far from universal acclaim.[277] It is 'controversial' and prompted 'an intense and often divisive debate'.[278] It was one of the 'most contentiously negotiated articles' in the *CRPD*; its contentious nature was evidenced by the high number of reservations, understandings and declarations that have been lodged on it.'[279] 'In many respects, the language of the *CRPD* offers all the clarity of the riddles of the Delphic Oracle'.[280] Its meaning is far from clear and debated.[281]

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[273] Senate Committee on Community Affairs, Parliament of Australia, *The Involuntary or Coerced Sterilisation of people with Disabilities in Australia* (Report, July 2013) [3.7]. See also Australian Human Rights Commission, Draft General Comment on Article 12 of the CRPD (28 February 2014) <https://humanrights.gov.au/our-work/legal/submission/draft-general-comment-article-12-crpd>; see also Michael Small, The Convention on the Rights of Persons with Disabilities (24 October 2007) Australian Human Rights Commission <https://humanrights.gov.au/about/news/speeches/convention-rights-persons-disabilities>.

[274] Neeraj Gill et al, 'Measuring the Impact of Revised Mental Health Legislation on Human Rights in Queensland, Australia' (2020) *International Journal of Law and Psychiatry* 73, 76.

[275] Jill Stavert, 'The Exercise of Legal Capacity, Supported Decision-Making and Scotland's Mental Health and Incapacity Legislation: Working with CRPD Challenges' (2015) 4 *Laws* 296; John Dawson, 'A Realistic Approach to Assessing Mental Health Laws' Compliance with the UNCRPD' (2015) 40 *International Journal of Law and Psychiatry* 70.

[276] Bernadette McSherry, 'Mental Health Laws: Where to from Here' (2014) 40(1) *Monash University Law Review* 175.

[277] Matthe Scholten and Jakov Gather, 'Adverse Consequences of Article 12 of the UN Convention on the Rights of Persons with Disabilities for Persons with Mental Disabilities and an Alternative Way Forward' (2018) 44(4) *Journal of Medical Ethics* 206; John Dawson, 'A Realistic Approach to Assessing Mental Health Laws' Compliance with the UNCRPD' (2015) 40 *International Journal of Law and Psychiatry* 70, 72–3.

[278] Sascha Callaghan and Christopher Ryan, 'An Evolving Revolution: Evaluating Australia's Compliance with the Convention on the Rights of Persons with Disabilities in Mental Health Law' (2016) 39(2) *University of New South Wales Law Journal* 596, 597.

[279] Anna Arstein-Kerslake and Eilionóir Flynn, 'The General Comment on Article 12 of the Convention on the Rights of Persons with Disabilities: A Roadmap for Equality before the Law' (2015) 20(4) *International Journal of Human Rights* 471.

[280] Sascha Callaghan and Christopher Ryan, 'An Evolving Revolution: Evaluating Australia's Compliance with the Convention on the Rights of Persons with Disabilities in Mental Health Law' (2016) 39(2) *University of New South Wales Law Journal* 596, 601.

[281] Ibid 601–5; Bruce Alston, 'Towards Supported Decision-Making: Article 12 of the Convention on the Rights of Persons with Disabilities and Guardianship Law Reform' (2017) 35(2) *Disability, Rights and Law Reform in Australia* 20, 26–27.

2.1.37 The Committee released the subsequent General Comment in an attempt to reconcile the ambiguity.[282] However, the General Comment did little to resolve the debate and has not found international acceptance. 'Without any established alternatives to capacity-based approaches to medical treatment, nor any broad-based support for abolishing involuntary treatment in mental health, these recommendations looked to be impossible to meet.'[283]

2.1.38 The Comment has also been subject to much academic criticism.[284] Dawson[285] and Callaghan and Ryan[286] dispute the blunt interpretations of the *CRPD* favoured by the Committee and the Office of the High Commissioner for Human Rights. Szmukler, Daw and Callard 'suggest that very few would support the idea that the state never, even as a last resort, has a duty to protect those who are clearly unable to make crucial treatment decisions for themselves.'[287]

2.1.39 Callaghan and Ryan similarly argue:

> … that in order to give effect to the provisions of the CRPD, new supported decision-making regimes must be incorporated into mental health legislation but that these must admit a limited role for substituted decisions, including involuntary treatment, where a person lacks decision-making capacity. We argue that such a scheme can, and must, respect the rights, will and preferences of the person affected. Furthermore, we suggest that failing to account for it in law will jeopardise rights more than it protects them.[288]

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[282] John Dawson, 'A Realistic Approach to Assessing Mental Health Laws' Compliance with the UNCRPD' (2015) 40 *International Journal of Law and Psychiatry* 70, 72.

[283] Sascha Callaghan and Christopher Ryan, 'An Evolving Revolution: Evaluating Australia's Compliance with the Convention on the Rights of Persons with Disabilities in Mental Health Law' (2016) 39(2) *University of New South Wales Law Journal* 596, 604.

[284] See, for example, George Szmukler, Rowena Daw and Felicity Callard, 'Mental Health Law and the UN Convention on the Rights of Persons with Disabilities' (2014) 37(3) *International Journal of Law and Psychiatry* 245; John Dawson, 'A Realistic Approach to Assessing Mental Health Laws' Compliance with the UNCRPD' (2015) 40 *International Journal of Law and Psychiatry* 70; Melvyn Freeman et al, 'Reversing Hard Won Victories in the Name of Human Rights: A Critique of the General Comment on Article 12 of the UN Convention on the Rights of Persons with Disabilities' (2015) 2(9) *Lancet Psychiatry* 844; George Szmukler, 'The UN Convention on the Rights of Persons with Disabilities: "Rights, Will and Preferences" in Relation to Mental Health Disabilities' (2017) 54 *International Journal of Law and Psychiatry* 90; George Szmukler, 'Involuntary Detention and Treatment: Are We Edging Toward a "Paradigm Shift"?' (2020) 46(2) *Schizophrenia Bulletin* 231; Matthe Scholten and Jakov Gather, 'Adverse Consequences of Article 12 of the UN Convention on the Rights of Persons with Disabilities for Persons with Mental Disabilities and an Alternative Way Forward' (2018) 44(4) *Journal of Medical Ethics* 206; George Szmukler, '"Capacity", "Best Interests", "Will and Preferences" and the UN Convention on the Rights of Persons with Disabilities' (2019) 18(1) *World Psychiatry* 34; Jose de Almeida, 'The CRPD Article 12, the Limits of Reductionist Approaches to Complex Issues and the Necessary Search for Compromise' (2018) 19(1)*World Psychiatry* 46; Kay Wilson, 'The Abolition or Reform of Mental Health Law: How Should the Law Recognise and Respond to the Vulnerability of Persons with Mental Impairment?' (2020) 28(1) *Medical Law Review* 30; Toni Wharehoka, 'Disability Rights and Compulsory Psychiatric Treatment: the Case for a Balanced Approach under the Mental Health (Compulsory Assessment and Treatment) Act 1992' (2021) *Victoria University Wellington Law Review* 221.

[285] John Dawson, 'A Realistic Approach to Assessing Mental Health Laws' Compliance with the UNCRPD' (2015) 40 *International Journal of Law and Psychiatry* 70.

[286] Sascha Callaghan and Christopher Ryan, 'Is there a Future for Involuntary Treatment in Rights Based Mental Health Law?' (2015) 21(5) *Psychiatry, Psychology and Law* 747.

[287] George Szmukler, Rowena Daw and Felicity Callard, 'Mental Health Law and the UN Convention on the Rights of Persons with Disabilities' (2014) 37(3) *International Journal of Law and Psychiatry* 245.

[288] Sascha Callaghan and Christopher Ryan, 'Is there a Future for Involuntary Treatment in Rights Based Mental Health Law?' (2015) 21(5) *Psychiatry, Psychology and Law* 747. See also John Dawson, 'A Realistic Approach to Assessing Mental Health Laws' Compliance with the UNCRPD' (2015) 40 *International Journal of Law and Psychiatry* 70.

2.1.40 It has been raised that, for individuals with varying degrees of mental capacity, full access to the right to refuse treatment may sometimes disrupt their right to access optimal health care. As a result, failing to account for decision-making capacity in some cases may jeopardise the right to the highest attainable standards of physical and mental health, social inclusion and adequate standard of living.[289] One author elaborates:

> Unfortunately, the danger [of harm to a consumer] is real. A large number of States Parties that have ratified the Convention have also expressed their disagreement with the Committee's interpretation, in particular regarding the absolute prohibition of substitute decision-making. An increasing number of human rights experts, scholars and clinicians have stated their conviction that this interpretation, if accepted, would result in serious adverse consequences for people with mental health disorders and psychosocial disabilities, and would undermine some of the hard-won critical rights of these people. Although many mental health service users' organisations support the prohibition of involuntary admission and treatment, there are indicators showing that this view is not shared by all people with mental disorders nor by the majority of family members. In this context, we have to conclude that the possibility that governments will change their mental health laws in accordance with the directives of the Committee seems rather remote.[290]

2.1.41 The comments of a New Zealand author are telling:

> The Comment takes an absolutist approach and tends to miss the reality of mental health in Aotearoa New Zealand. The Comment fails to recognise that limitations on an individual's liberty can be justified. This oversight can be dangerous when applied to a mental health context as it could potentially create worse situations for mentally ill individuals. Limitations on individual liberty can be justified, which happens in everyone's life regardless of disability status. For example, if a mentally ill individual exhibits behaviours which create an imminent and serious threat of physical harm to themselves or others, it could be justifiable to make them subject to compulsory treatment to ensure society is protected from harm. This is justifiable because people without mental illnesses will be subject to similar preventative treatment if they exhibit those same behaviours. This also means subjecting mentally ill persons to compulsory treatment is not necessarily discriminatory. If substituted decision-making models and best interest assessments are never used in a mental health context, as the Comment advocates, it could mean that people suffering mental illnesses could refuse treatment to help control their dangerous behaviours and could potentially act in a way that creates a worse situation than compulsory psychiatric treatment (for example, being criminally convicted). The Comment also does not seem to take into account the decision-making capacity of an individual. In some situations, it may not be appropriate to allow individuals to make decisions due to their limited decision-making capacity. If an individual cannot process the information given to them regarding a decision, it would be inappropriate for them to make that decision themselves. This is another reason why the Comment should not be fully adopted in Aotearoa New Zealand. The Comment is also silent on indigenous perspectives of autonomy… Overall, the Comment has pitfalls which makes adopting it completely an

[289] Sascha Callaghan and Christopher Ryan, 'Is there a Future for Involuntary Treatment in Rights Based Mental Health Law?' (2015) 21(5) *Psychiatry, Psychology and Law* 747; Melvyn Freeman et al, 'Reversing Hard Won Victories in the Name of Human Rights: A Critique of the General Comment on Article 12 of the UN Convention on the Rights of Persons with Disabilities' (2015) 2(9) *Lancet Psychiatry* 844; Matthe Scholten and Jakov Gather, 'Adverse Consequences of Article 12 of the UN Convention on the Rights of Persons with Disabilities for Persons with Mental Disabilities and an Alternative Way Forward' (2018) 44(4) *Journal of Medical Ethics* 206; Neeraj Gill et al, 'Measuring the Impact of Revised Mental Health Legislation on Human Rights in Queensland, Australia' (2020) *International Journal of Law and Psychiatry* 73.

[290] Jose de Almeida, 'The CRPD Article 12, the Limits of Reductionist Approaches to Complex Issues and the Necessary Search for Compromise' (2018) 19(1) *World Psychiatry* 46.

> inappropriate decision if society wants to protect vulnerable individuals in an Aotearoa New Zealand mental health context.[291]

2.1.42 One article suggests that, given the unlikely adoption of the Committee's absolute approach, the challenge is determining the preferable way forward:

> The General Comment stated that compliance with the *CRPD* required the outright abolition of 'mental health laws that permit forced treatment' – a demand that was received with concern, if not dismay, in many quarters. With no government in Australia or elsewhere seriously contemplating such a radical move, especially given the absence of a well-developed alternative, the question has now become one of how to interpret and implement the CRPD's important goals, notwithstanding some of the troublesome aspects of the interpretation preferred by the administering Committee.[292]

2.1.43 The ALRC, in its considered response to the *CRPD* and the General Comments, formulated a set of underlying principles to underpin law and practice in this area. The ALRC:

> … recommends a set of National Decision-Making Principles and accompanying Guidelines to provide the first part of the modelling in Commonwealth laws… These Principles should guide reform of Commonwealth laws and legal frameworks and the review of state and territory laws. The National Decision-Making Principles identify four central ideas in all recent law reform work on capacity. These are that: everyone has an equal right to make decisions and to have their decisions respected; persons who need support should be given access to the support they need in decision-making; a person's will and preferences must direct decisions that affect their lives; and there must be appropriate and effective safeguards in relation to interventions for persons who may require decision-making support. The Principles reflect the paradigm shift signalled in the United Nations Convention on the Rights of People with Disabilities (*CRPD*) to recognise people with disabilities as persons before the law and their right to make choices for themselves. The emphasis is on the autonomy and independence of persons with disability who may require support in making decisions – their will and preferences must drive decisions that they are supported in making, and that others may make on their behalf. The National Decision-Making Principles provide a conceptual overlay, consistent with the *CRPD*, for a Commonwealth decision-making model that encourages supported decision-making.[293]

2.1.44 However, the ALRC was unconvinced of the assertion that the *CRPD* precluded or prevented recourse to substitute decision-making or involuntary treatment in certain circumstances. The ALRC noted the General Comment was provided merely 'by way of guidance' and is not binding on Australia.[294] It also declined to recommend withdrawing Australia's interpretive declaration as called

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[291] Toni Wharehoka, 'Disability Rights and Compulsory Psychiatric Treatment: the Case for a Balanced Approach under the Mental Health (Compulsory Assessment and Treatment) Act 1992' (2021) *Victoria University Wellington Law Review* 221, 241–2. The author argues for a 'balanced approach', that creates as the threshold 'imminent and serious harm to themselves or others. This harm should be actual, or threatened, physical harm': at 243. The author adds that 'mentally ill individuals have the right to make decisions under mental health law subject to justifiable limitations upon these rights if such decisions create a serious danger to the individual or others, significantly impacts their standard of living, or would be inappropriate to follow due to the individual's decision-making capacity': at 244.

[292] Sascha Callaghan and Christopher Ryan, 'An Evolving Revolution: Evaluating Australia's Compliance with the Convention on the Rights of Persons with Disabilities in Mental Health Law' (2016) 39(2) *University of New South Wales Law Journal* 596, 597. See also John Dawson, 'A Realistic Approach to Assessing Mental Health Laws' Compliance with the UNCRPD' (2015) 40 *International Journal of Law and Psychiatry* 70.

[293] Australian Law Reform Commission, *Equality, Capacity and Disability in Commonwealth Laws* (Report No 124, November 2014) 63–4 [3.1]–[3.4].

[294] Ibid 48 [2.56]

for by the Committee, remarking that, notwithstanding any 'confusion … or negative messaging' that it may carry, '[i]nsofar as the Declaration is simply stating that there are occasions when a person may be appointed to act on behalf of another – as a substitute – the ALRC considers that this is a correct understanding of the *CRPD*'.[295]

2.1.45 Other law reform bodies have also rejected the absolute approach of the General Comment.[296]

2.2 SALRI's Observations and Conclusions

2.2.1 SALRI agrees with the ALRC and supports a more nuanced approach than that of the General Comment. As Callaghan and Ryan contend:

> We conclude that a properly calibrated supported decision-making regime will accommodate a limited power to treat patients without consent where the person lacks decision-making capacity, and where support has failed. In addition, we suggest that this mechanism will better protect rights than alternatives that prohibit involuntary treatment in any circumstances, because failing to acknowledge substituted decision-making in some contexts will obscure the reality of some forms of decision-making and limit scope for public oversight.[297]

2.2.2 SALRI notes the various criticisms of the Committee's view[298] and consistent with the approach of both the Commonwealth and the ALRC, proceeds on the premise that the law validly allows for involuntary psychiatric treatment as the last resort, with strong legislative safeguards. Clear examples include where a person lacks decision-making capacity[299] or has decision-making capacity, but poses a risk of serious harm to themselves or others.[300] SALRI also reiterates that 'treatment without consent can be facilitative, in that it may provide access to urgent or beneficial treatment in circumstances where it otherwise could not be administered because valid consent cannot be

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[295] Ibid 57 [2.96]–[2.97].

[296] See, for example, Victorian Law Reform Commission, *Guardianship* (Report No 24, April 2012).

[297] Sascha Callaghan and Christopher Ryan, 'Is there a Future for Involuntary Treatment in Rights Based Mental Health Law?' (2015) 21(5) *Psychiatry, Psychology and Law* 747, 748.

[298] See, for example, George Szmukler, Rowena Daw and Felicity Callard, 'Mental Health Law and the UN Convention on the Rights of Persons with Disabilities' (2014) 37(3) *International Journal of Law and Psychiatry* 245; Melvyn Freeman et al, 'Reversing Hard Won Victories in the Name of Human Rights: A Critique of the General Comment on Article 12 of the UN Convention on the Rights of Persons with Disabilities' (2015) 2(9) *Lancet Psychiatry* 844; John Dawson, 'A Realistic Approach to Assessing Mental Health Laws' Compliance with the UNCRPD' (2015) 40 *International Journal of Law and Psychiatry* 70; Matthe Scholten and Jakov Gather, 'Adverse Consequences of Article 12 of the UN Convention on the Rights of Persons with Disabilities for Persons with Mental Disabilities and an Alternative Way Forward' (2018) 44(4) *Journal of Medical Ethics* 206; George Szmukler, '"Capacity", "Best Interests", "Will and Preferences" and the UN Convention on the Rights of Persons with Disabilities' (2019) 18(1) *World Psychiatry* 34; George Szmukler, 'Involuntary Detention and Treatment: Are We Edging Toward a "Paradigm Shift"?' (2020) 46(2) *Schizophrenia Bulletin* 231.

[299] George Szmukler, Rowena Daw and Felicity Callard, 'Mental Health Law and the UN Convention on the Rights of Persons with Disabilities' (2014) 37(3) *International Journal of Law and Psychiatry* 245; George Szmukler, 'Involuntary Detention and Treatment: Are We Edging Toward a "Paradigm Shift"?' (2020) 46(2) *Schizophrenia Bulletin* 231.

[300] Toni Wharehoka, 'Disability Rights and Compulsory Psychiatric Treatment: The Case for a Balanced Approach under the Mental Health (Compulsory Assessment and Treatment) Act 1992' (2021) *Victoria University Wellington Law Review* 221.

obtained'.[301] An absolute prohibition on involuntary treatment, no matter the circumstances, is unlikely to be seen as credible, at least in the near future.[302]

2.2.3 SALRI acknowledges, as pointed out in consultation by various parties, that an individual's capacity to refuse treatment may well be overlooked in practice and the requirement for impaired decision-making capacity as a criterion for involuntary treatment may not have its intended effect.[303] The capacity-based provisions in mental health laws, now introduced in most Australian jurisdictions, have done little to reduce the incidence of involuntary measures,[304] an outcome in line with international experience.[305] This has been said to be attributable to a lack of systematised voluntary alternatives to compulsory treatment, a paternalistic and restrictive culture in mental health services and the risk aversion of clinicians and society.[306]

2.2.4 The Victorian experience is significant. SALRI's review draws on the voluminous work of the Victorian Royal Commission spanning an Interim Report and seven comprehensive final Reports. The *Mental Health and Wellbeing Act 2022* (Vic) ('*MHWA*') will come into effect on 1 September 2023.[307] The new Victorian Act and the repeal of its predecessor, the *Mental Health Act 2014* (Vic) was one of the key recommendations of the Royal Commission.[308] Findings included, the phasing out of seclusion and restraint,[309] a greater emphasis on supported decision-making for mental health consumers,[310] and a commitment to compulsory treatment being used as a last resort.[311] The Royal Commission's recommendations seek to transform Victoria's mental health system from one which has 'catastrophically failed to live up to expectations'[312] into a system that 'encourage[s] a human rights-based culture to flourish.'[313]

2.2.5 The *MHWA* is a major Act, totalling some 652 pages, which ushers in wide-ranging reforms to the mental health system. These reforms range from the institutional and administrative to

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[301] Sascha Callaghan and Christopher Ryan, 'Is there a Future for Involuntary Treatment in Rights Based Mental Health Law?' (2015) 21(5) *Psychiatry, Psychology and Law* 747, 753.

[302] George Szmukler, 'Involuntary Detention and Treatment: Are We Edging Toward a "Paradigm Shift"?' (2020) 46(2) *Schizophrenia Bulletin* 231, 233.

[303] SALRI was told by a number of parties, notably consumers, that the mere presence of a disability and/or disagreeing with a medical practitioner's recommended treatment for a mental illness are often viewed as tantamount to impaired decision-making capacity.

[304] Tim Foley and Christopher Ryan, 'The Frequency of References to Decision-Making Capacity in Reports to the NSW Mental Health Review Tribunal Did Not Change after Legislative Reforms That Promoted Them' (2020) 28(2) *Australasian Psychiatry* 171.

[305] Piers Gooding, Bernadette McSherry, and Cath Roper, 'Preventing and Reducing "Coercion" in Mental Health Services: An International Scoping Review of English-Language Studies' (2020) 142(1) *Acta Psychiatrica Scandinavica* 27.

[306] Neeraj Gill et al, 'Measuring the Impact of Revised Mental Health Legislation on Human Rights in Queensland, Australia. (2020) *International Journal of Law and Psychiatry* 73.

[307] SALRI draws on the helpful overview prepared by Cindy Tucker. See Cindy Tucker, *Towards a Consumer-Centred Mental Health System? An Exploration of the Mental Health and Wellbeing Act 2022 (Vic)* (26 December 2022) Mondaq <https://www.mondaq.com/australia/healthcare/1264986/towards-a-consumer-centred-mental-health-system-an-exploration-of-the-mental-health-and-wellbeing-act-2022-vic>.

[308] *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021) Summary and Recommendations, 78 (Recommendation 42).

[309] Ibid 90 Recommendation 54.

[310] Ibid 92 Recommendation 56.

[311] Ibid 91 Recommendation 55.

[312] *Royal Commission into Victoria's Mental Health System* (Interim Report, November 2019) 12.

[313] *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021) vol 4, 35.

other consumer-centred, rights-based reforms. The *MHWA* is intended to 'empower and engage with all the people' who use Victoria's mental health system and increase the system's accessibility while 'support[ing] the agency and autonomy of people who engage with the mental health and wellbeing system'.[314]

2.2.6 As part of this review, SALRI was asked by the Hon Chris Picton MP, the Minister for Health and Wellbeing, to consider the impact, if any, of the *MHA* on the delivery of mental health services.[315] In order to address this new Term of Reference, SALRI examined how these principles can be operationalised in practice; whether their translation into practice impacts a consumer's access to mental health services, and if so, how this may be improved; and accountability mechanisms to monitor compliance with the principles and enforce consequences for non-compliance. A focus on the guiding principles and accountability was largely borne out of the recent Victorian Royal Commission. The intended changes to the Victorian law aimed to strengthen the objectives and principles, support access to care and treatment which is rights-based and enforce accountability mechanisms and monitoring arrangements. This was recommended in response to the lack of clear accountability mechanisms ensuring mental health principles are translated into practice.

2.2.7 According to its Terms of Reference, SALRI was not to examine the provision or delivery of mental health services. SALRI acknowledges that, as was often pointed out in consultation, there are very real issues and needs in this area, however, such issues are beyond the scope of this review. SALRI has instead made a number of suggestions around these issues, in addition to the formal recommendations. Reform of the *MHA*, whilst important, is not a complete solution. Changes in practice, policy and culture must also accompany legislative reforms.[316]

2.2.8 SALRI reiterates that many issues of resourcing, operation and culture were raised in its consultation by many parties of diverse perspectives. These longstanding issues include acute problems in access for regional, remote and rural communities[317] and Aboriginal communities;[318] lack of funding and available services; bed access; hospital Key Performance Indicators; cultural and operational concerns and onerous administrative and bureaucratic requirements.[319] These considerations all impact

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[314] Victoria, *Parliamentary Debates*, Legislative Assembly, 23 June 2022, 2644 (James Merlino).

[315] This additional Term of Reference raises operational and resourcing issues that, in part, are specifically beyond SALRI's review and where there was inconsistency, no recommendations could be made by SALRI. However, these barriers have been addressed in suggestions made outside of the formal recommendations.

[316] Indeed, this was identified during the 2009 parliamentary debate. 'Whilst we accept that it is important to get the legal rights and protection right, we will never have a world class mental health system unless we have the other side of the equation, that is, the adequate and appropriate resources to ensure that it is carried out… it is fair to say that we already have a system of mental health services that is running on the smell of an oily rag. Many people cannot access or obtain help or services in a timely manner': South Australia, *Parliamentary Debates*, House of Assembly, 5 February 2009, 1450, 1456 (Vickie Chapman).

[317] SALRI heard on all its regional trips of particular issues and concerns in the availability and delivery of mental health services outside Adelaide. One concern is the acute shortage of mental health practitioners outside the city.

[318] There are particular issues and concerns in mental health for Aboriginal communities. See also Part 4 Aboriginal Mental Health. SALRI acknowledges the insight and valuable input of Charlie Jackson OAM, Beth Turner and Evelyn Varcoe to this review.

[319] The RANZCP, for example, told SALRI: 'A number of barriers prevent a more complete enactment of human rights aspirations and best practice being provided to all persons seeking mental health care. New mental health legislation across the States and Territories have introduced substantial new administrative requirements, but governments have not always provided extra staff and resources to meet those requirements. As a result, many mental health services find that compliance with the relevant Mental Health Act comes at the cost of time spent on clinical practice. This development makes it harder to develop the rapport with patients necessary to build strong therapeutic relationships and foster recovery. For example, in WA, before the new Act was introduced about half of all psychiatrists were spending over 80% of their time doing clinical work. Now less than a third do

the effective provision and delivery of mental health services in South Australia and consequently, the implementation of human rights in practice. Therefore, several of SALRI's recommendations have direct implications for the barriers that exist in regard to the provision of mental health services. However, many of these barriers are beyond the scope of this review. SALRI has raised several proposed suggestions which draw attention to operational or practical measures for future consideration.

2.2.9 Some operational and practical measures included within SALRI's suggestions address:

- Alternatives to the Emergency Department ('ED') in public hospitals for mental health-related attendances;[320]
- Further review and investigation into the allocation of resourcing, staffing, infrastructure, and funding of Community Mental Health Teams;
- If adequately resourced, funded and staffed, the possibility of using Community Mental Health Teams as an alternative to the ED.[321]
- Further review and investigation into the resourcing, staffing (including staff retention and resident specialists), infrastructure and funding of regional, rural and remote mental health services.

2.2.10 In relation to the suitability of EDs for the treatment and management of persons with mental illness, SALRI's consultation revealed the need to explore alternatives to ED. This includes where the police have used their care and control powers under s 57 of the *MHA*. The police are often compelled to wait several hours before the consumer is transferred into the care of the hospital, which prevents those officers from attending to other more urgent calls.[322] The use of EDs in treating (or

so. In some cases, considerable unpaid overtime is now required to meet the administrative workload. Adequate resourcing is also required to ensure that effective, culturally-informed alternatives to involuntary treatment can be provided to all who need them – in particular, Aboriginal and Torres Strait Islander peoples and those from multicultural backgrounds. Additionally, the mental health Acts are growing increasingly complex in their own right, and the detail of what they require from mental health services varies substantially between different jurisdictions. This variation has been recognised as a barrier to understanding how rates of incidents such as involuntary treatment and restrictive interventions vary between different jurisdictions, and how to reduce them further.'

[320] The various problems in the role and use of EDs for the treatment of persons with mental illness, as SALRI often heard in its regional consultation, are compounded for regional, rural and remote settings. David Perkins et al, 'Factors Associated with Reported Service Use for Mental Health Problems by Residents of Rural and Remote Communities: Cross-Sectional Findings from a Baseline Survey'(2013) 13 *BMC Health Services Research* 157; Hannah Beks, Christopher Healey and Kate Schlicht, "'When You're It": A Qualitative Study Exploring the Rural Nurses experience of Managing Mental Health Presentations' (2018) 18(3) *Rural and Remote Health* 4616; Sharene Pascoe, Christina Aggar and Olivia Penman, 'Wait Times in an Australian Emergency Department: A Comparison of Mental Health and Non-Mental Health Wait Patients in a Regional Emergency Department' (2022) 31(3) *International Journal of Mental Health Nursing* 544; Rishaan Pawaskar et al, 'Staff Perceptions of the Management of Mental Health Presentations to the Emergency Department of a Rural Australian Hospital: Qualitative Study' (2022) 22 *BMC Health Services Research* 87.

[321] SALRI heard of the value of Community Mental Health Teams as an alternative to the use of EDs. See also Consumers of Mental Health WA, *Alternatives to Emergency Departments Project Report* (September 2019); Enrico Castillo et al, 'Community Interventions to Promote Mental Health and Social Equity' (2019) 21(5) *Current Psychiatry Reports* 35. See further Part 9 Role of Police.

[322] See Part 9 Role of Police.

'boarding')[323] persons with mental illness is detrimental and undesirable for consumers and also already stretched EDs and staff, other patients and police.[324] 'There is mounting evidence that the ED is not appropriate nor effective in responding to people in mental health crises.'[325] Several studies have reported many health practitioners within the ED often feel ill-equipped and lack confidence in assessing and managing mental health-related presentations.[326] The ED environment is widely seen as 'inappropriate' and 'not ideal' to care for individuals with mental illness, particularly when agitated.[327]

2.2.11 SALRI notes, as often raised in consultation, of the benefits of an approach other than EDs to treat persons with mental illness.[328] As one study observed:

> Thematic analyses revealed that a range of resource, environmental, staff and patient factors contribute to difficulties in managing mental health patients. Solutions suggested by interviewees included improved resources, ED redesign and improved links to resources outside the ED… Although the provision of timely and quality care is expected for all patients attending EDs, there

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[323] Kimberley Nordstom et al, 'Boarding of Mentally Ill Patients in Emergency Departments: American Psychiatric Association Resource Document' (2019) 20(5) *Western Journal of Emergency Medicine* 690.

[324] See, for example, George Jelinik et al, 'Barriers to the Operation of Mental Health Legislation in Australian Emergency Departments: a Qualitative Analysis' (2011) 18(4) *Journal of Law and Medicine* 716; Tracey Weiland et al, 'Optimal Management of Mental Health Patients in Australian Emergency Departments: Barriers and Solutions' (2011) 23(6) *Emergency Medicine Australasia* 677; Kelli Innes et al, 'Caring for the Mental Illness Patient in Emergency Departments – an Exploration of the Issues from a Healthcare Provider Perspective' (2014) 23(13) *Journal of Clinical Nursing* 2003; Michelle Heyland and Mary Johnson, 'Evaluating an Alternative to the Emergency Department for Adults in Mental Health Crisis' (2017) 38(7) *Issues In Mental Health Nursing* 557; Australasian College for Emergency Medicine, *The Long Wait: An Analysis of Mental Health Presentations to Australian Emergency Departments*: Report (2018); Consumers of Mental Health WA, *Alternatives to Emergency Departments Project* (Report, September 2019); Helena Roennfeldt et al, 'Subjective Experiences of Mental Health Crisis Care in Emergency Departments: A Narrative Review of the Qualitative Literature' (2021) 18(8) *International Journal of Environmental Research and Public Health* 9650; Rishaan Pawaskar et al, 'Staff Perceptions of the Management of Mental Health Presentations to the Emergency Department of a Rural Australian Hospital: Qualitative Study' (2022) 22 *BMC Health Services Research* 87.

[325] Helena Roennfeldt et al, 'Subjective Experiences of Mental Health Crisis Care in Emergency Departments: A Narrative Review of the Qualitative Literature' (2021) 18(8) *International Journal of Environmental Research and Public Health* 9650.

[326] Kelli Innes et al, 'Caring for the Mental Illness Patient in Emergency Departments – an Exploration of the Issues from a Healthcare Provider Perspective' (2014) 23(13) *Journal of Clinical Nursing* 2003, Hannah Beks, Christoher Healey and Kate Schlicht, '"When You're It": A Qualitative Study Exploring the Rural Nurses Experience of Managing Mental Health Presentations' (2018) 18(3) *Rural and Remote Health* 4616; Rishaan Pawaskar et al, 'Staff Perceptions of the Management of Mental Health Presentations to the Emergency Department of a Rural Australian Hospital: Qualitative Study' (2022) 22 *BMC Health Services Research* 87; Talitha Peart, Debra Kerr and Adam Searby, 'Novice Nurses' Experiences in Provision of Mental Ill Health Care within a Regional Emergency Department: A Descriptive Qualitative Study' (2022) *International Journal of Mental Health Nursing* 1 (forthcoming).

[327] Talitha Peart, Debra Kerr and Adam Searby, 'Novice Nurses' Experiences in Provision of Mental Ill Health Care within a Regional Emergency Department: A Descriptive Qualitative Study' (2022) *International Journal of Mental Health Nursing* 1 (forthcoming) 1, 6. See also Marc Broadbent, Lorna Moxham and Trudy Dwyer, 'Implications of the Emergency Treatment Triage Environment on Triage Practice for Clients with a Mental Illness at Triage in an Australian Context' (2014) 17(1) *Australasian Emergency Nursing Journal* 23, Mona Shattell et al, 'A Recovery-Oriented Alternative to Hospital Emergency Departments for persons in Emotional Distress: "The Living Room" (2014) 35(1) *Issues in Mental Health Nursing* 4; Hannah Beks, Christopher Healey and Kate Schlicht, '"When You're It": A Qualitative Study Exploring the Rural Nurses Experience of Managing Mental Health Presentations' (2018) 18(3) *Rural and Remote Health* 4616; Helena Roennfeldt et al, 'Subjective Experiences of Mental Health Crisis Care in Emergency Departments: A Narrative Review of the Qualitative Literature' (2021) 18(8) *International Journal of Environmental Research and Public Health* 9650; Rishaan Pawaskar et al, 'Staff Perceptions of the Management of Mental Health Presentations to the Emergency Department of a Rural Australian Hospital: Qualitative Study' (2022) 22 *BMC Health Services Research* 87.

[328] This supports the case for a co-response model for mental health crisis intervention. See Part 9 Role of Police. See also SALRI Recommendation 44.

> exist multiple barriers to provision of adequate care for ED patients presenting with mental illness. Many of these are systems-based and thus require systems-based solutions.

2.2.12 Another Australian study commented on the need for meaningful alternatives to existing EDs:

> Other research has identified barriers to the provision of quality nursing care to [consumers] in the ED. Similarly, [consumers] also perceive the physical environment of the ED to be overstimulating and lacking in privacy arrangements. These findings support the establishment of ED environments that are specific to providing care to individuals presenting with [an] acute [mental health crisis], such as the 'Living Room' models.[329]

2.2.13 The use of EDs for persons with mental illness in some circumstances is inevitable, but SALRI suggests that further review and investigation into alternatives to EDs in public hospitals should be explored for mental health-related attendances. Such alternatives raise significant potential benefits for consumers as well as policy and operational benefits for hard pressed EDs, police and health staff. SALRI heard of the value of Community Mental Health Teams as an alternative to the use of EDs.[330] Much work has been carried out in South Australia in this context and SALRI suggests that further review and investigation into the allocation of resourcing, staffing, infrastructure, and funding of Community Mental Health Teams an alternative to the use of EDs should be explored.[331]

2.2.14 The various problems in the role and use of EDs for the treatment of persons with mental illness, as SALRI often heard in its regional consultation, are compounded for regional, rural and remote EDs.[332] SALRI suggests that further review and investigation into the resourcing, staffing (including staff retention and resident specialists), infrastructure and funding of regional, rural and remote mental health services is explored.

2.2.15 SALRI was also informed about the impacts following the de-institutionalisation and mainstreaming of mental health services in South Australia. Further, consultees noted the absence of adequate resourcing, funding and staffing of community mental health teams has led to operational, resourcing and cultural issues. A number of experienced clinicians and mental health practitioners spoke highly of Hillcrest Hospital. SALRI was advised the model of care implemented by Hillcrest Hospital reflected a holistic approach to mental health and wellbeing, promoting social activities,

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[329] Talitha Peart, Debra Kerr and Adam Searby, 'Novice Nurses' Experiences in Provision of Mental Ill Health Care within a Regional Emergency Department: A Descriptive Qualitative Study' (2022) *International Journal of Mental Health Nursing* 1, 8 (forthcoming). Neami National, for example, described to SALRI their approach under the Urgent Medical Health Care Centre, which opened in 2021. See further Part 9 Role of Police.

[330] See also Consumers of Mental Health WA, *Alternatives to Emergency Departments Project Report* (September 2019); Enrico Castillo et al, 'Community Interventions to Promote Mental Health and Social Equity' (2019) 21(5) *Current Psychiatry Reports* 35. See also Part 9 Role of Police.

[331] See further Part 9 Role of Police.

[332] David Perkins et al, 'Factors Associated with Reported Service Use for Mental Health Problems by Residents of Rural and Remote Communities: Cross-Sectional Findings from a Baseline Survey'(2013) 13 *BMC Health Services Research* 157; Hannah Beks, Christopher Healey and Kate Schlicht, '"When You're It": A Qualitative Study Exploring the Rural Nurses experience of Managing Mental Health Presentations' (2018) 18(3) *Rural and Remote Health* 4616; Sharene Pascoe, Christina Aggar and Olivia Penman, 'Wait Times in an Australian Emergency Department: A Comparison of Mental Health and Non-Mental Health Wait Patients in a Regional Emergency Department' (2022) 31(3) *International Journal of Mental Health Nursing* 544; Rishaan Pawaskar et al, 'Staff Perceptions of the Management of Mental Health Presentations to the Emergency Department of a Rural Australian Hospital: Qualitative Study' (2022) 22 *BMC Health Services Research* 87.

offering employment opportunities and access to a wide range of services, including a hairdressing salon, physiotherapy, a dentist and an optometrist.

2.2.16 As part of this review and consistent with past references,[333] SALRI heard about issues relating to patient information sharing and access between Local Health Networks. This causes delays and difficulties in providing effective treatment for consumers. This was particularly problematic for regional, rural and remote hospitals and services. This issue was most powerfully highlighted to SALRI by Mr and Mrs Papageorgiou, in relation to the management and treatment of their son, Theo.[334] SALRI proposes that SA Health should undertake steps to ensure access to patient records across Local Health Networks can occur promptly and without technical delay.

2.2.17 A theme SALRI heard in consultation was that the present *MHA* has an undue focus on acute treatment and fails to highlight a wider holistic approach. This theme was often voiced at SALRI's Roundtables and individual meetings. One medical practitioner noted that, 'because of the *MHA*'s acute design, services are going towards acute care.' Accordingly, a consumer reported feeling as though 'people need to worsen their own situation to get help in a crisis.' An attendee at the Government Roundtable suggested that, without changes to the Act which address this concern and broaden its focus to include a wider notion of mental wellness, the *MHA* is a 'mental illness act, not a mental health act.' SALRI proposes that the title of the *Mental Health Act 2009* (SA) should be amended to the *Mental Health and Wellbeing Act* (SA). This is an important symbolic change to reflect the need under the *MHA* for a wider holistic approach to mental health, with a focus on prevention and promotion, as opposed to treatment at the acute stage.

2.2.18 SALRI recommends that, to demonstrate the shift to a more holistic approach, the definition of a 'mental health and wellbeing service' should be added to s 3 of the *MHA*, with reference to the comprehensive definition in s 3 of the *Mental Health and Wellbeing Act 2022* (Vic). SALRI is also of the view that the statutory objects contained in s 6 of the *MHA* should be amended to provide a greater focus on the promotion of wellbeing and prevention strategies, to help facilitate this shift from a crisis focused approach in the Act to one of wellbeing.

2.2.19 This was also a recurring theme in the Victorian Royal Commission:

> The Commission's vision for community-based mental health and wellbeing support is for a system that approaches treatment, care and support holistically. This means reorienting the current approach, which too often emphasises a 'biomedical model' of understanding mental illness and focuses on physical illness, to one that is more holistic.[335]

2.2.20 Although there is debate as to the preferable terms,[336] SALRI favours the term 'consumer'. This is consistent with the approach of the Victorian Royal Commission and is now incorporated in s 3 of the new Victorian *MHWA*. It also aligns with the practice of the Office of the Chief Psychiatrist and the views of consumers and consumer groups in SALRI's consultation. SALRI also notes that it is the preference of the Chief Psychiatrist to use the term 'person' where possible.

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[333] John Williams et al, *Abortion: A Review of South Australian Law and Practice* (South Australian Law Reform Institute, 2019) 457–62.

[334] This was also raised by the Deputy Coroner in Theo Papageorgiou's Inquest: *Inquest into the Death of Theo Nikolas Papageorgiou* (2021) 09/2020 (0176/2016) SACC (Schapel, Deputy State Coroner).

[335] *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021) vol 1, 306. See also at: 19–24, 93, 113, 139–188, 224, 243, 303–309, 392, 408, 597, 601.

[336] See above Glossary.

2.2.21 SALRI is of the view that all references to 'patient' in the *MHA* should be amended to 'consumer', except in the circumstances where a person is admitted to a treatment centre, such as a hospital. SALRI additionally recommends that a definition of 'consumer' should be added to s 3 of the *MHA*, with reference to the definition in s 3 of the *MHWA*.[337] SALRI further recommends that the term 'voluntary community patient' in the *MHA* should be amended to 'voluntary community consumer'.

2.2.22 As a consequential amendment, SALRI proposes that the definition of a 'mental health and wellbeing service' should be inserted into s 3 of the *MHA*, with reference to the definition in s 3 of the *MHWA*.[338]

2.2.23 The *MHA* currently applies to persons with alcohol and/or drug addiction. Schedule 1 of the *MHA* provides that a person does not have a mental illness merely because of any one or more of the following including 'the person takes or has taken alcohol or any other drug'.[339] However, Schedule 1 provides that 'nothing prevents, in relation to a person who takes or has taken alcohol or any other drug, the serious or permanent physiological, biochemical or psychological effects of drug taking from being regarded as an indication that a person is suffering from mental illness.'

2.2.24 The intersection between mental illness and drug and/or alcohol use was often raised in SALRI's consultation. In consultation, this intersection was described as complex and nuanced. As a result, SALRI was advised that it may take time to determine whether a person is self-medicating to cope and/or mask mental health symptoms or whether drug and/or alcohol addiction has caused a mental illness. Consultation also identified the importance of collaboration between mental health and drug and alcohol services, as there may be a considerable degree of overlap.[340] SALRI heard of different practices in relation to the treatment of alcohol and/or drug addiction under the *MHA*. Noting its complexity, SALRI recommends that the definition of a 'mental illness' in s 3 of the *MHA* should continue to incorporate Schedule 1 (list of certain conduct that does not indicate mental illness). In particular, the use of drugs and alcohol should be prioritised, as provision (a) under Schedule 1. This retains the flexibility that is appropriate in mental health treatment and reinforces the increasing

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[337] Section 3 provides: '"consumer" means a person who—

(a) has received mental health and wellbeing services from a mental health and wellbeing service provider; or

(b) is receiving mental health and wellbeing services from a mental health and wellbeing service provider; or

(c) was assessed by an authorised psychiatrist and was not provided with treatment; or

(d) sought or is seeking mental health and wellbeing services from a mental health and wellbeing service provider and was not or is not provided with those services.'

[338] Section 3 provides: '"mental health and wellbeing service" means a professional service—

(a) performed for the primary purpose of—

(i) improving or supporting a person's mental health and wellbeing; or

(ii) assessing, or providing treatment, care or support to, a person for mental illness or psychological distress; or

(iii) providing care or support to a person who is a family member, carer, or supporter, of a person with mental illness or psychological distress; or

(b) that is prescribed to be a mental health and wellbeing service—

but does not include—

(c) a non-legal mental health advocacy service; or

(d) a prescribed professional service.'

[339] *Mental Health Act 2009* (SA) Sch 1(k).

[340] See also *Question of Law Reserved (No 1 of 2021)* [2021] SASCA 148.

prevalence of illicit drug use, in the absence of an alternative legislative framework to address drug/alcohol use.

2.2.25 SALRI notes that various parties raised the application of the *MHA* with respect to particular cohorts, namely, persons with drug and/or alcohol addiction, older persons, especially those with a cognitive impairment or neurocognitive disorder[341] and children and adolescents.[342] As a result, SALRI is of the view that a separate review should be conducted into the use of the *MHA* for these cohorts.

2.2.26 SALRI also proposes that the definition of 'child' in s 3 of the *MHA* should be retained as a person under 18 years of age and this should be consistent throughout the Act (see also ss 4, 47(5)).

2.2.27 The premise and definition of consent under the *MHA* was raised to SALRI by a number of consultees. SALRI is of the view that the definition of consent in s 3 of the *MHA* should be amended to 'valid consent', with reference to the definition of 'informed consent' in s 86 of the *Mental Health and Wellbeing Act 2022* (Vic).[343]

2.2.28 Section 111 of the *MHA* requires a review of the Act's operation to be tabled in Parliament every five years. The OCP considered this is too frequent and would support, in principle, extending this review period to require a review to commence within five years, but report to Parliament within seven years. This position reflects the terms of the new Victorian Act and the complexities of reviewing laws that impacts significantly on rights and liberties. It also accounts for the time involved in training the community and clinicians on any consequent amendments to the Act.

2.2.29 SALRI concurs with this approach. However, SALRI recommends that it should remain at the discretion of Parliament regarding the timeframe for a Final Report to be tabled.

2.2.30 It is important that the law in this area is regularly reviewed to keep up with advancements in policy and practice. However, due to the complexities which arise with changes to law and practice, excessive reviews must be avoided. This complexity is reflected in the voluminous work of the Victorian Royal Commission (spread over seven volumes) and the necessary length of SALRI's present review. Therefore, SALRI recommends that the *MHA* be amended to require a further review to commence within five years.

2.2.31 Recommendations

RECOMMENDATION 1

SALRI recommends that the title of the *Mental Health Act 2009* (SA) should be amended to the *Mental Health and Wellbeing Act* (SA).

[341] SALRI notes this was especially highlighted by Aged Rights Advocacy Service and Emily Conroy of the Law Reform class.

[342] This was identified by various parties, notably, the Commissioner for Children and Young People, the Commissioner for Aboriginal Children and Young People and mental health professionals working in child and adolescent mental health.

[343] Section 86 of the *Mental Health and Wellbeing Act 2022* (Vic) gives a comprehensive definition.

RECOMMENDATION 2

SALRI recommends that a review of the *Mental Health Act 2009* (SA) is to commence within five years.

RECOMMENDATION 3

SALRI recommends that SA Health should undertake steps to ensure access to patient records across Local Health Networks can occur promptly and without technical delay.

RECOMMENDATION 4

SALRI recommends that all references to 'patient' in the *Mental Health Act 2009* (SA) should be amended to 'consumer', except in the circumstances where a person is admitted to a treatment centre, such as a hospital. SALRI further recommends that the term 'voluntary community patient' in the *Mental Health Act 2009* (SA) should be amended to 'voluntary community consumer'.

RECOMMENDATION 5

SALRI recommends that a definition of 'consumer' should be added to s 3 of the *Mental Health Act 2009* (SA), with reference to the definition in s 3 of the *Mental Health and Wellbeing Act 2022* (Vic).[344]

RECOMMENDATION 6

SALRI recommends that the definition of a 'mental health and wellbeing service' should be added to s 3 of the *Mental Health Act 2009* (SA), with reference to the definition in s 3 of the *Mental Health and Wellbeing Act 2022* (Vic).[345]

[344] Section 3 provides: '"consumer" means a person who—

(a) has received mental health and wellbeing services from a mental health and wellbeing service provider; or
(b) is receiving mental health and wellbeing services from a mental health and wellbeing service provider; or
(c) was assessed by an authorised psychiatrist and was not provided with treatment; or
(d) sought or is seeking mental health and wellbeing services from a mental health and wellbeing service provider and was not or is not provided with those services.'

[345] Section 3 provides: '"mental health and wellbeing service" means a professional service—

(a) performed for the primary purpose of—
  (i) improving or supporting a person's mental health and wellbeing; or
  (ii) assessing, or providing treatment, care or support to, a person for mental illness or psychological distress; or
  (iii) providing care or support to a person who is a family member, carer, or supporter, of a person with mental illness or psychological distress; or
(b) that is prescribed to be a mental health and wellbeing service—

but does not include—

(c) a non-legal mental health advocacy service; or
(d) a prescribed professional service.'

RECOMMENDATION 7

SALRI recommends that the statutory objects contained in s 6 of the *Mental Health Act 2009* (SA) should be amended to provide a greater focus on the promotion of wellbeing and prevention strategies, to help facilitate a shift from a crisis focused approach in the Act to one of wellbeing.

RECOMMENDATION 8

SALRI recommends that, noting the often complex intersection between mental illness and the use and effects of alcohol and/or drugs, the definition of a 'mental illness' in s 3 of the *Mental Health Act 2009* (SA) should incorporate Schedule 1 (list of certain conduct that does not indicate mental illness) and in particular, the use of drugs and alcohol should be prioritised, as provision (a) under Schedule 1.

RECOMMENDATION 9

SALRI recommends that the definition of 'child' in s 3 of the *Mental Health Act 2009* (SA) should be retained as a person under 18 years of age and this should be consistent throughout the Act (see ss 4, 47(5)).

RECOMMENDATION 10

SALRI recommends that the definition of consent in s 3 of the *Mental Health Act 2009* (SA) should be amended to 'valid consent', with reference to the definition of 'informed consent' in s 86 of the *Mental Health and Wellbeing Act 2022* (Vic).[346]

RECOMMENDATION 11

SALRI recommends that a separate review should be conducted into the use of the *Mental Health Act 2009* (SA) for:

i. Persons with drug and/or alcohol addiction; and
ii. Older persons, especially those with a cognitive impairment or neurocognitive disorder; and
iii. Children and adolescents.

2.2.32 Suggestions

SUGGESTION 1

SALRI suggests that further review and investigation into alternatives to the Emergency Department in public hospitals should be explored for mental health-related attendances.

[346] Section 86 gives a comprehensive definition.

SUGGESTION 2

SALRI suggests that further review and investigation into the allocation of resourcing, staffing, infrastructure and funding of Community Mental Health Teams is explored.

SUGGESTION 3

SALRI suggests that further review and investigation into the resourcing, staffing (including staff retention and resident specialists), infrastructure and funding of regional, rural and remote mental health services is explored.

Part 3 - Decision-making Capacity and Supported Decision-making

3.1 Background

3.1.1 The legal test and concept of 'capacity' is central to decision-making under the law. Capacity serves as both the rationale and the threshold for decision-making under the law.[347] The term has been understood in different ways at different times and contexts, being both a 'complex and contested' concept,[348] which causes 'widespread confusion and uncertainty.'[349] The role and application of capacity in various contexts were recurring themes in SALRI's recent references,[350] and current review. This is no coincidence. The role and application of capacity under the *MHA* also proved a prominent theme in the present reference. Linked to capacity, the role, application, and indeed the importance of supported decision-making have also proved recurring recent themes in recent SALRI references.[351]

3.1.2 Decision-making capacity refers to an individual's ability to make their own decisions. These decisions may fall within various categories, such as finances, health or medical, accommodation or lifestyle. Contemporary society places significant value on a person's autonomy and freedom to make decisions, including in the context of a person's mental health and in the *MHA*.[352] Consequently, when laws interfere with a person's ability to exercise this autonomous decision-making, it is important to ensure this interference is reasonable, proportionate, and necessary in the circumstances.

3.1.3 There is no single legal definition of capacity in South Australia (or elsewhere).[353] Rather, the legal definition of decision-making capacity is decision-specific, meaning it is based on the type of decision which is being made or the type of transaction involved.[354] This means there are a variety of

[347] Law Commission of Ontario, *Legal Capacity, Decision-Making and Guardianship* (Final Report, March 2017) 57.

[348] Law Reform Committee, Parliament of Victoria, *Inquiry into Powers of Attorney* (Parliamentary Paper No 352, August 2010) 108.

[349] Law Commission of Ontario, *Legal Capacity, Decision-Making and Guardianship* (Discussion Paper, May 2014).

[350] Sylvia Villios et al, *Valuable Instrument or the Single Most Abused Legal Document in our Judicial System? A Review of the Role and Operation of Enduring Powers of Attorney in South Australia* (Report No 15, December 2020) 121–175; David Plater et al, *Providing a Voice to the Vulnerable: A Study of Communication Assistance in South Australia* (South Australian Law Reform Institute, Adelaide, 2021); David Plater et al, '*Autonomy and Safeguarding are not Mutually Inconsistent': A Review of the Operation of the Ageing and Adult Safeguarding Act 1995 (SA)* (South Australian Law Reform Institute, 2022) 154–225.

[351] David Plater et al, *'Autonomy and Safeguarding are not Mutually Inconsistent': A Review of the Operation of the Ageing and Adult Safeguarding Act 1995 (SA)* (South Australian Law Reform Institute, 2022) vii, 160 [6.3.8]–[6.3.9], 162 [6.4.11]–[6.4.13], 166 [6.5.3]–[6.5.5], 354 [12.3.5]–[12.3.6]. See also NSW Law Reform Commission, *Review of the Guardianship Act 1987* (Report No 145, 2018) 19–21 [3.25]–[3.32]; Terry Carney, 'Supported Decision-Making in Australia: Meeting the Challenge of Moving from Capacity to Capacity-Building?' (2017) 35(2) *Law in Context* 44.

[352] See, for example, Yusur Al-Azzawi, *Safety and Autonomy in the Australian Mental Health Services Sector: Recommendations Based on a Review of the International Literature* (Disability Research Institute, University of Melbourne, May 2016).

[353] Australian Law Reform Commission, *Equality, Capacity And Disability In Commonwealth Laws* (Issues Paper 44, November 2014) 36 [93]–[97]. As one article notes: 'the search for a single test of competency is a search for a Holy Grail': Brian Murray, 'Mental Capacity: Different Models and their Controversies' (2017) 23 *British Journal of Psychiatric Advances* 366, 367. See also Loren Roth, Alan Meisel and Charles Lidz, 'Tests of Competency to Consent to Treatment' (1977) 134 *American Journal of Psychiatry* 279.

[354] *Gibbons v Wright* (1954) 91 CLR 423.

legal tests of capacity.[355] Some are contained in statutes such as the *Ageing and Adult Safeguarding Act 1995*[356] and the *Advance Care Directives Act 2015 ('ACD Act')*.[357] Other definitions have been developed in the common law, such as the test for testamentary capacity.[358] The assessment of capacity, whilst vital, is far from straightforward in practice.[359]

3.1.4 Capacity is pivotal in the application of the *MHA*. For instance, treatment can only be carried out under the *MHA* without the consumer's consent when specific criteria are satisfied, one of which includes impaired decision-making capacity. Similarly, the South Australian Civil and Administrative Tribunal ('SACAT') can only order or authorise treatment, in the event the party is found to lack decision-making capacity.[360]

3.1.5 The implications of a finding that a consumer does or does not have capacity under the *MHA* are significant. As has been observed:

> Capacity, in law, serves as the effective threshold of autonomy, dividing the autonomous, on the one side, from the non-autonomous, on the other, on the basis of an individual's ability to engage in the process of rational (and therefore autonomous) thought, explained as the ability to exercise one's will to reflect upon, and choose between desires, and to adopt those chosen as one's 'own'.[361]

3.1.6 Indeed, these implications may be 'momentous'.[362] As the Ontario Law Reform Commission observed:

> Because the test for legal capacity determines the threshold for the application of the law, and because the consequences of a determination regarding legal capacity may be momentous, approaches to legal capacity are highly contested. The relatively abstract nature of the concept of legal capacity, embedded as it is in multiple intersecting legal, ethical, medical and social concepts and realities, makes these debates challenging. Adding to the challenge is the difficulty of operationalizing the concept of legal capacity, particularly the nuanced approach adopted in Ontario's laws.[363] It may be difficult to disentangle implementation issues from shortfalls in the conception itself.[364]

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[355] See, for example, Australian Law Reform Commission, *Equality, Capacity And Disability In Commonwealth Laws* (Issues Paper 44, November 2014) 36 [93]–[97]; Bernadette McSherry, 'Mental Health Laws: Where to from Here' (2014) 40(1) *Monash University Law Review* 175.

[356] *Ageing and Adult Safeguarding Act 1995* (SA) s 5.

[357] *Advance Care Directives Act 2015* (SA) s 7.

[358] *Banks v Goodfellow* (1870) LR 5 QB 549; *Gibbons v Wright* (1954) 91 CLR 423; *Zorbas v Sidiropoulous (No 2)* [2009] NSWCA 197. See also Sylvia Villios et al, *Valuable Instrument or the Single Most Abused Legal Document in our Judicial System? A Review of the Role and Operation of Powers of Enduring Attorney in South Australia* (South Australian Law Reform Institute, 2020) 121–75.

[359] Sylvia Villios et al, *Valuable Instrument or the Single Most Abused Legal Document in our Judicial System? A Review of the Role and Operation of Powers of Enduring Attorney in South Australia* (South Australian Law Reform Institute, 2020) 157–9 [4.5.28]–[4.5.33]. See also generally Ann McDonald, 'The Impact of the 2005 Mental Capacity Act on Social Workers' Decision Making and Approaches to the Assessment of Risk' (2010) 40(4) *British Journal of Social Work* 1229; Mark Jayes et al, 'How do Health and Social Care Professionals in England and Wales Assess Mental Capacity? A Literature Review' (2019) 42(19) *Disability and Rehabilitation* 2797.

[360] *Mental Health Act 2009* (SA) s 5A.

[361] Margaret Hall, 'Mental Capacity in the (Civil) Law: Capacity, Autonomy, and Vulnerability' (2012) 58(1) *McGill Law Journal* 61, 65.

[362] Law Commission of Ontario, *Legal Capacity, Decision-Making and Guardianship* (Final Report, March 2017) 58.

[363] A similar nuanced approach to decision-making capacity exists under South Australian law, including the *Mental Health Act 2009* (SA).

[364] Law Commission of Ontario, *Legal Capacity, Decision-Making and Guardianship* (Final Report, March 2017) 58.

3.1.7 Section 5A of the *MHA* sets out the criteria for determining 'decision-making capacity'. This provision begins by providing a presumption of capacity. That is, a person, in the absence of evidence or a law of the State to the contrary, to be presumed to have full decision-making capacity in respect of decisions about their health care, residential and accommodation arrangements and personal affairs. A person is taken under s 5A(2) to have impaired decision-making capacity in respect of a particular decision if the person is not capable of:

> understanding any information that may be relevant to the decision (including information relating to the consequences of making a particular decision); or
>
> retaining such information; or
>
> using such information in the course of making the decision; or
>
> communicating his or her decision in any manner.[365]

3.1.8 The assessment of capacity, whilst vital, is far from straightforward in practice.[366]

3.1.9 The *MHA* enables, under certain circumstances, interference with a person's human rights.[367] Through the enforcement of involuntary treatment, a consumer must comply with a treatment order for their diagnosed mental illness. The *MHA* establishes two types of treatment orders – Community Treatment Orders ('CTOs')[368] and Inpatient Treatment Orders ('ITOs').[369]

3.1.10 These orders are legally permissible means of requiring a consumer to receive treatment, without their consent. The basis on which these orders can be made, is the satisfaction of a number of criteria. One criterion which must be satisfied is that the consumer has impaired decision-making capacity in relation to the treatment of their mental illness. Consequently, SALRI was asked to consider whether the definition of decision-making capacity and the capacity criterion for treatment orders remains appropriate.

3.1.11 Accordingly, SALRI considered the utility of incorporating a supported decision-making model, whether further clarification regarding the assessment of capacity is warranted and the findings of the Theo Papageorgio Inquest.[370] The Deputy State Coroner ('Deputy Coroner'), in particular, suggested that the criterion requiring impaired decision-making to be satisfied for an order of involuntary treatment to be removed.[371]

3.1.12 One scenario often presented to SALRI during consultation, reflecting the intricate relationship between decision-making capacity and consent, was in the context of a consumer who has made a lifestyle decision which is likely to or will inevitably result in their death. In these circumstances, the consumer has been able to make a reasoned decision and express their justifications to the medical

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[365] *Mental Health Act 2009* (SA) s 5A(2).

[366] Sylvia Villios et al, *Valuable Instrument or the Single Most Abused Legal Document in our Judicial System? A Review of the Role and Operation of Powers of Enduring Attorney in South Australia* (South Australian Law Reform Institute, 2020) 157–9 [4.5.28]–[4.5.33]. See also generally Ann McDonald, 'The Impact of the 2005 Mental Capacity Act on Social Workers' Decision Making and Approaches to the Assessment of Risk' (2010) 40(4) *British Journal of Social Work* 1229; Mark Jayes et al, 'How do Health and Social Care Professionals in England and Wales Assess Mental Capacity? A Literature Review' (2019) 42(19) *Disability and Rehabilitation* 2797.

[367] This may include the right to liberty, freedom of movement and autonomy in decision-making.

[368] *Mental Health Act 2009* (SA) Pt 4.

[369] Ibid Pt 5.

[370] Contained within SALRI's Terms of Reference.

[371] SALRI has recommended that this criterion be retained: see SALRI Recommendation 15.

practitioner. Where there is no extenuating depression, the consumer's autonomy in decision-making must be respected. SALRI notes that this raises ethical issues, and it cannot delve into the ethics of such decision-making. However, SALRI also acknowledges the importance of safeguarding autonomy, and that the role of qualified mental health practitioners exercising their clinical judgment will be relied upon in cases of this nature.

3.1.13 In its previous references, SALRI has comprehensively examined the law, policy and practice relating to decision-making capacity.[372] SALRI recognises that capacity represents the interface between legal and medical/clinical understandings and practices. As a result, a discussion of capacity must be multi-disciplinary.

3.1.14 Generally, there are six guiding principles which dictate the definition and assessment of capacity, as set out below:[373]

> **1. Presume the individual has capacity**. Cultural literacy is important in the application of this principle. An individual's culture, language, religion and ethnicity may dictate views on autonomy and the process of decision-making.[374] In addition, an appropriate balance between the autonomy and the best interests of the individual must be achieved.[375] This facilitates a shift away from a paternalistic view of autonomy, to one acknowledging the importance of maintaining the individual's autonomy to retain capacity.
>
> **2. 'Capacity is decision-specific'.**[376] Assessment of capacity are tailored to the specific decision being made. It is critical to note that capacity is also *time-specific*, meaning the assessment must question whether the individual has decision-making capacity *at the time of the assessment*.[377]
>
> **3. One must not assume an individual lacks capacity due to their appearance**. This refers to the way in which an individual presents themselves, behaves and communicates.[378] This includes impairments such as Parkinson's Disease, Autism, Attention Deficit Hyperactive Disorder or Multiple Sclerosis.[379]
>
> **4. The decision-making ability of the individual is assessed, not the merits of their final decision.** The 'right to make a decision includes the right to take risks and to make decisions with which others disagree. This is known as dignity of risk'.[380]
>
> **5. The individual's privacy must be respected**; and

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[372] SALRI examined the role and operation of enduring Powers of Attorney in South Australia. A prominent theme raised in that Report was the definition and assessment of decision-making capacity. Ancillary issues raised related to fluctuating capacity and its practical implications. See Sylvia Villios et al, *Valuable Instrument or the Single Most Abused Legal Document in our Judicial System? A Review of the Role and Operation of Powers of Enduring Attorney in South Australia* (South Australian Law Reform Institute, 2020) 129–32 [4.3.1]–[4.3.13], 159–160 [4.5.36]–[4.5.41], 174–5 [4.5.121]–[4.5.127].

[373] Communities and Justice, *Capacity Toolkit* (2008) Government of NSW <https://www.justice.nsw.gov.au/diversityservices/Pages/divserv/ds_capacity_tool/ds_capacity_tool.aspx> 11–2.

[374] Ibid 28.

[375] Ibid 29.

[376] Ibid 32.

[377] Ibid.

[378] Ibid 34.

[379] Ibid.

[380] Ibid 36.

6. The use of substitute decision-making is a 'last resort'.[381] The assessment must consider appropriate measures to assist the individual in maintaining their decision-making capacity.[382] Measures include the use of an interpreter, an advocate or a communication aid.[383]

3.1.15 The assessment of capacity under the *MHA* is a primary means to protect the consumer's interests and rights. This is achieved by presuming an adult has the capacity and, when their capacity is questioned, undertaking an assessment in a way which promotes and supports their autonomy.

3.1.16 Due to the contextual nature of capacity, its assessment is highly significant within the process of satisfying the legislative criteria to enforce a treatment order. SALRI's consultation has revealed this process is often undertaken without many issues, relying on the clinical judgment of the treating medical practitioner.

3.1.17 Despite this, SALRI actively sought feedback regarding the definition and approach to assessing decision-making capacity. Feedback indicated that the assessment of capacity under the *MHA* could be more nuanced.[384] This was observed for those with a neurological/neurocognitive disorder such as dementia, where decision-making capacity may fluctuate.[385] As one author notes (and as SALRI was told), 'one day they [a person with dementia] seem completely lost and on another perfectly aware of the world around them.'[386] Further, the varied, fluctuating, and progressive nature of dementia presents unique challenges for the application of the *MHA*.[387] In the absence of a statute focussed solely on dementia, the *MHA* was described to SALRI as an 'adequate proxy' by geriatricians. Nevertheless, capacity assessments for those with fluctuating capacity (notably, for people with neurological/neurocognitive disorders such as dementia) presents unique challenges and may demand time, resources, and a level of continuity of care that may be difficult to achieve in practice.

3.1.18 While there is the statutory recognition that capacity may fluctuate, the *MHA* does not contain an explicit provision requiring reasonable steps to be taken to conduct a capacity assessment during a time at which, and in an environment where, the person's decision-making capacity can be assessed most accurately, or that the person being assessed is provided with the appropriate supports

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[381] Communities and Justice, *Capacity Toolkit* (2008) Government of NSW <https://www.justice.nsw.gov.au/diversityservices/Pages/divserv/ds_capacity_tool/ds_capacity_tool.aspx> 42.

[382] Ibid.

[383] Ibid.

[384] See also Sylvia Villios et al, *Valuable Instrument or the Single Most Abused Legal Document in our Judicial System? A Review of the Role and Operation of Powers of Enduring Attorney in South Australia* (South Australian Law Reform Institute, 2020) 157–159 [4.5.28]–[4.5.33]; Ann McDonald, 'The Impact of the 2005 Mental Capacity Act on Social Workers' Decision Making and Approaches to the Assessment of Risk' (2010) 40(4) *British Journal of Social Work* 1229; Mark Jayes et al, 'How do Health and Social Care Professionals in England and Wales Assess Mental Capacity? A Literature Review' (2019) 42(19) *Disability and Rehabilitation* 2797.

[385] Dementia has been raised to SALRI in this context in both past and present references. It is significant that it cannot be assumed from a diagnosis that the individual will lose capacity – each individual has a different experience.

[386] Kevin De Sabbata, 'Dementia, Treatment Decisions, and the UN Convention on the Rights of Persons with Disabilities. A New Framework for Old Problems' (2020) 11 *Frontiers in Psychiatry* 2.

[387] Such a provision could enhance decision-making for individuals living with dementia: Kevin De Sabbata, 'Dementia, Treatment Decisions, and the UN Convention on the Rights of Persons with Disabilities. A New Framework for Old Problems' (2020) 11 *Frontiers in Psychiatry* 2.

to enable the person to give informed consent.[388] Such a provision can be found in the new Victorian mental health legislation.[389]

3.1.19 Decision-making capacity plays an important role in many facets of law, medicine and public policy. As a result, it continues to be a recurring theme, relevant to many areas of reform.

3.2 Current Law in South Australia

Legislative Definition

3.2.1 The *MHA* contains a definition of 'decision-making capacity'.[390] This definition is derived from the common law (in both succession law – financial decision-making capacity,[391] and medical law – medical decision-making capacity).[392]

3.2.2 As discussed above, under s 5A(1) of the *MHA*, all adults are presumed to have full decision-making capacity for health care, residential and accommodation arrangements and personal affairs.

3.2.3 Section 5A(2) *MHA* proceeds to define 'decision-making capacity' as:

> … 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 the 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) in the case of a person who has given an advance care directive—the person has satisfied any requirement in the advance care directive that sets out when the person is to be considered to have impaired decision-making capacity (however described) in respect of a decision of the relevant kind.

3.2.4 Importantly, a person will not lack capacity because:

- They do not understand the specific details of the information (for example, matters of a technical or trivial nature);[393]
- Can only retain or remember the information for a limited time;[394]

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[388] *Mental Health and Wellbeing Act 2022* (Vic) s 87(3)(a)–(b).

[389] See, for example, Ibid.

[390] *Mental Health Act 2009* (SA) s 5A.

[391] *Gibbons v Wright* (1954) 91 CLR 423; *Re K* [1988] 1 Ch 310.

[392] *Re B (Adult: Refusal of Medical Treatment)* [2002] 2 All ER 449; *Re T (Adult: Refusal of Medical Treatment)* [1992] 4 All ER 649.

[393] *Mental Health Act 2009* (SA) s 5A(3)(a).

[394] Ibid s 5A(3)(b).

- May fluctuate between having capacity and losing capacity;[395] and
- Makes a decision which has a negative outcome for them.[396]

3.2.5 SALRI reiterates, as often told in consultation, that the presence of a mental illness **does not** denote the individual lacks decision-making capacity.[397] As one commentator colourfully notes:

> … these patients are generally free [under the *MHA*] to choose or reject treatment based on the same principles that a person with capacity has. Hang on, are you saying people with a mental illness can also have capacity. Yes I am, and you must not conflate the two. It does not automatically follow that a person with mental illness lacks capacity. Mental health and mental capacity are different concepts. A person with mental illness may [or may not] lack capacity… Mental illness is not an absolute condition that points to a reduction in autonomy… please do not presume that a person with a diagnosed mental illness lacks capacity.[398]

Common Law Definition

3.2.6 The common law also contains a presumption that all adults have the capacity to make their own decisions, unless there is evidence to the contrary.[399] This was highlighted and relied on in SALRI's present consultation, notably by consumer groups and consumers at SALRI's various community sessions.

3.2.7 The common law principles concerning the definition and nature of capacity are largely consistent, despite some minor differences in their articulation depending on the specific area of law these principles are applied. For instance, the common law recognises that capacity is 'decision-specific,' or 'issue-specific'.[400] This may require an adult to understand the nature, purpose and effect of the particular decision.[401] Alternatively, within the context of a person executing a legal instrument, such as an enduring Power of Attorney, the question of capacity must be determined 'by reference to the transaction in which the person proposes to engage'.[402]

3.2.8 Regardless of the slightly varied expressions of the decision-making definition, the underlying premises remains consistent.

3.2.9 The common law tests do not enforce a single fixed standard of capacity to be applied to all decision-making.[403] This flexibility is intentional. It assists in the fulfilment of the guiding principles

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[395] Ibid s 5A(3)(c). See also *Re D(J)* [1982] Ch 237, 243–4; Sylvia Villios et al, *Valuable Instrument or the Single Most Abused Legal Document in our Judicial System? A Review of the Role and Operation of Powers of Enduring Attorney in South Australia* (South Australian Law Reform Institute, 2020) 129–132 [4.3.1]–[4.3.13], 159–160 [4.5.36]–[4.5.41], 174–5 [4.5.121]–[4.5.127].

[396] *Mental Health Act 2009* (SA) s 5A(3)(d).

[397] See also *PBU & NJE v Mental Health Tribunal* [2018] VSC 564; *Re C (Adult: Refusal of Medical Treatment)* [1994] 1 All ER 819.

[398] Stephen Bartlett, *Ethics and the Law in Health Services Delivery,* QUT Pressbooks <https://qut.pressbooks.pub/csb338/> [7.01].

[399] In the context of medical decision-making, see *Re B (Adult: Refusal of Medical Treatment)* [2002] 2 All ER 449; *Re T (Adult: Refusal of Medical Treatment)* [1992] 4 All ER 649; *Re MB (Medical Treatment)* [1997] EWCA Civ 3093. In the context of financial decision-making, see *Attorney-General v Parnther* (1792) 29 ER 632; *Borthwick v Carruthers* (1787) 99 ER 1300; *Dalle-Molle v Manos* (2004) 88 SASR 193, 198; *Gibbons v Wright* (1954) 91 CLR 423, 437.

[400] *Dalle-Molle v Manos* (2004) 88 SASR 193, 198. See also *Gibbons v Wright* (1954) 91 CLR 423, 437–8.

[401] *Re C (Adult: Refusal of Medical Treatment)* [1994] 1 All ER 819.

[402] *Dalle-Molle v Manos* (2004) 88 SASR 193, 198. See also *Gibbons v Wright* (1954) 91 CLR 423, 437.

[403] Darryl Browne, 'Mental Capacity: The Tests and Assessment' (2018) 145 *Precedent* 12.

which underpin our modern understanding of capacity. Further, the level of capacity required to undertake one task, such as completing a cash transaction, as opposed to determining whether to invest in the share market, will differ.[404] This same logic applies to any decision-making scenario, whether it be simple or complex decisions relating to medical treatment, pursuing a legal action or entering a contract.

3.2.10 Finally, the fluctuating nature of capacity has been recognised by the common law.[405] Importantly, it does not preclude a person from being deemed to have decision-making capacity.[406] This is also reiterated within the definition in the *MHA*.

3.3 Law in Other Jurisdictions

Legislative Definitions

3.3.1 A number of jurisdictions contain legislative definitions of decision-making capacity in the context of the *MHA*, including Victoria,[407] Western Australia,[408] the Australian Capital Territory ('ACT'),[409] Tasmania[410] and Queensland.[411] These definitions are largely consistent, premised upon the four key principles of understanding information, retaining relevant information, using information in making a decision and communicating a decision.

3.3.2 The ACT has adopted a slightly different approach, where the definition of 'decision-making capacity' is expanded, outlining principles of decision-making capacity in further provisions of the *Mental Health Act 2015* (ACT) ('*MHA* (ACT)').[412] The principles are similar to those in South Australia's *MHA*, relating to fluctuating capacity, the decision-specific nature of capacity and the presumption of capacity.

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[404] The exercise of basic and complex skills require different thresholds of capacity. Someone may be incapable in one respect (such as to make important financial decisions like selling a house), but not others (such as buying a packet of cigarettes each day or week). See also *Bailey v Bailey* (1924) 34 CLR 558, 571; Sylvia Villios et al, *Valuable Instrument or the Single Most Abused Legal Document in our Judicial System? A Review of the Role and Operation of Powers of Enduring Attorney in South Australia* (South Australian Law Reform Institute, 2020) 134 [4.4.11].

[405] *Re D(J)* [1982] Ch 237, 243–234; *Hoffmann v Waters* [2007] SASC 273. See further Sylvia Villios et al, *Valuable Instrument or the Single Most Abused Legal Document in our Judicial System? A Review of the Role and Operation of Powers of Enduring Attorney in South Australia* (South Australian Law Reform Institute, 2020) 129–132 [4.3.1]–[4.3.13], 159–160 [4.5.36]–[4.5.41], 174–5 [4.5.121]–[4.5.127].

[406] In the context of testamentary capacity, see *Hoffmann v Waters* [2007] SASC 273, in which Debelle J recognised that an individual is deemed to have capacity during a lucid interval. The status of an individual's capacity during a lucid interval remains unclear in light of *Gibbons v Wright*. The High Court in *Gibbons v Wright* confirmed that an individual does not regain capacity during a lucid interval: (1954) 91 CLR 423, 440. This is problematic, in light of the widespread understanding that capacity can fluctuate. See also Sylvia Villios et al, *Valuable Instrument or the Single Most Abused Legal Document in our Judicial System? A Review of the Role and Operation of Powers of Enduring Attorney in South Australia* (South Australian Law Reform Institute, 2020) 129–132 [4.3.1]–[4.3.13], 159–160 [4.5.36]–[4.5.41], 174–5 [4.5.121]–[4.5.127].

[407] *Mental Health and Wellbeing Act 2022* (Vic) s 87.

[408] *Mental Health Act 2014* (WA) s 15.

[409] *Mental Health Act 2015* (ACT) s 7.

[410] *Mental Health Act 2013* (Tas) s 7.

[411] *Mental Health Act 2016* (Qld) s 14.

[412] *Mental Health Act 2015* (ACT) s 8.

3.3.3 In addition, the *MHA* (ACT) also includes a principle relating to supported decision-making, namely '…a person must not be treated as not having decision-making capacity *unless all practicable steps* to *assist the person* to make decisions have been taken…'[413]

3.3.4 Another principle states that '…a person who does not have decision-making capacity must always be supported to make decisions about the person's treatment, care or support to the best of the person's ability.'[414] This highlights the need to ensure adequate supports are provided to assist a person in decision-making, regardless of their capacity.

3.3.5 The *MHA* (ACT) provisions represent a rights-based approach, endorsing a supported decision-making framework. Importantly, supported decision-making should not be contingent on whether a person has decision-making capacity.

3.3.6 SALRI supports such a supported decision-making model within s 5A of the *MHA*.[415]

Capacity as a Criterion for Treatment Orders

3.3.7 Other jurisdictions include impaired decision-making capacity as a criterion for the enforcement of both community and inpatient treatment orders.[416]

3.3.8 Despite the recent findings and recommendation of the Deputy Coroner,[417] SALRI's consultation revealed strong support to retain the impaired decision-making criterion in the *MHA*.

3.4 Issues

Legislative Definition of 'Decision-Making Capacity'

3.4.1 Capacity is a nuanced term and concept. It is not binary, meaning it is not as simple as saying a person will either have capacity or not. Following this, a person may lack capacity in one respect (such as buying weekly groceries and medication), but not in another circumstance (such as selling a house).[418] Though the law is premised on the assumption that there is a clear distinction between capable and incapable, this is often (as SALRI heard in consultation) a very fine line.[419] Importantly, the presence of a disability, mental illness, cognitive impairment or neurodegenerative

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[413] Ibid s 8(1)(d) (emphasis added).

[414] Ibid s 8(1)(c).

[415] The need for the *Mental Health Act 2009* (SA) and present practices to give greater and more explicit effect to the vital premise of supported decision-making was raised by many parties in SALRI's present consultation such as Purple Orange, Mind Australia Ltd, Disability Rights Advocacy Service Inc, Dr Susan Peukert, the Australian Psychological Society and Speech Pathology Australia.

[416] See *Mental Health Act 2013* (Tas) s 40(e); *Mental Health Act 2014* (WA) ss 25(1)(c) & 25(2)(c); *Mental Health Act 2015* (ACT) ss 58(2)(b) & 66(2)(b); *Mental Health Act 2016* (Qld) s 12(1)(b); *Mental Health and Related Services Act 1998* (NT) s 16(b)(iii).

[417] *Inquest into the Death of Theo Nikolas Papageorgiou* (2021) 09/2020 (0176/2016) SACC (Schapel, Deputy State Coroner) Recommendation 4.

[418] *Bailey v Bailey* (1924) 34 CLR 558, 571.

[419] See also Sylvia Villios et al, *Valuable Instrument or the Single Most Abused Legal Document in our Judicial System? A Review of the Role and Operation of Powers of Enduring Attorney in South Australia* (South Australian Law Reform Institute, 2020) 134 [4.4.11]. In the context of legal testamentary capacity, Lord Cranworth in a 19th century English case, observed of the difficulty involved: 'There is no possibility of mistaking midnight for noon; but at what precise moment twilight becomes darkness is hard to determine' *Boyse v Rossborough* (1857) 6 HLC 1, 45.

disorder does not mean the person lacks capacity.[420] This outdated position is consistent with a paternalistic view of mental impairments and the 'medical theory of mind being one and indivisible'.[421]

3.4.2 SALRI, drawing on its extensive consultation[422] and research, is of the view that the current definition in s 5A of the *MHA* remains appropriate. It is consistent with other legislative definitions observed in South Australian statutes,[423] including the *Advance Care Directives Act 2013* (SA)[424] and *Ageing and Adult Safeguarding Act 1995* (SA).[425] Most notably, it is decision-specific, includes a statutory presumption of capacity and recognises it may fluctuate.

3.4.3 In SALRI's recent review of the operation of *Ageing and Adult Safeguarding Act 1995* (SA), the statutory construction of the 'impaired decision-making capacity' legislative definition was considered.[426] In light of the consistency between definitions across the *MHA* and the *Ageing and Adult Safeguarding Act 1995* (SA), SALRI's findings remain relevant.

3.4.4 In the context of mental health, decision-making capacity should be assessed based on the specific treatment plan, lifestyle decisions, accommodation decisions and financial decisions. For example, when assessing decision-making capacity for treatment orders, the clinician should assess the person's capacity in relation to the 'appropriate treatment' for their mental illness. However, if the clinician is assessing the person's decision-making capacity to consent or refuse medication for a separate medical co-morbidity, such as heart disease, the assessment will be tailored to this decision.

3.4.5 SALRI reiterates the decision-specific nature of capacity and the presumption that adults have decision-making capacity. The fundamental tenets of decision-making capacity, as identified by s 5A(2) of the *MHA*, can be applied to any relevant decision. SALRI's consultation revealed support to provide greater clarification in relation to the assessment approach. In response to this, the current construction of the decision-making capacity definition was considered. Two possible options were explored – reforms to make the definition more prescriptive or proscriptive.

3.4.6 The rationale for a more prescriptive or detailed definition is based on a need to provide more guidance for assessments of capacity. Given capacity is nuanced, decision- and context-specific, those responsible for its assessment may benefit from clearer and more explicit statutory provisions. Some submissions indicated support for greater clarity, especially as a means to ensure practitioners tasked with assessing decision-making capacity, have the necessary understanding to do so adequately.

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[420] *PBU & NJE v Mental Health Tribunal* [2018] VSC 564; Law Reform Committee, Parliament of Victoria, *Inquiry into Powers of Attorney* (Parliamentary Paper No 352, August 2010) 111; Sylvia Villios et al, *Valuable Instrument or the Single Most Abused Legal Document in our Judicial System? A Review of the Role and Operation of Powers of Enduring Attorney in South Australia* (South Australian Law Reform Institute, 2020) 159 [4.5.34]–[4.5.35].

[421] Danuta Mendelson, 'Assessment of Competency: A Primer' (2006) 14(2) *Journal of Law and Medicine* 156, 161.

[422] There were only limited suggestions for changes to the statutory definition of capacity in the *Mental Health Act 2009* (SA). The prevailing view in SALRI's consultation was that the current definition is sound.

[423] SALRI's present consultation revealed many parties disliked the definition of 'mental incapacity' within s 3 of the *Guardianship and Administration Act 1993* (SA). This has proved a recurring theme. See also David Plater et al, *'Autonomy and Safeguarding are not Mutually Inconsistent': A Review of the Operation of the Ageing and Adult Safeguarding Act 1995 (SA)* (South Australian Law Reform Institute, 2022) 2173.

[424] *Advance Care Directives Act 2013* (SA) s 7.

[425] *Ageing and Adult Safeguarding Act 1995* (SA) s 5(2).

[426] David Plater et al, *'Autonomy and Safeguarding are not Mutually Inconsistent': A Review of the Operation of the Ageing and Adult Safeguarding Act 1995 (SA)* (South Australian Law Reform Institute, 2022) 154–83.

3.4.7 However, this prescriptive definition may be problematic. As observed in SALRI's recent review,[427] and as revealed in consultation for the *MHA,* a core tenet of the definition is its deliberate ambiguity, which enables a clinician to exercise professional and clinical judgment when assessing capacity. This flexibility recognises that capacity is both a legal and medical/clinical construct. If the legislative definition is too prescriptive, for example in relation to dictating processes for its assessment, it cannot account for the varying, yet legitimate, approaches adopted by medical specialists and health practitioners.

3.4.8 In contrast, a broader or proscriptive definition may continue to cause uncertainty associated with decision-making capacity. The definition should not be too expansive, as this may risk allowing a departure from the current nuanced understandings of capacity, and back to false assumptions relating to disability, mental illness and capacity. For example, an individual's appearance is not an indicator of incapacity,[428] nor is the presence of a disability or mental illness.[429]

3.4.9 An additional factor to consider is the utility of incorporating guiding principles as a tool to clarify the definition and assessment of decision-making capacity. The introduction of a toolkit or guidelines to assist with the assessment of capacity, serves as an educational tool for practitioners and interested members of the community. A key purpose of such a toolkit is to enhance understandings of capacity across various decision-making domains and offer guidance in relation to how an assessment may be undertaken. A toolkit or guidelines relating to decision-making capacity would serve to represent the dynamic nature of capacity, whilst also setting boundaries to rebut generalised or outdated understandings of capacity.[430] Further, this is intended to lead to a greater understanding of rights on behalf of consumers, family members, friends, carers and other interested parties. SALRI's previous consultation on past references has revealed such toolkits can also be utilised in other contexts by medical/health practitioners and others when engaging with a client and their support persons.[431]

The Decision-Making Capacity Criterion

3.4.10 As part of this review, SALRI was asked to consider the decisions in *PBU & NJE v Mental Health Tribunal* ('*PBU & NJE*')[432] and *TSC v Department for Health and Wellbeing* ('*TSC*').[433]

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[427] David Plater et al, *'Autonomy and Safeguarding are not Mutually Inconsistent': A Review of the Operation of the Ageing and Adult Safeguarding Act 1995 (SA)* (South Australian Law Reform Institute, 2022) 159.

[428] Ibid 159–60 [6.3.7]. See also Sylvia Villios et al, *Valuable Instrument or the Single Most Abused Legal Document in our Judicial System? A Review of the Role and Operation of Powers of Enduring Attorney in South Australia* (South Australian Law Reform Institute, 2020) 166 [4.5.75].

[429] Sylvia Villios et al, *Valuable Instrument or the Single Most Abused Legal Document in our Judicial System? A Review of the Role and Operation of Powers of Enduring Attorney in South Australia* (South Australian Law Reform Institute, 2020) 134 [4.4.18], 159 [4.5.34]–[4.5.35]. Parties such as Natalie Wade at Equality Lawyers and Maggie Rutjens of Disability Advocacy and Complaints Service of South Australia Inc and Kaela Dore, a lawyer, told SALRI that all too often in practice there is a generalised assumption that the presence of an intellectual disability denotes incapacity.

[430] Danuta Mendelson, 'Assessment of Competency: A Primer' (2006) 14(2) *Journal of Law and Medicine* 156, 161.

[431] Capacity assessment toolkits or guidance also assists in relation to powers of attorney and adult safeguarding. See also Sylvia Villios et al, *Valuable Instrument or the Single Most Abused Legal Document in our Judicial System? A Review of the Role and Operation of Powers of Enduring Attorney in South Australia* (South Australian Law Reform Institute, 2020) 151–6 [4.5.10]–[4.5.22]; David Plater et al, *'Autonomy and Safeguarding are not Mutually Inconsistent': A Review of the Operation of the Ageing and Adult Safeguarding Act 1995 (SA)* (South Australian Law Reform Institute, 2022) 167–78 [6.6.1]–[6.9.7], rec 21–24.

[432] [2018] VSC 564. See also Appendix 1.

[433] [2021] SASCA 93. See also Appendix 2.

3.4.11 SALRI was also asked to consider the findings of the Deputy Coroner following the inquest into Theo Papageorgiou's death ('the Inquest'),[434] where the Deputy Coroner referred to the capacity criterion as a 'legal impediment.'[435] Further, according to the Deputy Coroner, under the law applicable at the time of Theo's death,[436] '[a]n unimpaired decision-making capacity on the part of the individual concerned could not of itself, as a matter of law, stand in the way of the exercise of the discretion to impose mandatory treatment and detention for that purpose if necessary.'[437] This subsequently changed, following the 2014 review of the *MHA* (the 'Statutory Review'), which saw the introduction of the capacity criterion (and the definition of decision-making capacity).[438]

3.4.12 The present law is clear. As the Deputy Coroner observed:

> … where a person who is a danger to themselves or others but has an unimpaired capacity to give informed consent and refuses to give consent, may not be detained or treated involuntarily regardless of how irrational that refusal might be in all of the circumstances.[439]

3.4.13 The Deputy Coroner was troubled by this approach and ultimately recommended that, except in relation to electroconvulsive therapy and neurosurgery, the relevant provisions of the *MHA* should be amended, by deleting as a requirement for the imposition of any level of ITO or CTO that the person in question has impaired decision-making capacity relating to appropriate treatment of the person's mental illness.[440] The Deputy Coroner explained:

> The additional element relating to decision-making capacity now applies across the board in South Australia in relation to ITOs of all levels and even to CTOs of both levels. And that is so regardless of whether the order is imposed by a general practitioner working under the pressures of a rural Emergency Department or is imposed within the relative comfort of SACAT in both its original and review jurisdictions. No account is taken of the differing circumstances in which the

[434] *Inquest into the Death of Theo Nikolas Papageorgiou* (2021) 09/2020 (0176/2016) SACC (Schapel, Deputy State Coroner) 13.

[435] Ibid 13, 95 [14.12].

[436] SALRI reiterates its condolences to the Papageorgiou family and thanks Mr and Mrs Papageorgiou for their contribution to this reference.

[437] *Inquest into the Death of Theo Nikolas Papageorgiou* (2021) 09/2020 (0176/2016) SACC (Schapel, Deputy State Coroner) 94 [14.10]. The Deputy Coroner was not supportive of such a requirement. See also: 'This circumstance would hardly be surprising. One would think that a person who has a mental illness that requires treatment for that person's own protection from harm or for the protection of others from harm might frequently have impaired decision-making capacity relating to, and have uncertain insight into, the appropriate treatment for their mental illness': 94 [14.9]. 'If a person has a mental illness that involves a need for the person to undergo treatment for the person's own protection from harm or for the protection of others from harm, then there will be an almost inevitable impact upon the person's decision-making capacity relating to the appropriate treatment for the person's mental illness. Therefore, the question that would need to be posed is why is there a need for specific consideration to be given to that capacity? What the relevant provision in the *Mental Health Act 2009* (SA) now seems to be suggesting is that where a person has a mental illness and that because of the mental illness the person requires treatment for that person's own protection from harm or for the protection of others from harm, and there is no less restrictive means other than an ITO of ensuring appropriate treatment of the person's illness, all of that counts for nought if the person despite that mental illness and despite its potentially harmful consequences has unimpaired decision-making capacity relating to their appropriate treatment. So if that person elected not to undergo treatment, there is nothing that can be done for that person and that is so however unreasonable the refusal to undergo treatment either in a detained environment or in any other environment might be, and regardless of the danger that the person might present to him or herself or to somebody else. Even a community treatment order would not be lawful given that the imposition of such an order requires satisfaction of the same criteria including impaired decision-making capacity': 102–3 [14.26].

[438] Ibid 94–8.

[439] Ibid 105 [14.29].

[440] Ibid 116 Recommendation 4.

> imposition of an ITO or a CTO needs to be considered. Indeed, perhaps the most important decision that can be made, being the initial deprivation of the person's liberty when a level 1 ITO is imposed in the first instance, is frequently made by the person least equipped to make it. The issue of capacity is an element that is apparently troubling sections of the psychiatric community and is liable to defeat the making of an ITO in cases where an ITO is not only appropriate but plainly essential for the person's own protection from harm or for the protection of the general community from harm. It is an element that effectively reduces a consideration of what is in the best interests of the patient with a mental illness to a matter of irrelevance… it must be emphasised that the *MHA* not only deals with the treatment and detention of persons who are at risk of self-harm, but also deals with the treatment and detention of persons who are at risk of inflicting harm on the community. The *MHA* has an objective not only to protect individuals who have a mental illness from harm, but also an objective to protect the general community from harm from those individuals. A provision that enables a person with a mental illness to avoid treatment, either as a detained inpatient or in the community, and to do so in circumstances where they present as a danger to the public, simply because that person is perceived to have the capacity to make a decision to avoid treatment would clearly be incompatible with and defeat that objective. And it is not difficult to think of such circumstances that would not be readily amenable to police intervention. I intend making a recommendation in these findings that the requirements within the *MHA 2009* relating to a requirement for impaired decision-making capacity be deleted except as they relate to ECT and neurosurgery.[441]

3.4.14 It is also notable that this requirement was only introduced to the *MHA* in 2017.[442] Impaired decision-making capacity as a threshold criterion to imposing involuntary treatment orders was introduced in South Australia in June 2017, following a recommendation of the Chief Psychiatrist.[443] In making this recommendation, the Chief Psychiatrist stated:

> 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.[444]

3.4.15 In relation to the utility and operation of the capacity criterion, lessons can be drawn from the decisions in *PBU & NJE* and *TSC*. Both provide valuable clarity with respect to the operation of the impaired decision-making capacity criterion required for treatment orders. In both cases, the consumers disagreed with their diagnosis. In the Victorian case of *PBU & NJE*,[445] PBU and NJE did not accept, believe or carry any insight into their diagnosis of schizophrenia. Similarly, in *TSC*, the applicant accepted his diagnosis of post-traumatic stress disorder but did not accept his primary diagnosis of schizophrenia.

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[441] *Inquest into the Death of Theo Nikolas Papageorgiou* (2021) 09/2020 (0176/2016) SACC (Schapel, Deputy State Coroner) 106–7 [14.31]–[14.32].

[442] *Mental Health (Review) Amendment Act 2016* (SA).

[443] Ibid ss 13(3), 16(2), 17(3), 21(2), 25(2); Office of the Chief Psychiatrist, *The Review of the Mental Health Act 2009 - A Report by the Chief Psychiatrist of South Australia* (SA Health, 23 May 2014) 50.

[444] Office of the Chief Psychiatrist, *The Review of the Mental Health Act 2009 - A Report by the Chief Psychiatrist of South Australia* (SA Health, 23 May 2014) 7. The inclusion of impaired decision-making capacity as a threshold criterion for imposing involuntary treatment also aligns the *Mental Health Act 2009* (SA) with well-established common law principles regarding the rights of autonomous adults to make informed decisions. '[An] adult patient who ... *Suffers from no mental incapacity* has an absolute right to choose whether to consent to medical treatment ... It exists notwithstanding that the reasons for making the choice are rational, irrational, unknown or even non-existent': *Re T (Adult)* [1992] 4 All ER 649 [3] (Lord Donaldson).

[445] *PBU & NJE v Mental Health Tribunal* [2018] VSC 564.

3.4.16 Three distinctions between *PBU & NJE* and *TSC* must be raised at the outset:

- The legislative framework (*Mental Health Acts*) between South Australia and Victoria are similar, but not identical;[446]
- Victoria must also consider compatibility with the *Charter of Human Rights and Responsibilities Act 2006* (Vic). South Australia does not have a Charter of Human Rights;[447] and
- In light of the decision-specific nature of decision-making capacity, the type of treatment is relevant. *PBU & NJE* concerned electroconvulsive therapy, while *TSC* concerned depot injections of a psychiatric medication.

3.4.17 In *PBU & NJE v Mental Health Tribunal*,[448] Bell J also held that the requirements under the Victorian *MHA* (similar, though not identical to the South Australian *MHA)* to establish capacity are relatively low.

3.4.18 Despite these subtle differences, some key points can be extracted. First, insight is not solely determinative of impaired decision-making capacity.[449] However, it is one relevant factor to consider in the assessment of capacity.[450] Bell J held '[s]o may it be accepted that lack of belief of insight in respect of a mental illness or need for treatment may be capable of supporting a finding of incapacity. The question is whether it does.'[451] Secondly, the capacity to 'understand' information and a capacity to 'use' information overlap, indicating that the test for capacity does not solely rely on cognitive ability.[452] The South Australian Court of Appeal has held:

> It must be accepted that a conclusion that a person does not understand some piece of information relating to a decision about health care does not necessarily mean that the person is incapable of understanding or using it. However, the totality of the evidence may well support that further conclusion.[453]

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[446] *PBU & NJE v Mental Health Tribunal* [2018] VSC 564 [23].

[447] Ibid [33].

[448] *PBU & NJE v Mental Health Tribunal* [2018] VSC 564. 'A capacity test applying to people with mental disability is plain-bread discriminatory on that ground if the standard of functioning required of those persons is greater than the relatively low standard required of people generally. As we have seen, the general capacity standard of the common law requires only that the person, whether mentally disabled or not, is able to understand the general nature, purpose and effect of the medical treatment, transaction or proceeding in question. The capacity test must be applied in a non-discriminatory manner so as to ensure that people with mental illness are not deprived of their equal right to exercise legal capacity upon the basis of contestable value-judgments relating to their illness, decisions or behaviour, rather than upon the basis of the neutral application of the statutory criteria (s 68(2)(c)). In short, the test is not to be applied so as to produce social conformity at the expense of personal autonomy. The threshold of capacity in s 68(1)(a)–(d) is relatively low and requires only that the person understands and is able to remember and use or weigh the relevant information and communicate a decision in terms of the general nature, purpose and effect of the treatment. The threshold is not that the person understands the information sufficiently to make a rational or well-considered decision, is able make such a decision or has actually done so. The person does not need to have an understanding and possess those abilities in terms of the actual details of the proposed treatment but only the salient features': at [178], [206].

[449] Ibid [194].

[450] Ibid.

[451] Ibid [198].

[452] *TSC v Department for Health and Wellbeing* [2021] SASCA 93 [57].

[453] Ibid.

3.4.19 Again, the subtle nuances in the relevant statutory provisions must be considered. In South Australia, impaired decision-making capacity with respect to a particular decision requires that a person be incapable of understanding relevant information. In contrast, the Victorian provision reflects a 'positive framework', whereby a person has capacity to provide informed consent if they understand relevant information. The focus on whether a person is 'able' to do so differs from South Australia, which reflects a greater focus on a capacity to understand information.[454]

3.4.20 The Court further emphasised that the assessment of capacity must be holistic, taking into account the 'evidential background.'[455] In *TSC*, it was found that the applicant's lack of understanding relating to the seriousness of his illness, failure to accept his diagnosis and lack of ability to comprehend the likely consequences of the treatment regime cannot be considered in a vacuum.[456] The court found a lack of comprehension as to the likely consequences of a depot medication cannot be separated from the applicant's inability to appreciate his condition.[457] As such, the Court held:

> The applicant was unable to identify the benefits of the depot injections. He identified only one detriment, in that the injections cause him pain.
>
> When read together, these integrated conclusions of the Tribunal demonstrate a failure by the applicant to understand the nature and quality of his condition which translates to an inability to make judgments as to the appropriate treatment. As the Tribunal then concluded:
>
> > In our view, [the applicant's] psychotic condition has clouded his judgement and we consider that [his] lack of insight amounts to a lack of decision-making capacity with respect to appropriate treatment for his mental health condition.
>
> The evidence supported this conclusion of incapacity with respect to appropriate treatment for the applicant's mental health condition. The conclusion does not rely on impermissible inferences.[458]

3.4.21 The decision in *TSC* indicates capacity assessments must be undertaken thoroughly, considering relevant collateral information. It also highlights the intersection between clinical capacity, as assessed by a qualified clinician, and legal capacity.

3.4.22 Both *PBU & NJE* and *TSC* reflect the importance of safeguarding the decision-making autonomy of an individual. It also reinforces the notion that a person has the right to make an unwise decision, as the operation of the criterion for treatment orders does not enforce a 'best interests' test. The removal of this criterion would likely diminish the evidentiary threshold required to enforce a treatment order.

3.4.23 SALRI has considered the common law positions as demonstrated above. SALRI also acknowledges the validity of the Deputy Coroner's findings and views in relation to the capacity criterion in the *MHA*. However, following SALRI's extensive consultation with a wide variety of parties, including medical and health practitioners, consumers and NGOs, there was overwhelming support for the retention of this criterion.[459] This approach is seen as reflecting contemporary

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[454] *TSC v Department for Health and Wellbeing* [2021] SASCA 93 [25]–[26].

[455] Ibid [59].

[456] Ibid [58]–[63].

[457] Ibid [61].

[458] Ibid [61]–[63].

[459] There was a dissenting view that to insist upon decision making incapacity as a prerequisite to enforced treatment under the *Mental Health Act 2009* (SA) seems to be taking the consumer's autonomy too far and, consistent as

understanding and human rights principles and is essential to retaining the consumer's autonomy.[460] Consultation also indicated the critical role of this factor in providing an additional safeguard for consumers, while enforcing a degree of accountability upon the clinician initiating the treatment order.

3.4.24 SALRI has therefore recommended retention of impaired decision-making capacity as one of the criterions for the imposition of a CTO or ITO.[461]

3.4.25 However, this does not mean that this sensitive issue cannot benefit from enhanced clarity. As the Rural and Remote Mental Health Service cogently pointed out to SALRI in consultation:

> The findings of the Coroner's inquest into the death of Theo Papageorgiou recommend that the 'impaired decision making capacity' criterion for the making of treatment orders should be removed altogether, as it is too vague, is in opposition to the other criteria and often leads to confusion and delayed clinical decision making by General Practitioners and psychiatrists. This recommendation is of particular weight in country settings, where medical officer isolation and infrequency of making treatment orders make this criterion particularly perplexing and time-consuming. While the RRMHS does not support the removal of the criterion, it does support rewording the criterion so that it is better understood by all parties (without restricting clinical decision making or the capacity to review those decisions) and so that it cannot countermand the other three criteria. In addition to rewording the criterion itself, a Chief Psychiatrist factsheet should be produced to provide straightforward guidance about it – lengthy descriptions and/or definitions should not be in legislation.

Capacity Assessment, Guidelines and Toolkits

3.4.26 In SALRI's recent reviews of the *Powers of Attorney and Agency Acy 1984* (SA) [462] and *Ageing and Adult Safeguarding Act 1995* (SA),[463] the utility of publishing guidelines and/or toolkits to assist in understanding the definition and assessment of decision-making capacity were discussed.

3.4.27 Firstly, consideration must be given to the appropriate department or agency tasked with publishing such a resource. The importance of consultation with relevant stakeholders, such as consumer groups, carers, the Royal Australian and New Zealand College of Psychiatrists SA Branch ('RANZCP') and health practitioners, must also be a paramount consideration.

3.4.28 The flexibility of a toolkit or guidelines relating to decision-making capacity enables each decision-making domain to be addressed, highlighting the decision-specific nature of capacity. For example, a Toolkit or Guidelines could be structured according to the type/context of the decision,

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raised by the Deputy Coroner, in circumstances disclosing a real threat to life or serious harm, a more interventionist approach may be justified. This approach was raised in discussion with members of the Law Commission of England and Wales. However, the Deputy Coroner's recommendation to remove impaired decision-making as a ground for involuntary treatment under the *Mental Health Act 2009* (SA) received no real support in SALRI's consultation.

[460] See SALRI Recommendation 15.

[461] See SALRI Recommendation 15.

[462] Sylvia Villios et al, *Valuable Instrument or the Single Most Abused Legal Document in our Judicial System? A Review of the Role and Operation of Powers of Enduring Attorney in South Australia* (South Australian Law Reform Institute, Adelaide, 2020) 151–6, 173; David Plater et al, *'Autonomy and Safeguarding are not Mutually Inconsistent': A Review of the Operation of the Ageing and Adult Safeguarding Act 1995 (SA)* (South Australian Law Reform Institute, 2022) 167–176.

[463] Sylvia Villios et al, *Valuable Instrument or the Single Most Abused Legal Document in our Judicial System? A Review of the Role and Operation of Powers of Enduring Attorney in South Australia* (South Australian Law Reform Institute, Adelaide, 2020) 151–156, 173; David Plater et al, *'Autonomy and Safeguarding are not Mutually Inconsistent': A Review of the Operation of the Ageing and Adult Safeguarding Act 1995 (SA)* (South Australian Law Reform Institute, 2022) 167–178 [6.6.1]–[6.9.7], rec 21–4.

such as finances, guardianship, mental health, medical and lifestyle or accommodation. This further emphasises the need to consult with relevant stakeholders to ensure the nuances associated with the understanding and assessment of decision-making capacity are properly conveyed.

3.4.29 A toolkit or guidelines may also be a rights-based instrument, offering a means to promote rights, such as autonomy and self-determination. Attendees at the Disability Advocacy Roundtable discussion all agreed that South Australia should publish a toolkit similar to those in other jurisdictions, as it can be unclear on how to assess capacity. Attendees noted the toolkit must:

- Provide information in an accessible way (such as having an Easy Read option);
- Contain a list of what constitutes decision-making capacity;
- Clarify that if the person makes a decision that would be objectively 'wrong' or different to the clinician, it does not mean they lack decision-making capacity;
- Clarify a person's rights; and
- Include vignettes, as these are important facilitators of supported decision-making.[464]

3.4.30 SALRI considers that the objects and principles set out in Part 2 of the *ACD Act*, reflect best practice in capacity assessment. Importantly, these principles promote a supported decision-making approach, ensuring that the adult is empowered to continue to make decisions (with support) for as long as possible, including periods of fluctuating capacity.[465]

3.4.31 Establishing toolkits or guidelines to inform and assist capacity assessment has been useful throughout numerous Australian jurisdictions.

3.4.32 For instance, in South Australia, the Law Society of South Australia has produced Client Capacity Guidelines ('LSSA Guidelines').[466] Although these LSSA Guidelines were devised for use by a legal practitioner, they advocate for and promote the same principles as in the *MHA*. The LSSA Guidelines also note:

> A 'decision specific' approach also recognises that decision making includes a capacity to identify, understand and retain information relevant to:
>
> (a) contemplated decisions, including the implications of any such decision;
> (b) use of that information for the purpose of making a decision; and
> (c) weighing up information to balance risks and needs.[467]

3.4.33 In the context of the decision-making capacity of an adult, the use of information and guidelines relating to 'appropriate' treatment, is particularly relevant. Therefore, to gain informed consent, the relevant party should exercise evaluative judgment in using the relevant information and considering the potential consequences of the available options. This was reinforced by the South Australian Court of Appeal in *TSC*.

3.4.34 In other Australian jurisdictions, there are various consistencies, including the presumption of capacity, the preservation of autonomy, the utility of capacity assessments undertaken

[464] This was also supported by other practitioners with expertise in older person's mental health.

[465] See also New South Wales Law Reform Commission, *Review of the Guardianship Act 1987* (Report No 145, May 2018) 19–21 [3.25]–[3.32].

[466] Law Society of South Australia, *Client Capacity – Statement of Principles with Guidelines* (21 May 2021).

[467] Ibid 11.

by medical or health practitioners and the identification of guiding capacity principles.[468] Of these, the NSW Capacity Toolkit and the Queensland Capacity Guidelines will be discussed.

New South Wales Capacity Toolkit

3.4.35 The most established resource is the Capacity Toolkit provided by the NSW Attorney General's Department in 2008 ('NSW Toolkit'). This resource was designed to be used by any person, such as a legal practitioner, an advocate, family member or friend or a health professional when called upon to assess the capacity of an individual.[469]

3.4.36 The NSW Toolkit notes that a capacity assessment should be considered when a specific 'trigger' is identified.[470] These 'triggers' serve as potential indicia of incapacity, and they include, but are not limited to:

- obvious memory issues;
- a loss of language ability (for example, word finding difficulties or aphasia caused by stroke); and
- persistent confusion or changes in personality.[471]

3.4.37 In completing an assessment, the Toolkit informs users of some important considerations. For instance, definitions of 'support' in decision-making, 'coercion', 'influence' and 'autonomy' may be informed by values, norms, culture, religion and language. Notably, persons in CALD [472] communities may have unique requirements such as an interpreter, and the assessment must be adapted to acknowledge different cultural perceptions of decision-making and decision-making process.[473] Further, the NSW Toolkit encourages the use of open-ended questions.[474] These considerations are not unique to the NSW Toolkit. The need to develop culturally appropriate tools for the assessment of capacity has been previously raised by SALRI.[475] This remains an area requiring further consideration.[476]

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[468] See further David Plater et al, *'Autonomy and Safeguarding are not Mutually Inconsistent': A Review of the Operation of the Ageing and Adult Safeguarding Act 1995 (SA)* (South Australian Law Reform Institute, 2022) 167–178 [6.6.1]–[6.9.7], rec 21–24.

[469] Communities and Justice, *Capacity Toolkit* (2008) Government of NSW <https://www.justice.nsw.gov.au/diversityservices/Pages/divserv/ds_capacity_tool/ds_capacity_tool.aspx>.

[470] Ibid 50.

[471] Ibid 50–1.

[472] Culturally and Linguistically Diverse ('CALD').

[473] Communities and Justice, *Capacity Toolkit* (2008) Government of NSW <https://www.justice.nsw.gov.au/diversityservices/Pages/divserv/ds_capacity_tool/ds_capacity_tool.aspx> 64.

[474] Ibid 68.

[475] Sylvia Villios et al, *Valuable Instrument or the Single Most Abused Legal Document in our Judicial System? A Review of the Role and Operation of Powers of Enduring Attorney in South Australia* (South Australian Law Reform Institute, 2020) Part 9 Vulnerable Populations, in particular 382–3 [9.1.52]–[9.1.63] and 387–9 [9.1.76] – [9.1.81].

[476] Dr Tracey Westerman, a clinical psychologist, is widely known for her work in Aboriginal mental health, cultural competency and suicide prevention. Dr Westerman has developed culturally appropriate assessment tools, which have subsequently been statistically, scientifically and culturally validated for use by Indigenous Psychological Services. See Indigenous Psychological Services, *Products and Tests* (2022) <https://indigenouspsychservices.com.au/products-tests/>.

3.4.38 Finally, the NSW Toolkit supports the input of medical and other health practitioners to provide additional assessments or second opinions. It is noted that a general practitioner, psychiatrist, geriatrician, neuropsychologist or clinical psychologist could undertake such an assessment.[477]

3.4.39 The NSW Toolkit provides a sound starting point[478] and seeks to clarify uncertainties relating to decision-making capacity by presenting accessible information in simple language. A Toolkit which offers assistance in a variety of specific decision-making contexts, such as health, mental health, finance and lifestyle could be particularly beneficial. Alternatively, a mental health specific toolkit or guideline may be introduced.

Queensland Capacity Assessment Guidelines

3.4.40 The Queensland Capacity Assessment Guidelines ('Qld Guidelines') outline the guiding principles when assessing capacity, the applicable legal tests, offer practical guidance and provide relevant checklists for capacity assessment depending on the type of decision.[479]

3.4.41 The Qld Guidelines were framed in the context of Queensland's guardianship laws.[480] Much like South Australia's LSSA Guidelines, the underlying principles of capacity and its assessment are applicable to all decision-making. The Qld Guidelines, cite two tests for capacity based on the type of decision:[481]

1. the general test of capacity, which is to be applied when assessing capacity for decisions about personal, health or financial matters; and
2. the test for making an enduring document, which is to be applied when assessing capacity for making an advance health directive or enduring power of attorney.

3.4.42 In relation to the general capacity test, personal matters, broadly relate to someone's care or welfare. The general capacity test sets out three criteria – understanding the nature and effect of the specific decision, making a decision freely and voluntarily and communicating the decision.[482]

3.4.43 The Qld Guidelines offer both an educational and practical resource for any party who may undertake a capacity assessment. It can be used by general members of the community or health practitioners. It may also serve as a tool for a health professional to use when engaging with a person whose capacity is questioned.

The Importance of Capacity Assessments

3.4.44 The assessment of capacity has transformed into an inter-disciplinary exercise requiring collaboration. Nevertheless, the role and opinion of the medical/health professional forms a significant part of the assessment. Therefore, modern society's values, along with medical/legal knowledge and

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[477] Indigenous Psychological Services, *Products and Tests* (2022) <https://indigenouspsychservices.com.au/products-tests/> 56.

[478] See also, for example, British Medical Association and the Law Society of England, *Assessment of Mental Capacity: Guidance for Doctors and Lawyers* (BMJ Books, 2nd ed, 2004); Law Society of South Australia, *Client Capacity – Statement of Principles with Guidelines* (21 May 2021).

[479] Queensland Government, *Queensland Capacity Assessment Guidelines 2020* (2020).

[480] *Guardian and Administration Act 2000* (Qld).

[481] Queensland Government, *Queensland Capacity Assessment Guidelines 2020* (2020) 15.

[482] Ibid.

practice, must inform the test for capacity and its assessment.[483] 'The law of mental capacity is incomplete if it does not properly incorporate medical expertise and practice'.[484]

3.4.45 Assessment of capacity will differ according to the specific profession involved. In a medical or health context, capacity is assessed through the application of testing materials, functional competence assessments, clinical interviews and more. In this context, the importance of the human rights approach to capacity assessment[485] must not be diminished. Advancements in capacity assessment promote autonomy and the significance attached to a determination of incapacity. A capacity test which upholds the individual's rights must also recognise the modern advancements in medicine and neuroscience.

3.4.46 The nature of assessment and diagnosis has changed and improved over time. As explained by Kelly Purser, modern capacity assessments are multi-disciplinary, as legal practitioners rely on medical and/or health input and clinical capacity assessments.[486] This is deemed necessary because 'conditions, such as dementia, are increasing and each profession has their own specific skill set, neither of which, independently, is enough to satisfactorily assess complex cases where legal capacity is in question'.[487] This supports a shift away from the need to reconcile legal and medical roles. Rather, a symbiotic relationship, whereby the legal and medical roles are defined and can work together to ensure capacity is assessed properly, can be supported.

3.4.47 A further challenge identified by Purser is the potentially detrimental effect of professional misunderstandings pertaining to distinct legal and medical roles.[488] This misunderstanding extends to the role of each profession, including distinct medical specialties and the specific assessment undertaken.[489] It was emphasised:

> This misunderstanding is further amplified by miscommunication between the professions, both of which can have a negative impact on the assessment, and the autonomy of the individual who is being assessed. This is concerning, especially in practice where such a misinterpretation can have the greatest impact.[490]

3.4.48 There have been major advances in medical understanding of psychiatry, psychology and other impairments which may lead to incapacity.[491] The need for clinical capacity assessments is

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[483] Sylvia Villios et al, *Valuable Instrument or the Single Most Abused Legal Document in our Judicial System? A Review of the Role and Operation of Powers of Enduring Attorney in South Australia* (South Australian Law Reform Institute, Adelaide, 2020) 148 [4.4.97].

[484] Kenneth Shulman et al, '*Banks v Goodfellow* (1870): Time to Update the Test for Testamentary Capacity' (2017) 95(1) *Canadian Bar Review* 251, 253, quoting Arthur Fish, 'Cognitive Neuroscience and the Solicitor's Approach to Mental Incapacity' (2010) in The Law Society of Upper Canada (eds), *Special Lectures 2010: A Medical-Legal Approach to Estate Planning and Decision Making for Older Clients* (Toronto: Irwin Law, 2011) 133.

[485] See further David Plater et al, *'Autonomy and Safeguarding are not Mutually Inconsistent': A Review of the Operation of the Ageing and Adult Safeguarding Act 1995* (SA) (South Australian Law Reform Institute, 2022) 170–1 [6.7.7]–[6.7.12]

[486] Kelly Purser, 'Assessing Testamentary Capacity in the 21st Century: Is Banks v Goodfellow Still Relevant?' (2015) 38(3) *University of New South Wales Law Journal* 854, 855.

[487] Ibid.

[488] Ibid.

[489] Ibid.

[490] Ibid.

[491] See Carmelle Peisah, 'Reflections on Changes in Defining Testamentary Capacity' (2005) 17(4) *International Psychogeriatrics* 709; Kenneth Shulman et al, '*Banks v Goodfellow* (1870): Time to Update the Test for Testamentary Capacity' (2017) 95(1) *Canadian Bar Review* 251, 261. The relevance of dementia to the test for capacity 'is especially significant as dementia is one of the main mentally disabling conditions confronting modern society with the

arguably more important in circumstances where intervention may be exercised to override the choice of an adult who has decision-making capacity.

A Human Rights-Based Approach to Capacity Assessment

3.4.49 The determination that an individual does not have mental capacity has 'profound and highly personal impacts' on a person's life, and the law relating to capacity assessment should ensure that a consumer's dignity and freedoms are upheld to the fullest extent.[492] There is a fine line between protecting potentially vulnerable individuals and an unduly restricting the person's ability to autonomously choose.[493]

3.4.50 A finding of incapacity is a major event that undermines an individual's autonomy. As a result, the law presumes an individual is capable of making decisions based on their will and preferences. This has been described as 'long cherished' right, and where capacity is contested at law, the burden of proof lies with the party asserting their incapacity.[494] This concept of autonomy underpins the human rights-based approach to assessment of capacity. Tom Beauchamp and James Childress observe that '[t]o respect autonomous agents is to acknowledge their right to hold views, to make choices, and to take actions based on their values and beliefs'.[495]

3.4.51 Human rights law provides that all individuals are equal before the law and all individuals, regardless of age, race, capacity or incapacity, are to be treated equally. In contemporary society, liberalism is reflected through individual freedom and self-governance.[496]

3.4.52 Article 12(2) of the UN *Convention on the Rights of Persons with Disabilities* ('*CRPD*') notes that 'persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life'.[497] This is underpinned by the notions of individual autonomy and freedom to make choices.[498] The mere existence of a disability or impairment does not translate to legal incapacity.[499] As the Committee on the Rights of Persons with Disabilities has observed, '[l]egal capacity is indispensable for the exercise of civil, political, economic, social and cultural rights'.[500] Therefore, the removal of legal capacity is seen to challenge an individual's fundamental human rights.

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incidences of dementia expected to increase fourfold by 2050': Kelly Purser, 'Assessing Testamentary Capacity in the 21st Century: Is *Banks v Goodfellow* Still Relevant?' (2015) 38(3) *University of New South Wales Law Journal* 854.

[492] Michael Kirby, 'Book Review: Who Can Decide? The Six Step Capacity Assessment Process' (2003) 2 *Elder Law Review* 10.

[493] Grant Gillett, 'Taking the Moral Measure of Mental Capacity: Interpretation and Implementation' (2017) 24(4) *Journal of Law and Medicine* 767, 768.

[494] *Masterman-Lister v Brutton & Co* [2003] 3 All ER 162, 169.

[495] Tom Beauchamp and James Childress, *Principles of Biomedical Ethics* (Oxford University Press, 7th ed, 2013) 106.

[496] Nina Kohn, 'A Civil Rights Approach to Elder Law' in Israel Doron and Ann Soden (eds), *Beyond Elder Law: New Directions in Law and Ageing* (Springer, 2010) 19, 21.

[497] *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007, 2515 UNTS 3 (entered into force 3 May 2008) art 12(2).

[498] Committee on the Rights of Persons with Disabilities, *General Comment No 1Article 12: Equal Recognition Before The Law*, 11th sess, UN Doc CRPD/C/GC/1 (11 April 2014).

[499] See generally Anna Arstein-Kerslake, *Restoring Voice to People with Cognitive Disabilities* (Cambridge University Press, 2017). Parties such as Natalie Wade at Equality Lawyers and Maggie Rutjens at the Disability Advocacy and Complaints Service of South Australia Inc and Kaela Dore, a lawyer, told SALRI that all too often in practice, there is a generalised assumption that the presence of an intellectual disability denotes incapacity.

[500] Committee on the Rights of Persons with Disabilities, *General Comment No 1Article 12: Equal Recognition Before The Law*, 11th sess, UN Doc CRPD/C/GC/1 (11 April 2014) 2.

3.4.53 The Committee on the Rights of Persons with Disabilities also distinguished between the concepts of 'legal capacity' and 'mental capacity'. Legal capacity refers to the 'ability to hold rights and duties … and to exercise those rights and duties'.[501] In contrast, mental capacity refers to decision-making ability.[502] The Committee concluded that 'perceived or actual deficits in mental capacity must not be used as justification for denying legal capacity'.[503] These concepts are often conflated. A person who is deemed to have impairment in decision-making ability, secondary to a disability such as a cognitive impairment, is automatically deprived of their legal capacity to make decisions.[504] The Committee further noted two problems associated with the functional test for capacity, which are premised on an understanding of the nature and consequences of a decision. First, as SALRI was reminded in consultation by parties such as Maggie Rutjens of Disability Advocacy and Complaints Service of South Australia Inc, Natalie Wade of Equality Lawyers and Purple Orange and others in the disability sector and community, this test is potentially applied in a discriminatory manner to persons with a disability.[505] This may be underpinned by inherent generalised assumptions regarding the relationship between an impairment and incapacity. Secondly, it relies on the ability of the assessor to understand the 'inner-workings of the human mind'.[506] If this assessment is properly undertaken by qualified practitioners, an accurate determination of capacity can be achieved.

3.4.54 The human rights-based approach highlights the importance of undertaking a capacity assessment consistently and carefully. The diagnosis of a mental illness, cognitive impairment or a neurodegenerative disorder does not necessarily render an individual legally incapacitated. In the absence of adequate and evidence-based capacity assessments, the individual may be unfairly impacted. In applying a human rights lens to the issue of capacity, a finding of incapacity is a significant outcome, particularly in a mental health system, that in principle, emphasises a consumer's autonomy.

Legislative Endorsement of Supported Decision-making

3.4.55 As part of the present review of the *MHA*, SALRI was asked to consider the enumeration of a supported decision-making ('SDM') model into the *MHA*. This is an opportune time to endorse the SDM model, particularly in light of international commentary, the importance of safeguarding rights, upholding decision-making autonomy and personhood.[507] As noted in the United Kingdom's 2018 independent review of its mental health laws:

> [Mental health law] confers powers on the state that do not exist across the rest of health care. These powers are usually exercised when people are at their most vulnerable. Where people are anxious, quite reasonably, that their rights and personal dignity may suffer through the use of those powers, the state is under a heavy obligation both to ensure that they are no greater than necessary and to oversee and regulate their use.[508]

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[501] Committee on the Rights of Persons with Disabilities, *General Comment No 1Article 12: Equal Recognition Before The Law*, 11th sess, UN Doc CRPD/C/GC/1 (11 April 2014) 3.

[502] Ibid.

[503] Ibid.

[504] Ibid.

[505] Ibid 4.

[506] Ibid.

[507] See Renata Kokanovic et al, 'Supported decision-making from the perspectives of mental health service users, family members supporting them and mental health practitioners' (2018) 52(9) *Australian and New Zealand Journal of Psychiatry* 826.

[508] Prof Sir Simon Wessely et al, The independent review of the Mental Health Act: Interim Report (Interim Report, 1 May 2018) 5.

3.4.56 This reinforces the need to ensure measures to promote consumer rights are enhanced under mental health laws. This extends beyond legislative change, requiring change in practice and attitudes concerning mental health, decision-making capacity and autonomy. SDM is merely one example of a means to achieve greater consumer autonomy and accountability of parties involved in treatment decisions.

3.4.57 The principles underpinning a SDM framework are derived from the *CRPD*.

3.4.58 It is imperative that consumer voices and experience guide the design and implementation of SDM in practice. Statutory endorsement of SDM provides much needed legal authority requiring users of the *MHA* to apply this model. However, the translation of this model in practice must be carefully considered to ensure and monitor adherence.

3.4.59 The international landscape of decision-making has shifted from a substitute decision-making, to a SDM paradigm.[509] The Committee on the Rights of Persons with Disabilities described the SDM regime as one which:

> … comprises various support options which give primacy to a person's will and preferences and respect human rights norms. It should provide protection for all rights, including those related to autonomy … and rights related to freedom from abuse and ill-treatment (right to life, right to physical integrity, etc).[510]

3.4.60 SDM is described as a 'less restrictive alternative',[511] as opposed to substitute decision-making. Pursuant to Article 3(1) *CRPD*, '[r]espect for inherent dignity, individual autonomy including the *freedom to make one's own choices*, and independence of persons' is a fundamental principle of the Convention.[512] Further, article 12(3) requires that State Parties take 'appropriate measures to provide access' to supports enabling a person to exercise legal capacity.[513] These measures should promote a person with or without impaired decision-making capacity to exercise autonomy, with any supports required.

3.4.61 Currently, the *MHA* does not explicitly adopt a SDM approach. However, the guiding principles contained under s of the 7 *MHA* are extensive and refer to measures that form part of a SDM approach. For example, the following principles highlight the importance of information sharing, involving the consumer and support persons and the accessibility of such information:

> (i) [consumers] (together with their family or other carers or supporters) should be provided with comprehensive information about their illnesses, any orders that apply to them, their legal rights, the treatments and other services that are to be provided or offered to them and what alternatives are available;

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[509] See Committee on the Rights of Persons with Disabilities, *General Comment No 1Article 12: Equal Recognition Before The Law*, 11th sess, UN Doc CRPD/C/GC/1 (11 April 2014) [3]. For a discussion on supported decision-making, see Sylvia Villios and Olga Pandos, 'A Review of Advance Care Directives and Enduring Powers of Attorney in South Australia: Preserving Autonomy and Preventing Abuse' (2022) 43(1) *Adelaide Law Review* 225, Pt 3C.

[510] Committee on the Rights of Persons with Disabilities, *General Comment No 1Article 12: Equal Recognition Before The Law*, 11th sess, UN Doc CRPD/C/GC/1 (11 April 2014) [29].

[511] See Matthé Scholten et al, 'Combining Supported Decision-Making with Competence Assessment: A Way to Protect Persons with Impaired Decision-Making Capacity against Undue Influence' (2021) 21(11) *The American Journal of Bioethics* 45.

[512] *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007, 2515 UNTS 3 (entered into force 3 May 2008) art 3(1) (emphasis added).

[513] Ibid art 12(3).

(j) information should be provided in a way that ensures as far as practicable that it can be understood by those to whom it is provided.[514]

3.4.62 SALRI agrees that presently there is an opportunity to expand upon the existing guiding principles, and to explicitly adopt SDM as the preferred decision-making approach under the *MHA*.

3.4.63 The translation of SDM in the context of mental health treatment must be considered further to ensure necessary provisions and resources are available to facilitate the operation of this model.[515] SDM is also complemented by the rise in recovery-oriented practice, which advocates for consumer autonomy in all facets of decision-making, including those with risk.

3.4.64 A shift to SDM in South Australia may yield a number of advantages. Evidence indicates consumer involvement leads to a decrease in unnecessary treatment and improvement in clinical outcomes.[516] This does not detract from the need to enforce involuntary treatment under certain circumstances, but it does highlight the complex judgment involved in exercising functions to enforce involuntary treatment. Furthermore, such a shift would provide a moral imperative to promote consumer autonomy in decision-making, better position relevant persons in the mental health care system to actively respect human rights and ensure equal opportunity for consumers.[517]

3.4.65 The impetus to shift from a substitute decision-making paradigm to SDM is evident both nationally and internationally. In their 2017 Report on Mental Capacity and Deprivation of Liberty, the Law Commission United Kingdom noted the role of SDM in enabling a consumer to retain decision-making capacity.[518] Consistent with the *CRPD*, SDM operates on the presumption that all individuals have decision-making capacity and where necessary, some may require supports to exercise this capacity.[519] The introduction of a SDM scheme was said to provide a number of benefits, notably 'greater certainty and transparency for individuals, families, carers, professionals and service providers…'[520] As a result, the Law Commission endorsed the principle observed under the *Mental Capacity Act 2005* (UK), requiring all practicable steps must be taken to assist an individual to make a decision, 'before they are treated as lacking capacity to make that decision.'[521] This is consistent with the approach adopted by Victoria[522] and the ACT.[523]

3.4.66 In practice, SDM can be observed through the work of mental health advocacy services and the use of advance care directives ('ACDs').[524] Soumitra Pathare and Laura Shields describe SDM in mental health in the following terms:

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[514] *Mental Health Act 2009* (SA) ss 7(i)–(j).

[515] In particular, the use of microboards have been raised during SALRI's consultation. Microboards offer one means of practically implementing supported decision-making. Their utility in relation to long-term care of a person, who remains central to all decision-making.

[516] Magenta Simmonds and Patricia Gooding, 'Spot the difference: shared decision-making and supported decision-making in mental health' (2017) 34(4) *Irish Journal of Psychological Medicine* 275.

[517] Ibid.

[518] Law Commission UK, *Mental Capacity and Deprivation of Liberty* (13 March 2017) 167.

[519] Ibid.

[520] Ibid 168.

[521] Ibid.

[522] Reference to 'appropriate supports': *Mental Health and Wellbeing Act 2022* (Vic) ss 6 & 87(2)(e), (3)(b).

[523] See *Mental Health Act 2015* (ACT) ss 8(1)(c), (d).

[524] Soumitra Pathare and Laura Shields, 'Supported decision-making for persons with mental illness: a review' (2012) 34(2) *Public Health Reviews* 1, 276.

> … can consist of organisations, networks, provisions or agreements with the aim of supporting and assisting an individual with a mental illness to make and communicate decisions. In supported decision- making, the individual is always the primary decision maker, but it is acknowledged that autonomy can be communicated in a number of ways, thus provision of support in different forms and intervals can assist in the expression of autonomous decisions.[525]

3.4.67 SDM allows a consumer to retain legal capacity to make decisions, regardless of the level of support required.[526] It may also be associated with the concept of 'shared decision-making', which refers to skills and practices exercised by a clinician in order to engage in a collaborative decision-making process.[527] Whilst nuanced differences may be drawn between each concept, it may be argued they operate in tandem to achieve the same goal – supporting a person to exercise their decision-making capacity.

3.4.68 Shared decision-making, has a particular focus on the interaction between a clinician and consumer. This is particularly relevant for Aboriginal consumers and the inherent need to address barriers in receiving culturally appropriate engagement with a clinician.

3.4.69 With respect to necessary supports, these may take the form of a legal instrument (such as an ACD), a decision aid, a nominated support person, a communication device or measures to facilitate a discussion (preferred location and time of day).

3.4.70 SDM involves access to what have been called 'decision aids'.[528] These aids may convey information about a topic specific to a decision, such as the benefits or risks associated with a psychiatric medication. This should prompt a discussion between the clinician and consumer about the topic and the consumer's wishes and preferences. A systematic review revealed that decision aids increase knowledge, decrease confusion about which decision to make, promotes an informed values-based decision and encourages involvement of the concerned person.[529] The design and use of decision aids must involve consumers. Historically, the ongoing stigma associated with mental illness has been caused by paternalistic systems of care, which involved 'coercion, presumption of lack of insight and … capacity and disempowerment'.[530]

3.4.71 SDM invites support to reach a decision, however, it does not advocate for the removal of decision-making autonomy from a consumer experiencing a mental health challenge.[531] The necessary supports required will be dependent on the consumer. This is consistent with the Office of the Chief Psychiatrist's fact sheet on decision-making capacity, which states:

> If a person is experiencing difficulty making their own decisions, they should be given support to make them, before being assessed as not having decision-making capacity. An assessment of decision-making capacity should assess the capacity a person with mental illness is able to exercise *with support from others*.[532]

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[525] Soumitra Pathare and Laura Shields, 'Supported decision-making for persons with mental illness: a review' (2012) 34(2) *Public Health Reviews* 1, 4.

[526] Ibid.

[527] Ibid.

[528] Ibid.

[529] Ibid.

[530] Ibid 278.

[531] Ibid 279.

[532] Office of the Chief Psychiatrist, *Factsheet Mental Health Act 2009: Decision-making capacity* (16 May 2022) 3.

3.4.72 SALRI's consultation with consumers revealed the need for greater use and recognition of ACDs involving mental health treatment. SALRI acknowledges that ACDs are important instruments in facilitating SDM. This is consistent with the notion that ACDs are a 'practical method for formalising supported decision-making in ways "that take account of varying mental health conditions and the specific institutional contexts in which mental health treatment is provided"'.[533] SALRI also recognises the role of an ACD in restoring the empowerment and self-determination of a consumer. Although the use and operation of ACDs falls outside the scope of SALRI's review, it is imperative that measures are taken to review the ACD scheme to ensure its effectiveness in mental health contexts.

3.4.73 A common criticism about the *MHA* raised in SALRI's consultation was its crisis-oriented focus. There was wide support to shift the focus of the *MHA* to prevention and wellbeing, promoting the positive rights of consumers. An example of this is active engagement of the consumer in decisions relating to their mental illness and treatment. In order to actively promote SDM, legislative endorsement must be coupled with recognition of dignity of risk. SALRI supports the Dignity of Risk principle contained in the *Mental Health and Wellbeing Act 2022* (Vic), which states:

> A person receiving mental health and wellbeing services has the right to take reasonable risks in order to achieve personal growth, self-esteem and overall quality of life. Respecting this right in providing mental health and wellbeing services involves balancing the duty of care owed to all people experiencing mental illness or psychological distress with actions to afford each person the dignity of risk.[534]

3.4.74 The SA Lived Experience Leadership and Advocacy Network ('LELAN') also emphasised in their submission:

> … people living with distress or diagnosed mental illness have the same right to a dignity of risk as any other person, even if decisions may impact their lives unfavourably. People with a mental health diagnosis are allowed to live in a messy house, mismanage their money and eat unhealthy food as is the right of others without a mental health diagnosis.

3.4.75 This principle reinforces the well understood notion that each individual has the right to make mistakes or a decision that may involve risk or an adverse outcome. In the context of mental health, SDM is an important vehicle to empower a consumer to exercise decision-making autonomy.

3.5 Consultation Data Overview

3.5.1 In relation to the definition of 'decision-making capacity', it must be noted that this definition operates when a clinician is determining whether the 'impaired decision-making' criterion is satisfied for a treatment order. As a result, the discussion relating to decision-making capacity will be separated into two distinct issues:

1. The current definition of 'decision-making capacity' under s 5A *MHA*; and
2. The practical operation of this definition in the context of treatment orders, to satisfy the 'impaired decision-making capacity' criterion.

[533] Office of the Chief Psychiatrist, *Factsheet Mental Health Act 2009: Decision-making capacity* (16 May 2022) 3.

[534] *Mental Health and Wellbeing Act 2022* (Vic) s 23.

The Definition of Decision-making Capacity under s 5A MHA

3.5.2 The definition contained within s 5A *MHA* outlines the legal test for decision-making capacity. The way in which a clinician applies this test is reflected by a capacity assessment.

3.5.3 It was emphasised during SALRI's Government Roundtable, that 'legal issues of capacity are quite different from medical questions of capacity' and that 'there are different approaches and tools to assess capacity.'

3.5.4 In their submission to SALRI, the Central Adelaide Local Health Network ('CALHN'):

> … notes the summary paragraph on capacity, including that capacity is decision-specific, a person has the right to make mistakes or choices that others may not agree with, and that even if a person has a mental illness, this does not mean that they cannot make their own decisions. This paragraph sums up the understanding and approach of psychiatrists in the application of the *MHA* and there is no evidence to suggest that there is widespread misinterpretation of the Act in this regard. Therefore, we see no benefit in changing the criteria.

3.5.5 Purple Orange noted the term 'capacity' is widely used across legal and clinical settings, which the disability community already interacts with. This familiarity across disciplines and sectors is a benefit of retaining a consistent definition across the relevant legislation. This was also raised in the Rural and Remote Mental Health Service submission, which highlighted:

> The definitions of impaired decision-making capacity in the *MHA* currently match the definitions in the [*Advance Care Directives Act*] and [*Consent to Medical Treatment and Palliative Care Act*], providing universality and common definitions between the 3 health-related acts contemplating capacity … It might be reasonable to bring the [definition in the *Guardianship and Administration Act*] in line with the other Acts. It is essential that the definitions between acts remain consistent.

3.5.6 SALRI agrees with this view.

3.5.7 Consultation revealed common themes relating to understandings of decision-making capacity. Speech Pathology Australia described it as 'fluid and decision specific, as decision making is a skill that is learned and must continually be extended.' During SALRI's Psychology/Neuropsychology Roundtable, the following principles were identified about decision-making capacity:

- It is time- and decision-specific;
- It is about the ability to make decisions about your care at a particular point in time;
- A clinician cannot and will not assess future decision-making capacity;
- The capacity assessment considers risk management, ethics and potential conflicts;
- A capacity assessment should be undertaken where a trigger is identified, otherwise capacity is presumed; and
- The clinician considers the time of day and medications prior to and during an assessment.

3.5.8 In their submission to SALRI, LELAN emphasised '[r]ecognition that capacity for decision-making will be different for each decision, therefore a determination of capacity is required for each and every decision and in each environment.' The OCP's Lived Experience Advisory Group reiterated that '[d]ecision-making capacity should not be a blanket rule…' and 'reduced capacity should

not apply to the whole of a person, while a person may be considered to lack capacity in one area of their life it does not mean they lack capacity in other areas.' This was also reinforced by Lived Experience Australia, noting 'capacity should not be seen as total and in all things.' These points are also consistent with Purple Orange's submission, which stated 'conceptualisations of "capacity" attest to various levels of capacity, rather than a single differentiation between competent or not competent.'

3.5.9 During SALRI's co-facilitated Focus Group with Aspire Recovery Connection, participants reiterated the need to '[i]mplement and uphold supported decision making, not this "black and white you have capacity or you don't" approach.' Another participant noted the need to '[r]ecognise and respect that people still have capacity to make decisions even when they are really unwell.'

3.5.10 An important facet of the current definition is recognition that decision-making capacity may fluctuate. One Roundtable attendee described capacity as a 'continuum'.

3.5.11 The impact of assumptions extends beyond disability, to persons diagnosed with a mental illness. As raised by Lived Experience Australia:

> All too often, when the diagnosis of mental illness is apparent, service providers make assumptions about the person's capacity that may be unduly influenced by inherent stigmatised or discriminatory views. In our own lived experience research with consumers in SA and nationally, we have heard from many people who have been subject to the *MHA* who have not been listened to, not able to 'reason' with clinicians, even when they have expressed real and rational concerns.

3.5.12 SALRI's consultation with consumers revealed the need to consider the impact of diagnosis, stigmatisation and pre-conceived assumptions in relation to decision-making capacity and its assessment. One consumer described this as '…when you've got the diagnosis, that just overtakes everything. You have no rights anymore, you can be discriminated against…' Aspire Recovery Connection's submission reiterated the 'impact of psychiatric diagnosis' on stigma and discrimination, noting this extends to 'self-stigma and whether a person can feel hopeful for recovery from the pain and suffering they are living with.' Another participant, during LELAN's community consultations highlighted the importance of respecting autonomy and self-determination, expressing '[t]he fundamental values are recognising psychiatric patients' rights to self-determination and autonomy; and needs to be treated with kindness and a recognition that they may be very unwell. I value my rights to self-determination and autonomy over risk-minimisation.'

3.5.13 Similar concerns were raised to SALRI during the Focus Group with Aspire Recovery Connection. Consumers 'felt their knowledge of their own mental and emotional wellbeing and when and how services were needed were largely dismissed and the "system" took over that decision making when they were in a state of an otherwise avoidable crisis.' Similarly, a participant in SALRI's co-facilitated Focus Group with LELAN noted 'some people find comfort in diagnosis', but the stigma and label of one is permanent.

3.5.14 Other submissions also addressed the need for cultural and attitude changes in relation to the treatment of mental illness and efforts to de-stigmatise a diagnosis. In the context of decision-making capacity, this is particularly relevant for assessment. As noted by a YourSAy survey respondent, '[h]aving a lived mental illness does not make you incapable of making decisions in regards to your life.'

3.5.15 Consistent with the guiding principles for capacity, various characteristics of a person cannot be sole determinants. For example, Speech Pathology Australia noted 'communication ability

alone does not determine capacity.' LELAN noted 'a more sophisticated understanding around capacity and the fact that if someone is exhibiting unusual thoughts, feelings and beliefs it does not mean they have zero capacity.' A point of contention and concern was raised by Aspire Recovery Connection in their submission to SALRI:

> ARC is extremely concerned that the current legislation allows for a person's autonomy to be taken away, simply because they don't agree with the diagnosis they've been given or the fact that their 'symptoms' need to be medically managed. Disagreement with a diagnostic approach to make sense of a person's distress or unusual thoughts, experiences and behaviours should never be a reason to take away a person's right to choose how, if, and when they access medical treatment. Nor should their disagreement with a psychiatrist's treatment recommendations be a reason to take away the right to choose whether to engage in this treatment or not, especially in circumstances when the person does not pose a significant risk of harm to themselves or others.

3.5.16 Neami National raised the complex nature of capacity assessment in cases where a consumer may lack insight into their mental illness, reject a diagnosis or information provided to them. These circumstances are often encountered during the process of invoking a treatment order, satisfying the 'impaired decision-making capacity' criterion. As a result, Neami National supported greater clarity in assessing capacity under these circumstances 'in a manner that balances clinician's legal safety and the guest's right to dignity of risk.'

3.5.17 This refers to issues raised in the cases of *PBU & NJE* and *TSC*. This highlights the nuance associated with capacity assessment, disagreement with diagnosis and understanding of a diagnosis and treatment. The role of the clinician is especially critical at this point, to ensure an assessment is undertaken competently. Importantly, the presence of a mental illness, cognitive impairment or disability does not mean an individual lacks decision-making capacity. Purple Orange reiterated this in the context of disability, noting assumptions regarding the presence of a disability cannot translate to a determination of impaired decision-making capacity.

3.5.18 There were varying views relating to the definition of 'decision-making capacity' under s 5A of the *MHA* by clinicians and members of community. The OCP noted they receive many enquiries by clinicians seeking guidance on the assessment of capacity and complaints from consumers regarding the outcome of the assessment. Despite this, a common theme raised during SALRI's Roundtable discussions and private meetings with mental health practitioners revealed support for the current definition to be retained.

3.5.19 At SALRI's Disability Advocacy Roundtable, all attendees agreed the current definition should be retained. However, consideration could be given to recognising culture, language differences and generational challenges.

3.5.20 The Rural and Remote Mental Health Service noted the current definition:

> … provides a balance between restrictive detail and permissive vagueness (from a legislative perspective). This balance allows clinicians to consider impaired decision-making capacity, and possible actions relating to it, across the continuum of unique circumstances of every patient and allows patients and/or their advocates to argue for their capacity. However, while the current wording is appropriately flexible from a legislative perspective (for both use and review), it is not always readily understandable by clinicians, patients and families from a clinical, laymen or emergency situation perspective.
>
> Very strict or detailed definitions would remove options for clinicians for the safe treatment and management of people with impaired decision-making capacity AND would reduce the ability of

> consumers and/or advocates to argue against a particular finding of impairment (which has already met exacting requirements). RRMHS does not support a strict or overly detailed definition.

3.5.21 SALRI recognises and reinforces the need for a clear definition of decision-making capacity, as aptly raised by Lived Experience Australia, '[t]he potential to take away patients rights … means that great care should be taken in the wording of the Act, given its legal basis.' They further submitted that the current wording of s 5A of the *MHA* is sufficient. However, regard to the fluctuating nature of capacity and the impact of insight into mental illness could be considered further. In their submission to SALRI, the Hon Tammy Franks MLC also supported clarification relating to the fluctuating nature of capacity and asked how this situation would be managed in the context of enforcing a treatment order. They also raised this in the context of article 12 of the *CRPD*.

3.5.22 The Office of the Public Advocate ('OPA') submitted:

> The current definition of impaired decision-making capacity in the *MHA* is consistent that in some other South Australian laws, including the *Advance Care Directives Act 2013* and the *Consent to Medical Treatment and Palliative Care Act 1995*. The *MHA* importantly includes a presumption of decision-making capacity unless there is evidence to the contrary. The OPA notes that the current definition of impaired decision-making capacity in the *MHA* better reflects contemporary values and expectations when compared, for example, to the definition of 'mental incapacity' in the *Guardianship and Administration Act 1993* (*GAA*). The *GAA* does not expressly refer to a presumption of capacity nor does it acknowledge that capacity can be decision-specific. The concepts reflected in the current *MHA* definition, if properly and consistently applied, go a long way in promoting the rights of people with impaired decision-making capacity to make their own decisions in line with Article 12 of the UN *CRPD*.

3.5.23 OPA further supported amendments to strengthen the current definition, by reinforcing dignity of risk and supported decision-making. However, such amendments would require uniformity across all statutes dealing with decision-making capacity. The definition of 'mental incapacity' was raised to SALRI throughout consultations, with many noting it is an inappropriate definition and requires review to align the definition with that in other legislation.[535]

3.5.24 The Australian Psychological Society ('APS') suggested 'extra-legislative guidance' could accompany the current definition, namely the endorsement of supported decision-making, as observed in Victoria and the ACT. This was said to 'balance the highly individualistic and cognitive focus of the statutory criteria.' SALRI agrees with this view, whereby the definition recognises assessment of decision-making capacity should assess the capacity a person with mental illness is able to exercise *with support from others*. This is currently reflected in the OCP's fact sheet on decision-making capacity.[536] The APS also endorsed the approach taken in the *Mental Health and Wellbeing Act 2022* (Vic), which acknowledges decision-making capacity may be present if an individual, as far as is reasonable, is provided with supports. The APS described this approach as a '…formulation [that] rightly recognises decision-making, and decision-making capacity, as a relational, contextually-sensitive and dynamic process which is not easily negated.'

3.5.25 To bolster the importance of the presumption of decision-making capacity and the need to carefully consider it as part of the process to enforce a treatment order, the Legal Services

[535] This was raised in SALRI's Government Roundtable, experts in older person's mental health and private meetings with parties.

[536] See Office of the Chief Psychiatrist, Factsheet – *Mental Health Act 2009*: Decision-Making Capacity (16 May 2022) <Fact-sheet-Decision-making-capacity-20221605.pdf>.

Commission recommended the insertion of a provision into s 5A of the *MHA* that 'provides paramount consideration of the patients decision-making capacity when assessing whether an order under the *MH Act* can or should be made.' The OCP also supported the prioritisation of decision-making capacity as a criterion of treatment orders but offered an alternative solution to achieve the same goal.

Including a clearer definition of 'impaired decision-making capacity' for treatment orders

3.5.26 SALRI's consultation focussed on two issues pertaining to the definition of 'impaired decision-making capacity'. First, SALRI sought views regarding the definition of this criterion, as it applies to the enforcement of a treatment order. Second, consultation revealed views regarding the operation of this definition in practice – which refers to the capacity assessment undertaken by a mental health professional. A related issue SALRI was asked to consider was whether this impaired decision-making capacity criterion should be retained within the set of criteria to enforce a treatment order.

Clarification of 'impaired decision-making capacity'

3.5.27 In the context of treatment orders, there was wide support in consultation to provide clarity to the definition and application of 'impaired decision-making capacity'. As presented above, discussion revealed the *MHA*'s current definition remains sufficient, although considerations to strengthen supported decision-making and accountability should be explored further.

3.5.28 The OCP's Human Rights and Coercion Reduction Committee recommended the definition should enhance accountability relating to the assessment of decision-making capacity. It was suggested that evidence of a capacity assessment would play a critical role in protecting human rights of consumers. Legislative clarification detailing the process of a capacity assessment was also raised, whereby the *MHA* could include specific criteria and mandate documentation of the assessment. The process of assessment could be defined by the Chief Psychiatrist, through the publication of Standards. Similarly, the APS suggested measures to 'allow for the adaptive and evidence-based implementation of a principle-based approach to decision-making capacity through standards.'[537] SALRI was informed the assessment of decision-making capacity requires a specialised skillset and clinical judgment. SALRI acknowledges these positions and notes the submission of the OCP, which stated '[c]linicians may approach the question of capacity in different ways.' This sentiment was reinforced to SALRI frequently during consultation through mental health clinicians who routinely undertake capacity assessments. Given the particular approach or cognitive tool used to assess capacity may differ between practitioners, the definition of decision-making capacity remains deliberately flexible.

3.5.29 There was wide support from clinicians to retain this flexibility, or what was also described as ambiguity, enabling clinical judgment to be exercised. One geriatrician particularly noted that they 'favour slight ambiguity'. During a Medical Roundtable discussion with psychiatry and geriatrics, one attendee noted a disconnect between the definition and practice. Despite this, attendees agreed the definition does appear appropriate, with one attendee supporting the cultural shift from risk aversion to capacity is important. This was raised by one consultee, who noted there may always be a gap between the law and culture or practice.

3.5.30 In SALRI's Psychology/Neuropsychology Roundtable, attendees agreed that as clinicians, they do not have too much difficulty with the definition in the law. Despite the fact that the definition

[537] The APS recommended the establishment of a Chief Psychologist under the *Mental Health Act 2009* (SA) who could work collaboratively with the Chief Psychiatrist to assist in executing functions under s 90.

does not neatly align with psychometric tools, it is not feasible. It was agreed the definition requires a sufficient degree of ambiguity.

3.5.31 A majority of survey respondents on YourSAy also agreed the current definition was sufficiently clear, with some noting it may be the interpretation that causes issues.

3.5.32 SALRI notes the definition remains consistent with other pieces of legislation (as raised by parties including OPA) and the importance of allowing a degree of flexibility to account for varying approaches to capacity assessment.

3.5.33 The Child and Adolescent Health Community of Practice suggested a clearer definition of decision-making capacity dependent on the child's age must be considered. Following this, clinicians working in child and adolescent mental health are able to determine decision-making capacity based on developmental age, as opposed to chronological age. As a result, legislative clarity with respect to the approach of capacity assessments in children and adolescents would be welcomed. This type of amendment would go to addressing concerns that younger populations are consistently unrepresented across the development of legislation and policies. The need for a separate definition for children was also raised by the Commissioner for Aboriginal Children and Young People.

3.5.34 The Child Protection and Policy Unit of SA Health also supported a clearer definition of decision-making capacity, 'including evidence to support age-appropriate supported decision-making, inclusive and trusting of children and young people being able to express opinions on decisions that affect their lives.' Further, they suggested that these age-appropriate assessment tools should encourage providing reasons to children and adolescents detailing the outcome of a capacity assessment they have undergone.

3.5.35 To assist in the legislative clarification of 'impaired decision-making capacity' for treatment orders, the Legal Services Commissions recommended the insertion of explanatory notes. These could 'provide examples of what does not amount to lack of capacity, for example, a patient refusing to accept a diagnosis of the mental health condition, is not of itself an indication of impaired decision-making capacity.' If this recommendation were adopted, it must be recognised that it would be unfeasible to comprehensively capture all of the examples reflecting circumstances that do not amount to lack of capacity within the explanatory notes.

3.5.36 Aged Rights Advocacy Service ('ARAS') raised the need for clarification for persons with behavioural and psychological symptoms of dementia. In particular, '[o]lder adults experiencing cognitive and emotional disturbances due to stress, anxiety or depression need to be safeguarded against potential misdiagnosis of dementia.'

3.5.37 One party, the Australasian College for Emergency Medicine, held strong views regarding the definition of impaired decision-making capacity, noting:

> … it is the view of the College that impaired decision-making capacity specific for the use of placing a person on a treatment order must be clearly defined and included in the Act. This should form part of a broader formal review of the criteria for compulsory treatment.

3.5.38 The enumeration of specific circumstances which constitute impaired decision-making capacity would require extensive consultation with clinicians applying for treatment orders. SALRI is cognisant of the limitations associated with providing express criteria that determine whether the impaired decision-making capacity criterion has been satisfied. However, SALRI acknowledges the

need to offer clarification pertaining to the understanding, meaning and application of this criterion in practice.

3.5.39 The OCP supported in principle, amendments to the *MHA* that 'emphasise and prioritise the importance of this criterion.' Subsequently, the OCP suggested the adoption of capacity assessment principles, as observed in the NSW Toolkit regarding capacity or Part 3.1 of Victoria's new legislation,[538] could be incorporated into the *MHA*'s guiding principles. The OCP's Human Rights and Reduction Committee also raised the utility of toolkits or guidelines to complement a Standard issued by the Chief Psychiatrist offering clarity for impaired decision-making capacity. The Committee further noted that statutory and practice guidance relating to the application of the decision-making capacity presumption is warranted and defining a threshold for making an assessment.

3.5.40 As an alternative option, the introduction of a capacity toolkit or guidelines was supported during consultation. This could address nuances in the definition of 'impaired decision-making capacity' for children and adolescents, older persons and others. Many jurisdictions have introduced a capacity toolkit or guidelines to offer greater clarity in the assessment of decision-making capacity. These were described in consultation as a 'support', that could aid a mental health professional, allied health professional, consumer, family, carers or friends.

3.5.41 Similar themes were raised in SALRI's Nursing and Social Work Roundtable, where there was broad agreement between attendees that there is value for a Toolkit, especially one that is universal or consistent between jurisdictions. It was noted a toolkit acts as a prompt and should be accessible for all people and professionals, including those working in a non-health related field.

3.5.42 The OCP's Older Person's Mental Health Leadership Group also agreed that a toolkit would be useful to offer guidance. Some expressed a preference for the NSW Toolkit. Consultation with Uniting Country in Port Augusta also revealed broad support for the introduction of a toolkit, which should be accompanied with more training around decision-making capacity to increase understanding.

3.5.43 Overall, consultation revealed support for the publication of a capacity toolkit or guidelines.

Assessment of Capacity

3.5.44 The *MHA* provides the foundational principles forming understanding of decision-making capacity. To enforce involuntary treatment, the individual must be deemed to have impaired decision-making capacity. To determine this, a qualified clinician must undertake a capacity assessment.

3.5.45 In the context of a treatment order, a person must have impaired decision-making capacity 'relating to *appropriate* treatment of the person's mental illness'.[539] Consequently, decision-making capacity is based upon 'appropriate' treatment. SALRI's consultation revealed wide support to remove the term 'appropriate'.[540]

3.5.46 SALRI's consultation revealed broad support to clarify the meaning and assessment of impaired decision-making capacity. According to the RANZCP SA Branch, '[t]he provisions of the *MHA* as they are currently applied in practice seem to be used appropriately, and SACAT seems

[538] *Mental Health and Wellbeing Act 2022* (Vic) Pt 3.1.

[539] See *Mental Health Act 2009* (SA) ss 10(1)(c), 16(1)(c), 21(1)(ba), 25(2)(ba), 29(1)(ba) (emphasis added).

[540] For further discussion on the term 'appropriate', see Part 5 Inpatient Treatment Orders.

confident that the *MHA* is being invoked in the correct situations.' Despite this, the RANZCP noted 'there does seem to be a lack of clarity within the *MHA* about "impaired decision-making capacity."' As part of a capacity assessment, psychiatrists are expected to comply with the RANZCP Code of Ethics Principle 5 concerning consent, capacity and decision-making. Of particular relevance in Principle 5:

> Psychiatrists shall seek valid consent from their patients before undertaking any procedure, treatment or provision of a report for legal or other purposes.
>
> 5.1 In seeking consent, psychiatrists shall inform and ensure that the patient understands the purpose, nature, benefits, side-effects, risks and costs of a proposed procedure or treatment. They shall also inform the patient of reasonable alternatives. They should also ensure that the patient understands the implications of not having the proposed procedure or treatment.
>
> 5.2 In seeking consent, psychiatrists shall communicate with patients using vocabulary that enables the patient to comprehend the relevant information.
>
> 5.3 Psychiatrists shall ensure that the patient consents freely.
>
> 5.4 When psychiatrists need to assess a patient's capacity to provide consent, they should be aware that certain decisions require a higher level of capacity and that capacity may fluctuate.
>
> 5.5 Psychiatrists shall provide the patient with new information, if it becomes available, that might influence the patient's original consent.
>
> 5.6 Psychiatrists shall support the decision-making of a patient with impaired capacity so that, where possible, a decision can be validly made.[541]
>
> …

3.5.47 These points are consistent with accepted principles underpinning decision-making capacity. The RANZCP noted that where a person's decision-making capacity may be impaired, psychiatrists have a 'duty to assess their ability in the context of suitable support for that ability.' They further noted:

> Taking a strict reading of the *MHA* as it is currently worded, it does not sufficiently address the case of a patient whose judgement is impaired by mental illness to such a degree that their decisions would put themself or others at significant risk, but who is still able to understand, retain and use information to make and communicate a decision.
>
> Under a literal reading of the *MHA* it would appear that a treatment order could not be written for such a person.
>
> In practice, impaired judgement has been used as an accepted standard by SACAT to argue for impaired capacity, and the *MHA* should be amended to make that clear.

3.5.48 This appears to be consistent with the Court in *TSC*, but may challenge the approach adopted in *PBU & NJE*. SALRI's regional consultations revealed similar approaches to that proposed by the RANZCP in relation to the relevance of impaired judgment and insight as one aspect of a capacity assessment.

[541] RANZCP, *Code of Ethics* (2018) principle 5.

3.5.49 Following this, the RANZCP recommended that clarity pertaining to the criteria for impaired decision-making capacity would 'support healthcare practitioners in making treatment orders when required.'

3.5.50 Further, due to the nuanced and complex nature of mental health, any change to law or practice, however minor, can have significant effects, and as such:

> *MHA* criteria and guidelines around 'impaired decision-making capacity' should not be imposed on clinicians nor consumers, but rather be mutually developed with input and ownership from key stakeholders, [for example] that might include the RANZCP, a lived experience group, a carers' group, the Coroner…

3.5.51 This enables further interrogation and consultation of issues for all stakeholders and interested parties, to subsequently provide advice to the Government on a best practice consensus. The impact of unintended consequences was also raised by CALHN:

> It is noted that well-intentioned changes often have unintended consequences and that more specific wording is unlikely to improve the application of the Act, and there is considerable risk that it will lead to excessively narrow interpretations and people with mental illness being denied treatment despite significant impairment in capacity as properly understood. It is also important to note that persons subject to involuntary treatment under the *MHA,* have the right to appeal against the order to the SA Civil and Administration Tribunal (SACAT). The Tribunal has the obligation to test psychiatrists' understanding of capacity and specifically for the person involved and the decisions that need to be made. This provides the person the protection of an individual assessment of their capacity. CALHN submits that this is a safer and more appropriate approach than a broad-brush change to something that is well understood and well-articulated under Part 1, Section 5A.

3.5.52 The need for accountability on behalf of a clinician undertaking a capacity assessment was raised to SALRI. The OCP submitted:

> … the consideration of this criteria [impaired decision-making capacity criterion] is often not well documented making it difficult, particularly for consumers and their families, to determine how a conclusion has been reached. Clinicians may approach the question of capacity in different ways. While assessment should always be thoroughly documented in clinical case notes, under the Act, a formal 'statement of reasons' … is only required to be completed on the making or extending of a Level 2 ITO or when the decision to confirm a Level 1 CTO or ITO is appealed to SACAT.

3.5.53 As such, the OCP would support in principle, amendments pertaining to the enumeration of capacity principles and in particular, emphasis that:

> … a fresh capacity assessment is required on each occasion a treatment decision is purported to be made and at each (regular) clinical review, that capacity can fluctuate over time, and that a history of mental illness does not mean a person lacks decision-making capacity.[542]

3.5.54 Similarly, the OCP's Human Rights and Coercion Reduction Committee submitted that '[i]t is not always evident that capacity has been assessed.' The Committee considers capacity assessment to be a 'critical issue in protecting the human rights of people who need mental health care and treatment and also in delivering high quality care.' As a means to clarify a capacity assessment, the Committee suggested the inclusion of specific criteria within the *MHA*, with an additional provision

[542] The need to repeat capacity assessments was raised by many parties during consultation, including Speech Pathology Australia.

requiring documentation of the assessment. It was noted the assessment should require the collection of evidence to inform a decision. In obtaining relevant evidence, the person must receive information in a manner that they understand, particularly when the person may be feeling distressed or unwell. This was also reiterated by Mind Australia, noting the importance of protecting a person's right to the information they need in order to make a decision. In particular, information must be provided in accessible formats and where proactive communication is encouraged and facilitated.

3.5.55 Submissions from the SA Health Lived Experience Workforce and CALHN Consumer and Carer Advisory Group advocated for greater accountability and auditing. The CALHN Consumer and Carer Advisory Group recommended that improvements need to be made regarding the auditing and accountability of decision-making capacity assessments. It was commented that 'it should be clearly documented the reason why a clinician believes someone lacks decision making capacity and this documentation should be regularly audited for compliance.' Survey responses from YourSAy also supported the requirement to provide written reasons.

3.5.56 The Legal Services Commission also supported the inclusion of a requirement under the *MHA* to provide a written record of 'the basis upon which a treating medical professional determined the decision-making capacity of a patient. It is suggested that this may enhance the importance of this criteria.'

3.5.57 Similarly, the Law Society of South Australia noted, from a legal perspective, 'reasons for decisions being made are often crucial in retrospectively challenging those decisions. Requiring all treating health practitioners to record reasons for decisions would be an ideal response.' However, they raised the concern that this requirement would 'create an unworkable burden' for clinicians. Further consideration must be given to this practical burden and the need to ensure access to justice for consumers who wish to challenge a decision.

3.5.58 The OCP's Human Rights and Coercion Reduction Committee also advocated for additional training on capacity and its assessment for both authorised officers and police. The Committee also emphasised that capacity assessments should consider the use of supported decision-making. This was also raised by ARAS in the context of older persons. ARAS welcomed a supported decision-making approach, 'on the basis [that] impaired decision-making is not a defining factor and the wishes or known preferences of the older adult should be respected and taken into account at all times, as practicable'.

3.5.59 LELAN described impaired decision-making capacity and its approach as follows:

> This means not allowing such decisions to be based on the person's experience of unusual thoughts, feelings and beliefs without ascertaining their decision-making capacity in other areas of their lives. It requires taking into account the environment in which the assessment is being made (ie hospital) and even if there is impaired decision making, seeing this as a spectrum, not black and white. When decision making capacity is impaired, 'supported decision-making' should be required rather than taking away a person's rights to make decisions on their own behalf altogether.

3.5.60 Further, LELAN submitted:

> The standard for determining 'impaired decision-making capacity' needs to become higher to ensure and protect the human rights of those with the least capacity for self-agency and highest risk of restrictive practices an individual or a group has. For example, where making a determination that would involve a significant limitation on the human rights of a person or group, such as a person being involuntarily detained, a higher standard would be required under the Act.

3.5.61 In order to facilitate these changes, LELAN recognised this must be accompanied by changes to procedure and practice, involving:

- Determination of impaired decision-making capacity should … be a least restrictive practice, ie:
  - Applied to individual decisions for the shortest duration
  - Be withdrawn as soon as possible after each application
  - Require continued review
  - Be withdrawn when the person is well enough and no longer wants to continue treatment
  - With limited legislative authority for health practitioners to override the person's capacity for decision-making
- Considerations for the impact that the context and environment has on the person's self-agency and capacity for decision-making, such as stress, physical, chemical, mechanical and environmental restraint, including seclusion
- The impact of diversity and the cultural context of a person's self-agency and capacity for decision-making
- The impact of cumulative and historical context of negative lived experience, marginalisation, abuse, fear, stigma and racism on a person's self-agency and capacity for decision-making.

3.5.62 In relation to the environment and time of a capacity assessment, one consumer noted '[c]ontext needs to be considered. Many people's capacity is heavily influenced based on the point in time and environment, e.g. hospitals, SAPOL are often very triggering environments/situations for people which significantly impairs their capacity to understand and process information.' Purple Orange raised a similar concern relating to the capacity assessment approach. They noted it should be 'fair and transparent' and recommended that an assessment should be undertaken:

> … where a level of capacity is questioned and that it is done so at a time and in an environment that will result in the most accurate and transparent results, and where any default assumption is that of competence not incompetence.

3.5.63 The Disability Rights Advocacy Service noted the law could be strengthened to adequately consider personal circumstances when making a treatment order. This refers to '…past and current treatment and its outcomes, a focus on offering the least restrictive practice possible, explaining the benefits and risks of treatments to an individual, and liaising with families and carers…'

3.5.64 The RANZCP advocated for 'recovery-oriented practice' that initially has a focus on restoring decision-making capacity and at 'later stages pursuing broader recovery goals. Strong therapeutic relationships are needed to make this work, and many other elements are expected to play a large role, such as peer support, supported decision-making, and culturally-informed practice.'

3.5.65 The OCP's Lived Experience Advisory Group agreed that the process of assessing capacity must be scrutinised. They recommended that the number of assessments before and during involuntary treatment should be increased. They further recommended to 'consider different capacity levels as it increases and decreases gradually; therefore, the assessment can include levels like minimal,

moderated, and substantial instead of yes or no.' SALRI notes this raises an important point regarding the wide understanding that capacity fluctuates. It also reinforces it is not a binary concept and therefore not a uniform determination for all decision-making domains. Further, access to documentation outlining the reasons for a determination may help to alleviate the current gaps in understanding how a clinician approaches an assessment.

3.5.66 Lived Experience Australia was of the view that the fluctuating nature of capacity requires further consideration:

> A person with mental illness who is subject to the *MHA* may not have insight into their own mental health conditions, this may fluctuate, or it may vary according to condition and context. They may also not fully recognise the impacts that this may have on family/carers and the community. They may, in some circumstances, be unduly influenced by spurious claims, scams, or otherwise vulnerable to suggestions that are not in their interests, and which they otherwise would be alternative decisions about if they were in recovery. Any person may make decisions or choices that they would otherwise regret; however, the issues of suggestibility and manipulation are different concerns, particularly where impaired decisions-making capacity is apparent. They may be a risk to themselves or others but not grasp the relevancy to themselves. They may well understand health care, ie hospitalisation, where they reside, and some understanding of their personal affairs. There must always be vigilance in understanding decision-making capacity to ensure the concerns raised by others to distinguish between persuasion, offers, threats and coercion in care.

3.5.67 Discussions from SALRI's Psychology/Neuropsychology Roundtable raised the importance of a clinical interview to establish rapport and collect collateral information to help inform the assessment.

3.5.68 Capacity assessments play an integral role in upholding the rights of a consumer. The outcome of an assessment is significant, as it forms part of the procedure to enforce involuntary treatment. SALRI acknowledges this is a significant interference of a person's rights, liberty, autonomy and self-determination.

3.5.69 Accordingly, a mechanism to strengthen accountability within the process of invoking a treatment order is supported. One such mechanism worthwhile of exploring is a requirement to provide written reasons for the outcome of a capacity assessment for treatment orders. However, the practical implications of this must be considered carefully.

Retaining the Impaired Decision-making Capacity Criterion

3.5.70 The impaired decision-making capacity criterion was inserted in 2017, following the *MHA*'s first statutory review.[543] It features as one of the criteria that must be satisfied in order to invoke a treatment order.

3.5.71 Subsequent to its introduction, the findings of the Deputy Coroner in the Inquest into Theo Papageorgiou's death were critical. The Deputy Coroner concluded:

> I recommend that except in relation to electro-convulsive therapy and neurosurgery, the relevant provisions of the *Mental Health Act 2009* be amended by deleting as a requirement for the imposition of any level of Inpatient Treatment Order or Community Treatment Order that the

[543] Office of the Chief Psychiatrist, *The Review of the Mental Health Act 2009 - A Report by the Chief Psychiatrist of South Australia* (SA Health, 23 May 2014).

person in question has impaired decision-making capacity relating to appropriate treatment of the person's mental illness.[544]

3.5.72 During SALRI's consultations, the view of the Deputy Coroner was acknowledged, but strongly disputed (particularly by clinicians). Consultation revealed a broad consensus that the impaired decision-making criterion should be retained. This consensus was observed in written submissions, private meetings and Roundtable discussions with various parties (both mental health specialists, mental health practitioners (psychologists, nurses and social workers), consumers (including the OCP's LEAG), Mental Health NGOs and other Government officials).

3.5.73 SALRI also notes and agrees with the OCP's submission:

> … without commenting here on the specific clinical circumstances of Papageorgiou's case, as a general proposition, an accurate consideration and assessment of capacity, with a thorough and contemporaneous recording of this decision, is likely to identify those who are in need of support or involuntary treatment in a way that will uphold rights, and also identify the needs of people who may require an Order. It is the OCP's view that appropriate assessment should lead to appropriate orders.

3.5.74 Further, the OCP held the view that 'the decision-making capacity criterion for involuntary treatment orders is one of the most important human rights safeguards currently in the Act.' This was reinforced during one of SALRI's Medical Roundtable discussions, where it was described as 'one of the most progressive reforms to the *MHA* – removing this criterion would be to regress. It would be a step back regarding least restrictive practice.'

3.5.75 The OCP elaborated on the importance of the criterion, stating:

> While involuntary treatment for severe mental illness remains necessary in our current health system and community, a balance must be struck between a person's right to self-determination – including their right to make what are perceived to be 'poor decisions' in relation to their mental health – and their right to good health. The OCP considers that if a person has been properly assessed as having capacity with respect to the treatment of their mental illness, there is no role for involuntary treatment, which can indeed cause further harm and distress.

3.5.76 From the perspective of regional mental health, the Rural and Remote Mental Health Service noted that the Deputy Coroner's recommendation to remove the criterion 'is of particular weight in country settings', due to the isolation of medical officers and the infrequency of making treatment orders renders this criterion 'perplexing and time-consuming.' Despite this observation, the Rural and Remote Mental Health Service did not support removal of the criterion. However, they support a rewording of the criterion to enhance understanding. It was emphasised that these changes should not restrict clinical decision-making or the capacity to review decisions. The introduction of a fact sheet published by the Chief Psychiatrist was suggested to provide straightforward guidance. Finally, they concluded 'lengthy descriptions and/or definitions should not be in legislation.'

3.5.77 The RANZCP submitted that the criterion 'should definitely be retained, as a person's right to informed consent in their own care is an important principle of our health system.' Their submission noted the 'prevailing imperative' of the public and government policy is to keep people safe from harm, which is reflected in South Australia's endorsement of a 'Zero suicide' policy and the Deputy Coroner's finding. Following this, the RANZCP found that '…the removal of impaired

[544] *Inquest into the Death of Theo Nikolas Papageorgiou* (2021) 09/2020 (0176/2016) SACC (Schapel, Deputy State Coroner) 117.

decision-making capacity from the *MHA* would be a very significant change, the clear message is that there is a mandate for the primary focus of the Act to be that of safety and protection.'

3.5.78 The implementation of accountability mechanisms pertaining to the capacity assessment outcome may alleviate concerns relating to the approach of the clinician. It is important that a consumer is offered a clear pathway to understand the reasons for the outcome and be supported to challenge the outcome if they so choose. SALRI emphasises that capacity assessment is an area whereby trust and reliance must be placed upon the clinical acumen and expertise of professionals undertaking the assessment.

Facilitating Supported Decision-making

3.5.79 SALRI's consultation revealed extensive support to provide a supported decision-making ('SDM') framework within the *MHA*. Many parties raised the importance of SDM in the promotion of rights and to align the law with international principles and best practice. The shift away from substitute decision-making represents greater emphasis on autonomy and self-determination. It may also be the impetus to drive cultural changes in practice, to ensure all individuals are provided with supports to exercise their decision-making capacity.

3.5.80 As noted by Speech Pathology Australia, '[a]utonomy, the concept that people have a right to make decisions and choices that impact upon their own lives, is a critical factor when discussing supported decision-making.'

3.5.81 The OCP supports, in principle, amendments to explicitly adopt SDM, as a means to align the *MHA* with the requirements of the *CRPD*. This was also endorsed by the OCP's Human Rights and Coercion Reduction Committee, emphasising that under a human-rights based approach, SDM is preferred over substitute decision-making. Speech Pathology Australia recommend the development of a SDM framework, with communication being the 'cornerstone of this framework.' Many parties supported the endorsement and legislative provision of SDM, including but not limited to, the Mental Health Commissioners, ARAS, the RANZCP, Disability Rights Advocacy Service, Australian Nursing and Midwifery Federation, South Australian Council on Intellectual Disability, Purple Orange and the Public Health Association.

3.5.82 Purple Orange specifically submitted that SALRI's Review is an 'excellent opportunity to better protect the rights of people with lived experience of mental illness through providing a framework that allows for genuine supported decision-making.'

3.5.83 CALHN expressed their understanding that 'the Act as it currently stands does allow for supported decision-making and it is the experience of our clinicians that this is the preferred option in clinical practice.'

3.5.84 In the context of older persons, ARAS reiterated that a SDM approach must be premised on respect for personal wishes and known preferences. Further, this approach cannot operate on the assumption that impaired decision-making is a defining factor, to deprive a person of their decision-making autonomy. One of the aims of SDM is to enhance a person's decision-making capacity, or in cases where there may be a degree of impairment, offer support that enables them to retain their decision-making autonomy. The RANZCP also reinforced the importance of maintaining a person's rights as the primary consideration, particularly where they have impaired decision-making capacity.

3.5.85 LELAN raised a concern that 'words alone are not enough' to ensure rights are actively upheld. SDM is one avenue to actively translate rights into practice and it must be accompanied by

greater accountability mechanisms to monitor adherence with rights/principles.[545] During SALRI's Focus Group with LELAN, it was noted that SDM is important, but its translation in practice may be difficult. Careful consideration must be given to ensure it is properly implemented in practice.

A Definition of Supported Decision-making?

3.5.86 The utility of a definition of supported decision-making under the *MHA* was raised to SALRI by several parties. The OPA, for example, submitted that:

> Supported Decision-Making (SDM) is an emerging and increasingly accepted practice whereby people with a disability or cognitive impairment are assisted to exercise their legal rights to the greatest extent possible. It is driven by the UNCRPD. Moving away from a focus on individual capacity, to the right to be supported in the decision-making process, requires a paradigm shift in thinking about decision-making by people with cognitive impairment. SDM may have a place in the *MHA* and/or the regulations or guidelines for its operation.

3.5.87 OPA suggested requirements regarding the steps taken to practice SDM and recognise the preferences of a person may be inserted into the guiding principles or care and treatment plans.[546]

3.5.88 Mind Australia advocated for a clear definition of SDM to be included in the *MHA* and raised the need to distinguish between SDM and shared decision-making. They noted the law 'should also determine the situations in which shared decision-making is appropriate, in cases where supported decision-making cannot be supported.'

3.5.89 An alternative or accompaniment to a definition, is enumerating SDM within the guiding principles or objects of the *MHA*. The Commissioner for Aboriginal Children and Young People, April Lawrie, suggested s 6 of the *MHA* (Objects) could include 'rights to decision-making, including for those with impaired decision-making capacity where appropriate and within the context of a clear definition.' Importantly, the rights of Aboriginal children and young people should also be addressed.

3.5.90 Similarly, the Disability Rights Advocacy Service advocated for an amendment to the objects and guiding principles, endorsing SDM as the preferred approach and explicitly identifying substitute decision-making as a last resort. SDM also promotes a least restrictive option in the context of mental health. Lived Experience Australia also recognised the role of the objects and guiding principles in sufficiently addressing human rights of consumers.

3.5.91 The Rural and Remote Mental Health Service observed:

> While it would build on human rights to add a provision to the guiding principles sections of all these acts that clinicians/staff will engage in supported decision making with the patient where practicable, the details of what supported decision making looks like should be described in policy, not in legislation. An all of health and disability approach to this issue would be the best option, with minimum attempts/requirements, exemptions, processes and resources to carry out what will be an additional impost on clinicians, patients and administration and data staff. This will require significant culture change across the health and disability sectors, which will require significant resource allocation and support from both the State and Commonwealth governments.

[545] For a detailed discussion on the operationalisation of guiding principles, see Part 12 Guiding Principles and Accountability Mechanisms.

[546] See *Mental Health Act 2009* (SA) Pt 6.

3.5.92 A different approach was offered by the RANZCP, to consider designing legislative provisions based on Patient Charters, which are 'reasonably uniform'.

3.5.93 The OCP referred to the Victorian approach, which integrates the use of 'appropriate supports' throughout the Act. The term 'appropriate supports' is defined under s 6 of the *Mental Health and Wellbeing Act 2022* (Vic), defining various measures and examples that may assist a person in exercising their decision-making autonomy. The OCP supports the use of such examples, to offer guidance to clinical staff about the requirements of SDM. The Victorian approach also imposes an obligation to take reasonable steps to provide appropriate supports in the assessment of capacity. For example, s 87(3)(b) of the *Mental Health and Wellbeing Act 2022* (Vic) states that 'the person carrying out the assessment must take all reasonable steps to ensure that … the person being assessed is provided with appropriate supports to enable the person to give informed consent.'

3.5.94 The *MHA* currently does not explicitly reference SDM. The OPA raised the utility of s 47 of the *MHA*, which entitles a consumer to have a support person assisting them to exercise rights and communicate with medical staff. However, OPA noted '[t]his is important but [it] does not represent SDM of itself.'

3.5.95 While Part 8 of the *MHA,* which deals with 'further protections for persons with mental illness,' offer some safeguards, there is opportunity to strengthen provisions to reflect SDM and its principles. This is consistent with the general themes raised in SALRI's consultation, to transform the *MHA* into a more 'rights-based' instrument and shift away from a 'crisis Act' to a 'wellbeing and prevention Act'.

How to Implement Supported Decision-making in Practice?

3.5.96 A number of SALRI's submissions and consultations provided valuable insight into how SDM may operate in practice. Parties noted the importance of enabling provisions within the *MHA* to facilitate its implementation.

3.5.97 OPA provided examples of SDM, including 'modified language or visual aids, breaking down one complex decision into a series of smaller ones, taking additional time, or engaging a supporter who assists by discussing information or helping to communicate the person's decision.' Therefore, SDM encompasses formal and informal arrangements.

3.5.98 The Public Health Association of Australia identified the following key provisions of a SDM regime, consistent with the *CRPD*:

- support must be available to all; high level of support needs or non-conventional communication must not serve as barriers to accessing support.
- support must be available at nominal or no cost; lack of financial resources must not be a barrier to accessing support.
- an individual has the right to refuse support, cease or change support arrangements or relationships at any time.
- facilitation to create support should be provided for people who are isolated and without naturally occurring support.
- safeguards mechanisms must ensure that the individual's will and preferences are respected and protect against undue influence.

- reasonable accommodations may be required to enable people with disability to engage in the supported decision-making process on an equal basis with others. Examples of such accommodations include access to buildings and the provision of information in accessible formats.

- supported decision-making systems should not overregulate the lives of people with disability.

3.5.99 There was extensive support for the presence of a supporter, family member, friend, carer or trusted person to be involved in decision-making, if a person so requires. The SA Child and Adolescent Health Community of Practice noted in their submission, '[p]arents/caregivers and/or relevant family members need to be involved in the decision-making process of children and young people who are not considered to have the capacity based on their assessed developmental age.'

3.5.100 In the context of CALD communities, SALRI's co-facilitated Focus Group with Multicultural Communities Council of SA ('MCCSA') revealed support for the need to have a family member or trusted person in the hospital setting.

3.5.101 As noted by Speech Pathology Australia, communication represents a core tenet of SDM. Communication extends to the mode, format, content and delivery of information needed to make a decision, including the use of interpreters. One consumer told LELAN '[a] lot can be resolved by just allowing someone to talk and by listening to them and allowing them the space to be heard and understood, not just making a decision based on paperwork and brief observations.'

3.5.102 Importantly, specific supports for persons from a CALD background must also be considered. There was unanimous agreement during SALRI's Focus Group with MCCSA that there was a need for interpreters in all hospitals. Further, in addition to interpreters, there was strong unanimous support for the presence of a cultural advisor. This advisor can provide an opinion on the cultural needs of the person, offer insights into community values and expectations, challenges, and cultural barriers.

3.5.103 SALRI held a number of consumer and disability Focus Groups. Notably, during SALRI's Focus Groups co-facilitated with Purple Orange, Our Voice SA and the South Australian Council on Intellectual Disability ('SACID') – a strong recurring theme was the need for SDM measures to be implemented in practice. Participants highlighted that a more comprehensive understanding of disability and in particular autism and neurodivergence, is needed.

3.5.104 SALRI's consultations revealed significant issues with the intersection of the National Disability Insurance Scheme ('NDIS') and mental health services. SALRI recognises this is a complex area, traversing state and federal law and policy. It is also acknowledged that current issues in service delivery for people requiring NDIS and mental health assistance may lead to a person 'falling through the gaps' and with their needs left unattended. SALRI heard this was the case for complex disability and mental illness and children and adolescents (especially those that no longer fall under Child and Adolescent Mental Health or Adult Mental Health). Our Voice SA raised the need for a dedicated person who has knowledge of the disability system and to act as an advocate for a person with a dual disability, while they navigate the mental health system.

3.5.105 Notably, it was agreed that mental health and disability are interrelated and the separation of systems into siloes (NDIS and mental health) creates challenges. The issues relating to the

intersection and interaction of the NDIS and mental health falls outside the scope of SALRI's review. However, these issues remained prominent, indicating a need for further consideration.[547]

3.5.106 SALRI was told that some participants with an intellectual disability or autism are unable to communicate when they feel distressed or overwhelmed. Supports to offer SDM in these circumstances where a person is rendered non-verbal are especially important. This was often raised in the case of presenting to the emergency department and feeling overwhelmed due to the sensory overload of the environment. As a result, there was extensive support to consider sensory regulation and changes to mental health service access and delivery for persons with a disability. It was noted efforts must be taken to co-regulate and create a safe sensory environment. Participants in SALRI's Focus Group with SACID described a helpful environment to receive help as one which is neutral, quiet, a separate area, with dolls or soft toys and calming colours. This was also raised by participants in SALRI's Focus Group with Our Voice SA. Participants here suggested access to a room to calm down. This calming environment could have sensory lights and music.

3.5.107 During SALRI's Disability Advocacy Roundtable, a representative of Our Voice SA noted that in a disability context people may need assistance to make a decision. They often set out explicit steps on how to make a decision, include 'pros and cons' of the decision and start with making smaller decisions leading up to the bigger decision. This was described as 'priming' people and boosting confidence. As a result, they suggested a Toolkit could set out explicitly how to make a decision and how and where to get information. In breaking up a decision into smaller ones, it was noted that even though the cons list was always longer, the group rationalised the decision by saying the cons 'might' happen whereas the goods things 'will' happen.

3.5.108 SALRI's Disability Focus Group discussions revealed key themes concerning a need to access information in plain English and Easy Read. In SALRI's Focus Group with SACID, participants noted that information can be difficult to process. As such, it should be provided in a variety of formats (such as braille), including verbally, with pictures, using short words, Easy Read and avoiding the use of too many words. It was also emphasised that it is imperative to build a relationship and rapport with a person in order to understand their disability and supports required.

3.5.109 In an effort to promote SDM, SACID has established the Strong Minds Series, to educate by developing skills in different contexts and building resilience, or a 'strong mind.' One participant noted 'I am the boss of my own life.' The series is comprised of a workshop and has been developed into five books, looking at different topics, such as healthy habits, emotions and thinking first. Skills for decision-making are addressed and knowledge of rights in various contexts. One participant acknowledged that prior to engaging with SACID, they did not know they had any rights.

3.5.110 SACID have also developed a useful tool called Conversation Cards. These cards were co-designed with persons with an intellectual disability and aim 'to open up conversation between people with disability and their supporters about decision making.' SALRI notes this resource would serve as a valuable tool to facilitate SDM, increase awareness and education and enable better understanding of rights. There are six sets of cards – feelings cards, action cards, decision stories, rights cards, coaching cards and mystery questions. Of particular relevance to decision-making are the rights cards. Cards within each set provide a short, simple statement, accompanied by a picture. The back of the card provides further information about the statement provided. For example, for the right to learn

[547] See also David Plater et al, '*Autonomy and Safeguarding are not Mutually Inconsistent': A Review of the Operation of the Ageing and Adult Safeguarding Act 1995 (SA)* (South Australian Law Reform Institute, 2022) 32–33, rec 1.

how to make decisions card, further information notes that a person can learn to take risks, change their mind and make mistakes. Reference to dignity of risk is important, SALRI was told this was a means to enhance capacity.[548]

3.5.111 The rights cards state:

> I have the right to make my own decisions.
>
> I have the right to information I can understand.
>
> I have the right to make decisions in private.
>
> I have the right to learn how to make decisions.
>
> I have the right to get support for decisions.
>
> I have the right to choose my Decision Supporters.
>
> I have the right to respect for who I am and what I want.
>
> I have the right to feel safe in all parts of my life.
>
> I have the right to be treated fairly.

3.5.112 The Conversation Cards are accompanied by a Decision Supporter Guide, which offers some valuable instruction pertaining to SDM for people with an intellectual disability:

> [A co-designer stated] Decisions are part of you and what you are doing. You make choices and decisions for yourself and sometimes all of us need to get some support for decision making.
>
> Decisions can be small or big, easy or hard. This depends on the person who makes the decision, the decision that needs to be made and what else is happening in their life.
>
> Everyone needs support to make decisions.
>
> The support can be for long-term goals and everyday choices.
>
> Support is about what people want, what people need and what people choose for their own life.
>
> Supported decision making is important because it is about putting the person and their will and preference at the centre of decision making.

3.5.113 The Conversation Cards may be used in a number of circumstances, including circles of support or microboards,[549] peer groups, education and training workshops, family and friends and more.

3.5.114 During SALRI's Disability Advocacy Roundtable, one participant referred to the utility of the cards, as the 'feelings cards' can be shown to a medical professional in a health setting to describe their emotions. This would be particularly useful for people who become non-verbal in different environments. All Roundtable participants supported the idea of a person having a card with their name, the best way to communicate with them and the best person to contact. This could be a wallet-sized card that provides these details. A person can rely on the card in high stress environments where they experience dysregulation. A similar idea was raised in the SALRI's Focus Group with MCCSA, whereby participants supported a card listing contacts, interpreters and advocates for a consumer.

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[548] This was raised during SALRI's Disability Advocacy Roundtable discussion.

[549] SALRI has encountered the utility of microboards in previous references.

3.5.115 An approach adopted in the United Kingdom was raised, whereby a green lanyard with sunflowers acts as an identifier of people with non-visible disabilities. However, there were practical issues, relating to the number of schemes staff need to be aware of and understand. A wallet card would circumvent these issues. All attendees recognised that 'everyone copes differently' and one approach will not work for everyone. SDM is individualised.

3.5.116 Communication was also raised to SALRI by consumers, whereby trauma and fear are associated with mental health services. Consumers raised the issue that many have a history of trauma within the mental health system. This emphasises the need to create a better environment, with active listening and respect. Knowledge of who to talk to and what different services can offer is also important.

3.5.117 One participant raised concern that services expect a person to communicate emotions verbally. This highlights verbal communication may not be the most effective means of communication. Similar themes were raised to SALRI in the context of disability. Offering supports to assist in communication would be welcomed. This reiterated support to involve family, friends, carers, a trusted person or peer workers and the need for trauma-informed practices on behalf of medical practitioners.

3.5.118 LELAN made the following observations, in relation to supporting a consumer in the decision-making process:

- Ensuring access to independent individual advocacy for people with lived experience to balance the power, education and authority available to a person when presented with an order and/or application for involuntary treatment.
- Actively facilitate support for access to information about the persons rights including access to information about them.
- Support for the person to make decisions as the default practice rather than just support to understand when decision making has been taken away.

3.5.119 Views from Aspire Recovery Connection noted:

> They [consumers] also felt treating professionals with whom they had a long standing and trusted relationship with (e.g. private psychiatrists, psychologists and GPs) as well as peer workers, carers and friends should be consulted with in treatment decisions made under involuntary treatment orders.

3.5.120 Other means of facilitating support raised by Aspire Recovery Connection were access to mental health specialised advocacy services and '[l]isten to people when they are asking for help, not only when they've reached a point of crisis.'

3.5.121 A key theme raised in survey responses on YourSAy was the need for better advocacy services and support. Other measures to safeguard the rights of consumers and promote SDM raised in survey responses included the delivery of appropriate case-based treatment, improving collaboration between mental health units and drug and alcohol services, increased funding to employ more mental health practitioners, enhance accountability mechanisms in the *MHA* and using simple, clear language to convey information.

3.5.122 The SA Health Lived Experience Workforce suggested the creation of video resources with subtitles. These resources should be co-produced with consumers.

3.5.123 The Country and Outback Health Lived Experience Advisory Panel advocated for more support workers, to encourage a proactive approach to help prevent a person experiencing a mental health crisis. This is particularly pertinent for the emergency department and hospital setting. The Panel noted that a peer worker was best placed to assist in a crisis situation. The use of a peer support worker has proven to be an effective means of de-escalating situations and offering support to a consumer. SALRI's regional visit to Whyalla saw the implementation of the peer support worker model and its value and utility.

3.5.124 There was wide support in consultation, particularly from consumers and persons with a disability, that the emergency department is not the appropriate place for a person to present with a mental health challenge. For example, the SA Health Lived Experience Workforce supports diversion and alternatives to the emergency department. Many views in consultation, including medical practitioners, raised the need to separate mental health from the emergency department. Participants in SALRI's Focus Group with the MCCSA noted the absence of a separate mental health emergency department was problematic. The noise and overcrowding of the emergency department was said to be overwhelming for a consumer.

3.5.125 Several suggestions were raised as alternatives, including expanding and offering different geographic locations of centres such as the Urgent Mental Health Care Centre and harnessing community mental health teams with resources to facilitate an emergency department specifically for mental health. SALRI notes these views and emphasises that significant resourcing and funding would be required to accommodate this re-structure.

3.5.126 Many parties, including but not limited to, Mind Australia, OPA, Public Health Association, Mental Health Commissioners and the SA Child and Adolescent Health Community of Practice suggested SDM can be facilitated through Advance Care Directives (ACDs) or advanced statements, nominated support persons and the inclusion of peer or consumer workers.[550] The Mental Health Commissioners suggested that the involvement of a peer worker, advocate or social worker should be mandated.

3.5.127 YourSAy survey respondents supported greater use of ACDs or treatment plans and the need for peer workers. One respondent noted:

> Understanding that a person living with mental distress is likely to be extremely heightened when in a clinical setting where they have previously experienced a breach of their human rights and fear this being repeated. Using peer workers, in a non clinical environment will yield a much more accurate assessment of a person's capacity, where they feel listened to, not judged and understood. With a compassion centred approach, supported decision is incredibly effective and there should not be the need to take away a person's autonomy around the treatment they receive when this is done well.

3.5.128 Mind Australia reiterated the need to consider how these tools (ACDs and support persons) can be embedded into practice. They recognised the importance of such tools in promoting autonomy and dignity of a person.

3.5.129 ARAS suggested the inclusion of a 'dedicated mental health section' within ACDs, to act as a further safeguard for an older adult with a lived experience of mental illness. Expanding upon this,

[550] A few submissions raised the inclusion of a right to a second opinion, as observed in Victoria.

ARAS proposed the mental health section could refer to principles, terms of voluntary and involuntary treatment orders, electroconvulsive therapy, informed consent and SDM.

3.5.130 The OPA submitted that the use of ACDs in mental health could be further considered and explored, as it is a means to ensure decisions are in accordance with a person's will and preferences. This is also consistent with the UN Committee on the Rights of Persons with Disabilities broad view that the ability to plan in advance enables a person to express their will and preferences.

3.5.131 The APS advocated for greater use of ACDs, noting barriers in relation to their implementation across the mental health system prevents the realisation of their benefits. They described the process of setting up an ACD as therapeutic and could be incorporated into psychological therapy. It was recommended 'including direct references to ACDs within the *MHA* would provide greater procedural clarity and also reinforce the importance of ACDs as part of a rights and capacity-oriented mental health system.' Further, consideration should be given to impose a positive obligation on decision-makers to check for the presence of an ACD. This should be undertaken prior to exercising powers to enforce involuntary treatment, patient assistance requests and patient transport requests.

3.5.132 The OCP's Lived Experience Advocacy Group advocated for strengthening the binding nature of ACDs, which is of particular relevance to electroconvulsive therapy.[551] This was also supported by the OCP's Human Rights and Coercion Reduction Committee and the APS. The OCP's Human Rights and Coercion Reduction Committee recommended, in addition to increasing the binding nature of an ACD, requiring those involved in engaging with the *MHA* to verify whether a person has an ACD. The Committee stated that if a person has an active ACD, their wishes should not be overruled unless there is an imminent risk to the life or safety of the person. The OCP's Lived Experience Advocacy Group concurred with this recommendation. The APS suggested amendments to allow an ACD to contain a binding refusal of mental health treatment, which can be overridden in limited circumstances. Further, the APS recommended that:

> … the scope of the section 12 [*Advance Care Directives Act*] prohibition be revised to allow for an ACD to include provisions about the *type* of treatment to be received or not received (e.g., not consenting to a particular type of medication, but consenting to another appropriate medication or psychological intervention) where this does not amount to a complete refusal of treatment under the *MHA*.

3.5.133 The utility and binding nature of ACDs in the context of mental health must be explored further. SALRI agrees that further examination of the *Advance Care Directives Act 2013* (SA) is warranted, to explore possible amendments regarding the binding nature of directives.

3.6 SALRI's Observations and Conclusions

3.6.1 Decision-making capacity and SDM have particular importance in the context of the *MHA*. This Part discussed the definition of decision-making capacity, its operation when applied in the context of treatment orders, capacity assessment and SDM. Key rights and values pertaining to autonomy, dignity of risk, self-determination and equality underpin decision-making capacity.

[551] For further discussion, see Part 7 Electroconvulsive Therapy.

3.6.2 A number of key points can be made about capacity.

1. First, capacity is decision-specific, which means it is determined based on the particular decision.[552]

2. Secondly, it is a person's right to make mistakes or choices that others may not agree with or regard as imprudent or unwise.[553] 'A person is allowed to make whatever decision she likes about her property, good or bad, with happy or disastrous effect, so long as she is capable.'[554] The determination of capacity is not a value-based judgment.

3. Thirdly, the presence of a disability, mental illness, cognitive impairment or neurodegenerative disorder does not mean they lack capacity and are unable make their own decisions.[555] Where a person may require assistance in making a decision, a supported decision-making approach is preferred.

3.6.3 These key points are entirely consistent with the guiding principles underpinning the assessment and understanding of decision-making capacity.

3.6.4 The *MHA* is one of the few legal instruments that authorises interference with rights. SALRI recognises that decision-making capacity is highly valuable and the determination of impaired decision-making capacity is significant.

3.6.5 SALRI was told about the trauma and emotions accompanying a loss of rights and liberty. Given impaired decision-making capacity operates as one of the criteria needing to be satisfied to enforce a treatment order, it is imperative that this step is approached thoroughly by a skilled clinician, with care, dignity, transparency and accountability.

3.6.6 SALRI acknowledges that the current definition of decision-making capacity under s 5A of the *MHA* remains fit for purpose, with possible scope to insert explicit endorsement of a SDM model. It is consistent with other legislative definitions and is premised upon the four steps of understanding information, the ability to retain it and use it in the course of making a decision and communicating a decision, by any means appropriate. Further, the factors contained within s 5A of the *MHA* are consistent with the guiding principles of capacity. Importantly, it recognises fluctuating capacity, which in practice, introduces a number of considerations. The value of definitional consistency cannot be undermined, as noted by one survey respondent on YourSAy, the definition needs to be consistent, as 'too many area specific definitions causes confusion.'

3.6.7 SALRI agrees that dignity of risk should be addressed in the *MHA* as a guiding principle.[556]

3.6.8 Although outside the remit of SALRI's review, the definition of 'mental incapacity' contained within s 3 of the *Guardianship and Administration Act 1993* (SA) could usefully be examined.

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[552] *Gibbons* v Wright (1954) 91 CLR 423.

[553] *Re: T (Refusal of Treatment)* [1992] 3 WLR 782.

[554] *Re C (TH) and the Protected Estates Act* [1999] NSWSC 456, [17].

[555] *PBU & NJE v Mental Health Tribunal* [2018] VSC 564. See also Sylvia Villios et al, *Valuable Instrument or the Single Most Abused Legal Document in our Judicial System? A Review of the Role and Operation of Powers of Enduring Attorney in South Australia* (South Australian Law Reform Institute, 2020) 159 [4.5.34]–[4.5.35].

[556] See further Part 12 Guiding Principles and Accountability Mechanisms.

3.6.9 SALRI also notes that some parties in consultation advocated for amendments to the definition of 'consent' under s of the 3 *MHA*. SALRI supports the amendment of this definition, with particular regard to the definition of 'informed consent' contained in s 86 of the *Mental Health and Wellbeing Act 2022* (Vic).

3.6.10 SALRI emphasises the importance of the presumption of capacity. The decision to determine an individual lacks capacity is significant and can have an ongoing impact on their life, despite the individual regaining capacity.

3.6.11 SALRI emphasises that a capacity assessment can only be undertaken by a health professional, including a general practitioner, psychiatrist, geriatrician, psychologist or neuropsychologist. However, SALRI acknowledges the barriers to accessing these assessments, including availability of practitioners (especially in regional/rural communities), wait times and cost.

3.6.12 SALRI recognises that decision-making capacity is a complex construct, drawing upon various disciplines, including law, medicine, psychology and neuropsychology. It is a recurring theme in SALRI's previous references.

3.6.13 The legislative definition of decision-making capacity must retain a degree of ambiguity, most notably in relation to its assessment. SALRI acknowledges that the assessment of decision-making capacity varies according to specific professions and disciplines. As a result, a definition which is too prescriptive would place limitations on a professional's ability to exercise clinical judgment and discretion. It is indeed an area whereby trust and reliance must be placed upon the clinical acumen and expertise of practitioners undertaking capacity assessments. This been previously raised to SALRI by many parties in consultation, notably Dr Chris Moy of the AMA(SA). SALRI concurs with this approach.[557]

3.6.14 An individualised approach to capacity assessment reflects a human rights-based framework, as the assessment is tailored to the individual, representing a person-centred approach. The definition's ambiguity enables the approach to be personalised. The insertion of specific criteria of what may or may not constitute decision-making capacity may be counterproductive, de-personalising the definition and compromising a person-centred approach. It is a case-by-case assessment, which is informed by a matrix of factors by experienced clinicians.

3.6.15 Measures to offer education for consumers and members of community to increase understanding of decision-making capacity and its assessment is necessary. SALRI supports the introduction of a South Australian Capacity Toolkit or Guidelines, as observed in NSW or Queensland. This would serve as an educative tool for any member of the community and address varying aspects of capacity, its definition and process for assessment.

3.6.16 A Toolkit or Guidelines can address concerns in consultation relating to the need for clarity of the impaired decision-making capacity criterion. This resource may also address, in more detail, various approaches to capacity assessment. However, as noted by psychologists/neuropsychologists, it is not feasible to capture all of the various psychometric tools available for assessment (noting these are also subject to revisions as part of ongoing professional development and understanding and may compromise the validity of specific tools). SALRI notes that

[557] See also David Plater et al, *'Autonomy and Safeguarding are not Mutually Inconsistent': A Review of the Operation of the Ageing and Adult Safeguarding Act 1995 (SA)* (South Australian Law Reform Institute, 2022) 166 [6.5.1].

these toolkits or guidelines should be co-designed with relevant stakeholders, to ensure information is accurate and reflective of best practice.

3.6.17 Further, the need to develop culturally appropriate tools for the assessment of capacity has been previously raised by SALRI.[558] This remains an area requiring further consideration.[559]

3.6.18 SALRI acknowledges the Deputy Coroner's recommendation. In relation to the impaired decision-making capacity criterion for treatment orders, SALRI's consultation strongly supported that it be retained. SALRI favours retention of the present law. This approach is seen as reflecting contemporary understanding and essential to retaining the consumer's autonomy.

3.6.19 Many in consultation described this criterion as a necessary safeguard for a consumer. SALRI agrees in principle that accountability could be strengthened to ensure a consumer has access to the reasons for the outcome of a capacity assessment. This may involve an additional provision within s 5A of the *MHA* to mandate written reasons for a capacity assessment. Alternatively, this provision may be incorporated within the criteria for treatment orders. The practical implications of documenting written reasons for an assessment at the point of making a treatment order must be further considered. Parties raised the administrative and time burden associated with this requirement. Its operation must also be examined where a treatment order is made in cases of urgency or settings such as the emergency department.

3.6.20 SALRI agrees with the OCP's view that a capacity assessment should be undertaken each time a clinical review occurs. The need for capacity assessment reviews is a necessary safeguard for persons with fluctuating capacity and to ensure a person is able to regain their capacity.

3.6.21 In an effort to transform SA's *MHA* into a rights-based instrument, SALRI agrees that SDM should be endorsed within the definition of decision-making capacity under s 5A of the *MHA*. SALRI agrees with the approach adopted by both Victoria and the ACT, with a preference for the ACT model. Namely, that the following provisions or provisions similar to, sections 8(1)(c) and (d) *Mental Health Act 2015* (ACT) are enumerated:

> (c) a person who does not have decision-making capacity must always be supported to make decisions about the person's treatment, care or support to the best of the person's ability;
>
> (d) a person must not be treated as not having decision-making capacity unless all practicable steps to assist the person to make decisions have been taken;

3.6.22 Alternatively, SALRI considers that regard should be given to s 87(3)(b) of the *Mental Health and Wellbeing Act 2022* (Vic):

> (b) the person being assessed is provided with appropriate supports to enable the person to give informed consent.

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[558] Sylvia Villios et al, *Valuable Instrument or the Single Most Abused Legal Document in our Judicial System? A Review of the Role and Operation of Powers of Enduring Attorney in South Australia* (South Australian Law Reform Institute, 2020) Part 9 Vulnerable Populations, in particular 382–3 [9.1.52]–[9.1.63] and 387–9 [9.1.76]–[9.1.81].

[559] Dr Tracey Westerman, a clinical psychologist, is widely known for her work in Aboriginal mental health, cultural competency and suicide prevention. Dr Westerman has developed culturally appropriate assessment tools, which have subsequently been statistically, scientifically and culturally validated for use by Indigenous Psychological Services. See Indigenous Psychological Services, *Products and Tests* (2022) <https://indigenouspsychservices.com.au/products-tests/>.

3.6.23 SALRI also notes ss 4(4)(d) and (5) of the *Voluntary Assisted Dying Act 2021* (SA), which also endorses SDM:

> (d) a person has decision making capacity to make a decision if it is possible for the person to make a decision with practicable and appropriate support.
>
> Example—
>
> Practicable and appropriate support includes things such as—
>
> (a) using information or formats tailored to the particular needs of a person;
>
> (b) communicating or assisting a person to communicate the person's decision;
>
> (c) giving a person additional time and discussing the matter with the person;
>
> (d) using technology that alleviates the effects of a person's disability.
>
> (5) A person who is assessing whether a person has decision making capacity for the purposes of this Act must take reasonable steps to conduct the assessment at a time and in an environment in which the person's decision making capacity can be most accurately assessed.

3.6.24 SALRI supports measures to strengthen the authority of directives relating to mental health treatment, including psychiatric medication and electroconvulsive therapy, contained within a valid ACD. Provided a person has decision-making capacity at the time in which the ACD is made, any directive should, as far as is practicable, be effective and binding, consistent with the law and practice in other areas of health care. SALRI recognises this may require consequential amendments to the *Advance Care Directives Act 2013* (SA), in particular s 12.

3.6.25 SALRI also supports the inclusion of an immunity clause for medical practitioners, in cases where compliance with a directive inevitably results in the person's death. The most common case raised to SALRI was a catatonic person requiring emergency ECT within a small timeframe to prevent death. Where this person has a valid ACD and a directive refusing emergency ECT, the medical practitioner will be immune from legal action in the event of death. SALRI recommends further consideration be given to the role of the South Australian Civil and Administrative Tribunal, to introduce discretions to override ACD directives, under limited circumstances. These may include where the person had impaired decision-making capacity at the time in which the ACD was made and/or at the time of making the ACD, the person did not understand the nature and effect of the directive. The Tribunal should, as far as is practicable, make orders that are consistent with the directives contained within a valid ACD.

3.6.26 In addition to legislative amendments, SALRI strongly supports the use of resources, such as SACID's Conversation Cards, to assist those with a disability to communicate and receive support. SALRI recognises there are a myriad of supports that can facilitate SDM. Further consideration must be given to ensuring mental health services have the training, tools, infrastructure, resourcing and funding to implement these supports.

3.6.27 Recommendations

RECOMMENDATION 12

SALRI recommends that the current definition of 'decision-making capacity' in s 5A(2) of the *Mental Health Act 2009* (SA) should be retained and s 5A(3) should be amended to endorse a supported decision-making framework, giving consideration to s 8(1)(c) and (d) of the *Mental Health Act 2015* (ACT) to provide that:

a. A person who does not have decision-making capacity should[560] be supported to make decisions about the person's treatment, care or support to the best of the person's ability;

b. A person must not be treated as not having decision-making capacity unless all practicable steps to assist the person to make decisions have been taken.

RECOMMENDATION 13

SALRI recommends that the most suitable department or agency, in consultation with relevant interested parties (such as consumer groups and the RANZCP) should draft a capacity assessment Toolkit or Guidelines in South Australia, to be utilised as a non-legislative, educative tool for any interested member of the community or medical or other health practitioner. The Toolkit or Guidelines should be concise, written in plain English and in easily accessible formats (such as Easy Read and videos) to all members of the community and should be made available in various translated languages.

RECOMMENDATION 14

SALRI further recommends that any Toolkit or Guidelines developed should specifically address the following:

a. Implications of capacity and its assessment for Aboriginal communities and Culturally and Linguistically Diverse communities, noting that such communities should be consulted to facilitate a process of co-design.

b. Provide clarity and explanations relating to impaired decision-making capacity in the context of mental health.

RECOMMENDATION 15

SALRI recommends that the 'impaired decision-making capacity' criterion contained in relation to the grounds for a Community Treatment Order or Inpatient Treatment Order in ss 10(1)(c), 16(1)(c), 21(1)(ba), 25(2)(ba) and 29(1)(ba) of the *Mental Health Act 2009* (SA) should be retained.

[560] SALRI supports the term 'should' – which places less limitations on the operation of the provision.

RECOMMENDATION 16

SALRI recommends that measures to enforce accountability following a clinical capacity assessment, particularly in the making of a treatment order, such as providing written reasons, should be considered further and, where appropriate, implemented.

RECOMMENDATION 17

SALRI recommends that directives relating to mental health treatment (including specific psychiatric medication and electroconvulsive therapy) contained within a valid Advance Care Directive made pursuant to the *Advance Care Directives Act 2013* (SA) should, as far as practicable, be effective and binding, consistent with the law and practice in other areas of health care, with any necessary consequential amendments to the *Advance Care Directives Act 2013* (SA) to be made to achieve this aim.

3.6.28 Suggestions

SUGGESTION 4

SALRI suggests that the definition of 'decision-making capacity' as appears in the *Mental Health Act 2009* (SA) be used across all South Australian legislation for consistency. Any amendments should be made to relevant pieces of legislation to provide this consistency.

SUGGESTION 5

SALRI suggests that Conversation Cards or a wallet-sized information card should be available for consumers, in particular persons with a disability, such as an intellectual disability.

Part 4 – Aboriginal Mental Health

4.1 Background

4.1.1 The acute effects and implications of mental health issues for Aboriginal communities are well established,[561] especially in the context of the justice system.[562] The First Peoples Disability Network, for example, reported to the Law Council of Australia that Aboriginal and Torres Strait Islander people are 2.1 times more likely to be living with disability than other Australians and five times more likely to experience a mental health condition than other Australians.[563]

4.1.2 The wider context to this is significant. As one article observes:

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[561] See, for example, Beverley Raphael and Pat Swan, 'The Mental Health of Aboriginal and Torres Strait People' (1997) 26(3) *International Journal of Mental Health* 9; Robert Parker, 'Australia's Aboriginal Population and Mental Health' (2010) 198(1) *Journal of Nervous and Mental Disease* 3; Ernest Hunter, 'Disadvantage and Discontent: A Review of Issues Relevant to the Mental Health of Rural and Remote Indigenous Australians' (2007) 15(2) *Australian Journal of Rural Health* 88; Anthony Jorm et al, 'Mental Health of Indigenous Australians: a Review of Findings from Community Surveys' (2012) 196(2) *Medical Journal of Australia* 118; Nadia Day, *Mental Health Services for Aboriginal Australians Inadequate, Inappropriate, Report Warns* (6 November 2014) ABC News <https://www.abc.net.au/news/2014-11-06/mental-health-services-aboriginal-australians-called-inadequate/5873124>; Emma Black et al, 'A Systematic Review: Identifying the Prevalence rates of Psychiatric Disorder in Australia's Indigenous Populations' (2015) 49(5) *Australian and New Zealand Journal of Psychiatry* 412; John Stewart and Brigid Andersen, *Indigenous People with Mental Health Issues "On a Train" to Jail: UNSW Study* (2 November 2015) ABC News <https://www.abc.net.au/news/2015-11-02/indigenous-people-mental-health-issues/6904838>; Bushra Nasir et al, 'Common Mental Disorders among Indigenous People Living in Regional, Remote and Metropolitan Australia: a Cross-Sectional Study' (2018) 8(6) *BMJ Open* 1, 1–11; Julie Power, *Uncle Jack Charles wants us all to try a little tenderness* (12 November 2020) Sydney Morning Herald <https://www.smh.com.au/national/uncle-jack-charles-wants-us-all-to-try-a-little-tenderness-20201111-p56dl7.html>; James Ogilvie et al, 'Prevalence of Psychiatric Disorders for Indigenous Australians: a Population-Based Birth Cohort Study' (2021) 30 (e21) *Epidemiology and Psychiatric Sciences* 1, 1–9.

[562] The wider implications in relation to the justice system are telling. 'Indigenous Australians with mental and cognitive disabilities are forced into the criminal justice system early in life in the absence of alternative pathways. Although this also applies to non-Indigenous people with mental and cognitive disabilities who are highly disadvantaged, the impact on Indigenous Australians is significantly greater across all measures and experiences gathered in the studies across the project': Eileen Baldry et al, *A Predictable and Preventable Path: Aboriginal People with Mental and Cognitive Disabilities in the Criminal Justice System* (University of New South Wales, October 2015) 12. 'Police have become the default frontline response to Aboriginal people with mental and cognitive disabilities. In the absence of culturally responsive and therapeutic community based support, regular police contact from a young age sets this group up for a lifetime of "management" by the criminal justice system. … We found that police are often the first and only service to show up to a crisis involving Aboriginal people with mental and cognitive disabilities': Eileen Baldry, Elizabeth McEntyre and Ruth McCausland, 'Aboriginal people with disabilities get caught in a spiral of over-policing', (4 November 2015) The Conversation <https://theconversation.com/aboriginal-people-with-disabilities-get-caught-in-a-spiral-of-over-policing-49294>; This is especially evident amongst Aboriginal people within the prison system. A 2010 Senate Inquiry found that approximately 98 per cent of Aboriginal and Torres Strait Islander inmates across all jurisdictions have a cognitive disability: Community Affairs References Committee, Parliament of Australia, *Hear Us: Inquiry into Hearing Health in Australia* (2010) [8.103]. See also Edward Heffernan et al, 'Prevalence of Mental Illness among Aboriginal and Torres Strait Islander People in Queensland Prisons' (2012) 197 *Medical Journal of Australia* 1; Eileen Baldry et al, *A Predictable and Preventable path: Aboriginal People with Mental and Cognitive Disabilities in the Criminal Justice System* (University of New South Wales, October 2015). In Queensland, 86 per cent of Aboriginal and Torres Strait Islander women who were in prison were suffering from mental disorders: Edward Heffernan et al, 'Prevalence of Mental Illness among Aboriginal and Torres Strait Islander People in Queensland prisons' (2012) 197 *Medical Journal of Australia* 1, 37–41. Many children in the juvenile detention system also live with trauma-related developmental and mental health conditions: Law Council of Australia, *The Justice Project: Aboriginal and Torres Strait Australians* (Final Report, August 2018) 73. See further 10–11, 13, 16–7, 73.

[563] Law Council of Australia, *The Justice Project: People with Disability* (Final Report, August 2018) 9.

> Aboriginal people also have particular mental health needs as disadvantage and discrimination combine with the devastating grief and trauma that are a consequence of the past systematic removal of children and destruction of communities, and the continuing experience of loss from incarceration, illness and premature deaths of family members.[564]

4.1.3 Another study elaborates:

> From the onset of colonisation in 1788, as was the case for many other Indigenous peoples, the subsequent centuries were characterised by genocide; by forced removal from land, peoples, families; by enslavement; and by assimilation and destruction of cultural ways. Despite this, the fact that Indigenous people have sustained their identity, and are experiencing a cultural renaissance, is a testimony to the determination of the human spirit.[565]

4.1.4 These themes were powerfully expressed in SALRI's consultation, notably by various Aboriginal Elders such as Charlie Jackson OAM[566] and members of Aboriginal communities and Aboriginal community health agencies.

4.1.5 The *Mental Health Act 2009* (SA) (*MHA*) lays the foundation for mental health treatment for all South Australians, including those from Aboriginal communities. SALRI sought to ensure the review of the *MHA* actively considered the application and appropriateness of current law and practice for Aboriginal communities.[567] SALRI notes the position of the Victorian Royal Commission:

> In the face of significant challenges stemming from invasion, dispossession and ongoing systemic racism and marginalisation, Aboriginal communities remain resilient. The Commission recognises the leadership and ingenuity of many Aboriginal Elders, communities and community-controlled organisations in supporting better social and emotional wellbeing outcomes for Aboriginal people.[568]

4.1.6 Mental health is a complex and sensitive subject matter, especially for Aboriginal communities. SALRI emphasises that numerous factors – all of which can be inter-related, contribute to Aboriginal mental health. SALRI's consultation with Aboriginal community members revealed mental health is impacted by the legacy of colonisation manifesting in experiences of historical and continuing intergenerational trauma in Aboriginal communities and people, child protection, grief and loss, domestic violence, sexual assault, criminal justice (notably, youth detention), systemic social and institutional disadvantage, education and lack of access to culturally appropriate services. These are but

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564 Mental Health Commission of NSW, *Aboriginal Communities* (September 2014) <https://www.nswmentalhealthcommission.com.au/content/aboriginal-communities>.

565 Patricia Dudgeonet al, 'Contemporary Aboriginal Perceptions of Community' in Adrian Fisher et al (eds), *Psychological Sense of Community: Research, Applications, and Implications* (Springer Science, 2002) 247.

566 'According to Mr Jackson, both vulnerability and mental health come up often in Aboriginal communities. "When we talk about people being vulnerable, Aboriginal people haven't made themselves vulnerable," he said. "It's government policy that has made Aboriginal people vulnerable for the simple reason that there's not a lot of support out there for Aboriginal people." He said Aboriginal people have been facing hundreds of years of emotional and psychological pressures which affect the whole community. "The younger generation are experiencing that at the moment," Mr Jackson said': Aidan Curtis, 'Elders meet with SALRI on how the law can better include Aboriginal Communities', *The Transcontinental* (Port Augusta) (online, 25 May 2022), <https://www.transcontinental.com.au/story/7753043/elders-have-their-say-on-law-reform/>.

567 Aidan Curtis, 'Elders meet with SALRI on how the law can better include Aboriginal Communities', *The Transcontinental* (Port Augusta) (online, 25 May 2022), <https://www.transcontinental.com.au/story/7753043/elders-have-their-say-on-law-reform/>.
SALRI acknowledges and appreciates the particular insight and valuable input of Charlie Jackson OAM, Beth Turner, Evelyn Varcoe and Aunty Yvonne Agius.

568 *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021) vol 3, 142.

a few of the factors interacting to influence mental health. Recognising and understanding the complex interplay of these factors is critical for all parties involved in the administration of the *MHA*.

4.1.7 South Australia's rich cultural diversity highlights the need to ensure future laws and policies consider the specific needs, interests and concerns of Aboriginal communities. Mistrust of the Government and related entities must be recognised as an outcome of historical and continuing intergenerational trauma and oppression.[569] In areas of law, policy and practice, it is therefore vital that Aboriginal community members are actively involved in their design and implementation.

4.1.8 There are nine Aboriginal townships within South Australia – Amata, Koonibba, Maralinga Tjarutja (Oak Valley), Mimili, Nepabunna (Nipapanha), Pukatja (Ernabella), Raukkan, Umuwa and Yalata, and over 30 distinct Aboriginal Nations.[570] Whether an Aboriginal person lives inside or outside of these townships, does not impact the need for culturally relevant and sensitive information and services, and does not diminish experiences and barriers associated with the mental health system.

4.1.9 This Part seeks to identify factors contributing to Aboriginal mental health and the ways in which the current *MHA* addresses mental health in communities and considers possible changes to present law and practice. It also considers ways in which the *MHA* could become a more culturally appropriate and inclusive statute with the capacity to recognise and promote Aboriginal culture, lore and practice. The issues raised are relevant to all Aboriginal communities in South Australia.

4.2 What is Mental Health?

4.2.1 Mental health can be described as a 'holistic concept' that captures connection to land, culture, spirituality and ancestry.[571] Aboriginal Community Controlled Health Organisations have provided guidance in relation to a culturally appropriate definition of 'health', based upon a holistic notion of health, inclusive of social and emotional wellbeing.[572] It has been noted the broad concept of social and emotional wellbeing provides the foundation for physical and mental health.[573] The Victorian Royal Commission described social and emotional wellbeing as 'being resilient, being and feeling culturally safe and connected, having and realising aspirations, and being satisfied with life.'[574] This means that although social and emotional wellbeing issues can be separate to mental health and mental illness, they interact and influence one another.[575] This is consistent with Patricia Dudgeon et

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[569] Law Council of Australia, *The Justice Project: Aboriginal and Torres Strait Australians* (Final Report, August 2018) 7–10.

[570] National Indigenous Australians Agency, *Communities List* (2020) <https://www.indigenous.gov.au/communities/list-view?title=&field_indig_state_tid=21>.

[571] Australian Institute of Health and Welfare, *Indigenous Health and Wellbeing* (7 July 2022) <https://www.aihw.gov.au/reports/australias-health/indigenous-health-and-wellbeing#Social%20and%20emotional%20wellbeing>.

[572] Australian Institute of Health and Welfare, *Social & emotional wellbeing* (24 March 2022) <https://www.indigenousmhspc.gov.au/topics/sewb#aboutthistopic>.

[573] Australian Institute of Health and Welfare, *Social & emotional wellbeing* (24 March 2022) <https://www.indigenousmhspc.gov.au/topics/sewb#aboutthistopic>.

[574] Royal Commission into Victoria's Mental Health System (Final Report, February 2021) vol 3, 142.

[575] Australian Institute of Health and Welfare, *Social & emotional wellbeing* (Web Page, 24 March 2022) <https://www.indigenousmhspc.gov.au/topics/sewb#aboutthistopic>; Department of the Prime Minister and Cabinet, *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017-2023* (2017).

al, who noted 'good mental health is indicated by feeling a sense of belonging, having strong cultural identity, maintaining positive interpersonal relationships, and feeling that life has purpose and value.'[576]

4.2.2 The Productivity Commission highlighted that for Aboriginal communities mental health is a holistic concept: 'The individual social and emotional wellbeing of Aboriginal and Torres Strait Islander people is affected by overlapping connections to culture, country, spirituality and ancestors, body, mind and emotions, family and kinship as well as community.'[577]

4.2.3 A number of determinants influence mental health and these must be actively addressed when working with an Aboriginal person. This was raised by Dr Graham Gee et al, who noted 'poor mental health can be affected by major stressors such as removal from family, incarceration, death of a close friend or family member, discrimination and unemployment, as well as stressors from everyday life'.[578] This was reinforced by the Victorian Royal Commission, in which Jill Gallagher, CEO of the Victorian Aboriginal Community Controlled Health Organisation, raised the 'direct relationship between poor mental health and wellbeing, and loss of land, culture, identity, self-worth and the breakdown of traditional kinship structures and roles' within Aboriginal communities.'[579]

4.2.4 The Victorian Royal Commission elaborated:[580]

> People's communities, neighbourhoods and environments affect their health and wellbeing. The Commission has already acknowledged the evidence that 'mental health is shaped by the social, cultural, economic and physical environments in which people live'.[581] This knowledge has been long held by Aboriginal peoples and is now formalised in Aboriginal approaches to social and emotional wellbeing. The Aboriginal concept of social and emotional wellbeing takes a holistic view of mental health that is 'not limited to connections between the mind and the body'.[582] This concept 'captures Aboriginal people's connections to land, to spirit, spirituality and ancestors, to culture, and to community, family and kinship'.[583] Building from its work in the interim report, the Commission acknowledges there is much to be learned from the Aboriginal social and emotional wellbeing model. This includes the importance of connecting dimensions of wellbeing: people's bodies, emotions, families and communities, spirit and culture.[584] Consistent with the social and

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[576] Patricia Dudgeon et al, *Voices of the people: The National Empowerment Project: National Summary Report 2014: Promoting cultural, social and emotional wellbeing to strengthen Aboriginal and Torres Strait Islander communities* (University of Western Australia, 2014); Patricia Dudgeon and Roz Walker, 'Decolonising psychology: discourses, strategies and practice' (2015) 3(1) *Journal of Social and Political Psychology* 276, 276–97.

[577] Productivity Commission, *Mental Health, Inquiry Report,* No 95 (2020) vol 2, 400.

[578] Graham Gee, Patricia Dudgeon, Clinton Schultz, Amanda Hart and Kerrie Kelly, 'Social and emotional wellbeing and mental health: an Aboriginal perspective' in Patricia Dudgeon, Helen Milroy and Roz Walker (eds), *Working together: Aboriginal and Torres Strait Islander mental health and wellbeing principles and practice* (Department of the Prime Minister and Cabinet, Canberra, 2nd ed, 2014).

[579] *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021) vol 3, 142.

[580] Ibid vol 1, 304.

[581] Victoria, Royal Commission into Victoria's Mental Health System, *Interim Report* (February 2021) 13.

[582] Graham Gee, Patricia Dudgeon, Clinton Schultz, Amanda Hart and Kerrie Kelly, 'Social and emotional wellbeing and mental health: an Aboriginal perspective' in Patricia Dudgeon, Helen Milroy and Roz Walker (eds), *Working together: Aboriginal and Torres Strait Islander mental health and wellbeing principles and practice* (Department of the Prime Minister and Cabinet, Canberra, 2nd ed, 2014) 55, 57. See also Victoria, Royal Commission into Victoria's Mental Health System, *Interim Report* (February 2021) 474.

[583] Graham Gee, Patricia Dudgeon, Clinton Schultz, Amanda Hart and Kerrie Kelly, 'Social and emotional wellbeing and mental health: an Aboriginal perspective' in Patricia Dudgeon, Helen Milroy and Roz Walker (eds), *Working together: Aboriginal and Torres Strait Islander mental health and wellbeing principles and practice* (Department of the Prime Minister and Cabinet, Canberra, 2nd ed, 2014) 55, 57.

[584] Ibid.

emotional wellbeing model, the Commission acknowledges the important role of experiences of 'safety and security, sense of belonging, control or mastery, self-esteem, meaning making, values and motivation, and the need for secure relationships'.[585]

4.2.5 Mental illness can be observed as a distinct term, which indicates a diagnosis has been made. In the context of Aboriginal people, it is preferable that an expert clinician, who is culturally competent and aware, undertakes the appropriate assessment in a 'culturally safe' environment.[586] Robert Parker and Helen Milroy define culturally unsafe practices as 'any action which diminishes, demeans or disempowers the cultural identity and wellbeing of an individual, whereas culturally safe practice is simply defined as "effective clinical practice for a person from another culture"'.[587] Access to culturally aware medical practice is a significant issue among Aboriginal communities, in particular remote communities. It has been observed that 'serious and unrecognised miscommunication is pervasive in non-Aboriginal doctor/Aboriginal patient interactions.'[588] This communication barrier is also exacerbated by the absence of properly accredited interpreters during interactions.[589]

4.2.6 While the Diagnostic and Statistical Manual of Mental Disorders V ('DSM-IV') exists as a diagnostic tool for mental illness, it is a 'mono-cultural'[590] classification manual premised on Western conceptions of mental health and mental illness.[591] This is a significant limitation which may compromise the validity of mental illness diagnoses for Aboriginal people. In addition, the methodologies adopted in assessment must be carefully considered, including the use of ethnic and racial categories and the interpretation of assessments and statistics (prevalence of mental illness).[592]

4.2.7 Dr Tracy Westerman AM, a Nyamal woman from the Pilbara region in Western Australia and clinical psychologist, is widely known for her work in Aboriginal mental health, cultural competency and suicide prevention. Dr Westerman has recently examined culture-bound syndromes in Aboriginal populations, drawing upon the Outline for Cultural Formulation framework contained within the DSM-IV.[593] According to the DSM-IV, a culture-bound syndrome is defined as 'recurrent, locality-specific patterns of aberrant behaviour and troubling experience that may or may not be linked to a particular DSM-IV diagnostic category'.[594]

4.2.8 The National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017-2023 ('National Strategic Framework') was

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[585] Ibid 58.

[586] Robert Parker and Helen Milroy, 'Mental Illness in Aboriginal and Torres Strait Islander Peoples' in Patricia Dudgeon, Helen Milroy and Roz Walker (eds), *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing* (Department of the Prime Minister and Cabinet, Canberra, 2nd ed, 2014) 113.

[587] Ibid 114.

[588] Ibid.

[589] For a detailed discussion of cultural communication barriers and the importance of proper interpreters, see SALRI's Final Report on the Role and Operation of Communication Partners in South Australia: David Plater et al, *Providing a Voice to the Vulnerable: A study of Communication Assistance in South Australia* (South Australian Law Reform Institute, 2021) 162–8 [6.3.36]–[6.3.54].

[590] Tracy Westerman, 'Culture-Bound Syndromes in Aboriginal Australian Populations' (2021) 25(1) *Clinical Psychologist* 19, 20.

[591] Ibid 113.

[592] Ibid.

[593] See Tracy Westerman, 'Culture-Bound Syndromes in Aboriginal Australian populations' (2021) 25(1) *Clinical Psychologist* 19.

[594] Ibid 19.

introduced as a tool to guide policy development and practice. It is premised upon these nine key principles:

1. Health is viewed as a holistic concept, that incorporates mental health and physical, spiritual and cultural health and the importance of land to wellbeing.[595] Any disruption in the harmony of these means mental illness challenges will continue.[596]

2. The provision of health services is contingent upon self-determination.[597]

3. A proper understanding of culture is integral in the design, development and delivery of services and should guide assessment, care and management, particularly in the context of mental health.[598]

4. It is critical that there is recognition that experiences of historical and continuing loss and trauma directly impact cultural wellbeing and the effects of these experiences are intergenerational.[599]

5. The human rights of Aboriginal people must be recognised and respected, and a failure to do so causes an ongoing disruption to mental health.[600] Notably, human rights relevant to mental health must be addressed.[601]

6. Racism, stigma, social disadvantage, and environmental adversity and injustice are continuing stressors, with negative impacts on mental health and wellbeing.[602]

7. The importance and centrality of kinship and family must be respected and acknowledged to include broader concepts of family and the bonds of reciprocal affection, responsibility and sharing.[603]

8. Aboriginal culture is not homogenous, nor are Aboriginal communities – there are numerous languages, kinships and ways of living which may vary depending on geographical context, such as urban, rural or remote communities).[604]

9. Aboriginal people have significant strengths, creativity and endurance, with a comprehensive understanding of relationships between human beings and the environment.[605]

4.2.9 These principles highlight the key considerations that should underpin policy and practice in health. In addition to these principles, SALRI notes the need to engage in honest and respectful

[595] Department of the Prime Minister and Cabinet, *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017-2023* (2017) 3.

[596] Ibid.

[597] Ibid.

[598] Ibid.

[599] Ibid.

[600] Ibid.

[601] Ibid.

[602] Ibid.

[603] Ibid.

[604] Ibid.

[605] Ibid.

consultation with Aboriginal communities to ensure active participation of members of community in the law reform and policy development process.[606]

4.3 Mental Illness in Aboriginal Communities

4.3.1 A number of factors impact the mental health of Aboriginal people.[607] SALRI particularly focuses on Aboriginal mental health due to the ongoing arguments and desire to transform mental health service delivery (in both a clinical and governance capacity) into a culturally appropriate and safe system for Aboriginal consumers.

4.3.2 Mental health services should be observed through a cultural lens. It has been noted that '[s]ignificant cultural differences in experiences and expression of trauma and mental health problems place … [Aboriginal people] at risk of misdiagnosis and ineffective management.'[608]

Suicide

4.3.3 From 2017 to 2021, nearly a quarter (24%) of deaths for Aboriginal people aged 0 – 24 years were due to suicide, compared to non-Aboriginal people in this age group (17%). Aboriginal and Torres Strait Islander youth (up to 24 years old) have been identified as up to 14 times more likely to die by suicide than other Australian youth.[609] In SALRI's consultation with Aboriginal Elders and communities, suicide was understandably identified as a mental health priority. Of particular importance, and frequently raised to SALRI during consultation, was this increasing prevalence of suicide among children and young people. Data supports the prevalence of 'premature mortality', whereby suicide rates are twice as high in young Aboriginal people, when compared to non-Aboriginal people.[610]

4.3.4 SALRI was often told of the acute concerns regarding the high suicide rate in Aboriginal communities, consistent with wider sources.[611] The Productivity Commission noted that the 'suicide rates of Aboriginal and Torres Strait Islander people are more than double that of other Australians, with

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606 See also SALRI's Executive Summary.

607 Bridget McNamara et al, 'Factors Relating to high psychological distress in Indigenous Australians and their contribution to Indigenous–non-Indigenous disparities' (2018) 42(2) *Australian and New Zealand Journal of Public Health* 145.

608 Edward Heffernan et al, 'PTSD Among Aboriginal and Torres Strait Islander People in Custody in Australia: Prevalence and Correlates' (2015) 28 *Journal of Traumatic Stress* 523, 524.

609 Joanne Dickson et al, 'A Systematic Review of the Antecedents and prevalence of suicide, self-harm and suicide ideation in Australian Aboriginal and Torres Strait Islander Youth' (2019) 16(17) *International Journal of Environmental Research and Public Health* 3154.

610 Ibid.

611 See, for example, ibid; Mandy Gibson, 'Suicide Rates for Young Aboriginal and Torres Strait Islander People: the Influence of Community Level Cultural Connectedness' (2021) 214(11) *Medical Journal of Australia* 514; Patricia Dudgeon, Tom Calma and Christopher Holland, 'The Context and Causes of the Suicide of Indigenous People in Australia' (2017) 2(2) *Journal of Indigenous Wellbeing* 5; Coroners Court of Victoria, *Suicides of Aboriginal and Torres Strait Island People, Victoria 2018-2021* (January 2022); Diego De Leo et al, *Suicide in Indigenous Populations of Queensland* (Australian Institute for Suicide Research and Prevention and National Centre of Excellence in Suicide Prevention, 2012). 'Suicide was virtually unknown in traditional Aboriginal society. Even in post-colonial Australia, with its widespread dispossession and denial of basic human rights, it was very rare. While the validity of the statistical data on which these assertions are based is questionable, it seems suicide rates among Aborigines and Torres Strait Islanders before 1960 were lower than in the general population. It is against this background that the apparent explosion in the incidence of suicide among the original Australians in the later part of the 20th century has caused such concern and consternation': at v.

young males and those in regional communities particularly at risk.'[612] According to age standardised rates, suicide rates in Aboriginal people are significantly higher (1.4 to 2.4 times more likely)[613] than non-Aboriginal people.[614]

4.3.5 In South Australia, the highest suicide rates were observed in the 35 – 44 year age group (57.7 deaths per 100,000 people).[615] It must be noted in the period of 2017 to 2021 in South Australia, the suicide rate for Aboriginal females was not reported.[616] The age standardised rate of suicide in South Australia was 24% in the period 2017 to 2021.[617]

4.3.6 Intergenerational and cumulative trauma have been identified as factors contributing to the rise in suicide rates.[618] This trauma follows historical and political determinants, such as colonisation, dispossession and assimilation policies.[619] It is also a product of cultural and social determinants such as systemic racism and poverty.[620]

4.3.7 The Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project also identified the following 'complex and interrelated factors that heighten the risk for suicidal behaviours and self-harm':[621]

- Continued socio-economic disadvantage and psychological stressors;
- Grief experienced by premature death of family, community members and friends;
- Grief experienced by death due to suicide;
- Violence and interpersonal conflict;
- Intergenerational trauma, grief and loss resulting from dislocation, forced removal of children and mistreatment;
- Systemic, individual and institutional racism and discrimination;
- Loss of purpose and meaning in life;

[612] Productivity Commission, *Mental Health, Inquiry Report*, No 95 (2020) vol 1, 22.

[613] Australian Institute of Health and Welfare, *Deaths by suicide amongst Indigenous Australians* (November 2022) <https://www.aihw.gov.au/suicide-self-harm-monitoring/data/populations-age-groups/suicide-indigenous-australians>.

[614] Australian Institute of Health and Welfare, *Deaths by suicide amongst Indigenous Australians* (November 2022) <https://www.aihw.gov.au/suicide-self-harm-monitoring/data/populations-age-groups/suicide-indigenous-australians>.

[615] Australian Institute of Health and Welfare, *Deaths by suicide amongst Indigenous Australians* (November 2022) <https://www.aihw.gov.au/suicide-self-harm-monitoring/data/populations-age-groups/suicide-indigenous-australians>.

[616] Ibid.

[617] Ibid.

[618] The Centre of Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention, *CBPATSISP Fact Sheet No 1: The Aboriginal and Torres Strait Islander Suicide Gap* (October 2021).

[619] Ibid.

[620] Ibid. See also Productivity Commission, *Mental Health, Inquiry Report*, No 95 (2020) vol 2, 433.

[621] The Centre of Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention, *Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project Fact Sheet 1: What we know about suicide prevention for Aboriginal and Torres Strait Islander peoples* (2015).

- Poor health, medical co-morbidities, severe mental health and wellbeing challenges;
- Access gap to mental health services that are culturally aware and appropriate. One study noted 34.5% of Aboriginal people who experienced high or very high rates of psychological distress, also encountered barriers to accessing health services.[622]

4.3.8 In relation to addressing the prevalence of suicide, a necessary starting point is acknowledgement and sensitivity that Aboriginal suicide is different from non-Aboriginal suicide.[623] Further, it is known that a number of demographics are at higher risk of suicide, including young people, people with a lived experience of suicide, members of the LGBTIQ community, those who are imprisoned or otherwise in the justice system and homeless people.[624]

4.3.9 Of particular concern, and raised often to SALRI during consultation, were the suicide rates among children and young people. The Victorian Royal Commission reported that in 2016, suicide of children and young people represented 30% of all suicide deaths in Australia.[625] The significance of this statistic is contextualised by the fact that Aboriginal children and young people only represent 3 – 4% of Australia's demographic.[626]

4.3.10 It has also been noted the suicide gap is most significant in the younger demographic, approximately 15 to 19 years of age.[627] A number of complex factors are attributable to the high rates of suicide among this demographic, including the historical, political, cultural and social determinants raised above. However, it must also be recognised that Aboriginal children and young people are:

> … disproportionately exposed to *grief, trauma, loss and discrimination* which greatly affects their *social and emotional wellbeing*. Many also experience a range of *negative impacts* associated with *chronic economic disadvantage, lack of access to appropriate support services, ongoing discrimination by the criminal justice, limited educational and employment opportunities, loss of Elders and other adult family members and mentors due to early deaths or imprisonment*. Indigenous youth are also directly impacted by *very high rates of psychological distress* and exposure to life stressors.[628]

4.3.11 The impact of exposure to life stressors cannot be underestimated – these stressors may involve death, unemployment, pregnancy, serious illness, mental illness or conflict with police.[629] In addition to these stressors, Aboriginal children and young people may also experience psychological insecurity, depression, anxiety, loss of parents or kinship, conflict with other people and perceptual and cognitive impairment due to alcohol or substance abuse.[630] Family and domestic violence is also a

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[622] The Centre of Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention, *Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project Fact Sheet 1: What we know about suicide prevention for Aboriginal and Torres Strait Islander peoples* (2015).

[623] The Centre of Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention, *CBPATSISP Fact Sheet No 1: The Aboriginal and Torres Strait Islander Suicide Gap* (October 2021).

[624] Ibid.

[625] *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021) vol 3, 145.

[626] Ibid.

[627] The Centre of Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention, *Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project Fact Sheet 3: Suicide prevention for Aboriginal and Torres Strait Islander young people* (2015).

[628] Ibid (emphasis added).

[629] Ibid.

[630] Ibid. See also *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021) vol 3, 152.

contributing factor, leading to an increased risk of suicide or suicidal ideation in children.[631] For those who have had a family or community member suicide, this may increase the risk of copy-cat suicides.[632] This was raised during SALRI's consultation with Aboriginal Health (within SA Health), in which there is an increasing prevalence of 'copy-cat' suicide among young people. SALRI was told rates of copy-cat suicide were higher in males aged 17 to 29 years.

4.3.12 Dudgeon et al reported that children who suicide often reside in a non-parental residence and are more likely to take their own life outside of their family home.[633]

4.3.13 A combination of these stressors and factors may lead to weakened connections to 'identity-forming structures and support systems critical to their healthy transition from childhood to adolescence into adulthood.'[634] Consequently, this may contribute to feelings such as a 'loss of hope or will to live.'[635]

4.3.14 The strategies to address suicide should include multi-level prevention efforts.[636] The Victorian Royal Commission reinforced the importance of healing practices, noting they are 'recognised internationally for their effectiveness in addressing intergenerational trauma, improving wellbeing and reducing rates of suicide, incarceration, domestic and family violence and drug and substance abuse.'[637] Notably, among young people, healing practices that aim to renew and strengthen cultural identity has been associated with a decrease in suicide rates.[638]

4.3.15 The Victorian Royal Commission recommended the establishment of a Suicide Prevention and Response Office, to be led by the State Suicide Prevention and Response Adviser, who reports back to the Chief Officer for Mental Health and Wellbeing.[639] The role of the Suicide Prevention and Response Office would be to 'co-design or acquire an existing, evidence-informed training product and implement free, online, standardised community gatekeeper training that all Victorian adults can access. The office will also implement culturally safe community gatekeeper training that is developed and delivered by Aboriginal people.'[640] Postvention bereavement support was also advocated, to be provided by the Victorian Aboriginal Community Controlled Health

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631 Patricia Dudgeon et al, *Connection between family, kinship and social and emotional wellbeing* (2021) v.

632 Living is for Everyone, *Fact Sheet 16: Suicide prevention in Indigenous communities* (2007).

633 Patricia Dudgeon et al, *Connection between family, kinship and social and emotional wellbeing* (Report, 2021) 8; see also Joanne Dickson et al, 'A Systematic Review of the Antecedents and Prevalence of Suicide, Self-Harm and Suicide Ideation in Australian Aboriginal and Torres Strait Islander Youth' (2019) 16 *International Journal of Environmental Research and Public Health* 3154.

634 The Centre of Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention, *Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project Fact Sheet 3: Suicide prevention for Aboriginal and Torres Strait Islander young people* (2015).

635 Ibid.

636 The Centre of Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention, *Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project Fact Sheet 1: What we know about suicide prevention for Aboriginal and Torres Strait Islander peoples* (2015).

637 *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021) vol 3, 162.

638 Ibid 167.

639 See Recommendation 26: ibid 451. The Victorian Government has established a Suicide Prevention and Response Victorian Secretaries Board Subcommittee, which will enforce accountability for suicide prevention and response outcomes. The Suicide Prevention and Response Office will soon be established, in addition to a new State suicide prevention and response strategy: Victorian Department of Health, *Recommendation 26: Governance arrangements for suicide prevention and response efforts* (17 March 2022) <https://www.health.vic.gov.au/mental-health-reform/recommendation-26>.

640 Ibid 483.

Organisation.[641] Post-suicide interventions offered through Aboriginal controlled community health organisations were identified as an 'immediate priority'.[642]

4.3.16 The Aboriginal and Torres Strait Islander Suicide Prevention Project identified a table of 'success factors' for suicide prevention (see **Figure 1** on the following page). Factors in blue font represent those collated from the meta-evaluation of community-led Aboriginal suicide prevention programs.

[641] *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021) vol 3, 491.

[642] Ibid.

Figure 1: Success factors for suicide prevention.[643]

(Factors in blue font represent those collated from the meta-evaluation of community-led Aboriginal suicide prevention programs)

UNIVERSAL/ INDIGENOUS COMMUNITY-WIDE In this report 'universal' is used to indicate community-wide responses, not population-wide responses as the term usually indicates	**Primordial prevention**	• Addressing community challenges, poverty, social determinants of health • Cultural elements – building identity, SEWB, healing • Alcohol /drug use reduction
	Primary prevention	• Gatekeeper training – Indigenous-specific • Awareness-raising programs about suicide risk/use of DVDs with no assumption of literacy • Reducing access to lethal means of suicide • Training of frontline staff/GPs in detecting depression and suicide risk • E-health services/internet/crisis call lines and chat services • Responsible suicide reporting by the media
SELECTIVE – AT RISK GROUPS	**School age**	• School-based peer support and mental health literacy programs • Culture being taught in schools
	Young people	• Peer-to-peer mentoring, and education and leadership on suicide prevention • Programs to engage/divert, including sport • Connecting to culture/country/Elders • Providing hope for the future, education – preparing for employment
INDICATED – AT RISK INDIVIDUALS	**Clinical elements**	• Access to counsellors/mental health support • 24/7 availability • Awareness of critical risk periods and responsiveness at those times • Crisis response teams after a suicide/postvention • Continuing care/assertive outreach post ED after a suicide attempt • Clear referral pathways • Time protocols • High quality and culturally appropriate treatments • Cultural competence of staff/mandatory training requirements
COMMON ELEMENTS	**Community leadership/ cultural framework**	• Community empowerment, development, ownership – community-specific responses • Involvement of Elders • Cultural framework
	Provider	• Partnerships with community organisations and ACCHS • Employment of community members/peer workforce • Indicators for evaluation • Cross-agency collaboration • Data collections • Dissemination of learnings

[643] The Centre of Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention, *Fact Sheet 5: What Works in Indigenous Suicide Prevention* (2019).

4.3.17 It has been noted that self-determination is the fundamental 'governing systemic principle, theory and mechanism that delivers best-practice Indigenous suicide prevention programs and policy.'[644] This was also reinforced in a South Australian Consultation Report, following the introduction of the *Suicide Prevention Act 2021* (SA).[645]

4.3.18 In South Australia, the *Suicide Prevention Act 2021* was introduced to decrease the incidence of suicide, promote best practice suicide prevention state-wide policies, identify the role of the State in prevention, provide training and education, a framework for response and particular initiatives targeting priority population groups.[646] A Consultation Feedback Report, released in September 2021, offered insights into the development of a *State Suicide Prevention Plan*.

4.3.19 Prevention strategies to specifically address suicide and self-harm among children and young people require:

- Continuing work and efforts across a range of services with expertise in the health and wellbeing of children, young people and families to address the plethora of determinants impacting life-course;
- Programs and services to develop and improve social and emotional competencies, to lay the foundation for resilience throughout life, with effective coping strategies for stress and conflict;
- Services that assist families protect children and young people from sources of risk and adversity that will increase vulnerability to self-harm;
- Community-based strategies fostering engagement and connection with Elders;
- Education and support programs for frontline workers to increase cultural knowledge and awareness of complexities experienced by children and young people; and
- 24 hour support. Research efforts to ascertain the time and means of suicide and self-harm attempts indicate death in children and young people is often caused by intentional self-harm.[647]

4.3.20 Efforts must also be made on behalf of service providers and staff to:

- Build partnerships and relationships of trust with young people;
- Embed learning opportunities in social and community activities;
- Work with families, in addition to the young person;
- Recognise existing strengths and interests in the community;

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[644] Patricia Dudgeon et al, *Connection between family, kinship and social and emotional wellbeing* (2021) vi.

[645] Wellbeing SA, *What we heard about suicide in South Australia Consultation Report* (September 2021) 11.

[646] See *Suicide Prevention Act 2021* (SA) s 7. SALRI also notes the helpful input of the Hon John Dawkins as to the background and rationale of this Act.

[647] The Centre of Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention, *Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project Fact Sheet 3: Suicide prevention for Aboriginal and Torres Strait Islander young people* (2015).

- Identify local mentors and role models;
- Improve partnerships between agencies; and
- Recognise aspirations of young people and community may not align with common expectations of funders and their perception of successful outcomes.[648]

4.3.21 Accurate data collection and analysis should also accompany all efforts to address the rates of suicide in Aboriginal populations.

4.3.22 Consultation with Aboriginal communities reinforced the importance of connection to family, community and culture.[649] Some measures to strengthen connection to Country, community and family included going back to Country, arranging community events and providing yarning spaces.[650] It was suggested that training to provide community members with the skills to support each other could be passed on from one male and one female member.[651] Aboriginal communities also expressed the need to recognise and address the impact of intergenerational trauma on suicide rates.[652] In addition, the systemic discrimination and high suicide rate in prison was also identified by Aboriginal communities as a contributing factor to suicide rates.[653] In response to this, it was suggested that community-based peer support schemes could be developed for Aboriginal people in custody.[654]

4.3.23 It is integral that Aboriginal people are actively involved and consulted when developing suicide prevention strategies. Cultural differences may mean that the term 'suicide' may not exist in a language or culture group.[655] This extends to appropriate interventions or support. For example, some communities do not rely on language to comfort a person, and therefore require alternative approaches.[656]

4.3.24 The high prevalence of suicide among Aboriginal people is telling. Ongoing efforts to ensure prevention and postvention strategies are culturally appropriate must remain a priority. A regular theme highlighted to SALRI was the notion that mental health laws are focussed on mental illness, as opposed to prevention and wellbeing. This also applies to Aboriginal mental health, which requires efforts to ensure accessibility to culturally aware, competent mental health services and practitioners.

[648] The Centre of Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention, *Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project Fact Sheet 3: Suicide prevention for Aboriginal and Torres Strait Islander young people* (2015).

[649] Wellbeing SA, *What we heard about Suicide in South Australia Consultation Report* (September 2021) 9.

[650] Ibid 10.

[651] Ibid 11.

[652] Ibid 13.

[653] Ibid.

[654] Ibid.

[655] Ibid 19.

[656] Ibid.

Mental and behavioural conditions

4.3.25 Data from the latest National Aboriginal and Torres Strait Islander Health Survey in 2018 – 2019 revealed depression was the second most common condition reported, at 13%.[657] Depression among females was higher than males (16% females, 10% males).[658]

4.3.26 In 2018, mental and substance use disorders were identified as the leading cause of total disease burden (at 23%), with the following causes of burden including:[659]

- Anxiety disorders: 23%
- Alcohol use disorders: 19%
- Depressive disorders: 19%
- Drug use disorders (alcohol excluded): 9%
- Schizophrenia: 7%

4.3.27 Approximately 24% of people aged two years and above reported having a mental or behavioural condition.[660] Overall, the proportion of people with a mental or behavioural condition was approximately the same for females (25%) and males (23%) and three times higher for those living in non-remote areas (28%) as opposed to remote areas (10%).[661] Anxiety was the most common condition reported (17%), with rates higher in females (21%) than males (12%).[662] Rates of psychological distress were also notable – with 31% of people aged 18 years and above reporting high or very high levels, which are indicative of a person's current and future mental health and wellbeing.[663]

Post Traumatic Stress Disorder

4.3.28 The consequences of colonisation have translated into intergenerational trauma for Aboriginal communities.[664] This may translate into post traumatic stress disorder ('PTSD').[665]

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[657] Australian Bureau of Statistics, *National Aboriginal and Torres Strait Islander Health Survey* (December 2019) <https://www.abs.gov.au/statistics/people/aboriginal-and-torres-strait-islander-peoples/national-aboriginal-and-torres-strait-islander-health-survey/latest-release#key-statistics>.

[658] Ibid.

[659] Australian Institute of Health and Welfare: Indigenous Mental Health and Suicide Prevention Clearinghouse, *Mental health* (November 2022) <https://www.indigenousmhspc.gov.au/topics/mental-health#relatedpublications>.

[660] Australian Bureau of Statistics, *National Aboriginal and Torres Strait Islander Health Survey* (December 2019) <https://www.abs.gov.au/statistics/people/aboriginal-and-torres-strait-islander-peoples/national-aboriginal-and-torres-strait-islander-health-survey/latest-release#key-statistics>.

[661] Ibid.

[662] Ibid.

[663] Ibid.

[664] Anthea Kreig, 'The Experience of Collective Trauma in Australian Indigenous Communities' (2009) *Australasian Psychiatry* 17(1) S28; Edward Heffernan et al, 'PTSD Among Aboriginal and Torres Strait Islander People in Custody in Australia: Prevalence and Correlates' (2015) 28 *Journal of Traumatic Stress* 523; Karen Menzies, 'Understanding the Australian Aboriginal Experience of Collective, Historical and Intergenerational Trauma' (2019) (6) *International Social Work* 1–13; Bushra Nasir et al, 'Traumatic Life Events and Risk of Post-Traumatic Stress Disorder among the Indigenous Population of Regional, Remote and Metropolitan Central-Eastern Australia: a Cross-Sectional Study' (2021) 11 *BMJ Open* 1.

[665] See Cross Cultural Consultants, *PTSD and Its Impacts in Aboriginal Australia* (June 2017) <https://www.cccnt.com.au/ptsd-and-its-impacts-in-aboriginal-australia/>.

4.3.29 Due to the limited reliable data on PTSD within Aboriginal communities, one study noted that the high rates of psychological distress and mental and behavioural conditions suggest that PTSD rates are elevated.[666] Heffernan et al noted '[t]he high prevalence of psychological distress among Indigenous Australians is thought to relate to the traumatic impacts of colonisation, the forced removal of children by the state, and policies and practices that resulted in social, economic, and cultural discrimination.'[667] Another recent study elaborates:

> The European colonisation of Australia and racism have resulted in forced removal of the Indigenous population from traditional lands and children from parents ('stolen generation'), together with genocide, marginalisation, injustice, deprivation, loss of identity and much more. This has resulted in 'collective trauma' or 'historical/intergeneration trauma'. The appropriateness of diagnostic criteria and treatment of PTSD in the context of collective trauma has been questioned. Perhaps a more appropriate diagnosis for our Indigenous population is complex post-traumatic stress disorder… Our study shows that the prevalence of potentially more harmful traumas and PTSD in this Indigenous cohort is twice that of the general Australian population. Urgent attention by Australian communities and governments to the underlying social determinants of sexual and physical violence and other traumas, particularly in childhood, is urgently required to break the intergenerational cycle leading to the existing tragic situation.[668]

4.3.30 Heffernan et al examined the prevalence of PTSD among Aboriginal prison inmates. The results revealed PTSD was 'highly prevalent' – with a 12 month prevalence of 12.1% for males and 32.3% for females.[669] When compared with non-Aboriginal prison inmates, these statistics are significant – 12-month prevalence of 4.3% in males and 8.3% in females.[670] In addition, PTSD among Aboriginal people was found to be associated with previous experience of sexual and physical trauma.[671] A diagnosis of PTSD was also accompanied by high rates of co-occurring mental illness and substance use disorders and high rates of suicidal ideation and suicide attempts.[672]

4.3.31 Other studies into the prevalence of PTSD and the impact of intergenerational trauma also suggest increased rates of PTSD amongst Aboriginal communities outside of a prison context.[673]

Grief

4.3.32 The high incidence of premature death among Aboriginal communities was previously noted. The impact of grief upon a person's mental health and wellbeing must be recognised. The loss

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[666] Edward Heffernan et al, 'PTSD Among Aboriginal and Torres Strait Islander People in Custody in Australia: Prevalence and Correlates' (2015) 28 *Journal of Traumatic Stress* 523.

[667] Ibid 523–4.

[668] Bushra Nasir et al, 'Traumatic life events and risk of post-traumatic stress disorder among the Indigenous population of regional, remote and metropolitan Central-Eastern Australia: a cross-sectional study' (2021) 11 *BMJ Open* 1, 8–9.

[669] Edward Heffernan et al, 'PTSD Among Aboriginal and Torres Strait Islander People in Custody in Australia: Prevalence and Correlates' (2015) 28 *Journal of Traumatic Stress* 523, 527.

[670] Ibid.

[671] Ibid.

[672] Ibid.

[673] See, for example, Gelaye Nadew, 'Exposure to Traumatic Events, relevance of Posttraumatic Stress Disorder and Alcohol Abuse in Aboriginal Communities' (2012) 12(4) *Rural Remote Health* 1667; Bushra Nasir et al, 'Traumatic life events and risk of post-traumatic stress disorder among the Indigenous population of regional, remote and metropolitan Central-Eastern Australia: a cross-sectional study' (2021) 11 *BMJ Open* 1. Similar findings exist in Canada.

of family, a friend or community member has been identified as a contributing factor to mental ill-health in Aboriginal populations.

4.3.33 SALRI was informed by an Aboriginal mental health worker that grief is different to intergenerational trauma, having a profound impact on the development and growth of Aboriginal people. In addition to the loss of a loved one, it also means losing connection with community.

4.3.34 Although grief is not a mental illness, mental health services should offer culturally appropriate supports for Aboriginal people experiencing grief. The likelihood of a child or young person being exposed to grief is higher. As noted by Dudgeon et al, '[Aboriginal] people are burdened by relentless grief due to the large numbers of deaths in families and kinship groups, and this grief has a profound impact on their [social and emotional wellbeing].'[674] Efforts must be made to assist in building resilience and adequate support networks.

Data Collection

4.3.35 It is clear that the prevalence of mental health disorders is notable among Aboriginal communities.

4.3.36 SALRI proposes that the *MHA* could be a means to support or facilitate the introduction of a culturally aware and responsive framework in South Australia for Aboriginal mental health services. This has been explored and implemented in Victoria following the Royal Commission. SALRI raises that similar avenues to transform the *MHA* into a more culturally effective and appropriate legislative framework for the provision of mental health services to Aboriginal communities should be explored.

4.4 Social and Emotional Wellbeing Model

4.4.1 The National Strategic Framework principles promote social and emotional wellbeing as 'an expression of traditional life-affirming Indigenous knowledge systems about collective and land-based wellbeing.'[675] It is a key premise that facilitates culturally aware and effective approaches to address suicide prevention and aligns with holistic definitions of health. The concept of social and emotional wellbeing is comprised of 'seven interrelated domains: body, mind and emotions, family and kinship, community, culture, Country, and spirituality.'[676] '[O]ptimal social and emotional wellbeing' is fully realised when these domains achieve 'harmonious and healthy connections.'[677]

4.4.2 It has been noted that westernised or mainstream conceptions of mental health do not necessarily align with Aboriginal understandings, which rely on the complex relationships of physical, emotional and spiritual wellbeing, community and environment.[678] As a result, mental health falls within the remit of social and emotional wellbeing, which recognises cultural understandings.[679] Dr Gee et al, described social and emotional wellbeing as:

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[674] Patricia Dudgeon et al, *Connection between family, kinship and social and emotional wellbeing* (2021) 8.

[675] Ibid 2.

[676] Patricia Dudgeon et al, *Connection between family, kinship and social and emotional wellbeing* (2021) 2. SALRI was also informed that connection to water forms part of social and emotional wellbeing.

[677] Ibid.

[678] *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021) vol 3, 146.

[679] See generally Productivity Commission, *Mental Health, Inquiry Report*, No 95 (2020) vol 2, 398–406.

> … a complex term that for many Aboriginal people refers to a holistic view of health that includes mental wellbeing and mental health disorders – but importantly, it links the mental health of individual and families, and the wellbeing of whole communities, to more than physical, emotional and mental wellbeing. [Social and emotional wellbeing] from an Aboriginal perspective, recognises that mental health is also shaped by connections to culture, land, extended kinship, the ancestors, and spirituality. The other important part of [social and emotional wellbeing] that distinguishes it from conventional understandings of mental health is that these connections are influenced not only by social determinants of health, but also by historical, political and cultural determinants. Historical, political and cultural factors shape the presentation and meaning of how mental health symptoms are understood for Aboriginal clients, in many different ways.[680]

4.4.3 Social and emotional wellbeing has been characterised as an effective model to address health concerns, including mental health.[681] This model joins physical and mental health to cultural determinants, such as family, kin, Country, spirituality, community and culture.[682] Underpinned by a number of elements, this model recognises the significance of connection to Country to guide practice, and identifies factors that undermine wellbeing, such as political disempowerment, racism and poverty.[683]

4.4.4 A representation of social and emotional wellbeing from an Aboriginal and Torres Strait Islander's perspective is shown in **Figure 2** below. Dr Gee et al notes this 'conception of self is grounded within a collectivist perspective that views the self as inseparable from, and embedded within, family and community.'[684]

[680] Graham Gee et al, 'Aboriginal and Torres Strait Islander Social and Emotional Wellbeing' in Patricia Dudgeon, Helen Milroy and Roz Walker (eds), *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing* (Department of the Prime Minister and Cabinet, Canberra, 2nd ed, 2014).

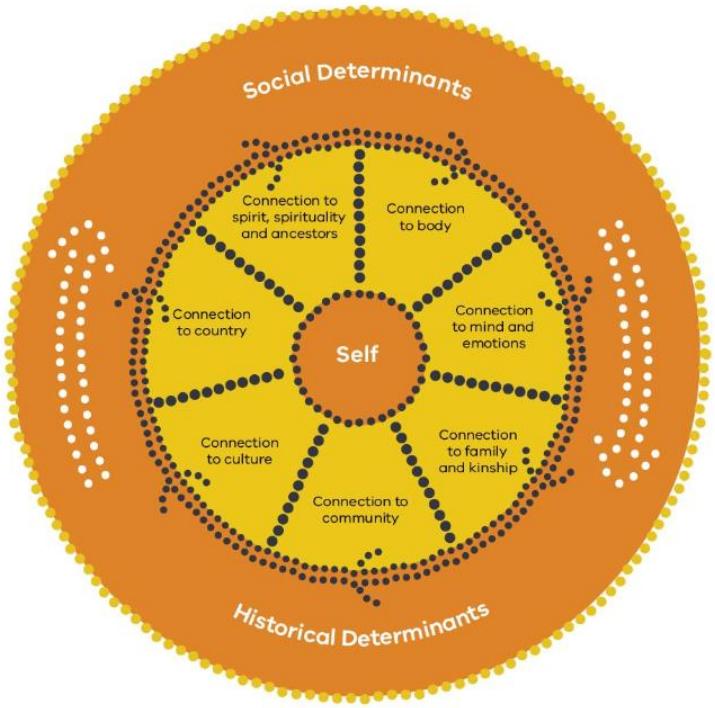
[681] Ibid 3; see also Karabena Consulting, *'... Country can't hear English ...' A guide supporting the implementation of cultural determinants of health and wellbeing with Aboriginal and Torres Strait Islander Peoples Report* (15 June 2020) 11.

[682] Ibid.

[683] Ibid.

[684] Graham Gee et al, 'Aboriginal and Torres Strait Islander Social and Emotional Wellbeing' in Patricia Dudgeon, Helen Milroy and Roz Walker (eds), *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing* (Department of the Prime Minister and Cabinet, Canberra, 2nd ed, 2014) 57. See also Productivity Commission, *Mental Health, Inquiry Report,* No 95 (2020) vol 2, 398–401.

Figure 2: A representation of social and emotional wellbeing from an Aboriginal and Torres Strait Islander's perspective.[685]



4.4.5 The domains of wellbeing depicted in **Figure 2** above are ingrained within bodily, individual or intrapersonal experience.[686] Each of these domains are expanded below.

Connection to Body

4.4.6 Connection to body concerns the physical health and wellbeing of a person, including health indicators such as weight, nutrition, disability and co-morbidities.[687]

Connection to Mind and Emotions

4.4.7 This domain refers to mental health, wellbeing or alternatively, poor mental health.[688] It also encompasses cognitive, emotional and psychological human experience, including 'the experience of safety and security, a sense of belonging, control or mastery, self-esteem, meaning making, values and motivation, and the need for secure relationships.'[689]

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[685] Graham Gee et al, 'Aboriginal and Torres Strait Islander Social and Emotional Wellbeing' in Patricia Dudgeon, Helen Milroy and Roz Walker (eds), *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing* (Department of the Prime Minister and Cabinet, Canberra, 2nd ed, 2014) 57. See also Productivity Commission, *Mental Health, Inquiry Report,* No 95 (2020) vol 2, 398–401.

[686] Graham Gee et al, 'Aboriginal and Torres Strait Islander Social and Emotional Wellbeing' in Patricia Dudgeon, Helen Milroy and Roz Walker (eds), *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing* (Department of the Prime Minister and Cabinet, Canberra, 2nd ed, 2014) 58.

[687] Ibid.

[688] Ibid.

[689] Ibid.

4.4.8 Drawing on the increasing understanding of culture-bound disorders, it has been noted that Western psychiatric classification systems cannot be used for Aboriginal consumers.[690] For culture-bound disorders, they may 'often mimic mental health disorders, however, the triggers and maintaining factors lie with the cultural beliefs of the client, and therefore resolution often needs to occur at the cultural level'.[691] Symptoms associated with culture-bound mental health disorders may resemble symptoms indicative of a Western mental illness diagnosis, however, additional symptom patterns of distress must be recognised[692] to prevent incorrect diagnosis. This reinforces the need to provide culturally appropriate responses and interventions for Aboriginal consumers. For example, the use of traditional healing methods may be a preferred therapeutic intervention.[693]

Connection to Family and Kinship

4.4.9 This domain relies on interpersonal interactions. In particular, connection and family and kinship are integral to maintaining 'interconnectedness through cultural ties and reciprocal relationships.'[694] Kinship is fundamental in Aboriginal communities and has been described as 'the glue that holds Aboriginal and Torres Strait Islander societies together'.[695] Kinship systems govern roles, obligations and responsibilities to kin.[696] It 'locates all Aboriginal and Torres Strait Islander peoples in networks of belonging and webs of relationships that incorporate people, places, plants, animals and ancestors.'[697] These systems and kin terms vary, highlighting cultural diversity and the importance of observing and respecting these cultures..[698]

4.4.10 In the context of mental health, it is important that health and other practitioners understands kinship and family obligations. Helen Milroy notes that, while kinship offers a 'broad base of support',[699] obligations may also 'create a significant burden for some families'.[700] As a result, Milroy concludes from a clinical perspective:

> … it is important to map the family's kinship system as this will establish the broader nature of attachment relationships and what roles others play in the family system. It will also be easier to locate the client as they may move between support systems. It may be difficult to establish who

[690] Graham Gee et al, 'Aboriginal and Torres Strait Islander Social and Emotional Wellbeing' in Patricia Dudgeon, Helen Milroy and Roz Walker (eds), *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing* (Department of the Prime Minister and Cabinet, Canberra, 2nd ed, 2014) 59.

[691] Ibid.

[692] Ibid.

[693] Ibid. See also Productivity Commission, *Mental Health, Inquiry Report,* No 95 (2020) vol 2, 402–4.

[694] Graham Gee et al, 'Aboriginal and Torres Strait Islander Social and Emotional Wellbeing' in Patricia Dudgeon, Helen Milroy and Roz Walker (eds), *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing* (Department of the Prime Minister and Cabinet, Canberra, 2nd ed, 2014) 59.

[695] Bruce Pascoe and David Horton, *The Little Red Yellow Black Book: An Introduction to Indigenous Australia* (Australian Institute of Aboriginal and Torres Strait Islander Studies, 4th ed, 2018) 25.

[696] Ibid.

[697] Ibid.

[698] Ibid.

[699] Helen Milroy, 'Children are our future: Understanding the needs of Aboriginal children and their families' in Anne Sved Williams and Vicki Cowling (eds), *Infants of Parents with Mental Illness: Developmental, Clinical, Cultural and Personal Perspectives* (Australian Academic Press, 2008) 128.

[700] Ibid.

> the biological parents are, as opposed to the 'bringing them up' parents, and rules of kinship add complexity to understanding issues of confidentiality, consent, custody and guardianship.[701]

4.4.11 This understanding on behalf of a practitioner will also enable and promote respect for avoidance relationships.[702] This refers to specific relationships which prevents one individual from speaking to or addressing another or being in the same room.[703] These relationships 'are about respecting your family and are not about disrespect. The term "poison" is also used to describe avoidance, this term is meant with respect. You do not touch or go near poison.'[704] A common example of an avoidance relationship is between the individual and his father-in-law.[705] Another common 'no room' avoidance relationship is observed between a mother-in-law and her son-in-law.[706]

Connection to Community

4.4.12 Community is a fundamental tenet of identity and self.[707] Gee et al describes community as 'a collective space where building a sense of identity and participating in family and kinship networks occurs, and where personal connections and sociocultural norms are maintained.'[708] Dudgeon et al also observes:

> … [the] concept of community can have political, social and geographic connotations, but at its most fundamental level it has widespread currency as signifying belonging to a group of Aboriginal people. There are distinct elements to this sense of belonging within an Aboriginal domain that differ from social relationships in mainstream western culture.[709]

4.4.13 Community is intricately linked to identity and developing a sense of belonging. As a result, methods to strengthen and promote cultural and community identity is important. The introduction of Aboriginal Community Controlled Health Organisations has led to the protection and advancement of cultural identity and furthered a sense of ownership, belonging and cultural pride.[710]

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[701] Helen Milroy, 'Children are our future: Understanding the needs of Aboriginal children and their families' in Anne Sved Williams and Vicki Cowling (eds), *Infants of Parents with Mental Illness: Developmental, Clinical, Cultural and Personal Perspectives* (Australian Academic Press, 2008) 128.

[702] See also Graham Gee et al, 'Aboriginal and Torres Strait Islander Social and Emotional Wellbeing' in Patricia Dudgeon, Helen Milroy and Roz Walker (eds), *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing* (Department of the Prime Minister and Cabinet, Canberra, 2nd ed, 2014) 60.

[703] The Law Society of South Australia, *Lawyers' Protocols for Dealing with Aboriginal Clients in South Australia,* 3rd ed (2020) 40.

[704] Remote Area Health Corps, *Cultural Orientation Handbook* (2013) 30.

[705] Ibid.

[706] Ibid.

[707] Graham Gee et al, 'Aboriginal and Torres Strait Islander Social and Emotional Wellbeing' in Patricia Dudgeon, Helen Milroy and Roz Walker (eds), *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing* (Department of the Prime Minister and Cabinet, Canberra, 2nd ed, 2014) 60.

[708] Ibid. See also Patricia Dudgeon et al, 'Contemporary Aboriginal Perceptions of Community' in Adrian Fisher, Christopher Sonn and Brian Bishop (eds), *Psychological Sense of Community: Research, Applications, and Implications* (Springer Science, 2002) 247, 247–66.

[709] Patricia Dudgeon et al, 'Contemporary Aboriginal Perceptions of Community' in Adrian Fisher, Christopher Sonn and Brian Bishop (eds), *Psychological Sense of Community: Research, Applications, and Implications* (Springer Science, 2002) 247, 265.

[710] Graham Gee et al, 'Aboriginal and Torres Strait Islander Social and Emotional Wellbeing' in Patricia Dudgeon, Helen Milroy and Roz Walker (eds), *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing* (Department of the Prime Minister and Cabinet, Canberra, 2nd ed, 2014) 60.

Connection to Spirit, Spirituality and Ancestors

4.4.14 Cultural views are often rooted in the connection to spirituality, the essence of which is conveyed as 'The Dreaming' or 'The Dreamtime'.[711] These terms depict 'Aboriginal metaphysical world views' and the ways in which spirituality is termed will depend upon each community and language.[712]

4.4.15 Spirituality represents knowledge passed down by ancestors and may present itself in the form of rituals, stories, ceremonies and cultural practices connecting a person, land and place.[713] Connection to spirituality has been notably impacted by the historical and ongoing consequences of colonisation.[714] The mental health impact upon Aboriginal communities, as SALRI was often told in consultation, of historical and ongoing intergenerational trauma due to colonisation is notable.

Connection to Country

4.4.16 Connection to Country is intricately related to spirituality and has been defined as 'an area to which people have a traditional or spiritual association, and the sense of connection as a deep experience, belief or feeling of belonging to Country.'[715]

Connection to Culture

4.4.17 Aboriginal culture may be articulated in various ways. Gee et al refer to culture as a 'capacity and opportunity to sustain and (re)create a healthy, strong relationship to their Aboriginal or Torres Strait Islander heritage. This includes all of the associated systems of knowledge, law and practices that comprise this heritage.'[716] A universal definition of culture is difficult to articulate, given its complexities and nuances. However, the preservation of cultural identity, values and participation in cultural practices is an integral component of the social and emotional wellbeing model.[717]

4.4.18 It is sound practice that practitioners should ensure Aboriginal consumers are supported in developing and strengthening continuity and security in identity, re-affirming and strengthening their cultural values and developing strategies to deal with racial discrimination.[718] This form of discrimination has been linked to anxiety, depression and other mental health challenges.[719]

4.4.19 In light of the historical and ongoing intergenerational trauma experienced by Aboriginal people, Gee et al observed:

> For some Aboriginal and Torres Strait Islander families and communities, the extent of cultural loss associated with colonisation has been profound. Many members of the Stolen Generations and their descendants continue to experience a deep grief and a longing to reconnect with their cultural heritage and ancestry. With appropriate cultural supervision, and in the right circumstances, it is important for practitioners to be able to provide clients with an opportunity to discuss whether issues such as cultural loss, identity and belonging are in any way linked to their

[711] Graham Gee et al, 'Aboriginal and Torres Strait Islander Social and Emotional Wellbeing' in Patricia Dudgeon, Helen Milroy and Roz Walker (eds), *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing* (Department of the Prime Minister and Cabinet, Canberra, 2nd ed, 2014) 60.

[712] Ibid.

[713] Ibid.

[714] Ibid.

[715] Ibid.

[716] Ibid 61.

[717] See Ibid.

[718] Ibid.

[719] Ibid.

> current difficulties, and whether personal work in this area is important for their healing process. Practitioners need to make sure they have a sound knowledge of the appropriate cultural services available in the community.[720]

4.4.20 Respect and appreciation for the ongoing trauma experienced by Aboriginal people must be considered in the context of mental health. Continuity of culture supports individual and collective resilience against life experiences, self-determination and suicide prevention.[721]

The Social and Emotional Wellbeing Model and Consumer Engagement

4.4.21 It is evident that the social and emotional wellbeing model represents a 'complex, multidimensional concept of health' that traverses 'conventional understandings of mental health and mental disorder'.[722] In addition to the factors defining social and emotional wellbeing, the issues associated with it include:

> … grief, loss, trauma, abuse, violence, substance misuse, physical health problems, child development problems, gender identity issues, child removals, incarceration, cultural dislocation, racism and social disadvantage ... while mental health problems may include crisis reactions, anxiety, states, depression, post-traumatic stress, self-harm, and psychosis.[723]

4.4.22 These issues can also act as risk factors which may impact a person's mental health. This model also informs varying presentations of psychological symptoms, the cause of symptoms, appropriate therapeutic approaches, and better outcomes.[724] It is widely known that Aboriginal people have low rates of engagement with mental health services.[725] This may be attributed to a number of factors, including the absence of valid and culturally appropriate assessment tools, access to qualified culturally competent practitioners and cultural communication barriers.[726] Cultural communication barriers may refer to the confidential nature of information, that may only be disclosed according to cultural hierarchy and status.[727] These considerations often impede access to culturally appropriate mental health services and assessment, as evidenced by the West Australian Coronial Inquiry, which investigated the suicide of 13 Aboriginal children in the Kimberley region.[728] The Inquiry deemed these

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[720] Graham Gee et al, 'Aboriginal and Torres Strait Islander Social and Emotional Wellbeing' in Patricia Dudgeon, Helen Milroy and Roz Walker (eds), *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing* (Department of the Prime Minister and Cabinet, Canberra, 2nd ed, 2014).

[721] Patricia Dudgeon et al, *Connection between family, kinship and social and emotional wellbeing* (2021) 2.

[722] Graham Gee et al, 'Aboriginal and Torres Strait Islander Social and Emotional Wellbeing' in Patricia Dudgeon, Helen Milroy and Roz Walker (eds), *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing* (Department of the Prime Minister and Cabinet, Canberra, 2nd ed, 2014) 63.

[723] Ibid.

[724] Ibid.

[725] See Tracy Westerman, 'Culture-bound syndromes in Aboriginal Australian populations' (2021) 25(1) *Clinical Psychologist* 19, 20; see also Tracy Westerman, 'Engaging Australian Aboriginal youth in mental health services' (2010) 45(3) *Australian Psychologist* 212, 212–22.

[726] Tracy Westerman, 'Culture-Bound Syndromes in Aboriginal Australian Populations' (2021) 25(1) *Clinical Psychologist* 19, 20.

[727] Ibid; see also Robert Tonkinson, 'Egalitarianism and Inequality in a Western Desert Culture' (1988) 5(4) *Anthropological Forum* 545, 545–58.

[728] Tracy Westerman, 'Culture-Bound Syndromes in Aboriginal Australian Populations' (2021) 25(1) *Clinical Psychologist* 19, 20; Rosalinda Fogliani, *Inquest into the deaths of: Children and Young Persons in the Kimberley Region, Western Australia, Coronial Inquiry Final Report* (2019).

'preventable deaths', many of which were caused by a 'system failure' or lack of access to services that were culturally appropriate.[729] Coroner Fogliani concluded:

> The considerable services already being provided to the region are not enough. They are still being provided from the perspective of mainstream services, that are adapted in an endeavour to fit into a culturally relevant paradigm. It may be time to consider whether the services themselves need to be co-designed in a completely different way, that recognises at a foundational level, the need for a more collective and inclusive approach towards cultural healing for Aboriginal communities.
>
> If the cultural healing is able to occur at the community level, underpinned by the principles of self-determination and empowerment, there is a prospect of the benefits of this healing being passed on to children and young persons, through stronger, safer, more resilient communities, and families.
>
> If this course is chosen it will require significant commitment of funding and a preparedness to engage with the Aboriginal communities to co-design the services. It will also require both short and long term perspectives to be taken of the factors that give rise to the unacceptable levels of poverty within the region, and that generate the social determinants of ill health.[730]

4.4.23 There is scant empirical evidence relating to validated and effective assessment tools, preventative programs and therapeutic interventions. This further exacerbates the mental health knowledge deficit in Australia.[731] There is a need to incorporate cultural competence in mental health services to achieve both clinical and cultural competence.[732] Clinical competence may be described as the 'extent to which certain therapeutic techniques are proven to be useful treatments for certain disorders'.[733] Cultural competence refers to the 'ability of practitioners to identify, intervene and treat mental health complaints in ways that recognise the central role that culture plays in mental illness'.[734]

4.4.24 The barriers to accessing mental health services reinforce the need to operationalise the principles underpinning the social and emotional wellbeing model, which is cognisant of Aboriginal conceptualisation of mental health and wellbeing.[735] Dr Tracy Westerman identifies two constructs impacting engagement of Aboriginal people with mental health services – the cultural appropriateness

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[729] Ibid; see also Tracy Westerman, 'Engagement of Indigenous clients in mental health services: What role do cultural differences play?' (2004) 3(3) *Australian e-Journal for the Advancement of Mental Health* 88.

[730] Rosalinda Fogliani, *Inquest into the deaths of: Children and Young Persons in the Kimberley Region, Western Australia, Coronial Inquiry Final Report* (2019) 372–3 [1745]–[1747].

[731] See Tracy Westerman, 'Engagement of Indigenous Clients in Mental Health Services: What Role do Cultural Differences play?' (2004) 3(3) *Australian e-Journal for the Advancement of Mental Health* 88.

[732] Ibid 89.

[733] Ibid 89; see also Department of the Prime Minister and Cabinet, *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017-2023* (2017) 17.

[734] Tracy Westerman, 'Engagement of Indigenous Clients in Mental Health Services: What Role do Cultural Differences play?' (2004) 3(3) *Australian e-Journal for the Advancement of Mental Health* 88, 89; see also Roz Walker, Clinton Schultz and Christopher Sonn, 'Cultural Competence – Transforming Policy, Services, Programs and Practice' in Patricia Dudgeon, Helen Milroy and Roz Walker (eds), *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing* (Department of the Prime Minister and Cabinet, Canberra, 2nd ed, 2014) 196.

[735] See Tracy Westerman, 'Engagement of Indigenous Clients in Mental Health Services: What Role do Cultural Differences Play?' (2004) 3(3) *Australian e-Journal for the Advancement of Mental Health* 88, 89; see also Roz Walker, Clinton Schultz and Christopher Sonn, 'Cultural Competence – Transforming Policy, Services, Programs and Practice' in Patricia Dudgeon, Helen Milroy and Roz Walker (eds), *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing* (Department of the Prime Minister and Cabinet, Canberra, 2nd ed, 2014) 196.

of strategies adopted by practitioners to engage an Aboriginal consumer, and the inherent qualities of the practitioner-consumer relationship.[736]

4.5 Culturally Appropriate Engagement Strategies

4.5.1 In relation to the use of inappropriate processes to engage Aboriginal consumers, the following factors were identified:

- **Appropriateness of introductions:** this involves greater knowledge and understanding on behalf of the practitioner of the importance of connection to land, Country and genealogy.[737] This also requires an understanding of language barriers[738] and actively seeking interpreting assistance.

- **Assessments outside cultural context:** of particular importance is the environment in which engagement takes place. It was noted that '[t]here are many examples of misdiagnosis, under-diagnosis and over-diagnosis occurring with Indigenous people as a direct result of being assessed outside of their country/community, or preferred cultural context.'[739] An unfamiliar environment may compound the client's distress.[740] In order to appropriately address this issue, Dr Westerman noted two elements must be considered: '[f]irst, whether the symptoms are evident across both mainstream and cultural contexts, and second, whether these symptoms impair the individual within both of these environments.'[741]

- **Failure to acknowledge mental health as a holistic concept:** mental illness is considered alongside a person's physical, mental, emotional, spiritual and cultural states of being.[742] It is not uncommon for an Aboriginal person to express notions of 'being unwell within themselves', without attributing this to a particular physical symptom or mood.[743] Further, ill health may be viewed as been having caused by an external culturally-based reason.[744] For example, mental health may be impacted where there is cultural wrongdoing or retribution.[745] This is reflective of the social and emotional wellbeing model, which recognises the intersectionality of spirituality, land, culture and family.

- **The role of cultural consultants:** it has been argued this role should form standard practice in mainstream mental health services.[746] Often the practice of 'vouching' – which refers to the circumstance where an Aboriginal person expresses positive or negative information about

[736] Tracy Westerman, 'Engagement of Indigenous Clients in Mental Health Services: What Role do Cultural Differences Play?' (2004) 3(3) *Australian e-Journal for the Advancement of Mental Health* 88, 89.

[737] Ibid.

[738] Ibid.

[739] Ibid.

[740] Ibid 90.

[741] Ibid.

[742] Ibid 91.

[743] Ibid.

[744] Ibid.

[745] Ibid. See also Mark Sheldon, 'Psychiatric Assessment in Remote Indigenous Communities' (2001) 35 *Australian and New Zealand Journal of Psychiatry* 435; Tracy Westerman, "Culture-Bound Syndromes in Aboriginal Australian Populations' (2021) 25(1) *Clinical Psychologist* 19, 24.

[746] Tracy Westerman, 'Engagement of Indigenous Clients in Mental Health Services: What Role do Cultural Differences Play?' (2004) 3(3) *Australian e-Journal for the Advancement of Mental Health* 88, 91.

another person, forms an important part of the practitioner-consumer relationship.[747] It was noted that engagement of a cultural consultant must be culturally respectful, which requires an understanding and appreciation of avoidance relationships, tribal and language groups, the gender of the consultant and whether the consultant can be 'vouched for'.[748]

- **Communication styles:** the way in which a conversation flows may differ. Often, it is recommended to avoid direct questions and answers. Instead, an approach which focusses on narrative, with open-ended questions that are positively phrased will serve as an effective means of communication.[749]

4.5.2 These factors rely on the principles identified within the social and emotional wellbeing model.

Qualities within the Practitioner-Consumer Relationship

4.5.3 Two key factors were identified as integral when engaging with an Aboriginal consumer – cultural disparity and gender.

4.5.4 Engagement with an Aboriginal consumer is directly influenced by the cultural disparity between the consumer and practitioner.[750] This has been identified as a 'major contributor' to the lack of engagement.[751]

4.5.5 Gender is an important facet of culturally appropriate interactions, whereby it is generally inappropriate for a mental health practitioner to engage with a consumer of the opposite gender.[752] Often, consumers may feel shame for interacting in personal discussions with a person of the opposite gender.[753]

4.6 Practical Applications of the Social and Emotional Wellbeing Model

4.6.1 The social and emotional wellbeing model embraces and promotes the centrality of human rights.[754] It has been observed that:

> Human rights are moral, legal, and political devices for protecting the dignity, wellbeing and survival of human beings. Recognition of human rights in mental health is particularly relevant in culturally diverse societies that include cultural minorities and particularly where Indigenous cultures have been displaced, marginalised, disenfranchised and forcibly assimilated by colonisers

[747] Tracy Westerman, 'Engagement of Indigenous Clients in Mental Health Services: What Role do Cultural Differences Play?' (2004) 3(3) *Australian e-Journal for the Advancement of Mental Health* 88, 91.

[748] Ibid.

[749] Ibid.

[750] Ibid 92.

[751] Ibid. See also Judith Kearins, 'Visual Spatial Memory in Australian Indigenous Children of the Desert Regions' (1981) 13 *Cognitive Psychology* 434.

[752] Tracy Westerman, 'Engagement of Indigenous Clients in Mental Health Services: What Role do Cultural Differences Play?' (2004) 3(3) *Australian e-Journal for the Advancement of Mental Health* 88, 92.

[753] Ibid. See also Wellbeing SA, *What we heard about suicide in South Australia, Consultation Report* (September 2021) 19.

[754] Roz Walker, Clinton Schultz and Christopher Sonn, 'Cultural Competence – Transforming Policy, Services, Programs and Practice' in Patricia Dudgeon, Helen Milroy and Roz Walker (eds), *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing* (Department of the Prime Minister and Cabinet, Canberra, 2nd ed, 2014) 196.

and settlers. These rights are intended to 'assist individuals and communities to achieve the highest attainable standard of physical and mental health, including autonomy, information, education, and participation' and are further reinforced by the *2007 United Nations Declaration on the Rights of Indigenous Peoples*.[755]

4.6.2 The UN *Declaration on the Rights of Indigenous Peoples* ('UNDRIP') recognises the human rights of Indigenous peoples. The rights contained within the UNDRIP promote equality,[756] freedom from discrimination,[757] autonomy,[758] participation[759] and self-determination.[760] Articles 18 and 19 provide the right to participate and engage in productive consultation for legislative and administrative reforms.[761] Most notably, Article 24(2) states that 'individuals have an equal right to the enjoyment of the highest attainable standard of physical and mental health. States shall take the necessary steps with a view to achieving progressively the full realisation of this right'.[762]

4.6.3 The UNDRIP emphasises a responsibility to ensure mainstream mental health services are culturally safe, appropriate and responsive to the needs of Aboriginal people.[763] A failure to do so 'erodes fundamental cultural and human rights for all [Aboriginal] peoples.'[764]

4.6.4 The operationalisation of human rights or guiding principles will be further explored in Part 12 Guiding Principles and Accountability Mechanisms. However, it is important to note that various solutions exist to address the current deficits in mental health service delivery. Proposed solutions include:[765]

1. Using culturally appropriate counselling techniques;[766]
2. Cultural supervision;[767]

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[755] Roz Walker, Clinton Schultz and Christopher Sonn, 'Cultural Competence – Transforming Policy, Services, Programs and Practice' in Patricia Dudgeon, Helen Milroy and Roz Walker (eds), *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing* (Department of the Prime Minister and Cabinet, Canberra, 2nd ed, 2014) 196.

[756] *United Nations Declaration on the Rights of Indigenous Peoples,* UN GAOR 62nd sess, 107th plen mtg, Agenda Item 68, GA Res 61/295, UN Doc A/RES/61/295 (adopted 13 September 2007) art 2.

[757] Ibid.

[758] Ibid art 4.

[759] Ibid art 5.

[760] Ibid arts 3–4.

[761] Ibid arts 18–19.

[762] Ibid art 24(2).

[763] See Roz Walker, Clinton Schultz and Christopher Sonn, 'Cultural Competence – Transforming Policy, Services, Programs and Practice' in Patricia Dudgeon, Helen Milroy and Roz Walker (eds), *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing* (Department of the Prime Minister and Cabinet, Canberra, 2nd ed, 2014) 197.

[764] Ibid.

[765] See also Graham Gee et al, 'Aboriginal and Torres Strait Islander Social and Emotional Wellbeing' in Patricia Dudgeon, Helen Milroy and Roz Walker (eds), *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing* (Department of the Prime Minister and Cabinet, Canberra, 2nd ed, 2014) 59; see also David Vicary and Tracy Westerman, 'That's just the way he is: Some Implications of Aboriginal Mental Health Beliefs' (2004) 3(3) *Australian e-Journal for the Advancement of Mental Health* 103.

[766] Tracy Westerman, 'Engagement of Indigenous Clients in Mental Health Services: What Role do Cultural Differences Play?' (2004) 3(3) *Australian e-Journal for the Advancement of Mental Health* 88, 91.

[767] Ibid.

3. Developing and distributing accessible information regarding culture specific mental health problems;[768]

4. Integrating culturally appropriate treatment approaches in interventions. For example, as raised by Coroner Fogliani, the facilitation of traditional healing methods and recognition of traditional processes to address mental health problems;[769]

5. Offering outreach services to increase visibility of mental health services;[770] and

6. Developing a referral process between Aboriginal communities and mental health services.[771]

4.6.5 Similar findings were also advocated for in the Victorian Royal Commission, which acknowledged the urgent need to address mental illness in Aboriginal communities and the central role of self-determined Aboriginal social and emotional wellbeing services.[772] The Royal Commission recommended that a new Aboriginal Social and Emotional Wellbeing Centre should be established to support the expansion of social and emotional wellbeing services.[773] It was noted that the Emotional Wellbeing Centre could be facilitated using the following mechanisms:

- Allocated recurrent funding to develop and extend multidisciplinary social and emotional wellbeing terms within state-wide Aboriginal community-controlled health organisatons;[774]

- The introduction of scholarships to support Aboriginal social and emotional wellbeing team members the opportunity to obtain recognised clinical mental health qualifications from public tertiary institutions;[775]

- Recurrent funding for the Victorian Aboriginal Community Controlled Health Organisation to develop, host and maintain the Aboriginal Social and Emotional Wellbeing Centre.[776] This would involve a collaborative effort with organisations holding clinical and research expertise in Aboriginal mental health;[777] and

- Development and expansion of social and emotional wellbeing services through:

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[768] Tracy Westerman, 'Engagement of Indigenous Clients in Mental Health Services: What Role do Cultural Differences Play?' (2004) 3(3) *Australian e-Journal for the Advancement of Mental Health* 88, 91.

[769] Ibid 92. See further Jane McKendrick et al, *Aboriginal and Torres Strait Islander Healing programs: a Literature Review* (The Healing Foundation, 2013); Gareth Nortje et al, 'Effectiveness of Traditional Healers in Treating Mental Disorders: a Systematic Review' (2016) 3(2) *Lancet psychiatry* 154; Terrance Cox, Jonathon Mond and Ha Hoang '"We're also Healers": Elders Leading the Way in Aboriginal Community Healing' (2022) 28(4) *Australian Journal of Primary Health* 283; Australian Government, *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017-2023* (2017).

[770] Tracy Westerman, 'Engagement of Indigenous Clients in Mental Health Services: What Role do Cultural Differences Play?' (2004) 3(3) *Australian e-Journal for the Advancement of Mental Health* 88, 92.

[771] Ibid.

[772] *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021) vol 3, 148. See also Productivity Commission, *Mental Health* (Report No 95, June Productivity Commission, *Mental Health, Inquiry Report*, No 95 (2020) 2020) vol 2, 398–406.

[773] *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021) vol 3, 148.

[774] Ibid [Box 20.1].

[775] Ibid.

[776] Ibid.

[777] Ibid.

- Clinical, organisational and cultural governance;[778]
- Workforce development;[779]
- Establishment of guidance, tools and practical supports to promote clinical effectiveness for the assessment, diagnosis and treatment of mental illness;[780] and
- Development and distribution of research and evidence for social and emotional wellbeing models and assembling communities of practice.[781]

4.6.6 Considering the important connections between family, kinship and social and emotional wellbeing, Dudgeon et al outlined a number of methods to empower and strengthen Aboriginal people. These methods serve as pathways to strengthen connection to family and kin, interrupting 'the transmission of historical trauma, decrease stress, strengthen identity, and increase resilience.'[782] The identified pathways involved:

- Housing security and safety;
- Healing centres;
- Employment opportunities;
- Cultural healing spaces for women and men;
- Promoting care and connection with Country;
- Preserving and promoting cultural practices;
- Intergenerational knowledge sharing;
- Promoting and facilitating use of language;
- Connection with skin groups; and
- Engagement with Lore and cultural values.[783]

4.6.7 Of these approaches, a number of these have been identified as specifically effective in suicide prevention. This is discussed in further detail below.

4.6.8 It is important to consider how to best operationalise the social and emotional wellbeing model, to promote access to culturally aware and appropriate mental health services and better outcomes for Aboriginal consumers. The preservation, continuation and promotion of cultural determinants will support better health outcomes.[784] The *My Life My Lead* Report also observed that:

> Cultural Determinants originate from and promote a strength based perspective, acknowledging that stronger connections to culture and Country build stronger individual and collective identities,

[778] *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021) vol 3, 148.

[779] Ibid.

[780] Ibid.

[781] Ibid.

[782] Patricia Dudgeon et al, *Connection between Family, Kinship and Social and Emotional Wellbeing* (2021) vi.

[783] Ibid.

[784] Ibid 11.

a sense of self-esteem, resilience, and improved outcomes across the other determinants of health including education, economic stability and community safety.[785]

4.6.9 The Report also acknowledged:

> Aboriginal and Torres Strait Islander cultures are the oldest living cultures in the world, which exemplify the dynamic and adaptive nature of these cultures. Cultural determinants are enabled, supported and protected through traditional cultural practice, kinship, connection to land and Country, art, song and ceremony, dance, healing, spirituality, empowerment, ancestry, belonging and self-determination. While many Aboriginal and Torres Strait Islander people, families and communities that reside in metropolitan and regional areas are separated from their Country and kin, strong cultural determinants of health can still be enabled and maintained through languages, relationships, customs and community networks.[786]

4.6.10 Future efforts and plans to improve access to mental health services and increase their cultural appropriateness should involve respectful, genuine partnerships with Aboriginal communities.[787]

4.7 Aboriginal Mental Health in South Australia's Legislation

4.7.1 The *MHA* directly refers to Aboriginal and Torres Strait Islander people in two separate provisions – in the definition of 'relative'[788] and in the context of a guiding principle which mental health services ought to take into account.[789] The guiding principles serve as important statements that should govern the performance and functions of those engaging with the *MHA*. It states that mental health services should take into account:

> … in the case of persons of Aboriginal or Torres Strait Islander descent—the persons' traditional beliefs and practices and, when practicable and appropriate, involve collaboration with health workers and traditional healers from their communities…[790]

4.7.2 The recognition of traditional healing and cultural practice is important.[791] However, SALRI's consultation, especially with Aboriginal communities, also revealed a continued need to implement changes to enhance the cultural appropriateness of the current *MHA*.

4.7.3 In Victoria, the new *Mental Health and Wellbeing Act 2022* includes a Statement of Recognition:

> (1) The Parliament recognises that Aboriginal people in Victoria are First Nations people of Australia and acknowledges their enduring connection to Country, kin, land and culture.
>
> (2) The Parliament acknowledges the following—

[785] Department of Health, My Life My Lead: Opportunities for strengthening approaches to the social determinants and cultural determinants of Indigenous health (December 2017) 7.

[786] Ibid.

[787] Ibid.

[788] See *Mental Health Act 2009* (SA) s 3.

[789] Ibid s 7(ca)(iv).

[790] Ibid.

[791] Productivity Commission, *Mental Health, Inquiry Report*, No 95 (2020) vol 2, 402–4.

(a) that Aboriginal self-determination serves as a foundational principle to improve mental health and wellbeing outcomes of Aboriginal people in Victoria;

(b) the lasting impact of laws, practices and policies on the mental health and wellbeing outcomes of Aboriginal and Torres Strait Islander people since colonisation and enduring to this day;

(c) cultural dislocation, oppression, intergenerational trauma, lack of healing, systemic racism, institutionalised inequality and the loss of land, lore and language continue to harm the mental health and wellbeing of Aboriginal people in Victoria today;

(d) the strength of Aboriginal people, culture, kinship and communities in the face of historical and ongoing injustices;

(e) Aboriginal people's ongoing connection to culture, community and Country and the importance of this connection for the mental health and wellbeing of Aboriginal people in Victoria.

(3) It is the intention of Parliament that the mental health system recognises, respects and supports the distinct cultural rights of Aboriginal people and their right to receive culturally safe holistic mental health and wellbeing services throughout Victoria.

(4) The Parliament supports initiatives which address the ongoing mental health inequalities experienced by Aboriginal people in Victoria.

(5) The Parliament recognises the essential role of Aboriginal community controlled health organisations in meeting the mental health and wellbeing and care needs of Aboriginal people in Victoria.

(6) The Parliament supports the development of future reforms which further Aboriginal self-determination within mental health and wellbeing services in Victoria.[792]

4.7.4 This *Statement of Recognition* reinforces the social and emotional wellbeing model, acknowledges the historical and ongoing impact of colonisation and respects the strength and resilience of Aboriginal culture and connection.

4.7.5 The Victorian Act also supports the importance of cultural safety, in its Cultural Safety principle, which states:

(1) Mental health and wellbeing services are to be culturally safe and responsive to people of all racial, ethnic, faith-based and cultural backgrounds.

(2) … Regard is to be given to Aboriginal and Torres Strait Islander people's unique culture and identity, including connections to family and kinship, community, Country and waters.

(3) Treatment and care for Aboriginal and Torres Strait Islander peoples is, to the extent that it is practicable and appropriate to do so, to be decided and given having regard to the views of elders, traditional healers and Aboriginal and Torres Strait Islander mental health workers.[793]

4.7.6 The understanding and promotion of mental health through a cultural lens is significant. The cultural safety principle aims to reinforce the need for culturally aware and appropriate responses to mental health and therapeutic intervention. The involvement of Elders, traditional healers and

[792] *Mental Health and Wellbeing Act 2022* (Vic) s 13.

[793] Ibid s 27.

Aboriginal mental health workers is integral to a culturally responsive system. It is also consistent with known strategies and approaches to implement the social and emotional wellbeing model.

4.7.7 In response to ways in which South Australia's *MHA* could become more culturally appropriate, SALRI's consultation with Aboriginal Elders and community members reiterated the need for greater implementation of culturally aware and responsive practices. In addition, it was noted that many policies and procedures of mental health services are formulated without community consultation input. This reinforces the need for active involvement of Aboriginal community members in the development and delivery of culturally aware and responsive mental health services.

4.7.8 SALRI also explored particular issues impacting access to mental health services. Consultation raised significant access issues for those living in regional areas. The absence of services and the 'fly in fly out' specialist model does not adequately cater for the needs of those living in the regions.[794] This also results in consumers being taken to Adelaide, which is far from home, community and Country. It is acknowledged that maintaining connection to community, culture and Country are critical to social and emotional wellbeing. Further, the small size of a regional community raised issues of privacy and confidentiality which can act as deterrents to accessing services. Other themes in consultation raised the issues identified by Dr Westerman – how to appropriately engage with an Aboriginal consumer. For example, inconsistent care delivered by different practitioners led to a consumer feeling disempowered and tired of repeating the same story. The importance of connection to family and community was noted, highlighting the need to bolster existing support networks within communities.

4.7.9 Finally, in consultation with Aboriginal community members, SALRI considered ways in which the *MHA* could support Aboriginal communities. Consultation revealed several points, including:

- A need to employ Aboriginal mental health workers, who are culturally competent and understand the historical and ongoing impact of colonisation – 'we inherited what colonisation did, the trauma, suffering and grief.'
- The involvement of Elders in support and healing. It was noted that 'Elders are community encyclopaedias, they have the answers.'[795]
- Active involvement with Aboriginal community members and in particular, young people, to become more culturally competent and aware.
- Listening to the stories and life journey of community members in a safe space, akin to a yarning space. These spaces are separate for men and women.

4.7.10 During SALRI's consultation, two parties raised the need to incorporate an explicit statement of recognition, similar to the recent Victorian Act.

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[794] See also Stephen Duckett, *Fly-in, Fly-out Heath Care Fails Remote Aboriginal Communities* (29 August 2012) The Conversation <https://theconversation.com/fly-in-fly-out-heath-care-fails-remote-aboriginal-communities-7948>; Patrick Martin, *First Nations Elders Dismayed about FIFO Mental Health Model Planned for South Australia's APY Lands* (3 November 2022) ABC News <https://www.abc.net.au/news/2022-11-03/aboriginal-children-without-mental-health-workers-in-communities/101556026>.

[795] See also Productivity Commission, *Mental Health, Inquiry Report*, No 95 (2020) vol 2, 402–4.

4.7.11 The presence of an Aboriginal Voice in Parliament was also raised to SALRI, to assist in understanding the effects and needs of Aboriginal people.

4.7.12 Efforts to facilitate an understanding of Aboriginal mental health and promote a more culturally appropriate legislative instrument may be addressed through the introduction of a Statement of Recognition. The guiding principles may also be strengthened to explicitly refer to cultural safety in the design, development and delivery of mental health services.

4.7.13 SALRI was also informed about the value of Dadirri (Deep Listening), which assists in understanding the needs of Aboriginal people, especially in relation to mental health and mental illness. It was noted that active listening, without diagnosing, suggesting or expressing one's own thoughts can assist in understanding health holistically.

4.8 Factors Impacting Mental Health

4.8.1 SALRI's consultation revealed the need to view mental health holistically[796] and to recognise the interplay of various factors contributing to mental ill health in Aboriginal communities. These include:

- The historical and ongoing impact of colonisation and the Stolen Generations;[797]
- Child removal and displacement;[798]

[796] Productivity Commission, *Mental Health, Inquiry Report*, No 95 (June 2020) vol 2, 398–404.

[797] It is a complicated area, but the operation of past and present child protection law and practices in relation to Aboriginal children have been a recurring issue raised to SALRI by Aboriginal Elders and community members in both past and present references. The impact of displacement upon both the child and parent can have lasting effects, some of which have even been described as the ongoing Stolen Generation. See further Lorena Allam, *"Alarming Rate": Removal of Australia's Indigenous Children Escalating, Report Warns* (16 November 2020) The Guardian, <https://www.theguardian.com/australia-news/2020/nov/16/alarming-rate-removal-of-australias-indigenous-children-escalating-report-warns>; ABC News, *Aboriginal Children Entering State Care in SA at "Worsening Rate", Data Shows* (13 May 2021) <https://www.abc.net.au/news/2021-05-13/proportion-of-aboriginal-children-in-sa-care-getting-worse/100136520>; Jacynta Krakouer et al, *First Nations Children are still being Removed at Disproportionate Rates. Cultural Assumptions about Parenting need to Change* (26 November 2021) The Conversation <https://theconversation.com/first-nations-children-are-still-being-removed-at-disproportionate-rates-cultural-assumptions-about-parenting-need-to-change-169090>; Michael McGowan, *"People Think it is all in the Past": Push to Reform System taking Aboriginal Kids from Families* (14 March 2022) The Guardian <https://www.theguardian.com/australia-news/2022/mar/14/people-think-its-all-in-the-past-push-to-reform-system-taking-aboriginal-kids-from-families>; Fiona Blackwood, *Aboriginal Organisations should be given more Control over Indigenous Kids in Child Protection System, Advocacy Group Says* (24 August 2022) ABC News <https://www.abc.net.au/news/2022-08-24/aboriginal-organisations-should-oversee-kids-needingcare/101356742>; Thomas Kelsall, *SA Inquiry into State Removal of Aboriginal Children* (1 July 2022) In Daily <https://indaily.com.au/news/2022/07/01/sa-inquiry-into-state-removal-of-aboriginal-children/>; Adeshola Ore and Cait Kelly, *Victoria's Child Protection System is Creating "New Stolen Generation", Aboriginal Leader Says* (5 December 2022) The Guardian <https://www.theguardian.com/australia-news/2022/dec/05/victorias-child-protection-system-is-creating-new-stolen-generation-aboriginal-leader-says>.

[798] It is a complicated area, but child protection law and practices in relation to Aboriginal children have been a recurring issue raised to SALRI by Aboriginal Elders and community members in both past and present references. The statistics are significant. Aboriginal children are removed from their homes at disproportionate rates. The South Australian Commissioner for Children and Young People has noted: 'the continued over-representation of Aboriginal compared to non-Aboriginal 0–17-year-olds in care services over time. The rate is now so high that one in every 11 Aboriginal children and young people in South Australia were in care at 30 June 2020 (84.5 per 1,000 children). The rate of Aboriginal 0 to 17 year-olds in care services per 1,000 children increased from 62.1 to 84.5 compared to 6.0 to 7.4 for non-Aboriginal 0 to 17 year-olds between 2015-16 and 2019-20. This illustrates the continued worsening rate of Aboriginal, compared to non-Aboriginal, children and young people being drawn

- Imprisonment rates (notably youth detention);
- Prevalence of family violence;
- Prevalence of sexual assault;
- Unemployment;
- Housing;
- Education; and
- Socio-economic status.

4.8.2 These factors are not new or uncommon. Rather, SALRI has encountered these issues in both past and present references. As one leading Elder told SALRI 'the gap is not closing at all, it's actually getting wider.' The recognition that these factors all impact social and emotional wellbeing is but one step toward improvement. Changes in practice, culture, attitudes and policy should also accompany efforts to transform the mental health system into an effective and culturally aware system for Aboriginal people.

4.8.3 For the purposes of this discussion, a brief overview of the impact of colonisation, child protection, imprisonment and domestic violence will be provided.

Impact of Colonisation and Child Removal Practices

4.8.4 The effects of colonisation continue today – the trauma of which is known to be intergenerational.[799] Colonisation has been identified as a risk factor causing increased risk of mental ill

into the child protection system': South Australian Guardian for Children and Young People, *Snapshot of South Australian Aboriginal Children and Young People in Care and/or Detention from the Report on Government Services 2021* (May 2021) 7. See also at: 2. Another study found that between 1 July 2014 and 30 June 2016, Aboriginal children aged 10–16 were 16 times as likely as non-Indigenous Australians of the same age to be both in the child protection system and under youth justice supervision. See Australian Institute of Health and Welfare, *Young People in Child Protection and under Youth Justice Supervision* 2015–16 (2017) v. The Law Council of Australia was told that Aboriginal children are seven times more likely to have received child protective services, and 9.8 times more likely to be placed in out-of-home care than non-Indigenous children. See Law Council of Australia, *The Justice Project: Aboriginal and Torres Strait Australians* (Final Report, August 2018) 20. The Law Council said: 'The *Aboriginal and Torres Strait Islander Child Placement Principle* should continue to inform child protection policy and barriers to its full implementation should addressed. A federal target to eliminate the over-representation of Aboriginal and Torres Strait Islander children in out of home care should form part of the Closing the Gap framework and the Australian Law Reform Commission's recent recommendation supporting a national review of child protection should be implemented': at 6. The *Aboriginal and Torres Strait Islander Child Placement Principle* promotes the placement of Aboriginal children on out-of-home care orders with Aboriginal or non-Aboriginal relatives or kin or other Aboriginal caregivers. There are issues and concerns and the South Australian Commissioner for Aboriginal Children and Young People is presently examining how the *Aboriginal and Torres Strait Islander Child Placement Principle* is applied in South Australia in the removal and placement of Aboriginal children in out-of-home care. See further at: Commissioner for Aboriginal Children and Young People, *Inquiry* <https://cacyp.com.au/inquiry/>. See also South Australian Guardian for Children and Young People, *Snapshot of South Australian Aboriginal Children and Young People in Care and/or Detention from the Report on Government Services 2021* (May 2021) 11–4.

[799] Bushra Nasir et al, 'Traumatic Life Events and Risk of Post-Traumatic Stress Disorder among the Indigenous Population of Regional, Remote and Metropolitan Central-Eastern Australia: a Cross-Sectional study' (2021) 11 *BMJ Open* 1; Patricia Dudgeon et al, *Connection between Family, Kinship and Social and Emotional Wellbeing* (2021).

health, due to cultural dislocation, loss of identity, the Stolen Generation and loss of practices.[800] The Stolen Generations led to the loss of culture and Aboriginal identity.[801]

4.8.5 The Stolen Generations saw the forced removal of generations of children from their family and community, breaking attachment bonds from their mothers that are known to form part of healthy emotional and physical development.[802] Following separation, children experienced 'substantial, profound and chronic levels of child abuse and neglect', and families and communities experienced grief and trauma directly relating to the forced removal.[803] This was reinforced in the findings of the Royal Commission into Institutional Responses to Child Sexual Abuse, which highlighted that many members of the Stolen Generations experienced suicidal ideations and attempted suicide.[804] Children of the Stolen Generations also experienced sexual and other forms of abuse by adults and other children.[805]

4.8.6 In their 2017 Report, released for the 20 year anniversary of the landmark *Bringing Them Home* Report, the Healing Foundation noted:

> Children were moved to institutions run by churches and non-government organisations, adopted by non-Indigenous families, or placed with non-Aboriginal households to work as domestic servants and farm hands. Many children suffered very harsh, degrading treatment (including sexual abuse), limited or no contact with families, and were frequently indoctrinated to believe in the inferiority of Aboriginal and Torres Strait Islander people and culture.[806]

4.8.7 The continuing effects of the Stolen Generations include:

- Significantly poor physical health;
- More than double the rate of mental illness and alcohol abuse;
- Decimated community family and social structures; and
- Significant trauma and distress.[807]

4.8.8 Both past and ongoing child removal practices were raised by many parties in SALRI's consultation as a major factor impacting mental health in Aboriginal communities. The practice of removing children from families results in suffering on behalf of parents for the loss of their child and their right to love and raise their child.[808] Parents resorted to suffering in silence, staying in abusive relationships, suffering the effects of alcohol abuse and unable to seek support for their mental health.[809]

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[800] Patricia Dudgeon et al, *Connection between Family, Kinship and Social and Emotional Wellbeing* (2021) 8.

[801] *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, December 2017) vol 2, 90.

[802] Patricia Dudgeon et al, *Connection between Family, Kinship and Social and Emotional Wellbeing* (Report, 2021) 11.

[803] Ibid.

[804] *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, December 2017) vol 2, 237.

[805] Ibid.

[806] Healing Foundation, *Bringing Them Home 20 years on: An Action Plan for Healing* (2017) 7.

[807] Ibid 20.

[808] Ibid 21.

[809] Ibid.

4.8.9 The Law Council noted that Aboriginal women may be afraid to report incidences of family violence for fear that their children will be removed.[810] The Law Council elaborated:

> Many Aboriginal and Torres Strait Islander people have experience of intergenerational trauma linked with the justice system, and many also have personal prior experience of it working 'against them' instead of 'for them'.811 This lack of trust 'affects all aspects of the interaction between Indigenous Australians and access to justice'.812 It has led to police, government, social services and the law being viewed as a tool of oppression by many. This distrust is particularly apparent in the family law sphere, fuelled by policies relating to the forced removal of children and current patterns of engagement with the child protection system. The Family Law Council identifies this as a key reason why Aboriginal and Torres Strait Islander people have 'a resistance to engagement with, and even fear of, family law system services'.813 The distrust in the family system is a major barrier for women experiencing family violence, who are reluctant to report it to authorities. A JCCD [Judicial Council on Cultural Diversity] report on Aboriginal and Torres Strait Islander Women's Experience of the Court found that Aboriginal and Torres Strait Islander women fear that reporting family violence will lead to authorities removing their children. NFVPLS [National Family Violence Prevention Legal Service] agreed, observing that Aboriginal and Torres Strait Islander women who have been the victims of domestic violence have had historically and continue to have traumatic experiences with the legal system involving the removal of children.[814]

4.8.10 SALRI was also told of the ongoing impact of child removal practices, which serve as a deterrent for an Aboriginal parent to seek mental health support or assistance, for fear of losing their child or children.

4.8.11 The Healing Foundation also noted this fear, noting 'many did not seek support for any of their problems, including their own mental health for fear of being judged unfit parents and their children being taken.'[815] The Healing Foundation also concluded:

> The increasing levels of contemporary child removal from Aboriginal families was an issue that the Bringing Them Home report canvassed in depth. Numerous participants acknowledged that while the intent of child removal practices today is different to that experienced by the Stolen Generations, the effect is potentially the same: a loss of identity and the exacerbation of intergenerational trauma.[816]

4.8.12 The experiences of trauma can result in lifelong effects, including mental illness.[817] The trauma:

> … can be transferred from the first generation of survivors that have experienced (or witnessed) it directly in the past to the second and further generations of descendants of the survivors … [this] intergenerational trauma … is defined as the subjective experiencing and remembering of

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[810] Law Council of Australia, *The Justice Project: Aboriginal and Torres Strait Australians* (Final Report, August 2018) 6; Family Law Council, *Improving the Family Law System for Aboriginal and Torres Strait Islander Clients* (February 2021) 4.

[811] Pascoe Pleasance et al, *Reshaping Legal Assistance Services: Building on the Evidence Base - A Discussion Paper* (Law and Justice Foundation of New South Wales, April 2014) 135.

[812] Productivity Commission, *Access to Justice Arrangements:* P*roductivity Commission Inquiry Report, No 72* (2014) vol 2, 765, quoting the Queensland Indigenous Family Violence Legal Service.

[813] Family Law Council, *Improving the Family Law System for Aboriginal and Torres Strait Islander Clients* (February 2021) 4.

[814] Law Council of Australia, *The Justice Project: Aboriginal and Torres Strait Australians* (Final Report, August 2018) 30.

[815] Healing Foundation, *Bringing Them Home 20 years on: An Action Plan for Healing* (2017) 21.

[816] Ibid.

[817] Ibid 22.

> events in the mind of an individual or the life of a community, passed from adults to children in cyclic processes as cumulative emotional and psychological wounding.[818]

4.8.13 Due to the increased likelihood of mental illness, it is important that mental health services provide trauma-informed care, delivered by culturally competent practitioners.[819] It has been recommended that:

> The development of a suite of trauma training packages that are designed with Stolen Generations survivors would ensure governments, professionals and services are learning the skills and the means to respond effectively to Stolen Generations survivors without causing more harm. Trauma-informed organisations use a strengths-based approach based on an understanding of the impact of trauma; emphasise the physical, psychological, and emotional safety of clients and staff; and help people affected by trauma to rebuild a sense of control and empowerment.[820]

4.8.14 In addition, as observed in Victoria, the introduction of Healing Centres offers a culturally aware approach for members of the Stolen Generations to seek support.[821]

Family Violence and Sexual Assault

4.8.15 During SALRI's consultation, the incidence of family violence and sexual assault were raised as significant contributors to mental health and wellbeing.

4.8.16 Aboriginal women report higher levels of physical violence during their lifetime than non-Indigenous women, and the violence is more likely to include sexual violence.[822] 'Family violence and sexual assault are reported to be at crisis levels in many Indigenous communities.'[823] The 'high unreporting rates' of such violence by Aboriginal victims also needs to be noted.[824]

4.8.17 In 2018, it was reported that Aboriginal women as a group are at the greatest risk of family, domestic and sexual violence.[825] Aboriginal peoples might be at least 6.5 times more likely to report being a victim of family violence–related offending than non–Aboriginal peoples.[826] Aboriginal women are 34.2 times more likely to be hospitalised as a result of family violence.[827] Results from the 2018–19 period revealed Aboriginal people were 14 times more likely to be hospitalised for assault than non-

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[818] Healing Foundation, *Bringing Them Home 20 Years on: An Action Plan for Healing* (2017) 22.

[819] Ibid 30.

[820] Ibid.

[821] Ibid 32.

[822] Australian Law Reform Commission, *Family Violence: a National Legal Response* (Report 114, November 2010) 87 [1.9].

[823] Monique Keel, *Family Violence and Sexual Assault in Indigenous Communities "Walking the Talk" (Briefing No 4)* (Australian Institute of Family Studies, 2004) 1.

[824] Law Council of Australia, *The Justice Project: Aboriginal and Torres Strait Australians* (Final Report, August 2018) 19. See also Australian Law Reform Commission, *Family Violence: a National Legal Response* (Report 114, November 2010) 1109–10 [24.48], 1193–5 [26.30]–[26.36].

[825] Law Council of Australia, *The Justice Project: Aboriginal and Torres Strait Australians* (Final Report, August 2018) 19.

[826] Victoria, Royal Commission into Family Violence, *Report and Recommendations* (March 2016) vol 1, 59.

[827] Ibid. In 2014–15, Aboriginal and Torres Strait Islander women were 32 times as likely to be hospitalised due to family violence as non-Indigenous women. See Law Council of Australia, *The Justice Project: Aboriginal and Torres Strait Australians* (Final Report, August 2018) 19.

Aboriginal people.[828] Recent data indicates that Aboriginal women remain at high risk, with increased rates of hospitalisation due to injuries sustained from a family violence relationship.[829]

4.8.18 Despite a lack of reliable data, it is clear that sexual violence impacts Aboriginal communities 'disproportionately'[830] 'Sexual violence in Indigenous communities occurs at rates that far exceed those for non-Indigenous Australians.'[831] In South Australia, in 2021, there were 119 recorded Aboriginal victims of sexual assault, with 81–91% of those being females.[832]

4.8.19 These rates of violence in Aboriginal communities 'must be seen in the context of the historical, political, social and cultural environments in which it occurs.'[833] The Law Council has observed that rates of family violence in Aboriginal communities are linked to factors not present in the broader population, including dispossession, inherited trauma and complex disadvantage, which have 'impaired community functioning and increased Aboriginal families' vulnerability to family violence.'[834] Aboriginal women also experience domestic violence at the hands of men from a variety of cultural backgrounds.[835]

4.8.20 Following the Children on Anangu Pitjantjatjara Yankunytjatjara (APY) Lands Commission of Inquiry: A Report Into Sexual Abuse, also known as the Mullighan Report, examined the incidence and impact of sexual abuse of children. A summary of the evidence indicated:

- It was 'reasonably possible' that 141 children had been sexually assaulted in the APY Lands, a majority (113 cases) were females.[836]
- There were 269 allegations of sexual abuse, demonstrating widespread incidence.[837] The abuse would likely be repeated over years and the Report noted the number of allegations was not an accurate indication of the incidence of abuse.[838]

[828] Australian Institute of Health and Welfare, *Indigenous Community Safety* (16 September 2021) <https://www.aihw.gov.au/reports/australias-welfare/indigenous-community-safety>.

[829] Australian Institute of Health and Welfare, *Family, domestic and sexual violence* (9 November 2022) <https://www.aihw.gov.au/reports/domestic-violence/family-domestic-and-sexual-violence#common>.

[830] Australian Law Reform Commission, *Family Violence: a National Legal Response* (Report 114, November 2010) 1108–9 [24.45].

[831] Denise Lievore, *Non-Reporting and Hidden Recording of Sexual Assault: An International Review* (2003) 56.

[832] Australian Bureau of Statistics, *Recorded Crime – Victims 2021* (July 2022) <https://www.abs.gov.au/statistics/people/crime-and-justice/recorded-crime-victims/latest-release#aboriginal-and-torres-strait-islander-victims-of-crime>.

[833] NSW Department of Health, *NSW Aboriginal Family Health Strategy 2011-2016* (2011) 8.

[834] Law Council of Australia, *The Justice Project: Aboriginal and Torres Strait Australians* (Final Report, August 2018) 19, quoting NSW Department of Health, *NSW Aboriginal Family Health Strategy 2011-2016* (2011) 8. See also Australian Law Reform Commission, *Family Violence: a National Legal Response* (Report 114, November 2010) 1109 [24.46]–[24.47]. However, SALRI highlights as the ALRC has noted, 'the importance of framing family violence in a human rights context, in particular to ensure that violence against Indigenous women and children cannot be minimised by reference to cultural practices or arguments which supposedly condone violence': at 1110 [24.48].

[835] Law Council of Australia, *The Justice Project: Aboriginal and Torres Strait Australians* (Final Report, August 2018) 19.

[836] Office of the Chief Psychiatrist, *Chief Psychiatrist Review: Child and Adolescent Mental Health Services APY Lands* (Final Report, 3 December 2021) 7.

[837] Ibid.

[838] Ibid.

- Children (including those under 10 years of age) were sexually abused and abuse involved extra-familial males abusing both females and males, extra-familial children abusing children and intra-familial abuse.[839]

4.8.21 The Inquiry considered pathways to establish therapeutic responses for children, treatment and long-term care and the provision of welfare, social services and mental health services in the APY Lands.[840] The Chief Psychiatrist's subsequent Review in 2021 examining implementation of the Mulligan Report recommendations referred to the remoteness and isolation of the APY Lands. It noted the introduction of 'a metropolitan service with metropolitan thinking and management will only disempower the service required and lose any progress in improving Anangu mental health and wellbeing.'[841] The Review also identified a number of key themes from consultation, including a need for Lands-based clinicians and a continued 'unmet need' for child and adolescent mental health services.[842]

4.8.22 The impact of sexual abuse, as reflected in the Mulligan Report and the Chief Psychiatrist's subsequent Review is ongoing, strengthening the argument for reform of mental health services and service delivery to all, especially those living in rural and remote communities.

4.8.23 The complex interplay of these factors and the prevalence of sexual assault and family violence must be considered as relevant to mental health and wellbeing. The impact of family violence has been associated with compounding mental health challenges, suicide, suicidal ideation and the continuing transmission of trauma across generations.[843]

Imprisonment

4.8.24 Aboriginal people remain over-represented in both the adult and youth criminal justice systems.[844]

4.8.25 The imprisonment rate for Aboriginal and Torres Strait Islander people has been noted as 12.5 times higher than the rate of imprisonment for non-Indigenous people.[845] Aboriginal and Torres Strait Islander people are said to constitute 27 per cent of the total adult prison population and the proportion of Aboriginal and Torres Strait Islander people in prison continues to rise.[846] Aboriginal and Torres Strait Islander women are imprisoned at more than 20 times the rate of non-Aboriginal and Torres Strait Islander women.[847]

4.8.26 A 2018 study found that more than half (58%) of all young people in detention on an average day in 2016–17 were Aboriginal or Torres Strait Islander people and that Aboriginal or Torres Strait Islander young people aged 10–17 were 24 times more likely to be in detention than young people

[839] Ibid 8.

[840] Ibid.

[841] Ibid 32.

[842] Ibid 14–6.

[843] Patricia Dudgeon et al, *Connection between Family, Kinship and Social and Emotional Wellbeing* (2021) 15.

[844] Australian Institute for Health and Welfare, *Youth Detention Population in Australia 2021* (2021) 3; Law Council of Australia, *The Justice Project: Aboriginal and Torres Strait Australians* (Final Report, August 2018) 14–6.

[845] Australian Law Reform Commission, *Pathways to Justice – Inquiry into the incarceration rate of Aboriginal and Torres Strait Islander Peoples* (Report 133, December 2017) 94–6.

[846] Law Council of Australia, *The Justice Project: Aboriginal and Torres Strait Australians* (Final Report, August 2018) 14.

[847] Ibid 15.

who are not Aboriginal or Torres Strait Islanders.[848] Recent national data revealed that 50% of young people, aged 10 to 17 years in detention were Aboriginal.[849] To contextualise the significance of this, young Aboriginal people make up only 6% of this cohort in Australia.[850] It was further noted that young Aboriginal Australians within this demographic are 20 times more likely to be in detention than young non-Aboriginal Australians.[851] In 2020–21, the rate of youth detention for Aboriginal and Torres Strait Islander young people aged 10 to 17 years was higher than the rate for non-Aboriginal and Torres Strait Islander young people in all Australian States and Territories.[852]

4.8.27 Although the size of the youth detention population has decreased in South Australia from the period June 2017 to June 2021,[853] detention remains disproportionate for Aboriginal youths.[854] In 2021, it was reported by the Guardian for Children and Young People, Penny Wright, the rate of Aboriginal children and young people in detention is 22.7 times higher than non-Aboriginal children in South Australia'.[855]

4.8.28 The impact of acute imprisonment is the loss of connection to family, community, kinship and culture.[856] Dudgeon et al stated:

> Incarceration all too often re-traumatises already traumatised men, women and children. It puts them at further risk of suicide and suicide-related behaviour: fathers and mothers are incarcerated, the connection to their children is severed, and attachment bonds disrupted. Indeed, women who have been released from prison are at 14 times higher risk from suicide.[857]

4.8.29 Imprisonment has also been identified as a contributing source to continuing trauma and long-term health concerns.[858]

Impacts on Mental Health and Wellbeing

4.8.30 Reflecting the powerful themes presented in consultation, notably with Aboriginal Elders and community members, SALRI has sought to highlight the complex relationship between mental health and wellbeing and systemic factors confronting Aboriginal communities. Appreciating this reinforces the importance of employing the social and emotional wellbeing model to inform understandings of mental health. These factors, although outside the scope of this review, are relevant

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[848] Australian Institute of Health and Welfare, *Youth Justice in Australia 2016–17* (2018) 8.

[849] Australian Institute for Health and Welfare, *Youth Detention Population in Australia 2021* (2021) 3.

[850] Ibid.

[851] Ibid vi.

[852] Victorian Sentencing Advisory Council, *Indigenous Young People in Detention* (2022) <https://www.sentencingcouncil.vic.gov.au/sentencing-statistics/indigenous-young-people-in-detention>.

[853] Australian Institute for Health and Welfare, *Youth Detention Population in Australia 2021* (2021) 15.

[854] The rate for Aboriginal and Torres Strait Islander young people in detention in South Australia was approximately 16.5 times the rate for non-Aboriginal and Torres Strait Islander young people. Victorian Sentencing Advisory Council, *Indigenous Young People in Detention* (2022) <https://www.sentencingcouncil.vic.gov.au/sentencing-statistics/indigenous-young-people-in-detention>.

[855] ABC News, *Aboriginal Children Entering State Care in SA at "Worsening Rate", Data Shows* (13 May 2021), <https://www.abc.net.au/news/2021-05-13/proportion-of-aboriginal-children-in-sa-care-getting-worse/100136520>. See also South Australian Guardian for Children and Young People, *Snapshot of South Australian Aboriginal Children and Young People in Care and/or Detention from the Report on Government Services 2021* (May 2021) 3, 24.

[856] Patricia Dudgeon et al, *Connection between Family, Kinship and Social and Emotional Wellbeing* (2021) 14.

[857] Ibid 14–5.

[858] Ibid.

considerations for practitioners engaging with the mental health system and laws, especially in their application to Aboriginal communities.

4.9 SALRI's Observations and Conclusions

4.9.1 SALRI recognises the relative absence in the *MHA* of any reference to the particular needs and circumstances of Aboriginal communities is significant. SALRI was told during consultation in Whyalla that the *MHA* does not incorporate Aboriginal culture, rather it is 'dismissed'. This was reiterated by one Aboriginal Elder who noted 'the laws are not made for us' and 'it never will be'.

4.9.2 SALRI supports the social and emotional wellbeing model and initiatives to implement this model in practice. The Victorian Royal Commission was also struck with the importance of applying the holistic concept of social and emotional wellbeing:

> The Commission received compelling evidence from Aboriginal witnesses and services, which recommended expanding multidisciplinary models of care that apply the Aboriginal concept of social and emotional wellbeing. Social and emotional wellbeing means being resilient, being and feeling culturally safe and connected, having and realising aspirations, and being satisfied with life. Aboriginal leaders and senior representatives from Aboriginal organisations told the Commission that communities have been calling for self-determined social and emotional wellbeing models of care for decades so that Aboriginal people themselves can provide services promoting their social and emotional wellbeing. It was action, not more consultation, that was needed.[859]

4.9.3 In their submission to SALRI, the South Australian Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Committee, described mental health services as a 'complex maze', with Aboriginal and mainstream services attempting to meet their needs, 'often with very poor understanding of and communication between service providers, consumers and carers.' As a result, the Committee concluded that 'care may be inadequate and potentially dangerous situations occur.' Charlie Jackson, a leading Elder, powerfully told SALRI at a meeting in Port Augusta: 'Aboriginal people are not vulnerable. It is the system that's made us vulnerable.'

4.9.4 The negative, continuing effects of intergenerational trauma and federal and state laws, practices and policies was emphasised in the Committee's submission, noting they are tied to poor mental health outcomes. This was reiterated during SALRI's consultation in Port Augusta with Aboriginal Elders and community members, where it was emphasised, 'invasion and colonisation has made a huge impact on our people'. It was likened to a chain reaction and 'it's still going on'.

4.9.5 SALRI was told additional factors impacting the mental health of young Aboriginal people included COVID-19, remoteness, unemployment and the disconnect between mental health and cultural wellbeing. It was noted mental health and culture are interrelated. SALRI was told many young people rely on drugs to escape reality.

4.9.6 SALRI recognises that mental health is impacted by many factors – including but not limited to historical and ongoing intergenerational trauma, cultural dislocation, dispossession, and discrimination. Additional factors, such as housing, unemployment, incarceration and child removal practices also contribute to mental ill-health. Aboriginal mental health cannot be treated in isolation.

4.9.7 SALRI supports the work of the South Australian Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Committee, in fulfilling their role in offering a whole of

[859] *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021) vol 5, 349.

community and government approach to suicide prevention and mental health reform. SALRI also notes their important work to date, including the development of the South Australian Aboriginal and Torres Strait Islander Suicide Prevention and Wellbeing Plan. This Plan was established following consultation with communities and clinicians (with feedback provided to the OCP dating back to 2013), findings and recommendations of mental health and social emotional wellbeing reports published by Aboriginal Community Controlled Health and SA Health teams and consultation with Aboriginal communities.

4.9.8 The Committee reinforced the effectiveness of framing future reforms upon the principles of self-determination, drawing on the strengths of Aboriginal people and culture. Mr Jackson referred to the resilience of Aboriginal people and culture, noting 'our flame is still burning.'

4.9.9 SALRI supports the Committee's recommendation that the *MHA* should 'reflect and recognise':[860]

- Aboriginal and Torres Strait Islander's ongoing connection to land, seas, water though connection to Country, kin and culture.
- Acknowledge the importance of this connection for the mental health and wellbeing of Aboriginal people.
- That mental health and wellbeing of Aboriginal and Torres Strait Islander is through self-determination and where physical, emotional, social and spiritual aspects are considered and valued.
- Lasting impact of state and federal laws, practices and policies since colonisation that endure to this day.
- Acknowledge the strength of Aboriginal culture, kinship and communities in the face of historical and ongoing injustices.
- The role and leadership of the South Australian Aboriginal Community Controlled Health Services (ACCHS) and the Aboriginal Health Council South Australia.
- Aboriginal self-determination serves as a foundational principle to improve mental health and wellbeing outcomes of Aboriginal people.
- Cultural dislocation, oppression, intergenerational trauma, lack of healing, systemic racism, institutionalised inequality and the loss of land, lore and language continue to harm the mental health and wellbeing of Aboriginal people today.

4.9.10 These principles draw upon the Victorian Statement of Recognition and the National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017-2023. The Committee supports in principle, the adoption of this approach, drawing upon both Victoria and the National Strategic Framework, as a means of 'fostering systemic change and real engagement and inclusion with the Act's guiding principles at the service level.'

[860] See SALRI Recommendation 57. SALRI recommends that specific regard should be given to the National Strategic Framework principles.

SALRI's Government Roundtable also revealed support to bolster Aboriginal mental health within the *MHA* guiding principles.

4.9.11 In discussion with Aboriginal Elders and community members in Port Augusta, it was reinforced that a 'bottom up approach' to law and policy reform is needed. Further, changes to law and policy should be driven and formulated by Aboriginal communities.

4.9.12 SALRI recommends the inclusion of a Statement of Recognition into the *MHA*, as observed in Victoria and measures to strengthen the guiding principles, to reflect those of the National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017-2023.

4.9.13 The value of Aboriginal Community Controlled Mental Health Services (ACCHS) was raised to SALRI. The Port Lincoln Aboriginal Health Service reiterated that ACCHS bodies are best placed to identify and convey the needs of community. They drew upon the existing network between services in the Eyre Peninsula, who meet quarterly to discuss and share information about consumers and track those who have absconded. In this context, the need for better communication was raised. ARAS was generally supportive of the recommendations from the Victorian Royal Commission, which included the establishment and expansion of multi-disciplinary social and emotional wellbeing teams in ACCHS with state-wide coverage.

4.9.14 Efforts must also be made to ensure the workforce within mental health are capable of providing culturally appropriate support. Aboriginal Mental Health (SA Health) highlighted the value of Ngangkari Healers, noting they make a 'big difference' in mental health units. The ability to prioritise and reinforce the role and utility of Ngangkari Healers within the *MHA* was recommended to SALRI. This was also supported by Pangula Mannamurna Aboriginal Corporation in Mount Gambier. Further, the employment of Social and Emotional Wellbeing Officers and Aboriginal Liaison Officers within mental health units was raised. Pangula Mannamurna Aboriginal Corporation supported the employment of an Aboriginal Liaison Officer in all hospitals. It was noted 'clients feel more at ease' in an environment where there is a 'raft of people that are unfamiliar faces'.

4.9.15 The importance of an Aboriginal Liaison Officer was also raised by the Child and Adolescent Health Community of Practice, who noted:

> [Consumers] from regional or rural Aboriginal communities, who are transferred into a metropolitan tertiary facility for assessment are at increased risk of trauma and require additional resources and culturally safe care by an experienced Aboriginal Support Liaison Officer. Consideration should be given to explicitly mandate the offer to involve an Aboriginal Support Liaison Officer at the initiation of care and transfer to ensure culturally safe care.

4.9.16 SALRI is well aware of the challenges and difficulties in the recruitment and retention of mental health practitioners in regional, rural and remote communities. For example, SALRI was told there are only three resident psychiatrists outside metropolitan Adelaide.

4.9.17 ARAS was also supportive of the need for an Aboriginal mental health worker.[861]

4.9.18 SALRI supports greater emphasis on the value of Ngangkari Healers, Aboriginal Liaison Officers and Social and Emotional Wellbeing Officers within the *MHA*. It would be of value to

[861] ARAS also supported the presence of an 'Aboriginal legal officer'.

consider resourcing and funding of these positions within Local Health Networks, to achieve an integrated mental health service, capable of offering culturally appropriate and responsive supports.

4.9.19 Pangula Mannamurna Aboriginal Corporation noted many Aboriginal consumers do not understand the *MHA* or the implications/purpose of a treatment order. This emphasises the need for access to culturally appropriate supports. One Aboriginal Elder raised the absence of culturally appropriate counselling services and a community consultant/contact. Mind Australia described lack of access to culturally appropriate services as a 'human rights concern – people have a right to access respectful and appropriate services which meet their needs, in the community in which they live.'[862] The OCP's LEAG supported explicit considerations for Aboriginal and CALD consumers, referring to language and culture as 'two main factors that affect the capacity to understand what is happening while under the Act.'

4.9.20 These support measures can be promoted under the *MHA* guiding principles, structured into care and treatment plans and through changes to service delivery. Pangula Mannamurna Aboriginal Corporation referred to the limited access to an Elder and Aboriginal Liaison Officers for consumers. The Department for Correctional Services suggested that s 47 of the *MHA* (provision of support) could apply a 'cultural lens'. This could recognise culturally appropriate supports for consumers, which may be family, kinship and community supports.

4.9.21 This effort must also extend to practices within the hospital and community setting. For example, in consultation with Aboriginal Mental Health (SA Health), an effective strategy for engagement with Aboriginal consumers was arranging a regular community lunch. This provides staff with an opportunity to speak with consumers, follow up and offer support. The importance of changing environment, such as leaving the hospital for a coffee and chat, and de-escalation techniques was reinforced. Pangula Mannamurna Aboriginal Corporation also suggested visits to Country for community connection should be facilitated.

4.9.22 There was broad support that the use of telehealth services for mental health is difficult and ineffective. Consultation with the Tarpari Wellbeing Centre in Port Pirie also raised the utility and appropriateness of telehealth services.

4.9.23 The impact of culturally appropriate services was also raised by the Commissioner for Aboriginal Children and Young People:

> Aboriginal and Torres Strait Islander people will be reluctant to access services that do not recognise cultural beliefs and practices and are not open to working collaboratively with Aboriginal health workers and other cultural healers. In the case of children and young people, if they are not supported to share their views and contribute meaningfully to decision-making for their mental health, they will be reluctant to engage or return for further treatment.

4.9.24 The RANZCP suggested that adequate resourcing is necessary to enable the provision of 'effective, culturally-informed alternatives to involuntary treatment', particularly for Aboriginal and CALD consumers. The OCP's Human Rights and Coercion Reduction Committee submitted that 'special considerations' should be in place for Aboriginal and CALD consumers, in the context of involuntary treatment.

4.9.25 The implementation of culturally appropriate strategies for engagement, support and treatment of Aboriginal consumers is critical. As noted by Patricia Dudgeon and Zena Burgess, '[h]ow

[862] This is also relevant to members of CALD communities.

can a system help you if it doesn't understand or even acknowledge you, your community and your culture?'[863] Respectful, productive engagement with Aboriginal communities is necessary to develop these strategies.

4.9.26 Some parties, including Pangula Mannamurna Aboriginal Corporation and the Department for Correctional Services suggested the utility of a mandatory notification scheme, similar to that found under the *Summary Offences Act 1953* (SA). In SALRI's consultation with parties in Mount Gambier, it was suggested that the appropriate ACCHS should be notified when an Aboriginal consumer engages with the mental health system (either a treatment order or voluntary attendance to a mainstream service). Pangula Mannamurna Aboriginal Corporation have a memorandum of understanding with the Local Health Network requiring the mental health service to notify them. As a result, they can be involved from the beginning of a consumer's journey through to discharge and subsequent follow up. Under this agreement, all Aboriginal consumers are asked whether they would like support from Pangula Mannamurna Aboriginal Corporation. If support is accepted, the Local Health Network will facilitate contact.

4.9.27 SALRI recognises the utility of this notification system and supports the consideration of practical measures to implement such a system across South Australia.[864]

4.9.28 Similar themes and findings relating to the need for a culturally responsive and appropriate mental health service have been previously reported. The 2015 National Review of Mental Health Programmes and Services, which had a particular focus on Aboriginal Mental Health, made a number of recommendations.[865] The Review suggested the establishment of integrated mental health social and emotional wellbeing teams within all Aboriginal Primary Health Care Organisations and ACCHS.[866] The functions of these teams included mental health screening, treatment and support, alcohol and drug abuse, chronic illness support, promotion of social and emotional wellbeing and strengthening of community.[867] A further recommendation was the need for culturally responsive and accountable mental health services, which encompasses policy development, cultural awareness training and fostering partnerships with Aboriginal health services.[868] Finally, the need for dedicated Aboriginal services was emphasised, to ensure mainstream services offer appropriate referral and discharge and cultural support during admission to a hospital.[869]

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[863] Patricia Dudgeon and Zena Burgess, 'Healing among Indigenous People is more Crucial Now than Ever. Here's a Way Forward', *The Guardian* (online, 6 July 2021) < https://www.theguardian.com/commentisfree/2021/jul/06/healing-among-indigenous-people-is-more-crucial-now-than-ever-heres-a-way-forward#:~:text=1%20year%20old-,Healing%20among%20Indigenous%20people%20is%20more%20crucial%20now%20than,Here's%20a%20way%20forward&text=This%20year%20Naidoc%20week%20focuses,and%20Torres%20Strait%20Islander%20peoples>.

[864] SALRI notes the concerns relating to the mandatory nature of similar notification systems and issues relating to privacy. In particular, further practical consideration should be given for consumers who have impaired decision-making capacity.

[865] See Australian Government National Mental Health Commission, *National Review of Mental Health Programmes and Services Report released* (Web Page, 16 April 2015) <https://www.mentalhealthcommission.gov.au/news-and-media/media-releases/2015/april/review-of-mental-health-programmes-and-services>.

[866] Jill Giese, *Strong Recommendations Address Dire Status of Indigenous Australians' Mental Health* (Web Page, June 2015) <https://psychology.org.au/inpsych/2015/june/indigenous-mental-health>.

[867] Ibid.

[868] Ibid.

[869] Ibid.

4.9.29 SALRI has had a particular focus on Aboriginal mental health in this review. Research, data and literature offer valuable insights into pathways forward to improve mental health services and service delivery for Aboriginal consumers. An important aspect of improvement is an acknowledgement of history and ongoing adversity faced by Aboriginal communities on a daily basis.

4.9.30 Recommendations

RECOMMENDATION 18

SALRI recommends that appropriate measures to promote Aboriginal mental health and culturally responsive and appropriate services (including effective, culturally-informed alternatives to involuntary treatment) are considered and progressed. SALRI further recommends that measures to implement a Social and Emotional Wellbeing model, with Ngangkari Healers, Aboriginal Liaison Officers and Social and Emotional Wellbeing Officers within the *Mental Health Act 2009* (SA) should be examined. In addition, SALRI recommends that consideration should be given to resourcing and funding of these measures and positions within Local Health Networks, to achieve an integrated mental health service, capable of offering culturally appropriate and responsive supports.

RECOMMENDATION 19

SALRI recommends that s 47 of the *Mental Health Act 2009* (SA) should be amended to recognise culturally appropriate responsibilities through family, kinship, and community structures to allow for cultural considerations in which individuals are allowed to provide support under the Act.

4.9.31 Suggestion

SUGGESTION 6

SALRI suggests that consideration be given to implementing a notification system, as observed between Pangula Mannamurna Aboriginal Corporation and the Local Health Network, requiring notification of an Aboriginal consumer to the relevant Aboriginal Community Controlled Health Service.

Part 5 – Inpatient Treatment Orders

5.1 Background

5.1.1 The role and use of restrictive practices and involuntary treatment under the *MHA* unsurprisingly proved to be recurring and contentious topics in both SALRI's consultation and research, with various views expressed. A prominent part of this was in relation to the role and use of Inpatient Treatment Orders ('ITOs').[870] Various levels of ITOs can be made in South Australia under the *MHA* that authorise involuntary inpatient treatment for a mental illness. An ITO, as it involves involuntary treatment for a mental illness, has drastic implications on consumers, and debate as to their role and use is longstanding. As a study from the European Union notes:

> The involuntary placement and involuntary treatment of mentally ill patients are central issues in mental health care. Their massive impact upon the liberty and freedom of the persons concerned have made them a topic of controversial legal and ethical debates for more than 100 years.[871]

5.1.2 Involuntary treatment of mental health has existed since society first began trying to manage persons with mental illness. Despite controversy, involuntary treatment continues to be used in current mental health service delivery in Australia and internationally.[872] Consumers, practitioners and policy makers have engaged in lively debates regarding the merits or otherwise of involuntary treatment.[873] Various consumers, carers and advocacy groups shared with SALRI their often distressing experiences associated with ITOs. SALRI heard divergent views and suggestions as to the role and operation of ITOs under the *MHA*.

5.1.3 The *MHA* states that 'mental health services should be provided on a voluntary basis as far as possible, and in the least restrictive way and in the least restrictive environment that is consistent with their efficacy and public safety.'[874] Further, the operation of ITOs and restrictive practices in the *MHA* were intended only as a 'last resort for safety reasons and not as a punishment or for the convenience of others.'[875]

5.1.4 These central principles originate in the Mental Health Bill 2008 (SA) ('Bill') which drew upon a major review undertaken by Ian Bidmeade of the former *Mental Health Act 1993* (SA).[876] Bidmeade's report proposed a number of changes to modernise the law and improve responses to people with mental illness, including 'greater emphasis on community care, not just hospital or institutional care'.[877]

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[870] Melissa Floyd, 'Involuntary Mental Health Treatment: The Mental Health Consumer as Expert' (2013) 24(3) *Journal of Progressive Human Services* 187.

[871] Central Institute of Mental Health, *Compulsory Admission and Involuntary Treatment of Mentally Ill Patients – Legislation and Practice in EU-Member States* (Final Report, 15 May 2002) 2.

[872] The role and use CTOs are also contentious. See Richard O'Reilly, 'Why Are Community Treatment Orders Controversial?' (2004) 49(9) *Canadian Journal of Psychiatry* 579.

[873] Melissa Floyd, 'Involuntary Mental Health Treatment: The Mental Health Consumer as Expert' (2013) 24(3) *Journal of Progressive Human Services* 187.

[874] *Mental Health Act 2009* (SA) s 7(b). See also South Australia, *Parliamentary Debates*, House of Assembly, 12 November 2008, 843 (Jane Lomax-Smith).

[875] South Australia, *Parliamentary Debates*, House of Assembly, 12 November 2008, 886 (Jane Lomax-Smith).

[876] Ian Bidmeade, *Paving the Way, Review of Mental Legislation in South Australia Report* (April 2005).

[877] South Australia, *Parliamentary Debates*, House of Assembly, 12 November 2008, 885 (Jane Lomax-Smith).

5.1.5 The Bill was introduced to the South Australian Parliament on 12 November 2008, replacing the previous *Mental Health Act 1993* (SA). The present 2009 Act commenced operation on 1 July 2010. The new Act had ambitious aims as the Minister for Mental Health and Substance Abuse explained:

> A world class mental health system depends on an effective legislative framework to ensure that society can fulfil its obligation to care for individuals with serious mental illness. There is an expectation in the community, and an obligation on the part of government, that where a person is unable to make an informed decision about their own mental health and welfare, and they are vulnerable or pose a risk to others, intervention can take place to ensure they obtain the assessment, treatment and care that is necessary… The *Mental Health Bill 2008* incorporates provisions which bring South Australia into line with contemporary approaches to the management of serious mental health issues and includes innovations designed to assist people to obtain assistance in a manner which aims to minimise the extent to which their freedom is curtailed and to protect their rights.[878]

5.1.6 The *MHA* emphasises respect for a consumer's human rights and autonomy and these should only be encroached upon in limited and carefully defined circumstances.[879] It seeks to ensure that the 'freedom, rights, dignity and self-respect' of persons with acute mental illness are respected 'as far as is consistent with their protection, the protection of the public [and] for that purpose, to confer appropriately limited powers to make orders for community treatment, or inpatient treatment, of such persons where required.'[880]

5.1.7 Significant international developments regarding the protection of human rights for persons with disability, formed the rationale of the *MHA*. In particular, this concerned the move away from a medical model of disability, to social and supported decision-making models of disability.[881]

5.1.8 Australia had become signatory to, and subsequently ratified, the *United Nations Convention on the Rights of Persons with Disability* ('*CRPD*'),[882] which requires States 'to adopt appropriate legislative, administrative and other measures for the implementation of the rights recognised in the Convention,'[883] which included the rights of persons with acute mental illness.[884] The purpose of the *CRPD* is to:

> … promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity. Persons

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[878] South Australia, *Parliamentary Debates*, House of Assembly, 12 November 2008, 884–5 (Jane Lomax-Smith).

[879] The extent to which such laws are effective in respecting a consumer's human rights is debated. See Chris Maylea et al, 'Consumers' Experiences of Rights-Based Mental Health Laws: Lessons from Victoria, Australia' (2021) 78 *International Journal of Law and Psychiatry* 1.

[880] *Mental Health Act 2009* (SA) s 6(a)(ii), (b). See further, Marianne Wyder et al, 'The Experiences of the Legal Processes of Involuntary Treatment Orders: Tension between the Legal and Medical Frameworks' (2015) 38 *International Journal of Law and Psychiatry* 44.

[881] See generally South Australia, *Parliamentary Debates*, House of Assembly, 12 November 2008 884–907 (Jane Lomax-Smith).

[882] *Convention on the Rights of Persons with Disabilities*, UN GAOR 61st sess, plen mtg 76, Agenda Item 67(b), UN Doc RES A/61/106 (adopted 24 January 2007) ('*CRPD*'). See also Neeraj Gill et al, Measuring the Impact of Revised Mental Health Legislation on Human Rights in Queensland, Australia' (2020) 73 *International Journal of Law and Psychiatry* 101, 634.

[883] Neeraj Gill et al, Measuring the Impact of Revised Mental Health Legislation on Human Rights in Queensland, Australia' (2020) 73 *International Journal of Law and Psychiatry* 101,634, 101,635.

[884] See, for instance, *Convention on the Rights of Persons with Disabilities*, UN GAOR 61st sess, plen mtg 76, Agenda Item 67(b), UN Doc RES A/61/106 (adopted 24 January 2007) arts 5, 12, 14, 15, 18.

> with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.[885]

5.1.9 Consistent with the *CRPD*[886] and the *MHA* objects, the *MHA* establishes a legislative framework to impose an involuntary inpatient treatment order on persons with acute mental illness, subject to strong safeguards. ITOs require a person with mental illness to undergo 'mental health treatment, including involuntary detention, medication, restraint, seclusion and other interventions … without the individual's consent.'[887] In these circumstances, key principles which inform all aspects of the powers and functions exercised under the *MHA* such as preference for least restrictive practices and the presumption of decision-making capacity, become even more pronounced.

5.1.10 Subjecting a person to an ITO can have significant impacts on that person, as well as the broader community. The involuntary nature of the medical treatment is generally inconsistent with well-established legal principles underpinning respect for autonomy, bodily integrity and obtaining consent to medical treatment.[888] In addressing the impetus behind ITO provisions in mental health laws, Marianne Wyder et al remark that the law:

> … aims to balance the many conflicting individual and community interests by providing statutory safeguards to allow for the lawful detention and treatment of patients while ensuring that the patient's rights are respected. The fundamental aim of mental health legislation is to protect, promote and improve the lives and wellbeing of citizens.[889]

5.1.11 It is therefore unsurprising that ITOs are subject to strict scrutiny under the *MHA*, especially given the complex interests that must be carefully considered.

5.1.12 SALRI notes that the academic literature concerning consumer experiences and the effectiveness of ITOs is varied, and there is no consensus on whether ITOs are beneficial for consumers.[890]

5.1.13 For example, in a 2015 study from Queensland regarding 25 patient experiences of ITOs, Wyder et al observed the following divergent patient perspectives:

> … ten participants felt that the ITO had protected them from harm and had greatly benefited from the experience. Twelve participants experienced the ITO as an intrusion into their liberty and physical integrity, and felt that the hospital experience had not been beneficial to their recovery. Three participants had a more mixed experience. Two of these felt that while being in

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[885] *Convention on the Rights of Persons with Disabilities*, UN GAOR 61st sess, plen mtg 76, Agenda Item 67(b), UN Doc RES A/61/106 (adopted 24 January 2007) art 1.

[886] However, the *Mental Health Act 2009* (SA) (as with elsewhere in Australia) does not implement the absolute approach of the UN Committee in precluding any element of substitute decision-making or involuntary treatment. See further Part 2 Background and Context to South Australia's Mental Health Laws.

[887] Bobbie Clugston, Amy Young and Edward Heffernan, 'A Comparison of the Reported Use of Involuntary Treatment Orders within Australian Jurisdictions' (2018) 26(5) *Australasian Psychiatry* 482. See also, Office of the Chief Psychiatrist, *Annual Report of the Office of the Chief Psychiatrist 2021-22* (SA Health, 30 September 2022).

[888] For judicial statement of principles relating to valid consent to medical treatment see *H Ltd v J* [2010] SASC 176; *Hunter and New England Area Health Service v A* (2009) 74 NSWLR 88. See also, Marianne Wyder et al, 'The Experiences of the Legal Processes of Involuntary Treatment Orders: Tension between the Legal and Medical Frameworks' (2015) 38 *International Journal of Law and Psychiatry* 44.

[889] Marianne Wyder et al, 'The Experiences of the Legal Processes of Involuntary Treatment Orders: Tension between the Legal and Medical Frameworks' (2015) 38 *International Journal of Law and Psychiatry* 44, 45.

[890] Ibid; Christina Katsakou et al, 'Psychiatric Patients' Views on Why their Involuntary Hospitalisation was Right or Wrong: A Qualitative Study' (2012) 47 *Social Psychiatry and Psychiatric Epidemiology* 1169.

> hospital had been beneficial, the ITO was still experienced as too intrusive and the last participant felt that the hospital experience had been negative, but was not concerned with having been placed under an ITO.[891]

5.1.14 This study further observed that participants who reported negative experiences associated with being placed under an ITO 'felt that the ITO took away their liberty … Participants either felt that they did were not in need of treatment or that the treatment they had received had not been appropriate.'[892] Other participants 'had a more mixed experience of being placed under an ITO.'[893]

5.1.15 Another similar study suggested that participants:

> … who agreed with the intervention believed that it ensured they received medical treatment, averted further harm and offered them the opportunity to recover in a safe place. They felt that coercion was necessary, as they could not recognise that they needed help when they were acutely unwell and would have refused any treatment. Those who believed that involuntary hospitalisation was wrong thought that their problems could have been managed through less intensive and/or coercive community interventions, and experienced the admission as an unjust infringement of their autonomy, which poses a permanent threat to their independence.[894]

5.1.16 The empirical research on consumer experiences of ITOs is mixed and there is no consensus in the existing literature presently.[895] Indeed, this also emerges in the research regarding consumer experiences and Community Treatment Orders ('CTOs').[896]

5.1.17 An ITO made pursuant to the *MHA* authorises mandatory treatment for a person's mental illness or any other illness that may be causing or contributing to it. However, an ITO does not

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[891] Marianne Wyder et al, 'The Experiences of the Legal Processes of Involuntary Treatment Orders: Tension between the Legal and Medical Frameworks' (2015) 38 *International Journal of Law and Psychiatry* 44, 46. This division in the experience of patients has been found elsewhere. See Christina Katsakou et al, 'Psychiatric Patients' Views on why their Involuntary Hospitalisation was Right or Wrong: a Qualitative Study' (2012) 47(7) *Social Psychiatry and Psychiatric Epidemiology* 1169; Inger Johansson and Berit Lundman, 'Patients' Experience of Involuntary Psychiatric Care: Good Opportunities and Great Losses' (2012) 9(6) *Journal of Psychiatric and Mental Health Nursing* 639; Marianne Wyder et al, 'Personal Recovery and Involuntary Mental Health Admissions: The Importance of Control, Relationships and Hope' (2013) 5(3) *Health* 574; Sophie Isobel, '"In some ways it all helps but in some ways it doesn't": The Complexities of Service Users' Experiences of Inpatient Mental Health Care in Australia' (2019) 28 *International Journal of Mental Health Nurs*ing 105.

[892] Marianne Wyder et al, 'The Experiences of the Legal Processes of Involuntary Treatment Orders: Tension between the Legal and Medical Frameworks' (2015) 38 *International Journal of Law and Psychiatry* 44, 49. Similar findings have been reported elsewhere. See Rebecca Murphy et al, 'Service Users' Experiences of Involuntary Hospital Admission Under the Mental Health Act 2001 in the Republic of Ireland' (2017) 68 *Psychiatric Services* 1127; Kanna Sugiura, Elvira Pertega and Christopher Holmberg, 'Experiences of Involuntary Psychiatric Admission Decision-Making: a Systematic Review and Meta-Synthesis of the Perspectives of Service Users, Informal Carers, and Professionals' (2020) 73 *International Journal of Law and Psychiatry* 101645.

[893] Marianne Wyder et al, 'The Experiences of the Legal Processes of Involuntary Treatment Orders: Tension between the Legal and Medical Frameworks' (2015) 38 *International Journal of Law and Psychiatry* 44, 49.

[894] Christina Katsakou et al, 'Psychiatric Patients' Views on why their Involuntary Hospitalisation was Right or Wrong: A Qualitative Study' (2012) 47 *Social Psychiatry and Psychiatric Epidemiology* 1169, 1174–75. See also Marianne Wyder et al, 'Personal Recovery and Involuntary Mental Health Admissions: The Importance of Control, Relationships and Hope' (2013) 5(3) *Health* 574.

[895] See, for example, Inger Johansson and Berit Lundman, 'Patients' Experience of Involuntary Psychiatric Care: Good Opportunities and Great Losses' (2012) 9(6) *Journal of Psychiatric and Mental Health Nursing* 639; Sophie Isobel, '"In Some Ways it all Helps but in Some Ways it Doesn't': The Complexities of Service Users' Experiences of Inpatient Mental Health Care in Australia (2018) 28 *International Journal of Mental Health Nursing* 105.

[896] It should be noted that the evidence is still seen as 'inconclusive': Steve Kisely, Yong Yu and Dan Siskind, 'A Systematic Review and Meta-Analysis of Predictors and Outcomes of Community Treatment Orders in Australia and New Zealand (2021) 55(7) *Australia and New Zealand Journal of Psychiatry* 649.

permit the provision of prescribed psychiatric treatment,[897] defined as electroconvulsive therapy ('ECT') or neurosurgery for mental illness under the *MHA*.[898]

5.1.18 Although ITOs may appear harsh and can have dramatic impacts on consumers, it is necessary to emphasise that this part of the *MHA* is designed to operate in circumstances of crisis and ITOs are put in place to protect persons with a mental illness at risk of harming themselves or others.[899] In the 2014 statutory review of the *Mental Health Act 2009* (SA) ('2014 Statutory Review'), the former Chief Psychiatrist, Dr Panayiotis Tyllis, explained that treatment orders such as ITOs 'can be life-saving and may be the best of several difficult options for a patient or their support persons in challenging situations.'[900]

5.1.19 Despite the threshold test for the imposition of an ITO requires there should be no less restrictive means available to protect the person at risk of harming themselves or others, recent data has shown that the use of ITOs is high.[901] In the latest report published by the Office of the Chief Psychiatrist ('OCP') for the 2021-22 financial year ('OCP Annual Report 2021-22'), it was observed that treatment orders had been steadily increasing in recent years in South Australia.[902] This, along with the increasing rate of CTO use, was deemed a concern.[903]

5.1.20 To impose an ITO on an individual, several criteria need to be established, all of which are set out in the *MHA*. These grounds are consistent with the grounds for a CTO.

5.1.21 Ambiguity concerning key terminology – or the absence of that terminology – utilised in the ITO provisions of the *MHA* are issues of contention. It is mandatory for the *MHA* to be reviewed every five years.[904] The 2014 Statutory Review identified important issues concerning the definition of terms such as harm, preclusion of physical harm and the lack of decision-making capacity as threshold criteria for ITOs.[905]

5.1.22 The issues identified and proposals raised in the 2014 Statutory Review resulted in amendments to the *Mental Health Act 2009* (SA), with the South Australian Parliament passing the

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[897] *Mental Health Act 2009* (SA) s 3 (definition of 'prescribed psychiatric treatment').

[898] Ibid ss 3 (definition of 'neurosurgery'), (definition of 'ECT') 42, 43.

[899] Office of the Chief Psychiatrist, *Annual Report of the Office of the Chief Psychiatrist 2021-22* (SA Health, 30 September 2022) 54.

[900] Office of the Chief Psychiatrist, *The Review of the Mental Health Act 2009 - A Report by the Chief Psychiatrist of South Australia* (SA Health, 23 May 2014) foreword; Office of the Chief Psychiatrist, *The Annual Report of the Chief Psychiatrist of South Australia 2013-14* (SA Health, 30 September 2014) 23.

[901] This trend is reflected in other international jurisdictions. See NHS Digital, *Mental Health Statistics, Annual Figures 2021-22* (27 October 2022) <Detentions: differences between groups of people - NDRS (digital.nhs.uk)>; Explanatory Notes, Draft Mental Health Bill 2022 (UK) 3–4; UK Government, *Modernising the Mental Health Act: Increasing Choice, Reducing Compulsion – Final Report of the Independent Review of the Mental Health Act 1983* (December 2018) 45–9.

[902] Office of the Chief Psychiatrist, *Annual Report of the Office of the Chief Psychiatrist 2021-22* (SA Health, 30 September 2022) 54. See also Bobbie Clugston, Amy Young and Edward Heffernan, 'A Comparison of the Reported Use of Involuntary Treatment Orders within Australian Jurisdictions' (2018) 26(5) *Australasian Psychiatry* 482.

[903] Edwina Light et al, 'Community Treatment Orders in Australia: Rates and Patterns of Use' (2012) 20(6) *Australasian Psychiatry* 478; Edwina Light, 'Rates of Use of Community Treatment Orders in Australia' (2019) 69(4) *International Journal of Law and Psychiatry* 83.

[904] *Mental Health Act 2009* (SA) s 111.

[905] Office of the Chief Psychiatrist, *The Review of the Mental Health Act 2009 - A Report by the Chief Psychiatrist of South Australia* (SA Health, 23 May 2014); Office of the Chief Psychiatrist, *The Annual Report of the Chief Psychiatrist of South Australia 2013-14* (SA Health, 30 September 2014) 45–51.

Mental Health (Review) Amendment Act 2016 (SA).[906] In the Second Reading Speech, the then Minister for Health, Mental Health and Substance Abuse, the Hon Jack Snelling, remarked that 'the review found that the Act required amendment [and] there are 63 proposed legislative amendments [with] five improv[ing] clarity enhancing understanding of and compliance with the Act,'[907] and 17 amendments proposing changes to the definition of key terms and language used throughout the Act.[908] A significant change was adding the requirement for impaired decision-making capacity as one of the criterions for the making of either a CTO or ITO.

5.1.23 It was further noted by the Minister that mental health laws 'must change over time in order to reflect contemporary attitudes and approaches to acceptance and treatment of mental illness. It must be expressed in a way that provides maximum flexibility to enable individuals with responsibilities and powers under the Act to carry out their roles effectively.'[909] This statement continues to be important and applicable today.[910]

5.1.24 The findings and recommendations of the Inquest concerning the death of Theo Papageorgiou released in late 2021 (the 'Inquest'), shed further light on issues with mental health services, particularly regional areas and ITOs.[911] SALRI has had careful regard to the Inquest's findings.

5.2 Coronial Inquest into the Death of Theo Nikolas Papageorgiou

Background

5.2.1 Theo Nikolas Papageorgiou's suicide in 2016 was a tragic event, and the subsequent Inquest revealed concerning issues pertaining to the treatment he received for his underlying mental illness over a fourteen-month period, which ultimately culminated in his death.[912] SALRI's Terms of Reference require regard to be given to the findings of the Inquest.

5.2.2 The Deputy Coroner found that, from the time Theo first sought medical treatment for his mental illness until his death, he had experienced 'many months of mental illness which had manifested itself at various times in paranoid and delusional ideation, manic behaviour and most recently with depression and expressions of hopelessness.'[913]

5.2.3 In late 2021, the Deputy Coroner released his findings and recommendations. This revealed concerning shortfalls regarding the medical treatment that Theo had received. It was noted that 'throughout the period from and including the beginning of [Theo] detention under the ITO until his death, [his] management lacked leadership and cohesion.'[914]

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[906] *Mental Health (Review) Amendment Act 2016* (SA) s 17(1)–(5).

[907] South Australia, *Parliamentary Debates*, House of Assembly, 2 December 2015, 3923 (Jack Snelling).

[908] Ibid 3923 (Jack Snelling).

[909] Ibid 3923.

[910] Indeed, this is the rationale of SALRI's present review.

[911] *Inquest into the Death of Theo Nikolas Papageorgiou* (2021) 09/2020 (0176/2016) SACC (Schapel, Deputy State Coroner). SALRI had the opportunity of meeting Theo's parents as part of its consultation and reiterates its appreciation for their helpful input.

[912] *Inquest into the Death of Theo Nikolas Papageorgiou* (2021) 09/2020 (0176/2016) SACC [2.1]–[2.3] (Schapel, Deputy State Coroner).

[913] Ibid [15.10].

[914] Ibid [2.1].

5.2.4 A critical issue identified by the Deputy Coroner was that 'there was inadequate regard paid to [Theo's] longitudinal history. Most if not all of the assessments of [him] that took place during that period were of a cross-sectional nature that did not adequately take into account [his] longitudinal history, and in particular have regard to the collateral information about [him] that could have been provided by [his] parents',[915] which would have demonstrated his deteriorating mental health.[916]

5.2.5 It was observed that over a 14 month period, Theo attended multiple consultations with GPs, trialled numerous medications prescribed by different medical practitioners, had been placed under a Level 1 ITO which was prematurely revoked, presented multiple times to the ED of the local hospital, and had been seen by several mental health specialists, including psychiatrists.[917] The Deputy Coroner observed that if proper medical history had been considered concerning Theo's mental illness, especially when the decision to revoke his Level 1 ITO was made:

> … it would have been seen that Mr Papageorgiou's presentation in November 2015 [when the ITO was made] was probably a relapse of a psychosis that he had exhibited in November 2014 and following. The diagnosis that this was a first episode psychosis, and not a relapsed or an ongoing psychosis, had the potential to engender adverse consequences in respect of Theo's care and treatment. If it had been recognised that Theo's latest episode of November 2015 should be viewed against the entire background and history, a differing trajectory of treatment would have been imposed. Such a regime of treatment would have involved a need to guard against the possibility of relapse, would have involved consideration being given to a possible diagnosis of bipolar disorder with the risk of Theo developing depressive illness and also would have involved consideration being given to a different medication regime.[918]

5.2.6 The Deputy Coroner details the facts and evidence surrounding Theo's treatment from the various health practitioners. To avoid repetition, this information will not be considered here. Rather, this discussion will focus on the Deputy Coroner's recommendations that have significant bearing on the law relating to ITOs under the *MHA*.

5.2.7 The Deputy Coroner identified several issues concerning the ITO provisions under the *MHA*. The issues relevant to this Part can be summarised as follows:

- Issue 1 – The inability of the Riverland General Hospital ('RGH'), Berri, to accommodate patients under a Level 2 ITO.[919]
- Issue 2 – Lack of Clinical File Sharing between Departments & Improper Clinical Care.
- Issue 3 – The requirement for impaired decision-making capacity as a criterion for the imposition of an ITO.

5.2.8 It was found that these three issues, among others, were contributing factors to Theo's death. The findings and recommendations in relation to these issues will be addressed in turn below.

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[915] Ibid [15.10].

[916] Theo's parents also relayed this theme to SALRI.

[917] *Inquest into the Death of Theo Nikolas Papageorgiou* (2021) 09/2020 (0176/2016) SACC [15.10] (Schapel, Deputy State Coroner).

[918] Ibid [15.6] (Schapel, Deputy State Coroner).

[919] Ibid [3.10] (Schapel, Deputy State Coroner).

Issue 1 - Inability of the RGH to treat Patients under a Level 2 ITO

5.2.9 Under the *MHA*,[920] the Chief Psychiatrist can determine 'public incorporated hospitals and private licensed hospitals as approved treatment centres or limited treatment centres.'[921] On 24 November 2015, Theo was placed under a Level 1 ITO, detained and involuntarily treated at RGH, an approved treatment centre for Level 1 ITOs.[922] At the relevant point in time, the RGH was not permitted to treat patients under a Level 2 ITO, requiring transfer to an approved facility in a metropolitan area. The Deputy State Coroner remarked that this is a circumstance that 'should never be repeated at any other country medical facility'.[923]

5.2.10 Although the RGH is now able to accommodate persons under a Level 2 ITO,[924] this point requires consideration as it serves a broader purpose in SALRI's statutory review, which is to present recommendations for any appropriate changes to the *MHA*.

5.2.11 The Deputy Coroner was of the view that the inability of the RGH to accommodate patients under a Level 2 ITO played a significant part in the refusal to convert Theo's Level 1 ITO to a Level 2 ITO. The Deputy Coroner observed that 'a level 2 ITO would have involved [Theo] being sent to Adelaide which was a matter that [he] no doubt would have resisted with some vehemence considering his reaction when he was detained in the first instance. That said, if Theo needed to be sent to Adelaide, he should have been sent to Adelaide regardless of his own attitude in my view.'[925]

5.2.12 The Deputy Coroner continued, finding that the 'limited ability of the RGH to accommodate inpatients detained under a level 2 ITO created an atmosphere of deterrence against imposing this measure on a patient already detained at the RGH at Berri under a level 1 ITO.'[926] Findings further highlighted that this was an erroneous decision of the treating medical practitioner, as inadequate consideration was given to Theo's clinical needs at that time.[927]

5.2.13 The Deputy Coroner suggested:

> A comprehensive review be conducted in relation to clinical resources in respect of mental health services in all rural regions in South Australia. The review should be conducted with a view to … [ensure] hospitals in regional areas that administer mental health services being provided with the ability and resources to administer level 2 Inpatient Treatment Orders.[928]

[920] *Mental Health Act 2009* (SA) ss 96, 97.

[921] Office of the Chief Psychiatrist, *Annual Report of the Office of the Chief Psychiatrist 2021-22* (SA Health, 30 September 2022) 10.

[922] *Inquest into the Death of Theo Nikolas Papageorgiou* (2021) 09/2020 (0176/2016) SACC [15.5] (Schapel, Deputy State Coroner).

[923] Ibid.

[924] Ibid [12.3].

[925] Ibid [5.7].

[926] Ibid [15.5].

[927] Ibid [15.8].

[928] Ibid [16.10]. Recommendation 2(iii).

Issue 2 – Lack of Clinical File Sharing between Departments & Improper Clinical Care and Staffing

5.2.14 The systemic failure to share clinical files was viewed as an issue of importance in the Inquest.[929] The Deputy Coroner noted that there was no sharing of clinical files between the RGH ED, the CMHT, the Berri Integrated Mental Health Unit or the Emergency Triage Liaison Service ('ETLS'). The Deputy Coroner found that the lack of information sharing between these SA Health entities and other providers (including the GP and private psychologist) caused 'unacceptable gaps in the clinical system'.[930]

5.2.15 It was clear that Theo had sought treatment for his mental illness from different service providers in the Riverland over a 14 month period.[931] Theo's mental illness progressed and his mental health deteriorated, especially when Theo was placed under a Level 1 ITO several weeks preceding his death, with failures to have proper regard to his longitudinal history, and in particular have regard to the collateral information about [him] that could have been provided by his parents.[932] The Coroner said that the failure of the respective health services to share patient's clinical files/notes was exacerbated by the 'transience of staff in the mental health services in the Riverland that included locum practitioners and to a lack of mental health care resources in that region.'[933]

5.2.16 Additionally, the lack of specialist oversight and proper management of Theo following his discharge from the Level 1 ITO on 30 November 2015, was also a contributing factor to his death. On this point, the Deputy Coroner was in agreement with the Chief Psychiatrist's observations, remarking that 'so many parts of the health service were involved and did not recognise the need for a comprehensive review contributed to the underestimation of Theo's clinical risk.'[934] It was highlighted that 'an adequate model and provision of clinical supervision is required to ensure members of a multi-disciplinary team provide a high standard of care and identify reasons for a person's deteriorating clinical state.'[935]

5.2.17 Although the issues raised by the Deputy Coroner may appear tangential to the focus of this Part, they are directly related to the role and operation of ITOs under the *MHA*, particularly for regional consumers. The cumulative effect of the lack of file sharing, lack of clinical supervision, oversight and management, and lack of continuity care, contributed to Theo being erroneously diagnosed whilst he was being treated as an involuntary inpatient under a Level 1 ITO in November 2015.[936] It also resulted in inadequate consideration of the need for Theo to be placed under another Level 1 ITO on subsequent dates. This was especially the case in the days preceding Theo's death where he presented multiple times to RGH.[937]

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[929] Shortfalls in information sharing under the *Mental Health Act 2009* (SA) was raised by Mr Papageorgiou's parents and others to SALRI. A particular concern raised to SALRI was information sharing about a patient between city and rural locations.

[930] *Inquest into the Death of Theo Nikolas Papageorgiou* (2021) 09/2020 (0176/2016) SACC [13.3] (citations omitted). See SALRI Recommendation 3.

[931] *Inquest into the Death of Theo Nikolas Papageorgiou* (2021) 09/2020 (0176/2016) SACC [15.10].

[932] Ibid [15.10].

[933] Ibid.

[934] Ibid [13.3].

[935] Ibid.

[936] Ibid [15.6].

[937] Ibid [15.13]–[15.14].

5.2.18 The Deputy Coroner made several recommendations, including emphasising the need for psychiatrists, other practitioners and clinicians to undertake adequate assessments of consumers in analogous circumstances. This includes a requirement to gather consumers' 'longitudinal history [and] collateral information from family members and associates [and to] evaluate and identify a deterioration in the mental health of a patient from one presentation to the next.'[938] It was also recommended that 'there may be a need for general practitioners practicing in rural hospitals to utilise the services of Emergency Triage Liaison Service',[939] and the need for 'psychiatric evaluation of a patient who makes repeated presentations'.[940]

Issue 3 – The requirement for impaired decision-making capacity as a criterion for the imposition of an ITO

5.2.19 The Deputy Coroner considered the requirement for impaired decision-making capacity as a criterion for the imposition of an ITO in detail.[941] This issue is considered elsewhere in SALRI's review.[942]

5.2.20 Impaired decision-making capacity is one of the criterions for the making of a Level 1, 2 or 3 ITO under the *MHA*.[943] Impaired decision-making capacity was not part of the original Act as it was passed in 2009, and was also not part of legislative framework for imposition of an ITO in 2015 and 2016 when the events concerning Theo transpired.[944] This requirement therefore did not exist as a legal requirement to imposing – or revoking – Theo's ITO.[945] The Deputy Coroner, however, observed that the issue of impaired decision-making capacity was central to the Inquest as:

> In the course of this current inquest more than one medical practitioner who was involved referred to the issue of [Theo's] decision-making capacity in the context of whether or not the ITO of which [Theo's] had been the subject should be revoked, renewed or indeed imposed in the first instance. The evidence of at least one of these medical practitioners suggested that [Theo's] decision-making capacity played a part in the decisions made as far as detention or continuing detention under the *MHA* was concerned.[946]

5.2.21 The requirement that impaired decision-making capacity should form part of the legislative framework of s 21(1), s 25(2) and s 29(1) of the *MHA* was made following the 2014 Statutory Review of the *MHA* by the OCP.

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[938] *Inquest into the Death of Theo Nikolas Papageorgiou* (2021) 09/2020 (0176/2016) SACC [16.10].

[939] Ibid.

[940] Ibid.

[941] *Mental Health Act 2009* (SA) s 21(1)(ba).

[942] See Part 3 Decision-making Capacity and Supported Decision-making.

[943] *Mental Health Act 2009* (SA) ss 21(1)(ba), 25(2)(ba), 29(1)(ba).

[944] *Inquest into the Death of Theo Nikolas Papageorgiou* (2021) 09/2020 (0176/2016) SACC [14.9].

[945] *Mental Health Act 2009* (SA) s 111.

[946] *Inquest into the Death of Theo Nikolas Papageorgiou* (2021) 09/2020 (0176/2016) SACC [14.11]; see also [14.17], [14.18].

5.2.22 Prior to the 2016 amendment,[947] the initial legislative framework for imposing a Level 1 ITO required the medical practitioner or authorised health professional to be satisfied that it appears:

> (a) the person has a mental illness; and
>
> (b) because of the mental illness, the person requires treatment for the person's own protection from harm (including harm involved in the continuation or deterioration of the person's condition) or for the protection of others from harm; and
>
> (c) there is no less restrictive means than an inpatient treatment order of ensuring appropriate treatment of the person's illness.[948]

5.2.23 In its review of the *MHA*, the OCP recommended that 'the threshold criteria for involuntary treatment should include a capacity criterion'.[949] The OCP's recommendation for impaired decision-making capacity as a criterion was premised on wider developments and the recent introduction of the *Advance Care Directives Act 2013* (SA) ('*ACD Act*'), which included impaired decision-making capacity as a criterion for activating an advance care directive ('ACD').

5.2.24 It was recommended that an additional provision be inserted into the statutory framework for granting an ITO requiring that the person 'has impaired decision-making capacity relating to appropriate treatment of the person's mental illness.'[950] Consequently, the *Mental Health (Review) Amendment Act 2016* (SA)[951] included these amendments.

5.2.25 The new legislative framework for imposing a Level 1 ITO requires satisfaction of four elements, and if any one element cannot be satisfied, then an ITO cannot be lawfully imposed. The amended s 21 of the *MHA* requires that:

> (a) the person has a mental illness; and
>
> (b) because of the mental illness, the person requires treatment for the person's own protection from harm (whether physical or mental, and including harm involved in the continuation or deterioration of the person's condition) or for the protection of others from harm; and
>
> **(ba) the person has impaired decision-making capacity relating to appropriate treatment of the person's mental illness;** and
>
> (c) there is no less restrictive means than an inpatient treatment order of ensuring appropriate treatment of the person's illness.[952]

5.2.26 In the Second Reading Speech for the Mental Health (Review) Amendment Bill 2016 (SA), the Minister said that the proposed amendments were based on recent developments in contemporary human rights of persons with mental illness.[953] This was the likely catalyst behind the introduction of impaired decision-making capacity criterion. The Deputy Coroner was critical of this response, unpersuaded by the reasoning for the recommendation that impaired decision-making

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[947] See *Mental Health (Review) Amendment Act 2016* (SA).

[948] *Mental Health Act 2009* (SA) ss 21(1)(a)-(c), referred to in *Inquest into the Death of Theo Nikolas Papageorgiou* (2021) 09/2020 (0176/2016) SACC [14.2] (Schapel, Deputy State Coroner).

[949] *Inquest into the Death of Theo Nikolas Papageorgiou* (2021) 09/2020 (0176/2016) SACC [14.21] (Schapel, Deputy State Coroner) (citations omitted).

[950] *Mental Health Act 2009* (SA) ss 21(1)(ba).

[951] Ibid ss 17(3), 21(2), 25(2). These commenced operation on 5 June 2017.

[952] Ibid s 21(1) (emphasis added).

[953] South Australia, *Parliamentary Debates*, House of Assembly, 2 December 2015, 3923 (Jack Snelling).

capacity should operate as a threshold criterion for involuntary treatment. The Deputy Coroner observed an omission as to providing an explanation for 'why the capacity criterion was now necessary when it had not been considered necessary when the new *MHA* 2009 was enacted in the first place.'[954]

5.2.27 The Deputy Coroner further noted that the *ACD Act* only has a tangential connection to the 'acute situations involving the prevention of physical or mental harm to individuals or to the public in general,' which are integral objects of the *MHA*.[955]

5.2.28 In drawing out further points of difference between involuntary treatment orders under the *MHA* and requirements for activating an ACD, the Deputy Coroner observed:

> … the essential element in the activation of an advance care directive is the existence of impaired decision-making capacity and that all else flows from that, the essential element in the imposition of an ITO under the *MHA* is a mental illness that may require acute treatment for the protection from harm. In reality there was no proper parallel to be drawn from the *Advance Care Directives Act*.[956]

5.2.29 Requiring demonstration of impaired decision-making capacity for the activation of an ACD is unrelated to the issues that arise in the context of involuntarily placing a person who has an acute mental illness under an ITO.

5.2.30 The Deputy Coroner regarded the logic of requiring impaired decision-making capacity as one of the pre-conditions for making an ITO as flawed, explaining:

> What the relevant provision in the *MHA* now seems to be suggesting is that where a person has a mental illness and that because of the mental illness the person requires treatment for that person's own protection from harm or for the protection of others from harm, and there is no less restrictive means other than an ITO of ensuring appropriate treatment of the person's illness, all of that counts for nought if the person despite that mental illness and despite its potentially harmful consequences has unimpaired decision-making capacity relating to their appropriate treatment … The section 21(1)(ba) amendment appears to work on the questionable assumption that a person who is so mentally ill that he or she requires treatment for their own protection or for the protection of others might nevertheless quite rationally decide not to have that treatment thereby avoiding detention and treatment, and possibly as a result, putting themselves and/or the general public at risk of harm.[957]

5.2.31 SALRI notes that impaired decision-making capacity as one of the criterions for the imposition of an ITO may remain a contentious issue. SALRI, after careful consideration, is of the view, whilst acknowledging the validity of the Deputy Coroner's reasoning and his suggestion to remove impaired decision-making capacity as a criterion, that the law should remain unchanged on this point.

5.3 Current Law in South Australia

5.3.1 Inpatient Treatment Orders have been described as an order that lawfully permits for the involuntary detention and treatment of a person as an inpatient at an approved treatment centre with

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[954] *Inquest into the Death of Theo Nikolas Papageorgiou* (2021) 09/2020 (0176/2016) SACC [14.22].

[955] Ibid.

[956] Ibid.

[957] Ibid [14.26].

a view to treat them for their acute mental illness.[958] Given the significant infringement on fundamental individual rights, such as the right to autonomy, bodily integrity and self-determination and liberty,[959] strict criteria have been established which must be satisfied prior to an ITO being imposed.

5.3.2 The *MHA* provides for three levels of ITOs – Level 1, Level 2 and Level 3 – with the predominant difference between them being the duration of the order and who may impose an ITO.[960] The *MHA* includes strong safeguards to ensure that an ITO is an option of 'last resort'.[961] Further, treatment under an ITO can only be provided at a treatment centre that has been approved by the Chief Psychiatrist as either an Approved Treatment Centre, or Limited Treatment Centre under the *MHA*.[962] The requirement that a person be treated at a treatment centre aligns with the objects of the *MHA*, ensuring that a person with acute mental illness 'receive a comprehensive range of services of the highest standard for their treatment, care and rehabilitation with the goal of bringing about their recovery as far as is possible.'[963]

5.3.3 Due to the involuntary nature of detention and treatment under ITOs, the *MHA* permits staff at a treatment centre to take measures to ensure the treatment authorised in the ITO is carried out,[964] or 'for the maintenance of order and security at the centre or the prevention of harm or nuisance to others.'[965] This includes the power of staff to confine or restrain consumers, or use force, but only to the extent reasonably required in the circumstance.[966] The key terms utilised in s 34A of the *MHA*, which authorises use of confinement, restraint and use of force, are not defined.

5.3.4 Therefore, when resorting to these measures, the *MHA*'s objects and guiding principles must be applied.[967] For instance, individuals with an acute mental illness should 'retain their freedom, rights, dignity and self-respect as far as is consistent with their protection, the protection of the public and the proper delivery of the services.'[968] A further relevant guiding principle is that 'mental health services should … be provided in accordance with international treaties and agreements to which Australia is a signatory.'[969]

5.3.5 Nevertheless, whether these terms require definition, or should be replaced by the already defined term 'restrictive practice,'[970] should be considered. This is important, as the implications of adopting the term 'restrictive practice' under s 34A of the *MHA* would require the Restraint and

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[958] Ibid [3.2].

[959] See, for example, *Rogers v Whitaker* (1992) 175 CLR 479; *Brightwater Care Group (Inc) v Rossiter* [2009] WASC 229, [24], [26], [31] (Martin CJ); *Re T* [1993] Fam 95; *Schloendorff v Society of New York Hospital* 211 NY 125 (1914), 129 (Cardozo J).

[960] *Mental Health Act 2009* (SA) ss 21(4), 25(6), 29(5).

[961] Ibid ss 7(1)(b), 21(1)(C), (2), 25(2)(C), (3), 29(1)(C), (2).

[962] Ibid ss 96, 97.

[963] Ibid s 6(a)(i).

[964] Ibid 34A(2)(a).

[965] Ibid s 34A(2)(b).

[966] Ibid s 34A(1), (2).

[967] Ibid s 34A(3). See also Part 12 Guiding Principles and Accountability Mechanisms.

[968] *Mental Health Act 2009* (SA) s 6(a)(ii).

[969] Ibid s 7(1)(ac).

[970] Ibid s 3 (definition of 'restrictive practice').

Seclusion Standard published by the Chief Psychiatrist on 1 February 2021 to be applied, providing further safeguards for patients subject to an ITO.[971]

5.3.6 The statutory requirements for imposition of Level 1, 2 and 3 treatment orders are considered below.[972]

5.3.7 SALRI notes at the outset that key terminology adopted in the *MHA* for Level 1, Level 2 and Level 3 ITOs is largely consistent. Therefore, to avoid repetition, this discussion will reference a previously provided definition where appropriate.

Level 1 Inpatient Treatment Order

5.3.8 A Level 1 ITO (ITO 1) has been described as an order requiring a person to be 'given treatment [at a treatment centre] for his or her mental illness or any other illness of a kind authorised by a medical practitioner who has examined the patient. The treatment may be given despite the absence or refusal of consent to the treatment.'[973] Four criteria need to be satisfied prior to imposing an ITO 1, which are set out in s 21(1) of the *MHA* and provided below, that:

> (a) the person has a mental illness;[974] and
>
> (b) because of the mental illness, the person requires treatment for the person's own protection from harm (whether physical or mental, and including harm involved in the continuation or deterioration of the person's condition) or for the protection of others from harm;[975] and
>
> (ba) the person has impaired decision-making capacity relating to appropriate treatment of the person's mental illness;[976] and
>
> (c) there is no less restrictive means than an inpatient treatment order of ensuring appropriate treatment of the person's illness.[977]

5.3.9 The standard to which each criterion must be satisfied requires a clinical threshold to be met, evident through the use of the term 'appear', following an examination of the person.[978] However, if any of the criteria listed above cannot be satisfied to the requisite standard, then an ITO 1 cannot be lawfully imposed. Further, the *MHA* defines certain terms and provides additional clarity on key provisions relating to ITO 1, which require further consideration.

5.3.10 Additional safeguards require that a person subjected to an ITO 1 must be reviewed by a different psychiatrist or Authorised Medical Practitioner within 24 hours of the order being made or

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[971] Government of South Australia, Chief Psychiatrist Restraint and Seclusion Standard: A Standard to Reduce and Eliminate where Possible the Use of Restraint and Seclusion Applied under the *Mental Health Act 2009* (SA), *Office of the Chief Psychiatrist* (Web Page, 1 July 2021) <https://www.chiefpsychiatrist.sa.gov.au/policies-standards-and-reports/policies-and-standards/restraint-and-seclusion-chief-psychiatrist-standard>.

[972] Several additional provisions that apply to ITOs in general under the *Mental Health Act 2009* (SA) have not been discussed here. These provisions relate to the interaction between unrevoked community treatment orders and ITOs, duty of directors of treatment centres and ITOs, leave requirements for consumers subject to an ITO and transfer of involuntary patients to other treatment centres. For consideration of these legislative provisions see *Mental Health Act 2009* (SA) ss 32–34, 35–38.

[973] *Inquest into the Death of Theo Nikolas Papageorgiou* (2021) 09/2020 (0176/2016) SACC [3.4] (Schapel, Deputy State Coroner); *Mental Health Act 2009* (SA) s 24(2).

[974] *Mental Health Act 2009* (SA) s 21(1)(a).

[975] Ibid s 21(1)(b).

[976] Ibid s 21(1)(ba).

[977] Ibid s 21(1)(c).

[978] Ibid s 21(1).

as soon as practicable.[979] During this review, the order may be confirmed or revoked.[980] However, this provision does not act as a barrier to initiating treatment, as the *MHA* states that the person subject to an ITO can be treated prior to being reviewed.[981] When imposing an ITO under s 21(1) of the *MHA*, or confirming or revoking under s 21(5), it is provided that an 'opinion about a person [may be formed] based on his or her own observations and any other available evidence that he or she considers reliable and relevant.'[982] The *MHA* does not limit or specify what evidence a medical practitioner or authorised mental health professional may take into account when performing this function, so long as it is reliable and relevant.

5.3.11 Further, in ensuring that no less restrictive means are available to the person to receive appropriate treatment for their mental illness, the *MHA* requires consideration of 'the prospects of the person receiving all treatment of the illness necessary for the protection of the person and others on a voluntary basis or in compliance with a community treatment order.'[983] If, in the circumstances, the person could receive appropriate treatment without the need of an ITO, then this is a relevant consideration.

5.3.12 Under the *MHA*, consumers have the right to receive a copy of the ITO,[984] a statement of rights,[985] and if the order is revoked, a copy of the revocation.[986] If the person subject to the ITO cannot read or comprehend the statement of rights, there is a duty for the medical practitioner or authorised mental health professional to take practicable steps to communicate this information.[987] Additionally, a copy of the ITO 1 and a statement of rights, and if applicable a copy of a revocation order,[988] must also be sent or given to the person's guardian, medical agent, relative, carer or friend as soon as practicable.[989]

Definition of Medical Practitioner and Authorised Mental Health Professional

5.3.13 Level 1 ITOs can only be made by an Authorised Medical Practitioner[990] or Authorised Mental Health Professional ('AMHP').[991] The definition of medical practitioner is broad, meaning a doctor registered under the *Health Practitioner Regulation National Law*.[992] AMHPs are defined as senior

[979] Ibid s 21(5)(a), (b), (c).

[980] Ibid s 21(5)(d).

[981] *Mental Health Act 2009* (SA) s 24(3).

[982] Ibid s 21(6).

[983] Ibid s 21(2).

[984] Ibid s 23(1).

[985] Ibid s 23(2); *Mental Health Regulations 2010* (SA) s 4(3).

[986] *Mental Health Act 2009* (SA) s 23(5).

[987] Ibid s 23(3). An issue raised in SALRI's consultation was that this requirement may not be effectively carried out and many patients are left bemused about their situation.

[988] *Mental Health Act 2009* (SA) s 23(5)(b).

[989] Ibid ss 23(4), 23(6).

[990] Office of the Chief Psychiatrist, *Annual Report of the Office of the Chief Psychiatrist 2021-22* (SA Health, 30 September 2022) 13.

[991] *Mental Health Act 2009* (SA) s 21(1).

[992] Ibid s 3 (definition of 'medical practitioner').

mental health clinicians who have undertaken further training in mental illness and who must undergo continuing professional development in the area of mental illness.[993]

Duration

5.3.14 Level 1 ITOs do not operate indefinitely and can be revoked earlier by a psychiatrist or Authorised Medical Practitioner.[994] During the period of operation, ITO 1 permit medical practitioners to lawfully detain a person at a treatment centre to administer involuntary treatment for their mental illness, 'or for any other illness that may be causing or contributing to the mental illness.'[995]

5.3.15 An ITO 1 is only valid for a 'time fixed in the order which must be 2pm on a business day not later than seven days after the day on which it is made.'[996] The maximum duration is seven days, but they may be revoked at any time prior to the expiry period by a psychiatrist or Authorised Medical Practitioner.[997] An ITO 1 cannot be extended beyond seven days, and if a patient requires further treatment, an additional order can be made 'for the treatment of the patient as an inpatient in an approved treatment centre. This further order is known as a level 2 ITO'.[998] Level 2 ITOs are considered further below.

Treatment for Mental Illness

5.3.16 Mental illness is broadly defined and means 'any illness or disorder of the mind.'[999] However, in relation to what treatment may be provided under an ITO 1, the *MHA* restricts treatment to the person's mental illness or any other illness that may be causing or contributing to it.[1000] It does not permit treatment of conditions or illnesses outside of these parameters,[1001] and treating outside the confines of the *MHA* may constitute a trespass to the person.[1002] The *MHA* is explicit in that it does not permit prescribed treatment as defined in the *Guardianship and Administration Act 1993* (SA), which means 'termination of pregnancy, sterilisation or any other medical treatment prescribed by regulations'.[1003]

5.3.17 The ambiguous definition of treatment under the *MHA* has been a point of contention, and indeed a focus of consultation on ITOs, as treatment for other physical health issues, such as diabetes caused by psychiatric medication, is unlikely to be covered under the law. Whether broader

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[993] Ibid s 3 (definition of 'authorised mental health professionals'). For discussion concerning authorised mental health professionals see Office of the Chief Psychiatrist, *Annual Report of the Office of the Chief Psychiatrist 2021-22* (SA Health, 30 September 2022) 13.

[994] *Mental Health Act 2009* (SA) s 21(7); Authorised Medical Practitioners are defined as 'medical practitioners who have significant psychiatric experience to carry out most of the powers and functions of psychiatrists, except those relating to prescribed psychiatric treatment,' see Office of the Chief Psychiatrist, Annual Report of the Office of the Chief Psychiatrist 2021-22 (SA Health, 30 September 2022) 13.

[995] *Mental Health Act 2009* (SA) s 24(1).

[996] Ibid s 21(4).

[997] Ibid s 21(7).

[998] *Inquest into the Death of Theo Nikolas Papageorgiou* (2021) 09/2020 (0176/2016) SACC [3.5] (Schapel, Deputy State Coroner); *Mental Health Act 2009* (SA) s 25.

[999] *Mental Health Act 2009* (SA) s 3 (definition of 'mental illness').

[1000] Ibid s 24(1).

[1001] Ibid s 24(1).

[1002] *Rogers v Whitaker* (1992) 175 CLR 479.

[1003] *Guardianship and Administration Act 1993* (SA) s 3 (definition of 'prescribed treatment').

physical health issues could be treated under an ITO if the legislative definition of treatment was expanded was addressed in SALRI's consultation.[1004]

5.3.18 It is necessary to consider the existing legal framework for provision of medical treatment in the absence of consent outside the *MHA*. For instance, if a person's diabetes caused by administration of psychiatric medication cannot be lawfully treated under an ITO due to the current definition of 'treatment', then it is necessary to look to existing law – both legislative and common law – that may apply in this area. If existing law applies, then this may negate the need for any legislative amendment of 'treatment' under the *MHA*.

5.3.19 The *Consent to Medical Treatment and Palliative Care Act 1995* (SA) ('*Consent Act*') establishes the legislative framework in South Australia for consent to medical treatment and the provision of emergency medical treatment when consent cannot be obtained.[1005] The emergency medical treatment provisions are raised if the person requiring treatment is incapable of consenting or has impaired decision-making capacity,[1006] the treatment is required to address a medically confirmed,[1007] 'imminent risk to life or health',[1008] and it is unlikely that the person has refused consent to the treatment if they are aged over 16 years.[1009]

5.3.20 Section 13 of the *Consent Act* and s 21 of the *MHA* are not mutually exclusive, and a person can lawfully be treated in the absence of consent under both Acts if the respective legislative criteria are met. Therefore, a person subject to an ITO for treatment of severe mental illness can also be treated involuntarily for a physical illness unrelated to their mental illness, if the criteria in the *Consent Act* are satisfied.[1010]

5.3.21 However, the emergency medical treatment provisions in the *Consent Act* are of limited application, only applying in medical emergencies when consent cannot be obtained to meet an imminent risk to life or health.[1011] Based on a consideration of the *Consent Act*, it is unlikely that the emergency medical treatment provisions can be relied on to treat physical illness such as diabetes in the face of refusal, unless the refusal poses an imminent risk to their life or health and the person has impaired decision-making capacity.[1012]

5.3.22 Under the common law, the provision of emergency medical treatment without consent is also an established rule. In *H Ltd v J,*[1013] Kourakis J, citing McDougall J in *Hunter and New England Area Health Service v A,*[1014] highlighted the exception to the usual requirement to obtain a patient's consent for the provision of medical treatment:

[1004] See SALRI Recommendation 24.

[1005] *Consent to Medical Treatment and Palliative Care Act 1995* (SA) s 13.

[1006] Ibid s 13(1)(a).

[1007] Ibid s 13(1)(b).

[1008] Ibid s 13(1)(b).

[1009] Ibid s 13(1)(c), (d).

[1010] Ibid s 13.

[1011] Ibid s 13(1)(a), (b).

[1012] For judicial consideration of refusal of medical treatment by a person suffering from schizophrenia, see *Re C (Adult: Refusal of Medical Treatment)* [1994] 1 WLR 290.

[1013] *H Ltd v J* [2010] SASC 176.

[1014] *Hunter and New England Area Health Service v A* (2009) 74 NSWLR 88.

> Except in the case of an emergency where it is not practicable to obtain consent … it is at common law a battery to administer medical treatment to a person without the person's consent … Emergency medical treatment that is reasonably necessary in the particular case may be administered to a person without the person's consent if the person's condition is such that it is not possible to obtain his or her consent, and it is not practicable to obtain the consent of someone else authorised to give it, and if the person has not signified that he or she does not wish the treatment, or treatment of that kind, to be carried out.[1015]

5.3.23 It is beyond the scope of this review to examine the interaction between s 13 of the *Consent Act* and the common law rule regarding the provision of emergency medical treatment. It is unclear whether there has been any judicial consideration to date on this point. However, the common law approach is that the provision of medical treatment without consent is permissible only in a medical emergency and only then to the extent that it is reasonably necessary to respond to that emergency situation. It is unlikely that the common law rule extends to provision of medical treatment that is not reasonably necessary to respond to the emergency situation.

5.3.24 Therefore, if a person is subject to an ITO and refuses medical treatment for a physical condition or illness that is not a mental illness or is not causing or contributing to their mental illness, then their refusal should be respected unless the emergency medical treatment provisions in the *Consent Act* arise.

Definition of Harm

5.3.25 Protection from 'harm' is a key consideration for the imposition of an ITO 1. The *MHA* requires that the person 'requires treatment for the person's own protection from harm (whether physical or mental, and including harm involved in the continuation or deterioration of the person's condition)'.[1016] Protection from harm also encompasses the public who may be harmed.[1017] There is no requirement that the person or the general public be *at risk of harm*, with the *MHA* requiring that it must *appear* that 'the person has a mental illness and because of the mental illness, the person requires treatment for the person's own protection from harm … or for the protection of others from harm.'[1018] Further, there is no requirement that the harm be serious. The notion of 'harm' in the *MHA*, or indeed elsewhere[1019] is a broad and elastic term.[1020]

5.3.26 In the Inquest into Theo's death, the Deputy Coroner considered what protection from 'harm' means under s 21 of the *MHA*. It was observed that there is a need to:

> … protect a person with a mental illness from harm, but also … to protect other persons from the harm that might be presented by a person with a mental illness. Those other persons would obviously include the general public. That the protection of persons other than the person with a mental illness is an important consideration in relation to the administration of the *MHA* is reflected in the Objects provision in the Act, s 6. One of those objects is that persons with severe

[1015] *H Ltd v J* [2010] SASC 176, [40] (Kourakis J).

[1016] *Mental Health Act 2009* (SA) s 21(1)(b).

[1017] Ibid s 21(1)(b).

[1018] Ibid s 21(1), (a), (b).

[1019] See, for example, *Criminal Law Consolidation Act 1935* s 31; *R v Donovan* [1934] 2 KB 498.

[1020] SALRI accepts that the threshold of 'harm' is simply too low to warrant the intrusion and effects on a consumer of either a CTO or ITO. See SALRI Recommendations 21 and 29.

> mental illness should retain their freedom, rights, dignity and self-respect as far as is consistent with their protection and 'the protection of the public'.[1021]

5.3.27 The Deputy Coroner continued, observing:

> … harm from which the person with a mental illness might need protection can consist of harm involved in the continuation or deterioration of the person's condition. Thus seen, the harm to the person with a mental illness that the *MHA* contemplates is not necessarily confined to self-harm of a physical nature. The need for protection of a person from an exacerbation of the person's mental illness of itself could trigger an ITO if all other elements are satisfied.[1022]

5.3.28 It is evident that harm in the *MHA* in relation to the making of an ITO (or a CTO) includes protection from self-harm, both physical and mental – protection of the public from harm posed by the person with a mental illness and extends to protection from the continuation or exacerbation of the person's mental illness. It is currently unclear whether protection from harm extends to other types of harm such as reputational harm or financial harm that may arise, which could have a significant impact on the person in the future.

Impaired Decision-Making Capacity[1023]

5.3.29 The requirement that the person have impaired decision-making capacity must relate to appropriate treatment of their mental illness. Impaired decision-making capacity is a complex topic and there are important guiding principles that must be taken into consideration when assessing whether a person has impaired decision-making capacity in relation to treatment for their mental illness.[1024] As mentioned above, impaired decision-making capacity was not part of the first iteration of the *MHA* in 2009 for the making of an ITO. This requirement was later added by the *Mental Health (Review) Amendment Act 2016* (SA).[1025]

5.3.30 Also mentioned above, it was recommended in the 2014 Statutory Review that 'the threshold criteria for involuntary treatment should include a capacity criterion'.[1026]

5.3.31 Given that human rights considerations and a focus on autonomy underpin the *MHA*, the inclusion of the requirement that the person must have impaired decision-making capacity is consistent with this approach. However, the impaired decision-making capacity requirement proved contentious[1027] at the Inquest into Theo's death. The Deputy Coroner recommended that the *MHA* should 'be amended by deleting as a requirement for the imposition of any level of Inpatient Treatment

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[1021] *Inquest into the Death of Theo Nikolas Papageorgiou* (2021) 09/2020 (0176/2016) SACC [14.3] (Schapel, Deputy State Coroner) (citations omitted).

[1022] Ibid [14.4].

[1023] See further Part 3 Decision-making Capacity and Supported Decision-making.

[1024] See generally Part 3 Decision-making Capacity and Supported Decision-making.

[1025] *Mental Health Act 2009* (SA) ss 17(3), 21(2), 25(2).

[1026] *Inquest into the Death of Theo Nikolas Papageorgiou* (2021) 09/2020 (0176/2016) SACC [14.21] (Schapel, Deputy State Coroner) (citations omitted).

[1027] See also John Dawson, 'A Realistic Approach to Assessing Mental health Laws' Compliance with the UNCRPD' (2015) 40 *International Journal of Law and Psychiatry* 70; Toni Wharehoka, 'Disability Rights and Compulsory Psychiatric Treatment: the Case for a Balanced Approach under the Mental Health (Compulsory Assessment and Treatment) Act 1992' (2021) *Victoria University Wellington Law Review* 221.

Order or Community Treatment Order that the person in question has impaired decision-making capacity relating to appropriate treatment of the person's mental illness.'[1028]

5.3.32 Whether this requirement should form part of the legislative criteria for the imposition of a CTO or ITO was carefully considered by SALRI and discussed in consultation.

Level 2 Inpatient Treatment Orders

5.3.33 A Level 2 Inpatient Treatment Order ('ITO 2') can only be imposed on a person currently subject to an ITO 1, if after further examination by a psychiatrist or Authorised Medical Practitioner and prior to the expiration of an ITO 1, the person requires further treatment as an inpatient at an approved treatment centre.[1029] The criteria for imposition of an ITO 2 are identical to an ITO 1. However, the standard to which each element need be proved is higher, requiring a psychiatrist or Authorised Medical Practitioner be *satisfied* that each criterion is met, instead of it *appearing* that each criterion is met.[1030] Therefore, they must be satisfied that:

- the person has a mental illness,[1031] and
- requires treatment for their own protection or for the protection of others,[1032] and
- they have impaired decision-making capacity,[1033] and
- the imposition of an ITO 2 is the least restrictive means of ensuring that the person receives appropriate treatment.[1034]

5.3.34 For an ITO 2, the definition of 'mental illness',[1035] 'harm',[1036] impaired decision-making capacity,[1037] and the requirements relating to an ITO being the least restrictive means, are consistent with the definitions provided above for ITO 1s.[1038] Furthermore, when imposing an ITO 2 under s 25(2) of the *MHA*, an 'opinion about a person [may be formed] based on his or her own observations and any other available evidence that he or she considers reliable and relevant.'[1039] Therefore, consistent with the rule for ITO 1s, the *MHA* does not limit or specify what evidence a medical practitioner or authorised mental health professional may take into account when performing this function, so long as it is reliable and relevant.

[1028] *Inquest into the Death of Theo Nikolas Papageorgiou* (2021) 09/2020 (0176/2016) SACC [16.10(4)] (Schapel, Deputy State Coroner).

[1029] *Mental Health Act 2009* (SA) s 25(1). It is necessary to note that Level 2 Inpatient Treatment Orders can only be imposed by a psychiatrist or Authorised Medical Practitioner. This is different from Level 1 Inpatient Treatment Orders, which can be imposed by a medical practitioner or authorised mental health professional see *Mental Health Act 2009* (SA) ss 21(1), 25(1), (2), (7).

[1030] Ibid s 25(1); cf s 21(1).

[1031] Ibid 25(1)(a).

[1032] Ibid s 25(1)(b).

[1033] Ibid s 25(1)(ba).

[1034] Ibid s 25(1)(c).

[1035] Ibid s 25(2)(a).

[1036] Ibid s 25(2)(b).

[1037] Ibid s 25(2)(ba).

[1038] Ibid s 25(2)(c).

[1039] Ibid s 25(4).

5.3.35 A significant point of difference with an ITO 2 is the duration for which the order applies. Under the *MHA*, an ITO 2 is valid for '42 days after the day on which the order was made.'[1040] This is the maximum period for which an ITO 2 applies, although the order can expire at an earlier date fixed in the order or can be revoked any time prior to the expiration of the order.[1041]

5.3.36 Unlike ITO 1s, ITO 2s can be extended for an additional 42 days period.[1042] However, this can only occur if the consumer has been examined by a different psychiatrist or Authorised Medical Practitioner.[1043]

5.3.37 A patient who is subject to an ITO 2 has the same rights to receive a copy of the order, a statement of rights and a copy of any revocation, with these provisions consistent with the procedure for ITO 1s.[1044]

5.3.38 The provisions relating to permissible treatment for ITO 2s are consistent with the legislative framework for treatment set out for ITO 1s discussed above. Treatment under an ITO 2 is limited to treatment for the person's 'mental illness, or for any other illness that may be causing or contributing to it.'[1045] Importantly, this treatment can be provided despite the absence or refusal of consent expressed by the person.[1046] However, treatment under the *MHA* does not extend to prescribed psychiatric treatment defined as electroconvulsive therapy and neurosurgery,[1047] or to prescribed treatment under the *Guardianship and Administration Act 1993* (SA), defined as 'termination of pregnancy, sterilisation or any other medical treatment prescribed by the regulations.'[1048] Additionally, as discussed above in the context of ITO 1s, it is unlikely that involuntary treatment for physical illness outside the scope of this definition are permitted unless emergency medical treatment provisions apply under existing law.

Level 3 Inpatient Treatment Orders

5.3.39 Level 3 Inpatient Treatment Orders ('ITO 3') are the highest level ITO that can be imposed under the *MHA*, mandating that an adult be subject to involuntary detention and treatment as an inpatient at an approved treatment centre for up to 12 calendar months.[1049] However, for a child (defined as a person under 18 years of age), an ITO 3 can only be imposed for six calendar months.[1050]

5.3.40 Due to the extended duration, only the South Australian Civil and Administrative Tribunal ('SACAT') can impose an ITO 3, upon application by the 'Public Advocate, the director of an approved treatment centre or an employee in an approved treatment centre authorised by the

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[1040] Ibid s 25(6).

[1041] Ibid.

[1042] Ibid s 25(7).

[1043] Ibid.

[1044] *Mental Health Act 2009* (SA) s 27(1)-(6); *Mental Health Regulations 2010* (SA) s 4(4).

[1045] Ibid s 28(1). SALRI has proposed a minor change to clarify the meaning of 'treatment'. See SALRI Recommendation 24.

[1046] *Mental Health Act 2009* (SA) s 28(2).

[1047] Ibid s 3 (definition of 'prescribed psychiatric treatment'), (definition of 'neurosurgery'), (definition of 'ECT'). SALRI was informed that neurosurgery has not occurred in SA for 50 years and none is planned to occur in the foreseeable future.

[1048] *Guardianship and Administration Act 1993* (SA) s 3 (definition of 'prescribed treatment').

[1049] *Mental Health Act 2009* (SA) s 29(5)(b).

[1050] Ibid s 29(5)(a).

Director.'[1051] The person to whom the application for an ITO 3 applies must already be subject to an ITO 1, ITO 2 or ITO 3.[1052]

5.3.41 The provisions relating to SACAT and ITO 3s are consistent with the provisions for imposing an ITO 2. That is, they must be:

- *satisfied* that the person has a mental illness,[1053] and
- requires treatment for it for their own protection from harm or for the protection of others,[1054] and
- they have impaired decision making capacity,[1055] and
- imposition of an ITO 3 is the least restrictive means of ensuring that the person receives appropriate treatment.[1056]

5.3.42 The revocation or variation of an ITO 3 can only be made by SACAT, upon the application of authorised parties. The *MHA* defines who has standing to apply for a revocation or variation, stating that this can only be sought by the consumer, the Public Advocate, a medical practitioner, a mental health clinician, or a guardian, medical agent, relative, carer or friend of the consumer, or any other person who satisfies SACAT they have a proper interest in the welfare of the consumer.[1057]

5.3.43 The definition of mental illness,[1058] harm,[1059] impaired decision-making capacity,[1060] and the requirements relating to an ITO being least restrictive means are consistent with the definitions provided above for ITO 1s.[1061]

5.3.44 The provisions relating to permissible treatment under an ITO 3 are consistent with the legislative framework for treatment set out for ITO 1s. Therefore, treatment under an ITO 3 is limited to treatment for the person's 'mental illness, or for any other illness that may be causing or contributing to it.'[1062]

[1051] Ibid ss 29(1), (4), 3 (definition of 'Tribunal').

[1052] Ibid s 29(3).

[1053] Ibid s 29(1)(a).

[1054] Ibid s 29(1)(b).

[1055] *Mental Health Act 2009* (SA) s 29(1)(ba).

[1056] Ibid s 29(1)(c).

[1057] Ibid s 29(7).

[1058] Ibid s 29(1)(a).

[1059] Ibid s 29(1)(b).

[1060] Ibid s 29(1)(ba).

[1061] Ibid s 29(1)(c), (2).

[1062] Ibid s 31(1).

5.4 Law in Other Jurisdictions

Victoria

5.4.1 The Victorian Government established the Royal Commission into Victoria's Mental Health System in February 2019.[1063] This was against the backdrop of widespread concern about the troubled Victorian mental healthcare system which had 'despite the goodwill and hard work of many people … deteriorated for a multitude of reasons and over the course of many years.'[1064] The context for establishing a Royal Commission to review the mental health system was that:

> … the present system is not designed or equipped to support the diverse needs of people living with mental illness or psychological distress, families, carers and supporters, let alone to cope with unforeseen pressures that may arise. The 2019–20 severe bushfire season and the COVID-19 pandemic shone further light on the pressures on the mental health system.[1065]

5.4.2 It was further noted that recent developments at local, national and international levels placing increased emphasis on, and protection of, human rights, had resulted in Victoria's mental health system falling behind, failing to keep pace with these important developments and initiatives.[1066]

5.4.3 A central issue in the Royal Commission's Final Report was that human rights were often breached and consumers' dignity was often not respected under the existing mental health system, especially due to 'an excessive use of restrictive practices and compulsory orders.'[1067] This issue is not unique to Victoria, and the records from Queensland and South Australia, also shows the high use of compulsory treatment orders.[1068] For instance, in a recent article on the use of compulsory treatment orders such as ITOs and CTOs in Queensland, Neeraj Gill et al observed:

> … despite reforms intended to enhance patient autonomy, the prevalence of compulsory treatment orders increased after implementation of the new legislation. Possible reasons behind this unintended consequence of the legislative reform may include a lack of systematised voluntary alternatives to compulsory treatment, a paternalistic and restrictive culture in mental health services and risk aversion in clinicians and society.[1069]

5.4.4 These concerns were reiterated by various parties in SALRI's consultation.[1070]

5.4.5 The Royal Commission put forward 65 recommendations for consideration by the Victorian Government, with a view to improving the mental health and wellbeing of Victorians. Recommendation 42 called for the repeal of the existing legislation – *Mental Health Act 2014* (Vic) – and introducing a new Act for mental health, the *Mental Health and Wellbeing Act*. The impetus behind

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[1063] *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021) vol 1, 3.

[1064] Ibid.

[1065] Ibid vol 1, 4.

[1066] *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021) vol 1, 4.

[1067] Ibid vol 1, 18; see also ibid vol 4, 377–85.

[1068] See, for example, Edwina Light et al, 'Community Treatment Orders in Australia: Rates and Patterns of Use' (2012) 20(6) *Australasian Psychiatry* 478; Bobbie Clugston, Amy Young and Edward Heffernan, 'A Comparison of the Reported Use of Involuntary Treatment Orders within Australian Jurisdictions' (2018) 26(5) *Australasian Psychiatry* 482; Edwina Light, 'Rates of Use of Community Treatment Orders in Australia' (2019) 69(4) *International Journal of Law and Psychiatry* 83.

[1069] Neeraj Gill et al, 'Measuring the Impact of Revised Mental Health Legislation on Human Rights in Queensland, Australia' (2010) 73 *International Journal of Law and Psychiatry*, 101634, 1.

[1070] In particular, this was raised by consumers and consumer groups.

the introduction of a new Act, as opposed to simply amending the existing *Mental Health Act 2014* (Vic) was that:

> … fundamental change across many parts of the mental health system is needed to realise the Commission's aspirations for a redesigned system. To this end, a new *Mental Health and Wellbeing Act* is urgently needed. The new Act will support the new mental health and wellbeing system to be contemporary and adaptive with a focus on community-based mental health and wellbeing services. The new Act will also rebalance the legal framework and broaden the focus beyond compulsory treatment towards the attainment of good mental health and wellbeing.[1071]

5.4.6 The Royal Commission also recommended widespread reforms to compulsory treatment provisions, recommending that measures should be implemented to ensure that compulsory treatment orders are genuinely only used as a 'last resort'.[1072] On this point, the Royal Commission observed that both the rate and duration of compulsory treatment orders in the Victorian mental health system 'are too high, and that it is a systemic failure that compulsorily treating a person has become, in some instances, the default response'.[1073] The new Victorian Act is designed to address the high number of compulsory treatment orders in Victoria, as well as simplify and clarify 'the statutory provisions relating to compulsory … treatment such that they are no longer the defining feature of Victoria's mental health laws.'[1074]

5.4.7 Consistent with the Royal Commission's recommendations, the *Mental Health and Wellbeing Act 2022* (Vic) ('*MHWA*') passed and received royal assent on 6 September 2022. The Act is set to commence operation on 1 September 2023.[1075] The *MHWA* repeals the existing *Mental Health Act 2014* (Vic) and seeks to 'lay the foundation for the vision of the Royal Commission into Victoria's Mental Health System to transform the mental health and wellbeing system and to support the delivery of person-centred services that are responsive to the needs and preferences of Victorians.'[1076]

5.4.8 Major reforms to compulsory assessment and treatment are a significant feature of the new Victorian Act. Although the *MHWA* is not yet in force, the new Act will be the focus of this discussion. In the Second Reading Speech of the Mental Health and Wellbeing Bill 2022 (Vic), the Minister for Mental Health remarked that the new mental health framework:

> … was to better ensure that legislative human rights protections were fully and properly implemented in practice. This has been achieved in the Bill by introducing greater detail with respect to the objectives and principles that are to guide decision-making by all persons exercising functions and powers with respect to compulsory assessment and treatment decisions and other significant decisions and functions under the Bill.[1077]

5.4.9 To exemplify the human rights approach underlying the Bill, the Minister explained that the key principles evoked in the *MHWA* included the balancing of the harm principle and the autonomy principle.[1078] It was explained that these principles are essential to the operation of involuntary assessment and treatment provisions as their function is to ensure that individual human

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[1071] *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021) vol 4, 34.

[1072] Ibid vol 4, 361.

[1073] *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021) vol 1, 364.

[1074] Ibid vol 1, 78.

[1075] *Mental Health and Wellbeing Act 2022* (Vic) s 2.

[1076] *Mental Health and Wellbeing Act 2022* (Vic) preamble.

[1077] Victoria, *Parliamentary Debates*, Legislative Assembly, 23 June 2022, 2644 (James Merlino).

[1078] Ibid 2644 (James Merlino).

rights are only restricted or curtailed in serious circumstances, and that the 'will and preferences of a person are to be given effect to the greatest extent possible.'[1079]

Compulsory Assessment Orders and Compulsory Treatment Orders under the Mental Health and Wellness Act 2022 (Vic)

5.4.10 Important aspects of the *MHWA* are the inclusion of Compulsory Assessment Order Criteria and Compulsory Treatment Order Criteria.[1080] Compulsory Assessment Orders authorise a psychiatrist to 'compulsorily examine the assessment patient for the purpose of determining whether the compulsory treatment criteria apply to the patient.'[1081] However, Compulsory Assessment Orders do not authorise the involuntary treatment of a person unless urgent treatment is required to prevent 'serious deterioration in the patient's mental or physical health or serious harm to the patient or to another person.'[1082] Therefore, compulsory treatment for mental illness cannot be authorised in an assessment order, unless the above exception applies.

5.4.11 Under the new Act, there are two types of Compulsory Treatment Orders authorised, being Temporary Treatment Orders and Treatment Orders.[1083] The provisions relating to Compulsory Assessment Orders and Compulsory Treatment Orders are considered below.[1084]

Compulsory Assessment Orders

5.4.12 There are two types of Compulsory Assessment Orders: Community Assessment Orders ('CAO') and Inpatient Assessment Orders ('IAO').[1085] CAOs are less restrictive as they permit examination of the person in the community,[1086] whilst IAOs authorise 'the detention of the assessment patient for the purpose of transporting the patient to the responsible designated mental health service and the detention of the patient for the purpose of examining the patient at the service under the order.'[1087]

5.4.13 Consistent with the least restrictive measures approach, the new Act states that IAOs can only be made if the 'practitioner is satisfied that the person cannot be assessed in the community.'[1088] The inclusion of compulsory assessment order provisions is consistent with the objectives of the *MHWA* 'to protect and promote the human rights and dignity of people living with mental illness by providing them with assessment and treatment in the least restrictive way possible in the circumstances.'[1089]

[1079] Ibid.

[1080] *Mental Health and Wellbeing Act 2022* (Vic) ss 142, 143.

[1081] Ibid s 146(1).

[1082] *Mental Health and Wellbeing Act 2022* (Vic) s 160(2)(a), (b), (1).

[1083] Ibid ss 180, 181, 189 and 192.

[1084] It is necessary to note that the Act also authorises the Courts to make a Compulsory Assessment Orders, requiring that a person be examined by an authorised psychiatrist under a community patient or inpatient see *Mental Health and Wellbeing Act 2022* (Vic) ss 168 and 173. Furthermore, the Act sets out comprehensive steps to be followed in relation to Court Assessment Orders. Discussion of these orders are beyond the scope of this review, however, for further consideration see *Mental Health and Wellbeing Act 2022* (Vic) Pt 4.3.

[1085] *Mental Health and Wellbeing Act 2022* (Vic) s 145(1)(a), (b).

[1086] Ibid s 146(2).

[1087] Ibid s 146(3).

[1088] Ibid s 145(2).

[1089] Ibid s 12(e).

5.4.14 The legislative criteria that must be satisfied for a compulsory assessment order to be imposed under s 142 *MHWA* are as follows:[1090]

> (a) the person appears to have mental illness; and
>
> (b) because the person appears to have mental illness, the person appears to need immediate treatment to prevent—
>
> (i) serious deterioration in the person's mental or physical health; or
>
> (ii) serious harm to the person or to another person; and
>
> (c) if the person is made subject to an assessment order, the person can be assessed; and
>
> (d) there are no less restrictive means reasonably available to enable the person to be assessed.

5.4.15 Under the new Act, only Registered Medical Practitioners ('RMP') or authorised mental health practitioners ('AMHP') can make an assessment order if they have reviewed the person in the previous 24 hours and are satisfied that the criteria apply. The *MHWA* defines AMHPs as registered psychologist, registered nurse, social worker, registered occupational therapist or any member of a prescribed class of person.[1091]

5.4.16 The threshold test for imposition of an assessment orders is a lower standard test than what is required for imposition of a treatment order – a consequence of the nature of the two orders. It need only *appear* to the RMP or AMHP that the person has a mental illness and because of the mental illness, they *appear* to need immediate treatment.[1092]

5.4.17 Mental illness is defined as 'a medical condition that is characterised by a significant disturbance of thought, mood, perception or memory'.[1093] This definition is accompanied by a statement of principle that excludes certain factors from being indicative of mental illness, aimed to safeguard persons from being subject to prejudicial treatment.[1094]

Compulsory Assessment Orders: Definition of Treatment

5.4.18 Compulsory Assessment Orders do not authorise the involuntary treatment of a person unless urgent treatment is required to prevent 'serious deterioration in the patient's mental or physical health or serious harm to the patient or to another person.'[1095] Compulsory treatment for mental illness cannot be authorised in an assessment order, unless the above exception applies. It is, however, necessary to consider the definition of treatment under this provision – it is still an element of s 142.[1096]

[1090] Ibid s 142(a)–(d).

[1091] *Mental Health and Wellbeing Act 2022* (Vic) s 3 (definition of 'authorised mental health practitioner').

[1092] Ibid s 142(a), (b).

[1093] Ibid s 4(1).

[1094] Under s 4(2) of the *Mental Health and Wellbeing Act 2022*, a person is not to be considered to have mental illness by reason only regarding a person's political, philosophical or religious opinions or beliefs, a person's particular sexual preference, sexual behaviour gender identity or sexual orientation, that the person engages in conduct that is contrary to community standards of acceptable conduct, that the person engages in illegal or antisocial conduct or behaviour, that the person is intellectually disabled, that the person uses drugs or alcohol, that the person has a particular economic or social status or is a member of a particular cultural or racial group, that the person is or has previously been involved in family conflict, that the person is experiencing or has experienced psychological distress, or that the person has previously been diagnosed with, or treated for, mental illness.

[1095] Ibid ss 160(2)(a), (b), (1).

[1096] Ibid s 142(b).

5.4.19 It is useful to understand the parameters of what is authorised under this provision. Treatment is defined as being 'for mental illness only,'[1097] and requires the use of professional skill 'to remedy or alleviate the person's mental illness or to alleviate the symptoms and reduce the ill effects of the person's mental illness'.[1098] The *MHWA*, however, also includes provisions for consent to medical treatment,[1099] mandating that informed consent must be obtained prior to administration of any medical treatment,[1100] even if the person is subject to an assessment or treatment order.[1101] Human rights principles such as the *CRPD* are embedded throughout the *MHWA*, which adopts the position that persons are presumed to have decision-making capacity in relation to medical treatment.[1102] However, the *MHW Act* establishes a hierarchy of persons authorised to give informed consent to medical treatment in the event that a person lacks decision-making capacity.[1103] For adults – persons aged 18 years and over, these persons are:

> (a) the patient's medical treatment decision maker;
>
> (b) a person appointed by VCAT to make decisions about the proposed medical treatment;
>
> (c) a person appointed under a guardianship order within the meaning of the *Guardianship and Administration Act 2019* with power to make decisions concerning the proposed medical treatment; or
>
> (d) subject to section 93, the authorised psychiatrist.[1104]

5.4.20 For persons under 18 years of age, the *MHWA* authorises a person with 'legal authority to consent to the medical treatment for the patient and who is reasonably available, willing and able to make a decision about the proposed medical treatment.'[1105] However, if this cannot be satisfied, an authorised psychiatrist can give valid consent to the administration of the medical treatment.[1106]

5.4.21 If an authorised psychiatrist is consenting to medical treatment on behalf of a person under the new Act, additional factors must be taken into consideration. The pivotal consideration is that the authorised psychiatrist must be satisfied that the medical treatment would benefit the consumer.[1107] Further, additional factors for consideration are included in the *MHWA*,[1108] but only are to be observed only 'to the extent that is reasonable in the circumstances.'[1109] These include, the consumer's views and preferences in relation to the medical treatment;[1110] alternatives to the proposed

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[1097] Ibid ss 5(4), 88.

[1098] Ibid s 5(1)(a), (b).

[1099] Ibid s 91.

[1100] Ibid Pt 3.2.

[1101] Ibid s 3 (definition of 'patient').

[1102] See Victoria, *Parliamentary Debates*, Legislative Assembly, 23 June 2022, 2647–8 (James Merlino).

[1103] See *Mental Health and Wellbeing Act 2022* (Vic) s 92.

[1104] Ibid s 92(1)(a)-(d).

[1105] Ibid s 92(2)(a).

[1106] Ibid s 92(2)(b).

[1107] Ibid s 93(1).

[1108] Ibid s 93(2).

[1109] Ibid s 93(2).

[1110] Ibid s 93(2)(a).

treatment;[1111] any values directives given by the consumer,[1112] and if the person is under the age of 16 years, the parent's views regarding the proposed medical treatment.[1113]

5.4.22 Importantly, the authorised psychiatrist must not give consent to medical treatment if the person is likely to regain capacity within a reasonable period of time.[1114] However, this provision can be overridden if 'delay in giving the medical treatment to the patient could result in serious harm to, or deterioration in, the mental or physical health of the patient.'[1115]

5.4.23 The provisions relating to consent to medical treatment for persons who lack decision-making capacity to give informed consent under the *MHWA* operate in addition to existing law governing provision of emergency medical treatment.[1116] Under the *MHWA*, there is no requirement that the medical treatment must be in response to a medical emergency. Medical treatment is defined as treatment 'for the purposes of diagnosing a physical … condition, preventing disease, restoring or replacing bodily function in the face of disease or injury or improving comfort and quality of life.'[1117] This includes 'treatment with physical or surgical therapy',[1118] and 'treatment with prescription pharmaceuticals.'[1119] It is evident that *MHWA* includes extensive rules relating to provision of medical treatment in situations where there is no medical emergency and the person lacks decision-making capacity to consent.

Serious Deterioration in Mental or Physical Health and Serious Harm

5.4.24 The compulsory assessment criteria requires that it need only *appear* the person needs immediate *treatment* to prevent serious deterioration in mental or physical health, or serious harm to them self or another.[1120]

5.4.25 The terms 'serious deterioration' and 'serious harm' are not defined in the *MHWA*. It will be a question of fact in each situation the criteria for compulsory treatment are sought to be applied. However, it is evident by the use of the descriptor 'serious,' that the deterioration or harm to the person or others due to their mental illness must be greater than the harm caused by curtailing their human rights by imposing a compulsory order.[1121]

5.4.26 In the Second Reading Speech, the Minister highlighted the essential decision-making principles included in the then Mental Health and Wellbeing Bill 2022 (Vic) relative to treatment and intervention provisions.[1122] It was stated that the requirement for 'serious deterioration' or 'serious

[1111] Ibid s 93(2)(b).

[1112] Ibid s 93(2)(c).

[1113] Ibid s 93(2)(g); for a full list of these considerations see ss 93(2), (3) and (4).

[1114] Ibid s 93(3).

[1115] Ibid s 93(4).

[1116] See *Medical Treatment and Planning Decisions Act 2016* (Vic) s 53.

[1117] *Medical Treatment and Planning Decisions Act 2016* (Vic) s 3 (definition of 'medical treatment') and *Mental Health and Wellbeing Act 2022* (Vic) s 3 (definition of 'medical treatment').

[1118] *Medical Treatment and Planning Decisions Act 2016* (Vic) s 3(a) (definition of 'medical treatment').

[1119] Ibid s 3(c) (definition of 'medical treatment').

[1120] *Mental Health and Wellbeing Act 2022* s 142(b)(i), (ii).

[1121] See Victoria, *Parliamentary Debates*, Legislative Assembly, 23 June 2022, 2644 (James Merlino).

[1122] Ibid 2646 (James Merlino).

harm' as threshold tests for imposition of a compulsory order was predicated on a balancing of harm principle. The Minister explained:

> … the balancing of harm principle … provides that compulsory assessment and treatment … are not to be used unless the serious harm or deterioration to be prevented is likely to be more significant than the harm to the person that may result from their use.[1123]

5.4.27 The Balancing of Harm Principle is retained in the *MHWA*,[1124] and is one of five principles in the Act that relates to compulsory assessment orders. Additionally, the *MHWA* also requires that the treatment meet an immediacy requirement, thus establishing a higher bar to impose an assessment order.[1125]

Procedural Safeguards

5.4.28 The new Victorian Act establishes procedural steps to be followed prior to undertaking an examination for making an assessment order such as disclosing their identity to the person, informing them that an examination will take place and the purpose of the examination.[1126] If the RMP or the AMHP are satisfied that the criteria for imposing a CAO or an IOA are satisfied, then the person must be examined by an authorised psychiatrist to determine whether a compulsory treatment order should be imposed.[1127] Therefore, while RMPs or AMHPs can impose an assessment order, it is the duty of the authorised psychiatrist to ascertain whether a treatment order should be imposed. If the authorised psychiatrist is of the opinion that the treatment order criteria are not met, then the assessment order must be revoked immediately,[1128] and the person subject to the assessment order must be informed of the revocation and the reason(s) why.[1129]

5.4.29 Additional safeguards incorporated into the *MHWA* requires that the person subject to a compulsory assessment order be given information pertaining to the purpose of the order and a statement of rights.[1130] Furthermore, specific persons listed in the *MHWA* must be notified such as a nominated support person, guardian or, if the person is aged under 16 years, a parent.[1131]

Duration

5.4.30 CAOs and IAOs are only valid for a limited duration: 24 hours for CAOs,[1132] and for IAOs, 24 hours after the patient is received at the designated mental health service or 72 hours after the order was first made by the RMP or the AMHP.[1133] The *MHWA* permits RMPs and AMHPs powers to vary the conditions of an existing CAOs and IAOs in limited circumstances.[1134] Furthermore,

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[1123] Ibid.

[1124] *Mental Health and Wellbeing Act 2022* s 78(1), (2).

[1125] Ibid s 142(b).

[1126] *Mental Health and Wellbeing Act 2022* (Vic) s 144(3)(a)–(c).

[1127] Ibid ss 146(1), 3 (definition of 'authorised psychiatrist'); see also s 148 for mandatory information that must be contained in an assessment order.

[1128] Ibid s 161.

[1129] Ibid s 162. The Act also requires that other persons to be notified of the revocation order such as the person's nominated support person or guardian: see s 163.

[1130] Ibid s 150.

[1131] Ibid ss 151, 152.

[1132] Ibid s 147(1).

[1133] Ibid ss 147(2)(a)(b), 149.

[1134] See Ibid s 153, 154, 155.

authorised psychiatrists under the Act are permitted to extend an assessment order for 24 hours on two occasions if they cannot ascertain whether the person requires treatment under a compulsory treatment order.[1135]

5.4.31 CAOs and IAOs are a limited type of order that require a person to undergo mandatory evaluation by an authorised psychiatrist either in the community or as an inpatient. Assessment Orders do not generally authorise administration of involuntary treatment, except in exceptional circumstances described in the *MHWA*. Assessment orders can be made by RMPs and AHMPs for the purpose of ensuring that the person is assessed by an authorised psychiatrist for the purpose of determining whether involuntary treatment is required.[1136]

Treatment Orders under the Mental Health and Wellness Act 2022 **(Vic)**

5.4.32 The *MHWA* authorises two types of treatment orders: Temporary Treatment Orders ('TTO') and Treatment Orders ('TO'). The acronyms TTO and TO will be used when discussing provisions specific to that type of order. However, when addressing criteria common to both orders, the term Treatment Order will be used instead.

5.4.33 The compulsory treatment criteria detailed in s 143 of the *MHWA*[1137] are consistent for both types of orders, and are outlined as follows:

> The compulsory treatment criteria for a person to be made subject to a temporary treatment order or treatment order are that—
>
> (a) the person has mental illness; and
>
> (b) because the person has mental illness, the person needs immediate treatment to prevent—
>
> (i) serious deterioration in the person's mental or physical health; or
>
> (ii) serious harm to the person or to another person; and
>
> (c) if the person is made subject to a temporary treatment order or treatment order, the
>
> immediate treatment will be provided to the person; and
>
> (d) there are no less restrictive means reasonably available to enable the person to receive the
>
> immediate treatment.

[1135] Ibid s 165.

[1136] SALRI considered whether such assessment orders were warranted in a South Australian context as a prelude to making either a CTO or ITO. Having these additional, preliminary orders may also serve to address the lack of clarity and a degree of overlap raised by several parties to SALRI, including the Chief Psychiatrist, between the use of care and control powers under s 56 of the *Mental Health Act 2009* (SA) and ITOs/CTOs. Such assessment orders are of utility, but SALRI was not convinced of their suitability in South Australia, especially in a regional, remote and rural context. SALRI considers the flexibility of the current s 56 is preferable, whilst more specificity in s 56, could be helpful, particularly regarding such time limits. However, such precision is impracticable in a South Australian context, especially outside metropolitan areas. The Chief Psychiatrist's reasoning is also noted: Office of the Chief Psychiatrist, Submission to SALRI, *Review of the Mental Health Act 2009 (SA)*, 9 September 2022, 10. '[There] are some advantages to using care and control powers rather than treatment orders. Under care and control powers, a person does not need to be transported to an authorised treatment centre as they are required to be under an ITO. This may be a consideration in areas where an ATC may be some distance from the person under assessment. Additionally, if someone is assessed after being able to settle, they may not require an ITO and will have no record on their health history.'

[1137] *Mental Health and Wellbeing Act 2022* (Vic) s 143(a)–(d).

Temporary Treatment Orders

5.4.34 An authorised psychiatrist can impose a TTO on a person who is subject to an assessment order.[1138] The person must be examined by the authorised psychiatrist, and must be satisfied that all compulsory treatment criteria in s 143 of the *MHWA* have been met.[1139] *The MHWA* also establishes a list of factors that the authorised psychiatrist must have regard to when determining whether to impose a TTO,[1140] which operate to ensure, in a limited way, that the person's views and preferences are taken into consideration 'to the extent that is reasonable in the circumstances.'[1141]

5.4.35 An important distinguishing feature between the *MHWA* and the South Australian law is that the *MHWA* does not require the person to have impaired decision-making capacity for a TTO to be imposed. In the Second Reading Speech for the Mental Health and Wellbeing Bill 2022 (Vic), the Victorian Minister for Mental Health discussed the intention behind this position at length.[1142] The Minister explained that the Bill allows:

> … for the use of restrictive interventions [Treatment Orders] and for assessment and treatment without the consent of the patient in specific, limited circumstances, ***even where that patient has capacity.*** This aspect of the Bill … allows for a person who has capacity to be treated for mental illness without their consent. Clause 89 provides that if a patient does not have capacity to give informed consent to treatment proposed by an authorised psychiatrist or has capacity to give informed consent but does not give it, and the authorised psychiatrist is satisfied that the treatment is clinically appropriate and there is no less restrictive way for the patient to be treated, they may make a treatment decision for the patient.[1143]

5.4.36 In acknowledging that this position is at odds with well-established common law principles relating to decision-making capacity and refusal of medical treatment, the Minister observed that strict criteria had been included to ensure that this response was only operational in exceptional circumstances.[1144] Further, it was highlighted that the Bill included principles that operated to ensure that the person subject to the treatment order could still have their views and preferences taken into consideration.[1145]

5.4.37 Expanding on this point, the Minister remarked:

> In deciding whether there is no less restrictive way for the patient to be treated, the authorised psychiatrist must consider and give appropriate weight to a range of specified matters, including the patient's views and preferences, the views and preferences of the patient expressed in their advanced statement of preferences or the patient's views expressed by their nominated support person, and the likely consequences for the patient if the treatment is not administered. Further … the balancing of harm principle with respect to treatment and interventions … provides that compulsory … treatment … cannot be used unless the serious harm or deterioration to be

[1138] *Mental Health and Wellbeing Act 2022* (Vic) s 180(1).

[1139] Ibid s 180(1)(a), (b).

[1140] Ibid ss 88, 89, 180(2)(a).

[1141] Ibid ss 89(4), 180(2).

[1142] Victoria, *Parliamentary Debates*, Legislative Assembly, 23 June 2022, 2646–9 (James Merlino).

[1143] Ibid 2647 (own emphasis).

[1144] Ibid 2647.

[1145] Ibid.

prevented is likely to be more significant than the harm to the person that may result from their use.[1146]

5.4.38 The *MHWA* does not establish a separate legislative framework for community treatment orders and inpatient treatment orders that South Australia has under the *MHA*. It is the responsibility of the authorised psychiatrist to determine whether the person is to be placed on a Community Temporary Treatment Order ('CTTO') or an Inpatient Temporary Treatment Order ('ITTO').[1147] As the name suggests, a CTTO permits the person to remain in the community while they receive involuntary treatment. Conversely, an ITTO authorises a person to be treated compulsorily, as well as authorising 'the detention of the temporary treatment patient for the purpose of transporting the patient to the responsible designated mental health service and the detention of the patient for the purpose of providing treatment to the patient at the service under the order.'[1148] Consistent with the least restrictive measures approach inherent in the new Act, an ITTO can only be imposed if an authorised psychiatrist is satisfied that the person cannot be treated in the community.[1149]

5.4.39 The maximum duration of a TTO is 28 days, with day 1 commencing the day the order was made.[1150] However, if the compulsory treatment criteria no longer apply to the person, then the order must be revoked immediately.[1151] Furthermore, *MHWA* establishes provisions for the person or for authorised persons to apply to the Victorian Mental Health Tribunal ('Victorian Tribunal') to have the order revoked.[1152] The person subjected to the TTO must be provided with a copy of the order and a statement of rights.[1153]

5.4.40 The new Act requires that Victorian Tribunal and other persons be notified of the TTO.[1154] Specific terms included in the compulsory treatment criteria under s 143 have been defined, and therefore, require further discussion. It is necessary to note at the outset that the definition of several terms are consistent with the definitions provided in the Compulsory Assessment Order Criteria.

Temporary Treatment Orders: Definition of Treatment

5.4.41 To impose a TTO the person must have a mental illness,[1155] which is different from the test for imposition of an Assessment Order, where the Act requires that the person '*appear* to have a mental illness.'[1156] Furthermore, they must require *immediate treatment* because of their mental illness.[1157]

5.4.42 The definition of treatment under s 143(b) is consistent with the definition of treatment for s 142(b).

[1146] Ibid.

[1147] *Mental Health and Wellbeing Act 2022* (Vic) s 181(1)(a), (b).

[1148] Ibid ss 182(3), 185.

[1149] *Mental Health and Wellbeing Act 2022* (Vic) s 181.

[1150] Ibid s 183.

[1151] Ibid s 205.

[1152] Ibid s 206.

[1153] Ibid s 186(c).

[1154] Ibid ss 187, 188.

[1155] Ibid s 143(a).

[1156] Ibid s 142(a).

[1157] Ibid s 143(c).

Serious Deterioration in Mental or Physical Health and Serious Harm

5.4.43 The *MHWA* requires that 'because the person has mental illness, the person needs immediate treatment to prevent … serious deterioration in the person's mental or physical health [or] serious harm to the person or to another person.'[1158] The requirement that the deterioration or harm be serious is consistent with the requirements for imposition of an assessment order. Therefore, the same definition applies.

5.4.44 Under the new Act, TTOs are the least restrictive treatment order as they are only valid for 28 days. The *MHWA* establishes provisions for a person to be transitioned to the more restrictive treatment order, if the compulsory treatment criteria still apply and the TTO has not expired.[1159]

Treatment Orders

5.4.45 Transition to a TO can only be made upon application by an authorised psychiatrist to the Victorian Tribunal prior to the expiration of a TTO.[1160] Treatment Orders, like Temporary Treatment Orders, are a type of order that require a person be treated involuntarily,[1161] either as a community patient or as an impatient at a facility.[1162] If an inpatient treatment order is made, this also permits 'the detention of the treatment patient for the purpose of transporting the patient to the responsible designated mental health service and the detention of the patient for the purpose of providing treatment to the patient at the service under the order.'[1163]

5.4.46 If an application for a TO is made to the Victorian Tribunal, the person must be examined by an authorised psychiatrist, who must be satisfied that all compulsory treatment criteria included in s 143 of the *MHWA* have been met.[1164] The same compulsory treatment criteria apply which is included in s 143 of the *MHWA*. Thus, the definition of key terminology included in s 143, such as 'treatment', 'serious deterioration' and 'serious harm', is consistent, and will not be considered here.

5.4.47 The *MHWA* also establishes a list of criteria that the authorised psychiatrist must have regard to in determining whether to apply to the Victorian Tribunal for a TO,[1165] which operate to ensure, in a limited way, that the person's views and preferences are taken into consideration 'to the extent that is reasonable in the circumstances.'[1166] Important procedural requirements for TOs are included in s 191 of the *MHWA*.[1167] It is up to the Victorian Tribunal to determine if the compulsory treatment criteria still apply to the person,[1168] and if the Tribunal is satisfied, then a TO must be ordered. Conversely, if the Victorian Tribunal is satisfied that the compulsory treatment criteria no longer apply, then the TTO must be revoked by the Tribunal.[1169]

[1158] Ibid ss 143(b)(i), (ii).

[1159] Ibid s 189.

[1160] *Mental Health and Wellbeing Act 2022* (Vic) ss 189, 190.

[1161] Ibid s 195(1).

[1162] Ibid s 195(2), (3).

[1163] Ibid s 195(3); see also s 197.

[1164] Ibid ss 190(1)(a), (b).

[1165] Ibid ss 88, 89, 180(2)(a).

[1166] Ibid ss 89(4), 190(2).

[1167] Ibid s 191.

[1168] Ibid s 192(2)(a).

[1169] Ibid s 192(2)(b).

5.4.48 The *MHWA* also establishes a list of criteria that the Victorian Tribunal must have regard to when determining whether to impose a TO,[1170] which operate to ensure, in a limited way, that the person's views and preferences are taken into consideration 'to the extent that is reasonable in the circumstances.'[1171] Further, the Victorian Tribunal must determine whether a CTO or an ITO should be imposed, although the Act makes it explicit that an ITO can only be ordered if the Tribunal is satisfied that the person cannot be treated in the community.[1172]

5.4.49 The duration of TOs varies depending on whether the person is aged 18 years and over. In the case of persons aged under 18 years, the maximum duration of a TO is three months.[1173] However, for persons aged 18 years and over, the maximum duration of a TO is six months.[1174]

Summary

5.4.50 The *MHWA* is expected to commence operation on the 1 September 2023. Human rights principles are embedded throughout the new Act, which aim to ensure that persons with mental illness are treated with dignity and respect, with the least restrictive measures approach an integral consideration throughout the law. The new Act establishes substantive and procedural criteria and safeguards for imposition of Assessment Orders and Treatment Orders. There are significant differences between the *MHWA* and South Australia's *MHA*.

5.4.51 Under the *MHWA*, provisions regulating treatment orders has been simplified, with the Act recognising two types of treatment orders, inpatient and community treatment orders. Further, the new Act confers jurisdiction on authorised psychiatrists or the Mental Health Tribunal to determine if treatment should be community based, or as an inpatient within a facility. The *MHWA* includes Assessment Order provisions, which require a person to be mandatorily assessed by an authorised psychiatrist to ascertain whether a treatment order should be imposed.

5.4.52 The *MHWA* has excluded impaired decision-making capacity as a criterion for the imposition of an assessment order or treatment order. In recognising the impact that this has on individual human rights, the *MHWA* establishes a higher threshold test for harm, requiring that the person needs immediate treatment to prevent 'serious deterioration in the person's mental or physical health [or] serious harm to the person or to another person.'[1175]

5.4.53 Importantly, the new Victorian Act includes several provisions governing the administration of medical treatment for persons subject to a treatment order, which permit authorised psychiatrists to treat physical illnesses or conditions in certain circumstances in the absence or refusal of the person's consent if capacity to consent has been lost.

5.4.54 SALRI has had careful regard to the new Victorian Act, which is a major reform in the area of mental health law. However, it cannot be simply transferred to a South Australian context.

[1170] Ibid ss 88, 89, 180(2)(a).

[1171] Ibid s 192(3).

[1172] Ibid s 194.

[1173] *Mental Health and Wellbeing Act 2022* (Vic) s 193(b).

[1174] Ibid s 193(a). It is necessary to note that the *Mental Health and Wellbeing Act 2022* (Vic) includes provisions to vary and revoke treatment orders and temporary treatment orders, including transitioning a patient from an inpatient treatment order to a community treatment order, vice versa. For discussion on these provisions see *Mental Health and Wellbeing Act 2022* (Vic) Pt 4.6—Variation and revocation of temporary treatment orders and treatment orders.

[1175] *Mental Health and Wellbeing Act 2022* (Vic) s 143(b)(i)–(ii).

There are differences between South Australia and Victoria (including regional factors and how the two States deal with laws regarding human rights).

Queensland

5.4.55 The framework for ITO-equivalents in Queensland's legislation was also of interest in SALRI's review.

5.4.56 The *Mental Health Act 2016* (QLD) ('*MHA* (Qld)') commenced on 5 March 2017, replacing the *Mental Health Act 2000* (Qld).[1176] The *MHA* (Qld) significantly amended the previous approach concerning involuntary treatment orders, replacing them with Treatment Authorities ('TAs'). A TA is a 'lawful authority to provide treatment and care to a person who has a mental illness who does not have capacity to consent to be treated.'[1177] TAs can be either community based or require the person to receive treatment and care as an inpatient if a community TA is inappropriate given the person's treatment needs.[1178]

5.4.57 For a TA to be imposed, the consumer must be examined by an Authorised Medical Practitioner who determines that the treatment criteria are met and there are no less restrictive means for treating their mental illness. The definition of treatment criteria is provided in s 12 of the *MHA* (Qld) and states:[1179]

> **'treatment criteria'** for a person are all of the following—
>
> (a) the person has a mental illness; and
>
> (b) the person does not have capacity to consent to be treated for the illness; and
>
> (c) because of the person's illness, the absence of involuntary treatment, or the absence of continued involuntary treatment, is likely to result in—
>
> (i) imminent serious harm to the person or others; or
>
> (ii) the person suffering serious mental or physical deterioration.

5.4.58 The *MHA* (Qld) places impaired decision-making capacity as a criterion for the imposition of a TA. The Explanatory Notes accompanying the Mental Health Amendment Bill 2016 (Qld) provided that the new framework regulating TAs, including the definition of treatment criteria, aimed to strengthen patient rights by 'tightening the criteria … to focus on a person's lack of capacity to consent to treatment and the risk of serious harm to the person or others.'[1180]

5.4.59 Consistent with the position in South Australia and Victoria, the *MHA* (Qld) requires that 'there is no less restrictive way for the person to receive treatment and care for the person's mental illness, including, for example, under an advance health directive.'[1181] Importantly, 'if the person's treatment and care needs can reasonably be met in a 'less restrictive way', a treatment authority cannot

[1176] Queensland Health, *Evaluation of the Mental Health Act 2016 Implementation* (Queensland Government, April 2010) 1.

[1177] *Mental Health Act 2016* (Qld) s 18 (1).

[1178] Ibid s 18 (4)(a), (b).

[1179] Ibid s 12(1).

[1180] Explanatory Notes, Mental Health Amendment Bill 2016 (Qld) 1.

[1181] *Mental Health Act 2016* (Qld) ss 18(2), 30(b).

be made.'[1182] There is uniformity between Queensland, South Australia and Victorian Acts that aim to ensure that individual human rights and liberty are restricted to the least possible extent.

5.4.60 However, TAs can only be made in Queensland if a medical practitioner or authorised mental health practitioner has imposed a Recommendation for Assessment and the person has been assessed by an Authorised Medical Practitioner.[1183] Therefore, the *MHA* (Qld) establishes a clear procedure to subject a person to assessment prior to them being placed under a TA.[1184]

Recommendation for Assessment

5.4.61 The purpose of a Recommendation for Assessment is to have a person assessed by an Authorised Medical Practitioner to determine if a treatment order is required.[1185] A key feature of the *Qld MHA* is that it clearly promotes voluntary assessment whenever possible.[1186]

5.4.62 This is exemplified in s 31(2)(a) which provides that the 'examination [for recommendation for assessment] may be carried out if the person asks for, or consents to, the examination.'[1187] The *MHA* (Qld), however, authorises a practitioner or Authorised Mental Health Practitioner ('AMHP') to detain a person who voluntarily consents to an examination and use 'the force that is necessary and reasonable in the circumstances,'[1188] if they are satisfied that the Recommendation for Assessment criteria are satisfied and an order for assessment should be imposed.[1189] An important threshold criterion for detaining someone who voluntarily consents to an examination for a recommendation for assessment is that there is a risk that the person will leave prior to the making of a Recommendation for Assessment.[1190]

5.4.63 A medical practitioner or AMHP can make a Recommendation for Assessment.[1191] Pivotal requirements for the imposition of a Recommendation for Assessment are that the treatment criteria[1192] may apply to the person and this is the least restrictive measure for the person to receive treatment for their mental illness.[1193] Further, the Recommendation for Assessment must be made within seven days of examination.[1194] If a Recommendation for Assessment is made, it is valid for seven days and can be revoked at any time prior to the person being assessed if the treatment criteria no longer apply.[1195]

5.4.64 For the purpose of s 12(a) of the *MHA* (Qld) treatment criteria provisions, mental illness is defined as a 'condition characterised by a clinically significant disturbance of thought, mood,

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[1182] Explanatory Notes, Mental Health Amendment Bill 2016 (Qld) 2.

[1183] *Mental Health Act 2016* (Qld) ss 31(1), 39.

[1184] Office of the Chief Psychiatrist (Qld), *Annual Report of the Chief Psychiatrist 2021-2022,* (Queensland Health, 3 November 2022) 17; *Mental Health Act 2016* (Qld) s 30.

[1185] *Mental Health Act 2016* (Qld) s 43.

[1186] Office of the Chief Psychiatrist (Qld), *Annual Report of the Chief Psychiatrist 2021-2022,* (Queensland Health, 3 November 2022).

[1187] *Mental Health Act 2016* (Qld) s 31(2)(a).

[1188] Ibid s 37.

[1189] Ibid ss 36, 39.

[1190] Ibid s 36(1)(c); see also ss 36(2), (3), 38 for additional requirements relating to powers to detain.

[1191] Ibid s 31(1).

[1192] Ibid s 12(1).

[1193] Ibid s 39(1)(a), (b).

[1194] Ibid s 39(2).

[1195] Ibid ss 41, 42.

perception or memory.'[1196] The definition is accompanied by a list of criteria in s 10(2), which prevent certain factors alone being indicative that a person has a mental illness. For example, if the person 'holds or refuses to hold a particular religious, cultural, philosophical or political belief or opinion or the person is a member of a particular racial group.'[1197] The *MHA* (Qld) clarifies that these factors do not prevent a person from having a mental illness,[1198] but merely operate to safeguard persons from being subject to prejudicial treatment simply because, inter alia, they belong to a particular racial group or hold certain religious beliefs.[1199]

5.4.65 The capacity to consent to treatment for illness has been given a legislative definition, requiring that the person is capable of understanding, in general terms:

- that the person has an illness, or symptoms of an illness, that affects the person's mental health and wellbeing;[1200] and
- the nature and purpose of the treatment for the illness;[1201] and
- the benefits and risks of the treatment, and alternatives to the treatment;[1202] and
- the consequences of not receiving the treatment.[1203]

5.4.66 The *MHA* (Qld) provides if the consumer is not capable of understanding any one of the four criteria listed above, then they would not have capacity to consent to be treated for their illness.[1204]

5.4.67 The threshold criteria for harm under the *MHA* (Qld) is that the absence of involuntary treatment is likely to result in:

- imminent serious harm to the person or others; or
- the person suffering serious mental or physical deterioration.[1205]

5.4.68 Imminent serious harm and serious mental or physical deterioration are not defined in the *Qld MHA*. However, use of this language as threshold criteria for imposing a Recommendation for Assessment is consistent with the least restrictive principles adopted by ensuring that individual human rights and liberties are only interfered with in exceptional and serious circumstances.[1206]

5.4.69 The Mental Health Review Tribunal is also empowered to make an Examination Authority under the *MHA* (Qld).[1207] An Examination Authority operates in circumstances where there is concern that the person has a mental illness and requires examination for assessment, however it

[1196] Ibid s 10(1).

[1197] Ibid s 10(2)(a), (b).

[1198] *Mental Health Act 2016* (Qld) s 10(3).

[1199] For a full list of considerations see Ibid s 10(2)(a)–(k).

[1200] Ibid s 14(1)(a)(i).

[1201] Ibid s 14(1)(a)(ii).

[1202] Ibid s 14(1)(a)(iii).

[1203] Ibid s 14(1)(a)(iv).

[1204] Ibid s 12(1)(b).

[1205] Ibid s 12(1)(c)(i), (ii).

[1206] Office of the Chief Psychiatrist (Qld), *Annual Report of the Chief Psychiatrist 2021-2022,* (Queensland Health, 3 November 2022) 10.

[1207] *Mental Health Act 2016* (Qld) ss 28(2)(a), 32.

was not possible to examine the person voluntarily under a Recommendation for Assessment.[1208] An Examination Authority confers broad powers on medical practitioners and AMHPs, including the authority to enter premises to find the person and limited power to detain.[1209] Further, in exercising a function or power under an Examination Authority, a medical practitioner or AMHP may use reasonable help and force 'that is necessary in the circumstances.'[1210] This provision is utilised in 'circumstances where there is, or may be, serious risk of harm or worsening health and all reasonable efforts have been made to engage the person in a voluntary examination.'[1211] An Examination Authority is an additional measure utilised to have a person mandatorily assessed to determine whether a Recommendation for Assessment should be imposed.[1212]

Assessments

5.4.70 An Authorised Medical Practitioner, who must be different than the medical practitioner who made the Recommendation for Assessment, must assess a person to determine whether a TA applies.[1213] The *MHA* (Qld) sets out the procedure that must be followed in performing an Assessment of a consumer. The purpose of the Assessment is for the Authorised Medical Practitioner to decide whether the treatment criteria apply to the person and whether there is a less restrictive way for the person to receive treatment for their mental illness.[1214]

5.4.71 In relation to determining whether there are less restrictive treatments for the consumer's mental illness, the Authorised Medical Practitioner:

> … must take reasonable steps to find out whether there is a less restrictive way for the person to receive treatment and care for the person's mental illness, including, for example, by searching the person's health records to find out whether the person has made an advance health directive or has a personal guardian.[1215]

5.4.72 The definition of treatment criteria is identical to that which applies to Recommendation for Assessments and is included in s 12 of the *MHA* (Qld). Further, the definitions of the relevant terms in s 12 of the *MHA* (Qld) such as 'mental illness,' 'capacity to consent' and 'serious harm' threshold requirements are discussed above.

5.4.73 The *MHA* (Qld) sets out requirements for how a person who is subject to a Recommendation for Assessment may be assessed, and includes provisions for detaining the consumer for assessment.[1216] Detention for assessment purposes can only be imposed for 24 hours or less, and the consumer must be assessed in either 'an authorised mental health service or public sector health

[1208] Office of the Chief Psychiatrist (Qld), *Annual Report of the Chief Psychiatrist 2021-2022,* (Queensland Health, 3 November 2022) 19.

[1209] *Mental Health Act 2016* (Qld) ss 32–35.

[1210] *Mental Health Act 2016* (Qld) ss 33, 34.

[1211] Office of the Chief Psychiatrist (Qld), *Annual Report of the Chief Psychiatrist 2021-2022,* (Queensland Health, 3 November 2022) 19.

[1212] *Mental Health Act 2016* (Qld) s 31(2)(b).

[1213] Ibid s 43(1), (2). There is some leniency regarding this rule that applies in rural and remote areas see s 43(3).

[1214] Ibid ss 43(1), (2).

[1215] Ibid s 43(4).

[1216] Ibid ss 44, 45.

service facility.'[1217] The detention period can be extended by an Authorised Medical Practitioner, but for a maximum of 72 hours.[1218]

5.4.74 Finally, if the Authorised Medical Practitioner determines that the treatment criteria do not apply to the consumer, or there is a less restrictive method of treatment, then the consumer must be informed of the outcome, its effect on them. This outcome must also be noted on the Recommendation for Assessment.[1219]

Treatment Authority

5.4.75 A TA may be imposed on a person if an Authorised Medical Practitioner determines that the treatment criteria apply and the no less restrictive measures test does not apply.[1220] Procedures regulating the form of TA have been included in the *MHA* (Qld), which require:

- the grounds on which the treatment criteria are satisfied;
- the category of the TA; and
- whether treatment is to be provided in the community or in an inpatient setting at an authorised mental health service.[1221]

5.4.76 Specific factors must be considered when deciding to place a person under an inpatient TA. The *MHA* (Qld) specifies that:

> … the category of the authority is inpatient only if the authorised doctor considers, after having regard to the relevant circumstances of the person, that 1 or more of the following can not reasonably be met if the category of the authority is community—
>
> (a) the person's treatment and care needs;
>
> (b) the safety and welfare of the person;
>
> (c) the safety of others.[1222]

5.4.77 At least one of the above factors must be satisfied for the person to be placed under an inpatient TA. If an inpatient TA is applied, then the *MHA* (Qld) requires the Authorised Medical Practitioner to consider whether the person can receive treatment for their mental illness in the community on a limited basis.[1223] Consistent with the human rights focus of the *MHA* (Qld), when determining the nature and extent of the treatment of a person's mental illness under a TA, the Authorised Medical Practitioner must 'have regard to the views, wishes and preferences of the person, to the extent they can be expressed, including, for example, in an advance health directive.'[1224]

[1217] Ibid s 45(1).

[1218] Ibid s 45(2).

[1219] *Mental Health Act 2016* (Qld) s 47(1)–(3).

[1220] Ibid s 47(a), (b).

[1221] Ibid ss 50(1)(b)(i)–(v), 51.

[1222] Ibid s 51(3)(a)–(c).

[1223] Ibid s 52(1).

[1224] Ibid s 53(2)(b). The *Mental Health Act 2016* (Qld) s 54 sets out provisions concerning when an advance care directive is not followed. Consideration of these elements is beyond the scope of this discussion.

5.4.78 There are also mechanisms of review in certain circumstances where TAs are imposed on consumers. If a psychiatrist did not authorise the TA, an authorised psychiatrist must review the TA, to confirm the treatment criteria apply and that there are no less restrictive measures for the treatment.[1225] If these conditions are not met, then the TA must be revoked.[1226] If the TA is confirmed, the authorised psychiatrist also must review the category of the TA, whether the TA required amending and decide the nature and extent of the treatment and care for the person.[1227] This review must occur within three days or within seven days if the person is in a rural or remote area.[1228]

5.4.79 The *MHA* (Qld) also includes provisions governing the responsibilities of Authorised Medical Practitioners and authorised mental health services for a consumer's treatment and care while they are under a TA.[1229] This requires the person to undergo a first assessment if they are placed under an inpatient TA and a subsequent assessment must occur within three months following the first assessment.[1230] A person can be assessed at any time if the authorised psychiatrist determines that the treatment criteria no longer apply to the person or there may be a less restrictive means for the person to receive treatment,[1231] and if these conditions are met, the TA must be revoked.[1232]

5.4.80 The consideration of a person's decision-making capacity to consent to treatment for their mental illness is an important factor when determining whether a TA be revoked. The *MHA* (Qld) provides that 'the authorised doctor is not required to revoke the treatment authority if the authorised doctor considers the patient's capacity to consent to be treated for the patient's mental illness is not stable.'[1233] The impetus behind this provision reflects situations where a person has fluctuating capacity to consent to be treated in a short period of time.[1234]

Duration of Treatment Authorities

5.4.81 The TA provisions under the *MHA* (Qld) do not establish criteria regulating the duration of the TA. Instead, a framework for review of a TA by the Mental Health Review Tribunal is established.

5.4.82 The two predominant types of review are periodic review and applicant review. Periodic Review of a TA occurs at defined periods of time being:

> (a) within 28 days after the authority is made; and
>
> (b) within 6 months after the review under *paragraph (a)* is completed; and
>
> (c) within 6 months after the review under *paragraph (b)* is completed; and
>
> (d) at intervals of not more than 12 months after the review under *paragraph (c)* is completed.[1235]

[1225] Ibid s 57(1)(a), (b).

[1226] Ibid s 57(4).

[1227] *Mental Health Act 2016* (Qld) s 57(2)(a), (b).

[1228] Ibid s 56(3)(a), (b).

[1229] Ibid ss 202, 203.

[1230] Ibid s 205 (1), (2).

[1231] Ibid s 205(1)–(4).

[1232] Ibid s 206(2).

[1233] Ibid s 206(3).

[1234] Ibid s 206(3).

[1235] Ibid s 413(1)(a)–(d).

5.4.83 In addition to these criteria, the Mental Health Review Tribunal may conduct a review of a TA of its own initiative.[1236]

5.4.84 Certain interested parties are permitted to apply to the Mental Health Review Tribunal seeking review of a TA at any time. The person themselves, an interested party of the person or the Chief Psychiatrist have standing to apply for review.[1237] Other relevant considerations are that Authorised Medical Practitioners and psychiatrists are permitted to amend TAs, including the category, limited community treatment provisions or conditions of the TA.[1238]

5.4.85 Therefore, the duration of a TA is not specified in the *MHA* (Qld). Instead, it clearly establishes a framework of ongoing review to ensure that a TA is not in force longer than necessary, and that human rights and liberties are interfered with to the smallest possible extent. Division 4 of the *MHA* (Qld) includes further powers and procedures of the Mental Health Review Tribunal when reviewing TAs.[1239]

United Kingdom

5.4.86 SALRI has also considered the legislative framework in the United Kingdom.

5.4.87 The *Mental Health Act 1983* (UK) ('*MHA* (UK)') establishes a framework to provide treatment and care for persons who are mentally disordered.[1240] In the 2021-22 Mental Health Statistics: Annual Figures Report, it was observed that the number of detentions made under the *MHA* (UK) continued to rise annually, which was viewed as a matter of concern. It was noted that in recent years 'there has been a steep rise in the use of the short-term detention for assessment.'[1241] To address this issue, an independent review was established to examine the use of the *MHA* (UK) ('Independent Review').[1242]

5.4.88 In addition to examining the reasons underlying the increasing rate of detentions under the *MHA* (UK), the government also noted further issues raised by stakeholders that:

> … some processes relating to the act are out of step with a modern mental health system, including but not limited to:
>
> - the balance of safeguards available to patients, such as tribunals, second opinions, and requirements for consent

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[1236] Ibid s 413(3).

[1237] Ibid s 413(2).

[1238] See *Mental Health Act 2016* (Qld) ss 209, 210.

[1239] See Ibid ss 419–29. Discussion of these provisions is beyond the scope of this review. There are specific circumstances that will end a treatment authority. There were outlined in the Chief Psychiatrist 2021-22 Annual Report. The Chief Psychiatrist stated that a TA will end if 'a second examination by an authorised psychiatrist is required, and the treatment authority is not confirmed or revoked by the psychiatrist within the three-day period; a treatment authority is made for a person who is already subject to an order or authority under the Act. This usually occurs in emergency situations where the treatment authority is made to ensure the person receives necessary treatment and care; and if the Mental Health Court makes a forensic order (mental health) or treatment support order for the patient or if the patient is transferred interstate or is deceased see Office of the Chief Psychiatrist (Qld), *Annual Report of the Chief Psychiatrist 2021-2022* (Queensland Health, 3 November 2022) 25.

[1240] *Mental Health Act 1983* (UK) s 1(1).

[1241] UK Government, *Modernising the Mental Health Act: Increasing Choice, Reducing Compulsion – Final Report of the Independent Review of the Mental Health Act 1983* (December 2018) 49.

[1242] NHS Digital, *Mental Health Act Statistics, Annual Figures 2021-22* (27 October 2022) <Mental Health Act Statistics, Annual Figures, 2021-22 - NDRS (digital.nhs.uk)>.

- the ability of the detained person to determine which family or carers have a say in their care, and of families to find appropriate information about their loved one
- that detention may in some cases be used to detain rather than treat.[1243]

5.4.89 The final report from the Independent Review titled, *Modernising the Mental Health Act, Increasing Choice, Reducing Compulsion*,[1244] was released in December 2018.[1245] The Chair of the Independent Review[1246] noted that one of the main issues in this complex area of law was balancing the right of respect for individual autonomy and the obligation of the State to protect the vulnerable from harm.[1247] It was noted that the existing legal framework governing mental health was outdated and did not take into consideration the 'fundamental importance of human rights in mental health care,'[1248] especially with respect to the *CRPD* which has been ratified in the United Kingdom.[1249]

5.4.90 The lack of dignity afforded to persons suffering from a mental illness and subject to involuntary treatment was a key issue before the Independent Review Committee which observed:

> Dignity is essential both to improvement and to maintaining better health and reducing the risk of further admissions. Lack of dignity, and a lack of a trust that patients will be treated kindly and with respect, inspires fear. We have heard how many service users fear that being compulsorily admitted to hospital will worsen, not improve, their mental distress.[1250]

5.4.91 It was noted that there was a widespread concern among mental health services patients, especially individuals who had been involuntarily detained and treated. These concerns translated into a disincentive to seek voluntary treatment out of fear of being abused, which had a detrimental effect on consumers' overall health.[1251] In recognising this concern, the Independent Review Committee

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[1243] Department of Health and Social Care, *Terms of Reference: Independent Review of the Mental Health Act 1983* (4 October 2017) <Terms of reference: independent review of the Mental Health Act 1983 - GOV.UK (www.gov.uk)>.

[1244] UK Government, *Modernising the Mental Health Act: Increasing Choice, Reducing Compulsion – Final Report of the Independent Review of the Mental Health Act 1983* (December 2018).

[1245] The Review was expansive. 'Its key recommendation is that the four principles of choice and autonomy, least restriction, therapeutic benefit, and the person as an individual should be included in the Act and govern all decisions taken under the Act. People's choices, wishes, and preferences should carry far more legal weight. Shared decision- making should be used as far as is possible. Criteria for detention should be strengthened and justification must be transparent. Statutory Advance Choice Documents ('ACDs') should be created. An improved response for those patients who come into contact with the police is necessary. Action is needed to promote equality for people from ethnic minority backgrounds. There should be community-based support for people with a learning disability, autism, or both to avoid, if possible, hospital admission and support timely discharge. Investment in services is necessary as laws are modernised': Gerald Lynch, Phillip Campbell and Catherine Taggart, 'Modernising the Mental Health Act: Getting the Balance Right' (2018) 392 *The Lancet* 2532–4.

[1246] Professor Sir Simon Wessely (Regius Professor of Psychiatry at King's College London and President of the Royal Society of Medicine) was the Chair of the Review, with Vice Chairs Steve Gilbert (service user and serious mental health living consultant), Sir Mark Hedley (retired High Court judge) and Rabbi Baroness Julia Neuberger (former CEO of the King's Fund and Chair of the Liverpool Care Pathway Review).

[1247] UK Government, *Modernising the Mental Health Act: Increasing Choice, Reducing Compulsion – Final Report of the Independent Review of the Mental Health Act 1983* (December 2018). This theme was also raised to SALRI in conversation with the Law Commission.

[1248] Ibid 19.

[1249] Ibid.

[1250] Ibid 17. SALRI also notes the helpful input of Jean Lee, an English lawyer, to current issues in this area of the law in England.

[1251] UK Government, *Modernising the Mental Health Act: Increasing Choice, Reducing Compulsion – Final Report of the Independent Review of the Mental Health Act 1983* (December 2018) 17–8. See also Mary O'Hagan, 'Force in Mental Health Services: International User/Survivor Perspectives' (2004) 7 *Mental Health Practice* 12; Graham Danzer and

suggested that the existing law should be amended to provide better alternatives for persons suffering from severe mental illness and to ensure that least restrictive practices were an important consideration.[1252]

5.4.92 The traumatic impact that being involuntarily detained involuntarily in an inpatient environment was a focal point of the Independent Review Committee's Report.[1253] It was noted:

> Wards become people's home, often for many months, and so should offer a positive community for the patient where they can build new relationships. Sadly, people are often placed in some of the worst estate that the NHS has, just when they need the best. The physical environment of wards has become affected by an increasingly risk- and infection averse approach, which can create the kind of institutional atmosphere that psychiatry has 29 been trying to move away from for the last half century. We therefore call for new capital investment by the government and NHS to modernise the mental health estate.[1254]

5.4.93 The Independent Review Committee proposed major reforms to the existing mental health laws in the United Kingdom, with human rights considerations to be embedded throughout the law. In recognising the integral role of human rights considerations, the Committee, however, declined to accept the absolute position of the UN Committee on the Rights of Persons with Disabilities, and instead recommended that the United Kingdom should 'repeal legislation and practices that authorise non-consensual involuntary, compulsory treatment and detention of persons with disabilities on the basis of actual or perceived impairment.'[1255] It was viewed that this recommendation was inconsistent with the duty of the State to detain and treat someone who is acutely mentally ill and poses a serious risk of harm to themselves or others.[1256]

5.4.94 In further addressing the complex issues that arise in the context of persons with acute mental illness and the impact that involuntary detention and treatment has on human rights, the Independent Review Committee observed that the view of the UN Committee on the Rights of Persons with Disabilities went too far and was not suitable in the context of the United Kingdom. The

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Asha Wilkus-Stone, 'The Give and Take of Freedom: The Role of Involuntary Hospitalisation and Treatment in Recovery from Mental Illness' (2015) 79(3) *Bulletin of the Menninger Clinic* 255.

[1252] UK Government, *Modernising the Mental Health Act: Increasing Choice, Reducing Compulsion – Final Report of the Independent Review of the Mental Health Act 1983* (December 2018).

[1253] Ibid 28–9.

[1254] Ibid.

[1255] Ibid. A similar view has been taken in Australia and New Zealand. See Sascha Callaghan and Christopher James Ryan, 'Rising to the Human Rights Challenge in Compulsory Treatment – New Approaches to Mental Health Law in Australia' (2012) 46 *Australian and New Zealand Journal of Psychiatry* 61; Sascha Callaghan and Christopher Ryan, 'An Evolving Revolution: Evaluating Australia's Compliance with the Convention on the Rights of Persons with Disabilities in Mental Health Law' (2016) 39(2) *University of New South Wales Law Journal* 596; Toni Wharehoka, 'Disability Rights and Compulsory Psychiatric Treatment: the Case for a Balanced Approach under the Mental Health (Compulsory Assessment and Treatment) Act 1992' (2021) *Victoria University Wellington Law Review* 221.

[1256] UK Government, *Modernising the Mental Health Act: Increasing Choice, Reducing Compulsion – Final Report of the Independent Review of the Mental Health Act 1983* (December 2018) 61. This approach has roved controversial and much criticised and has also been rejected in Australia and New Zealand. See also John Dawson, 'A Realistic Approach to Assessing Mental Health Laws' Compliance with the UNCRPD' (2015) 40 *International Journal of Law and Psychiatry* 70; Sascha Callaghan and Christopher Ryan, 'An Evolving Revolution: Evaluating Australia's Compliance with the Convention on the Rights of Persons with Disabilities in Mental Health Law' (2016) 39(2) *University of New South Wales Law Journal* 596; Toni Wharehoka, 'Disability Rights and Compulsory Psychiatric Treatment: the Case for a Balanced Approach under the Mental Health (Compulsory Assessment and Treatment) Act 1992' (2021) *Victoria University Wellington Law Review* 221.

Committee cogently commented that repealing involuntary assessment and treatment provisions raised adverse effects:

> … [it] could prevent intervention when a person is refusing help at that time but would stop them from doing something that they would never have done when well. For example, treatment for people who experience psychotic delusions that make them want to harm themselves or others. Individuals have a right to support, care, and treatment, and we believe that to withhold these on the basis of a disability would amount to a greater violation of their rights than detention and treatment under the *MHA* which is carefully regulated, and contains many safeguards.[1257]

5.4.95 The Independent Review Committee made 153 recommendations to significantly amend the *Mental Health Act 1983* (UK), especially the involuntary treatment provisions.[1258] Consequently, the UK Government introduced a Draft Mental Health Bill on 27 June 2022.[1259] In the Explanatory Notes for the Bill, it was noted that the key amendments were to:

- Better ensure that detentions and treatment made under the *MHA* are necessary, with revisions to the criteria which must be met in order for a person to be detained, treated, or otherwise made subject to the *MHA* and provide faster, more frequent reviews and appeals of both detentions and treatment; and
- Strengthen the voice of patients – with reforms adding statutory weight to patients' rights to be involved with planning for their care, and to make choices and refusals regarding the treatment they receive.[1260]

5.4.96 Some of the proposed changes relating to involuntary treatment and detention of persons with a mental disorder are the criteria for the provision of treatment without consent, requiring a second opinion and a compelling reason.[1261]

5.4.97 The proposed framework operates in circumstances where:

- the person with a mental disorder;
- the person requires treatment for their mental disorder;
- the person has capacity to consent but consent has withheld.[1262]

5.4.98 This new provision emphasises the importance of patient autonomy and consent, requiring stricter requirements to be met when treating a person involuntarily. For instance, a threshold test has been included requiring that there be a compelling reason to administer the treatment. The Bill states that 'a patient may not be given any of those forms of medical treatment unless there is a compelling reason to give treatment of that form and a second opinion appointed medical practitioner has certified in writing,[1263] and includes a list of additional criteria that must be satisfied.[1264]

[1257] UK Government, *Modernising the Mental Health Act: Increasing Choice, Reducing Compulsion – Final Report of the Independent Review of the Mental Health Act 1983* (December 2018) 62.

[1258] Ibid 297–314.

[1259] Draft Mental Health Bill 2022 (UK).

[1260] Explanatory Notes, Draft Mental Health Bill 2022 (UK) 2.

[1261] Draft Mental Health Bill 2022 (UK) s 11(2).

[1262] Ibid.

[1263] Ibid.

[1264] Ibid s 11.

5.4.99 Under the existing *MHA* (UK), a framework is established to detain person's with a mental disorder for assessment at a hospital under an admission for assessment,[1265] and if they require treatment, under an admission for treatment.[1266]

5.4.100 The criteria to impose an admission for assessment under s 2(2) of the *MHA* (UK) requires that:

> (a) he [or she] is suffering from mental disorder of a nature or degree which warrants the detention of the patient in a hospital for assessment (or for assessment followed by medical treatment) for at least a limited period; and
>
> (b) he [or she] ought to be so detained in the interests of his [or her] own health or safety or with a view to the protection of other persons.[1267]

5.4.101 The Draft Mental Health Bill proposed to delete s 2(2)(b) of the existing Act, replacing it with a higher threshold test.[1268] The proposed criteria for an application for admission for assessment are:

> (b) serious harm may be caused to the health or safety of the patient or of another person unless the patient is so detained; and
>
> (c) given the nature, degree and likelihood of the harm, and how soon it would occur, the patient ought to be so detained.[1269]

5.4.102 Relating to admission for treatment orders, the current *MHA* (UK) requires that:

> a) he [or she] is suffering from mental disorder of a nature or degree which makes it appropriate for him [or her] to receive medical treatment in a hospital; and
>
> …
>
> (c) it is necessary for the health or safety of the patient or for the protection of other persons that he [or she] should receive such treatment and it cannot be provided unless he [or she] is detained under this section; and
>
> (d) appropriate medical treatment is available for him [or her].[1270]

5.4.103 However, the Bill will significantly reform this existing approach, aligning with the human rights focus recommended by the Independent Review. For imposition of an admission for treatment, the Bill proposes substitutes paragraphs (c) and (d) above, instead requiring:

> (b) serious harm may be caused to the health or safety of the patient or of another person unless the patient receives medical treatment,
>
> (c) it is necessary, given the nature, degree and likelihood of the harm, and how soon it would occur, for the patient to receive medical treatment,
>
> (d) the necessary treatment cannot be provided unless the patient is detained under this Act, and

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[1265] *Mental Health Act 1983* (UK) s 2.

[1266] Ibid s 3.

[1267] Ibid s 2(2).

[1268] Draft Mental Health Bill 2022 (UK) s 3(2).

[1269] Ibid s 3(2).

[1270] *Mental Health Act 1983* (UK) s (2)(a)–(d).

(e) appropriate medical treatment is available for the patient.[1271]

5.4.104 The Draft Mental Health Reform Bill seeks to increase the criteria for the involuntary detention of a person for assessment purposes and involuntarily detaining or treating a person under an admission for treatment order. Further amendments are also proposed in the UK Bill aimed at strengthening the requirement around involuntary treatment of a person for their mental disorder, even if they have decision-making capacity and withhold consent to the medical treatment.

5.4.105 As with the new Victorian Act, the UK Bill is a major measure and of direct interest for consideration of significant law reform in this area.

5.5 Issues

Utility and Effectiveness of ITOs

5.5.1 The role and use of ITOs are contentious and prompt much debate. Further, there is 'limited evidence' concerning the use and effect of ITOs.[1272] 'From the evidence currently available we cannot conclude on the effectiveness of any particular intervention.'[1273] The effectiveness of compulsory inpatient treatment has never been formally assessed, given the practical and ethical difficulties of finding suitable controls for a study.[1274]

5.5.2 Whilst not completely comprehensive, there are various and often differing studies as to the benefits or otherwise of involuntary inpatient treatment for persons with mental illness.

5.5.3 Some studies report clinical or other benefits.[1275] Studies generally reveal involuntary consumers show clinical improvement and the majority of involuntary inpatient consumers, retrospectively, agree that their treatment had been necessary and in their best interests.[1276] Some consumers subjected to coercive treatment come to view it as necessary, regarding hospital as a place of safety that can offer protection against self-harm, suicide and impulses to harm others.[1277]

5.5.4 One English study, whilst finding divergent experiences and views amongst involuntary inpatients, found one cohort with retrospectively positive views as to their treatment. This cohort believed that in hindsight, hospitalisation ensured they received treatment, averted further harm and

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[1271] Draft Mental Health Bill 2022 (UK) s 3(3).

[1272] Domenico Giacco et al, 'Interventions for Involuntary Psychiatric Inpatients: A Systematic Review' (2018) 54 *European Psychiatry* 41.

[1273] Ibid 48.

[1274] Neeraj Gill et al, 'Measuring the Impact of Revised Mental Health Legislation on Human Rights in Queensland, Australia (2020) *International Journal of Law and Psychiatry* 73, 78.

[1275] See, for example, Christina Katsakou and Stefan Priebe, 'Outcomes of Involuntary Hospital admission: a Review' (2006) 114(4) *Acta Psychitrica Scandinavia* 232; Bruce Link et al, 'Stigma and Coercion in the Context of Outpatient Treatment for People with Mental Illnesses' (2008) 67 *Social Science and Medicine* 409; Stefan Priebe et al, 'Patients' Views and Readmissions 1 Year after Involuntary Hospitalisation (2009) 194(1) *British Journal of Psychiatry* 49; Stefan Priebe et al, 'Patients' Views of Involuntary Hospital Admission after 1 and 3 months: Prospective Study in 11 European Countries (2010) 196(3) *British Journal of Psychiatry* 179; Ingrid Sibitz et al, 'Impact of Coercive Measures on Life Stories: Qualitative Study' (2011) 199(3) *British Journal of Psychiatry* 239; Christina Katsakou et al, 'Coercion and Treatment Satisfaction Among Involuntary Patients' (2016) 61(3) *Psychiatric Services* 286; Eva Krieger et al 'Patients' Attitudes Towards and Acceptance of Coercion in Psychiatry' (2018) 260 *Psychiatric Research* 478.

[1276] Christina Katsakou and Stefan Priebe, 'Outcomes of Involuntary Hospital admission: a Review' (2006) 114(4) *Acta Psychitrica Scandinavia* 232.

[1277] Christina Katsakou and Stefan Priebe, 'Patient's Experiences of Involuntary Hospital Admission and Treatment: A Review of Qualitative Studies' (2007) 16(2) *Epidemiologia e Psichiatria Sociale* 178.

offered them the opportunity to recover in a safe place.[1278] They also felt that coercion to bring about their treatment was necessary, as they could not, when they were acutely unwell, recognise they needed help.[1279]

5.5.5 Similarly, another study from England found a view amongst involuntary inpatients that, with hindsight, their enforced treatment had been in their best interests as a 'necessary emergency brake'.[1280] The authors elaborated:

> Some participants volunteered that involuntary admission was necessary to maintain their safety or the safety of others. In situations of acute crises, involuntary admission provided a degree of containment and safety not immediately obtainable through other means. 'I was really not well at this time, what else could they do? And, well, it was important, well, and also necessary . . . it is an experience that is not absolutely necessary in life, but what I reckon, because I have had this experience in my own life, that it was necessary.' The need for admission to hospital was often not recognised at the time it occurred, but looking back on events some people concluded that they were not in control and were on a trajectory of destructive behaviour if left unchecked. 'It was the only possibility to bring me back to normality.'[1281]

5.5.6 In contrast, other studies have reported a lack of benefit and adverse effects of involuntary treatment.[1282] One study in 2008 noted that, compared with voluntary admissions, involuntary admissions have been associated with longer stays in hospital, higher readmission rates, higher risk of being involuntarily readmitted and a greater likelihood of dying by suicide.[1283] They were also more dissatisfied with treatment and frequently felt that hospitalisation was not justified.[1284]

5.5.7 Some evidence suggests that involuntary treatment under an ITO can have a detrimental effect on consumers' overall recovery from mental illness,[1285] or might discourage consumers from

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[1278] Christina Katsakou et al, 'Psychiatric Patients' Views on why their Involuntary Hospitalisation was Right or Wrong: a Qualitative Study' (2012) 47(7) *Social Psychiatry and Psychiatric Epidemiology* 1169.

[1279] Ibid.

[1280] Ingrid Sibitz et al, 'Impact of Coercive Measures on Life Stories: Qualitative Study' (2011) 199(3) *British Journal of Psychiatry* 239.

[1281] Ibid 240.

[1282] See, for example, Mary O'Hagan, 'Force in Mental Health Services: International User/Survivor Perspectives' (2004) 7 *Mental Health Practice* 12; Christopher. Maylea, 'A Rejection of Involuntary Treatment in Mental Health Social Work' (2017) 11(4) *Ethics and Social Welfare* 336; Marianna Wyder, 'The Experiences of the Legal Processes of Involuntary Treatment Orders: Tension between the Legal and Medical Frameworks' (2015) 38 *International Journal of law and psychiatry* 44; Marianne Wyder et al, 'Therapeutic Relationships and Involuntary Treatment Orders: Service Users' Interactions with Health-Care Professionals on the Ward' (2015) 24 *International Journal of Mental Health Nursing* 181; Rebecca Murphy et al, 'Service Users' Experiences of Involuntary Hospital Admission Under the Mental Health Act 2001 in the Republic of Ireland' (2017) 68 *Psychiatric Services* 1127; Kanna Sugiura, Elvira Pertega and Christopher Holmberg, 'Experiences of Involuntary Psychiatric Admission Decision-Making: a Systematic Review and Meta-Synthesis of the Perspectives of Service Users, Informal Carers, and Professionals' (2020) 73 *International Journal of Law and Psychiatry* 101645.

[1283] Thomas Kallert, Matthias Glockner and Matthias Schutzwohl, 'Involuntary vs Voluntary Hospital Admission - a Systematic Literature Review on Outcome Diversity (2008) 295 *European Archives of Psychiatry and Clinical Neuroscience* 195.

[1284] Ibid. The lack of benefits from involuntary treatment and the adverse effects, were also raised to SALRI by a number of submissions, notably Citizens Commission on Human Rights.

[1285] Ibid. An Irish study highlights the trauma found by patients: see Rebecca Murphy et al, 'Service Users' Experiences of Involuntary Hospital Admission Under the Mental Health Act 2001 in the Republic of Ireland' (2017) 68 *Psychiatric Services* 1127. 'Nineteen of the 50 participants indicated that aspects of their involuntary admission had a detrimental and prolonged negative impact on their mental health (Table 4). Twelve participants likened the impact of their detention and admission to that of enduring a trauma (C1) and described feeling worse after discharge from the hospital than prior to admission (C2). These participants recalled experiencing panic, flashbacks, and

seeking future assistance from mental health services.[1286] Marianne Wyder et al noted that 'there is increasing evidence that an involuntary hospital admission and treatment can undermine the therapeutic relationship and people's trust in mental health services.'[1287]

5.5.8 Other 'findings suggest that involuntary inpatient care is often frightening and distressing'.[1288] One Australian study found for many consumers, involuntary treatment was experienced as a 'strong power imbalance' and as violation of their personal integrity and a loss of their basic human rights.[1289] 'Consumers in this group felt that they were not treated as human beings… Many felt that the experience had left them invisible, feeling like an animal or criminal, as an object of care without the same human value as a healthy person.'[1290]

5.5.9 As an individual who had been subject to an ITO told an Australian study in 2018:

> It was disgusting. I don't know how to put it in words. They didn't harm me physically, but they were very harmful emotionally, spiritually and mentally…. I wasn't valued in any way, shape or form. My opinion, my person, what I was going through … I didn't feel valid as a human being … my voice was taken away.[1291]

5.5.10 Disempowerment is a consistent theme.[1292] One meta-analysis commented:

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nightmares about events that occurred during the transfer and admission process, including persistent thoughts about their experience or nightmares regarding being physically restrained or coerced in their own homes (C3, C4, and C5). Six participants spoke of a debilitating level of apprehension and self-surveillance that permeated their lives postdischarge and described living in a constant state of fear that they could lose their liberty and be readmitted at any moment (C6). These participants reported experiencing significant panic when they observed or were in contact with people or objects that reminded them of their admission': at 1129–1130. The Chief Psychiatrist also made this point to SALRI.

[1286] Mary O'Hagan, 'Force in Mental Health Services: International User/Survivor Perspectives' (2004) 7 *Mental Health Practice* 12; Graham Danzer and Asha Wilkus-Stone, 'The Give and Take of Freedom: The Role of Involuntary Hospitalisation and Treatment in Recovery from Mental Illness' (2015) 79(3) *Bulletin of the Menninger Clinic* 255. The Chief Psychiatrist also made this point to SALRI.

[1287] Marianne Wyder et al, 'Therapeutic Relationships and Involuntary Treatment Orders: Service Users' Interactions with Health-Care Professionals on the Ward' (2015) 24 *International Journal of Mental Health Nursing* 181, 182.

[1288] Syeda Ferhana Akther et al, 'Patients' Experiences of Assessment and Detention under Mental Health Legislation: Systematic Review and Qualitative Meta-Synthesis' (2019)5(3) *BJPschy Open* 1, 7. See also, for example, Marianne Wyder et al, 'Personal Recovery and Involuntary Mental Health Admissions: The Importance of Control, Relationships and Hope' (2013) 5(3) *Health* 574; Rebecca Murphy et al, 'Service Users' Experiences of Involuntary Hospital Admission Under the Mental Health Act 2001 in the Republic of Ireland' (2017) 68 *Psychiatric Services* 1127. The findings as to the coercive and distressing effects of ITOs is consistent with some of the themes expressed to SALRI by consumers, consumer groups and survey responses. One participant, for example, remarked that their experience of being placed under an ITO as an adolescent 'still traumatises [them]', and they were now in their late 40's. It was further explained that when they refused to take prescribed medication as an inpatient on an ITO and tried to express their reason for refusal, the nurse returned with four adults who physically restrained them and administered the medication.

[1289] Marianne Wyder et al, 'Personal Recovery and Involuntary Mental Health Admissions: The Importance of Control, Relationships and Hope' (2013) 5(3) *Health* 574, 576.

[1290] Ibid.

[1291] Sophie Isobel, '"In Some Ways it all Helps but in Some Ways it Doesn't": The Complexities of Service Users' Experiences of Inpatient Mental Health Care in Australia' (2018) 28 *International Journal of Mental Health Nursing* 105. Similarly, one patient quoted in an Irish study said: 'I suppose when you're involuntary, having that sort of label on you and knowing that you're trapped there [in the hospital]… feel very much like you've had your human rights taken away, you feel imprisoned, and you kind of feel, as I said before, a second-class citizen': Rebecca Murphy et al, 'Service Users' Experiences of Involuntary Hospital Admission Under the Mental Health Act 2001 in the Republic of Ireland' (2017) 68 *Psychiatric Services* 1127, 1130.

[1292] See, for example, Kanna Sugiura, Elvira Pertega and Christopher Holmberg, 'Experiences of Involuntary Psychiatric Admission Decision-Making: a Systematic Review and Meta-Synthesis of the Perspectives of Service

> Across many studies, patients reported reduced feelings of self-worth and self-respect following involuntary admission. Although some believed that their involuntary admission had been necessary many patients described the experience as disempowering and dehumanising. Patients' experiences of disempowerment were mentioned in almost every study and were consistently reported to be exacerbated by a lack of information and involvement in treatment decisions (as described in the first theme), as well as by a lack of autonomy on the ward and concerns about the potentially lasting stigma of involuntary admission. Some factors that improved self-worth were also described… Experiences of powerlessness encompassed not only a lack of choice about treatment but also about how they spent their time on the ward; some patients felt that they lacked any autonomy. Patients complained about having to adhere to seemingly arbitrary ward routines, such as enforced bedtimes… Patients frequently reported that they felt dehumanised during coercive interventions.[1293]

5.5.11 Considering the strong views expressed above regarding the detrimental impacts of involuntary treatment on consumers, it is significant that of the limited research that has been conducted to date, views remain highly varied, particularly from consumers.[1294] The lack of definitive findings remains notable.

5.5.12 SALRI notes that, as with the research as to the utility of CTOs,[1295] it is beyond the scope of this review to determine the validity of reported effects and/or benefits of ITOs. 'Empirical evidence relating to the outcomes and impacts of involuntary hospitalisation or treatment remains scarce and inconsistent.'[1296]

5.5.13 In a recent illustrative study, Wyder et al similarly observed that participants' individual experience of involuntary hospital admission is varied, with some participants recognising 'the need for treatment and described their care in largely positive terms [however] [o]thers strongly resisted treatment and experienced their care as coercive and oppressive when placed under an ITO.'[1297]

Users, Informal Carers, and Professionals' (2020) 73 *International Journal of Law and Psychiatry* 101645; Marianne Wyder et al, 'Personal Recovery and Involuntary Mental Health Admissions: The Importance of Control, Relationships and Hope' (2013) 5(3) *Health* 574.

[1293] Syeda Ferhana Akther et al, 'Patients' Experiences of Assessment and Detention under Mental Health Legislation: Systematic Review and Qualitative Meta-Synthesis' (2019)5(3) *BJPschy Open* 1, 7.

[1294] See, for example, Christina Katsakou and Stefan Priebe, 'Patient's Experiences of Involuntary Hospital Admission and Treatment: A Review of Qualitative Studies' (2007) 16(2) *Epidemiologia e Psichiatria Sociale* 178; Christina Katsakou et al, 'Psychiatric Patients' Views on why their Involuntary Hospitalisation was Right or Wrong: a Qualitative Study' (2012) 47(7) *Social Psychiatry and Psychiatric Epidemiology* 1169; Toril Terkelsen and Inger Larsen, 'The Locked Psychiatric Ward: Hotel or Detention Camp for People with Dual Diagnosis' (2013) 22(5) *Journal of Mental Health* 412; Camilla Haw et al, 'Coercive Treatments in Forensic Psychiatry: a study of Patients' Experiences and Preferences (2011) 22 *Journal of Forensic Psychiatry and Psychology* 564; Inger Johansson and Berit Lundman, 'Patients' Experience of Involuntary Psychiatric Care: Good Opportunities and Great Losses' (2012) 9(6) *Journal of Psychiatric and Mental Health Nursing* 639; Rosalie Hughes, Mark Hayward and W Finlay, 'Patients' Perceptions of the Impact of Involuntary Inpatient Care on Self, Relationships and Recover' (2009) 18(2) *Journal of Mental Health* 152; Tara Seed, John Fox and Katherine Berry, 'The Experience of Involuntary Detention in Acute Psychiatric Care. A Review and Synthesis of Qualitative Studies' (2016) *International Journal of Nursing Studies* 82; Sophie Isobel, '"In Some Ways it all Helps but in Some Ways it Doesn't": The Complexities of Service Users' Experiences of Inpatient Mental Health Care in Australia' (2018) 28 *International Journal of Mental Health Nursing* 105.

[1295] See further Part 6 Community Treatment Orders.

[1296] Ingrid Sibitz et al, 'Impact of Coercive Measures on Life Stories: Qualitative Study' (2011) 199(3) *British Journal of Psychiatry* 239. See also Torseten Jacobsen, 'Involuntary Treatment in Europe: Different Countries, Different practices (2012) 25(4) *Current opinion in Psychiatry 307*. 'Involuntary treatment is burdened by the lack of evidence… involuntary treatment is still caught up in tradition. There is a lack of standard and proof of effectiveness': at 307.

[1297] Marianne Wyder et al, 'Therapeutic Relationships and Involuntary Treatment Orders: Service Users' Interactions with Health-Care Professionals on the Ward' (2015) 24 *International Journal of Mental Health Nursing* 181, 187.

Despite this variance in attitudes and experiences, what all participants agreed on was that 'staff attitudes and behaviours had the potential to make difference to their experiences of the ITO and being admitted to hospital.'[1298]

5.5.14 In summary, some find it positive, some negative and others are ambivalent.[1299] It very much appears to depend strongly on the individual consumer, their circumstances and treatment.

Prevalence of ITOs

5.5.15 During SALRI's consultation, various concerns were raised about the use and prevalence of ITOs under the *MHA*.

5.5.16 The OCP observed that the use of both ITOs and CTOs in South Australia remains high. In the 2020-2021 Annual Report, the OCP remarked that 'in 2020-21 there were 12476 treatment orders active. Since 2015-16 the use of treatment orders [ITOs and CTOs] has increased, with the 12476 an increase of 19.3% compared to 2015-16.'[1300] ITOs make up most of the compulsory orders under the *MHA*. The OPA noted to SALRI that of the 12,476 active treatment orders in 2020-21, 80.2% (10,005) were ITOs.

5.5.17 There were differing views in SALRI's consultation as to the implications of the prevalence of ITOs (and CTOs) in South Australia. Concern was expressed to SALRI by various parties, notably consumers and consumer groups, as to the prevalence of ITOs, underlining that involuntary detention and treatment are generally inconsistent with a consumer's human rights, with modern societal values, and the *MHA's* focus on voluntary practices.

5.5.18 Other parties raised that present law and practice seem to work well. The RANZCP, for example, said:

> The provisions of the *MHA* as they are currently applied in practice seem to be used appropriately, and SACAT seems confident that the *MHA* is being invoked in the correct situations. It is the RANZCP SA Branch's impression that it is uncommon for SACAT to overturn a psychiatrist's decision to apply the *MHA*.

5.5.19 A 2018 study noted that ITO rates in South Australia are high when compared to other Australian jurisdictions.[1301] This study, however, observed that data collection on the imposition of ITOs was insufficient, and this limited the ability to make reliable inter-jurisdictional comparisons. Given that the high rate of ITOs being recorded, it was argued that 'the development of an agreed metric, public reporting and benchmarking data relevant to involuntary treatment is a necessary component to understanding current practice and informing future practice.'[1302] Other parties raised

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[1298] Ibid.

[1299] Christina Katsakou et al, 'Psychiatric Patients' Views on why their Involuntary Hospitalisation was Right or Wrong: a Qualitative Study' (2012) 47(7) *Social Psychiatry and Psychiatric Epidemiology* 1169.

[1300] Office of the Chief Psychiatrist, *Annual Report of the Office of the Chief Psychiatrist 2021-22* (SA Health, 30 September 2022) 54.

[1301] See also Edwina Light et al, 'Community Treatment Orders in Australia: Rates and Patterns of Use' (2012) 20(6) *Australasian Psychiatry* 478; Edwina Light, 'Rates of Use of Community Treatment Orders in Australia' (2019) 69(4) *International Journal of Law and Psychiatry* 83.

[1302] Bobbie Clugston, Amy Young and Edward Heffernan, 'A Comparison of the Reported Use of Involuntary Treatment Orders Within Australian Jurisdictions' (2018) 26(5) *Australasian Psychiatry* 482, 484.

this point in consultation. The Legal Services Commission, for example, stated '[t]he use of ITOs in South Australia requires closer examination.' SALRI agrees with this position.

5.5.20 It is difficult to gauge the underlying reasons for high use of ITOs in South Australia. There is a need for further research to be conducted. SALRI, consistent with its position as to the prevalence of CTOs,[1303] considers any effort as part of the current review, to reliably explain the high rate of ITOs, compared with other Australian states, would be unduly speculative.

5.5.21 SALRI is of the view that meaningful empirical research needs to be undertaken to properly understand the high prevalence of ITOs and its implications in South Australia, and that further detailed consideration of empirical demographic data is necessary to shed light on the factors contributing to that prevalence. Importantly, this data would assist in understanding the implications of reported rates. These are complex and multi-faceted questions.[1304]

Metropolitan and Regional

5.5.22 The OCP's Annual Report 2021-22 ('OCP Annual Report 2021-22') provides that Adelaide's eastern, western and inner southern suburbs recorded the highest rate of ITOs for all levels, with the remaining areas recording comparatively lesser rates of ITOs.[1305] Based on SALRI's metropolitan and regional consultation, this is likely to be due to the lack of availability of mental health services in regional areas compared to eastern, western and inner southern metropolitan areas. The limited availability of mental health services in regional, rural and remote areas was emphasised in SALRI's regional consultation. This resourcing issue may impede the ability of persons in these areas to receive appropriate treatment, or be placed under an ITO, due to the limited resources available.

5.5.23 The limited ability for regional hospitals in South Australia to accommodate an ITO 2 was a point of discussion in the recent Inquest into Theo's death. Subsequent to the recommendations made by the Deputy Coroner at this Inquest,[1306] the OCP engaged independent reviewers to undertake a review of clinical resources and mental health services in regional/rural South Australia.[1307] The Deputy Coroner recommended this review should be aimed at improving services for consumers in regional areas, with a view to ensure that:

> (i) Community Mental Health Teams in regional areas being staffed by a resident team consultant psychiatrist and a resident psychiatric registrar. It is recognised that in order for this recommendation to be implemented there will be a need to incentivise these positions.
>
> (ii) … there is continuity of care in relation to the management of mental health patients in regional areas.

[1303] See Part 6 Community Treatment Orders. See also Lisa Brophy et al, 'The Urgent Need to Review the Use of CTOs and Compliance with the UNCRPD Across Australian Jurisdictions' (2021) 28(1) *International Journal of Mental Health and Capacity Law* 3, 7–8.

[1304] See SALRI Recommendation 23 and 35.

[1305] Office of the Chief Psychiatrist, *Annual Report of the Office of the Chief Psychiatrist 2021-22* (SA Health, 30 September 2022).

[1306] *Inquest into the Death of Theo Nikolas Papageorgiou* (2021) 09/2020 (0176/2016) SACC [16.10(2)] (Schapel, Deputy State Coroner).

[1307] Office of the Chief Psychiatrist, *Annual Report of the Office of the Chief Psychiatrist 2021-22* (SA Health, 30 September 2022).

(iii) hospitals in regional areas that administer mental health services being provided with the ability and resources to administer level 2 Inpatient Treatment Orders.[1308]

5.5.24 During the Inquest into Theo's death, the inability of the local regional hospital – the RGH at Berri – to administer Level 2 ITOs under the *MHA* was considered at length by the Deputy Coroner. On this point, the Deputy Coroner observed:

> … the limited ability of the RGH at Berri to accommodate inpatients detained under a level 2 ITO created an atmosphere of deterrence against imposing this measure on a patient already detained at the RGH at Berri under a level 1 ITO. To my mind such a circumstance should never be repeated at any other country medical facility.[1309]

5.5.25 During the Inquest it was noted that the RGH is now authorised to treat consumers placed under an ITO 2.[1310] However, it remains to be seen whether this issue is more widespread among regional hospitals, or indeed whether similar changes have been implemented at other regional hospitals. At the time of drafting of SALRI's Report, the final report on the review into regional mental health services has not yet been published. However, this report is expected to be completed in late 2022, which will provide important insight into the state of mental health services in regional, rural and remote South Australia, including issues concerning ITOs, with a view to making suitable improvements to the provision of mental health services for consumers residing in those areas.

5.5.26 Concerns were repeatedly expressed to SALRI, notably on all its regional trips, regarding the availability of appropriate mental health services and support in regional, rural and remote areas. SALRI notes that the findings and recommendations of the Regional Mental Health Services will be of interest when the final report is released.

Aboriginal Communities

5.5.27 A number of parties told SALRI of their concern at what was seen as the disproportionate number of Aboriginal people on ITOs or CTOs in South Australia.

5.5.28 Data released by the OCP consistently demonstrates that Aboriginal persons are more likely to be subject to an ITO compared with the general population. In the 2015-16 Annual Report, the OCP observed 'Aboriginal and Torres Strait Islander people are much more likely to be on an ITO of any duration compared to the general population, being nearly four times the rate for a level 1, 5 times for a level 2 and 6 times for a level 3.'[1311]

5.5.29 For the 2016-2017 period, this figure increased to five times more likely for ITO 1s and remained consistent for ITO 2s and ITO 3s.[1312] It was noted in the 2017-2018 period that ITOs rates are 'moderately higher' for Aboriginal communities, with the data indicating that '6.9% for ITO1s,

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[1308] *Inquest into the Death of Theo Nikolas Papageorgiou* (2021) 09/2020 (0176/2016) SACC [16.10(2)] (Schapel, Deputy State Coroner).

[1309] *Inquest into the Death of Theo Nikolas Papageorgiou* (2021) 09/2020 (0176/2016) SACC [16.10(2)] (Schapel, Deputy State Coroner) [15.5].

[1310] Ibid [12.3].

[1311] Office of the Chief Psychiatrist, *Annual Report of the Office of the Chief Psychiatrist 2021-22* (SA Health, 30 September 2022).

[1312] Office of the Chief Psychiatrist, *The Year in Review* (2022) <https://www.chiefpsychiatrist.sa.gov.au/policies-standards-and-reports/reports/annual-report-of-the-chief-psychiatrist> 33. This also seems to be the case for CTOs. See also Steve Kisely, Katherine Moss, and Dan Siskind, 'Efficacy of Compulsory Community Treatment and Use in Minority Ethnic Populations: A Statewide Cohort Study' (2020) 54(1) *Australian and New Zealand Journal of Psychiatry* 76.

6.3% for ITO2s and 10.7% for ITO 3s,'[1313] when compared to the general population, which is 5.5%.[1314] This is also reflected in the 2018-19 Annual Report.[1315] The 2019-2020, 2020-21 and 2021-22 Annual Reports, data suggests that Aboriginal communities were still subject to an ITO at 'slightly higher' rates than the general population for all three reporting periods.[1316]

5.5.30 In the OCP Annual Report 2021-22, it was noted that a number of mental health strategies continued to be provided to South Australia's Aboriginal communities with a view to 'provide oversight and strategic advice for implementing positive changes for mental health service provision'.[1317]

5.5.31 A key initiative in this reporting period was the continued development of the Aboriginal Health and Wellbeing Centre, which aims to improve mental health services to Aboriginal and Torres Strait Islander communities across South Australia.[1318] On this point, the OCP remarked that the Aboriginal Health and Wellbeing Centre will 'significantly improve access to care and treatment to complement and link to existing services, including mental health and broader social and emotional wellbeing services.'[1319]

5.5.32 Aboriginal communities' overrepresentation in South Australia's rates of involuntary treatment orders is also reflected in other jurisdictions. For instance, Wharehoka argues that mental health law is in need of reform as 'the most recent report on mental health services in New Zealand highlight[s] that Māori were disproportionately overrepresented in compulsory assessment and treatment under the [legislation].'[1320] However, Wharehoka cogently argues against strict implementation of the *CRPD* to reform mental health laws in New Zealand, observing that it fails to take Māori perspectives of autonomy into account, especially in the context of decision-making processes and is inherently flawed as it is based on Western notions of autonomy.

5.5.33 SALRI is of the view that further examination is necessary as to the apparent prevalence of ITOs in Aboriginal communities and the wider implications of ITOs.[1321]

[1313] Office of the Chief Psychiatrist, *Annual Report of the Office of the Chief Psychiatrist 2021-22* (SA Health, 30 September 2022).

[1314] Office of the Chief Psychiatrist, *Annual Report of the Office of the Chief Psychiatrist 2017-18* (SA Health, 30 September 2018).

[1315] Ibid 35.

[1316] Ibid; Office of the Chief Psychiatrist, *Annual Report of the Office of the Chief Psychiatrist 2020-21* (SA Health, 30 September 2021) 37; Office of the Chief Psychiatrist, *Annual Report of the Office of the Chief Psychiatrist 2021-22* (SA Health, 30 September 2022).

[1317] Office of the Chief Psychiatrist, *Annual Report of the Office of the Chief Psychiatrist 2021-22* (SA Health, 30 September 2022).

[1318] Ibid.

[1319] Ibid.

[1320] Toni Wharehoka, 'Disability Rights and Compulsory Psychiatric Treatment: the Case for a Balanced Approach under the Mental Health (Compulsory Assessment and Treatment) Act 1992' (2021) *Victoria University Wellington Law Review* 221.

[1321] See SALRI Recommendation 23.

CALD Communities

5.5.34 It is increasingly reported that ITO rates are disproportionately higher for persons from CALD communities[1322] in both national and international jurisdictions, such as the UK.[1323] In the OCP Annual Report 2021-22, the Chief Psychiatrist observed that there are 286,206 people living in South Australia who were born overseas in countries where English is not considered the first language, and have been identified as coming from a CALD background.[1324] For this reporting period, the OCP noted that a total of 10.7% (1038) of all ITOs imposed on persons during this period were from a CALD background.[1325] During this reporting period, the rates of Level 2 and Level 3 ITOs were slightly higher for persons from a CALD background when compared to the general population, being 13.2% and 11.5% respectively.[1326]

5.5.35 The OCP commenced recording ITO data for persons from CALD communities in their 2017-18 Annual Report.[1327] Therefore, there is no data available for the 2015-16 and 2016-17 reporting periods. In the 2017-18 Annual Report, the OCP noted that 'the proportion of CALD people subject to ITOs is moderately higher, at 8.8% for ITO 1s, 11.8% for ITO 2s and 10.7% for ITO 3s, than their proportion in adult acute inpatient services of 6.7%.'[1328]

5.5.36 A similar pattern was reflected in the 2018-19, 2019-20 and 2020-21 Annual Reports from the OCP, where the figures show that the rate of all levels of ITOs imposed on persons from CALD communities were moderately higher than the general population. It is evident that there has been a significant increase in the number of ITOs imposed on persons from CALD backgrounds commencing the 2019-20 reporting period, which has remained largely consistent up to and including the 2021-22 reporting period.

5.5.37 The lack of availability of accredited interpreters or translators for persons from a CALD community was raised during SALRI's consultation. This issue was raised during SALRI's co-facilitated Focus Group with Multicultural Communities Council of SA. It was noted the lack of appropriate translators or interpreters is a concern, especially for older migrants suffering from mental health and memory issues.

5.5.38 SALRI is of the view that further examination is necessary as to the apparent prevalence of ITOs for CALD communities and the wider implications.[1329]

[1322] Culturally and Linguistically Diverse communities.

[1323] UK Government, *Modernising the Mental Health Act: Increasing Choice, Reducing Compulsion – Final Report of the Independent Review of the Mental Health Act 1983* (December 2018) 10, 58–9.

[1324] Office of the Chief Psychiatrist, *Annual Report of the Office of the Chief Psychiatrist 2021-22* (SA Health, 30 September 2022).

[1325] Ibid.

[1326] Ibid.

[1327] Office of the Chief Psychiatrist, *Annual Report of the Office of the Chief Psychiatrist 2017-18* (SA Health, 30 September 2018).

[1328] Ibid. This over-representation also emerges with respect to CTOs in CALD communities. See below Part 6 Community Treatment Orders at [6.4.53]–[6.4.57]. See also Steve Kisely, Yong Yu and Dan Siskind, 'A Systematic Review and Meta-Analysis of Predictors and Outcomes of Community Treatment Orders in Australia and New Zealand (2021) 55(7) *Australia and New Zealand Journal of Psychiatry* 649.

[1329] See SALRI Recommendation 23.

Persons with a Disability

5.5.39 Data concerning the number of persons with a disability subject to an ITO is not currently provided in the annual reports published by the OCP. Therefore, it is not possible to comment on this in the South Australian context.

Child and Adolescent Mental Health

5.5.40 Recent statistics indicate that the proportion of ITOs placed on children aged between 0 – 15 years is low, with the OCP Annual Report 2021-22 indicating that a total of 35 ITO 1s were made for this age group. In the 2020-2021 reporting period a similar percentage of ITO 1s were reported.[1330]

5.5.41 SALRI notes that a number of submissions and comments raised concerns about children being placed in wards with adult patients. Parties, notably the Citizens Commission on Human Rights, called for this practice to be criminalised. SALRI was told by more than one party in consultation that this practice does not occur in South Australia.

5.5.42 It was also raised during consultation that there is a misunderstanding concerning how the ITO criteria apply to children. It was further noted in consultation with SALRI that youth and adolescent mental health services are lacking in rural, regional and remote areas, and it is 'very difficult' for children to receive treatment for mental illness outside of metropolitan Adelaide.

5.5.43 SALRI notes that the use of ITOs on children is a sensitive issue (as a number of parties such as the Commissioner for Children and Young People and the Commissioner for Aboriginal Children and Young People raised in consultation). In 2018, the OCP commenced a Review of Youth Mental Health Services in South Australia.[1331] The impetus for the review stemmed from 'specific service delivery issues for young people [including] barriers to seeking help', poor access to services and service gaps between child and adolescent mental health services and adult mental health services.[1332]

5.5.44 SALRI notes that 'consideration of these findings and ways to address them, has been incorporated into the South Australian Mental Health Services Plan 2020-2025'.[1333]

5.5.45 SALRI has also suggested that further consideration needs to be given to the application of the *MHA* to children and adolescents.[1334]

Older Persons and Mental Health

5.5.46 The OCP Annual Report 2021-22 indicated that the prevalence of all levels of ITOs declined for older Australians.[1335] However, there was a spike in Level 3 ITOs for 55-64 age group,

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[1330] Office of the Chief Psychiatrist, *Annual Report of the Office of the Chief Psychiatrist 2021-22* (SA Health, 30 September 2022).

[1331] Alessandra Radovini, *Youth Mental Health Service Provision in South Australia: Final Report* (March 2019).

[1332] Ibid 3–4.

[1333] Office of the Chief Psychiatrist, *Review of Youth Mental Health* (2023) <https://www.chiefpsychiatrist.sa.gov.au/policies-standards-and-reports/reports/reviews-and-investigations/chief-psychiatrist-reviews>.

[1334] See SALRI Recommendation 11.

[1335] Office of the Chief Psychiatrist, *Annual Report of the Office of the Chief Psychiatrist 2021-22* (SA Health, 30 September 2022).

with 15.4% of ITOs imposed.[1336] A similar pattern was reflected in the 2020-2021 reporting period. However, there was a spike in ITO 3s for 55-64 age group, with 15.3% of ITOs imposed, and in the 75-84 age group with 11.9% of ITOs imposed.[1337]

5.5.47 The application of the *MHA* for neurocognitive disorders, otherwise colloquially known as 'dementia', is an issue that requires further consideration.

Use of ITOs for Drug and Alcohol Addiction

5.5.48 SALRI notes that many consultees, notably practitioners, agencies and NGOs working in this area, raised that drug and alcohol abuse and mental illness should not necessarily be viewed as separate and distinct. There is a degree of overlap and are often concomitant issues. However, there was a division in consultation between treating teams with drug and alcohol abuse issues being treated by Drugs & Alcohol Services South Australia ('DASSA') and not mental health teams and vice versa. One view was drug and alcohol related issues or conditions should not be treated under the *MHA*. Others took a more nuanced approach – integrating DASSA within mental health wards.

5.5.49 One participant in SALRI's regional consultation said that 'treatment of drug and alcohol issues shouldn't preclude the treatment of mental health issues – both should be looked at simultaneously.' Another participant at a regional consultation remarked there is a 'need to, to some extent, treat drug and alcohol and mental health issues at the same time. People here are definitely self-medicating with drugs and alcohol.' Other consultees shared this view.

5.5.50 Another consultee observed that in regional South Australia, Aboriginal communities were overrepresented with drug and alcohol abuse and mental illness. During SALRI's regional consultation, concerns were raised that persons were not offered treatment for mental illness unless they had received treatment for underlying drug and alcohol abuse, with several consultees noting limitations with this response.

5.6 Consultation Data Overview

5.6.1 There were divergent views as to the role and value of ITOs, particularly by consumers and consumer groups.

5.6.2 Health practitioners and others viewed ITOs as necessary in suitable and carefully defined circumstances, notably for consumers with impaired decision-making capacity, and where there is clear clinical benefit for the consumer.

5.6.3 A number of parties in consultation and survey respondents expressed their opposition to the premise of involuntary detention and treatment. Several community-based submissions requested that involuntary admission and treatment should be ceased, whilst another community member called involuntary treatment a 'gross violation of human rights.' One submission said that 'involuntary detainment and treatment' should be 'eliminated in the law as per the World Health Organization's and United Nations instructions with heavy criminal penalties for each instance of these

[1336] Office of the Chief Psychiatrist, *Annual Report of the Office of the Chief Psychiatrist 2021-22* (SA Health, 30 September 2022).

[1337] Ibid.

occurring.'[1338] Other consultees and survey responses provided similar views. Another submission declared:

> Involuntary detainment must be abolished from the Act, particularly and especially for children. This is an absolute gross violation of rights, and is extremely difficult or impossible for a patient or family member to fight. Involuntary incarceration is based entirely upon opinion of a psychiatrist(s). There is no laboratory test or evidential proof of any 'chemical imbalance' in any person's brain. There is no acceptable definition of mental illness that isn't wildly subjective and based upon opinion only. How can psychiatric incarceration be considered anything but a gross violation of human rights?

5.6.4 The Citizens Commission on Human Rights[1339] expressed its strong objections to 'coercive psychiatric practices', noting such practices are unwarranted on policy and human rights grounds and are not effective. They said that South Australians 'are still being involuntarily detained and treated against their will', including restraint and seclusion, but 'also potentially dangerous psychotropic drugs if they are on an involuntary treatment order or a community treatment order'. Citizens Commission on Human Rights argued that 'involuntary detainment and involuntary treatment are made criminal offences under the SA *Mental Health Act* with criminal fines and prison terms for each instance. Only a Judge should have the power to order the forced detainment of a person.'

5.6.5 There were other concerns as to the operation of ITOs. For instance, the OCP's Human Rights and Coercion Reduction Committee observed that the Statement of Rights provided to consumers subject to an ITO is often otiose due to its inability to be easily understood by consumers with diverse literacy skills and consumers who are experiencing high levels of mental health distress. Further, this poses a real issue for Aboriginal and CALD consumers. The Committee also highlighted that ensuring people understand their rights 'is a good practice to gain control and power over their lives.' It was further noted that:

> The current Act requires that a statement of rights be provided. A new Act could require that as well as the provision of written rights, that the rights be explained, with the expectation that they be understood. Services could take a number of steps when rights are not understood including requiring that a person be referred to either peer workers, community visitors, lay advocated, or other suitable officers to meet with a person and explain rights and to provide ongoing support in exercising rights if required.

5.6.6 A common theme raised by many consumers during SALRI's Focus Group discussions, was the issue of coercion and control. Many consumers viewed the coercive powers permitted under the *MHA* not to be conducive to recovery and understanding about mental illness. One consumer noted that when they were placed under an ITO, it 'felt like a mechanism to control me and not to improve my condition'. Other consumers noted there was very little collaboration with them concerning what treatment was included in an ITO. Further, treatment under an ITO was described as controlling and that fear of being detained as a form of punishment acted as a barrier for consumers

[1338] This party added: 'I am now 55 years old, when I was only 18 years old I was forcibly detained and subjected to treatment- very much against my will, not one person was interested in the fact that I didn't want to be treated. I found that particularly degrading and after two weeks I was let out and I was in horrible shape, couldn't sleep couldn't concentrate, couldn't work.'

[1339] SALRI notes the detailed submission of Citizens Commission on Human Rights. They explained 'CCHR was established in 1969 by the Church of Scientology and Professor of Psychiatry the late Dr Thomas Szasz, as an independent body to investigate and expose psychiatric violations of human rights and to clean up the field of mental health ...'.

to proactively access voluntary treatment. SALRI was also advised that consumers, when placed under an ITO were unaware and did not understand what was happening.

5.6.7 During SALRI's Medical Specialist Roundtable, it was noted there should be an onus on the person making the ITO to justify the proposed treatment, as opposed to the psychiatrist upon review for confirmation or revocation. It was agreed that providing written reasons was important.

Use of Force under ITOs

5.6.8 Currently, s 34A of the *MHA* confers certain powers to enforce an ITO. This provision enables treatment centre staff to take measures for the confinement of a consumer or use of force reasonably required in the circumstances for carrying out the ITO and ensuring compliance with the *MHA*. These powers can also assist in the maintenance of the ITO, security at the centre or the prevention of harm or nuisance to others.

5.6.9 SALRI notes there were divergent views concerning whether health or other staff under the *MHA* should be allowed to detain and use force on persons subject to an ITO.

5.6.10 Various bodies such as the RANZCP submitted '…the current arrangements for authorised officers (ambulance officers, police and hospital staff) to use reasonable force as necessary should remain.' However, they prefaced this with '…every effort should be made to ensure that consumers are treated in the least restrictive environment and in the least restrictive manner possible, the RANZCP supports these powers under the *MHA*.'

5.6.11 The Australian Psychological Society were of the view that:

> … coercive powers (including detention, the use of force and restrictive practices) cannot be considered to be a desirable feature of contemporary mental health legislation. Coercive powers are not only incompatible with a rights-oriented mental health framework but can also undermine the psychological, therapeutic and relational factors which promote recovery. The goal should be to have a mental health system that does not require coercive powers and restrictive practices.

5.6.12 SALRI has considered the broad issue of the use of reasonable force under the *MHA* elsewhere.[1340] SALRI is of the view that, consistent with existing law, it is necessary under limited circumstances, to authorise the use of force for the purposes of enforcing an ITO.

5.6.13 Accordingly, s 34A of the *MHA* does not require change in relation to the measures already allowed to enforce an ITO.[1341] The law should continue allowing the use of reasonable force as a last resort by medical practitioners and authorised officers who have undergone suitable training.

The Definition of 'treatment'

5.6.14 SALRI notes that there were differing views whether the definition of 'treatment' should be amended in the *MHA* to include an assessment or other medical/health issues.

5.6.15 Consultation revealed the current definition of treatment under the *MHA* is ambiguous.[1342] The *MHA* requires that the treatment given to a person under an ITO must fall within

[1340] See Part 9 Role of Police.

[1341] See *Mental Health Act 2009* (SA) s 34A.

[1342] Ibid s 24(1).

this definition, which generally requires that any authorised treatment must have a connection to the person's mental illness.

5.6.16 Given the law emphasises respect for individual autonomy, recognising few exceptions to this rule, it is likely that treatment for chronic medical conditions without the patient's consent would be beyond the scope of the current definition. Further, while emergency medical treatment provisions can be utilised in a medical emergency,[1343] it must be ensured that the person has impaired decision-making capacity, requires treatment to meet an imminent threat to life or health, has not refused the treatment and has the written consent of two medical practitioners.

5.6.17 The existing provisions under the *Guardianship and Administration Act 1993* (SA) ('*GA Act*') are the most likely avenue for recourse if a person subjected to an ITO requires treatment for a medical condition or illness. However, SALRI notes that the requirements of the legislative framework under the *GA Act* may act as barriers to providing treatment for medical conditions or illnesses for persons subjected to an ITO.

5.6.18 The *GA Act* also provides an avenue for administration of medical treatment for protected persons to provide 'proper medical or dental treatment, day-to-day care and well-being of the person.'[1344]

5.6.19 Section 32 of the *GA Act* permits SACAT to make orders in relation to protected persons. SACAT has considerable authority under s 32, including orders that the person be detained in a place where they will reside which includes administration of medical treatment, subject to satisfaction of specific criteria. However, s 32 orders only apply to protected persons under the *GA Act*.

5.6.20 Protected persons are defined as persons subject to a guardianship order under the relevant Act.[1345] SACAT can make a guardianship order for a person if they are satisfied that the person has a mental incapacity and an order for limited or full guardianship should be made for that person.[1346] Section 32 orders under the *GA Act* permit SACAT, upon application, to make special orders for protected persons, including authorising 'persons from time to time involved in the care of the person to use such force as may be reasonably necessary for the purpose of ensuring the proper medical or dental treatment, day-to-day care and well-being of the person.'[1347] However, an order can only be made on the grounds that the health of a person would be seriously at risk if the order were not made.[1348]

5.6.21 SALRI recognises there were different views concerning whether the definition of treatment should be expanded under the *MHA*. For example, Mind Australia proposed:

> We should prioritise the physical health of people experiencing mental ill-health. However, we are concerned about this being via expansion of treatments included under ITOs. We are concerned expansion of the definition of treatment will lead to increased use of ITOs. ITOs should be used as a last resort, with the focus instead on providing voluntary treatment in-line with a human rights and supported decision-making approach wherever possible.

[1343] *Consent to Medical Treatment and Palliative Care Act 1995* (SA) s 13.

[1344] *Guardianship and Administration Act 1993* (SA) s 32.

[1345] Ibid s 3 (definition of 'protected person').

[1346] Ibid s 29(1).

[1347] Ibid s 32(1)(c).

[1348] *Guardianship and Administration Act 1993* (SA) s 32(2).

5.6.22 SALRI acknowledges this concern and agrees that treatment of medical conditions should be provided on a voluntary basis to the greatest extent practicable. This was reinforced in SALRI's Medical Specialist Roundtable, where participants agreed that if the patient has capacity to make a decision about other treatment or medication, their consent or refusal is respected. RANZCP also raised this in their submission to SALRI, noting '[w]here possible the consumer should still be asked to provide consent if they have capacity to do so, and if not then every effort should be made to undertake a shared decision making process to provide that consent.'

5.6.23 This was also raised in SALRI's Nursing and Social Work Roundtable. Mental health nurses informed SALRI about the practice involved in administering non-psychiatric medication for patients under an ITO. They will talk to the patient, seek consent and return at a later time if necessary.

5.6.24 RANZCP supported clarification and further consultation with relevant stakeholders:

> This issue does need resolution and a clear path forward, either as part of the *MHA* or clearly covered in other Acts. A more focused and nuanced discussion with all stakeholders will be required. Some initial considerations:
>
> 1) Expansion of ITOs to include an assessment of mental health issues seems both logical, unproblematic and within the intent of the legislation.
>
> A diagnosis and specific treatment is not always clear on a first assessment and occasionally a period of longitudinal assessment of a few days is required before it is clear what (if any) treatment is appropriate. Sometimes treatment itself is the containment and support of the hospital environment and staff.
>
> 2) It would seem logical that *some* medical treatments could be provided under the provisions of an ITO, e.g. medication for diabetes…
>
> 3) This notwithstanding, treatment for physical health problems for people under an ITO should not mean that standard consent to medical procedure processes would not need to be undertaken.
>
> Any medical intervention which would normally require a consent form to be signed, should be outside of the scope of ITOs. These should be covered under the scope of the *Guardianship and Administration Act 1993* or a separate Act.
>
> Any report intended for legal or insurance purposes should also continue to be subject to consent procedures.

5.6.25 The Central Adelaide Local Health Network ('CALHN') also agreed:

> … the *MHA* should include assessment and/or treatment of other medical /health issues as it has been noted that following amendments in 2016, involuntary assessment/treatment of medical issues consequent to mental illness with impaired decision-making capacity were not seemingly allowed for by the *MHA*. Examples included the prescription of an infusion of antidote following an overdose or the treatment of injuries following a deliberate motor vehicle accident in the context of Major Depression and a suicide attempt. A change to include involuntary treatment of these related medical issues would provide clarity and safeguard clinicians providing appropriate treatment in such circumstances.

5.6.26 Consultation with psychiatrists also revealed that in the context of older persons, the definition of 'treatment' is particularly relevant as physical conditions are closely related to mental health. CALHN agreed, submitting '[t]he situation becomes more complex when one considers the

use of the *MHA* for the involuntary detention and treatment/management of persons with progressive neurological disorders or dementia.'

5.6.27 In their submission to SALRI, CALHN offered an example:

> A person detained under the *MHA* should primarily be detained in order to treat the mental illness, but it is a false dichotomy to suggest that psychiatric treatment and treatment of medical or other health issues are separate. Mental illness and disorders can be caused by a range of medical conditions.
>
> A simple example may be a Manic Episode caused by prescription of a steroid. The treatment for the manic episode may require involuntary treatment in a secure mental health unit to protect the person from typical behaviours associated with mania, such as driving too fast, overspending and uncharacteristic promiscuity. The person is likely to require the administration of antipsychotic and/or mood stabilising medications through supported decision-making and/or in an involuntary capacity. However, the primary treatment will include cessation of the persons 'medical' treatment, ie the steroid that caused the mania. The person is likely to lack capacity to make informed consent to the cessation of a medication that makes them feel euphoric and full of energy, yet it is not a psychiatric medication, it had been prescribed for a 'medical' reason. The person would also need blood tests and possibly other investigations when making the initial diagnosis and for the safe initiation of medications (such as Lithium for example), or the safe monitoring of treatment. Strictly applied, a *MHA* that only applies to a person's mental illness/disorder and did not allow for 'medical' investigation and/or treatment would require application to the South Australian Civil and Administration Tribunal (SACAT) for an alternative decision-maker, an untenable situation that is not entertained as the Act is currently applied in practice.

5.6.28 Another example frequently raised to SALRI by medical practitioners was the monitoring of bloods for patients on Clozapine – an anti-psychotic medication. The issue concerned whether a blood test, required to monitor Clozapine levels, fell within the remit of the current 'treatment' definition. As raised by CALHN in the context of Lithium levels, regular bloods are required to ensure safe monitoring of treatment. SALRI's Medical Specialist Roundtable revealed a consensus that there was benefit in the definition's ambiguity. It was described as a clinical judgment. It was agreed that if an issue is a direct cause or consequence of the mental illness, the *MHA* should be invoked.

5.6.29 One party highlighted to SALRI the need to address untreated medical conditions which are likely to have been neglected due to the existence of mental illness, stating:

> … where an individual is determined to lack capacity regarding their mental health, if they are also determined to lack capacity regarding other health issues and failure to address these issues may result in harm or a significantly increased risk of harm to their wellbeing (and there are no advanced care directives to the contrary) then treatment should be expanded to include assessment of these issues.

5.6.30 Lived Experience Australia opposed broadening the definition of 'treatment'. They asserted that treatment 'MUST relate specifically to mental illness and the person's decision-making capacities. Expanding the definition would allow more powers to detain and use force against a person. As such, LEA feels very strongly that the definition of treatment should remain as is within the *MHA*.'

5.6.31 SALRI notes that the use of ITOs is unlikely to increase in South Australia if the definition of treatment were expanded or amended under the *MHA* to include provision of medical treatment, as the foundational criteria for imposition of an ITO would remain consistent. Any medical treatment

provisions would only be engaged in situations where the person is under an ITO and would not operate as a relevant criterion for imposition of an ITO.

5.6.32 The majority (69%) of SALRI's YourSAy survey respondents were in favour of expanding the definition of treatment to include treatment for medical illnesses and conditions under ITOs. Only 29% disagreed, with 2% remaining undecided.

5.6.33 Those in favour of expanding the definition often cited the need to adopt a holistic approach to treatment and that there are often underlying medical illnesses that have been left untreated due to the presence of mental illness. Those against expanding the definition cited a variety of reasons including the right to autonomy, the avoidance of coercive practices and the existence of other laws, such as the *GA Act*, as an appropriate mechanism to treat medical conditions.

5.6.34 The Legal Services Commission and the Office of the Public Advocate ('OPA') suggested a modest change to 'treatment' in the *MHA* to clarify what can be validly carried out. The OPA submitted '…it may be appropriate to consider changes whereby injuries or illnesses which are 'causing, contributing or connected to' the person's mental illness are captured and able to be treated under the powers of the ITO.' SALRI supports this suggestion. It is a logical and worthwhile measure that will clarify the law without diminishing the central premise of valid consent or the ability of a consumer to refuse treatment.[1349]

5.7 SALRI's Observations and Conclusions

5.7.1 SALRI reiterates there are differing views in both research and consultation as to the value or otherwise of ITOs. These views cannot be reconciled.

5.7.2 The use of coercive powers such as the power to detain and treat consumers involuntarily under an ITO was a regular issue of concern during consultation. Many consumers relaying negative experiences when placed under an ITO, as well as some advocacy groups and professional bodies expressing unease toward the use of coercive powers.

5.7.3 SALRI acknowledges the various concerns expressed to it as to the use of ITOs. An ITO is an option that has drastic implications for the patient, their carer and families. However, SALRI is of the view that it would be inappropriate and undesirable to preclude the making of an ITO under the *MHA*.

5.7.4 As noted by medical practitioners and others, ITOs serve an important function in protecting individuals who are acutely unwell, lack decision-making capacity and the wider community from harm. Involuntary treatment, as the then South Australian Chief Psychiatrist, Dr Panayiotis Tyllis, explained in 2014, 'can be life-saving and may be the best of several difficult options for a patient or their support persons in challenging situations.'[1350] SALRI acknowledges the making of an ITO should always be carefully considered and used only as an option of last resort in accordance with principles of least restrictive practices to respond to a mental health crisis.[1351]

[1349] See SALRI Recommendation 24.

[1350] Office of the Chief Psychiatrist, *The Review of the Mental Health Act 2009 - A Report by the Chief Psychiatrist of South Australia* (SA Health, 23 May 2014) foreword.

[1351] In a study published in 2015, Zhang et al performed a statutory review of the criteria for imposition of involuntary treatment orders. The statutory review included diverse countries including districts of Europe, the Americas, Australasia and Asia with a view to recommending a standardised approach to involuntary detention and treatment

5.7.5 SALRI concurs that the *MHA* is a crisis-focussed statute designed to treat persons with acute mental illness, which requires a balancing of competing interests such as the consumer's welfare, the consumer's right to autonomy and supported decision-making. SALRI's position is that ITOs should be retained in their current form under the *MHA*. However, SALRI emphasises the importance of substantive and procedural safeguards, including its use as a 'last resort' and the requirement that impaired decision-making capacity remain one of the criterions for the imposition of an ITO (or CTO).[1352]

5.7.6 The rate of ITOs in South Australia is significant. SALRI, consistent with its position as to the prevalence of CTOs,[1353] considers any effort as part of the current review, to reliably explain the high rate of ITOs compared with other Australian states would be unduly speculative. SALRI is of the view that further detailed consideration with the use of empirical demographic data is necessary to shed light on the factors to account for the rate of ITOs in South Australia and their implications, especially for CALD and Aboriginal consumers. These are all complex and multi-faceted questions.[1354]

5.7.7 SALRI accepts that the present concept of harm in the *MHA* for the making of an ITO (or CTO)[1355] is too low a threshold. SALRI accepts the threshold of 'harm' is simply too low to warrant the considerable intrusion and effects of an ITO on a consumer. The threshold of 'serious harm' for the making of an ITO (or CTO) exists elsewhere in Australia[1356] and is also consistent with medical practice and the rationale of CTOs and ITOs.[1357] Such orders should not be lightly made.

5.7.8 The qualification of 'serious harm' is also contained within the new Victorian Act. Therefore, SALRI proposes that the *MHA* should be amended to incorporate 'serious harm' as the relevant threshold for the making of either an ITO or CTO. SALRI considers the ACT provision of 'serious harm' provides the preferable statutory construction for the making of an ITO (or CTO). Under the *MHA* (ACT) provision, the relevant decision maker 'believes on reasonable grounds that, because of the mental disorder (in South Australia, mental illness), the person is doing, or is likely to

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criteria in the 'mainland of China and to contribute to improved mental-health care,' see Simei Zhang et al, 'Involuntary Admission and Treatment of Patients with Mental Disorder' (2015) 21(1) *Neuroscience Bulletin* 99, 111. Although there were variations concerning the statutory criteria for placement of an ITO, similarities were evident among the majority of jurisdictions. It was observed by Zhang that 'a diagnosed psychiatric disorder, imminent danger to self or to others, a causal link between the disorder and the danger, and the need for treatment, are the most frequently used determinants set out by the legal requirements for compulsory disposition' at 111.

[1352] See SALRI Recommendation 15.

[1353] See also Lisa Brophy et al, 'The Urgent Need to Review the Use of CTOs and Compliance with the UNCRPD Across Australian Jurisdictions' (2021) 28(1) *International Journal of Mental Health and Capacity Law* 3, 7–8.

[1354] See SALRI Recommendation 23.

[1355] See Part 6 Community Treatment Orders.

[1356] *Mental Health Act 2014* (WA) s 25(2)(b)(ii); *Mental Health Act 2014* (Vic) s 5(b)(ii); *Mental Health Act 2015* (ACT) s 66(2)(c).

[1357] It is also of interest that an amendment to the *Mental Health Act 2009* (SA) to impose serious harm as the criteria for a CTO or ITO was unsuccessfully moved in the 2009 parliamentary debate. See South Australia, *Parliamentary Debates*, Legislative Council, 30 April 2009, 2002–8. The Hon David Winderlich MLC, moving this amendment, noted the drastic effects of both an ITO and CTO and argued that 'harm' was too low a threshold to warrant such orders and the significant restrictions on a consumer's civil rights and 'serious harm' was the preferable test. Mr Winderlich quoted the Bidmeade review: 'It should be clarified that a mentally ill person can be detained or ordered to have treatment where there is a serious likelihood of immediate or imminent harm to the person or others, or serious deterioration in the person's physical or mental condition': at 2203. The amendment was opposed on the basis that 'serious harm' was too high and subjective as a test and would frustrate early intervention and treatment. See South Australia, *Parliamentary Debates*, Legislative Council, 30 April 2009, 2003–5.

do, serious harm to themself or someone else; or is suffering, or is likely to suffer, serious mental or physical deterioration.'[1358]

5.7.9 SALRI considered, consistent with its approach to CTOs, whether the existing three levels of ITOs should be replaced with a single universal ITO. SALRI recognises the value of consistency. However, the operation of CTOs and ITOs is quite distinct. The rationale for a single ITO does not exist. No party in consultation raised discarding the current three levels of ITOs, nor did they favour a single ITO. Therefore, SALRI recommends that the three levels of ITOs should be retained.

5.7.10 SALRI emphasises the importance of revoking an ITO when the patient no longer meets the criteria. Further, an authorised psychiatrist may transition a person from an ITO to a CTO at any time if they are of the opinion that an ITO is no longer the least restrictive practice available to treat the consumer's mental illness.

5.7.11 SALRI acknowledges the legitimate concerns that have been raised in consultation regarding children and ITOs. SALRI recommends that the *MHA* should include specific provisions to further safeguard children subjected to an ITO.

5.7.12 Recommendations

RECOMMENDATION 20

SALRI recommends that the term 'appropriate' in relation to 'the person has impaired decision-making capacity relating to *appropriate* treatment of the person's mental illness', contained in ss 10(1)(c), 16(1)(c), 21(1)(ba), 25(2)(ba) and 29(1)(ba) of the *Mental Health Act 2009* (SA) should be removed.

RECOMMENDATION 21

SALRI recommends that the *Mental Health Act 2009* (SA) should be amended to include 'serious harm' as a threshold criterion for the imposition of an Inpatient Treatment Order.[1359]

RECOMMENDATION 22

SALRI recommends that the existing three Levels of Inpatient Treatment Orders in the *Mental Health Act 2009* (SA) should be retained.

[1358] *Mental Health Act 2015* (ACT) s 66(2)(c).

[1359] SALRI prefers the ACT definition of 'serious harm'. Section 58(2) of the *Mental Health Act 2015* (ACT) provides the relevant tribunal may make the counterpart of an Inpatient Treatment Order if it 'believes on reasonable grounds that, because of the mental illness, the person is doing, or is likely to do, serious harm to themself or someone else; or is suffering, or is likely to suffer, serious mental or physical deterioration'.

RECOMMENDATION 23

SALRI recommends that further research, analysis and interrogation of data concerning the general use and effectiveness of Inpatient Treatment Orders is required, including the disproportionately high prevalence of Inpatient Treatment Orders in South Australia for Aboriginal people and Culturally and Linguistically Diverse people.[1360] SALRI further recommends that such findings should be reported in the Chief Psychiatrist's Annual Report under s 92(1)(a) of the *Mental Health Act 2009* (SA).

RECOMMENDATION 24

SALRI recommends that the definition of 'treatment' in ss 24(1), 28(1) and 31(1) of the *Mental Health Act 2009* (SA) should be amended to the treatment of mental illness that may be 'causing, contributing *or connected to'* the person's mental illness.[1361]

RECOMMENDATION 25

SALRI recommends that the Office of the Chief Psychiatrist consider the publication of, or amendments to, existing standards or directives clarifying and offering consistency regarding the definition of the term 'treatment', pursuant to s 90(2) of the *Mental Health Act 2009* (SA).

RECOMMENDATION 26

SALRI recommends that the *Mental Health Act 2009* (SA) should be amended to clarify the scope of s 56 to ensure this power is reasonably used to facilitate an assessment within a timely manner. SALRI further recommends that reference to an 'assessment' should be added within ss 56(3)(c) and (d) of the *Mental Health Act 2009* (SA).

RECOMMENDATION 27

SALRI recommends that the relevant Minister advancing amendments to the *Mental Health Act 2009* (SA) should include specific provisions to safeguard children subject to an Inpatient Treatment Order.

RECOMMENDATION 28

SALRI recommends that the current use of force provisions in the *Mental Health Act 2009* should be retained, whilst recommending for these to be used as a last resort, with the employment of suitable de-escalation techniques.

[1360] This question raises involved issues that are beyond the scope of SALRI's review and also requires empirical data and analysis.

[1361] The Office of the Public Advocate recommended the inclusion of 'connected to'. A similar approach was also suggested by the Office of the Chief Psychiatrist. A common example provided to SALRI in consultation with medical practitioners was administering a blood test to monitor Clozapine levels and whether this fell within the current definition of 'treatment'.

5.7.13 Suggestion

SUGGESTION 7

SALRI suggests that the *Mental Health Act 2009* (SA) be amended to clarify s 56 to ensure this power is used reasonably to facilitate an assessment within a timely manner.

SALRI further recommends that reference to an 'assessment' could be inserted within sections 56(3)(c) and (d) *Mental Health Act 2009* (SA).[1362]

[1362] For example, s 56(3)(d) could be amended to (d) the authorised officer may restrain the person by means of the administration of a drug or an assessment for a treatment order when that is reasonably required in the circumstances.

Part 6 – Community Treatment Orders

6.1 Background

6.1.1 Community Treatment Orders ('CTOs')[1363] are a statutory means by which persons with mental illness receive compulsory community-based treatment. CTOs were first devised as a response to the process of deinstitutionalisation and the shift to community based psychiatric support and treatment in the 1980s, and are now used in over 70 jurisdictions worldwide[1364] at an increasing rate.[1365] Such orders for persons 'with serious mental disorders has become accepted practice in many countries around the world.'[1366] Consumers subject to a CTO are able to receive medical treatment for their mental illness despite the absence of or refusal to consent[1367] while living in the community, rather than in hospital. A CTO is therefore considered a preferable and less restrictive approach to involuntary inpatient treatment (a matter also often expressed to SALRI in consultation).

6.1.2 CTOs are a significant component of the *MHA*. A CTO can only be made when there are no less restrictive ways of ensuring that a person receives appropriate treatment. It should be noted that one of the prerequisites for the making of a CTO in South Australia is that the consumer lacks the capacity to make decisions relating to appropriate treatment of their mental illness.[1368]

6.1.3 It is widely acknowledged that CTOs are powerful instruments which may encroach on consumers' human rights,[1369] including their autonomy and personal integrity,[1370] and have real and significant implications on the consumer.[1371] The UN *Convention of the Rights of Persons with Disabilities*

[1363] In some jurisdictions, statutory orders similar to CTOs for involuntary psychiatric treatment in community settings might be referred to as 'treatment orders' (community), 'community management orders', 'treatment authorities' (community), 'psychiatric treatment orders', 'outpatient treatment orders' or 'outpatient commitment'. See Edwina Light, 'Rates of Use of Community Treatment orders in Australia' (2019) 64 *International Journal of Law and Psychiatry* 83.

[1364] Edwina Light et al, 'How Shortcomings in the Mental Health System Affect the Use of Involuntary Community Treatment Orders' (2017) 41 *Australian Health Review* 35; Lisa Brophy and Fiona McDermott, 'What's Driving Involuntary Treatment in the Community? The Social, Policy, Legal and Ethical Context' (2003) 11 *Australasian Psychiatry: Bulletin of the Royal Australian and New Zealand College of Psychiatrists* S84.

[1365] See, for example, Department for Health and Wellbeing (SA), *Annual Report of the Chief Psychiatrist of Australia* (2021) 35; Edwina Light, 'Rates of Use of Community Treatment Orders in Australia' (2019) 69(4) *International Journal of Law and Psychiatry* 83. The number of CTOs in South Australia has increased from 1,704 in 2015-16 to 2,471 in 2020-21.

[1366] Scott Weich et al, 'Evaluating the Effects of Community Treatment Orders (CTOs) in England Using the Mental Health Services Dataset (MHSDS): protocol for a national, population-based study' (2018) 8(10) *BMJ Open* 1.

[1367] *Mental Health Act 2009* (SA) ss 13(3), 18(3).

[1368] Ibid ss 10(1)(c), 16(1)(c).

[1369] Lisa Brophy and Fiona McDermott, 'What's Driving Involuntary Treatment in the Community? The Social, Policy, Legal and Ethical Context' (2003) 11 *Australasian Psychiatry: Bulletin of the Royal Australian and New Zealand College of Psychiatrists* S84; John Dawson, 'Community Treatment Orders and Human Rights' (2008) 26(2) *Law in Context* 146; Bernadette McSherry, 'Protecting the Integrity of the Person: Developing Limitations on Involuntary Treatment' (2008) 26(2) *Law in Context* 111.

[1370] Bernadette McSherry, 'Protecting the Integrity of the Person: Developing Limitations on Involuntary Treatment' (2008) 26(2) *Law in Context* 111.

[1371] See Edwina Light et al, 'The Lived Experience of Involuntary Community Treatment: a Qualitative Study of Mental Health Consumers and Carers' (2014) 22(4) *Australian Psychiatry* 345. Consumers and consumer groups and others highlighted to SALRI both the emotional and physical effects of CTOs, notably the often drastic effects of certain medications on consumers. The treatment most commonly administered under a CTO is a periodic depot injection of psychiatric medication. See Edwina Light, 'Rates of use of community treatment orders in Australia' (2019) 64 (May–June) *International Journal of Law and Psychiatry* 83, 84. Psychiatric medication is often accompanied

('*CRPD*')[1372] has greatly influenced mental health reform in Australia since its ratification in 2008, and highlights the importance of the individual consumer's autonomy and supported decision-making,[1373] and challenges the concept of involuntary treatment in mental health laws.[1374] The *CRPD* principles are 'reconcilable with capacity-based [mental health] law', which assumes that persons with mental illness have decision-making capacity.[1375]

6.1.4 The role and use of CTOs was a prominent theme in SALRI's consultation and research, attracting much debate and discussion. The role and use of CTOs proved a detailed aspect of SALRI's review of the operation of the *MHA* 'because the issues in this area are complex and there are no jurisdictions where CTOs are managed perfectly.'[1376]

6.1.5 The role of CTOs has been noted as 'controversial in many respects, including concerns about their effectiveness and impact'.[1377] Indeed, it has been said that 'few recent issues in psychiatry have polarised the various stakeholders in the mental health system as much as has the propriety of introducing community treatment orders (CTOs).'[1378] There is a great deal of conflicting research over 30 years as to the utility and effectiveness of CTOs and a lack of consensus in that considerable research that now exists.[1379] To add to the complications, there is even disagreement as to how to best assess the effectiveness of CTOs and resolve the lack of a single reliable indicator.[1380] It has been

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by severe side effects. For example, side effects associated with anti-psychotic medication may include akathisia (an inability to remain still), weight gain, cardiovascular and metabolic side effects, and tardive dyskinesia (an involuntary neurological movement disorder). See Cherrie Galletly et al, 'Royal Australian and New Zealand College of Psychiatrists Clinical Practice Guidelines for the Management of Schizophrenia and Related Disorders' (2016) 50(5) *Australian and New Zealand Journal of Psychiatry* 1, 33; South Australia, *Parliamentary Debates*, Legislative Council, 30 April 2009 2202–3. These side-effects were often raised by consumers to SALRI as to the effects of medication.

[1372] *Convention on the Rights of Persons with Disabilities*, UN GAOR 61st sess, plen mtg 76, Agenda Item 67(b), UN Doc RES A/61/106 (adopted 24 January 2007).

[1373] See Part 2 Background and Context to South Australia's Mental Health Laws.

[1374] Sascha Callaghan and Christopher Ryan, 'Is There a Future for Involuntary Treatment in Rights-based Mental Health Law?' (2014) 21(5) *Psychiatry, Psychology and Law* 747; Australian Law Reform Commission, *Legislative and regulatory framework* (12 November 2013) Australian Government <https://www.alrc.gov.au/publication/equality-capacity-and-disability-in-commonwealth-laws-ip-44/equality-capacity-and-disability-in-commonwealth-laws/legislative-and-regulatory-framework/>.

[1375] Wayne Martin et al, *Achieving CRPD Compliance: Is the Mental Capacity Act of England and Wales compatible with the UN Convention on the Rights of Persons with Disability? If not, what next?* (September 2014); George Szmukler and Brendan Kelly, 'We Should Replace Conventional Mental Health Law with Capacity-Based Law' (2016) 209(6) *British Journal of Psychiatry* 449, 450.

[1376] Office of the Western Australian Chief Psychiatrist, *Community Treatment Orders: A Review* (December 2001) 3.

[1377] Lisa Brophy et al, 'Community Treatment Orders and Supported Decision-Making' (2019) 10 *Frontier in Psychiatry* 1, 2.

[1378] Richard 'O'Reilly, 'Why Are Community Treatment Orders Controversial?' 49(9) *Canadian Journal of Psychiatry* 579.

[1379] See, for example, Wikus Barkhuizen et al, 'Community Treatment Orders and Associations with Readmission Rates and Duration of Psychiatric Hospital Admission: a Controlled Electronic Case Register Study' (2020) 10 *BMJ Open* 1, 2–3; Jorun Rugkåsa, 'Effectiveness of Community Treatment Orders: The International Evidence' (2016) 61(1) *Canadian Journal of Psychiatry* 15, 16–22; Scott Weich et al, 'Evaluating the Effects of Community Treatment Orders (CTOs) in England using the Mental Health Services Dataset (MHSDS): Protocol for a National, Population-Based Study' (2018) 8(10) *BMJ Open* 1, 2.

[1380] Jorun Rugkåsa and Tom Burns, 'Community Treatment Orders: Are They Useful?' (2018) 23(4) *British Journal of Psychiatric Advances* 222. Since 2013, every Australian jurisdiction, except the Northern Territory, has reformed its mental health legislation to either prohibit or strongly discourage forced psychiatric treatment in those who competently refuse it. It is also necessary to bear this in mind in considering studies with different regimes or in Australia before 2013. See Christopher Ryan, 'Community Treatment Orders are (Somewhat) Effective: Their

reported that '[r]esearch in this area is challenging' and there are also many individual consumer factors that affect CTO outcomes.[1381]

6.1.6 The use of CTOs Australia-wide is high by international standards, yet the use of CTOs in South Australia is relatively high compared with other Australian jurisdictions.[1382] There was a stark division of opinion in SALRI's consultation as to whether this high use of CTOs in South Australia is desirable or undesirable. However, as early as 2012, an Australian study found '[t]he high (by world standards), increasing and variable use of CTOs in Australia is concerning and raises important implications for mental health policymakers and legislators.'[1383]

6.1.7 Supporters of CTOs justify their role and use by arguing they support and facilitate the treatment of persons in the community (as opposed to involuntary treatment in hospitals), 'stem the tide of the "revolving door syndrome"'[1384] and reduce the rate of re-admissions while increasing medication compliance. This rationale is not untenable. As one relatively early Western Australian review explained, the rationale for CTOs is as follows:

> … the introduction of CTOs was seen as a way patients would receive treatment, if necessary without their consent, while living in the community. This form of involuntary treatment was viewed as a less restrictive option than being a detained patient in an authorised hospital and would reduce the 'revolving door' of admission, discharge and readmission that had become so common for many people with a mental illness.[1385]

Future in the Context of Rights-Based Mental Health Law' (2018) 51(3) *Australian and New Zealand Journal of Psychiatry* 11.

[1381] Daniel Maughan et al, 'A Systematic Review of the Effect of Community Treatment Orders on Service Use' (2014) 49(4) *Social Psychiatry and Psychiatric Epidemiology* 651, 662.

[1382] Edwina Light et al, 'Community Treatment Orders in Australia: Rates and Patterns of Use' (2012) 20(6) *Australasian Psychiatry* 478; Edwina Light, 'Rates of Use of Community Treatment Orders in Australia' (2019) 69(4) *International Journal of Law and Psychiatry* 83. The rates of CTOs and the reasons for these rates are complicated issues. See Edwina Light et al, 'Community Treatment Orders in Australia: Rates and Patterns of Use' (2012) 20(6) *Australasian Psychiatry* 478; Edwina Light et al, 'How Shortcomings in the Mental Health System Affect the Use of Involuntary Community Treatment Orders' (2017) 41(3) *Australian Health Review* 451.

[1383] Edwina Light et al, 'Community Treatment Orders in Australia: Rates and Patterns of Use' (2012) 20(6) *Australasian Psychiatry* 478.

[1384] Magnus Mfoafo-M'Carthy, 'Community Treatment Orders and the Experiences of Ethnic Minority Individuals Diagnosed with Serious Mental Illness in the Canadian Mental Health System' (2014) 13(1) *International Journal for Equity in Health* 69, 70. This refers to the regular problem of consumers going in and out of hospital after failing to take their medication outside a hospital setting.

[1385] Office of the Western Australian Chief Psychiatrist, *Community Treatment Orders: A Review* (December 2001) 3. See further at: 11–16. The Western Australian review elaborated: 'The rationale for the introduction of [CTOs]… was a realisation that the law was allowing a vulnerable group of people to slip through the cracks in mental health services and receive no assistance… people with a chronic mental illness who failed to obtain treatment on their own and who then decompensated and exhibited bizarre behaviour, could not be civilly committed until they did something dangerous even though they had a history of becoming dangerous in the later stages of decompensation. Family, friends, mental health professionals and courts had to sit by and wait for those persons to threaten, attempt, or complete acts which could result in harm before civil commitment could be used to restrain and force treatment on them… a significant percentage of patients discharged will be readmitted to in-patient facilities shortly after discharge into the community. Up to half of people with a chronic mental illness demonstrate signs of relapse that warrant re-hospitalisation within six months. The term given is the 'revolving door' and many researchers note that CTOs were primarily introduced to either stop or more realistically slow down the speed by which that door revolved… the problem of the 'revolving door' in psychiatric hospitals has vexed society for quite some time. Courts and mental health personnel alike have been increasingly discouraged by the parade of patients who improve when committed to hospitals but who fail to follow through with treatment afterward and therefore must be re-hospitalised time and time again': at 11.

6.1.8 The West Australian Review added in an Australian context:

> From an Australian perspective… the rationale for the introduction of CTOs can be traced to the closure of large psychiatric hospitals and the increasing use of community based psychiatric programs. It became clear that there was a group of difficult-to-treat patients who persistently failed to comply with community treatment and required involuntary admission to hospital for stabilisation. It was for such 'revolving door' patients, usually suffering from severe psychotic illnesses that the CTO was developed. With compulsory community treatment, it was argued that such patients would spend less time in hospital, gain more insight into their condition and be able to make effective use of community resources, even after the order was terminate.[1386]

6.1.9 Though the evidence to support the rationale and value of CTOs remains the subject of much contention and conflicting research, the debate in the medical profession has shifted from whether CTOs should be used, to questions regarding the circumstances in which the erosion of a consumer's rights by a CTO may be justified.[1387]

6.1.10 **Table 1** below outlines the arguments for and against CTOs, as summarised by a 2016 study.[1388]

Table 1: Pros and cons of CTOs	
Pros	***Cons***
• Coercion with treatment for mental illness in the consumer's best interest is justified on ethical grounds and is a feature of the legislative arrangements in many jurisdictions. • There is no clear logical reason why this right or duty to appropriate treatment should be available in the restrictive hospital setting, but not in the community. • For this purpose, it can be necessary to compel non-adherent consumers to accept necessary treatment and medication. • There is sufficient professional experience showing consumers improving under a CTO to justify this type of coercion. • Many clinical studies of CTOs have shown relevant benefits for consumers.	• Many consumers relapse under a CTO. • CTOs increase health service use. • A number of non-randomised studies have provided negative and conflicting results and thus have not provided sufficient evidence to support CTOs. • Three independent RCTs and a meta-analysis of their data have shown no benefit of the CTO on the number of hospital admissions and other relevant outcomes. • Consumers on a CTOs have shown even less adherence to depot injections than those not on a CTO. • Anecdotal reports do not provide significant evidence for the efficacy of a CTO. They may be the result of the regression to the mean (for

[1386] Office of the Western Australian Chief Psychiatrist, *Community Treatment Orders: A Review* (December 2001) 12. See also Ronan McIvor, 'The Community Treatment Order: Clinical and Ethical Issues' (1988) 32 *Australian and New Zealand Journal of Psychiatry* 223.

[1387] Steve Kisely and Richard O'Reilly, 'Reappraising Community Treatment Orders – can there be Consensus?' (2015) 202(8) *Medical Journal of Australia* 415; John Dawson, 'Community Treatment Orders and Human Rights' (2008) 26(2) *Law in Context* 146, 148.

[1388] Reinhard Heun, Subodh Dave, and Paul Rowlands, 'Little Evidence for Community Treatment Orders – a Battle Fought with Heavy Weapons' (2016) 40(3) *BJPsych Bulletin* 115. See also Jorun Rugkåsa and Tom Burns, 'Community Treatment Orders: Are They Useful?' (2018) 23(4) *British Journal of Psychiatric Advances* 222, 223.

• Randomised controlled trials (RCTs) with negative results to consumers have not included appropriate groups of consumers who would likely benefit from a CTO, or the trials have not applied the CTO appropriately.	example, the CTO is implemented at a time when the consumer is at their most ill) and improvements are therefore the likely results of a natural variance course of the mental illness. • Consumer's human rights may be violated by CTOs. • Owing to flaws in the application of compulsory community care, consumers are at risk of being subjected to new forms of social control of an unclear nature without adequate legal protection. • Without evidence, there cannot be any ethical justification to use coercion and severe deprivation of freedom and liberty against consumers.

6.1.11 More than one party in consultation with SALRI stated that in South Australia, common practice for enforcing CTOs was primarily risk-focused rather than capacity-based.[1389] This raises significant implications. It was suggested to SALRI that a focus on risk assessment excluding proper considerations of capacity, may result in the making of CTOs regarding individuals who, on careful, closer examination, do possess the requisite capacity. This is a complex area which requires reliance upon experienced clinical judgment in applying the criteria to enforce a CTO, in particular, a risk assessment.

6.1.12 Unlike in other jurisdictions, where there is mandated regard for the effectiveness or availability of community-based treatment, South Australia's CTO regime aims to protect the consumer and the community from 'harm'. The numerous CTO critics consider that in the hands of medical practitioners, CTOs are an excessively powerful mechanism, which may be improperly regarded as a 'panacea for effective outpatient treatment.'[1390] The use of CTOs by medical practitioners may also lead to the deprioritising of consumer's views, preferences and objectives in favour of prevention and risk reduction in the process.[1391] Consequently, CTOs may be viewed 'as stigmatising and disempowering'.[1392]

[1389] See *Mental Health Act 2009* (SA) ss 10(1)(b), 16(1)(b).

[1390] Krysia Canvin et al., 'Patient, Psychiatrist and Family Carer Experiences of Community Treatment Orders: Qualitative Study.' (2014) 49(2) *Social Psychiatry and Psychiatric Epidemiology* 1880.

[1391] Magnus Mfoafo-M'Carthy, 'Community Treatment Orders and the Experiences of Ethnic Minority Individuals Diagnosed with Serious Mental Illness in the Canadian Mental Health System.' (2014) 13(1) *International Journal for Equity in Health* 69.

[1392] Lisa Brophy and David Ring, 'The Efficacy of Involuntary Treatment in the Community*:* Consumer and Service Provider Perspectives' (2004) 2(2) *Social Work in Mental Health* 157.

6.1.13 Criticism of CTOs also centres on the coercive effect on consumers and their loss of autonomy.[1393] CTOs are seen as an ineffectual and misguided form of 'benevolent coercion'.[1394] The Western Australian Review, for example, explained:

> … the most fundamental argument against CTOs is that systems of benevolent coercion rarely provide effective therapy but quickly come to serve social monitoring functions instead… In effect although CTOs are established with the intent of reaching an undeserved and difficult population they usually become little more than ways to provide standard services to marginally difficult clients … When benevolent treatment and coercion operate together it would appear that coercion becomes pervasive whereas treatment remains nominal. As a result, efforts at mixing state monitoring and community treatment often foster the concern that the inevitable outcome will be an infringement of civil liberties without any guarantee of improved functioning for the individuals involved. Mental health consumers and advocates are also deeply concerned that outpatient commitment extends coercive social control into the community and that the dislike of coercion deters people with mental illness from seeking treatment.[1395]

6.1.14 Despite this dissonance between the rights-based approach and the focus on autonomy, it has been pointed out that mental health laws and the approach undertaken in the South Australian CTO framework cannot simply abdicate its responsibility to safeguard potentially vulnerable adults from harm.[1396] 'The State has long recognised a responsibility to protect those who cannot, by reason of mental incapacity, protect themselves, so to the extent that CTOs might be efficacious this should surely be the population targeted.'[1397] As Professor Vine aptly told the Victorian Royal Commission, 'leaving a person untreated, tormented by auditory hallucinations and delusions and at great risk of harm is not compatible with international conventions on human rights'.[1398] SALRI, consistent with its recent approach elsewhere,[1399] considers that it is necessary that South Australia's approach to CTOs should balance the rationale for CTOs with its implications on both consumers' human rights and welfare. As the European Court of Human Rights has acknowledged:

> [T]he need for domestic authorities to reach, in each particular case, a balance between the respect for the dignity and self-determination of the individual and the need to protect the individual and

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[1393] See, for example, John Dawson et al, 'Ambivalence About Community Treatment Orders' (2003) 26(3) *International Journal of Law and Psychiatry* 243; Katherine Pridham et al, 'Perception of Coercion Among Patients With a Psychiatric Community Treatment Order: A Literature Review' (2016) 67(1) *Psychiatric Services* 16; Jorun Rugkåsa et al, 'What does being on a Community Treatment Orders Entail? A 3-Year Follow-Up of the OCTET CTO Cohort' (2017) 52(4) *Social Psychiatry and Psychiatric Epidemiology* 465; Jeffrey Geller et al, 'Involuntary Outpatient Treatment as "Deinstitutionalised Coercion": the Net Widening Concern' (2006) 29(6) *International Journal of Law and Psychiatry* 551.

[1394] Office of the Western Australian Chief Psychiatrist, *Community Treatment Orders: A Review* (December 2001) 9. See also Katherine Pridham et al, 'Perception of Coercion Among Patients With a Psychiatric Community Treatment Order: A Literature Review' (2016) 67(1) *Psychiatric Services* 16.

[1395] Office of the Western Australian Chief Psychiatrist, *Community Treatment Orders: A Review* (December 2001) 9–10. See also Edward Mulvey et al, 'The Promise and Perils of Involuntary Outpatient Commitment' (1987) 42 *American Psychologist* 571.

[1396] See generally David Plater et al, '*Autonomy and Safeguarding are not Mutually Inconsistent': A Review of the Operation of the Ageing and Adult Safeguarding Act 1995* (SA) (South Australian Law Reform Institute, 2022).

[1397] Christopher Ryan, 'Community Treatment Orders are (Somewhat) Effective: Their Future in the Context of Rights-Based Mental Health Law' (2018) 51(3) *Australian and New Zealand Journal of Psychiatry* 11, 12.

[1398] See Submissions of Associate Professor Ruth Vine in *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021) vol 4, 369.

[1399] See generally David Plater et al, *'Autonomy and Safeguarding are not Mutually Inconsistent': A Review of the Operation of the Ageing and Adult Safeguarding Act 1995* (SA) (South Australian Law Reform Institute, 2022).

safeguard his or her interests, especially under the circumstances where his or her individual qualities or situation places the person in a particularly vulnerable position.[1400]

6.2 Current Law in South Australia

6.2.1 Under a CTO, treatment can be given despite the absence or refusal of consent by the consumer.[1401] Sections 10 and 16 of the *MHA* provide for the making of Level 1 CTOs ('CTO 1') and Level 2 CTOs ('CTO 2'), respectively. The key distinctions between the two types of CTOs are their maximum duration, and the decision-maker for the order.

6.2.2 A CTO 1 can last up to 42 days[1402] and can be made by a psychiatrist, an authorised medical practitioner, or an authorised mental health professional, upon examination of the consumer by the ordering party.[1403] This order may be varied or revoked by a psychiatrist or authorised medical practitioner who has examined the consumer at any time.[1404]

6.2.3 A CTO 2 can be made for up to 12 months[1405] (or six months, if the consumer is a child[1406]) by the South Australian Civil and Administrative Tribunal ('SACAT')[1407] upon application by an interested party (such as a medical practitioner, guardian, relative, carer or friend of the consumer).[1408] This order can only be varied or revoked by SACAT[1409] upon application by an interested party, including the consumer.[1410] Importantly, SACAT does not determine the type of treatment to be administered - this decision is made by the person's treating psychiatrist or mental health team.[1411]

Criteria

6.2.4 For either level of CTO to be made, the relevant decision-maker must be satisfied of four criteria.[1412] First, that the person has a mental illness. Secondly, that, because of the mental illness, the person requires treatment for their own or others' protection from 'harm'. Thirdly, that the person has impaired decision-making capacity in relation to their treatment.[1413] Finally, there must be no less restrictive means of ensuring that the person receives the treatment. These criteria indicate that the *MHA* attempts to strike an often-elusive balance between outcomes that are the least restrictive, and outcomes based on preventative, risk-based approaches to compulsory community treatment.

6.2.5 Harm is not explicitly defined, but 'harm' for the purposes of both a CTO and ITO under the *MHA,* means that the person 'requires treatment for the person's own protection from harm

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[1400] *AMV v Finland* [2017] ECHR 273 [90].

[1401] *Mental Health Act 2009* (SA) ss 13(3), 18(3).

[1402] Ibid s 10(4).

[1403] Ibid s 10(1).

[1404] Ibid s 10(7).

[1405] Ibid s 16(5)(b).

[1406] Ibid s 16(5)(a).

[1407] Ibid s 16(1).

[1408] Ibid s 16(4).

[1409] Ibid s 16(7).

[1410] Ibid s 16(8).

[1411] *Re FAQ* [2021] SACAT 105 [66].

[1412] *Mental Health Act 2009* (SA) ss 10(1), 16(1).

[1413] Ibid s 5A.

(whether physical or mental, and including harm involved in the continuation or deterioration of the person's condition) or for the protection of others from harm.'[1414]

6.2.6 For the purpose of considering whether there is no less restrictive means for ensuring appropriate *treatment* of the person's mental illness than a CTO or ITO, consideration under the *MHA* 'must be given, amongst other things, to the prospects of the person receiving all treatment of the illness necessary for the protection of the person and others on a voluntary basis.'[1415]

Notification

6.2.7 Once a CTO 1 is made, the consumer must be provided with a copy of the order and a statement of rights.[1416] A copy of this order and a statement of rights must also be provided to a guardian, medical agent, relative, carer or friend of the patient.[1417] There is no provision in the *MHA* in relation to CTO 2s which mirrors the notification requirements in place for CTO 1s.

6.2.8 The Chief Psychiatrist must be notified of the making, variation, and revocation of either type of CTO.[1418] The Chief Psychiatrist also has a duty to ensure monitoring of compliance with a CTO by ensuring that a mental health clinician is assigned to each consumer who has received notice. This mental health clinician, in turn, has an ongoing responsibility for monitoring and reporting to the Chief Psychiatrist regarding the consumer's compliance with the order.[1419]

Review

6.2.9 Reviews of a decision to make either a CTO 1 or a CTO 2 are undertaken by SACAT.[1420] Where an application to vary or revoke a CTO 2 prior to its expiry is brought to SACAT, the case will be heard before a panel consisting of one SACAT Member and one psychiatrist.[1421] Where an interested party wants a further review of the CTO 2, an appeal can be made to the Supreme Court.[1422]

6.3 Law in Other Jurisdictions

Australia

6.3.1 The law governing the criteria for the imposition of CTOs across Australia is varied, though there are similarities across all jurisdictions. **Table 2** below provides a comparison of the provisions providing the criteria for CTOs, automatic review of CTOs, and non-compliance in each jurisdiction.

[1414] *Mental Health Act 2009* (SA) s 10(1), s 16(1). See also s 21(1), s 25(1) for the making of an ITO.

[1415] Ibid s 10(2), s 16(s). See also s 21(2), s 25(s) for the making of an ITO.

[1416] Ibid s 12.

[1417] Ibid s 12(6). The Office of the Chief Psychiatrist's Human Rights and Coercion Reduction Committee noted this requirement is problematic in practice as both consumers and carers report it is often not understood. They suggested that this notice should be both proven and properly explained. Non-legal independent advocates could assist.

[1418] *Mental Health Act 2009* (SA) ss 10(8), 11, 17.

[1419] Ibid ss 14, 19.

[1420] Ibid ss 81, 83A; *South Australian Civil and Administrative Tribunal Act 2013* (SA) s 34.

[1421] See, for example, *IRE v Department for Health and Wellbeing* [2022] SACAT 24.

[1422] *South Australian Civil and Administrative Tribunal Act 2013* (SA) s 71.

Table 2: Comparison of CTOs in Australian Jurisdictions									
		SA	**NSW**	**VIC**	**WA**	**NT**	**QLD**	**ACT**	**TAS**
CRITERIA	Has a mental illness or disorder	✓	✓	✓	✓	✓	✓	✓	✓
	Requires treatment for protection of self or others from harm	✓		✓	✓	✓	✓	✓	✓
	Impaired or no decision-making capacity	✓			✓		✓	✓	✓
	No less restrictive means	✓	✓	✓	✓			✓	
	Quality of care provided under CTO		✓					✓	✓
	Availability of care in community				✓	✓			
	History of acceptance or refusal of appropriate treatment		✓						
	Consumer's views, preferences, and recovery outcomes			✓					
AUTOMATIC REVIEW	Regular review by practitioner		✓		✓	✓			
	Regular review by Tribunal				✓	✓	✓	✓	✓
	Practitioner power to revoke order if consumer no longer meets criteria		✓	✓	✓	✓	✓	✓	
NON-COMPLIANCE	Record-keeping requirement				✓				
	Description of non-compliance		✓		✓	✓		✓	✓
	Notice of non-compliance to consumer				✓	✓		✓	
	Order for transport	✓			✓	✓		✓	✓
	ITO as a consequence	✓	✓		✓	✓		✓	✓

6.3.2 Though the laws in most Australian jurisdictions (except NSW, the Northern Territory and Queensland) have similar grounds to South Australia for the making of a CTO, some States and Territories require an element of a *serious* risk of harm to the person or the community to be satisfied, rather than merely 'harm' as required by the *MHA*. Serious harm is a ground in Western Australia,[1423] Victoria[1424] and the ACT.[1425] However, the respective statutes do not explicitly define 'serious harm'.[1426]

6.3.3 Additionally, NSW, Tasmania and the ACT require at least one additional element to be satisfied for a CTO to be imposed. The relevant Acts consider the quality of care that may be provided to the consumer under a CTO.[1427] In Western Australia and the Northern Territory, the availability of the required care in the community is also relevant.[1428] In NSW, the consumer's history of acceptance or refusal of appropriate treatment is considered.[1429] Victoria is currently the only State in which the consumer's views and preferences, and any recovery outcomes they would like to achieve, is made clear in the Act as a relevant consideration.

6.3.4 It is important to note that South Australia is the only State in which no automatic review of a CTO is required. Additionally, only South Australia and Tasmania do not confer universally applicable powers of revocation on a medical practitioner if a consumer under their care and supervision no longer meets the relevant criteria.[1430]

6.3.5 The *MHA* is largely silent as to non-compliance with a CTO, being mentioned only twice. Section 20(1) of the *MHA* provides that non-compliance is a relevant factor where a decision-maker is considering whether to make an ITO, and s 55(1)(a) allows a decision-maker to issue a transport request in relation to a consumer under a CTO. However, the consequences of non-compliance are not clearly outlined in the *MHA*. Similarly, the Victorian and Queensland Acts do not reference the consequences of non-compliance with a CTO.

Canada, Scotland and the United Kingdom

6.3.6 **Table 3** below provides a comparison between CTO laws in South Australia, Scotland, the United Kingdom, and the Canadian provinces of Alberta, Saskatchewan and Ontario. In these

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[1423] The Western Australian definition provides an involuntary order may be made if 'because of the mental illness, there is 'a significant risk to the health or safety of the person or to the safety of another person; or a significant risk of serious harm to the person or to another person': *Mental Health Act 2014* (WA) s 25(2).

[1424] The Victorian definition provides that treatment may be given 'because the person has mental illness, the person needs immediate treatment to prevent serious deterioration in the person's mental or physical health; or serious harm to the person or to another person': *Mental Health Act 2014* (Vic) s 5(b)(ii).

[1425] The ACT definition provides the tribunal 'believes on reasonable grounds that, because of the mental disorder, the person is doing, or is likely to do, serious harm to themself or someone else; or is suffering, or is likely to suffer, serious mental or physical deterioration': *Mental Health Act 2015* (ACT) s 66(2)(c).

[1426] *Mental Health Act 2014* (WA) s 25(2)(b); *Mental Health Act 2014* (Vic) s 5(b)(ii); *Mental Health Act 2015* (ACT) s 66(2)(c).

[1427] *Mental Health Act 2007* (NSW) s 53(3)(b); *Mental Health Act 2013* (Tas) ss 40(c), (d); *Mental Health Act 2015* (ACT) s 66(2)(e).

[1428] *Mental Health Act 2014* (WA) s 25(2)(d); *Mental Health and Related Services Act 1998* (NT) s 16(c). During consultation, one medical practitioner raised the need for this criteria in South Australia: 'We… need to look at what should occur when it is impossible to actually use a [CTO 2] to provide ongoing care… as well as having a treatable illness, there needs to be at least some expectation that the treatment can be delivered (not talking here about service understaffing or resourcing) – and delivered safely.'

[1429] *Mental Health Act 2007* (NSW) s 53(3)(c).

[1430] Although practitioners can revoke or vary the less restrictive CTO1s; see *Mental Health Act 2009* (SA) s 10(7).

jurisdictions, CTOs are only used where the consumer has demonstrated a history of mental illness that has led to admission(s) to hospital mental health centres or the imposition of a previous CTO.

Table 3: Comparison of CTOs in South Australia, Canada, Scotland and the UK							
		SA	**Alberta**	**Saskatchewan**	**Ontario**	**Scotland**	**UK**
CRITERIA	Has a mental illness or disorder	✓	✓	✓	✓	✓	✓
	Requires treatment for protection of self or others from harm	✓	✓	✓	✓	✓	✓
	Impaired or no decision-making capacity	✓	✓	✓		✓	✓
	No less restrictive means	✓					
	Consideration of consent, on balance		✓		✓		
	Ability to comply with order		✓	✓	✓		
	History of CTO or admission to mental health centre		✓	✓	✓	✓	✓
	Availability of services in accordance with treatment plan		✓	✓	✓		✓
AUTOMATIC REVIEW	Regular review by practitioner					✓	✓
	Regular review by Tribunal		✓	✓		✓	✓
	Practitioner power to revoke order if consumer no longer meets criteria		✓	✓	✓	✓	✓
NON-COMPLIANCE	Record-keeping requirement						
	Description of non-compliance						
	Notice of non-compliance to consumer		✓			✓	
	Order for transport	✓	✓	✓	✓	✓	✓
	ITO as a consequence	✓	✓	✓	✓	✓	✓

6.3.7 All international jurisdictions (except Scotland) consider the availability of community services as part of deciding whether to impose a CTO.[1431] Once ordered, each international jurisdiction requires a review of the CTO to be conducted by a tribunal, usually upon expiry of the order.[1432] Additionally, medical practitioners have the power (or duty, in Scotland)[1433] to revoke orders once they form the opinion that a consumer no longer meets the criteria warranting a CTO.[1434]

6.3.8 As in South Australia, none of the international jurisdictions noted above explicitly require medical practitioners to keep records of non-compliance or describe the types of behaviours that may constitute non-compliance. However, each jurisdiction explicitly sets out the consequences of non-compliance: in particular, transport orders[1435] (or 'powers of recall') and the making of equivalent orders to ITO. Additionally, Alberta and Scotland require that notice of non-compliance is provided to the consumer.[1436]

6.4 Issues

Utility and effectiveness

6.4.1 The use and effect of CTOs has been and remains the subject of considerable research for approximately over 30 years. However, the medical and academic literature remains divided over the effectiveness of CTOs.[1437] This is consistent with the highly varied views in SALRI's comprehensive consultation on this point. A key concern regarding CTOs is the inconclusive evidence as to whether CTOs are an effective alternative to standard care.[1438] Adding complication, is the lack of any single reliable indicator for measuring and determining the effectiveness of CTOs. [1439]

6.4.2 Some studies dispute, or at least question or doubt, the effectiveness of CTOs.[1440] It has been observed that 'there is very little evidence to suggest that CTOs are associated with any positive

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[1431] *Mental Health Act,* RSA 2000*,* c M-13*,* s 9.1(1)(d); *Mental Health Services Act,* RSS 1986, c M-13.1*,* s 33.1(4)(c)(v); *Mental Health Act,* RSO 1990, c M.7, s 24,3(1)(iv)(B); *Mental Health Act 1983* (UK) s 17A(5)(e).

[1432] *Mental Health Act*, RSA 2000, c M-13, ss 39(1), 39(2); *Mental Health Services Act*, RSS 1986, c M-13.1, s 34(5.2), *Mental Health Act*, RSO 1990, c M.7, s 39.1(3); *Mental Health (Care and Treatment) Act 2003* (Scot) ss 77(2), 78(2); *Mental Health Act 1983* (UK) s 20A.

[1433] *Mental Health (Care and Treatment) Act 2003* (Scot) s 79(2).

[1434] *Mental Health Act*, RSA 2000, c M-13, s 9.5; *Mental Health Services Act*, RSS 1986, c M-13.1, s 24.5(3); *Mental Health Act*, RSO 1990, c M.7, s 33.4(5); *Mental Health (Care and Treatment) Act 2003* (Scot) s 79(2), *Mental Health Act 1983* (UK) s 23(2)(c).

[1435] *Mental Health Act*, RSA 2000, c M-13, s 9.6; *Mental Health Services Act*, RSS 1986, c M-13.1, s 24.6; *Mental Health Act*, RSO 1990, c M.7, s 33.4(4); *Mental Health (Care and Treatment) Act 2003* (Scot) s 112(4); *Mental Health Act 1983* (UK) s 17E(2).

[1436] *Mental Health Act*, RSA 2000, c M-13, s 9.6(2), *Mental Health (Care and Treatment) Act 2003* (Scot) s 113(2)(a).

[1437] Wikus Barkhuizen et al, 'Community Treatment Orders and Associations with Readmission Rates and Duration of Psychiatric Hospital Admission: a Controlled Electronic Case Register Study' (2020) 10 *BMJ Open* 1, 2–3.

[1438] See Edwina Light et al, 'Involuntary Psychiatric treatment in the Community: General Practitioners and the Implementation of Community Treatment Orders' (2015) 44(7) *Australian Family Physician* 485, 486.

[1439] Jorun Rugkåsa and Tom Burns, 'Community Treatment Orders: Are They Useful?' (2018) 23(4) *British Journal of Psychiatric Advances* 222, 225. Since 2013, every Australian jurisdiction, except the Northern Territory, has reformed its mental health legislation to either prohibit or strongly discourage forced psychiatric treatment in those who competently refuse it. This should be noted in considering studies with different CTO regimes or from Australia before 2013. See Christopher Ryan, 'Community Treatment Orders are (Somewhat) Effective: Their Future in the Context of Rights-Based Mental Health Law' (2018) 51(3) *Australian and New Zealand Journal of Psychiatry* 11.

[1440] See, for example, Steve Kisely, Leslie Campbell and Neil Preston, 'Compulsory Community and Involuntary Outpatient Treatment for People with Severe Mental Disorders' (2005) *Cochrane Database of Systematic Reviews* 3; Rachel Churchill et al, *International Experiences of Using Community Treatment Orders* (Institute of Psychiatry, Kings

outcomes'.[1441] One study found research to date 'provide[s] no significant evidence that CTOs affect health-service use'.[1442] Another study concluded that 'there is no strong evidence to support the claims made for compulsory community treatment'.[1443] A comprehensive 2006 international study on CTOs concluded that it was not yet possible to state whether CTOs are beneficial or harmful, that there was inconsistent evidence about the effects of CTOs on clinical and quality-of-life outcomes, and that stakeholder perceptions were mixed.[1444] A systematic review by Daniel Maughan et al found mixed results, but the authors still concluded that there was no evidence that CTOs led to improvements in regard to readmissions, length of stay, or the utilisation of community services.[1445] 'There is now robust evidence in the literature that CTOs have no significant effects on hospitalisation and other service use outcomes.'[1446] A comprehensive 2014 review also questioned the rationale of CTOs: 'CTOs may not lead to significant differences in readmission, social functioning, or symptomatology, compared with standard care. Their use should be kept under review.[1447] A 2016 international review found 'there is no evidence of patient benefit from current CTO outcome studies. This casts doubt over the usefulness and ethical positioning regarding the use of CTOs.'[1448] A 2018 review could not confirm there are clear clinical or other benefits of CTOs and the authors noted their belief 'that this gives

College London, London, 2007); Edwina Light et al, 'Out of Sight, Out of Mind: Making Involuntary Community Treatment Visible in the Mental Health System', (2012) 196(9) *Medical Journal of Australia* 591; John Dawson and Jorun Rugkåsa, 'Community Treatment Orders: Current Evidence and the Implications' (2013) 203(6) *British Journal of Psychiatry* 406; Tom Burns et al, 'Community Treatment Orders for Patients with Psychosis (OCTET): a Randomised Controlled Trial' (2013) 381 *The Lancet* 1627; Steve Kelsey and Katharine Hall, 'An Updated Meta-Analysis of Randomised Controlled Evidence for the Effectiveness of Community Treatment Orders' (2014) 59(10) *Canadian Journal of Psychiatry* 561; Daniel Maughan et al, 'A Systematic Review of the Effect of Community Treatment Orders on Service Use' (2014) 49(4) *Social Psychiatry and Psychiatric Epidemiology* 651; Sharon Lawn et al, 'A Qualitative Study Examining the Presence and Consequences of Moral Framings in Patients' and Mental Health Workers' Experiences of Community Treatment Orders' (2015) 15 *BMC Psychiatry* 274; Renihard Heun, Subodh Dave, and Paul Rowlands, 'Little Evidence for Community Treatment Orders–a Battle Fought with Heavy Weapons' (2016) 40(3) *BJPsych Bulletin* 115; John Dawson, 'Doubts About the Clinical Effectiveness of Community Treatment Orders' (2016) 61(10) *Canadian Journal of Psychiatry* 4; Jorun Rugkåsa, 'Effectiveness of Community Treatment Orders: The International Evidence' (2016) 61(1) *Canadian Journal of Psychiatry* 15; Francis Vergunst et al, 'Community Treatment Orders and Social Outcomes for Patients with Psychosis: a 48-Month Follow-Up Study' (2017) 52(11)*Social Psychiatry and Psychiatric Epidemiology* 1375; Jorun Rugkåsa and Tom Burns, 'Community Treatment Orders: Are They Useful?' (2018) 23(4) *British Journal of Psychiatric Advances* 222; Lisa Brophy, 'The Urgent Need to Review the Use of CTOs and Compliance with the UNCRPD Across Australian Jurisdictions' (2021) 28(1) *International Journal of Mental Health and Capacity Law* 3.

[1441] Rachel Churchill et al, *International Experiences of Using Community Treatment Orders* (Institute of Psychiatry, Kings College London, London, 2007) 194. See also at: 14.

[1442] Steve Kisely, Leslie Campbell and Neil Preston, 'Compulsory Community and Involuntary Outpatient Treatment for People with Severe Mental Disorders' (2005) *Cochrane Database of Systematic Reviews* 3.

[1443] Ibid; Richard Mullen, John Dawson and Anita Gibbs, 'Dilemmas for Clinicians in Use of Community Treatment Orders' (2006) 29(6) *International Journal of Law and Psychiatry* 535.

[1444] Rachel Churchill et al, *International Experiences of Using Community Treatment Orders* (Institute of Psychiatry, Kings College London, London, 2007).

[1445] Daniel Maughan et al, 'A Systematic Review of the Effect of Community Treatment Orders on Service Use' (2014) 49(4) *Social Psychiatry and Psychiatric Epidemiology* 651.

[1446] Ibid.

[1447] Steve Kelsey and Katharine Hall, 'An Updated Meta-Analysis of Randomised Controlled Evidence for the Effectiveness of Community Treatment Orders' (2014) 59(10) *Canadian Journal of Psychiatry* 561.

[1448] Jorun Rugkåsa, 'Effectiveness of Community Treatment Orders: The International Evidence' (2016) 61(1) *Canadian Journal of Psychiatry* 15.

serious cause for concern and that the time is ripe to think alternatively about how we seek to help those whose lives are made exceptionally difficult by severe mental illness.[1449]

6.4.3 Some Australian literature also notes a lack of marked benefit for consumers, as shown by a lack of significant improvement in rates of hospital admission or treatment adherence.[1450] Australian experts and commentators have called for the abolition, or at least reconsideration, of CTOs as ineffective, unethical and in breach of international human rights.[1451] A South Australian study asserted there is 'little evidence for CTOs producing positive clinical outcomes' and 'most research has shown that CTOs do not reduce readmission rates or duration, or increase time to readmission or treatment adherence'.[1452] The authors said that 'current Australian mental health legislation appears to focus on the process of imposing CTOs, with little accountability for what workers, services and consumers do during the CTO period.'[1453]

6.4.4 Another study noted the absence of any 'clear benefit' from CTOs, concluding:

> … in well-coordinated mental health services the imposition of compulsory supervision does not reduce the rate of readmission of psychotic patients. We found no support in terms of any reduction in overall hospital admission to justify the significant curtailment of patients' personal liberty. The evidence is now strong that the use of CTOs does not confer early patient benefits despite substantial curtailment of individual freedoms.[1454]

6.4.5 A common theme is the unease amongst consumers regarding CTOs.[1455] One review identified three themes in particular: feelings of coercion and control, medication seen as the main reason for a CTO, and the perception of CTOs as a safety net.[1456] Most consumers in this review described the CTO experience as wholly negative, both the process of being placed on a CTO and its

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[1449] Jorun Rugkåsa and Tom Burns, 'Community Treatment Orders: Are They Useful?' (2018) 23(4) *British Journal of Psychiatric Advances* 222, 229.

[1450] See for example, Suzanne Dawson, Eimear Muir-Cochrane, Alan Simpson and Sharon Lawn, 'Risk versus Recovery: Care Planning with Individuals on Community Treatment Orders,' (2021) 30 *International Journal of Mental Health Nursing* 1248; Edwina Light et al, 'Out of Sight, Out of Mind: Making Involuntary Community Treatment Visible in the Mental Health System', (2012) 196(9) *Medical Journal of Australia* 591; Sharon Lawn et al, 'A Qualitative Study Examining the Presence and Consequence of Moral Framings in Patients' and Mental Health Workers' Experiences of Community Treatment Orders' (2015) 15 *BMC Psychiatry* 274; Stephane Morandi et al, 'Community Treatment Order: Identifying the Need for more Evidence-Based Justification of its Use in First Episode Psychosis Patients' (2017) 185 *Schizophrenia Research* 67.

[1451] Piers Gooding and Bernadette McSherry, 'Alternatives to Compulsory Detention and Treatment and Coercive Practices in Mental Health Settings' (2018) 26(2) *Journal of Law and Medicine* 300; Lisa Brophy et al, 'The Urgent Need to Review the Use of CTOs and Compliance with the UNCRPD Across Australian Jurisdictions' (2021) 28(1) *International Journal of Mental Health and Capacity Law* 3.

[1452] Sharon Lawn et al, 'A Qualitative Study Examining the Presence and Consequence of Moral Framings in Patients' and Mental Health Workers' Experiences of Community Treatment Orders' (2015) 15 *BMC Psychiatry* 274.

[1453] Ibid.

[1454] Tom Burns et al, 'Community Treatment Orders for Patients with Psychosis (OCTET): a Randomised Controlled Trial' (2013) 381 *The Lancet* 1627, 1632.

[1455] See, for example, John Dawson et al, 'Ambivalence About Community Treatment Orders' (2003) 26(3) *International Journal of Law and Psychiatry* 243; Deborah Corring, Richard O'Reilly and Christina Sommerdyk, 'A Systematic Review of the Views and Experiences of Subjects of Community Treatment Orders' (2017) 52 *International Journal of Law and Psychiatry* 77.

[1456] Deborah Corring, Richard O'Reilly and Christina Sommerdyk, 'A Systematic Review of the Views and Experiences of Subjects of Community Treatment Orders' (2017) 52 *International Journal of Law and Psychiatry* 77.

impact, though others saw some benefits related to receiving treatment when they were unwell or being discharged from hospital.[1457]

6.4.6 The theme of coercion and disempowerment is raised elsewhere[1458] (and was noted to SALRI by some parties).[1459] One study highlighted that 'most patient see CTOs as a form of control and surveillance'.[1460] One South Australian study found that consumers had diverse views as to the value of their CTOs.[1461] Some consumers, viewed the structures behind CTOs as 'coercive and saw this as a violation of their autonomy over their life and home'.[1462] One consumer said:

> I associate [my psychiatrist] with, I call it the Mental Sickness Industry. I associate her with that. I associate her with trauma. I had the police come around to my house once and they were hassling me, the Mental - I call it Mental Sickness Industry, that's what I call it. They were harassing me about taking medication and drugs and stuff because I didn't get to an appointment because - and basically, she was there and so I associate her with that and I associate her with being violated in my own home. Like, I'm happy to have you in my home because you asked permission, you didn't force your way in here. You respect my autonomy…[1463]

6.4.7 Even a psychiatrist quoted in a recent Australian study was frank in their less than positive assessment of CTOs:

> People hate being on a CTO. It's, it's like their, their autonomy is taken away. And I still think … we don't properly ascertain what are the real problems that are going to happen to the person. I mean, I still think we're being very paternalistic. We're not letting people make mistakes or find out for themselves.[1464]

6.4.8 One Australian article noted the 'invisibility' of CTOs in mental health policy, which raises questions about the transparency and accountability of the mental health system, and 'whether this policy silence ultimately entrenches the marginalisation of, and discrimination against, people living with mental illness.'[1465] The authors expanded on their concerns:

[1457] Ibid.

[1458] See, for example, John Dawson et al, 'Ambivalence About Community Treatment Orders' (2003) 26(3) *International Journal of Law and Psychiatry* 243; Jorun Rugkåsa et al, 'What does being on a Community Treatment Orders Entail? A 3-Year Follow-Up of the OCTET CTO Cohort' (2017) 52(4) *Social Psychiatry and Psychiatric Epidemiology* 465; Jeffrey Geller et al, 'Involuntary Outpatient Treatment as "Deinstitutionalised Coercion": the Net Widening Concern' (2006) 29(6) *International Journal of Law and Psychiatry* 551.

[1459] For example, consumers advised SALRI that they did not like the CTO experience because they felt it was controlled and exclusively medical. One consumer noted a CTO should be called a 'CMO' (Community Medication Orders), as they are focussed on medication. If the focus was shifted to more holistic treatment, better results would be achieved. Another Focus Group with consumers revealed they feel as though the treatment prescribed under a CTO is 'very controlling' and motivated by a fear of detention. Consultation with consumers and consumer groups revealed they felt disempowered and their voices were not heard or valued in discussions about their treatment under a CTO.

[1460] Krysia Canvin et al. 'Patient, Psychiatrist and Family Carer Experiences of Community Treatment Orders: Qualitative Study' (2014) 49 *Social Psychiatry and Psychiatric Epidemiology* 1873, 1881.

[1461] John McMillan, Sharon Lawn and Toni Delany-Crowe, 'Trust and Community Treatment Orders' (2019) 10 *Frontiers in Psychiatry* 1.

[1462] Ibid 5.

[1463] Ibid.

[1464] Lisa Brophy et al, 'Community Treatment Orders and Supported Decision-Making' (2019) 10 *Frontiers in Psychiatry* 1, 4.

[1465] Edwina Light et al, 'Out of Sight, Out of Mind: Making Involuntary Community Treatment Visible in the Mental Health System' (2012) 196(9) *Medical Journal of Australia* 591.

> In addition to the uncertainties about efficacy, the ethical justification of CTOs is also far from clear. CTOs raise a number of ethical dilemmas for practitioners concerning consent, autonomy, coercion, paternalism and beneficence, as well as confidentiality, agency and privacy, and the accountability of the state to provide appropriate and quality services. Criticisms of CTOs include their potential to undermine non-coercive efforts to engage patients, and the inappropriateness of any attempts to increase coercion to compensate for under-resourced services. There are also concerns about the impact of CTOs on fundamental human rights and about the legal criteria and scope conferred by different CTO systems. CTOs are intrusive and grant professionals powers to monitor a person's condition, provide non-consensual treatment, and take a person to a psychiatric facility for treatment. Such powers have an enormous impact on the privacy and autonomy interests of patients. Operating at, or beyond, the boundaries of human rights, CTOs place significant duties on governments to provide adequately resourced community mental health and accommodation services.[1466]

6.4.9 A South Australian study found that the views of consumers and staff 'was quite different, with consumers overwhelmingly experiencing and perceiving CTOs as coercive (that is, punishing, controlling and scrutinising), whereas staff tended to perceive them as necessary, beneficial and supportive, despite their coerciveness.'[1467]

6.4.10 Even if CTOs are effective, it is not clear whether any benefit is due to their compulsory nature or simply a result of the intensity of treatment that they facilitate.[1468]

6.4.11 Other studies as to the utility of CTOs are indecisive[1469] or produce mixed results.[1470] One UK survey of the views and experiences of mental health practitioners in adult community mental health teams and approved mental health practitioners regarding the use of CTOs said 'the benefits of CTOs remain uncertain and there is a lack of high-quality research evidence for the outcomes and

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[1466] Edwina Light et al, 'Out of Sight, Out of Mind: Making Involuntary Community Treatment Visible in the Mental Health System' (2012) 196(9) *Medical Journal of Australia* 591, 592.

[1467] Sharon Lawn et al, 'Examining the Use of Metaphors to Understand the Experience of Community Treatment Orders for Patients and Mental Health Workers' (2016) 16 *BMC Psychiatry* 32.

[1468] Anthony O'Brien, Brian McKenna and Robert Kydd, 'Compulsory Community Mental Health Treatment: Literature Review' (2009) 46 *International Journal of Nursing Studies* 1245.

[1469] See, for example, Ronan McIvor, 'The Community Treatment Order: Clinical and Ethical Issues'(1998) 32(2) *Australian and New Zealand Psychiatry* 223; Richard O'Reilly, 'Why Are Community Treatment Orders Controversial?' 49(9) *Canadian Journal of Psychiatry* 579; Stephen Kisely et al, 'Randomised and Non-Randomised Evidence for the Effect of Compulsory Community and Involuntary Out-Patient Treatment on Health Service Use: Systematic Review and Meta-Analysis' (2007) 37(1) *Psychological Medicine* 3;Edwina Light et al, 'The Lived Experience of Involuntary Community Treatment: a Qualitative Study of Mental Health Consumers and Carers' (2014) 22(4) *Australian Psychiatry* 345; Delphine Coyle et al, 'Compulsion in the Community: Mental Health Professionals' Views and Experiences of CTOs' (2013) 37 *The Psychiatrist* 315, 320; Georgios Mikellides, Artemis Stefani and Marianna Tantele, 'Community Treatment Orders: International Perspective' (2019) 16(4) *British Journal Psychiatry International* 83.

[1470] See, for example, Philip Burgess et al, 'Do Community Treatment Orders for Mental Illness Reduce Readmission to Hospital? An Epidemiological Study' (2006) 41(7) *Social Psychiatry and Psychiatric Epidemiology* 574; Anthony O'Brien, Brian McKenna and Robert Kydd, 'Compulsory Community Mental Health Treatment: Literature Review' (2009) 46(9) *International Journal of Nursing Studies* 1245; Krysia Canvin et al, 'Patient, Psychiatrist and Family Carer Experiences of Community Treatment Orders: Qualitative Study' (2014) 49 *Social Psychiatry and Psychiatric Epidemiology* 1873; Sharon Lawn et al, 'Examining the Use of Metaphors to Understand the Experience of Community Treatment Orders for Patients and Mental Health Workers' (2016) 16 *BMC Psychiatry* 32; John McMillan, Sharon Lawn and Toni Delany-Crowe, 'Trust and Community Treatment Orders' (2019) 10 *Frontiers in Psychiatry* 1; Wikus Barkhuizen et al, 'Community Treatment Orders and Associations with Readmission Rates and Duration of Psychiatric Hospital Admission: a Controlled Electronic Case Register Study' (2020) 10 *BMJ Open* 1.

effectiveness of CTOs'.[1471] In 2019, it was noted that 'Australian jurisdictions continue to use CTOs at high and varying rates, despite unresolved questions about their role and impact' and greater transparency and further research are necessary.[1472]

6.4.12 Studies also support, on occasion with a degree of caution, the use of CTOs as worthwhile or beneficial.[1473]

6.4.13 A Victorian study in 2022, examined mental health admissions between 2000 – 2017.[1474] Results indicated that Victoria relied less upon CTOs as a less restrictive alternative to hospitalisation as an inpatient. However, this correlated with an increase in initial hospitalisations for consumers with a severe mental illness.[1475] The study also concluded that 'CTO placement enabled shorter hospital stays and longer community stays between hospitalisations.'[1476] The constraints of resourcing, case management and community follow up were also identified as impediments to the use of a CTO as a less restrictive alternative to hospitalisation.[1477]

[1471] Delphine Coyle et al, 'Compulsion in the Community: Mental Health Professionals' Views and Experiences of CTOs' (2013) 37 *The Psychiatrist* 315, 320; Krysia Canvin et al, 'Patient, Psychiatrist and Family Carer Experiences of Community Treatment Orders: Qualitative Study' (2014) 49(12) *Social Psychiatry and Psychiatric Epidemiology* 1873.

[1472] Edwina Light, 'Rates of Use of Community Treatment Orders in Australia' (2019) 64 *International Journal of Law and Psychiatry* 83.

[1473] See for example, Sarah Romans et al, 'How Mental Health Clinicians View Community Treatment Orders: a National New Zealand Survey' (2004) 38 *Australian and New Zealand Journal of Psychiatry* 836; Marvin Swartz and Jeffrey Swanson, 'Involuntary Outpatient Commitment, Community Treatment Orders, and Assisted Outpatient Treatment: What's in the Data?' (2004) 49(9) *Canadian Journal of Psychiatry* 585, 588, 590; John Dawson, *Community Treatment Orders: International Comparisons* (Law Foundation of New Zealand, 2005); Richard O'Reilly, D Keegan and J Elias, 'A Survey of the Use of Community Treatment Orders by Psychiatrists in Saskatchewan' (2005) 45 *Canadian Journal of Psychiatry* 79; Graham Ingram, David Muirhead and Carol Harvey, 'Effectiveness of Community Treatment Orders for Treatment of Schizophrenia with Oral or Depot Antipsychotic Medication: Clinical Outcomes' (2006) 40(6) *Australian and New Zealand Journal of Psychiatry* 596; Richard Mullen, John Dawson and Anita Gibbs, 'Dilemmas for Clinicians in Use of Community Treatment Orders' (2006) 29(6) *International Journal of Law and Psychiatry* 535; Steven Segal and Philip Burgess, 'The Utility of Extended Outpatient Civil Commitment' (2006) 29(6) *International Journal of Law and Psychiatry* 525; Alison Hunt et al, 'Community Treatment Orders in Toronto: the Emerging Data' (2007) 52(10) *Canadian Journal of Psychiatry* 647; Graham Ingram, David Muirhead and Carol Harvey, 'Effectiveness of Community Treatment Orders for Treatment of Schizophrenia with Oral or Depot Antipsychotic Medication: Changes in Problem Behaviours and Social Functioning' (2009) 43(1) *Australian and New Zealand Journal of Psychiatry* 1077; Catherine Manning et al, 'Community Treatment Orders in England and Wales: National Survey of Clinicians' Views and Use' (2009) 35(9) *The Psychiatrist* 328; Muffazal Rawala and Susham Gupta, 'Use of Community Treatment Orders in an Inner London Assertive Outreach Service'(2014) 38 *Psychiatric Bulletin* 13; Deborah Coring et al, 'What Clinicians Say About the Experience of Working With Individuals on Community Treatment Orders' (2018) 69(7) *Psychiatric Services* 791; Hanne Stuen et al, 'Responsibilities with Conflicting Priorities: a Qualitative Study of ACT Providers' Experiences with Community Treatment Orders' (2018) 18(1) *BMC Health Services Research* 290; Christopher Ryan, 'Community Treatment Orders are (Somewhat) Effective: their Future in the Context of Rights-Based Mental Health Law' (2019) 53(1) *Australian and New Zealand Journal of Psychiatry* 11; Anthony Harris et al, 'Community Treatment Orders Increase Community Care and Delay Readmission while in Force: Results from a Large Population-Based Study' (2019) 53(3) *Australian and New Zealand Journal of Psychiatry* 228; Ben Beaglehome, Giles Newton-Howes and Chris Frampton, 'Compulsory Community Treatment Orders in New Zealand and the Provision of Care: An Examination of National Databases and Predictors of Outcome' (2021) 17 *The Lancet Regional Health – Western Pacific* 1.

[1474] Steven Segal, Lachlan Rimes and Leena Badran, 'Need for Treatment, A Less Restrictive Alternative to Hospitalisation, and Treatment Provision: The Utility of Community Treatment Orders' (2022) *Schizophrenia Bulletin Open* (advance).

[1475] Ibid 24.

[1476] Ibid.

[1477] Ibid.

6.4.14 A large scale Western Australian study found some positive effects of CTOs in reducing frequency or length of psychiatric hospitalisations and improved treatment adherence.[1478] Further studies have reinforced a number of benefits associated with a CTO, such as reduced mortality risk, medication compliance, increase use and access of mental health services and initial diagnosis of a life threatening physical illness.[1479]

6.4.15 In brief, family members and clinicians are generally positive about the effect of CTOs, but consumers are ambivalent.[1480] Consumers, clinicians and family members agree that CTOs are preferable to involuntary treatment in hospital.[1481]

6.4.16 Clinicians view CTOs as providing benefits to their clients, but may well struggle with the coercive nature of these tools.[1482] In New Zealand (where CTOs have been available since 1992), surveys of psychiatrists and other mental health practitioners found that 79% of psychiatrists and 85% of non-psychiatrist mental health practitioners prefer to work in a system with CTOs.[1483] A survey of 50 psychiatrists in Saskatchewan reported that 62% of respondents were at least satisfied with the effect of CTOs on consumer care.[1484] A 2009 survey of members of the Royal College of Psychiatrists, found that psychiatrists were generally positive about the role of CTOs and 60% expressed a preference to work in a system that included CTOs.[1485] The survey rated clinical reasons as being the most important factors in the use of CTOs, both in terms of commencing and ending orders, rather than ethical or bureaucratic concerns. Promoting adherence to medication, protecting individuals from the consequences of relapse and ensuring contact with health practitioners were considered to be the most important factors in commencing a CTO.[1486]

6.4.17 A more recent study of medical and other mental health practitioners found:

> Our respondents believed that CTOs could improve the development of a therapeutic relationship with the patient over time with continued treatment, support and greater insight on the part of the patient. The majority (74% of psychiatrists and 50% of other mental health professionals) also agreed to some extent that the benefits of CTOs outweighed any coercive impact on the patient. The vast majority supported the use of CTOs, with 83% of psychiatrists and 67% of other professionals in favour of their continued availability. It would appear that there has been a marked shift in the mental health professionals' views and experiences of CTOs since the New Zealand

[1478] Steve Kisely et al, 'An Eleven-Year Evaluation of the Effect of Community Treatment Orders on Changes in Mental Health Service Use' (2013) 47 *Journal of Psychiatric Research* 650.

[1479] Steven Segal, Lachlan Rimes and Leena Badran, 'Need for Treatment, A Less Restrictive Alternative to Hospitalisation, and Treatment Provision: The Utility of Community Treatment Orders' (2022) *Schizophrenia Bulletin Open* (advance) 22.

[1480] Steve Kisely, 'Canadian Studies on the Effectiveness of Community Treatment Orders' (2016) 61(1) *Canadian Journal of Psychiatry* 7. See further at: 12.

[1481] Marvin Swartz et al, 'Assessment of Four Stakeholder Groups' Preferences Concerning Outpatient Commitment for Persons with Schizophrenia' (2003) 160 *American Journal of Psychiatry* 1139.

[1482] Deborah Coring et al, 'What Clinicians Say About the Experience of Working with Individuals on Community Treatment Orders' (2018) 69(7) *Psychiatric Services* 791.

[1483] Sarah Romans et al, 'How Mental Health Clinicians View Community Treatment Orders: a National New Zealand Survey' (2004) 38 *Australian and New Zealand Journal of Psychiatry* 836.

[1484] Richard O'Reilly, D Keegan and J Elias, 'A Survey of the Use of Community Treatment Orders by Psychiatrists in Saskatchewan' (2000) 45 *Canadian Journal of Psychiatry* 79.

[1485] Catherine Manning et al, 'Community Treatment Orders in England and Wales: National Survey of Clinicians' Views and Use' (2009) 35 *The Psychiatrist* 328.

[1486] Ibid. See also Delphine Coyle et al, 'Compulsion in the Community: Mental Health Professionals' Views and Experiences of CTOs' (2013) 37 *The Psychiatrist* 315, 316.

> mental health professionals' survey and the UK psychiatrists' survey… our figure of 83% suggests a substantial increase in the level of support for the use of CTOs among psychiatrists in the few years since CTOs have been in use.[1487]

6.4.18 A 2021 New Zealand study revealed CTOs are associated with increased community care, and increased dispensing of psychiatric medication.[1488] Specifically, consumers with a diagnosis of a psychotic disorder were found to be more likely to have reduced frequency and length of admissions whilst under a CTO.[1489]

6.4.19 One study, whilst equivocal as to the overall value of CTOs, still noted:

> … we found that experiences of CTOs and legal interpretations affecting practice are diverse. However, the common themes discussed above support… that CTOs can be considered most useful with those accepting their authority, but potentially counter-productive for those antagonised by it… To conclude, our findings suggest CTOs can be effective for the 'right' service user with certain needs and perceptions; for example, to work within clear boundaries. We support the argument that CTOs may be used beneficially with a restricted group of 'revolving door' patients for whom other options have been unsuccessful. Data from our study suggests CTOs were more successful when they were a carefully planned intervention, rather than where they were made almost as a matter of course. Therefore, we recommend that assessments should not be rushed and should involve the service user as much as possible, as well as nearest relatives where appropriate. In particular, the decision making process should take account of how service users' particular needs and perceptions may impact upon a CTO providing a useful framework to support recovery.[1490]

6.4.20 Qualitative studies also reveal consumers' ambivalence and mixed perceptions of the utility and effectiveness of a CTO in their treatment.[1491] While some consumers considered CTOs as a 'protective framework, and a positive component in their recovery',[1492] others described it as a coercive tool, which is primarily used to ensure medication adherence.[1493]

[1487] Delphine Coyle et al, 'Compulsion in the Community: Mental Health Professionals' Views and Experiences of CTOs' (2013) 37 *The Psychiatrist* 315, 317, 319.

[1488] Ben Beaglehole, Giles Newton-Howes and Chris Frampton, 'Compulsory Community Treatment Orders in New Zealand and the Provision of Care: An Examination of National Databases and Predictors of Outcome.' (2021) 17 *The Lancet Regional Health – Western Pacific* 1.

[1489] Ibid 5.

[1490] Julia Stroud, Laura Banks, and Karolina Doughty, 'Community Treatment Orders: Learning from Experiences of Service Users, Practitioners and Nearest Relatives' (2015) 24(2) *Journal of Mental Health* 88, 91.

[1491] See, for example, John Dawson et al, 'Ambivalence About Community Treatment Orders' (2003) 26(3) *International Journal of Law and Psychiatry* 243; Richard O'Reilly et al, 'A Qualitative Analysis of the Use of Community Treatment Orders in Saskatchewan' (2006) 29(6) *International Journal of Law and Psychiatry* 515; Krysia Canvin et al, 'Patient, Psychiatrist and Family Carer Experiences of Community Treatment Orders: Qualitative Study' (2014) 49 *Social Psychiatry and Psychiatric Epidemiology* 1873; Deborah Corring, Richard O'Reilly and Christina Sommerdyk, 'A Systematic Review of the Views and Experiences of Subjects of Community Treatment Orders' (2017) 52 *International Journal of Law and Psychiatry* 77; Steve Kisely, 'Canadian Studies on the Effectiveness of Community Treatment Orders' (2016) 61(1) *Canadian Journal of Psychiatry* 7, 12.

[1492] Hann Stuen et al, 'Increased Influence and Collaboration: a Qualitative Study of Patients' Experiences of Community Treatment Orders within an Assertive Community Treatment Setting' (2015) 15(1) *BMC Health Services Research* 409, 412. See also Sharon Lawn et al, 'A Qualitative Study Examining the Presence and Consequence of Moral Framings in Patients' and Mental Health Workers' Experiences of Community Treatment Orders' (2015) 15 *BMC Psychiatry* 274, 277.

[1493] Hann Stuen et al, 'Increased Influence and Collaboration: a Qualitative Study of Patients' Experiences of Community Treatment Orders within an Assertive Community Treatment Setting' (2015) 15(1) *BMC Health Services Research* 409, 417. See also Tien Ngoc Thi Bui et al, 'Exploring Mental Health Clients' Current Medication

6.4.21 Mental health practitioners tend to see more benefits to the use of CTOs than consumers.[1494] Clinicians are often identified to be supportive of the value of CTOs.[1495] The New Zealand study indicating many psychiatrist's preference to work with CTOs also found that CTOs are properly used in most cases, can enhance consumer's priority for care, provide a structure for treatment, support continuing contact and produce a period of stability for consumers during which other therapeutic changes can occur.[1496] It was also noted however that these orders can harm therapeutic relationships, especially in the short term, but when properly used the overall benefits outweighed the coercive impact. The other mental health practitioners surveyed held similar views. A minority of clinicians did not support the use of CTOs.[1497]

6.4.22 Another New Zealand study found that family members generally favour the use of CTOs and perceive a positive influence on their relative, on themselves, on family relationships, and on relations with the clinical team.[1498] Family members were found to be aware of the ethical and other dilemmas that accompany the use of compulsory community care.[1499]

6.4.23 Consumers also accept that CTOs can offer benefits, generally in terms of obtaining services they might otherwise find difficult to access, and avoiding hospital admission.[1500] Indeed, a New Zealand study found that the majority of consumers were generally supportive of the CTO, especially if the alternative was hospital.[1501] Many valued the access to services and acknowledged feeling a sense of security. They also attributed improvements in their health to treatment under the CTO.[1502] A minority of consumers were strongly opposed to the order, due to experiencing reduced choice about medication and restrictions on residence and travel. However, most restrictions did not unduly hinder them. The majority of consumers viewed the order as a helpful step towards community stability.[1503]

Knowledge, Beliefs and Experience with Healthcare Providers in the Community in South Australia' (2022) 30(6) *Health and Social Care in the Community* 1.

[1494] Deborah Corring, Richard O'Reilly and Christina Sommerdyk, 'A Systematic Review of the Views and Experiences of Subjects of Community Treatment Orders' (2017) 52 *International Journal of Law and Psychiatry* 77.

[1495] See, for example, Sarah Romans et al, 'How Mental Health Clinicians View Community Treatment Orders: a National New Zealand Survey' (2004) 38 *Australian and New Zealand Journal of Psychiatry* 836; Richard O'Reilly et al, 'A Qualitative Analysis of the Use of Community Treatment Orders in Saskatchewan' (2006) 29(6) *International Journal of law and Psychiatry* 515; Catherine Manning et al, 'Community Treatment Orders in England and Wales: National Survey of Clinicians' Views and Use' (2011) 35 *The Psychiatrist* 328; Steve Kisely, 'Canadian Studies on the Effectiveness of Community Treatment Orders' (2016) 61(1) *Canadian Journal of Psychiatry* 7, 12.

[1496] Sarah Romans et al, 'How Mental Health Clinicians View Community Treatment Orders: a National New Zealand Survey' (2004) 38 *Australian and New Zealand Journal of Psychiatry* 836.

[1497] Ibid. See also Catherine Manning, 'Community Treatment Orders in England and Wales: National Survey of Clinicians' Views and Use' (2011) 35 *The Psychiatrist* 328.

[1498] Richard Mullen, Anita Gibbs, and John Dawson, 'Family Perspective on Community Treatment Orders: A New Zealand Study' (2016) 52(5) *International Journal of Social Psychiatry* 1.

[1499] Ibid; Anita Gibbs, John Dawson and Richard Mullen, 'Community Treatment Orders for People with Serious Mental Illness: a New Zealand Study' (2006) 36 *British Journal of Social Work* 1085.

[1500] Anita Gibbs, et al, 'How Patients in New Zealand View Community Treatment Orders' (2005) 14 *Journal of Mental Health* 357; Anita Gibbs, John Dawson and Richard Mullen, 'Community Treatment Orders for People with Serious Mental Illness: a New Zealand Study' (2006) 36 *British Journal of Social Work* 1085.

[1501] Anita Gibbs et al, 'How Patients in New Zealand View Community Treatment Orders' (2005) 14 *Journal of Mental Health* 357.

[1502] Ibid.

[1503] Ibid. See also Anita Gibbs, John Dawson and Richard Mullen, 'Community Treatment Orders for People with Serious Mental Illness: A New Zealand Study' (2016) 36(7) *British Journal of Social Work* 1085.

6.4.24 The literature regularly notes the dissonance between use of CTOs and other compulsory treatment with best practice, a 'recovery-oriented' approach.[1504] These findings were echoed in SALRI consultations with consumers, who often reported feeling 'controlled' by CTOs, and disempowered in decision-making regarding their own treatment and their voices were not heard. The differences between consumer and health practitioner perspectives on the utility and effectiveness of CTOs raises concerns in the context of findings of the power imbalances within these relationships. This again raises that the CTO experience is often associated with feelings of disempowerment in consumers[1505] which is exacerbated by the clinician-led decision-making which so often characterises consumer-practitioner relationships in this setting.[1506] The possible effects of consumers' perception of CTOs as a coercive tool, and the effect of a perceived or actual power imbalance between consumers and practitioners, will be explored in more depth below.

6.4.25 SALRI acknowledges the diversity of views in research and commentary on the role and utility of CTOs. It is impossible to reconcile these views. 'The ambiguity of the research evidence highlights that there is no clear consensus on the instrumental value of CTOs.'[1507] SALRI is unable to resolve 'the polemic debates in which CTOs remain enmeshed'.[1508]

6.4.26 SALRI notes the insightful comments of one Canadian study:

> Patient commitment will continue to be a controversial treatment intervention, regardless of empirical findings about its effectiveness or lack thereof. Advocates and opponents of [CTOs] sometimes selectively use data about [CTO's] benefits or detriments as a 'straw man' to argue strongly held views about autonomy and paternalism in mental health treatment. Many opponents of [CTO] believe that it may serve as a barrier to improving services because policy-makers will seize upon it as a quick and inexpensive remedy for a lack of community-based services. However, current data suggests that, if [CTO] is effective, it can only be so when more intensive services are provided, obviating its use as an inexpensive remedy.[1509]

6.4.27 SALRI also highlights that studies of the views and experiences of consumers, clinicians, and family members conducted in the United States, Europe, Canada or Australia show 'a very similar picture',[1510] namely:

> Clinicians prefer to have CTOs available as an option and many believe CTOs have the desired effects. Family members often find CTOs necessary or helpful, but are concerned that the order is insufficient to help patients lead better lives, and that other community services must also be

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[1504] See, for example, Sharon Lawn et al, 'A Qualitative Study Examining the Presence and Consequences of Moral Framings in Patients' and Mental Health Workers' Experiences of Community Treatment Orders' (2015) 15 *BMC Psychiatry* 274, 275.

[1505] Wayne Weavell, *Are Mental Health Treatment Orders out of Order?* (3 June 2016) The University of Melbourne <https://pursuit.unimelb.edu.au/articles/are-mental-health-treatment-orders-out-of-order>.

[1506] Suzanne Dawson et al, 'Community Treatment Orders and Care Planning: How is Engagement and Decision-Making Enacted? (2021) 24(5) *Health Expectations: An International Journal of Public Participation in Health Care and Health Policy* 1859, 1863.

[1507] Edwina Light et al, 'The Lived Experience of Involuntary Community Treatment: a Qualitative Study of Mental Health Consumers and Carers' (2014) 22(4) *Australian Psychiatry* 345, 346.

[1508] Edwina Light. 'Rates of Use of Community Treatment orders in Australia' (2019) 64 *International Journal of Law and Psychiatry* 83.

[1509] See, for example, Marvin Swartz and Jeffrey Swanson, 'Involuntary Outpatient Commitment, Community Treatment Orders, and Assisted Outpatient Treatment: What's in the Data?' (2004) 49(9) *Canadian Journal of Psychiatry* 585, 590.

[1510] Jorun Rugkåsa, 'Effectiveness of Community Treatment Orders: The International Evidence' (2016) 61(1) *Canadian Journal of Psychiatry* 15.

> offered. Patients reportedly hold mixed views. Many find some aspects of the order helpful, while other aspects are seen as coercive and to restrict their lives in ways that can be highly problematic. The highest priority for all three groups is usually to avoid hospital admission. It is worth noting that the experienced advantages of CTO often are expressed by way of comparison with detention in hospital, not with receiving comprehensive community services voluntarily.[1511]

6.4.28 It is significant that this overview is also consistent with SALRI's own findings in the survey responses and elsewhere in consultation. SALRI recognises that findings from various studies, both nationally and internationally, are context-specific and influenced by the structure and operation of the relevant mental health system. This also captures issues of resourcing, staffing and infrastructure to facilitate access to community mental health treatment and management.

Increasing prevalence

6.4.29 The use of CTOs in Australia is high compared with often-variable use internationally,[1512] but differs considerably between Australian States and Territories (an issue that was the subject of much comment and consideration in SALRI's consultation).[1513] The use of CTOs in Australia varies considerably within and between jurisdictions.[1514] Contemporary rates of CTO use in Australia range from 40.0 per 100,000 population (in Western Australia) to 112.5 per 100,000 (in South Australia). Since the last national survey, the rates of people subject to CTOs fell in two jurisdictions (Victoria and Western Australia). However, the rates of CTOs made were higher than previous figures across Australia as a whole.[1515]

6.4.30 Australian jurisdictions continue to use CTOs at high and varying rates, despite unresolved questions about their purpose, impact and effectiveness. Edwina Light et al observed some of the possible reasons and the implications for varied CTO use across Australia:

> Changing rates of CTO use may therefore be attributed to a range of different influences, including: the attitude of clinicians; the powers provided to treat involuntary outpatients; the threat of clinicians being liable for the conduct of patients in the community; the perceived impact of coercion on therapeutic relationships; perceptions that persons with mental disorders in the community pose a public risk; a greater number of people receiving a less restrictive method of treatment than involuntary hospitalisation; and the adequacy of system resourcing and structures to respond to recurrent or chronically disabling disorders. The potential explanation for the wide variation of rates of use of CTOs in different Australian jurisdictions may entail subtle differences in *Mental Health Acts* across States and territories, differences in the resourcing of community

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[1511] Ibid.

[1512] Despite the apparently random variation in international CTO prevalence, the characteristics of consumers subject to CTOs are reassuringly consistent across countries. Around two-thirds are male, and the same proportion is diagnosed with schizophrenia. The mean age is around 40, and consumers typically have several prior hospital admissions and a history of non-adherence to out-patient care. Many have problems with substance misuse and have criminal records. Most are single, live in rented accommodation alone or, less often, with their family, and almost none are in regular employment. See Jorun Rugkåsa and Tom Burns, 'Community Treatment Orders: Are They Useful?' (2018) 23(4) *British Journal of Psychiatric Advances* 222, 224. This is also the group of consumers on CTOs in the UK: at 224. The findings in an Australia context are broadly consistent.

[1513] The factors influencing CTO use have been noted as so dynamic and fluid so 'widely varying rates of use of CTOs can develop in different jurisdictions with otherwise similar legal traditions, and rapid changes can occur in the rate of use of CTOs, over time, even within a single jurisdiction, without any change occurring in the law': John Dawson, 'Factors Influencing the Rate of Use of Community Treatment Orders' (2007) 6(2) *Psychiatry* 42.

[1514] Edwina Light, 'Rates of Use of Community Treatment Orders in Australia' (2019) 64 *International Journal of Law and Psychiatry* 83.

[1515] Ibid.

compared to inpatient mental health services across jurisdictions, or the differential effects of the intercession of third parties such as state coroners or statutory bodies.[1516]

6.4.31 Transparency and accountability around the use of CTOs requires improvement and could be achieved through regular and uniform public reporting of all CTO data across Australia.[1517]

6.4.32 **Table 4** below summarises the annual number of CTOs made by Australian state or territory in the 2016/17 period, as summarised by a 2019 study by Light:[1518]

Table 4: Australian CTO rates 2016/17						
Loc'n	**Population '000**	**Period of data collection for this study**	**Number of CTOs/year**	**Rate of CTOs made**	**Number of individuals under a CTO/year**	**Rate of people subject to CTOs**
ACT	404.4	-	-	-	-	-
NSW	7797.8	2016/17	5362	68.7	3751	48.1
NT	244 (Dec 2015)	2015/16	178	72.9	-	-
QLD	4928.5 (June 2017)	3/6/2017	3258	66.1	3258	66.1
SA	1717	2016/17	1933	112.5	-	-
TAS	519.1	-	-	-	-	-
VIC	6244.2	2016/17	6769	108.4	4773	76.4
WA	2567.8	2016/17	-	-	1052	40.9

6.4.33 The most recent South Australian data regarding CTO use shows that the practice is more prevalent than ever before. The South Australian Chief Psychiatrist's Annual Report for 2020/21 period ('2020/21 Report') shows that 2471 CTOs were made, with CTO 2s constituting most of these orders (1623) compared to CTO 1s (848).[1519] This represents an increase of 43.9% compared to the

[1516] Edwina Light et al, 'Out of Sight, Out of Mind: Making Involuntary Community Treatment Visible in the Mental Health System' (2012) 196(9) *Medical Journal of Australia* 591.

[1517] Edwina Light, 'Rates of Use of Community Treatment Orders in Australia' (2019) 64 *International Journal of Law and Psychiatry* 83.

[1518] Ibid 85.

[1519] Department for Health and Wellbeing (SA), *Annual Report of the Chief Psychiatrist of Australia* (2021) 36.

2018/19 period (1717).[1520] In 2021/22, the rate of CTOs has increased to a total of 2533, comprising 877 (CTO 1) and 1656 (CTO 2).[1521]

6.4.34 The high rate of CTO use, in a context where the evidence as to its utility and effectiveness is ambiguous at best, may be of concern. It 'raises questions of whether the measure is being appropriately targeted to high needs groups, or whether it has become a default option in defensively-oriented mental health services'.[1522] A number of parties expressed their concerns to SALRI at the increasing prevalence of CTOs and their clear view that the rates are excessive.

6.4.35 Alternatively, others disagreed with this premise. The Royal Australian and New Zealand College of Psychiatrists SA Branch ('RANZCP') challenged the assumption that a rise in active CTOs indicates a problem with the mental health system, and that, 'suggestions to reduce the number of active CTOs are needed'. The RANZCP submitted to SALRI that the high rates of CTO use in South Australia may not necessarily singularly indicate an issue. It may instead indicate that consumers' access to community mental health teams have improved in recent years, and that those teams have significantly increased their ability to provide care to those who require it.[1523] The RANZCP reiterated that many of the issues surrounding the use and rate of CTOs are directly related to the resourcing of mental health services, 'as that so greatly affects the provision and quality of services.'

6.4.36 A number of medical practitioners, health practitioners and service providers similarly told SALRI that the high number of CTOs may reflect that the system is working as intended, particularly in circumstances where a CTO is preferable to an ITO.

6.4.37 SALRI's consultation suggested that some factors influencing the increase in CTOs may include the need to comply with hospital Key Performance Indicators ('KPIs'), and mental health bed shortages, which can lead to premature discharge of consumers by placing them on CTOs in order to ensure their necessary continued treatment.[1524] For example, in SALRI's Medical Specialist Roundtable, it was raised that the average length of a consumer's stay in hospital is now 12 days, despite the knowledge that psychiatric medication often takes 14 days to establish whether it is effective.

6.4.38 SALRI's Psychology/Neuropsychology Roundtable revealed that there has been an increase in the use of CTOs as part of what was termed defensive medical practice, where consumers

[1520] Department for Health and Wellbeing (SA), *Annual Report of the Chief Psychiatrist of Australia* (2019) 31.

[1521] The Chief Psychiatrist made clear to SALRI his wish for the rate of CTOs in South Australia to decrease. 'The OCP would welcome SALRI's consideration as to how the Act could be amended to reduce reliance upon CTOs in community mental health, while ensuring service standards are maintained.'

[1522] Sharon Lawn et al, 'A Qualitative Study Examining the Presence and Consequences of Moral Framings in Patients' and Mental Health Workers' Experiences of Community Treatment Orders' (2015) 15 *BMC Psychiatry* 274, 275.

[1523] One medical practitioner noted that 'access to mental health teams has changed, we are around a lot more than we used to be and have good coverage to make sure those who need care, receive it. This increasing rate may be a sign of good practice.'

[1524] This was mentioned in roundtables with medical practitioners and NGOs. One medical practitioner noted that CTOs can make it look as though a consumer 'is being treated even if it is not really working'. One NGO noted to SALRI that 'people are often put on CTOs to discharge them due to mental health bed shortages'. Neami, an NGO, noted to SALRI: 'We are also aware that Community Treatment Orders (CTO) are being used as a mechanism to maintain Community Mental Health Services including psychiatry. Community Mental Health Teams (CMHT) are often overwhelmed with referrals. When trying to manage demand, CMHTs may need to discharge those consumers whose need is less pressing, although further care would be beneficial. The CMHT is not able to discharge consumers on CTOs.'

are placed on CTOs out of a fear that the person will hurt themselves.[1525] This was raised by the RANZCP, who reported feedback received from those working within the public mental health system, which referred to a limited and reducing tolerance for frontline staff to make decisions not to treat or to decline treatment due to risks a consumer poses to staff or because they are itinerant.

6.4.39 One psychologist during SALRI's Psychology/Neuropsychology Roundtable shared that a consumer had been threatened with a CTO if they refused the medication they had been prescribed, despite their desire to cease the medication due to its side effects. Other participants identified the lack of support available to consumers in the community, particularly psychosocial support, which could lead to escalation of mental health crises to the extent a CTO was required.[1526] Other concerns related to environmental factors, including housing, medication access and cost. These factors need to be addressed to ensure a consumer is able to fully benefit from a CTO.

6.4.40 Stakeholders also raised the inappropriate use of CTOs as regular post-discharge orders. A senior consultant psychiatrist summarised these concerns in her submission to SALRI:

> I have serious concerns that Level 1 CTOs are being misused. Several inpatient units routinely put almost all consumers who are referred to community mental health teams on a CTO level 1 at the time of discharge… whilst Level 1 CTOs are potentially being used to discharge earlier they do not ensure compliance with treatment… some discharge summaries even state that the level 1 has been put in place to ensure the CMHT accepts the referral – though our data indicates we only decline referrals if the person is not residing in our area or does not have a psychotic illness… CTO level 1s are being used as a forcing function on community teams, rather than as per the consumer's needs.

6.4.41 The RANZCP also noted staff 'within mental health teams consider that they will be under significant scrutiny if any adverse event takes place. This has resulted to a certain extent in the unintended consequence of CTOs being used as a post-discharge treatment order, to help prioritise a consumer for follow-up attention or being applied to consumers discharged from hospital or prison who are unlikely to be locatable by community mental health teams for treatment – with that situation being known at the time the CTO is applied.'

6.4.42 Many consumers are subject to repeated orders, particularly CTO 2s. In 2020/21, 9.9% of consumers under CTO1s and 36.5% of consumers under CTO 2s were placed under two or more of the same orders within a 12 month period. In their submission to SALRI, the Legal Services Commission highlighted that the ambiguity of risk-assessment methods can lead to the indefinite placement of consumers on consecutive CTO 2s. For example, they identified a consumer who had been placed under 13 consecutive CTO 2s as the result of a risk identified 13 years prior. This risk continued to be sufficient to persuade SACAT that the order was required, despite no incidents having been reported since the making of the initial order.

6.4.43 The perceived inappropriate use of CTOs in South Australia was raised to SALRI by various parties.

[1525] One psychologist noted that when 'patients [threaten] to hurt themselves, [they can] scare clinicians, [which] lead[s] to defensive medical practice' of placing consumers on CTOs.

[1526] A participant in the Mental Health NGO Roundtable noted that 'best practice is impeded by resource shortages and funding issues. As a result, services are not available consistently'. Additionally, 'people struggle to access evidence-based treatment' due to long waitlists, 'and get so distressed they end up going on a CTO: forced into short term, inadequate treatment, then released after a traumatising response.'

Metropolitan vs regional

6.4.44 The 2020/21 Report indicates that CTOs in South Australia are more prevalent in the eastern and western metropolitan areas, while the outer south and south-east regions and rural areas are underrepresented.[1527] Based on the feedback provided to SALRI in metropolitan and regional areas of Australia, it is likely that this is the result of a lack of availability of mental health services in regional areas compared to the eastern and western metropolitan areas. During one of SALRI's Medical Specialist Roundtables, a psychiatrist offered insight into a regional perspective. It was noted that CTOs are not as common as metropolitan Adelaide. A number of factors were identified as possible reasons for this observation. This included longer lengths of stay in hospital, greater reliance on general practitioners and the lack of resources for regional community teams to offer management and follow up post discharge. Consequently, a person is more likely to stay in hospital longer and stabilises, reducing the need for a CTO upon their discharge.

6.4.45 Similar themes were raised by mental health workers in Port Lincoln, who reported that the strict criteria and need for evidence is a deterrent for making CTOs in regional areas when they are primarily used for medication compliance rather than engagement with other services. Consequently, this contributes to an increased length of stay in hospital and greater reliance upon general practitioners to manage mental illness.[1528] Access to mental health services, including holistic services and other broad supports, are therefore important to ensure that care is adequately and appropriately provided in regional areas.

6.4.46 An Aboriginal Cultural Adviser and mental health professional in the Barossa Valley and Adelaide Hills region reported the '24/7' nature of their work, where more regular contact with consumers is anticipated as it is likely that he will come into contact with consumers in community areas.

6.4.47 The acute absence of mental health specialist and support services, and mental health practitioners in rural, regional and remote communities was a recurring theme in SALRI's consultation and has major implications for the operation of the *MHA* outside Adelaide.

Aboriginal communities

6.4.48 It is significant that Aboriginal consumers are over-represented in the South Australian use of CTOs, which accords with their wider over-representation in the mental health system. Despite constituting only 2% of the South Australian population, Aboriginal consumers are subject to 12.4% of all CTO 1s and 10.7% of all CTO 2s. The over-representation of Aboriginal consumers subject to CTOs was pointed out to SALRI by numerous parties in consultation.[1529] The disproportionate use of

[1527] Department for Health and Wellbeing (SA), *Annual Report of the Chief Psychiatrist of Australia* (2019) 35.

[1528] SALRI's consultation with medical practitioners revealed that this is common in regional areas.

[1529] Mind Australia, for example said: 'CTO use is on the rise partly due to a lack of appropriate and accessible services in the community. In particular, there is a lack of appropriate and accessible services which are culturally safe and sensitive for First Nations people and Culturally and Linguistically Diverse people. Therefore, instead of receiving support in the community when it is needed, people's mental health and wellbeing is deteriorating or escalating to the point of requiring a CTO to ensure they gain access to services. This is a human rights concern – people have a right to access respectful and appropriate services which meet their needs, in the community in which they live.'

CTOs in Aboriginal communities emerges from one Queensland study,[1530] but otherwise seems to be largely overlooked in Australian literature.[1531]

6.4.49 Studies based in New Zealand have recognised that Māori consumers are 3.6 times more likely than non-Māori consumers to be under CTOs.[1532] Queensland-based studies on ethnically diverse experiences of CTOs have concluded that Indigenous consumers are not more likely to be placed on a CTO than other Australian-born populations.[1533] However, the same studies also indicate that there are higher rates of ITOs for Aboriginal consumers.

6.4.50 The RANZCP told SALRI an increase in the use of CTOs among Aboriginal consumers does not intrinsically indicate a problem. 'If the assertion is that CTOs are being incorrectly used on these groups, then that is of concern and a review of services' practices and procedures might be warranted.'

6.4.51 SALRI's consultation also supported the need for further consideration of Aboriginal experiences of CTOs, particularly in relation to staff members. A regional mental health worker recounted an experience with an Aboriginal consumer who presented late for his depot medication. The consumer was argumentative and threatening, and 'not like himself'. The mental health worker was able to de-escalate the situation over 10 to 20 minutes, leading to the provision of the depot medication to the consumer, though he noted that during the process, he was unsure whether he should call a 'code black'[1534]. He noted that many people are not trained to de-escalate situations in a culturally appropriate manner, where they can distinguish the mental health issue from cultural issues.

6.4.52 The tensions between the literature, the statistics presented by the 2020/21 Report, and the consultation data may indicate the invisibility of the causes for and effects of CTOs on Aboriginal consumers and communities, particularly in the South Australian context, suggesting that more research, analysis and interrogation of this data is required.

CALD communities

6.4.53 Several parties raised the use of CTOs in Culturally and Linguistically Diverse ('CALD') communities. CALD consumers appear to be proportionately represented in the use of CTOs,[1535]

[1530] Steve Kisely, Katherine Moss, and Dan Siskind, 'Efficacy of Compulsory Community Treatment and Use in Minority Ethnic Populations: A Statewide Cohort Study' (2020) 54(1) *Australian and New Zealand Journal of Psychiatry* 76. Cf Stephen Kisely and Jianguo Xiao, 'Cultural and Linguistic Diversity Increases the Likelihood of Compulsory Community Treatment', (2018) 197 *Schizophrenia Research* 104; Steve Kisely et al, 'A Systematic Review and Meta-Analysis of Predictors and Outcomes of Community Treatment Orders in Australia and New Zealand' (2021) 55(7) *Australia and New Zealand Journal of Psychiatry* 650.

[1531] Steve Kisely, Katherine Moss, and Dan Siskind, 'Efficacy of Compulsory Community Treatment and Use in Minority Ethnic Populations: A Statewide Cohort Study' (2020) 54(1) *Australian and New Zealand Journal of Psychiatry* 76.

[1532] Alison Schneller, Katey Thom, and Peter Adams, 'Towards Changing Compulsory Community Mental Health Treatment in New Zealand: Shining Light on How Community Treatment Orders are Produced' (2018) 7(3) *Laws* 30.

[1533] Steve Kisely and Jianguo Xiao, 'Cultural and Linguistic Diversity Increases the Likelihood of Compulsory Community Treatment', (2018) 197 *Schizophrenia Research* 104, 106; Steve Kisely, Jianguo Xiao and Le Jian, 'Changes in Determinants of Compulsory Community Treatment over 11 years. A Population-Based Analysis of Linked Mental Health Databases' (2015) 230 *Psychiatry Research* 400, 404.

[1534] A Code Black indicates a threat of violence.

[1535] UK studies have found a higher incidence of CTOs among black consumers which indicate that black and minority ethnic groups are apparently over-represented in compulsory mental healthcare admission and treatment. See, for example, Muffazal Rawala and Susham Gupta, 'Use of Community Treatment Orders in an Inner London Assertive Outreach Service' (2014) 38 *Psychiatric Bulletin* 13, 16; Wikus Barkhuizen et al, 'Community Treatment

constituting 14.2% of CTO 1s, 12.4% of CTO2s, and 14.2% of the South Australian population.[1536] This represents a slight increase in the overall number of CALD consumers subject to CTOs in South Australia in comparison to the 2018/19 period, where CALD consumers constituted 11.7% of CTO 1s and 12.9% of CTO 2s.[1537]

6.4.54 Studies on the experiences of CALD consumers while on CTOs have predictably produced mixed results. There is some evidence that persons from CALD communities are more likely to be the subject of a CTO.[1538] Some CALD consumers reported enhanced rapport with clinical teams during their CTO, with many participants in a 2014 Canadian study reporting that they felt 'heard and treated with respect and dignity'.[1539] A Queensland study, in contrast, found that CALD consumers who required an interpreter were 'almost three times more likely to be treated on a CTO than those who did not require the use of an interpreter'.[1540] It is possible that the accessibility of services, when improved by translation services, increase CALD consumers' access to community mental health treatment.[1541] This was reinforced during SALRI's co-facilitated Focus Group with Multicultural Communities Council SA ('MCCSA'), in which participants emphasised the need for qualified interpreters and translated materials. Additionally, participants raised the need for cultural awareness.

6.4.55 It may be that 'those with limited proficiency in English are at risk of being evaluated negatively'[1542] and could even be an indication of CALD consumers' experience of systemic disadvantage in the mental health care system. This highlights the need for an understanding of differing cultural beliefs and the provision of culturally sensitive services. For example, the evil eye is perceived differently amongst European cultures. These cultural nuances should not be dismissed

Orders and Associations with Readmission Rates and Duration of Psychiatric Hospital Admission: a Controlled Electronic Case Register Study' (2020) 10 *BMJ Open* 1, 7.

[1536] Office of the Chief Psychiatrist, *Annual Report of the Office of the Chief Psychiatrist 2021-22* (SA Health, 30 September 2022).

[1537] Office of the Chief Psychiatrist, *Annual Report of the Office of the Chief Psychiatrist 2018-19* (SA Health, 30 September 2019) 31. The RANZCP told SALRI an increase in the use of CTOs among Aboriginal and Culturally and Linguistically Diverse communities does not intrinsically indicate a problem. 'If the assertion is that CTOs are being incorrectly used on these groups, then that is of concern and a review of services' practices and procedures might be warranted.'

[1538] See, for example, Steve Kisely, Katherine Moss, and Dan Siskind, 'Efficacy of Compulsory Community Treatment and Use in Minority Ethnic Populations: A Statewide Cohort Study' (2020) 54(1) *Australian and New Zealand Journal of Psychiatry* 76; Steve Kisely et al, 'A Systematic Review and Meta-Analysis of Predictors and Outcomes of Community Treatment Orders in Australia and New Zealand' (2021) 55(7) *Australia and New Zealand Journal of Psychiatry* 650.

[1539] Magnus Mfoafo-M'Carthy, 'Community Treatment Orders and the Experiences of Ethnic Minority Individuals Diagnosed with Serious Mental Illness in the Canadian Mental Health System.' (2014) 13(1) *International Journal for Equity in Health* 69.

[1540] Katherine Moss et al, 'Compulsory Community Treatment and Ethnicity: Findings from a Culturally and Linguistically Diverse Area of Queensland' (2019) 62 *International Journal of Law and Psychiatry* 154, 157. See also Steve Kisely, Katherine Moss, and Dan Siskind 'Efficacy of Compulsory Community Treatment and Use in Minority Ethnic Populations: A Statewide Cohort Study' (2020) 54(1) *Australian and New Zealand Journal of Psychiatry* 76.

[1541] SALRI's Focus Group with MCCSA revealed the cost of mental health services is a common barrier impacting access for consumers from a lower socio-economic background, common to CALD communities. Further, the wait times to access a mental health service was also a barrier identified during discussion.

[1542] Katherine Moss et al, 'Compulsory Community Treatment and Ethnicity: Findings from a Culturally and Linguistically Diverse Area of Queensland' (2019) 62 *International Journal of Law and Psychiatry* 154, 157. See also Steve Kisely, Katherine Moss, and Dan Siskind 'Efficacy of Compulsory Community Treatment and Use in Minority Ethnic Populations: A Statewide Cohort Study' (2020) 54(1) *Australian and New Zealand Journal of Psychiatry* 76.

when engaging with a CALD consumer. Generally, the experiences of CALD consumers can be further exacerbated with the stigmatisation generally experienced by persons with lived experience of mental illness.[1543] Therefore, a poor experience of mental health service provision may lead to worse mental health outcomes overall.[1544]

6.4.56 Several parties in consultation told SALRI that CTOs are disproportionally applied to Aboriginal and CALD communities. Lived Experience Australia SA, for example, submitted:

> There is emerging evidence that forced community treatment is applied arbitrarily and disproportionately affects marginalised groups such as Aboriginal and Torres Strait Islander peoples and those from CALD backgrounds… there is an urgent need to understand why this variation occurs to ensure the human rights of people with mental health conditions are realised.

6.4.57 While the slight increase in the number of CALD consumers subject to CTOs may not currently be a cause for concern, SALRI raises the need for further research, analysis and interrogation of data pertaining to CTOs and CALD consumers.

Persons with a disability

6.4.58 Data regarding the number of persons with a disability subject to CTOs has not been included in the 2020/21 Report.[1545] As a result, the experiences of consumers with a disability subject to CTOs is not publicly available in South Australia.

6.4.59 However, SALRI has heard in both past and present consultation that persons with a disability are often the subject of generalised and simplistic assumptions, including that the mere presence of a disability either denotes a mental illness and/or a lack of decision-making capacity.[1546] SALRI's present consultation suggests that persons with autism and psychosocial disorders in particular experience exacerbated levels of these assumptions as the result of stigmatisation linked to their diagnoses. Consumers and psychologists raised the possibility that CTOs are not adequately considered in the context of autism, with consumers reporting that they felt that a diagnosis of autism may lead to false conclusions that autism 'disqualifies' a consumer from having decision-making capacity.

6.4.60 Importantly, persons with a disability also reported that they experienced barriers to mental health treatment which made CTOs desirable. One consumer reported that the NDIS and mental health support they could access through their general practitioner would not fund any treatment, other than 'talk-based therapy', when they preferred medication. They felt as though 'people need to worsen their own situation to get help in a crisis'.

[1543] Stephen Kisely and Jianguo Xiao, 'Cultural and Linguistic Diversity Increases the Likelihood of Compulsory Community Treatment' (2018) 197 *Schizophrenia Research* 104, 107; Magnus Mfoafo-M'Carthy, 'Community Treatment Orders and the Experiences of Ethnic Minority Individuals Diagnosed with Serious Mental Illness in the Canadian Mental Health System' (2014) 13(1) *International Journal for Equity in Health* 69, 76.

[1544] Stephen Kisely and Jianguo Xiao, 'Cultural and Linguistic Diversity Increases the Likelihood of Compulsory Community Treatment' (2018) 197 *Schizophrenia Research* 104, 107.

[1545] Office of the Chief Psychiatrist, *Annual Report of the Office of the Chief Psychiatrist 2021-22* (SA Health, 30 September 2022).

[1546] One psychologist noted that 'the application of CTOs have not been considered for diagnoses and treatment of autism.'

Use of Community Treatment Orders

6.4.61 The 2020/21 Report shows that the majority of CTO 1s and CTO 2s are made for their maximum durations with only 7.6% of these orders revoked earlier.[1547] This may not be an issue if the making of orders for their maximum duration are necessary, and they are the least restrictive option for a consumer's treatment. However, the Chief Psychiatrist's submission to SALRI notes that CTOs which could have been revoked earlier are regularly left to expire at the end of their term. In the case of CTO 2s, this may be attributable to the bureaucratic and administrative difficulties involved in having to make an application to SACAT to vary or revoke the order.[1548] The practice of making orders to their maximum duration may similarly be a result of the administrative burden of making a fresh application for a CTO if it expires earlier than necessary.

6.4.62 SALRI's consultation also suggests that CTOs may be primarily used as a means of ensuring medication compliance.[1549] A senior consultant psychiatrist, said CTO1s 'are being used as a forcing function on community teams, rather than as per the consumer's needs.' The RANZCP commented:

> Many working within the mental health system consider that some of the treatment given to those under CTOs does not represent best practice. In many cases, CTOs are used primarily to ensure that patients are consistently receiving their medication, where the preference would be that they are receiving a holistic prescribed treatment.
>
> This would represent a period of prescribed treatment in which the consumer and their family can see its benefits, working actively with them to improve that person's outcomes, revocation of the CTO at an appropriate time, and continuing to monitor and provide support as needed.[1550]

6.4.63 The Central Adelaide Local Health Network ('CALHN') submitted:

> Before any changes to the law are made, it is appropriate that there is a detailed analysis of what is occurring in the mental health system. It is worth noting that Community Treatment Orders (CTOs) are often used as a means of providing less restrictive treatment than an Inpatient Treatment Order and/or to support people to have treatment in the community rather than in hospital.

[1547] Department for Health and Wellbeing (SA), *Annual Report of the Chief Psychiatrist of Australia* (2021) 35.

[1548] *Mental Health Act 2009* (SA) s 16(7).

[1549] This was suggested, for example, by the Country and Outback Health Lived Experience Advisory Panel and in SALRI's Focus Group with the Lived Experience Leadership and Advocacy Network. See, also, for example, Lisa Brophy et al, 'Community Treatment Orders and Supported Decision-Making' (2019) 10 *Frontiers in Psychiatry* 1, 5–6; Jorun Rugkåsa et al, 'What does being on a Community Treatment Orders Entail? A 3-Year Follow-Up of the OCTET CTO Cohort' (2017) 52(4) *Social Psychiatry and Psychiatric Epidemiology* 465; Deborah Corring, Richard O'Reilly and Christina Sommerdyk, 'A Systematic Review of the Views and Experiences of Subjects of Community Treatment Orders' (2017) 52 *International Journal of Law and Psychiatry* 77; Hann Stuen et al, 'Increased Influence and Collaboration: a Qualitative Study of patients' Experiences of Community Treatment Orders within an Assertive Community Treatment Setting' (2015) 15(1) *BMC Health Services Research* 409, 413; Wayne Weavell, *Are Mental Health Treatment Orders Out of Order?* (3 June 2016) The University of Melbourne <https://pursuit.unimelb.edu.au/articles/are-mental-health-treatment-orders-out-of-order>.

[1550] The RANZCP stated it has reports of frustration from staff within the public mental health system and 'a perception that to a certain extent those responsible for oversight see the process of attempting treatment as more important than the reality of implementing meaningful and more effective treatment.' They emphasised that 'the RANZCP SA Branch is not presenting these issues as necessarily representing the reality of public mental health practice – the sample size of those responding with these criticisms is not large enough to warrant that conclusion.'

6.4.64 Further, CALHN recommended 'that there be a detailed analysis of the potential drivers and associations between different parts of the mental health system before using changes to the law to act as a forcing function without an understanding of the causes or consequences.'

6.4.65 The Hon Tammy Franks MLC raised concerns regarding the coercive nature of CTOs:

> Advocates have warned that CTOs are frequently reduced to little more than arrest and forced medication rather than providing a pathway to effective treatment… the broad scope and intrusive nature of CTOs allows room for abuse, and has shaped CTOs as a tool for control rather than a recovery method.

6.4.66 Though most interested parties agreed with the suggestion that CTOs should be used to facilitate more holistic services, medical practitioners indicated that it seemed more difficult to enforce non-medical treatment, such as therapy.

Child and adolescent mental health

6.4.67 A number of parties highlighted to SALRI that particular care and sensitivity is necessary in the use of CTOs for children.

6.4.68 Children and adolescents aged 0 to 15 years are subject to the smallest number of CTOs, with only 3 CTO 1s (0.4%) made for child and adolescent consumers in 2020/21.[1551] This significantly increases to 101 CTO 1s (11.9%) and 112 CTO 2s (6.9%) for those aged 16-24 years. Though this could indicate that children are more likely to access voluntary mental health services, some parties in SALRI's consultation highlighted there is a systemic failure to consider child and adolescent consumers in community mental health approaches.[1552]

6.4.69 Consultation with medical practitioners and staff from the Women's and Children's Hospital revealed perceptions that the *MHA* is written for adults, and fails to provide for children and parents, as well as clinicians in paediatric mental health care. It was also noted that it may be positive that less children are on CTOs, due to the possible negative psychological effects of involuntary treatment. Concerns were also raised in relation to the use of psychiatric medication in children and adolescents. This should be a last resort, following non-pharmacological interventions, where appropriate, in the first instance. Additionally, consultation was able to identify that there is a service gap for community-based mental health care for 16 to 18 year olds.

Older persons mental health

6.4.70 Older persons are under-represented in the use of CTOs, with those aged 65 and above subject to 5.1% of CTO 1s and 6.8% of CTO 2s, despite constituting 19.4% of the South Australian population.[1553] There is an apparent lack of literature relating to the experience of older persons on CTOs, despite the number of people subject to them.

[1551] Office of the Chief Psychiatrist, *Annual Report of the Office of the Chief Psychiatrist 2021-22* (SA Health, 30 September 2022) 33.

[1552] In particular, medical practitioners from the Women's and Children's Hospital and the Child and Adolescent Health Community of Practice noted that 'The Act is written for adults', with few provisions relating to children. They additionally identified a gap in the provision of services for 16 to 18 year olds. It was also noted that children often require trauma-informed mental health treatment approaches. The philosophy of treatment is different, supporting the argument that the *Mental Health Act 2009* (SA) should more thoroughly consider the treatment of children and adolescents.

[1553] Office of the Chief Psychiatrist, *Annual Report of the Office of the Chief Psychiatrist 2021-22* (SA Health, 30 September 2022).

6.4.71 The lack of literature and understanding in this area may create an issue in practice with regard to those with a neurocognitive disorder, or colloquially 'dementia'. There are particular concerns about the effectiveness of adopting practices which infringe upon a person's right to liberty for those with cognitive impairment. The nature of a cognitive impairment in some contexts is that while a person may exhibit behavioural problems, such as agitation, this does not pose the same level of risk of harm when compared to a person under the influence of an illicit substance. For those with a cognitive impairment, it is best practice to look at 'the cause of a person's symptoms and not to respond to the symptoms themselves.'[1554] This suggests that this is a clinical issue, highlighting the need for further training to learn how to effectively manage those with cognitive impairment and de-escalate situations without the use of restraint or involuntary treatment.[1555]

Forensic mental health

6.4.72 There are three issues in relation to the operation of CTOs in forensic mental health:

1. The operation of CTOs in prison;
2. The need for a Forensic CTO, which only applies in the forensic setting; and
3. Resolving operational issues raised in cases involving the *MHA* and the *Criminal Law Consolidation Act 1935* (SA) ('*CLCA*').

6.4.73 The current operation of mental health services within prisons was described as a 'highly fragmented model' and a prisoner may be subject to involuntary treatment, whilst in custody. For an ITO, the prisoner will simply be transferred to a mental health inpatient unit of a hospital. However, there are operational issues in relation to the delivery and administration of CTOs for prisoners. One psychiatrist working within SA's Prisons informed SALRI that a prison does not fall within the remit of any Community Mental Health Team.[1556]

6.4.74 Some identified difficulties relating to the operation of CTOs for persons in custody include:

- For prisoners released without secure housing, the absence of an address precludes a CTO and highlights an operational gap whereby a Community Mental Health Team cannot accept the consumer;
- In practice, it is difficult to review orders made within 24 hours due to limited staffing and availability;
- Following the making of a CTO, it is unclear who takes primary responsibility for the monitoring of CTO compliance and reporting requirements to the Chief Psychiatrist;
- When a prisoner enters a prison with an active CTO, there is no mechanism to detect the presence of a CTO; and

[1554] Senate Committee on Community Affairs, Parliament of Australia, *Care and Management of Younger and Older Australians Living with Dementia and Behavioural and Psychiatric Symptoms of Dementia* (2014).

[1555] Piers Gooding and Bernadette McSherry, 'Alternatives to Compulsory Detention and Treatment and Coercive Practices in Mental Health Settings' (2018) 26(2) *Journal of Law and Medicine* 300.

[1556] Currently within the prison system, health care (including mental health), is facilitated through Prison Health, which is a primary care service. They are supported by consultation liaison psychiatric clinics, but are not connected to any Community Mental Health Team.

- As a result of a fragmented system, care planning becomes complex, with particular challenges in communicating with the prisoner's family or carers.

6.4.75 The operation of CTOs among the prison population is an area requiring specific investigation and consideration.

6.4.76 As a result of the difficulties with the operation of CTOs in prison there appears to be a need for Forensic CTOs in the mental health space. SALRI's Medical Specialist Roundtable revealed that CTOs may be under-used in forensic settings, with two common outcomes. Firstly, the consumer is placed on a CTO, which is effective, however treatment ceases as it is too difficult to monitor and ensure compliance. Second, a consumer is placed on a CTO and fails to comply following effective treatment, causing potential relapse.

6.4.77 In their submission to SALRI, the OCP recommended that consideration should be given to the introduction of a Forensic CTO, as operates in NSW – which offers greater oversight and review in comparison to general CTOs.[1557] This was also supported by the Department for Correctional Services. Following an independent review in June 2021 (known as the McGrath Report), recommendations were made in relation to SA's forensic mental health system. One such recommendation included the establishment of a Mental Health Review Tribunal – which, in consultation with SACAT, could be operationalised as a specialist stream within SACAT.[1558] The OCP noted that the *MHA* may be a 'more appropriate statutory home for provisions relating to the assessment, treatment and supervision' of forensic consumers.[1559]

6.4.78 SALRI was also informed of an operational issue pertaining to cases involving the *MHA* and *CLCA*. A consultant forensic psychiatrist provided their experience. SALRI was told forensic consumers remain under the supervision of the Forensic Mental Health Service. Following discharge from hospital, consumers on licence conditions remain under the care of the Clinical Director of the Forensic Mental Health Service (via delegation from the Minister for Health). In their experience, an application for a CTO via SACAT is often unsuccessful, as it is argued the *CLCA* overrides the *MHA*. As a result, their experience has led to a conclusion that there is no mechanism to enforce treatment where there is a risk to the community – which is inconsistent with the expectations of the *CLCA*. SALRI was told that greater consideration and clarity with respect to the concurrent use of both the *CLCA* and *MHA* is required.

6.4.79 The role and application of the *CLCA* and accompanying operational issues falls outside the scope of SALRI's review. However, it is suggested that the operational issue identified, particularly in the concurrent use of the *CLCA* and *MHA* and strategies for resolution, should be considered.

Addressing non-compliance

6.4.80 The consequences for a consumer of non-compliance to a CTO under the *MHA* are not clear or consistent. It is unclear whether or how a consumer should be put on notice of non-compliance; how long after a notice is issued, an ITO should be considered; or whether any records of non-compliance should be kept.

[1557] Government organisations also considered the possibility of forensic CTOs as valuable for allowing more systematic recognition of consumers in the prison community.

[1558] See SALRI Suggestion 10.

[1559] The role and operation of the criminal law is largely beyond the scope of this review.

6.4.81 Despite this uncertainty, it has been suggested that adherence to CTOs are largely driven by the belief that non-adherence will lead to hospitalisation.[1560] This raises concerns related to the well-documented adverse effects of coercion in mental health treatment, which often leads to disengagement from mental health services due to the traumatic experience of involuntary treatment.[1561] Studies show that coercion in mental health treatment can undermine a consumer's trust in their mental health team and in the system generally, which in turn erodes efficacy of care.[1562] An Australian study into consumer perspectives of CTOs found that consumers framed the CTO experience morally, and often held views that they had been placed on CTOs because they were being 'punished for being bad, being seen as untrustworthy, and having faults to be corrected via coercive mental health services practices'.[1563]

6.4.82 The issue of 'reasonable force' under the *MHA* by police and/or authorised officers to ensure compliance with CTOs proved a contentious item in SALRI's consultation. This was consistent with the differing views SALRI heard as to the issue of the use of 'reasonable force' in respect of the care and control powers under s 56 and s 57 of the *MHA* and the use of force or coercive practices in general terms under the *MHA*.

6.4.83 Consultation regarding the use of 'reasonable force'[1564] to ensure compliance with CTOs revealed mixed results. SALRI's survey results were also representative of this point. A majority of respondents replied 'yes' to the question, 'Should the *MHA* be changed to include a power to use reasonable force in cases involving non-compliance with a CTO?', with some qualifying that force should only be used as a last resort, with regard to the safety of all concerned, and with strict limitations. Those who rejected this raised concerns that this would exacerbate the negative impacts of CTOs, as outlined above. Other respondents noted that 'force is already happening with no recourse'.

6.4.84 Other parties raised that the lack of specific power to use reasonable force in response to non-compliance with a CTO leads to further questions regarding the transparency and accountability of the process. Additionally, the lack of clarity as to the level of non-compliance which should prompt consideration of an application for an ITO, and reporting requirements, lead to the invisibility of variance in mental health practitioners' practice, and add to concerns that CTOs may be too powerful a tool.

[1560] See, for example, Hann Stuen et al, 'Increased Influence and Collaboration: a Qualitative Study of Patients' Experiences of Community Treatment Orders within an Assertive Setting' (2015) 15(1) *BMC Health Services Research* 409, 415; Sharon Lawn et al, 'A Qualitative Study Examining the Presence and Consequences of Moral Framings in Patients' and Mental Health Workers' Experiences of Community Treatment Orders' (2015) 15 *BMC Psychiatry* 274, 287; Deborah Corring, Richard O'Reilly and Christina Sommerdyk, 'A Systematic Review of the Views and Experiences of Subjects of Community Treatment Orders' (2017) 52 *International Journal of Law and Psychiatry* 77.

[1561] Philippe Golay et al, 'Feeling Coerced during Psychiatric Hospitalisation: Impact of Perceived Status of Admission and Perceived Usefulness of Hospitalisation' (2019) 67 *International Journal of Law and Psychiatry* 1, 2; Office of the Western Australian Chief Psychiatrist, *Community Treatment Orders: A Review* (December 2001) 9–10; Tom Burns et al, 'Coercion in Mental Health: a Trial of the Effectiveness of Community Treatment Orders and an Investigation of Informal Coercion in Community Mental Health Care' (2016) 4(21) *Programme Grants for Applied Research*.

[1562] Richard Mullen, John Dawson and Anita Gibbs, 'Dilemmas for Clinicians in Use of Community Treatment Orders' (2006) 29(6) *International Journal of Law and Psychiatry* 535; Suzanne Dawson et al, 'Community Treatment Orders and Care Planning: How is Engagement and Decision-Making Enacted?' (2021) *Health Expectations: An International Journal of Public Participation in Health Care and Health Policy* 24(5) 1859; Office of the Western Australian Chief Psychiatrist, *Community Treatment Orders: A Review* (December 2001) 9–10.

[1563] Sharon Lawn et al, 'A Qualitative Study Examining the Presence and Consequences of Moral Framings in Patients' and Mental Health Workers' Experiences of Community Treatment Orders' (2015) 15 *BMC Psychiatry* 274, 275.

[1564] See also Part 9 Role of Police.

6.4.85 Other parties, including health practitioners and service providers, disagreed with this approach. Many parties, especially medical practitioners and mental health practitioners, pointed out to SALRI that, although it is something to be avoided in practice if possible, the ability to use 'reasonable force' to ensure compliance with a CTO is necessary and appropriate.

6.4.86 Significant support was expressed for the premise that the *MHA* should include an explicit power for the use of 'reasonable force' for compliance with a CTO, if only as a 'last resort'. Various parties saw this as appropriate and warranted, especially noting the paramount need to protect the safety of health staff, consumers and other consumers. The RANZCP, for example, supported this change, stating an ability to use 'reasonable force' to enforce a CTO will benefit the welfare of consumers, the public, and healthcare providers.[1565] They submitted:

> Part of the definition of a person under a CTO is that they are, 'at risk to themselves or others.' If a person requires treatment for their own welfare and safety, or the safety of others, that clearly needs to be accompanied by such provision as required to enable mental health services to administer that treatment. To have provisions for an Order than cannot be enforced makes the Act useless in practice. The Act already implies the power to use reasonable force in 13(3) and 18(3): 'The treatment may be given despite the absence or refusal of consent to the treatment'. The lack of a specific provision allowing reasonable force is a significant issue for staff working within mental health teams. They report ongoing concerns about their safety from consumers who are actively opposing their treatment, with staff being threatened or assaulted not uncommon. This change to the *MHA* would improve safety and predictability for staff, consumers and police and would be greatly beneficial and welcomed.

6.4.87 SALRI notes these concerns and is obviously sympathetic to arguments relating to staff safety as well as the welfare of consumers and the community.

6.4.88 CALHN also supported a power to use reasonable force for non-compliance, noting:

> … it is inherent in the making of an order for involuntary treatment that there is a provision for the use of 'reasonable' force.
>
> 'Reasonable' should be given its everyday meaning in order that it can be appropriately applied for each person, as it should be noted that force applied to one person may be appropriate, but inappropriate for another.
>
> Again, the persons authorised to apply reasonable force in cases involving non-compliance with a CTO should be defined in regulations and include but are not limited to: clinicians (including General Practitioners for some country areas); ambulance officers; police officers; and correctional services officers.

6.4.89 However, SALRI notes that opposition or misgivings were expressed by various parties as to the inclusion of an explicit power in the *MHA* to use 'reasonable force' in the administration or enforcement of CTOs. Many consumers and advocacy groups opposed such a suggestion. Several parties saw the ability to use force under the *MHA* to ensure compliance with a CTO as undermining sound clinical practice. The Office of the Public Advocate said that consideration should be given to whether serious non-compliance with a CTO could be addressed in a way that is less restrictive than using either an ITO or s 56 and s 57 care and control powers. Lived Experience Australia stated it does

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[1565] See also Royal Australian and New Zealand College of Psychiatrists, Minimising and, where possible, eliminating the use of seclusion and restraint in people with mental illness (Position Statement 61) (August 2021) <https://www.ranzcp.org/news-policy/policy-and-advocacy/position-statements/minimising-use-of-seclusion-and-restraint>.

not condone the use of any force, reasonable or otherwise and cultural and operational changes are preferable. Lived Experience Australia said mental health clinicians are trained in the use of de-escalation techniques, but it is often the case currently that security is brought into mental health units as the first response when a person states that they do not want to take medication. They added: 'We do, however, absolutely acknowledge the need if life is at risk, and suitable force should be taken to ensure the safety of everyone.'

6.4.90 Finally, parties concerned with the welfare of children, such as the Commissioner for Children and Young People and medical practitioners from the Women's and Children's Hospital, raised the *MHA*'s silence as to the Act's application to children. SALRI concurs with this point and suggests that the *MHA* should be amended to include specific provisions regarding the application of CTOs to children.

6.4.91 SALRI also heard differing views as to the use of 'reasonable force' under the care and control powers under s 56 and s 57 of the *MHA* as well as the ability to use force or coercive practices in general terms under the *MHA*.

6.5 Consultation Data Overview

6.5.1 It is no surprise that, given the conflicting research, there were divergent views in SALRI's consultation as to the rationale, use and effectiveness of CTOs. On one hand, there was outright opposition to CTOs and calls for their abolition or, at least drastic restrictions on their use. There were those who expressed qualified support for CTOs, noting their concerns as to their use and prevalence in South Australia, providing that their use should only be on a careful and cautious clinical basis after detailed consideration. On the other hand, there were parties who viewed CTOs as a valuable and beneficial option under the *MHA* and that the present system largely works well.

6.5.2 There was no consensus and overall, SALRI's consultation revealed divergent perspectives on the role and use of CTOs. Though most interested parties could recognise their utility in the current mental health system, there was also a recognition of their limitations.[1566] The common themes that arose in the consultation process and survey responses was the necessity of CTOs, the inappropriate use of CTOs, a lack of resources for community follow up, issues with transparency and accountability in the use of CTOs, and the need for more consumer and carer involvement in treatment.

6.5.3 Lived Experience Australia accepted that many people, because of their mental illness, may require a CTO, though practice could be reframed. The Office of the Public Advocate, whilst noting the need for no less restrictive option to be appropriate, acknowledged that there are times when a CTO provides a less restrictive alternative to compulsory inpatient treatment and 'CTOs are an important mechanism for the treatment of people with serious mental illness'.[1567] The RANZCP told SALRI that 'there is no legal or best practice medical justification to limit or reduce the number of CTOs.' They observed that the provision for CTOs in the *MHA* exists for good reason, 'the simplest of which is that some patients have chronic treatment-resistant illness and require ongoing

[1566] They concluded that CTOs become a double-edged sword because, while forced cooperation might lead some consumers to accept medication in the long-term, other consumers might associate the experience with the loss of autonomy and develop negative attitudes to medication, help-seeking from mental health services and indeed the medical profession, more generally.

[1567] The Office of the Public Advocate raised the rising numbers of CTOs are worthy of noting and the reasons for this need to be better understood to inform legislative reform and policy making.

CTOs in order to ensure they are receiving the medication they need for both their own safety and that of others.'

6.5.4 SALRI's consultations with mental health practitioners have indicated that they consider CTOs an important and valuable tool in a consumer's recovery. Their reasons for this ranged from the accessibility of services to those who would otherwise be unable to afford their medication, to the ability or perceived ability to 'control' consumers' adherence to treatment.[1568] One psychiatrist gave an example of a consumer on Kangaroo Island who has been able to receive treatment for 12 years due to consecutive CTOs made for the same amount of time, who would have otherwise refused treatment.

6.5.5 One medical practitioner stated that one benefit of a CTO to the consumer is that they do not need to pay for medication, which can otherwise be financially burdensome. An attendee at SALRI's Nursing and Social Work Roundtable noted that, from their perspective, a CTO is a 'guaranteed ticket entry' to a community mental health team, ensuring access to a mental health service. However, a psychologist raised concerns that 'community mental health teams are not adequately resourced to follow up CTOs.'

6.5.6 Various consultees argued that the use of CTOs, whilst of utility, should be reduced and restricted in South Australia. A carer consultant with a lived experience perspective told SALRI that law and practice should 'absolutely' be reframed to reduce the number of CTOs, stating:

> I would ask why has there been an increase in CTOs? Are the medical staff not understanding the criteria of meeting a CTO order? CTOs are a form of restraint and therefore takes away a person's right to choose. How is this best practice or least restrictive practice or incorporating Trauma informed practices? I would advocate for an independent third party to support the person with information to give the person an opportunity to make an informed decision.

6.5.7 The Disability Rights Advocacy Service ('DRAS') argued that it is necessary to limit and more strictly regulate the use and number of CTOs. Persons subject to CTOs should be able to have access to wrap-around supports and a trauma-informed approach that are personalised to their individual circumstances. Consumers with disability are often not heard and treatment options inadequately explained to them. They must be involved in decision-making about treatment options available to them. DRAS proposed mandating that under the *MHA,* consumers subject to CTOs must be 'provided a multidisciplinary treatment team of psychiatry, clinical psychology, counselling, nursing, or social workers, among other things – subject to their personal circumstances and conditions and what supports are appropriate.'

6.5.8 The Australian Psychological Society advocated for the reduction of the number of CTOs, noting the *MHA* should incorporate and facilitate the use of supported decision-making. CTOs should be more than a legal mechanism for the involuntary administration of psychiatric medication in the community.[1569] 'Providing responsive, appropriate and evidence-based interventions led by psychologists in the community would increase the effectiveness of CTOs in bringing about recovery as far as is possible, with the overall aim of reducing their use.'

[1568] One medical practitioner indicated that they 'feel as though [they] have more control of the consumer when a CTO is in place' and noted that when a CTO is in place it at least looks as though a consumer is being treated even if it is not really working, or actually being administered.

[1569] This comment was often recounted to SALRI in consultation and one consumer noted that CTOs are not about treatment but rather medication and to call them 'treatment orders' is misleading and they should be 'medication orders'.

6.5.9 Dr Susan Peukert also supported reducing the use of CTOs. She noted that CTOs play an 'important role' in treating people with mental illness in the community and 'without that treatment, they may otherwise need to be treated as an inpatient under an ITO.' Dr Peukert emphasised the need for a meaningful supported decision-making model to underpin the *MHA* and contended that individuals lose the ability to participate in their own treatment decisions under the *MHA*. In 'losing their right to make autonomous decisions with legal effect… they are relegated to having decisions made on their behalf.' More frequent and mandatory reviews under the *MHA* were also raised as a mechanism to reduce the number of CTOs while maintaining them for their important role in the community.

6.5.10 Various consultees opposed CTOs as a form of 'involuntary' treatment that inevitably undermines the rights of consumers. One community member asked SALRI to 'please ensure that … involuntary admission and treatment are implemented in the *Mental Health Act.*'[1570] Another consultee told SALRI the 'short answer' is 'never' should involuntary treatment be administered under the *MHA* and the right to refuse treatment is a human right. A different consultee said that present law and practice allows 'very damaging and unworkable treatments to be used, and indeed forced upon patients against their will'. They further noted it is the State's role to see that its citizens are protected from human rights violations and 'I believe this *Mental Health Act* violates human rights in the name of "help" by not only allowing, but enforcing, damaging and unworkable treatments and practices in psychiatric institutions.'

Necessity of CTOs

6.5.11 There were differing views expressed as to the necessity of CTOs made in South Australia.

6.5.12 A number of parties, reflecting the findings of many (though far from most) studies, questioned the role and utility of CTOs. There was a clear view from some consultees that too many CTOs are made and they are all too often unnecessary or inappropriate. However, most stakeholder groups and interested parties could recognise the necessity of CTOs in situations where a person was a risk to themselves or the community, particularly where a consumer does not recognise that they are unwell. The Legal Services Commission and others raised that a CTO should be available in circumstances of prevention of 'serious harm.'

6.5.13 One carer shared his belief that his son's CTO is important in his son's continued recovery:

> … [my son's] CTOs have never been long enough to get him well enough to be in a position to sensibly appraise or deal with his substance abuse problems … or contemplate therapy. … [he] needs more (and longer) Treatment Orders – not less.

6.5.14 Access to mental health services were also raised as a reason CTOs were necessary. An attendee at the Mental Health NGO Roundtable stated that, in their experience, 'a lot of family members support CTOs as it is a way of guaranteeing treatment,' as it is generally thought that 'there is very little support in the community for mental health'.[1571]

[1570] For discussion of the international human rights context, see Part 2 Background and Context to South Australia's Mental Health Laws.

[1571] See also Richard O'Reilly et al, 'A Qualitative Analysis of the Use of Community Treatment Orders in Saskatchewan' (2006) 29(6) *International Journal of law and Psychiatry* 515; Richard Mullen, Anita Gibbs, and John Dawson, 'Family Perspective on Community Treatment Orders: A New Zealand Study' (2016) 52(5) *International Journal of Social Psychiatry* 1.

6.5.15 One regional carer shared that, following her child's discharge from the hospital:

> We have had no follow up from [health services] … in trying to help my son I recently had a consultation with a psychologist via Zoom and this cost me $480 which is not claimable. I am incurring considerable expenditure trying to obtain proper treatment for my son… There is considerable financial burden and no financial assistance. It has taken a great toll on my own mental health and wellbeing. All of the above illustrates the lack of services and support within this rural area and I am concerned for the future wellbeing of my family.

6.5.16 The importance of the perspective of family members was noted by several consultees. The Mood Disorders Carers Support Group, for example, noted that wherever possible carers should be included in their 'loved one's mental health treatment' as a carer know their loved one better than anyone does. 'They know what kind of person they were before they became unwell and are often the first point of contact in the mental health system.'[1572]

6.5.17 Various consultees, including the Australian Psychological Society, noted that the overall goal in South Australia should be to reduce CTOs in favour of voluntary and non-coercive options for treatment which are accessible, appropriate and sustainable (though other parties doubted this was a realistic substitute).[1573] The South Australian Mental Health Commissioners stated:

> We appreciate there will always be the need for some people to be treated under a treatment order, however, we believe, as with inpatient treatment orders, they are an overused mechanism due to lack of other available care and support options … If the mental health system is operating effectively, with a range of early interventions and prevention services and programs that enable early treatment and empower human rights, there should be a reduced need to impose community treatment orders (CTOs) ... if consumers were given adequate psychosocial supports in the home and in community, we could reduce the need for CTOs.

6.5.18 Lived Experience Australia SA acknowledged:

> … [there are] potential adverse impacts of not having a CTO in place where it is clearly of value in ensuring effective treatment and care… [so] cultural change within mental health services with regard to improved listening, involvement in decisions about care, involvement in care planning and so forth is what is needed.

6.5.19 Aspire Recovery Connection referred to community members detailing experiences of 'excessive use of restrictive practice and reported multiple and repeated experiences of coercion' and when they reached a 'point of crisis' their own knowledge of their mental and emotional wellbeing and when and how services were needed were largely dismissed and the 'system' took over that decision-making. Aspire Recovery Connection noted its 'extreme concern' and it has witnessed directly and heard from many of its members that involuntary treatment orders have been put in place because the person is displaying persistent 'symptoms' of their 'mental illness' and/or does not accept they have a 'mental illness' or disagrees with the psychiatrist's view, even when they are not a risk to themselves or others. These grounds should not be a reason 'to take away the right to choose whether to engage in this treatment or not, especially in circumstances when the person does not pose a significant risk of

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[1572] Mood Disorders Carers Support Group, *A Case for Improving Practices for People Living with Mental Illness; The Carers Perspective* (8 August 2022) 7.

[1573] A number of parties, especially service providers and health practitioners, noted that even with 'the best will in the world' it is not realistic to expect all consumers will take their medication on a purely voluntary basis. Noting issues of mental illness, especially combined with the effects of alcohol or illicit drugs, some consumers simply will not take medication on a voluntary basis and CTOs for such consumers are both unavoidable and necessary.

harm to themselves or others.' Aspire Recovery Connection agreed that if a person poses a serious threat to harming themselves or others, then there are grounds for involuntary treatment 'in extremely limited circumstances under the *MHA*, but cautioned involuntary treatment should not be allowed just because: 'Someone is just angry, upset or scared, but not a significant risk.'

6.5.20 Other parties such as LELAN and the OCP's Lived Experience Advisory Group also voiced their concerns to SALRI over what they perceived as the excessive and inappropriate use of CTOs and adverse effects upon consumers.

6.5.21 There were also concerns raised by consumers and advocacy groups that consumers and their support systems were unaware of their rights or even unable to recognise when they were being treated with coercion.

6.5.22 Consumers in particular, regularly raised their desire for the provision and accessibility of more holistic treatment, with both medicated and non-medicated treatment options over which they could have choice and control. One consumer raised that wellbeing should be considered holistically, rather than as a security concern. Another proposed the use of CTOs to facilitate welfare visits to help consumers more holistically.

Transparency and accountability

6.5.23 Most consultees and respondents told SALRI there is a need to improve the transparency and accountability mechanisms in relation to CTOs.[1574] In particular, the need to facilitate information sharing across services, improve the uniformity of record keeping practices, and ensure the regular review of CTOs were identified.

6.5.24 Service providers at Port Lincoln raised the need for therapists to be able to share information regarding the effect of a CTO on a consumer's mental and general health.[1575] A submission to SALRI by the Alcohol and Drug Foundation further noted the need for integrated treatment with a 'no wrong door' approach, which would enable consumers to access the treatment they needed regardless of where they sought assistance. This view was shared by other parties.

6.5.25 A member of the community shared her experience with a friend for whom she was a support person. The consumer refused contact with mental health services during a crisis, due to a traumatic experience while under an ITO. Her support person contacted an NGO for assistance, and the consumer was subsequently able to access integrated treatment for which her specialists and care team collaborated. As a result, she is now stable and continues to receive voluntary treatment.

6.5.26 Other consultees, including consumers and the Legal Services Commission, submitted that decision-makers should provide written reasons for their decisions. In particular, it was said, notably by the Legal Services Commission, that the decision-maker's assessment of the criteria under the *MHA* should be written and provided to the consumer in order to make the review process more accessible and transparent. It was also proposed that the statement of reasons should be explained to the consumer.[1576]

[1574] See also Edwina Light et al, 'Out of Sight, Out of Mind: Making Involuntary Community Treatment Visible in the Mental Health System' (2012) 196(9) *Medical Journal of Australia* 591.

[1575] Information sharing under the *Mental Health Act 2009* (SA) was a wider recurring concern. See SALRI Recommendation 3.

[1576] SALRI was told by medical practitioners and mental health professionals that the statement of reasons and rights are routinely explained to a consumer.

6.5.27 One psychiatrist suggested that the two levels within CTOs should be removed. If a CTO is determined to be clinically necessary, the psychiatrist can initiate a CTO, with a mandated SACAT review occurring 4 to 6 weeks post-order. This could then be accompanied by a new review system for CTOs, or an expiry after a prescribed timeframe, as observed for ITOs.

6.5.28 Another medical practitioner stated that:

> The whole approach to CTOs should be done differently; a holistic prescribed treatment rather than just an order for an injection (depot). A time of prescribed treatment [would enable] all interested parties [to] see [the] benefits. We could work with the consumer and their family, deliberately revoke the CTO at an appropriate time, and then continue to monitor for 3 to 6 months.

6.5.29 The Legal Services Commission proposed the introduction of a legislative 'cycle-breaker' to limit 'the continuous use of CTO2s', elaborating:

> … a provision could be introduced that there can be no more than two consecutive CTO2s in any given three-year period. The forced break in the cycle will have the added benefit of requiring the treating team to explore alternative treatment of care… Anecdotal feedback received from patients suggest that when they feel part of the conversation, they are happy to consent to recommended treatment care.

6.5.30 The Legal Services Commission also proposed:

> Once an existing CTO2 was close to expiring and if the medical team was of the view a second CTO2 order should be made, that such an application could only be made in conjunction with a review of the patient by the treating psychiatrist, [rather than] … collateral information only.

6.5.31 A number of interested parties and practitioners also suggested that consecutive CTOs should be automatically reviewed upon each renewal.[1577]

6.5.32 There was mixed feedback on the suggestion that CTO levels in the *MHA* should be removed in favour of a single universal CTO based on doubts that SACAT would have the capacity to undertake regular reviews of CTOs.[1578] However, one practitioner noted that 'positively, [CTO 2s] are being scheduled in a much more timely manner now than they were in the past'. Government agencies stated that the review period should be considered and defined, and that other models of oversight should be considered; the UK model was provided as an example of adequate oversight.

Consumer and carer involvement

6.5.33 Consumers often noted to SALRI that they were left out of treatment decisions, leading them to feel controlled, helpless and stigmatised. One regional mental health worker noted that consumers often did not want to speak to their mental health teams because they worry that they may be 'locked up', and do not trust the medications they may be put on by the team.

6.5.34 One person with lived experience of mental illness stated that the purpose of any kind of restriction under the *MHA* should be 'to support people's wellbeing to support them to live a good life'.

[1577] This was suggested in roundtables with government bodies, nurses, social workers and psychologists.

[1578] See Part 10 The South Australian Civil and Administrative Tribunal and Legal Representation.

6.5.35 Other consumers noted the benefits of CTOs, with one stating that a CTO intervention 'saved [her] life'. Another consumer wrote:

> Being on a treatment order has benefits. It can secure a reliable income in the form of a disability pension, assist with securing accommodation, medications are free, a Treatment Order ensures a regular point of contact with the Mental Health Services which for people who are socially isolated can be their only regular contact and form of support. A Treatment Order is the gateway to accessing services, Social Workers and the NDIS. Therefore, there are many poorly understood benefits to being on a Treatment Order besides providing treatment.

6.5.36 A strong theme in consultation was the need for enhanced consideration for supported decision-making under the *MHA* (including for CTOs), as summarised by this submission by LELAN:

> People with community treatment needs have the right to be supported in the broader context of care and support planning, risk mitigation and early intervention. Person-centred healthcare that includes access to community support, counselling, partnering in care decisions and participation in care planning and decision-making is fundamental to all health care and should be equally applied to community support measures for people experiencing distress or diagnosed mental illness.

6.5.37 A psychiatrist noted that treatment plans, which could be made with consumers, could be given more weight and used as a way of including consumer perspectives about where they want to receive treatment, who they want as a contact person or case worker, and how they feel about inpatient settings.

6.5.38 Additionally, consultees including consumers, often advocated for more carer involvement,[1579] for example, by ensuring that they are notified when a CTO is revoked or expires. Carers who form part of the Mood Disorders Carers Support Group submitted that 'there have been very limited opportunities for discussions with any of [our son's mental health care] team. We feel invisible yet have so much to offer and the desire to help our loved ones. We want to see them independent and living their own life.'

6.5.39 Several NGOs and consumers raised the need for an approach to CTOs which integrates supported decision-making and recognises the capacity of the consumer and their carers to make decisions regarding their treatment.[1580] To this end, Mind Australia submitted that, if the balance of care was to be shifted back to the community through the promotion of voluntary treatment, early intervention, and supported decision-making, the rate and negative impact of CTOs may be reduced.

6.6 SALRI's Observations and Conclusions

6.6.1 SALRI heard a number of compelling accounts of the conflicting experiences of consumers, their families and carers subject to CTOs. SALRI recognises that the rationale and use of CTOs rarely is a subject of consensus, as demonstrated in both the literature and in consultation.

[1579] This view was raised, for example, by Whyalla consumers and the Mood Disorders Carers Support Group.

[1580] Purple Orange, for example, highlighted this point to SALRI.

'CTOs remain one of the most contested issues in psychiatry.'[1581] It is notable that experiences differ and 'there is no such thing as the definitive patient, psychiatrist or family carer experience of CTOs'.[1582]

6.6.2 Stakeholders and researchers often hold opposing views on the use and efficacy of CTOs; whether they can be considered least restrictive practice in any case; and even whether their increasing prevalence is a positive or negative indicator of the operation of the mental health care system.

6.6.3 However, despite the disagreement in the views of consultees, most groups and consultees crucially agreed that there are some situations and contexts in which CTOs would be necessary. The diversity in views, and necessity of CTOs, makes the areas in which there is consensus even more significant. Transparency, accountability, and the need for consumers and their support persons to be involved in the decisions made about their treatment consistently arose as areas for improvement. It is also notable that repeated concerns were expressed in SALRI's consultation by a wide range of parties as to practical, operational and resourcing issues and implications in the role and use of CTOs under the *MHA*. There are also legitimate, even if unresolved, questions as to the prevalence of CTOs in South Australia.

6.6.4 SALRI acknowledges, reflecting both its multidisciplinary research and comprehensive consultation, that the use and rationale of CTOs are contentious. SALRI accepts that there are concerns and many academic studies and researchers question the efficacy of CTOs, and this approach was shared by many parties, notably consumers and advocacy groups, in SALRI's consultation.

6.6.5 SALRI notes that CTOs (as with ITOs and electroconvulsive therapy) are explicitly permitted by the *MHA* and elsewhere in Australia, the UK, Canada, the USA and approximately 70 other countries. CTOs are part of accepted modern medical practice throughout both Australia and in many international jurisdictions. Their use in Australia is subject to various statutory, official and professional requirements and is contemplated and endorsed by lead professional associations such as the Australian Medical Association ('AMA') and the RANZCP. There is also a robust body of research that highlights the utility and benefits in at least some circumstances of the proper use of CTOs to assist in the treatment of persons with mental illness. SALRI also notes this is a statutory review of the operation of the *MHA* and this review is not an opportunity for a thorough evaluation of the rationale and use of CTOs (as with both ITOs[1583] and ECT[1584] where again there are strong views in both research and consultation).

6.6.6 SALRI is therefore of the view that the *MHA* should continue to provide for the use of CTOs, however there are several aspects of the current law and practice where changes could be made to clarify the operation of CTOs under the *MHA*. SALRI also notes the importance of sound and well informed clinical and professional practice to guide the use of CTOs.

6.6.7 Two authors, noting the continuing uncertainty and debate as to the effect of CTOs, offered the following sound advice in an Australian context:

> In view of the continued uncertainty about the effectiveness of CTOs, what should clinicians and legislators do? As CTOs are coercive, clinicians have a responsibility, irrespective of their

[1581] Edwina Light et al, 'Out of Sight, Out of Mind: Making Involuntary Community Treatment Visible in the Mental Health System', (2012) 196(9) *Medical Journal of Australia* 591, 592.

[1582] Krysia Canvin et al. 'Patient, Psychiatrist and Family Carer Experiences of Community Treatment Orders: Qualitative Study' (2014) 49 *Social Psychiatry and Psychiatric Epidemiology* 1873, 1881.

[1583] See Part 5 Inpatient Treatment Orders.

[1584] See Part 7 Electroconvulsive Therapy.

> effectiveness, to use CTOs judiciously and only if less coercive approaches have failed. Of concern is the marked variation in the use of CTOs in different jurisdictions. While it is unclear if this indicates overuse or underuse, clinicians should avoid the temptation to routinely place patients on CTOs… Policymakers must recognise that CTOs are a vehicle for delivering services and are not an alternative to providing care… CTOs have become standard practice in Australia without questioning of the wide variations in their use or their research base. When evidence of clinical effectiveness is unclear, health policy is more likely to be shaped by political and social factors. Given several Australian *Mental Health Acts* are under review, the issue is too important to be uninformed by reliable data.[1585]

6.6.8 SALRI agrees with these comments.

6.6.9 A recent Australian study is telling.[1586] The author noted that since 2013, every Australian jurisdiction, except the Northern Territory, has reformed its mental health laws to either prohibit or strongly discourage forced psychiatric treatment in those who competently refuse it. Few people who competently refuse treatment under the *MHA* should still be subject to CTOs. It is therefore important to examine the role and use of CTOs in the context of this contemporary legislative environment. The author concludes:

> CTOs are diminished but not yet defeated. It is possible that CTOs are far more potent when their use is restricted to those who lack decision-making capacity… and a possible strong benefit when directed to incompetent patients was being 'washed out' by their use in many people capable of deciding for themselves. There is still a place for ongoing CTO research in patients who are largely recovered, but who still, despite our best efforts at providing support and education, either do not understand the information relevant to the utility of treatment or cannot use and weigh that information as a result of the effects of their mental illness. The state has long recognised a responsibility to protect those who cannot, by reason of mental incapacity, protect themselves, so to the extent that CTOs might be efficacious this should surely be the population targeted.[1587]

6.6.10 SALRI agrees with these observations and emphasises the need for strong accountability mechanisms in an area in which it is widely recognised that consumers' human rights are vulnerable to infringement. SALRI notes that representatives of South Australian government bodies agreed, during consultation, that greater analysis and interrogation of data regarding the numbers of both CTOs and ITOs is necessary.[1588]

6.6.11 The prevalence of CTOs in South Australia was a recurring theme in consultation. SALRI notes the high number of CTOs in South Australia, which are even high in the context of Australia's rate of CTOs when compared internationally.[1589] The implications of the high rate of CTOs were subject to differing interpretations. On the one hand, a regular view expressed to SALRI (notably by professional bodies and medical and other health practitioners) was that the prevalence of CTOs in South Australia is not necessarily negative. It was explained that the high rate of CTOs is preferable to

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[1585] Steve Kisely and Richard O'Reilly, 'Reappraising Community Treatment Orders – can there be Consensus?' (2015) 202(8) *Medical Journal of Australia* 415.

[1586] Christopher Ryan, 'Community Treatment Orders are (Somewhat) Effective: Their Future in the Context of Rights-Based Mental Health Law' (2018) 51(3) *Australian and New Zealand Journal of Psychiatry* 11.

[1587] Ibid 12.

[1588] The Child and Adolescent Health Community of Practice submitted that 'CTOs should be monitored rather than being "limited" in numbers. The reasons behind the increase of CTOs should be evaluated to obtain a greater understanding of the contributing factors for out of hospital care.'

[1589] See Edwina Light, 'Rates of Use of Community Treatment Orders in Australia' (2019) 69(4) *International Journal of Law and Psychiatry* 83.

consumers being placed on ITOs. Indeed, applying this view, the South Australian statistics indicated that CTOs are actually working as intended. On the other hand, concerns were regularly expressed to SALRI by consumer and disability groups that the high rate of CTOs in South Australia is of real concern. The suggestion was that, especially as impaired decision-making capacity is one of the criterions for the making of a CTO, CTOs are being imposed far too often and for consumers who do not meet the legislative criteria. They are seen as a form of 'defensive medicine'.

6.6.12 SALRI notes that the explanation of the prevalence of CTOs in South Australia, when compared with other Australian States, cannot be explained by the law, as other *MHA*s across Australia are largely similar. SALRI proposes that any explanation for the number of CTOs in South Australia must be analysed and interpreted in the context of South Australia and medical and/or operational practices in South Australia. SALRI reiterates that the reasons for the numbers of CTOs is a complicated and multifaceted question. As Light comments:

> It is also recognised that there are likely multiple clinical, ethical and political factors driving the use of CTOs in any one jurisdiction, including the resourcing and organisation of mental health and other public services, and the perspectives of clinicians and others making decisions about the use of involuntary treatment.[1590]

6.6.13 SALRI in the current review, considers any effort to reliably explain the high rate of CTOs compared with elsewhere in Australia would be unduly speculative. Similarly, the RANZCP does not believe 'it is the purview of it, or any single organisation, to present a 'solution' to CTO reform.' They cogently noted that the implications of any reform will be 'multifaceted and warrant open discussion, ownership and broad support from a wide range of both clinical and lived experience stakeholders.' As several parties also suggested in consultation,[1591] SALRI is of the view that further detailed consideration with the use of empirical demographic data is necessary to shed light on the factors to account for the high rate of CTOs in South Australia and their implications.

6.6.14 SALRI notes the need for further detailed research into the variable rates of CTOs across Australia has also been highlighted by group of leading researchers who 'made the case for a research agenda that addresses the minimal research that has been undertaken to address the variations of CTO use across Australian jurisdictions.'[1592] The researchers elaborated:

> The driving factors underpinning this variance remain unclear. The variance suggests that the implementation of CTOs is complex with multiple factors–including law, policy, practice, service culture and stigma–all playing a role… It is essential to uncover whether the differences in justifications for CTO use are related to variations in laws, practices, or system funding and organisation. Gathering and analysing the demographic data as to who is placed on CTOs and gathering feedback from those with severe mental health conditions, their families, carers and supporters and mental health practitioners will help explain why such discrepancies exist… There is a need for research to remedy this lack of knowledge and provide an understanding of the needs of those currently being placed on CTOs. Having high quality data on who is subjected to forced community treatment, and on what grounds, is a national and international health and human

[1590] Ibid.

[1591] The RANZCP, for example said; 'Further exploration would seem warranted, preferably conducted by an external party and in a manner where respondents can be confident of anonymity. If found to be true, these practice issues surrounding CTOs should be addressed. Doing so would require both system-wide cultural and operational changes, and the resources necessary to implement them.'

[1592] Lisa Brophy et al, 'The Urgent Need to Review the Use of CTOs and Compliance with the UNCRPD Across Australian Jurisdictions' (2021) 28(1) *International Journal of Mental Health and Capacity Law* 3.

> rights priority. It is knowledge that is likely to be of significant value to mental health service providers and may be used in the future to improve models of health care targeting people with severe mental illness. It will also benefit ongoing reforms to the mental health system and assist Australia to meet its obligations under the *CRPD*.[1593]

6.6.15 SALRI largely concurs with this reasoning. SALRI supports the need for further proper consideration of the reasons for the prevalence of CTOs in South Australia and examination of the implications of this.

6.6.16 Further, various consumers and advocacy groups relayed to SALRI what were seen as their coercive and disempowering experiences under the *MHA*, including in the use of CTOs.

6.6.17 Most consultees recognised that a CTO is a powerful means for control over a consumer and their treatment. The distinction in their perspectives concerned whether they believed this was positive or negative. Consumers and advocacy groups tended to view it as a negative experience (though this was far from universal amongst consumers),[1594] whereas many medical and mental health practitioners and service providers considered it one of the benefits of the CTO scheme.[1595]

6.6.18 SALRI reiterates that any CTO (or ITO) should not be made lightly and should only be made after careful clinical consideration and regard to the *MHA*. Some practitioners and consumers alike raised to SALRI the inappropriate use of CTOs as defensive medical practice. In particular, SALRI reiterates the concerns expressed by a psychiatrist, that medical practitioners are inclined to make CTOs for consumers with diagnoses of schizophrenia, substance abuse, and antisocial personality disorder, to help themselves feel as though they have more control over the consumer and their treatment.

6.6.19 SALRI notes that there is a considerable volume of literature regarding the detrimental effects of coercion in mental health practices (including CTOs),[1596] and notes that law reform alone cannot address the issues of coercion and control in the use of mental health practices such as CTOs. As SALRI was often told in consultation, training, education, and a larger cultural and/or operational shift is necessary to ensure the protection of consumers' rights. SALRI supports the implementation of measures to improve transparency, such as record-keeping with regard to non-compliance and assessments undertaken when deciding on the implementation of any order.

6.6.20 One of the existing criteria in the *MHA* for the making of a CTO (or an ITO) is premised upon the risk of 'harm'. This is not defined. This threshold, perhaps surprisingly, was not a prominent theme in SALRI's consultation. However, SALRI notes that a number of parties in consultation, notably at various roundtables, suggested that the threshold of harm is too low, and it would be preferable to insert the threshold of 'serious harm' for the making of a CTO (or an ITO).

[1593] Lisa Brophy et al, 'The Urgent Need to Review the Use of CTOs and Compliance with the UNCRPD Across Australian Jurisdictions' (2021) 28(1) *International Journal of Mental Health and Capacity Law* 37–8.

[1594] However, some consumers told SALRI they saw CTOs in positive terms. This also emerges in research findings.

[1595] Though some practitioners and service providers disagreed. A similar theme emerges in research. See also Sarah Romans et al, 'How Mental Health Clinicians View Community Treatment Orders: a National New Zealand Survey' (2004) 38 *Australian and New Zealand Journal of Psychiatry* 836; Catherine Manning, 'Community Treatment Orders in England and Wales: National Survey of Clinicians' Views and Use' (2011) 35 *The Psychiatrist* 328.

[1596] Office of the Western Australian Chief Psychiatrist, *Community Treatment Orders: A Review* (December 2001) 9–10; Edward Mulvey et al, 'The Promise and Perils of Involuntary Outpatient Commitment' (1987) 42 *American Psychologist* 571.

6.6.21 One consultee, based on the extensive research undertaken as a journalist and on observations gained as a carer and consumer, commented that law and practice should be reframed to reduce and limit CTOs, and the concept of 'harm' in the *MHA* for the making of a CTO or ITO is too low, facilitating unnecessary and excessive involuntary orders. They explained:

> … the formulation is too open ended and inclusive and does not define or limit the harm conceived or stipulate its severity or degree and certainly does not stipulate it must be greater than the harm involved in imposing a coercive order, with the consequence… The *MHA* requires coercive powers because when the State protects vulnerable people or people around them from serious harm it can create an overall benefit that can outweigh the harm usually involved in the coercion. But… if the power is handed over with carte blanche and without clear restrictions on the power's use, as in the current *MHA*, then there is a great injustice and the probability that greater harm than good is done through imposition of coercion unnecessarily.

6.6.22 The Legal Services Commission declared that a CTO or ITO under the *MHA* should be a 'last resort' and reference to 'serious harm' in the *MHA* 'may serve to make it clear that it is only in severe cases that the use of CTOs and ITOs are appropriate'.

6.6.23 SALRI accepts that the present concept of harm in the *MHA* to allow the making of a CTO (or ITO) is too low a threshold. The notion of 'harm' in the *MHA*, or indeed elsewhere[1597] is a wide and elastic term. SALRI accepts that the threshold of 'harm' is simply too low to warrant the intrusion and effects on a consumer of a CTO (or ITO).

6.6.24 As there is concern as to the prevalence of CTOs in South Australia, it is also prudent to clarify and make clear the limited circumstances in which a CTO can and should be properly made. The threshold of 'serious harm' for the making of a CTO (or ITO) exists elsewhere in Australia[1598] and is consistent with medical practice and the expectations and rationale of treatment orders. SALRI therefore recommends that the *MHA* should be amended to incorporate 'serious harm' as the threshold for the making of either a CTO or ITO.

6.6.25 SALRI considers the *MHA*(ACT) concept of 'serious harm' provides the preferable construction for the making of a CTO (or ITO) in that the relevant decision-maker 'believes on reasonable grounds that, because of the mental disorder (in South Australia a mental illness), the person is doing, or is likely to do, serious harm to themself or someone else; or is suffering, or is likely to suffer, serious mental or physical deterioration.'[1599] SALRI supports the inclusion of this construction of 'serious harm' in the *MHA*.

6.6.26 SALRI notes that the Chief Psychiatrist has a legislative duty to ensure that a mental health clinician is appointed for each consumer on a CTO to ensure monitoring and compliance. SALRI considers that this may be more appropriately assigned to the Director of the relevant mental health service and suggests that the *MHA* should be amended accordingly.

6.6.27 SALRI notes that accountability is a vital factor in considering the operation and duration of a CTO. The question of a time scale for review is a significant consideration, as was raised by many parties in SALRI's consultation. Most consultees agreed that review should be regular, and automatically required upon its re-application. However, it was often raised that SACAT is ill-equipped

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[1597] See, for example, *Criminal Law Consolidation Act 1935* s 31; *R v Donovan* [1934] 2 KB 498.

[1598] *Mental Health Act 2014* (WA) s 25(2)(b)(ii); *Mental Health Act 2014* (Vic) s 5(b)(ii); *Mental Health Act 2015* (ACT) s 66(2)(c).

[1599] *Mental Health Act 2015* (ACT) s 66(2)(c).

to conduct these regular reviews, regardless of their necessity. This is the factor which regularly influenced discourse surrounding the removal or retention of CTO levels. SALRI therefore supports the suggestion that CTO levels are removed in favour of one universal CTO which could be made by medical practitioners or authorised mental health practitioners and subject to automatic reviews by a body or tribunal such as SACAT. SALRI recommends the CTO is reviewed within 4 to 6 weeks, at six months following its imposition and annually thereafter. A review will also be undertaken each time a CTO is made.[1600]

6.6.28 SALRI also supports that consideration be given by SACAT to establishing a specific mental health stream, in light of the limitations of their capacity to undertake regular reviews.[1601]

6.6.29 SALRI also recognises the bureaucratic and that administrative burdens placed upon medical practitioners and mental health practitioners. These may contribute to the apparent lack of transparency with consumers and their support networks, and difficulties and delays with the review and revocation or variation of orders. This may have also led to orders remaining in place for longer than necessary; in particular, when a less restrictive approach could have been taken for a consumer's treatment. SALRI therefore supports the development of an approach to CTO review that includes automatic reviews at prescribed intervals.

6.6.30 SALRI observes that there is no notification requirement for CTO 2s equivalent to the requirement for CTO 1s. Regardless of whether CTO levels are removed or kept, SALRI suggests that notification requirements should be kept uniform. Each time a CTO is made, varied, revoked, or expires, the consumer and relevant persons, such as their carers, substitute decision-makers and advocates (including legal representatives) should be notified. SALRI proposes that the *MHA* should be amended to clarify this matter.

6.6.31 A significant omission in the present *MHA* was identified by many parties, including both medical practitioners and consumers, as the absence of any reference to non-compliance with a CTO. The *MHA* is largely silent as to what constitutes non-compliance with a CTO, and the consequences and options that arise. SALRI suggest that the *MHA* should be amended to clarify this matter. SALRI further suggest that these amendments make clear the following aspects of the matter:

- Conduct which constitutes non-compliance;
- Responsibilities of medical practitioners and authorised mental health professionals in attempting to obtain compliance;
- Records of non-compliance to be kept by medical practitioners and authorised mental health professionals;
- Notice of non-compliance, including possible consequences, is reasonably attempted to be given to consumers.

6.6.32 SALRI notes that opposition or concerns were expressed by various parties as to the inclusion of an explicit power in the *MHA* to use 'reasonable force' in cases of non-compliance, to facilitate the enforcement of a CTO. Many consumers and advocacy groups opposed this suggestion, identifying it as a form of coercive involuntary treatment. Other consultees also perceived a power to

[1600] See SALRI Recommendation 31.

[1601] See Part 10 The South Australian Civil and Administrative Tribunal and Legal Representation. See also SALRI Suggestion 10.

use 'reasonable force' in cases involving non-compliance with a CTO as at odds with sound clinical practice. Such a power may be seen to risk placing medical practitioners and authorised officers in a difficult position and is at odds with the consent- based and person-centred notions of modern health practice. The ANMF, for example, stated '[p]ractice needs to be collaborative and consultative with the person requiring care.'

6.6.33 However, SALRI notes that support was expressed for the premise that the *MHA* should include an explicit power for the use of 'reasonable force' for compliance with a CTO. SALRI reiterates the view of the RANZCP, who submitted that this will benefit the welfare of consumers, the public, and healthcare providers. Further, the RANZCP noted:

> The lack of an explicit provision allowing reasonable force is a significant issue for staff working within mental health teams. They report ongoing concerns [from psychiatrists] about their safety from consumers who are actively opposing their treatment, with staff being threatened or assaulted not uncommon. This change to the *MHA* would improve safety and predictability for staff, consumers and police and would be greatly beneficial and welcomed.[1602]

6.6.34 SALRI notes these concerns and is sympathetic to arguments relating to staff safety as well as the welfare of consumers. A medical practitioner and mental health professional has a right to a safe workplace and should not be a minor consideration.

6.6.35 SALRI, whilst aware of the differing views, is therefore of the view that it is appropriate to include an explicit power in the *MHA* for authorised mental health practitioners and authorised officers, drawing on s 56 of the *MHA*, to use 'reasonable force' as a 'last resort' where no other option is practicable or available. Such a power should not be exercised lightly and its use should be contingent upon appropriate training, operational guidance and protocols.

6.6.36 Finally, parties concerned with the welfare of children, such as the Commissioner for Children and Young People and medical practitioners from the Women's and Children's Hospital, raised the *MHA*'s considerable silence as to the Act's application to children. SALRI concurs and suggests that the *MHA* should be amended to include specific provisions regarding the application of CTOs to children.

6.6.37 Recommendations

RECOMMENDATION 29

SALRI recommends that the *Mental Health Act 2009* (SA) should be amended to include 'serious harm' as a threshold criterion for the imposition of a Community Treatment Order.[1603]

[1602] See also Royal Australian and New Zealand College of Psychiatrists, *Minimising and, where possible, eliminating the use of seclusion and restraint in people with mental illness* (Position Statement 61) (August 2021) <https://www.ranzcp.org/news-policy/policy-and-advocacy/position-statements/minimising-use-of-seclusion-and-restraint>.

[1603] SALRI favours the ACT definition of 'serious harm'. Section 66(2) of the *Mental Health Act 2015* (ACT) provides the relevant tribunal may make the counterpart of a CTO if it 'believes on reasonable grounds that, because of the mental illness, the person is doing, or is likely to do, serious harm to themself or someone else; or is suffering, or is likely to suffer, serious mental or physical deterioration'.

RECOMMENDATION 30

SALRI recommends that the *Mental Health Act 2009* (SA) should be amended to ensure that Directors of Mental Health Services hold the duty to ensure that a mental health clinician is appointed for each consumer on a Community Treatment Order to ensure monitoring and compliance, rather than the Chief Psychiatrist.

RECOMMENDATION 31

SALRI recommends that the *Mental Health Act 2009* (SA) should be amended to provide that the present two Community Treatment Order levels are removed in favour of a single universal Community Treatment Order, which could be made by medical practitioners or authorised mental health professionals and subject to automatic reviews by a body or tribunal such as the South Australian Civil and Administrative Tribunal. In particular, SALRI proposes the following review periods:

i. Within 4–6 weeks of its making.
ii. Upon six months of its imposition, and annually thereafter.
iii. Each time another Community Treatment Order is made.
iv. Each time a Community Treatment Order is varied.[1604]

RECOMMENDATION 32

SALRI recommends that non-compliance with a Community Treatment Order should be explicitly addressed in the *Mental Health Act 2009* (SA). This provision could include matters such as:

i. Conduct which constitutes non-compliance;
ii. Responsibilities of medical practitioners and authorised mental health professionals in attempting to obtain compliance;
iii. Records of non-compliance to be kept by medical practitioners and authorised mental health professionals;
iv. Notice of non-compliance, including possible consequences, is reasonably attempted to be given to consumers.

RECOMMENDATION 33

SALRI recommends that the *Mental Health Act 2009* (SA) should include a power allowing authorised mental health professionals and authorised officers to use 'reasonable force' in the administration and enforcement of a Community Treatment Order where there is non-compliance.

[1604] SALRI reiterates in this context that ss 11–12 of the *Mental Health Act 2009* (SA) are pivotal to ensure that consumers and relevant persons (such as carers, substitute decision-makers, and representatives/advocates (including legal representatives)) are notified each time a Community Treatment Order is made, varied, revoked, or expires.

RECOMMENDATION 34

SALRI recommends that the *Mental Health Act 2009* (SA) should be amended to include specific provisions regarding the application of Community Treatment Orders to children.

RECOMMENDATION 35

SALRI recommends that further research, analysis and interrogation of data concerning the general use and effectiveness of Community Treatment Orders is required, including the disproportionately high prevalence of Community Treatment Orders in South Australia for Aboriginal people and Culturally and Linguistically Diverse people.[1605] SALRI further recommends that such findings should be reported in the Chief Psychiatrist's Annual Report under s 92(1)(a) *Mental Health Act 2009* (SA).

RECOMMENDATION 36

SALRI recommends that consideration should be given to the introduction of a Forensic Community Treatment Order, with reference to the NSW model which has greater oversight and review than a Community Treatment Order under the current *Mental Health Act 2009* (SA).

6.6.38 Suggestions

SUGGESTION 8 (General)

SALRI suggests that further review should be undertaken into the use of the *Mental Health Act 2009* (SA) for consumers in prison.[1606]

SUGGESTION 9 (General)

SALRI suggests that further review into the concurrent operation and practices involving the *Mental Health Act 2009* (SA) and *Criminal Law Consolidation Act 1935* (SA) be undertaken.

[1605] This question raises involved issues that are beyond the scope of SALRI's review and also requires empirical data and analysis.

[1606] SALRI was told that prisons are not covered by any Community Mental Health Team. Health care is delivered by Prison Health, which is a primary care service and supported by consultation liaison psychiatric clinics. This raises issues in relation to care planning, enforcement of treatment in the community and issues in communication pertaining to an existing CTO for a person entering prison or upon their release.

Part 7 – Electroconvulsive Therapy

7.1 Introduction

7.1.1 Electroconvulsive therapy ('ECT') is one of the prescribed psychiatric treatments defined under the *Mental Health Act 2009* (SA) ('*MHA*').[1607] In their latest report, the Office of the Chief Psychiatrist ('OCP') of South Australia ('SA') defined ECT as:

> … a specialised medical procedure where controlled seizures are induced under general anaesthesia. ECT is performed by a qualified multidisciplinary team that includes a psychiatrist and an anaesthetist. ECT is only used in specific circumstances, most commonly to treat major depression and sometimes other severe mental illness such as acute mania, catatonia and schizophrenia.[1608]

7.1.2 It is clear that, as the many submissions that SALRI received highlight, the use of ECT remains contentious.[1609] One author notes:

> While ECT is viewed by many clinicians and recipients as indispensable in treating debilitating and 'life-threatening' severe mental illness, it nevertheless remains, arguably, the most stigmatised, misunderstood, contested, and feared psychiatric or perhaps even medical, treatment.[1610]

7.1.3 The use of emergency ECT under the *MHA* – indicating a lack of voluntary consent, was widely raised in SALRI's research and consultation with various views and concerns expressed. SALRI acknowledges the historical and ongoing community perception and stigma towards ECT, some of which still argue it is contentious.[1611] However, many studies highlight that modern ECT is valid, effective and a recognised treatment performed by specialised staff for mental illness.[1612] The value of ECT extends to individuals who lack capacity.[1613] As one study concludes:

> ECT is a safe and effective treatment for schizophrenia, bipolar mania and depression, and may provide similar or greater benefits in patients lacking capacity to consent, compared to those with

[1607] *Mental Health Act 2009* (SA) s 3 (definition of 'prescribed psychiatric treatment'). Neurosurgery for mental illness is also another form of prescribed psychiatric treatment under the *Mental Health Act 2009* (SA), however, it is not currently performed in South Australia: see *Mental Health Act 2009* (SA) s 3 (definition of 'prescribed psychiatric treatment'); see also Office of the Chief Psychiatrist, *The Year in Review* (2022) <https://www.chiefpsychiatrist.sa.gov.au/policies-standards-and-reports/reports/annual-report-of-the-chief-psychiatrist>.

[1608] Office of the Chief Psychiatrist, *The Year in Review* (2022) <https://www.chiefpsychiatrist.sa.gov.au/policies-standards-and-reports/reports/annual-report-of-the-chief-psychiatrist>.

[1609] There were various submissions, notably from Citizens Commission on Human Rights, expressing strong concerns regarding the use of ECT.

[1610] Tania Gergel, '"Shock Tactics", Ethics, and Fear. An Academic and Personal Perspective on the Case Against ECT' (2022) 220(3) *British Journal of Psychiatry* 109.

[1611] See, for example, Thomas Cryzyk, 'Electroconvulsive Therapy: why it is still Controversial' (2012) 16(7) Mental Health Practice 22. The historical abuses associated with ECT are notable. See Steven Jenkusky, 'Public Perceptions of Electroconvulsive Therapy: A Historic Review' (1992) 10(2) *Jefferson Journal of Psychiatry* 2; Merrilyn Walton, 'Deep Sleep Therapy and Chelmsford Private Hospital: Have we Learnt Anything?' (2013) 21(3) Australasian Psychiatry 206.

[1612] See below at [7.6.1].

[1613] Pern-Chern Tor et al, 'Outcomes in Patients with and without Capacity in Electroconvulsive Therapy' (2020) 266 *Journal of Affective Disorders* 151; Martha Finnegan, Stephanie O'Connor and Declan McLoughlin, 'Involuntary and Voluntary Electroconvulsive Therapy: A Case-Control Study' (2018) 11(4) *Brain Stimulation* 860.

> capacity. These results support the provision of a framework for substitute decision making in the patients' best interests for ECT in patients unable to provide their own consent.[1614]

7.1.4 The method for the administration of ECT is different to that used in the past.[1615]

7.1.5 This review is governed by its Terms of Reference and it must be noted that it is not within SALRI's remit to determine whether ECT is an effective or appropriate treatment for mental illness. Consistent with its Terms of Reference, SALRI has considered matters relating to the oversight, consent and emergency use of ECT. Further, SALRI was asked to consider whether the use of reasonable restrictive practices should be authorised for medical practitioners, in cases involving emergency ECT and ECT administered under an Inpatient Treatment Order ('ITO').

7.1.6 ECT as a treatment for mental illness is a divisive issue that has been subjected to wide-spread critical debate, especially given the history of inappropriate and unethical experimentation on persons with mental illness in the 20th century, which coincided with the development of eugenics.[1616]

7.1.7 As a treatment for mental illness, ECT has advanced significantly since its initial development in the 1930s.[1617] The use of ECT, however, remains controversial and is accompanied by negative community perceptions. A submission noted:

> … much of the stigma attached to ECT is based on treatment from the 1950s and 1960s in which high doses of electricity were administered without anaesthesia. People often recall movie depictions of ECT like in 'One Flew Over The Cuckoos Nest'.

7.1.8 SALRI received a number of written submissions calling for a complete prohibition on ECT, with many citing the perceived long-term significant side-effects associated with ECT as support for their position.

7.1.9 Watts, Peltzman and Shiner argued that the controversy surrounding ECT stems from its historical use, especially in the 1980s and 1990s, noting that:

> Historically, estimates of the mortality rate associated with ECT were derived from a review of the literature that reflected ECT treatment during the 1980s and 1990s. However, substantial improvements in ECT practice have occurred since that time, including enhanced anaesthesia practice and the advent of brief-pulse ECT.[1618]

7.1.10 The authors concluded that ECT, although not risk free, posed 'no greater risk of death than if they had elected not to have ECT, and the risk of death … may be reduced by as much as

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[1614] Pern-Chern Tor et al, 'Outcomes in Patients with and without Capacity in Electroconvulsive Therapy' (2020) 266 *Journal of Affective Disorders* 151.

[1615] Adriana Hermida et al, 'Electroconvulsive Therapy in Depression: Current Practice and Future Direction' (2018) 41(3) *Psychiatric Clinics of North America* 341.

[1616] For a contrasting view of ECT, see Linda Andre, *Doctors of Deception: What they don't want you to know about Shock Treatment* (2009, Rutgers University Press) 4.

[1617] ECT as a form of treatment for schizophrenia was first introduced in 1938: see Diarmin Sinclair et al, 'Electroconvulsive Therapy for Treatment Resistant Schizophrenia' (2019) 3 *Cochrane Library* 1.

[1618] Bradley Watts, Talya Peltzman and Brian Shiner, 'Mortality after Electroconvulsive Therapy' (2021) 219 *British Journal of Psychiatry* 588.

20%.'[1619] One psychiatrist highlighted to SALRI that '[ECT] has far less morbidity or adverse impact on patients than many procedures that are utilised within medicine.'

7.1.11 This was also raised by the Central Adelaide Local Health Network ('CALHN'):

> The primary issue with ECT is stigma and therefore it should be treated no differently from any other procedure to which a patient has consented appropriately. The notion that ECT should only be used when it is 'necessary' is inappropriate. Like any medical treatment, ECT should be presented as a viable treatment option for patients in which it is *clinically indicated* so that the person can make an informed choice. There are many situations in which ECT may not be 'necessary' as there are other treatment options, but ECT may be the most clinically effective, have the fewest side effects or be the preferred option of the person. In these cases, the law should reflect that ECT is simply a medical procedure like any other.
>
> It is not appropriate for the law to reflect prejudice or stigma, thereby reinforcing the stigma against ECT and contributing to the infrequent use of this highly safe and effective method of treatment for people with some of the most debilitating mental disorders.

7.1.12 Castanada-Ramirez et al reported that, in the adult population, there is greater empirical research when compared with children and adolescents concerning the safety and efficacy of ECT, remarking that 'adults with mood disorders that do not improve despite multiple medication trials, approximately two-thirds (between 60 and 80%) respond to ECT.'[1620]

7.1.13 Some literature reveals division within psychiatry concerning particular applications of ECT. For example, in 2019, Sinclair et al[1621] stated that:

> There is inconsistency among expert groups about the use of ECT and its indications. The American Psychiatric Association recommends the use of ECT in schizophrenia in the following circumstances: when psychotic symptoms in the present episode have an abrupt or recent onset, when schizophrenia is of the catatonic type, or when there is a history of a favourable response to ECT. The Royal College of Psychiatrists states that 1) while the treatment of choice for schizophrenia is drug therapy, ECT may be considered for treatment-resistant cases and catatonia, and 2) although there is some evidence supporting the short term effectiveness of ECT, evidence for sustained medium- and long-term benefits is lacking. The National Institute for Health and Care Excellence (NICE) only recommends ECT for severe depressive illness, a prolonged or severe episode of mania, or catatonia (which may also occur in other disorders such as depression).[1622]

7.1.14 When establishing the new Mental Health Bill 2008, the Minister referred to its intention:

> [The] Mental Health Bill 2008 incorporates provisions which bring South Australia into line with contemporary approaches to the management of serious mental health issues and includes innovations designed to assist people to obtain assistance in a manner which aims to minimise the extent to which their freedom is curtailed and to protect their rights.[1623]

[1619] Bradley Watts, Talya Peltzman and Brian Shiner, 'Mortality after Electroconvulsive Therapy' (2021) 219 *British Journal of Psychiatry* 588, 592.

[1620] Santiago Castaneda-Ramirez et al, 'Systematic Review: Electroconvulsive Therapy for Treatment-Resistant Mood Disorders in Children and Adolescents' (2022) *European Child and Adolescent Psychiatry* 1, 2.

[1621] Diarmid Sinclair et al, 'Electroconvulsive Therapy for Treatment Resistant Schizophrenia' (2019) 3 *Cochrane Library* 1.

[1622] Ibid 11.

[1623] South Australia, *Parliamentary Debates,* Legislative Council, 4 June 2008, 3097 (Jane Lomax-Smith).

7.1.15 Consistent with this legislative intent, the Mental Health Bill 2008 established a separate framework governing the use of ECT, which at the time, was a less commonly used form of treatment for mental illness.[1624] The relevant Minister noted that the legislative framework regulating the use of ECT required consent of either the patient, their representative or the Board.[1625] Furthermore, it was emphasised that ECT could only be administered for a maximum of 12 episodes over a three-month period.[1626] However, in cases of emergency, ECT could be administered without consent 'if the psychiatrist administering the treatment in these circumstances [advises] the Chief Psychiatrist of their actions within one working day. This requirement will enable the provision of emergency ECT to be monitored.'[1627]

7.1.16 Section 42 of the *MHA* regulates the provision of prescribed psychiatric treatment, which includes ECT. However, although the new *MHA* – and ECT provisions – were the subject of wide-spread and meaningful review and consultation, the subsequent statutory review[1628] of the *MHA* undertaken by the Office of the Chief Psychiatrist identified issues with the existing legislative approach to ECT. As a result, amendments to the ECT provisions were introduced by the *Mental Health (Review) Amendment Act 2016* (SA) ('*Review Amendment Act*').

7.1.17 A key statutory amendment to the *MHA* was the establishment of the Prescribed Psychiatric Treatment Panel ('PPTP').[1629] In the 2014 Statutory Review, the OCP observed that the:

> … current provisions for decision-making for … prescribed psychiatric treatment [ECT] 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 complex ECT cases referred to it.[1630]

7.1.18 SALRI notes that the PPTP have raised concern regarding the ambiguity surrounding the definition of 'complex cases,' and the criteria that give rise to a referral for their consideration, which enliven their jurisdiction.

7.1.19 It was further noted that the PPTP should be presided over by the Chief Psychiatrist and consist of 'a psychiatrist, a neurosurgeon, a lawyer, a member of the South Australian Civil and Administrative Tribunal, a bioethicist and a carer.'[1631]

7.1.20 Other amendments to the ECT provisions introduced by the *Review Amendment Act* included the provision that consent to administration of ECT does not authorise the use of reasonable force to administer ECT to a person. The rationale behind the exclusion of reasonable force to administer ECT was predicated on the notion that reasonable force should 'be a rare event only in cases of significant risk.'[1632] However, it was noted that if the person has an ITO and ECT was an

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[1624] South Australia, *Parliamentary Debates,* Legislative Council, 4 June 2008, 3098 (Jane Lomax-Smith).

[1625] Ibid.

[1626] Ibid.

[1627] Ibid.

[1628] Office of the Chief Psychiatrist, *The Review of the Mental Health Act 2009 – A Report by the Chief Psychiatrist of South Australia* (1 July 2014).

[1629] *Mental Health Review Amendment Act 2016* (SA) s 35.

[1630] Office of the Chief Psychiatrist, *The Review of the Mental Health Act 2009 – A Report by the Chief Psychiatrist of South Australia* (1 July 2014) 31.

[1631] Ibid 32.

[1632] Ibid 29.

authorised treatment prescribed by the psychiatrist, then this should operate outside the prohibition on using force. The use of force is authorised to administer treatment under an ITO.[1633]

7.1.21 SALRI notes that concerns were raised during consultation concerning the current legislative framework governing the provision of ECT, including the prohibition on using force under the *MHA*.[1634] The main issue raised was the inefficiency that arises as a consequence of the *MHA* prohibiting the use of force to administer ECT, and thus requiring the treating psychiatrist to make an application under s 29 and s 32 of the *Guardianship and Administration Act 1993* (SA) ('*GA Act*').

7.1.22 Sections 29 and 32 of the *GA Act* authorise SACAT to appoint a guardian and subsequently make an order to allow persons 'from time to time involved in the care of the person to use such force as may be reasonably necessary for the purpose of ensuring the proper medical or dental treatment, day-to-day care and well-being of the person.'[1635]

7.1.23 The effect of the interaction between the *MHA* and *GA Act* has created a legislative framework that is largely inflexible for accommodating the administration of emergency ECT. In the context of emergency ECT, an application to SACAT is required if force will be necessary to administer ECT. SALRI was informed that this results treatment delays and may be detrimental to the patient or consumer.

7.2 Current Law in South Australia

7.2.1 The provision of ECT is governed by Part 7, Division 1 of the *MHA*.[1636] The Act establishes separate requirements for provision of ECT, depending on whether ECT has been consented to by the patient (or an authorised representative of the patient) or whether emergency ECT is required.

ECT with Consent

7.2.2 For ECT provided with consent, the conditions are that:

> (a) the patient has a mental illness; and
>
> (b) ECT, or a course of ECT, has been authorised for treatment of the illness by a psychiatrist who has examined the patient; and
>
> (c) written consent to the treatment has been given.[1637]

7.2.3 The framework for consent to ECT is dependent upon variables such as age and decision-making capacity. For minors aged under 16 years, a parent, guardian or SACAT can provide consent to ECT.[1638] It is necessary to note that the legislation appears to have displaced the common law principle of *Gillick*[1639] competence; therefore, a minor of sufficient maturity capable of making a

[1633] It was noted to SALRI that this conflict raised concerns in practice for medical practitioners.

[1634] *Mental Health Act 2009* (SA) s 42(4)(b).

[1635] Ibid s 32(1)(c); see also ss 29, 32(1a).

[1636] Ibid s 42.

[1637] Ibid s 42(1)(a)–(c).

[1638] Ibid s 42(1)(c)(iii).

[1639] *Gillick v West Norfolk and Wisbech Area Health Authority* [1985] UKHL 7, [1986] AC 112.

decision in relation to ECT under the age of 16 cannot consent to treatment,[1640] and a parent, guardian or SACAT must provide consent.

7.2.4 Pursuant to s 42(1)(c)(i) of the *MHA*, for persons aged 16 years and over who are capable of making decisions, consent for ECT must be obtained from the person themselves.[1641] SALRI notes that the definition of a 'child' requires amendment for consistency and recommends a child should be a person under 18 years of age. If the person is deemed incapable of making decisions, the legislation notes that a substitute decision-maker ('SDM'), if appointed under a valid Advance Care Directive ('ACD') or SACAT can provide written consent.[1642] Further, if an ACD appoints more than one SDM, consent must be given by all SDMs.[1643] In the event the person does not have an ACD, then persons authorised to consent to ECT are a medical agent or guardian of the patient or SACAT.[1644]

7.2.5 It is important to note that consent to administer ECT also includes consent to be administered anaesthetic for the procedure, which negates the requirement to obtain separate consent for anaesthetic.[1645] The legislation also provides that consent to be administered ECT can be withdrawn at any time by the person or body who initially provided the consent.[1646]

7.2.6 However, as alluded to in the introduction, consent to ECT does not include consent to use force to administer ECT,[1647] which has been flagged as an issue by stakeholders in SALRI's consultation.

7.2.7 SALRI notes that the rationale behind prohibiting the use of force to administer voluntary ECT appears to be that force should not be required if valid consent has been provided.[1648] In cases where consent to ECT has been provided, but force is required to administer it, a SACAT order must be made permitting the use of force reasonably required in the circumstances.[1649]

7.2.8 Consent to a course of ECT is limited and is valid for a maximum of three months and a maximum of 12 episodes of ECT.[1650] The first episode of ECT performed to ascertain the correct dose of ECT is counted as one of the 12 episodes in the course.[1651] Therefore, if the patient requires more than 12 episodes, or the course of ECT extends beyond the three-month maximum period, further consent to ECT must be obtained, as there is no provision to extend the initial consent.[1652]

[1640] *Mental Health Act 2009* (SA) s 42(1)(c)(i).

[1641] Ibid s 42(1)(c)(i).

[1642] Ibid s 42(1)(c)(ii)(A).

[1643] Ibid s 42(1)(c)(ii)(A).

[1644] Ibid s 42(1)(c)(ii)(B).

[1645] Ibid s 42(4)(a).

[1646] Ibid s 42(4)(c).

[1647] Ibid s 42(4)(b). Use of force to administer voluntary ECT which has been consented to is not permitted under the *Mental Health Act 2009* (SA) and is likely to constitute a civil and/or criminal assault and battery: For civil matters, this would constitute a trespass to the person, including battery or assault. See also *Criminal Law Consolidation Act 1935* (SA) s 20.

[1648] See, for example, Office of the Chief Psychiatrist, *The Review of the Mental Health Act 2009 – A Report by the Chief Psychiatrist of South Australia* (1 July 2014) 29.

[1649] *Guardianship and Administration Act 1993* (SA) ss 29, 32.

[1650] *Mental Health Act 2009* (SA) s 42(2).

[1651] Ibid s 42(3).

[1652] Ibid s 42(2); the psychiatrist who administers or authorises the ECT must report this to the Chief Psychiatrist within 1 business day using the approved form see *Mental Health Act 2009* (SA) s 42(7), (8).

7.2.9 If consent to a course of ECT has been provided, then the psychiatrist who administers or authorises it must notify the Chief Psychiatrist within one business day.[1653]

7.2.10 The reasoning behind the limited consent period was addressed in the 2014 Statutory Review of the *Mental Health Act 2009* (SA), and was predicated on evidence-based practice, patient safety and the need for increased oversight of prescribed psychiatric treatment.[1654] On this point, the OCP observed that:

> The [ECT] 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 … for some patients, this does not warrant amending the consent provisions. It is recommended that the consent provisions remain unchanged.[1655]

7.2.11 SALRI notes the consent provisions relating to ECT, except in cases of emergency ECT under the *MHA* were not raised as an issue during consultation. As such, SALRI does not recommend any change to the existing legislative framework.

Emergency ECT

7.2.12 While the *MHA* prefers voluntary ECT, emergency ECT provisions are included in the *MHA*. This authorises the administration of an episode of ECT without consent, if a psychiatrist considers that:

> (a) the patient has a mental illness of such a nature that administration of that particular episode of ECT is urgently needed for the patient's well-being; and
>
> (b) in the circumstances it is not practicable to obtain that consent.[1656]

7.2.13 The emergency ECT provisions only apply to administration of one episode of ECT if the above conditions are met. Further, if an episode of emergency ECT is administered, then the psychiatrist who administers or authorises it must notify the Chief Psychiatrist within one business day.[1657]

Prescribed Psychiatric Treatment Panel

7.2.14 The PPTP oversee cases of ECT, which fall within the triggers for review provided in s 41C of the *MHA*. The triggers for review pertain to longer-term periodic use of ECT. The functions of the PPTP are stated as follows:

> **41C—Functions of Panel**
>
> The Prescribed Psychiatric Treatment Panel has the following functions in relation to the regulation of prescribed psychiatric treatments:

[1653] *Mental Health Act 2009* (SA) s 42(7), (8).

[1654] Office of the Chief Psychiatrist, *The Review of the Mental Health Act 2009 – A Report by the Chief Psychiatrist of South Australia* (1 July 2014) 29.

[1655] Ibid.

[1656] *Mental Health Act 2009* (SA) s 42(6)(a), (b).

[1657] Ibid s 42(7), (8).

(a) to conduct a review of the progress of a patient who has, in the course of any 12 month period, received 3 or more courses of ECT treatment;

(b) to conduct a review of the progress of a patient to whom, in the course of any 12 month period, 2 or more episodes of ECT have been administered without consent in reliance on section 42(6);

(c) …

(d) to carry out any other function conferred on the Panel under this Act.

7.2.15 Therefore, the PPTP's jurisdiction to review cases is enlivened where a person has received three or more courses of ECT in a 12 month period or two or more emergency ECT episodes in a 12 month period.[1658] This limits their function to a retrospective case review.

7.2.16 The legislation is specific concerning constitution of the PPTP, requiring a multi-disciplinary review team. Sections 41A(1) and (2) of the *MHA* require that the Panel consists of:

a) the Chief Psychiatrist; and

(b) no more than 8 other persons appointed by the Governor on the recommendation of the Minister, of whom at least—

(i) 1 must be a patient or former patient; and

(ii) 1 must be a carer or former carer; and

(iii) 1 must be a senior psychiatrist; and

(iv) 1 must be a neurosurgeon; and

(v) 1 must be a legal practitioner in this State; and

(vi) 1 must be a person with credentials and experience in bioethics.

7.2.17 SALRI notes the utility of requiring a neurosurgeon on the PPTP was raised during consultation. There are limited numbers of consultant neurosurgeons based in South Australia and neurosurgery for mental illness is not currently performed in South Australia.[1659] As a result, the PPTP have only been called upon to review cases for ECT.

7.2.18 In their submission to SALRI the Section for Electroconvulsive Therapy and Neurostimulation (SA) of the RANZCP ('SA SECN RANZCP') put forward:

> Whilst the authorisation of neurosurgery is a necessary role for the PPTP, it should be acknowledged that such surgery hasn't occurred in SA for 50 years and none is planned to occur in the foreseeable future, so this is more a theoretical role for the PPTP than an actual role. However, with evidence emerging about the role of deep brain stimulation, it might occur at some point in the future, so it is good to have a review/authorisation mechanism in the *MHA* in case this happens, so this can remain. However, we should not expect it to be actually used any time soon.

7.2.19 SALRI notes the PPTP raised concerns with the scope of their functions in their submission. The predominant issue for consideration in their submission centred on the disconnect

[1658] *Mental Health Act 2009* (SA) s 41C(a), (b).

[1659] Office of the Chief Psychiatrist, *Annual Report of the Office of the Chief Psychiatrist 2021-22* (SA Health, 30 September 2022) 24.

between the role and function of the PPTP recommended in the 2014 Statutory Review of the *MHA* and the subsequent legislative amendment, which adopted a narrower view of the functions of the PPTP.[1660]

7.2.20 In the first iteration of the *Mental Health Act 2009* (SA) there was no multi-disciplinary statutory body established to review cases of prescribed psychiatric treatment. In their report, the OCP observed that:

> The current provisions for decision making for … prescribed psychiatric treatment [including ECT] 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.[1661]

7.2.21 Pursuant to this observation, the OCP recommended that a PPTP should be established in the legislation, with the function to review complex cases of ECT.[1662] This recommendation was included in the *Mental Health Review Amendment Act 2016* (SA).[1663] The OCP noted that the PPTP should be called upon to consider complex ECT cases and issues of consent 'on application by the patient, a parent or guardian, a medical practitioner or the Board under this section.'[1664]

7.2.22 The issue raised by the PPTP was that the '2014 Review appears to leave open the meaning of "complex ECT case," and does not attempt to provide a definition beyond "complex ECT clinical or consent matter."' This wording was not adopted by Parliament in the subsequent amendment to the *MHA* who chose to establish parameters around the definition of 'complex ECT cases' in s 41C(a) and (b) of the *MHA*.

7.2.23 The PPTP expressed that 'the Section 41C Review Triggers are not working effectively and do not always capture "complex ECT cases" that are appropriate for panel review,' noting that some complex cases have enlivened the PPTP's 'review triggers' as a consequence of procedural issues. The PPTP's concern centres on the appropriateness of the current review triggers enlivening ss 41C(a) and (b). They argue the current triggers are likely to overlook complex ECT cases requiring review and capture cases caused by procedural errors when applying the s 41C criteria. The PPTP recommended that these provisions be 'reconsidered to ensure the mechanism of Panel review is reserved for ECT cases which are truly complex for clinical or consent reasons.'

7.2.24 The PPTP submitted that in defining a 'complex case', there should be consideration of:

- Concerns regarding consent to ECT;
- Any use of restraint or restrictive practices;
- Where a significant medical adverse event in relation to an episode of ECT has been noted on the SLS;

[1660] Office of the Chief Psychiatrist, *The Review of the Mental Health Act 2009 – A Report by the Chief Psychiatrist of South Australia* (1 July 2014) 29.

[1661] Ibid 31.

[1662] Ibid.

[1663] *Mental Health Review Amendment Act 2016* (SA) s 35.

[1664] Office of the Chief Psychiatrist, *The Review of the Mental Health Act 2009 – A Report by the Chief Psychiatrist of South Australia* (1 July 2014) 29.

- Three or more acute courses of treatment per year;
- Instances of very prolonged courses of treatment (e.g., where a course of treatment exceeds a threshold of (for example) 20 episodes);
- Cases of maintenance ECT that have continued for 3+ years;
- Cases featuring clinically complex treatment-resistance;
- Cases featuring clinically complex comorbidities;
- The use of ECT on children and young people aged under 18; and
- Cases where ECT-naïve patients are prescribed bitemporal ECT as a first treatment.

7.2.25 The Royal Australian and New Zealand College of Psychiatrists ('RANZCP') supported these considerations.

7.2.26 SALRI acknowledges that these are valid concerns raised by the PPTP, noting that there is a disparity between the initial recommendations of the functions of the PPTP as envisioned by the OCP in the 2014 Statutory Review and their current operation.

7.3 Law in Other Jurisdictions

Victoria

7.3.1 Within Australia, Victoria has most recently finalised a comprehensive review of its mental health laws. As such, SALRI has given in depth consideration to the law that will govern the administration of ECT upon the commencement of the new Victorian Act in September 2023.

7.3.2 The Victorian Royal Commission, whose findings have led to the new Victorian Act, was, in part, established in response to the widespread concern that the Victorian mental health system was fractured, and had 'despite the goodwill and hard work of many people … deteriorated for a multitude of reasons and over the course of many years.'[1665]

7.3.3 It was further noted that recent developments at local, national and international levels concerning increased emphasis on, and protection of, human rights had resulted in Victoria's mental health system falling behind, failing to keep pace with important reform initiatives in this area.[1666]

7.3.4 In Victoria, the range of treatments for mental illness a person can be involuntarily subjected to are wide-ranging. They include 'the administration of medication, hospital stays, electroconvulsive treatment and neurosurgery for mental illness.'[1667] Electroconvulsive treatment is equivalent to ECT in South Australia.[1668]

7.3.5 Consistent with the Royal Commissions recommendation, the *Mental Health and Wellbeing Act 2022* (Vic) ('*MHWA*') is set to commence operation on 1 September 2023.[1669] The *MHWA* repeals the existing *Mental Health Act 2014* (Vic) and was drafted with a view to 'lay the foundation for the

[1665] *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021) vol 1, 3.

[1666] Ibid vol 1, 4.

[1667] Ibid vol 4, 365.

[1668] Ibid.

[1669] *Mental Health and Wellbeing Act 2022* (Vic) s 2.

vision of the Royal Commission into Victoria's Mental Health System to transform the mental health and wellbeing system and to support the delivery of person-centred services that are responsive to the needs and preferences of Victorians.'[1670]

7.3.6 To exemplify the human rights approach underlying the new bill, the Minister explained that key principles evoked in the proposed legislation included the balancing of harm and the autonomy principles.[1671] It was noted that these principles were essential to the operation of involuntary treatment provisions, which can include ECT, as their function was to ensure that individual human rights were only restricted or curtailed in serious circumstances, and that the 'will and preferences of a person are to be given effect to the greatest extent possible.'[1672]

7.3.7 In the second reading speech, the Minister for Education and Mental Health explained the new legislative framework regulating the provision of ECT in the *MHWA*, explaining that:

> ECT can be performed on an adult patient without their consent by order of the Mental Health Tribunal (MHT). An application to the MHT can only be made by an authorised psychiatrist where the patient does not have capacity to give informed consent and the authorised psychiatrist is satisfied that in the circumstances there is no less restrictive way for the patient to be treated. In deciding whether there is no less restrictive way for the patient to be treated, the authorised psychiatrist must consider and give appropriate weight to a range of specified matters including the patient's views and preferences, the patient's views expressed by the patient's nominated support person and the likely consequences for the patient if ECT is not administered. Division 3 of Pt 3.5 [of the *MHW Act*] provides for applications with respect to adults who are not patients. As an additional protection, an order of the MHT is required for the performance of ECT on a young person regardless of whether that young person consents or not. Division 4 of Pt 3.5 provides for applications to be made to the MHT with respect to young patients and Division 5 provides for applications with respect to young persons who are not patients. Before granting an application, the MHT must also be satisfied that there is no less restrictive way for an adult or young person who does not consent to ECT to be treated ... Clauses 105 and 115 provide that for adults and young people who are not under compulsory orders (ie who are not patients) to receive non-consensual ECT their medical treatment decision-maker must give informed consent in writing or an adult can give an instructional directive consenting to ECT. These clauses invoke the decision-making rules in the Medical Treatment, Planning and Decisions Act 2016 that prioritise the wishes of the proposed recipient in decision-making. There are safeguards in clauses 102, 107, 112 and 117 to deal with changing circumstances which require that ECT must end.[1673]

7.3.8 It is evident from the Minister's Second Reading Speech that the proposed statutory rules relating to provision of ECT include voluntary and involuntary ECT. The Bill sought to prioritise, to the greatest extent possible, human rights principles by requiring that even for involuntary ECT, consideration is to be given to the person's views and preferences. Additional safeguards were also included relating to ECT for young people which requires an ECT order from the Mental Health Tribunal regardless of whether consent to ECT was provided or not.

[1670] *Mental Health and Wellbeing Act 2022* (Vic) preamble.

[1671] Victoria, *Parliamentary Debates,* Legislative Assembly, 23 June 2022, 2644 (Gabrielle Williams).

[1672] Ibid.

[1673] Ibid 2647–8.

7.3.9 A course of ECT is defined as being 12 episodes of ECT over a six-month period,[1674] and if the Mental Health Tribunal (MHT) make an order for ECT, the number of ECT episodes and the duration of the order must be specified but cannot exceed this statutory restriction.[1675]

7.3.10 The *MHWA* includes procedural provisions relating to application for an ECT order, including that a hearing from an ECT order must occur within five business days.[1676] However, in cases of emergency ECT, an urgent hearing of an ECT application can be requested. The conditions that must be satisfied are, that ECT is needed:

> (a) to save the life of the person in respect of whom the application is made; or
>
> (b) to prevent serious damage to the health of the person in respect of whom the application is made; or
>
> (c) to prevent the person in respect of whom the application is made from suffering or continuing to suffer significant pain or distress.[1677]

7.3.11 Similar to the legislative approach adopted under the *MHA,* the *MHWA* establishes provisions for voluntary and involuntary ECT. Further, the *MHWA* establishes a separate framework for adult persons who are currently patients and non-patients and young persons who are patient's and non-patients under the Act.[1678] A patient is defined under the legislation as meaning:

> (a) an assessment patient; or
>
> (b) a court assessment patient;
>
> (c) a temporary treatment patient;
>
> (d) a treatment patient;
>
> (e) a security patient;
>
> (f) a forensic patient.[1679]

Adult Patients

7.3.12 ECT can be administered voluntarily to adults,[1680] if they provide written informed consent.[1681] However, if the adult does not have capacity to give informed consent, an application to the MHT seeking an order for ECT can be made.[1682] In addition to lacking capacity to give informed consent to ECT, the psychiatrist seeking the order must be satisfied that 'in the circumstances there is no less restrictive way for the patient to be treated'.[1683] This includes a list of considerations such as the person's preferences regarding ECT and the 'patient's relevant views and preferences specified in their

[1674] *Mental Health and Wellbeing Act 2022* (Vic) s 95(a), (b).

[1675] Ibid s 96(1)(a), (b).

[1676] Ibid s 97(1).

[1677] Ibid s 97(2)(a), (c).

[1678] See Ibid ss 98, 99, 103.

[1679] Ibid s 2 (definition of 'patient')

[1680] See Ibid s 98(a). An adult is defined as a person 18 years or older.

[1681] Ibid s 98(a).

[1682] Ibid ss 98(b), 99(1)(a).

[1683] Ibid s 99(1)(b).

advance statement of preferences.'[1684] The MHT will grant the order if it is satisfied that these two conditions are met.[1685] Further, if the MHT make an order authorising or refusing ECT, they are mandated under the legislation to notify specified persons.[1686] A list of considerations regarding least restrictive means must also be provided by the psychiatrist.[1687]

Adult Non-Patient

7.3.13 In the case of adults who are not patients, the framework is similar in that ECT can be administered if the person has provided written consent,[1688] meaning that they have decision-making capacity to consent, or if they do not have capacity to consent, then the MHT can authorise ECT.[1689] If an order is sought, in addition to being incapable of providing informed consent, the psychiatrist applying for the order must be satisfied that there is 'no less restrictive way of the person to be treated.'[1690] However, the person must also have either provided informed consent to ECT in an instructional directive, or their medical treatment decision-maker must have provided informed consent to ECT.[1691]

7.3.14 If the MHT is satisfied that these criteria are met, they can make an order for the administration of ECT and must notify the persons/bodies specified in the legislation of the order.[1692]

Young Persons – Patients

7.3.15 Administration of ECT to a young person[1693] who is a patient requires an order from the MHT authorising ECT. This is a mandatory requirement regardless of whether informed consent to ECT has been obtained.[1694] In cases where a young person is incapable of giving informed consent and the psychiatrist is satisfied that there is no less restrictive way for the young person to be treated, an order is also required.[1695] A list of considerations that the psychiatrist and MHT must have regard to in deciding 'whether there is a less restrictive way for the young person to be treated' has been included in the legislation.[1696]

7.3.16 Regardless of whether an order is made or not, the MHT must notify the persons and bodies specified in the Act of the decision.[1697]

[1684] Ibid s 99(2)(a), (b); see also s 99(2)(c)–(h).

[1685] *Mental Health and Wellbeing Act 2022* (Vic) s 100.

[1686] Ibid s 101.

[1687] Ibid s 104(2)(a)-(i).

[1688] Ibid s 103(a).

[1689] Ibid ss 103(b), 104(1)(a).

[1690] Ibid s 104(1)(b).

[1691] Ibid s 104(1)(c)(i)(ii).

[1692] Ibid s 106.

[1693] A young person is defined as a person under 18 years of age: Ibid s 2.

[1694] Ibid s 108.

[1695] Ibid s 109(1)(b).

[1696] Ibid ss 109(2)(a)-(i), 110(a)(ii).

[1697] Ibid s 111.

Young Persons – Non-Patients

7.3.17 Administration of ECT to a young person who is not a patient can only be provided if an order authorising administration of ECT has been provided by the MHT.[1698] In the case of young persons who are not patients, the framework is similar, in that ECT can be provided if the person has given written informed consent,[1699] meaning that they have decision-making capacity to consent, or if they do not have capacity to consent, then the MHT can authorise ECT.[1700]

7.3.18 If an order for administration of ECT is sought because the young person is not capable of giving informed consent, the psychiatrist applying for the order must be satisfied that there is 'no less restrictive way for the young person to be treated.'[1701] However, the young person's medical treatment decision-maker must have given informed consent to ECT.[1702] Further, a list of considerations that the psychiatrist and MHT must have regard to in deciding 'whether there is a less restrictive way for the young person to be treated' has been included in the legislation.[1703]

7.3.19 If the MHT is satisfied that these criteria are met, then they can make an order for the administration of ECT and must then notify the persons/bodies specified in the legislation of the order.[1704]

United Kingdom

7.3.20 To provide an international perspective on the governance of ECT, SALRI has elected to consider the legislative framework in the United Kingdom ('UK'), given the historical connection between the UK and Australia in the establishment of law.

7.3.21 The *Mental Health Act 1983* (UK) ('*MHA* (UK)') establishes a framework to provide treatment and care for persons who are mentally disordered.[1705] In the 2021-22 Mental Health Statistics: Annual Figures Report, it was observed that the number of detentions made under the Act continued to rise annually, which was viewed as a matter of concern. It was noted that in recent years 'there has been a steep rise in the use of the short-term detention for assessment.'[1706] To address this issue, an Independent Review was established to examine the use of the *MHA* (UK).[1707]

7.3.22 The Independent Review identified many issues with the existing legislative framework, noting that many stakeholders identified that some processes relating to the act are out of step with a modern mental health system, including but not limited to:

[1698] Ibid s 113.

[1699] *Mental Health and Wellbeing Act 2022* (Vic) s 114(1)(a).

[1700] Ibid ss 114(1)(b).

[1701] Ibid s 114(1)(b)(ii).

[1702] Ibid s 114(1)(b)(i).

[1703] Ibid ss 114(2)(a)-(j), 115(a)(ii)(B).

[1704] Ibid s 116.

[1705] *Mental Health Act 1983* (UK) s 1(1).

[1706] National Health Service (UK), *Modernising the Mental Health Act: Increasing Choice, Reducing Compulsion – Final Report of the Independent Review of the Mental Health Act 1983* (December 2018) 49.

[1707] National Health Service (UK), *Mental Health Act Statistics, Annual Figures 2021-22* (27 October 2022) <https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-act-statistics-annual-figures/2021-22-annual-figures>.

> … the balance of safeguards available to patients, such as tribunals, second opinions, and requirements for consent
>
> the ability of the detained person to determine which family or carers have a say in their care, and of families to find appropriate information about their loved one
>
> that detention may in some cases be used to detain rather than treat.[1708]

7.3.23 The final report titled *Modernising the Mental Health Act, Increasing Choice, Reducing Compulsion*,[1709] was released in December 2018. The Chair of the Independent Review noted that one of the biggest issues in the complex area of mental health law was balancing the right of respect for individual autonomy and the obligation of the State to protect the vulnerable from harm.[1710] It was noted that the existing legal framework governing mental health was outdated and did not take into consideration the 'fundamental importance of human rights in mental health care,'[1711] especially the UN *Convention on the Rights of Persons with Disabilities* which has been ratified in the UK.[1712]

7.3.24 The lack of dignity afforded to persons suffering from a mental illness and subjected to involuntary treatment was a key matter before the Independent Review committee who observed that:

> Dignity is essential both to improvement and to maintaining better health and reducing the risk of further admissions. Lack of dignity, and a lack of a trust that patients will be treated kindly and with respect, inspires fear. We have heard how many service users fear that being compulsorily admitted to hospital will worsen, not improve, their mental distress.[1713]

7.3.25 In relation to the administration of ECT, the Independent Review observed that respect for dignity should be firmly embedded throughout the *MHA* (UK). For example, this may be reflected by limiting the circumstances in which a person's advance refusal (Advance Care Directive, know as an Advance Choice Document (ACD) in the UK) of ECT could be overturned, such as with judicial review.[1714] It was further noted that:

> Some patients and service users have very strong views around this [ECT] and we have heard from some who feel that they would refuse ECT even if that imperilled their life. We have as a general principle adhered to the view that no ACD or expression of wish or preference can ever be 100% binding, for clear ethical and policy reasons …however, certain interventions require even greater safeguards. So we propose the ACDs or other expressions of wishes or preferences around ECT could only be overrules by authorisation of a judge … on strict criteria involving immediate risk to life, probably in circumstances where a person is now in a situation that they are unable to express any intention to change their mind – such as catatonia or depressive disorder.[1715]

[1708] Department of Health and Social Care (UK), *Terms of Reference: Independent Review of the Mental Health Act 1983* (4 October 2017) <https://www.gov.uk/government/publications/mental-health-act-independent-review/terms-of-reference-independent-review-of-the-mental-health-act-1983#background>.

[1709] National Health Service (UK), *Modernising the Mental Health Act: Increasing Choice, Reducing Compulsion – Final Report of the Independent Review of the Mental Health Act 1983* (December 2018) 49.

[1710] Ibid.

[1711] Ibid 19.

[1712] Ibid.

[1713] Ibid 17.

[1714] Ibid 18.

[1715] Ibid 22.

7.3.26 The UK Government introduced a Draft Mental Health Bill in Parliament in June 2022 for pre-legislative scrutiny,[1716] which aims to replace the existing *Mental Health Act 1983* (UK). The Explanatory Notes that accompanied the Draft Mental Health Bill amends the relevant sections of the *Mental Health Act 1983* (UK) which pertain to administration of ECT. The most notable amendments concerning ECT in the new Draft Bill relate to provision of emergency ECT, implementing additional safeguards for patients who have refused ECT when they had decision-making capacity or have expressed this in an advance directive.[1717] As the Draft Mental Health Bill is at pre-legislative scrutiny stage, further consideration of this has not been undertaken.

7.3.27 Section 58A of the *MHA* (UK) regulates the provision of ECT. This establishes a separate framework for adults capable of consenting to ECT, minors under the age of 18 capable of consenting to ECT and adults and minors incapable of consenting to ECT.[1718] While the *MHA (UK)* permits administration of treatment deemed urgent, this specifically excludes ECT.[1719] Therefore, ECT cannot currently be administered in emergency or urgent situations.

Consenting Adults

7.3.28 The *MHA* (UK) provides that persons 18 years and older who have capacity, can consent to ECT. However, in addition to this, an approved clinician or registered medical practitioner must also confirm that the person has decision-making capacity to consent, certifying in writing that they are 'capable of understanding the nature, purpose and likely effects of the treatment and has consented to it.'[1720]

Consenting Minors

7.3.29 The process for consenting to ECT varies slightly for persons under 18 years of age. The legislation still recognises that valid consent can be provided but avoids specifying what age this can be done. Instead, the legislation requires an independent registered medical practitioner, who is not the treating clinician, to certify in writing that the treatment is appropriate and the patient is capable of understanding the 'nature, purpose and likely effects of the treatment and has consented to it.'[1721]

Adults and Minors – Lacking Decision-Making Capacity

7.3.30 ECT can still be provided to adults and minors who lack decision-making capacity. However, additional safeguards have been embedded into the consent process.[1722] An independent medical practitioner, who is not responsible for the treatment of the patient, certifies in writing that the person is not capable of understanding either the nature, purpose and likely side effects of the treatment,[1723] and that the treatment is appropriate.[1724] In addition to this, the provision of involuntary

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[1716] Department of Health and Social Care and Ministry of Justice, *Policy Paper Draft Mental Health Bill 2022* (27 June 2022) <www.gov.uk/government/publications/draft-mental-health-bill-2022>.

[1717] UK Government, *Draft Mental Health Bill: Explanatory Notes* (27 June 2022) 17–8.

[1718] *Mental Health Act 1983* (UK) s 58A(3)–(5).

[1719] Ibid s 62(1) and (1A) 9.

[1720] Ibid s 58A(3)(c).

[1721] Ibid s 58A(4)(c)(i), (ii). This is similar to the *Gillick* principle as it applies in Australia: See *Gillick v West Norfolk and Wisbech Area Health Authority* [1985] UKHL 7, [1986] AC 112.

[1722] *Mental Health Act 1983* (UK) s 58A(6)(a), (b).

[1723] Ibid s 58A(5)(a).

[1724] Ibid s 58A(5)(b).

ECT must not conflict with a valid advance directive refusing administration of ECT,[1725] or a decision made by a 'donee or deputy or by the Court of Protection.'[1726]

7.3.31 Further to this, the registered medical practitioner must consult two other persons who are involved in the professional care of the patient. However, the *MHA* (UK) prohibits the clinician responsible for the patient or the clinician in charge of treating the patient from being consulted to provide an opinion concerning the person's lack of decision-making capacity.[1727] The *MHA* (UK) specifies that one nurse must be consulted and one other person who is not a nurse or registered medical practitioner.[1728]

Withdrawal of Consent

7.3.32 An important protection in the legislation is the right of patients to withdraw their consent at any time after the treatment has commenced.[1729] This applies to both minors and adults. However, consent to ECT is automatically withdrawn if the capable person 'is no longer capable of understanding [the] nature, purpose and effects' of ECT.[1730]

7.3.33 In recognition of the fluctuating and complex nature of capacity, the *MHA* (UK) also provides for situations where capacity was initially lacking but then regained during the treatment. Where a person was initially deemed incapable of consenting to ECT and a certificate was issued in accordance with the legislation authorising ECT, if the person regains their capacity, then the authorisation of ECT provided by an independent registered medical practitioner is automatically withdrawn.[1731] Therefore, it is evident that the legislation prioritises respect for autonomy by recognising that the person must retain decision-making capacity throughout the entire duration of the treatment.

7.4 Issues

Prevalence of ECT

7.4.1 SALRI was told that in South Australia, ECT is undertaken in the public and private mental health systems – four locations in the public sector[1732] and one in the private sector.[1733]

7.4.2 The OCP provides a limited statistical overview of the administration of ECT on an annual basis. Their most recent Annual Report indicates the number of people who received ECT

[1725] Ibid s 58A(5)(c)(i).

[1726] Ibid ss 58A(5)(c)(ii), 58A(9)(c), (d); donee is a person appointed under a lasting power of attorney that has been validly created by the person see *Mental Capacity Act 2005* (UK) s 9; a deputy is appointed by the patient and included in an order of the Court of Protection, see *Mental Capacity Act 2005* (UK) s 16.

[1727] *Mental Health Act 1983* (UK) s 58A(6)(a)(b).

[1728] Ibid s 58A(6)(a).

[1729] Ibid s 60(1).

[1730] Ibid ss 60(1A)(a), (b), (1B).

[1731] Ibid ss (1C), (1D).

[1732] Flinders Medical Centre, the Queen Elizabeth Hospital, Glenside Health Services and Lyell McEwen Hospital.

[1733] The Adelaide Clinic Ramsay Health Care.

between 30 June 2017 and 30 June 2022, in both public and private hospitals, has remained largely consistent.[1734]

7.4.3 Across both public and private settings, the highest percentage of ECT was administered to persons aged between 60-79,[1735] and females were overrepresented in the data concerning administration of ECT in the 2021-22 period, with women twice as likely to receive ECT.[1736] For instance, the 2016-2017 Annual Report recorded 59% of persons who received ECT were female in public settings, with a slight increase to 65% in private settings.[1737]

7.4.4 A similar trend has been reported in Victoria where empirical research indicated that during the period 1998-2007, where 61.7% of persons who were administered ECT were female,[1738] and in the UK.[1739]

7.4.5 In South Australia no data was reported concerning administration of ECT on Aboriginal and Torres Strait Islander persons due to privacy issues however 11.9% of persons who received ECT were from CALD communities.[1740]

7.4.6 The majority of ECT treatments were for persons diagnosed with depressive disorders, accounting for 65.9% and 64.5% of the total number of ECT treatments across public and private hospital settings respectively.[1741] This was followed by schizoaffective disorders and bipolar disorder.[1742] Finally, nearly half of patients received between 6 – 12 episodes of ECT (48.9%), which is consistent with 'best practice understandings of ECT treatment efficacy.'[1743]

[1734] The highest number of people receiving ECT in the 2017-18 period (n = 551), and the lowest in the 2018-19 period (n = 527), with the annual figures for the remaining falling between these two values: Office of the Chief Psychiatrist, *Annual Report of the Office of the Chief Psychiatrist 2021-22* (SA Health, 30 September 2022) 24.

[1735] Ibid 25.

[1736] Office of the Chief Psychiatrist, *Annual Report of the Office of the Chief Psychiatrist 2021-22* (SA Health, 30 September 2022) 25. 'The rate of females receiving ECT in South Australia has increased over recent years, with the most significant rise occurring in the 2021-2022 reporting period.'

[1737] Office of the Chief Psychiatrist, *Annual Report of the Office of the Chief Psychiatrist 2017-18* (SA Health, 30 September 2018) 25.

[1738] Chris Plakiotis, Kuruvilla George and Daniel O'Connor, 'Has Electroconvulsive Therapy Use Remained Stable over time? A Decade of Electroconvulsive Therapy Service Provision in Victoria, Australia' (2012) *Australian and New Zealand Journal of Psychiatry* 522, 525.

[1739] John Read et al, 'A Second Independent Audit of Electroconvulsive Therapy in England, 2019: Use Demographics Consent, and Adherence to Guidelines and Legislation' (2021) 94 *Psychology and Psychotherapy: Theory, Research and Practice* 603.

[1740] Office of the Chief Psychiatrist, *Annual Report of the Office of the Chief Psychiatrist 2021-22* (SA Health, 30 September 2022) 25.

[1741] Ibid. See also Chris Plakiotis, Kuruvilla George and Daniel O'Connor, 'Has Electroconvulsive Therapy use Remained Stable over time? A Decade of Electroconvulsive Therapy Service Provision in Victoria, Australia' (2012) *Australian and New Zealand Journal of Psychiatry* 522, 525.

[1742] Office of the Chief Psychiatrist, *Annual Report of the Office of the Chief Psychiatrist 2021-22* (SA Health, 30 September 2022) 25.

[1743] Ibid 26.

7.5 Consultation Data Overview

General Observations

7.5.1 SALRI acknowledges community concerns about the use of ECT in South Australia.[1744] However, there was strong support among psychiatrists and mental health professionals that ECT is an effective treatment for certain mental illnesses. For instance, one psychiatrist submitted that:

> ECT is the single most effective biological treatment for a number of severe psychiatric illnesses [and] it is generally used for the treatment of major depressive disorders but also has an evidence base utility for the treatment of mania and also for schizophrenia.

7.5.2 Despite this, there were divergent views, particularly consumers and members of the community,[1745] concerning the current ECT provisions under the *MHA*. Many members of the community favoured a complete ban on ECT, arguing it should be deemed an unlawful practice. However, SALRI's consultation noted that, as advised by a psychiatrist, 'in the vast majority of cases, [ECT is] given to patients who consent voluntarily for their treatment having had the treatment, its benefits, limitations and risks explained in detail.'

7.5.3 Several consumers shared their experience with ECT with SALRI, detailing the negative side effects they experienced. During SALRI's consultation with consumers and consumer groups, it was noted that while some negative effects came from ECT itself, many of the concerns arose from the overall treatment experience. This refers to the circumstances that led to their hospital admission and ECT treatment. This may have included the involuntary nature of the procedure, the use of care and control powers that led to their hospital admission and other surrounding circumstances. However, SALRI still notes the valid concerns raised by consumers and consumer groups on this issue.

7.5.4 The Public Health Association of Australia did not advocate for a complete abolition of ECT, and instead called for a total ban on involuntary ECT. However, there was no consensus on this view. One psychiatrist was of the view that if the emergency ECT provisions were removed from the legislation this could 'severely affect the wellbeing of the patient.' In addressing the issue of the absence of the definition of 'urgent need' to provide emergency ECT under section 42(6)(a) of the *MHA*, this meaning could be clarified by identifying that 'treatment needs to be given urgently whilst awaiting substitute decision maker consent and if not given urgently the patient would be at a very real risk of either severe morbidity or mortality.'

7.5.5 It is beyond SALRI's remit to comment on the validity of ECT or its appropriateness as a form of treatment. However, SALRI recognises the importance of retaining mechanisms to monitor, regulate and review ECT, to ensure it continues to represent an accepted mental health treatment and best practice.

7.5.6 The current oversight mechanisms were reinforced by a psychiatrist during consultation, '…the oversight of ECT in South Australia is substantial and certainly not in proportion with the oversight of most medical procedures used within the wider medical profession.'

[1744] For example, the Citizens Commission on Human Rights recommended that '[e]lectroshock is torture, not therapy and must be banned in the *SA Mental Health Act* for all ages with severe criminal fines and prison terms for its use.'

[1745] These submissions were received from community members who were not identified as consumers or health practitioners.

Use of Reasonable Force to Administer ECT

7.5.7 A recurring theme that arose during SALRI's consultation was the administrative inefficiency created by the interaction between the *MHA* and *GA Act*. Specifically, for emergency ECT, which may require the use of force, a clinician currently makes two applications to seek this authorisation. The clinician can apply to SACAT under the *MHA* and for a guardianship order under s 32 of the *GA Act*. This results in treatment delays and creates confusion among clinicians regarding the most appropriate pathway to obtain authorisation for use of force.

7.5.8 Consultation revealed a discrepancy in the *MHA* in relation to the use of force to administer treatment under an ITO and ECT provisions. While use of force is permitted under an ITO to administer treatment for mental illness, this does not apply to ECT. This was raised by one consultee, who observed that these restrictions on the use of force are internally inconsistent, with some provisions permitting the use of force to administer treatment involuntarily, and others (including ECT), explicitly prohibiting the use of force.

7.5.9 This was also raised by the PPTP, who described the current processes as an impediment to administering treatment, especially in time critical cases. The SA SECN RANZCP submitted that use of s 32 of the *GA Act* should be avoided for emergency ECT. They recommended the ECT provisions contained in the *MHA* should be reviewed to permit the use of reasonable force for emergency ECT, with appropriate safeguards. They submitted that **'**the current section that stated that coercion cannot be used to facilitate ECT should be removed and replaced with a description of circumstances when it can be used, with appropriate safeguards and reporting procedures.'

7.5.10 There was strong support among clinicians to enable the use of force to administer emergency ECT. In their submission to SALRI, the Central Adelaide Local Health Network ('CALHN') stated:

> The use of reasonable force to ensure a person receives ECT should only apply in those cases in which a person is subject to an Inpatient Treatment Order and consent for ECT and the use of reasonable force has been granted by a substitute decision-maker, either by a Power of Attorney or the SACAT.
>
> It should never be applied to a person who is a voluntary patient under the *MHA*.

7.5.11 The SA SECN RANZCP also supported the use of force for emergency ECT, identifying circumstances where it may be appropriate:

> The use of restrictive practices to facilitate ECT should occur only when there is a clear clinical harm to the person if they so not receive ECT and all reasonable alternatives to facilitate ECT without any coercion have been tried.
>
> Coercive practices to facilitate ECT should not occur when the patient has provided their own voluntary consent.
>
> Coercive practices should only occur when ECT is being provided as an emergency treatment under emergency consent provisions or when SACAT or a substitute Decision Maker/Guardian had provided substitute consent.
>
> Any use of restrictive practices must be documented in the case record and reported to the OCP.

7.5.12 Another psychiatrist submitted:

> The fact that one treatment in psychiatry can be provided with the use of reasonable force under the *MHA* whilst another cannot be given under the use of reasonable force would seem to me to be an inconsistent situation within the Act and … [this review] needs to redress this situation.

7.5.13 CALHN referred to current practice and proposed ways in which a consumer's rights could be better protected in cases of emergency ECT:

> It is important to understand that emergency ECT occurs because of a mismatch between the clinical need and the availability of the SACAT to hear a case.
>
> The rights of the consumer could best be protected if all emergency ECT required a brief application for an emergency hearing before the SACAT for a course of no more than 3 treatments.
>
> - The application should be streamlined.
> - The SACAT would be required to hear the matter, including by telephone or video-conference within 6 hours of receiving the application.
> - The view of the patient and Next of Kin should be considered.
> - A decision to grant Emergency ECT for no more than 3 treatments should be followed by a full hearing within 7 days to review the order and hear a case for a full course of ECT.
>
> This would ensure that patients are not denied life-saving treatment, but there is an opportunity for the patient and Next of Kin to be heard before an independent tribunal.

7.5.14 The Legal Services Commission of South Australia ('LSCSA') noted the current procedure requiring an application to SACAT for the appointment of the public advocate as a guardian, who must then apply to SACAT to have the treating team authorise the use of reasonable force for ECT was problematic. The LSCSA submitted that:

> … this practice is beyond the intended role of the Public Advocate and the purpose and intent of the Guardianship and Administration Act. This issue is best addressed under the MH Act under which power to provide ECT treatment arises.

7.5.15 The Office of the Public Advocate (OPA) addressed this issue at length in their submission. They highlighted the difficulty staff at the OPA face when appointed guardian, under the *GA Act* to authorise the use of force to administer ECT. The OPA submitted that:

> Given that the guardian does not themselves authorise or approve the use of force (authorisation is given to the treating team by the SACAT), and that the SACAT has the power to consent to ECT, the need for a guardianship order in addition to the oversight of the SACAT (and often on top of an ITO), is a duplication. In some cases, the SACAT will be satisfied of the need for ECT and make the special powers order, but will appoint the Public Advocate as guardian to provide the written consent to ECT. In practice, this can mean that the treating psychiatrists must go through the process of explaining the risks and benefits of ECT again to an OPA staff member who has delegations to consent to ECT, if that staff member has not been present at the SACAT hearing. In addition, the insertion of a guardianship order can result in the person experiencing more limitations on their decision-making control.
>
> In practice, when the OPA becomes guardian for this specific purpose, there may be no additional decisions that are required and often the OPA does not receive an update about the patient's

> treatment before the order lapses. It is difficult to see how the OPA, or a private guardian, adds value to the process or provides a genuine safeguard in such circumstances.

7.5.16 The OPA raised significant concern regarding the current legislative procedure and were of the view that the *GA Act* should not be used to authorise this, but rather it should be included in the *MHA*. It was recommended that 'the process for authorising the use of force in relation to ECT be managed separately from guardianship and substitute decision-making schemes, for example by empowering SACAT to provide authority directly to the treatment team.' SALRI recognises this concern and supports consistency across South Australian legislation to avoid confusion.

7.5.17 In relation to children and young people, the Commissioner for Aboriginal Children and Young People expressed a different view submitting that force should never be used to administer ECT.

7.5.18 In their submission to SALRI, the Lived Experience Leadership and Advocacy Network ('LELAN') stated it:

> … does not support any expansion of the powers to the Act that increases legislated authority to use power in any way to reduce the human rights of people with lived experience of distress or diagnosed mental illness. This includes to use of force, irrespective of it being defined in legislation as reasonable, to 'ensure a person receives electroconvulsive therapy'. Section 42 of the Act should be tightened to remove powers for any use of restrictive practices (force) to administer ECT, irrespective of the person's decision-making capacity.

7.5.19 Lived Experience Australia agreed, noting 'force for ECT is never appropriate.' They further noted:

> … if emergency ECT is considered within the *MHA*, then people and/or their families and carers MUST be provided with sufficient time and information to make the informed decision, receive a copy of their rights to refuse, seek a second opinion, etc and these processes must be written into the *MHA*.

7.5.20 SALRI notes the concerns of all parties on both sides of the debate, whose views cannot be reconciled. However, SALRI is of the view, after careful consideration of the consultation data and literature in this area, that there will be circumstances where ECT must be undertaken without consent. As such, the use of reasonable restrictive practice may be required to administer ECT authorised under an ITO or cases of an emergency. SALRI supports this practice, on the condition that legislative safeguards are implemented.[1746]

Role and Functions of the PPTP

7.5.21 Concern over the current review triggers and functions of the PPTP under the *MHA* were raised by several parties, including the PPTP, the LSCSA, SACAT and SA SECN RANZCP.

7.5.22 CALHN submitted that '[t]he PPTP should not have a role in monitoring voluntary treatment.' Rather, they should only provide oversight into any ECT that is provided in an involuntary capacity.' This view was further expanded:

> ECT is a medical procedure no different from surgery, endoscopy or interventional radiology and there are mechanisms embedded within health service standards for the monitoring and

[1746] See SALRI Recommendation 37.

management of adverse incidents, which in ECT are relatively few. This also applies to other forms of neurostimulation.

7.5.23 On the issue of the PPTP's review triggers, the PPTP observed that there was an obvious conflict concerning their role, as recommended in the previous statutory review of the *MHA* and their current legislative functions. The existing law limits the PPTP to a retrospective review of certain cases specified under the Act. Many submissions received by SALRI, with several parties advocating for a more active role for the PPTP under the legislation.

7.5.24 For instance, the Commissioner for Aboriginal Children and Young People submitted that the PPTP should have broader functions under the *MHA* in relation to reviewing cases of ECT for children and young people. Noting that they should have oversight of all cases for persons under 18 years of age.

7.5.25 The SA SECN RANZCP observed that the legislative triggers for PPTP involvement should be reviewed. It was submitted that 'consent triggers that are truly unusual, e.g. five or more consents in a year (this wouldn't include maintenance ECT), or three or more emergency consents in one course', would be appropriate for PPTP review. Further they suggested that the existing legal position be amended, to include a non-exhaustive list of complex cases that necessitate PPTP review, including:

- All cases where the person is aged less than 18 years.
- All cases where restrictive practices have been authorised or used.
- Cases where the SLS [Safety Learning System] report rating is at SAC 1 or 2.
- Cases referred by a service/practitioner or a patient/carer (or other 'interested party') who can request a review.
- Possibly some clinical triggers that would require services/clinicians to self-report e.g. an index course longer than 20 sessions, use of bitemporal placement, presence of significant adverse events (e.g. prolonged or status seizure), etc.

7.5.26 The OPA expressed a similar view, calling for the PPTP's review triggers to be strengthened and clarified under the *MHA*.

7.6 SALRI's Observations and Conclusions

7.6.1 SALRI accepts that ECT remains stigmatised with negative community perceptions, which reflect valid historical issues with its use.[1747] However, although there are dissenting views,[1748]

[1747] Merrilyn Walton, 'Deep Sleep Therapy and Chelmsford Private Hospital: Have we Learnt Anything?' (2013) 21(3) *Australasian Psychiatry* 206.

[1748] See, for example, John Read and Richard Bentell, 'The Effectiveness of Electroconvulsive Therapy: A Literature Review' (2010) 19(4) *Epidemiology and Psychiatric Sciences* 333; Talya Peltzman, Brian Shiner and Bradley Watts, 'Effects of Electroconvulsive Therapy on Short-Term Suicide Mortality in a Risk-Matched Patient Population' (2020) 36(3) *Journal of Electroconvulsive Therapy* 187; John Read, Irving Kirsch and Laura McGrath, 'Electroconvulsive Therapy for Depression: A Review of the Quality of ECT vs Sham ECT Trials and Meta-Analyses' (2019) 21(2) *Ethical Human Psychology and Psychiatry* 64; David González-Pando et al, 'Ethical Implications of Electroconvulsive Therapy: A Review' (2021) 23(1) *Ethical Human Psychology and Psychiatry* 1; John Read et al, 'A Second Independent Audit of Electroconvulsive Therapy in England, 2019: Use Demographics Consent, and Adherence to Guidelines and Legislation' (2021) 94 *Psychology and Psychotherapy: Theory, Research and Practice* 603.

many studies highlight that modern ECT is valid, effective and a recognised treatment for mental illness performed by specialised staff.[1749] Therefore, SALRI recognises that ECT is a sophisticated and accepted form of treatment for mental illness. The value of ECT, in particular, extends to individuals who lack decision-making capacity.[1750]

7.6.2 Consultation revealed strong support, particularly from clinicians, that the *MHA* should permit the use of reasonable restrictive practice for emergency ECT. A psychiatrist offered the following example during SALRI's consultation:

> Depression can make patients so unwell that they do not eat or drink. They can become highly suicidal and be at very high risk. In these circumstances it is possible to deliver emergency ECT as a life saving measure where the person does not have decision making capacity, there is no substitute decision maker and there is not time to seek SACAT approval.

7.6.3 SALRI notes a majority of cases where ECT is undertaken are voluntary and thus the use of restrictive practices is largely irrelevant.

7.6.4 In cases of involuntary ECT – which may be administered as an authorised treatment under an ITO or in emergency circumstances, clinicians are unable to lawfully use reasonable restrictive practices, despite being able to do so for other psychiatric treatments. SALRI's consultation revealed this discrepancy has led to clinicians relying upon the *GA Act* to seek an order to use force to administer ECT under these circumstances. In practice, this is causing time delays due to the need for two concurrent applications to SACAT and as such, a more streamlined process would be welcomed.

7.6.5 In light of its extensive research and consultation, SALRI recommends that s 42(4)(b) of the *MHA* should be amended to authorise the use of reasonable restrictive practices to facilitate the provision of emergency ECT, with appropriate safeguards and reporting procedures.[1751] Further,

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[1749] See, for example, Tyler Kaster, Zafiris Daskalakis and Daniel Blumberger, 'Clinical Effectiveness and Cognitive Impact of Electroconvulsive Therapy for Schizophrenia: A Large Retrospective Study' (2017) 78(4) *Journal of Clinical Psychiatry* e353; Sandee Grover et al, 'ECT in Schizophrenia: a Review of the Evidence' (2018) 31(3) *Acta Neuropsychiatrica* 115; Peter Giacobbe et al, 'Improvements in Health-Related Quality of Life With Electroconvulsive Therapy: a Meta-Analysis' (2018) 3492 *Journal of ECT* 87; Marilyne Landry et al, 'Current Practices of Electroconvulsive Therapy in Mental Disorders: a Systematic Review and Meta-Analysis of Short and Long-Term Cognitive Effects' (2021) 37(2) *Journal of ECT* 119; Sohag Sanghani et al, 'Electroconvulsive Therapy in Schizophrenia: a Review of Recent Literature' (2018) 31(3) *Current Opinion in Psychiatry* 213; Adriana Hermida et al, 'Electroconvulsive Therapy in Depression: Current Practice and Future Direction' (2018) 41(3) *Psychiatric Clinics of North America* 341; Julian Muntz et al, 'Comparative Efficacy and Acceptability of Non-Surgical Brain Stimulation for the Acute Treatment of Major Depressive Episodes in Adults: Systematic Review and Network Meta-Analysis' (2019) 27 *British Medical Journal* 364; Georgios Petrides et al, 'Electroconvulsive Therapy Augmentation in Clozapine-Resistant Schizophrenia: A Prospective, Randomized Study' (2019) 17(1) *Focus : Journal of Life Long learning in Psychiatry* 76; Akihiro Takamiya et al, 'Attitudes Toward Electroconvulsive Therapy Among Involuntary and Voluntary Patients' (2019) 35(3) *Journal of ECT* 169; Vincent Wong et al, 'Effectiveness and Cognitive Changes With Ultrabrief Right Unilateral and Other Forms of Electroconvulsive Therapy in the Treatment of Mania' (2019) 35(1) *Journal of ECT* 40; James Luccarelli et al, 'Maintenance ECT is Associated with Sustained Improvement in Depression Symptoms without Adverse Cognitive Effects in a Retrospective Cohort of 100 Patients each Receiving 50 or more ECT Treatments' (2020) 271 *Journal of Affective Disorders* 109; Tyler Laster et al, 'Risk of Serious Medical Events in Patients with Depression Treated with Electroconvulsive Therapy: a Propensity Score Matched, Retrospective Cohort Study' (2021) 8 *Lancet Psychiatry* 686; George Kirov et al, 'Electroconvulsive Therapy for Depression: 80 years of Progress' (2021) 219(5) *British Journal of Psychiatry* 594.

[1750] See, for example, Pern-Chern Tor et al, 'Outcomes in Patients with and without Capacity in Electroconvulsive Therapy' (2020) 266 *Journal of Affective Disorders* 151; Martha Finnegan, Stephanie O'Connor and Declan McLoughlin, 'Involuntary and Voluntary Electroconvulsive Therapy: A Case-Control Study' (2018) 11(4) *Brain Stimulation* 860.

[1751] See SALRI Recommendation 37.

SALRI recommends the inclusion of explanatory notes providing a description of the circumstances when emergency ECT can be used.[1752]

7.6.6 SALRI recognises the value of the PPTP as a safeguard in offering retrospective oversight and as such they should be retained under the *MHA*. Currently the composition of the PPTP includes one neurosurgeon. Although neurosurgery has not been performed in South Australia for 50 years, SALRI recommends this category of member be retained. SALRI was advised that evidence is emerging regarding the role of deep brain stimulation. In light of this evidence, neurosurgery might occur at some point in the future (noting, however, it is not in the foreseeable future). In these circumstances, the existence of an established review/authorisation mechanism would be of utility.

7.6.7 In relation to the current role and remit of the PPTP, SALRI was advised that their jurisdiction is too broad, often capturing cases of maintenance ECT. The result of this is a potential overburdening of the PPTP which interferes with their ability to focus on more complex cases. As a result, the PPTP submitted to SALRI that their jurisdiction be limited by revising the s 41C review triggers.

7.6.8 SALRI is of the view that the review triggers should be amended, to enable the PPTP to review a 'complex case'.[1753] SALRI notes the term 'complex case' requires definition, which is largely a clinical determination. As a result, SALRI recommends that the term 'complex case' should be defined, in consultation with the Panel, the Chief Psychiatrist and other relevant interested parties.[1754]

7.6.9 When a determination is made as to the definition of a 'complex case', SALRI is of the view that this should not be enshrined in legislation, but rather set out in Regulations or as a Directive issued by the Chief Psychiatrist. This will enable the definition of the term to be easily revised in the future, with advancements in clinical understanding.

7.6.10 Noting the possibly evolving nature of 'complex cases', SALRI recommends the PPTP should be able to invite the attendance of other relevant persons to provide specialist input, such as Aboriginal, Culturally and Linguistically Diverse or LGBTIQ representatives, where a case so requires.[1755] Given the current lack of neurosurgery cases in South Australia, SALRI is also of the view that the neurosurgeon panel member should only need to attend a meeting where the case requires their expertise.[1756]

[1752] Ibid.

[1753] See SALRI Recommendation 38.

[1754] Ibid.

[1755] See SALRI Recommendation 40.

[1756] See SALRI Recommendation 39.

7.6.11 Recommendations

RECOMMENDATION 37

SALRI recommends that s 42(4)(b) of the *Mental Health Act 2009* (SA) should be amended to authorise the use of reasonable restrictive practices to facilitate the provision of emergency Electroconvulsive Therapy ('ECT').[1757] In addition, SALRI recommends that consideration should be given to the inclusion of explanatory notes providing a description of the circumstances when emergency ECT can be used, with appropriate safeguards and reporting procedures, including, but not limited to:

a. The use of restrictive practices to facilitate ECT should occur only when there is a clear clinical harm to the person if they do not receive ECT and all reasonable alternatives to facilitate or carry out ECT without any coercion have been attempted.

b. Coercive practices to facilitate or carry out ECT should not occur when the person has provided valid consent.

c. Coercive practices should only occur when ECT is being provided as an emergency treatment:

   i. Under emergency consent provisions; or
   ii. The South Australian Civil and Administrative Tribunal provides authorisation; or
   iii. A substitute decision-maker or guardian provides substitute consent.

d. Any use of restrictive practices must be documented in the case record and reported to the Office of the Chief Psychiatrist.

   i. Reports of such cases should be reported in the Chief Psychiatrist's Annual Report under s 92(1)(a) of the *Mental Health Act 2009* (SA).

RECOMMENDATION 38

SALRI recommends that the s 41C of the *Mental Health Act 2009* (SA) identifying the review triggers of the Prescribed Psychiatric Treatment Panel should be amended, to enable the Panel to review a 'complex case'. SALRI further recommends that the term 'complex case' should be defined, in consultation with the Panel, the Chief Psychiatrist and other relevant interested parties.[1758]

[1757] SALRI notes that amendments to authorise the use of reasonable restrictive practices to facilitate emergency ECT under *Mental Health Act 2009* (SA) may avoid the need to rely on s 32 of the *Guardianship and Administration Act 1993* (SA).

[1758] In their submission to SALRI, the Panel identified a number of cases which may constitute a 'complex case', such as any use of restraint or restrictive practices, cases featuring clinically complex treatment-resistance, cases featuring clinically complex comorbidities and the use of ECT on children and young people aged under 18. It is noted that this would require cooperation with ECT clinical coordinators and treating psychiatrists, to ensure a referral constitutes a 'complex case'.

RECOMMENDATION 39

SALRI recommends that membership of a neurosurgeon on the Prescribed Psychiatric Treatment Panel be retained, however, the requirement for them to attend a meeting should be subject to the requirements of the case.

RECOMMENDATION 40

SALRI recommends that consideration should be given to allowing the Prescribed Psychiatric Treatment Panel to invite specialist input from relevant persons, such as an Aboriginal, Culturally and Linguistically Diverse or LGBTIQ representative, where a case so requires.

Part 8 – Restrictive Practices and Control Powers

8.1 Background

8.1.1 The *Mental Health Act 2009* (SA) ('*MHA*') authorises the use of restrictive practices by certain classes of officers, including authorised officers and police officers. The role and use of restrictive practices under the *MHA* proved a prominent theme in both SALRI's research and consultation.

8.1.2 In accordance with the *MHA*, restrictive practices can only be utilised when the person is placed under care and control, an Inpatient Treatment Order ('ITO') or a Community Treatment Order ('CTO') for the administration of authorised treatment. Under the *MHA*, restrictive practices cannot be used to administer electroconvulsive therapy.

8.1.3 In July 2021, the Office of the Chief Psychiatrist ('OCP') released a Standard governing the use of restrictive practices, with a view to ensure that such measures are only applied in limited circumstances, where there is no less restrictive means of de-escalating the situation.[1759] The Standard covers vital information concerning when each restrictive practice defined in the *MHA* can be used and the procedures relevant to each practice before, during and after the incident. This includes the requirement for trauma-informed debriefing with the person subjected to the restrictive practice and reporting of the incident in the incident reporting system.[1760]

8.1.4 The focus of the Standard is '[t]he reduction and elimination of seclusion and restraint [and] focusses on the authorisation for restraint, and the review of such incidents after they have occurred.'[1761] For each type of restrictive practice, the current Standard clearly defines the indication for its use, the party vested with the power to authorise its use and relevant procedures. This includes the reporting procedure when a restrictive practice is used,[1762] as well as addressing specific standards for young people and children.[1763]

8.1.5 As part of its Terms of Reference, SALRI was asked to consider whether the *MHA* should enable any authorised party to exercise restrictive practices and reasonable force. In doing so, SALRI has examined the current provision, namely s 56 of the *MHA*, which enables authorised officers to use reasonable force when necessary. The definition of 'reasonable' was raised during SALRI's consultation and the appropriateness of authorised officers in exercising these powers.

8.1.6 SALRI received many submissions calling for a prohibition on the use of restrictive practices under the *MHA*. However, there was no consensus in consultation concerning the use and effectiveness of restrictive practices, with divergent views expressed and notable differences between mental health professionals and consumers. For example, many consumers and consumer groups opposed the use of restrictive practices, highlighting the distress and trauma associated with their use, and their interference with human rights. Other parties expressed a different view.

[1759] Office of the Chief Psychiatrist, *Chief Psychiatrist Restraint and Seclusion Standard: A Standard to Reduce and Eliminate where Possible the Use of Restraint and Seclusion applied under the Mental Health Act 2009* (28 May 2021) 5.

[1760] Ibid 5–7.

[1761] Ibid 1.

[1762] Ibid.

[1763] Ibid 14.

8.1.7 In 2015, the OCP convened the Trauma Informed Practice Working Group, with the object of 'discussing and planning ongoing reduction strategies and have included facilitation by the OCP of a group of trainers in Trauma Informed Care across health, ambulance, correctional and police services.'[1764]

8.1.8 Current issues relating to restrictive practices and care and control powers centre on notions of human rights, dignity, consent, and welfare of the consumer, the community and mental health practitioners. As noted by the OCP in its submission to SALRI, '[u]sing s 56 powers would be considered appropriate to allow reasonable time for the consumer's distress to resolve, for the purpose of making a more accurate assessment.' SALRI notes there are concerns relating to the appropriateness of laws allowing a party to use reasonable force. The way in which 'reasonable' is defined and applied in practice may also need to be clarified. If reasonable force is exercised, this may require the use of a restrictive practice. As a result, the nature and type of restrictive practice must be considered necessary in a particular situation.

8.1.9 The OCP released *A Standard to Reduce and Eliminate where possible the use of Restraint and Seclusion applied under the Mental Health Act 2009* ('the Standard') in May 2021,[1765] which is an authorised power of the Chief Psychiatrist under s 90 of the *MHA*.

8.1.10 This background provides the policy context for the role and use of restrictive practices and reasonable force under the *MHA*.

8.2 Current Law in South Australia

Restrictive Practices

8.2.1 A restrictive practice takes a variety of forms and aims to limit a person's freedom to move. In the OCP's Annual Report 2020-21, four types of restrictive practice were identified:[1766]

1. **Chemical:** using medication without consent.
2. **Mechanical:** using a device, such as a lap belt, bed rails, a princess chair, clothing or low bed.[1767]
3. **Physical:** using physical force with your hands or body or placing a person in a particular position which limits movement.[1768]
4. **Seclusion:** placing a person in a room on their own, without a way to leave. For example, this may be a room with no ability to exit (a locked door) or no access to a call bell.[1769]

[1764] Office of the Chief Psychiatrist, *Annual Report of the Office of the Chief Psychiatrist 2020—21* (SA Health, 30 September 2021) 18.

[1765] Office of the Chief Psychiatrist, *Chief Psychiatrist Restraint and Seclusion Standard: A Standard to Reduce and Eliminate where Possible the Use of Restraint and Seclusion applied under the Mental Health Act 2009* (28 May 2021) 5—14.

[1766] Office of the Chief Psychiatrist, *Annual Report of the Office of the Chief Psychiatrist 2020—21* (SA Health, 30 September 2021) 25. Some practices may not be related to movement, such as searching belongings, restricting visitors/phone calls or access to a phone/computer.

[1767] Aged Care Quality and Safety Commission, *Overview of restrictive practices* (2021).

[1768] Ibid.

[1769] Ibid.

8.2.2 The *MHA* defines the term 'restrictive practice' as:

> (a) the use of physical, mechanical or chemical means to restrain the patient; and
>
> (b) seclusion or the confinement of the patient on his or her own in an area from which he or she cannot leave of his or her own volition…[1770]

8.2.3 However, the *MHA* does not provide a legislative definition of the types of restrictive practices, as outlined in the OCP's Annual Report.

Care and Control Powers

8.2.4 A significant area of consideration in the use of reasonable force falls within the remit of 'care and control powers'.[1771]

8.2.5 The exercise of care and control powers are different from restrictive practices, as defined under the *MHA* and permit authorised officers to place persons under their care and control.[1772] This confers specific powers to lawfully detain a person if it appears that the person has a mental illness and 'the person has caused, or there is a significant risk of the person causing, harm to himself or herself or others or property or the person otherwise requires medical examination.'[1773] Given the power to detain a person involuntarily is a significant deprivation of personal liberty, the *MHA* establishes a high threshold test for harm by requiring that it be 'significant.' In this context, 'significant' refers to the risk of the harm occurring, as opposed to the type of harm.

8.2.6 Restrictive practices can be utilised on an individual who is under care and control, if the criteria are satisfied. However, a care and control power is not a type of restrictive practice, and operates independently to allow a person to be lawfully detained for a medical examination.[1774]

8.2.7 If reasonable force is exercised, this may require the use of a restrictive practice. Under s 56 of the *MHA*, authorised officers are able to exercise a number of powers, including taking a person into their care and control and using force or restraint, where reasonably necessary.

8.2.8 Pursuant to s 56 of the *MHA*, in exercising powers, the authorised officer may restrain a person, by using reasonable force required in the circumstances or chemical restraint. The officer may also search the person's clothing and possessions, removing items that may cause harm to themselves or others.[1775] If the person placed under care and control is not already at a treatment centre or place where they can be medically examined, the authorised officer can arrange for the transport of the person for medical examination or treatment.[1776] Similar to the requirement concerning ITO and CTOs, the person must be given a statement of rights.[1777]

[1770] *Mental Health Act 2009* (SA) s 3 (definition of 'restrictive practices').

[1771] See further Part 9 Role of Police.

[1772] *Mental Health Act 2009* (SA) s 56(1)(c)(i), (ii).

[1773] Ibid s 56(1)(c) (ii).

[1774] SALRI heard from a number of consultees of the overlap in practice between care and control powers and ITOs and CTOs and the benefit of greater 'clarity' in the *Mental Health Act 2009* (SA). See further Part 9 Role of Police.

[1775] *Mental Health Act 2009* (SA) s 56(3)(a)–(f).

[1776] Ibid s 56(4)(c)(i).

[1777] Ibid s 56(4)(c)(ii).

8.2.9 The following officers are defined as an 'authorised officer' under s 3 of the *MHA*:

> (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 of Australia (Central Operations) Incorporated or the Royal Flying Doctor Service of Australia (South Eastern Section); or
>
> (d) a person, or a person of a class, approved by the Chief Psychiatrist, by notice in the Gazette, for the purposes of this definition; or
>
> (e) any other person, or person of a class, prescribed by the regulations for the purposes of this definition.[1778]

8.2.10 In 2017, the Chief Psychiatrist determined that all emergency department physicians above the level of resident – or if employed by the Northern Adelaide Local Health Network or the Southern Adelaide Local Health Network as a registrar and above – and all registered South Australian Medical Practitioners, South Australian Ambulance Service Employees, are authorised officers for the purpose of s 56 of the *MHA*.

8.2.11 The *MHA* does not specify the duration by which the exercise of care and control powers remain in force. Instead, it recognises this is dependent on many different variables. Therefore, the order remains in force 'as reasonably required for the purpose of enabling or facilitating the medical examination or treatment.'[1779] Data concerning the exercise of care and control powers is not collected in South Australia. Therefore, it is not possible to gain further insight into the number and reasons for orders made. SALRI notes that several submissions raised concern with inappropriate use of care and control powers. As a result, SALRI notes that it would be beneficial if data concerning the exercise of care and control powers was collected and reported. This data is currently collected for restrictive practices.

8.3 Law in Other Jurisdictions

8.3.1 A number of jurisdictions, such as Queensland,[1780] Western Australia,[1781] Tasmania[1782] and the Northern Territory,[1783] provide legislative definitions of some or all of the types of restrictive practices. Further, the legislation may stipulate the process to receive authorisation to use a restrictive practice.[1784] In Queensland, the law also provides for a 'reduction and elimination plan', which is developed by an authorised doctor, detailing measures to reduce or eliminate the use of mechanical restraint and/or seclusion.[1785]

[1778] *Mental Health Act 2009* (SA) s 3 (definition of 'authorised officer').

[1779] Ibid s 56(5).

[1780] See *Mental Health Act 2016* (Qld) Ch 8.

[1781] See *Mental Health Act 2014* (WA) Pt 14.

[1782] See *Mental Health Act 2013* (Tas) s 3. This contains definitions of chemical, mechanical and physical restraint, the term 'restraint' and seclusion.

[1783] See *Mental Health and Related Services Act 1998* (NT) Pt 9.

[1784] See, for example, *Mental Health Act 2014* (WA) ss 213–25.

[1785] *Mental Health Act 2016* (Qld) s 264.

8.3.2 In light of the recent Victorian Royal Commission and the forthcoming major Act, SALRI has focussed on the developments governing restrictive practices in Victoria.

Victoria

8.3.3 The *Mental Health and Wellbeing Act 2022* (Vic) ('*MHWA*') authorises the use of restrictive interventions which is defined as bodily restraint, chemical restraint and seclusion.[1786] Bodily restraint is defined to include physical and mechanical restraint.[1787] Mechanical restraint is 'the use of a device to prevent or restrict a person's movement.'[1788] In contrast, physical restraint is defined as:

> … the use by a person of their body to prevent or restrict another person's movement but does not include the giving of physical support or assistance to a person in the least restrictive way that is reasonably necessary to—
>
> (a) enable the person to be supported or assisted to carry out daily activities; or
>
> (b) redirect the person because they are disoriented.[1789]

8.3.4 Chemical restraint is defined as:

> … the giving of a drug to a person for the primary purpose of controlling the person's behaviour by restricting their freedom of movement but does not include the giving of a drug to a person for the purpose of treatment or medical treatment.[1790]

8.3.5 Finally, seclusion is the 'the sole confinement of a person to a room or any other enclosed space from which it is not within the control of the person confined to leave.'[1791]

8.3.6 Unlike the South Australian *MHA*, the Victorian *MHWA* strictly regulates the used of restricted interventions in the legislation,[1792] and places a responsibility on service providers to aim to 'reduce and eliminate the use of restrictive interventions,'[1793] with a view to eliminate the use of restrictive interventions in mental health treatment.[1794] Further, restrictive interventions can only be used on a person in situations to prevent imminent and serious harm to the self or others,[1795] or if bodily restraint is used, 'to administer treatment or medical treatment to the person,'[1796] and can only be used as long as necessary to achieve these purposes.[1797] Consistent with the emphasis placed on least restrictive practices, restrictive interventions are only authorised if there are no other less restrictive means of achieving the purpose of preventing imminent and serious harm or administering treatment (or medical treatment) to the person.[1798] The *MHWA* also requires the person authorised to administer a restrictive intervention must document their considerations and reasons for using the restrictive

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[1786] *Mental Health and Wellbeing Act 2022* (Vic) s 3(1) (definition of 'restrictive intervention) ('*MHWA*').

[1787] Ibid s 3(1) (definition of 'bodily restraint').

[1788] Ibid s 3(1) (definition of 'mechanical restraint').

[1789] Ibid s 3(1) (definition of 'physical restraint').

[1790] Ibid s 3(1) (definition of 'chemical restraint').

[1791] Ibid s 3(1) (definition of 'seclusion').

[1792] See Ibid Pt 3.7.

[1793] Ibid s 125.

[1794] Ibid s 125(b).

[1795] Ibid s 127(a).

[1796] Ibid s 127(b).

[1797] Ibid s 129(1).

[1798] Ibid s 128.

intervention.[1799] A list of additional safeguards and procedures are also provided, which must be followed when a restrictive intervention is used – these strive to maintain and promote the human rights focus of the legislation.[1800]

8.4 Issues

The Definition of Reasonable Force

8.4.1 The definition of reasonable force varies across Australian States, among individuals, and their interpretations. Usually, the term 'reasonable force' must be interpreted contextually, within the *MHA*.

8.4.2 There is no single or specific definition and the term is open to interpretation. However, there is an argument that it requires a clear definition within the *MHA*, as the provision is too broad. From a legal perspective, the term 'reasonable force' would usually encapsulate a 'response that is proportionate to the nature of the [threat] and takes into account all of the circumstances in which the force is used'.[1801] Importantly, the principle of proportionality should dictate the use of restrictive practice and force, if required. SALRI acknowledges that in the context of mental health, the use of reasonable force is a clinical judgment exercised by a qualified mental health professional or authorised officer.

8.4.3 The use of force has also been associated in the context of self-defence or to protect an individual. What is considered as reasonable force depends on all of the factors in the circumstances.

8.4.4 The use of reasonable force is precautionary and used as a last resort, where the circumstances necessitate a mental health professional or authorised officer to gain control over a situation that has or appears to become violent.

8.4.5 In explaining reasonable force, the United Kingdom has specified that reasonable force includes 'protecting yourself in the heat of the moment', or 'stopping an individual from running off'.[1802] This also includes asking questions such as:

> Was the use of force necessary in the circumstances?
>
> Was there a need for any force at all?[1803]
>
> Are you using force maliciously?
>
> What is the aggressor's size or build compared to your own?
>
> Will you stop using force when the situation is resolved?[1804]

[1799] Ibid s 133.

[1800] See Ibid ss 133–8.

[1801] The Law Society of Western Australia, *Self-defence in the Criminal Law of Western Australia* <https://www.lawsocietywa.asn.au/news/self-defence-in-the-criminal-law-of-western-australia/#:~:text=%E2%80%9CSelf%2Ddefence%20encompasses%20the%20idea,which%20the%20force%20is%20used>.

[1802] GOV.UK, *Using Reasonable Force Against Intruders* <https://www.gov.uk/reasonable-force-against-intruders>.

[1803] The Crown Prosecution Service, *Self-Defence and the Prevention of Crime* (9 September 2022) <https://www.cps.gov.uk/legal-guidance/self-defence-and-prevention-crime>.

[1804] The Professional Security Officer, *The Use of "Reasonable Force": A Guide for Security Professionals* <https://theprofessionalsecurityofficer.com/the-use-of-reasonable-force-a-guide-for-security-professionals/>.

8.4.6 These questions would be asked on the basis of the facts as the person honestly believed them to be. Asking these questions will help guide in determining what constitutes as reasonable or unreasonable force.

8.4.7 Although the extent of reasonable force is a subjective test, it retains an objective element. In determining if reasonable force was inflicted, one has to ask themselves:

> … whether, on the basis of the facts as the individual believed them to be, a reasonable person would regard the force used as reasonable or excessive.[1805]

8.4.8 The Department of Health in Tasmania noted the following points in relation to the use of reasonable force:

- The urgency of the situation. Is there an immediate risk of physical harm to the person or other people?
- Whether any force is required in this situation? Can the person be asked if they are willing to go with the authorised officer? Would the presence of other people be sufficient?
- What type of force is necessary in this situation? Would taking the person by the arm be sufficient or is restraint required?
- If there is no immediate risk to physical safety of the person or others, have all alternatives been explored? Is the person willing to go to hospital with a relative or friend?[1806]

8.4.9 Further, an authorised officer must consider:

- Whether the force is necessary and why; and
- Whether the method chosen is appropriate to the situation.[1807]

8.4.10 Consequently, the central questions are premised upon whether the use of force or restrictive practice was *necessary*, *proportionate* and *reasonable*.

8.4.11 Despite the central premise of necessity, 'the fact that an act was considered necessary does not mean that the resulting action was reasonable.'[1808] This reiterates that the judgment of what may be 'necessary' is an integral factor in defining 'reasonable force'. Some may argue that 'necessary' indicates it is absolutely needed as a last resort. In contrast, others may argue it is essential for a legitimate purpose or reason.

The Use of Reasonable Force

8.4.12 As part of this review, SALRI contemplated whether the *MHA* ought to allow identified parties to use 'reasonable force' and if so, under what circumstances. Currently, the *MHA* enables authorised officers to use reasonable force.

[1805] The Crown Prosecution Service, *Self-Defence and the Prevention of Crime* (9 September 2022) <https://www.cps.gov.uk/legal-guidance/self-defence-and-prevention-crime>.

[1806] The Department of Health Tasmania, *Authorised Officers* <https://doh.health.tas.gov.au/__data/assets/pdf_file/0019/8614/dhhs_mhactguide_ch-3.pdf> 19.

[1807] Ibid.

[1808] *R v Clegg* (1995) 1 AC 482 HL.

Authorised Officers

8.4.13 The role of an authorised officer is to take care and control of people with acute mental illness, requiring a medical examination.[1809] There are a number of classes of authorised officers. These include medical practitioners, mental health professionals, ambulance officers, experienced correctional officers, Headspace employees for the Youth Early Psychosis Programme (registered nurses (levels 1, 2 and 3)).[1810]

8.4.14 Section 56 of the *MHA* provides broad powers to authorised officers. They may restrain a person physically or by administration of a drug, as well as the use force to a person as reasonably required in the circumstances.[1811]

8.4.15 For example, the Department of Health Tasmania noted, in exercising these powers:

> … the professional judgement of an authorised officer is required to decide when it is necessary to use these powers. If there is no risk to safety, an authorised officer can take a person into protective custody and take them to an approved hospital without seeking police assistance. This avoids people with a mental illness experiencing the stigma of being transported by the police when their involvement is not required.[1812]

8.4.16 The role of authorised officers was raised to SALRI. Many consultees noted that authorised officers lack the infrastructure (for example, resourcing and staffing) to undertake reasonable force safely without other agencies like SAPOL, for instance.

8.4.17 The core themes from SALRI's consultation indicated that authorised officers would be more effective than waiting for SAPOL to arrive. Some consultees noted that authorised officers should be made available as required. In addition, authorised officers would seem less frightening and more necessary, when compared to SAPOL.[1813]

8.4.18 According to the *MHA,* an authorised officer means a mental health clinician; or an ambulance officer; or a person employed as a medical officer or flight nurse by the Royal Flying Doctor Service of Australia (Central Operations) Incorporated or the Royal Flying Doctor Service of Australia (South Eastern Section); or a person, or a person of a class, approved by the Chief Psychiatrist, by notice in the Gazette, for the purposes of this definition.[1814]

8.4.19 It is likely that an authorised officer captured within the above definition has the necessary experience, education and expertise regarding mental health as a result of their profession. However, the *MHA* does not specify the process or training required of an individual to become an authorised officer.

8.4.20 There will be instances where the use of a restrictive practice or reasonable force is required.[1815] However, any use of restrictive practice or reasonable force must be a last resort. SALRI

[1809] See *Mental Health Act 2009* (SA) s 56(1)(c). See further Part 9 Role of Police.

[1810] Office of the Chief Psychiatrist, *Mental Health Act 2009: Authorised Officers* (Web Page) <https://s3-ap-southeast-2.amazonaws.com/sahealth-ocp-assets/general-downloads/Official-Listing-Authorised-Officers.pdf>.

[1811] *Mental Health Act 2009* (SA) s 56(3)(c)(d).

[1812] The Department of Health Tasmania, *Authorised Officers* <https://doh.health.tas.gov.au/__data/assets/pdf_file/0019/8614/dhhs_mhactguide_ch-3.pdf> 18.

[1813] For a discussion of SAPOL's powers to use force, see Part 9 Role of Police.

[1814] *Mental Health Act 2009* (SA) s 3.

[1815] See Part 9 Role of Police.

reiterates the need to undertake de-escalation techniques to prevent the restrictive practice and use of reasonable force. As previously noted, the use of restrictive practice and reasonable force must be made on a case-by-case basis, relying upon the clinical or professional judgment of the relevant officer.

8.4.21 It is of SALRI's view that the power for authorised officers to use force should be retained as it is. This is further supported by the written submissions by the Commissioner for Aboriginal Children & Young People. Additionally, guided by the consultation data, accredited mental health training and cultural competency training be enforced and made mandatory before an individual becomes an authorised office. This is also supported by the Mental Health Commissioners in their written submissions to SALRI. This will allow an individual to have the understanding and compassion towards patients they encounter. Alternatively, there should be an accountability mechanism that keeps authorised officers in check, ensuring that they do not misuse the broad powers they receive from the *MHA*.

South Australia Police

8.4.22 SALRI has thoroughly examined the use of restrictive practice and reasonable force by SAPOL under s 57 of the *MHA*. Please see Part 9 Role of Police in this Report.

Hospital Security

8.4.23 In examining whether other parties should be authorised to use reasonable force, the role of hospital security guards was often raised to SALRI. In particular, as a means to alleviate the burden on SAPOL. However, SALRI notes that hospital security guards should not be authorised to use reasonable force. For a detailed discussion on the role of hospital security, please see Part 9 Role of Police in this Report.

Human Rights Implications of Reasonable Force

8.4.24 Article 1 of the *Universal Declaration of Human Rights* states that: 'All human beings are born free and equal in dignity and rights.' This prompts the question, when the use of force is inflicted on an individual – do they have equal dignity and rights?

8.4.25 The use of restrictive practices raises a number of ethical and legal issues and constitutes an interference with a consumer's human rights.[1816] Further, in response to the degree of restraint or force, its use may result in harm, including psychological distress, trauma, physical injury and in some cases, death.[1817]

8.4.26 Further, it has been reported that:

> … people who have experienced physical or sexual abuse and trauma who are exposed to physical restraint are at increased risk of developing or exacerbating conditions such as anxiety, depression, or the recurrence of post-traumatic stress disorder.[1818]

8.4.27 In the context of mental illness, the use of force may traumatise the consumer against whom the force is used, but also their family and friends.

8.4.28 In addition, the use of restrictive practices may fracture the rapport and relationship between a mental health professional and consumer. In the context of disability, this was reported by

[1816] See Director of Forensic Disability, *Use of Reasonable Force Policy Paper* (9 January 2023) 2.

[1817] Ibid.

[1818] Ibid.

the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability ('Disability Royal Commission'), who noted:

> Restrictive practices can damage relationships and trust between a person with disability and the person carrying out the restrictive practice, such as a support worker, doctor or teacher. They can increase power imbalances and feelings of helplessness and lead to a loss of independence.[1819]

8.4.29 Similar themes were raised during SALRI's consultation, whereby the use of restrictive practices diminished the consumer's trust in the mental health system.

Prevalence and Effectiveness of Restrictive Practices

8.4.30 Restrictive practices may be needed where there is a risk of harm that cannot be 'effectively managed by more positive approaches'.[1820]

8.4.31 There is little evidence to support the use of restrictive practices as being effective measures in reducing or addressing behaviours of concern. For instance, one study revealed '…overall, the evidence in favour of chemical restraint for controlling behaviours of concern such as aggression, is weak.'[1821] It was further noted:

> … available data to date suggests that restrictive interventions do not lead to reduction in the occurrence of behaviours of concern except in the short term (ie while applied) and that what is needed is a better understanding of the functions of behaviours of concern and the individual needs of the person and interventions that address those functions and needs.[1822]

8.4.32 The prevalence of restrictive practices, in particular cohorts, must be noted. For example, respondents to the Disability Royal Commission submitted:

> … disproportionate numbers of First Nations people may be affected by restrictive practices. SA Health told us that Aboriginal or Torres Strait Islander people are at greater risk of restraint and seclusion as they are overrepresented in admissions to mental health services and psychiatric intensive care units.[1823]

8.4.33 The frequency and use of such practices are also relevant to persons with a disability, children and adolescents and older persons. SALRI's consultation with disability and consumer groups highlighted the punitive nature of restrictive practices. In particular, consultation with disability groups emphasised the prevalence of the use of restrictive practices.

Persons with a Disability

8.4.34 Restrictive practices limit a person with disability and limit their rights and freedom of movement.[1824] The Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability noted that 'some consider [restrictive practices] a 'disability-specific' form of violence.

[1819] Commonwealth of Australia, Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Restrictive practices Issues Paper* (26 May 2020) 2.

[1820] Commonwealth of Australia, Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Overview of responses to the Restrictive practices Issues Paper* (April 2021) 10.

[1821] Lynne Webber et al, 'Restraint and Seclusion of People on Compulsory Treatment Orders in Victoria, Australia in 2008-2009' (2010) 17(4) *Psychiatry, Psychology and Law* 562, 564.

[1822] Ibid 572.

[1823] Ibid 6.

[1824] Ibid 3.

Society has a long history of restricting the rights or freedom of movement of certain people in society, including people with disability.'[1825]

8.4.35 The 'ongoing effects' of restrictive practices must be highlighted and for persons with a disability, 'may occur at any point in a person's life, including in childhood, teenage years and adulthood.'[1826]

8.4.36 The Children and Young People with Disability Australia's 2019 National Education Survey indicated that one third of students with disability had encountered and experienced seclusion or restraint in 2018.[1827] Further, it was reported:

> While restrictive practices can prevent harm to people with disability or those around them, multiple negative effects were also identified. These include causing trauma and re-traumatisation of people, which in some cases can lead to suicidal ideation.[1828]

8.4.37 Other consultees in the Disability Royal Commission noted that 'restrictive practices will cause physical harm, poor health, reduced lifespan, and possibly death'.[1829]

8.4.38 Further, it has been argued that restrictive practices are not an adequate means to address the source of the behaviour of concern. The Disability Advocacy Resource Unit raised:

- People with disability who have limited communication skills and/ or emotional regulation skills may self-harm in response to underlying factors such as confusion, anxiety, trauma, sensory impairments, or an underlying illness or pain.
- Controlling one behaviour using a restrictive practice can lead to other behaviours of concern.
- A restrictive practice may be triggering to a person with a history of trauma and abuse.
- A restrictive practice can cause trauma and psychological distress.
- The use of a restrictive practice may result in a loss of dignity for the person with disability.
- A restrictive practice can limit personal freedom and the person's ability to engage in activities of daily life.
- They can reduce meaningful interactions with carers and support staff.
- Long-term use of restrictive practices may lead to an over-reliance, which could result in the person seeking restraint or becoming anxious without the restraint.[1830]

[1825] Commonwealth of Australia, Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Restrictive practices Issues Paper* (26 May 2020) 2.

[1826] Ibid 3.

[1827] Commonwealth of Australia, Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Overview of responses to the Restrictive practices Issues Paper* (April 2021) 6.

[1828] Ibid.

[1829] Ibid.

[1830] Disability Advocacy Resource Unit, *Regulated Restrictive Practice* (3 March 2021) <https://www.daru.org.au/resource/regulated-restrictive-practice>.

8.4.39 Finally, the use of restrictive practices may 'deny respect and basic rights and respect for dignity to people with disability and may be degrading.'[1831] This raises issues relating to culture and practice, which was noted by Advocacy for Inclusion:

> … a culture has developed of using it as a convenient mechanism to work more quickly with people who are interpreted as being 'difficult' or 'challenging'. It seems to have become the cultural norm to make things easier for disability workers and health professionals.[1832]

8.4.40 It has been argued that the increased prevalence of restrictive practices normalises its use, such that it may be deemed as 'standard practice'.[1833] As a result 'when the use of restrictive practices is normalised, it trivialises interfering with the rights and freedoms of people with disability, which 'contributes to the dehumanisation of people with disability.'[1834]

8.4.41 This further strengthens the need for appropriate training and expertise of authorised officers, who are authorised to exercise these powers. In addition, the ongoing impact and effects of restrictive practices highlights the need for its use as a last resort.

Children and Adolescents

8.4.42 The use of restrictive practices may be required for children and adolescents, in very limited circumstances. For instance, they may be used to manage imminent danger as a response to aggression or self-harm.[1835]

8.4.43 The effectiveness of restrictive practices for children and adolescents is questionable. One of the risks is the 'profoundly detrimental effect on therapeutic relationships between care staff' and the child.[1836] They are also 'particularly counter-therapeutic for children with abuse history'.[1837]

8.4.44 The 2022 South Australian Restrictive Practices Guidelines noted:

> Children (especially those who are in out-of-home care due to abuse, neglect, significant medical needs or disability) are at heightened risk of adverse effects from restrictive practices, particularly physical restraint and seclusion. The use of these restrictive practices may jeopardise children's ability to form safe and trusting relationships with adults and compromise their ability to self-regulate and self-manage. The use of restrictive practices may also contribute to children and young people's feelings of anxiety, fear, helplessness, and hypervigilance.[1838]

[1831] Commonwealth of Australia, Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Overview of responses to the Restrictive practices Issues Paper* (April 2021) 6–7.

[1832] Advocacy for Inclusion, Submission to Australian Human Rights Council, *Response to Australian Human Rights Commission: OPCAT in Australia* Consultation Paper (July 2017) 4–5.

[1833] Commonwealth of Australia, Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Overview of responses to the Restrictive practices Issues Paper* (April 2021) 7.

[1834] Ibid.

[1835] Lisa Sealey, *Restrictive Practices in Child & Adolescent,* (Thesis Master of Nursing, University of Technology Sydney, 2022).

[1836] John Baker et al, 'Components of interventions to reduce restrictive practices with children and young people in institutional settings: the Contrast systematic mapping review' (2022) 10(8) *Health and Social Care Delivery Research* <https://www.ncbi.nlm.nih.gov/books/NBK580344/pdf/Bookshelf_NBK580344.pdf >.

[1837] Ibid.

[1838] Department of Human Services, *Restrictive Practices Guidelines* (6 January 2022) 8.

8.4.45 In the context of children with a disability, another consequence of restrictive practices has been described as 'occupational apartheid',[1839] whereby:

> … the experience of alienation and deprivation which occurs when children with disabilities become occupationally marginalised when their carers segregate them from their peers. They are precluded from partaking in everyday activities because their primary occupations of playing, being a student, having a hobby and developing life skills are constantly challenged, compromised, trivialised and dismissed by those who inflict unwanted and unnecessary restraint.[1840]

8.4.46 A submission to the Disability Royal Commission also noted that there may be 'immediate escalation of distress, intense feelings of despair, shame, terror, rage, anxiety, helplessness, humiliation, vulnerability, loneliness, injustice and powerlessness.'[1841]

8.4.47 Additionally, the United Nations raised concerns on the use of restrictive practices with children who have psychosocial disorders which would further worsen their condition.[1842] For example, it has been reported that restrictive practices increase vulnerability, particularly in children with a disability:

> … children with any type of disability are 3.44 times more likely to be a victim of some type of abuse as compared to children without disabilities.[1843] Of all types of disability, children with behaviour disorders and children with intellectual disability are both at an increased risk for all three forms of abuse (neglect, physical and sexual abuse) compared to children with other types of disabilities (speech/language, hearing impairments).[1844]

8.4.48 As noted to SALRI by mental health professionals working in child and adolescent mental health, the philosophy of treatment differs in this cohort. The approach to treat children and adolescents must be tailored to their needs, to reduce the need for restrictive practice.

Minimising the Use of Restrictive Practices

8.4.49 In the Royal Australian and New Zealand College of Psychiatrist's ('RANZCP') Position Statement, it was noted '[s]eclusion and restraint should never be used to control behaviour, as a punishment or because of inadequate resources.'[1845]

8.4.50 The RANZCP also reinforced that:

> Continuing to work towards minimising, and where possible eliminating, the use of seclusion and restraint is achievable. It requires leadership, commitment and motivation, and a change in culture

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[1839] Queensland Advocacy Incorporated, Submission, *The Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability* (2020) 13.

[1840] Ibid.

[1841] Ibid.

[1842] John Baker et al, 'Components of interventions to reduce restrictive practices with children and young people in institutional settings: the Contrast systematic mapping review' (2022) 10(8) *Health and Social Care Delivery Research* 2.

[1843] Queensland Advocacy Incorporated, Submission, *The Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability* (2020) 14.

[1844] Ibid.

[1845] The Royal Australian & New Zealand College of Psychiatrists, *Position Statement 61: Minimising and, where possible, eliminating the use of seclusion and restraint in people with mental illness* (August 2021) <https://www.ranzcp.org/news-policy/policy-and-advocacy/position-statements/minimising-use-of-seclusion-and-restraint>.

underpinned by the recovery model with a focus on workforce and training, prevention and early intervention, good clinical care, and supporting practice change.[1846]

8.4.51 The National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Service Sector identified six strategies to reduce and eliminate restrictive practices:

1. Person-centred focus
2. Leadership towards organisational change
3. Use of data to inform practice and supported by research evidence.
4. Workforce development
5. Use of restraint and seclusion reduction tools (including evidence-based assessment, prevention approaches, emergency management plans, environmental changes and meaningful activities integrated into the individual's support plan)
6. Debriefing and practice review.[1847]

8.4.52 In the context of residential aged care facilities, the Australian Medical Association noted that 'medical practitioners have an educative and mentoring role in minimising the use of restrictive practices and advocating for the rights and wellbeing of their patients.'[1848]

8.4.53 There are alternative ways to minimise restrictive practices through person-centred approaches.[1849] In their Position Statement, the RANZCP stated:

> Alternative models and strategies which move towards minimising, and where possible eliminating, seclusion and restraint are required including proper utilisation of space to promote de-escalation. Such models and strategies balance supporting the autonomy of people with mental health conditions whilst providing access to care and ensuring the safety of the individual, staff and the community. These strategies should include post-incident de-briefing for staff and the individual and provide information which encourages using lessons learned to inform future best practice. To assist with this process and to ensure the needs of people with mental health conditions are met, co-production and design involving people with lived experience should feature strongly in system change.[1850]

8.4.54 Further, it must be recognised that the:

> Use of seclusion and restraint requires a balance of professional and legal obligations to care and protect the individual, as well as the individual's family and the wider community. Family and whānau should be involved in supporting those who experience seclusion and restraint, especially for Aboriginal and Torres Strait Islander peoples …[1851]

[1846] Ibid.

[1847] The NDIS Quality and Safeguard Commission, *Regulated Restrictive Practices Guide* (October 2020) 8.

[1848] Australian Medical Association Australia, *Use of restrictive practices in Residential Aged Care Facilities Position Statement* (2022) 4.

[1849] Department of Social Services Australian Government, *National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Service Sector* <https://agedcare.royalcommission.gov.au/system/files/2020-06/RCD.9999.0033.0001.pdf> 10.

[1850] The Royal Australian & New Zealand College of Psychiatrists, *Position Statement 61: Minimising and, where possible, eliminating the use of seclusion and restraint in people with mental illness* (August 2021) <https://www.ranzcp.org/news-policy/policy-and-advocacy/position-statements/minimising-use-of-seclusion-and-restraint>.

[1851] Ibid.

8.4.55 The Australian Commission on Safety and Quality in Health Care suggested:

> The key to minimising use of restrictive practices is to be alert to changes in a person's behaviour or demeanour that may suggest a deterioration in their mental state. Be receptive to information from the person themselves, and from their carers and families. People who have experienced mental health issues, or cared for someone who does, often have detailed knowledge about what can lead to a deterioration in their mental state, and what strategies are most effective for restoring their capacity to manage their mental state without the use of restrictive practices.[1852]

8.4.56 According to the RANZCP's Position Statement, restrictive practices can be reduced through the provision of supported recovery and trauma-informed practice principles.[1853] Consumers traumatised by previous restrictive practices are:

> … less likely to utilise mental health services even when required. Ensuring that any use of seclusion and restraint is undertaken in a manner which acknowledges individuals and their circumstances as much as possible, is crucial. In addition, the use of seclusion and restraint is not a substitute for inadequate resources (such as lack of trained staff). They should never be used as a method of punishment.[1854]

8.4.57 In conclusion, the RANZCP recommended:

- Ensure all mental health services have appropriate policies, resources and frameworks aimed at minimising, working towards eliminating, the use of seclusion and restraint and a culture which uses seclusion and restraint only as a last resort.
- Ensure people with lived experience of mental health conditions are involved in designing policies, frameworks and spaces for best methods to minimise the use of seclusion and restraint in mental health services.
- Provide consistency of definitions and data across jurisdictions to allow for more accurate data collection on the use of seclusion and restraint in Australia and New Zealand.
- Establish long-term research programs into resources, models and strategies which work towards minimising, and where possible, eliminating the use of seclusion and restraint.
- Strengthen cultural approaches that are effective at reducing seclusion and restraint among Aboriginal and Torres Strait Islander peoples …
- Ensure individuals and staff who have been exposed to seclusion and restraint are provided with appropriate trauma-informed post-incident debriefing.
- All post-incident debriefing should utilise a lessons-learnt approach to inform future best practice.[1855]

[1852] Australian Commission on Safety and Quality in Health Care, *Action 5.35 Minimising restrictive practices: restraint* <https://www.safetyandquality.gov.au/standards/nsqhs-standards/comprehensive-care-standard/minimising-patient-harm/action-535#strategies-for-improvement>.

[1853] The Royal Australian & New Zealand College of Psychiatrists, *Position Statement 61: Minimising and, where possible, eliminating the use of seclusion and restraint in people with mental illness* (August 2021) <https://www.ranzcp.org/news-policy/policy-and-advocacy/position-statements/minimising-use-of-seclusion-and-restraint>.

[1854] Ibid.

[1855] Ibid.

8.4.58 In an attempt to reduce restrictive practices and promote a person-centred approach, the National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Service Sector recommended:

- Development and regular review of individual/behaviour support plans (including strategies for de-escalation and ensuring the safety of the person, staff and others) that are based on valid and evidence-based risk assessments, in conjunction with people with disability, and their guardians or advocates where appropriate, as active participants in decisions about their lives, support and care.
- Development and use of appropriate individualised behavioural and environmental risk assessment tools by disability service providers, which are in line with human rights and person-centred approaches.
- Development of individualised and evidence-based practices such as teaching the use of replacement skills (skills the person can use to replace the challenging behaviours), based on the principles of positive behaviour support.
- Availability of tools to assist people with disability and their guardians or advocates (where appropriate) to participate in decision making.[1856]

8.4.59 According to the Queensland Advocacy Incorporated:

> Using preventative measures, such as advance safety planning, to minimise the use of restrictive practices by addressing the person's clinical needs and environmental triggers or verbal strategies and de-escalation techniques to help the person to manage their behaviour of concern without mechanical restraint.[1857]

8.4.60 Efforts to reduce the use of restrictive practices are multi-faceted. Measures to do so require appropriately trained specialised mental health staff or authorised officers. Any use of restrictive practices must be a last resort, which is clearly documented and reviewed. SALRI recognises restrictive practices are a significant interference with a consumer's human rights. Therefore, its use must be necessary, proportionate and reasonable. This is dictated by the circumstances and relies upon the clinical judgment of the mental health professional or authorised officer. SALRI notes that measures to minimise the use of restrictive practices warrants further, ongoing consideration.

8.5 Consultation Data Overview

8.5.1 SALRI's consultation revealed a diverse range of views concerning both the use of reasonable force and the way in which 'reasonable' should be defined. It was raised by Aspire Recovery Connection that '[i]nvoluntary treatment orders leading to restrictive practice are too often put in place, not because the person is a risk of serious harm to themselves or others, but rather because they do not agree that their behaviour is a symptom of a mental illness requiring medical treatment.' SALRI's consultation with consumers and consumer groups revealed that the imposition of a treatment order was described as restrictive, which may also be accompanied by the use of reasonable force. In SALRI's

[1856] Department of Social Services Australian Government, *National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Service Sector* <https://agedcare.royalcommission.gov.au/system/files/2020-06/RCD.9999.0033.0001.pdf> 10.

[1857] Queensland Advocacy Incorporated, Submission, *The Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability* (2020) 22.

Disability Advocacy Roundtable discussion, attendees highlighted that the presence of a hospital security guard can also be perceived as a restrictive practice.

8.5.2 One consumer stated '[t]he harm done by 'reasonable force' is often much worse than the potential harm. It's all about how much force and how much control because so much harm is done by it.'

8.5.3 SALRI reiterates the importance of ensuring any use of restrictive practice and reasonable force is a last resort, following de-escalation techniques. Further, it required, it must be necessary, proportionate and reasonable.

The Definition of 'Reasonable'

8.5.4 There was a wide range of views in SALRI's consultation in relation to the way in which 'reasonable' should be defined.

8.5.5 The SA Health Lived Experience Workforce highlighted the term 'reasonable' was an ambiguous and subjective term requiring amendment. It was described as 'an unworkable phrase'. would benefit from clarity. Another participant in SALRI's consultation observed that 'reasonable' is open to interpretation, which is why a 'very clear definition is a must so when using reasonable force everyone will have a clear understanding of what this means and looks like.'

8.5.6 The Lived Experience Leadership and Advocacy Network ('LELAN') submitted:

> The meaning of reasonable is varied and open to interpretation. This is not appropriate in law or in the context of force or control. Reasonable can be applied in the context of:
>
> - Rational and logical to mean: used by someone with sound judgement, being fair and sensible 'a decision made by a reasonable person with experience and knowledge.'
> - Practical and appropriate to mean: as much as is appropriate; moderate 'a reasonable approach acceptable and appropriate.'
> - Degree of response to mean: an appropriate response to the level of the situation 'reasonable given the situation' 'It was reasonable to use such force given the circumstances'
>
> All of these rely on an interpretation in the eyes of the person, group or society determining what they believe is reasonable and rely on a sufficient level of skills, knowledge, and judgment to interpret what is reasonable in the law, for the situation, for the environment and primarily for the individual.

8.5.7 Similarly, Lived Experience Australia submitted:

> … the term 'reasonable' is solely in the eyes of the person undertaking these controls and powers and is therefore open to being mis-used and biasing the health professional who may or may not have sufficient skills or information to fully judge the situation or needs of the person before them. Only authorised personnel with adequate training should ever be engaged within these areas and only as a matter of last resort, for the shortest possible time. It should be overseen/authorised by a mental health clinician, preferably one who knows the person, has empathy and respect for the person and high-level skills.

8.5.8 One consumer stated that '[r]easonable must consider the long-term implications of the force used and the harm caused by the force ... Reasonable should not give professionals the right to cause physical or emotional or mental harm.'

8.5.9 Many consultees believed that reasonable force should be appropriate and fitting the level of aggression, resistance or threat. While many noted that reasonable force should only be used if there is a clear risk of harm and if there is imminent danger, one noted '…the main consideration is "Will this achieve my aim?"'. Another stated '[t]he reasonable force is a clinical judgement - it may vary depending on how escalated a person is and how much risk they pose to themselves'.

8.5.10 In relation to proportionality, one consultee submitted that '[r]easonable [f]orce is defined as the same of force used against you at the time. It must be reasonable and proportionate to the force being used against you.' Ultimately, 'the appropriate use of force [is] dependent on [the] person's demeanour and level of risk involved.' Similarly, the Australian Nursing and Midwifery Federation offered the following definition – '[t]he reasonable force necessary to prevent someone causing harm to themselves or others. The degree of force used must be proportionate to the degree of threat of harm.'

8.5.11 In their submission to SALRI, the Royal Australian and New Zealand College of Psychiatrists ('RANZCP') defined 'reasonable' as '… the minimal amount of force, delivered in the least restrictive manner possible, that can ensure the safety of all parties (consumer, staff and others) and ensure authorised treatment is provided in order to restore the person's mental health.'

8.5.12 The term reasonable can be defined as using a force necessary and as needed to support the safety of a person and others. The justification for the use of reasonable force is an important factor, one consultee noted '[r]easonable should be defined as being in accordance with reason, not extreme or excessive'.

8.5.13 The Australasian College for Emergency Medicine stated:

> People presenting to the ED with acute behavioural disturbance should be treated with empathy and respect. Restrictive practices are a last option after initial approaches are unsuccessful and there is an ongoing risk to the safety of patients or staff. A graded, collaborative approach is required utilising verbal de-escalation, trauma-informed communication, stimulus reduction, and where appropriate anxiolytic medication voluntarily taken before application of a restrictive practice.

8.5.14 They further acknowledged the role of clinical judgment when exercising force deemed 'reasonable':

> … any proposed changes to mental health legislation regarding restrictive practices and their use must be balanced by the need to protect patients and others in response to immediate risk. Specialist emergency physicians are highly trained and skilled at making rapid determinations about the best course of action for the care of a patient. Clinical judgement must be acknowledged and respected in assessing complex presentations and managing harmful behaviour.

8.5.15 The Rural and Remote Mental Health Service also addressed clinical judgment:

> [Reasonable force] is a straight-forward flexible definition, allowing health professionals to use their clinical judgement in its application but also a broad definition for review by SACAT or a Court. This allows equally for ease of use and ease of review, as the common English understanding of words can be used by everyone to make decisions.

8.5.16 The contextual nature of the term 'reasonable' was raised by the Commissioner for Aboriginal Children and Young People. The Commissioner emphasised '[w]hen contextualising the interpretation of 'reasonable' force, we have seen many unreasonable and disproportionate approaches from police and other authorised officers when assisting Aboriginal people with mental illnesses.'

8.5.17 In the context of children and adolescents, the Child and Adolescent Health Community of Practice suggested:

> The term 'reasonable force needs clearer definition in terms of patients under the age of 18 years and consideration given to ensure 'reasonable force' is appropriate for the patient's developmental age and is not disproportionate. There needs to be a stronger review of restraint (including chemical restraint) and seclusion activities in children, specifically as opposed to adult care, irrespective of the patient being in a mental health ward.

8.5.18 In addition, they noted '[i]n principle, any force or restraint should be avoided in children, however should 'reasonable restraint" be necessary for adequate care, consideration needs to be provided for the oversight of a patient under the age of 18.'

8.5.19 In SALRI's consultation with medical practitioners and mental health professionals working within child and adolescent mental health, it was emphasised restrictive practices should not be used for children. The use of netting for children and young people was raised to SALRI. In response to behavioural issues, de-escalation techniques are used. It was noted restrictive practices may occur occasionally where there is an older adolescent under the influence of an illicit drug and due to their weight, height and strength, reasonable force was required.

8.5.20 This highlights that context will influence the definition of 'reasonable' under the circumstances. Context may refer to environment, the age of the consumer, whether the consumer is Aboriginal or Culturally and Linguistically Diverse. SALRI's Roundtable with mental health professionals in Port Pirie also referred to the contextual nature of 'reasonable' and the need for pragmatic approaches.

8.5.21 The importance of context was also raised by The Rural and Remote Mental Health Service, who noted:

> Reasonable is not currently defined in the *MHA*, as it is used in a number of circumstances (ie reasonable steps, limits, privacy, excuse, grounds, notice, enquiries and force) using the standard English definition and the common legal interpretation of that, ie that an objective review of the circumstances would find an action reasonable. It would not be of value to define 'reasonable' by itself.

8.5.22 Context is particularly important for consumers living in regional, rural and remote communities. For example, in Berri, a consumer described their experience in voluntarily attending the Emergency Department. Upon arrival, they would be escorted to a bare room containing a couple of chairs, with no water or TV. The consumer would wait hours to be seen, alone in this room. This example highlights that a restrictive practice may occur in different contexts,[1858] as the consumer believed they could not leave the room until they were attended to.

[1858] This was also raised in SALRI's Disability Advocacy Roundtable, which referred to the punitive nature of seclusion. An attendee questioned 'who was ever calmed down on their own?' Another attendee stated 'seclusion is punishment'. However, they noted it must be distinguished from self-seclusion, which is a choice.

8.5.23 Similarly, SALRI was informed, in the context of child and adolescent mental health, that the culture of the institution determines the use of a restrictive practice and its reasonableness. This was reinforced by the Australasian College for Emergency Medicine, who argued '[t]he use of restrictive practices in many circumstances is a symptom of system failure.' Further, Mind Australia raised that '… an adequately resourced community mental health system and acute mental health system would likely reduce the risk-focused approach that often results in overuse of restrictive practice and control practice.' The current resourcing for mental health was raised by another party, who indicated '[mental health] staff do not have the infrastructure to undertake this safely without those other agencies'.

8.5.24 SALRI's YourSAy survey responses revealed similar themes pertaining to the definition of 'reasonable'. One respondent questioned 'if you were to get 10 of the practitioners [and] contemporary peers, and gave them the same exact scenario, would the action you took in this event, be replicated and then deemed reasonable?' Another respondent defined 'reasonable' as using minimum force, 'not leaving permanent injury or excessive discomfort', and executed in the shortest time possible. Many respondents supported the idea that reasonable would include 'a calm and respectful way'. Further, the importance of human rights was raised – reinforcing all people should have the '[f]reedom to be treated in a humane way without restraint or coercion'.

8.5.25 Other parties suggested the use of reasonable force requires peer led services:

> This [reasonable force] will never be adequately defined in a balanced way until [mental health] support is provided in non-coercive relationships within trauma-informed, validating, respectful peer-designed, peer led services.

8.5.26 Some consultees noted that the terms 'reasonable' and 'force' should not be paired together, describing '[r]easonable force is an oxymoron. If reasonable force is allowed it will inevitably become misused. Massive human rights abuse against the most vulnerable [and] already traumatised.'

8.5.27 Many parties highlighted that 'reasonable' must be defined on a case-by-case basis. However, one party identified the issue that 'any Authorised officer or medical officer is subject to bias and discrimination and can fabricate 'reasonable' where power is present it can be abused.'

8.5.28 SALRI received a number of suggestions that the term 'reasonable force' should be defined and/or clarified. One suggestion was to narrow the scope or clarify or define the premise of 'reasonable force' used by police under s 57 and authorised officers under s 56 of the *MHA*. SALRI can understand the preference for clarity and oversight in this sensitive area, especially for children. Given the infinite variety of circumstances that will arise, it is impracticable or inappropriate to define this familiar term in the law. It has to depend on an individual situation, including the age of the consumer. It is always open for interested agencies to have protocols or guidance as to how such powers should be exercised.[1859]

Authorisation of Reasonable Force and Control Powers

8.5.29 SALRI's consultation revealed that the use of reasonable force should be undertaken as a last resort, by qualified, trained mental health professionals. One consumer described their experience of restrictive practice as 'the most de-humanising experience.' This highlights the significant interference of human rights and the trauma caused by restrictive practices.

[1859] See also Part 9 Role of Police at [9.2.6].

8.5.30 The impact of restrictive practices and use of reasonable force was raised by a number of parties. The OCP's Lived Experience Advisory Group submitted:

> Coercion only increases anxiety and the effects of trauma, a person in trauma is less likely to respond to treatment. Coercion Reduction de-escalates a trauma response and enables a person to more likely be responsive to treatment with better outcomes.

8.5.31 The LELAN noted '[i]mplementation of the use of reasonable force in practice still remains cautionary and fraught with risk. Legislated powers to use force are easily used as a first response rather than a last response.' Mind Australia emphasised '[t]here needs to be a sense of security in the system which is not threatening, traumatising or dehumanising for consumers or carers.'

8.5.32 A respondent to the YourSAy survey noted '[f]orce and exercise of control can be used when arresting dangerous criminals. If a person with mental illness has not committed a crime, why should they be treated like criminals?'

8.5.33 Another party stated:

> [Consumers] that have had existing mental health conditions exacerbated and developed a mistrusting relationship with healthcare professionals and providers, police or tribunals as a result of restrictive practices used against them. These have significant, long-term, detrimental impacts and should be limited in scope.

8.5.34 This was also reinforced by the Disability Rights Advocacy Service:

> It is also important to note that the use of restrictive practices and force can have long-term detrimental impacts on the health and well-being of individuals and therefore should be measured and limited in scope.

8.5.35 The impact of restrictive practices is significant and ongoing. It may impact future access to mental health services and raises risk of re-traumatisation for consumers.

If Authorised – Under What Circumstances?

8.5.36 In relation to the circumstances in which reasonable force could be used, there were varying views.

8.5.37 In the context of treating children and young people with severe mental illness, the Commissioner for Children and Young People submitted that the Convention on the Rights of the Child should be recognised in the *MHA* and additional safeguards should be included that reflect the needs of children and young people. It was submitted that the *MHA* should recognise that 'there are certain restrictive practices and restraints that should not be used on children.' Further, the Commissioner for Children and Young People added that 'to better align with human rights principles, the Act should set goals to reduce restrictive practices with the view to eliminate restrictive practices within a certain timeframe, similar to the Victorian Bill.'

8.5.38 There was wide support that restrictive practices should be minimised and if required, should be an option of last resort.

8.5.39 This was raised by the Mental Health Commissioners of South Australia, who observed that force and restrictive practices should always be used as an option of last resort. They noted de-escalation techniques should be used in the first instance and stated that:

> While the Act states that restrictive practices and medication are to be used for therapeutic reasons, and not for the convenience of others … we believe that greater strength needs to be given to these provisions within the Act, so they are referred to not just in the guiding principles … but in reference to imposition and use of force.

8.5.40 The Disability Rights Advocacy Service suggested that 'the *MHA* should only allow use of reasonable force and control powers as a last resort. Staff should be trained in de-escalation responses and trauma-informed approaches.'

8.5.41 Similarly, the SA Health Lived Experience Workforce submitted that:

> … [they] are advocates for the least restrictive practice in health care at all times. We believe trauma informed care, sensory modulation, verbal de-escalation techniques and peer support are key factors in reducing restrictive practices. Alternative models of de-escalation should be considered in staff training and development.

8.5.42 SALRI notes that this view received broad support.

8.5.43 During one of SALRI's co-facilitated Focus Groups, it was submitted that there is still a case for use of restrictive practices. However, they must be used in the least restrictive way and always with the view to protect the person or others from safety.

8.5.44 Lived Experience Australia considered that:

> … in a very small number of instances, the use of reasonable force or control powers is appropriate. However, we believe this should be confined to the community environment where people can be an imminent risk to themselves or others.

8.5.45 Further, they submitted:

> … that in a small number of instances in the Emergency Room environment, for example, chemical, physical or even mechanical restraint may be considered appropriate, used only in order to keep the clinicians, public and the person themselves free from harm. These powers should only be used as a last resort.

8.5.46 Finally, Lived Experience Australia concluded that where any such practice is required:

> It would be considered that escalation of concerning behaviours should be dealt with by the mental health clinicians, who should be well trained in de-escalation techniques, knowledge, and skills. Force and control via seclusion, mechanical, or physical means must be eliminated.

8.5.47 The Australian Nursing and Midwifery Federation did not support the use of reasonable force and control powers, noting it '… can impact on the therapeutic relationship between the client and the clinician. Practice needs to be collaborative and consultative with the person requiring care.' Further, they argued that '[r]estraint should only be used in accordance with approved protocols and best practice by properly trained professional staff in an appropriate environment.'

8.5.48 The Office of the Public Advocate recognised reasonable force may be required in limited circumstances:

> It is acknowledged that use of reasonable force and control powers is sometimes necessary in circumstances where a person's safety or wellbeing, or that of the community, is at risk. However, this should only ever be used as a last resort in emergency situations and only for as long as necessary, in order to protect the rights of persons with mental illness. Use of these powers should also be subject to review and reporting requirements.

8.5.49 The Australasian College for Emergency Medicine elaborated on the circumstances in which reasonable force could be used:

> The use of restrictive practices in EDs and the drivers of their use are complex and sometimes necessary to protect an individual patient, and/or the people around them (staff, carers and other patients). EDs provide a compelling window into the strengths and weaknesses of South Australia's mental health system.
>
> … any proposed changes to mental health legislation regarding restrictive practices and their use must be balanced by the need to protect patients and others in response to immediate risk. Specialist emergency physicians are highly trained and skilled at making rapid determinations about the best course of action for the care of a patient …

8.5.50 They further recommended:

> … that physical or mechanical restraint may only be used if it is necessary to prevent imminent and serious harm to the patient or others. Physical restraint may be used to administer medical treatment including to facilitate safe assessment. Any physical or mechanical restraint should be used for as short a duration as possible, and only as a bridge to effective de-escalation.
>
> ACEM regards seclusion as a practice that has no therapeutic benefit and can disrupt therapeutic relationships between patient and clinician. EDs have significant difference in resources including number and availability of security personnel, senior medical and nursing staff, and high acuity bed availability. Despite this, every effort should be made for the safe, timely and dignified treatment of people experiencing severe behavioural disturbance. This is not achieved through seclusion.

8.5.51 They also advocated for a clear definition of each type of restrictive practice.

8.5.52 The LELAN also suggested circumstances in which reasonable force may be used:

> It is LELANs view that such powers would be defined in the legislation for use:
>
> - Only in such circumstances where there is immediate risk to the safety of the person and/or others;
> - Only for the duration of the immediate risk to safety of the person and/or others;
> - Only for the use of the least restrictive force or control for the shortest duration;
> - Only used by trained clinicians in combination with de-escalation techniques;
> - No use of restrictive practices that risk being seen or used as punishment, coercion and threat such as mechanical and/or physical restraint or seclusion;
> - Not for use in inpatient mental health services unless all other interventions and de-escalation techniques have been expended as a last resort.

8.5.53 Consultation revealed that the use of restrictive practices and reasonable force should be an option of last resort, in very limited circumstances. Many parties called for the ban of specific types of restrictive practice.[1860] However, as noted by an attendee in SALRI's Disability Advocacy Roundtable, banning one practice will create a 'slippery slope', prompting an increase in the use of another practice.

[1860] There was support for a ban on restrictive practices in SALRI's co-facilitated Focus Group with Our Voice SA.

8.5.54 Alternatively, many parties favoured greater scrutiny and reporting regarding the use of restrictive practices and reasonable force. For example, the Australasian College for Emergency Medicine supported 'clear clinical governance frameworks, standardised documentation tools and reporting pathways that allow for system improvement.' They recommended:

> The minimum data recorded for each restrictive practice event should include:
>
> - The reason/s for using the restrictive practice. Multiple reasons may apply, including but not limited to:
>   - Prevention of serious harm to the patient
>   - Prevention of serious harm to another person
>   - Facilitation of medical assessment and/or treatment
>   - Facilitation of mental health assessment and/or treatment
> - The measures used prior to the restrictive practice being utilised
> - The type of restrictive practice
> - Level of access block at the time of the restrictive practice was utilised
> - Length of stay for admitted patients
> - Waiting times to see a mental health clinician

8.5.55 The Child and Adolescent Health Community of Practice highlighted:

> Currently, it is not clear whether it is mandated to report the restraint of a patient to a Chief Psychiatrist for a mental health patient whose been admitted to a medical ward, in the Emergency Department or children's ward. Consideration needs to be given for the regular review and reporting of the restraint of children, and increased clarity should be considered in terms of what is deemed 'unreasonable force' in respect to violence in children.

8.5.56 Another party noted that the presence of accountability measures for the use of unreasonable force is necessary. In the absence of an accountability mechanism '… changing the wording of the Act is purely an exercise in semantics and will do nothing to protect the rights of people subject to force, control powers and restrictive practices "under the Act" in practice.'

8.5.57 The SA Health Lived Experience Workforce advocated for 'open and transparent discussions about restrictive practices.' In addition, they suggested regular auditing and inspections of seclusion rooms are necessary, with post restrictive practice de-briefing.

8.5.58 SALRI's consultation indicated the value of monitoring oversight and use of restrictive practice and reasonable force. SALRI agrees that these measures are integral.

Who Should Use Reasonable Force?

8.5.59 Some parties noted that only community health workers, people with lived experience and those with mental health training should be allowed to use force. YourSAy survey responses indicated that '[f]orce and control should only be used by person's trained and qualified in control techniques'. Further, another respondent raised '[i]n hospitals there should always be one trained person who can react immediately and offer advice'.

8.5.60 Some respondents indicated that only someone known to the consumer should be allowed to use force against them.

8.5.61 The LELAN submitted that the following considerations should guide and determine the appropriate party to exercise these powers:

- Support before force or control
- Peer support before clinical intervention
- De-escalation strategies before use of restraint
- Removal of others before seclusion or isolation
- Clinical intervention before security or law enforcement.

8.5.62 Lived Experience Australia emphasised that hospital security guards should not be authorised to use reasonable force, arguing it 'adds to the stigma of mental health issues.' Further, they submitted the use of hospital security guards '… is most inappropriate given their [lack of] knowledge of people's behaviour when affected by mental health issues.' The Rural and Remote Mental Health Service raised the 'ongoing confusion' regarding the role of hospital security guards.

8.5.63 The Mental Health Commissioners of South Australia reinforced the need for accredited training and ongoing training to maintain accreditation.

8.5.64 The Central Adelaide Local Health Network recommended:

> … the category of prescribed persons who are allowed to exercise these functions is defined within regulations rather than the Act itself, and should include senior clinicians or authorised persons under the direction of senior clinicians.

8.5.65 Overall, consultation indicated the current authorised officers vested with the power to use reasonable force under s 56 *MHA* is appropriate. This is due to their expertise and training.

8.6 SALRI's Observations and Conclusions

8.6.1 SALRI's consultation revealed a diverse range of perspectives on the use of restrictive practices and reasonable force. It is imperative to highlight the importance of adequate training, expertise and experience in exercising these powers. In addition, SALRI emphasises that these powers should be used as a last resort and advocates for the use of de-escalation techniques.

8.6.2 As a result, SALRI recommends that the use of reasonable force provisions in the *MHA* for authorised officers (who have undertaken suitable training) and police should be retained, recognising the need to ensure the safety of consumers, mental health practitioners and community. Further, SALRI recommends that authorised officers and SAPOL should undertake ongoing training in de-escalation techniques to avoid the use of force wherever practicable.

8.6.3 SALRI supports mechanisms for reporting, oversight and accountability regarding the use of restrictive practices and reasonable force. It is also acknowledged that resourcing and staffing are factors impacting mental health service delivery, which includes the use of restrictive interventions. However, SALRI acknowledges there may be circumstances where these powers are required. If required, SALRI notes that this relies on the clinical judgment of the medical practitioner or authorised officer.

8.6.4 The apparent overlap between care and control powers and treatment orders under the *MHA* was raised by various parties, notably the OCP and Neami National, to SALRI. It was suggested that this causes confusion in practice, particularly for regional, remote and rural communities. Several parties said there would be value in providing greater 'clarity' in the *MHA*, including to clearly distinguish a treatment order and care and control powers.[1861] In response to this, SALRI considered whether preliminary orders (such as assessment orders in Victoria),[1862] were warranted in a South Australian context as a prelude to making either a CTO or ITO. They may serve to address the lack of clarity and a degree of overlap raised by several parties to SALRI, including the Chief Psychiatrist, between the use of care and control powers under s 56 of the *MHA* and treatment orders. SALRI considers the flexibility of the current s 56 is preferable, whilst more specificity could be helpful, particularly regarding time limits. However, such precision is impracticable in a South Australian context, especially outside metropolitan areas. SALRI also notes the OCP's reasoning that care and control powers do not require a person to be transported to an authorised treatment centre. This is particularly relevant for consumers in regional, rural and remote settings, where a centre may be a long distance away. Further, '… if someone is assessed after being able to settle, they may not require an ITO and will have no record on their health history.'

8.6.5 The suggestion of greater clarity to s 56 of the *MHA* is not without merit. However, SALRI considers it is preferably a matter of clinical judgment in a South Australian context as to whether a person is placed under care and control or a treatment order is imposed. Further, SALRI was not convinced of the suitability of preliminary orders in South Australia, especially in a regional, rural and remote context.

8.6.6 SALRI also notes there is no time limit to the exercise of care and control powers. Rather, a requirement to utilise the power for as long as is 'reasonable'. A number of parties in SALRI's consultation raised the benefits of adding clarity on this point in the *MHA*, including to clearly distinguish between what circumstances care and control powers should be utilised and the point at which a CTO or ITO should be imposed. SALRI reiterates that any time limit for care and control powers is unrealistic in South Australia, especially with regard to regional, rural and remote communities and the distance to an approved treatment centre. What is deemed reasonable will depend on the individual circumstances of each situation.

8.6.7 Recommendations

RECOMMENDATION 41

SALRI recommends that the care and control powers and the use of force provisions in s 56 (authorised officers) and s 57 (police) of the *Mental Health Act 2009* (SA) should be retained.

RECOMMENDATION 42

SALRI recommends that authorised officers and the South Australia Police undertake ongoing training in de-escalation techniques to avoid the use of force wherever practicable.

[1861] See generally Part 9 Role of Police.

[1862] See further Part 5 Inpatient Treatment Orders at [5.4.31].

Part 9 – Role of Police

9.1 Background

9.1.1 A prominent topic in SALRI's consultation was in relation to the role and operation of the police and the use of 'coercive powers' by police and others under the *Mental Health Act 2009* (SA) ('*MHA*').[1863] These are not simple questions.

9.1.2 The *MHA* provides police with broad powers to deal with persons with a mental illness[1864] or persons perceived to have a mental illness.[1865] These reflect longstanding common law powers.[1866] Historically, government policy to manage persons with mental illness was to place and hold them in psychiatric institutions, often in confronting circumstances.[1867] Since the 1960s, the policy focus has shifted to administering mental health treatment in community-based settings.[1868] Issues of mental illness, far from been hidden 'out of sight', have therefore become far more visible in the community.[1869] To accommodate this shift in approach, partnerships between public health organisations and police bodies were developed and implemented.[1870] In South Australia, this partnership sees a police-focused response under the *MHA* to incidents of mental illness,[1871] where the

[1863] See further Part 8 Restrictive Practices and Control Powers.

[1864] There are various terms. SALRI uses the term 'mental illness'. See Glossary.

[1865] These statutory powers are often referred to as 'care or control powers' or 'coercive powers': see Joanne Bradbury, Matt Ireland and Helen Stasa, 'Mental Health Emergency Transport: the Pot-Holed Road to Care' (2014) 200(6) *Medical Journal of Australia* 348; *Mental Health Act 2009* (SA) s 57(5).

[1866] Saleem Shah, 'Mental Disorder and the Criminal Justice System: Some Overarching Issues' (1989) 12 *International Journal of Law and Psychiatry* 231, 238–9. 'The rationale for the police to intervene in the lives of persons with mental illness derives from two common law principles: the power and authority of the police to protect the safety and welfare of the community, and the state's paternalistic or *parens patriae* authority, which dictates protection for citizens with disabilities who cannot care for themselves, such as those who are acutely mentally ill. Often both principles are involved when police are dealing with persons with mental illness who pose a threat of danger to the community or to themselves': Harry Lamb, Linda Weinberger and Walter DeCuir, 'The Police and Mental Health' (2002) 53(10) *Psychiatric Services* 1266.

[1867] See Peter Bartlett and David Wright (eds), *Outside the Walls of the Asylum: The History of Care in the Community 1750-2000* (The Athlone Press, 1999).

[1868] See Ibid; Christine Bigby and Chris Fyffe, 'Tensions Between Institutional Closure and Deinstitutionalisation: what can be Learned from Victoria's Institutional Redevelopment?' (2006) 21(6) *Disability and Society* 567, 568; Katrina Clifford, 'The Thin Blue Line of Mental Health in Australia' (2010) 11(4) *Police Practice and Research: An International Journal* 355.

[1869] Robert Laing et al, 'Application of a Model for the Development of a Mental Health Service Delivery Collaboration Between Police and the Health Service' (2009) 30(5) *Issues in Mental Health Nursing* 337, 338; Dorothy Cotton, 'The Attitudes of Canadian Police officers toward the mentally ill' (2004) 27(2) *International Journal of Law and Psychiatry* 135; Rob van den Brink, 'Role of the Police in Linking Individuals Experiencing Mental Health Crises with Mental Health Services' (2012) 12(171) *BMC Psychiatry* 1.

[1870] Roberta Julian et al, 'Exploring Law Enforcement and Public Health as a Collective Impact Initiative: Lessons Learned from Tasmania as a Case Study' (2017) 3(2) *Journal of Criminological Research, Policy and Practice* 79, 79–80. Auke van Dijk and Nick Crofts 'Law Enforcement and Public Health as an Emerging Field' (2017) 27(3) *Policing and Society* 261, 262. Trentham Furness et al, 'Perceptions of Procedural Justice and Coercion during Community-Based Mental Health Crisis: A Comparison Study among Stand-Alone Police Response and Co-Responding Police and Mental Health Clinician Response' (2016) 11(4) *Policing: A Journal of Policy and Practice* 400, 400–3.

[1871] This is as opposed to a health-focused response where police would have less involvement in managing mental health crises. Instead, the default emergency service response would be the state's ambulance service and police involvement will only be required where it is 'necessary to ensure the safety of consumers, families, carers and supporters, workers and/or the community': *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021) vol 1, 519.

police are typically first responders to mental health crises.[1872] In this role as mental-health interventionists, police now interact with consumers more frequently than in the past.[1873] As one study comments:

> With deinstitutionalisation and the influx into the community of persons with severe mental illness, the police have become frontline professionals who manage these persons when they are in crisis… the issues raised by this phenomenon as it affects both the law enforcement and mental health systems…. The police often fulfil the role of gatekeeper in deciding whether a person with mental illness who has come to their attention should enter the mental health system or the criminal justice system.[1874]

9.1.3 The involvement of the police under the *MHA* is perhaps inevitable, but nevertheless may be problematic. Police are increasingly utilised as effective 'gatekeepers' or 'one stop shops' to the mental health service system.[1875] Given that most people experiencing a mental health crisis have done nothing illegal,[1876] as the Victorian Royal Commission notes, the involvement of police can prove 'humiliating and traumatic'.[1877] The Royal Commission, in observations equally applicable in a South Australian context, noted that many consumers, carers and service providers – including Victoria Police itself – expressed dismay about the growing involvement of police in situations where people are

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[1872] Mark Carroll, 'Mental Health System Overburdening Police' (2005) 88(6) *Police Journal* 18. Police as emergency first responders to mental health crises occurs in most Western countries, see: Jennifer Wood et al, *Police Interventions with Persons Affected by Mental Illness: A Critical Review of Global Thinking and Practice* (Centre for Behavioural Health Services and Criminal Justice Research, March 2011).

[1873] Joel Carroll, 'Mental Health System Overburdening Police' (2005) 88(6) *Police Journal* 18; Joel Godfredson et al, 'Police Discretion and Encounters with People Experiencing Mental Illness' (2010) 37(12) *Criminal Justice and Behaviour* 1392, 1393; Kayla Gomez and Stephanie Robertson, 'Attitudes Towards Mental Illness' (2022) *Journal of Criminal Justice Education* 1. This increased interaction has also been credited to the reduced availability of inpatient beds and stricter criteria for admission into institutionalised care: see Harry Lamb and Linda Weinberger, 'The Shift of Psychiatric Inpatient Care From Hospitals to Jails and Prisons' (2005) 33(4) *Journal of American Academy of Psychiatry Law* 529, 529*,* 532; William Wells and Joseph Schafer, 'Officer Perceptions of Police Responses to Persons with a Mental Illness'(2006) 29(4) *Policing: An International Journal* 578, 587–8.

[1874] Harry Lamb, Linda Weinberger and Walter DeCuir, 'The Police and Mental Health' (2002) 53(10) *Psychiatric Services* 1266. See further Kimberlie Dean et al, *The Justice System and Mental Health: A Review of the Literature (Report for the Australian Government National Mental Health Commission Report for the Australian Government National Mental Health Commission)* (August 2013); Senate Select Committee on Mental Health, *A national approach to mental health – From Crisis to community – First Report* (Parliament of Australia, 2006) [3.1].

[1875] *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021) 558; Melissa Davey, "Just Putting Out Fires": How Police Remain the Default Frontline in Mental Health Crisis (1 May 2021) The Guardian <https://www.theguardian.com/australia-news/2021/may/01/just-putting-out-fires-how-police-remain-the-default-frontline-in-mental-health-crisis>. See also Harry Lamb, Linda Weinberger and Walter DeCuir, 'The Police and Mental Health' (2014) 53(10) Psychiatric Services 1266.

[1876] Numerous investigations, studies and reviews over many years have highlighted that most people with a mental illness, including those with major illnesses, do not commit crimes. But persons with mental illness nevertheless are overrepresented in the criminal justice system and in prison. See Melissa Davey, *"Just Putting Out Fires": How Police Remain the Default Frontline in Mental Health Crisis* (1 May 2021) The Guardian <https://www.theguardian.com/australia-news/2021/may/01/just-putting-out-fires-how-police-remain-the-default-frontline-in-mental-health-crisis>. See further Kimberlie Dean et al, *The Justice System and Mental Health: A Review of the Literature (Report for the Australian Government National Mental Health Commission Report for the Australian Government National Mental Health Commission)* (August 2013); Senate Select Committee on Mental Health, *A national approach to mental health – From Crisis to community – First Report* (Parliament of Australia, 2006) [3.1].

[1877] *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021) vol 1, 515. See, also Tara Seed, John Fox and Katherine Berry, 'The Experiences of Involuntary Detention in Acute Psychiatric Care: a Review and Synthesis of Qualitative Studies' (2016) 61 *International Journal of Nursing Studies* 82; Genevieve Riley et al, '"A Frightening Experience": Detainees' and Carers' Experiences of been Detained Under Section 136 of the Mental Health Act' (2011) 55 *Medicine, Science and Law* 164; Joanne Bradbury et al, 'Lived Experiences of Involuntary Transport Under Mental Health Act Legislation' (2016) 26 *International Journal of Mental Health Nursing* 580.

experiencing a mental health crisis.[1878] The Royal Commission heard that Victoria's mental health system has defaulted to utilising police as the first responders to mental health crises and that police are often at the frontline due to a lack of alternative services (as is the same in South Australia as SALRI repeatedly heard in consultation). Many consumers, families, carers and supporters told the Victorian Royal Commission about the distress and embarrassment caused by the involvement of police.[1879]

9.1.4 These themes were reiterated by many parties in SALRI's consultation. As the Office of the Public Advocate neatly summarised:

> Whilst sometimes necessary in the circumstances where a person's safety or the safety of others is at risk, the involvement of police in a mental health crisis is not always the best solution to enforcement of the *MHA*. It can have the effect of criminalising and stigmatising people with a mental illness and can exacerbate trauma. As highlighted in the Royal Commission into Victoria's mental health system, there can be over-reliance on police to respond to mental health crises. It noted that police are not, and should not be expected to be, experts in responding to people experiencing mental illness or psychological distress. It also noted that police often have limited options besides transporting people to an emergency department.

9.1.5 The role of police under the *MHA* is 'complex' and 'complicated',[1880] proving to be a demanding and difficult area of law to navigate for police. 'The interface between the mental health services and the criminal justice system presents challenges both for professionals and patients [as] both systems are stressed and inherently complex.'[1881] The police are not and cannot be psychiatrists or mental health nurses.[1882] It is often said that the police are ill-equipped and inadequately trained to perform their roles under the *MHA*.[1883] Despite this concern, it is also noted that there is already a considerable amount of time and resources expended by police in relation to their various responsibilities under the *MHA*.[1884]

9.1.6 In relation to the use of police time and resources, one particular problem identified is the time police spend in hospital emergency departments attending on persons with a mental illness under

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[1878] The Police Association Victoria, Submission, *Royal Commission into Victoria's Mental Health System*, July 2019, 26–7; Mental Health Complaints Commissioner, Submission, *Royal Commission into Victoria's Mental Health System*, July 2019. See also *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021) vol 1, 515.

[1879] *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021) vol 1, 558.

[1880] Matthew Morgan, 'Police Responses to Persons with Mental Illness: The Policy and Procedures Manual of One Australian Police Agency and 'Procedural Justice Policy' (2021) 10(2) *Social Sciences* 42.

[1881] Aileen O'Brien et al, 'Public Mental Health Crisis Management and Section 136 of the Mental Health Act' (2018) 44(5) *Journal of Medical Ethics* 349.

[1882] Rhiannon Lane, '"I'm a Police Officer not a Social Worker or Mental Health Nurse": Online Discourses of Exclusion and Resistance Regarding Mental Health-Related Policework' 29(5) *Journal of Community Applied Social Psychology* 429.

[1883] Katrina Clifford, 'The Thin Blue line of Mental Health in Australia' (2010) 11(4) *Police Practice and Research* 355; Joel Godfredson et al, 'Police Perceptions of their Encounters with Individuals Experiencing Mental Illness: A Victorian Survey' (2011) 44(2) *Australian and New Zealand Journal of Criminology* 180; Alice Park et al, 'Models of Mental Health Triage for Individuals Coming to the Attention of the Police Who May Be Experiencing Mental Health Crisis: A Scoping Review' (2019) 15(2) *Policing: A Journal of Policy and Practice* 859.

[1884] *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021) vol 1, 510–5, 558–9. SAPOL also made clear the considerable demands placed upon police through their duties under the *Mental Health Act 2009* (SA). The Police Commissioner's submission noted that, in 2021, police had attended 18,467 mental health-related incidents. There had been a 59% increase in police calls in two years. The time spent by police on these calls has also increased by 87% over the last five years.

police care and control powers.[1885] It is reported that the lengthy waits in these settings are often a matter of hours, and these periods of waiting do not necessarily yield productive results for all consumers.[1886] SALRI heard from some consultees, particularly those in regional settings, that consumers may return to the community without admission, treatment or follow up. Depending on the jurisdiction, Australian police agencies can spend anywhere between 10 and 30% of their time routinely involved in the management of consumers for a variety of reasons, such as searching for consumers who have absconded from psychiatric services, connecting persons to mental health services, and/or responding to mental health crises, including incidents of violent or aggressive behaviour.[1887] This has the inevitable effect of limiting police capacity to attend on what are perceived as 'core policing' roles.[1888]

9.1.7 Over recent years, to accompany the process of deinstitutionalisation and the major shift to mental health treatment and care in community-based settings, the police have increasingly moved in both Australia and other international jurisdictions, to a 'systems approach'. This is typically a model involving close association and co-ordination between the police and specialist mental health services.[1889] SALRI refers to this approach as the 'co-response model'[1890] (though there are other terms).[1891] A co-response model is where mental health practitioners assist the police during incidents, either in person or remotely from a control room.[1892] As one author explains, 'these teams are based on the idea that the more police and mental health workers collaborate, the better the two systems can

[1885] See for example, Rachel Wardrop et al, 'Predictors of Emergency Departmental Service Outcome for People Brought in by Police: a Retrospective Cohort Study' (2022) 63 *International Emergency Nursing* 101, 188.

[1886] See, for example, Ibid. Due to constraints on the health system, consumers may be released from hospital unwell. This theme was often raised in SALRI's consultation. One Mount Gambier practitioner called it a frustrating 'turf and surf' situation. See also Nicola Mclean and Lisa Marshall, 'A Front Line Police Perspective of Mental Health Issues and Services' (2010) 20 *Criminal Behaviour and Mental Health* 62, 63.

[1887] Matthew Morgan, 'Police Responses to Persons with Mental Illness: The Policy and Procedures Manual of One Australian Police Agency and 'Procedural Justice Policy' (2021) 10(2) *Social Sciences* 42.

[1888] See generally Matthew Moran and Claire Paterson, "It's Mental Health, Not Mental Police': A Human Rights Approach to Mental Health Triage and Section 136 of the Mental Health Act 1983' (2019) 13(2) *Policing* 123; Rhiannon Lane, '"I'm a Police Officer not a Social Worker or Mental Health Nurse": Online Discourses of Exclusion and Resistance Regarding Mental Health-Related Policework' 29(5) *Journal of Community Applied Social Psychology* 429.

[1889] Dorothy Cotton and Terry Coleman, 'Canadian Police Agencies and their Interactions with Persons with a Mental Illness: a Systems Approach (2010) 11(4) *Police Practice and Research Journal of Psychiatric Research* 301; Arthur Lurigio and Amy Watson, 'The Police and People with Mental Illness: New Approaches to a Longstanding Problem' (2010) 10(1) *Journal of Police Crisis Negotiations* 3.

[1890] See generally Stephen Puntis et al, 'A Systematic Review of Co-Responder Models of Police Mental Health "Street" Triage' (2018) 18(1) *BMC Psychiatry* 256; Jacek Koziarski, Christopher O'Connor and Tyler Frederick, 'Policing Mental Health: The Composition and Perceived Challenges of Co-Response Teams and Crisis Intervention Teams in the Canadian Context' (2021) 22(1) *Police Practice and Research* 977.

[1891] Gilla Shario et al, 'Co-Responding Police-Mental Health Services: a Review' (2014) 42(5) *Administration and Policy in Mental Health and Mental Health Services Research* 606, 608. 'Triage' is often also used. See, for example, Wendy Dyer, Melanie Steer and Paul Biddle, 'Mental Health Street Triage' (2015) 9(4) *Policing* 377; Margaret Heslin et al, 'Decision Analytic Model Exploring the Cost and Cost-Offset Implications of Street Triage' (2016) 6(2) *BMJ Open* 1. The term 'men in white coats' was also used in SALRI's consultation by practitioners who referred to the previous mental health regime when patients would be picked up by mental health staff and taken to a psychiatric hospital.

[1892] Stephen Puntis et al, 'A Systematic Review of Co-Responder Models of Police Mental Health "Street" Triage' (2018) 18 *BMC Psychiatry* 256. There are other models. One is the Crisis Intervention Team which involves highly trained police in mental health handling and issues. The co-response and crisis intervention team model may be used in tandem. The co-response model is widely used in both the UK and Australia. It has been trialled in South Australia.

serve consumers and each other effectively.'[1893] The co-response model is the predominant model in the UK and is increasingly used throughout Australia.[1894] There is an existing trial program in South Australia that utilises a co-response model.[1895]

9.1.8 There is no single co-response model and debate as to the precise details persists.[1896] Despite this, there was overwhelming support in SALRI's consultation (notably from SAPOL, consumers and consumer groups) for the use of this model in South Australia. There was also overwhelming acceptance in consultation, albeit on occasion with reservations, that it is unrealistic to remove the police role under the *MHA*. There will always be a need for '24/7' availability of police emergency response services to mental health crises, particularly to prevent harm to individuals, including consumers and others, such as medical staff and family members.

9.1.9 The interaction between police and persons with mental illness can result in tragic outcomes, including situations where police are compelled to use lethal force,[1897] or where a person with mental illness dies in police custody.[1898] Situations like these, underpinned by the broader concern of police intervention in relation to persons with mental illness, has raised policy and other concerns around the appropriateness of police intervention under the *MHA*.[1899] The health-police partnership has given rise to practical issues, namely raising resourcing and operational implications for the involved agencies and the operation of inter-agency collaboration within a fragmented and often overstretched healthcare system. To properly understand the complexities of the police role and powers under the *MHA*, it must be understood that the police as mental health interventionists is

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[1893] Cheryl Forchuk et al, 'Psychiatric Crisis Services in Three Communities' (2010) 29 *Canadian Journal of Community Mental Health* 73, 76.

[1894] Stephen Puntis et al, 'A Systematic Review of Co-Responder Models of Police Mental Health "Street" Triage' (2018) 18 *BMC Psychiatry* 256, 263.

[1895] This model has been trialled in the Northern Adelaide Local Health Network and has recently commenced in the Central Adelaide Local Health Network.

[1896] Gilla Shario et al, 'Co-Responding Police-Mental Health Services: a Review' (2014) 42(5) *Administration and Policy in Mental Health and Mental Health Services Research* 606, 608. There is no single model. 'There is also wide variation in the implementation of the co-response model, with differences in hours of operation, staffing, and incident response': Indeed, 19 different models have been identified. See Stephen Puntis et al, 'A Systematic Review of Co-Responder Models of Police Mental Health "Street" Triage' (2018) 18 *BMC Psychiatry* 256, 258.

[1897] See, for example, *Inquest into the Death of Alexander Peter Kuskoff* (2015) 38/2015 (1685/2015) SACC (Schapel, Deputy State Coroner). In 2015, Alexander Peter Kuskoff was experiencing a mental health challenge and ultimately died in custody when SAPOL officers attended his property to take him into their care and control under the *Mental Health Act 2009* (SA).

[1898] Australian Government, *Police Shootings of People with Mental Illness Research Paper No 34* (Australian Institute of Criminology, May 2013) 2; James Ogloff et al, *The Identification of Mental Disorders in the Criminal Justice System* (Criminology Research Council Consultancy, 2006) 22; Dragana Kesic, Stuart Thomas, and James Ogloff, 'Analysis of Fatal Police Shooting: Time, Space and Suicide by Police' (2012) 39(8) *Criminal Justice and Behaviour* 1107, 1120–1. The impact upon individual police officers should also not be overlooked. Irina Komarovskaya et al, 'The Impact of Killing and Injuring Others on Mental Health Symptoms among Police Officers' (2011) 45(10) *Journal of Psychiatric Research* 1332. 'Overall, the current study found that although a small percentage of police officers report experiences of seriously injuring or killing another person in the line of duty in the first three years of service, when these experiences occur, they are significantly associated with posttraumatic stress symptoms and possibly depression. The results highlight the importance of providing timely assessment and when indicated treatment for those who have been exposed to killing or seriously injuring someone in the line of duty': at 1337–8.

[1899] Leone Howes, Isabelle Bartkowiak-Théron and Nicole Asquith, 'A Federation of Clutter: The Bourgeoning Language of Vulnerability in Australian Policing Policies' in Nicole Asquith, Isabelle Bartkowiak-Théron and Karl Roberts (eds), *Policing Encounters with Vulnerability* (Palgrave Macmillan, 2017) 89–117, 89–90; Matthew Morgan and Craig Paterson, '"It's Mental Health, Not Mental Police": A Human Rights Approach to Mental Health Triage and Section 136 of the Mental Health Act 1983' (2019) 13(2) *Policing: A Journal of Policy and Practice* 123, 124.

merely one aspect of a broader mental health policy and exists within a healthcare system that is challenged to accommodate the demands for mental health care.

9.2 Current Law in South Australia

9.2.1 Section 57 of the *MHA* confers certain powers on police. These are what are commonly called 'care and control powers' (or orders),[1900] designed for the welfare of both consumers and others.

9.2.2 Where it would be reasonably required, a police officer may apprehend, detain, and transport a person with a mental illness to a prescribed place under the *MHA*, for the purpose of facilitating medical examination or for treatment of that person.[1901] These powers can be exercised in a range of situations including where an officer reasonably suspects that the person has a mental illness,[1902] is at risk of harming themselves or others, and the person requires medical examination.[1903] A police officer is not required to exercise medical expertise when assessing a person's mental state.[1904]

9.2.3 Additionally, a police officer can apprehend, detain, and transport a person where they reasonably believe a person is absent from a facility without leave,[1905] where a patient has issued an assistance request,[1906] or where a patient has issued a transport request.[1907] A patient assistance request can be issued by a medical practitioner or a mental health clinician under s 54A of the *MHA* where a consumer is non-compliant with their CTO. This enables a police officer to exercise their care and control powers for the purpose of assisting the administration of medical treatment.

9.2.4 The police have a difficult role under the *MHA* in identifying and responding to persons with mental illness.[1908] Section 57(3) provides a police officer is not required to exercise any medical expertise in the exercise of their powers under s 57 in order to form an opinion about a person and the officer may form such an opinion based on the officer's observations of the person's behaviour or

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[1900] See further Part 8 Restrictive Practice and Control Powers.

[1901] *Mental Health Act 2009* (SA) s 57(6).

[1902] Mental illness is defined under the act as an 'illness or disorder of the mind': *Mental Health Act 2009* (SA) s 3. Schedule 1 includes factors that do not constitute a mental illness: A person does not have a mental illness merely because of any 1 or more of the following: (a) the person expresses or refuses or fails to express, or has expressed or refused or failed to express, a particular political opinion or belief; (b) the person expresses or refuses or fails to express, or has expressed or refused or failed to express, a particular religious opinion or belief; (c) the person expresses or refuses or fails to express, or has expressed or refused or failed to express, a particular philosophy; (d) the person expresses or refuses or fails to express, or has expressed or refused or failed to express, a particular sexual preference or sexual orientation; (e) the person engages in or refuses or fails to engage in, or has engaged in or refused or failed to engage in, a particular political activity; (f) the person engages in or refuses or fails to engage in, or has engaged in or refused or failed to engage in, a particular religious activity; (g) the person engages in or has engaged in a particular sexual activity or sexual promiscuity; (h) the person engages in or has engaged in immoral conduct; (i) the person engages in or has engaged in illegal conduct; (j) the person has developmental disability of mind; (k) the person takes or has taken alcohol or any other drug; (l) the person engages in or has engaged in anti-social behaviour; (m) the person has a particular economic or social status or is a member of a particular cultural or racial group. However, nothing prevents, in relation to a person who takes or has taken alcohol or any other drug, the serious or permanent physiological, biochemical or psychological effects of drug taking from being regarded as an indication that a person is suffering from mental illness.

[1903] *Mental Health Act 2009* (SA) s 57(6).

[1904] Ibid s 57(3).

[1905] Ibid s 57(1)(b).

[1906] Ibid s 57(1)(a)(i).

[1907] Ibid s 57(1)(a)(i).

[1908] Joel Godfredson et al, 'Police Perceptions of their Encounters with Individuals Experiencing Mental Illness: A Victorian Survey' (2011) 44(2) *Australian and New Zealand Journal of Criminology* 180.

appearance or reports about the person's behaviour, appearance or history (which may include reports about matters occurring outside South Australia).

9.2.5 In circumstances where a police officer has apprehended a person for reasons not described in s 57, the person may 'be released from police custody for the purpose of medical examination or treatment'.[1909] If requested by the Police Commissioner, and where no ITO is placed on the person, the person must be held by the medical facility until police can retake custody of the person.[1910]

9.2.6 To allow a police officer to exercise these care and control powers, s 57 of the *MHA* allows an officer to 'enter and remain in a place'. Additionally, an officer can search the person and seize any items 'the person may use to cause harm to himself or herself or others or property'.[1911] The police are also entitled to use 'reasonable force' to carry out their s 57 powers if required under the circumstances.[1912]

9.2.7 The role of the police and their use of 'reasonable force' under the *MHA* proved to be a recurring issue in SALRI's consultation. There were various views expressed. A common denominator was the acceptance by most parties that the role of the police, including the ability to use reasonable force as a 'last resort' measure, is not ideal, but perhaps necessary.

9.2.8 It is also necessary to note that s 56 of the *MHA* provides similar care and control powers to an 'authorised officer'. An authorised officer covers a wide range of mental health related roles, namely a mental health clinician, an ambulance officer, a medical officer or flight nurse of the Royal Flying Doctor Service of Australia, or a person (or class of persons) approved by the Chief Psychiatrist. Section 56 care and control powers can be exercised in the same circumstances as s 57 care and control powers, and an authorised officer can use reasonable force and restrictive practices to carry out these s 56 powers.[1913] However, there are differences in the powers exercisable by each officer. Unlike an

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[1909] *Mental Health Act 2009* (SA) s 57(9).

[1910] Notification under s 57(10) of the Act to the Commissioner of Police of action taken under the Act in relation to a person who has been arrested for an offence and released from police custody for the purpose of medical examination or treatment under the Act must be given as soon as practicable after the action is taken in accordance with the following requirements: (a) if a community treatment order is made in respect of the person as a result of the examination—the notification must include details of the type of order and its duration; (b) if an inpatient treatment order is made in respect of the person as a result of the examination or before the expiry of such an order made as a result of the examination—the notification must include details of the type of order and its duration and specify the treatment centre at which the person is an involuntary inpatient; (c) if the person is subsequently transferred to another treatment centre—the notification must specify the treatment centre to which the person is transferred: *Mental Health Regulations 2009* (SA).

[1911] *Mental Health Act 2009* (SA) s 57(f).

[1912] Some parties in consultation expressed unease at the police role under the *Mental Health Act 2009* (SA), notably in their powers. One suggestion was to narrow the scope or clarify or define the premise of 'reasonable force' used by police under s 57 and authorised officers under s 56. The SA Health Lived Experience Workforce, for example, told SALRI that 'reasonable force' is 'an ambiguous and subjective term that must be changed. This is an unworkable phrase.' The South Australian Child and Adolescent Health Community of Practice had particular concerns over the use of 'reasonable' force on children under the *Mental Health Act 2009* (SA). SALRI can understand the preference for clarity and oversight in this sensitive area, especially for children. Given the infinite variety of circumstances that will arise, it is impracticable or inappropriate to define this familiar term in the law. It has to depend on an individual situation, including the age of the consumer. It is always open for interested agencies to have protocols or guidance as to how such powers should be exercised.

[1913] *Mental Health Act 2009* (SA) s 56(3)(c), (d). SALRI notes that, whilst flexibility under s 56 is useful as to the categories of authorised officers, the importance of suitable training and professional guidance is reiterated and that the use of force should be a 'last resort'.

authorised officer, a police officer *cannot* administer a drug/medication. Further, an authorised officer *cannot* use reasonable force to break into a place, although a police officer may do so.

9.2.9 The use of the s 56 powers is subject to various protocols and operational guidance. The wider role and use of the care and control powers under s 56 and s 57 was raised by many parties in SALRI's consultation. There was no consensus. Several parties also raised the intersection and lack of clarity between the role and use of care and control powers, and the role and use of CTOs or ITOs.

9.2.10 The Chief Psychiatrist explained the rationale of these powers, and particular issues which arise in South Australia:

> The powers are exercisable as reasonably required for the purpose of enabling or facilitating the treatment or medical examination. The length of the mental state examination is what determines the necessary length of the use of s 56 powers. The Act does not place a limit on the length of time that s 56 powers may be used, but does say that the powers may be exercised only for as long 'as reasonably required for the purpose of enabling or facilitating the medical examination or treatment of the person'. The powers available to s56 are not available for the ongoing management of patients they are intended only for short term use. The OCP is aware that, in practice, clinicians may need to hold someone under care and control powers for many hours in order to properly assess them, for example to allow for the person to settle from a distressing situation or for the effects of drugs to subside. There are no clear avenues for someone under care and control powers to seek review of their treatment as there are under inpatient and community treatment orders. For this reason, it is sometimes seen as preferable to make a decision about placing someone on a treatment order as soon as possible in order to protect their rights. Countering those considerations are some advantages to using care and control powers rather than treatment orders. Under care and control powers, a person does not need to be transported to an authorised treatment centre as they are required to be under an ITO. This may be a consideration in areas where an ATC may be some distance from the person under assessment. Additionally, if someone is assessed after being able to settle, they may not require an ITO and will have no record on their health history. It is the view of this Office that if a longer examination is deemed necessary in the particular circumstances, there is no legal impediment to this, so long as the assessment is reasonably required for enabling the medical examination of treatment of the person. In circumstances where a longer assessment is reasonably required, a justification as to why this is the case must always be thoroughly reflected in the clinical case notes. While it will always be a matter of clinical judgement as to whether a consumer meets the criteria for an ITO, in cases where immediate medical examination is required, it is the view of my Office that the (short and long-term) interests of the consumer are better served by taking the least restrictive approach. Using s56 powers would be considered appropriate to allow reasonable time for the consumer's distress to resolve, for the purpose of making a more accurate assessment. The OCP would support in principle support amendments to the Act that clarify this use of care and control powers.[1914]

9.2.11 SALRI adopts this helpful overview as background to many of the issues which arise.

[1914] The intersection between the role and use of care and control powers and CTOs and ITOs were raised by a few parties in consultation, such as the Chief Psychiatrist, and it was suggested that greater 'clarity' is prudent to clearly distinguish between care and control powers and a CTO or ITO. See further Part 8 Restrictive Practices and Control Powers.

9.3 Law in Other Jurisdictions

Australia

9.3.1 The police powers regarding persons with mental illness are similar across Australian jurisdictions. As a result, the present law in South Australia is not markedly different. **Table 5** on the following page summarises and compares the law across Australian jurisdictions.

Table 5 – Comparison of police powers in relation to mental health in Australia							
	ACT	**NSW**	**NT**	**WA**	**QLD**	**VIC**	**TAS**
Legislation	*Mental Health Act 2015* (ACT)	*Mental Health Act 2007* (NSW)	*Mental Health and Related Services Act 1998* (NT)	*Mental Health Act 2014* (WA)	*Public Health Act 2005* (Qld)	*Mental Health Act 2014* (Vic)	*Mental Health Act 2013* (Tas)
Care and Control powers	S 80(1) - PO may apprehend person where they *believe* on *reasonable grounds* the person: has a mental disorder or mental illness; has attempted or is likely to attempt suicide or inflict serious harm on themselves or another; and requires immediate examination by a doctor and does not agree to be examined immediately.	S 22 – PO may apprehend and detain person who appears mentally ill or mentally disturbed if PO *believes* on *reasonable grounds* the person: Is committing or has recently committed an offence; or b. Has recently tried to kill themself, or it is probable they will attempt to kill themselves or another, or cause serious physical harm to themself or another; and c. It would be beneficial the person is dealt with under the Act rather than otherwise in law.	S 32A(1), (2) - PO can apprehend person where PO *believes*, on reasonable grounds: (a) a person may require treatment or care under this Act having regard to the appearance and behaviour of the person; and (b) the person is likely to cause serious harm to himself or herself or to someone else unless apprehended immediately; and (c) it is not practicable in the circumstances to seek the assistance of an authorised psychiatric practitioner, a medical practitioner or a designated mental health practitioner.	S 156(1) – police officer may apprehend a person where he/she *suspects* on reasonable grounds (a) the person has a mental illness; and (b) because of the mental illness it is necessary to apprehend the person to protect the health, or safety of the person, another person, or to prevent serious damage to property	S 157B(1), (3) – PO may detain the person if PO *believes*: a. the person's behaviour, including the way they are communicating, indicates the person is at immediate risk of serious harm; and b. the risk appears to result from a major disturbance in the person's mental capacity, whether caused by illness, disability, injury, intoxication or another reason; and c. The person appears to require urgent examination. Or treatment and care, for the disturbances.	S 351(1) PO may apprehend person where *satisfied* a. a person *appears* to have a mental illness; and b. the apparent mental illness, requires the person to be apprehended to prevent serious and imminent harm to the person, or to another person.	S 17(1) PO can take a person into protective custody where the officer *reasonably believes*: (a) the person has a mental illness; and (b) the person should be examined to see if he/she needs to be assessed against the assessment criteria, or the treatment criteria; and (c) the person's safety or the safety of other persons is likely to be at risk if the person is not taken into protective custody.
Convey obligations	S 80(1) – PO may take person to approved mental health facility.	S 81(1) – PO may take or transfer any person to or from a mental health facility or other health facility.	S 32A(2), (3) - PO may bring the person to an authorised psychiatric practitioner, a medical practitioner or a designated mental health practitioner for an assessment under	S 156(3) - As soon as practicable after apprehending the person, police officer must arrange for person to be assessed by a medical practitioner or	S 157B(1), (3) – PO may transport the detained person to a treatment or care place.	S 351(5) - As soon as practicable the PO must arrange person to be taken to a registered medical practitioner or mental health practitioner; or a public	S 18(1)(a) - Must escort person to an approved assessment centre (or ensure another authorised person does).

			section 33 as soon as practicable.	an authorised mental health practitioner.		hospital, denominational hospital, privately-operated hospital or public health service.	S 72(2), (5) – PO may be directed to transport person by an authorised transfer direction in CFP form.
Definition	S 80 – **Mental illness**: serious condition that seriously impairs (temporarily or permanently) functioning of person in 1 or more areas of though, mood, volition, perception, orientation or memory and is characterised by Presence of at least one of the following symptoms: delusions, hallucinations, serious disorders of streams of through, serious disorders of thought form, serious disturbance of mood; or sustained or repeated irrational behaviour that may be taken to indicate the presence of at least 1 of the symptoms	S 4 - ***mental illness*** means a condition that seriously impairs, either temporarily or permanently, the mental functioning of a person and is characterised by the presence in the person of any one or more of the following symptoms— (a) delusions, (b) hallucinations, (c) serious disorder of thought form, (d) a severe disturbance of mood, (e) sustained or repeated irrational behaviour indicating the presence of any one or more of the symptoms referred to in paragraphs (a)–(d).	S 6(1) A ***mental illness*** is a condition that seriously impairs, either temporarily or permanently, the mental functioning of a person in one or more of the areas of thought, mood, volition, perception, orientation or memory and is characterised: (a) by the presence of at least one of the following symptoms: delusions; ii)hallucinations; (iii) serious disorders of the stream of thought; iv) serious disorders of thought form; v) serious disturbances of mood; or (b) by sustained or repeated irrational behaviour that may be taken to indicate the presence of at least one of the symptoms referred to in paragraph (a).	S 6(1) – a person who has a **mental illness** is a person who has a condition that a. is characterised by a disturbance of thought, mood, volition, perception, orientation or memory; and b. significantly impairs (temporarily or permanently) the person's judgment or behaviour.	S 10 - ***Mental illness*** is a condition characterised by a clinically significant disturbance of thought, mood, perception or memory. ****Note this definition is included in Mental Health Act 2016 (Qld).***	S 4(1) – ***Mental illness*** is a medical condition that is characterised by a significant disturbance of thought, mood, perception or memory.	S 4 – person is taken to have ***mental illness*** if they experience temporarily, repeatedly or continually – (i) a serious impairment of thought (which may include delusions); or (ii) a serious impairment of mood, volition, perception or cognition; nothing prevents the serious or permanent physiological, biochemical or psychological effects of alcohol use or drug-taking from being regarded as an indication that a person has a mental illness.
Search and Seize	Ss 264(1)(f), (2)– PO may search person if there are reasonable grounds for *believing* that the person is carrying anything that	Ss 81(1), (4), (5) – PO can carry out a frisk search or ordinary search if the PO carrying out the search *reasonably*	N/A in Act.	S 156(2), 159(2) – PO may search, in accordance with sections 163 and 172, the person,	S 443 – PO may search and research a person in custody. While the person is in custody PO may take and retain	Ss 354(1), (2), (5) – PO may search person where PO is *reasonably satisfied*	S 109(1)(e); Sch 2 cl 2(1) – PO can use reasonable force against a person when enlisted to assist a custodian or escort of a

	would present a danger to the authorised person or another person; or that could be used to assist the person to escape the authorised person's custody. PO can seize and detain any items found in the search.	*suspects* the other person is carrying anything that would present danger to the person or another, or that could be used to assist the person's escape from custody. PO may seize and detain these objects.		and any article found on or with the person.	anything found during the search that may endanger anyone's safety, may be used for an escape or anything else PO *reasonably believes* should be kept in safe custody.	that the person is carrying any thing that a. presents a danger to the health and safety of the person or another person; or (b) could be used to assist the person to escape. S 356(1) – PO can seize and detain a thing found as a result of a search conducted under section 354 if PO is *reasonably satisfied* that the thing— (a) presents a danger to the health and safety of the person or another person; or (b) could be used to assist the person to escape.	person, or when authorised by either the Chief Forensic Psychiatrist or the controlling authority of a Secure Mental Health Unit.
Entry into Place	S 263(1)(d), (2)(a) – PO may with necessary and reasonable assistance and minimum force, enter any premises to apprehend, remove or take the person to a place	S 21(2) – PO may enter premises to apprehend person, and may apprehend the person without a warrant and take a person to a mental health or other health facility	S 32A(7)(b) – PO may enter private premises or any other private place where PO reasonably believes the person may be found	Ss 156(2), 159(2) – For the purpose of apprehension, PO may enter any premises where person is reasonably expected to be	S 21(1)(e); (4) –PO may enter a place and stay there for a reasonable time to detain a person under another act. S21(1)(4) – PO who enters a place may search the place for the person.	S 353(1), (2), (3)(c), (4) – PO may enter any premises where they have reasonable grounds for being satisfied that the person may be found there. PO may use reasonable force to gain entry if they are not given permission to	S 109(1)(e); Sch 2 cl 1(a), (d) – PO can use reasonable force against a person when enlisted to assist a custodian or escort of a person, or when authorised by either the Chief Forensic Psychiatrist or the controlling authority of a Secure Mental Health Unit.

					***Note this provision is contained in the Police Powers and Responsibilities Act 2000* (Qld)**	enter the premises by a person at the premises.	
Force/ restraint against person	S 236(1)(d), (2)(a), (c) – PO may, with necessary and reasonable assistance and *minimum* force, enter any premises to apprehend, remove or take the person to a place. PO must use the minimum amount of force necessary to apprehend the person and remove the person.	S 81(2) – PO may use *reasonable force* under s 81 transport of person and may restrain the person in any way *reasonably necessary* in the circumstances.	S 32A(7)(a) – PO may use *reasonable* force and assistance for purpose of apprehension.	Ss 156(2), 172(1) – PO may use reasonable force for the purpose of apprehending someone under s 156(1).	S 615 – when exercising or attempting to exercise a power under any act against a person, a PO can use *reasonably necessary* force to help exercise the power. Also lawful for PO to exercise *reasonably necessary* force to prevent a person from escaping custody. Force does not include force likely to cause grievous bodily harm or death to the person. ***Note this provision is contained in the Police Powers and Responsibilities Act 2000* (Qld)**	N/A in act	S 109(1)(e); Sch 2 cl 1(a), (b) – PO can use reasonable force against a person when enlisted to assist a custodian or escort of a person, or when authorised by either the Chief Forensic Psychiatrist or the controlling authority of a Secure Mental Health Unit.

9.3.2 Similar to South Australia, all other Australian jurisdictions allow a police officer to apprehend, detain, and transport a person to a prescribed place where the person risks harming themselves or others.[1915] These care and control powers are to be exercised to transport the person to undertake medical assessment or treatment.[1916] Before detaining the person, a police officer must form either a 'reasonable belief' or 'reasonable suspicion'[1917] that the person is 'mentally ill' or 'mentally disturbed', as required by the relevant Act.

9.3.3 The Queensland Act differs. The relevant provision requires a police officer to form a belief that the person is experiencing a 'major disturbance' in their 'mental capacity'.[1918] On its face, this definition is broader than 'mental illness' as it allows a police officer to exercise their powers under the Act where the disturbance is caused by disability, intoxication, injury, or another reason.[1919]

9.3.4 Most jurisdictions also allow a police officer to search a person and seize items where the item may pose a threat to safety.[1920] These powers are additional to allowing a police officer to enter a place to look for a person,[1921] use force to enter a premises[1922] and use force and restraint against a person.[1923]

9.3.5 Similar powers as in s 56 of the *MHA* in South Australia exist in other States and Territories allowing certain categories of person other than police officers to exercise 'care and control' powers on persons with mental illness.

[1915] The harm threshold differs between jurisdictions. SALRI favours a threshold of 'serious harm' based on the ACT approach: see SALRI Recommendations 21 and 29.

[1916] *Mental Health Act 2015* (ACT) s 80(1); *Mental Health Act 2007* (NSW) ss 22(2), 81(1); *Mental Health and Related Services Act 1998* (NT) s 32A(2),(3); *Mental Health Act 2014* (WA) s 156(3); *Public Health Act 2005* (Qld) s 157B(1),(3); *Mental Health Act 2014* (Vic) s 351(5); *Mental Health Act 2013* (Tas) ss 18(1)(a), 72(2),(5).

[1917] Suspicion and belief are different states of mind. See *George v Rockett* (1990) 170 CLR 104, 106. Suspicion is a lower threshold than belief. A suspicion is a 'working hypothesis for which there is some supporting material'. In contrast, 'a belief is held on information which is accepted as reliable and implies a reasonable satisfaction fact is at least more likely to be true than any other alternative fact': *R v Nguyen* (2013) 117 SASR 432, 437 at [21]. A suspicion that something exists 'is more than a mere idle wondering … it is a positive feeling of actual apprehension or mistrust, amounting to a slight opinion, but without sufficient evidence': *Queensland Bacon Pty Ltd v Rees* (1966) 115 CLR 266, 303.

[1918] *Public Health Act 2005* (Qld) s 157B(1).

[1919] *Inquest into the deaths of Anthony William Young, Shaun Basil Kumeroa, Edward Wayne Logan, Laval Donovan Zimmer and Troy Martin Foster* (2017) 2013/2988; 2014/3598; 2014/4321; 2014/4239; 2014/4357 Coroners Court of Queensland (Ryan, State Coroner) 38 [138], 88 [309].

[1920] *Mental Health Act 2015* (ACT) s 264(1)(f), (2); *Mental Health Act 2007* (NSW) s 81(1), (4), (5); *Mental Health Act 2014* (WA) ss 156(2), 159(2); *Police Powers and Responsibilities Act 2000* (Qld) s 443; *Mental Health Act* 2014 (Vic) s 354(1), (2), (5).

[1921] *Mental Health Act 2015* (ACT) s 263(1)(d), (2)(a); *Mental Health Act 2007* (NSW) s 21(2); *Mental Health and Related Services Act 1998* (NT) s 32A(7)(b); *Mental Health Act 2014* (WA) ss 156(2), 172(1); *Police Powers and Responsibilities Act 2000* (Qld) s 21(1)(e), (4); *Mental Health Act 2014* (Vic) s 353(1), (2), (3)(c), (4).

[1922] *Mental Health Act 2015* (ACT) s 263(1)(d), (2)(a); *Mental Health Act 2014* (Vic) s 353(1), (2), (3)(c), (4); *Mental Health Act 2013* (Tas) s 95, sch 2 cl 1(a), (d).

[1923] *Mental Health Act 2015* (ACT) s 263(1)(d), (2)(a),(c); *Mental Health Act 2007* (NSW) s 81(2); *Mental Health and Related Services Act 1998* (NT) s 32A(7)(a); *Mental Health Act 2014* (WA) ss 156(2), 172(2); *Police Powers and Responsibilities Act 2000* (Qld) s 615; *Mental Health Act 2013* (Tas): note this power is only afforded when the police officer is enlisted to assist a custodian or escort under the Act (also see s 95).

9.3.6 Largely similar to Australia's approach and management to police powers and mental health, are the legislative equivalents in the United Kingdom, Canada, and the United States of America.[1924]

United Kingdom

9.3.7 In the UK, a constable may take a person into their care and control where that person 'appears to be suffering from a mental disorder and to be in immediate need of care and control' and it is necessary 'to do so in the interests of that person or for the protection of other persons'.[1925] When a person is taken into a constable's care and control, the constable must take the person to a 'place of safety', or if the person is already at a 'place of safety', the constable must keep that person there or remove them to another 'place of safety'.[1926]

9.3.8 Unlike Australian approaches, UK care and control powers can only be exercised in a public place.[1927] Additionally, where practicable to do so, a constable must consult a medical practitioner, registered nurse, approved health professional or a person as specified in the regulations, prior to determining to remove or keep a person at a 'place of safety'.[1928] In addition, a person cannot be detained for longer than 24 hours under the care and control provision.[1929] This is in contrast to the South Australian position where there is no time limit; rather a requirement to utilise the power for as long as is 'reasonable'. A number of parties in SALRI's consultation raised the benefits of adding clarity on this point in the *MHA*, including to clearly distinguish between what circumstances care and control powers should be utilised, rather than imposing a CTO or ITO.

Canada

9.3.9 All Canadian provinces afford police officers care and control powers in emergency situations[1930] and the provincial laws use the definition of 'mental disturbance' rather than 'mental illness'.[1931] Additionally, Canadian laws often requires a police officer to explain to a consumer why

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[1924] Jennifer Wood et al, *Police Interventions with Persons Affected by Mental Illness: A Critical Review of Global Thinking and Practice* (Centre for Behavioural Health Services and Criminal Justice Research, March 2011) 22.

[1925] *Mental Health Act 1983* UK s 136(1).

[1926] Ibid s 136(1)(a), (b). A place of safety 'means residential accommodation provided by a local social services authority under Part 1 of the Care Act 2014 or Part 4 of the Social Services and Well-being (Wales) Act 2014…A hospital as defined by this Act, a police station, an independent hospital or care home, or mentally disordered persons or any other suitable place': s 135(6). Children cannot be taken to a police station as a 'place of safety': 136A(1).

[1927] These powers cannot be exercised in any place of residence, including a 'yard, garden, garage or outhouse' other than one that shares use with other 'houses, flats or rooms': *Mental Health Act 1983* (UK) s 136(1A).

[1928] *Mental Health Act 1983* UK s 136(1C).

[1929] Ibid s 136(2), s 136(2A).

[1930] *Mental Health Act,* RSA 2000, c M-13, s 12; *Mental Health Act,* RSBC 1996, c 288, s 28; *Mental Health Act,* CCSM 1998, c M110 s 12; *Mental Health Act,* RSNB 1973, c M-10 s 8; *Mental Health Care and Treatment Act,* SNL 2006, c M-9.1 s 20; *Mental Health Act*, SNWT 2015, c 26 s 12; *Involuntary Psychiatric Treatment Act,* SNS 2008, c 42 s 14; *Mental Health Act,* RSNWT 1988, c 19 s 54; *Mental Health Act,* RSO 1990, c M.7 s 17; *Mental Health Act,* RSPEI 1988, c E-10.1; *Act Respecting the Protection of Persons Whose Mental State Presents a Danger to Themselves or to Others*, SQ 1996, c P-38.00 s 8; *Mental Health Services Act*, SS 1984-85-86, c M-13.1 s 20(1); *Mental Health Act,* RSY 2002, c 150 s 8(1).

[1931] *Mental Health Act,* RSA 2000, c M-13 s 1(1)(g); *Mental Health Act,* RSBC 1996 c 288 s 1 (definition of 'person with a mental disorder'); *Mental Health Act* CCSM 1998, c M110 s 1 (definition of 'mental disorder'); *Mental Health Care and Treatment Act*, SNL 2006, c M-9.1 2(1)(k); *Mental Health Act*, SNWT 2015, c 26 s 1(1) (definition of 'mental disorder'); *Involuntary Psychiatric Treatment Act,* SNS 2008, c 42 s 3(q); *Mental Health Act,* RSNWT 1988, c 19 s 2(1) (definition of 'mental disorder'); *Mental Health Act* RSO 1990, c M.7 s 1 (definition of 'mental disorder'); *Mental*

they are being detained, what the consumers' rights are in the situation, and where the consumer is being transported.[1932]

9.3.10 Quebec's legislation differs notably, as it minimises police involvement and is an example of a health-led (rather than a police-led) response to mental health crises. Quebec's law provides that police intervention is only available at the request of a crisis intervention unit and can only be requested where such a unit 'considers that the mental state of the person presents a grave and immediate danger to himself or … others…'.[1933]

9.3.11 The Nunavut approach is highly important to the Australian context. This approach places great focus on ensuring its mental health laws provide culturally appropriate and respectful treatment to its Indigenous Inuit population.[1934] One mechanism is to allow an Indigenous person to nominate a *tikkuaqtaujuq* (selected representative) whose role is largely to ensure and facilitate culturally appropriate treatment to the nominating person.[1935] This becomes relevant where emergency care and control powers are utilised by police to detain a person. Here, the detained person is afforded the right 'to communicate with their *tikkuaqtaujuq*…'[1936] among other things.[1937]

United States of America

9.3.12 Each State in the United States of America has its own mental health legislation. SALRI has only considered the New York and Californian legislative schemes in detail.

9.3.13 Comparable mental health law in New York provides that a police officer (or a peace officer) may take a person into custody when that person 'appears to be mentally ill and is conducting [themself] in a manner which is likely to result in serious harm to the person or others'.[1938] The 'likelihood to result in serious harm' threshold has been interpreted to mean 'threats of or attempts at suicide or serious bodily harm or other conduct demonstrating that [the person] is dangerous to [themself]'. The 'likelihood to result in serious harm' threshold to others has been

Health Act, RSPEI 1988, c E-10.1 s 1(k); *Mental Health Services Act*, SS 1984-85-86, c M-13.1 s 2(j); *Mental Health Act,* RSY 2002, c 150 s 1 (definition of 'mental disorder').

[1932] See, for example, *Mental Health Care and Treatment Act*, SNL 2006, c M-9.1, s 10; *Mental Health Act,* RSNB 1973, c M-10, s 10.1; *Mental Health Act* RSNWT 1988, c 19 s 30.

[1933] *Act Respecting the Protection of Persons Whose Mental State Presents a Danger to Themselves or to Others*, SQ 1996, c P-38.001 s 8.

[1934] It is notable that 85.9% of Nunavut's population identify as Indigenous: Statistics Canada, *Municipalities in Canada with the largest and fastest-growing populations between 2011 and 2016* (8 February 2017).

[1935] *Mental Health Act,* RSNWT 1988, c 19 s 3(1). This demonstrates clearly defined and meaningful roles for Inuit family, community, and culture through TSR which reflects Inuit social values. Additionally, the TSR is consulted throughout the consumer's interaction with the mental health system. Recognising the TSR also encourages planning a culturally meaningful network prior to crisis eventuating. Efforts will also be made to have a support person accompany peace officers in circumstances where it is safe and practicable. Derek Neary, *Made-in-Nunavut Mental Health Act adopted* (June 1 2021) Nunavut News <https://www.nunavutnews.com/news/made-in-nunavut-mental-health-act-adopted/>; Health Justice, *5 Important Things About Nunavut's New Mental Health Act* (April 14 2019) <https://www.healthjustice.ca/blog/5-important-things-nunavut-mha>.

[1936] *Mental Health Act,* RSNWT 1988, c 19 s 30(1)(c).

[1937] Rights in the provision include: (a) to be informed promptly of the reasons for the apprehension; (b) to retain and instruct a lawyer without delay and to be informed of that right and of the means of accessing a lawyer; (c) to communicate with an individual of their choice in the event of any delay in transporting the individual to a health facility: *Mental Health Act* RSNWT 1988, c 19 s 30(1).

[1938] *Mental Health Act*, 9 NY Mental Hygiene Law (1972) § s 9.41(a).

interpreted to mean 'a substantial risk of physical harm to other persons as manifested by homicidal or other violent behaviour by which others are placed in reasonable fear of serious physical harm'.[1939]

9.3.14 In New York, when this power arises, the police officer may remove the person, or direct the person to be removed, to a hospital or a comprehensive psychiatric emergency program that is specified in the relevant Act.[1940] The officer may detain the person 'in another safe and comfortable place' pending the person's examination at or admission to the relevant hospital or program.[1941] When this power is exercised, the police officer must immediately inform the Director of Community Services, or the city or county's relevant health officer of this fact.[1942]

9.3.15 Where a person satisfies grounds for police to exercise their powers to detain in New York (a person appearing to be mentally ill and acting in a manner likely to cause serious harm), the person 'may voluntarily agree to be transported to a crisis stabilization centre … for care and treatment'.[1943] When a person is transported to a crisis stabilisation centre, the attending staff at the facility are to assess the person and determine whether the person's mental health needs can be satisfied at the facility.[1944]

9.3.16 California's law provides similar discretionary care and control powers, however, these powers are broader and the relevant provisions more prescriptive than elsewhere. Californian law provides that, where there is probable cause, a police officer[1945] can take a person or cause a person to be taken into their custody for a 72 hour period. The police officer exercising this power must be satisfied that the person is a danger to themselves or a danger to others 'as a result of a mental health disorder', or where the person is 'gravely disabled'.[1946] When a police officer takes a person into their custody under this provision, the officer must take the detained person 'for assessment, evaluation, and crisis intervention, or placement for evaluation and treatment in a [designated] facility'.[1947] When determining whether a person can be taken into custody under this provision, the police officer 'shall[1948] consider available relevant information about the historical course of the person's mental disorder if the authorised person determines that the information has a reasonable bearing on the

[1939] *Mental Health Act*, 9 NY Mental Hygiene Law (1972) § s 9.01 definition of 'likelihood to result in serious harm' or 'likely to result in serious harm'.

[1940] *Mental Health Act*, 9 NY Mental Hygiene Law (1972) § s 9.41(a).

[1941] Ibid.

[1942] Ibid.

[1943] Ibid § s 9.41(b).

[1944] Ibid.

[1945] The provision provides these powers to a peace officer, professional person in charge of a facility designated by the county for evaluation and treatment, member of the attending staff, as defined by regulation, of a facility designated by the county for evaluation and treatment, designated members of a mobile crisis team, or professional person designated by the county. 'Peace officer' means a duly sworn peace officer as that term is defined in Chapter 4.5 (commencing with s 830 of Title 3 of Part 2 of the Penal Code who has completed the basic training course established by the Commission on Peace Officer Standards and Training or any parole officer or probation officer specified in s 830.5 of the Penal Code when acting in relation to cases for which he or she has a legally mandated responsibility: 5 Cal Welfare and Institutions Code (1937) § 5008(i). Police are included in the definition of 'peace officer' in the Penal Code: 4.5 Cal Penal Code (1872) § 830, 830.1(a).

[1946] 5 Cal Welfare and Institutions Code (1937) § 5150(a).

[1947] Ibid.

[1948] In California, 'shall' is mandatory and 'may' is permissive.

determination'.[1949] An officer determining whether to take a person into custody is not limited to 'consideration of the danger of imminent harm'.[1950]

9.3.17 Further, when a person taken into custody under the provision is transported to the designated facility for evaluation and treatment, the attending staff or a professional person will determine whether relevant assessment and treatment can be provided on a voluntary basis.[1951] Additionally, the Californian law provides that where an acute in-patient bed is unavailable, mental health personnel are prohibited from advising police that the person must be otherwise detained by police, and the police officer cannot be prohibited from transporting the person directly to the designated facility.[1952] When a police officer has transported a person to a designated facility, the police officer shall not be required for a period longer than 'the time necessary to complete documentation of the factual basis of the detention under s 5150 and a safe and orderly transfer of physical custody of the person'.[1953]

9.3.18 Where it is determined that 'the person cannot be properly served without being detained', the police officer must provide an application in writing to the admitting facility detailing 'the circumstances under which the persons condition was called to the attention of the peace officer', the facts providing probable cause to detain the person,[1954] and whether the police officer referred to the historical course of the person's mental health.[1955] Where an officer transports the person to a designated facility, the officer is not required beyond 'the time necessary to complete documentation of the factual basis of the detention under s 5150 and a safe and orderly transfer of physical custody of the person.'[1956]

9.3.19 The police officer must tell the person being taken into custody that they are not under criminal arrest and they are being taken for 'an examination by mental health professionals' at a relevant facility and the mental health staff will inform the person of their rights.[1957] At the facility the person is given information by admission staff in English (and in the person's preferred language) detailing why they are being detained, that they can be held for up to 72 hours, and that this may involve being transferred to another facility.[1958]

[1949] 5 Cal Welfare and Institutions Code (1937) § 5150(b), 5150.05. '[I]nformation about the historical course of the person's mental disorder includes evidence presented by the person who has provided or is providing mental health or related support services to the person subject to a determination described in subdivision (a), evidence presented by one or more members of the family of that person, and evidence presented by the person subject to a determination described in subdivision (a) or anyone designated by that person': at s 5150.05.

[1950] 5 Cal Welfare and Institutions Code (1937) § 5150(b).

[1951] Ibid § 5150(c).

[1952] Ibid § 5150.1.

[1953] Ibid § 5150.2. This provision is of interest as a regular concern in consultation was the lack of clarity in police 'transferring' a consumer detained under s 56 and potential lengthy waits in EDs and the lack of any explicit 'holding power' for others than police officers.

[1954] 5 Cal Welfare and Institutions Code (1937) § 5150(e).

[1955] Ibid § 5150(e).

[1956] Ibid § 5150.2.

[1957] Ibid § 5150(g)(1). Additionally, if the person is taken into custody at their residence a police officer must inform the person that they are able to bring 'a few personal items' and that the person can 'make a phone call and leave a note' informing the person's friends and/or family where they are being taken. An officer must also tell the person to inform them if they require if the person requires 'assistance with turning off any appliances or water': § 5150(g)(2).

[1958] 5 Cal Welfare and Institutions Code (1937) § 5150(i)(1).

9.4 **Issues**

9.4.1 It is important, as SALRI often heard in consultation (consistent with wider research),[1959] not to generalise about the risks or dangers of violence presented by persons with mental illness. SALRI's consultation with mental health practitioners, including forensic psychologists, psychiatrists, adult mental health psychiatrists, psychologists and nurses, reiterated that a majority (though not all) of the circumstances requiring SAPOL's intervention, involved an individual under the influence of illicit drugs (whether at ED or home visits for CTO treatment).

9.4.2 Without disregarding the consultation findings described above, it is also important to appreciate that situations involving persons with mental health challenges are complex and often emotionally charged. Police presence may perpetuate stigmatisation of mental illness. In crisis situations, consumers may be confused, distressed or frightened, and could exhibit anti-social or aggressive behaviour for those, or other reasons.[1960]

9.4.3 Other factors must be considered, including a history of illicit drug use (in particular, methamphetamines).[1961] These factors may create a risk that would not otherwise be present. However, a large majority of consumers are not violent and most situations are resolved peacefully or constructively.[1962]

9.4.4 Where circumstances arise that the consumer is aggressive and considered hostile, this may require police to use non-fatal or fatal force against these consumers.[1963] Encounters, where force is required stem from a danger to the consumer, the attending police officer and others present. This

[1959] See, for example, Amy Watson, Patrick Corrigan and Victor Ottati, 'Police Officer Attitudes and Decisions Regarding Persons with Mental Illness' (2004) 55 *Psychiatric Services* 46; Abby Mulay et al, 'Crisis Intervention Training and Implicit Stigma Toward Mental Illness: Reducing Bias Among Criminal Justice Personnel' (2016) 15(4) *International Journal of Forensic Mental Heath* 369; Jim Ruiz and Chad Miller, 'An Exploratory Study of Pennsylvania Police Officers' Perceptions of Dangerousness and their Ability to Manage Persons with mental Illness' (2004) 7(3) *Police Quarterly* 359. The lack of education, training, policies, and procedures has a tendency to cause line [police] officers to respond improperly. Instead of approaching the call as a person with an illness, oftentimes police officers will approach as though the patient is a dangerous felon. Such perceptions have a tendency to lead to a self-fulfilling prophecy when injury or death may occur to the patient, police officers, or both' at: 359.

[1960] Linda Teplin and Nancy Pruett, 'Police as Street Corner Psychiatrist: Managing the Mentally Ill' (1992) 15(2) *International Journal of Law and Psychiatry* 139, 140; Duncan Chappell, 'Policing and Emotionally Disturbed Persons: Disseminating Knowledge, Removing Stigma and Enhancing Performance' (2008) 40(1) *Australian Journal of Forensic Sciences* 37.

[1961] Arthur Lurigio and James Swartz, 'Changing the Contours of the Criminal Justice System To Meet the Needs of Persons With Serious Mental Illness' in National Institute of Justice, *Policies, Processes, and Procedures of the Criminal Justice System vol 45* (National Institute of Justice, 2000).

[1962] Nicola McLean and Lisa Marshall, 'A Front Line Police Perspective of Mental Health Issues and Services' (2010) 20(1) *Criminal Behaviour and Mental Health* 62, 68; Victoria Herrington, 'Inter-agency Cooperation and Joined-up Working in Police Responses to Persons with a Mental Illness: Lessons from New South Wales' (2012) 6(2) *Policing: A Journal of Policy and Practice* 388, 389.

[1963] *Inquest into the death of Courtney Topic* (2018) 2015/42730 New South Wales Coroner's Court (Ryan, Deputy State Coroner) 12 [95]–[102]; *Inquest into the Death of Alexander Peter Kuskoff* (2015) 38/2015 (1685/2015) SACC (Schapel, Deputy State Coroner) 1–2 [1.1], 2–3 [1.5], 9 [2.2].

can have lasting consequences for all parties.[1964] How a situation develops and whether force is used will always depend on a complex interaction of factors.[1965]

9.4.5 SALRI heard differing views in consultation regarding the risk or danger posed by some consumers, typically dealt with by police and mental health practitioners. One view is that violent episodes are rare and can generally, though not always, be managed and avoided with the 'right approach', suitable training and skills. During SALRI's Nursing and Social Work Roundtable, mental health nurses raised the risks associated with CTO home visits. The mental health team must minimise risk to themselves, particularly in cases where the individual has a history of illicit drug use. Consultation revealed violent or aggressive behaviour was also common in hospital, especially ED settings. For example, all attendees at SALRI's Nursing and Social Work Roundtable agreed that higher levels of violence are common, in certain community teams, which are typically drug related, not mental health related.

9.4.6 The risk of violence toward health practitioners is not confined to ED or hospital settings. Various health practitioners and service providers shared their experiences with SALRI as to the threat or use of violence toward them in a community setting, such as while enforcing treatment under a CTO.[1966] SALRI heard that the police are sometimes necessary to ensure the safety of mental health staff.

Current practice of SAPOL powers

9.4.7 In practice, SAPOL may exercise their powers under the *MHA* in a variety of circumstances. They may encounter a mental health-related crisis in the course of their duties or by referral from a triage service or be required to attend after a person calls 000.[1967] They may also support, as SALRI was told, the administration of CTOs by mental health staff or others under the *MHA*.[1968]

9.4.8 Attendance by a police officer becomes more likely as the risk of harm increases and generally occurs once a consumer has reached a crisis point.[1969] When a police officer responds, it is

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[1964] Amy Watson et al, 'Improving Police Response to Persons with Mental Illness: A Multi-Level Conceptualisation of CIT' (2008) 31(4) *International Journal of Law and Psychiatry* 359, 360; Dragana Kesic, Stuart Thomas, and James Ogloff, 'Analysis of Fatal Police Shooting: Time, Space and Suicide by Police' (2012) 39(8) *Criminal Justice and Behaviour* 1107, 1116.

[1965] These include, for example: consumer and officer perceptions, the environment of the mental health crisis, and danger of the situation. See, for example, Joel Godfredson et al, 'Police Discretion and Encounters with People Experiencing Mental Illness' (2010) 37(12) *Criminal Justice and Behaviour* 1392; Fanny de Tribolet-Hardy, Dragana Kesic and Stuart Thomas, 'Police Management of Mental Health Crisis Situations in the Community: Status Quo, Current Gaps and Future Directions' (2015) 25(3) *Policing and Society* 294, 295–6.

[1966] SALRI was advised that while this risk may arise from the consumer, either due to their mental illness or illicit drug use, the risk can also stem from external sources such as others present or the environment where a meeting is occurring.

[1967] Jennifer Teller, 'Crisis Intervention Team Training for Police Officers Responding to Mental Disturbance Calls' (2006) 57(2) *Psychiatric Services* 232, 232–4; Kimberley Horspool, Sarah Drabble and Alicia O'Cathain, 'Implementing Street Triage: a Qualitative Study of Collaboration between Police and Mental Health Services' (2016) 16 *BMC Psychiatry* 1, 2. For South Australian triage service (Crisis Assessment Team) see: Government of South Australia, *SA Health Mental Health Services* <https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/services/mental+health+and+drug+and+alcohol+services/mental+health+services/mental+health+services>. For triage in other Australian jurisdictions, see: Health Direct, *CATT - the crisis assessment and treatment team* <https://www.healthdirect.gov.au/crisis-management>.

[1968] *Mental Health Act 2009* (SA) ss 57(1)(a)(i), 54A(1).

[1969] Joanne Bradbury, Matt Ireland and Helen Stasa, 'Mental Health Emergency Transport: the Pot-Holed Road to Care' (2014) 200(6) *Medical Journal of Australia* 348, 349; Yitzchak Hollander et al, 'Challenges Relating to the

often (especially in regional, rural and remote locations) done so without the assistance or input of mental health specialists.[1970] Police are afforded considerable discretion in responding to mental health crises.[1971] A police officer may resolve the situation themselves without formally using their care and control powers, take the person to the hospital or some other facility, contact a crisis assessment and treatment team (or equivalent) or arrest the person.[1972] The officer has broad power to decide when they may utilise the care and control powers, either with a view to obtaining a treatment outcome, or make an arrest with a view to obtaining a criminal justice outcome.[1973] There is extreme reliance on police to manage and respond to these situations, particularly in the regions. In part, this is because SAPOL is the only agency available to respond to acute mental health crises on a 24/7 basis.[1974]

9.4.9 A large proportion of policing work now consists of responding to welfare incidents or public health issues.[1975] Consequently, there is considerable debate around whether police should remain mental health interventionists or have a reduced role in these circumstances and in the management of persons with mental illness. This debate was evident in SALRI's consultation.

9.4.10 Traditionally, policing has been understood as 'crime fighting' and law enforcement. However, in recent decades, police have been increasingly required to respond more extensively to issues of public welfare and safety.[1976] This has led to police becoming embedded into the broader mental health policy response, requiring them to respond to mental health crises in a capacity that

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Interface Between Crisis Mental Health Clinicians and Police When Engaging with People with a Mental Illness' (2012) 19(3) *Psychiatry, Psychology and Law* 402. Note however, police can still attend where there is little danger.

[1970] Police Federation of Australia, Submission to the Select Committee on Mental Health and Suicide Prevention, *Mental Health and Suicide Prevention Inquiry* (24 March 2021) 9; *Inquest into the Death of Alexander Peter Kuskoff* (2015) 38/2015 (1685/2015) SACC (Schapel, Deputy State Coroner) 35 [6.13]. Co-response models where police and mental health specialists respond to an MHC together, or specialised training models have been trialled in South Australia. These models have been trialled in other Australian jurisdictions, see: Allen Consulting Group, *Police, Ambulance and Clinical Early Response (PACER) Evaluation Report* (2012); The Sellenger Centre for Research in Law Justice and Social Change, *WA Police Force Mental Health Co-Response Evaluation Report* (March 2018); Victoria Herrington et al, *The Impact of the NSW Police Force Mental Health Intervention Team* (Charles Sturt University, December 2009).

[1971] Joel Godfredson et al, 'Police Discretion and Encounters with People Experiencing Mental Illness' (2010) 37(12) *Criminal Justice and Behaviour* 1392; Joel Godfredson et al, 'Police Perceptions of their Encounters with Individuals Experiencing Mental Illness: A Victorian Survey' (2011) 44(2) *Australian and New Zealand Journal of Criminology* 180.

[1972] James Ogloff et al, *The Identification of Mental Disorders in the Criminal Justice System* (Criminology Research Council Consultancy, 2006) 22; Linda Teplin and Nancy Pruett, 'Police as Street Corner Psychiatrist: Managing the Mentally Ill' (1992) 15(2) *International Journal of Law and Psychiatry* 139, 144–54; Amy Watson et al, 'Improving Police Response to Persons with Mental Illness: A Multi-Level Conceptualisation of CIT' (2008) 31(4) *International Journal of Law and Psychiatry* 359.

[1973] Harry Lamb, Linda Weinberger and Walter DeCuir, 'The Police and Mental Health' (2002) 53(10) *Psychiatry Online* 1266; Joel Godfredson et al, 'Police Discretion and Encounters with People Experiencing Mental Illness' (2010) 37(12) *Criminal Justice and Behaviour* 1392.

[1974] Isabelle Bartkowiak-Théron and Nicole Asquith, 'Conceptual Divides and Practice Synergies in Law Enforcement and Public Health: Some Lessons from Policing Vulnerability in Australia' (2017) 27(3) *Policing and Society* 276, 279–80.

[1975] Matthew Morgan and Toby Miles-Johnson, 'Responding to Persons with Mental Illness (PWMI): Police Recruit Perceptions of Mental Health Response Training and Engagement' (2022) 8(1) *Cogent Social Sciences* 1, 2, citing Erin Kruger, 'Mental health and the policing context' in Philip Birch, Michael Kennedy and Erin Krueger (eds), *Australian policing: Critical issues in 21st Century police practice* (Routledge, 2020) 367–82; Commonwealth of Australia, *Inquiry into Mental Health Report of the Productivity Commission,* No 95, vol 1 (2020) 1026.

[1976] Auke van Dijk and Nick Crofts 'Law enforcement and public health as an emerging field' (2017) 27(3) *Policing and Society* 261, 262; Matthew Morgan and Craig Paterson, "It's Mental Health, Not Mental Police': A Human Rights Approach to Mental Health Triage and Section 136 of the Mental Health Act 1983' (2019) 13(2) *Policing: A Journal of Policy and Practice* 123, 123–5.

exceeds 'traditional' law enforcement.[1977] Indeed, internationally and in Australia, novel interagency schemes with the health sector have sought to co-ordinate police responses to incidents involving persons with mental illness and have the potential to positively shape the experiences in instances where police or law enforcement persons are required to be involved.

Practice and experience in metropolitan vs regional contexts

9.4.11 It is not disputed that mental health services are even more difficult to access in regional, rural and remote areas.[1978] This is often attributable to the absence of mental health services and expertise, stigma surrounding mental health, and other challenges associated with geographic barriers to access.[1979] Mental health service delivery is generally more costly, however funding allocation often does not reflect this.[1980] This is compounded by acute workforce shortages within the mental health system.[1981] Often police, as SALRI was also told, are the only emergency agency available to respond to mental health crises in these areas.[1982]

9.4.12 The Rural and Remote Mental Health Service summarised the issues with s 56 and s 57 of the *MHA* powers and how their current use contributes to resource strain in rural and remote areas, explaining:

> The powers of the *MHA* are also used for people with delirium, dementia, intoxication and intellectual disability. These powers are used in this way because:
>
> - The definition of 'mental illness' in the *MHA* is broad enough 'any illness or disorder of the mind' that dementia, delirium, intoxication and intellectual disability will sometimes meet that definition or meet it for a certain period of time.
> - South Australia's health services do not rely on the common law principles (as some other jurisdictions do) of duty of care and defence of necessity to provide involuntary care, control and treatment, meaning that clinicians must use defined legislated powers to keep patients safe and provide treatment.
> - The Government and Drug and Alcohol Services of South Australia have made a policy decision not to use the powers of the *Public Intoxication Act 1984* to establish sobering-up

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[1977] Jennifer Wood et al, *Police Interventions with Persons Affected by Mental Illness: A Critical Review of Global Thinking and Practice* (Centre for Behavioural Health Services and Criminal Justice Research, March 2011) 5; Victoria Herrington and Rodney Pope, 'The Impact of Police Training in Mental Health: an Example from Australia' (2014) 24(5) *Policing and Society* 501, 502; Matthew Morgan and Craig Paterson, "It's Mental Health, Not Mental Police': A Human Rights Approach to Mental Health Triage and Section 136 of the Mental Health Act 1983' (2019) 13(2) *Policing: A Journal of Policy and Practice* 123, 131.

[1978] W Robinson et al, 'Rural Experiences with Mental Illness: Through the Eyes of Patients and their Families' (2012) 30(4) *Fam Syst Health* 308. A strong theme in SALRI's visits and sessions outside Adelaide was the frequent lack of effective mental health services outside Adelaide, Both Berri and Mount Gambier, for example were cited as especially problematic in this context.

[1979] *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021) vol 3, 453–5; Julie Henderson et al, 'Community Mental Health Nursing: Keeping Pace with Care Delivery?' (2008) 17(3) *International Journal of Mental Health Nursing* 162, 167.

[1980] *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021) vol 3, 475.

[1981] Ibid 477.

[1982] Joanne Bradbury, Matt Ireland and Helen Stasa, 'Mental health emergency transport: the pot-holed road to care' (2014) 200(6) *Medical Journal of Australia* 348, 350; Police Federation of Australia, Submission to the Productivity Commission, *Inquiry into Mental Health* (23 January 2020) 2.

centres where people who are intoxicated can be held in custody until they are sober enough to no longer be at risk.

- The emergency powers of section 13 of the *Consent to Medical Treatment and Palliative Care Act 1995* are only useable in limited circumstances for immediately life-threatening situations only, where without immediate intervention the person will die.

These problems impact the use of the *MHA* and the access that people with mental illness have to services because there are a number of related mental conditions, states and/or illnesses that are also being subject to the *MHA*, when there are better ways (clinically and legislatively) to provide safety and treatment for those other people.

The use of the *MHA* for non-mental illness purposes is particularly impactful for rural and remote people as it often results in the person being transported to a different region and/or metropolitan Adelaide, usually with the use of chemical and physical restraint. This results in circumstances where someone who is intoxicated or experiencing delirium, and is brought to their local country hospital, is sedated and netted to a barouche for transport unnecessarily when they could be assessed and treated locally if appropriate legislative or policy means were made available to clinicians.

While the use of the *MHA* in these ways is seemingly lawful, and arguably keeps vulnerable people safe and allows treatment to be commenced to prevent further harm, a regular theme to SALRI was that there are better and more effective ways to address their needs.

9.4.13 The Rural and Remote Mental Health Service added that, in their view:

There are two solutions to this problem:

1. The introduction of the equivalent of s 56 care and control into the Consent to *Medical Treatment and Palliative Care Act 1995*, to enable staff from SAAS, SAPOL, emergency departments, geriatric services, post-surgery services etc to have a defined short-term capacity to keep someone safe in custody and provide treatment, when a person is thought disordered and unsafe, while they work out what might be happening for the person and seek more formal and/or longer-term authority to provide involuntary care. (The Legal and Legislative Policy Unit, Department for Health and Wellbeing, previously drafted and consulted on amendments to the CMTPCA in 2019-20. This work should be revisited and progressed.)

2. The introduction of a policy directive by the Department for Health and Wellbeing that recognises the use of the common law principles of duty of care and defence of necessity, describes how they can be used and must be documented, and describes the protections from liability for clinicians and public officers etc under s 74 of the *Public Sector Act 2009*.

9.4.14 The Victorian Royal Commission recognised the increased challenges that rural and remote areas face and suggested Adult and Older Adult Area Mental Health and Wellbeing Services 'provide a centrally coordinated crisis response function' that combines 'crisis assessment and response functions across multiple area services or even a whole region'.[1983] The Royal Commission explained:

This [centrally coordinated response] is consistent with evidence before the Commission that greater centralisation of triage functions over larger geographical areas promotes consistency of practice, strong clinical governance and accountability, and the development of a workforce that is highly skilled in assessing and responding to requests for urgent assistance. These services will be appropriately resourced to deliver high call-answer rates, with minimal waits to speak with a clinician. They will be equipped with technology to allow video as well as telephone consultations

[1983] *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021) vol 1, 525.

> and high-quality collection of consumer information…[n]ew arrangements for sharing information between service providers, with consumer consent, will provide Area Mental Health and Wellbeing Services with greater access to information about the consumer's history. This will help clinicians make decisions in crisis situations.[1984]

9.4.15 The Royal Commission added:

> In emergency situations, callers will be transferred to Triple Zero (000). The Area Mental Health and Wellbeing Service will collaborate closely with emergency services in these situations and provide necessary assistance. For example, where paramedics attend to a person who they believe can be safely left at home, it may be appropriate for the Area Mental Health and Wellbeing Service to send a crisis outreach team or arrange a same day or next day appointment at a clinic, where possible.[1985]

9.4.16 Overall, consultation revealed more positive experiences with SAPOL involvement in the regions. This was often attributed to the small community size, stronger community and social networking, familiarity and rapport among residents. Despite this, consultation with Aboriginal Elders revealed ambivalence as to the involvement of police officers.

Retaining powers under the MHA

9.4.17 The current system positions police as the 'gatekeepers' for mental health crises, to manage the transition and handover of a consumer to hospital.[1986] As a result, there is concern that the involvement of police officers associates mental illness with criminality. It was emphasised to SALRI that it is not a crime to have a mental illness and police presence merely contributes to this stigma.[1987]

9.4.18 It has been argued that police are compelled to act as 'streetcorner psychiatrists'[1988] or 'society's de facto 24/7 mental health workers'.[1989] However, as has been noted, police are not medical or mental health professionals. Their lack of detailed medical training or mental health expertise makes them ill-equipped to assess a person's mental state.[1990] This is compounded by the fact that '[t]he

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[1984] *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021) vol 1, 525.

[1985] Ibid.

[1986] See, for example, Harry Lamb, Linda Weinberger and Walter DeCuir, 'The Police and Mental Health' (2002) 53(10) *Psychiatry Online* 1266; Arthur Lurigio and Amy Watson, 'The Police and People with Mental Illness: New Approaches to a Longstanding Problem' (2010) 10(1-2) 3, 3–5; Joel Godfredson et al, 'Police Discretion and Encounters with People Experiencing Mental Illness' (2010) 37(12) *Criminal Justice and Behaviour* 1392; Jennifer Wood et al, *Police Interventions with Persons Affected by Mental Illness: A Critical Review of Global Thinking and Practice* (Centre for Behavioural Health Services and Criminal Justice Research, March 2011) 7; Matthew Morgan and Craig Paterson, '"It's Mental Health, Not Mental Police": A Human Rights Approach to Mental Health Triage and Section 136 of the Mental Health Act 1983' (2019) 13(2) *Policing: A Journal of Policy and Practice* 123, 125.

[1987] See, for example, Harry Lamb et al, 'Outcome for Psychiatric Emergency Patients seen by an Outreach Police-Mental Health Team' (1995) 46(12) *Psychiatric Services* 1267; Jennifer Schulenberg, 'Police Decision-Making in the Gray-Zone: The Dynamics of Police-Citizen Encounters with Mentally Ill Persons' (2015) 43(4) *Criminal Justice and Behaviour* 459, 477; Harry Lamb and Linda Weinberger, 'Understanding and Treating Offenders with Serious Mental Illness in Public Sector Mental Health' (2017) 35(4) *Behavioural Sciences and the Law* 303, 305. Some 40 % of persons entering prison in Australia report a previous mental health diagnosis: Australian Institute of Health and Welfare, *The Health of Australia's prisoners 2018* (Catalogue No PHE 246, 2019) vi.

[1988] Linda Teplin and Nancy Pruett, 'Police as Streetcorner Psychiatrists: Managing the Mentally Ill' (1992) 15 *International Journal of Law and Psychiatry* 139.

[1989] Gilla Shario et al, 'Co-Responding Police-Mental Health Services: a Review' (2014) 42(5) *Administration and Policy in Mental Health and Mental Health Services Research* 606.

[1990] Matthew Morgan and Toby Miles-Johnson, 'Responding to Persons with Mental Illness (PWMI): Police Recruit Perceptions of Mental Health Response Training and Engagement' (2022) 8(1) *Cogent Social Sciences* 1, 5; Stuart Thomas and Amy Watson, 'A Focus for Mental Health Training for Police' (2017) 3(2) *Journal of Criminological*

potential for a police officer to engage with use-of-force decisions is inherent in the nature of the responsibilities of operational policing'.[1991] Further issues occur as police may be resistant to accept their role in responding to mental health situations as legitimate.[1992] Consequently, this led to the enquiry of police involvement and whether it should be limited to situations of public safety, or where an individual poses a risk of harm to themselves or others.[1993]

9.4.19 The police are placed in a difficult position through no fault of their own.[1994] As one study observes:

> The police are typically the first and often the sole community resource called on to respond to urgent situations involving persons with mental illness. They are responsible for either recognising the need for treatment for an individual with mental illness and connecting the person with the proper treatment resources or making the determination that the individual's illegal activity is the primary concern and that the person should be arrested. This responsibility thrusts them into the role of primary gatekeepers who determine whether the mental health or the criminal justice system can best meet the needs of the individual with acute psychiatric problems. As a result, law enforcement officers may have assumed the role of 'street-corner psychiatrist' by default. It would appear that many officers have grown accustomed to this role and consider it one of their duties; however, other officers do so reluctantly, and some with resentment.[1995] A major problem with having to fulfill this role is that the police have little training in performing this kind of triage.[1996]

9.4.20 The distress extends to carers and parents.[1997] As a parent told the Royal Commission:

> It is heartbreaking seeing your child being forcibly taken for treatment. Whilst the Police do the best they can, there should be other options before it becomes life threatening for either the consumer or the family member.[1998]

Research, Policy and Practice 93; John McDaniel, 'Reconciling Mental Health, Public Policing and Police Accountability' (2019) 92(1) *The Police Journal: Theory, Practice and Principles* 72, 79.

[1991] Amanda Davies, 'Shoot/do not Shoot – What are the Influences? The Police Recruit Perspective' (2017) 27(5) *Policing and Society* 494. Also see: Anthony O'Brien and Katey Thom, 'Police Use of TASER Devices in Mental Health Emergencies: A Review' (2014) 37(4) *International Journal of Law and Psychiatry* 421.

[1992] Toby Miles-Johnson and Matthew Morgan, 'Operational response: Policing persons with mental illness in Australia' (2022) 55(2) *Journal of Criminology* 260, 272 ('Operational Response'); Rhiannon Lane, '"I'm a Police Officer not a Social Worker or Mental Health Nurse": Online Discourses of Exclusion and Resistance Regarding Mental Health-Related Policework' 29(5) *Journal of Community Applied Social Psychology* 429, 438; Dorothy Cotton, 'The Attitudes of Canadian Police Officers toward the Mentally Ill' (2004) 27(2) *International Journal of Law and Psychiatry* 135, 143–4.

[1993] Toby Miles-Johnson and Matthew Morgan, 'Operational response: Policing persons with mental illness in Australia' (2022) 55(2) *Journal of Criminology* 260, 267–8; *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021) vol 1, 564; Anne Fry et al, 'Social Control Agents or Front-Line Carers for People with Mental Health Problems: Police and Mental Health Services in Sydney, Australia' (2002) 10(4) *Health and Social Care in the Community* 277, 283.

[1994] A recurring theme in SALRI's consultation was avoiding direct criticism of SAPOL, consultees noted that the police are left with a very difficult task under the *Mental Health Act 2009* (SA). See also Joel Godfredson et al, 'Police Perceptions of their Encounters with Individuals Experiencing Mental Illness: A Victorian Survey' (2011) 44(2) *Australian and New Zealand Journal of Criminology* 180.

[1995] See also Randy Borum, 'Improving High-Risk Encounters Between People with Mental Illness and the Police' (2000) 28 *Journal of the American Academy of Psychiatry and the Law* 332, 332–7.

[1996] Harry Lamb, Linda Weinberger and Walter DeCuir, 'The Police and Mental Health' (2002) 53(10) *Psychiatry Online* 1266.

[1997] This theme also strongly emerged in SALRI's consultation.

[1998] *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021) vol 4, 371.

9.4.21 It should be noted that not all parties find the police input negative. Throughout the Royal Commission's community consultation, 'many people spoke of how police were, in some instances, the only services that responded when they asked for help'.[1999]

9.4.22 The Victorian Royal Commission also identified that it is necessary to 'ensure that, wherever possible, emergency services' responses to people experiencing time-critical mental health crises are led by health professionals rather than police.'[2000] The rationale is that 'Police will be involved only where necessary to protect people's safety'.[2001]

9.4.23 These views were reiterated by many parties from various perspectives in SALRI's consultation. However, it was also acknowledged that the police role under the *MHA* is inevitable. As SAPOL explained:

> It is acknowledged that mental health is predominantly an SA Health issue, however, given the volume of mental health related events that is continuing to increase, the time spent by patrols on mental health events and the lack of a timely response by mental health services, SAAS and Hospital ED's, a strategy to create a more efficient system and reduce demand on SAPOL resources is needed pending the implementation of a more effective mental health system.

9.4.24 SALRI agrees with these comments. It is inevitable that the police will retain a significant role under the *MHA*, preferably under a co-response model. SALRI also supports the vital premise that police ideally should be involved only where necessary to ensure safety.[2002]

9.4.25 The implications upon police exercising their duties under the *MHA* are significant and often overlooked.[2003]

9.4.26 A 2018 English study by Her Majesty's Inspectorate of Constabulary and Fire and Rescue Services ('HMICFRS') *Policing and Mental Health: Picking up the Pieces* Report focuses on a range of issues regarding the role of police in mental health settings. From its title, the main thrust of the HMICFRS Report is clear:

1. The police are called upon to respond to too many people experiencing mental health crisis. This is not considered an appropriate use of police resources.
2. The concern is repeated that police officers have not been adequately trained to support people in the midst of a mental health crisis.
3. It may also put people who are experiencing a crisis at greater risk – they may not receive appropriate treatment or the mental health concerns may not be identified by officers.

[1999] Ibid.

[2000] *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021) vol 5, 237.

[2001] Ibid 85.

[2002] Ibid 237–85. 'The Commission's consultations on crisis responses revealed universal agreement that people experiencing mental health crises should receive a health-led response in the community wherever possible. Although some participants recalled positive experiences with police, they noted that police are not – and should not be expected to be – experts in responding to people experiencing mental illness or psychological distress': at vol 1, 560. SALRI agrees with these comments.

[2003] There is not only the operational demands on policing, but the implications for individual officers. See further Nicola Mclean and Lisa Marshall, 'A Front Line Police Perspective of Mental Health Issues and Services' (2010) 20 *Criminal Behaviour and Mental Health* 62; Joel Godfredson et al, 'Police Discretion and Encounters with People Experiencing Mental Illness' (2010) 37(12) *Criminal Justice and Behaviour* 1392' Mark Carroll, 'Mental Health System Overburdening Police' (2005) 88(6) *Police Journal* 18.

4. It is clearly the case that police officers have a range of transferable skills that they can use in these situations. However, this is not quite the same as feeling properly trained and supported to respond.[2004]

9.4.27 These findings, though expressed in an English context, have application for Australia,[2005] and are also consistent with the themes in SALRI's consultation.

Transport to emergency departments

9.4.28 When detained under s 57 *MHA* police commonly transport the person with mental illness to a hospital emergency department ('ED') for medical examination. This situation is problematic and less than ideal in dealing with persons with mental illness. The ED may not be the appropriate place of care for many consumers as it is a volatile high-stimulus environment which can escalate or exacerbate a mental health crisis.[2006] This raises a separate issue, pertaining to the current practice of using the ED for mental health-related attendances. The primary issue identified in SALRI's consultation were the long wait times, whereby SAPOL accompany the consumer until handover occurs.

Rationale for the co-response model

9.4.29 The co-response model received strong support in SALRI's consultation. SAPOL, in particular, made clear its support for implementation of this model. The benefits of a co-response model were often raised.

9.4.30 The role of police as mental health interventionists exists within a broader public health policy framework. Collaboration between public health agencies and police is integral to effectively handling mental health crises.[2007] However, the present system is fragmented as different service providers function largely in cultural and operational 'silos'.[2008]

9.4.31 The rationale of this model is:

> The co-responding police-mental health program involves a collaboration of specially trained police officers and mental healthcare workers that provide on-site services to EDPs in the community. The theory underlying these programs is that a joint response is preferable as police are specialists in handling situations that involve violence and potential injury while mental health professionals are specialists in providing mental health consultation to officers and mental health care to individuals in crisis…. There are multiple objectives for the co-responding police-mental health program, including: deescalating crises, preventing injuries to individuals in crisis and the

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[2004] Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services, *Policing and Mental Health: Picking up the Pieces* (2018).

[2005] See, for example, Katrina Clifford, 'The Thin Blue Line of Mental Health in Australia' (2010) 11(4) *Police Practice and Research* 355; Joel Godfredson et al, 'Police Discretion and Encounters with People Experiencing Mental Illness' (2010) 37(12) *Criminal Justice and Behaviour* 1392; Toby Miles-Johnson and Matthew Morgan, 'Operational response: Policing persons with mental illness in Australia' (2022) 55(2) *Journal of Criminology* 260.

[2006] Maria Duggan et al, *Nowhere else to go: Why Australia's Health System Results in People with Mental Illness Getting 'Stuck' In Emergency Departments* (September 2020) 1–2.

[2007] Jennifer Schulenberg, 'Police Decision-Making in the Grey Zone: The Dynamics of Police Citizen Encounters with Mentally Ill Persons' (2016) 43(4) *Criminal Justice and Behaviour* 459, 477.

[2008] Ibid, 477–8; Isabelle Bartkowiak-Théron and Nicole Asquith, 'Conceptual Divides and Practice Synergies in Law Enforcement and Public Health: Some Lessons from Policing Vulnerability in Australia' (2017) 27(3) *Policing and Society* 276, 284–6; Katie Biley et al, 'Barriers and facilitators to implementing an urban co-responding police-mental health team' (2018) 6(21) *Health and Justice* 1, 9.

> response team, linking individuals who are experiencing psychiatric emergencies to appropriate services in the community, and reducing pressure on both the justice system (e.g. by decreasing arrests and officer's time involved with handling psychiatric emergency situations) as well as the health care system (e.g. by decreasing unnecessary visits to the emergency department). Furthermore, these programs often aim to be accountable and cost effective. A coordinated approach is needed in order to optimally achieve these goals.[2009]

9.4.32 To facilitate a coordinated approach, roles and responsibilities between health agencies and SAPOL must be delineated. All Australian jurisdictions have introduced 'Memoranda of Understanding' ('MOUs') or protocols between police and relevant health agencies.[2010] Importantly, these MOUs facilitate information sharing between agencies.[2011] The distribution of information from health bodies to police regarding a consumer's health history prior to police response is seen as imperative to achieving positive mental health crises responses. When an attending police officer possesses this information, the officer is better appraised and can tailor their approach to the situation accordingly.[2012] In some Australian jurisdictions, the lack of information sharing was a contributing factor to fatalities in the course of police responses.[2013]

9.4.33 Problematically, MOUs do not always translate into outcomes. Information sharing is limited in practice and responsibility for information sharing is often unclear.[2014] For example, police are only supposed to be used as a 'last resort' (as SALRI was also told) when transporting a person in a mental health crisis.[2015] However, as police are generally the first responders to mental health crises, they often end up transporting the consumer.[2016]

[2009] Gilla Shario et al, 'Co-Responding Police-Mental Health Services: a Review' (2014) 42(5) *Administration and Policy in Mental Health and Mental Health Services Research* 606, 607–8. See also Harry Lamb et al, 'Outcome for Psychiatric Emergency Patients seen by an Outreach Police-Mental Health Team' (1995) 46(12) *Psychiatric Services* 1267.

[2010] Police Federation of Australia, Submission to the Select Committee on Mental Health and Suicide Prevention, *Mental Health and Suicide Prevention Inquiry* (24 March 2021) 26.

[2011] See, for example: Royal Flying Doctor service, SA Health, South Australian Ambulance Service and South Australia Police, *Mental Health and Emergency Services Memorandum of Understanding*, (14 July 2010) 19–20; NSW Health and NSW Police, *NSW Health NSW Police Force Memorandum of Understanding* (22 December 2017) 1.3; State Government of Victoria and Victoria Police, *Department of Health and Victoria Police Protocol for Mental Health* (2010) 29–32.

[2012] Victoria Herrington et al, *The Impact of the NSW Police Force Mental Health Intervention Team* (Charles Sturt University, December 2009) 37; Brian McKenna et al, 'Police and Mental Health Clinician Partnership in Response to Mental Health Crisis: A Qualitative Study' (2015) 24(5) *International Journal of Mental Health Nursing* 386, 389–92.

[2013] *Inquest into the deaths of Anthony William Young, Shaun Basil Kumeroa, Edward Wayne Logan, Laval Donovan Zimmer and Troy Martin Foster* (2017) 2013/2988; 2014/3598; 2014/4321; 2014/4239; 2014/4357 Coroners Court of Queensland (Ryan, State Coroner)136–148; *Inquest into the Death of Alexander Peter Kuskoff* (2015) 38/2015 (1685/2015) SACC (Schapel, Deputy State Coroner) 99 [20.3]; Victor Adebowale, *Independent Commission on Mental Health and Policing Report* (2013) 23.

[2014] Fanny de Tribolet-Hardy, Dragana Kesic and Stuart Thomas, 'Police Management of Mental Health Crisis Situations in the Community: Status Quo, Current Gaps and Future Directions' (2015) 25(3) *Policing and Society* 294, 300–1; Yitzchak Hollander et al, 'Challenges Relating to the Interface Between Crisis Mental Health Clinicians and Police When Engaging with People with a Mental Illness' (2012) 19(3) *Psychiatry, Psychology and Law* 402, 406–8; Victoria Herrington et al, *The Impact of the NSW Police Force Mental Health Intervention Team* (Charles Sturt University, December 2009) 36–7.

[2015] Royal Flying Doctor service, SA Health, South Australian Ambulance Service and South Australia Police, *Mental Health and Emergency Services Memorandum of Understanding*, (14 July 2010) 5; NSW Health and NSW Police, *NSW Health NSW Police Force Memorandum of Understanding* (22 December 2017) 3.3.2; State Government of Victoria and Victoria Police, *Department of Health and Victoria Police Protocol for Mental Health* (2010) 8.

[2016] Tasmin Short et al, 'The Nature of Police Involvement in Mental Health Transfers' (2014) 15(4) *Police Practice and Research* 336, 344; Police Federation of Australia, Submission to the Select Committee on Mental Health and Suicide Prevention, *Mental Health and Suicide Prevention Inquiry* (24 March 2021) 26.

9.4.34 A police officer cited in one study described his role dealing with persons with mental illness as a 'never ending cycle of hospital transport' and proposed that mental health nurses under a co-response model are well placed to assist police and provide alternatives to ED transport.[2017]

9.4.35 The Victorian Government advised the Royal Commission that a lack of mental health services is leading to an increased reliance on police. The Commission's interim report stated that between 2014 and 2018, mental health transfers, where police transfer a person experiencing a mental health crisis to hospital, increased by 13 per cent annually, and 'psychiatric crisis' or 'suicide attempt or threat' computer-aided dispatch events increased by 10.9 per cent annually. In comparison, non-mental health computer-aided dispatch events increased by 3.6 per cent each year. In 2017–18 Victoria Police attended 43,000 events relating to a psychiatric crisis or suicide attempt or threat and conducted 14,000 transfers to an emergency department or designated health facility for an urgent mental health response. Police responded to mental health callouts on average once every 12 minutes in that year. Victoria Police observed that 'for many of these callouts, a health-based intervention, rather than a law enforcement one, would have likely been the most beneficial response'. In his evidence to the Royal Commission, Assistant Commissioner Glenn Weir, Victoria Police, noted that 'unnecessary contact between police and people experiencing mental health issues should be minimised as this can compound stigma and add to the person's trauma, leading to suboptimal outcomes'.

9.4.36 Fitzroy Legal Service described the current approach of sending police as first responders as failing to 'meaningfully engage people with appropriate community services' and that it may cause harm through the 'trauma and stigma of a public, at times violent arrest, further criminalisation, and potentially imprisonment.'[2018] The need for alternative, health-based interventions in many of these circumstances is clear.[2019]

9.4.37 SAPOL also made it clear in consultation with SALRI that there are considerable demands placed on police through their duties under the *MHA*. The Police Commissioner's submission provided that police in 2021 had attended 18,467 mental health related incidents. Further, time spent on phone calls relating to mental health crises increased by 87% over the last five years. These demands on police have only been compounded by COVID-19. SAPOL officers spend an 'inordinate amount of time' either waiting for an ambulance to attend or waiting for a consumer to be assessed. If police use their powers under s 57, officers are frequently required to remain at EDs for extended periods until care and control can be transferred. The Commissioner observed that the demands on SAPOL under the *MHA* are such that 'it has a significant impact on SAPOL resources and its ability to provide other core functions'.

9.4.38 These strains on police resources are a symptom of a larger problem. The health system cannot keep up with demand for care, making mental health care often inaccessible.[2020] This issue is twofold. First, the lack of access to early intervention leads to the person reaching a point of crisis,

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[2017] Abirami Kirubarajan, 'What Can We Expect of Police in the Face of Deficient Mental Health Systems: Qualitative Insights from Chicago Police Officers' (2021) 29 *Journal of Psychiatric Mental Health Nursing* 504.

[2018] *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021) vol 3, 364.

[2019] Ibid, 362–3.

[2020] *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021) vol 1, 517; Terry Coleman and Dorothy Cotton, 'A Strategic Approach to Police Interactions with People with a Mental Illness' (2016) 1(2) *Journal of Community Safety and Wellbeing* 7; Office of the Public Advocate (Queensland), *Preserving Life and Dignity in Distress: Responding to Critical Mental Health Incidents - Discussion Paper 4* (March 2005) 11.

which could have otherwise been prevented.[2021] Secondly, when police refer a person to a hospital or mental health facility, they may not meet admission criteria, or is often unable to access suitable treatment and is consequently discharged without adequate support. Consumers unable to receive proper care in these circumstances lead to a 'bounce-back' problem so police respond again to consumers in crisis they have previously attended on.[2022]

9.4.39 This pattern was highlighted in SALRI's consultation as a regular and frustrating event, notably by health practitioners, support agencies and mental health practitioners. It was said that all too often consumers are dealt with by the police under s 57 and are taken to hospital (potentially diverting police resources for several hours), to only be promptly discharged following involuntary attendance at the ED. One Mount Gambier practitioner referred to this as 'turf and surf' and a particular problem in Mount Gambier.[2023]

9.4.40 The Victorian Royal Commission explained:

> The Commission's strategy also aims to reduce police involvement in mental health crises. It has recommended a major shift away from police being the first responders in these situations, moving instead towards a health-led response. Wherever possible and safe, Ambulance Victoria will be the default emergency services responder when people call Triple Zero (000). Police will be involved only where necessary to ensure the safety of consumers, families, carers and supporters, workers and/or the community. This reform will establish the comprehensive, networked system of crisis supports that is critical to ensuring people are not drawn unnecessarily into settings and situations that may worsen their illness and distress.[2024]

9.4.41 The Victorian Royal Commission was clear 'police will be involved only where necessary to protect people's safety.'[2025] They recommended:

> … that the Victorian Government: 1. ensure that, wherever possible, emergency services' responses to people experiencing time-critical mental health crises are led by health professionals rather than police. 2. support Ambulance Victoria, Victoria Police and the Emergency Services Telecommunications Authority to work together to revise current protocols and practices such that, wherever possible and safe: a. Triple Zero (000) calls concerning mental health crises are diverted to Ambulance Victoria rather than Victoria Police; and b. responses to mental health crises requiring the attendance of both ambulance and police are led by paramedics (with support from mental health clinicians where required). 3. ensure that mental health clinical assistance is available to ambulance and police via: a 24-hours-a-day telehealth consultation system for officers

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[2021] Senate Select Committee on Mental Health, *A national approach to mental health – From Crisis to community – First Report* (Parliament of Australia, 2006) 18.

[2022] See also Nicola Mclean and Lisa Marshall, 'A Front Line Police Perspective of Mental Health Issues and Services' (2010) 20 *Criminal Behaviour and Mental Health* 62, 63; Commonwealth of Australia, *Inquiry into Mental Health Report of the Productivity Commission,* No 95, vol 1 (2020) 1032; Police Federation of Australia, Submission to the Productivity Commission, *Inquiry into Mental Health* (23 January 2020) 2.

[2023] See also Nicola Mclean and Lisa Marshall, 'A Front Line Police Perspective of Mental Health Issues and Services' (2010) 20 *Criminal Behaviour and Mental Health* 62, 63. An Australian Study of individuals detained by police under care and control powers determined that 67% of persons involuntarily detained by police were discharged and did not go on to be hospitalised, being deemed as not requiring immediate treatment and care. See Karim Al-Khafaji et al, 'Characteristics and Outcome of Patients brought to an Emergency Department by Police under the Provisions (Section 10) of the Mental Health Act in Victoria, Australia' (2014) 37(4) *International Journal of Law and Psychiatry* 415. See also the similar findings by Beth Ward et al, 'Characteristics and Outcome of Patients Transported by Police to Emergency Departments under Section 351 of the *Mental Health Act 2014* (Vic)' (2022) 34(2) *Emergency Medicine Australasia* 263.

[2024] *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021) vol 1 519–20.

[2025] Ibid vol 1, 85.

responding to mental health crises; b. in-person co-responders in high-volume areas and time periods; and c. diversion secondary triage and referral services for Triple Zero (000) callers who do not require a police or ambulance dispatch.

The co-response model

9.4.42 These sentiments are compelling. However, a health-led response is being trialled in the Northern Adelaide Local Health Network and more recently, the Central Adelaide Local Health Network to determine its efficacy and tailor the model to the mental health system in South Australia.

9.4.43 Each Australian State (with Tasmania currently commencing a trial) has implemented a type of co-response model. The Victorian model combines a police officer and a mental health clinician responding to mental health-related police events as a secondary response. There are 19 Mental Health and Police ('MHaP') response teams across Victoria. Two reviews have been positive.[2026] A similar model exists in NSW.[2027] Models have also run with some success in Western Australia[2028] and Queensland.[2029] At its centre, the co-response model involves a 'co-response unit' composed of a police officer, a mental health clinician, and dependant on the model, a paramedic, who attend a mental health crisis.[2030] Within the co-response unit the police ensure safety of the parties involved, and the mental health clinician assesses the consumer's mental state and determines appropriate care and transport.[2031] A paramedic is included in the co-response unit to provide medical treatment and some types of medication to the consumer if required. Interagency collaboration also allows the crisis response unit to access police and health databases to assist decision-making throughout the response.[2032]

9.4.44 It should be noted that s 56 of the *MHA* giving authorised officers 'care and control' powers already allows the co-response model to occur in practice in South Australia.

9.4.45 From August 2022, SAPOL partnered with Northern Adelaide Local Health Network's Division of Mental Health and are now trialling a co-response team where a mental health clinician and police officer respond together to guide consumers into appropriate care pathways and improve outcomes for community and consumer. The trial is 12 months and operates seven days a week from 11am to 11pm.

9.4.46 There is only limited research as to the effectiveness of co-response models.[2033] For example, one study looking at the evidence to date was struck by 'a striking lack of evidence for the

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[2026] SALRI is grateful for the material provided by Inspector Julian Coram of SAPOL.

[2027] In NSW, mental health clinicians operate solo from a police station supporting police mental health events and as a secondary response, mental health clinicians attend and undertake assessments when the scene is safe. This scheme covers 15 sites across metro NSW and 2 regional sites with $6.1million funding from April 2020.

[2028] Pamela Henry and Nikki Rajakaruna, *WA Police Force Mental Health Co-Response Evaluation Report* (29 March 2018).

[2029] Jan Robertson et al, 'Cairns Mental Health Co-Responder Project: Essential Elements and Challenges to Programme Implementation' (2019) 29(3) *International Journal of Mental Health Nursing* 1.

[2030] This is set out in SAPOL's helpful submission to SALRI.

[2031] Allen Consulting Group, *Police, Ambulance and Clinical Early Response (PACER) Evaluation* (18 April 2012) 24; Pamela Henry and Nikki Rajakaruna, *WA Police Force Mental Health Co-Response Evaluation Report* (29 March 2018) 55; Canberra Health Services, *PACER Fact Sheet* (2020).

[2032] Allen Consulting Group, *Police, Ambulance and Clinical Early Response (PACER) Evaluation* (18 April 2012) 25; Jan Robertson et al, 'Cairns Mental Health Co-Responder Project: Essential elements and challenges to programme implementation' (2019) 29(3) *International Journal of Mental Health Nursing* 1, 3.

[2033] Stephen Puntis, 'A Systematic Review of Co-Responder Models of Police Mental Health "Street" Triage' (2018) 18(1) *BMC Psychiatry* 256.

effectiveness of co-response models of triage despite the substantial investment these services have received.'[2034]

9.4.47 However, many studies have reported the effectiveness of the co-response model.[2035] The benefits of the model was also raised to SALRI by SAPOL and others. Evaluations demonstrate the co-response model provides better health outcomes for consumers and connection with support services,[2036] including the reduced use of force,[2037] reduced ED presentations[2038] (also raised by SAPOL), reduced ED waiting time,[2039] and reduced consumer arrests and detention.[2040]

9.4.48 These benefits were also reinforced by SAPOL, who noted:

> Evaluation reports have been conducted on a number of these models and results have proven to;
>
> - reduce police time spent on scene
> - release the primary responding patrol from the scene earlier
> - reduce conveyances to ED's
> - reduce time spent waiting in ED's
> - provide more efficient assessments of detainees in custody
> - provide a better outcome for those experiencing a mental health crisis

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[2034] Ibid 274.

[2035] See, for example, Gilla Shario et al, 'Co-Responding Police-Mental Health Services: a Review' (2014) 42(5) *Administration and policy in Mental Health and Mental Health Services Research* 1; Laura Mulgrew, 'Co-Responding Police and Mental Health Service Models: an exploration of how Effective Collaborative Models are in Responding to Individuals Experiencing a Mental Health Crisis' (2022) *British Journal of Mental Health Nursing* 1; Etienne Blais et al, 'Assessing the Capability of a Co-Responding Police-Mental Health Program to Connect Emotionally Disturbed People with Community Resources and Decrease Police Use-of-Force' (2022) 18 *Journal of Experimental Criminology* 41.

[2036] See, for example, Stephen Kisely et al, 'A Controlled Before-and-After Evaluation of a Mobile Crisis Partnership between Mental Health and Police Services in Nova Scotia' (2010) 55(10) *Canadian Journal of Psychiatry* 662; Pamela Henry and Nikki Rajakaruna, *WA Police Force Mental Health Co-Response Evaluation Report* (29 March 2018) 55; Jan Robertson et al, 'Cairns Mental Health Co-Responder Project: Essential elements and challenges to programme implementation' (2019) 29(3) *International Journal of Mental Health Nursing* 1, 7; Etienne Blais et al, 'Assessing the Capability of a Co-Responding Police-Mental Health Program to Connect Emotionally Disturbed People with Community Resources and Decrease Police Use-of-Force' (2022) 18 *Journal of Experimental Criminology* 41; Canberra Health Services, *PACER Fact Sheet* (2020).

[2037] Pamela Henry and Nikki Rajakaruna, *WA Police Force Mental Health Co-Response Evaluation Report* (29 March 2018) 89; Jan Robertson et al, 'Cairns Mental Health Co-Responder Project: Essential Elements and Challenges to Programme Implementation' (2019) 29(3) *International Journal of Mental Health Nursing* 1, 5. SAPOL's submission to SALRI also noted this benefit.

[2038] See, for example, Janet Landeen et al, 'Delineating the Population Served by a Mobile Crisis Team: Organising Diversity' (2004) 49(1) *Canadian Journal of Psychiatry* 45; Pamela Henry and Nikki Rajakaruna, *WA Police Force Mental Health Co-Response Evaluation Report* (29 March 2018) 79.

[2039] Allen Consulting Group, *Police, Ambulance and Clinical Early Response (PACER) Evaluation* (Final Report, 18 April 2012) 42.

[2040] Wendy Dyer, Melanie Steer and Paul Biddle, 'Mental Health Street Triage' (2015) 9(4) *Policing* 377; Margaret Heslin et al, 'Costs of the Police Service and Mental Healthcare Pathways Experienced by Individuals with Enduring Mental Health Needs. (2017) 210(2) *British Journal of Psychiatry* 157; Oliver Jenkins et al, 'Police Liaison and Section 136: Comparison of Two Different Approaches' (2017) 41(2) *British Journal of Psychiatric Bulletin* 76; Emma McGeough and Rebecca Foster, *What Works? Collaborative Police and Health Interventions for Mental Health Distress* (2018) 4–5.

9.4.49 In addition, the model is more cost efficient.[2041] SAPOL advised SALRI of the cost value of the Victorian co-response model:

> Two detailed reports have been conducted in 2012 and 2020 on this model. An independent cost analysis of the Victorian model (conducted in 2012), which accounted for Police, Ambulance and Hospital costs, determined that the PACER model was cost effective based on the assumptions made about the data. A further report on the Victorian Model, the Final Evaluation report of Mental Health and Police Response (MHaPR), May 2020, conducted by the Centre for Evaluation and Research Evidence Department of Health and Human Services determined: 'Cost efficiency is indicated with one MHaPR location citing savings of $784,000 per annum to one hospital and $154,000 per annum to another (2017).' These figures have not been verified but are indicative of potentially substantial return on the annual investment of approximately $240,000 per annum per location.

9.4.50 A co-response model also reduces police attendance time at mental health crises[2042] and reduces strain on the hospital system.[2043]

9.4.51 Consumers have also reported more positive perceptions under a co-response model.[2044] Consumers found the co-response service less distressing than standard police responses.[2045] It has been found that a co-response model, whilst not without issues, is less distressing for consumers than standard police responses.[2046] Consumers have reported that previous interactions with the police were traumatic,[2047] and how in prior encounters with police, their illness had been treated as a criminal matter

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[2041] The average cost per crisis response was calculated to be 23% lower with the introduction of the triage program in one analysis: Roger Scott, 'Evaluation of a Mobile Crisis Program: Effectiveness, Efficiency and Consumer Satisfaction' (2000) 51(9) *Psychiatric Services* 1153. See Allen Consulting Group, *Police*, *Ambulance and Clinical Early Response (PACER) Evaluation* (Final Report, 18 April 2012) 47; Gilla Shario et al, 'Co-Responding Police-Mental Health Services: a Review' (2014) 42(5) *Administration and Policy in Mental Health and Mental Health Services Research* 606, 613–4; Roger Scott, 'Evaluation of a Mobile Crisis Program: Effectiveness, Efficiency and Consumer Satisfaction' (2000) 51(9) *Psychiatric Services* 1153; Margaret Heslin et al, 'Decision Analytic Model Exploring the Cost and Cost-Offset Implications of Street Triage' (2016) 6(2) *BMJ Open* 1; Margaret Heslin et al, 'Costs of the Police Service and Mental Healthcare Pathways Experienced by Individuals with Enduring Mental Health Needs' (2017) 210(2) *British Journal of Psychiatry* 157; Stephen Puntis et al, 'A Systematic Review of Co-Responder Models of Police Mental Health "Street" Triage' (2018) 18 *BMC Psychiatry* 256, 262,; Jan Robertson et al, 'Cairns Mental Health Co-Responder Project: Essential elements and challenges to programme implementation' (2019) 29(3) *International Journal of Mental Health Nursing* 1, 3; Pamela Henry and Nikki Rajakaruna, *WA Police Force Mental Health Co-Response Evaluation Report* (29 March 2018).

[2042] Allen Consulting Group, *Police*, *Ambulance and Clinical Early Response (PACER) Evaluation* (18 April 2012) 32.

[2043] Ibid 35; Jan Robertson et al, 'Cairns Mental Health Co-Responder Project: Essential elements and challenges to programme implementation' (2019) 29(3) *International Journal of Mental Health Nursing* 1, 7; Canberra Health Services, *PACER Fact Sheet* (2020).

[2044] Gilla Shario et al, 'Co-Responding Police-Mental Health Services: a Review' (2014) 42(5) *Administration and Policy in Mental Health and Mental Health Services Research* 606, 614; Stephen Puntis et al, 'A Systematic Review of Co-Responder Models of Police Mental Health "Street" Triage' (2018) 18(1) *BMC Psychiatry* 256, 262–3; Laura Mulgrew, 'Co-Responding Police and Mental Health Service Models: an Exploration of how Effective Collaborative Models are in Responding to Individuals Experiencing a Mental Health Crisis' (2022) *British Journal of Mental Health Nursing* 1.

[2045] Sarah Senker and Matthew Scott, *Essex Street Triage Evaluation December 2015* (2016); Stephen Puntis et al, 'A Systematic Review of Co-Responder Models of Police Mental Health "Street" Triage' (2018) 18(1) *BMC Psychiatry* 256, 263.

[2046] Sarah Senker and Matthew Scott, *Essex Street Triage Evaluation December 2015* (2016); Zoe Hobson, Lynne Grossmith and Paul Dawson, *Research into the London Mental Health Street Triage Pilot* (MOPAC Evidence and Insight, December 2015).

[2047] See, for example, Eloisa Evangelista et al, 'Crisis Averted: how Consumers Experienced a Police and Clinical Early Response (PACER) Unit Responding to a Mental Health Crisis' (2016) 25(4*) International Journal of Mental Health Nursing* 367; Wendy Dyer, Melanie Steer and Paul Biddle, 'Mental Health Street Triage' (2015) 9(4) *Policing* 377;

rather than a mental health one.[2048] Co-response models were viewed as better at facilitating de-escalation, less threatening, and less stigmatising.[2049]

9.4.52 Police officers valued the service and found it reduced the time spent at incidents.[2050] A reduction in the use of police detention has been found.[2051] For example, a UK study by Margaret Heslin et al, found a significant reduction in mental health detentions in custody.[2052]

9.4.53 Stakeholder consultations of a co-response police-mental health program in Victoria reported that 'among the stakeholders consulted in this project [ie the Area Mental Health Service, Victoria Police, and Ambulance Victoria], there is widespread support for improved inter-agency collaboration in responding and managing mental health crises in the community.'[2053] Importantly, police responding with a mental health clinician means the police officer can learn how to better effectively manage a mental crisis in a practical environment.[2054] This can have the flow on effect on aiding to reduce police stigma towards mental illness and persons with lived experience more generally.[2055]

Brian McKenna et al, 'Police and Mental Health Clinician Partnership in Response to Mental Health Crisis: a Qualitative Study' (2015) 24(5) *International Journal of Mental Health Nursing* 386.

[2048] Kara Boscarato et al, 'Consumer Experience of Formal Crisis-Response Services and Preferred Methods of Crisis Intervention' (2014) 23(4) *International Journal of Mental Health Nursing* 287; Eloisa Evangelista et al, 'Crisis Averted: how Consumers Experienced a Police and Clinical Early Response (PACER) Unit Responding to a Mental Health Crisis' (2016) 25(4*) International Journal of Mental Health Nursing* 367; Brian McKenna et al, 'Police and Mental Health Clinician Partnership in Response to Mental Health Crisis: a Qualitative Study' (2015) 24(5) *International Journal of Mental Health Nursing* 386.

[2049] Maritt Kirst et al, 'Examining Implementation of Mobile, Police-Mental Health Crisis Intervention Teams in a Large Urban Centre' (2015) 24(6) *Journal of Mental Health* 369; Kara Boscarato et al, 'Consumer Experience of Formal Crisis-Response Services and Preferred Methods of Crisis Intervention' (2014) 23(4) *International Journal of Mental Health Nursing* 287; Eloisa Evangelista et al, 'Crisis Averted: how Consumers Experienced a Police and Clinical Early Response (PACER) Unit Responding to a Mental Health Crisis' (2016) 25(4*) International Journal of Mental Health Nursing* 367; Brian McKenna et al, 'Police and Mental Health Clinician Partnership in Response to Mental Health Crisis: a Qualitative Study' (2015) 24(5) *International Journal of Mental Health Nursing* 386; Stephen Kisely et al, 'A Controlled before-and-after Evaluation of a Mobile Crisis Partnership between Mental Health and Police Services in Nova Scotia' (2010) 55(10) *Canadian Journal of Psychiatry* 662.

[2050] See, for example, Sarah Senker and Matthew Scott, *Essex Street Triage Evaluation December 2015* (2016); Michelle Fitts and Jan Robertson, *Review of the Cairns Mental Health Co-Responder Project* (2017); Bianca Reveruzzi and Stephen Pilling, *Street Triage: Report on the Evaluation of Nine Pilot Schemes in England* (University College London, March 2016).

[2051] Zoe Hobson, Lynne Grossmith and Paul Dawson, *Research into the London Mental Health Street Triage Pilot* (MOPAC Evidence and Insight, December 2015); Annie Irvine, Lyndsey Allen and Martin Webber, *Evaluation of the Scarborough, Whitby and Ryedale Street Triage service research report* (Department for Social Policy and Social Work, University of York, 2016).

[2052] Margaret Heslin et al, 'Costs of the Police Service and Mental Healthcare Pathways Experienced by Individuals with Enduring Mental Health Needs' (2017) 210(2) *British Journal of Psychiatry* 157; Oliver Jenkins et al. 'Police Liaison and Section 136: Comparison of Two Different Approaches'(2017) 41(2) *British Journal of Psychiatric Bulletin* 76; Patrick Keown et al. 'Too much Detention? Street Triage and Detentions under Section 136 Mental Health Act in the North-East of England: a Descriptive Study of the Effects of a Street Triage Intervention' (2016) 6(11) *BMJ Open* 1.

[2053] Allen Consulting Group, *Police, Ambulance and Clinical Early Response (PACER) Evaluation* (18 April 2012) vii.

[2054] Additionally, this collaboration allows mental health to be discussed more openly about taking care of each other which can further reduce stigma about police experience mental health challenges: Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services, *Policing and Mental Health: Picking Up the Pieces* (November 2018) 48.

[2055] Ibid.

9.4.54 After examining all models implemented in Australia, SAPOL told SALRI it is of the view that the Victorian co-response model is the preferred option to trial.[2056] SAPOL informed SALRI that co-response models can extend past the emergency response of a mental health crisis, explaining:

> Co-responder models also have the ability to attend custodial facilities and conduct mental health assessments of detainees, removing the need for patrols to convey and remain with detainees in ED's in the majority of instances. Mental health clinicians have been utilised in Western Australia within the Perth Watch-house [a custodial facility used to hold alleged offenders awaiting court or bail] to conduct mental health assessments of detainees bought into the watch-house with positive results. In NSW, the co-responder is regularly tasked to cell complexes to conduct mental health assessments of detainees as opposed to conveying to ED's.

9.4.55 Additionally, SAPOL added:

> A SAPOL led co-responder program that attends SAPOL Mental Health events and custodial facilities to conduct mental health assessments will release patrols from these events sooner, reduce detentions and conveyances to ED's and reduce the time being spent guarding detainees in hospitals, therefore reducing overall demand on frontline resources.

9.4.56 A co-response model cannot avoid the necessity for police to attend in at least some circumstances.

9.4.57 Resourcing and operational challenges in regional, rural and remote areas are significant and may mean there will likely be times where a mental health clinician is unavailable to respond with a police officer. In metropolitan areas where a mental health clinician is unavailable, negative impacts on a consumer and the attending police officer can be minimised through use of technology allowing the attending officer to video call a mental health clinician for advice. However, this technology may not be possible in rural and remote areas, where internet connection is less reliable and digital services are less accessible.[2057]

Alternatives to EDs under a Co-response Model

9.4.58 Through SALRI's consultation and research, a particular benefit of a co-response model was reducing long waits in ED for both police and consumers. Under a co-response model, there is scope to divert transport away from the ED, to an alternative location.

[2056] In the Victorian model (the Mental Health and Police Response Program) two co-responder models operate alongside each other from Victoria Police and Ambulance Victoria. A police officer is the first responder to the mental health event who attends the scene and ensures it is safe. If required, the attending officer requests the co-response unit to attend. The co-response unit attends as the second response and relieves the first responding officer upon its arrival if it is safe to do so. This overview was helpfully provided in the SAPOL submission to SALRI.

[2057] Katie Fisher, Andrew Davey and Parker Magin, 'Telehealth for Australian General Practice: The Present and the Future' (2022) 51(8) *Australian Journal of General Practice* 626, 627.

9.4.59 Consumers presenting to an ED for mental health-related challenges typically wait longer for care than non-mental health attendances,[2058] and the care they receive is regularly described as inadequate.[2059] The Australasian Emergency Medical Response College informed SALRI:

> The College is concerned by the lengthy delays to access definitive care that is experienced by people with acute mental health care needs. In the current mental health system, people experiencing mental health crises are subjected to unacceptably long waits in the ED for examination by a psychiatrist and admission into a mental health bed.

9.4.60 They further explained the use of EDs in these circumstances is a symptom of wider health care system issues caused by:

> … the systematic underfunding of specialist mental health services and lack of inpatient capacity has created a situation where patients who should be bypassing EDs altogether are being directed to the ED to await assessment simply because gaps in community and inpatient mental health services have left these people with nowhere else to go.

9.4.61 It is recognised that a consumer experiencing a mental health crisis who presents (or is taken) to the ED prefers a respectful space and environment with low levels of stimulation.[2060] For example, a 'crisis hub', called the Mental Health Observation Area, has been established in Western Australia to provide a calmer and more appropriate environment for consumers experiencing mental health crises. This specialised mental health area is attached to the Joondalup Health Campus. The ED medical practitioners can refer consumers to the Mental Health Observation Area, where they will be admitted and assessed by the psychiatric liaison when the referral is confirmed.[2061]

9.4.62 The value of such facilities in South Australia was emphasised by many parties to SALRI's consultation, including consumers, advocacy groups, service providers and health practitioners. There are existing programs in South Australia that involve a co-response model, though these programs can be expanded.

9.4.63 For example, in South Australia, the Urgent Mental Health Care Centre ('UMHCC') opened in March 2021 and is operated by Neami National. The Centre provides 24/7 support and

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[2058] Simon Judkins et al, 'Mental Health Patients in Emergency Departments are Suffering: the National Failure and Shame of the Current System. A Report on the Australasian College for Emergency Medicine's Mental Health in the Emergency Department Summit' (2019) 27(6) *Australian Psychiatry* 615, 615–6; Australasian College for Emergency Medicine Department of Policy, Research and Advocacy, *The Long Wait: An Analysis of Mental Health Presentations to Australian Emergency Departments* (October 2018) 11–2; Maria Duggan et al, *Nowhere Else to Go: Why Australia's Health System Results in People With Mental Illness Getting 'Stuck' in Emergency Departments* (September 2020) 1, 10.

[2059] Stephen Allison and Tarun Bastiampillai, 'Mental Health Services Reach the Tipping Point in Australian Acute Hospitals' (2015) 203(11) *Medical Journal Australia* 432, 434; Maria Duggan et al, *Nowhere Else to Go: Why Australia's Health System Results in People With Mental Illness "Getting 'Stuck" in Emergency Departments* (September 2020) 1, 10. This theme was also highlighted in SALRI's consultation.

[2060] Maria Duggan et al, *Nowhere Else to Go: Why Australia's Health System Results in People With Mental Illness Getting 'Stuck' in Emergency Departments* (September 2020) 1, 10, 4; *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021) vol 1, 545–6; Victorian and Tasmanian Public Health Network Alliance, Submission, *Royal Commission into Victoria's Mental Health System* (July 2019) 16. Government of Western Australia Department of Health Medical Service Improvement Program, *Service improvement project summaries* (20 November 2015) 5.

[2061] Government of Western Australia Department of Health Medical Service Improvement Program, *Service improvement project summaries* (20 November 2015) 5. This was opposed to the previous system where a consumer presenting to the ED would have to be deemed suitable for admission by an ED doctor, the consumer would have to wait for this decision to be confirmed by the psychiatry liaison team which would cause long wait times and delays; Joondalup Health Campus, *Mental Health Services* <https://www.joondaluphealthcampus.com.au/Services/Mental-Health-Services>.

serves as an alternative to ED for people 'experiencing mental ill-health and distress.' In relation to the UMHCC, Neami National submitted:

> … [the Centre] contributes to reducing the critical issue of long wait times at the nearby Royal Adelaide Hospital and others. UMHCC has been co-designed with people who have experienced mental health crises and aims to challenge traditional models of mental health care for people with acute experiences of mental ill-health.

9.4.64 The use of evidence-based recovery approaches, with an aftercare service for exiting guests ensures assertive follow up when needed. Further, the service is person-centred, providing trauma-informed support and employs a 'peer first, peer last' consumer journey that works to address power imbalance and ensure that the support provided reflects the guests' needs and desires whilst carefully balancing guest safety with the right to dignity of risk.'

9.4.65 The UMHCC team is comprised of peer support workers, mental health nurses, consultant psychiatrists, allied health professionals, senior medical practitioner and nurse practitioners. A referral to the UMHCC may be received from SAPOL, SAAS, Mental Health Triage, consumers and support persons. The UMHCC reduces the burden on hospital EDs and increases accessibility of services for consumers.

9.4.66 Although EDs have an inevitable role to play in the care and treatment of consumers under the *MHA*, there is wide recognition of the need for community-based and non-community-based services that can act as viable alternatives to ED settings and cater to the differing levels of psychological distress and varying needs of persons with mental illness.[2062] As was observed by the Victorian Royal Commission:

> While acknowledging the critical role of hospital emergency departments in assessing and treating some people experiencing a mental health crisis, the Commission recommends new and reformed service elements that will reduce the need for people to attend hospital emergency departments.[2063]

9.4.67 Various Australian jurisdictions, including South Australia,[2064] have established facilities known as 'safe havens' (also known as Crisis Cafés, Crisis Stabilisation Units, and Crisis Respite Facilities) to provide a safe, non-clinical environment for consumers to deescalate their psychological distress.

9.4.68 For example, in South Australia, Sonder is a not-for-profit organisation, with multiple offices located across Adelaide. Sonder offers a Safe Haven to support adults, children and adolescents experiencing mental health concerns, to improve wellbeing and pursue a meaningful, hopeful life.[2065] Sonder is also the lead agency for Headspace Adelaide, Edinburgh North, Onkaparinga and Marion. The Headspace centres serve as a 'one-stop-shop for young people who need help with mental health, physical health, alcohol and other drugs or work and study support.'[2066]

[2062] *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021) vol 1, 548–54.

[2063] Ibid vol 1, 519.

[2064] See, for example Sonder, *About Us* (2023) <https://sonder.net.au/about-us/>.

[2065] Sonder, *About Us* (2023) <https://sonder.net.au/about-us/>.

[2066] Ibid.

9.4.69 These facilities have various names and models, and differ between jurisdictions. However, they are primarily staffed with peer-workers (workers with lived experience),[2067] who link consumers to appropriate services[2068] and are located in residential areas, on hospital campuses, or adjoining a hospital ED.[2069]

9.4.70 Such facilities can be seen as a valuable support to a co-response model. There was wide support in principle, during SALRI's consultation for alternatives to ED to be considered for mental health-related attendances.[2070]

9.4.71 For example, St Vincent's Hospital in Melbourne established a 'crisis café'.[2071] It is located on the hospital campus and open after hours (6-8pm Friday, and 2-8pm on Saturday and Sunday).[2072] Staff would identify persons in the ED who appeared distressed and invite them into the café so they could have a less confronting and more supported environment to de-escalate.

9.4.72 The Victorian Royal Commission heard positive consumer feedback about this program, with one party stating:

> I definitely don't get as lonely as when I started coming here. To the point that I actually might not even come here as regularly as I used to come ... I actually quite enjoy ... leading my own life a bit more. If Safe Haven hadn't been here, it's quite possible I would have been presenting to emergency.[2073]

9.4.73 Crisis Stabilisation Units and Crisis Respite Facilities can involve a short-term stay (with the length of stay appearing to vary between a maximum of 23 hours or 14 days).[2074] One party told the Victorian Royal Commission:

> People who are in distress or who are feeling on the edge of suicide often feel much more comfortable going to respite centres than to places where they are likely to be locked up and possibly secluded. There are many people who will do anything to stay out of an inpatient unit,

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[2067] Katherine Mok et al, *The lived experience perspective of suicide: A rapid review* (July 2020) 39; Note however some Crisis Stabilisation Units and Crisis Respite facilities are staffed with clinical workers e.g. social worker. A peer workforce is highly valued as it provides relatability, normalises mental health, consumers can want to become a peer-worker.

[2068] Caroline Pierotti, Angela Alei and Craig Pacheco 'Crisis Stabilization and Crisis Respite' (2016) *Institute for Social Research* 1, 1–2; Michelle Heyland and Mary Johnson, 'Evaluating an Alternative to the Emergency Department for Adults in Mental Health Crisis' (2017) 38(7) *Issues in Mental Health Nursing* 557, 559; *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021) vol 1, 519.

[2069] See, for example NHS England, *Safe Haven Cafe in Aldershot* <https://www.england.nhs.uk/mental-health/case-studies/crisis-mental-health-case-studies/aldershot/>; *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021) vol 1, 445, 550; St Vincent's Hospital Sydney, *The Safe Haven Café* (2022) <https://www.svhs.org.au/our-services/list-of-services/mental-health/safe-haven>; Royal Perth Hospital, *Safe Haven* (1 July 2022) Government of Western Australia <https://www.rph.health.wa.gov.au/Services/Safe-Haven>.

[2070] Consumers of Mental Health WA, *Alternatives to Emergency Departments* (September 2019) 29.

[2071] Crisis Cafès originated in Aldershot, United Kingdom in 2014. The pilot program saw consumers reporting satisfaction with the service and the trial was cost efficient and continues to this day. Different to the St Vincent's Hospital model, the cafè is not adjoined to a hospital. In this way, the service can also act as a preventative measure to mitigate the chance of the consumer developing crisis symptoms. Although it sees success, the initial evaluation revealed that Visitors sometimes attended the facility for reasons other than de-escalating crisis symptoms.

[2072] St Vincent's Hospital Melbourne and PwC, *Economic Impact of the Safe Haven Café Melbourne* (November 2018) x.

[2073] *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021) vol 1, 551. However, a review of the facility revealed potentials for misuse and persons using facility as an alternative to a homeless shelter: Ibid viii.

[2074] Verletta Saxon et al, 'Behavioral Health Crisis Stabilization Centers: A New Normal' (2018) 2(3) *Journal of Mental Health and Clinical Psychology* 23, 24; Caroline Pierotti, Angela Alei and Craig Pacheco 'Crisis Stabilization and Crisis Respite' (2016) *Institute for Social Research* 1, 1–2.

> but who will willingly approach a respite centre. They will come in under their own steam if they are allowed to, because they feel that there will be people there who understand them, and see it as a place of refuge. The UK studies have shown that people with similar levels of psychopathology and risk find respite centres more acceptable environments to receive treatment in, and the clinical outcomes are at least as good.[2075]

9.4.74 A similar facility is the crisis stabilisation unit located at Robina Hospital on the Gold Coast. The unit was designed and is staffed by clinicians and people with lived experience. It includes eight short stay beds and 12 chairs for consumers experiencing mental distress. Referrals can come from police, the Queensland ambulance service and hospital EDs.[2076] A range of Crisis Stabilisation Units and Crisis Respite Facilities have also been established in the United States.[2077]

9.4.75 Evaluations demonstrate consumers report high satisfaction with these types of facilities as they can assist with the management of crisis symptoms[2078] and support consumers with complex needs.[2079] Further, they reduce ED presentations, relieve pressure on the emergency system,[2080] and are cost effective.[2081]

9.4.76 The Victorian Royal Commission suggested establishing acute crisis stabilisation facilities which mimic crisis respite facilities, but are staffed by mental health practitioners, including psychiatrists, who can administer medication to consumers requiring clinical intervention or consumers engaged in substance misuse.[2082]

9.4.77 Further, it is crucial to note any alternative to ED must be culturally responsive for Aboriginal[2083] consumers. Reports have identified mental health service delivery is often incompatible

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[2075] *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021)21) vol 1, 552.

[2076] Queensland Government, *Queensland's first Crisis Stabilisation Unit opens at Robina Hospital* (30 August 2021) <https://www.goldcoast.health.qld.gov.au/about-us/news/queenslands-first-crisis-stabilisation-unit-opens-robina-hospital>.

[2077] See Caroline Pierotti, Angela Alei and Craig Pacheco 'Crisis Stabilization and Crisis Respite' (2016) *Institute for Social Research* 1.

[2078] Stephen Briggs, Jo Finch and Rhiannon Firth, *Evaluation of a Non-Statutory 'Place of Calm', a Service which Provides Support after a Suicidal Crisis to Inform Future Commissioning Intentions* (April 2016) 4; Alison Griffiths and Katherine Gale, *Independent Evaluation of the North East Hampshire and Farnham Vanguard Aldershot Safe Haven Service* (October 2017) 22; Jill Grant and Anne Westhues, 'Mental Health Crisis/Respite Service: A Process Evaluation' (2012) 10(1) *Social Work in Mental Health* 34, 42–3; Sue Gillieatt et al, 'Evaluation of a West Australian Residential Mental Health Respite Service' (2017) 26(3) *Health and Social Care in the Community* 442, e447.

[2079] Mental Health Crisis Transformation Challenge Award Steering Group, *Mental Health Crisis Care Provision Transformation Programme Interim Evaluation Report* (September 2016) 20–1.

[2080] See: *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021) vol 1, 520; Robyn Kruk et al, *Sustainable Health Review Final Report to the Western Australian Government* (Department of Health, Western Australia, 2018) 65; Katherine Mok et al, *The lived experience perspective of suicide: A rapid review* (July 2020) 26; Carolyn Wood, *Out of Hours Crisis Café for North East Glasgow* (April 2017) 39; Consumers of Mental Health WA, *Alternatives to Emergency Departments* (September 2019) 6.

[2081] St Vincent's Hospital Melbourne and PwC, *Economic impact of the Safe Haven Café Melbourne* (November 2018) vii; Lisa Wood et al, *Choices Post Discharge Project* (November 2019) vi; North East Hampshire and Farnham Clinical Commissioning Group, *'The Safe Haven' Aldershot Evaluation Draft Report 3* (July 2014) 4, 8; Julie Seibert et al, *Crisis Services: Effectiveness, Cost-Effectiveness and Funding Strategies* (2014) 9; Joshua Barocas et al, 'An Economic Analysis of the Cost of a Regional Crisis Stabilization Unit' (2022) 28(1) *Correctional Health Care* 54.

[2082] *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021) vol 1, 519, 555–6.

[2083] In this Chapter, 'Aboriginal' refers to both Aboriginal and Torres Strait Islander people. 'Indigenous' is retained when used as part of the title of a report, program or quotation.

with Aboriginal cultural needs,[2084] which often focus on holistic understandings of social and mental wellbeing.[2085] Failing to recognise this can exacerbate problems, as explained in the Fifth National Mental Health and Suicide Prevention Plan:[2086]

> Non-Indigenous clinicians need to be able to interpret presenting 'symptoms' within the cultural context in which they occur rather than viewing the presenting person solely through the lens of Western clinical practice. However, few non-Indigenous clinicians are trained to understand this, and these gaps in cultural knowledge can lead to misdiagnosis or to mental illness remaining undiagnosed.

9.4.78 It has been suggested that service delivery should have a focus on trauma-informed care[2087] and include Aboriginal peer-workers where possible.[2088] Additionally, it is important to enable connection to family and kinship.[2089]

9.4.79 A study in New Zealand examined the cultural appropriateness of service provisions for Maori patients in various acute care units, including short or long stay facilities.[2090] It found some units incorporated whānau rooms which are a safe space where relatives/friends can visit a consumer.[2091] The study recommended facilities should be redesigned to allocate greater space 'for improved whānau rooms to allow the family to stay connected to tangata whaiora, with provision for sharing kai/eating, sleeping, children and play space.'[2092]

9.4.80 Additionally, the study suggested including cultural practices, for example, a 'whare whakatau' (a formal welcoming space) to accommodate cultural protocols 'around arrival and welcome, gathering, ceremonial events, treatment and activities, discharge and farewell.'[2093] Further, the study proposed interior and exterior facades of facilities should include 'Māori design in the form of wayfinding and expression of Māori narratives, principles and values',[2094] as well as increasing access to therapeutic outdoor spaces which can allow for socialisation and contemplation.[2095]

9.4.81 Whilst a co-response model is not a 'silver bullet' to address the various concerns as to the operation of the *MHA*, SALRI concurs as to the benefits of a co-response model for mental health crises. SALRI notes the ongoing work and trials in South Australia and commends such models to underpin the operation of s 57 of the *MHA*. SALRI suggests that this work is continued, and further

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[2084] Australian Health Ministers' Advisory Council, *A national framework for recovery-oriented mental health services: Guide for clinicians and providers* (2013) 31.

[2085] Patricia Dudgeon et al, *Solutions that Work: What Evidence and Our People Tell Us: Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project Report* (2016) 23; Australian Health Ministers' Advisory Council, *A national framework for recovery-oriented mental health services: Guide for clinicians and providers* (2013) 30.

[2086] National Mental Health Strategy, *The Fifth National Mental Health and Suicide Prevention Plan* (August 2017) 1–30.

[2087] Patricia Dudgeon et al, *Solutions that Work: What Evidence and Our People Tell Us: Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project Report* (2016) 32.

[2088] Ibid 4.

[2089] Australian Health Ministers' Advisory Council, *A national framework for recovery-oriented mental health services: Guide for clinicians and providers* (2013) 50.

[2090] Gabrielle Jenkin et al, 'Contemporary Issues in Acute Mental Health Facility Design: Insights from the Aotearoa-New Zealand Experience' (2022) *Kōtuitui: New Zealand Journal of Social Sciences Online* (forthcoming) 1.

[2091] Ibid 6.

[2092] Ibid 15.

[2093] Ibid.

[2094] Ibid 1.

[2095] Ibid.

investigations are undertaken, with a view to finding suitable alternatives to ED settings for persons experiencing mental health crises.

Training

9.4.82 It is often argued that the police, through no fault of their own, lack the necessary training to effectively manage and respond to mental health crises.[2096] Police may also feel they lack these skills.[2097] '[D]istinguishing between the disordered and the disorderly is a difficult discretionary exercise for police officers, especially in the presence of drugs and/or alcohol'.[2098] These themes were echoed in SALRI's consultation.

9.4.83 Canadian studies by Stephen Kisely et al, and Maritt Kirst et al, provide that the most common reason, responsible for 49%[2099] and 55%[2100] of all mental health related call-outs in the respective studies, was concern for an individual's welfare due to suicidal behaviour. This highlights that police must be equipped to respond to a variety of highly sensitive circumstances, further increasing the need for training.

9.4.84 Where police lack the necessary knowledge and expertise to identify, respond to and manage mental health crises,[2101] they may struggle to use appropriate de-escalation techniques. This may occur if police wrongly assume a consumer will (or can) act irrationally.[2102] Common responses that escalate such situations include when police use standard law enforcement tactics, such as yelling commands, and lacking the understanding that the person may not have the capacity to understand the consequences of non-compliance.[2103] Further, it may also involve the police 'going into' the situation too swiftly where a slower approach would be beneficial.[2104] These situations can also escalate because police do not understand the demeanour or acts of a consumer. The officer may perceive the consumer to be resisting the officer, or pose a greater risk of harm to themselves or others.[2105] This is

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[2096] See, for example, Anne Fry et al, 'Social Control Agents or Front-Line Carers for People with Mental Health Problems: Police and Mental Health Services in Sydney, Australia'(2002)10(4)*Health and Social Care in the Community* 277; Katrina Clifford, 'The Thin Blue Line of Mental Health in Australia' (2010) 11(4) *Police Practice and Research: An International Journal* 355; Joel Godfredson et al, 'Police Perceptions of their Encounters with Individuals Experiencing Mental Illness: A Victorian Survey' (2011) 44(2) *Australian and New Zealand Journal of Criminology* 180; Stuart Thomas and Amy Watson, 'A Focus for Mental Health Training for Police' (2017) 3(2) *Journal of Criminological Research, Policy and Practice* 93.

[2097] William Wells and Joseph Schafer, 'Officer Perceptions of Police Responses to Persons with a Mental Illness' (2006) 29(4) *Policing* 578.

[2098] See also Harry Lamb et al, 'The Police and Mental Health' 126 (2002) *Psychiatric Services* 126.

[2099] Stephen Kisely et al, 'A Controlled before-and-after Evaluation of a Mobile Crisis Partnership Between Mental Health and Police Services in Nova Scotia' (2010) 55(10) *Canadian Journal of Psychiatry* 662.

[2100] Maritt Kirst et al, 'Examining Implementation of Mobile, Police-Mental Health Crisis Intervention Teams in a Large Urban Centre' (2015) 24(6) *Journal of Mental Health* 369.

[2101] Victoria, Office of Police Integrity, Submission to President of the Legislative Council and Speaker of the Legislative Assembly, *Policing People who Appear to be Mentally Ill* (Paper 190, Victorian Government November 2012) 31–32.

[2102] Amy Kerr, Melissa Morabito and Amy Watson, 'Police Encounters, Mental Illness, and Injury: An Exploratory Investigation' (2010) 10(1-2) *Journal of Police Crisis Negotiations* 116, 117.

[2103] Gary Cordner, *People with Mental Illness: Problem-Orientated Guide for Police* (US Department of Justice, Office of Community Oriented Policing Services, 2006) 4; James Fyfe, 'Policing the Emotionally Disturbed' (2000) 28(3) *Journal of the American Academy of Psychiatry Law* 345, 345–7.

[2104] *Inquest into the death of Courtney Topic* (2018) 2015/42730 New South Wales Coroner's Court (Ryan, Deputy State Coroner) 21[168].

[2105]Amy Kerr, Melissa Morabito and Amy Watson, 'Police Encounters, Mental Illness, and Injury: An Exploratory Investigation' (2010) 10(1-2) *Journal of Police Crisis Negotiations* 116, 119; Brian McKenna et al, 'Police and Mental

heightened as officers may perceive persons with mental illness as irrational, violent, volatile and more unpredictable than individuals without mental illness.[2106] This may increase the likelihood of police force being used.[2107] These situations highlight the continuing impact of stigma attached to mental illness and emphasises the need for mental health training.

9.4.85 Other suggestions to de-escalate situations include enhanced training, better information sharing between EDs to identify whether a person has perpetrated violence against staff in the past, and the provision of mental health training or aggression management training to ED nurses.[2108] These suggestions address a risk posed by any person attending ED and does not solely apply to mental health-related attendances. It has also been suggested that peer workers and/or mental health clinicians should be placed in ED to identify persons who may be experiencing a mental health challenge and assist with de-escalation, or facilitate the person's admission to a more suitable service.[2109]

9.4.86 The issue of enhanced police training[2110] in South Australia to enforce the *MHA* and effectively deal with persons with mental illness was raised by many parties in consultation. Such training is important, but not a panacea. Training needs to be viewed in the wider context:

> Police officers require training and experience to work effectively with mentally ill people. Such training must cover three main areas: understanding mental illness; identifying those with mental illness who may be in crisis; and communicating and interacting with them in a non-violent way to reduce their distress and de-escalate them. Most importantly, the training needs to involve opportunities to develop and practice communication and de-escalation skills. Existing … police mental health training programs are highly variable and few have been carefully tested to determine their efficacy in achieving the training aims … Some researchers have been critical of the focus on training, however, noting that it cannot make an appreciable difference without additional infrastructure support for the police and for people with mental illness with whom they come into contact. It is unfortunate that, even with the announced training advances, so little time and resources are dedicated to assist police to work more effectively with people with mental illnesses … On its own, training can help officers better understand mental illness; they may also learn helpful skills for dealing with people who may be irrational. However, better outcomes for people

Health Clinician Partnership in Response to Mental Health Crisis: A Qualitative Study' (2015) 24(5) *International Journal of Mental Health Nursing* 386, 388.

[2106] Kayla Gomez and Stephanie Robertson, 'Attitudes towards Mental Illness' (2022) *Journal of Criminal Justice Education* 1. 10; Sara Soomro and Phillip Yanos, 'Predictors of Mental Health Stigma among Police Officers: the Role of Trauma and PTSD' (2019) 34 *Journal of Police and Criminal Psychology* 175, 181; Laura Oxburgh et al, 'Police Officers' Perceptions and Experiences with Mentally Discorded Suspects' (2016) 49(Part A) *International Journal of Law and Psychiatry* 138, 145.

[2107] Terry Coleman and Dorothy Cotton, 'Reducing Risk and Improving Outcomes of Police Interactions with People with Mental Illness' (2010) 10(1-2) *Journal of Police Crisis Negotiations* 39, 54; Amy Kerr, Melissa Morabito and Amy Watson, 'Police Encounters, Mental Illness, and Injury: An Exploratory Investigation' (2010) 10(1-2) *Journal of Police Crisis Negotiations* 116.

[2108] Hila Dafny, Gavin Beccaria and Amanda Muller, 'Australian Nurses' Perceptions About Workplace Violence Management, Strategies and Support Services' (2021) 30(6) *Journal of Nursing Management* 1629.

[2109] Maria Duggan et al, *Nowhere Else to Go: Why Australia's Health System Results in People With Mental Illness Getting 'Stuck' in Emergency Departments* (September 2020) 4.

[2110] South Australian police already undergo both general and specialist training in this area as SAPOL's submission outlined.

> with mental illness who encounter the police will require a whole-of-government response, including the implementation of safe crisis units and the provision of mental health services.[2111]

9.4.87 Such training can be very helpful to enhance and equip police both generally, and at a specialist level. It can be useful for police to improve the knowledge and skills required to deal with persons with mental illness.[2112] However, as the above quote highlights, it is not a universal solution. This is not to diminish the importance of suitable police training, especially when considered as part of a co-response model which SALRI sees as a desirable model for implementation under the *MHA*.[2113]

The Intersection of Illicit Drug Use and Mental Illness

9.4.88 The intersection of drugs and mental illness was a recurring theme in SALRI's consultation.[2114] The interaction extends beyond the clinical approach, to service delivery and provision.

9.4.89 In the context of this discussion, the increasing prevalence of illicit drug use was raised to SALRI during consultation. A person may use illicit drugs to self-medicate, to cope and/or conceal with mental health symptoms. Alternatively, the use (or prolonged use) of illicit drugs may have led to the development of a mental illness. Consequently, higher numbers of attendances at EDs are drug related, and the risks of violence or aggression, particularly caused by illicit drug use, has increased.

9.4.90 The implications of this complex and largely unclear intersection, was also highlighted by the Victorian Royal Commission, which observed:

> Victoria's alcohol and other drug sector sees an increasing number of consumers who have complex support needs, including those relating to mental illness and psychological distress. Submissions from Victoria's alcohol and other drug services have identified a range of challenges

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[2111] James Ogloff and Stuart Thomas, *Training Police to Better Respond to People with Mental Illness* (4 March 2014) The Conversation <https://theconversation.com/training-police-to-better-respond-to-people-with-mental-illness-23651>.

[2112] See, for example, Joel Godfredson et al, 'Police Perceptions of their Encounters with Individuals Experiencing Mental Illness: A Victorian Survey' (2011) 44(2) *Australian and New Zealand Journal of Criminology* 180. Victoria Herrington and Rodney Pope, 'The Impact of Police Training in Mental Health: An Example from Australia' (2013) 23(5) *Policing and Society* 501; Yasmeen Krameddine and Peter Silverstone,' 'How to Improve Interactions between Police and the Mentally Ill' (2014) 5 *Front Psychiatry* 186; Jennifer Wood and Amy Watson, 'Improving Police Interventions During Mental Health-Related Encounters: Past, Present and Future' (2017) 27(3) *Policing and Society* 289; Matthew Morgan and Toby Miles-Johnson., 'Responding to Persons with Mental Illness (PWMI): Police Recruit Perceptions of Mental Health Response Training and Engagement' (2022) 8(1) *Current Social Sciences* 1. The value of such training, both in general and specialist terms, was reiterated in SALRI's consultation.

[2113] The results to date, though incomplete, regarding the effectiveness of the co-response model to deal with mental health crises are encouraging.

[2114] The Alcohol and Drug Foundation, for example, explained; 'Mental health is the result of interactions between a range of determinants of health across a person's life course. One of these determinants is if, when, and how a person uses alcohol and other drugs. The relationship between AOD use and mental health is complex and bidirectional. The consumption of AOD can make a mental health condition worse, and people with a mental health condition or who are experiencing short-term mental distress can turn to alcohol and other drug use as a coping strategy in response to those symptoms or feelings. Conversely, someone with an AOD dependence may start to experience issues in their personal or work life. The end of a relationship or loss of a job may result in symptoms of anxiety or depression on top of their existing dependence. In each case the result can be a co-occurring alcohol and other drug dependence and mental health condition which creates a worse impairment and more challenging prospects for management than people with either condition alone. People with dual conditions face higher rates of relapse and subsequent hospital visits, incarceration, unemployment, and family difficulties'.

> to providing treatment, care and support for people living with mental illness of psychological distress. This can cause challenges for the mental health system and other services.[2115]

9.4.91 One party told the Royal Commission:

> There remains a cohort of people living with [mental illness and substance use or addiction] who do not fit into either service system. These people are often too unwell to be supported in an AOD setting and not unwell enough to get access to acute or community mental health services, often leading to greater demand on emergency services, police (and corrections) or the coronial system.[2116]

9.4.92 Ms Gail Bradley, Interim Operations Director of the North-Western Mental Health Service, stated:

> … in relation to alcohol and other drugs, probably about 40 per cent of people who have a severe mental illness also have a substance misuse or dependence problem … helping them with that problem if they want the help is a really … important thing to be able to do, but we don't really have the capability amongst our mental health workforce … [we] employ alcohol and other drug clinicians…[but] in the other area mental health services within North-Western Mental Health [there is only] access to a 0.3 position … It's simply not adequate.[2117]

The role and utility of hospital security

9.4.93 Security is available to all wards within a hospital and may be called upon where there is a threat of violence. Often, this is known as a Code Black. SALRI's review considered whether s 57 powers should be extended to hospital security guards, as a means to reduce the burden on SAPOL. However, consultation revealed that security guards do not have the required training to attend to all incidents, particularly those relating to mental health crises, and they may be unavailable, especially in regional, rural and remote settings. As a result, the s 57 care and control powers are most appropriately vested with SAPOL.

9.4.94 Despite this, there remains a role for hospital security. A concern raised to SALRI, by some health practitioners and service providers, was the incidence of violence (both the threat and use of force) committed in various circumstances. This may take place in both a community and hospital setting. In particular, the ED is acknowledged as a difficult place to work due to its fast-paced nature and the unknown circumstances regarding those who attend and the risks they may pose. This applies to any person attending the ED, not only those with a mental health-related challenge.

9.4.95 Violence committed by patients against health practitioners, especially ED nurses and mental health nurses, is not uncommon.[2118] This is consistent with what SALRI heard through

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[2115] *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021) vol 3, 319.

[2116] Ibid.

[2117] Ibid 320.

[2118] See, for example, Brett McKinnon and Wendy Cross, 'Occupational Violence and Assault in Mental Health Nursing: A Scoping Project for a Victorian Mental Health Service' (2008) 17(1) *International Journal of Mental Health Nursing* 9; Melissa Cunningham, "*Our Biggest fear is People will be Killed": One in Three Mental Health Workers Victim of Violent Assault* (13 July 2019) The Age <https://www.theage.com.au/national/victoria/our-biggest-fear-is-people-will-be-killed-one-in-three-mental-health-workers-victim-of-violent-assault-20190710-p525tq.html>; Laoise Renwick et al, 'The Physical and Mental Health of Acute Psychiatric Ward Staff, and its Relationship to Experience of Physical Violence' (2019) 28(1) *International Journal of Mental Health Nursing* 268; Maria Baby, Paul Glue and Dave Carlyle "'Violence is not Part of our Job": a Thematic Analysis of Psychiatric Mental Health Nurses' Experiences of Patient Assaults from a New Zealand Perspective' (2014) 35(9) *Issues Mental Health Nursing* 647; Gabrielle Jenkin et al, 'Places of Safety? Fear and Violence in Acute Mental Health Facilities: A Large

consultation, as to the risk of violence in both hospital and community settings. Increasingly, the legal system has been acknowledging that assaults against nurses (and other health practitioners) are a violation of their human rights and violence should not be tolerated.[2119] A core function of any ward in a hospital is to provide a therapeutic environment for individuals at their most vulnerable. 'For this to happen, [the unit or ward] must be a rewarding place to work, and a safe place to be'[2120] for both staff and patients.

9.4.96 One 2018 study reported that a 'majority of violent patients were affected by drugs and/or alcohol in the absence of a psychiatric diagnosis' and as a result, '[i]nterventions to reduce access to and misuse of alcohol and illicit drugs could have a substantial impact on the concerning increase of violence in the ED.'[2121] During SALRI's consultation, the effects of methamphetamines were often emphasised. It must be noted this 2018 study related to violence in the ED only and was not limited to violence arising from patients with mental health issues. Results from the study demonstrated 'that psychiatric diagnoses, excluding alcohol use or substance use disorder, were not majorly associated with the violence that occurred.'[2122]

9.4.97 Other studies reported that often, when violence occurs, physical or chemical restraint may be used.[2123] Further, violence is more common when a police officer is not present.[2124]

9.4.98 While there is clearly a growing belief of the increased existence of violent incidents toward health practitioners, much of the data surrounding its prevalence is taken from other Australian and international jurisdictions. South Australia should consider its own circumstances based on data collected locally.

9.4.99 These issues highlight the need for hospital security guards to attend to these incidents, when required. Indeed, there is growing support nationally and internationally (and in SALRI's

Qualitative Study of Staff and Service User Perspectives' (2022) 17(5) *PLOS One* 1; Kate Midena and Harry Frost, *"Catastrophic Event" Imminent as Physical Assault Rate Escalates at Canberra's Dhulwa Mental Health Unit* (6 April 2022) ABC News Online <https://www.abc.net.au/news/2022-04-06/violence-escalates-at-canberra-dhulwa-mental-health-unit/100969104>; L Moylan and M Cullinan, 'Frequency of Assault and Severity of Injury of Psychiatric Nurses in Relation to the Nurses' Decision to Restrain' (2021) 18(6) *Psychiatric and Mental Health Nursing* 526; Jacqueline Pich and Michael Roche, 'Violence on the Job: The Experiences of Nurses and Midwives with Violence from Patients and Their Friends and Relatives' (2020) 8(4) *Healthcare* 522, 523.

[2119] *Criminal Law Consolidation Act 1935* (SA) s 20AA (assault or causing harm to emergency workers). See also Regan Murray et al, 'A Systematic Review of Workplace Violence Against Emergency Medical Services Responders' (2020) 29(4) *New Solutions* 484. Maria Baby, Paul Glue and Dave Carlyle '"Violence is not Part of our Job": a Thematic Analysis of Psychiatric Mental Health Nurses' Experiences of Patient Assaults from a New Zealand Perspective' (2014) 35(9) *Issues Mental Health Nursing* 647. The attitude of nurses has reportedly changed during the last two decades from a therapeutic to a safety paradigm. Nurses currently view coercive measures as undesirable, but necessary to deal with aggression and the safety of staff and others. See Paul Doedens et al, 'Influence of Nursing Staff Attitudes and Characteristics on the Use of Coercive Measures in Acute Mental Health services-A Systematic Review' (2020) 27(4) *Journal of Psychiatric Mental Health Nursing* 446.

[2120] Gabrielle Jenkin et al, 'Places of Safety? Fear and Violence in Acute Mental Health Facilities: A Large Qualitative Study of Staff and Service User Perspectives' (2022) 17(5) *PLOS One* 1.

[2121] Shradha Nikathil, 'Increasing Workplace Violence in an Australian Adult Emergency Department' (2018) 30(2) *Emergency Medicine Australasia* 181.

[2122] Ibid 185.

[2123] Biswadev Mitra et al, 'Security Interventions for Workplace Violence in the Emergency Department' (2018) 30(6) *Emergency Medicine Australasia* 802, 805–6.

[2124] Ibid 806.

consultation) for security personnel to be placed in ED environments on a 24/7 basis to address serious safety concerns.[2125]

9.4.100 As SALRI was reminded in consultation by parties such as Anh Caprile of the Legal Services Commission, it is also significant that:

> Individuals can respond to unforeseeable triggers unnecessarily and exhibit violent and/or aggressive behaviours due to the nature of their condition. It is unhelpful to focus solely on substance use as people with disability can (but not always) be substance users, and substance users more often than not have underlying (and can be undiagnosed) conditions. Either way it means the individual is first and foremost a vulnerable client, and needs appropriate treatment and management by trained professionals at initial contact and ongoing engagement both in the community and other settings like ED.[2126]

9.4.101 Not all South Australian hospitals, including EDs, have 24/7 security coverage.[2127] Even if a security guard is available, SALRI often heard in consultation that there is doubt and uncertainty as to what they can legally do. Many health practitioners referred to the perception that security guards are unable to 'lay hands on anyone'.

9.4.102 Whether security guards should be utilised in hospital settings was more controversial. SALRI received divergent views. Lived Experience Australia explained:

> [W]e are seeing security guards being used more frequently in all mental health, ED, and other health settings. We believe that these personnel should only be engaged to the extent to keep the public safe. We are seeing mental health clinicians on inpatient units calling for security when they seem unable or unwilling to engage with someone who they deem to be a danger to them. LEA believes this is most inappropriate given their knowledge of people's behaviour when affected by mental health issues. The use of these guards adds to the stigma of mental health issues and should reasonably be eliminated.

9.4.103 SALRI acknowledges these concerns and agrees that the use of security guards raises valid concerns and should be used if there are no other suitable options. However, SALRI also recognises that it is vital to protect mental health clinicians, health care staff, as well as other hospital patients. All people have the right to be safe.

[2125] Biswadev Mitra et al, 'Security Interventions for Workplace Violence in the Emergency Department' (2018) 30(6) *Emergency Medicine Australasia* 802, 805; Bradley Partridge and Julia Affleck, 'Verbal abuse and physical assault in the emergency department: Rates of Violence, Perceptions of Safety, and Attitudes Towards Security' (2017) 20(3) *Australasian Emergency Nursing Journal* 139, 139, 144.

[2126] See also generally Jim Ruiz and Chad Miller, 'An Exploratory Study of Pennsylvania Police Officers' Perceptions of Dangerousness and their Ability to Manage Persons with Mental Illness' (2004) 7(3) *Police Quarterly* 359; Joel Godfredson et al, 'Police Perceptions of their Encounters with Individuals Experiencing Mental Illness: A Victorian Survey' (2011) 44(2) *Australian and New Zealand Journal of Criminology* 180; Matthew Morgan and Toby Miles-Johnson., 'Responding to Persons with Mental Illness (PWMI): Police Recruit Perceptions of Mental Health Response Training and Engagement' (2022) 8(1) *Current Social Sciences* 1. 'Research suggests that police often misinterpret the idiosyncrasies of a mental health crisis as behaviour that is dangerous and in need of coercive control, whereas health professionals often appropriately interpret such behaviour as in need of care': at 3.

[2127] Port Lincoln now has 24/7 security following the sustained advocacy of the Australian Nursing and Midwifery Federation (SA Branch). ANMF (SA Branch) *24/7 security at Port Lincoln to provide peace of mind for nurses and midwives* (12 September 2022) <https://www.anmfsa.org.au/Web/News/2022/24_7_security_at_Port_Lincoln_to_provide_peace_of_mind_for_nurses_and_midwives.aspx>.

9.4.104 Without explicitly commenting on whether employing security in mental health settings is appropriate or inappropriate, the Rural and Remote Mental Health Service added that in regard to CTOs:

> There is ongoing confusion and lack of clarity about the use of security guards. Again, this could be addressed by a Chief Psychiatrist determination or inclusion of a section similar to 34, 34A and 35.

9.4.105 SALRI acknowledges that the underlying theme of the literature and the consultation, is that the health environment, and ED's in particular, are becoming increasingly difficult places to work. This is due to a combination of factors, many of which do not relate to mental health.

9.4.106 The *MHA* enables police to transport a person to the ED or another facility for a medical examination. This raises the questions as to the appropriateness of their role and what else may be established to offset this need. As a result, hospital security guards were considered as an alternative to police officers, particularly once a person has been transported to the hospital. However, it was largely agreed s 57 powers should not extend to hospital security guards. This is due to a number of factors, including the lack of specialist mental health training, ambiguity concerning the powers or functions of the guards and availability (especially for regional, rural and remote settings).

9.5 Consultation Data Overview

Police involvement generally

9.5.1 In consultation, consistent with wider research, SALRI was presented with many examples by consumers, carers or family members, of distressing experiences relating to interactions where police were exercising their powers under the *MHA*.[2128] There was a strong view that, wherever practicable, the use of police in addressing mental health events should be avoided, or at least reduced.

9.5.2 SALRI's consultation with consumers, family members and health practitioners also revealed positive interactions with the police.[2129] There was wide acknowledgment that police undertake a demanding and difficult role in the mental health system, in which they are not adequately trained or equipped to fully perform.

[2128] *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021) vol 1, 558; Christopher White, 'An Inevitable Response? A Lived Experienced Perspective on Emergency Responses to Mental Health Crises' (2019) 28(1) *Journal of Psychiatric and Mental Health Nursing* 90, 92; Syeda Akther et al, 'Patients' Experiences of Assessment and Detention under Mental Health Legislation: Systematic Review and Qualitative Meta-Synthesis' (2019) 5(3) *BJPsych Open* 1, 6.

[2129] This is consistent with research. Lily Jones and Stuart Thomas, 'A Pilot Study Exploring Mental Health Consumers' Experiences with the Police' (2019) 26(2) *Psychiatry, Psychology and Law* 235; *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021) vol 1, 560. As one carer told the Victorian Royal Commission: 'When I call [the Crisis Assessment and Treatment Team], they say call the police … My son has threatened to kill me before when he's been psychotic and off his medication and I have had to take out an [intervention order]. While I have had some good experiences with police and ambulance, not all understand mental illness and they shouldn't be the main point of call for people who need specialised treatment for mental illness. Police have fined my son for walking close to the freeway when he was suicidal. Instead of getting him help, he spent the night in jail. But without the police my son would be dead. I am grateful that the police were there, however it is not their job': at *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021) vol 1, 515.

9.5.3 Though there is debate as to the precise details,[2130] there was overwhelming support in SALRI's consultation for a co-response model in South Australia. This support came from consumers, consumer and advocacy groups, service providers, health practitioners and SAPOL.

9.5.4 SAPOL observed:

> Consumers also saw value in a co-response model. As one consumer attendee at a roundtables aid: 'Peer Workers should be used [to assist police] wherever there is an opportunity. They are the only person trained to keep focused on the person and their rights throughout a situation.'

9.5.5 There was also overwhelming acceptance in consultation, albeit on occasion with reservations, that it is unrealistic to discard the necessary police role under the *MHA*. There is a need for '24/7' availability of emergency response services for mental health crises, particularly when a person is at risk of harming themselves or others. SAPOL, whilst favouring a co-response model, accepted this vital premise. As noted by an Anglicare practitioner:

> Not always, but often in a lot of our services, the time that a mental health issue becomes an emergency is when behaviour escalates to a point the individual, others, or property are at risk of harm/damage and it's not always purely mental health, it can be fuelled by alcohol/drugs/cognitive capacity etc'.

9.5.6 Another Anglicare practitioner submitted:

> From a service provider view point SAPOL provide an essential service when our customers are unstable/psychotic, however in saying this I believe that there is a necessity to provide SAPOL with further training/understanding of people living with both Disabilities and Mental Health concerns which can be heightened with substance misuse.

9.5.7 These observations emphasise the contributory role of illicit drugs in fuelling or causing escalation of behaviours warranting police involvement under the *MHA*.

9.5.8 Many parties, notably consumers and consumer and advocacy groups, either opposed the use of reasonable force by police (or indeed other powers under s 56), or, more commonly, submitted that such force should only be utilised in restricted and narrow circumstances. This approach was often seen as part of the premise that involuntary treatment and force should not be used (or used only very narrowly) under the *MHA*, on a policy and human rights basis.

9.5.9 The Public Health Association of Australia, for example, said:

> The involvement of SAPOL in enforcing the *Mental Health Act 2009* contributes to stigma associated with mental ill health. Restraint of people living with mental ill health is associated with trauma, dehumanisation and 'othering'. Further, police often lack the necessary training to act as first responders to people in mental health crises.

9.5.10 Various parties such as Mind Australia, suggested the need for greater clarity in the use of police and other powers under the *MHA*.

9.5.11 The Rural and Remote Mental Health Service advocated a view similar to the status quo. It contended that SAPOL should be able to apprehend a person (other than under criminal laws) they

[2130] There is no single model. 'There is also wide variation in the implementation of the co-response model, with differences in hours of operation, staffing, and incident response': Indeed, 19 different models have been identified. See Stephen Puntis et al, 'A Systematic Review of Co-Responder Models of Police Mental Health "Street" Triage' (2018) 18 *BMC Psychiatry* 256.

encounter in their normal policing activities where that person appears to have a mental illness and pose a harm risk, and/or when they are requested by other services to help manage dangerous situations. They added it is appropriate for SAPOL to do so as the agency:

> … already provide[s] non-crime related services (that stem from a health or social matter) for people experiencing domestic violence, child abuse, intoxication and intellectual disability. The SA Police core principles to: protect the community from disorder, preserve the peace, assist the public, make communities safer, collaboration and public safety, all provide for police to participate in activities that are broader than just preventing crime.

9.5.12 In saying this, the prevailing view from SALRI's consultation is that police involvement in mental health crises should be limited, which would signify a departure from current practices. For example, the Australasian College for Emergency Medicine contended:

> … behavioural disturbance is primarily a health issue and therefore considers where appropriate and safe to do so, health professionals should be prioritised to exercise the power to detain and use force, while acknowledging that in some circumstances a police officer or security officer may need to do so to ensure the safety of healthcare workers, other patients and members of the community. We also consider that all less restrictive options must be tried or considered first.

9.5.13 Various examples were presented in consultation. One health service in the context of a CTO offered the following example of where the police were necessary in situations where consumers do not recognise they are a danger to themselves and others:

> … [w]e had a situation where a customer left site for 2-3 days and was non compliant with his medication when he returned to site he had purchased a knife and was delusional wanting to kill everyone on site. The site was placed into lock down, SAPOL, SAAS and his Community Mental Health Team were notified and luckily he was apprehended and detained under the Mental Health Act until he was stabilised to return to our services. There is a necessity for these orders [and the role of the police] to remain in the cases of very unwell people within our society to ensure the safety of everyone.

9.5.14 The Public Health Association of Australia suggested:

> In cases where SAPOL involvement is necessary, strategies to ensure police are appropriately trained to work with people experiencing mental health issues could incorporate the implementation of programs that see police officers accompanied by trained mental health support workers. Similar approaches have been trialled, with success, in Western Australia,[2131] New South Wales and Queensland.

9.5.15 The Office of the Public Advocate proposed:

> An expanded crisis response capacity should be considered, so that emergencies are health-led wherever possible and safe, rather than police-led. SAAS and SAPOL sometimes provide a joint

[2131] Western Australia has implemented the Western Australia Police Force Mental Health Co-Response Model which saw two police offices and one mental health clinician attend an emergency mental health crisis as the first response. In this model the mental health condition was co-located with police in Districts where the trial was run. The role of the mental health clinician was to perform initial medical assessment of the consumer and check the consumer's mental health and hospital records for potential mental health issues. The evaluation of the trial saw better care provided to consumers at the emergency response stage. Additionally, the trial resulted in a reduce number of consumers transported to the ED, the emergency response spending less time attending to the consumer when no ED transport was required, shorted ED wait times, and a reduced demand on responding officers (and emergency services generally). In saying this, the model was found to be resource intensive: see Pamela Henry and Nikki Rajakaruna, *WA Police Force Mental Health Co-Response Evaluation Report* (29 March 2018).

> response, which can be an effective collaboration. This would also require appropriate resourcing of police and mental health clinical partnership models, which have been shown to improve outcomes in other jurisdictions (for example the Police Force Mental Health Co-Response Commissioning trial in Western Australia). Other initiatives, like the development of 'safe spaces', as recommended by the Victorian Royal Commission, and the new 'Urgent Mental Health Treatment Centre' in Adelaide's CBD are important in providing alternative avenues for people to get help without it becoming a crisis situation requiring police involvement.

9.5.16 SALRI does not disagree with these comments made by the Office of the Public Advocate and believes that this is the preferred approach.[2132] Further, as many parties (including consumer groups) acknowledged, there will be inevitable situations where the safety of the consumer or others is at risk and a police response is appropriate or necessary. This premise was accepted by SAPOL. The RANZCP noted that no other body exists with the capacity to undertake this role and that in the absence of such, the police role and powers under the *MHA* should remain.

9.5.17 The Aged Rights Advocacy Service ('ARAS') raised whether the *MHA* should confer powers to use force and detain a person experiencing a mental health crisis. ARAS highlighted the need for 'comprehensive training provided to first responders on how to differentiate between behavioural episodes associated with dementia and mental health conditions.' It suggested that where safe to do so, a mental health response team should be the first response to an emergency mental health call and conduct a 'mental health screening risk assessment' which is to form the basis of detention under the *MHA*. ARAS said a 'mental health screening risk assessment' should be undertaken prior to the involvement of a police officer. ARAS suggests that a qualified emergency mental health response team should be first responders to events in community settings, if deemed safe to do so.[2133]

Retaining s 57 MHA powers

9.5.18 There was broad agreement in SALRI's consultation, albeit on occasion with reservations and disagreement as to when such powers should be utilised,[2134] that it is unrealistic to discard the police role under the *MHA*.

9.5.19 The Rural and Remote Mental Health Service agreed that '[i]t is vital that Police retain the capacity to act under the *MHA*'. They expressed a concern relating to the use of the *MHA* for:

> … people with delirium, dementia, intoxication and intellectual disability … The powers that are used this way are section 56 care and control (by non-mental health clinicians and SAAS), section 57 care and control (by SAPOL) and section 21(1) making of a level 1 ITO (by non-mental health clinicians).

[2132] However, South Australia's acute ramping crisis may require further consideration regarding the involvement of SAAS in the co-response model.

[2133] In its submission, ARAS supported the use of s 57 care and control powers to intervene in situations where 'an older person's physical or mental safety is at risk of immediate harm or a deterioration in their condition, for example in situations of severe neglect or at risk of malnutrition or attempts to self-harm or to protect public safety or to safeguard an older person from an abusive family member whose mental health wellbeing is compromised'. SALRI acknowledges the need to address these valid concerns. However, SALRI is of the view that extending s 57 to address these concerns is inappropriate as it is using the *Mental Health Act 2009* (SA) for a purpose other than to address mental health concerns. This issue merits further future consideration.

[2134] In the Lived Experience Leadership and Advocacy Network's submission to SALRI, they opposed any extension to s 57 powers under the *Mental Health Act 2009* (SA).

9.5.20 This leads to:

> … a fundamental problem with options available for involuntary control, custody and treatment in South Australia which affect the use and efficacy of those powers under the *MHA*. This is the single largest issue connected with the *MHA* and has far-reaching effects across mental health services, disability services, emergency departments, geriatric services, post-surgical services, and drug and alcohol services, and impacts patients, families, clinicians and professionals from across SA Health, SA Ambulance Service, SA Police, Royal Flying Doctor Service and the SA Civil and Administrative Tribunal.

9.5.21 SALRI heard varying opinions about the use of the s 56 and s 57 *MHA* powers in regard to persons placed under a CTO. The less than clear intersection of the care and control powers and a CTO or ITO was raised by several parties, notably by the Chief Psychiatrist. The benefit of greater 'clarity' in the *MHA* was also noted. The Rural and Remote Mental Health Service told SALRI it supported these care and control powers being used in circumstances where a person is non-compliant with their CTO (which the *MHA* currently allows) and added:

> … it should be possible for a person non-compliant with their CTO to be taken to a Treatment Centre, Authorised Community Mental Health Facility or other appropriate health facility (such as a hospital or GP clinic), dependent on the circumstances. (For example, a non-compliant country person could be taken to their local non-treatment centre hospital and a non-compliant metro person could be taken to their community mental health centre.) The review should examine if this should be included in the legislation, or enacted through a Chief Psychiatrist determination, or both (ie legislation says 'can be taken to a place authorised by the Chief Psychiatrist' and the Chief Psych must publish a list of approved places).

9.5.22 Lived Experience Australia took a different view, suggesting s 57 powers should not be exercisable where a person does not comply with their CTO. They also submitted that SAPOL should not be involved if a consumer does not comply with a CTO, noting '[w]e believe this is the responsibility of mental health teams.'

9.5.23 The Lived Experience Leadership and Advocacy Network ('LELAN') argued that SAPOL's powers should only exist in relation to their role and responsibility in the community:

> SAPOL has the same responsibility to ensure the safety of people living with and recovering from mental illness and protecting the safety of others where a person's behaviour may actually or potentially put them at risk. SAPOL's powers should only exist in relation to their role and responsibility in the community.'

9.5.24 As a result, LELAN held the view that:

> … SAPOL should not have powers specifically as part of mental health services or have powers of force or control under the Act. Nor should SAPOL have specific powers under the Act to use force or have powers of control in relation to compliance with CTOs. Where SAPOL responds to calls for assistance in matters of personal and public safety in relation to the actions of a person experiencing distress or diagnosed mental illness, SAPOL should be required to involve a mental health clinician/mental health response team, which may include a Peer Worker as one of the responders.

9.5.25 LELAN made clear it does not support any expansion of the powers to the *MHA* that increases legislated authority to use power in any way to reduce the human rights of persons experiencing distress or diagnosed mental illness. Indeed, the *MHA* 'should be paired back to a least restrictive approach that serves to keep the person with lived experience and the community safe.'

They further noted that '[a]ny changes to the *MHA* to include a power to use reasonable force, would require a definition of reasonable force and any definition would need to be defined in the construct of human rights and consent.' In response to this, LELAN posed three questions:

> Who then, interprets reasonable force – is it the service provider, the health practitioner, the police or security guards or is it the person being forced?
>
> Isn't the person being forced able to use the same reasonable force to resist this infringement on their human rights – and how does this balance its use?
>
> Is the use of reasonable force by its very nature, coercive and threatening – and what are the laws that protect the individual from this behaviour?

9.5.26 The Australian Nursing and Midwifery Federation ('ANMF') did not comment on SAPOL's involvement under s 57, but noted '[a]ll care should be provided in the least restrictive manner by observing the rights of individuals requiring care. It is essential that the provision of care maximises human liberty and freedom.' Further, they submitted that 'using force and control powers can impact the therapeutic relationship between the client and the clinician and noted that practice needs to be collaborative and consultative with the person requiring care.'[2135]

9.5.27 Additionally, various consultees provide insight into the use of care and control powers with regard to ITOs. Neami National raised the role and application of care and control powers under s 56 of the *MHA* (and by implication s 57) as they appear to offer a more flexible alternative to an ITO, enabling UMHCC staff to support people in distress, but with the ability to scale down support as the person stabilises. They elaborated:

> Neami is proposing to use s 56 Care and Control powers more extensively, though this presents some challenges that could be examined by the SALRI in their review of the Act. The benefit of using an ITO is its capacity to facilitate treatment within a clear framework of rights and responsibilities. The particular problem for the UMHCC is that revocation of an ITO requires a consultant psychiatrist or an equivalent authorised medical practitioner, positions that are not routinely rostered at the UMHCC. As a result, all guests under an ITO must be transported to hospital even where the situation has settled significantly and risk has subsided. Unlike an ITO, Care and Control is a reversible mechanism should the person stabilise whilst in care. Where an ITO has been made and guests are being transferred to the hospital, they are likely to experience long wait times, between waiting for an ambulance, being admitted to the Emergency Department and undergoing urgent mental health assessment. During this time, the guest's situation may deescalate to a point where restrictive practice may no longer be required. Additionally, it's important to note that an ITO is recorded in the person's permanent health records and may negatively impact other areas of the person's life. Neami proposes that s 56 powers of Care and Control be used more extensively with clearer regulation. To ensure Care and Control is a safe option for consumers, Neami recommends that the SALRI review the lack of regulation on the time a person can be subject to the Care and Control powers to ensure people are not being unnecessarily detained or 'held' in the system for lengthy periods. This can be achieved by: providing clarity to the time limit applicable under s 56, providing clarity about the person's rights while under Care and Control including the right to appeal, ensuring all people under Care and Control have access to and are provided with a Statement of Rights, enabling the Office of the Chief Psychiatrist to maintain records of the use of Care and Control to protect individuals from repeated or frequent use of restrictive orders, such as the use of restrictive practices within seven days of previous use.

[2135] This was also raised to SALRI during various Roundtable discussions.

9.5.28 A former mental health nurse provided further practical insight into the interplay between ITOs and s 56 *MHA* powers. They explained ITOs are often made by medical officers in ED for intoxicated persons voicing suicidality who, when they become sober, have no recollection of this, but due to the ITO, must remain in the hospital and wait for a consultant review. It was suggested it may be useful to amend the *MHA* so that in such circumstances, s 56 should remain operative until the consumer becomes sober.

9.5.29 The OCP provided advantages and disadvantages of using care and control powers instead of an ITO, and stated:

> The OCP is aware that in practice, clinicians may need to hold someone under care and control powers for many hours in order to properly assess them, for example to allow for the person to settle from a distressing situation or for the effects of drugs to subside. There are no clear avenues for someone under care and control powers to seek review of their treatment as there are under inpatient and community treatment orders. For this reason, it is sometimes seen as preferable to make a decision about placing someone on a treatment order as soon as possible in order to protect their rights.
>
> Countering those considerations are some advantages to using care and control powers rather than treatment orders. Under care and control powers, a person does not need to be transported to an authorised treatment centre as they are required to be under an ITO. This may be a consideration in areas where an ATC may be some distance from the person under assessment. Additionally, if someone is assessed after being able to settle, they may not require an ITO and will have no record on their health history.

9.5.30 There are queries as to whether, as a matter of practice, s 57 *MHA* powers should extend to use on persons who are under the influence of an illicit drug or have alcohol intoxication. As raised by the Rural and Remote Mental Health Service, the use of the *MHA* in these circumstances may be attributed to resourcing issues. SALRI accepts this concern, and its added significance in a regional, rural and remote contexts. However, there are divergent views. SALRI adopts the view voiced by the Australian Drug Foundation:

> The current evidence-based guidelines in Australia suggest that the integrated treatment of mental health and AOD use disorders is best practice.
>
> Ideally, staff involved in treating drug dependency need to include treatment of psychiatric disorders for dual diagnosis clients. Similarly, psychiatric staff should have the capacity to introduce substance treatments into mental health service programs.
>
> Another option for specialist AOD and mental health practitioners and services is to adopt a 'no wrong door' approach. This ensures that individuals who present for support or treatment to one specialist can also be treated for their dual diagnosis by another specialist, or multiple specialists. Sometimes this can happen across a number of organisations.
>
> Services that adopt a 'no wrong door' approach are committed to ensuring any door into the health care system will lead a person to the treatment that is appropriate for them. This helps prevent people with a dual diagnosis and other complex needs from falling through the cracks.

Should hospital staff be able to use reasonable force to 'hold' a person?

9.5.31 Another topic raised in SALRI's consultation was whether, and in what circumstances, hospital staff should be able to use reasonable force when 'holding' a person. These powers would allow authorised officers to 'hold' persons, using reasonable force if necessary, where they have

committed an offence, but require treatment. Consequently, the use of force in this circumstance would allow the authorised officer to 'hold' the person until police arrive.

9.5.32 The varied views reflected the wider debate in SALRI's consultation as to whether, or in what circumstances, 'reasonable force' should be used.

9.5.33 As explained previously, under the *MHA* an authorised officer covers a wide range of mental health related roles including a mental health clinician.[2136] Section 56 care and control powers can be exercised in the same circumstances as s 57 care and control powers, and an authorised officer can use reasonable force and restrictive practices to carry out these s 56 powers.[2137]

9.5.34 SAPOL informed SALRI that the present law already adequately allows hospital staff to 'hold' a person. However, there are operational issues, including that staff are 'reticent' to use force to prevent a person from absconding and would rather rely on hospital security (who may be unavailable or unable to intervene). SAPOL raised whether the applicable MOU needs revision.[2138]

9.5.35 A number of consultees, including consumers and consumer and advocacy groups such as LELAN, opposed this power, describing it as undesirable and inappropriate. One consultee stated '[h]ospital staff are not police officers nor security guards and this would place hospital staff at a greater risk of injury/harm or even trauma.' The ANMF also did not support this power as 'hospital staff are untrained to forcibly "hold" a person not requiring treatment'.

9.5.36 Lived Experience Australia similarly explained:

> There are risks to staff performing this role (physical and psychological), to the person (physical and psychological, trauma), and to the relationship, trust and future potential help-seeking, where the people tasked with providing care and also using coercion to provide that care. There is also concern for the distress that witnessing coercion can have for other patients, family members (eg children) or others in the immediate environment in which force is implemented. Every effort should be used to avoid staff needing to resort to use of force…. The core business of mental health inpatient units is to provide treatment and care to address the acute mental health needs of the person, and to keep people with mental illness safe from harm to themselves and/or others. They have the knowledge, skills, mandate etc to use these things to protect a person, rather than force to hold a person.

9.5.37 Other parties, such as the Legal Services Commission and the SA Health Child Protection and Policy Unit, took a different approach. Whilst noting the need for care in the exercise of such a power, these parties supported 'in principle' the power to 'hold' a person, but noted that it will require resourcing, investment and development of appropriate building infrastructure and human resourcing (clinical and non-clinical).

9.5.38 The Office of the Public Advocate said:

> Under s 57(9), a person who has been arrested may be released from police custody for the purposes of medical examination or treatment under the *MHA*. If an ITO is not subsequently made, or ceases to apply, in respect to the person, they must be 'held and returned' to police

[2136] *Mental Health Act 2009* (SA) s 3 ('authorised officer').

[2137] Ibid s 56(3)(c), (d). SALRI notes that, whilst flexibility under s 56 is useful as to the categories of authorised officers, the importance of suitable training and professional guidance is reiterated and that the use of force should be a 'last resort'.

[2138] Royal Flying Doctor service, SA Health, South Australian Ambulance Service and South Australia Police, *Mental Health and Emergency Services Memorandum of Understanding*, (14 July 2010).

custody. If there is a brief time lapse between hospital staff determining that an ITO is not required, or no longer applies, and SAPOL arriving to take custody of the person, then the ability to safely and securely 'hold' the person would potentially avoid the need to apply to the SACAT to seek special powers orders of detention under the *GAA*. Short-term 'holding' powers would need to be subject to appropriate authority and safeguards, including time limits, recording and oversight requirements.

9.5.39 The Australasian College for Emergency Medicine also supported this power, explaining:

> … any proposed changes to mental health legislation regarding restrictive practices and their use must be balanced by the need to protect patients and others in response to immediate risk. Specialist emergency physicians are highly trained and skilled at making rapid determinations about the best course of action for the care of a patient. Clinical judgement must be acknowledged and respected in assessing complex presentations and managing harmful behaviour. Our members report that they would experience great difficulty in safely managing many presentations without the ability to use physical restraint, combined with sedation as a medical treatment. Therefore, it is ACEM's view that any treatment that has a therapeutic impact or allows for the safe assessment or treatment of a medical condition falls outside the definition of a restrictive practice.

9.5.40 The RANZCP 'provisionally supports' allowing hospital staff to use reasonable force to 'hold' a person until SAPOL arrives but had concerns as to whether the professional indemnity insurance of health practitioners involved would cover them for unintended consequences, including injury to self, others or being accused or charged with assault or similar. They added:

> Given this is a requirement under the *MHA*, authorised officers within a hospital should be extended the ability to facilitate the exercise of police powers. There are a number of concerns over health professionals having custodial powers and the meaning behind this change, which SALRI should take into account.
>
> • Consideration is needed as to the extent to which these custodial powers are intended to replace rather than complement police.
>
> • Workforce considerations are needed, especially regarding training, support, and guidance for the health professional in exercising these powers.
>
> • Further discussions and collaboration would be needed between lived experience, clinicians, and organisations such as SA Ambulance Service, SA Police and the Australian College for Emergency Medicine, as it involves a significant change in practice.

9.5.41 With regard to the use of reasonable force under the *MHA* generally, the Office of the Public Advocate noted the 'use of reasonable force and s 56 control powers is sometimes necessary in circumstances where a person's safety or wellbeing, or that of the community, is at risk.' However, they also clarified that force should only be used as a last resort, in emergency situations and only for as long as necessary, in order to protect the rights of consumers.

9.5.42 A former mental health nurse expressed a similar position, and added:

> … managing a violent patient rather than restraint/seclusion is traumatising for other patients (and visitors) and it is simply impossible to adequately convey how unsafe it is to work in an emergency department or a psychiatric ward. Reflecting on the multitude of violent situations that I have experienced in my work, I doubt that many of them made it to incident report because what a member of the public would consider criminal, in practice is considered mundane. It is essential that restraint and seclusion remain a legislated option.

9.5.43 The Rural and Remote Mental Health Service supported this power, submitting:

> The powers in s57(9) and (10), whereby the police can drop an arrested or apprehended person at an (appropriate) health facility for mental health assessment and/or treatment and can ask the health facility to hold the person after that assessment or treatment until the police can be present to take the person back into custody, should remain.

9.5.44 The Australasian College for Emergency Medicine took issue with the current provisions and outlined they:

> Are not fit for purpose, and any prospective changes made to the Act must be made after exhaustive consultation with all relevant stakeholders. ACEM recommends that legislative provisions relating to custodial arrangements needs to undergo a comprehensive formal review.

9.5.45 The Rural and Remote Mental Health Service agreed with this sentiment, noting '[t]he provisions…should be made clearer with explicit powers for health staff to use reasonable force, as the current wording has led to confusion between agencies.'

9.5.46 Many of the views heard and considered by SALRI were consistent with the broader questions relating to the use of force and the role of authorised officers generally. The sentiment recurring throughout consultation revealed, in principle, support for authorised officers to use powers reasonable force to 'hold' a person, until SAPOL arrives. Those that expressed reservations, were mostly in relation to operational challenges.

Cross border arrangements

9.5.47 Another question that arose through SALRI's consultation was whether the law should allow the use of care and control powers to enforce cross borders arrangements.

9.5.48 If the law did allow for the use of care and control powers to enforce cross border arrangements, the law must then provide provisions for an independent third party to provide support and information, so the consumer can make informed decisions. There must also be references to ensuring accountability and monitoring in the statute, as well as clear, strictly defined operational guidelines. Finally, safety and quality mechanisms for auditing and review purposes appear to be necessary to ensure accountability and transparency.

9.5.49 One consultee noted '[my] understanding [is that] there is a Memorandum of Understanding…between states for treatment of people with mental health issues who are on a CTO or under the care of a community mental health team.'

9.5.50 The Rural and Remote Mental Health Service agreed that:

> Care and control powers to facilitate cross-border transfers are an essential component of state jurisdictions being able to work together to ensure a person's safety and health. While SA has the most collaborative and health-focused cross-border provisions, this section of the *MHA* is the most complicated and should be simplified if possible. It would also provide clarity to explicitly allow reasonable force to carry out cross-border transfers, if they have met the exacting criteria of the *MHA* and the Chief Psychiatrist determined forms.

9.5.51 The RANZCP also supported this change. They noted:

> [Mental Health Acts] vary greatly between different jurisdictions, and this variation is a barrier to pursuing best practice and reducing the incidence of involuntary treatment.

> The RANZCP advocates for greater consistency between the [Mental Health Acts] generally, which may help resolve some of these issues.

9.5.52 The Australasian College for Emergency Medicine agreed 'this would be an appropriate provision that will require individual agreements with each of the States and Territories.'

9.5.53 In contrast, LELAN did not support any expansion of these powers. However, they did advocate for:

> … greater transparency of reporting and accountability across borders. The failure of the mental health care system is a national issue and as such, a clear, transparent nationally consistent approach, including comparable legislated powers, is necessary to improve the safety, rights and care of people with lived experience.

9.5.54 Similarly, Lived Experience Australia held the view that 'communication and integration of mental health legislation should be a national issue and consistent across borders. This should also include more transparent reporting and accountability at a national level.'

9.6 SALRI's Observations and Conclusions

9.6.1 From SALRI's consultation, it is clear that many (though not all) consumers and carers, consistent with the evidence presented to the Victorian Royal Commission and other studies, find the involvement of the police under the *MHA* problematic, a blunt instrument that is 'humiliating and traumatic.'[2139]

9.6.2 The Office of the Chief Psychiatrist's Lived Experience Advisory Group emphasised:

> Stigma is a cultural determinant of health that reduce the social inclusion of people with lived experience. The distorted notion of 'Dangerous person' related to people with lived experience is reinforced, among other causes, when they are transported in police patrols.
>
> SAPOL needs to have a differentiated approach for people under the influence of alcohol and other drugs and people experiencing a crisis related to mental health distress. It is recommended specific training for SAPOL or SAAS so they can differentiate between someone under the influence of drugs and alcohol or a person with mental health challenges.

9.6.3 The Disability Rights Advocacy Service reinforced that '[p]ersons with mental health conditions must not be criminalised for having such conditions.'

9.6.4 SALRI's review has highlighted s 57 *MHA* powers (and more broadly s 56 *MHA* powers) exist within the broader multi-faceted healthcare system. With health agencies in South Australia and elsewhere often unable to respond effectively to emergency mental health crises, the responsibility has fallen to SAPOL, which itself has its own demands and pressures. Many of the problems with s 56 and s 57 *MHA* and the wider role and use of police appear largely operational. Meaningful change in practice requires consideration of South Australia's wider mental health care system.

[2139] *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021) vol 1 , 515. See also Tara Seed, John Fox and Katherine Berry, 'The Experiences of Involuntary Detention in Acute Psychiatric Care: a Review and Synthesis of Qualitative Studies' (2016) 61 *International Journal of Nursing Studies* 82; Genevieve Riley et al, '"A Frightening Experience": Detainees' and carers' experiences of being detained under Section 136 of the Mental Health Act' (2011) 55 *Medicine, Science and Law* 164; Joanne Bradbury et al, 'Lived Experiences of Involuntary Transport Under Mental Health Act Legislation' (2016) 26 *International Journal of Mental Health Nursing* 580.

9.6.5 SALRI accepts the use of the police under the *MHA* is less than ideal for various cogent reasons of both policy and practice. SALRI also concurs with the premise of the Victorian Royal Commission that 'police will be involved only where necessary to protect people's safety.'[2140] However, there is, at this stage, no realistic or practicable alternative to the use of SAPOL in South Australia. Hospital security guards are not appropriate or equipped to exercise these powers.

9.6.6 As a result, SALRI is of the view that the police role under s 57 of the *MHA* remains appropriate and necessary under certain circumstances.

9.6.7 Simultaneously, SALRI sees opportunity and wide scope for operational reform within the existing legislative framework. Operational changes, notably an enhanced move towards a co-response model, are necessary to improve the fair and effective operation of the *MHA*, especially for consumers. This should also reduce, though not remove, the negative perceptions and experiences of consumers.

9.6.8 The need for SAPOL involvement in responding to mental health crises is neatly summarised in the following:

> The term 'need' is purposely used to differentiate between a want, or a nice thing to have, as there is an absolute 'need' to address current community demand. This demand for noncriminal welfare checks may not constitute policing business. However, until community members perceive themselves as able to access relevant mental health services, they will continue to contact police, who are compelled to respond to crisis incidents. Therefore, there will be a need for a co-response model until the gaps in the mental health system are identified and subsequently filled.[2141]

9.6.9 There was overwhelming acceptance in SALRI's consultation, albeit on occasion with reservations, that it is unrealistic to discard the police role under the *MHA*. There will always be a need for '24/7' availability of police emergency response services to prevent harm to consumers and others. This remains in the context of an enhanced move towards a co-response model. There was overwhelming support in SALRI's consultation (notably from both SAPOL and consumers) for such a model in South Australia to underpin the operation of the *MHA* is persuasive. This model was supported by SALRI's consultation and research.[2142] There was broad agreement in consultation on the value of this model.

9.6.10 There is no single co-response model and debate as to the precise details of its operation is ongoing.[2143] Any model must be developed and launched in a thoughtful manner to meet the needs of the community.[2144] It is settled, that any mechanism that can reduce admissions to EDs under the

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[2140] *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021) vol 5, 85.

[2141] South Australia Police, Submission to South Australian Law Reform Institute, *Review of the Mental Health Act 2009* (7 September 2022) quoting Pamela Henry and Nikki Rajakaruna, *WA Police Force Mental Health Co-Response Evaluation Report* (29 March 2018) 10–11.

[2142] Laura Mulgrew, 'Co-Responding Police and Mental Health Service Models: an exploration of how Effective Collaborative Models are in Responding to Individuals Experiencing a Mental Health Crisis' (2022) *British Journal of Mental Health Nursing* 1.

[2143] Gilla Shario et al, 'Co-Responding Police-Mental Health Services: a Review' (2014) 42(5) *Administration and Policy in Mental Health and Mental Health Services Research* 606, 608. There is no single model. 'There is also wide variation in the implementation of the co-response model, with differences in hours of operation, staffing, and incident response': Stephen Puntis et al, 'A Systematic Review of Co-Responder Models of Police Mental Health "Street" Triage' (2018) 18 *BMC Psychiatry* 256. Indeed, 19 different models to date have been identified: at 258.

[2144] Laura Mulgrew, 'Co-Responding Police and Mental Health Service Models: an exploration of how Effective Collaborative Models are in Responding to Individuals Experiencing a Mental Health Crisis' (2022) 11(4) *British Journal of Mental Health Nursing* 1.

MHA is welcome, particularly with the broad understanding that 'hospital admissions are costly and present a burden on limited resources.'[2145]

9.6.11 SALRI accepts the evidence is limited in some respects, but the research to date supports the case for a co-response approach. As one comprehensive review concluded:

> Overall, we found that co-response models were associated with a reduction in the use of police powers of detention … a reduction in detainment in police custody. Unfortunately, due to the design of the studies one cannot determine whether this is due to the intervention or other factors such as changes in policy, changes in mental health provision, or greater public scrutiny of mental health detentions. Evidence from the qualitative studies we included in this review suggests that service users found the co-response interventions less distressing and less criminalising than a standard police response. Service users also reported quicker access to mental health support at the time of crisis, although this did not extend to gaining access to mental health services at follow-up … Preliminary evidence suggests that co-response models of mental health police triage may reduce the use of police powers of detention on people with mental illness and be more acceptable to service users than a standard response. However, there remains a lack of quality of reporting in studies, few controlled studies investigating the effectiveness of co-response triage, and a lack of focus on the characteristics and outcomes of service users.[2146]

9.6.12 Whilst it will not rectify all concerns raised, SALRI concurs as to the benefits of a co-response model for mental health crises. SALRI acknowledges the ongoing work in South Australia and recommends that such models underpin the exercise of s 56 and s 57 powers under the *MHA*. This model will be further complemented by a shift toward the use of a specialised workforce.

9.6.13 SALRI recommends the continued operation and evaluation of the co-responder model in South Australia and further consideration should be given to the development of a specialised mental health workforce to facilitate the operation of this model.

9.6.14 SALRI acknowledges that the role of the police and, in particular, the use of 'reasonable force' as part of the care and control powers under s 56 and s 57 is contentious and attracts divergent views in research and consultation. SALRI accepts there is a valid argument for greater clarity for the rationale and use of care and control powers.[2147] However, SALRI reiterates that, in a South Australian context, it is preferable for the care and control powers in s 56 and s 57 of the *MHA* to remain in their present form. In addition, SALRI recommends that South Australia should strive for a health-led response to mental health crises, where police involvement is ideally confined to situations where there is a risk of harm to the person and/or others.

9.6.15 SALRI's reasoning is well illustrated by the comments in consultation with a health service:

> From a service provider view point SAPOL provide an essential service when our customers are unstable/psychotic however in saying this I believe that there is a necessity to provide SAPOL with further training/understanding of people living with both Disabilities and Mental Health concerns which can be heightened with substance misuse. We had an issue just recently where a customer became heightened and became verbally threatening to staff and other

[2145] Gilla Shario et al, 'Co-Responding Police-Mental Health Services: a Review' (2014) 42(5) *Administration and Policy in Mental Health and Mental Health Services Research* 606, 613.

[2146] Stephen Puntis et al, 'A Systematic Review of Co-Responder Models of Police Mental Health "Street" Triage' (2018) 18 *BMC Psychiatry* 256, 263, 265.

[2147] See further Part 8 Restrictive Practices and Control Powers.

> customers. SAPOL was called to which they responded 3 hours after the report, had a conversation with the customer and left site. The customer became even more heightened becoming physically aggressive where SAPOL once again called. Once again SAPOL took an extensive amount to time to respond during which time staff were in contact with Community Mental Health practitioners who know the customer extremely well and we were advised from the information provided to them that he was experiencing a psychotic episode and that staff and customers should remove themselves from his presence. When SAPOL and SAAS came on site a while later the customer physically assaulted a female staff member and it took six Police Officers and SAAS to place him in the ambulance and transport him to the hospital where he was assessed and later discharged after a 30 minute period. He was charged with assault and SAPOL wanted to release him back to the accommodation site even though we had provided them with information from Community Mental Health that the customer should be detained. This highlighted that there needs to be more collaboration/understanding between agencies/stakeholders.

9.6.16 The ability of police and authorised officers to use 'reasonable force' is not solely a legal issue. As such, it is a 'very sensitive moral and safety topic for not just the consumer, but their families and health care providers with no easy answer and very often there will be no finding at this stage the person has mental illness or falls within the grounds for a CTO or ITO.'

9.6.17 It is important, as SALRI often heard in consultation (consistent with wider research),[2148] not to generalise about the risks or dangers of violence presented by persons with a mental illness. Most often it is individuals under the influence of illicit drugs that are violent and/or aggressive. SALRI's consultation with mental health practitioners, including forensic psychologists, psychiatrists, adult mental health psychiatrists, psychologists and nurses, reiterated that a majority of (though not all) circumstances requiring SAPOL's intervention, involved an individual under the influence of illicit drugs (whether at ED or home visits for CTO treatment).

9.6.18 SALRI acknowledges the concerns of consumers, consumer and advocacy groups and various commentators and experts in relation to the use of care and control powers. However, SALRI is well aware of the paramount need to ensure the safety of all parties – police, hospital staff, consumers and other patients. The use of 'reasonable force' under the *MHA*, whether by police or authorised officers, should be a 'last resort', where no other less restrictive alternatives are practicable. Any such law should also be subject to operational and professional protocols and SALRI crucially emphasises these powers should only be exercised by authorised officers (drawing on s 56), after suitable training.

9.6.19 There were differing views relating to the ability of hospital staff to use reasonable force to 'hold' a person until SAPOL arrives. SALRI notes that various consumers and consumer and advocacy groups opposed this suggestion. Other parties, including various health practitioners and RANZCP, whilst supportive in principle, identified having reservations regarding both policy and practice. In contrast, various parties were supportive, noting the need for this power to be carefully used by suitable and trained staff.

9.6.20 SALRI notes and adopts the insightful comments and reasoning of the Legal Services Commission:

> In some extreme circumstances, SAPOL is best placed to manage a patient the subject of an order under the *MH Act* to protect not only the patient but others from the risk of harm. There are, however, acute cases where SAPOL are either on their way or have left after delivering a patient

[2148] Amy Watson, Patrick Corrigan and Victor Ottati, 'Police Officer Attitudes and Decisions Regarding Persons with Mental Illness' (2004) 55 *Psychiatric Services* 46.

> into the care of the mental health team, where the patient remains psychotic and protective measures may be necessary. This situation would require the use of lawful restrictive practices by hospital staff for the protection of the patient, other patients, and their own safety. Appropriate training of and standards for police and hospital staff are key to ensuring that [such] restrictive practices are applied appropriately. It is noted that the Chief Psychiatrist has published a Standard regarding the use of restrictive practices.

9.6.21 In light of its consultation, SALRI recommends that, where a person has committed an offence, and is in police custody and requires treatment, the *MHA* should be amended to allow authorised mental health professionals and authorised officers to use reasonable force to 'hold' a person until police arrive.

9.6.22 The issue of SAPOL training to enforce the *MHA* and manage persons with a mental illness was significant and raised by many parties in consultation. Such training is important and can be very helpful in equipping police on both a general and specialist basis to improve their knowledge and skills to deal with mental health crises.[2149] SALRI does not wish to discourage such training, indeed the contrary. However, such training, whilst valuable, is not a panacea.[2150] SALRI also accepts the expectations of training have to be realistic and it is simply not feasible to expect the constable on general duties patrol to have the same expertise as a psychiatrist or mental health professional. This was noted by a number of parties in consultation.

9.6.23 Therefore, SALRI recommends that SAPOL provide appropriate initial and ongoing specialist mental health training for police officers. SALRI further favours the involvement of mental health clinicians and professionals and appropriately trained police officers in mental health for crisis intervention.

9.6.24 Recommendations

RECOMMENDATION 43

SALRI recommends that the role and powers of the South Australia Police in s 57 of the *Mental Health Act 2009* (SA) should be retained.

RECOMMENDATION 44

SALRI recommends the continued operation and evaluation of the co-responder model in South Australia to underpin the operation of the *Mental Health Act 2009* (SA)[2151] and further consideration should be given to the development of a specialised mental health workforce to facilitate the operation of a co-response model.

[2149] See, for example Victoria Herrington and Rodney Pope, 'The Impact of Police Training in Mental Health: An Example from Australia' (2013) 23(5) *Policing and Society* 501.

[2150] James Ogloff and Stuart Thomas, *Training Police to Better Respond to People with Mental Illness* (4 March 2014) The Conversation <https://theconversation.com/training-police-to-better-respond-to-people-with-mental-illness-23651>.

[2151] Such a model received wide support in SALRI's consultation from SAPOL, consumer groups and health practitioners. Such a model has sound policy, operational and resourcing benefits.

RECOMMENDATION 45

SALRI further recommends the involvement of mental health clinicians and professionals and appropriately trained police officers in mental health for crisis intervention.

RECOMMENDATION 46

SALRI recommends that South Australia Police provide appropriate initial and ongoing specialist mental health training for police officers.[2152]

RECOMMENDATION 47

SALRI recommends that, where a person has committed an offence, and is in police custody and requires treatment, the *Mental Health Act 2009* (SA) should be amended to allow authorised mental health professionals and authorised officers to use reasonable force to 'hold' a person until police arrive.

[2152] SALRI notes that certain training in this context is already provided to SAPOL officers at different ranks.

Part 10 - The South Australian Civil and Administrative Tribunal and Legal Representation

10.1 Background

10.1.1 The application of the South Australian Civil and Administrative Tribunal ('SACAT') to proceedings under the *MHA* is a significant issue. SACAT and similar bodies are required to make often difficult and sensitive legal decisions regarding whether or not a person with a mental illness will be subject to involuntary treatment, and possibly, whether or not they must also be detained. The balance between accessibility and fairness can be elusive (as SALRI was reminded in consultation) and mental health review tribunals such as SACAT, face the onerous task of balancing obligations of efficiency and accessibility with the obligation to promote active consumer participation and provision of procedural fairness.[2153] Mental health review tribunals generally allow, but neither require nor provide, legal representation to consumers.[2154] This absence of guaranteed legal representation may create significant access to justice challenges for consumers.

10.1.2 The rationale for providing tribunals, rather than courts, with the decision-making role under the *MHA* is to promote both accessibility and efficiency.[2155] The premise is that by moving away from formal adversarial court procedures to a cost effective, flexible and informal set of procedures, matters can be more swiftly finalised, and unrepresented individuals can more meaningfully and effectively participate in the proceedings.[2156] Such bodies are typically established as multidisciplinary panels with legal, medical and lay expertise.[2157] However, such tribunals, as with any administrative decisions that affect a person's rights, interests or legitimate expectations, are still required to observe the rules of procedural fairness or natural justice.[2158] What procedural fairness requires of a decision-

[2153] Sam Boyle and Tamara Walsh, 'Procedural Fairness in Mental Health Review Tribunals: the Views of Patient Advocates' (2021) 28(2) *Psychiatry, Psychology and Law* 163, 166.

[2154] Penelope Weller, 'Taking a Reflexive Turn: Non-Adversarial Justice and Mental Health Review Tribunals' (2011) 37(1) *Monash University Law Review* 81, 96. 'In practice, representation before MHRTs is largely dependent upon the usually limited public provision of legal services, which results in low levels of representation': at 96. See also Valerie Williams, 'The Challenge for Australian Jurisdictions to Guarantee Free Qualified Representation before Mental Health Tribunals and Boards of Review: Learning from the Tasmanian Experience' (2009) 16 *Psychiatry, Psychology and Law* 108, 109.

[2155] Robin Creyke, 'Tribunals – "Carving Out the Philosophy of Their Existence": The Challenge for the 21st Century' (2012) 71 *Australian Institute of Administrative Law Forum* 19, 21–2.

[2156] Sam Boyle and Tamara Walsh, 'Procedural Fairness in Mental Health Review Tribunals: the Views of Patient Advocates' (2021) 28(2) *Psychiatry, Psychology and Law* 163. See also *South Australian Civil and Administrative Tribunal Act 2013* (SA) s 8. 'Mental health tribunals are generally seen as independent forums and are responsible for making decisions about compulsory treatment in both community and hospital environments. They ostensibly act as a safeguard for individuals subject to involuntary treatment, providing checks and balances against clinical decision-making by testing whether legislative criteria have been met. Tribunals are often regarded as being more participatory than court-based systems in that they actively involve individuals subject to compulsory treatment in the decision-making process. Moreover, multi-member, multidisciplinary, panels are designed to strengthen the decision-making process by ensuring that a variety of expertise informs deliberation': Aisha Macgregor, Michael Brown and Jill Stavert, 'Are Mental Health Tribunals Operating in Accordance with International Human Rights Standards? A Systematic Review of the International Literature' (2019) 27(4) *Health and Social Care in the Community* 494, 495.

[2157] Jake Buckingham, 'A Critical Analysis of Legal Representation in Queensland's Mental Health Review Tribunal', (2018) 6(1) *Griffith Law Journal* 132, 141–4.

[2158] *Kioa v West* (1985) 159 CLR 550, 585 (Mason J); Anina Johnson, 'The Value of Procedural Fairness in Mental Health Review Tribunal Hearings' (Paper presented at the Australian Institute of Administrative Law National Conference, Brisbane, Queensland, 21 July 2016).

maker will vary according to the specific circumstances of the decision being made.[2159] It is expected that SACAT and similar decision makers 'will act with utmost care, rigour and impartiality'.[2160] 'Striking the right balance between fairness on one hand, and accessibility on the other, has been noted as an ongoing challenge for Australian [*MHA*] tribunals.'[2161]

10.1.3 In South Australia, SACAT is the body[2162] with the power under the *MHA* to make and review various orders relating to persons with mental illness. Within SACAT's original jurisdiction is the ability to review level 1 Community Treatment Orders ('CTOs'), make treatment orders, determine applications for level 2 CTOs and Level 3 Inpatient Treatment Orders ('ITOs') and consent to prescribed psychiatric treatment, which includes electroconvulsive therapy ('ECT') and neurosurgery.[2163] SACAT can resolve matters at a conference or mediation, or through a decision at a hearing.[2164] In some circumstances, where SACAT is not the decision-maker (for example, a decision is made by a medical practitioner or the Chief Psychiatrist), SACAT may have to be notified.[2165] SACAT is guided by the guiding principles in the performance of their functions regarding the provision of mental health services.[2166]

10.1.4 The effects of decisions by SACAT and similar bodies are 'momentous' for consumers.[2167] SACAT's orders involve treatment and/or detention that may have profound implications for the consumer and other parties closely involved.[2168] One study observed that it is a 'drastic outcome', and 'being detained and treated against one's will is a profoundly invasive experience, which most people would find distressing'.[2169] The impact of CTOs on consumers should not be understated. The medication administered under a CTO can result in major side effects on a consumer (a fact often made clear to SALRI in consultation). Further, 'the fact that the provisions of the [*MHA*] relating to

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[2159] *Kioa v West* (1985) 159 CLR 550, 585.

[2160] Sam Boyle and Tamara Walsh. 'Procedural Fairness in Mental Health Review Tribunals: the Views of Patient Advocates' (2021) 28(2) *Psychiatry, Psychology and Law* 163.

[2161] Ibid.

[2162] Determining whether a power is judicial or administrative in nature is a difficult task. See Anna Olijnyk and Stephen McDonald, 'The High Court's Decision in *Burns v Corbett*: Consequences, and Ways Forward, For State Tribunals' (2019) 95 *Australian Institute of Administrative Law Forum* 10. It depends on the nature of the powers exercised: *Attorney General (SA) v Raschke* (2019) SASCFC 83. Whether SACAT or any similar body is a court is a complex issue beyond the scope of this Report. SACAT, as it is presently constituted, does not meet the definition of a 'court'. See *Attorney General (SA) v Raschke* (2019) SASCFC 83. The Commonwealth Constitution reserves jurisdiction in certain matters to 'Courts' (*Australian Constitution* ss 75 & 76) to be defined by the Commonwealth Parliament (at: s 77). The High Court's decision in *Burns v Corbett* (2018) 265 CLR 304 confirmed that State administrative tribunals, unless properly constituted as a court, cannot exercise powers in cases involving this 'federal diversity' jurisdiction. See also *Citta Hobart Pty Ltd v Cawthorn* [2022] HCA 16.

[2163] South Australian Civil and Administrative Tribunal, *Jurisdiction List* (2022) <https://www.sacat.sa.gov.au/about-sacat/who-we-are/jurisdiction-list>.

[2164] Ibid.

[2165] For example, the decision to transfer a patient to an interstate facility under *Mental Health Act 2009* (SA) s 70(4)(b).

[2166] *Mental Health Act 2009* (SA) s 7.

[2167] Law Commission of Ontario, *Legal Capacity, Decision-Making and Guardianship* (Final Report, March 2017) 58.

[2168] Fleur Beaupert, 'Mental Health Tribunals: From Crisis to Quality Care?' (2007) 32(4) *Alternative Law Journal* 219; Fleur Beaupert, 'Mental Health Tribunal Processes and Advocacy Arrangements: Little Wins are No Small Feat' (2009) 16(1) *Psychiatry, Psychology and the Law* 90, 92. 'Mental health tribunals make decisions that may impact on a person's health and wellbeing, family and social relationships, employment situation and prospects, place of residence (or detention), and ability to exercise control over many aspects of their life… a crucial decision about the treatment and management of their mental illness with far-reaching implications for their daily lives': at 92.

[2169] Sam Boyle, Tamara Walsh and Lucinda Nelson, 'A Study into the Operation of the Queensland Mental Health Review Tribunal' (2021) 29(1) *Medical Law Review* 106, 106–7.

a community treatment order have the potential, if the order is not complied with, to result in the involuntary incarceration of the appellant in an institution, thereby depriving [them of their] freedom."[2170]

10.1.5 The role of legal representatives under the *MHA* is therefore vital.[2171] As one lawyer who practises in this area commented:

> Representing the mentally disordered can be a lonely, stressful and thankless task. Yet it remains a fundamentally important task. The representative provides the skilled voice for a patient who has lost his liberty. Representatives should take pride in what they do and never doubt the difference they can make to the lives of those who are unable to fight their case alone.[2172]

10.1.6 The absence of guaranteed legal representation for consumers before mental health tribunals is a recurring concern[2173] (as reiterated in SALRI's consultation), particularly in conjunction with the concerns regarding the role and operation of mental health tribunals.[2174] These concerns include how well informed consumers are about the proceedings before such bodies, how the practical effectiveness of consumer participation, the probative value of the evidence relied upon by tribunals, and the extent to which medical evidence is effectively challenged.[2175] There appears to be a perception, whether justified or not, from published research in this area and SALRI's consultation that many, if

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[2170] *EO v Mental Health Review Board* [2000] WASC 203 [39].

[2171] See, for example, Paul Veitch, 'The Case for "Good" Legal Representation Is it Worth Fighting For?' (2011) 21 *Journal of Mental Health Law* 15; Terry Carney, Fleur Beaupert, Julia Perry and David Tait, 'Advocacy and Participation in Mental Health Cases: Realisable Rights or Pipe-Dreams?' (2008) 26(2) *Law and Context* 125; Fleur Beaupert, 'Mental Health Tribunal Processes and Advocacy Arrangements: "Little Wins" are No Small Feat' (2009) 16(1) *Psychiatry, Psychology and Law* 90.

[2172] Paul Veitch, 'The Case for "Good" Legal Representation Is it Worth Fighting for The Case For' (2011) 21 *International Journal of Mental Health and Capacity Law* 15, 23.

[2173] Terry Carney, Fleur Beaupert, Julia Perry and David Tait, 'Advocacy and Participation in Mental Health Cases: Realisable Rights or Pipe-Dreams?' (2008) 26(2) *Law and Context* 125, 126.

[2174] See generally, Sameer Sarkar and Gwen Adshead, 'Black Robes and White Coats: Who will Win the New Mental Health Tribunals?' (2005) 186 *British Journal of Psychiatry* 96, 96–98; Amar Shah, 'Is the Mental Health Review Tribunal Inherently Unfair to Patients?' (2009) 17(1) *Psychiatry, Psychology and Law* 25, 25–31; Ian Freckelton, 'Therapeutic Jurisprudence Misunderstood and Misrepresented: The Price and Risks of Influence' (2008) 30(2) *Thomas Jefferson Law Review* 575, 587; Terry Carney and David Tait, 'Mental Health Tribunals – Rights, Protection, or Treatment? Lessons from the ARC Linkage Grant Study?' (2011) 18(1) *Psychiatry, Psychology and Law* 112; Terry Carney, 'Australian Mental Health Tribunals: "Space" for Rights, Protection, Treatment and Governance?' (2012) 35 *International Journal of Law and Psychiatry* 1; Katey Thom and Ivana Nakarada-Kordic, 'Mental Health Review Tribunals in Action: A Systematic Review of the Empirical Literature' (2014) 21(1) *Psychiatry, Psychology and Law* 112; Christopher Maylea and Christopher Ryan, 'Decision-Making Capacity and the Victorian Mental Health Tribunal' (2017) 24 *International Journal of Mental Health and Capacity Law* 87; Julie Ridley and Susan Hunter, 'Subjective Experiences of Compulsory Treatment from a Qualitative Study of Early Implementation of the Mental Health (Care and Treatment) (Scotland) Act 2003' (2013) 21 *Health and Social Care in the Community* 509; Sam Boyle, Tamara Walsh and Lucinda Nelson, 'A Study into the Operation of the Queensland Mental Health Review Tribunal' (2021) 29(1) *Medical Law Review* 106; Aisha MacGregor, 'Meaningful Participation or Tokenism for Individuals on Community Based Compulsory Treatment Orders? Views and Experiences of the Mental Health Tribunal in Scotland' (2022) 31(2) *Journal of Mental Health* 158.

[2175] Sam Boyle and Tamara Walsh, 'Procedural Fairness in Mental Health Review Tribunals: the Views of Patient Advocates' (2021) 28(2) *Psychiatry, Psychology and Law* 163; Aisha Macgregor, Michael Brown and Jill Stavert, 'Are Mental Health Tribunals Operating in Accordance with International Human Rights Standards? A Systematic Review of the International Literature' (2019) 27(4) *Health and Social Care in the Community* 494. As one overall study of the literature concluded: 'Eight themes were identified across the literature and these were participation, information and understanding, patient representation, the power of the medical domain, feelings of powerlessness, perceptions of fairness, risk and the impact on relationships. The findings call into question whether mental health tribunals necessarily operate in compliance with international human rights standards. This article suggests that mental health tribunals may need to do more to safeguard legislative principles and human rights standards that promote patient autonomy': at 494.

not most, consumers are unable to effectively participate in such proceedings.[2176] Participants have even described their involvement as 'tokenistic'[2177] and the decisions of the tribunal as a mere 'rubber-stamp' of the medical team's determination'.[2178] In this view, the necessary role of legal representatives is greatly elevated.

10.1.7 The literature stresses the importance of support and representation during the hearing of a matter. SALRI highlights that these are general concerns that emerge throughout the literature and are not necessarily expressed in relation to SACAT's role.

10.2 Current Law in South Australia

Treatment Orders

10.2.1 SACAT may order a level 2 CTO ('CTO 2') if there are no less restrictive means of ensuring treatment for a person with mental illness and who has impaired decision-making capacity.[2179] The same test is applied by SACAT when considering whether to order a level 3 ITO ('ITO 3').[2180]

10.2.2 A CTO 2 can be imposed upon application to SACAT or imposed in lieu of an ITO 3.[2181] An application to impose a CTO 2 can be made by a patient, the Public Advocate, a medical practitioner, a mental health clinician, a guardian, medical agent, relative, carer, or friend of the person, or any other person who satisfies SACAT that he or she has a proper interest in the welfare of the

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[2176] Terry Carney et al, *Australian Mental Health Tribunals: Space for Fairness, Freedom, Protection and Treatment?* (Themis Press, 2011) 251; Sam Boyle and Tamara Walsh, 'Procedural Fairness in Mental Health Review Tribunals: the Views of Patient Advocates' (2021) 28(2) *Psychiatry, Psychology and Law* 163, 168. 'Clients don't even know the process of the tribunal hearing and they just are a bit clueless [about] what's happening.' 'I don't think they would often understand the processes. It's a very foreign process unless you've been through them all the time.'

[2177] Aisha MacGregor, 'Meaningful Participation or Tokenism for Individuals on Community Based Compulsory Treatment Orders? Views and Experiences of the Mental Health Tribunal in Scotland' (2022) 31(2) *Journal of Mental Health* 158.

[2178] Sam Boyle and Tamara Walsh, 'Procedural Fairness in Mental Health Review Tribunals: the Views of Patient Advocates' (2021) 28(2) *Psychiatry, Psychology and Law* 163, 168. 'Participants used many other phrases to express the same view, including: 'psychiatrists rule the day' (FG2, S2); 'whatever the psychiatrists says goes' (FG2, S3); 'doctors are the law' (FG3, S4); 'the treating team's evidence is gold every time' (FG5); 'whatever the medical staff say, goes/It's their tribunal' (FG7); 'most of it is just, trust me, I'm a doctor' (FG7); 'the clinical team's position is taken first and foremost' (FG9). In four of the focus groups, the phrase 'tick and flick' was used to describe the tribunal's decision-making process – the consensus was that there was generally no substantive engagement with the relevant legislative criteria and no independent discussion or critique of the psychiatrists' recommendations': at 171. See also Sam Boyle, Tamara Walsh and Lucinda Nelson, 'A Study into the Operation of the Queensland Mental Health Review Tribunal' (2021) 29(1) *Medical Law Review* 106, 118–120. The criticisms in the Queensland study were rejected by the Queensland MHRT resident, Annette McMullan, who questioned the methodology and findings of this study. 'Ms McMullan, who has both legal and nursing qualifications, said the study was limited in its scope, relying on interviews with only those who represented or provided advice to persons appearing before the tribunal': Rory Callinan, *Study into Queensland's Mental Health Review Tribunal Raises Concerns About Oversight of Patients* (2 June 2021) ABC News <https://www.abc.net.au/news/2021-06-02/study-raises-concerns-about-qld-mental-health-review-tribunal/100181556>. See also Anina Johnson, 'The Value of Procedural Fairness in Mental Health Review Tribunal Hearings' (Paper presented at the Australian Institute of Administrative Law National Conference 86, Brisbane, Queensland, 21 July 2016). 'However, it should not be presumed that the MHRT simply adopts without question the clinical team's recommendation': at 16.

[2179] *Mental Health Act 2009* (SA) s 16(1)(a)–(d).

[2180] Ibid s 29(1)(a)–(c).

[2181] Ibid s 16(3).

patient.[2182] The same list of parties can make an application for variation or revocation of a CTO 2[2183] and the variation or revocation of an ITO 3. [2184] SACAT may, on application, make an order to vary or revoke a CTO 2 at any time.[2185]

10.2.3 An application to SACAT to impose an ITO 3 can be made by the Public Advocate, the Director of an approved treatment centre, or an employee in an approved treatment centre authorised by the Director of the centre for that purpose.[2186] This list is different to the list of parties who can apply for a CTO 2.[2187]

10.2.4 SACAT may, on application and by order, vary or revoke an ITO 3 at any time.[2188]

10.2.5 The nature and implications of these orders are significant (as SALRI was often reminded in consultation). Tribunals such as SACAT act as the 'gatekeeper'[2189] for treatment and detention under the *MHA* and 'are critical both to patient's welfare and rights'.[2190] These are not simple decisions, indeed they are 'very weighty'.[2191]

10.2.6 One study makes plain the 'very difficult'[2192] nature of such decisions:

> Mental health tribunals have difficult decisions to make. On one hand, they must consider the risk that people with mental illnesses may pose to themselves, or to the community. If they allow someone out of involuntary detention and treatment and that person goes on to commit suicide or a serious crime, the decision to release that person will come under heavy scrutiny. On the other hand, involuntary detention and treatment is highly invasive, and would be considered a serious violation of human rights in other contexts. A central goal of mental health legislation is to ensure that people who need treatment for mental illness are able to receive it, even if their illness means they are unable to understand that it is necessary, but it may still be experienced as unwelcome, or even oppressive, at the time.[2193]

[2182] *Mental Health Act 2009* (SA) s 16(4).

[2183] Ibid s 16(8).

[2184] Ibid s 29(7).

[2185] Ibid s 16(7).

[2186] Ibid s 29(4).

[2187] Ibid s 29(7).

[2188] Ibid s 29(6).

[2189] Penelope Weller, 'Taking a Reflexive Turn: Non-Adversarial Justice and Mental Health Review Tribunals' (2011) 37(1) *Monash University Law Review* 81, 88; Michael Cain et al, *The NSW Mental Health Review Tribunal: An Analysis of Clients, Matters and Determinations* (Law and Justice Foundation of NSW, 2011) xviii. Bodies such as SACAT 'perform a crucial gate-keeping role in balancing the interests and rights of mentally ill patients in terms of their liberty with their safety and the safety of the community.' This gate-keeping role is particularly important given that 'people with mental disorders are, or can be, particularly vulnerable to abuse and violation of rights' and 'tend to experience greater difficulties in accessing justice than other groups, and also experience greater discrimination and disadvantage': at 1.

[2190] Terry Carney et al, 'Mental Health Tribunals: ""TJ" Implications of Weighing Fairness, Freedom, Protection and Treatment' (2007) 17(1) *Journal of Judicial Administration* 46, 46–58.

[2191] Sam Boyle and Tamara Walsh. 'Procedural Fairness in Mental Health Review Tribunals: the Views of Patient Advocates' (2021) 28(2) *Psychiatry, Psychology and Law* 163.

[2192] Sam Boyle, Tamara Walsh and Lucinda Nelson, 'A Study into the Operation of the Queensland Mental Health Review Tribunal' (2021) 29(1) *Medical Law Review* 106, 126.

[2193] Ibid 107.

Legal Representation

10.2.7 The issue of legal representation in relation to proceedings before SACAT under the *MHA* was raised by many parties in consultation, perhaps most notably by the Law Society in its submission to SALRI.[2194] It was often pointed out that an entitlement to legal representation under the *MHA* before SACAT is of limited utility without some scheme or framework to provide for such legal (or other)[2195] representation. The low rate of legal representation for consumers before mental health tribunals has been noted[2196] (including in SALRI's consultation in relation to SACAT).[2197] For example, Victoria Legal Aid submitted to the Law Council of Australia that the majority of compulsory consumers involved in Victorian Mental Health Tribunal proceedings are not legally represented, less than 18% generally, but for CTOs as low as 6% and for ECT as low as 8%.[2198] In contrast, in NSW, legal representation was provided in 77% of all hearings in the NSW Mental Health Review Tribunal civil jurisdiction.[2199] It has been further noted:

> A legal representative was more likely to be in attendance for certain types of matters, with significantly higher levels of legal representation noted in relation to Tribunal hearings that involved Temporary Patient orders (79%; also known as In-patient orders) and applications for Protected Estates Orders (79%). It was very uncommon (1%) for a legal representative to appear at a CTO hearing. It was only slightly more common (7%) for a lawyer to represent a client at an ECT hearing. The client's legal representative was almost always a Legal Aid NSW solicitor from the Mental Health Advocacy Service (MHAS).[2200]

[2194] The Law Society of South Australia, Submission to SALRI, *Review of the Mental Health Act 2009 (SA)*, 23 August 2020.

[2195] Terry Carney, Fleur Beaupert, Julia Perry and David Tait, 'Advocacy and Participation in Mental Health Cases: Realisable Rights or Pipe-Dreams?' (2008) 26(2) *Law and Context* 125, 141–5. It is important not to overlook the utility and value of non-legal advocates and that effective representation for consumers and other interested parties extends to outside a tribunal to advice and assistance.

[2196] See, for example, Ibid 127; Michael Cain et al, *The NSW Mental Health Review Tribunal: An Analysis of Clients, Matters and Determinations* (Law and Justice Foundation of NSW, 2011) 26; Terry Carney and David Tait, 'Mental Health Tribunals – Rights, Protection, or Treatment? Lessons from the ARC Linkage Grant Study?' (2011) 18 *Psychiatry, Psychology and Law* 137, 141; Stephanie Corsetti*, Low Mental Health Legal Representation in Regional Victoria Affects Patient Outcomes, Legal Aid Says* (21 March 2018) ABC News <https://www.abc.net.au/news/2018-03-21/mental-health-legal-representation-low-in-regional-victoria/9571696>.

[2197] There are no apparent official statistics, but SALRI understands that most consumers under the *Mental Health Act 2009* (SA) before SACAT are legally unrepresented.

[2198] Victoria Legal Aid, Submission No 18 to the Justice Project*, A National Blueprint for Justice for All* (30 August 2017) 10. The low rate of legal representation for consumers in Victoria remains notable. Victoria has two providers of free legal representation for Tribunal hearings – Victoria Legal Aid (VLA) and the Mental Health Legal Centre (MHLC). In the Victorian Tribunal's first year of operation in 2014, legal representatives appeared in 19% of hearings, but this fell to approximately 15% in each of the following three years, and in 2018/19 fell further to 13%. See Mental Health Tribunal of Victoria, Submission to the Productivity Commission*, Mental Health Inquiry* (January 2020) 6. The Victorian Royal Commission identified funding constraints as a main reason for this low uptake of lawyers. See *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021) vol 4, 397.

[2199] Mental Health Review Tribunal of New South Wales, *Annual Report 2014–2015* (2015) 24.

[2200] Michael Cain et al, *The NSW Mental Health Review Tribunal: An Analysis of Clients, Matters and Determinations* (Law and Justice Foundation of NSW, 2011) xvi.

10.2.8 Although consumers in Victoria are legally entitled to legal representation before the Tribunal,[2201] they are still facing difficulties with only 13% of consumers using the resource in 2018-2019[2202] compared with 83% of consumers in NSW in the same time period.[2203]

10.2.9 The absence of a scheme or framework for the provision of legal representation for consumers was widely seen in consultation as problematic for first instance proceedings in SACAT.

10.2.10 Section 84 of the *MHA* establishes the legal representation scheme in South Australia in order to provide free legal representation to all persons who are the subject of an order under review, such as the imposition of an ITO. In every review or appeal, or application for permission for review or appeal, the person to whom the proceedings relate is entitled to legal representation[2204] by a practitioner chosen by the person or in default of a person making a choice, chosen by such a person or authority as the scheme contemplates.[2205]

10.2.11 Legal representation will be organised by SACAT and is administered by the Legal Services Commission of South Australia,[2206] at no cost to the consumer.[2207] This scheme is funded by the Minister for Health and Wellbeing.[2208] In the 2021-2022 financial year, there were 352 total instances where legal representation was provided by the Legal Services Commission with almost all of these reviews relating to level 2 ITOs ('ITO 2').[2209]

10.2.12 The present scheme was helpfully described by SACAT to SALRI as follows:

> Section 84 of the *MHA* establishes the legal representation scheme in order to provide legal representation free of charge to all persons who are subject to an order under review. Where the Tribunal makes an order, for example to impose a Level 2 Community Treatment Order (Level 2 CTO) under section 16 of the *MHA*, this order is made under SACAT's 'original jurisdiction' and the person subject to that order is not entitled to legal representation at the hearing under the scheme. Where the Tribunal has been requested to review its own decision under s 70 of the *South Australian Civil and Administrative Tribunal Act 2013* (SACAT Act) this is the 'internal review jurisdiction of the Tribunal. An example of this might be an application to review of the Tribunal's own decision to order a Level 2 CTO in its original jurisdiction. In those circumstances, the person who is subject to that order under review is entitled to legal representation under the scheme established by section 84 of the *MHA*.[2210]

10.2.13 The person subject to the *MHA* proceeding retains the right to appear personally, by the Public Advocate, or by a representative pursuant to any other provision of the Act.[2211] Otherwise, a

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[2201] *Mental Health Act 2014* (Vic) s 184(3).

[2202] Mental Health Review Tribunal (NSW), *Annual Report 2018–19* (2019) 27, see Table 30.

[2203] Ibid 25.

[2204] *Mental Health Act 2009* (SA) s 84(1).

[2205] Ibid s 84(2).

[2206] Chief Psychiatrist of South Australia, *Annual Report* (Report, 2022) 11.

[2207] South Australian Civil and Administrative Tribunal, *Applications for Internal Review of a Decision made by the Community Stream of SACAT* (2020).

[2208] *Mental Health Act 2009* (SA) s 81.

[2209] Chief Psychiatrist of South Australia, *Annual Report* (2022) 11. Legal representation was provided by the Legal Services Commission to 339 consumers subject of reviews of level 2 ITOs.

[2210] SACAT supported extending the provision of legal representation to consumers under the *Mental Health Act 2009* (SA) to any proceeding before SACAT.

[2211] *Mental Health Act 2009* (SA) s 84(4).

person who is the subject of proceedings before SACAT is entitled to appear before SACAT by a Public Advocate or, if the matter is not an internal review, a recognised advocate.[2212] Aside from legal representation, the consumer is entitled to be supported by a guardian, medical agent, relative, carer, friend, community visitor, an advocate or where the consumer is a child, a parent.[2213]

10.2.14 The *MHA* affords a measure of procedural fairness by ensuring that a consumer or patient is given a copy of the order or decision[2214] and statement of rights.[2215] The decision-maker must also ensure a copy of the order or decision and the statement of rights is sent or given to a guardian, medical agent, relative, carer, or friend of the patient as soon as practicable.[2216] On request of a person with a right to internal review or a person who SACAT thinks has a proper interest in the matter, SACAT must provide a written statement of reasons for its decision to that person. SACAT will not provide reasons for its decision if the request is made after the period for the review has expired, if a review has been instituted or after the review has been decided.[2217]

10.2.15 The *MHA* recognises in its 'principles' that consumers (together with family or other carers or supporters) should be provided with comprehensive information about their illnesses, any orders that apply to them, their legal rights, the treatments and other services that are to be provided or offered to them and what alternatives are available.[2218] Carers and family members are also consulted prior to making a comprehensive treatment and care plan.[2219]

10.2.16 The Law Society reiterated its long-standing concern to SALRI that presently, legal representation is not provided at first instance to people who appear before SACAT in relation to matters under the *MHA*, which include:

1. ITOs – which provide for long term involuntary detention and treatment in a psychiatric hospital;
2. CTOs – which provide for involuntary medical treatment in the community, frequently by depot injection; and
3. Orders that a person be given involuntary ECT.[2220]

10.2.17 The Law Society's concern is that the denial of the provision of legal representation in such first instance matters before SACAT under the *MHA* 'presents a significant barrier to access to justice, particularly given the context in which such matters often progress.' The Law Society drew a parallel to SALRI between this experience and those who are legally unrepresented in the criminal justice system, with the common factor being the potential deprivation of liberty for those who are unsuccessful, adding: 'The context of such orders, which often involve individuals with sometimes significant mental illness or disability who may likely have low legal capability, is emphasised.'

[2212] *Mental Health Act 2009* (SA) s 85B(1).

[2213] Ibid s 47(2). The value of advocates for consumers other than legal practitioners should not be overlooked. Neither should the value of assistance or advice for consumers outside the tribunal.

[2214] Ibid s 46(1)(a).

[2215] Ibid s 46(1)(b)(i)–(ii).

[2216] Ibid s 46(3), (4).

[2217] Ibid s 85A(a), (b).

[2218] Ibid s 7(i).

[2219] Ibid s 7(c).

[2220] There are several significant orders of a similar scope, which can be made under the *Guardianship and Administration Act 1993* (SA), which fall outside the scope of SALRI's current review.

Electroconvulsive Therapy

10.2.18 Electroconvulsive Therapy ('ECT') is a specialised medical procedure where controlled seizures are induced under general anaesthesia and is most commonly used to treat major depression and sometimes other severe mental illnesses such as acute mania, catatonia, and schizophrenia.[2221] ECT is the only prescribed psychiatric treatment currently practiced in South Australia.[2222] The *MHA* also establishes a Prescribed Psychiatric Treatment Panel, which conducts reviews of consumers undergoing ECT and to authorise the carrying out of neurosurgery as treatment.[2223]

10.2.19 SACAT can provide written consent to authorise ECT in specific circumstances:

- If a patient over 16 years of age is incapable of making decision on their behalf and has an advanced care directive;[2224]
- Any situation where the patient is over 16 years of age and is incapable of making a decision for themselves; or[2225]
- If the patient is under 16 years of age.[2226]

10.2.20 Before providing consent to ECT, SACAT must be satisfied that no substitute decision-maker is available to consent to the medical treatment, and the consumer is incapable of making a decision on their own behalf.[2227]

10.2.21 An application for SACAT's consent under s 42 of the *MHA* to administer ECT may be made by a medical practitioner or a mental health clinician.[2228] The Electroconvulsive Therapy Policy guidelines state that an application to SACAT can be made where:

a) It is not an emergency situation;

b) The patient does not have decision-making capacity to consent to or/refuse ECT;

c) The patient does not have legally appointed supported decision maker who can consent/refuse on the patient's behalf; and

d) An application to SACAT for ECT must include a psychiatrist's supporting opinion that the proposed ECT treatment is necessary and appropriate and is in accordance with accepted clinical practice.[2229]

10.2.22 In limited circumstances, consent is not required if the psychiatrist considers that the person urgently requires ECT for their wellbeing and it is not practicable to obtain consent.[2230]

[2221] Office of the Chief Psychiatrist of South Australia, *Annual Report* (2022) 24.

[2222] Ibid.

[2223] *Mental Health Act 2009* (SA) s 41A-41C.

[2224] Ibid s 42(1)(c)(ii)(A).

[2225] Ibid s 42(1)(c)(ii)(B).

[2226] Ibid 42(1)(c).

[2227] South Australian Civil and Administrative Tribunal, *Consent to prescribed medical psychiatric treatments* (2022) <https://www.sacat.sa.gov.au/case-type/mental-health/consent-to-prescribed-medical-treatment>.

[2228] *Mental Health Act 2009* (SA) s 42(5).

[2229] SA Health, Government of South Australia, *Electroconvulsive Therapy Policy Guideline* (11 June 2020).

[2230] *Mental Health Act 2009* (SA) s 42(6).

Review processes

10.2.23 SACAT has a significant review function as empowered by the *MHA* such as:

1. A review of a CTO 2 made in respect of a child that continues to apply three months after the making of the order (the review must be conducted as soon as possible after the end of the three months);
2. A review of the circumstances in which a level 1 ITO ('ITO 1') was made if made within seven days of the expiry or revocation of a previous ITO applying to the same person (the review must be conducted as soon as possible after the making of the most recent ITO);
3. A review of the circumstances where an order extends an ITO 2 (the review must be conducted as soon as practicable after the making of the order to extend the ITO);
4. A review of the ITO 3 made in respect of a child and continues to apply three months after the making of the order (the review must be conducted as soon as practicable after the end of the three month period); and
5. Any review required by the Regulations.[2231]

10.2.24 SACAT may conduct any other review it considers appropriate as relating to a CTO or ITO or treatment administered to a person who falls within the scope of the *MHA*.[2232] Reviews of orders other than SACAT's orders come within SACAT's original jurisdiction.[2233]

10.2.25 A person (or an individual on their behalf) can request a review of a CTO or ITO *not* made by SACAT under s 34 of the *South Australian Civil and Administrative Tribunal Act 2013* (SA) ('*SACAT Act*')[2234] and this can be instituted at any time the order is in operation.[2235] The following persons can seek a review of the order:

1. The person to whom the order applies.
2. The Public Advocate.
3. A guardian, medical agent, relative, carer or friend of the person to whom the order applies.
4. Anyone who satisfies SACAT that they have a proper interest in the matter.

10.2.26 SACAT also has the power to conduct internal reviews in connection with Part 5 of the *SACAT Act*.[2236] An application for internal review may be made by the applicant in the initial proceeding, the person to whom the proceeding relates, the Public Advocate, any person who presented evidence or material before the tribunal, or any person who satisfies the Tribunal that they

[2231] *Mental Health Act 2009* (SA) s 79(1)(b), (c), (d), (e).

[2232] Ibid s 79(2).

[2233] Ibid s 79(5).

[2234] Ibid s 81(1).

[2235] Ibid s 81(2).

[2236] See Ibid s 83A generally. Note that the internal review provisions extend to decisions made in SACAT's original jurisdiction.

have a proper interest in the matter.[2237] The appeal will be conducted as an internal review of a SACAT decision and will be heard by another member of SACAT, usually more senior members and judges.[2238]

10.2.27 During the internal review, SACAT will examine the first decision and may allow further evidence or material to be presented. SACAT will affirm, vary, or set aside the decision that is being reviewed.[2239] SACAT may, on a review, provide to the Minister a written report on any matter SACAT considers should be drawn to the Minister's attention.[2240]

10.2.28 All interested persons in the case under review will be given notice of the internal review, and they have the opportunity to respond about whether they would wish to be involved.[2241] If a person is dissatisfied with the decision of SACAT in relation to the internal review appeal, they can apply to the Court of Appeal,[2242] but not in relation to decisions with SACAT's review jurisdiction.[2243]

10.3 Law in Other Jurisdictions

10.3.1 While there are increasing similarities in the mental health laws of each State and Territory, each jurisdiction's laws and frameworks regarding administrative decisions relating to the respective mental health law frameworks remains distinctive and are implemented in various ways.[2244] A summary of the law and frameworks regarding administrative decisions in other Australian jurisdictions is contained in a table at the end of this section.

Victoria

10.3.2 In Victoria, the *Mental Health Act 2014* (Vic) ('*MHA* (Vic)')[2245] establishes the Mental Health Tribunal[2246] to deal with matters related to mental health. The Mental Health Tribunal ('Victorian Tribunal') is an independent statutory tribunal whose primary functions are to protect the rights and dignity of people with mental illness, to determine whether the criteria for compulsory mental health treatment as established in the *MHA* (Vic) apply to a person, and whether or not to make a treatment order relating to that person.[2247] The Victorian Tribunal has 'all the powers necessary or convenient to enable it to perform its functions'.[2248]

[2237] *Mental Health Act 2009* (SA) s 83A(b).

[2238] SALRI was informed of this point in consultation. See also South Australian Civil and Administrative Tribunal, *Reviews of SACAT Decisions* (2022) <https://www.sacat.sa.gov.au/case-type/reviews-of-sacat-decisions>.

[2239] South Australian Civil and Administrative Tribunal, *Applications for Internal Review of a decision made by the Community Stream of SACAT* (2020) 1. The same applies for the review of a CTO or ITO under the *Mental Health Act 2009* (SA) s 80(2)(a), (b), (c), (d). This order could be for a treatment and care plan to be reviewed for example.

[2240] *Mental Health Act 2009* (SA) s 80(3).

[2241] South Australian Civil and Administrative Tribunal, *Applications for Internal Review of a decision made by the Community Stream of SACAT* (2020) 3.

[2242] *South Australian Civil and Administrative Tribunal Act 2013* (SA) s 71.

[2243] *Mental Health Act 2009* (SA) s 83A(h).

[2244] Stephen Tang, *Context, aims and principles* (16 March 2022) <https://austlii.community/foswiki/ACTLawHbk/ContextAimsAndPrinciples>.

[2245] This Act will be replaced by the *Mental Health and Wellbeing Act 2022* (Vic), which comes into force on 1 September 2023.

[2246] *Mental Health Act 2014* (Vic) s 152.

[2247] Department for Health Victoria, *Mental Health Tribunal* (29 May 2015) <https://www.health.vic.gov.au/practice-and-service-quality/mental-health-tribunal>.

[2248] *Mental Health Act 2014* (Vic) s 154.

10.3.3 The Victorian Mental Health Tribunal has a general division and a special division.[2249] Within the general division, the Tribunal hears and determines all matters within its jurisdiction except those relating to ECT or neurosurgery for mental illness, both of which are heard in the special division.[2250]

10.3.4 The functions of the Victorian Mental Health Tribunal include to:

1. Make applications for treatment orders, review treatment orders, and vary treatment orders;
2. Hear applications for revocation of Temporary Treatment Orders or Treatment Orders;
3. Hear applications for ECT and neurosurgery;
4. Hear matters relating to security patients; and
5. Hear applications to or against transfer a person's treatment to another health service.[2251]

Orders

10.3.5 The Victorian Tribunal has powers to make Treatment Orders to impose a CTO and/or ITO.[2252] These applications can only be made by an authorised psychiatrist within the prescribed time frame.[2253] The scope of parties who may apply for a CTO or ITO is narrower than the *MHA* in South Australia. In making a treatment order, the Victorian Tribunal must have regard to the perspectives of any relevant parties, including the consumer's nominated person, guardian, and carer if the decision would affect the carer.[2254] The Tribunal must only make an ITO if satisfied that treatment of the consumer cannot take place within the community.[2255]

10.3.6 The variation of Treatment Orders can be performed by an authorised psychiatrist in limited circumstances of changing an ITO to CTO or vice versa or changing a Temporary Order to a General Order.[2256]

10.3.7 An application to revoke a Treatment Order can be made by a person subject to the order, a guardian, a parent (if the patient is under 16 years), or a secretary (where applicable).[2257]

Legal Representation

10.3.8 Under s 184 of the *MHA* (Vic), a person who is the subject of a proceeding may be represented before the Victorian Tribunal by any authorised person.[2258] Where a person is not represented before the Tribunal, the Tribunal may appoint another person to represent that person.[2259] The Tribunal does not have an affiliation with a particular legal aid provider in Victoria, unlike in South Australia where the Legal Services Commission assists in the appointment of a legal representative.

[2249] *Mental Health Act 2014* (Vic) s 178(1).

[2250] Ibid ss 178(2), (3).

[2251] Department for Health Victoria, *Mental Health Tribunal* (29 May 2015) <https://www.health.vic.gov.au/practice-and-service-quality/mental-health-tribunal>.

[2252] *Mental Health Act 2014* (Vic) s 52.

[2253] Ibid ss 54(1), 54(4).

[2254] Ibid s 55(2).

[2255] Ibid s 55(3).

[2256] Ibid s 58.

[2257] Ibid s 60(2).

[2258] Ibid s 184(3).

[2259] *Mental Health Act 2014* (Vic) s 184(4).

10.3.9 There is no apparent right to legal representation for carers, guardians, and others. However, the Victorian Tribunal must give notice of a hearing to the guardian and carer or nominated person of the person who is subject to the proceeding.[2260] The Principles of the *MHA* (Vic) provide that persons receiving mental health services should be involved in all decisions about their assessment, treatment and recovery, and the *MHA* (Vic) is a proponent for supported decision making.[2261] The person who is a subject of a proceeding has the express right to appear before the Tribunal at the hearing.[2262]

10.3.10 The *MHA* (Vic) is underpinned by the *Victorian Charter of Human Rights and Responsibilities Act 2006* ('Charter') which endorses 20 fundamental human rights, including the right not to be subject to medical treatment without full, free and informed consent and the right to a fair hearing.[2263] 'In the mental health context, the Mental Health Tribunal and public mental health services designated by the *MHA* (Vic) and public authorities must comply with the Charter at all times.'[2264]

10.3.11 Anyone can support the consumer at a hearing including a family member, friend, carer, lawyer or a nominated person.[2265] Despite the lack of legal representation for carers and other key supports, the *MHA* (Vic) 'recognises and supports the important role of carers and other key support people that care for people with mental illnesses'[2266] and requires carers to be informed of events that directly affect the care relationship with the patient.[2267]

10.3.12 The party to the proceedings may also request a statement of reasons for a determination[2268] and if the request is made in within the prescribed time limit, the Victorian Tribunal must provide a statement of reasons to all parties to the relevant proceeding.[2269] Under the *MHA* (Vic), if an Assessment Order, Temporary Treatment Order, or Treatment is made or varied or revoked, the Tribunal must consider the views of the person's carer if the authorised psychiatrist is satisfied that the decision will directly affect the carer and the care relationship.[2270]

Electroconvulsive Therapy

10.3.13 ECT can only be performed in Victoria on a patient over the age of 18 years if the patient has consented or the Victorian Tribunal has granted an application pursuant to s 93 or s 94 (for a young person).[2271] An authorised psychiatrist may make an application to the Tribunal to perform a

[2260] *Mental Health Act 2014* (Vic) s 189.

[2261] Ibid s 11.

[2262] Ibid s 184(1).

[2263] Victorian *Charter of Human Rights and Responsibilities Act 2006 (Vic)*.

[2264] Legal Aid Victoria, *Your Advocacy Guide* (August 2018) 3.

[2265] Mental Health Review Tribunal, *What happens at a Tribunal hearing* (1 July 2022) <https://www.mht.vic.gov.au/what-happens-tribunal-hearing>.

[2266] Victoria State Government Department of Health, *Mental Health laws and your rights* (18 September 2015) Better Health Channel <https://www.betterhealth.vic.gov.au/health/servicesandsupport/mental-health-laws-and-your-rights#bhc-content>.

[2267] *Mental Health Act 2014* (Vic) s 10(h).

[2268] Ibid s 198.

[2269] Ibid s 198(4).

[2270] Ibid s 64(3)(e).

[2271] *Mental Health Act 2014* (Vic) s 92.

course of ECT on a patient if the patient does not have the capacity to give informed consent and there are no less restrictive means for the patient to be treated.[2272]

10.3.14 Under the *MHA* (Vic), an ECT applicant must be dealt with as soon as practicable and within five business days of receiving the application.[2273] An authorised psychiatrist who applies for ECT can request an urgent hearing if they view the ECT as necessary to save the person's life, to prevent 'serious harm' to the health of the person, or to prevent the person from suffering.[2274] There is no express provision in the *MHA* relating about the administration of ECT in urgent circumstances without the Tribunal's authorisation.

Reviews

10.3.15 The Victorian Tribunal is able to hear the following reviews:

1. Application for review of direction to vary Order[2275] and can be applied for by any person subject to the other, a guardian, a parent (if the patient is under the age of 16) or a secretary;[2276]
2. A security patient applying to review the decision not to grant a leave of absence;[2277] and
3. Review of direction to take security patient to another designated mental health service.[2278]

10.3.16 The Victorian Civil and Administrative Tribunal ('VCAT') is the appropriate body to review any determination made by the Mental Health Tribunal under the *MHA* (Vic).[2279] Any party to the proceedings can apply.[2280] Consumers must be made aware of their right to apply to VCAT for a review of a determination (other than questions of law) and the Victorian Tribunal must include this in their determination of proceedings.[2281] Questions of law arising from the proceeding can be referred to the Supreme Court.[2282]

10.3.17 Any complaints are the responsibility of the Mental Health Commissioner,[2283] whose role is to assess, investigate and resolve complaints, provide advice on any matter relating to a complaint, and assist consumers, other persons, and mental health providers to resolve complaints.[2284] Complaints can be made about any matter arising from the provision of mental health services or failure to provide mental health services.[2285]

[2272] *Mental Health Act 2014* (Vic) s 93(1).

[2273] Ibid s 95(1).

[2274] Ibid s 95(2).

[2275] Ibid s 66.

[2276] Ibid 66(2).

[2277] Ibid s 284.

[2278] Ibid s 294.

[2279] Ibid s 201.

[2280] Victorian Civil and Administrative Tribunal, *Mental Health* <https://www.vcat.vic.gov.au/mental-health>.

[2281] *Mental Health Act 2014* (Vic) s 195(3).

[2282] Ibid s 197.

[2283] Ibid pt 10.

[2284] Ibid s 228.

[2285] Ibid s 234.

New South Wales

10.3.18 The NSW Mental Health Review Tribunal ('NSW Tribunal') is established under s 140 of the *Mental Health Act 2007* (NSW) ('*MHA* (NSW) '). The Tribunal has wide powers to make and review orders about the treatment of people with mental illness in both civil and forensic hearings. In the civil hearings, the Tribunal may:

1. Conduct Mental Health Inquiries and make an ITO;[2286]
2. Hear appeals against an authorised medical officer's refusal to discharge an involuntary patient;
3. Make, vary or revoke CTO;
4. Hear appeals against a Magistrate's decision to make a CTO;
5. Regularly review the case of each involuntary patient; and
6. Approve the use of ECT for involuntary patients or determine if voluntary patients have consented to ECT.[2287]

10.3.19 The *MHA* (NSW) aims to facilitate the involvement of those persons, and persons caring for them, in decisions involving appropriate care and treatment.[2288]

10.3.20 The *MHA* (NSW) establishes principles for care and treatment such as:

> 1. Every effort that is reasonably practicable should be made to involve persons with a mental illness or mental disorder in the development of treatment plans and recovery plans and to consider their views and expressed wishes in that development;
>
> 2. People with a mental illness or mental disorder should be informed of their legal rights and other entitlements under this Act and all reasonable efforts should be made to ensure the information is given in the language, mode of communication or terms that they are most likely to understand; and
>
> 3. The role of carers for people with a mental illness or mental disorder and their rights under this Act to be kept informed, to be involved and to have information provided by them considered, should be given effect.[2289]

Orders

10.3.21 Applications to detain involuntary patients can be applied for by a range of parties including a medical practitioner, accredited person[2290] or a designated carer, principal care provider, relative, or friend of the person.[2291] For all persons who are medically examined for ongoing detention (similar to an ITO made under the South Australian *MHA*) in a mental health facility, the NSW Tribunal must undertake a mental health inquiry to determine whether an assessable person has a mental illness.[2292]

[2286] *Mental Health Act 2007* (NSW) ss 24, 35.

[2287] Mental Health Review Tribunal, *The Tribunal* (August 2021) <https://mail.mhrt.nsw.gov.au/the-tribunal/>.

[2288] *Mental Health Act 2007* (NSW) s 3(e).

[2289] Ibid s 68.

[2290] Ibid s 19.

[2291] Ibid s 26.

[2292] Ibid s 35.

10.3.22 Upon completing an inquiry, the NSW Tribunal, if satisfied that the assessable person has a mental illness, can order that person to be discharged into the care of a designated carer or principal care provider, impose a CTO or impose an order that the person be detained in a mental health facility for up to three months.[2293]

10.3.23 The NSW Tribunal can make applications for a CTO under Part 3 of the *MHA* (NSW), authorising compulsory treatment in the community of a person.[2294] This can be applied for by an authorised medical officer in the health facility where the affected person is detained, a medical practitioner familiar with the clinical history of the patient, and any other person prescribed by the regulations.[2295]

10.3.24 The NSW Tribunal can vary or revoke a CTO upon application by the affected person, the psychiatric case manager of the affected person, any person who could have applied for the order, or of its own motion.[2296] The application can only be made if there has been a 'substantial or material change in the circumstances surrounding the making of the order'.[2297] The Director of community treatment of a mental health facility implementing a treatment plan under a CTO can also revoke a CTO.[2298] Upon variation or revocation by a Director, the designated carer and principal care provider of the affected person should be notified.[2299]

10.3.25 The NSW Tribunal's decisions are legally binding and often involve the 'consideration of complex issues'.[2300]

Legal Representation

10.3.26 The *MHA* (NSW) aims to facilitate the involvement of those persons, and persons caring for them, in decisions involving appropriate care and treatment.[2301] Interestingly, the *MHA* (NSW) requires an 'assessable person' who is before the NSW Tribunal for a mental health inquiry, a person detained in a mental health facility, a person under 16 years old and a person who is absent from proceedings to be represented by a legal practitioner or by another person of their choice, with approval of the Tribunal, unless the person elects otherwise.[2302] A person appointed to assist the Tribunal in a matter may appear before the Tribunal in relation to any matter for which they are appointed.[2303] The *MHA* (NSW) provides that persons suffering from a mental illness, intellectual disability, developmental difficulty or from mental conditions, are presumed not to be an impediment to the representation of the person by an Australian legal practitioner before the Tribunal.[2304] An

[2293] Mental Health Act 2007 (NSW) s 35(5).

[2294] Ibid s 51.

[2295] Ibid s 51(2); *Mental Health Regulations 2019* (NSW) reg 9. Regulation 9 specifies that a director of a community treatment of a mental health facility and a designated carer can apply for a CTO.

[2296] *Mental Health Act 2007* (NSW) ss 65(1), (2).

[2297] Ibid s 65(3).

[2298] Ibid s 66.

[2299] Ibid s 66A.

[2300] Michael Cain et al, *The NSW Mental Health Review Tribunal: An Analysis of Clients, Matters and Determinations* (Law and Justice Foundation of NSW, 2011) 2.

[2301] *Mental Health Act 2007* (NSW) s 3(e).

[2302] Ibid s 154(2A)–(5).

[2303] Ibid s 154(1).

[2304] Ibid s 152.

authorised officer must also provide a person with their statement of rights of appeal when they are an involuntary patient detained in a facility.[2305]

10.3.27 In terms of other supports, any designated carer of an assessable person during an inquiry may appear at the inquiry with the approval of the NSW Tribunal.[2306] Under the *MHA* (NSW), a designated carer of a person includes a guardian, parents, spouse, or a close friend or relative of the consumer.[2307] Notification of the inquiry must be given to the assessable person and take reasonable steps to inform any designated career and principal care provider of a proposed mental health inquiry.[2308]

10.3.28 The NSW Tribunal has the power to permit another person (not a legal practitioner) to represent a person.[2309] The *MHA* (NSW) provides specifically for notifications to designated carers and principal care providers about various events that affect consumers or detained consumers including their discharge, proposed applications to the Tribunal for ECT, or the failure of the consumer to return to the Tribunal at the end of a period of leave.[2310] Carers are involved in the process under the *MHA* (NSW) and the Act specifically provides that an authorised officer must notify them of many decisions under the *MHA* (NSW), as detailed in s 78.

Electroconvulsive Therapy

10.3.29 The administration of ECT under the *MHA* (NSW) can only be administered to an involuntary patient or a person under 16 years of age if the NSW Tribunal has determined it at an ECT inquiry.[2311] An authorised medical officer may apply for an ECT administration inquiry, and this hearing must be held 'as soon as practicable' after an application is made to the Tribunal.[2312] During an ECT inquiry hearing, a patient generally has the right of appearance unless there are extenuating circumstances.[2313]

10.3.30 Under the *MHA* (NSW), urgent applications for ECT prior to a Mental Health Inquiry being held should, where practicable, hold both the ECT Inquiry and the Mental Health Inquiry at the same time.[2314]

Reviews

10.3.31 The Tribunal appears to have limited scope for internal reviews under the *MHA* (NSW). A designated carer or principal carer of an involuntary patient may apply to an authorised medical

[2305] *Mental Health Act 2007* (NSW) s 77.

[2306] Ibid s 34(2).

[2307] Ibid s 71.

[2308] Ibid s 76.

[2309] Mental Health Coordinating Council, *Legal proceedings under the Mental Health Act 2007 (NSW)* (16 March 2020) <https://mhrm.mhcc.org.au/chapters/4-nsw-mental-health-law-and-processes/4e-legal-proceedings/#4|E|1>.

[2310] *Mental Health Act 2007* (NSW) ss 73–79.

[2311] Ibid s 89(b), s 94(1).

[2312] Ibid s 95.

[2313] Ibid s 96(5A).

[2314] Mental Health Review Tribunal, *Practice Direction: Electro Convulsive Therapy (ECT) Determinations* (13 February 2019).

officer to discharge the patient.[2315] If the result is unsuccessful, the Tribunal can hear appeals against the decision of an authorised officer not to discharge an involuntary patent from a mental facility.[2316]

10.3.32 The NSW Tribunal may review the case of an involuntary consumer periodically, or in the absence of the consumer if an application is made by an authorised medical officer and the consumer has refused or is too unwell to attend within a reasonable period, and any legal representatives have been notified of the review.[2317] In reviewing the decision, the Tribunal must take into account the views of the consumer, any representative of the consumer, a designated carer, and principal care provider.[2318] Similar provisions apply when a person has breached their CTO and been detained in a mental health facility.[2319]

10.3.33 The affected person can appeal a CTO made by the NSW Tribunal to the Supreme Court on any question of law, or against the duration of the order. A CTO made by the Magistrate can be appealed to the Tribunal regarding the duration of the order on any question of law.[2320] This right of appeal as to questions of law is consistent with the process for legal proceedings generally and is not distinguishable for the *MHA* (NSW).[2321]

10.3.34 A person may appeal to the Supreme Court against a determination of the Tribunal made with respect to the person, or a failure or refusal of the Tribunal to make a determination in accordance with the provisions of the *MHA* (NSW).[2322] This applies to any decision of the NSW Tribunal.

Queensland

10.3.35 Queensland is also the only Australian jurisdiction to establish both a Mental Health Court and a Mental Health Review Tribunal ('Queensland Tribunal')to decide mental health applications.[2323]

10.3.36 The Queensland Tribunal operates under the *Mental Health Act 2016* (Qld) ('*MHA* (Qld) ') as a continuation from the repealed *Mental Health Act 2000* (Qld).[2324] The Tribunal's primary role is to review the appropriateness of treatment authorities, forensic orders, and treatment orders made under the *MHA* (Qld).[2325] The Tribunal will determine whether people are to be provided with medical treatment and has the power to impose binding declarations on consumers.[2326]

[2315] *Mental Health Act 2007* (NSW) s 43.

[2316] Ibid s 44.

[2317] Ibid s 37(3A).

[2318] Ibid s 37(3)(d).

[2319] Ibid s 63.

[2320] Ibid ss 67(1), (2).

[2321] Ibid.

[2322] Ibid s 163(1).

[2323] See generally Sam Boyle and Tamara Walsh, 'Procedural Fairness in Mental Health Review Tribunals: the Views of Patient Advocates' (2021) 28(2) *Psychiatry, Psychology and Law* 163; Sam Boyle, Tamara Walsh and Lucinda Nelson, 'A Study into the Operation of the Queensland Mental Health Review Tribunal' (2021) 29(1) *Medical Law Review* 106.

[2324] *Mental Health Act 2016* (Qld) ch 16 pt 2.

[2325] Queensland Health, *Mental Health Review Tribunal* (1 June 2020) <https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/clinical-staff/mental-health/act/topics/review-tribunal>.

[2326] Sam Boyle, Tamara Walsh, 'Procedural Fairness in Mental Health Review Tribunals: the Views of Patient Advocates' (2021) 28(2) *Psychiatry, Psychology and Law* 163, 164.

10.3.37 The role of the Queensland Tribunal under the *MHA* (Qld) is to review the status of a person's involuntary authority or order. This Tribunal is not involved in decisions relating to a person's treatment and care.[2327] However, it can make orders revoking an order, changing the category of an order, or changing the conditions of the order.[2328]

10.3.38 The Queensland Tribunal Reviews:

- Treatment Authorities;
- Treatment support orders;
- Forensic orders;
- Fitness for trial of particular persons; and
- Detention of minors in high security units.

10.3.39 The Queensland Tribunal hears applications for:

- Examination authorities;
- Perform regulated treatments such as ECT and neurosurgical procedures;
- Transfer of patients in and out of Queensland; and
- Confidentiality orders.

10.3.40 In some circumstances, the Queensland Tribunal also has the authority to make treatment authorities, treatment support orders and forensic orders.[2329]

Orders

10.3.41 Under the *MHA* (Qld), an authorised medical practitioner makes a treatment authority for the consumer and decides whether it will be an ITO or CTO.[2330] In some instances the Queensland Tribunal can make a treatment authority order in relation to forensic orders.

Legal representation

10.3.42 The *MHA* (Qld) makes it clear that the consumer is to be provided with the necessary support and information to assist them to express their views and preferences.[2331]

10.3.43 The *MHA* (Qld) mandates legal representation is *some* tribunal proceedings.[2332] At the Queensland Tribunal, the person who is the subject of a proceeding may be represented by a nominated support person, a lawyer, or another person.[2333] The Tribunal also has the power to appoint

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[2327] Queensland Health, 'Information for Patients', *Mental Health Review Tribunal* (2018) <https://www.mhrt.qld.gov.au/information-for/patients>.

[2328] Queensland Health, 'Application for Applicant Review' *Mental Health Review Tribunal* (Information Sheet, March 2019) Mental Health Review Tribunal.

[2329] Queensland Government, Mental Health Review Tribunal, *About the Tribunal* (2018) <https://www.mhrt.qld.gov.au/information-about/about-the-tribunal#What-does-the-tribunal-do>; Queensland Health, *Overview of the Act - Mental Health Act 2016 Fact Sheet* (12 November 2021).

[2330] *Mental Health Act 2016* (Qld) s 51.

[2331] Ibid s 5(d).

[2332] Jake Buckingham, 'A Critical Analysis of Legal Representation in Queensland's Mental Health Review Tribunal', (2018) 6(1) *Griffith Law Journal* 132, 135.

[2333] *Mental Health Act 2016* (Qld) s 739(1).

legal representation for a patient if it considers it to be in the patient's best interests.[2334] The Tribunal will appoint a lawyer for the person at no cost in the following instances:[2335]

1. If the person is a minor;
2. For a review of the person's fitness for trial;
3. For an application for approval to perform ECT;
4. For a review of a forensic order where the Attorney-General is to be represented; or[2336]
5. Confidentiality order.[2337]

10.3.44 A notice of appeal and hearing of a decision must clearly state the consumer's right to be represented at the hearing.[2338] An adult with decision-making capacity may waive the right to be represented by the appointed representative.[2339] There is a general right to representation in the Mental Health Court ensuring the consumer may be represented by a lawyer, and that they can appear in person at the hearing of the proceeding.[2340]

10.3.45 The *MHA* (Qld) makes clear that to the 'greatest extent practicable, family, carers, and other support persons of a person who has a mental illness are to be involved in decisions about the person's treatment and care, subject to the person's right to privacy.'[2341] Aside from legal representation, a person may appoint a family member, carer, or other support person to be their nominated support to the extent permitted in Part 12 or Part 16.[2342] The Act provides a right for the patient's nominated support persons, family, carers and other support persons to be given written notices,[2343] including a written statement of rights[2344] to be provided not only to the patient if requested, but to the patient's nominated support persons, family, carers and other support persons if requested.[2345] The roles and responsibilities of nominated support persons, family, carers, and other support persons including their right to participate in decisions about the patient's treatment is enshrined in the *MHA* (Qld).[2346]

Electroconvulsive Therapy[2347]

10.3.46 A medical practitioner may apply to the Queensland Tribunal for approval to give a person ECT to be determined at a hearing if the medical practitioner is satisfied that the adult is unable

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2334 *Mental Health Act 2016* (Qld) s 740(2).

2335 Ibid s 740(3), s 740(6).

2336 Queensland Health, *Overview of the Act - Mental Health Act 2016 Fact Sheet* (12 November 2021); *Mental Health Act 2016* (Qld) s 737(2).

2337 *Mental Health Act 2016* (Qld) s 722(4).

2338 Ibid s 535(3)(c).

2339 Ibid s 740(4).

2340 Ibid s 683.

2341 See for example, Ibid s 23(5), s 25(3), s 355(2)(a), s 427(2)(d).

2342 Ibid 224(d).

2343 Ibid s 275(e).

2344 Ibid s 277(1).

2345 Ibid s 278(c).

2346 Ibid s 291.

2347 See also Sam Boyle, Tamara Walsh and Lucinda Nelson, 'A Study into the Operation of the Queensland Mental Health Review Tribunal' (2021) 29(1) *Medical Law Review* 106, 124–6.

to give informed consent to the therapy or the person is a minor.[2348] Notice of the hearing must be given by the Tribunal to the person subject of the application and other relevant people within the required time periods.[2349]

10.3.47 In some emergency circumstances, a medical practitioner may administer ECT before the Tribunal provides a decision. This can only happen where the consumer is subject to a treatment authority, forensic order, treatment support order, they are absent without permission from an internal mental health service and detained in a Queensland mental health service, there is an emergency certificate in force and the application made to the Tribunal is pending, or that performing ECT is necessary to save the consumer's life or prevent them from suffering irreparable harm.[2350] The emergency certificate must be approved by both a medical practitioner and the Senior Medical Administrator.[2351]

10.3.48 The *MHA* (Qld) requires that the Tribunal hears the application for ECT as soon as practicable after the application is received.[2352]

Reviews

10.3.49 The *MHA* (Qld) provides for appeals to the Tribunal against a decision of the Chief Psychiatrist or the administrator of an authorised mental health service, an appeal to the Mental Health Court against a decision of the Tribunal, and an appeal to the Court of Appeal against a decision of the Mental Health Court on a reference in relation to a person.[2353]

10.3.50 Reviews of the imposition of a treatment authority if made by a non-psychiatrist is then reviewed by a psychiatrist.[2354] The Queensland Tribunal on the other hand conducts reviews of:

1. A treatment authority or in other circumstances can review a treatment authority on application by a person subject to the authority, or an interested person, or the chief psychiatrist, or of its own initiative (periodic review);[2355]
2. Forensic orders;[2356]
3. Period review of treatment support orders or upon an application by the person subject to the order, or an interested person, the Chief Psychiatrist, or of its own initiative;[2357]
4. Fitness for trial pursuant to Part 6 of Chapter 12; and
5. Detention of minors in high security units.[2358]

[2348] *Mental Health Act 2016* (Qld) s 507.

[2349] Ibid s 508.

[2350] Queensland Health, 'Application for Applicant Review', *Mental Health Tribunal* (Information Sheet, March 2019) 1; *Mental Health Act 2016* (Qld) s 237.

[2351] Queensland Health, 'Application for Applicant Review', *Mental Health Tribunal* (Information Sheet, March 2019) 1.

[2352] *Mental Health Act 2016* (Qld) s 727(a), (b).

[2353] Ibid s 29.

[2354] Ibid ss 56, 57.

[2355] Ibid s 413.

[2356] Ibid ch 12 pt 3.

[2357] Ibid s 465.

[2358] Ibid Pt 7.

10.3.51 Notice of a review by the Queensland Tribunal must be provided to the person subject to the authority, the applicant (if different to the person subject to the authority), the administrator of the authorised mental health service responsible for the person, and the Chief Psychiatrist.[2359] For other reviews, the persons who require notification may differ.[2360]

10.3.52 A person who has been given, or is entitled to be given, a decision notice may appeal to the Queensland Tribunal against a decision to which the notice relates.[2361] A person can request a written statement of reasons from the Tribunal which may assist the person in deciding whether or not to appeal to the Mental Health Court. In all circumstances, an interested person for the person at the subject of the application who is acting on the person's behalf can institute an appeal to the Mental Health Court.[2362]

10.3.53 An appeal to the Mental Health Court can be made by those persons mentioned in Schedule 2. For each type of decision set out in column 1 of the schedule the persons who may appeal are listed in the corresponding column 2.[2363] For most decisions of the Tribunal on review or in response to an application, an appeal can be instituted by the person the subject of the order, the treatment authority, or an interested person for the person subject to the order, and in many cases it can be instituted by the Chief Psychiatrist or the Attorney-General.[2364] The decision of the Mental Health Court is final and conclusive and cannot be challenged or appealed unless the decision is affected by jurisdictional error.[2365]

10.3.54 A person can appeal to the Court of Appeal against a decision of a Mental Health Court on a reference in relation to a person listed in the section.[2366]

Northern Territory

10.3.55 The Northern Territory Mental Health Review Tribunal ('NT Tribunal') makes decisions about the treatment and care of persons in the Northern Territory who suffer from mental illness and is given jurisdiction under Part 15 of the *Mental Health and Related Services Act 1998* (NT) ('*MHRSA* (NT)')[2367] The Tribunal can hear applications for orders of for involuntary admission,[2368] make community management orders (known as a CTO under the South Australian *MHA*)[2369] authorise

[2359] *Mental Health Act 2016* (Qld) s 418.

[2360] See Ibid ss 439, 460 for review of forensic orders, s 471 for treatment support orders, s 487 for fitness for trial, and s 500 for review of minors' detention in a high security unit.

[2361] Ibid s 533.

[2362] Queensland Government, Mental Health Review Tribunal, *The Appeals Process* (2018) <https://www.mhrt.qld.gov.au/information-about/the-appeals-process>.

[2363] *Mental Health Act 2016* (Qld) s 539.

[2364] Ibid sch 2.

[2365] Ibid s 538(1). A jurisdictional error arises when a decision-maker exceeds the authority or power conferred upon them. It means the decision-maker has failed to comply with an essential condition to or limit on the valid exercise of power, and this renders their decision invalid. See *Kirk v Industrial Court (NSW)* (2010) 239 CLR 531; *Craig v South Australia* (1995) 184 CLR 163.

[2366] *Mental Health Act 2016* (Qld) s 549.

[2367] *Mental Health and Related Services Act 1998* (NT) s 118.

[2368] Ibid s 44C.

[2369] Ibid s 48.

various treatments,[2370] and make determinations as to whether a person is able to give informed consent.[2371]

10.3.56 The fundamental principles of the *MHRSA* (NT) include that:

> 1. As far as possible, the person is to be involved in the development of any ongoing treatment plan or any discharge planning; and
>
> 2. The person's treatment and care is, as far as possible, to be appropriate to and consistent with the person's cultural beliefs, practices and mores, taking into account the views of the person's family and community.[2372]

Orders

10.3.57 The *MHRSA* (NT) sets out criteria for involuntary admission on grounds of mental illness, involuntary admission on the grounds of mental disturbance, involuntary admission on grounds of complex cognitive impairment, and involuntary treatment in the community.[2373] Assessment about whether treatment is required is conducted by a medical practitioner, an authorised psychiatric practitioner, or designated mental health practitioner.[2374] Once this is conducted, the authorised psychiatric practitioner must apply to the Northern Territory Tribunal for an order.[2375]

10.3.58 If an authorised psychiatric officer makes an interim community management order, they must notify the Tribunal[2376] so that the Tribunal may decide to make a community management order.[2377] Revocation of a community management order can be made by an authorised psychiatric practitioner so long as the Tribunal is properly notified.[2378]

Legal Representation

10.3.59 The *MHRSA* (NT) establishes various rights for people to whom this Act applies, including a consumer's relatives, friends, and representatives, and any other people with a genuine interest in the person, to make a complaint.[2379] Namely, the *MHRSA* (NT) establishes internal complaint procedures[2380] and affirms the right to complain to other independent complaint bodies.[2381]

10.3.60 At a hearing if the consumer who is subject to a review or involuntary detention application does not have a representative, and the NT Tribunal considers they require representation, the Tribunal must appoint a legal practitioner for that consumer.[2382] The person cannot object to the Tribunal's decision to appoint a legal representative.[2383] It is at the Tribunal's discretion to order the

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[2370] Ibid s 56.

[2371] Ibid s 126(a).

[2372] *Mental Health and Related Services Act 1998* (NT) ss 9(g) and (n).

[2373] Ibid ss 14, 15, 15A, 16.

[2374] Ibid s 32(4).

[2375] Ibid s 44C.

[2376] Ibid s 47.

[2377] Ibid s 48.

[2378] Ibid s 50A.

[2379] Ibid s 3(m).

[2380] Ibid s 3(n).

[2381] Ibid s 3(p).

[2382] Ibid s 131(2).

[2383] Ibid s 131(3).

Territory to pay all or part of the reasonable costs and disbursements of the legal practitioner in representing the person at the hearing.[2384]

10.3.61 The *MHRSA* (NT) provides that the NT Tribunal may conduct a hearing in the absence of the person or the person's representative if reasonable notice is given, the person had reasonable opportunity to attend the hearing, and the person or representative refuses to attend the hearing,[2385] or in other 'exceptional circumstances'.[2386]

10.3.62 The *MHRSA* (NT) recognises the rights of carers and families and includes the right of a carer to be provided with relevant information about their rights and entitlements and how they can exercise them. The *MHRSA* (NT) also provides that carers should be consulted in the ongoing treatment plan and discharge plans of the consumer, and as far as practicable and appropriate, family members should be consulted and involved in the consumer's treatment and care.[2387] Under the *MHRSA* (NT), a person can nominate a representative, either legal, or non-legal, to receive information and represent their interests. The representative is made aware of the imposition of a community management order[2388] and other orders such as the admission of the person.

10.3.63 Notification of orders (such as making or revoking a community management order) is made to the person, the person's adult guardian, their decision maker (if any), their legal practitioners, their primary carer (if the Tribunal considers it is in the person's best interests) and the principal community visitor.[2389] In some cases where a carer is not notified of a decision, the NT Tribunal must provide a written report of their decision, with reasons for the decision in the approved form.[2390] Part 12 of the *MHRSA* (NT) covers the rights of patients and carers including the right to receive information concerning medication or treatment,[2391] the discharge plan,[2392] and information on discharge.[2393] These rights also extend to the person's representative.

10.3.64 The *MHRSA* (NT) also provides that when a person appeals a decision of the NT Tribunal to the Supreme Court of the Northern Territory, they are entitled to be self-represented or represented by a legal practitioner or other person.[2394] The Supreme Court of the Northern Territory has the discretion to appoint a legal practitioner for unrepresented litigants and to order that the Tribunal pay all or part of the reasonable costs and disbursements of the legal practitioner.[2395]

Electroconvulsive Therapy

10.3.65 The NT Tribunal may authorise ECT in circumstances where consent is not given by the consumer if the Tribunal is satisfied that the person is unable to give informed consent, the Tribunal has received a report from two authorised psychiatric practitioners, and that ECT is a 'reasonable and

[2384] Ibid s 131(4).

[2385] Ibid s 131(5).

[2386] Ibid s 131(6).

[2387] Ibid s 12(a)–(c).

[2388] Ibid s 53(3).

[2389] Ibid ss 47(1), (2).

[2390] Ibid s 43(3).

[2391] Ibid s 88.

[2392] Ibid s 89.

[2393] Ibid s 90.

[2394] Ibid s 144(1).

[2395] Ibid s 144(2).

proper treatment' and without it, the person is likely to suffer serious mental or physical deterioration, and that all reasonable efforts have been made to consult the person's primary carer.[2396]

10.3.66 ECT may be performed where it is immediately necessary to save the person's life, to prevent the person suffering serious mental or physical deterioration, or to relieve severe distress.[2397] Where ECT is administered in urgent circumstances without prior Tribunal consent, the authorised psychiatric practitioners who made the decision must make a report to the Tribunal as soon as practicable explaining why authorisation was not obtained, and details of the treatment performed.[2398]

Reviews

10.3.67 The authorised psychiatric practitioner must undertake a review of the decision to admit a person as an involuntary patient on the grounds of mental disturbance within the prescribed timeframes.[2399]

10.3.68 The NT Tribunal conducts reviews of long-term voluntary admissions,[2400] involuntary admissions and community management orders.[2401] An application for review to the Tribunal can be made for the extensive list of matters covered in s 127 of the *MHRSA* (NT), including the decision to admit or refuse to admit a person as a voluntary person, or not giving the requisite information and notification to a person's primary representative or carer. The s 127 review application can be made by the person who is the subject of the order, or on the person's behalf by the person's adult guardian, the decision maker, the person's representative, a legal practitioner, or a person with a genuine interest in, or with real and immediate concern for the health or welfare of the person.[2402]

10.3.69 A person aggrieved by the decision of the NT Tribunal or refusal of the Tribunal may, with the leave of the Court, apply to the Supreme Court of the Northern Territory to appeal the decision.[2403] This Application can be made by a person who has a sufficient interest in the matter.[2404]

Tasmania

10.3.70 The *Mental Health Act 2013* (Tas) ('*MHA* (Tas)') is the primary source of authority for the involuntary assessment and treatment of persons with mental illness in Tasmania[2405] and establishes the Tasmanian Civil and Administrative Tribunal ('TCAT') with a Mental Health Stream as opposed to a specialist Mental Health Review Tribunal like in many other Australian jurisdictions. The Mental Health Stream of TCAT ('Tasmanian Tribunal') makes orders and conducts reviews under the *MHA* (Tas) and other Acts. Its main function is to authorise and review the treatment of persons with mental illness and determine the appropriate treatment, if any.[2406]

[2396] *Mental Health and Related Services Act 1998* (NT) s 66(2).

[2397] Ibid s 66(3).

[2398] Ibid s 66(4), (5). There do not appear to be any express provisions permitting emergency ECT in the *NT MHRSA*.

[2399] Ibid s 44.

[2400] Ibid s 122.

[2401] Ibid s 123.

[2402] Ibid s 127(3).

[2403] Ibid s 142(1).

[2404] Ibid s 142(2).

[2405] *Mental Health Act 2013* (Tas) s 13.

[2406] Tasmanian Civil & Administrative Tribunal, *Mental Health Stream* (11 August 2021) <https://www.tascat.tas.gov.au/mental-health>.

10.3.71 One object of the *MHA* (Tas) include to give everyone involved with such assessment and treatment clear direction as to their rights and responsibilities.[2407]

10.3.72 The functions of the Tasmanian Tribunal as set out in the *MHA* (Tas) include to make, vary renew and discharge treatment orders, authority the treatment of forensic patients, authorise special psychiatric treatment, determine applications for leave, and other functions under the Act including review functions.[2408] The orders that the Tasmanian Tribunal primarily reviews and makes are:

1. Assessment orders;
2. Interim treatment orders;
3. Treatment orders;
4. Supervision orders; and
5. Restriction orders.

10.3.73 The Tasmanian Tribunal has the objective to give everyone involved with such assessment and treatment clear direction as to their rights and responsibilities, an provide for the making of voluntary and free and informed consent.[2409]

Orders

10.3.74 Treatment orders, including interim treatment orders, are made by the Tasmanian Tribunal.[2410] Treatment orders can be applied for by any approved medical practitioner or the person subject to the treatment in certain circumstances.[2411] Variation of a treatment order can be done by the Tribunal at any time of its own motion or on the application of any approved medical practitioner or on the application of any person with the necessary standing.[2412]

10.3.75 An assessment order may be made by any medical practitioner and a range of people can apply to a medical practitioner for an assessment order including another medical practitioner,[2413] a nurse, a guardian, parent or support person of the patient in respect of whom the application is made.[2414]

Legal representation

10.3.76 The *MHA* (Tas) provides that a party to any proceedings may appear personally in the proceedings or be represented by an Australian legal practitioner, advocate, or other person.[2415] The consumer is able to ask Legal Aid for representation, but this is not facilitated by the Tasmanian

[2407] *Mental Health Act 2013* (Tas) s 12.
[2408] Ibid s 168.
[2409] Ibid s 12.
[2410] Ibid s 36, s 38.
[2411] Ibid s 37.
[2412] Ibid s 181(2).
[2413] Ibid s 22.
[2414] Ibid s 23(1).
[2415] Ibid s 7(3).

Tribunal.[2416] Schedule 4 of the *MHA* (Tas) provides that a party to any proceeding is entitled to attend the hearings, but the Tribunal may exclude any person it reasonably considers might be detrimental to the welfare of their own health or the health of another who is present.[2417]

10.3.77 A representative can be a consumer's guardian, patient's lawyer, the consumer's parent where the consumer is a minor, and any other person nominated by the person to represent their interests.[2418]

10.3.78 There is no mention of carers or friends in the *MHA* (Tas) which contrasts the express rights of those close to the consumer, as in the *MHA* (Vic) and *MHA* (NSW).

10.3.79 A statement of rights must be provided to a person admitted to or discharged from a facility as a patient.[2419] Where a person is being discharged, transferred facilities, or admitted, the controlling authority should make a reasonable attempt to notify at least one interested person (which includes a representative of the consumer a support person, anyone who the controlling authority reasonably regards as having a proper interest in the patient's welfare).[2420] The parent of a consumer who is a child is required to be given the same information as the consumer themselves.[2421]

Electroconvulsive Therapy

10.3.80 Tasmania is the exception in Australia, as ECT is not subject to any special provision. This is unlike other States and Territories, which have specific provisions to address a consumer's capacity to consent to ECT and what matters a person must be aware about in relation to this course of treatment.[2422] The *MHA* (Tas) does not explicitly refer to ECT, but mentions 'special psychiatric treatment' which includes 'psychosurgery.'[2423] Psychosurgery is defined as including the use of intracerebral electrodes to stimulate a person's brain.[2424]

10.3.81 An involuntary consumer may only be given special psychiatric treatment where it is authorised by the Tribunal under Part 6 of the *MHA* (Tas),[2425] which is reiterated under s 124.

10.3.82 An involuntary consumer may be given urgent circumstances treatment without the consumer's informed consent or Tasmanian Tribunal's authorisation if the medical practitioner authorises the treatment as being urgently needed in the patient's best interests and the necessary treatment outcome would be compromised by waiting for authorisation.[2426] To authorise this course

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[2416] Of note is the Tasmanian Mental Health Tribunal Representation Scheme which is provided representation by University of Tasmania law students in 65 per cent of tribunal matters. See Valerie Williams, 'The Challenge for Australian Jurisdictions to Guarantee Free Qualified Representation before Mental Health Tribunals and Boards of Review: Learning from the Tasmanian Experience' (2009) 16 *Psychiatry, Psychology and Law* 108, 109.

[2417] *Mental Health Act 2013* (Tas) sch 4 pt 2.

[2418] Ibid s 3.

[2419] Ibid ss 129(1), (2).

[2420] Ibid s 129(5).

[2421] Ibid s 137.

[2422] The Royal Australian & New Zealand College of Psychiatrists, *ECT – mental health legislation* (30 June 2017) <https://www.ranzcp.org/practice-education/guidelines-and-resources-for-practice/mental-health-legislation-australia-and-new-zealan/ect-mental-health-legislation>.

[2423] *Mental Health Act 2013* (Tas) s 122.

[2424] Ibid s 122(2).

[2425] *Mental Health Act 2013* (Tas) ss 16(2)(c), (d).

[2426] Ibid ss 55(1), (2).

of treatment, the medical practitioner must also be satisfied that the person has a mental illness, and requires urgent treatment for their own safety or for the safety of others.[2427]

10.3.83 The treatment applies until the first of the following occur:

1. The treatment is completed;
2. The medical practitioner stops the treatment;
3. A 96 hour period following the authorisation expires,
4. The assessment order, treatment order or interim treatment order ceases;
5. The person is discharged; or
6. The authorisation is set aside by the Tribunal.[2428]

10.3.84 A statement of reasons for the decision must be provided to a person once an application is made to the Tasmanian Tribunal for a written statement of its reasons for making any determination, and the Tribunal must comply with the request within 21 days of receiving it.[2429] The statement of reasons is to be provided to every party to the proceedings.[2430]

10.3.85 The *MHA* (Tas) generally does not require the reasons for the decision or the statement of rights to be provided for anyone other than the consumer, a party to the proceeding, and sometimes the relevant medical practitioner. This is in contrast to other States and Territories, where the relevant Tribunal is mandated to provide their decisions to relevant persons in the consumer's life, regardless of whether or not they are a party to the *MHA* proceeding.

Reviews

10.3.86 The Tasmanian Tribunal's review function extends quite broadly to the making of many orders such as treatment orders, orders to withhold information from consumers and orders for treatment in urgent circumstances.[2431] Generally, the Tribunal has the power to do this upon application, or of its own motion. The Tribunal also has the power to review several other decisions made under other Acts.[2432]

10.3.87 An application to review an assessment or treatment order can be made on the Tasmanian Tribunal's own motion, or upon application by someone with the required standing.[2433] A consumer, lawyer, advocate, support person, medical practitioner or others involved in the consumer's treatment can request a review, as well as the Chief Psychiatrist and anyone else the Tribunal believes has a valid interest.[2434]

[2427] Ibid s 5(3).

[2428] Ibid s 55(9).

[2429] Ibid sch 4, pt 6, s 1.

[2430] Ibid sch 4 pt 6.

[2431] Ibid s 179.

[2432] Ibid s 179(2).

[2433] *Mental Health Act 2013* (Tas) s 180, 181.

[2434] Tasmanian Civil & Administrative Tribunal, *Tribunal Reviews* (8 November 2021) <https://www.tascat.tas.gov.au/mental-health/tribunal_reviews>.

10.3.88 The right to appeal the decision of the Tasmanian Tribunal is not clearly stated in the *MHA* (Tas), but the Tribunal's website suggests that anyone involved in the hearing can appeal the Tribunal's decision. Appeals must be lodged with the Supreme Court of Tasmania within 30 days of the Tribunal making its decision at the hearing or providing a written statement of reasons.[2435] Such an appeal, as with any appeal of a Tribunal decision to the Supreme Court, would be required to comply with the rules of the Court and have merit to proceed. Such merit could include the finding containing an error of law.

Western Australia

10.3.89 The Mental Health Tribunal in Western Australia ('WA Tribunal') is established under the *Mental Health Act 2014* (WA) *('MHA* (WA)*').*[2436] Its primary role is to review a range of orders from the validity of treatment orders to the approval of psychosurgery.[2437] The purpose of the *MHA* (WA) is to provide for the treatment, care, support and protection of people who have mental illness, to provide for the protection of their rights, and to provide recognition of the role of carers and families in providing care and support to people who have a mental illness.[2438] The Tribunal can make orders and hear applications under the *MHA* (WA).

Orders

10.3.90 The imposition of a CTO or ITO in Western Australia is not made by the Western Australian Tribunal.

Legal Representation

10.3.91 In the Western Australian Tribunal, a party who is an adult subject of a proceeding may appear in person or be represented by a legal practitioner, mental health advocate, or a person who the Tribunal considers is willing and able to represent the adult's interests.[2439] The Tribunal has the power to mandate that a party be represented in the proceeding if in the Tribunal's opinion, it is not in the best interests of the party for the party to appear in person at the proceeding.[2440] The Tribunal may also make arrangements for representation for a party at the Tribunal's discretion.[2441] The *MHA* (WA) expressly recognises that having a mental illness is presumed not to be an impediment to the representation of the person by a legal practitioner at the Mental Health Tribunal and the State Administrative Tribunal.[2442]

10.3.92 A prescribed person under s 317 of the *MHA* (WA) includes a legal practitioner providing free legal advice who is representing a person with a mental illness. The *MHA* (WA) also expressly states that a prescribed person (including legal practitioners) cannot demand or receive any remuneration for representing a party in a proceeding.[2443] The person can also elect to have a nominated

[2435] Tasmanian Civil & Administrative Tribunal, *Decisions* (13 July 2022) <https://www.tascat.tas.gov.au/mental-health/decisions>.

[2436] *Mental Health Act 2014* (WA) s 380.

[2437] Government of Western Australia, Mental Health Tribunal Western Australia, *Other Applications* (21 November 2022) <https://www.mht.wa.gov.au/what-we-do/what-we-can-decide/other-applications/>.

[2438] *Mental Health Act 2014* (WA).

[2439] Ibid s 449(1).

[2440] Ibid s 449(2).

[2441] Ibid s 452.

[2442] Ibid ss 453, 500(4).

[2443] Ibid s 454(1).

person to assist the performance of a function under the *MHA* (WA) and to ensure the rights of the consumer are respected and their interests and wishes upheld.[2444] The nominated person is involved in many decisions and processes under the *MHA* (WA).

10.3.93 A person who is dissatisfied with a decision of the WA Tribunal can apply to the State Administrative Tribunal for a review of the decision.[2445] During a review at the State Administrative Tribunal, the party may be represented by another person, or must be represented if the State Administrative Tribunal makes an order that it is not in the best interest of the party to appear in person at the proceeding.[2446]

10.3.94 Schedule 1 of the *MHA* (WA) contains the *Charter of Mental Health Care Principles* ('Principles'). The Principles provide that a mental health service must clearly explain information about a person's legal rights, including those relating to representation, advocacy, and complaints procedures in order to help the person experiencing mental illness to understand, obtain assistance with, and uphold their rights.[2447]

10.3.95 In making a decision under the *MHA* (WA), the person or body making the decision must take into account the person's wishes as far as practicable, and the wishes of that person's guardians, if the person is a child, their parents, nominated person, carer, and close family members, and any other relevant person.[2448] The role of carers and families as well as other nominated persons is recognised and considered as an object of the *MHA* (WA).[2449]

10.3.96 Carers, close family members and other personal support persons must be made aware of a 'notifiable event' that has occurred in respect of a person as soon as practicable[2450] unless the Tribunal considers they are not entitled to be notified.[2451] The carer, close family members and other support person generally have a range of rights to know what is happening to the consumer,[2452] participate in the care and treatment of the patient[2453] and also have other rights such as requesting a further opinion of another psychiatrist if they are dissatisfied with the treatment being provided to a patient.[2454] The Tribunal must have regard to the patient's condition, and the views of a close friend, close family member or any support person of the patient in making any decision on review.[2455]

Electroconvulsive Therapy

10.3.97 ECT can be performed on the consumer if the Western Australian Tribunal approves and the medical practitioner performing ECT has regard to the guidelines published under s 547(1)(f). The

[2444] Ibid s 263.

[2445] Ibid s 494(1).

[2446] Ibid s 500.

[2447] Ibid sch 1, principle 13.

[2448] Ibid s 7.

[2449] Ibid s 10.

[2450] Ibid s 139; this is subject to s 142.

[2451] Ibid s 143(2).

[2452] Ibid s 245(1).

[2453] For example, being involved in the discharge plan for the patient under *Mental Health Act 2014* (WA) s 187(1).

[2454] *Mental Health Act 2014* (WA) s 182(2).

[2455] See, for example, see Ibid ss 407, 414, 420, 424, 427 among others.

consumer's psychiatrist may apply for approval to perform ECT.[2456] Before approving the ECT, the Tribunal must be satisfied of the items in s 412 and s 414 of the *MHA* (WA).

10.3.98 Emergency ECT can only be performed on an adult involuntary consumer if the ECT is required to save their life, if there is an imminent risk of the consumer harming themselves or others, if the Chief Psychiatrist approves, and it is performed at the appropriate place with reference to the relevant guidelines.[2457]

Reviews

10.3.99 An application for review may be made to the Tribunal for a review of various orders listed in s 390, including an inpatient or ITO treatment order or the transfer of a patient. Other reviews the Tribunal can undertake include reviews of orders restricting freedom of communication,[2458] or orders affecting a person's rights under the *MHA* (WA).[2459] An involuntary consumer, a carer, close family member or other person support person, mental health advocate or another person who the Tribunal deems has a sufficient interest in the matter can apply.[2460] The Tribunal may also initiate a review on its own initiative whenever it considers it appropriate.[2461] The Tribunal has strict guidelines for performing ECT on children or an involuntary adult patient detained under the *MHA* (WA).[2462]

10.3.100 The parties to the proceeding will be the involuntary consumer, the applicant for the review, and any other person whom the WA Tribunal considers has a sufficient interest in the matter.[2463]

10.3.101 The State Administrative Tribunal reviews decision of the WA Tribunal and applications can be made by a person to whom the order relates and is dissatisfied with the decision of the Tribunal, or any other person who has a sufficient interest.[2464]

10.3.102 A party may request the Western Australian Tribunal to provide the party with reasons for the Tribunal's decision in the proceeding and the Tribunal must comply with this request if it is made within the prescribed time period.[2465] Appeals to the Supreme Court can be made against a State Administrative Tribunal decision under the *MHA* (WA) by a person in respect of whom a decision is made is dissatisfied with the decision or any person with a sufficient interest in the matter.[2466] The grounds of appeal can be on fact or in law.[2467]

[2456] Ibid s 410(1).

[2457] Ibid s 199.

[2458] Ibid s 427.

[2459] Ibid s 434.

[2460] Ibid s 390(2).

[2461] Ibid s 391.

[2462] Ibid s 410.

[2463] Ibid s 393.

[2464] Ibid s 494.

[2465] Ibid s 469.

[2466] Ibid s 503.

[2467] Ibid s 504.

10.3.103 Most of the orders under the *MHA* (WA) require the decision-maker to provide reasons for the decision. The person must have their rights under the Act explained to them[2468] and this should also be explained to the carer, close family members, or other general support person of the patient.[2469]

Australian Capital Territory

10.3.104 The ACT Civil and Administrative Tribunal ('ACAT') is the relevant body making orders about a person's mental health treatment, care or support under the *Mental Health Act 2015* (ACT) ('*MHA* (ACT)').

10.3.105 The types of orders ACAT can make in relation to mental health matters include:

1. An application for an assessment order;
2. Application for mental health orders;
3. Application for forensic mental health;
4. Application for ECT;
5. Review of mental health orders;
6. Revocation of mental health orders;
7. Emergency detention; and
8. Referrals.[2470]

10.3.106 The objects of the *MHA* (ACT) are to promote the recovery of people with a mental health disorder and to promote their participation in their recovery, support their recovery.[2471] It is noted:

> The *Mental Health Act 2015* affirms the right of everyone to be actively involved in their mental health treatment, care and support. People are to be encouraged to participate and express their views and preferences about their mental health treatment regardless of whether they are receiving that treatment voluntarily or involuntarily.[2472]

Orders

10.3.107 A relevant person can apply to ACAT for a mental health order in relation to a person.[2473] ACAT will consider the assessment of the person under the assessment order or another relevant assessment in making the order.[2474] ACAT must also consult a parent, guardian, attorney, nominated person and other parties (all where applicable only) as far as reasonably practicable.[2475]

[2468] Ibid s 244.

[2469] Ibid s 245.

[2470] ACAT, *Mental Health Cases* (20 September 2022) <https://www.acat.act.gov.au/case-types/mental-health-cases>.

[2471] *Mental Health Act 2015* (ACT) s 5.

[2472] Stephen Tang, *Making decisions about mental health treatment, care and support* (16 March 2022) <https://austlii.community/foswiki/ACTLawHbk/MakingDecisionsAboutMentalHealthTreatmentCareAndSupport>.

[2473] *Mental Health Act 2015* (ACT) s 51.

[2474] Ibid s 53.

[2475] Ibid s 54.

10.3.108 Upon assessment, ACAT is able to make a psychiatric treatment order[2476] or a community care order[2477] in relation to a consumer. ACAT also has the power to amend or revoke mental health orders.[2478]

Legal representation

10.3.109 There are no apparent representation rights for adults under the *MHA* (ACT), but there is some protection for children, as ACAT may of its own initiative, or on the application of a relevant person, allow the person subject to the order to obtain representation and give reasonably necessary advice and assistance.[2479] A '*representative'* under parts of the *MHA* (ACT) includes a legal representative of the person.

10.3.110 The *MHA* (ACT) enables a person with a mental illness to appoint a nominated person to receive information under the *MHA* (ACT), the person's treatment, care and support.[2480] The nominated person could be a relative or friend, a carer, or neighbour.[2481]

10.3.111 The *MHA* (ACT) facilitates the involvement of close relatives, close friends and carers in treatment, care and support decisions, in partnership with medical practitioners. It also acknowledges the impact of mental disorder and mental illness on the close relatives, close friends and carers of those with mental illness, and their experience and knowledge of the person with mental illness.[2482]

10.3.112 When making an order, ACAT will consult, as far as reasonably practicable, with the nominated person, guardian, parent, legal practitioner and other persons where applicable. Before making a mental health order in relation to a person who has a carer, ACAT must inform the carer about the order and hearing.[2483] It is elaborated:

> The Act makes it clear that carers and others who support a person with mental illness or mental disorder should be involved in the person's treatment, care and support, if this is what the person wants. The Act therefore defines 'carer' narrowly in s 12, to ensure that only those who have a close personal connection to the person can participate in these important decisions.[2484]

10.3.113 A copy of the assessment must be provided to the person assessed, the Public Advocate, the parent of a child, the nominated person, guardian or legal practitioner where applicable.[2485] Notice of the outcome of assessment must be provided to the applicant.[2486]

[2476] Ibid s 58.

[2477] Ibid s 66.

[2478] Ibid s 79(6).

[2479] Ibid s 191(1).

[2480] Ibid s 20.

[2481] Ibid s 19.

[2482] Ibid s 6.

[2483] Ibid s 54.

[2484] Stephen Tang, *Important Concepts* (16 March 2022) <https://austlii.community/foswiki/ACTLawHbk/ImportantConcepts>.

[2485] *Mental Health Act 2015* (ACT) s 48.

[2486] Ibid s 49.

Electroconvulsive Therapy

10.3.114 For adults without decision-making capacity, ECT can only be administered if the person has an advance consent direction (also known as an advanced care directive) consenting to the ECT, it is administered in accordance with the direction, and the person does not refuse or resist.[2487] Application for ECT must be made to ACAT who, in making the decision, will take into account the wishes of the person, the views of the people responsible for the care of the person, the views of the people appearing at the proceeding and the views of a legal practitioner, guardian or nominated person where applicable.[2488]

10.3.115 Emergency ECT can be provided if the Chief Psychiatrist and the medical practitioner believe on reasonable grounds that ACAT could make an emergency order, and both people may jointly apply to ACAT for an emergency ECT order in relation to a person.[2489] In making an emergency order, ACAT must take into account the wishes of the person and those close to them.[2490] ACAT will make the emergency order where the person has a mental illness, lacks decision-making capacity, does not have an advanced consent direction refusing ECT, and administering ECT is necessary to save the person's life or prevent onset of risk to their life within three days, and other forms of treatment have been unsuccessful or are not appropriate.[2491]

Reviews

10.3.116 ACAT may review a mental health order in force of its own initiative or on application by a person or the person's representative[2492] which encompasses psychiatric treatment orders, community care orders and restriction orders. A representative under this review section includes a guardian, a person with the power of attorney, a nominated person, a close relative or close friend of the person, and the legal representative.[2493]

10.3.117 Certain people may apply to ACAT for a review of a reviewable decision including a person mentioned in Schedule 1, column 4 of the *MHA* (ACT), and a person whose interests are affected by the decision.[2494] A reviewable decision is one mentioned in Schedule 1, column 3 of the *ACT MHA* and includes the refusal to grant leave, refusal to issue a licence, amend a licence or cancel a licence.

10.3.118 The *MHA* (ACT) requires the responsible person to advise the person with mental illness of their right under the *MHA* (ACT) and provide a written statement including their right to obtain legal advice.[2495]

10.3.119 Appeals of ACAT decisions can be made to the Supreme Court of the Australian Capital Territory and brought by someone in relation to whom the decision was made, someone who appeared

[2487] Ibid s 149.

[2488] Ibid s 156.

[2489] Ibid s 160(1), (2).

[2490] Ibid s 161.

[2491] Ibid s 162.

[2492] Ibid s 79.

[2493] Ibid s 79(7).

[2494] Ibid s 260.

[2495] Ibid s 15(1).

before ACAT in the proceeding, a Discrimination Commissioner or anyone who obtains the leave of the Court.[2496]

10.3.120 **Table 6** below shows a summary of the current level of uniformity of the law and frameworks regarding administrative decisions in Australian jurisdictions.

[2496] Ibid s 267.

Table 6: Australian Jurisdictional Comparison of Administrative Decision-Making							
	Decision-Making Body	**Legislation**	**Powers to Make Orders**	**Applications**	**Legal Representation**	**ECT**	**Reviews/Appeals**
NSW	NSW Mental Health Review Tribunal ('NSW Tribunal')	**Section 140** *Mental Health Act 2007* (NSW)	**Section 35** Conduct Mental Health Inquiries **Section 37** Regularly review the case of each involuntary patient. **CTOs** **Sections 51(1), 53(1)** Power to make a CTO. **Section 53(6)** Must not specify a period longer than 12 months. **Section 67** Hear appeals against a Magistrate's decision to make a CTO. **Sections 93(3), 94, 95, 96** Approve the use of ECT for involuntary patients or determine if voluntary patients have consented to ECT. **Section 53(6)** Must not specify a period longer than 12 months.	**Section 51(2)** Persons may apply for a CTO: (a) the authorised medical officer of a mental health facility in which the affected person is detained or is a patient under this Act, (b) a medical practitioner who is familiar with the clinical history of the affected person, (c) any other person prescribed by the regulations. **Section 65** NSW Tribunal can vary or revoke a CTO upon application by the affected person, the psychiatric case manager of the affected person, any person who could have applied for the order, or of its own motion.	**Section 154** Requires an 'assessable person' who is before the NSW Tribunal for a mental health inquiry, a person detained in a mental health facility, a person under 16 years old and a person who is absent from proceedings to be represented by a legal practitioner or by another person of their choice, with approval of the Tribunal, unless the person elects otherwise. **Section 34(2)** Any designated carer of an assessable person during an inquiry may appear at the inquiry with the approval of the NSW Tribunal. (Designated carer: a guardian, parents, spouse, or a close friend or relative of the consumer: s 71) **Section 154(2A)** NSW Tribunal has the power to permit another person (not a legal practitioner) to represent a person.	**Section 94(1)** ECT may be administered to an involuntary patient or a person who is under the age of 16 years in accordance with an ECT determination made by the NSW Tribunal at an ECT administration inquiry. **Section 94(2)** An authorised medical officer may apply for an ECT administration inquiry. **Section 95** ECT inquiries must be held 'as soon as practicable' after an application is made to the Tribunal.	The NSW Tribunal has limited scope for internal reviews. **Section 44** Hear appeals against an authorised medical officer's refusal to discharge an involuntary patient. **Section 163** affected person can appeal a CTO made by the NSW Tribunal to the Supreme Court on any question of law, or against the duration of the order. **Section 67(1), (2)** A CTO made by the Magistrate can be appealed to the Tribunal regarding the duration of the order on any question of law.
VIC	Mental Health Tribunal (Victorian Tribunal)	**Section 152** *Mental Health Act 2014* (Vic)	**Section 52** Make Treatment Orders to impose a CTO and/or an ITO.	**Section 54** **Applications for orders** Can only be made by an authorised psychiatrist within the prescribed time frame.	**Section 184** (1) Person subject of a proceeding has the express right to appear before the Tribunal hearings. (3) Allows a person to be represented.	**Section 93(1)** An authorised psychiatrist may make an application to the Tribunal to perform ECT.	**Section 66** Application for review of direction to vary Order. Can be applied for by any person (a guardian, a parent (if the patient is under the age of 16) or a secretary).

			Section 153 The Victorian Tribunal can hear the following applications: Revocation of Temporary Treatment Orders or Treatment Orders; ECT and neurosurgery (in its special division); Regarding the transfer of a person's treatment to another health service; Regarding an interstate transfer order or an interstate transfer of treatment order for a compulsory patient; and Relating to security patients.	**Section 58** **Variation of order** can be performed by an authorised psychiatrist in limited circumstances of changing an ITO to CTO or vice versa or changing a Temporary Order to a General Order **Section 60(2)** An application to revoke a Treatment Order can be made by a person subject to the order, a guardian, a parent (if the patient is under 16 years), or a secretary (where applicable).	(4) If not represented, the Tribunal may appoint one. (There are no apparent rights to legal representation for carers, guardians, and others.) **Section 198(4)** Must give notice of a hearing to the guardian and carer or nominated person of the person who is subject to the proceeding.	**Section 95(1)** An ECT applicant must be dealt with within five business days of receiving the application. **Section 178(2), (3)** Heard in the Tribunal's Special Division, along with decisions regarding neurosurgery	**Section 284** A security patient applying to review the decision not to grant a leave of absence. **Section 294** Review of direction to take security patient to another designated mental health service
WA	Mental Health Tribunal in Western Australia ('WA Tribunal')	*Mental Health Act 2014* (WA)	The imposition of a CTO or ITO in Western Australia is **not** made by the WA Tribunal. Its primary role is to review a range of orders from the validity of treatment orders to the approval of psychosurgery.	**Section 398** The Tribunal may, on the application of a person specified in section 400(1) or on its own initiative, declare that a treatment order is or was valid or invalid. **Section 404** An application for review of admission of long-term voluntary inpatients may be made by (a) the long-term voluntary inpatient; (b) a carer, close family member or other personal support person of the long-term voluntary inpatient; (c) a mental health advocate;	**Section 449(1)** A party who is an adult subject of a proceeding may appear in person or be represented by a legal practitioner, mental health advocate, or a person who the Tribunal considers is willing and able to represent the adult's interests.	**Section 412, 414** WA Tribunal can approve ECT. Before approving the ECT, the Tribunal must be satisfied of the items in s 412 and s 414.	**Section 390** An application for review may be made to the Tribunal for a review of various orders. An involuntary consumer, a carer, close family member or other person support person, mental health advocate or another person who the Tribunal deems has a sufficient interest in the matter can apply. **Section 494** The State Administrative Tribunal reviews decision of the WA Tribunal and applications can be made by a person to whom the order relates and is dissatisfied with the decision of the Tribunal, or any other person who has a sufficient interest

				(d) any other person who, in the opinion of the Tribunal, has a sufficient interest in the matter. **Section 410(1)** The consumer's psychiatrist may apply for approval to perform ECT.			
QLD	Mental Health Review Tribunal	*Mental Health Act 2016* (Qld)	The Tribunal's primary role is to review the appropriateness of treatment authorities, forensic orders, and treatment orders made under the *Mental Health Act 2016* (Qld). Tribunal will determine whether people are to be provided with medical treatment, to review the status of a person's involuntary authority or order and has the power to impose binding declarations on consumers. Tribunal can make orders revoking an order, changing the category of an order, or changing the conditions of the order. **Section 51** An authorised medical practitioner makes a treatment authority for the consumer and decides whether it will be an ITO or CTO. In some instances the Queensland Tribunal can make a treatment authority order in	**The Queensland Tribunal hears applications for:** Examination authorities; Performance of regulated treatments such as ECT and neurosurgical procedures; Transfer of patients in and out of Queensland; and Confidentiality orders.	The Act mandates legal representation is *some* tribunal proceedings. **Section 5(d)** The consumer is to be provided with the necessary support and information to assist them to express their views and preferences. **Section 739** Consumer may be represented by a nominated support person, a lawyer, or another person. **Section 740(2)** Tribunal also has the power to appoint legal representation for a patient if it considers it to be in the patient's best interests. **The Tribunal will appoint a lawyer for the person at no cost:** 1. If the person is a minor; 2. For a review of the person's fitness for trial; 3. For an application for approval to perform ECT; 4. For a review of a forensic order where the Attorney-General is to be represented; or 5. Confidentiality order.	**Section 507** A medical practitioner may apply to the Queensland Tribunal for approval to give a person ECT to be determined at a hearing if the medical practitioner is satisfied that the adult is unable to give informed consent to the therapy or the person is a minor. **Section 727** Requires that the Tribunal hears the application for ECT as soon as practicable after the application is received.	1. Treatment Authorities; 2. Treatment support orders; 3. Forensic orders; Fitness for trial of particular persons; and 4. Detention of minors in high security units. **Schedule 2** For most decisions of the Tribunal on review or in response to an application, an appeal can be instituted by the person the subject of the order, the treatment authority, or an interested person for the person subject to the order, and in many cases it can be instituted by the Chief Psychiatrist or the Attorney-General. **Section 538(1)** The decision of the Mental Health Court is final and conclusive and cannot be challenged or appealed unless the decision is affected by jurisdictional error.

			relation to forensic orders.				
TAS	Tasmanian Civil and Administrative Tribunal ('TCAT')	*Mental Health Act 2013* (Tas) ('MHA Tas') *Tasmanian Civil and Administrative Tribunal Act 2020* (Tas) ('TCAT Act')	To authorise and review the treatment of persons with mental illness and determine the appropriate treatment, if any. The orders that the Tasmanian Tribunal primarily reviews and makes are: 1. Assessment orders; 2. Interim treatment orders; 3. Treatment orders; 4. Supervision orders; and 5. Restriction orders. **Section 181** Variation of a treatment order can be done by the Tribunal at any time of its own motion or on the application of any approved medical practitioner or on the application of any person with the necessary standing.	**Section 37** Treatment orders can be applied for by any approved medical practitioner or the person subject to the treatment in certain circumstances.	**Schedule 4 Part 2** 7(1) A party to any proceeding is entitled to attend the hearings, but the Tribunal may exclude any person it reasonably considers might be detrimental to the welfare of their own health or the health of another who is present. 7(3) A party to any proceedings may appear personally in the proceedings or be represented by an Australian legal practitioner, advocate, or other person The consumer is able to ask Legal Aid for representation, but this is not facilitated by the Tasmanian Tribunal. **Section 3 Definition** A representative can be a consumer's guardian, patient's lawyer, the consumer's parent where the consumer is a minor, and any other person nominated by the person to represent their interests.	ECT is not mentioned in the MHA Tas. **Part 6** An involuntary consumer may only be given special psychiatric treatment where it is authorised by the Tasmanian Tribunal. **Section 55(9)** The Tribunal can set aside authorisation for special psychiatric treatment.	**Sections 180, 181** An application to review an assessment or treatment order can be made on the Tasmanian Tribunal's own motion, or upon application by someone with the required standing. A consumer, lawyer, advocate, support person, medical practitioner or others involved in the consumer's treatment can request a review, as well as the Chief Psychiatrist and anyone else the Tribunal believes has a valid interest. **Appeal to Supreme Court of Tasmania** Required to comply with the rules of the Court and have merit to proceed. Such merit could include the finding containing an error of law.
ACT	ACT Civil and Administrative Tribunal ('ACAT')	*Mental Health Act 2015* (ACT)	**ACAT can make decisions with regard to:** 1. An application for an assessment order; 2. Application for mental health orders; 3. Application for forensic mental health; 4. Application for ECT; 5. Review of mental health orders;	**Section 51** A relevant person can apply to ACAT for a mental health order in relation to a person.	**Section 191(1)** There are no apparent representation rights for adults under the Act, but there is some protection for children, as ACAT may of its own initiative, or on the application of a relevant person, allow the person subject to the order to obtain representation and give reasonably necessary advice and assistance.	**Division 9.2.2** Application for ECT must be made to ACAT. ACAT must take in consideration a number of matters when making its decision.	**Section 79** ACAT may review a mental health order in force of its own initiative or on application by a person or the person's representative. Mental health orders include psychiatric treatment orders, community care orders and restriction orders. **Section 79(7)**

			6. Revocation of mental health orders; 7. Emergency detention; and 8. Referrals		A 'representative' under parts of the ACT MHA includes a legal representative of the person. **Sections 19, 20** The Act enables a person with a mental illness to appoint a nominated person to receive information under the ACT MHA, the person's treatment, care and support. The nominated person could be a relative or friend, a carer, or neighbour		A representative under this review section includes a guardian, a person with the power of attorney, a nominated person, a close relative or close friend of the person, and the legal representative. **Section 267** Appeals of ACAT decisions can be made to the Supreme Court of the Australian Capital Territory and brought by someone in relation to whom the decision was made, someone who appeared before ACAT in the proceeding, a Discrimination Commissioner or anyone who obtains the leave of the Court.
NT	NT Mental Health Review Tribunal	*Mental Health and Related Services Act 1998* (NT)	**Section 48** Make community management orders (CTO equivalent) **Section 56** Authorise various treatments. **Section 126(a)** Make determinations regarding informed consent.	**Section 44C** The Tribunal can hear applications for orders of for involuntary admission on application by an authorised psychiatric practitioner. **Section 50A** Revocation of a community management order can be made by an authorised psychiatric practitioner so long as the Tribunal is properly notified	**Section 131(2)** If the consumer who is subject to a review or involuntary detention application does not have a representative, and the NT Tribunal considers they require representation, the Tribunal must appoint a legal practitioner for that consumer. **Section 131(4)** It is at the Tribunal's discretion to order the Territory to pay all or part of the reasonable costs and disbursements of the legal practitioner. **Section 144(1)** When a person appeals a decision of the NT Tribunal to the Supreme Court of the Northern Territory, they are entitled to be self-represented or represented by a legal practitioner or other person.	**Section 66(2)** NT Tribunal may authorise ECT in certain circumstances. No express provisions permitting emergency ECT.	**Sections 122, 123** NT Tribunal conducts reviews of long-term voluntary admissions, involuntary admissions and community management orders. **Section 127** A review application can be made by the person subject of the order, or on the person's behalf a guardian, the decision maker, a representative, a legal practitioner, or a person with a genuine interest in, or with real and immediate concern for the health or welfare of the person **Section 142** A person aggrieved by the decision of the NT Tribunal or refusal of the Tribunal may, with the leave of the Court, apply to the Supreme Court of the Northern Territory to appeal the decision. This Application can be made by a person who has a sufficient interest in the matter.

10.4 **Issues**

10.4.1 A number of issues were identified prior to and throughout SALRI's consultation process in relation to the operation of the *MHA* and the role of SACAT.

Legal Representation – Procedural Fairness

10.4.2 Legal representation has long been recognised as essential to providing procedural fairness to ensure the relevant person's opinions and views are adequately expressed and considered.[2497] Procedural fairness is more than adhering to administrative hurdles and following procedure, it also aims to support the person subject of the decision throughout the proceedings so that they 'feel that they have been dealt with fairly'.[2498]

10.4.3 Chief Justice French raised several rationales for procedural fairness in his 2010 lecture at the University of Melbourne.[2499] The Chief Justice outlined:

1. That it is instrumental, that is to say, an aid to good decision-making.
2. That it supports the rule of law by promoting public confidence in official decision-making.
3. That it has a rhetorical or libertarian justification as a first principle of justice, a principle of constitutionalism.
4. That it gives due respect to the dignity of individuals – the dignitarian rationale.
5. By way of participatory rationale – it is democracy's guarantee of the opportunity for all to play their part in the political process.[2500]

10.4.4 'Each of these justifications has a part to play in MHRT hearings'.[2501] The need for mental health tribunals to observe procedural fairness is fundamental. It 'arguably remains one of the most important legal mechanisms for the protection of the rights of people with mental illnesses'.[2502]

10.4.5 The possibility of power imbalances inherent in a tribunal hearing means that ensuring an impartial and transparent process is as important as the ultimate decision. The maxim that 'Not only must Justice be done; it must also be seen to be done' must be the MHRT's guidepost.[2503]

[2497] Castan Centre for Human Rights Law, Mental Health Victoria, *The Human Rights Roadmap: 40 ways to operationalise human rights in Victoria's mental health and wellbeing system* (September 2022) 56.

[2498] Anina Johnson, 'The Value of Procedural Fairness in Mental Health Review Tribunal Hearings' (Paper presented at the Australian Institute of Administrative Law National Conference 86, Brisbane, Queensland, 21 July 2016) 11.

[2499] Chief Justice Robert French, High Court of Australia, *Procedural Fairness – Indispensable to Justice*? (Sir Anthony Mason Lecture delivered at the University of Melbourne Law School, Law Students' Society, 7 October 2010).

[2500] Ibid 1.

[2501] Anina Johnson, 'The Value of Procedural Fairness in Mental Health Review Tribunal Hearings' (Paper presented at the Australian Institute of Administrative Law National Conference 86, Brisbane, Queensland, 21 July 2016) 11.

[2502] Sam Boyle and Tamara Walsh, 'Procedural Fairness in Mental Health Review Tribunals: the Views of Patient Advocates' (2021) 28(2) *Psychiatry, Psychology and Law* 163, 174.

[2503] Anina Johnson, 'The Value of Procedural Fairness in Mental Health Review Tribunal Hearings' (Paper presented at the Australian Institute of Administrative Law National Conference 86, Brisbane, Queensland, 21 July 2016) 17.

Legal Representation

10.4.6 There are concerns about the role and operation of mental health tribunals, notably as to what is said to be the lack of meaningful participation by consumers in the proceedings and the deference shown by tribunals to clinical opinions.[2504] It has been said that the participatory rationale of mental health tribunals 'may be undermined by medicalised and legal cultural practices that dominate proceedings [and] a lack of meaningful patient involvement in tribunals can lead to feelings of powerlessness and perceptions about procedural unfairness.'[2505] A recent Scottish study highlighted consumer 'feelings of powerlessness' and 'the findings suggest that participation is often experienced as tokenistic in practice and that cultural change is required if people are to be meaningfully involved in tribunal proceedings'.[2506] There is a need for mental health tribunals to give effect, as far as practicable, to a supported decision-making model and respect the autonomy of a consumer under the *MHA*.[2507]

10.4.7 The need for bodies such as SACAT to balance the competing interests that arise in this area is notable:

[2504] See generally, Sameer Sarkar and Gwen Adshead, 'Black Robes and White Coats: Who will Win the New Mental Health Tribunals?' (2005) 186 *British Journal of Psychiatry* 96, 96–98. Amar Shah, 'Is the Mental Health Review Tribunal Inherently Unfair to Patients?' (2009) 17(1) *Psychiatry Psychology and Law* 25, 25–31; Ian Freckelton, 'Therapeutic Jurisprudence Misunderstood and Misrepresented: The Price and Risks of Influence' (2008) 30(2) *Thomas Jefferson Law Review* 575, 587; Terry Carney and David Tait, 'Mental Health Tribunals – Rights, Protection, or Treatment? Lessons from the ARC Linkage Grant Study?' (2011) 18(1) *Psychiatry, Psychology and Law* 112; Terry Carney, 'Australian Mental Health Tribunals: "Space" for Rights, Protection, Treatment and Governance?' (2012) 35 *International Journal of Law and Psychiatry* 1; Terry Carney, 'Australian Mental Health Tribunals: "Space" for Rights, protection, Treatment and Governance?' (2013) 35(1) *International Journal of* ; Katey Thom and Ivana Nakarada-Kordic, 'Mental Health Review Tribunals in Action: A Systematic Review of the Empirical Literature' (2014) 21(1) *Psychiatry, Psychology and Law* 112; Christopher Maylea and Christopher Ryan, 'Decision-Making Capacity and the Victorian Mental Health Tribunal' (2017) 24 *International Journal of Mental Health and Capacity Law* 87; Julie Ridley and Susan Hunter, 'Subjective Experiences of Compulsory Treatment from a Qualitative Study of Early Implementation of the Mental Health (Care and Treatment) (Scotland) Act 2003' (2013) 21 *Health and Social Care in the Community* 509; Aisha MacGregor, 'Meaningful Participation or Tokenism for Individuals on Community Based Compulsory Treatment Orders? Views and Experiences of the Mental Health Tribunal in Scotland' (2022) 31(2) *Journal of Mental Health* 158.

[2505] Aisha MacGregor, Michael Brown and Jill Stavert, 'Are Mental Health Tribunals Operating in Accordance with International Human Rights Standards? A Systematic Review of the International Literature' (2019) 27(4) *Health and Social Care in the Community* 494, 495. 'Feelings of powerlessness emerged as a key theme across the studies with clear implications for patient perceptions of autonomy. Individuals described feeling powerlessness in respect to both the tribunal process and outcome, exacerbated by the unequal power differentials between individuals and professionals involved in their care and treatment': at 509. See also Terry Carney, 'Australian Mental Health Tribunals: "Space" for Rights, Protection, Treatment and Governance?' (2012) 35 *International Journal of Law and Psychiatry* 1; Terry Carney and David Tait, 'Mental Health Tribunals – Rights, Protection, or Treatment? Lessons from the ARC Linkage Grant Study?' (2011) 18(1) *Psychiatry, Psychology and Law* 112; 122–126; Sam Boyle, Tamara Walsh and Lucinda Nelson, 'A Study into the Operation of the Queensland Mental Health Review Tribunal' (2021) 29(1) *Medical Law Review* 106, 118–20.

[2506] Aisha MacGregor, 'Meaningful Participation or Tokenism for Individuals on Community Based Compulsory Treatment Orders? Views and Experiences of the Mental Health Tribunal in Scotland' (2022) 31(2) *Journal of Mental Health* 158.

[2507] Christopher Maylea and Christopher Ryan, 'Decision-Making Capacity and the Victorian Mental Health Tribunal' (2017) 24 *International Journal of Mental Health and Capacity Law* 87, 90–2. The need for the *Mental Health Act 2009* (SA) and present practices to give greater and more explicit effect to the vital premise of supported decision making was raised by many parties in SALRI's consultation such as JFA Purple Orange, Mind Australia Ltd, Disability Rights Advocacy Service Inc, Dr Susan Peukert, the Australian Psychological Society and Speech Pathology Australia. See further Part 3 Decision-making Capacity and Supported Decision-making.

> Mental health tribunals are tasked with finding a balance in tensions which exist in many areas of law: between the rights of the individual and what is deemed to be in their best interests; between due process and expediency; and between the protection of the community and the wellbeing of the individual.[2508]

10.4.8 The importance of legal representation in tribunals for persons with mental illness is clear[2509] (as was often highlighted to SALRI in consultation by the Law Society, consumer groups and others). Persons with mental illness have been described 'as among the most vulnerable and disadvantaged in our community.'[2510]

10.4.9 As one study elaborates as to the importance of legal representation for consumers:

> As a result of their illness and related disadvantage … people with a mental illness are vulnerable to particular legal issues and come up against particular barriers that limit their ability to deal with these issues. The combination of poor financial circumstances, a perceived lack of credibility and cognitive and communication impairment pose major challenges for people with a mental illness seeking to participate in legal processes. People with a mental illness are likely to experience complex and multiple legal and other issues, which they are not always well placed to address, and which are deserving of particular attention from both research and service provision.[2511]

10.4.10 Another author similarly argues:

> Given the client group, MHTs would seem unique among all the other Tribunal jurisdictions in requiring that patients have advocacy. By definition, those appearing before MHTs are deemed mentally disordered and may therefore have great difficulty in self advocacy. This may be because they are thought disordered or delusional, or because they have learning disabilities. Whilst the MHT attempts to be informal, there still remains an adversarial quality to the proceedings and a case to be put by cross examination and submissions, which would be beyond the capacity of most patients. Even if the patient is mentally settled, he will not possess the legal skills or knowledge of the law to be able to advocate his case. Many patients will also lack capacity to be able to engage in the proceedings. Given the gravity of the proceedings, which involve issues concerning deprivation of liberty, appropriateness of treatment and future care options, self-representation would be totally inadequate.[2512]

10.4.11 This reasoning was reiterated in SALRI's consultation, notably by the Law Society and consumer groups. Lawyers are seen to support the meaningful participation of consumers in

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[2508] Christopher Maylea, 'Tensions in the Work of Mental Health Tribunals' (2019) 150 *Precedent* 13.

[2509] See, for example, Paul Veitch, 'The Case for "Good" Legal Representation Is it Worth Fighting For' (2011) 21 *International Journal of Mental Health and Capacity Law* 15; Fleur Beaupert, 'Mental Health Tribunal Processes and Advocacy Arrangements: "Little Wins" are No Small Feat' (2009) 16(1) *Psychiatry, Psychology and Law* 90; Chris Maylea, 'Tensions in the Work of Mental Health Tribunals' (2019) 150 *Precedent* 13; Jake Buckingham, 'A Critical Analysis of Legal Representation in Queensland's Mental Health Review Tribunal', (2018) 6(1) *Griffith Law Journal* 132, 149–152, 153–154; Rory Callinan, *Study into Queensland's Mental Health Review Tribunal Raises Concerns About Oversight of Patients* (2 June 2021) ABC News <https://www.abc.net.au/news/2021-06-02/study-raises-concerns-about-qld-mental-health-review-tribunal/100181556>; T O'Brien et al, 'A One Year Analysis of Appeals made to Mental Health Review Tribunals in New Zealand' (1995) 29(4) *Australian and New Zealand Journal of Psychiatry* 661.

[2510] Maria Karras et al, *On the Edge of Justice: the Legal Needs of People with Mental Illness in NSW* (Law and Justice Foundation of NSW, May 2006) xvi. See also at: 21; Michael Cain et al, *The NSW Mental Health Review Tribunal: An Analysis of Clients, Matters and Determinations* (Law and Justice Foundation of NSW, 2011) 5–7.

[2511] Maria Karras et al, *On the Edge of Justice: the Legal Needs of People with Mental Illness in NSW* (Law and Justice Foundation of NSW, May 2006) 1, foreword.

[2512] Paul Veitch, 'The Case for "Good" Legal Representation Is it Worth Fighting for The Case For' (2011) 21 *International Journal of Mental Health and Capacity Law* 15, 16–7.

proceedings under the *MHA*.[2513] Lawyers are also seen as bringing a welcome intellectual rigour to the tribunal proceedings in helping assess the relevance and probative value of the material put before the tribunal regarding the consumer.[2514] This is seen as particularly so if practitioners bring sensitivity and maturity to the process and are skilled in mediation and other non-adversarial approaches.[2515]

10.4.12 Legal representation for consumers in a *MHA* context is also supported by international human rights principles,[2516] notably the UN Convention on the Rights of Persons with Disabilities.[2517] As one study notes:

> Article 13(1) of the *Convention on the Rights of Persons with Disabilities* 2006 ('UN Disability Rights Convention') makes it clear that persons with disabilities should have 'effective access to justice … on an equal basis with others'. Article 17 requires governments to respect the 'physical and moral integrity' of all persons. The United Nations *Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care* (1991) include: a patient's right to choose and appoint a legal representative (Principle 18), access to legal aid for the indigent (Principle 1(6)) and a personal representative apart from a family member (Principle 2) ... Mandatory, free, and high quality legal representation for people facing mandatory detention for a mental illness, is similarly supported by the World Health Organisation (WHO, 2003).[2518]

10.4.13 It is important to note that legal representation is not a panacea.[2519] The adversarial approach taken by some lawyers can be at odds with the rationale of tribunals such as SACAT as an

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[2513] Penelope Weller, 'Taking a Reflexive Turn: Non-Adversarial Justice and Mental Health Review Tribunals' (2011) 37(1) *Monash University Law Review* 81.

[2514] Fleur Beaupert, 'Mental Health Tribunals from Crisis to Quality Care?' (2007) 32 (4) *Alternative Law Journal* 219.

[2515] Maria Bisogni, 'What is the Role of a Legal Representative Before the Mental Health Review Tribunal?' (2002) 40(10) *Law Society Journal* 72, 74; Paul Veitch, 'The Case for "Good" Legal Representation is it Worth Fighting For?' (2011) 21 *Journal of Mental Health Law* 15, 18. The demands on lawyers in dealing with some clients with mental illness should not be overlooked. See Maria Karras et al, *On the Edge of Justice: the Legal Needs of People with Mental Illness in NSW* (Law and Justice Foundation of NSW, May 2006) 122–3.

[2516] See, for example, John Coats, 'Mental Health Review Tribunals and Legal Representation: Equality of Arms?' (2004) 28 *Psychiatric Bulletin* 426; Terry Carney and Fleur Beaupert, 'Mental Health Tribunals: Rights Drowning in Un-"Chartered" Health Waters?' (2008) 13(2) *Australian Journal of Human Rights* 181; Terry Carney, Fleur Beaupert, Julia Perry and David Tait, 'Advocacy and Participation in Mental Health Cases: Realisable Rights or Pipe-Dreams?' (2008) 26(2) *Law and Context* 125, 130–1. See also *MS v Croatia (No 2)* [2015] ECHR 196.

[2517] The precise meaning of the *CRPD* with respect to involuntary psychiatric treatment is not straightforward and has led to much debate. See Sascha Callaghan and Christopher Ryan, 'An Evolving Revolution: Evaluating Australia's Compliance with the Convention on the Rights of Persons with Disabilities in Mental Health Law' (2016) 39 *University of New South Wales Law Journal* 596.

[2518] Terry Carney, Fleur Beaupert, Julia Perry and David Tait, 'Advocacy and Participation in Mental Health Cases: Realisable Rights or Pipe-Dreams?' (2008) 26(2) *Law and Context* 125, 126.

[2519] Ibid 137–9. This emerges in a recent Queensland study, see Sam Boyle and Tamara Walsh, 'Procedural Fairness in Mental Health Review Tribunals: the Views of Patient Advocates' (2021) 28(2) *Psychiatry, Psychology and Law* 163, 171–3: 'Participants in seven of the focus groups expressed the view that lawyers were 'useless' in MHRT hearings because the outcome of proceedings was predetermined. Many of the lawyers said that they felt that appearing before the tribunal was a 'waste of my time' because they were unable to influence the result. They made comments such as: What's the point in having an MHRT hearing? … I don't want to waste my time as a solicitor being allocated to a task like that if I can't fight it. There's no point. (FG2) It's sort of like they've already formed an opinion on a lot of these criteria before they even get to the hearing … it just seems like you're already playing from behind for a lot of these clients. (FG4, S5). The reason I stopped doing tribunal hearings was because I felt the outcome was predetermined and a waste of my time. (FG4, S4). Even when people are legally represented, it's like just completely pointless. I don't even think that they really can get to say anything, and if they do, again it's also completely discarded. (FG9).

informal, flexible and problem solving forum.[2520] There is a danger of mental health tribunals becoming drawn by lawyers into 'damaging adversarial practices'[2521] which would be to the detriment of a consumer's best interests, and may even lead to patients 'dying with their rights on'.[2522] Lawyers may struggle to reconcile the tensions between articulating or advancing a client's views and reflecting or promoting what may actually be in their best interests, notably where the client lacks capacity.[2523] Research concerning the ACT, NSW and Victorian tribunals observed that, at times lawyers found it difficult to adopt a less adversarial approach in tribunal hearings given their training and experience in courts.[2524] It may also be that, as SALRI was told by several parties (notably Jemma Holt of the Adelaide Law School and Maggie Rutjens), representation by persons other than legal practitioners[2525] is as

[2520] See, for example, Samuel Brakel, 'Searching for the Therapy in Therapeutic Jurisprudence' (2007) 33 *New England Journal on Criminal and Civil Confinement* 455; Terry Carney et al, *Australian Mental Health Tribunals: Space for Fairness, Freedom, Protection and Treatment?* (Themis Press, 2011) 252; Michael Cain et al, *The NSW Mental Health Review Tribunal: An Analysis of Clients, Matters and Determinations* (Law and Justice Foundation of NSW, 2011) 79; Jake Buckingham, 'A Critical Analysis of Legal Representation in Queensland's Mental Health Review Tribunal', (2018) 6(1) *Griffith Law Journal* 132, 152–153; Fleur Beaupert, 'Mental Health Tribunal Processes and Advocacy Arrangements: "Little Wins" Are No Small Feat' (2009) 16 *Psychiatry, Psychology and Law* 90, 101.

[2521] William Obomanu and Harry Kennedy, '"Juridogenic" Harm: Statutory Principles for the New Mental Health Tribunals' (2001) 25 *Psychiatric Bulletin* 331, 332. This concern is not untenable. The Royal Australian and New Zealand College of Psychiatrists said: 'If an adversarial approach to hearings is to be undertaken, all parties should have the right and access to legal representation, including medical practitioners giving evidence.'

[2522] Darold Treffert, 'Dying with Their Rights On' (2006) 130(9) *American Journal of Psychiatry* 1041. See also Jake Buckingham, 'A Critical Analysis of Legal Representation in Queensland's Mental Health Review Tribunal', (2018) 6(1) *Griffith Law Journal* 132, 153.

[2523] Paul Veitch, 'The Case for "Good" Legal Representation Is it Worth Fighting For' (2011) 21 *International Journal of Mental Health and Capacity Law* 15, 18; Terry Carney, Fleur Beaupert, Julia Perry and David Tait, 'Advocacy and Participation in Mental Health Cases: Realisable Rights or Pipe-Dreams?' (2008) 26(2) *Law and Context* 125, 134–137; Jake Buckingham, 'A Critical Analysis of Legal Representation in Queensland's Mental Health Review Tribunal', (2018) 6(1) *Griffith Law Journal* 132, 151–152. 'It is proper that these things be monitored [to] ensure that the statutory requirements are satisfied. But that does not mean that the duty ... [is] "to get his client off". The duty … has always been a delicate one … [to] ensure that the law is observed and that the protections provided … are available …. But to negate the application of beneficial powers for mere technical deficiencies may do damage to the client': Mahoney JA in *Harry v MHRT and Anor* [1994] 33 NSWLR 315, 335 (Mahoney JA).

[2524] Terry Carney et al, *Australian Mental Health Tribunals: Space for Fairness, Freedom, Protection and Treatment*? (Themis Press, 2011) 250.

[2525] One suggestion is the the Tasmanian Mental Health Tribunal Representation Scheme which provides representation by University of Tasmania law students in 65% of tribunal matters. See Valerie Williams, 'The Challenge for Australian Jurisdictions to Guarantee Free Qualified Representation before Mental Health Tribunals and Boards of Review: Learning from the Tasmanian Experience' (2009) 16 *Psychiatry, Psychology and Law* 108, 109. Margaret Castles of the Adelaide Law School additionally told SALRI: 'Representation other than by lawyers can be effective, but in many cases there are complex issues of medical evidence, fact, and legal interpretation that inform decisions to effectively deprive a person of their autonomy. Whilst lawyers may result in an adversarial approach, it needs to be noted that the interests of people affected (for example, by treatment orders or guardianship orders) are complex and diverse and legal representation may be necessary. The reality is that many people challenging proposed orders are ill informed, often cognitively affected, and do not have the experience or confidence to work within the legal system. Adequate resourcing of education, advice, and representation as a last resort is a necessary first step in ensuring human rights interests are met.'

effective in practice[2526] and that effective representation extends to advice to consumers outside a tribunal and tribunal hearings.[2527]

10.4.14 However, the value of legal representation to consumers before SACAT under the *MHA* should not be dismissed. There are various benefits of such representation (as was also noted to SALRI).[2528] It has been observed that lawyers advocating for consumers or patients at *MHA* tribunals not only enhances the consumer or patient's ability to actively participate in such hearings,[2529] but also improves the therapeutic benefits of the entire process.[2530] It is asserted that legal representation for consumers and patients helps to ensure that the tribunal upholds both the welfare and the legal rights of consumers. Lawyers might 'fully investigate and comprehend a patient's circumstances prior to [a hearing,] leading to critical decision-making between counsel and client as to how best to proceed'.[2531] The provision of legal representation for consumers supports the aims of supported decision-making.[2532] Lawyers are able to present material on behalf of consumers and argue on behalf of

[2526] See, for example, Wanda Bennetts et al, 'The "Tricky Dance" of Advocacy: A Study of Non-Legal Mental Health Advocacy' (2018) 24(12) *International Journal of Mental Health and Capacity Law* 12; Maria Karras et al, *On the Edge of Justice: the Legal Needs of people with a Mental Illness in NSW* (Law and Justice Foundation of New South Wales, 2006) 172–181; Fleur Beaupert, 'Mental Health Tribunal Processes and Advocacy Arrangements: Little Wins are No Small Feat' (2009) 16(1) *Psychiatry, Psychology and the Law* 90; Terry Carney, Fleur Beaupert, Julia Perry and David Tait, 'Advocacy and Participation in Mental Health Cases: Realisable Rights or Pipe-Dreams?' (2008) 26(2) *Law and Context* 125, 141–145; There are a range of advocacy services and NGOs performing a variety of individual and systemic advocacy roles. This is 'not to undermine the crucial role that legal advocates can play, but to open up discussion about the range of advocacy roles that may be needed to improve both legal and social outcomes': 141. 'In many instances, "advocacy" comes from participants other than legal advocates. A recent NSW report on access to justice for people with mental illnesses documented the invaluable assistance provided by non-legal service providers and lay advocates. Our data indicates a similarly wide spectrum of advocacy and support roles exist in the context of mental health tribunal proceedings': at 143.

[2527] Wanda Bennetts et al, 'The "Tricky Dance" of Advocacy: A Study of Non-Legal Mental Health Advocacy' (2018) 24(12) *International Journal of Mental Health and Capacity Law* 12; Fleur Beaupert, 'Mental Health Tribunal Processes and Advocacy Arrangements: Little Wins are No Small Feat' (2009) 16(1) *Psychiatry, Psychology and the Law* 90; Terry Carney, Fleur Beaupert, Julia Perry and David Tait, 'Advocacy and Participation in Mental Health Cases: Realisable Rights or Pipe-Dreams?' (2008) 26(2) *Law and Context* 125, 142–5. There is scope for effective advocacy outside the confines of tribunal hearings, such as negotiating about treatment options or other measures with case workers, medical practitioners and registrars: at 142. The importance of assistance and advice outside a tribunal, including by non-lawyers, should not be overlooked. 'They [the advocates] did not attend all MHT hearings with their clients, but would do so if specifically requested by clients; instead often performing a supportive role for clients prior to hearings, explaining what was likely to be discussed and helping to prepare what they would say at the hearing. On discovering that many clients did not understand why they were in hospital and certainly did not understand what was going to happen to them next or how they could assert their rights, this consumer network developed a program to inform clients about their rights in a way that would make sense to them. The advocates visit wards on a regular basis to explain to groups of consumers, in plain English, concepts such as 'voluntary' and 'involuntary' status, the MHT's role and avenues of redress': at 143.

[2528] Jake Buckingham, 'A Critical Analysis of Legal Representation in Queensland's Mental Health Review Tribunal', (2018) 6(1) *Griffith Law Journal* 132, 149–52.

[2529] See, for example, Terry Carney et al, *Australian Mental Health Tribunals: Space for Fairness, Freedom, Protection and Treatment?* (Themis Press, 2011) 253; Jake Buckingham, 'A Critical Analysis of Legal Representation in Queensland's Mental Health Review Tribunal', (2018) 6(1) *Griffith Law Journal* 132, 149–50.

[2530] Terry Carney, Fleur Beaupert, Julia Perry and David Tait, 'Advocacy and Participation in Mental Health Cases: Realisable Rights or Pipe-Dreams?' (2008) 26(2) *Law and Context* 125, 147; Fleur Beaupert, 'Mental Health Tribunal Processes and Advocacy Arrangements: Little Wins are No Small Feat' (2009) 16(1) *Psychiatry, Psychology and the Law* 90, 93–4.

[2531] Fleur Beaupert, 'Mental Health Tribunal Processes and Advocacy Arrangements: "Little Wins" Are No Small Feat' (2009) 16(1) *Psychiatry, Psychology and Law* 90, 96.

[2532] Jake Buckingham, 'A Critical Analysis of Legal Representation in Queensland's Mental Health Review Tribunal', (2018) 6(1) *Griffith Law Journal* 132, 151.

consumers as well as raise any concerns with the tribunal.[2533] SALRI was told that in many instances, consumers are unable to effectively advocate for themselves. As Buckingham comments:

> Patients' inability to effectively self-advocate is attributable to numerous factors, which include but are not confined to limited communication skills, a general fear of authority, sedative effects of medication, and other cultural or social barriers. Advocacy by lawyers allows patients to participate in the decision-making process about their treatment plan. Through legal representation, the focus of hearings is not only on the statutory criteria of the relevant order, but also the issues of most concern for patients.[2534]

10.4.15 The legal representation of consumers and other interested parties in proceedings under the *MHA* were raised by many parties in SALRI's consultation (though several parties acknowledged the operational and resourcing implications and any framework needs to be practicable).

10.4.16 Every review and appeal conducted by SACAT pursuant to Part 11 of the *MHA* entitles a consumer to legal representation.[2535] SACAT has both an original jurisdiction and an internal review jurisdiction under the *MHA*. The internal review jurisdiction of the Tribunal relates to their ability to review their own decisions, such as a review of the Tribunal's decision to impose a CTO 2. In these circumstances, a person subject to the order is entitled to legal representation. The original jurisdiction relates to SACAT's ability to make an order, for example a CTO 2 or an ITO 3. Within this original jurisdiction of SACAT, a person subject to the order is not entitled to legal representation.

10.4.17 The English Law Commission has recommended the continued availability of non-means-tested legal aid for consumers to, 'at a minimum', be available to challenge deprivations, actual or potential, of liberty.[2536] The Law Council of Australia has also pointed out the case for the provision of legal representation for consumers at mental health tribunals, including SACAT.[2537] The Law Council noted that accessible legal assistance can play an important role to promote the rights of persons 'in addition to ensuring access to justice for persons with disability, the provision of representation at first instance hearings is likely to ensure efficient use of court resources and reduce the number of appeals.'[2538] This approach has been expressed elsewhere.[2539] Allowing legal representation for SACAT first instance decisions also has the potential to reduce the number of reviews as clients would be able to present their case properly at the outset.[2540]

10.4.18 The denial of free legal representation at first instance before SACAT is an issue which has been raised by the Law Society of South Australia on a number of occasions, including in

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[2533] Fleur Beaupert, 'Mental Health Tribunal Processes and Advocacy Arrangements: "Little Wins" Are No Small Feat' (2009) 16(1) *Psychiatry, Psychology and Law* 90, 98.

[2534] Jake Buckingham, 'A Critical Analysis of Legal Representation in Queensland's Mental Health Review Tribunal', (2018) 6(1) *Griffith Law Journal* 132, 149.

[2535] *Mental Health Act 2015* (ACT) s 84, s 85B.

[2536] The Law Commission (England and Wales), *Mental Capacity and Deprivation of Liberty* (no 372) (13 March 2017) 141.

[2537] Law Council of Australia, *The Justice Project: People with Disability* (Final Report, August 2018) 57–60.

[2538] Ibid 57–8.

[2539] Recommendation 6.5 of the CASTAN Human Rights Victoria paper, for example is to 'drastically increase legal aid funding to ensure that every consumer seeking legal representation at the Mental Health Tribunal is able to access it:' Castan Centre for Human Rights Law, *The Human Rights Roadmap: 40 Ways to Operationalise Human Rights in Victoria's Mental Health and Wellbeing System* (September 2022) 56.

[2540] Jennifer Corkhill, 'Vulnerable People need Better Legal Protection in Guardianship Matters' (2022) 44(1) *The Bulletin (Law Society of South Australia)* 28. See also Jennifer Corkhill, 'The Case for Free Legal Representation for Matters under *the Mental Health Act* and Guardianship Board' (2014) 36(10) *The Bulletin* (Law Society of South Australia) 26.

submissions to the State Budget (in 2016-17, 2018-19, 2020-21 and 2022-23), the Tribunal, and former Attorneys-General.[2541] The Report of the Chief Psychiatrist into the *MHA* 2009 also recommended that consumers should have access to free legal representation for all hearings to consider treatment order applications before the Guardianship Board.

10.4.19 All other states except Western Australia provide some form of legal assistance for first instance applications.[2542] However, this is not always effective in practice. It has been found that in about 20% of cases in the NSW Tribunal, the person will not have access to the lawyer due to lack of opportunity or lack of financial means.[2543] The failure to provide free legal representation for consumers before SACAT been said[2544] to be odds with International Principle 18(1) of the UN *Principles for the Protection of Persons with Mental Illness and For The Improvement of Mental Health Care*.[2545] The Victorian Royal Commission advocated for increasing access to legal representation before the Victorian Tribunal to ensure consumers can effectively participate in their hearings and to assist the Tribunal to understand the consumer's views and preferences.[2546]

10.4.20 In its submission to the 2022-23 State Budget, the South Australian Law Society suggested that the South Australian Government should apportion funding for the facilitation of free legal representation for consumers at first instance SACAT proceedings, saying that '[s]ignificant injustices have occurred, and will continue to occur, when people with mental illness or disability are the subject of proceedings under the *Mental Health Act* ... without legal representation'.[2547] The Law Society reiterated this view in its submission to SALRI.

10.4.21 The second issue relating to legal representation under the *MHA* is whether family, friends and carers should also be entitled to legal representation within any legal representation scheme when bringing an application under the *MHA* on behalf of a consumer. The role of family and friends in hearings can be a difficult one on occasions where the person concerned are the ones most swiftly abused or attacked when the consumer's mental health deteriorates, or where family and friends have been the instigators (admittedly for sincere reasons) of compulsory mental health treatment.[2548]

10.4.22 The Deputy President of the NSW Mental Health Review Tribunal suggests that family and friends should 'generally be invited to offer their thoughts' at a Tribunal hearing especially where they have valuable insights into the consumer's life.[2549] Whether this should extend to free legal

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[2541] The Law Society of South Australia, Submission to SALRI, *Review of the Mental Health Act 2009 (SA)*, 23 August 2020.

[2542] Jennifer Corkhill, 'Vulnerable People need Better Legal Protection in Guardianship Matters' (2022) 44(1) *The Bulletin (Law Society of South Australia)* 28.

[2543] Anina Johnson, 'The Value of Procedural Fairness in Mental Health Review Tribunal Hearings' (Paper presented at the Australian Institute of Administrative Law National Conference 86, Brisbane, Queensland, 21 July 2016) 11.

[2544] Jennifer Corkhill, 'The Case for Free Legal Representation for Matters under the *Mental Health Act* and Guardianship Board' (2014) 36(10) *The Bulletin (Law Society of South Australia)* 26, 27–8.

[2545] *The Protection of Persons with Mental Illness and the Improvement of Mental Health Care*, GA Res 46/119, UN GAOR, 75th plen mtg, Agenda Item 98, UN Doc A/RES/46/119 (adopted 17 December 1991).

[2546] *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021) vol 4, 426.

[2547] The Law Society of South Australia, *State Budget Submissions 2022-23* (19 May 2022) 8.

[2548] Anina Johnson, 'The Value of Procedural Fairness in Mental Health Review Tribunal Hearings' (Paper presented at the Australian Institute of Administrative Law National Conference 86, Brisbane, Queensland, 21 July 2016) 16.

[2549] Ibid.

representation under any scheme is not simple, given the divergent interests that may arise[2550] as well as operational and resourcing considerations.

10.4.23 The third issue is if the *MHA* provides consumers with sufficient information about their rights and entitlements under the Act in a manner that accommodates the person's needs. For example, taking into account cultural and linguistic barriers, and disability. Under parts of the Act, clinicians are expressly required to provide copies of the Tribunal's orders and written statement of rights to the consumers.[2551] There was some suggestion to SALRI to increase the accessibility of this information in the ways it is presented, when it is presented, and the content of what is presented to persons.

Delays with Electroconvulsive Therapy Procedures

10.4.24 The current use of restrictive practices or reasonable force to administer ECT cannot be authorised under the *MHA* but can be authorised by an order from SACAT. There are strict requirements to obtain requisite authorisation to perform ECT on an involuntary patient due to the nature of the procedure. However, the *MHA* also provides for emergency ECT to be performed without prior approval from SACAT in some specific circumstances. The delays with hearings of ECT at SACAT may pose difficulties in adhering to the authorisation requirements under the *MHA*.

Utility of a Specialist Mental Health Tribunal

10.4.25 Mental Health Review Tribunals have been established in most States and Territories in Australia and operate as a standalone Tribunal in every state other than ACT and South Australia, where they form part of the broader Civil and Administrative Tribunal.[2552] The question of whether a Mental Health Review Tribunal should be established in South Australia was raised by several parties.[2553]

10.4.26 In South Australia, cases under the *MHA* are heard at SACAT which is a 'super-tribunal' comprising of nine different streams. There are tenable arguments in favour of establishing a specialist Mental Health Tribunal in South Australia (such as exists interstate) as the narrowed focus on one subject area may enhance expertise and make the hearing of cases more expedient and have specialised members. However, there are contrary views especially in a relatively small jurisdiction. The financial and practical implications of a specialist Tribunal would require 'trained dedicated registry staff who understand mental legislation, clientele and issues.'[2554] There is also the point that the NSW Tribunal and the Guardianship Tribunal might perform similar roles and both registries, but each have expert working knowledge with service providers and stakeholders in each jurisdiction.[2555] There is also the considerable expertise already held by SACAT in South Australia and the clarity and value of a single administrative tribunal in the State.[2556]

[2550] The family member or carer may well have different interests than those of the consumer.

[2551] See, for example, *Mental Health Act 2009* (SA) ss 12, 23, 27, 46.

[2552] NSW Mental Health Review Tribunal, Submission No 52 to the Standing Committee of Law and Justice, *Inquiry Into Opportunities to Consolidate Tribunals in NSW* (30 November 2011) 1; Sam Boyle and Tamara Walsh, 'Procedural fairness in mental health review tribunals: the views of patient advocates,' (2021) 28(2) *Psychiatry, Psychology and Law,* 163.

[2553] See *Mental Health and Wellbeing Act 2022* (Vic) Ch 7; *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021) vol 4, chs 26–8.

[2554] NSW Mental Health Review Tribunal, Submission No 52 to the Standing Committee of Law and Justice, *Inquiry into Opportunities to Consolidate Tribunals in NSW* (30 November 2011) 2.

[2555] Ibid 3.

[2556] This was one of the original rationales for the establishment of SACAT.

10.4.27 Professor Rees told the Victorian Royal Commission that it has been beneficial for the Mental Health Tribunal to be a dedicated, standalone body, rather than incorporated into the Victorian Civil and Administrative Tribunal, advising:

> … the expertise that people build on mental health review tribunals is incredibly important in terms of [knowing things such as] what relevant facilities are available in the community ... In a standalone tribunal people tend to build up appropriate expertise faster. My view is that there are no disadvantages, and distinct advantages, of having a separate Tribunal to make decisions on the use of compulsory treatment.[2557]

10.4.28 There are valid views both ways as to the establishment of a Mental Health Review Tribunal in South Australia. This issue is ultimately beyond SALRI's Terms of Reference and would require further consideration.

Appeal Rights and Procedural Fairness

10.4.29 The Office of the Chief Psychiatrist ('OCP') raised an issue with the removal of s 82 from a previous version of the *MHA* in South Australia. These changes to how SACAT can undertake reviews of treatment removed the capacity for a person to apply to the Supreme Court to appeal a decision made by SACAT in its review jurisdiction. This inability to review a decision made against a person might raise issues of procedural fairness, parallel to the discussions about legal representation above.

10.4.30 Another matter raised with SALRI concerns the rights of carers and families relating to nominated persons. The *MHA* requires a copy of treatment orders, statement of rights, and notices to be given to a guardian, relative, carer or friend of the consumer, unless the Director of the treatment centre believes it would be contrary to the consumer's interests. The South Australian OCP received an external submission requesting that, in cases where treating teams refuse to share copies of orders and other relevant documents, on the basis it would be contrary to the consumer's interests, there should be a requirement to advise those carers and families of their rights to appeal to SACAT to review that clinical decision.

10.4.31 A third procedural issue raised by the OCP to SALRI concerns the functions under s 90 of the *MHA* relating to the Chief Psychiatrist's functions. It was identified that the *MHA* does not specify consumer rights to have the Chief Psychiatrist involved in their complaint to the OCP and this was recommended as a potential change to the *MHA* to clarify the Chief Psychiatrist's role with respect to complaints, understanding that this would come at the end of the complaint process rather than at the beginning.

Issues with Inpatient Treatment Orders

10.4.32 The OCP raised several issues with SALRI as to minor procedural and wording in the *MHA* relating to ITOs:

- Under the current operation of s 29, an order to make a Level 3 ITO may overlap with an existing level 1 or level 2 ITO. As a procedural amendment, the OCP seeks to allow for the automatic expiry of a level 1 or level 2 ITO when SACAT makes a level 3 ITO.
- Under the current operation of s 29(4), only the public advocate and the director of a treatment centre (or someone authorized by them) can apply to SACAT for a level 3 ITO.

[2557] *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021) vol 4, 436.

This is inconsistent with the individuals who can apply to SACAT For a level 2 CTO (public advocate, medical practitioner, mental health clinician, guardian, or any other person with a proper interest). OCP requests a change that applications for a Level 3 ITO should be made by the same individuals who can apply for a level 2 CTO.

- Under s 16(7) and 29(6), Level 2 CTO and Level 3 ITOs are made only by order of the Tribunal. The variation and revocation process for an ITO is also made through the Tribunal. OCP recommends consideration to be given to a more efficient way for these orders to be varied, such as where a level 2 CTO consumer becomes a voluntary patient or where a Level 3 ITO consumer responds well to ECT Treatment. The problem with the operation of the current legislative process is that consumers may be subject to treatment orders longer than necessary.

- In relation to s 29(3) and 29(4a) of the *MHA*, it is states that Level 3 ITOs can only be made by the Tribunal in respect of person who whom a level 2 or level 3 ITO applies (not level 1). The OCP seeks a change to subsection (3) to say 'in respect of a person to whom a… level 2 or level 3 inpatient treatment order applies' and amend (4a) to say 'a level…2 inpatient treatment order'.

10.5 Consultation Data Overview

Legal Representation – Original Jurisdiction

10.5.1 There was almost unanimous support to SALRI for the entitlement of consumers to have legal representation in first instance proceedings for decisions made in the SACAT's original jurisdiction, namely for an ITO 3, a CTO 2 and ECT applications. This emerged in submissions, YourSAy survey responses and at SALRI's many roundtables and consultation sessions. The lack of legal representation was widely perceived to be a longstanding issue relating to SACAT orders and was generally perceived as a standard that should be ensured rather than as a mere entitlement.

10.5.2 It was widely said by the Law Society, consumer and advocacy groups and others that, to make a difference and be effective, any legal representation to consumers under the *MHA* should not just not be an entitlement, but needs to be provided for as well.[2558] Otherwise, many consumers will lack the resources or ability to secure legal representation before SACAT. Legal representation was viewed in SALRI's consultation as a necessity rather than an option, as there are, quoting one consultee, 'too many circumstances in which people don't understand what rights they have as a part of a review. They cannot find their own voice to speak up for themselves even if their circumstances have changed for the better. The people need someone to speak for them when they can't.'

10.5.3 The role of a legal representation was widely viewed in consultation as to enable a consumer to participate more effectively in important decisions under the *MHA* affecting their welfare and health.[2559] There was general agreement that 'legal and peer-support advocacy should be the norm for any application of the *MHA* and any review of a person's case under the Act'.

[2558] See also *MS v Croatia (No 2)* [2015] ECHR 196.

[2559] The wider importance of promoting the meaningful participation of consumers in decisions under the *Mental Health Act 2009* (SA) relating to them was highlighted by many parties in SALRI's consultation, including Purple Orange and Dr Susan Peukert. Dr Peukert, for example noted: 'Persons with mental health disabilities must receive timely and appropriate care when needed and be able to participate in their treatment decision-making as far as possible… It is recommended that any law reform recognise, understand, and respond to progress in related

10.5.4 The Legal Services Commission observed that the current legal representation scheme they provide does not extend to applications before SACAT in its original first instance jurisdiction, namely applications for a CTO 2, an ITO 3 and ECT orders. Many parties in consultation, including SALRI's YourSAy survey responses, agreed this was unsatisfactory.

10.5.5 The prevailing view in SALRI's consultation is that the denial of legal representation presents a significant barrier to access to justice. A parallel was drawn to legally unrepresented accused in the criminal system, with the common factor being the 'potential deprivation of liberty for those who are unsuccessful'. One party argued that 'a SACAT order is a legal document and it's no different than if someone commits a criminal offence; they are encouraged to have legal representation to assist with the articulating the views/beliefs, etc of the consumer.'

10.5.6 SACAT supported extending the provision of legal representation to consumers, explaining:

> In respect of legal representation and the Tribunal's original jurisdiction, it has been observed that it might be considered most beneficial for the scheme to be extended to those who are subject to applications for consent to prescribed psychiatric treatment under Part 7 of the *MHA*, for example, Electroconvulsive Therapy (ECT) under section 43 of the *MHA* or neurosurgery for mental illness under section 44 of the *MHA*. These are invasive treatments and often, due to the nature of the circumstances of these applications, the person who is the subject of the application cannot advocate on their own behalf. Separate legal representation in the Tribunal's original jurisdiction for these types of applications would act to protect the rights of the person and would greatly assist the Tribunal in its inquiry in determining those applications.

10.5.7 Another consultee found no argument against legal representation, saying that:

> … if people are coming under the *Mental Health Act* precisely because they are deemed to lack capacity, it makes no sense that the same Act would then expect the same person to (essentially) have full capacity in relation to, for example, knowing their legal rights in relation to the situation they are coming under the Act for and being able to independently present all relevant evidence or material in relation to the same.

10.5.8 The Law Society of South Australia said that legal representation for consumers involved in any proceeding at SACAT is 'imperative for a just and accessible regime' both in the review of its own decision and other reviews. The Lived Experience Leadership and Advocacy Network ('LELAN') submitted that 'the right to independent individual advocacy support and services for people with lived experience of distress or diagnosed mental illness should be built into the legislation and the mental health system.' The Office of the Public Advocate said free legal representation can be an 'important mechanism' to improve access to justice for people with impaired decision-making capacity and mental illness and there might be greater access to justice for people under compulsory orders under the *MHA* if they were also entitled to legal representation for internal reviews. A carer with lived experience expressed a similar view, noting: 'Absolutely, l believe it is everyone's right to have legal representation under the scheme, to protect a person's individual rights, to ensure accountability and transparency.'

10.5.9 The Rural and Remote Mental Health Service said that at present the wishes of consumers in practice are not often heard before SACAT, noting: 'Generally, it appears the *MHA* currently relies on consumers: a) knowing their rights to appeal; b) knowing they are entitled to a lawyer; and c) (as

human rights law. Any reforms must promote the equality, participation, and autonomy of persons with mental health disabilities to allow them greater influence over their treatment decisions.'

vulnerable people) presenting all relevant evidence or material at first instance without legal support.' Rural and Remote Health Service supported legal representation for consumers, but SACAT should have the ability to reject an application that is repetitious or vexatious and if such an amendment is made to the *MHA* 'then there will be an increase in the reviews undertaken by SACAT and the Government will need to increase SACAT resourcing.'

10.5.10 Lived Experience Australia was of the view that all people with lived experience should be provided with free legal representation when their case comes before SACAT. They added: 'Whilst this is applicable under the *MHA*, it does not relate often in practice. We know of people who come before SACAT with no legal representation.' Mind Australia also said consumers should have access to legal representation, even in cases where SACAT reviews its own decisions. 'There should be some third-party oversight of SACAT, and the system the Act governs as a whole. This could be in the form of a Commission.' The Disability Rights Advocacy Service similarly said individuals should be entitled to legal representation for internal reviews under the *MHA*, explaining:

> It is important that people with disability are supported throughout this process so their rights are upheld. SACAT should have the responsibility of referring people to legal representation or advocacy support… The rights and interests of the person impacted by a treatment order must be the primary consideration.

10.5.11 The Commissioner for Aboriginal Children and Young People said consumers should be entitled to legal representation under the scheme as 'the rights to procedural fairness should be upheld'. The South Australian Child and Adolescent Health Community of Practice noted that any legal representation scheme should extend to the parents of children aged under 16 years subject to proceedings under the *MHA*. Child Protection and Policy Unit, SA Health, noted that any representation scheme should extend both to children and their parents.

10.5.12 Some parties were more tempered in their support. For example, one consultee said that 'consumers should be given the right to legal representation - but the choice should also be theirs as to whether this representation is taken up.' It was said to be imperative to ensure the rights of the person are clearly and understandably presented so they have enough time to process and understand the information.

10.5.13 The operational and resourcing implications were identified by a number of parties.[2560] For example, the Royal Australian and New Zealand College of Psychiatrists SA Branch ('RANZCP') did not have a position on the issue of an entitlement to legal representation under the *MHA*, but commented:

> … any reforms which increased the administrative burden on mental health services and SACAT would have potentially significant resourcing implications, which are outside the scope of the SALRI review… We would like to reiterate that any changes to the *MHA* which would increase the already heavy administrative burden on SACAT must be carefully considered and SACAT well-resourced to handle them, in advance of any changes being implemented.

10.5.14 One consultee raised the 'dire consequences' of misdirected and insufficient legal representation, explaining:

> … cases where ill-informed legal representation has compromised a person's proper care and caused chaos in trying to provide services, fostered combative relationships with [mental health]

[2560] The operational implications raised included what was seen by more than one party as the perceived complexity and inaccessibility of navigation of the SACAT processes and website in *Mental Health Act 2009* (SA) proceedings.

> care providers who are actually just trying to do their job in the best interest of the person, and caused great expense to the service while wasting resources.

10.5.15 One problematic area of not having legal representation arises is where the consumer to whom the order applies is unable to attend and therefore their views are not heard by SACAT. In situations where an order is made for a child for an ECT application or an ITO 3, the lack of legal representation may accord with a lack of procedural fairness. In other situations, where the consumer is unable to attend and is not represented, there arises a stark power imbalance as 'medical professionals presenting their case have numerous documents and 'evidence' that they can present'.

Legal Representation – Extending the Scheme to Carers, Families and Interested Persons

10.5.16 SALRI's consultation revealed divided opinions on whether the legal representation scheme under the *MHA* should extend to carers, families and interested persons who bring an application to SACAT for review of an order. There was no consensus. The importance of having free legal representation for families and carers was repeatedly stated in consultation, especially because it was seen to support the applicant's knowledge of the person, their vulnerabilities, choices, other issues caused by their mental ill-health, particularly when the person may have limited or no insight at that stage in their illness.

10.5.17 One roundtable noted that there are two common circumstances relating to the involvement of family or friends: first is that there is a supportive family, or secondly the family does not want to be involved as they have initiated the entry of their relative into the mental health system.

10.5.18 In favour of legal representation was the argument that it would 'enable them to have a clearer understanding of what the practice entails and their responsibilities within that framework.' Lived Experience Australia, for example, said carers or families should also be entitled to free legal representation under the *MHA* for the person they are supporting. 'This will support their knowledge of the person, their vulnerabilities, choices, other issues caused by their mental ill-health, particularly when the person may have limited or no insight at that stage in their illness.'

10.5.19 LELAN said families and carers should have the scheme extended to them when they are providing direct support and/or caring for the person experiencing distress or diagnosed mental illness. LELAN also recognised the vital role that many families and carers play in assisting the consumer communicate and articulate their position and they therefore should be provided with the 'same legal representation' to apply for a review of treatment orders. Additionally, it was raised that carers and family members often 'bear the brunt of the difficulties of a consumer's deteriorating or difficult condition', and also the ones that have to deal with the repercussions of SACAT decision. They can also provide 'invaluable insight and experience into the person's severity symptoms and their impact on their day to day functioning, their compliance with medication and level of support required'.

10.5.20 The Commissioner for Aboriginal Children and Young People said the *MHA* legal representation scheme should be extended to provide legal representation to families and carers who apply for review of treatment orders as 'it is important that family and others supporting people with lived experience are afforded their right to legal representation'. Child Protection and Policy Unit, SA Health, also shared this approach.

10.5.21 There was a contrary view against extending the provision of legal representation to family members. SACAT, for example, told SALRI:

> In the Tribunal's observation, internal reviews of treatment orders are rarely initiated by family members or carers of the person subject to an order under the *MHA*. Given the limited public funding in this area, extending the legal representation scheme to provide representation to that group would likely provide limited utility and an extension of the legal representation scheme might be most beneficial if it is extended to patients who are subject to applications in the Tribunal's original jurisdiction.

10.5.22 Some responses also indicated that extending the scheme could expose consumers to abuse, especially when carers, family and friends may not share the same views as the consumer which results in conflicts in interests being presented to SACAT. As one consultee noted: 'In these cases, extending legal representation beyond the consumer may engender an adversarial hearing at SACAT that is less focused on the views of the consumer and their wellbeing.' A carer with lived experience was also cautious, saying the *MHA* legal representation scheme should only be extended to families and carers 'if it can be proven that the family/carer has the best intensions/interests of the person first and foremost. Clients are often very vulnerable, and we still need to protect their rights.'

10.5.23 Other parties held reservations about extending the scheme, with some saying it 'won't make any difference' if the scheme was extended due to the difficulties of accessing advocates for mental health related matters within the existing already hard-pressed advocacy services in South Australia. One practitioner said: 'Advocates are impossible to access and my clients cannot get representation even through JusticeNet.' The Law Society's Justice Access Committee was of the view that extending the legal representation scheme to families and carers would be problematic. It explained that, on one hand, families and caregivers may be motivated out of concern for the consumer, but on the other hand there may be instances where different carers and family could have conflicting ideas of the best interests of the consumer. There may be further issues of one caregiver or relative being able to afford legal representation and the other cannot, which can create unfairness.

10.5.24 More than one party noted that any scheme must be feasible and practicable and the costs must be borne in mind, especially in a tight fiscal climate. The Rural and Remote Mental Health Service, whilst broadly supporting the extension of legal representation to family and carers, raised how such an extension may be funded and funding must also be considered as 'there will be an increase in the reviews undertaken by SACAT and the Government will need to increase SACAT resourcing.'

10.5.25 Another criticism of practicality by the Legal Services Commission and others noted that expanding the legal representation scheme beyond consumers would require significant additional funding, including that the Legal Services Commission would need to provide grants of legal aid for representation by external practitioners to avoid conflict of interest.

10.5.26 A criticism raised in extending legal representation in light of operational practice is that, while legal representation would be an ideal scenario, internal reviews of treatment orders are in practice 'rarely initiated by family members or carers of the person subject to an order under the *MHA*' and given the limited public funding in this area, extending the scheme is unlikely to provide significant utility. One submission considered it might be more worthwhile to extend the legal representation scheme to those who are subject to applications for consent to prescribed psychiatric treatment.

10.5.27 Ultimately, both of the points of view agreed on the fact that the rights and interests of the consumer should be the primary consideration.

10.5.28 There were some alternative suggestions offered including:

- For family members to be included in the initial diagnosis as 'this would lessen the propensity for family members to object.'

- The Law Society's suggestion that SACAT take an approach similar to the Family Court where there are multiple relatives/caregivers engaging in the proceeding. The assumption is that despite opposing views, a representative of the person subject to the order is 'appointed to represent the interests of the child with reference to the views of parents. Such an approach should be preferred, so that the focus is on the best outcomes for the consumer rather than the disagreement between the different supporters.'

- The Rural and Remote Mental Health Service said the extension of legal representation to carers and families at SACAT should be limited to one review per order/matter to make it more efficient.

Legal Representation – Procedural Fairness

10.5.29 In improving procedural fairness and awareness of rights more generally,[2561] consumer groups suggested that:

> (a) rights should be explained to consumers by a person with lived experience (can be through video);
>
> (b) the rights should be explained a second time 1-2 days into treatment once consumers are generally more calm;
>
> (c) consider accessibility issues (language, comprehension, reading level) of statement of rights; and
>
> (d) consider amending statement of rights; consider funding for non-legal advocates in treatment centers to assists consumers to be aware of their rights. These same groups can apply for a declaration under s 398(1), apply for a review of a long-term voluntary inpatient's admission under s 405.

10.5.30 Similarly, there was significant value placed on ensuring that 'the rights of the person are clearly and understandably presented, that they have adequate time to process the information. This includes both information as to the worthwhileness of gaining legal representation, but also the information being considered by SACAT.'

10.5.31 The Legal Services Commission also added that to ensure procedural fairness:

> … it is recommended that treating medical practitioners or psychiatrists who make either an ITO or a CTO1 should, if the order is reviewed by the patient, be required to attend, and explain to the Tribunal the basis upon which the order was made and how the criteria under the relevant section of the Act is met.

10.5.32 Another submission added that 'SACAT requires investment and development in the recognin of children in the *MHA* and inclusive of age-appropriate supports for children, young people and their families and carers'.

[2561] See also Anina Johnson, 'The Value of Procedural Fairness in Mental Health Review Tribunal Hearings' (Paper presented at the Australian Institute of Administrative Law National Conference 86, Brisbane, Queensland, 21 July 2016).

10.5.33 Various provisions of the *MHA* such as s 9 and s 12 provide for the mandatory notification of various items to a guardian, medical agent, relative, friend or carer nominated by the patient. The Committee suggested to SALRI that, where either relevant notifying agency is aware that a consumer is legally represented, the legal representative should be included in this category. This may be especially important where the legal representative is the only person with whom the consumer is communicating.

Electroconvulsive Therapy Delays

10.5.34 SALRI heard from various medical practitioners that ECT are generally used to treat severe psychiatric illnesses but are also used for treatment of mania and schizophrenia.[2562] Due to the severity of these psychiatric conditions, the patient can become a serious risk of harm to either themselves or others. When the person is unable to make a decision for themselves, SACAT is able to provide substitute consent.

10.5.35 Delays arise at times when the identified substitute decision-maker is unavailable or because an application has been made to SACAT, but a hearing date not been set, and delays can place the patient 'at risk of morbidity or mortality'. As one party said: 'It is on these rare occasions that emergency ECT, that is ECT given under emergency ECT consent by a suitably qualified psychiatrist, can be given while waiting for the substitute decision maker to make the decision on behalf of the patient'. One psychiatrist suggested that 'maybe the law needs to define 'urgent need' in such a way as to identify that treatment needs to be given urgently while awaiting substitute decision maker consent and if not given the patient would be at a very real risk of either severe morbidity or mortality.'

10.5.36 SALRI's Medical Specialist Roundtable revealed that the medical practitioners 'do workarounds regarding treatment using the *MHA* due to SACAT delays – for example, making a treatment order while waiting for a SACAT decision'. Delays were identified as particularly problematic in geriatrics. The current wait time in SACAT was estimated to be one to one and a half weeks. In cases where emergency consent is needed, the medical practitioner is appointing a guardian to exercise the powers under s 32 of the *Guardianship and Administration Act 1993* (SA).

10.5.37 Some consultees shared their experiences in the medical field and demonstrated that there are circumstances where a consumer is at very high risk and it is possible to delivery emergency ECT as a life saving measure when the person does not have decision-making capacity, there is no substitute

[2562] There were divergent views in both SALRI's research and consultation as to the operation of emergency ECT, ranging from outright opposition to qualified support in restricted circumstances. The value of ECT as a treatment emerges in research. See, for example, Nancy Kerner and Joan Prudic, 'Current Electroconvulsive Therapy Practice and Research in the Geriatric Population' (2014) 4(1) *Neuropsychiatry* 33; Sohag Sanghani, Georgios Petrides and Charles Kellner, 'Electroconvulsive Therapy (ECT) in Schizophrenia: a Review of Recent Literature' (2018) 31(3) *Current Opinion Psychiatry* 213; Samara Dos Santos-Ribeiro et al, 'A Systematic Review of the Utility of Electroconvulsive Therapy in Broadly Defined Obsessive-Compulsive-Related Disorders' (2018) 20(5) Primary Care Companion for Central Nervous System Disorders 18; Daniel Maixner, 'Electroconvulsive Therapy Is an Essential Procedure' (2021) 178(5) *American Journal of psychiatry* 381; Yin-Bing Ying et al, 'Electroconvulsive Therapy is Associated with Lower Readmission Rates in patients with Schizophrenia' (2021) 14(4) *Brian Stimulation* 913; Akihiro Takamiya et al, 'Effectiveness of Electroconvulsive Therapy in Patients Lacking Decision Making Capacity: A Systematic Review and Meta-Analysis' (2022) 15(5) *Brain Stimulation* 1246. However, there are contrary findings as to the value of ECT. See, for example, John Read and Richard Bentell, 'The Effectiveness of Electroconvulsive Therapy: A Literature Review' (2010) 19(4) *Epidemiology and Psychiatric Sciences* 333; John Read et al, 'A Second Independent Audit of Electroconvulsive Therapy in England, 2019: Use Demographics Consent, and Adherence to Guidelines and Legislation' (2021) 94 *Psychology and Psychotherapy: Theory, Research and Practice* 603. See further Part 7 Electroconvulsive Therapy, in particular [7.6.1].

decision-maker and there is not enough time to seek SACAT's approval.[2563] In their submission to SALRI, SACAT noted:

> In practice, this results in increased complexity for the patient's treating team and for the Tribunal and requires, in the use of emergency ECT, an urgent interim application under the Act [*Guardianship and Administration Act 1993*] for guardianship orders with special powers followed by ongoing applications. Where there is an application for ongoing ECT consent, a concurrent application under the *G&A Act* for guardianship orders with special powers, resulting in additional hearing time for the applications to be concurrently considered by the Tribunal.

10.5.38 The Prescribed Psychiatric Treatment Panel told SALRI that s 41C(b) of the *MHA* often applies to cases that are no more complex than cases where there has been only one emergency consent to ECT, but multiple consents have been required, due to scheduling limitations of SACAT (such as consent applications made on Thursday but not heard by SACAT until the following Tuesday).

10.5.39 There were some strong views expressed to SALRI against the use of ECT at all, viewing it as medically unsound and its use as harmful and 'barbaric' (though recalling many others saw the value of ECT).[2564] Some individuals and groups such as LELAN expressed the view that 'ECT is not an emergency or lifesaving treatment, therefore it should only be used with the informed consent of the person who chooses such specific treatment' under supported decision-making with their treating health practitioner. Lived Experience Australia asserted that the use of ECT is never appropriate and there is adequate time in the lead up for a person to be informed about the use of ECT – use of force should not be necessary and there is no such thing as the need for an 'emergency' ECT.

10.5.40 A more pragmatic approach was taken by some parties accepting the use of ECT in certain emergency circumstances. One party offered the following view:

> … whilst it would be ideal for SACAT to have the capacity to schedule hearings for emergency ECT consent within 24 hours, seven days per week, the reality is that the resourcing required for this is unlikely to be available and would probably not be the best use of such limited resources compared to other competing mental health service needs. Therefore, the provision for Emergency ECT to be authorised by a psychiatrist if the patient is unable to give consent and ECT is required urgently, should remain.

10.5.41 A few parties took the view that when ECT is consented to by a substitute decision-maker (such as SACAT) on behalf of a person with impaired decision-making capacity, that consent does not allow for the use of reasonable force to carry out the ECT. They suggested that the *MHA* should be amended for s 42 to allow the use of reasonable force when ECT has been consented to by a substitute decision-maker or SACAT.

Mental Health Commission

10.5.42 There was a suggestion during SALRI's consultation that there should be some third-party oversight of SACAT potentially in the form of a Commission. The Rural and Remote Mental Health Service said the role of Mental Health Commissioners in South Australia has varied between successive Governments and before anything is implemented or enshrined in law, it is necessary to facilitate a collaborative discussion between all stakeholders in the mental health space to ensure the

[2563] This point was made to SALRI by the RANZCP.

[2564] See further Part 7 Electroconvulsive Therapy.

Commissioners have a 'valid and enhancing role' not one which 'duplicates or interferes with the roles of other people, officers, or agencies'.[2565]

10.5.43 SALRI has considered elsewhere the role of a Mental Health Commissioner under the *MHA* and its intersection with the various other parties with statutory roles in this area.[2566]

Other Issues

10.5.44 The Rural and Remote Mental Health Service suggested that the legal representation for cases under the *MHA* before the Supreme Court should be clarified.

10.6 SALRI's Observations and Conclusions

Legal Representation

10.6.1 The importance of SACAT's role under the *MHA* is clear. Bodies such as SACAT have a 'crucial gate-keeping role in balancing the interest and rights of mentally ill patients in terms of their liberty with their safety and the safety of the community'.[2567]

10.6.2 A Royal Commission in 1957 commented that: 'As the proceedings on applications to Mental Health Review Tribunals will usually be informal and neither the patient nor the hospital or local authority will usually need to be legally represented.'[2568] Such an approach must now be seen as outdated. SALRI is of the view that effective legal (or other) representation is vital under the *MHA* for at least consumers. There are major barriers for persons with mental illness that restrict or preclude them from seeking or accessing legal assistance (including lack of means and the limited availability of pro bono or low cost legal services)[2569] as well as participating in the legal system.[2570] There is a low rate

[2565] See further Part 11 The Community Visitor Scheme and Mental Health Commissioners.

[2566] See further Part 11 The Community Visitor Scheme and Mental Health Commissioners. See also Stephanie Richards, *Full-Time Mental Health Commissioner to be appointed in SA* (15 December 2022) In Daily <https://indaily.com.au/news/2022/12/15/full-time-mental-health-commissioner-to-be-appointed-in-sa/>.

[2567] Michael Cain et al, *The NSW Mental Health Review Tribunal: An Analysis of Clients, Matters and Determinations* (Law and Justice Foundation of NSW, 2011) 1.

[2568] Great Britain, *Royal Commission on the Law relating to Mental Illness and Mental Deficiency* (May 1957) 152.

[2569] Maria Karras et al, *On the Edge of Justice: the Legal Needs of People with Mental Illness in NSW* (Law and Justice Foundation of NSW, 2006) xviii-xx, 93–126. 'Consultations for this study and previous literature indicate that people with a mental illness tend to have low levels of income. People with a mental illness are therefore less likely to be able to afford private legal representation… As a result, many people with a mental illness are likely to be dependent on legal assistance and advice from Legal Aid, CLCs and pro bono legal service provision. However, service providers interviewed for this study were of the opinion that the limited availability and resources of these types of legal services can act as a barrier to accessing legal assistance for people with a mental illness': at 106. SALRI heard similar themes in its consultation.

[2570] Ibid 127–64.

of legal representation for consumers in mental health proceedings.[2571] 'This low rate of legal representation is not for lack of evidence about need.'[2572]

10.6.3 The many studies highlighting the value of legal representation in *MHA* proceedings for consumers are telling,[2573] as was the overwhelming support in both SALRI's consultation (including from SACAT) and research for the provision of legal representation for consumers under the *MHA*.

10.6.4 Such representation supports and promotes the consumer's meaningful participation in the proceedings,[2574] as well to safeguard and advance their interests. As the Law Society Justice Access Committee told SALRI, 'legal representation for consumers involved in any proceeding [under the *MHA*] in the SACAT is imperative for a just and accessible regime, both in case of a review of its own decisions, and other reviews.'[2575] Studies have shown that the perceived fairness of procedure has a significant impact on how those consumers compulsorily detained and treated for mental illness accept the decisions made about the and engage with treatment.[2576] SALRI accepts the powerful case for consumers appearing before SACAT under the *MHA* to have legal representation 'on the basis that vulnerable people should always have access to justice, including access to the benefits of independent representation and the intellectual rigour, mediation skills and problem-solving approaches that have come to be regarded as the expected skills of a competent lawyer.' [2577]

10.6.5 As one article asserts:

> The most secure foundation for representation—whether legal or lay—in MHT hearings may therefore reside in its role in giving expression to the right to participation. Or as others have expressed it, in serving as a vehicle for giving 'voice' to the person affected legal representation is

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[2571] See, for example, Terry Carney, Fleur Beaupert, Julia Perry and David Tait, 'Advocacy and Participation in Mental Health Cases: Realisable Rights or Pipe-Dreams?' (2008) 26(2) *Law and Context* 125, 127; Penelope Weller, 'Taking a Reflexive Turn: Non-Adversarial Justice and Mental Health Review Tribunals' (2011) 37(1) *Monash University Law Review* 81, 96; Michael Cain et al, *The NSW Mental Health Review Tribunal: An Analysis of Clients, Matters and Determinations* (Law and Justice Foundation of NSW, 2011) 26; Mental Health Review Tribunal of New South Wales, *Annual Report 2014–2015* (2015) 24; Victoria Legal Aid, 'Submission No 18 to the Justice Project', *A National Blueprint for Justice for All* (30 August 2017) 10.

[2572] Terry Carney, Fleur Beaupert, Julia Perry and David Tait, 'Advocacy and Participation in Mental Health Cases: Realisable Rights or Pipe-Dreams?' (2008) 26(2) *Law and Context* 125, 127.

[2573] See, for example, Genn Hazel and Genn Yvette, *The Effects of Representation in Tribunals* (Lord Chancellors Department, London, 1989) (this study of representation in Tribunals concluded that having representation before a MHT increased the chances of success by 15%; this was termed this the 'representation premium'); Paul Veitch, 'The Case for "Good" Legal Representation Is it Worth Fighting For?' (2011) 21 *Journal of Mental Health Law* 15; Fleur Beaupert, 'Mental Health Tribunal Processes and Advocacy Arrangements: "Little Wins" Are No Small Feat' (2009) 16(1) *Psychiatry, Psychology and Law* 90; Terry Carney, Fleur Beaupert, Julia Perry and David Tait, 'Advocacy and Participation in Mental Health Cases: Realisable Rights or Pipe-Dreams?' (2008) 26(2) *Law and Context* 125; Penelope Weller, 'Taking a Reflexive Turn: Non-Adversarial Justice and Mental Health Review Tribunals' (2011) 37(1) *Monash University Law Review* 81; Jake Buckingham, 'A Critical Analysis of Legal Representation in Queensland's Mental Health Review Tribunal', (2018) 6(1) *Griffith Law Journal* 132.

[2574] See generally Penelope Weller, 'Taking a Reflexive Turn: Non-Adversarial Justice and Mental Health Review Tribunals' (2011) 37(1) *Monash University Law Review* 81.

[2575] The Law Society of South Australia, Submission to SALRI, *Review of the Mental Health Act 2009 (SA)*, 23 August 2020.

[2576] Bruce Winick, *Civil Commitment: A Therapeutic Jurisprudence Model* (Carolina Academic Press, 2005) 145; James Livingston et al, 'Forensic Mental Health Tribunals: A Qualitative Study of Participants' Experiences and Views' (2016) 22(2) *Psychology, Public Policy and Law* 173.

[2577] Penelope Weller, 'Taking a Reflexive Turn: Non-Adversarial Justice and Mental Health Review Tribunals' (2011) 37(1) *Monash University Law Review* 81, 89. See also Sameer P Sarkar and Gwen Adshead, "Black Robes and White Coats": Who Will Win the New Mental Health Tribunals?' (2005) 186 *British Journal of Psychiatry* 96, 98.

> a necessary component of an acceptable system of mental health review, especially whenever liberty is at stake.[2578]

10.6.6 The fact that most other Australian jurisdictions and England provide legal representation for consumers is significant. The European Court of Human Rights has emphasised that, in the absence of 'special circumstances', the provision of effective legal representation is part of the procedural guarantees required in deprivation of liberty cases involving persons of 'unsound mind' and held that, in at least some circumstances, this right to legal representation is a fundamental right under Articles 5 and 6.[2579]

10.6.7 SALRI also notes, as pointed out by Ms Holt of the Adelaide Law School, that the benefits of representation under the *MHA* are not confined to legal practitioners and representation usefully extend to informed advice and assistance outside the tribunal.[2580] Maggie Rutjens of Disability Advocacy and Complaints Service of South Australia Inc told SALRI there 'is an important wider conversation to be had in this place'. Ms Rutjens added that: 'Especially with regards to applications for revocation, understanding the steps in SACAT proceedings and bridging the communication gap that can exist between legal practitioners and clients where the lexicon is complex with legal jargon.'

10.6.8 Several parties, including LELAN, told SALRI that carers or families should also have access to non-legal advocacy services for advice, including to promote supported decision-making.[2581]

[2578] Terry Carney, Fleur Beaupert, Julia Perry and David Tait, 'Advocacy and Participation in Mental Health Cases: Realisable Rights or Pipe-Dreams?' (2008) 26(2) *Law and Context* 125, 145–6.

[2579] *Megyeri v Germany* [1992] ECHR 49; *MS v Croatia (No 2)* [2015] ECHR 196. In *MS*, the court emphasised the importance of having actual legal – as opposed to generic advocacy or family – assistance in *Mental Health Act 2009* (SA) proceedings. The court highlighted the fact that those committed to care under the *Mental Health Act 2009* (SA) should not themselves have to take the initiative in obtaining such legal representation, is another illustration of the positive obligation on detaining authorities to promote access to a lawyer in the absence of special circumstances. The mere appointment or availability of a lawyer with the lawyer's actual assistance in the proceedings is inadequate:

> The Court reiterates that in the context of the guarantees for a review of compliance with the procedural and substantive conditions which are essential for the 'lawfulness', in [European] Convention terms, of an individual's deprivation of liberty, the relevant judicial proceedings need not always be attended by the same guarantees as those required under Article 6(1) for civil or criminal litigation. Nonetheless, it is essential that the person concerned should have access to a court and the opportunity to be heard either in person or, where necessary, through some form of representation.
>
> This implies, inter alia, that an individual confined in a psychiatric institution because of his or her mental condition should, unless there are special circumstances, actually receive legal assistance in the proceedings relating to the continuation, suspension or termination of his confinement. The importance of what is at stake for him or her, taken together with the very nature of the affliction, compel this conclusion. Moreover, this does not mean that persons committed to care under the head of 'unsound mind' should themselves take the initiative in obtaining legal representation before having recourse to a court.

[2580] SALRI notes the insightful comments of Margaret Castles of the Adelaide Law School: 'There is a history of law clinic involvement in specialised areas of tribunal work such as this. Lead by solicitors, students can provide effective information, preliminary advice, and assistance with documents in simple and complex cases. Models such as a weekly onsite clinic co-located at the relevant location, designed to deal with specific areas of law (for example, the Clinic operated by Adelaide Law School at the AAT to manage Robodebt claims), can provide ready access to parties engaged in tribunal hearings. Models that enable tribunal registry or members to directly refer parties in need of support have proven useful in many jurisdictions (for example, the Magistrates Court Legal Advice Service operated by Adelaide Law School, the Office for the Commissioner of Equal Opportunity) and facilitate access for people otherwise unsure where to go or how to seek out legal support through complex administrative processes. Law Clinics can provide valuable connectivity for parties navigating the system, generally operate holistically within a network of service providers, and can follow through with educational and other support services within the target user group.'

[2581] See also Wellbeing SA, *What we heard about suicide in South Australia Consultation Report* (September 2021) 11, 13.

10.6.9 SALRI shares the view that proceedings under the *MHA* should be focussed on the consumer and should not be distracted by an excessively adversarial or combative approach. Legal or other representation is not a panacea.[2582] Extension of the existing legal representation scheme to consumers for first instance SACAT *MHA* proceedings raises resource implications. However, the case for extension of the existing legal representation scheme to consumers for first instance SACAT *MHA* proceedings is compelling.

10.6.10 SALRI notes that proceedings before SACAT must be both effective and efficient as well as fair. This is not a simple task. As a recent Queensland study observes:

> The task of providing a tribunal procedure that is both fair on one hand, and sufficiently informal and efficient on the other, is obviously very difficult. In the context of decisions about involuntary treatment for people with mental illness, it is even more so.[2583]

10.6.11 However, SACAT is well placed and equipped to be both effective and efficient for consumers under the *MHA* as well as fair and accessible[2584]. One of SACAT's functions is to ensure that applications are processed and resolved as quickly as possible while receiving a just outcome.[2585] SACAT itself notes that 'the people who are potentially subject to the MHRT's orders are some of the most vulnerable participants in any court or tribunal process', especially since they might be detained in confronting circumstances and experiencing symptoms of mental illness which are distressing and disorientating.[2586] SACAT tries to address these issues and balance efficiency and fairness by identifying listing times for each application type while 'addressing needs for procedural fairness'.[2587] A patient's or consumer's inability to effectively self-advocate is attributable to numerous factors, which include, but are not limited to: poor communication skills, a general fear of authority, sedative effects of medication, and, especially for Aboriginal and cultural and linguistically diverse communities, other cultural or social barriers.[2588] Lawyers are able to 'convey their client's wishes' to the tribunal even if the client is too overwhelmed to be able to communicate those concerns themselves.[2589]

10.6.12 In SALRI's consultation, there was a strong view that legal representation under the *MHA* protects a consumer's interests and rights and ensures transparency and accountability of the decision-makers. When it comes to making a case at hearing, as one consumer powerfully said, 'when you struggle to get up in the morning, you aren't going to know what to do in this situation'.

[2582] Terry Carney, Fleur Beaupert, Julia Perry and David Tait, 'Advocacy and Participation in Mental Health Cases: Realisable Rights or Pipe-Dreams?' (2008) 26(2) *Law and Context* 125, 137–9.

[2583] Sam Boyle and Tamara Walsh, 'Procedural Fairness in Mental Health Review Tribunals: the Views of Patient Advocates' (2021) 28(2) *Psychiatry, Psychology and Law* 163, 178.

[2584] Due to the current composition of SACAT it does operate a significant case load which impacts its ability to respond in a timely manner for consumers. Operational determinations impact the degree of priority that can be justifiably given to matters under the *Mental Health Act 2009* (SA) without adversely impacting the other, equally impactful, responsibilities of SACAT.

[2585] South Australian Civil and Administrative Tribunal, *2020-21 Annual Report* (2021) 11.

[2586] Ibid 10.

[2587] Ibid 9.

[2588] Jake Buckingham, 'A Critical Analysis of Legal Representation in Queensland's Mental Health Review Tribunal', (2018) 6(1) *Griffith Law Journal* (2018) 132, 149.

[2589] Anina Johnson, The Value of Procedural Fairness in Mental Health Review Tribunal Hearings' (Paper presented at the Australian Institute of Administrative Law National Conference 86, Brisbane, Queensland, 21 July 2016) 13.

10.6.13 Another benefit of introducing legal representation, either by a legal practitioner or other suitably (legally) qualified person, is to promote a balanced power dynamic between the consumer's interests and medical evidence, by ensuring that the medical evidence can be appropriately challenged.[2590] Legal representation may also increase the level of systemic advocacy that helps positively shape public perception of the needs of persons with mental illness.[2591]

10.6.14 Legal representation, whether by a practitioner or legally qualified person, helps ensure a consumer is afforded procedural fairness and has the crucial right to fully participate in their hearing, as well as having their matter considered fairly and on the basis of the consumer's interests and wishes. This point was strongly supported and frequently raised during SALRI's consultation. As one submission aptly said:

> Without knowledge of one's legal rights including rights under the legislation, rights to appeal decisions, rights to legal representation and rights to information written about them by mental health services, the system fails to protect the rights of the person and fails to ensure the accountability of SACAT and its decision-making.

10.6.15 This all accords with SACAT's rationale. SACAT's vision for the agency is to be accessible and responsible to user needs and to uphold fairness as part of their values.[2592] Enabling a person to have legal representation 'provides a key support in a consumer's ability to exercise their autonomy and legal capacity'[2593] It can improve transparency and accountability in tribunal decisions and activities while simultaneously ensuring that consumers are supported in their decision-making.[2594] These principles are especially applicable for persons with mental illness.[2595]

Legal Representation – Extending the Scheme

10.6.16 At present, 'legal representation provided is only offered to the person the order is about',[2596] that is, the consumer. There were mixed views in SALRI's consultation about whether legal representation should be extended to carers, family, friends and others who can apply for a review under the *MHA*. The arguments in favour of extending the legal representation scheme were to allow those closest to a consumer to adequately put their case forward when applying for a review on behalf of the consumer. There were some calls to increase the recognition of the role of carers and families

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[2590] Jake Buckingham, 'A Critical Analysis of Legal Representation in Queensland's Mental Health Review Tribunal', (2018) 6(1) *Griffith Law Journal* 132, 150. 'Studies have found that tribunals often defer to medical opinion even when the preponderance of evidence showed it to be unsubstantiated. A patient's legal representative would be able to argue against the admission of irrelevant or unreliable evidence': at 150.

[2591] Ibid.

[2592] South Australian Civil and Administrative Tribunal, *2020-2021 Annual Report* (2020) 5.

[2593] *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021) vol 4, 398; Aisha Macgregor, Michael Brown, and Jill Stavert, 'Are Mental Health Tribunals Operating in Accordance with International Human Rights Standards? A Systematic Review of the International Literature' (2019) 27(4) *Health and Social Care in the Community* 494, 509.

[2594] Castan Centre for Human Rights Law, Mental Health Victoria, *The Human Rights Roadmap: 40 ways to operationalise human rights in Victoria's mental health and wellbeing system* (September 2022) 56.

[2595] Maria Karras et al, *On the Edge of Justice: the Legal Needs of People with Mental Illness in NSW* (Law and Justice Foundation of NSW, 2006) iii–iv.

[2596] South Australian Civil and Administrative Tribunal, *Applications for Internal Review of a decision made by the Community Stream of SACAT* <https://www.sacat.sa.gov.au/documents/fact-sheets/fact-sheets-general/2020-Internal-Review-Applications-of-decisions-made-by-the-Community-Stream-e.g.-Mental-Health,-Guardianship-and-Administration.pdf>.

in the lives of people with mental illness and extending legal representation could be seen as one way of acknowledging this.[2597]

10.6.17 However, SALRI notes there were various reservations. A cautionary note voiced by the Legal Services Commission was that under the *Guardianship and Administration Act 1993* (SA), legal representation is only available for the person to whom the order relates, so expanding the scope of the *MHA* to include families, carers and interested parties should have the consequence of creating an inconsistency between the two Acts.

10.6.18 SALRI finds the Law Society's unease about extending legal representation to family, carers or friends as compelling:

> … the Committee suggested extending this funding to families and carers would be problematic. Whilst families and caregivers are likely motivated by concern for the consumer, there can be instances where different carers and family have conflicting ideas of the best interests of the consumer. In such circumstances, the dispute may focus on their views rather than the wellbeing of the consumer. Conversely, if one caregiver or relative can afford legal representation and the other cannot, there can be an imbalance in capacity to provide relevant information to the SACAT. Where one representative wishes to advocate for a consumer in opposition to an institution or public authority, funding could be provided on a stepped basis. This would be in circumstances to present the case on behalf of the consumer, with a process of the SACAT to determine if continued representation is necessary to protect the interests and wellbeing of the consumer.

10.6.19 The provision of publicly funded legal representation for families and carers raises operational and resourcing implications and practical limitations. Funding is a valid concern when it comes to extending the scheme to encompass carers, family, friends and interested persons who can apply for a review. For this reason, SALRI strongly supports a scheme providing representation to consumers as a priority but not, as a matter of general practice, extending the scheme for others.

10.6.20 There is clearly a valid role for support persons in the *MHA*, but it should be noted that, without doubting their utility, support persons are not a substitute for lawyers. Consumers, carers, family members and others involved in the welfare of the consumer (where appropriate) should be notified of their rights, such as through a statement of rights, and encouraged to participate under the *MHA* in the process of hearings and reviews.

10.6.21 There are various advocacy and consumer groups and services as well as the Law Schools at the University of Adelaide, Flinders University and the University of South Australia that all provide various legal advisory services. It is therefore important to look beyond representation and advocacy under the *MHA* in the context of legal practitioners and/or within the tribunal:

[2597] This emerges elsewhere. 'The conventional view is that family members, spouses and other 'support' persons are allied with and supportive of the client's personal opinions on their need for treatment and care. Many such individuals are also the client's primary carer. However, the term 'support' person has broad connotations and such persons may have appeared before the Tribunal with views contrary to those of the client on the need for treatment and/or the type of determination they would like to see the Tribunal make. Protected Estate Orders, in particular, are matters dealt with by the Tribunal that may involve the views of family members or a spouse being in conflict with those of the client. Also, while the family is generally best placed to know the client well, many family members are estranged and do not associate with the client, often as a consequence of the client's mental illness. The low level of attendance of clients' support persons at Tribunal hearings may be explained by these factors as well as the client's right to privacy to not have their family notified of their Tribunal hearing': Michael Cain et al, *The NSW Mental Health Review Tribunal: An Analysis of Clients, Matters and Determinations* (Law and Justice Foundation of NSW, 2011) xvii.

> … legal representation is by no means the only form of advocacy that can assist the clients of mental health tribunals. A number of positive outcomes achieved by legal representatives are equally achievable by other types of advocates. Ultimately what is needed is effective advocacy tailored to the wishes, needs, and circumstances of individuals. To understand the full potential for advocacy to achieve positive outcomes in this context it is necessary to consider a person's ongoing relationship with health services and their journey as a service user. 'Mediational lawyering', which pays greater attention to this wider context, may be a particularly effective approach to legal representation in appropriate cases. Even so, legal representatives should be flexible in the way they advocate for their clients rather than assuming that one model is always preferable.[2598]

10.6.22 SALRI is of the view that the State Government, in consultation with interested parties such as the Law Society, the Legal Services Commission, the Aboriginal Legal Rights Movement, various advocacy and consumer groups and services and the Law Schools at the University of Adelaide, Flinders University and the University of South Australia, should jointly consider the development of assistance, advice and representation services for consumers and their friends, families or carers under the *MHA*. It is important to consider the varying degrees of legal and/or non-legal assistance these services may provide. A service developed jointly between the existing bodies and services mentioned above should also consider the current operational and resource limitations and consider an organisational design that serves to address the major challenges in representation for consumers and other relevant persons as raised throughout SALRI's consultations. It may be that such a service is limited to providing advice to consumers and other relevant persons regarding their rights, how to exercise them within Tribunal procedures, and how to manage their case before the Tribunal, particularly regarding first instance matters.

A Mental Health Tribunal

10.6.23 In South Australia, cases under the *MHA* are heard at SACAT which is a 'super-tribunal' comprising of nine different streams. Mental Health Review Tribunals have been established in most States and Territories in Australia and operate as a standalone Tribunal in every state other than ACT and South Australia, where they form part of a single wider Civil and Administrative Tribunal.[2599] The issue of whether a Mental Health Review Tribunal should be established in South Australia was raised by several parties in SALRI's consultation.[2600]

10.6.24 There have been positive outcomes from mental health tribunals in other States. The 'work of the [NSW] Tribunal to ensure that patients receive the best possible care in the least restrictive environment is both consistent with the overriding objectives of mental health legislation and the principles of therapeutic jurisprudence.'[2601] However, the existing tribunals are not without problems.[2602] One study, for example, noted: 'The NSW MHRT is not without its critics. The primary

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[2598] Fleur Beaupert, 'Mental Health Tribunal Processes and Advocacy Arrangements: Little Wins are No Small Feat' (2009) 16(1) *Psychiatry, Psychology and the Law* 90, 91.

[2599] NSW Mental Health Review Tribunal, Submission No 52 to the Standing Committee of Law and Justice*, Inquiry Into Opportunities to Consolidate Tribunals in NSW* (30 November 2011) 1; Sam Boyle and Tamara Walsh, 'Procedural fairness in mental health review tribunals: the views of patient advocates' (2021) 28(2) *Psychiatry, Psychology and Law* 163.

[2600] See *Mental Health and Wellbeing Act 2022* (Vic) ch 7; *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021) vol 4, chs 26–8.

[2601] Michael Cain et al, *The NSW Mental Health Review Tribunal: An Analysis of Clients, Matters and Determinations* (Law and Justice Foundation of NSW, October 2011)77.

[2602] Sam Boyle and Tamara Walsh, 'Procedural fairness in mental health review tribunals: the views of patient advocates' (2021) 28(2) *Psychiatry, Psychology and Law* 163.

legislated function of the MHRT – conducting mandatory external reviews of compulsory psychiatric care – has been viewed by some as being negative and mechanical.'[2603]

10.6.25 There are valid views both ways as to the establishment of a Mental Health Review Tribunal in South Australia. This issue is ultimately beyond SALRI's Terms of Reference and would require future and further consideration.

Electroconvulsive Therapy

10.6.26 Even if delays are an issue, the submissions from the Mental Health Commissioners and others to SALRI make it clear that if reasonable force is used to ensure a person receives ECT, this would need to be the 'absolute last resort' following 'extensive attempts to gain consent and compliance.'[2604]

Other Issues

10.6.27 Mechanisms to review the use of compulsory treatment in one form or another – whether that be a judicial review, tribunal review or review by fellow professionals through schemes such as the second psychiatric opinion service – feature strongly in the regulatory landscape of various jurisdictions.[2605]

10.6.28 Some literature suggests that each of the above models can contribute to protecting rights but none deliver a completely satisfactory level of protection to consumers. In her evaluation of different review models, Professor Mary Donnelly concluded that tribunal reviews hold the most potential to protect rights, ensure appropriate treatment and provide 'accessible, fair and participative process.'[2606]

10.6.29 SALRI agrees with the importance of ensuring that there are appeal rights from a decision or order of the Tribunal and that the *MHA* should reinstate the entitlement of an affected person to appeal to the Supreme Court when dissatisfied with a decision of SACAT in the review jurisdiction.

10.6.30 It is also appropriate to allow the appeal of a decision not to provide a copy of notices/treatment orders to nominated persons as they are entitled to under the *MHA*.

10.6.31 SALRI finds that procedural issues in relation to the operation of ITOs under s 29 of the *MHA*, raised by the OCP, are relatively uncontroversial. It would increase the efficiency and effectiveness of the *MHA* and be more cohesive with current practice.

[2603] Michael Cain et al, *The NSW Mental Health Review Tribunal: An Analysis of Clients, Matters and Determinations* (Law and Justice Foundation of NSW, 2011) xviii.

[2604] See further Part 7 Electroconvulsive Therapy.

[2605] *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021) vol 4, 431.

[2606] Ibid; Mary Donnelly, *Reviews of Treatment Decisions: Legalism, Process and the Protection of Rights', in Rethinking Rights-Based Mental Health Laws* (Oxford and Portland, Oregon, Hart Publishing, 2010) 295.

10.6.32 Recommendations

RECOMMENDATION 48

SALRI recommends that s 84 of the *Mental Health Act 2009* (SA) should be amended to provide for an extension of the present legal representation scheme to consumers in all proceedings under the Act in the South Australian Civil and Administrative Tribunal.[2607]

RECOMMENDATION 49

SALRI recommends that s 84 of the *Mental Health Act 2009* (SA) should remain and not be amended in respect to interested parties and therefore the present legal representation scheme should not be extended to interested parties pursuing an appeal of a treatment order under the *Mental Health Act 2009* (SA) in the South Australian Civil and Administrative Tribunal.

10.6.33 Suggestions

SUGGESTION 10

SALRI suggests that consideration could be given by the South Australian Civil and Administrative Tribunal to establishing a specific mental health stream.

SUGGESTION 11

SALRI suggests that the State Government, in consultation with interested parties including the Legal Services Commission, the Law Society of South Australia, the Clinical Legal Education programs at the three Adelaide Law Schools and consumer and disability groups, should consider the provision of advice and advocacy[2608] for consumers, carers, family members in connection to matters under the *Mental Health Act 2009* (SA), which is separate to the existing Legal Services Commission scheme for the provision of legal representation for consumers at the South Australian Civil and Administrative Tribunal.

[2607] Currently the legal representation scheme provided by the Legal Services Commission of South Australia only provides representation for consumers pursuing an appeal not in the first instance or primary proceedings.

[2608] Advocacy in this context encompasses both legal representation and non-legal support and advocacy in a legal setting.

Part 11 - The Community Visitor Scheme and Mental Health Commissioners

11.1 Background

11.1.1 The present *MHA* has a range of regulatory bodies and structures with various roles and powers, all of which seek to meet the aims and objectives of the Act. These entities include the Office of the Chief Psychiatrist ('OCP'),[2609] the Community Visitor Scheme ('CVS'),[2610] the Mental Health Commissioners ('MHCs') and the Health and Community Services Complaints Commissioner ('HCSCC').[2611]

11.1.2 The *MHA* is unclear in various respects as to the differing roles and functions of these bodies. Notably, there appears, on its face, to be a significant degree of overlap and duplication, causing complexity and confusion, especially for consumers and their families.

11.1.3 The role and functions of the Chief Psychiatrist and the Community Visitors are set out within the *MHA*. The role and function of the HCSCC is contained within a separate piece of legislation.[2612] In contrast, the MHC's role and functions are not set out in any Act.

11.1.4 SALRI was asked as part of its Terms of Reference to contemplate the ways in which the efficiency of, and access to, the CVS could be enhanced. Further, SALRI also considered whether the role and function of the MHCs should be defined in the *MHA* or elsewhere. In doing so, SALRI examined the respective roles of each regulatory body relevant to mental health in South Australia.[2613]

SA Mental Health Commission

11.1.5 The South Australian Government established the South Australian Mental Health Commission ('SAMHC') in October 2015, with a view to approaching mental health in a more holistic manner and to further demonstrate commitment to strengthening mental health and wellbeing across the State.[2614]

11.1.6 In 2015, the then Minister for Health, the Hon Jack Snelling stated to the House of Assembly, that the Government had 'made transforming our mental health system a priority.'[2615] The

[2609] *Mental Health Act 2009* (SA) Pt 12, div 2.

[2610] Ibid Pt 8, div 2.

[2611] See the *Health and Community Services Complaints Act 2004* (SA); HCSCC, *What does the HCSCC do* <https://www.hcscc.sa.gov.au/about/hcscc-role/>. SALRI in its present review of the *Mental Health Act 2009* (SA) has not found it necessary to review the role of the Health and Community Services Complaints Commissioner but has provided a high-level overview of its role and functions.

[2612] *Health and Community Services Complaints Act 2004* (SA) Pt 2.

[2613] As part of its consultation, SALRI held a Roundtable with the Chief Psychiatrist and members of the OPC, the Principal Community Visitor and Public Advocate, the Health and Community Services Complaints Commissioner and two of the present part time Mental Health Commissioners. This meeting revealed apparent overlap and undue complexity in the various functions of these respective bodies.

[2614] South Australian Mental Health Commission, *South Australian Mental Health Strategic Plan 2017–2022* (December 2017).

[2615] South Australia, *Parliamentary Debates*, House of Assembly, 29 October 2015, 3367 (Jack Snelling).

Minister also announced the first day of the South Australian Mental Health Commission. Mr Snelling said:

> We have spent significant time investigating commissions around the country and can report to the house that the South Australian commission will be established as an independent administrative unit, independent from SA Health and advising me directly as minister responsible.[2616]

11.1.7 It is important to note the Mental Health Commissioners do not have a statutory basis.

11.1.8 The SAMHC currently partners with a broad range of interested parties involved in the delivery of mental health services in South Australia. These stakeholders include consumers, carers, mental health service providers and practitioners and the State Government. Importantly, the SAMHC works across government agencies dealing with 'housing, health, education, employment, justice and disability.'[2617]

11.1.9 In 2019, under the Marshall Government, the role of the MHC was re-allocated to three part-time Commissioners. In December 2022, it was announced by the Minister for Health, the Hon Chris Picton MP, that the role of the MHC will revert to one full-time Commissioner.[2618] However, their method of appointment and role still remains undefined. It is also unclear what functions or powers are to be assigned to the one future MHC.

The Chief Psychiatrist

11.1.10 The Chief Psychiatrist is an independent officer whose powers, functions and responsibilities are prescribed by the *MHA*.[2619] The Chief Psychiatrist's functions are to:

> (a) to promote continuous improvement in the organisation and delivery of mental health services in South Australia;
>
> (b) to monitor the treatment of voluntary inpatients and involuntary inpatients, and the use of restrictive practices in relation to such patients;
>
> (c) to monitor the administration of this Act and the standard of mental health care provided in South Australia;
>
> (d) to advise the Minister on issues relating to mental health and to report to the Minister any matters of concern relating to the care or treatment of patients;
>
> (e) any other functions assigned to the Chief Psychiatrist by this Act or any other Act or by the Minister.[2620]

11.1.11 In addition to powers under the *MHA*, the Chief Psychiatrist has a number of powers and functions relating to mental health services and consumers which derive from the *Criminal Law Consolidation Act 1935* (SA) and the *Health Care Act 2008* (SA). The Chief Psychiatrist also provides

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[2616] South Australia, *Parliamentary Debates*, House of Assembly, 29 October 2015, 3367 (Jack Snelling).

[2617] Life In Mind, *SA Mental Health Commission (SAMHC)* <https://lifeinmind.org.au/organisations/sa-mental-health-commission-samhc>.

[2618] Stephanie Richards, 'Full-time Mental Health Commissioner to be Appointed in SA' (15 December 2022) *In Daily* <https://indaily.com.au/news/2022/12/15/full-time-mental-health-commissioner-to-be-appointed-in-sa/>.

[2619] See *Mental Health Act 2009* (SA) Div 2.

[2620] Office of the Chief Psychiatrist, *About Us* (2022) <https://www.chiefpsychiatrist.sa.gov.au/about-us>.

advice and support under other statutes that overlap with the *MHA*, including the *Advance Care Directives Act 2013* (SA), *Consent to Medical Treatment and Palliative Care Act 1995* (SA), and the *Guardianship and Administration Act 1993* (SA).

11.1.12 Pursuant to s 90 of the *MHA*, the Chief Psychiatrist may issue standards that are to be observed in the care or treatment of persons with a mental illness. Any standard issued will be binding on any hospital that is an 'incorporated hospital' under the *Health Care Act 2008* (SA) or is binding as a condition of the licence in force in respect of any private hospital premises under Part 10 of the *Health Care Act 2008* (SA). The OCP also undertakes a number of policy initiatives outside of those required by the *MHA*.

11.1.13 To supplement the roles noted above, the OCP can publish a report for the following reasons:

- If it is required under the *MHA*;
- For reviews or investigations undertaken using Chief Psychiatrist powers; and
- For work undertaken by the OCP on strategic and policy matters that have a state-wide focus.

Community Visitor Scheme

11.1.14 The community visitor model is longstanding.[2621] It has been accepted for centuries that the State has a responsibility to protect vulnerable citizens. This duty particularly arises due to age or impaired decision-making capacity. As a result, this led to the development of the inherent *parens patriae* jurisdiction of superior courts that can still be exercised today.[2622] One recent review observed:

> Community visiting has been in existence in Australia since 1843. By 1898 an inspector of asylums had authority across a wide range of matters including the use of restraint, nutrition, staffing levels and appointment of official visitors from the community. Key features retained by modern schemes are the oversight of institutions by independent members of the community, appointed by statute, with wide powers to visit, inspect and report on the experience of residents. Independent visiting as a key tool in quality and safeguarding has precedents in other settings.[2623]

11.1.15 The rationale of any CVS scheme was offered in a recent 2018 review:

> CVS all report annually to Parliament or Legislative Assembly, as well as providing immediate feedback to services and coordinating agencies. Reports include systemic advocacy as well as highlighting individual people and their situations. Every consultation forum offered 'eyes and ears of the Minister' as an important function of CVS. The fundamental contribution is through independent proactive oversight, witnessing and reporting any gap between the expected standard of disability services and actual practice. The ability to make unannounced visits has a strong preventative element, and avoids the best behaviour scenario of a planned audit. It also provides

[2621] The role in Australia dates back to 1843. 'And be it enacted that [sic] it shall and may be lawful for the said Governor to nominate and appoint some fit and proper person or persons not exceeding five in number to be the visitors of each lunatic asylum within the said Colony … and some one of such visitors so appointed shall be required to visit such lunatic asylum at least once in every week unless prevented by illness or other sufficient cause and shall from time to time make such reports to the Colonial Secretary as may be required by order of the said Governor': *Dangerous Lunatics Act 1843* (NSW).

[2622] Julian Gardner, *Review of the Community Visitors Scheme* (8 March 2019) 6.

[2623] Alison Plant et al, *Community Visitor Schemes Review Department of Social Services for the Disability Reform Council, Council of Australian Governments: Final Report* (December 2018) 17.

> the opportunity for early intervention – concerns can be addressed immediately and at source with the relevant teams rather than escalating into abuse or neglect. CVS are also able to take a multi-agency approach to asserting the rights of a person with disability. A problem may relate to disability accommodation but could also relate to interaction with the mental health system or the transport system. Through the process of visiting multiple services, CVS gain an overview of systemic issues that can be flagged to governments.[2624]

11.1.16 The South Australian Community Visitor Scheme ('CVS') is established under Part 8, Division 2 of the *MHA*. Part 8 of the *MHA* provides mechanisms to further protect persons with mental illness.[2625] The CVS must also comply with the *MHA* guiding principles.[2626]

11.1.17 The CVS is comprised of the Principal Community Visitor ('PCV'), Community Visitors ('CVs') and the public servants providing administrative support to the PCV and CVs. Division 2 of the *MHA* does not define the scope of activities for the CVS. Rather, it creates the roles and processes for the appointment of the PCV and CVs.[2627]

11.1.18 The CVS has functions under the *MHA,* the *Disability Services (Community Visitor Scheme) Regulations 2013* (SA), and the *Health Care Act 2008* (SA). Further, under the *Guardianship and Administration Act 1993* (SA), the Public Advocate also has delegated authority to instruct CVs to undertake visits to people under the guardianship of the Public Advocate who are participants in the NDIS.[2628]

11.1.19 An important part of the work of the CVS is to provide advocacy – both individual and systemic, with a general focus on issues which effect the rights of people interacting with the mental health system. The CVS provides this advocacy and assistance to consumers who are living with a disability or mental illness, their carers and family members.[2629]

11.1.20 The CVS has been described as 'the eyes and ears of the Minister and as providing an early warning system to the Minister.'[2630] Advocacy outcomes are reported to Local Health Networks ('LHNs') and the OCP.[2631] The PCV meets regularly with Directors of Mental Health Services for each LHN to discuss their reports and current and emerging issues.

[2624] Alison Plant et al, *Community Visitor Schemes Review Department of Social Services for the Disability Reform Council, Council of Australian Governments: Final Report* (December 2018) 30.

[2625] *Mental Health Act 2009* (SA) Pt 8.

[2626] Ibid s 7(1). See also Part 12 Guiding Principles and Accountability Mechanisms.

[2627] *Mental Health Act 2009* (SA) Pt 8, div 2.

[2628] *National Disability Insurance Scheme Act 2013* (Cth).

[2629] Community Visitor Scheme, *Advocacy and Assistance*, Government of South Australia <https://communityvisitorscheme.sa.gov.au/advocacy-and-assistance>.

[2630] Julian Gardner, *Review of the Community Visitors Scheme* (8 March 2019) 7.

[2631] In the case of visits to disability services, outcomes are reported to the Department of Human Services Disability Services and to the Office of the Public Advocate.

Community Visitor Scheme Parliamentary History

11.1.21 The CVS was not part of the original Mental Health Bill 2009[2632] ('the Bill'). The Bill received broad all party support in Parliament.[2633] However, various concerns were raised by Members of Parliament in debate regarding the delivery of mental health services, notably in regional contexts,[2634] and the use of coercive powers to enforce treatment for mental health.[2635] Another particular source of concern was the perceived need for a CVS to protect the welfare and rights of consumers.[2636]

11.1.22 The Hon Vickie Chapman unsuccessfully sought to amend the Bill in the Lower House to set up a CVS within the *MHA*, as had been favoured in the review by Ian Bidmeade, entitled *Paving the Way*, that ultimately led to the *MHA*.[2637] Ms Chapman referred to what she perceived as the inadequate powers of the Chief Psychiatrist under the Bill. This proposal was opposed by the Government on the basis such a scheme was unnecessary at that stage[2638] (and issues of cost were also raised).[2639] The Government noted its support, in principle, for an oversight model, but not the proposed CVS role.

11.1.23 On 30 April 2009, the Legislative Council considered and ultimately accepted amendments to the Mental Health Bill to incorporate a CVS.[2640]

11.1.24 The Hon Michelle Lensink of the Opposition, in moving this amendment, referred to key proposals made by Mr Bidmeade's Review. Ms Lensink stated:

> All States, apart from South Australia, have community visitor schemes to provide external monitoring of mental health and disability services … community visitor schemes offer the opportunity for ongoing checking of what is happening on the ground. The Victorian *Mental Health Act 1986* for example empowers community visitors to inquire into: the adequacy of services for assessment and treatment; facilities; opportunities for recreation, training, etc; the best possible care in the least possible restrictive environment; and complaints made by consumers to a community visitor.[2641]

[2632] Mental Health Bill 2009 (SA).

[2633] See South Australia, *Parliamentary Debates*, House of Assembly, 5 February 2009, 1448 (Vickie Chapman); South Australia, *Parliamentary Debates*, House of Assembly, 18 February 2009, 1600–34 (Jane Lomax-Smith); South Australia, *Parliamentary Debates*, Legislative council, 3 March 2009, 1462–6 (Michelle Lensink); South Australia, *Parliamentary Debates*, Legislative Council, 29 April 2009, 2134–52 (Ann Bressington).

[2634] South Australia, *Parliamentary Debates*, House of Assembly, 18 February 2009, 1619 (Lyn Breuer).

[2635] South Australia, *Parliamentary Debates*, Legislative Council, 29 April 2009, 2134–41 (Ann Bressington); 2141–3 (David Winderlich). The Hon Ann Bressington stated at 2135: 'A commonly-held belief is that locking up and forcibly drugging people diagnosed with mental illness is in their best interests as well as society's as a whole. The truth is far different. Rather than protecting the public from harm, public safety is decreased. Rather than helping psychiatric respondents, many are greatly harmed. The evidence on this is clear.' See James Gottstein, 'Involuntary Commitment and Forced Psychiatric Drugging in the Trial Courts: Rights Violations As a Matter Of Course' (2008) 25(51) *Alaska Law Review* 51.

[2636] '[A] valuable way of both engaging the community to support mentally ill people and ensuring the accountability of the professionals and the systems that care for the mentally ill.' South Australia, *Parliamentary Debates*, Legislative Council, 29 April 2009, 2142 (David Winderlich).

[2637] Ian Bidmeade, *Paving the Way, Review of Mental Legislation in South Australia Report* (April 2005).

[2638] South Australia, *Parliamentary Debates*, Legislative Council, 30 April 2009, 2199 (Michelle Lensink).

[2639] Ibid 2199–2200 (Michelle Lensink).

[2640] Ibid 2212.

[2641] Ibid 2199.

…

> Similar schemes for South Australia have been suggested in the past and have been endorsed in submissions to the Committee. An inter-departmental committee administered by the Mental Health Unit of the Department of Health is investigating the concept at the present time in relation to people with a mental illness, or intellectual disability.[2642]

11.1.25 There was discussion in the debate regarding the nature and extent of the CV role. There was support that the CVS should 'emphasise advocacy and synergy with other advocacy roles.'[2643]

11.1.26 As a result, the proposed CVS amendments were:

> The Act should provide for an involuntary patient to be supported by a relative, friend, carer, guardian or advocate during assessment, detention and treatment where possible.
>
> There is a need to evaluate further how the advocacy needs identified in this report can be met. It should involve advocacy agencies and the Commonwealth.
>
> The Committee [which is the relevant recommendation in this section] supports work being done to establish a community visitor scheme in the mental health area.[2644]

11.1.27 In response, the Government, whilst noting its 'in principle' support for an oversight model, reiterated its lack of support for a CVS scheme under the *MHA*. The Hon Gail Gago MLC for the Government explained:

> The Government does not support this amendment. The amendment and subsequent amendments regarding a community visitor scheme are not supported. The reason for this is that a scheme of this type, in which a number of ministers and their agencies have an interest as well as a range of non-government agencies and consumers, needs to be given much greater thought before it is established in a Bill or in any other form.[2645]
>
> … some consumers in receipt of health and community services are vulnerable or unwilling to raise concerns about their care [for] fear of retribution. This may be the case for children in care, people with a disability, people with a mental illness and the aged living in government and non-government residential care.[2646]

11.1.28 Other concerns were raised in relation to the CVS under the *MHA*. For example, concerns were expressed in the context of imposing professional experience and training criteria for CVs under the proposed scheme:

> While there is much to commend the scheme anticipated by the amendments, it will not provide the flexibility that will be required to meet the needs of all those with an interest in a scheme of this type. The scheme before Parliament assumes that the current or former medical practitioners and psychologists know about mental health issues by virtue of the fact that they are a medical practitioner or psychologist. Some will but many will not, and it is therefore not appropriate to single out these professions as potentially contributing more to a community visitor scheme than a mental health nurse or social worker with extensive experience in the mental health system. No

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[2642] Ibid.

[2643] South Australia, *Parliamentary Debates*, Legislative Council, 30 April 2009, 2199 (Michelle Lensink).

[2644] Ibid 2199.

[2645] South Australia, *Parliamentary Debates*, Legislative Council, 30 April 2009, 2200 (Gail Gago).

[2646] Ibid.

> one profession meets all of the needs of the people in the mental health system; therefore, no profession should be singled out as potentially able to contribute more.[2647]

11.1.29 The Government's reservations regarding a CVS were not shared by others in the Legislative Council. The Hon Mark Parnell MLC stated his support for a CVS under the *MHA*.[2648] He further referred to the need for protection of consumers and cited earlier comments, where he had stated 'unless the Government came up with an alternative model, I would support the Liberal amendment.'[2649] The Hon David Winderlich MLC agreed, supporting the amendment, stating that the scheme '… is a valuable support in the functioning of the mental health system and also a means of ensuring some sort of accountability and contact with the outside world to have a structured visitors scheme for people who are in detention.'[2650]

11.1.30 After the acceptance of the amendments establishing a CVS under the *MHA* in the Legislative Council,[2651] the Government in the House of Assembly on 2 June 2009 indicated its reluctant acceptance of the amendments. The Government reiterated its 'in principle' support for an oversight model, but repeated its doubts as to a CVS model, in particular, the effectiveness of prescribing certain professionals to act as CVs:

> To require that one of the community visitors is in these categories [medical practitioner, former medical practitioner or psychologist] is unnecessary and is likely to build into the scheme a degree of inflexibility which would hamper its development and practice. As far as I know, these qualifications are not required anywhere else in Australia, and I believe therefore that other jurisdictions would have recognised this impediment to this operation in this way.[2652]

11.1.31 The Government further recognised the attributes they perceived as necessary and desirable in a CV, to facilitate their advocacy role:

> It is certainly not the role of community visitors to second guess the medical treatment a patient is receiving. It is the role of a visitor to talk to the patients and ascertain whether or not they have any concerns about how they are being treated within the facility in the broader sense of the word and not just in regard to their medical treatment. Across Australia community visitors come from a range of backgrounds. However, one of the key characteristics they must have is a degree of empathy with patients and the capacity to engage them in discussion. A background in either medicine or psychology may be of assistance but is not necessary for this.[2653]

11.1.32 SALRI notes that this passage highlights the extent of a CV's role, which does not extend to clinical judgments relating to a consumer's treatment. While a background in medicine or psychology may be valuable, it is not necessary, as the CV acts as an advocate to the consumer. The Government's acceptance was obtained, contingent on the deletion of a provision requiring one of the visitors to be a current or former medical practitioner or psychologist.

[2647] Ibid.

[2648] South Australia, *Parliamentary Debates*, Legislative Council, 30 April 2009, 2201 (Mark Parnell).

[2649] Ibid.

[2650] South Australia, *Parliamentary Debates*, Legislative Council, 30 April 2009, 2201 (David Winderlich).

[2651] South Australia, *Parliamentary Debates*, Legislative Council, 30 April 2009, 2212 (Michelle Lensink).

[2652] South Australia, *Parliamentary Debates*, House of Assembly, 2 June 2009, 2845 (Jane Lomax-Smith).

[2653] Ibid.

Health and Community Services Complaints Commissioner

11.1.33 The HCSCC is an independent, statutory office established by the *Health and Community Services Complaints Act 2004* (SA).

11.1.34 This provides the only complaints mechanism specifically available to consumers. It allows consumers to complain on a number of grounds relating to the provision of health services.[2654] The HCSCC also assists consumers, carers and service providers with the resolutions of complaints.[2655]

11.1.35 In addition to the MHC, the HCSCC provides a regulatory and oversight role. SALRI's consultation revealed potential overlap and duplication of functions between the MHC and HCSCC, creating confusion regarding each body's role. This further strengthens the need for statutory clarity.[2656] However, the specialist knowledge offered by the MHC role could be a valuable resource for the HCSCC, when a mental health related complaint is received. This partnership could translate into the MHCs offering an advisory role to the HCSCC.

11.2 Current Law in South Australia

SA Mental Health Commissioner

11.2.1 The MHCs are appointed under s 68 of the *Constitution Act 1934* (SA).[2657] The *MHA* does not define their role, powers and functions.

11.2.2 According to the MHC submission to SALRI, the primary objectives of the Commissioner or Commissioners, are to 'strengthen the mental wellbeing and health care of South Australians by working with partners to influence decision making, set goals and transform systems and supports to improve people's lives.' Their role is also to 'bring together lived experience and professional expertise to drive reform and enhance the lives of people living with mental illness.'

11.2.3 To carry out these objectives, the Commissioners develop, at the request of the relevant Minister, reports and policies regarding specific issues relating to mental health, and publish research reports with recommendations as they relate to mental health in South Australia.

11.2.4 For instance, in 2017, the Commission announced that it was to become responsible for the coordination, evaluation and implementation of the 'South Australian Mental Health Strategic Plan 2017–2022."[2658] It would also continue to promote public awareness of mental health and wellbeing and destigmatise mental illness.

Community Visitor Scheme

11.2.5 In South Australia, the PCV is appointed by the Governor, who also imposes certain conditions on the PCV's operation. This includes the conditions that the PCV's tenure cannot exceed

[2654] *Health and Community Services Complaints Act 2004* (SA) s 25(1)(k).

[2655] Health and Community Services Complaints Commissioner, *What Does the HCSCC Do?* <https://www.hcscc.sa.gov.au/about/hcscc-role/>.

[2656] See SALRI Recommendation 56.

[2657] Also known as the Instrument of Appointment.

[2658] South Australian Mental Health Commission, *South Australian Mental Health Strategic Plan 2017–2022* (December 2017).

three years, but they are eligible for reappointment.[2659] The Governor may remove or suspend a person as PCV or a CV by presenting their reasons, on the ground of incompetence or misbehaviour, in both Houses of Parliament.[2660]

11.2.6 The CVS is jointly funded by SA Health and the Department of Human Services ('DHS'). The PCV is supported by a small office of five administrative staff who are DHS employees. These staff take day to day direction from the PCV, but all staff are employees of the DHS.

11.2.7 The CVs are volunteers. They are reimbursed for their out-of-pocket expenses and receive an honorarium each year. Whilst there are no formal qualifications required for the role, visitors must satisfy criteria developed by the CVS regarding their suitability for the role. At a minimum, candidates must be over 18 years of age; not working full-time; and willing to undergo appropriate screenings. They must demonstrate good communication skills, a desire to help individuals through advocacy and dedication to improving services. People with lived experience from Culturally and Linguistically Diverse backgrounds, or with Aboriginal heritage are encouraged to apply, along with people with lived or other experience in the disability and mental health sectors. Matters regarding CV's qualifications are not contained in the *MHA*.

11.2.8 The functions of the CVs are set out in s 51 of the *MHA*. They are to:

> (a) to conduct visits to and inspections of treatment centres as required or authorised under this Division;
>
> (ab) to conduct visits to and inspections of authorised community mental health facilities as required or authorised under this Division;
>
> (b) to refer matters of concern relating to the organisation or delivery of mental health services in South Australia or the care, treatment or control of patients to the Minister, the Chief Psychiatrist or any other appropriate person or body;
>
> (c) to act as advocates for patients to promote the proper resolution of issues relating to the care, treatment or control of patients, including issues raised by a guardian, medical agent, relative, carer or friend of a patient or any person who is providing support to a patient under this Act;
>
> (d) any other functions assigned to community visitors by this Act or any other Act.[2661]

11.2.9 Notably, under s 51(3) of the *MHA*, CVs 'have the authority to conduct inspections of the premises and operations of any hospital that is an incorporated hospital under the *Health Care Act 2008* (SA) and are also taken to be inspectors under Part 10 of that Act.[2662] SALRI notes that by the acquisition of powers under the two Acts,[2663] the CV's have considerable powers, potentially exceeding those of the Adult Safeguarding Unit.[2664] Indeed, the powers of CVs extend to requiring access to confidential medical records, even without a patient's knowledge or consent.

[2659] *Mental Health Act 2009* (SA) s 50(3).

[2660] Ibid s 50(5), (6).

[2661] Ibid s 51.

[2662] Ibid s 51(3); *Health Care Act 2008* (SA).

[2663] *Mental Health Act 2009* (SA); *Health Care Act 2008* (SA).

[2664] See also SALRI's recent legislative review of the *Ageing and Adult Safeguarding Act 1995* (SA): David Plater et al, '*Autonomy and Safeguarding are not Mutually Inconsistent': A Review of the Operation of the Ageing and Adult Safeguarding Act 1995 (SA)* (South Australian Law Reform Institute, 2022).

11.2.10 According to a 2019 Review of the CVS by Julian Gardner, while the functions of CVs are clearly stated in the *MHA,* it does not define the nature of their role. He noted '[t]he latter [the nature of the CV role] is critical given that any consideration of the qualification and training requirements of community visitors must relate to the nature of their role and to the functions that they are required to perform.'[2665]

11.2.11 Under s 53 of the *MHA*, a consumer may make a request to see a CV. A consumer's guardian, medical agent, relative, carer or friend or any person who is providing support to a consumer under the *MHA* can also make this request. When a request is made to the Director of a treatment centre where the consumer is an inpatient, the Director must advise a CV of the request within two days.[2666] The *MHA* provides further detail regarding CVS procedures for visits and inspections to treatment centres, authorised community mental health facilities, and for visits via audio-visual or other electronic means.[2667] The *MHA* does not contemplate information sharing in relation to the CVS.

11.2.12 The PCV has additional functions, including to:

- Oversee and coordinate performance of CV functions;
- Advise and assist other CVs in the performance of their functions; and
- Report to the Minister as directed by the Minister about performance of CV functions.[2668]

11.2.13 The PCV reports to the Minister for Health and Wellbeing on matters related to the scheme's functions under the *MHA* and to the Minister for Human Services on matters related to the scheme's functions under the *Disability Services (Community Visitor Scheme) Regulations 2013* (SA). An Advisory Committee provides strategic advice and support to the PCV, monitors the key issues arising from the work of the CVS and contributes to strategic networks and relationships. The Committee is not established by the *MHA* or any other statute.

11.2.14 Section 54 of the *MHA* also requires a PCV to provide annual reports to the relevant Minister. These reports are provided to both Houses of Parliament by the relevant Minister.[2669]

11.2.15 A PCV is permitted under s 51A of the *MHA* to delegate their functions or powers to another CV, so long as it does not interfere with the PCV's statutory powers.[2670]

11.2.16 Mr Gardner's Review raised the overlap between the OCP and CVS. This overlap was described, in addition to the distinct differences between the rationale of the OCP and CVS:

> It is important to accurately understand the full scope of the [CVS inspection] role when considering the requirements for training and for qualifications and in considering the complementarity of the role with that of the OCP. In some respects, CVs do inspect matters in common with those that are the concern of the Chief Psychiatrist. CVs do monitor compliance

[2665] Julian Gardner, *Review of the Community Visitors Scheme* (8 March 2019).

[2666] *Mental Health Act 2009* (SA) s 53(2).

[2667] *Mental Health Act 2009* (SA) ss 52, 52A, 52B.

[2668] Ibid s 51(2).

[2669] See for example, Principal Community Visitor, *Annual Report of the Principal Community Visitor 2021-22* (29 September 2022, Community Visitor Scheme South Australia).

[2670] *Mental Health Act 2009* (SA) s 51A.

with patients' rights under the *MHA* as well as any standards set by legislation or by instrumentalities of the state. However, their inspection role is not one akin to that which occurs during the process of accreditation nor to one of that is part of clinical governance. Both of these require high level technical or clinical knowledge.[2671]

11.2.17 Mr Gardner described the focus of the OCP role as technical or clinical and noted a degree of overlap may be beneficial:

> … there are aspects of OCP inspections that do overlap with those of CVs … The complementary nature of the two inspections is seen in the practice of the Chief Psychiatrist to obtain the reports made by the CVS on a facility before conducting an inspection of it … It illustrates the difference in the two roles but at the same time it illustrates the effectiveness of the combination, especially given the efficiency of the PCV in referring issues and following them up and the responsiveness of the OCP. The importance of the relationship is recognised in the holding of meetings between the PCV and the Chief Psychiatrist every two months. In discussions with representatives of schemes in other jurisdictions it was a common view that the community visitor schemes rely on the complementary inspections by the Chief Psychiatrist. It has already been noted that critical to the effectiveness of the CVS is that fact that CVs are independent of and external to the mental health system. The OCP is not. There is essential value in the combination of the two. There is no doubt that the two inspections have different functions … The complementary nature of the two schemes does, however, need to be made effective by good co-operation and collaboration. In my view this exists in South Australia. I am satisfied that the combination of CVS and OCP inspections is sufficiently comprehensive.[2672]

11.2.18 Mr Gardner also concluded:

> … positive changes have been made in the processes of the CVS and the OCP together with improved responsiveness of agencies responsible for responding to concerns raised by community visitors. The inspection protocols and processes and the reports used in the CVS are appropriate. The process for resolving issues applied by the CVS is methodical, timely, has appropriate steps for the escalation of serious or urgent matters and ensures that the appropriate persons do provide a response. The combination of CVS and OCP inspections is sufficiently comprehensive. No change is required to the current qualification requirements of community visitors in order to appropriately discharge their role. There are no current functions of community visitors that should be discharged by persons with specialist mental health qualifications. Community visitors are already trained in mental health care to the extent necessary for their role save that it is recommended that additional training be provided in the standards of treatment and care that they should reasonably expect to observe in contemporary practice. Opportunities should be explored for the cost-effective use of digital training material to be provided on-line to community visitors.[2673]

11.2.19 Mr Gardner also highlighted the need for independence, noting '[t]he fact that CVs are independent of and external to the mental health system is critical. CVs are members of the community who are required to ensure that the duties of the state are discharged and its responsibilities met in the care of vulnerable people.'[2674]

[2671] Julian Gardner, *Review of the Community Visitors Scheme* (8 March 2019) 7.

[2672] Julian Gardner, *Review of the Community Visitors Scheme* (8 March 2019) 12.

[2673] Julian Gardner, *Review of the Community Visitors Scheme* (8 March 2019) 4.

[2674] Ibid. Cf Bruce Lander, *Oakden: A Shameful Chapter in South Australia's History* (ICAC South Australia, 28 February 2018) who noted that 'it cannot be disputed that the CVS did not lead to identify most of the issues at Oakden, at least until Mrs Spriggs met with Mr Corcoran in June 2016. There are a number of possible reasons for this,

11.3 Law in Other Jurisdictions

11.3.1 Each State's mental health legislation varies with regard to Mental Health Commissions and Community Visitor Schemes. However, there are broad similarities across each Australian jurisdiction.

11.3.2 **Table 7** below provides a comparison of the provisions relating to each jurisdiction's respective Mental Health Commission or the jurisdiction's equivalent entity.

11.3.3 **Table 8** below provides a comparison of the provisions containing each jurisdiction's respective Community Visitor Scheme.

including that the community visitors were not trained or qualified in a way which would have enabled them to identify such issues': at 194. Mr Lander's recommendations related to the requirements for the qualifications and the training of community visitors. They reflected Mr Lander's view that had the qualifications and training of community visitors been different the deficiencies in the operations of Oakden would have been revealed and reported upon earlier. See also Julian Gardner, *Review of the Community Visitors Scheme* (8 March 2019) 5.

Table 7: Comparison of Mental Health Commissions and Equivalent Entities						
	Legislation	**Role**	**Appointment/ Removal**	**Term**	**Functions, Powers and Obligations**	**Processes**
SA	*Constitution Act 1934* (SA) The *MHA* does not reference the role.	Mental Health Commission and Commissioner	**Section 68** The Mental Health Commissioner(s) are appointed under s 68 of the *Constitution Act 1934* (SA)		'Strengthen the mental wellbeing and health care of South Australians by working with partners to influence decision making, set goals and transform systems and supports to improve people's lives.' 'Bring together lived experience and professional expertise to drive reform and enhance the lives of people living with mental illness.' Develop, at the request of the relevant Minister, reports and policies regarding specific issues relating to mental health, and publish research reports with recommendations as they relate to mental health in South Australia.	
NSW	*Mental Health Commission Act 2012* (NSW)	Mental Health Commissioner and Deputy Mental Health Commissioner	**Section 6(1)** The Governor may appoint a Mental Health Commissioner **Section 7(1)** The Governor may appoint one or more Deputy Mental Health Commissioners. **Section 8** The Commissioner or at least one Deputy Commissioner must be a person who has or has had a mental illness. **Schedule 1, cl** 1 (1) The Commissioner and Deputy Commissioners are entitled to be paid.	**Section 6(2)** To hold office for the period (not exceeding 5 years) and may not be appointed for more than 2 successive terms of office. **Section 7(2)** A Deputy Commissioner holds office for the period (not exceeding 3 years) and may not be appointed for more than 2 successive terms of office.	**Section 11** (a) people who have a mental illness, wherever they live, should have access to the best possible mental health care and support, (b) people who have a mental illness and their families and carers should be treated with respect and dignity, (c) the primary objective of the mental health system should be to support people who have a mental illness to participate fully in community life and lead meaningful lives, (d) the promotion of good mental health and the effective provision of mental health services are the shared responsibility of the government and non-government sectors, (e) an effective mental health system requires: (i) a co-ordinated and integrated approach across all levels of government and the non-government sector, including in the areas of health, housing, employment, education and justice, and (ii) communication and collaboration between people who have a mental illness and their families and carers, providers of mental health services and the whole community. **Section 12**	**Section 10 Mental Health Community Advisory Council** **13 Special reports** **14 Other reports** **16 Co-operation between Commission and public sector agencies** **20 Review of Commission and Act**

					(1) The Commission has the following functions: (a) to prepare, in consultation with providers of mental health and related services and government agencies, a draft strategic plan for the mental health system in New South Wales for submission to the Minister for approval, (b) to monitor and report on the implementation of the strategic plan, (c) to review and evaluate, and report and advise on, mental health services and other services and programs provided to people who have a mental illness, and other issues affecting people who have a mental illness, (d) to promote and facilitate the sharing of knowledge and ideas about mental health issues, (e) to undertake and commission research, innovation and policy development in relation to mental health issues, (f) to advocate for and promote the prevention of mental illness and early intervention strategies for mental health, (g) to advocate for and promote the general health and well-being of people who have a mental illness and their families and carers, (h) to educate the community about mental health issues, including for the purpose of reducing the stigma associated with mental illness and discrimination against people who have a mental illness.	
VIC	*Mental Health Act 2014* (Vic)	Mental Health Complaints Commissioner	**Section 226(2)** Appointed by the Governor in Council on recommendation of a Minister. **Section 226(4)** Governor in Council may specify other terms and conditions of appointment. **Section 226(5)** Entitled to receive remuneration and allowances as are fixed by the Governor in Council.	**Section 226(3)** Can hold office for a term, not exceeding 5 years, and is eligible for reappointment.	**Section 228** To 'accept, assess, manage and investigate complaints relating to mental health service providers,' resolve those complaints in a timely manner using various alternative dispute resolution mechanisms, and provide advice in relation to these complaints. To 'identify, analyse and review quality, safety and other issues arising out of complaints, and provide information and make recommendations for improving the provision of mental health services to, as appropriate mental health service providers, the chief psychiatrist, the Secretary, the Minister, the Agency within the meaning of the NDIS Act, the NDIS Commission; (vii) the Health Complaints Commissioner, the Australian Health Practitioner Regulation Agency, or a prescribed person or body.	**238 Preliminary assessment of complaint** **239 Information relating to complaint to be provided** **240 Circumstances in which Commissioner may close a complaint** **241 Notice of complaint closure** **242 Referring a complaint with or without consent** **243 Commissioner may accept complaints and undertakings** **244 Conciliation process**

			Section 227 Removed by the Governor in Council on the Minister's recommendation in certain circumstances.		**Section 228(f)-(i)** Should make information pertaining to the complaints and dispute resolution procedures accessible, and provide information and education to mental health services regarding their responsibilities in managing consumer complaints, and how to develop procedures and policies for dealing with consumer complaints. **Section 228(k)** Only at the direction of the Minister, the MHCC may investigate and report 'any matter relating to mental health service providers.' **Section 229** Provides broad powers allowing them to do all things necessary or convenient in connection to their functions.	**252 Investigation of a complaint**
WA	*Mental Health Act 2014* (WA)	Chief Mental Health Advocate	**Section 349** Appointed by the Minister. **Section 365** Entitled to the remuneration determined by the Minister on the recommendation of the Public Sector Commissioner **Section 67** The Minister may remove a person from the office of Chief Mental Health Advocate on numerous grounds. **Section 368(1)** The Minister may appoint a person to act in the office of the Chief Mental Health Advocate.	**Section 364** To hold office for the period (not exceeding 5 years) and eligible for reappointment	**Section 351(1)** a) ensuring that identified persons are visited or otherwise contacted in accordance with section 357; and b) promoting compliance with the Charter of Mental Health Care Principles by mental health services; and c) preparing and publishing information about, and promoting, the role of mental health advocates and how to contact the Chief Mental Health Advocate; and d) developing standards and protocols for the performance by mental health advocates of their functions under this Act; and e) ensuring that mental health advocates receive adequate training in relation to the performance of their functions under this Act; f) providing advice, assistance, control and direction to mental health advocates in relation to the performance of their functions under this Act; g) ensuring compliance with any directions given by the Minister or the Chief Mental Health Advocate under paragraph (f); and h) any other functions conferred on the Chief Mental Health Advocate by this Act or another written law. 2) The function of the Chief Mental Health Advocate under subsection (1)(c) does not include the publication of personal information about a person who has or may have a mental illness.	**Section 354** 1) Minister may, after consultation with the Chief Mental Health Advocate, issue written directions about the general policy to be followed by the Chief Mental Health Advocate in performing functions under this Act. 4) The Chief Mental Health Advocate must comply with a direction issued under this section **Section 355** (1) The Minister may issue a written direction requiring the Chief Mental Health Advocate (a) to report to the Minister about the provision of treatment or care by a particular mental health service to a particular person; or (b) to ensure that a particular mental health service is visited by a mental health advocate and to report to the Minister on the visit.

QLD	*Queensland Mental Health Commission Act 2013* (Qld)	Queensland Mental Health Commission	**Section 15** Appointed by the Governor in Council on the recommendation of the Minister.	**Section 18** Can hold office for a term not exceeding 5 years.	**Section 11(1)** Prepare and review a whole-of-government strategic plan; Monitor and report to the Minister on implementation of the whole-of-government strategic plan; Review, evaluate, report and advise on the mental health and substance misuse system; issues affecting consumers and issues affecting community mental health and substance misuse; Promote and facilitate the sharing of knowledge and ideas about mental health and substance misuse issues; Undertake and commission research in relation to mental health and substance misuse issues; support and promote the general health and wellbeing of people with a mental illness and people who misuse substances, and their families, carers and support persons; Support and promote social inclusion and recovery of people with a mental illness or who misuse substances; and Promote community awareness and understanding about mental health and substance misuse issues, including for the purpose of reducing stigma and discrimination.	**Section 11(2)** Must consider the following in the exercise of its functions: Systemic mental health and substance misuse issues; Comorbid issues including disability, chronic disease and homelessness; Issues for people with mental health and substance misuse issues in the criminal justice system. The particular views, needs and vulnerabilities of different sections of the Queensland community, including Aboriginal and Torres Strait Islander communities, CALD communities, regional and remote communities, other groups at risk of marginalisation and discrimination; and Contemporary evidence and relevant policy and strategic frameworks. The Commissioner must also engage and consult with people with mental health or substance misuse issues, and their families, carers and support persons, Hospital and Health Boards, the government, non-government and private sectors and other members of the community to the extent the commissioner considers appropriate.
TAS	*Mental Health Act 2013* (Tas)	-	-	-	-	-
ACT	*Mental Health Act 2015* (ACT)	-	-	-	-	-
NT	*Mental Health and Related Services Act 1998* (NT)	-	-	-	-	-

Table 8: Comparison of Community Visitors Schemes in Australia					
	Legislation	**Description**	**Appointment/Removal**	**Functions**	**Processes**
SA	*Mental Health Act 2009* (SA)	Community Visitors Scheme and Principal Community Visitor ('PCV')	**Section 50(2)** Positions determined by 2the Governor to carry out functions **Section 50(3)** The PCV or CVs are appointed and conditions determined by Governor. Their term is not to exceed 3 years, but they are eligible for reappointment. **Section 50(5), (6)** The Governor may remove or suspend a person as PCV or a CV by presenting their reasons, on the ground of incompetence or misbehaviour, in both Houses of Parliament.	**Section 51(1)** a) conduct visits, inspections of treatment centres ab) conduct visits and inspections of authorized community mental; health facilities b) relating to organization or delivery of mental health services in SA or care, treatment or control of patients to the minister, chief psychiatrist or other appropriate person c) act as advocates for patients and promote proper resolution of issues relating to care, treatment, control of patients, any issues raised by guardian, medical agent, relative, carer, friend or any support person d) any other functions assigned to CV by this act or other act **Section 51(2)** a) oversee and coordinate performance of CV functions b) advise, assist other CV in the performance of their functions- concerns to the minister, chief psychiatrist c) report to minister as directed by the minister about performance of CV functions d) any other functions assigned to CV by this act or other act **Section 51(3)** CVs 'have the authority to conduct inspections of the premises and operations of any hospital that is an incorporated hospital under the *Health Care Act 2008* (SA) and are also taken to be inspectors under Part 10 of that Act.	**Section 52** **Visits to and inspections of treatment centres** **Section 52A** **Visits to and inspection of authorised community mental health facilities** **Section 52B** **Visits and inspections by audiovisual or other electronic means** **Section 53** **Requests to see community visitors** **Section 54** **Reports by Principal Community Visitor**
NSW	*Mental Health Act 2007* (NSW)	Official Visitor and Principal Official Visitor ('POV')	**Section 128 (1)** Minister may, by instrument in writing, appoint a person to be the POV. **Section 129** (1) The Minister must, by instrument in writing, appoint official visitors. (2) A person may be appointed as an official visitor if they (a) are a medical practitioner, (b) are a registered psychologist, (c) have any other qualifications prescribed by the regulations, (d) are otherwise a suitably qualified or interested person. **Schedule 4, cl 2**	**Section 128** (2) The POV has the following functions— (a) to advise and assist official visitors in the exercise of the functions conferred or imposed on them by or under this Act, (b) to oversee the official visitor program conducted under this Act, (c) to report to the Minister, as directed by the Minister, about the exercise of the functions of the POV and official visitors, (d) to refer matters raising any significant public mental health issues or patient safety or care or treatment issues to the Minister or any other appropriate person or body, (e) to act as an advocate to the Minister for consumers of mental health care to promote the proper resolution of issues arising in the mental health system, (f) any other function conferred on the POV by or under this or any other Act. **Section 129** 3) An official visitor has the following functions— (a) to refer matters raising any significant public mental health issues or patient safety or care or treatment issues to the Principal official visitor or any other appropriate person or body,	**Section 131 - Inspections of mental health facilities by official visitors** **Section 132 - Obligations to facilitate exercise of functions by official visitors** **Section 133 - Reports to Minister** **Section 134 - Request by patient or other person at mental health facility to see official visitor** **134A Request by patient or other person at other**

			An official visitor holds office for the period (not exceeding 4 years) but is eligible for re-appointment. **Schedule 4, cl 3** An official visitor is entitled to be paid such remuneration determined by the Minister. **Schedule 4, cl 5** Suspension from office if the official visitor becomes a mentally incapacitated person.	(b) to act as an advocate for patients to promote the proper resolution of issues arising in the mental health system, including issues raised by a designated carer or principal care provider of a patient or person detained under this Act, (c) to inspect mental health facilities as directed by the Principal official visitor and in accordance with this Part, (d) any other function conferred on official visitors.	**health facility to see official visitor**
VIC	*Mental Health Act 2014* (Vic)	Community Visitors	**Section 214** (1) The Governor in Council may, on the recommendation of the Public Advocate, appoint as many community visitors as are necessary for the purpose of fulfilling their functions under this Act. (2) In recommending persons for appointment as community visitors, the Public Advocate must— (a) recommend, as far as practicable, an equal number of males and females; and (b) have regard to the desirability of having people of diverse backgrounds as community visitors. (3) A community visitor— (a) holds office for a period of 3 years; and (b) is eligible for reappointment at the end of his or her term of office; and (c) is entitled to be paid any fees and travelling and other allowances as are fixed by the Governor in Council from time to time; and (d) is not, in respect of the office of community visitor **215** (1) Governor in Council may specify terms and conditions of appointment in the instrument of appointment of a person as a community visitor. **Section 215(2)**	**Section 216** (a) to visit any prescribed premises and inquire into the following— (i) the adequacy of services and facilities provided at those premises to persons receiving mental health services (ii) whether the mental health services provided at those premises are provided in accordance with the objectives of this Act and the mental health principles; (iii) any failure to comply with the provisions of this Act or the regulations; (iv) any other matter that the community visitor is satisfied is appropriate, having regard to the objectives of this Act and the mental health principles; and (b) to assist persons receiving mental health services at those prescribed premises (i) in the resolution of any issues identified in the course of making an inquiry; and (ii) to seek support from other relevant bodies or services; and (iii) to make complaints to the Commissioner; and (c) to perform any other functions conferred on the community visitor by this Act. **217 Powers of community visitors** (1) When visiting a prescribed premises, a community visitor may— (a) enter and inspect any part of the premises; and (b) speak to any person receiving mental health services who wishes to speak to the community visitor; and (c) inspect any document, other than a clinical record, relating to a person receiving mental health services at the prescribed premises or any other record which is required to be kept under this Act or the regulations; and (d) with the consent of a person receiving mental health services, inspect any clinical record relating to the person receiving mental health	**219 Request to see a community visitor** (1) A person receiving mental health services at a prescribed premises, or any person on behalf of that person, may request the person in charge of the prescribed premises to arrange for the person to be visited by a community visitor. (2) Within 2 business days after receiving a request under subsection (1), the person in charge of the prescribed premises must advise a community visitor that a request has been made. **218 When may community visitors visit prescribed premises?** **220 Reasonable assistance to be given to community visitors** **221 Community Visitors Mental Health Board**

			The Governor in Council may, on the recommendation of the Public Advocate, remove a community visitor from office.		**222 - Matter may be referred** **Section 223** Reports by community visitors **225 Secrecy provision**
WA	*Mental Health Act 2014* (WA)	Council of Official Visitors, the Head of the Council of Official Visitors and official visitors	**Section 665** (2)(b) the responsible COV office holder under subsection (3) continues to hold office, and is entitled to receive from the Chief Mental Health Advocate such assistance as the responsible COV office holder reasonably requires, for the purpose of making the report. (3) For subsection (2)(b), the responsible COV office holder is — (a) a person — (i) who, immediately before commencement day, held office under the 1996 Act as an official visitor or a person on a panel; and (ii) who is nominated by the person referred to in paragraph (b) to make the report; or (b) if no-one is nominated under paragraph (a)(ii) — the person who, immediately before commencement day, held office under the 1996 Act as the Head of the Council of Official Visitors.	**664 Exercise of powers by official visitors and panels (1996 Act s. 190)** **(1)** Any information obtained by an official visitor or a panel in the course of a visit to a place under the 1996 Act section 190(2) (whether or not the visit was completed before commencement day) is taken to be information obtained by a mental health advocate in the course of a visit to a mental health service under section 359(1)(a). (2)A visit to a place by an official visitor or a panel under the 1996 Act section 190(2) that was started but not completed before commencement day can be completed by a mental health advocate under section 359(1)(a) as a visit to a mental health service.	**663 Request for visit by official visitor (1996 Act s. 189)** A request made under the 1996 Act section 189(1)(a) or (b) for an official visitor to visit a person that, immediately before commencement day, had not been dealt with under that Act is taken to be a request made under section 356(2)(a) or (b), as the case requires, for a mental health advocate to contact or otherwise visit the person. **665 Reports requested by Minister** **666 Final report about activities of official**
QLD	*Public Guardian Act 2014* (Qld) See also *Queensland Mental Health Commission*	Community Visitor Program ('CVP')	The CVP is organisationally comprehensive, with more than 100 community visitors working across a geographic area of 1.7 million kilometres. A Regional Visiting Manager oversees each zone and provides support and supervision	**Sections 39 and 41** Community visitors have the following functions: to deal with complaints and make inquiries into complaints and to regularly visit visitable sites (an authorised mental health service under the *Mental Health Act 2016* (Qld) that provides inpatient services; the forensic disability service or place, other than a private dwelling house, that is prescribed under a regulation). **Section 44**	

	Act 2013 (Qld)		to community visitors.[2675] Community visitors also report to the Public Guardian.	In the carrying out of these functions, a community visitor may 'do all things necessary or convenient'.	
TAS	*Mental Health Act 2013* (Tas)	Principal Official Visitor ('POV')	**Section 155** (1) Governor, on recommendation of the Minister, may appoint a Principal Official Visitor. (2) The Principal Official Visitor may appoint one or more Official Visitors.	**Section 102 - Refusal of visit** **Section 103 - Termination of visits** **Section 156 - Functions of Principal Official Visitor** (1) The Principal Official Visitor has the following functions: (a) to arrange for Official Visitors to visit approved facilities and any premises from which patients are provided with services under this Act; (b) to receive complaints from (or concerning) patients, including complaints referred to the Principal Official Visitor by Official Visitors; (c) to assess and conduct preliminary inquiries into complaints received from (or concerning) patients, including complaints referred to the Principal Official Visitor by Official Visitors; (d) to refer suspected contraventions of this Act, or other matters that may require investigation, to the Health Complaints Commissioner or Ombudsman; (e) to promote, amongst patients and administrators and in other relevant quarters, an awareness of Official Visitors and their role; (f) to report on suspected contraventions of this Act or standing orders or clinical guidelines; (g) to report on the extent to which the objects of this Act and the mental health service delivery principles are being met; (h) to raise with the responsible Minister or relevant Chief Psychiatrist any matters of particular concern that come to the Principal Official Visitor's attention; (i) to perform such other functions as are conferred on the Principal Official Visitor under this or any other Act. **Section 157 - Functions of Official Visitors** Any Official Visitor has the following functions: (a) to visit, in accordance with the arrangements made by the Principal Official Visitor, approved facilities and premises from which patients are provided with services under this Act; (b) to receive complaints from (or concerning) patients;SEP(c) to refer complaints received from (or concerning) patients to the Principal Official Visitor; (d) to report suspected contraventions of this Act, or other matters that may require investigation, to the Principal Official Visitor; (e) to check that patients are being informed of and accorded their rights; (f) to monitor the adequacy and quality of approved facilities, with particular regard to the recreational, occupational, training and rehabilitation facilities available to patients; (g) to raise with the Principal Official Visitor any matters of particular concern that come to the Official Visitor's attention;	**Section 160 - Visits** (1) The Principal Official Visitor must arrange for each approved facility to be visited by an Official Visitor at least once a month. (2) The Principal Official Visitor must arrange for an Official Visitor to visit premises in or from which a patient is being provided with services under this Act if requested to do so by – (a) the patient; or (b) a representative or support person of the patient; or (c) a person who, in the opinion of the Principal Official Visitor, has a genuine interest in the patient's welfare; or (d) the responsible Minister. **Section 161 - Complaints** (1) Any patient is entitled to make a complaint to an Official Visitor. (2) An Official Visitor may also accept a complaint, concerning any patient, from (a) a support person, or representative, of the patient; (b) a person who, in the opinion of the Official Visitor, has a genuine

[2675] Office of the Public Guardian, *Community Visitor Program* <https://www.publicguardian.qld.gov.au/about-us/community-visitor-program>.

				(h) to perform such other functions as are conferred on the Official Visitor under this or any other Act. **Section 159 - Powers of Official Visitors** (1) The Principal Official Visitor has the power to do all things necessary or convenient to be done to perform his or her functions. (2) An Official Visitor has the power to do all things necessary or convenient to be done to perform his or her functions. (3) The delegation of a function under section 158 also confers on the delegate power to do all things necessary or convenient to be done to perform that function. **Section 158 - Delegation** (1) The Principal Official Visitor may delegate any of his or her functions to an Official Visitor. (2) If the delegate under subsection (1) is a State Servant, he or she may perform the delegated functions in conjunction with State Service employment. (3) The power of delegation under subsection (1) cannot itself be delegated.	interest in the patient's welfare. (3) A complaint may be made by any available means acceptable to the Official Visitor concerned.
ACT	*Official Visitor Act 2012* (ACT) See also *Mental Health Act 2015* (ACT) Pt 12.3	Official Visitors	**Section 209** A person must not be appointed as an official visitor for a visitable place unless the person— (a) is a legal practitioner who has not less than 5 years practising experience; or (b) is a medical practitioner; or (c) has been nominated by a body representing consumers of mental health services; or (d) has experience and skill in the care of persons with a mental disorder or mental illness.	**Section 211** the adequacy of services provided at the visitable place for the assessment and treatment of people with mental disorder or a mental illness; and the appropriateness and standard of facilities at the visitable place for the recreation, occupation, education, training and rehabilitation of people receiving treatment, care or support for mental disorder or a mental illness; and the extent to which people receiving treatment, care or support for mental disorder or a mental illness at the visitable place are being provided the best possible treatment, care or support appropriate to their needs in the least possible restrictive environment and least possible intrusive manner consistent with the effective giving of that treatment, care or support; and any other matter that the official visitor considers appropriate.	**Section 214** Complaint about treatment, care or support provided at place other than visitable place **Section 213** Notice to official visitor of detainee receiving mental health treatment, care or support in correctional centre
NT	*Mental Health and Related Services Act 1998* (NT)	Principal Community Visitor and Community Visitors	**Section 103** (1) The Minister may appoint a person to be a community visitor. (2) A community visitor holds office for 3 years and is eligible for re-appointment. (3) A community visitor must have the qualifications determined by the Minister. **Section 103A(2), (3)** The Minister may terminate the appointment of a community visitor for inability, inefficiency, misbehaviour or physical or mental incapacity.	**Section 104** (1) A community visitor may inquire into and make recommendations relating to: (a) the adequacy of services for assessing and treating persons in approved treatment facilities or by approved treatment agencies; and (b) the standard and appropriateness of facilities for the accommodation, physical well being and welfare of persons receiving treatment or care at approved treatment facilities or by approved treatment agencies; and (c) the adequacy of information relating to rights of persons receiving treatment at approved treatment facilities or by approved treatment agencies and the complaint procedures under this Act; and (d) the accessibility and effectiveness of complaint procedures under Part 13; and (e) the failure of persons employed in approved treatment facilities or by approved treatment agencies to comply with this Act; and (f) any other matter that a community visitor considers appropriate having regard to the principles and objectives of this Act; and	**Section 108** Requests to see community visitors **Section 109** Reports by community visitors **Section 110** Community visitors panels

			The Minister must terminate the appointment of a community visitor if the person appointed: (a) ceases to hold a qualification that was a prerequisite for the appointment; or (b) becomes bankrupt, applies to take the benefit of any law for the relief of bankrupt or insolvent debtors, compounds with his or her creditors or makes an assignment of his or her remuneration for their benefit.	(g) any other matter as directed to the principal community visitor by the Minister. **Section 105** A community visitor is: (a) to be accessible to persons receiving treatment under this Act to hear any complaints that they may have and to resolve those complaints; and (b) to assist persons receiving treatment under this Act to make applications under this Act relating to complaints, reviews or appeals and, where appropriate, to present those applications. **Section 106** (1) A community visitor may, at any time without notice, enter an approved treatment facility or premises occupied by an approved treatment agency. **Section 107** A community visitor may, when in an approved treatment facility or the premises occupied by an approved treatment agency: (a) inspect any part of the facility or the premises; and (b) visit persons who are receiving treatment or care at the facility or from the agency; and (c) inspect documents or medical records relating to persons receiving treatment or care at the facility or from the agency; and (d) inspect any records or registers required to be kept by or under this Act.	

11.4 Consultation Data Overview

SA Mental Health Commissioner

11.4.1 A regular theme relayed to SALRI was the need for greater clarity regarding the roles and functions of the various regulatory bodies under the *MHA*. This is seen as necessary to clearly distinguish each body's roles and responsibilities. The present apparent overlap and undue complexity in the roles and functions of the various bodies was often raised to SALRI.

11.4.2 SALRI's YourSAy survey responses revealed strong support for explicitly recognising the role of MHCs in the *MHA*. Only three responses considered the role of the Commissioners to have no value, while 40 responses stated the role of MHCs should be clearly defined.

11.4.3 Nevertheless, in these three responses, there were misgivings as to the role of MHCs in South Australia. One response voiced a concern that a Commissioner could become 'corrupt'. Another noted that '[i]t appears that hospitals cannot follow the law … and there is no penalty.'

11.4.4 A third response provided that '[i]f the others did their jobs, there would be no need for the [SA]MHC!' This raised the question whether resources would be best used in defining the role and function of the SAMHC, or whether this exercise could be avoided if mental health services and workers perform according to the law and professional guidelines. Another survey response agreed with this concern, noting that 'funding for these roles could be more effectively utilised,' and suggested there would be merit in exploring the establishment of 'a Mental Health Legal Service or individual advocacy service which directly benefits consumers or carers.'

11.4.5 Alternatively, a significant proportion of respondents to SALRI's survey supported the existence of both the MHC and Commissioner and were supportive of the notion that their role should be clearly defined. SALRI agrees, noting the need for greater clarity in the *MHA* regarding the roles and functions of the MHC.

11.4.6 Another response noted that 'clearly defining the role of a Mental Health Commissioner would help to ensure that their optimal role and function is realised in practice, making a real difference to people.' This was stated in the context that there are many 'buzz words in mental health' including 'person-centred care,' 'recovery-oriented practice,' 'trauma-informed care,' which are over-used or mis-used to the detriment of consumers.

11.4.7 In the MHC's submission to SALRI, they agreed it is 'vitally important' that their role and functions be 'clearly defined and enshrined in legislation.'

11.4.8 Further, the MHCs advised SALRI that 'the present legislation has a focus on mental ill health and the Commissioners believe that a significant focus of our work should be on mental health promotion and prevention.' Accordingly, the MHC submitted that the key objectives enshrined in legislation should be to:

- Drive efforts to reform mental health in South Australia by working with partners to influence decision making, set goals and transform systems and supports to improve people's mental health and wellbeing.

- Engage and liaise with a broad range of communities and the mental health sector to identify and report on concerns, trends and opportunities within the mental health and wellbeing space.
- Raise mental health awareness and understanding through high impact promotion and education in families, schools, universities, workplaces, and communities.
- Facilitate community-based prevention and early intervention mental health research projects to identify promising practice and build the evidence base for prevention activities and a broad mental health prevention strategy.
- Maintain a whole-of-government policy monitoring, review and reporting role for mental health policy including Mental Health Services Plan and Suicide Prevention Plan in order to evaluate progress towards improving the overall mental health of all South Australians.'

11.4.9 The MHCs also raised their preference of having their roles and functions 'reflected in a standalone legislative framework', consistent with the models in Queensland,[2676] and New South Wales.[2677] Alternatively, it may be inserted into the *MHA*.

11.4.10 Regardless of whether the role and functions of the MHC are enshrined in the *MHA* or in standalone legislation, the MHCs suggested the model offered by the Commissioner for Children and Young People in the *Children and Young People (Oversight and Advocacy Bodies) Act 2016* (SA) is a suitable template to be adopted. They explained:

> The Commissioner for Children and Young People is a statutory officer independent from direction or control by the Crown. The Commissioner promotes and advocates for the rights, development and wellbeing of all children and young people in South Australia. The Commissioner is committed to advocating for children and young people's involvement in decision-making that affects them, with consideration given to those children and young people who are considered vulnerable and whose ability to make their views known is limited.

11.4.11 They further explained that the Commissioner for Children and Young People has a number of key responsibilities that are similar in nature to the MHCs. In particular, 'engagement, awareness raising, advocacy, monitoring and research.'

11.4.12 It is outside the scope of SALRI's review to assess the suitability of the *Children and Young People (Oversight and Advocacy Bodies) Act 2016* (SA) as a model for amendments to the *MHA* regarding the MHCs. However, SALRI reiterates its position that the role, functions, constitution, appointment and removal of the MHC should be added as a new standalone Division in the *MHA*. An alternative option would be the establishment of a standalone Act for the role and operation of the MHC. However, SALRI is of the view that a new division of the *MHA* is preferred, as the MHC's roles and functions are closely linked with the *MHA*.

11.4.13 Further responses from the survey stated that the role of the Commissioner 'should be more clearly defined so that it is clear that [they are] responsible for upholding the rights of persons with disability and mental health conditions,' and that 'a Mental Health Commissioner potentially has a crucial role and function, especially in terms of the various treatment, service and accountability issues previously discussed.'

[2676] *Queensland Mental Health Commission Act 2013* (Qld).

[2677] *Mental Health Commission Act 2012* (NSW).

11.4.14 The Lived Experience Leadership and Advocacy Network ('LELAN') also promoted clarity in the Commissioners' role:

> A Mental Health Commission should be and have the appropriate powers as a statutory body to ensure legislated obligations, independent authority and clear processes and practices for accountability across service systems to be upheld.

11.4.15 LELAN submitted they support a Mental Health Commission with statutory powers and protected independence 'which aligns with models in other jurisdictions'. In particular, LELAN offered the New Zealand Mental Health Commission as a model which South Australia could emulate. Importantly, it was noted that New Zealand also has a 'mixed history of changed place and importance in the mental health ecosystem before re-emerging stronger in 2021.' LELAN explained:

> The objective of the New Zealand Commission is 'system-level oversight, monitoring and advocacy'. The primary strength that it has in comparison to Australian Commission's is the focus on system accountability – beyond advisory, systems planning or commissioning functions. This is most clearly demonstrated through the publication of service monitoring and performance reports4 matched to previous Inquiry recommendations.

11.4.16 In circumstances where South Australia legislates the role of the Mental Health Commission (regardless of whether it relies on New Zealand as a model), LELAN recommended that the role of persons with lived experience should be strengthened and mandated in the Commission.

11.4.17 A survey response provided by LELAN noted:

> Independent advocates, independent statutory bodies and Community Visitors would result in:
>
> - Increased rights for consumers and families – accountability of mental health services ...
> - More recovery, less restriction, more safety and care ...
> - Documentation from an objective perspective that can be used for accountability.

11.4.18 This was reinforced by Lived Experience Australia, who argued '[t]here is a real need for an independent accountability entity that can ensure the rights of people are protected.' In light of this, they emphasised '[t]he independence of the Mental Health Commissioner role is paramount if the community is to trust the integrity of the role; they cannot simply be there to reinforce the views of the bureaucracy of the politics of the day.'

11.4.19 Consistent with views regarding independence and accountability, the Disability Rights Advocacy Service stated:

> The *MHA* must be updated to include more transparency and oversight measures. The legislation should provide the ability for the Mental Health Commissioner to conduct five yearly audits of mental health facilities to ensure they are following the *MHA* adequately and that the rights and interests of inpatients are respected as per the Objects and Principles of the Act. A report of the audit must be tabled in Parliament and be made publicly available.

11.4.20 The Public Health Association of Australia previously advocated to retain the independence of the MHCs and what was the SAMHC. However, the activities of the SAMHC now operate under Wellbeing SA. MHCs play an important role in holding the 'government to account for the performance and quality and safety of the mental health and wellbeing system'. The Public Health Association of Australia recommended that the role of the MHCs should be defined in the *MHA*, and

the Commissioners ought to provide the ability to implement the Mental Health Strategic Plan as originally intended.

11.4.21 The Office of the Public Advocate submitted:

> Commissioner roles are usually statutory officers and, therefore, a mental health commissioner should be included in the *MHA*. The scope, role, and responsibilities (particularly with respect to its interface with the Chief Psychiatrist and the Department of Health and Wellbeing) must be clear.

11.4.22 The Commissioner for Aboriginal Children and Young People 'welcomes the inclusion of the Mental Health Commissioner's role and function in the Act and considers the role will promote mental health and wellbeing of all South Australians as a priority and strengthen oversight and accountability mechanisms.'

11.4.23 The South Australian Child and Adolescent Health Community of Practice noted to SALRI that greater clarity and detail is warranted regarding the application of the *MHA* for children. In particular:

> The roles of the Mental Health Commissioner, Commissioner for Aboriginal Children and Young People, the Commissioner for Children and Young People and the SA Health Chief Child Protection Officer should be clearly defined and should be involved in any decision around mental health child monitoring.

11.4.24 The Aged Rights Advocacy Service favoured the inclusion of the Mental Health Commissioner's role and function in the *MHA* and 'considers the role will promote mental health and wellbeing of all South Australians as a priority and strengthen oversight and accountability mechanisms'.

11.4.25 A community member said the role of a Mental Health Commissioner should be clearly defined under the *MHA*, stating '… not everyone knows the difference between the OCP or the MHC or their roles. A clear definition would help with that.'

11.4.26 The RANZCP supported 'the need for an independent accountability entity which can ensure the rights of people are protected.' Further, they submitted '[t]he implementation of the Mental Health Commissioner as a statutory role would help to ensure that role's independence, and hence community confidence in its integrity and non-reliance on the bureaucracy or current Government.'

11.4.27 The Rural and Remote Mental Health Service favoured greater clarity regarding the role of the MHC, but sounded a cautionary note:

> The role of a Mental Health Commissioner is a key consideration when looking at shifting the focus of the *MHA* toward encouraging good mental health and wellbeing. In particular, whether the role and function/s of a Mental Health Commissioner should be clearly defined in the *MHA*. The Commissioners are currently appointed for a three year term to the South Australian Mental Health Commission, to assist in meeting the aims of the South Australian Mental Health Strategic Plan. These aims relate to improving the quality and delivery of mental health services, education and awareness and promoting person-centred care ... The role of the Mental Health Commissioners in South Australia is relatively new and their role and purpose has varied between Governments. Before their role(s) and power(s) are enshrined in legislation, a collaborative discussion across the sector between all stakeholders (consumers, carers, advocates, mental health services, Chief Psychiatrist, Department for Health and Wellbeing, Wellbeing SA, Principal Community Visitor/Public Advocate, Health and Community Services Complaints

> Commissioner, the Ombudsman etc) must be had and a consensus established, so that the Commissioners have a valid and enhancing role, not one with duplicates or interferes with the roles of other people, officers or agencies. It may be that the roles and functions of the Commissioners are not needed, or that it is more of a symbolic and public facing role which does not require legislated powers.

11.4.28 Mind Australia saw value in statutory clarity for the nature of the MHC role:

> Governance and accountability arrangements should be clearly defined in the Act. A Commissioner, if established in legislation, should have a role in monitoring the system and holding services to account for delivering high-quality services which meet the principles of the Act. They should also provide a place for complaints to be made by consumers, with those complaints investigated and determinations made. A Commissioner should also have a role to play in facilitating feedback and recommendations on how services could be improved in a way which protects the human rights of those accessing services, and assures quality.

11.4.29 In relation to the role of the MHC and the HCSCC, Lived Experience Australia suggested:

> Consideration could be given to strengthening the Health and Community Services Complaints Commission's role to undertake this work. Currently the Commission can conduct investigations but only make recommendations with no powers to enforce them.

11.4.30 SALRI notes the widespread support for the role of the MHC to be clearly defined and placed on an explicit statutory basis. This support was also observed in the YourSAy survey responses, which revealed a majority consensus on the benefit of retaining the role of the Commissioner and the need for a clear definition of their role and duties in the context of the whole mental health system.[2678] SALRI's Government Roundtable also revealed wide support for a clear definition of the MHC's roles and functions be placed on a statutory basis.

11.4.31 SALRI is of the view that it would be premature to explicitly identify and define the scope and roles/functions of the new statutory MHC. Rather, SALRI agrees with the Rural and Remote Mental Health Service, who observed this will require further consideration and consultation with interested parties.

11.4.32 Despite this, SALRI has proposed one function of the MHC. SALRI recommends that the present powers of inspection held by CVs under Part 10 of the *Health Care Act 2008* (SA)) should be removed and transferred to the new statutory MHC. This is consistent with SALRI's conclusions regarding the advocacy role of the CVS and the need to avoid duplication of functions. In light of the close connection between the current MHC role and the *MHA*, the transfer of inspection powers, due to the expertise and mental health knowledge of the MHC is appropriate. SALRI's review also indicated that the existing functions of the other statutory bodies or offices should not be unnecessarily duplicated in the MHC. Following this, matters of a clinical nature are appropriately vested with the OCP and should remain as such.

[2678] See SALRI Recommendation 51 and 52.

Community Visitor Scheme

11.4.33 The current PCV offered the following insight into the importance of the CVS:

> Through its independent oversight and advocacy, the CVS provides an important safeguarding function for people receiving care in a mental health treatment centre or hospital, or attending a community mental health facility.

11.4.34 There was broad support in SALRI's consultation for the advocacy role, whether individual or systemic, of the CVS. However, there were concerns regarding the extent of their powers, notably those pertaining to clinical matters, such as their powers of inspection, enabling access to medical records and inquiring into the treatment of consumers.

11.4.35 There has been further acknowledgement of the value of the CVS role in the context of disability services.[2679] One recent review noted that 'the feedback from stakeholders about community visiting outcomes for people with disability was consistently positive in all jurisdictions and across the different consultation methods.'[2680] The review further provided:

> The broad purpose common to all CVS is to visit people with disability and independently determine if their human rights are being met by the service systems they rely on. The importance of doing this with independence from the service system and governments' political imperatives was emphasised throughout the consultation informing the Review … At their best, CVS achieve important outcomes for people with disability in services, encouraging them to express their views, listening, building capacity in asserting rights or linking with supported decision-making processes and advocates. Visiting in person and talking assists people with disability to build confidence and experience in expressing their views and needs ...[2681]

11.4.36 Reiterating the significance of the services and support the CVS provide, a survey response noted: 'I would loved [*sic*] it if someone had of [*sic*] helped me talk through my fears, and explained that someone would be there if I ran into trouble.'

11.4.37 Julian Gardner described the role of the CVS under the *MHA* in the following terms:

> Community visitor schemes in South Australia and in other Australian jurisdictions were established to assist in discharging the duty of the state to protect vulnerable citizens. Mental illness can adversely impact on a person's cognitive and emotional capacity, making them less able to protect themselves and therefore more vulnerable to abuse and neglect. Some patients also experience significant restrictions on their human rights by being made subject to involuntary treatment and detention. Not only does this increase their vulnerability but it imposes an obligation on the state to ensure that their rights are respected and that their treatment is appropriate to their needs.[2682]

11.4.38 Mr Gardner further elaborated on the role and rationale of the CVS:

> Mental health facilities care for and in some cases confine vulnerable citizens. There are those who, while voluntarily in a facility, may, because of their mental illness, lack their usual cognitive

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[2679] See Julian Gardner, *Review of the Community Visitors Scheme* (8 March 2019) 7.

[2680] Alison Plant et al, *Community Visitor Schemes Review Department of Social Services for the Disability Reform Council, Council of Australian Governments: Final Report* (December 2018) 25.

[2681] Alison Plant et al, *Community Visitor Schemes Review Department of Social Services for the Disability Reform Council, Council of Australian Governments: Final Report* (December 2018) 25–6.

[2682] Julian Gardner, *Review of the Community Visitors Scheme* (8 March 2019) 8.

> and emotional capacities to protect themselves from neglect, harm or mistreatment … It is the role of CVs to provide an external, independent monitoring of mental health facilities to ensure that vulnerable people are treated with respect, that any restriction on their human rights is as minimal as necessary and that their care is of the highest reasonable standard.
>
> This role is discharged in two distinct ways. The first is that of inspection and the second is that of advocacy. The latter role in the CVS is limited in its scope but nevertheless invaluable. It means that a vulnerable person is able to talk in confidence to someone who has an official position but, of critical importance, is independent of the facility in which they are held. Not only can that person receive some reassurance and comfort from contact with an independent person but also it is possible for CVs to follow up and resolve matters that are troubling the person.[2683]

11.4.39 Various consultees, such as the Rural and Remote Mental Health Service, the Aged Rights Advocacy Service and the Australian Nursing and Midwifery Federation ('ANMF'), saw the benefit of the CVS role to provide further accountability and transparency for consumers. The ANMF suggested the CVS:

> … can be improved to enhance access to Community Visitors and its efficiency by supporting and the provision of additional funding to expand its safeguarding role for this vulnerable population to include NGO and private providers.

11.4.40 Mind Australia saw the value of the CVS role, stating:

> In our experience, people having access to advocates is a way of supporting supported decision-making. Further, being able to bring advocates with them can improve people's access to services and supports, and enhance their understanding of the care and support being provided as well as how the system operates. Advocates with a lived experience bring an added perspective that may be helpful.

11.4.41 The SA Health Lived Experience Workforce favoured further accountability for CVS reports, how they are actioned and how recommendations are implemented.

11.4.42 It was also recommended that SALRI consider prescribing a new model for the inspection of community mental health facilities, such as requiring the service to actively inform consumers of a CVS visit and assisting to schedule meetings. This could result in a more informative and valuable visit rather than relying on the mere possibility of consumers being present at CV visits. SALRI recognises these suggestions and notes the precise details of a CVS model fall outside the scope of SALRI's current review.

Improving Access to and Efficiency of the CVS

11.4.43 SALRI's YourSAy survey revealed little consensus as to how the CVS could be improved. Of the responses received, 35 respondents specifically noted they were unsure of how the CVS should be improved. SALRI argues this is a strong indication regarding the lack of awareness and understanding of the CVS's role in mental health.

11.4.44 Mr Gardner noted 'an examination of the functions of CVs under the *MHA* does not adequately address the question of the nature of the CVs' role.'[2684] It was also found that any of the

[2683] Ibid 6–7.

[2684] Julian Gardner, *Review of the Community Visitors Scheme* (8 March 2019) 6.

CVS's current functions should not be discharged only by persons with specialist mental health qualifications.[2685]

11.4.45 The Disability Rights Advocacy Service stated:

> The Community Visitor Scheme should be expanded under the *MHA* sections 50–54 as outlined above so that advocates have a right of entry to mental health facilities to support clients and advocate on their behalf. This includes adequate telecommunication contact and visiting inpatients in facilities. State Government may also wish to legislate stand-alone CVS legislation to provide consistency across the application of a Scheme across mental health facilities, disability care facilities, aged care, supported independent living or specialist disability accommodation, among other things.

11.4.46 The Public Health Association of Australia supported amendments for CVs to be notified of a request at an absolute maximum of two days. They further recommended that paid employees should be able to act in place of the PCV as a means of enhancing the efficiency of the process.

CVS Training and Education

11.4.47 SALRI's consultation revealed some suggestions for changes to the CVS role. For example, nine survey respondents raised the need for increased training and education of CVs. Many emphasised this is paramount. Further, it was suggested there is a need for better communication and dissemination of information to consumers regarding their rights and ability to request visitors, and the process of doing so. For example, in SALRI's Nursing and Social Work Roundtable, a majority of attendees were not aware of the CVS role in offering individual advocacy and agreed the CVS was not advertised well. Attendees also raised the value of formalising a Lived Experience consultant and Carer consultant role to offer advocacy services to consumers.

11.4.48 The PCV submitted that '[t]he ongoing training and development of CVs is crucial to the performance of the scheme. At present the PCV has limited options for directing CVs to participate in ongoing training and development.' Further, the PCV noted that CVs 'may be required to follow the directions of the PCV via the Conditions of Appointment, however, there is limited enforcement power available to the PCV if a CV fails to undertake training.'

11.4.49 SALRI views this as a significant deficit in the current CVS, which requires further review.

11.4.50 Mr Gardner's Review of the CVS also addressed issues relating to training:

> The suggestion that community visitors should be trained in mental health care raises the question 'to what level?' *It does not need to be to a level that would enable them to provide mental health care nor to a level at which they could undertake accreditation assessments or reviews of clinical governance. Such is not their role.* Community visitors should be and are already trained in mental health care to the extent necessary for their role. The training covers a broad understanding of mental illness, its impact on their role and on the relevant provisions of the *MHA*. There are, however, opportunities for improvement in expanding the training in mental health care. Community visitors form views about the level of care and treatment and whether it meets the standards that should be reasonably expected in current practice. There is an absence of documentation and clarity about what those standards are and the potential for assessments to be subjective and inconsistent. Therefore, it is recommended

[2685] Ibid 18.

that community visitors should also have training in the standards of treatment and care that they should expect to observe in their visit.[2686]

11.4.51 In its submission to SALRI, the PCV advocated that the *MHA* should 'explicitly require CVs to undertake ongoing training and development as directed/required by the PCV. This will ensure a high level of participation in training and maintain a high level of skills and knowledge among the CV group.'

11.4.52 SALRI's consultation also raised issues regarding the operation of the CVS, such as:

- The PCV has no power of suspension;
- The tenures of CVs are easily extended; and
- There is no power to suspend or effect the appointment of a CV. This requires the input of both Houses of Parliament, which is far too high a threshold to meet in practice.

11.5 SALRI's Observations and Conclusions

11.5.1 SALRI examined whether the role of the MHC should be defined in the *MHA* or elsewhere. There is no present statutorily defined role of the SAMHC and MHC in the *MHA*. This has created confusion, complexity and dissatisfaction in relation to the regulatory value offered by the MHCs regarding mental health services in South Australia. SALRI was also asked to consider the ways in which the CVS could be improved. The present apparent overlap and undue complexity in the roles and functions of the various bodies under the *MHA* was often raised to SALRI.

11.5.2 In order to address these issues, SALRI examined the regulatory bodies currently operating in relation to mental health. This enabled SALRI to determine the ways in which regulatory oversight could be improved and clarified.

11.5.3 SALRI also notes that further consideration is required, relating to access and operation of the MHC role and CVS for people living in regional, rural and remote settings.

11.5.4 SALRI's consultation raised a number of views relating to the degree of overlap and apparent undue complexity in the roles and functions of the various regulatory bodies under the *MHA*. Particular reference was made to the roles of the Chief Psychiatrist, the CVS, the MHCs and the HCSCC. It was raised that the various regulatory bodies perpetuated confusion amongst consumers and their families, who supported a mental health specialist advocacy service and a clearer complaints pathway.

11.5.5 In SALRI's consultations with the OCP, the PCV, the MHCs and the HCSCC, it was agreed that there is overlap and complexity regarding their respective roles/functions. As a result, all parties agreed this supported and strengthened the need for greater statutory clarity.

11.5.6 SALRI agrees and is of the view that greater clarity is necessary in the *MHA* as to the respective roles and functions of key agencies, notably the OCP,[2687] the MHCs, the CVS and the HCSCC.

[2686] Julian Gardner, *Review of the Community Visitors Scheme* (8 March 2019) 3 (emphasis added).

[2687] To promote a greater emphasis on child and adolescent mental health, SALRI also recommends that the OCP establish a Child and Adolescent Mental Health Committee: see SALRI Recommendation 55.

11.5.7 Recommendations

RECOMMENDATION 50

SALRI recommends that the Office of the Chief Psychiatrist should establish a Child and Adolescent Mental Health Committee.[2688]

RECOMMENDATION 51

SALRI recommends that greater clarity is necessary in the *Mental Health Act 2009* (SA) as to the respective roles and functions of key agencies, notably the Office of the Chief Psychiatrist, the Mental Health Commissioner(s),[2689] the Community Visitor Scheme and the Health and Community Services Complaints Commissioner.

A Statutory Basis for the Role and Functions of the Mental Health Commissioner

11.5.8 In December 2022, the Minister for Health, the Hon Chris Picton MP, stated that the role of the MHC will revert to one full-time Commissioner.[2690] SALRI has noted this significant development. However, the Commissioner's method of appointment and proposed role remains undefined. It is also unclear what functions or powers are to be assigned to the one future Mental Health Commissioner.

11.5.9 There was strong support to retain the MHCs in South Australia and provide a statutory basis for their role and functions. Some parties expressed support for their role and functions to be legislated within the *MHA*. In contrast, the MHCs preferred a standalone Act. Other parties did not explicitly favour a statute, but reinforced the need for independence and accountability.

11.5.10 In relation to a legislative framework to establish the role of the MHCs, SALRI notes other Australian jurisdictions provide examples of a statutory role for MHCs, including their functions and powers. For example, as raised by the MHC in their submission, the standalone *Queensland Mental Health Commission Act 2013* (Qld) includes the following helpful provisions:[2691]

> The object of this Act is to establish the Queensland Mental Health Commission to drive ongoing reform towards a more integrated, evidence-based, recovery-oriented mental health and substance misuse system.[2692]
>
> To achieve this object, the Queensland Mental Health Commission drives innovation and best practice through knowledge sharing, research and evidence-based policy and practice; and encourages integration of relevant services.[2693]

[2688] SALRI notes that the OCP has various Committees, but not one with a focus on child and adolescent mental health.

[2689] Stephanie Richards, *Full-Time Mental Health Commissioner to be appointed in SA* (15 December 2022) In Daily <https://indaily.com.au/news/2022/12/15/full-time-mental-health-commissioner-to-be-appointed-in-sa/>.

[2690] Ibid.

[2691] See also Table 7: Comparison of Mental Health Commissions and Equivalent Entities.

[2692] Queensland Mental Health Commission Act 2013 (Qld) s 4(1).

[2693] Ibid s 4(2)(a).

Persons implementing the provisions of this Act must have regard to the guiding principles of the Act.[2694]

In the exercise of its functions the Queensland Mental Health Commissioner must consider the following:

- Systemic mental health and substance misuse issues;
- Comorbid issues including disability, chronic disease and homelessness;
- Issues for people with mental health and substance misuse issues in the criminal justice system;
- The particular views, needs and vulnerabilities of different sections of the Queensland community, including Aboriginal and Torres Strait Islander communities, CALD communities, regional and remote communities, other groups at risk of marginalisation and discrimination; and
- Contemporary evidence and relevant policy and strategic frameworks.[2695]

11.5.11 In addition, the Queensland model defines the powers of the Queensland Mental Health Commission:

The Queensland Mental Health Commission has the power to:

- enter into contracts; and
- acquire, hold, deal with and dispose of property; and
- appoint agents and attorneys; and
- engage consultants or contractors; and
- do anything else necessary or convenient to be done in the performance of its functions.[2696]

The Queensland Mental Health Commission and relevant agencies must work cooperatively in the exercise of their respective functions.[2697]

11.5.12 SALRI commends the clarity offered by this legislative framework and considers that it would be helpful to legislate these functions and powers. In particular, SALRI supports Queensland's approach regarding the integration of mental health agencies' functions and services. This lack of integration was often raised in SALRI's consultation.

11.5.13 Some parties expressed doubt relating to the use and function of the Commissioners. The Commissioner role may be seen as duplicitous, and the need for their current investigative powers could be made redundant if mental health service delivery issues were resolved. Although it is not within the scope of SALRI's review to consider abolishing the role of the MHC, SALRI recognises the utility and value of the MHC role, notably if defined clearly and placed on a statutory basis.

[2694] Ibid s 5.

[2695] *Queensland Mental Health Commission Act 2013* (Qld) s 11(2).

[2696] Ibid s 12.

[2697] Ibid s 34(1).

11.5.14 SALRI acknowledges this review provides an opportunity to define the role, functions and powers of the MHCs within the *MHA* or elsewhere. As such, SALRI considers that the role, functions, constitution, appointment and removal of the MHC should be added as a new separate Division in the *MHA*. An alternative option would be the establishment of a standalone Act for the role and operation of the MHC. However, SALRI is of the view that a new division of the *MHA* is preferred, as the MHC's roles and functions are closely linked with the *MHA*.

11.5.15 SALRI is of the view that it would be premature to explicitly identify and define the scope and roles/functions of the new statutory MHC. It is not within the scope of SALRI's Terms of Reference to suggest the substantive amendments to the *MHA* or elsewhere in relation to the role and operation of the MHC. Rather, SALRI is of the view these amendments should preferably be determined by the MHCs, in consultation with relevant interested parties.

11.5.16 Despite this, SALRI has proposed one function of the MHC. SALRI was told by a number of parties that, whilst supportive of the advocacy role of CVs and linked powers necessary for this role, they did not favour CVs holding a clinical oversight role, viewing this clinical role as both inappropriate and undesirable. As a result, SALRI recommends that the present powers of inspection held by CVs under Part 10 of the *Health Care Act 2008* (SA)) should be removed and transferred to the new statutory MHC. This is consistent with SALRI's conclusions regarding the advocacy role of the CVS and the need to avoid duplication of functions. In light of the close connection between the current MHC role and the *MHA*, the transfer of inspection powers, due to the expertise and mental health knowledge of the MHC is appropriate. SALRI's review also indicated that the existing functions of the other statutory bodies or offices should not be unnecessarily duplicated in the MHC. Following this, matters of a clinical nature are appropriately vested with the OCP and should remain as such.

11.5.17 SALRI agrees there is a need for legislative clarity to usefully distinguish between the roles, functions and powers of the MHCs and other bodies under the *MHA* such as the CVS and the Chief Psychiatrist. SALRI considers that the roles, functions and powers of the MHC should be clearly set out and should complement, and not be in conflict with, other bodies under the *MHA* such as the Chief Psychiatrist or CVS.

11.5.18 In particular, SALRI recognises the utility of the HCSCC in providing a complaints mechanism. SALRI also notes the HCSCC may work in conjunction with the MHC, who is able to provide specialist expertise in relation to mental health related complaints.[2698] SALRI supports further consideration of the ways in which the MHCs may offer assistance to the HCSCC.

11.5.19 Recommendation

RECOMMENDATION 52

SALRI notes that particular clarity is necessary as to the role and functions of the Mental Health Commissioner(s) and therefore recommends that the role, functions, constitution, appointment and removal of the Mental Health Commissioner should be added as a new standalone Division in the *Mental Health Act 2009* (SA).

[2698] See Part 12 Guiding Principles and Accountability Mechanisms.

The CVS – Powers of Inspection

11.5.20 The role and operation of the CVS under the *MHA* was a significant issue raised in SALRI's review. The CVS plays an active and valuable role in South Australia, exercising a number of responsibilities under the *MHA*.[2699] In particular, the CVS has a significant role (and associated powers) under the *MHA* in relation to the inspection of mental health facilities.[2700] The CVS has been described as 'the eyes and ears of the Minister and as providing an early warning system to the Minister.'[2701]

11.5.21 It is beyond the scope of SALRI's review to discuss the various CVS that operate in South Australia[2702] and across Australia. It is a complex area, as SALRI has recently highlighted,[2703] compounded by ongoing changes in federal service delivery in areas such as disability and aged care. Further, there is no single CVS model – '[e]ach scheme operates differently and separately from the others in scope, scale and design.'[2704] There are 'major differences' between the CVS *MHA* roles in each State.[2705] For example, only Victoria and South Australia rely on a volunteer model, as opposed to a professional model.

11.5.22 SALRI identified an overlap in functions between the OCP and CVS. This was raised in the context of their function to inspect and report on the treatment of consumers. For example, one of the OCP's functions is to 'advise the Minister on issues relating to mental health and to report to the Minister any matters of concern relating to the care or treatment of patients.'[2706] In exercising this role, the Chief Psychiatrist has the authority to inspect the premises and operations of any 'incorporated hospital', may enter at any time; and may require the production of documents or records.[2707] It is the practice of the Chief Psychiatrist to carry out both unannounced and scheduled inspections.[2708] The focus of these inspections are clinical and technical.

11.5.23 SALRI notes that CVs are also taken to be inspectors under Part 10 of the *Health Care Act 2008* (SA). These wide powers enable CVs to access confidential patient records. This highlights an important area of overlap between the Chief Psychiatrist and CVs. SALRI's consultation revealed concerns pertaining a CV's ability to access patient records and the suitability of retaining this power.

11.5.24 There was wide support for the retention of the CVS advocacy role and the linked powers necessary in that context. SALRI also emphasises that consumers and consumer groups raised the need

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[2699] See generally *Mental Health Act 2009* (SA) Pt 8, div 2.

[2700] Ibid s 52, 52A.

[2701] Julian Gardner, *Review of the Community Visitors Scheme* (8 March 2019) 7.

[2702] The CVS also has functions in relation to disability services and State supported residential facilities.

[2703] David Plater et al, *'Autonomy and Safeguarding are not Mutually Inconsistent': A Review of the Operation of the Ageing and Adult Safeguarding Act 1995 (SA)* (South Australian Law Reform Institute, 2022) 348–349.

[2704] Alison Plant et al, *Community Visitor Schemes Review Department of Social Services for the Disability Reform Council, Council of Australian Governments: Final Report* (December 2018) 17.

[2705] Julian Gardner, *Review of the Community Visitors Scheme* (8 March 2019) 7.

[2706] *Mental Health Act 2009* (SA) s 90(1)(d).

[2707] Ibid s 90 (4), (5).

[2708] The ICAC Oakden Report was critical of the then practices of the OCP, observing that 'the statutory powers… were not exercised to the extent that they could have been': 193. Since the release of the ICAC Oakden Report, the Chief Psychiatrist implemented a more intensive program of inspections with a particular focus on those that are unannounced. The Chief Psychiatrist Inspections Policy Guideline 2019 lists three types of inspections; namely Standard inspection Comprehensive inspection and New Unit inspection. Bruce Lander KC, *Oakden: A Shameful Chapter in South Australia's History* (ICAC South Australia, 28 February 2018). See also Julian Gardner, *Review of the Community Visitors Scheme* (8 March 2019) 11.

for a mental health advocacy service in consultation. However, the ability of CVs, who are typically without medical expertise or training, accessing and reviewing highly confidential medical records, without a consumer's knowledge or consent is disquieting. The notion of CVs having the power as inspectors under Part 10 of the *Health Care Act 2008* (SA) to access the private medical records of a patient was deemed by mental health practitioners and service providers as inappropriate. SALRI considers that, with due respect to CVs, their power as inspectors under Part 10 of the *Health Care Act 2008* (SA) under the *MHA* is both unnecessary and undesirable. SALRI reiterates the focus of the CV role (and the linked powers) under the *MHA* should be advocacy – at an individual or systemic level – not clinical and technical oversight. The powers of CVs should be revised in this context and to address the current gap in relation to the absence of a specialist mental health advocacy service.

11.5.25 SALRI is of the view that the present roles and functions of the CVs in Part 9 of the *Mental Health Act 2009* (SA) should be retained (though subject to the direction of the MHC), but the present powers of inspection held by CVs under Part 10 of the *Health Care Act 2008* (SA)) should be removed and transferred to the new statutory MHC.

11.5.26 Recommendation

RECOMMENDATION 53

SALRI recommends that the present roles and functions of the Community Visitors in Part 9 of the *Mental Health Act 2009* (SA) should be retained (though subject to the direction of the Mental Health Commissioner), but the present powers of inspection held by Community Visitors under Part 10 of the *Health Care Act 2008* (SA)) should be removed and transferred to the new statutory Mental Health Commissioner.

The Advocacy Role of the CVS

11.5.27 There are challenges and benefits of the CVS role.[2709] They carry out their functions in an increasingly complex system.[2710] SALRI notes '[s]ome CVs also reported low awareness in the community with regard to the nature of their work, and suspected people who could benefit did not know how to get in touch.'[2711] Another challenge encountered was '… that of maintaining clear boundaries and not acting outside their legislative remit, including as case managers, or auditors.'[2712]

11.5.28 SALRI supports amendments to require a director of an authorised community mental health facility inform the CVS of a request within two days.

11.5.29 In their submission, the PCV recommended that 'the CVS should have authority to inquire into the care, treatment and control of consumers in community mental health facilities during a visit.' In relation to the inspection of records, they submitted:

> It is not explicit that the same powers apply to public hospitals however the CVS has legal advice that the same powers should apply across all mental health services.

[2709] Julian Gardner, *Review of the Community Visitors Scheme* (8 March 2019) 7.

[2710] Ibid.

[2711] Ibid 35.

[2712] Ibid 25.

> The powers to inspect documents should be clear and consistent across public and private services. It is suggested that the Act be amended to clearly state the powers to inspect documents.

11.5.30 SALRI respectfully disagrees with the PCV's position. Rather, SALRI accepts and agrees with the following statement of Mr Gardner:

> … it is not the function of a CV to conduct an inspection that evaluates the clinical practices of a facility. Such a role would require qualifications in mental health care. Their role does require high level communication and interpersonal skills; advocacy, negotiation and investigative skills; report writing skills; analytical skills; and high standards of ethics, integrity and commitment to promoting human rights.[2713]

11.5.31 Another review of the CVS by Alison Plant et al also agreed with this position:

> It is not a function of the CVs to monitor and review the clinical operations of the facilities that they visit. That is a function of the Chief Psychiatrist. They are not, for example, required to review the model of care or the adequacy of the system for reviewing critical incidents or the adequacy and basis for reaching a diagnosis nor to review medications that are prescribed. These are functions that would require specialist qualifications in mental health.[2714]

11.5.32 SALRI emphasises that the CVS is not the appropriate body to be dealing with clinical or technical matters. This role falls within the remit of other bodies, such as the OCP.

11.5.33 SALRI acknowledges the intention of the PCV to formalise the role of CVs to engage with, and advocate for, consumers. SALRI also recognises the advocacy role of the CVS is integral. As a result, SALRI is of the view that the role of the CVs should solely focus on providing advocacy services to consumers and patients, and appropriate measures should be taken, including any consequential amendments to the *MHA*, to standardise the role and function of CVs.

11.5.34 In relation to the CVS's advocacy role, SALRI notes the term 'advocate' requires clarification. The definition should be flexible given advocacy can vary according to the circumstances. For example, CVS advocacy may include ensuring:

- A consumer is advised of and understands their rights;
- Any safety concerns are addressed;
- Consumers are actively listened to and heard by the necessary bodies; and
- The process of making complaints is clear, with assistance available if required.

11.5.35 SALRI agrees with the views of Mr Gardner and others regarding the importance of training for CVs. Therefore, SALRI recommends that the future appointment of CVs, their functions and tenure be made by the relevant Minister, in consultation with the MHC and/or the PCV. The role and tenure of a CV should be subject to initial and ongoing appropriate training and oversight.

11.5.36 In brief, the focus of the role of CVs (and linked powers) under the *MHA* should be on advocacy, whether individual or systemic, and not on clinical or technical oversight.

[2713] Ibid 15.

[2714] Alison Plant et al, *Community Visitor Schemes Review Department of Social Services for the Disability Reform Council, Council of Australian Governments: Final Report* (December 2018) 17.

11.5.37 Recommendations

RECOMMENDATION 54

SALRI recommends that the role of the Community Visitors should solely focus on providing advocacy services to consumers and patients, and appropriate measures should be taken, including any consequential amendments to the *Mental Health Act 2009* (SA), to standardise the role and function of Community Visitors.

RECOMMENDATION 55

SALRI recommends that the future appointment of Community Visitors, their functions and tenure be made by the relevant Minister, in consultation with the Mental Health Commissioner and/or the Principal Community Visitor. The role and tenure of a Community Visitor should be subject to initial and ongoing appropriate training and oversight.

Part 12 - Guiding Principles and Accountability Mechanisms

12.1 Background

12.1.1 Section 6 of the *MHA* sets out the objects of the Act. This is supplemented by s 7 of the *MHA*, which identifies the guiding principles by which all parties involved in the administration of the Act must comply. It provides that the relevant Minister, SACAT, the Chief Psychiatrist, health professionals and other persons and bodies 'are to be guided' by these principles in the performance of their functions.[2715]

12.1.2 SALRI was asked to consider the utility of the *MHA* guiding principles, in particular to examine:

1. How these principles can be operationalised in practice;
2. Whether their translation into practice impacts a consumer's access to mental health services, and if so, how this may be improved; and
3. Accountability mechanisms to monitor compliance with the principles and enforce consequences for non-compliance.

12.1.3 A focus on the guiding principles and accountability was largely borne out of the recent Victorian Royal Commission. The intended changes to the Victorian law aimed to strengthen the objectives and principles, support access to care and treatment which is rights-based and enforce accountability mechanisms and monitoring arrangements. This was recommended in response to the lack of clear accountability mechanisms ensuring mental health principles are translated into practice.[2716]

12.1.4 The current list of guiding principles in South Australia is extensive, representing distinct human rights, best practice and desired outcomes for consumers. They serve as a foundation underpinning mental health law in SA and as an important symbolic function. Explicit endorsement of a guiding principle indicates a legislative and operational intent to adhere to a rights-based approach, promoting the rights of consumers. This was reinforced during consultation. It was noted to SALRI on more than one occasion, that guiding principles are aspirational, serving an important symbolic function. However, they are of little utility unless there is some measure under the *MHA* (and elsewhere) for accountability.[2717]

12.1.5 The guiding principles may also attempt to act as accountability measures for mental health professionals. However, if they are not translated into practice, this may prevent a consumer from receiving care and treatment which is person-centred, promoting supported decision-making and reinforced by effective accountability mechanisms.

12.1.6 It must be noted that pathways to lodge a complaint through the Australian Health Practitioner Regulation Agency, the Australian Medical Association (SA) or individual hospitals are

[2715] *Mental Health Act 2009* (SA) s 7(1).

[2716] *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021) vol 4, 32.

[2717] Parties such as Mind Australia urged SALRI to adopt the approach in the *Mental Health and Wellbeing Act 2022* (Vic).

separate complaint processes. In this Part, SALRI's discussion is limited to a complaints process regarding a failure to comply with the guiding principles. SALRI recognises principles pertaining to clinical practice and service quality may raise complaints which may be more appropriately pursued through a different complaint mechanism. For example, the Health and Community Services Complaints Commissioner or a hospital.

12.1.7 SALRI's consultation revealed the importance of the present guiding principles, reinforcing their utility. However, many argued they are inadequate in various respects. Views raising their inadequacy noted they are not explicit, lack clarity and fail to address some principles, such as dignity of risk.

12.1.8 Another recurring theme in SALRI's consultation related to the content of the guiding principles within the *MHA* and most notably, how these principles can be enforced in practice. This theme was often accompanied by the need for an accountability mechanism under the *MHA*. SALRI notes an accountability mechanism would serve three purposes:

1. To monitor and ensure the guiding principles are translated into practice;
2. To identify cases of non-compliance and enforce consequences;[2718] and
3. To evaluate the operational effectiveness of the guiding principles. This refers to fulfilment of the intended outcome of a principle in practice.

12.1.9 In determining an appropriate method for enforcement of principles, subsequent monitoring and oversight, SALRI considered the existing regulatory frameworks within the *MHA* and mental health system. Specifically, the roles of the Chief Psychiatrist and the Community Visitor Scheme are established under the *MHA*. In addition, the Mental Health Commissioners and the Health and Community Services Complaints Commissioner also provide a regulatory and oversight role. SALRI's consultation revealed overlap and duplication of functions, creating complexity and confusion regarding each body's role, as well as a lack of statutory clarity.[2719]

12.1.10 The *MHA* is one of few legislative instruments which enables interference with individual rights. As a result, it is integral that the legislation remains aligned with human rights principles. SALRI recognises that any interference with a human right, must be necessary, reasonable and proportionate. For example, in Victoria, the *Charter of Human Rights and Responsibilities Act 2006* (Vic) requires a statement of compatibility for any Bill introduced to Parliament.[2720] Where there are proposed laws that may be incompatible with human rights, the 'nature and extent' of that incompatibility must be identified and discussed.[2721] Careful consideration must be given to laws that authorise any interference with human rights. This strengthens the need for a 'rights-based' instrument and the inclusion of safeguards, oversight and accountability mechanisms.

12.1.11 It is in this context that the *Convention on the Rights of Persons with Disabilities* ('*CRPD*') has had a significant influence on mental health law in Australia. Since its ratification in 2008, this led to widespread reform in Australia and the introduction of the *MHA*. The *CRPD* was established to 'promote, protect, and ensure the full and equal enjoyment of all human rights and fundamental

[2718] SALRI's consultation revealed wide support for a mechanism that enforced consequences for a failure to comply with a guiding principle.

[2719] See SALRI Recommendation 51.

[2720] *Charter of Human Rights and Responsibilities Act 2006* (Vic) s 28(1).

[2721] Ibid s 28(3)(b).

freedoms by all persons with disabilities, and to promote respect for their inherent dignity.'[2722] In the context of mental health law, the introduction and implementation of the *CRPD* has advocated for a shift from the 'best-interest', 'risk-focused' approach to 'rights-based' approach.

12.1.12 In response to this shift and criticisms that the previous *Mental Health Act 1993* (SA) lacked 'a sufficient focus on consumer rights',[2723] the *Mental Health Bill 2008* (SA) was introduced. A key feature accompanying this Bill were the guiding principles. These principles were 'designed to provide guidance to all persons and bodies involved in the administration of the Act'[2724] and include mention of the quality of services,[2725] the importance of voluntary treatment,[2726] and contemplation of 'least restrictive' involuntary treatments where consistent with efficacy and public safety.[2727] Section 7 also crucially requires mental health services to be 'provided in accordance with international treaties and agreements to which Australia is signatory'.[2728]

12.1.13 Although the *MHA* was underpinned by the *CRPD*, the law remained subject to the legislative intention of lawmakers at the time, which was to:

> … provide a framework for the care and treatment … of the small minority of people [three percent] who are unwilling to accept treatment even though they may be placing their own safety or the safety of others in jeopardy.[2729]

12.1.14 In particular, as the relevant Minister observed in the Legislative Council:

> … the *Mental Health Bill 2008* incorporates provisions which bring South Australia into line with contemporary approaches to the management of serious mental health issues and includes innovations designed to assist people to obtain assistance in a manner which *aims to minimise the extent to which their freedom is curtailed and to protect their rights*.[2730]

12.1.15 In contrast to the *MHA*, the *CRPD* 'represents a fundamental shift from seeing persons with disability[2731] as merely objects of rights, entitled only to be protected and cared for, towards subjects of all human rights'.[2732] Article 25 of the *CRPD* emphasises the right of persons with disability to 'the enjoyment of the highest attainable standard of health', which obliges State parties to '…to provide access to health services… [and] to ensure those services are… adapted to provide equal protection and benefit.'[2733] The *CRPD* is a major advancement, representing the template exemplar for a rights-based legislative instrument. However, both the Convention and accompanying commentary

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[2722] *Convention on the Rights of Persons with Disabilities*, UN GAOR 61st sess, plen mtg 76, Agenda Item 67(b), UN Doc RES A/61/106 (3 May 2008, adopted 24 January 2007) art 1. See further Part 2 Background and Context to South Australia's Mental Health Laws.

[2723] South Australia, *Parliamentary Debates*, Legislative Council, 4 June 2008, 3096–118 (Gail Gago).

[2724] Ibid.

[2725] *Mental Health Act 2009* (SA) s 7(1)(a), (ab).

[2726] Ibid s 7(1)(b). SALRI notes that discussion of the *Mental Health Act 2009* (SA) often focuses on involuntary treatment in the form of ITOs and CTOs, but the great majority of persons with mental illness seek voluntary treatment and voluntary and informed treatment should obviously be encouraged.

[2727] Ibid s 7(1)(b).

[2728] Ibid s 7(1)(ac). See further Part 2 Background and Context to South Australia's Mental Health Laws.

[2729] South Australia, *Parliamentary Debates*, Legislative Council, 4 June 2008, 3096–3118 (Gail Gago).

[2730] Ibid (Gail Gago) (emphasis added).

[2731] A person with a lived experience of mental illness falls within the remit of the *CRPD*.

[2732] Yun Ju Song et al., 'Missing in action: the right to the highest attainable standard of mental health care' (2022) 16 *International Journal of Mental Health Systems* 26, 27 (emphasis added).

[2733] Ibid.

remain subject to debate in their application to persons with a lived experience of mental illness and in particular, the role of substitute decision-making and involuntary treatment.[2734]

12.1.16 Critics of Australian mental health laws argue the retention of involuntary treatment and risk-based assessments in the law represents a significant departure from its obligations under the *CRPD*.[2735] In particular, the Committee on the Rights of Persons with Disabilities ('the Committee') has stated:

> Persons with intellectual or psychosocial impairments are frequently considered dangerous to themselves and to others when they do not consent to and/or resist medical or therapeutic treatment … persons with disabilities are frequently denied equal protection under [criminal and other laws in place to deal with matters of risk of harm] by being derogated to a separate track of law, mental health laws. These laws commonly have a lower standard when it comes to human rights protection, and are incompatible with Article 14 of the Convention … decisions about medical and psychiatric treatment must be based on a determination of the person's autonomy, will and preferences. Deprivation of liberty on the basis of impairment or health conditions in mental health institutions which deprives persons with disabilities of their legal capacity also amounts to a violation of Article 12 of the Convention.[2736]

12.1.17 In the Australian context, the Committee recommended that Australia should:

> … repeal all legislation that authorises medical intervention without the free and informed consent of the persons with disabilities concerned, committal of individuals to detention in mental health facilities, or imposition of compulsory treatment, either in institutions or in the community, by means of Community Treatment Orders.[2737]

12.1.18 Under this interpretation of the *CRPD*,[2738] which has far from universal acceptance, South Australia's present scheme for substitute decision-making and involuntary treatment under the *MHA*

[2734] Sascha Callaghan and Christopher Ryan, 'An Evolving Revolution: Evaluating Australia's Compliance with the Convention on the Rights of Persons with Disabilities in Mental Health Law' (2016) 39(2) *University of New South Wales Law Journal* 596; George 'Involuntary Detention and Treatment: Are We Edging Toward a "Paradigm Shift"?' (2020) 46(2) *Schizophrenia Bulletin* 231.

[2735] Bernadette McSherry, 'Mental Health Laws: Where to from Here?' (2014) 40(1) *Monash University Law Review* 175; Anna Arstein-Kerslake and Eilionóir Flynn, 'The General Comment on Article 12 of the Convention on the Rights of Persons with Disabilities: A Roadmap for Equality before the Law' (2015) 20(4) *International Journal of Human Rights* 471; Piers Gooding, Bernadette McSherry and Cath Roper, 'Preventing and Reducing "Coercion" in Mental Health Services: An International Scoping Review of English-Language Studies' (2020) 142(1) *Acta Psychiatrica Scandinavica* 27.

[2736] Committee on the Rights of Persons with Disability, 'Guidelines on article 14 of the Convention on the Rights of Persons with Disabilities: The right to liberty and security of persons with disabilities' (Adopted in September 2015, 14th session) 3.

[2737] Committee on the Rights of Persons with Disabilities, *Concluding Observations on the Initial Report of Australia*, 10th sess, 118th mtg, UN Doc CRPD/C/AUS/CO/1 (21 October 2013) 5 [34]. See further Part 2 Background and Context to South Australia's Mental Health Laws.

[2738] John Dawson, 'A Realistic Approach to Assessing Mental Health Laws' Compliance with the UNCRPD' (2015) 40 *International Journal of Law and Psychiatry* 70, 72–73; Sascha Callaghan and Christopher Ryan, 'An Evolving Revolution: Evaluating Australia's Compliance with the Convention on the Rights of Persons with Disabilities in Mental Health Law' (2016) 39(2) *University of New South Wales Law Journal* 596; George 'Involuntary Detention and Treatment: Are We Edging Toward a "Paradigm Shift"?' (2020) 46(2) *Schizophrenia Bulletin* 231. See further Part 2 Background and Context to South Australia's Mental Health Laws.

is arguably inconsistent with international human rights principles, due to a lack of respect for an individual's will and preferences.[2739]

12.1.19 The World Health Organisation also emphasises the need for mental health treatment to preserve consumers' autonomy in decision-making, and has recognised the tension between the *CRPD* and common mental health practice:

> The *CRPD* commits countries to recognising that people with mental health conditions enjoy legal capacity on an equal basis with everyone else. And yet involuntary hospital admissions, and care against the wishes of someone experiencing a mental health condition, are routinely and widely practiced across the world … Today, in all countries, decisions made by clinicians or other officials can legally supersede the preference of individuals with mental health conditions, which can lead to them being detained against their will and forced to have treatment.[2740]

12.1.20 Despite such statements, Australia has made its view clear, concluding the *CPRD* does not preclude recourse to substitute decision-making and involuntary treatment. Australia declared:

> … its understanding that the Convention allows for fully supported or substituted decision-making arrangements, which provide for decisions to be made on behalf of a person, only where such arrangements are necessary, as a last resort and subject to safeguards.[2741]

12.1.21 This approach has been adopted by the ALRC[2742] and also aligns with SALRI's view, as stated earlier in this Report.[2743] Consistent with this view, 'leaving a person untreated, tormented by auditory hallucinations and delusions and at great risk of harm is not compatible with international conventions on human rights.'[2744] Similar views have been supported in other jurisdictions, including Norway, Estonia and Canada,[2745] as well as New England and New Zealand.[2746]

[2739] Committee on the Rights of Persons with Disabilities, *General Comment No 1: Article 12: Equal Recognition before the Law*, 11th sess, UN Doc CRPD/C/GC/1 (11 April 2014) at [7], [29].

[2740] World Mental Health Organisation, *World Mental Health Report* (2022) 88.

[2741] *Convention on the Rights of Persons with Disabilities*, UN GAOR 61st sess, plen mtg 76, Agenda Item 67(b), UN Doc RES A/61/106 (3 May 2008, adopted 24 January 2007). See also Australian Law Reform Commission, *Equality, Capacity and Disability in Commonwealth Laws* (Final Report, August 2014) 48–9. See also Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, 'Part 1 – Australia's position and interpretive approach', *The Australian Government's Background Paper on the United Nations Convention on the Rights of Persons with Disabilities* (16 June 2020) 11. See also 'Attachment A – Australia's Interpretative Declaration on the Convention on the Rights of Persons with Disabilities.' One example is where a person lacks decision making capacity. George Szmukler, Rowena Daw and Felicity Callard, 'Mental Health Law and the UN Convention on the Rights of Persons with Disabilities' (2014) 37(3) *International Journal of Law and Psychiatry* 245; George Szmukler, 'Involuntary Detention and Treatment: Are We Edging Toward a "Paradigm Shift"?' (2020) 46(2) *Schizophrenia Bulletin* 231. The Committee on the Rights of Persons with Disabilities has recommended that Australia review these declarations 'with a view to withdrawing them,' see Committee on the Rights of Persons with Disabilities, *Concluding Observations on the Initial Report of Australia*, 10th sess, 118th mtg, UN Doc CRPD/C/AUS/CO/1 (21 October 2013) 2 [9].

[2742] See Australian Law Reform Commission, *Equality, Capacity and Disability in Commonwealth Laws* (Final Report, August 2014) 11–2.

[2743] See further Part 2 Background and Context to South Australia's Mental Health Laws.

[2744] Associate Professor Ruth Vine, 'Submission to the Royal Commission into Victoria's Mental Health System', *Final Report* (February 2021) vol 4, 369.

[2745] Sascha Callaghan and Christopher James Ryan, 'An evolving revolution: Evaluating Australia's compliance with the Convention on the Rights of Persons with Disabilities in Mental Health Law' (2016) 39(2) *UNSW Law Journal* 596.

[2746] Toni Wharehoka, 'Disability Rights and Compulsory Psychiatric Treatment: the Case for a Balanced Approach under the Mental Health (Compulsory Assessment and Treatment) Act 1992' (2021) *Victoria University Wellington Law Review* 221.

12.1.22 Guiding principles arguably represent one component of a 'rights-based' approach. In order to translate this approach in practice, it must be accompanied by legislative and non-legislative reforms. Legislative reforms include accountability mechanisms and strengthening language in the *MHA* to reflect positive rights. In contrast, non-legislative reforms refer to resourcing, cultural and operational practices. SALRI recognises it is these non-legislative factors that may enable or impede the translation of guiding principles. This highlights the complexity associated with the enforcement of guiding principles and developing a regulatory framework capable of offering effective oversight and accountability for transgressions (namely, non-compliance with a principle/s).

12.2 Current Law in South Australia

12.2.1 Section 7 of the *MHA* outlines 13 guiding principles which 'the [relevant] Minister, the Tribunal, the Chief Psychiatrist, health professionals and other person and bodies involved in the administration of this Act are to be guided [by]… in the performance of their functions.'[2747] These are summarised in the first column of **Table 9** below.

12.2.2 Despite the 'fundamental role' the principles have in 'upholding positive rights', as one attendee at SALRI's Government Roundtable asserted, the current principles only explicitly reference 'rights' twice:

1. Consumers are to be provided with 'comprehensive information about their … legal rights';[2748] and
2. The 'rights … of children and other dependants of [consumers] should always be considered and protected as far as possible.'[2749]

12.2.3 The principles acknowledge, either directly or indirectly, rights contained in instruments such as the *CRPD*. However, the way in which many principles are phrased places a greater emphasis on the role of mental health service delivery in upholding a human right. For example, one principle states that 'mental health services should be designed to bring about the best therapeutic outcomes for [consumers], and, as far as possible, their recovery and participation in community life.'[2750] In its current form, the principle focusses on mental health service design to enforce a human right. If re-structured, using positive rights-based language, the principle may be translated to:

> A consumer is entitled to the best therapeutic outcome, which promotes recovery, general wellbeing and transition back to an active participant in their community.

12.2.4 Adopting this new construction, the principle retains its purpose – namely, a right to the best therapeutic outcome, which involves recovery-oriented practice and enables a consumer to regain ability to participate in the community. It arguably reflects language that is assertive, positive and rights-based. Principles that are consumer-centred, focussing on the rights of a consumer, as opposed to mental health service provision and delivery, may assist in clarifying the relevant human right and the purpose of the principle.

[2747] *Mental Health Act 2009* (SA) s 7(1).

[2748] Ibid s 7(1)(i).

[2749] Ibid s 7(1)(f).

[2750] Ibid s 7(1)(a).

12.2.5 Finally, the *MHA* lacks accountability mechanisms pertaining to the guiding principles. As shown in **Table 10** below, the only complaints mechanism specifically available to consumers is through the *Health and Community Services Complaints Act 2004* (SA), which allows for complaints to be made to the Health and Community Services Complaints Commissioner on a number of grounds relating to the provision of health services.[2751] SALRI notes that a consumer may appeal a treatment order to the South Australian Civil and Administrative Tribunal.[2752] However, this discussion is limited to consumer experiences in relation to the guiding principles, provision of and access to mental health services.

12.3 Law in Other Jurisdictions

12.3.1 The guiding principles and accountability mechanisms provided in each State's mental health legislation varies, though there are broad similarities across each Australian jurisdiction.

12.3.2 **Table 9** below provides a comparison of the provisions containing the guiding principles in each Act while **Table 10**[2753] compares the complaints mechanisms implemented within the mental health system in each Australian jurisdiction.

Table 9: Comparison of guiding principles in Australia

	SA	NSW	VIC	WA	NT	QLD	ACT	TAS
Bring about the best therapeutic outcomes	✓		✓	✓	✓		✓	
High quality and safety	✓	✓		✓				
In accordance with Australia's international obligations	✓							
Least restrictive, voluntary where possible	✓	✓	✓		✓			✓
Guided by treatment and care plans	✓	✓	✓	✓	✓			✓
Take into account individuals' differences, including cultural and spiritual differences of Aboriginal and Torres Strait Islanders	✓	✓	✓	✓	✓	✓	✓	✓
Regular medical examination and review	✓				✓			

[2751] *Health and Community Services Complaints Act 2004* (SA) s 25(1)(k).

[2752] See Part 10 South Australian Civil and Administrative Tribunal and Legal Representation.

[2753] See, for example Yun Ju Song et al., 'Missing in action: the right to the highest attainable standard of mental health care.' (2022) 16 *International Journal of Mental Health Systems* 26, 31.

Specific mention of children and young people	✓	✓	✓			✓		✓
Medication and restrictive practices to be used for therapeutic or safety reasons and not as punishment or convenience	✓	✓	✓					
Consumers and carers to be provided with information about treatment and rights	✓	✓		✓	✓	✓	✓	
Interference with rights, dignity and self-respect to be kept to the minimum		✓	✓	✓		✓	✓	✓
Priority for community-based treatment		✓			✓			✓
Consumers to be supported to pursue their own recovery and given information about treatment and alternatives		✓		✓		✓	✓	✓
Role of carers to be given effect		✓	✓	✓	✓		✓	✓
Dignity of risk			✓					
Respect for consumer's views about their own treatment			✓	✓		✓	✓	✓
Co-occurring medical and health needs to be recognised and addressed			✓	✓	✓			
Treatment of people with mental illness with dignity, equality, courtesy and compassion				✓				
Accessibility of services				✓			✓	

Respect for privacy and confidentiality				✓		✓		
Recognition of factors influencing mental health and wellbeing				✓			✓	
Accountability of mental health services				✓				✓
Reduction of stigma						✓		✓
Value of early intervention								✓
Raise community awareness and understanding of mental illness								✓

Table 10: Comparison of complaints mechanisms in Australia

Legislation	**Complaints process**
Mental Health Act 2014 (WA)	A complaint is to be brought directly to the mental health service provider or the Director under the *Health and Disability Services (Complaints) Act 1995* (WA).
Mental Health Act 2014 (VIC)	The Mental Health Complaints Commissioner (MHCC) was created under the *Mental Health Act 2014* (the Act) to help safeguard and promote the rights of consumers, carers, families, and support people in Victoria. The Act includes 12 mental health principles that must be upheld by staff of public mental health services. This will soon be replaced by a new scheme under the *Mental Health and Wellbeing Act 2022* (Vic).
Mental Health Act 2009 (SA)	No specific complaints process for mental health service provision, rather complaints are governed through the *Health and Community Services Complaints Act 2004* (SA).
Mental Health Act 2016 (Qld)	No legislative direction regarding the process of complaints, but a directive to the Office of the Chief Psychiatrist can investigate serious matters concerning the administration of the Act including, the rights of consumers.
Mental Health Act 2007 (NSW)	No complaints process referenced.
Mental Health Act 2015 (ACT)	No complaints process referenced.
Mental Health Act 2013 (TAS)	No complaints process referenced.
Mental Health and Related Services Act 1998 (NT)	Internal complaints procedure for mental health service provision.

12.3.3 Unlike the current construction of SA's guiding principles, most Australian jurisdictions focus on treatment outcomes or consumer's rights, reflecting a person-centred approach. For example, the NSW Act requires services to ensure that 'any interference with [consumers'] rights, dignity and self-respect is to be kept to the minimum necessary in the circumstances.'[2754] In contrast, the Tasmanian and Victorian Acts use positive language to highlight the importance of 'respecting and promoting' the rights, dignity and autonomy of consumers.[2755] The Queensland and ACT Acts both emphasise the need to recognise that consumers have the 'same human rights' as those who do not utilise mental health services.[2756] The Western Australian and ACT principles both include recognition that consumers continue to hold responsibilities in their lives.[2757]

12.3.4 Most jurisdictions require services to provide consumers with information about their treatment and their rights, including South Australia. The Western Australia and ACT Acts go further, explicitly stating that the purpose of this information is to 'help [consumers] to understand and to express views and make decisions'[2758] and 'obtain assistance and uphold their rights'.[2759]

12.3.5 In addition to the principles governing care and treatment of consumers, the Northern Territory Act has further principles relating specifically to the treatment of persons receiving *involuntary* admission and treatment; consumers of Aboriginal and Torres Strait Islander background; and the rights of carers and families.

12.3.6 Apart from Victoria and Western Australia, which have established complaints mechanisms, most States do not have a mechanism embedded within their mental health laws.

12.4 Issues

The utility of guiding principles

12.4.1 The guiding principles are a means to contextualise human rights, providing the necessary framework by which mental health laws should adhere. Following this, as identified by the Office of the Chief Psychiatrist ('OCP'), the principles 'reflect good ideals'. However, parties in SALRI's Medical Specialist Roundtable referred to the current principles as aspirational statements and the feasibility of their enforcement is questionable and difficult to operationalise in the abstract.

12.4.2 As noted by the Castan Centre for Human Rights Law, '[t]he tension between the values of beneficence and autonomy lies at the heart of modern controversies in mental health.'[2760] This requires a delicate balance of two fundamental values – one of which underpins the practice of clinicians, to promote the wellbeing and recovery of a consumer. The enforcement of an involuntary treatment order is one instance in which the balance is skewed toward beneficence, as opposed to autonomy. This was highlighted by one consumer in SALRI's focus group with LELAN, who stated '[i]t's difficult for hospitals to navigate the line between protection and agency and dignity … Just

[2754] *Mental Health Act 2007* (NSW) s 68(f).

[2755] *Mental Health Act 2014* (Vic) s 11(1)(e); *Mental Health Act 2013* (Tas) s 11(a).

[2756] *Mental Health Act 2015* (ACT) s 6(a); *Mental Health Act 2016* (Qld) s 5(a).

[2757] Ibid s 6(a); *Mental Health Act 2014* (WA) sch 1, cl 11.

[2758] *Mental Health Act 2014* (WA) sch 1, cl 12.

[2759] Ibid sch 1, cl 13.

[2760] Castan Centre for Human Rights Law, *The Human Rights Roadmap: 40 ways to operationalise human rights in Victoria's mental health and wellbeing system* (Report, September 2022) 16.

having a less punitive system that focusses on people's wellbeing other than risk management would be great.'

12.4.3 Given the *MHA* authorises interference with rights, the guiding principles offer an avenue by which the law can:

- Identify rights relevant to mental health and wellbeing and treatment;
- Promote appropriate use of powers under the *MHA*; and
- Endorse human rights principles and frameworks, such as supported decision-making.

12.4.4 It is apparent the utility of the guiding principles is closely related to their operation in practice. As such, this discussion will solely address the benefits of including guiding principles within the *MHA*.

12.4.5 The Office of the Public Advocate ('OPA') raised the utility of guiding principles, stating they '… play an important role in legislation, in that they seek to clarify the fundamental values and beliefs that underpin a legislative regime.' Additionally, their utility can be fully realised if 'properly embedded and understood', enabling the principles to influence decisions and practices under the *MHA*. The OCP recognised a 'central role' of the guiding principles is to provide 'an avenue to introduce rights-based protections into the legislation'.

12.4.6 The Commissioner for Children and Young People highlighted the guiding principles offer an opportunity to explicitly recognise international Conventions, such as the *Convention on the Rights of the Child* ('*CRC*') and the *CRPD*.[2761] The current principles can be strengthened to specifically address rights for children and adolescents accessing mental health services. The Commissioner for Children and Young People further noted the Victorian 'Wellbeing of young people principle', which promotes the wellbeing of this cohort.

12.4.7 However, as observed by Lived Experience Leadership and Advocacy Network ('LELAN'), '[t]hese guiding principles must be more than words.' Similarly, the Disability Rights Advocacy Service ('DRAS') noted '[t]he Guiding Principles … impact access to services by making services more accessible only if they are applied in practice – otherwise they are meaningless.'

12.4.8 These views were raised by several parties and identified a key limitation in the current law. The utility of the *MHA* guiding principles is compromised in the absence of guidance concerning the ways in which they may be translated in practice and an accountability mechanism.

12.4.9 The Victorian Royal Commission recognised the valuable role of the guiding principles in interpreting legislation. Referring to *PBU & NJE v Mental Health Tribunal*,[2762] in which Bell J referred to the objectives and principles of the *Mental Health Act 2014* (Vic) to interpret and apply provisions relating to electroconvulsive therapy, the Royal Commission heard that:

> This decision resulted in the Mental Health Tribunal developing an electroconvulsive treatment guideline for processes and matters to be considered in tribunal hearings relating to compulsory

[2761] The World Health Organisation's Comprehensive Mental Health Action Plan, emphasises the importance and need for legislation that complies with the 'International Covenant on Civil and Political Rights, the International Covenant Economic, Social and Cultural Rights, the Convention on the Rights of Persons with Disabilities, the Convention on the Rights of the Child and other relevant international and regional human rights instruments': see World Health Organisation, *Comprehensive Mental Health Action Plan 2013 – 2030* (Report, 2021) 2.

[2762] *PBU & NJE v Mental Health Tribunal* [2018] VSC 564. See also below Appendix 1.

> treatment orders … [leading] to practice improvements, including in the work of mental health services, the Mental Health Tribunal and the Office of the Chief Psychiatrist.[2763]

12.4.10 Therefore, statutory guiding principles have an important role in ensuring the *MHA* 'provides for the checks, balances and protections necessary for the transparent and accountable exercise of these powers.'[2764] As Bell J stated in *PBU & NJE*:

> … the objectives and principles [of the *Mental Health Act 2014* (Vic)] are intended to alter the balance of power between medical authority and persons having mental illness in the direction of respecting their inherent dignity and human rights.[2765]

12.4.11 Accordingly, a key criticism of the present *MHA* relates to its limitations as the result of its crisis-oriented focus. The utility and effectiveness of the principles may be compromised, as the original intent for their enactment was to guide the use of powers created 'primarily … to treat people with serious mental illness against their will'.[2766] As Associate Professor Simon Stafrace, Chief Adviser of Mental Health Reform Victoria, told the Royal Commission:

> … the system is achieving exactly the results it was set up to achieve, every time a decision was made to take funding out, without keeping track of its impact on patients and their families. It is achieving the results it was set up for, every time decisions were made to fragment the system further by introducing elements that linked poorly with one another and that were not integrated with the broader health system of preventative primary health … every time we … turned a blind eye to deteriorating hospitals, the sub-standard accommodation, the homelessness, the poverty and the violence that is all too common an experience for people with severe mental illness.[2767]

12.4.12 The Royal Commission also found that the *Mental Health Act 2014* (Vic) 'too often emphasises a 'biomedical model' of understanding mental illness.'[2768] This was reinforced in SALRI's consultation. Notably, the current *MHA* is concentrated on intervention at the acute, crisis point.[2769] As a result, there is less emphasis on principles relating to community treatment, early intervention and prevention strategies and general wellbeing. Consistent with this observation, a carer noted '[t]he lack of step-down support between crisis care and normal care is critically lacking.'

12.4.13 An attendee at the Medical Specialist Roundtable noted that the *MHA* is designed to promote defensive practice rather than rights-based approaches, allowing for dignity of risk. This causes issues where:

> … mental health services … become overly reliant on a medical model of care and a generic case management approach that does not empower the multidisciplinary workforce to help consumers, families, carers and supporters, using discipline-specific skills and expertise … the system … doesn't deliver all the things that we already have at our disposal in an effective way.[2770]

[2763] *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021) vol 4, 41.

[2764] South Australia, *Parliamentary Debates*, Legislative Council, 4 June 2008, 3096–118 (Gail Gago).

[2765] *PBU & NJE v Mental Health Tribunal* [2018] VSC 564 [67].

[2766] South Australia, *Parliamentary Debates*, Legislative Council, 4 June 2008, 3096–118 (Gail Gago).

[2767] *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021) vol 1, 53.

[2768] *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021) vol 4, 33.

[2769] For example, an attendee at the Government Roundtable stated the principles are 'clinic- or ward-centric', focusing more on what happens in the institution and hospital rather than the community.

[2770] *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021) vol 4, 376.

12.4.14 The guiding principles are valuable, providing the necessary foundation for a rights-based instrument. This is consistent with the World Health Organisation's ('WHO') view:

> Legislation that complies with international human rights instruments is needed to protect and promote human rights. Given that the causes and needs of mental health cross sectors, it is essential that laws and policies aimed at improved mental health address all sectors.[2771]

12.4.15 Further, in response to strengthening effective leadership and governance for mental health, the WHO has advocated for:

> Mental health law, whether an independent legislative document or integrated into other health and capacity-related laws, should codify the key principles, values and objectives of policy for mental health, for example by establishing legal and oversight mechanisms to promote human rights and the development of accessible health and social services in the community.[2772]

12.4.16 It is clear the utility of guiding principles extends beyond a mere symbolic function, to a necessary component in the adherence of human rights when powers under the *MHA* are exercised. The law may act as the impetus for the enforcement of guiding principles, by providing a framework which:

- Empowers appropriate bodies to determine how the principles can be translated into measurable outcomes;
- Identifies and empowers an appropriate body or bodies to monitor compliance and enforce consequences for non-compliance;
- Outlines a mechanism for monitoring, accountability and reporting; and
- Identifies the nature of the consequence where there is evidence of non-compliance.

12.4.17 In the absence of this legislative strengthening, including an accountability mechanism, as raised by the OCP, 'the guiding principles [will] be more aspirational than mandatory in nature.'

12.4.18 The Victorian Royal Commission reported findings concerning a gap between law and practice. They identified the need for 'strong, transparent accountability mechanisms':

> … to build the levels of trust held by people living with mental illness or psychological distress, families, carers and supporters in the commitment of mental health and wellbeing services to make decisions, and deliver treatment, care and support that promotes the objectives and principles contained in legislation.

12.4.19 The Royal Commission also recognised that meaningful accountability differs for 'consumers, families, carers, supporters … providers, the Victorian Government and the broader community.' SALRI's consultation with consumers accorded with the view that a consumer and carer's needs and preferences must be actively considered.

Enforcement and operationalisation of guiding principles

12.4.20 The conflict between beneficence and autonomy raises a broader issue in relation to the interaction of rights relevant to the *MHA*. Specifically, in practice, no human right is absolute. This

[2771] World Health Organisation, *World Mental Health Report: Transforming mental health for all* (2022) 6.

[2772] World Health Organisation, *Comprehensive Mental Health Action Plan 2013 – 2030* (2021) 7 [32].

indicates that the interference or limitation of a right may be authorised under certain circumstances. It is this interference that becomes the source of debate. This was explored by the Castan Centre for Human Rights Law:

> … human rights are intrinsically interrelated and interdependent. On their own, particular rights may become meaningless or even oppressive if not balanced with other rights that are applicable in the circumstances. A human rights-based system must provide for a holistic balance of all human rights, in the same way that mental health and wellbeing systems must holistically balance all ethical values. By recasting the so-called 'intractable' debates of mental health into a human rights framework, value conflicts can be translated into concrete legal questions with corresponding solutions. In particular, incorporating the proportionality principle into mental health and wellbeing systems will facilitate rights-based decision-making, ensuring a proportionate balance is struck in each case where human rights, and the underlying values which they embody, come into conflict.[2773]

12.4.21 The proportionality principle is a well-known legal construct. In circumstances where a balance must be struck between competing rights, such as beneficence and autonomy, the proportionality principles offers a practical solution.[2774] It requires a case-by-case assessment of the relevant interference with a right and whether this interference is necessary and justified.[2775] The law imposes safeguards to ensure interference is adequately justified. For example, the criteria to make a treatment order should, in practice, act as safeguards to ensure the making of an order is properly justified. Following this, the principle adopts the notion that 'the more substantial the interference the more that is required to justify it'.[2776]

12.4.22 Proportionality promotes objective decision-making and provides a solution to address circumstances where there may be incompatibility between rights. The powers authorised under the *MHA* provide relevant examples where rights come into conflict and a balance must be struck. Several principles, already addressed in the *MHA* and clinical practice, reflect the proportionality principle. These include using force as a last resort, promoting the least restrictive practice and requiring a careful balance of considerations prior to the making of a treatment order.[2777]

12.4.23 The Victorian Royal Commission also identified issues in relation to the enforcement of guiding principles. It reported a 'lack of structural clarity and accompanying accountability mechanisms regarding how the mental health principles are to be embedded in treatment, care and support.'[2778] The Commission noted there were parts within the mental health system where the guiding principles were applied.[2779] Similarly, SALRI's consultation with medical practitioners and mental health practitioners revealed principles were routinely applied in practice. This was largely a product of professional integrity, training and routine practice. Attendees at SALRI's Medical Specialist Roundtable noted that the principles are inherently addressed within clinical assessment and treatment approaches.

[2773] Castan Centre for Human Rights Law, *The Human Rights Roadmap: 40 ways to operationalise human rights in Victoria's mental health and wellbeing system* (September 2022) 16.

[2774] See Martin Curtice et al, 'The proportionality principle and what it means in practice' (2011) 35 *The Psychiatrist* 111.

[2775] Ibid.

[2776] Ibid 112.

[2777] See Ibid.

[2778] *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021) vol 4, 32.

[2779] Ibid.

12.4.24 As observed in Victoria, there were barriers inhibiting the full realisation of principles. The Commission identified one of the barriers were the presence of:

> … few incentives or mechanisms in the Act or related implementation strategies, such as reporting requirements, to drive the cultural change among the workforce that are necessary to embed new approaches and ways of working.[2780]

12.4.25 Further, the 'crisis-driven and reactive nature of the mental health system' exacerbated this barrier, leading to a culture of 'risk-management', that may impact the prioritisation of consumer autonomy.[2781] Similar themes were raised in the context of the SA *MHA*. Notably, the lack of guidance and measurable outcomes of each principle, coupled with the absence of an accountability mechanism to monitor and impose consequences for non-compliance.

12.4.26 An example of an accountability mechanism responding to allegations of non-compliance with the guiding principles is observed in Western Australia.[2782] A complaint alleging a service provider's failure to comply with the Act's principles may be made to the Health and Disability Services Complaints Office.[2783] An alternative solution is offered in Victoria, by the *Carers Recognition Act 2012* (Vic), which imposes mandated reporting upon care support organisations to prepare a report detailing its compliance with their obligations (guiding principles).[2784] A similar reporting requirement is found in the *Disability Act 2006* (Vic), which requires reporting on the implementation of objectives identified in a Disability Action Plan.[2785]

12.4.27 In South Australia, the *Suicide Prevention Act 2021* (SA) includes a similar mechanism to Victoria. The Act mandates annual reporting, which details compliance with the objectives, performance indicators and provisions contained within the State Suicide Prevention Plan.[2786] Further, the Minister may make recommendations relating to suicide prevention and may publish, on a website, details of compliance by a person or body with a recommendation.[2787]

12.4.28 These examples offer insight into the ways in which the law may incorporate a framework to enforce guiding principles. As such, SALRI notes the legislation may enforce an accountability mechanism through:

- The identification of an appropriate body to monitor compliance and/or receive complaints;
- Defining the scope and nature of complaints that may be made (this provides an opportunity to explicitly refer to compliance with guiding principles);

[2780] *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021) vol 4, 32.

[2781] Ibid 33. See also *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021) recommendations 42, 44 and 45.

[2782] See *Mental Health Act 2014* (WA) Pt 19.

[2783] Ibid. See also Mental Health Commission WA, *Statutory Review of the Mental Health Act (2014): Discussion Paper* (August 2021) 15, 41. The Western Australian *Mental Health Act* review is currently underway. One of the proposed amendments to this complaints mechanism is an amendment to enable complaints against Commonwealth funded mental health services. These services are currently excluded from the complaints mechanism.

[2784] *Carers Recognition Act 2012* (Vic) s 12(1). See also *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021) vol 4, 33.

[2785] *Disability Act 2006* (Vic) ss 37–38(3). See also *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021) vol 4, 33.

[2786] *Suicide Prevention Act 2021* (SA) ss 20, 23.

[2787] Ibid ss 27–28.

- Conferring power upon appropriate bodies to manage and investigate complaints;
- Mandating monitoring and reporting requirements; and/or
- Imposing consequences for non-compliance.

12.4.29 In relation to reporting requirements, the Commission also importantly noted the absence of public information detailing 'how service providers or other decision-makers act in accordance with the objectives or principles set out in the legislation.'[2788] This observation, in addition to consultation with various government stakeholders, formed the basis for SALRI's approach in dealing with non-compliance. This will be discussed below.

12.4.30 The way in which guiding principles may be operationalised in practice requires a multi-faceted approach. This must be accompanied by active consideration of the five factors identified above as means through which the *MHA* may enforce an accountability mechanism. It is evident that the utility of the guiding principles relies upon their translation into practice. This strengthens the need for measures to be incorporated into the *MHA* promoting and monitoring their enforcement and defining consequences for non-compliance.

12.5 Consultation Data Overview

12.5.1 SALRI's consultation revealed views regarding the:

1. Utility of the current guiding principles;
2. Enforcement of guiding principles in practice;
3. Impact, if any, upon access to mental health services; and
4. Ways in which the *MHA* can provide an accountability mechanism for compliance with the guiding principles.

The Utility of the Current Guiding Principles

12.5.2 SALRI's consultation raised the limited utility of the *MHA* in providing guidance for mental health and wellbeing. The crisis driven focus of the *MHA* diminishes the utility of the guiding principles. Further, a shift to a more 'rights-based' approach would assist in strengthening the utility of the principles.

12.5.3 An attendee at SALRI's Government Roundtable noted 'we currently have a mental illness act, not a Mental Health Act.' Other attendees at this Roundtable described the guiding principles as significant, with a fundamental role in upholding positive rights.

12.5.4 Some parties during consultation identified that, as a consequence, mental health services are unable to address mental health challenges before they reach a point of crisis.[2789] LELAN's submission aptly summarised the prevailing perspective regarding the Act's focus:

[2788] *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021) vol 4, 33.

[2789] One attendee at SALRI's Medical Specialist Roundtable noted, due to the *Mental Health Act 2009* (SA)'s focus on acute mental illness, funding and services are designed to address acute care.

> The focus of the Act should be to embed rights-based objectives and care including person-centred care and recovery planning, to provide greater powers of oversight, monitoring and review; to increase accountability for transparent decision-making; to increase reporting requirements by mental health services and clinicians in relation to any and all use of restrictive practices and treatments without consent whether authorised or not, and to require measures for implementing the guiding principles into practice and service delivery.

12.5.5 Additionally, consultees noted the *MHA* is, in practice, 'skewed in favour of clinicians rather than consumers, such that the legislation is protective, rather than rights-based.' There was support to amend the objects and guiding principles of the *MHA* in order to accommodate this view. For example, the OCP submitted that:

> … the objects of the Act may be adjusted to better reflect the idea that:
>
> - All South Australians have the right to good mental health and wellbeing, not simply treatment for acute mental illness.
> - Recovery-oriented, evidence-based treatment is paramount and included in this is the recognition that voluntary, collaborative treatment (as far as possible) leads to the best outcomes.
> - Similarly, use of the involuntary treatment pathways are to be as a last resort to ensure the least restrictive approach to treatment is always taken.
> - Inequities in access to mental health services must be reduced.
> - Comprehensive and, where appropriate, multi-disciplinary services should be offered to consumers on a voluntary basis to target the social determinants of mental ill health and psychological distress.

12.5.6 The Australasian College for Emergency Medicine submitted that 'the guiding principles must be reflected in the way that the system is designed, funded and delivered'. The OPA considers that 'if properly embedded and understood, principles should influence the day-to-day decisions and practice under the *MHA*'. The Law Society's submission aptly summarises this view:

> Implementation requires adoption and embodiment of principles across the board, at intake, treatment, legal advice, and legal proceeding level. As a result, the Act needs to focus on behaviour, review, enforcement, accountability, and monitoring at every level in the context of consumer experience with the health and legal system.

12.5.7 There was a distinct view in SALRI's consultation that the principles should reflect the rights contained in the *CRPD*.[2790] This was reinforced by Purple Orange, who suggested changes to the *MHA* 'must be in line with the UN Convention on the Rights of Persons with Disabilities, the National Decision-Making Principles and associated guidelines developed by the Australian Law Reform Commission, and national and international best practice.'

12.5.8 A recurring theme throughout consultation was the need to ensure the rights-based objectives of the *MHA* were fulfilled in the implementation of the guiding principles. The Australasian College for Emergency Medicine submitted that '… the guiding principles of the *MHA* should be thought of in a broader sense rather than at the point of service delivery.'

[2790] Some parties suggested the rights contained in the *CRPD* should be embedded throughout the *Mental Health Act 2009* (SA), rather than only being contained in section 7.

12.5.9 It is arguable that the utility and effectiveness of the guiding principles is limited by both the scope of the *MHA* itself, and the perceived lack of implementation of the principles in practice. As an attendee at the Government Roundtable suggested, without changes to the *MHA* which address these concerns and broaden its focus to include mental wellness,[2791] it will remain a crisis orientated Act. This was also raised by a carer who stated '[t]he mental health system is too crisis driven, fragmented, failure of early intervention support capacity building in people's lives.'

12.5.10 The need for a more explicit rights-based approach in the *MHA* was raised by several parties. Mind Australia, for example, favoured the adoption of the new Victorian approach:

> These [guiding] principles go a step further to build the foundations of a new system which is redesigned to better support people's mental health and wellbeing. These rights-based objectives and principles set the tone for the Act, and the system, prioritising the values and preferences of consumers, their families, carers and supports, and ensuring high-quality services. This includes establishing people with lived experience in system leadership and building accountability and transparency into the system whilst protecting rights and eliminating seclusion and restraint. The Act should focus on protecting and promoting positive rights, such as those contained in the *CRPD* including the right to enjoy the highest attainable standard of health.

12.5.11 Several parties highlighted the need to 'enforce a hierarchy of priority' among the principles.

12.5.12 In practice, this also includes ensuring that practitioners and those involved in the administration of the *MHA* understand the purpose for the guiding principles and seek to ensure that their compliance fulfils that purpose. For example, an attendee at the Medical Specialist Roundtable suggested medical practitioners should take the time '…to ensure the consumer understands their rights [when the statement of rights is given to them, to make the statement] meaningful: sometimes, a person won't be able to receive this information on their first day of treatment.'

12.5.13 An integral part of ensuring the *MHA* meets its rights-based objectives is centring the voice and lived experience of consumers and their carers. SALRI's consultation revealed widespread support for amendments to the *MHA* which would formalise the importance of consumer's and carer's feedback and increase engagement with their perspectives. The Legal Services Commission noted that '[a]lthough the legislation recognises that a patient's participation is a key element of their treatment, in practice, community feedback suggests that this is not their experience in reality. Many complain that decisions are being imposed upon them, and that their wishes and views are of little relevance.'

12.5.14 SALRI was also informed about the importance of upholding rights, through the enforcement of principles. It was noted this would improve a consumer's experience, trust and engagement with mental health services. Similar comments were raised to SALRI by other parties.

12.5.15 One carer noted that true engagement with a person's lived experience and perspective means 'accepting alternate or unusual experiences and perspectives and being curious, seeking meaning and understanding.' The Disability Rights Advocacy Service ('DRAS'), in its submission, stated that more adequate consideration of a consumer's individual circumstances includes:

> … consideration of past and current treatment and its outcomes, a focus on offering the least restrictive practice possible, explaining the benefits and risks of treatment to individuals, and liaising with families and carers ... The *MHA* should embed this throughout the legislation so that

[2791] See SALRI Recommendation 7. See further Part 2 Background and Context to South Australia's Mental Health Laws.

> the least restrictive option is considered at every point of an inpatient or community treatment order.

12.5.16 This should extend to specific consideration of differences resulting from culture, age, and other diverse perspectives. DRAS highlighted the need to ensure that Aboriginal and CALD consumers are appropriately supported by 'culturally safe services, access to interpreters who understand and are given training on the system, copies of documents … in their native language, and access to cultural supports.' This was also raised by the Commissioner for Aboriginal Children and Young People highlighted the importance of supporting children and young people in decision-making.

12.5.17 To assist in achieving a rights-based objective and prioritise consumer voices, there was wide support for legislative endorsement of supported decision-making. This was raised by many parties in SALRI's consultation, such as Purple Orange, Mind Australia, DRAS, Dr Susan Peukert, the Australian Psychological Society and Speech Pathology Australia.[2792]

12.5.18 DRAS considered supported decision-making and recovery-oriented practice were 'pivotal' components of a rights-based *MHA*:

> We must ensure that vulnerable people are not leaving these treatment orders or control powers worse off than when they went in. They must be given care, support and access to transparent complaint services, advocacy and/or legal representation if they are not provided with best practice or trauma-informed care.

12.5.19 The Legal Services Commission recognised that on the one hand, the *MHA* provides for medical treatment, but on the other, it aims to preserve and protect the human rights of consumers. These are often in direct tension. As a result, they suggested:

> The guiding principles of the Act therefore need to reflect how these two principles are to be balanced when decisions about [consumer] treatment are being made. The *MHA* refers to services being provided in accordance with international treaties and agreements to which Australia is a signatory. We suggest that the guiding principles under the Convention of Rights for People with a Disability (*CRPD*) should be specifically referred to in the *MHA*'s guiding principles. The Convention deals with mental health services and addresses matters such as respect for inherent dignity, and individual autonomy, including the freedom to make one's own choices as an independent person. The emphasis on rights-based principles may serve to balance priorities when making decisions regarding a [consumer's] care. Although the legislation recognises that a [consumer's] participation is a key element of their treatment, in practice, community feedback suggests that this is not their experience in reality. Many complain that decisions are being imposed upon them, and that their wishes and views are of little relevance. Consideration could be given to creating a specific mechanism for feedback and/or complaints to be made from [consumers] who feel that the guiding principles of the *MHA* have not been followed in their treatment and care experience.

[2792] For a detailed discussion on supported decision-making, see Part 3 Decision-making Capacity and Supported Decision-making. For example, one carer suggested that a 'guiding principle that outlines that consumers need to be supported as much as possible to be able to understand and … be able to have decision-making capacity' be implemented in the *Mental Health Act 2009* (SA). Dr Susan Peukert submitted more broadly that 'a guiding principle related to autonomy [should] be added to the *Mental Health Act 2009* (SA) to guide the interpretation of other provisions … and play a central role in the exercise of powers under the legislation …' For example, '[a]ll persons receiving mental health services must have their autonomy respected and promoted as far as practicable.'

12.5.20 Consultation also revealed ways in which the current guiding principles could be strengthened. Victoria's guiding principles under the new *Mental Health and Wellbeing Act 2022* (Vic) was widely supported. Attendees at SALRI's Government Roundtable suggested the principles should address access issues (to mental health services and supports). Further, it was raised that the *MHA* is very focussed on service delivery within institutions/hospitals, with limited focus on the provision of services in the community. As a result, it was proposed a greater focus on community mental health support is needed.

12.5.21 The Public Health Association noted the guiding principles should specifically address refugees, asylum seekers, prisoners[2793] and victims of domestic violence. As a result, they advocated for greater emphasis and consideration of these cohorts within the guiding principles.

12.5.22 The Mental Health Commissioners advocated for the inclusion of all the principles contained in the Victorian *Mental Health and Wellbeing Act 2022*.[2794] Specific reference was made to include the Lived Experience principle, with provision for 'reflective practice that includes pre-incident analysis and lived experience/peer support practitioners.'

12.5.23 Measures to strengthen safeguards for LGBTIQ consumers was raised to SALRI, with particular consideration regarding the enforcement of these principles in practice.

12.5.24 The Commissioner for Children and Young People advocated for greater protections for children and adolescents, which could be addressed in both the objects and guiding principles of the *MHA*. Further, in their submission to SALRI, the Commissioner stated:

> In the operationalising of an Act there is an opportunity to embed a different approach for children and young people. This includes but need not be limited to:
>
> - Making decisions that are child-centred, child-safe and in the best interests of the child;
> - Ensuring children have a voice to make decisions if they have the competency and capacity to do so;
> - Recognising that there are certain restrictive practices and restraints that should not be practised on children;
> - Providing children with individual advocates who can provide them with information and support, especially when they do not have a parent or guardian to advocate on their behalf; and
> - Ensuring there are opportunities for children and young people to provide feedback on services and be included in any stakeholder engagement.

12.5.25 The Commissioner also supported the approach in Victoria, which includes a specific principle for the wellbeing of children and young people, definitions and explicit examples of age-appropriate and culturally appropriate terms such as 'appropriate supports' and a new mental health and wellbeing system for children aged 0 – 11 years. The guiding principles could be strengthened to promote the rights of children and adolescents. This is in response to views that the current *MHA* is perceived as an Act for adults, which is not 'child friendly'.

[2793] This was also raised by the Department for Correctional Services.

[2794] *Mental Health and Wellbeing Act 2022* (Vic) s 21.

12.5.26 SALRI was informed that the philosophy of treatment is different for children and adolescents. As a result, interventions and treatment may not necessarily be medical. The Headspace Early Psychosis Program provides a valuable example for young people experiencing an early or first episode of psychosis or at risk of developing psychosis. There are also developmental and situational differences, whereby consumers may have trauma, family conflict and external pressures contributing to a mental health challenge. SALRI was also told about the importance of family and involving the child or adolescent in all conversations and decision-making. As such, principles to empower child and adolescent consumers and measures to de-stigmatise labels associated with a diagnosis and treatment, should be explored. This was also raised by the SA Child and Adolescent Health Community of Practice who advocated for greater consideration of rights and a 'trauma informed' approach. They noted:

> Due to the nature of growth, children are consistently evolving with their values and identity and health priorities - development, particularly in respect to their gender and disability, these considerations should be given prominent use of the Act.

12.5.27 As noted by representatives from Headspace in SALRI's Mental Health NGO Roundtable, the barriers for children and adolescents are a product of a disjointed mental health system. Some factors identified as impacting early access to mental health services included family dynamics and conflict, lack of school involvement and different opinions on behalf of the young person and their illness. SALRI notes the value in strengthening the guiding principles to reflect specific considerations for children and young people. If this is accompanied by a mechanism to enforce the principles and accountability for non-compliance, this may assist in bridging the gaps within child and adolescent mental health.

12.5.28 The OCP supported in principle, 'a clearer distillation of the most essential guiding principles that are key to the administration of the Act.' Specific reference and support of the Victorian approach to the mental health and wellbeing principles was raised. Following a clearer distillation of principles, as observed in Victoria, the OCP noted '[o]ne advantage of such clarity surrounding these principles is that they become more amenable to accountability mechanisms.'

Enforcement of Guiding Principles

12.5.29 SALRI's consultation sought views on ways in which the guiding principles can be enforced in practice. There was extensive support for the principles to be retained. Further, it was agreed the principles serve an important legislative function, by shaping the tone of the Act and promoting a rights-based framework.

12.5.30 A prominent concern raised during SALRI's consultation related to the operationalisation of the guiding principles – namely, their inadequate implementation in practice. Many parties, such as the Mental Health Commissioners, Mind Australia, the Commissioner for Aboriginal Children and Young People and the Australian Nursing and Midwifery Federation, supported the findings and approach taken by the Victorian Royal Commission, which advocated for stronger accountability mechanisms and monitoring.

12.5.31 This was raised by the Law Society, who commented that, though the 'guiding principles provide important interpretive support of legislative regimes, and should be observed', their implementation and enforcement 'can be culturally challenging and may take time to embed'. In

addition, it requires the provision of 'funding and other support … to meet these goals.' The Law Society further stated:

> Implementation [of the guiding principles] requires adoption and embodiment of principles across the board, at intake, treatment, legal advice, and legal proceeding level. As a result, the Act needs to focus on behaviour, review, enforcement, accountability, and monitoring at every level in the context of consumer experience with the health and legal system.

12.5.32 A lack of enforcement was identified as a key issue impacting the effectiveness of the principles. The Victorian Royal Commission identified the necessity of 'strong, clear and transparent [accountability] mechanisms' to effectively 'embed mental health principles in treatment, care and support.'[2795] An attendee at the Government Roundtable stated that a key focus of the present review should be to ensure the guiding principles are better operationally defined.

12.5.33 The impact of external, non-legislative factors, such as resourcing, funding, staffing, cultural and operational pressures was emphasised during consultation. These factors represent barriers to the enforcement of the guiding principles.

12.5.34 This was addressed by the Rural and Remote Mental Health Service ('RRMHS') who submitted:

> … the guiding principles are already mandatory, as they are legislated. While the current principles could be strengthened by replacing 'should' with 'must', this would be an academic exercise as the barriers to compliance are operational. Drafting more strongly worded guiding principles or including penalty provisions for non-compliance would also not address the underpinning issues.

12.5.35 RRMHS further stated that 'problems with upholding the guiding principles stem from two major issues – workforce and culture.' In relation to workforce issues, the RRMHS referred to the shortage of mental health clinicians, which has translated to vacancies within SA. Issues relating to staff recruitment and retention in regional, rural and remote communities was often raised to SALRI. Due to this shortage, the RRMHS noted clinicians are overworked, undertaking many roles or seeing more than the recommended number of patients. Access to specialist care in the regions was described to SALRI as 'diabolical'. In Port Pirie, SALRI was informed that there is currently no rotating psychiatrist to visit. During SALRI's visit to Port Lincoln, the phrase 'mental health blackspots' was used to describe the absence of mental health service providers. In practice, the significant staff shortages or absence of required expertise, means 'the full panoply of the guiding principles will not be enacted as clinicians focus on keeping people safe and providing treatment.'

12.5.36 Additionally, the RRMHS raised issues in culture, noting that 'profound changes in the provision of mental health service in South Australia over the last 25 years have not always been paired with corresponding culture change'. Several examples were provided, including de-institutionalisation in the late 1990s and the introduction of the stepped model of care in the 2000s. In light of workforce and cultural issues, the RRMHS suggested:

> To address system deficits in the carrying out of the guiding principles the Government must commit to reinvigorating the mental health workforce (including overseas recruitment short-term and increasing local education, graduation and employment medium- and long-term) and to building an ongoing commitment (and resources) to culture change into usual health service business.

[2795] *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021) vol 4, 41.

12.5.37 Attendees at SALRI's Medical Specialist Roundtable referred to hospital Key Performance Indicators – noting they may not adequately address the guiding principles and create pressures that may impact a clinician's ability to comply with the principles. The Australasian College for Emergency Medicine referred to similar issues, further noting that 'structural inequities of care' must be addressed, particularly for consumers living in regional, rural and remote communities and other marginalised groups. Provisions to address these inequities are also relevant in the context of operational and cultural practices impacting the enforcement of guiding principles.

12.5.38 One survey respondent highlighted 'there needs to be a culture change in mental health services that allows for these to actually be enforced.'

12.5.39 SALRI also notes current operational practices which enforce a principle may raise concerns. For example, during SALRI's Medical Specialist Roundtable, an attendee noted that while a statement of rights is given to consumers in accordance with the guiding principles, it is often provided at a time when the consumer does not have the capacity to understand its content and purpose.[2796] Though compliance is seemingly achieved, does it result in the desired outcome? Namely, each guiding principle should, in practice, achieve a measurable outcome.

12.5.40 SALRI recognises this measurable outcome will be dependent on the principle – it may be qualitative, quantitative or an evidentiary threshold. For example, one guiding principle states that 'mental health services should take into account…the cultural and linguistic backgrounds of persons.'[2797] If implemented in practice within a hospital setting, this may involve a qualified accredited interpreter, enabling a support person to remain with the consumer, identifying any cultural differences that may impact the consumer's understanding of mental health and offering trauma-informed care.[2798] The disconnect between compliance with a principle and its intended outcome in practice is arguably not a legislative issue. However, in practice, it impacts the effectiveness of the principle.

12.5.41 LELAN emphasised that guiding principles, although commendable, are inadequate without a mechanism to enforce them:

> These guiding principles must be more than words. Mental health services must be required to demonstrate application of these principles across all aspects of service delivery and should be required to report on active measures being used to ensure these guiding principles actually guide practice, service delivery, accountability and outcomes of care. The focus of the Act should be to embed rights based objectives and care including … to require measures for implementing the guiding principles into practice and service delivery … LELAN believes that whilst the legislation may outline clear principles of human rights of persons experiencing distress or diagnosed mental illness, the words alone are not enough to ensure these rights are actively ensured and promoted by health practitioners and health services. Greater focus needs to be applied to implementing, measuring and monitoring legislated principles into the practices and processes of mental health care.

12.5.42 Lived Experience Australia also highlighted the need for an enhanced focus on accountability to promote enforcement of principles:

> … whilst the Objects and guiding principles are clear, putting these into practice by the mental health services does not always happen. Hence, LEA queries whether there are any legal

[2796] This concern was raised to SALRI by other parties, notably consumers.

[2797] *Mental Health Act 2009* (SA) s 7(1)(ca)(ii).

[2798] This is particularly relevant to asylum seekers and refugees.

> implications for the services which either deliberately or unwittingly breaches any of these principles. We acknowledge these are principles only and are a guide to best practice but would like to see more written into the *MHA* to enable persons or families/carers to have a complaints mechanism that is independent and can make decisions rather than just recommendations such as the SA Health and Community Services Complaints Commission.

12.5.43 SALRI also recognises there is a clear gap in the enforceability of the principles due to the lack of explicit mechanisms to address non-compliance. SALRI notes, and agrees with, the Law Society's submission:

> Committee Members noted there is a choice between whether those guidelines are advisory or mandatory. The risk with the former is that they will be ignored and the risk with the latter is that compliance will become a 'tick box' exercise with no value to the consumer and merely used to 'cover' providers … the Committee considered the balance between legal compliance and cultural compliance - noting that without cultural compliance, legal compliance would be unachievable.

12.5.44 Additional measures to assist in the enforcement of the principles involved training mental health professionals. This was also raised during SALRI's Medical Specialist Roundtable, where attendees agreed more training for mental health practitioners focussing on the *MHA* and how to use it would be welcomed. Further, this ongoing training could be addressed within the Act.

12.5.45 Speech Pathology Australia noted that training regarding the 'barriers to engagement with, and participation in, verbally-mediated interventions experienced by those with communication difficulties' is necessary. Overall, views regarding the need for training was aptly summarised by a survey respondent who noted that 'without … training of public servants towards the enforcement of legal and human rights of consumers, no guiding principles will make an ounce of difference.'[2799] As noted by the Law Society in its submission, 'without cultural compliance, legal compliance would be unachievable.'

12.5.46 The YourSAy survey responses revealed that of the 45 responses received, 23 respondents were 'unsure' how the guiding principles could be enforced in practice. A greater number of respondents agreed that an enforcement mechanism should be included in the *MHA*, that specialised mental health training was needed and accountability for non-compliance was necessary. For example, one respondent stated '[consumers] must be given care, support and access to transparent complaint services and advocacy.'

12.5.47 Consultation revealed measures to improve and facilitate the enforcement of guiding principles was necessary. Further, enforcement was closely connected to a mechanism for monitoring and oversight.

Addressing access to mental health services

12.5.48 SALRI's consultation revealed views that the guiding principles do not adequately promote access to mental health services and may systemically impede early access to services due to its focus on acute treatment and care. For example, one consumer noted feeling as though 'people need to worsen their own situation to get help in a crisis.'

[2799] Other survey responses communicated similar ideas. One response noted that 'regular training is needed for staff. There needs to be a culture change in mental health services that allows for these to actually be enforced.' Another survey response stated that staff should be made to feel 'safe to speak if they observe and/or [are] a part of a service/program that isn't providing appropriate levels of support to consumers.'

12.5.49 The RRMHS asserted that 'the guiding principles themselves do not impact on service access for people experiencing mental illness', raising wider issues of workforce and culture as the factors with the most influence on access to mental health services:

> A person subject to a power of the *MHA* is more likely to get a service than a person voluntarily seeking treatment ... Consumers are not excluded from a service because of the *MHA*, instead people may not have access to a service because the service has limited resources and can only see the most acutely unwell people, or the service is stratified or siloed and has restrictive entry criteria, or the service the person needs does not exist. Sometimes the speed of access to services is determined by the level of restrictiveness of the *MHA* power used, rather than by the acuity of the illness or the least restrictive guiding principle. Services (mental health, general health, ED health, SAAS, SAPOL, RFDS) respond more quickly to ITOs over CTOs over ss 56/57, meaning that someone placed under s 56 in accordance with the least restrictive principle may not be seen as quickly as someone subject to an ITO…
>
> Improving access to services is a complex matter spanning across the clinical, resourcing and social equity realms. Improving access to services for people experiencing mental illness cannot be managed through legislation and can only be addressed by broad political and social change, which is then reflected in resource allocation and service culture change.

12.5.50 This was reinforced by the RANZCP, who noted:

> … [it does] not consider that *MHA* provisions are posing a barrier to consumers' access to services. Access to services is primarily a resourcing issue…
>
> Without adequate resourcing it is not possible to ensure effective, best-practice treatment for each person who requires it. In pursuing the goal of providing 'the highest attainable standard of health' it is critical that health services receive the funding necessary to provide accessible health services, including those focused on early interventions that can cease or slow the progression of a mental illness that may otherwise result in a need for a more restrictive intervention such as compulsory treatment.

12.5.51 Similar concerns relating to the current resourcing and operation of SA's mental health system was raised by the Australasian College for Emergency Medicine:

> The College is concerned by the lengthy delays to access definitive care that is experienced by people with acute mental health care needs. In the current mental health system, people experiencing mental health crises are subjected to unacceptably long waits in the ED for examination by a psychiatrist and admission into a mental health bed.
>
> The conditions created by the systematic underfunding of specialist mental health services and lack of inpatient capacity has created a situation where patients who should be bypassing EDs altogether are being directed to the ED to await assessment simply because gaps in community and inpatient mental health services have left these people with nowhere else to go.

12.5.52 In order to address these access issues, the Australasian College for Emergency Medicine suggested that the *MHA* should include 'provisions to ensure there is an adequate level of system capacity, and a guarantee of timely access to mental health care in safe and appropriate therapeutic environments.' By strengthening community-based responses to offer alternatives to ED would be beneficial, as 'the indefinite detention of mental health patients in EDs as 'counter-therapeutic".

12.5.53 Lived Experience Australia referred to the current climate of the mental health system:

> Access has been and remains a real issue in South Australia. People are being discharged before they should be, and there is a constant debate about whether someone on an inpatient unit is less acute than someone presenting to the emergency department. This bed pressure does not make for a safe environment and pushes clinicians to make decisions they would not wish to make. The system currently is broken, siloed, un-coordinated, and lacks integration. LEA does not see how the various elements of the *MHA* can change this situation.
>
> However, the *MHA* is set up as a legal entity to protect the rights of people with a lived experience and must remain, strengthened, and easily implemented. Having said this, if the culture of the mental health system was as it should be, then aspects of the *MHA* would not be required. Rather, de-escalation training, removal of security guards, etc would certainly enhance the environment in which safe and effective mental health care and treatment can and should be provided, for the amount of time required.

12.5.54 Clearly, issues relating to accessing mental health services are complex and multifaceted. Impact upon access is not solely attributed to the statutory language and framework provided by the *MHA*. Despite this, the *MHA*'s application to certain cohorts, such as children and adolescents or persons with a disability continues to create access issues. In its submission to SALRI, the Office of the Public Advocate ('OPA') noted their clients with dual diagnoses face difficulties accessing mental health treatment due to the stringent conditions placed upon mental health services by the *MHA*. The OPA gave an example of one scenario in which a client was able to access support under the *MHA* due to the presence of other non-mental health diagnoses:

> The Public Advocate is appointed guardian of Client A who has a complex presentation attributable to an interaction between diagnosed autism spectrum disorder, borderline intellectual disability, a history of trauma; and mental health issues including PTSD and depression … OPA has been unable to secure mental health support for Client A on the basis that the mental health presentations have been attributed to behaviour/disability and therefore diagnostic requirements for access to Mental Health Services are not met.

12.5.55 Due to the barriers to accessing mental health services for people with a dual diagnosis, the OPA recommended that the guiding principle relating to the needs of people with disability should be strengthened. Specific consideration to people with a disability and those with a dual disability is important.

12.5.56 In practice, this narrow focus can contribute to access issues for people with intellectual disability or complex needs, Culturally and Linguistically Diverse ('CALD') groups, and Aboriginal people. In particular, the Commissioner for Aboriginal Children and Young People commented:

> Aboriginal and Torres Strait Islander people will be reluctant to access services that do not recognise cultural beliefs and practices and are not open to working collaboratively with Aboriginal health workers and other cultural healers.

12.5.57 Ensuring that other cultural beliefs and practices are taken into account can also improve the provision of services generally. As identified by the Victorian Royal Commission, 'there is much to be learned' from the social and emotional wellbeing model:

> People's communities, neighbourhoods and environments affect their mental health and wellbeing … this knowledge has been long held by Aboriginal peoples and is now formalised in Aboriginal approaches to social and emotional wellbeing. The Aboriginal concept of social and emotional wellbeing takes a holistic view of mental health that is not limited to connections

> between the mind and the body … and captures Aboriginal people's connections to land, to spirit, spirituality and ancestors, to culture, and to community, family and kinship.[2800]

12.5.58 The LELAN suggested that the *MHA* guiding principles could be amended to improve consumer access by ensuring:

> … legislation that supports a recovery-oriented approach to care increase and improve consumer access to mental health services. Such strategies include a focus on removing restrictive practices, increasing training of mental health staff in de-escalation strategies, removal of practices and perceptions of threat and control through better training and ceasing the use of security personnel, increased community supports and care systems that include broader care planning and person-centred partnership in decision-making and care planning. Legislation and systems that rely on an imbalance of power and loss of rights, dignity and freedom and increased consumer experiences of threat, fear and distress or mistrust will continue to reduce access to services and fail to meet the needs of people with lived experience of mental illness….

12.5.59 SALRI's consultation also highlighted that access issues has led to greater reliance upon general practitioners ('GPs'). Consequently, treatment and care for non-acute mental illness and general wellbeing is often provided by primary health care services (which include GPs). This was especially relevant to consumers in regional communities. One regional Victoria-based general practitioner ('GP'), Dr Gerard Ingham, told the Victorian Royal Commission that GPs are key care providers for mental health in the community:

> I see GPs as both the glue and the gap-fillers of the mental health system … We see patients who will not be managed by the regional psychiatric service because the problems fall outside the types of mental health issues that they manage even though the problems can be very complex and challenging … I will provide counselling when the patient can't afford a psychologist or because I have known the patient for many years and have built up the trust to enable me to be best placed to help. If a patient needs to be seen today our practice will see them today … We turn nobody away in an emergency and we provide a '24/7' service … GPs provide cohesion between health professionals and between episodes of care over time.[2801]

12.5.60 A 2015 study on the role of GPs in involuntary community treatment similarly found that they were 'primary caregivers … a clinical resource in the (often over-stretched) community mental health system for the care of people with complex needs'.[2802] Further, the study reported that GPs 'enhanced patient care by managing often complex comorbidities, building strong therapeutic relationships and 'normalising' treatment.'[2803] Despite a GP's importance in the mental health system, their role is often invisible in reporting, policy and literature in mental health which 'can have serious implications.'[2804]

12.5.61 This was raised by an attendee SALRI's Medical Specialist Roundtable. It was noted that while GPs are expected to deal with mental health, some of them may not feel comfortable or equipped

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[2800] *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021) vol 1, 304. See Part 4 Aboriginal Mental Health.

[2801] *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021) vol 1, 333.

[2802] Edwina Light et al, 'Involuntary psychiatric treatment in the community: general practitioners and the implementation of community treatment orders' (2015) 44(7) *The Royal Australian College of General Practitioners* 485, 487.

[2803] Ibid.

[2804] Ibid 488.

to do so.[2805] The SA Health Lived Experience Workforce advocated for further education for GPs in relation to involuntary treatment and its implications and responding to suicide and distress.

12.5.62 Due to the lack of follow up for consumers living in regional, rural and remote settings, greater reliance may be placed on a GP. SALRI's consultation in a regional location revealed a consumer was taking over 30 tablets a day, which had been reduced from 46 tablets. Their medication was being managed by a GP.

12.5.63 SALRI recognises the increasing reliance upon GPs and their role in managing mental health challenges. This is a significant and often overlooked consideration.

12.5.64 Particular issues relating to access exist for consumers living in regional, rural and remote communities. One submission highlighted the lack of services and support in rural areas. Particular concerns are raised for children and adolescents requiring access to mental health services and follow up. The experience in accessing services often relayed to SALRI included numerous appointments with different specialists and mental health professionals at various regional and metropolitan mental health services, significant travel time, wait times and expenses.

12.5.65 Another example from Whyalla highlighted the disjointed nature of mental health services and improvements to 'open doors' between services, such as community mental health teams, forensic services and hospitals is needed.

12.5.66 Many consultees expressed a sense of disillusionment, despair and frustration and did not know where else to go for assistance.

12.5.67 SALRI notes that any efforts to address access to services must also consider the challenges faced by consumers living in regional, rural and remote areas.

Translating Guiding Principles into Measurable Outcomes

12.5.68 Consultation revealed a consensus that the guiding principles must be translated into measurable outcomes, which must be monitored for their enforcement. Further, in the event of non-compliance, an accountability mechanism is necessary.

12.5.69 SALRI notes that there are no explicit consequences for non-compliance with the guiding principles. In addition, there are no formal complaint mechanisms available to consumers or their carers to report non-compliance with guiding principles. SALRI's consultation with consumers and carers revealed the lack of clarity concerning consequences and accountability mechanisms, led to uncertainty regarding their rights and the purpose of the guiding principles.

12.5.70 The lack of accountability mechanisms in the *MHA* raised particular concern in SALRI's consultation. Consumers and consumer groups such as Lived Experience Australia and LELAN highlighted the need for meaningful accountability under the *MHA*, notably in giving real effect to the guiding principles.

12.5.71 As noted earlier, the measurable outcome must be operationally defined to translate the guiding principle in practice. In relation to the need for measurable outcomes, LELAN submitted that

[2805] As identified by Edwina Light et al, 'this indicates that there are opportunities to refine thinking around … engagement with GPs: Edwina Light et al, 'Involuntary Psychiatric Treatment in the Community: General Practitioners and the Implementation of Community Treatment Orders' (2015) 44(7) *The Royal Australian College of General Practitioners* 488.

'[p]erson reported outcomes and experience measures must be part of this evaluation.' In the context of children and adolescents, the SA Child and Adolescent Health Community of Practice advocated for greater scrutiny in relation to involuntary detainment for those under the age of 16. This should be monitored by an 'appointed state-wide Office of the Chief Child Psychiatrist, in collaboration with the Commissioner for Aboriginal Children and Young People, the Commissioner for Children and Young People and the Guardian for Children and Young People.'

12.5.72 Similarly, the Commissioner for Children and Young People recommended the development of strategic plans and 'annual reporting on services, demand for services, outcomes and other measures with regard to children and young people.' Examples of measures included the location of the service, who accessed the service, the number of practitioners in the service, number of beds, ability to service children and average time to treat a child.

12.5.73 The OCP Human Rights and Coercion Reduction Committee suggested that 'benchmarks should be met by the services, clinicians, and OCP, among other stakeholders.' The Committee offered the following examples:

> … new reporting by Clinical Directors to report how the guiding principles of the Act have been considered by practitioners in their service when deciding to use ITOs or CTOs to provide mental health care. In service planning, using a formal human rights tool would ensure new models of care are underpinned by the principles of the UNCRPD.

12.5.74 SALRI notes that the benchmarks or methods by which a service has considered the guiding principles must still be operationally defined.

Implementing mechanisms of oversight and accountability

12.5.75 The OCP proposed two approaches that would enforce accountability on behalf of service providers and those engaging with the guiding principles:

1. Referring to the approach adopted in Victoria, an annual report must be submitted to the Minister. This must report on a number of indicators, one of which is 'a summary of actions taken that demonstrate that reasonable efforts have been made by [the relevant oversight body] to comply with the mental health and wellbeing principles.'[2806] Similarly, the SA *MHA* could require a reporting function – the OCP would support this in principle, as a 'means of fostering systemic change and real engagement with the Act's guiding principles at the service level.'
2. Amendment to include a new function of the Chief Psychiatrist under section 90 of the *MHA*. The OCP suggested '[t]his new power may be to require service providers to report annually against the guiding principles in a similar manner to that proposed by … [Victoria].'[2807]

12.5.76 SALRI acknowledges that the OCP expressed preference for the first approach, requiring public reporting of compliance. It was noted this would limit the reporting burden on service providers, who are already subject to reporting obligations. Further, in the absence of a mechanism to sanction providers for non-compliance, this approach would still enforce accountability against the guiding principles.

[2806] *Mental Health and Wellbeing Act 2022* (Vic) s 427(1)–(2)(k).

[2807] This would be a similar accountability mechanism contained within s 26 of the *Suicide Prevention Act 2021* (SA).

12.5.77 Government representatives noted the lack of reporting on the guiding principles at the service level, and an attendee at the Government roundtable suggested that 'statutory officers could provide data and statistics in annual reports to report against [the] guiding principles.'

12.5.78 The Mental Health Commissioners also supported the Victorian approach, suggesting that 'a higher standard of accountability is provisioned in the [*MHA*], requiring "all reasonable efforts to comply" and "proper consideration" to the principles as the Victorian Act does.'

12.5.79 Consultation also revealed views with respect to the appropriate body, providing an oversight and accountability role. The Australian Nursing and Midwifery Federation supported the establishment of an independent statutory authority, such as the Victorian Mental Health and Wellbeing Commission. This was also raised by attendees at SALRI's Mental Health NGO Roundtable, who suggested an independent, overarching body could be vested with responsibility to monitor compliance.

12.5.80 This was also supported by Lived Experience Australia, who submitted:

> There is a real need for an independent accountability entity that can ensure the rights of people are protected. In the Victorian legislation, it is proposed to have a Mental Health and Wellbeing Commission as the oversight body. We have this in SA, but it was not implemented as a statutory body. This needs to be done as a matter of urgency. The independence of the Mental Health Commissioner role is paramount if the community is to trust the integrity of the role; they cannot simply be there to reinforce the views of the bureaucracy of the politics of the day.
>
> Consideration could be given to strengthening the Health and Community Services Complaints Commission's role to undertake this work. Currently the Commission can conduct investigations but only make recommendations with no powers to enforce them.

12.5.81 Alternatively, the DRAS suggested the role of auditing and reporting could be vested in the Mental Health Commissioners, with reports tabled in Parliament and made publicly available.

12.5.82 Consultation also raised different perspectives about the adequacy of oversight and accountability. The RRMHS considered that:

> The *MHA* makes every officer using a power of the Act responsible for the use of that power, with accountability for the *MHA* sitting alongside clinical responsibility. *MHA* and clinical responsibility flows from the individual clinical to the team leader to the service manager to the clinical director and professional leads. It may be helpful for the *MHA* to explicitly state that the system for responsibility for the use and administration of the Act within a service will be the same as the system used for clinical government in that service.

12.5.83 Following this, the RRMHS considered that the current mechanisms are sufficient as:

> The use of the *MHA* is monitored at a service, regional and LHN level through safety and quality, and clinical governance, mechanisms, and at the statewide level by the Office of the Chief Psychiatrist. The Chief Psychiatrist must produce an annual report providing details of the use and administration of the Act.

12.5.84 The RANZCP also submitted that the *MHA* 'should not regulate clinical matters in detail, although Tribunal oversight may be appropriate for some treatments.' Further, the current roles of the Chief Psychiatrist also contribute to effective accountability and monitoring.

12.5.85 Other parties in consultation, including government agencies and consumer groups, emphasised the need for more effective mechanisms. The Commissioner for Aboriginal Children and

Young People noted that monitoring should be 'strategic' at the systemic level, but when relating to individual treatment, 'should provide culturally appropriate avenues for Aboriginal people, as well as other cultural and linguistically diverse peoples.'

12.5.86 Some parties, including YourSAy respondents, contemplated the value of regular audits on mental health services, and public reporting, to 'ensure they are following the *MHA* adequately and the rights and interests of inpatients are respected as per the Objects and Principles of the Act.' In particular, DRAS advocated for the Mental Health Commissioner to undertake audits of mental health facilities.

12.5.87 Other mechanisms proposed were the use of Key Performance Indicators, user surveys and the use of the Safety Learning System to report incidents or complaints. For example, one survey respondent suggested that an 'exit from service survey/form [could be] completed by the consumer.'

12.5.88 The usefulness of accreditation, as an evaluative tool, was raised to SALRI, as it requires evidence that services are meeting defined standards/objectives and more. A similar process could be applied to compliance with the guiding principles, once they have been operationally defined.

12.5.89 The OPA suggested the following measures to enforce accountability and monitoring:

- Guidance, policies and procedures for adhering to the principles;
- Services could be required to report on compliance with the *MHA* principles through their service plans or annual reports;
- A complaints mechanism could be established which confirms that consumers have the right to complain about non-compliance with the principles;
- Clear and transparent performance measures that are easily accessible to consumers and the public.

12.5.90 Several parties raised the use of accreditation standards, a code of conduct or practice standards. These are more amenable to review for compliance. The NDIS was raised to SALRI as an example, whereby:

> … auditors strive to empower providers to not just meet these, but demonstrate innovative/best practice and continuous improvement, so it doesn't lose focus once the box is ticked. Additionally, the NDIS quality and safeguards commission make available pathways for people … to raise any concerns/complaints and ensure these are addressed, and the regulation of restrictive practice has put the spotlight on the sector, elevating awareness and accountability and again striving for best practice vs tick box compliance.

12.5.91 Attendees at the Mental Health NGO Roundtable questioned whether the principle requiring mental health services 'meet the highest levels of quality and safety'[2808] was based on a particular set of accreditation standards, and supported any amendments which would make the guiding principles more prescriptive. OPA noted that need for 'clear and transparent performance measures [which are] easily accessible to consumers and the public.'[2809]

[2808] *Mental Health Act 2009* (SA) s 7(ab).

[2809] In addition, the SA Health Child Protection Policy Unit noted its support for strategies to monitor and implement principles, including where annual reporting is required.

12.5.92 Consumers and consumer groups also expressed support for the creation of such standards. The OCP Lived Experience Advisory Group recommended the establishment of 'clear consequences' for those who fail to comply with the guiding principles and the involvement of regulatory bodies such as the Australian Health Practitioner Regulation Agency.

12.5.93 Most consultees also considered the necessity of creating specific mechanisms for feedback and complaints, especially relating to the guiding principles.[2810] Lived Experience Australia submitted these mechanisms should be available to consumers, family members and carers, and should be 'independent and can make decisions rather than recommendations such as the SA Health and Community Services Complaints Commissioner.'

12.5.94 The Legal Services Commission suggested the creation of a specific feedback or complaints mechanism where 'the guiding principles of the *[MHA]* have not been followed in their treatment and care experience.'

12.6 SALRI's Observations and Conclusions

12.6.1 SALRI notes there were many parties in consultation who believed the *MHA*'s current focus is too narrow. As a result, this framework may not place great consideration upon adequate support to prevent a consumer from reaching a point of crisis. One medical practitioner noted, as mental health services are 'funded to respond to acute mental illness … [they are restricted] in what they can do. Because of the *MHA*'s acute design, services are going towards acute care.'

12.6.2 In pursuit of shifting the focus and tone of the *MHA* toward early intervention, prevention and holistic wellbeing, SALRI supports amendments to s 6 Objects to reflect these aims. Further, greater emphasis on community treatment and management, including staffing, resourcing and funding should be considered. SALRI also recommends that the *MHA* is renamed to the *Mental Health and Wellbeing Act*.[2811]

12.6.3 Many parties during SALRI's consultation argued the *MHA* is failing to adequately recognise, uphold and protect the human rights of consumers. This was reinforced by the OCP, who noted complaints received by their office most frequently reflect a sense that, 'in practice, the Act is skewed in favour of clinicians rather than consumers, such that the legislation is protective, rather than rights-based.' Further, amendments to the guiding principles should move away from a risk averse approach, to avoid the possibility that 'compliance will become a 'tick box' exercise with no value to the consumer'.

12.6.4 SALRI notes the current tone of the *MHA* is at odds with its original intention, which was to '[provide] for the checks, balances and protections necessary for the transparent and accountable exercise of [its] powers.'[2812] Several parties offered solutions to this issue that included

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[2810] For example, the Legal Services Commission suggested that 'Consideration could be given to creating a specific mechanism for feedback and/or complaints to be made from patients who feel that the guiding principles of the MH Act have not been followed in their treatment and care experience.' The DRAS suggested that it would be especially important for consumers on ITOs and CTOs to have 'a comprehensive and transparent complaints procedure' to follow. One survey response noted that consumers 'must be given care, support and access to transparent complaint services and advocacy and/or legal representation.'

[2811] See SALRI Recommendation 1. See further Part 2 Background and Context to South Australia's Mental Health Laws.

[2812] South Australia, *Parliamentary Debates*, Legislative Council, 4 June 2008, 3096–118 (Gail Gago).

altering the principles to more explicitly reflect the rights contained within relevant international instruments, such as the *CRPD*.

12.6.5 However, it was also recognised that while the guiding principles are integral to ensuring the rights-based administration of the Act, their implementation must be observed throughout the entire mental health system. In law, this refers to a statutory rights-based approach.

12.6.6 SALRI accepts the utility of the guiding principles and notes the *MHA* incorporates a comprehensive list. However, SALRI recommends that the guiding principles under s 7 of the *MHA* should be retained, but re-structured to provide greater clarity and emphasis on mental health, wellbeing and prevention, with specific reference to the mental health and wellbeing principles observed in Victoria. SALRI proposes this will result in three benefits:

1. This re-structuring will provide much needed clarity regarding the intent or purpose of the principle, clearly identifying the relevant right it seeks to safeguard or promote.
2. The construction of the principle, or the way it may be phrased, can use assertive, positive rights-based language. For example, the Victorian Lived experience principle states:

> The lived experience of a person with mental illness or psychological distress and their carers, families and supporters *is to be recognised and valued* as experience *that makes them valuable leaders and active partners* in the mental health and wellbeing service system.[2813]

3. Greater clarity will assist in defining measurable outcomes, by which compliance with the principles may be monitored.

12.6.7 In light of the importance of assertive, positive rights-based language, SALRI recommends the phrase contained within s 7(1) of the *MHA* 'are to be guided' should be replaced with 'is to be actively considered'. Additionally, SALRI recommends that a Statement of Recognition, with reference to the National Strategic Framework[2814] and s 13 of the *Mental Health and Wellbeing Act 2022* (Vic), should be included as a guiding principle.[2815]

12.6.8 SALRI acknowledges the concerns and barriers pertaining to the implementation and operationalisation of the guiding principles in practice. SALRI notes there are three facets to a mechanism which enforces the guiding principles in practice:

1. An appointed body or bodies must be vested with the responsibility to develop standards by which the guiding principles are to be operationalised. The aim of this is to define the intended measurable outcome and determine how to operationally define the principles.
2. Identify an appropriate body or bodies to monitor and enforce compliance with the guiding principles, according to their agreed definition in practice. This refers to the specific mechanism that enables oversight, such as annual reporting.
3. Identify the most appropriate cause of action to address non-compliance with the guiding principles.

[2813] *Mental Health and Wellbeing Act 2022* (Vic) s 21.

[2814] This refers to the *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017-2023*.

[2815] SALRI also specifically recommends that dignity of risk should be inserted as a guiding principle within the *Mental Health Act 2009* (SA).

12.6.9 SALRI recommends that the OCP should convene a working group, with input and consultation from relevant interested parties, such as the Mental Health Commissioner, Health and Community Services Complaints Commissioner, Principal Community Visitor and Office of the Public Advocate, to identify and develop standards by which the guiding principles are to be operationalised.

12.6.10 SALRI further recommends that this working group may invite other parties, such as experts,[2816] consumers, Aboriginal, Culturally and Linguistically Diverse, LGBTIQ representatives to engage in the development of appropriate standards.

12.6.11 SALRI recommends that such standards should allow the OCP to monitor compliance with the guiding principles and determine appropriate responses or recourse for non-compliance. This monitoring role should include reporting of completed measures/initiatives/practices to enforce compliance with a principle and best practice. SALRI recognises concerns relating to the lack of consequences within the *MHA* for parties who fail to comply with the guiding principles. In response to this, SALRI supports the inclusion of a public reporting requirement, which may take the form of a public notice identifying the party who has failed to comply and measures to address, improve and resolve non-compliance.

12.6.12 There are two considerations when determining the most appropriate body to monitor compliance. First, there may be instances where a conflict of interest is raised, as the relevant guiding principle may require a body to monitor itself. Secondly, the guiding principles capture clinical and non-clinical matters. As a result, these considerations may warrant the delegation of a duty to monitor to another body or require specific expertise to adequately monitor compliance. Therefore, SALRI recommends that, in consultation with the working group, a duty to monitor compliance and address non-compliance, may be delegated (if agreed) to the most appropriate party.

12.6.13 SALRI further recommends that the OCP, in their role to promote the continuous improvement of organisation and delivery of mental health services, focus on the operationalisation of particular guiding principles each year, with progress to be reported in the Chief Psychiatrist's Annual Report under s 92(1)(a) of the *MHA*.

12.6.14 SALRI also acknowledges the absence of a clear complaints mechanism within the *MHA*, directly relating to non-compliance with the guiding principles. The introduction of an accountability mechanism, as per SALRI's recommendation, requiring public reporting and notice of non-compliance may alleviate concerns. However, SALRI supports further consideration regarding the implementation of a complaints mechanism. In particular, SALRI recognises the utility of the Health and Community Services Complaints Commissioner in providing this complaints mechanism. SALRI also notes that the Health and Community Services Complaints Commissioner may work in conjunction with the Mental Health Commissioner, who is able to provide specialist expertise in relation to mental health related complaints.

12.6.15 SALRI finally suggests that the incidental or technical amendments to clarify the operation of the *MHA* raised by the OCP are set out in Appendix 3. SALRI's response to these amendments can be found under the column 'SALRI's Views/Comments'.

[2816] Such as the Commissioner for Aboriginal Children and Young People and the Commissioner for Children and Young People.

12.6.16 Recommendations

RECOMMENDATION 56

SALRI recommends that the phrase contained within s 7(1) of the *Mental Health Act 2009* (SA) 'are to be guided' should be replaced with assertive positive rights-based language 'is to be actively considered'.

RECOMMENDATION 57

SALRI recommends that a Statement of Recognition, with regard to the National Strategic Framework and s 13 of the *Mental Health and Wellbeing Act 2022* (Vic) should be included as a guiding principle under the *Mental Health Act 2009* (SA).

RECOMMENDATION 58

SALRI recommends that the guiding principles under s 7 of the *Mental Health Act 2009* (SA) should be retained but restructured to provide greater clarity and emphasis on mental health, wellbeing and prevention, with specific regard to the *Mental Health and Wellbeing Act 2022* (Vic).[2817]

RECOMMENDATION 59

SALRI recommends that the Office of the Chief Psychiatrist should convene a working group, with input and consultation from relevant interested parties such as the Mental Health Commissioner, Health and Community Services Complaints Commissioner, Principal Community Visitor and Office of the Public Advocate, to identify and develop standards by which the guiding principles are to be operationalised. SALRI further recommends that this working group may invite other parties, such as experts,[2818] consumers, Aboriginal, Culturally and Linguistically Diverse and LGBTIQ representatives, to engage in the development of appropriate standards.

[2817] SALRI specifically recommends that dignity of risk should be inserted as a guiding principle within the *Mental Health Act 2009* (SA).

[2818] Such parties could include the Commissioner for Aboriginal Children and Young People and the Commissioner for Children and Young People.

RECOMMENDATION 60

SALRI recommends that such standards should allow the Office of the Chief Psychiatrist to monitor compliance with the guiding principles and determine appropriate responses or recourse for non-compliance.[2819] SALRI further recommends that, in consultation with the working group, a duty to monitor compliance and address non-compliance, may be delegated (if agreed) to the most appropriate party to avoid conflict of interests. In addition, SALRI recommends that the Office of the Chief Psychiatrist, in their role to promote the continuous improvement of organisation and delivery of mental health services, focus on the operationalisation of particular guiding principles each year, with progress to be reported in the Chief Psychiatrist's Annual Report under s 92(1)(a) of the *Mental Health Act 2009* (SA).

RECOMMENDATION 61

SALRI recommends that the incidental or technical amendments to clarify the operation of the *Mental Health Act 2009* (SA) or elsewhere as set out in Appendix 3 should be made.

[2819] This may take the form of a public notice identifying the party who has failed to comply and measures to address, improve and resolve non-compliance.

Appendix 1 – Case Note: *PBU & NJE v Mental Health Tribunal* [2018] VSC 5641135

Case Note: *PBU & NJE V Mental Health Tribunal* [2018] VSC 5642820

INTRODUCTION

In *PBU & NJE v Mental Health Tribunal*,[2821] Bell J held that the Victorian Civil and Administrative Tribunal ('VCAT') incorrectly interpreted the capacity to give consent test under the *Mental Health Act 2014* (Vic) ('*MHA*'). Properly applied, the test asks whether a person is capable of understanding, remembering, considering, and communicating the general nature, purpose, and effect of treatment. Whether the person actually does so is irrelevant, and a person does not lack capacity simply because they dispute their diagnosis. The court also emphasised that the test must be interpreted consistently with the *Charter of Human Rights and Responsibilities Act 2006* (Vic) ('Charter'). The case is significant for recognising the fundamental right of people with mental illness to make decisions about their own treatment.

CASE SUMMARY

A. Facts

This case concerned two unrelated individuals, identified as PBU and NJE.

In 2011, PBU was diagnosed with treatment-resistant schizophrenia,[2822] for which he was hospitalised several times. In December 2016, he was admitted to an acute psychiatric inpatient unit pursuant to an inpatient treatment order under s 45(3) of the Victorian *MHA*,[2823] at which point he refused to take medication and was experiencing psychosis. In February 2017, VCAT ordered that PBU undergo six electroconvulsive therapy ('ECT') treatments, five of which took place during that month and 'dramatically' improved his condition.[2824] However, PBU was then assessed as having regained capacity to refuse treatment, and the ECT was stopped.[2825]

The Victorian Mental Health Tribunal ('MHT') ordered that PBU undergo 12 further ECTs on 19 April 2017,[2826] which PBU applied for VCAT to review. PBU's psychiatrist and the Mental Health Service clinical director gave evidence to VCAT that PBU's condition was deteriorating and he was refusing to take medication and that ECT was the only appropriate treatment that would enable PBU to leave hospital.[2827] PBU disputed his schizophrenia diagnosis and asserted that his symptoms were more in line with depression, anxiety, and post-traumatic stress disorder ('PTSD'), for which he was

[2820] SALRI acknowledges the input of Olivia Bradley of the Law Reform class.

[2821] [2018] VSC 564 ('*PBU & NJE*').

[2822] Ibid [4].

[2823] Ibid.

[2824] Ibid [5].

[2825] Ibid [6].

[2826] Ibid [7]–[8].

[2827] Ibid [9].

willing to have psychiatric and psychological treatment.[2828] However, he did not want any treatment for schizophrenia, including ECT and anti-psychotic medication, and insisted his preference was to be discharged and allowed to go home.[2829]

NJE

Since 2004, NJE had been treated both voluntarily and involuntarily for treatment resistant schizophrenia.[2830] She was transferred to a regional secure extended inpatient unit in March 2017, where she stopped taking medication and declined routine health monitoring.[2831] Three applications were made for ECT, the first two of which were rejected on the basis that NJE had the capacity to refuse treatment. However, the MHT granted the third order for 12 ECT treatments. This order went to VCAT to review. NJE did not accept that she had schizophrenia or any other mental illness and wanted to undergo alternative treatment to ECT, despite having previously overdosed on antipsychotic medication.[2832] She also believed that she had psychic healing powers that could be affected by ECT.[2833]

VCAT Decisions

In two separate cases, VCAT determined that both PBU and NJE did not have the capacity to refuse ECT because, although they understood the nature of the treatment, they did not accept that they were schizophrenic.[2834] VCAT found that NJE could not 'use and weigh information' because she was unable to 'carefully consider the advantages and disadvantages' of treatment.[2835] Further, it found that there was no alternative less restrictive treatment. As such, VCAT ordered the treatment over the objections of the two patients.

Issues

Victoria Legal Aid appealed VCAT's decisions to the Supreme Court on PBU and NJE's behalf. The key issue on appeal was whether VCAT had failed to properly consider relevant human rights, as well as whether it correctly interpreted and applied the capacity to give informed consent test under the *MHA*. Another issue was whether there was a less restrictive way for PBU and NJE to be treated. Finally, with respect to NJE only, the court considered whether VCAT had incorrectly asked whether she had, in fact, used and weighed information, as opposed to whether she merely could do so.

Legislative Framework

Under the *MHA*, an order for compulsory treatment and detention can be made if a person has a mental illness and there is a risk of serious mental or physical deterioration, or serious harm to the person or others, such that immediate treatment is required.[2836] However, a person cannot be

[2828] Ibid [10].

[2829] Ibid.

[2830] Ibid [15].

[2831] Ibid [70].

[2832] Ibid [23], [28], [70].

[2833] Ibid [23], [28].

[2834] *PBU v Mental Health Tribunal (Human Rights)* [2017] VCAT 781, [80].

[2835] *NJE v Mental Health Tribunal (Human Rights)* [2017] VCAT 1070, [63]–[64].

[2836] *Mental Health Act 2014* (Vic) s 5.

compelled to undergo ECT unless VCAT is satisfied that they do not have the capacity to provide informed consent,[2837] and that ECT is the least restrictive option.[2838]

The test for capacity is set out in s 68(1) of the *MHA* and requires that a person can (a) understand relevant information provided, (b) remember relevant information, (c) use or weigh relevant information, and (d) communicate their decision. A person is presumed to have capacity, notwithstanding any mental illness.[2839] Capacity is issue-specific,[2840] can fluctuate,[2841] and may improve with support. Several sections of the Charter were also held to be relevant, including rights to equality before the law,[2842] protection from cruel, inhuman, or degrading treatment, including non-consensual medical treatment,[2843] privacy,[2844] freedom of expression, thought, conscience, religion, and belief,[2845] liberty and security of person,[2846] and humane treatment when deprived of liberty.[2847] PBU and NJE argued that these rights influenced the interpretation and application of the *MHA* in their favour to refuse the treatment.

Judgment

Human Rights

The court held that laws about capacity under the *MHA* raise rights to refuse medical treatment, self-determination, inviolability of person, equality before the law, and privacy.[2848] The court also emphasised VCAT's obligations as a public body under the Charter to ensure the human rights of people with mental illness, including by making decisions upholding their rights.[2849] Such rights will be breached if the limitation on exercising capacity is not justifiable. Since a person can lose their right to refuse treatment if they are found to lack capacity under the *MHA*, the court held that the capacity test must be interpreted and applied consistently with the Charter.[2850]

Capacity

Turning to the capacity test, the court recognised that a person will not lack capacity simply because they made an objectively unwise, unreasonable or irrational decision,[2851] or because they lack insight as to their condition.[2852] Indeed, Bell J noted that an 'appreciation' requirement was removed during the *MHA* consultation process.[2853] The court said that the test is functional and has a relatively low

[2837] Ibid s 96(1)(a)(i).

[2838] Ibid s 96(1)(a)(ii).

[2839] Ibid s 70(2).

[2840] Ibid s 68(2)(a).

[2841] Ibid s 68(2)(b). See also [2018] VSC 564, [149].

[2842] [2018] VSC 564, [110], citing *Charter of Human Rights and Responsibilities Act 2006* (Vic) s 8 ('Charter').

[2843] Ibid, citing Charter s 10.

[2844] Ibid, citing Charter s 13.

[2845] Ibid, citing Charter ss 14–15.

[2846] Ibid, citing Charter s 21.

[2847] Ibid, citing Charter s 22.

[2848] Ibid [112]–[128].

[2849] Ibid [129], citing Charter s 38(1).

[2850] Ibid [206].

[2851] Ibid [154]. See also [165]–[168], [201], [242], [279]–[280].

[2852] Ibid [194], [206], [279].

[2853] Ibid [188].

standard,[2854] concerning the person's ability to understand, remember, consider, and communicate the general nature, purpose and effect of the treatment,[2855] rather than whether they actually did so.[2856] His Honour held that impairment of cognitive functioning is insufficient; the person must completely lack capacity in those areas.[2857] Further, Bell J noted that since lack of insight is not material to determining capacity in an individual without a mental illness, it would be discriminatory for that factor to be determinative where an individual has a mental illness.[2858] The court also emphasised that social conformity must not be preferred over the patient's autonomy. Given the seriousness of the matter and the consequences flowing from a finding of no capacity, Bell J held that proof was required to the *Briginshaw* standard.[2859]

The court held that PBU did not lack capacity simply because he disputed his schizophrenia diagnosis,[2860] even though his symptoms included paranoia, delusions, and hallucinations, noting that refusing to accept a diagnosis would not be enough to rebut the presumption of capacity in a person without mental illness.[2861] Further, the court held that VCAT had erred by asking whether NJE had, in fact, used or weighed information, since the capacity test does not ask whether the patient has made a reasonable, balanced decision.[2862] Rather, the test is underpinned by rights considerations, and gives patients the freedom to make an unwise or irrational decision if they so choose. The court likened NJE's purported psychic healing abilities to prayer and did not consider evidence of this alone to demonstrate a lack of capacity.[2863]

Least Restrictive Treatment

Notwithstanding the court's findings as to capacity, Bell J went on to consider whether ECT was the least restrictive treatment available. The court rejected the argument that the criteria in s 5 of the *MHA*, which must be satisfied before an order for compulsory treatment can be made, limits the type of treatment that can be administered.[2864] As such, ECT could be ordered regardless of whether it was necessary to prevent serious deterioration of the patient's mental or physical health or serious harm to the patient or another person. The court held that the s 5 threshold does not preclude medical practitioners from providing treatment where those criteria are not satisfied.[2865] 47 However, the 'no less restrictive' test has a higher threshold than the 'best interests of the patient' test, recognising rights of self-determination and protection from personal violation.[2866] The court held that a broad range of factors must be considered, including the patient's wishes, even where the patient lacks capacity.[2867] This is to be balanced with medical or clinical evidence, therefore upholding the person's right to

[2854] Ibid [154].

[2855] Ibid [235], [280].

[2856] Ibid [206], [235]–[236].

[2857] Ibid [163]. See also [137]–[147], citing *Airedale NHS Trust v Bland* [1993] AC 789; *Hunter and New England Area Health Service v A* (2009) 74 NSWLR 88; *Malette v Shulman* (1990) 72 OR (2d) 417.

[2858] [2018] VSC 564, [231], [279].

[2859] Ibid [206] following *Briginshaw v Briginshaw* (1938) 60 CLR 336, 362 (Dixon J).

[2860] [2018] VSC 564, [33].

[2861] Ibid [228].

[2862] Ibid [182], [280].

[2863] Ibid [242].

[2864] Ibid [265].

[2865] Ibid [273].

[2866] Ibid [252].

[2867] Ibid [256]–[257].

health.[2868] The Court found that ECT was the least restrictive treatment for PBU and NJE, although this had no impact on the case's outcome.

SALRI notes that *PBU & NJE v Mental Health Tribunal* is a significant authority on the interpretation and application of the decision-making capacity test under the Victorian *MHA*.[2869] Bell J's judgment emphasises that the test of capacity is functional and has a relatively low threshold, thereby affording substantial scope to persons with mental illness in decision-making. The case is also notable for clarifying the relationship between the *MHA* and the Victorian Charter, protecting the inherent dignity of people with mental illness, and adopting a holistic approach to health by taking personal autonomy into account.[2870] The decision has been questioned as 'problematic clinically' by psychiatrists Russ Scott and Steve Prowacki,[2871] who argue that one of the 'crucial components' of decision-making capacity in a psychiatric patient is belief in and acceptance of their illness.[2872] The absence of such a criterion in the *MHA* capacity test, they contend, is 'a significant shortcoming'.[2873] The Court's recognition of the departure from 'best-interests paternalism' could have broad implications for the treatment of mental illness.[2874] The case demonstrates the ability of consumers to refuse to undergo treatment under the *MHA*, even if it may be in their best interests and their decision can be viewed as objectively unwise.

[2868] Ibid [206], [257].

[2869] *EBJ* [2019] VMHT 12 and *INN* [2019] VMHT 16.

[2870] [2018] VSC 564, [97].

[2871] Russ Scott and Steve Prowacki, 'Insight and Capacity to Consent to Electroconvulsive Therapy' (2019) 27(5) *Australasian Psychiatry* 428, 434.

[2872] Ibid.

[2873] Ibid. 'To posit that a patient with a severe mental illness would make a considered decision to choose the 'dignity,' 'autonomy space' and 'individual identity' of no or suboptimal treatment and languish institutionalised on a mental health ward, would appear to many mental health clinicians as illogical. It can be speculated that many clinicians would not accept the proposition that a person who has no insight into his or her serious mental illness, has at the same time, decision-making capacity to refuse evidence-based treatment for that serious mental illness.'

[2874] [2018] VSC 564, [281]. See also [252].

Appendix 2 – Case Note: *TSC v Department of Health and Wellbeing* [2021] SASCA 93

Case Note: *TSC V Department of Health and Wellbeing* [2021] SASCA 93

Background

This case concerned a 59 year old male applicant, who sought an appeal of a level 2 community treatment order made by SACAT.[2875] The applicant had a primary diagnosis of schizophrenia and a comorbid diagnosis of post-traumatic stress disorder ('PTSD').[2876] Within the hearing and subsequent appeals, the applicant did not accept the diagnosis of schizophrenia (though he did accept his diagnosis of PTSD).[2877] The applicant had been admitted to hospital on a number of occasions following non-compliance with prescribed psychiatric medication.[2878]

The applicant's treating medical practitioner made an application for a level 2 CTO under the *MHA* following the applicant's most recent admission to hospital.[2879] This hospital admission occurred after the applicant presented to the Bedford Park Medical Clinic and experienced an apparent psychotic episode.[2880] The applicant's aggression and hostility necessitated police intervention in transferring him to the hospital.[2881] The applicant was subsequently discharged from the hospital and was prescribed an anti-psychotic medication, to be administered through what is typically known as a 'depot'.[2882] A depot is a slow-release form of delivery of a medication, in this case, to be administered monthly, that may alternatively be taken through daily oral doses.[2883] The applicant identified that his objection to the depot was on the basis that the injection caused pain to his arm.[2884] The applicant failed to attend his depot injection two weeks following his discharge from hospital and then both subsequent monthly appointments.[2885]

SACAT accepted the two diagnoses and found evidence that the applicant satisfied the requirements of s16 of the *MHA*, making a CTO for 12 months.[2886] The hearing at which this decision was made was perhaps less than ideal. It was held via telephone and attended by a medical practitioner who was not the applicant's regular treating medical practitioner.[2887] The treating medical practitioner supplied

[2875] SALRI acknowledges the input of Nili McGrath of the Law Reform class. *TSC v Department of Health and Wellbeing* [2021] SASCA 93, [2], [8] ('*TSC*').

[2876] Ibid [8].

[2877] Ibid.

[2878] Ibid [9].

[2879] Ibid [10]–[12].

[2880] Ibid [10].

[2881] Ibid. It is a regular event for the police to have to attend to such incidents.

[2882] *TSC v Department of Health and Wellbeing* [2021] SASCA 93, [11].

[2883] Ibid.

[2884] Ibid [52].

[2885] Ibid [11].

[2886] Ibid [8], [12]; *Mental Health Act 2009* (SA) s 16.

[2887] Ibid [12].

a medical report that he had prepared to SACAT, in lieu of being able to attend.[2888] SACAT additionally relied upon a written submission made by the applicant and the written medical report of a third medical practitioner, detailing the applicant's 'chronic condition of schizophrenia and the established risks associated with discontinuing his medication'.[2889] SACAT was satisfied that the applicant had impaired decision-making capacity.

Legal Issue

This appeal considered the application of s 16(1)(c) and s 5A(2)(a)(iii), specifically, the concept of impaired decision-making capacity.[2890]

The Court of Appeal ('the Court') was required to determine whether SACAT had erred in its decision to impose the treatment order on the basis of its interpretation of the phrase 'impaired decision-making capacity' pursuant to s 16(1)(c).[2891] The Court also considered whether SACAT appropriately drew inferences from the evidence and whether it was open to SACAT to be satisfied of the applicant's incapacity on the evidence before them.[2892]

SACAT's decision at first instance found the applicant 'lacked decision-making capacity relating to appropriate treatment of his mental illness'.[2893] The appeal was not directed at SACAT's 'characterisation' of the test, rather the applicant submitted that the test was 'misapplied' when considering the specific facts and circumstance.[2894]

The applicant asserted that to conclude that he did not understand the 'precise nature' of his condition is contrary to s 5A(3)(a).[2895] Secondly, he argued that failure to comprehend the 'seriousness' of his condition was not a relevant assessment.[2896] Thirdly, he contested that a decision, even one that is not recommended or is foolish or unwise, does not establish incapacity.[2897] Finally, he submitted that it is not that he disagreed with treatment, but rather its method of administration, specifically that he would elect oral dosage.[2898]

Relevant Law

Section 5A provides a 'definition and descriptive limits of the concept of impaired decision-making capacity' as used in s 16(1)(c).[2899] The court focused on two main elements of this concept of capacity.

[2888] Ibid [12].

[2889] Ibid [12], [54], [65].

[2890] *Mental Health Act 2009* (SA) s 16(1)(c), s 5A(2)(a)(iii).

[2891] *TSC v Department of Health and Wellbeing* [2021] SASCA 93 [2].

[2892] Ibid.

[2893] Ibid [19].

[2894] Ibid [21].

[2895] Ibid [44], *Mental Health Act 2009* (SA) s 5A(3)(a).

[2896] Ibid [45].

[2897] Ibid [46].

[2898] Ibid [47].

[2899] *Mental Health Act 2009* (SA) s 16(1)(c), s 5A.

First, in order to have impaired decision making capacity, a consumer must not be able to understand information relevant to the decision.[2900] When considering the concept of 'capacity' legislatively, the Tribunal contemplated the decision of *PBU & NJE v Mental Health Tribunal* [2018] VSC 564 ('*PBU*'), whilst not identical, was under a similar legislative context.[2901] Capacity, as evidenced by the scrutiny offered to it in this case, is a complex concept. SACAT acknowledged that capacity does not require 'a person … to have fully [understood] all of the precise details', however they 'must be able to understand information relevant to the decision', be then able to 'retain that information at least for a sufficient period as to be able to use it to make a decision' and then 'communicate that decision'.[2902]

Further, SACAT recognised that having impaired decision-making capacity does not arise from a lack of understanding of the technical or trivial nature of aspects of their condition, but rather as held by Bell J in *PBU*, requires an increasingly 'functional approach' that questions 'whether, at the time the decision had to be made, the person could understand its nature and effects'.[2903] SACAT concluded that a functional approach is required for the test in s 5A(2)(a).[2904] Furthermore, the Court noted that the question of capacity is fact and context specific.[2905] SACAT held at first instance that the applicant's assessment of his mental condition, specifically his dispute as to his diagnosis of schizophrenia, exhibited a 'fundamental failure to appreciate the impact of that condition and the treatment that was required to address it'.[2906]

PBU considers the *Mental Health Act 2014* (Vic) which comparative to the South Australian *MHA*, expresses 'capacity' in positive terms and as such, the court noted, the *MHA* 'focuses more expressly on the capacity to understand the information'.[2907] The Court considered that the capacity test cannot entirely rely on 'cognitive ability' but that an overlap exists between the concepts of capacity to 'understand' information and capacity to 'use' it.[2908]

SACAT also considered as part of understanding s 5A(3)(a), that 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 matter.[2909] They maintained that, in this context, a failure to understand the severity of his condition by his disagreement of the diagnosis of schizophrenia and diminishing his behavior as 'mostly angry outbursts' as opposed to extended psychotic episodes, was not contrary to this provision, but rather a fundamental lack of understanding.[2910]

Secondly, that in determining capacity, the question of 'best interests [is] irrelevant'.[2911] When examining this intrinsically nuanced concept of capacity, the court affirmed the comments of Bell J in

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[2900] Ibid s5A(2)(a)(i).

[2901] *TSC v Department of Health and Wellbeing* [2021] SASCA 93 [23].

[2902] Ibid.

[2903] Ibid [30], [27].

[2904] *Mental Health Act 2009* (SA) s 5A(2)(a); *'TSC'* (n1) [27], [30].

[2905] *TSC v Department of Health and Wellbeing* [2021] SASCA 93 [40].

[2906] Ibid [56].

[2907] Ibid [26]; *Mental Health Act 2014* (Vic).

[2908] Ibid [57].

[2909] *Mental Health Act 2009* (SA) s 5A(3)(a).

[2910] *TSC v Department of Health and Wellbeing* [2021] SASCA 93 [55], [56], [60].

[2911] Ibid [38].

PBU, supporting the test stated in both ss 16(1)(c) and 5A(2) 'provides no room for an external assessment of what is in the person's 'best interests'… The test is one of capacity'.[2912] As the Court recognised, the legislative provisions of the Victorian Act, particularly 's 16(1)(c), as informed by s 5A(2), intrudes on what has long been understood to be a fundamental common law right to bodily integrity'.[2913] It is in very limited circumstances that the Court has this power and it only exists when an individual cannot genuinely perceive and appreciate their condition. Further, they are unable to understand information relating to their condition, process and retain this information and then communicate a decision.[2914] The Court recognised in this, that variation in human behavior plays a role in this assessment but that once again, individual, bodily autonomy is a fundamental right and cannot be rescinded on the basis that the Court, medical doctors or any other person for that matter, does not agree with the choice.[2915] Further, the Court stated that where such an intrusion is authorised by the relevant legislation, it is essential to ensure that the 'intrusion goes no further than that which has been authorised'.[2916]

Separately, the Court also considered the evidence before the Tribunal as earlier stated in the Background. The applicant contested the evidence from a medical practitioner who had not treated him and his own written submissions, on the basis they were not given in a doctor-patient consultation.[2917] On this issue, the Court noted that the Tribunal was a specialist Tribunal and was not bound by evidentiary rules.[2918] The Court affirmed that the nature and context of the hearing was sufficient for the Tribunal to reach a conclusion and that the extent of evidence provided enabled them to understand a full account of the applicant's perception, or lack thereof, of the seriousness of his condition.[2919]

Judgment

The Court upheld the Tribunal's determination that the applicant demonstrated a 'failure … to understand the nature and quality of his condition which translates to an inability to make judgments as to the appropriate treatment', and that this conclusion '[did] not rely on impermissible references.[2920]

The Court found that the Tribunal's conclusion that the applicant lacked proper understanding of the precise nature of his illness does not contradict s 5A(3)(a).[2921] The Court held that in this factual scenario the applicant's insistence of the 'brief' nature of his condition opposed the diagnosis of a 'chronic condition' and thus, is a 'fundamental matter that then feeds into the question of the appropriate treatment'.[2922] The Court rejected the applicant's submissions that his preference for an oral dosage is a matter of contestable judgment stating that this finding 'cannot be separated from

[2912] Ibid [35]; *Mental Health Act 2009* (SA) s 16(1)(c), s 5A(2).

[2913] Ibid [33]; *Mental Health Act 2009* (SA) s 16(1)(c), s 5A(2).

[2914] *Mental Health Act 2009* (SA) s 5A(2).

[2915] *TSC v Department of Health and Wellbeing* [2021] SASCA 93 [23].

[2916] *TSC v Department of Health and Wellbeing* [2021] SASCA 93 [34].

[2917] Ibid [15], [64].

[2918] Ibid [65].

[2919] Ibid [60], [62].

[2920] Ibid [62].

[2921] Ibid [59]; *Mental Health Act 2009* (SA) s 5A(3)(a).

[2922] *TSC v Department of Health and Wellbeing* [2021] SASCA 93 [59], [60].

those about the appreciation of his condition'.[2923] The Court held that 'when read together, these integrated conclusions of the Tribunal' demonstrate an innate failure of the applicant to understand the seriousness of his condition and make subsequent decisions regarding treatment.

Law Reform

In relation to law reform, it is prudent to consider whether greater safeguards are required to ensure the preservation of fundamental rights held by the individual as to their body. The applicant in this case felt that the evidence provided in his hearing did not appropriately reflect his circumstance, nor inform the Court. Whilst the Tribunal is not currently bound by evidentiary rules, the ability for greater evidentiary enquiry and the transparency that follows would improve the perception of a fair hearing. This may be achieved through the introduction of sworn evidence or in a more general capacity. It should also be noted that law reform cannot exist in a vacuum. This is particularly relevant to the Act, in which the interplay between disciplines, specifically that of medicine and law is inextricable.[2924] Evidentiary and general reform to the Act necessitates consultation with the mental health sector.

Conclusion

This case discussed the fundamental concept of decision-making capacity. This was discussed in the context of an individual's autonomous choice and the tension balancing a critical right of autonomy against legislative regimes designed to intervene in instances when a person does not have capacity to understand their condition. It emphasised the importance of ensuring that the application of the Act reflects the significance of its power to interfere with human rights. Further, its application should not extend beyond what is legislatively provided.

[2923] Ibid [61].

[2924] *Mental Health Act 2009* (SA).

Appendix 3 – SALRI comments on OCP Table of Issues

Mental Health Act 2009

Attachment 1 - Issues identified by OCP for legislative consideration

	Topic	Act Section	Issue / Amendment	Issue Type	Impact	SALRI Response / Comments
1	Administrative	109(a)	Lists documents that should be taken as genuine unless there is proof to the contrary. Add: Patient assistance request.	Administrative	Enhanced consistency	Accepted.
2	Administrative	109(e)	States that an apparently genuine Chief Psychiatrist standard 'approved by the Minister' will be taken as genuine unless there is proof to the contrary. Chief Psychiatrist standards no longer require the approval of the Minister and this reference should be removed. Remove: 'with the approval of the Minister'.	Administrative	Enhanced consistency	Accepted.
3	Appeal SACAT	83A(h)(ii)	Changes to how SACAT can undertake reviews of treatment orders have removed the capacity for a person to apply to the Supreme Court to appeal against a decision made by SACAT in its review jurisdiction. Change: The subsection to allow an application to the Supreme Court for an appeal against a decision made by SACAT in its review jurisdiction. This may require consequential amendment of the SACAT Act.	Legal and rights	Will enhance capacity for appealing decisions	Accepted.
4	Carers Human rights	12(6)(c) 23(6)(c) 27(6)(c)	The Act requires a copy of treatment orders, statement of rights and notices to be given to a guardian, relative, carer or friend of the consumer, unless the director of the treatment centre believes it would be contrary to the consumer's best interests. The OCP received an external submission requesting that, in cases where treating teams refuse to share copies of orders etc, there be a requirement to advise those carers, families of their rights to appeal to SACAT to review that clinical decision.	Legal	Enhanced rights	Supported.

			Consider: Balancing of consumer rights with carer rights to know (particularly where consumer living with carer) Consider: This would seem to require consumer to have nominated a particular carer (other jurisdictions do this, but SA has open definition). Perhaps better dealt with internally within health service.			
5	Carers Representation Human rights	84	The Act does not provide for legal representation for families and carers before the Tribunal. Submission requests an extension of the legal representation scheme to enable representation of families and carers wishes to apply for review of treatment orders. Considerations: funding.	Legal	Enhanced rights	Declined – due to SACAT's capacity and infrequency of reviews initiated by family members and carers. SALRI has recommended that s 84 of the *Mental Health Act 2009* (SA) should remain. It should not be amended with respect to interested parties. Therefore, the present legal representation scheme should not be extended to interested parties pursuing an appeal of a treatment order under the *Mental Health Act 2009* (SA) in the South Australian Civil and Administrative Tribunal.
6	Chief Psychiatrist functions	14, 19	The Chief Psychiatrist must ensure monitoring of compliance with level 1 CTOs and level 1 ITOs. Change: This should be amended so relevant Directors of the Mental Health Service assumes responsibility for this. Alternatively: Ensure appropriate delegations in place.	Administrative	Will provide certainty about responsibilities	Accepted – see SALRI Recommendation 30.
7	Chief Psychiatrist functions	90	The Act does not specify consumer rights to have the Chief Psychiatrist involved in their complaint to the OCP. Change: Amend the Act to clarify the CP role with respect to complaints (this comes at the end, rather than the beginning, of a complaints process.)	Administrative	Enhanced clarity around complaints mechanisms	Supported.
8	Chief Psychiatrist functions	90, 97, 97A	The only current means for the Chief Psychiatrist to sanction a service after CP inspection is Gazettal under s 97, 97A (public naming). However, problematically Gazettal of a treatment provider enlivens a requirement of the Community Visitors Scheme (CVS) to visit the service.	Administrative	To allow better functioning of the Act	Accepted – SALRI has recommended the CVS adopt an advocacy-based role, with issues of a clinical nature to fall within the remit of the Chief Psychiatrist and/or the new Mental Health Commissioner. See SALRI Recommendation 53 and 54.

			Change: Add a new section after s 90(5) to allow the CP to sanction a provider by placing restrictions or requirements as a result of the inspection process referred to in s 90(5).			
9	Community Visitors Scheme	52, 52A	The Act mandates the CVS visitation schedule to once every 2 months. Consider whether change is required so the visiting schedule is not mandated in the same way but is at the discretion of the Principal Community Visitor (cf. other jurisdictions with 6 monthly or no mandated schedule).	Administrative	Will enhance capacity of Principal Community Visitor to determine schedule	Accepted.
10	Community Visitors Scheme	50(3)	The Act requires community visitors to be appointed by the Governor. This process is unnecessarily onerous. Change: Amend the Act to allow Community Visitors to be appointed by the Principal Community Visitor; Consider new obligation on Principal Community Visitor to ensure Community Visitors appointed are appropriately trained.	Administrative	Will enhance efficiency of the Act	Declined – SALRI has recommended that future appointment of Community Visitors, their functions and tenure be made by the relevant Minister, based upon suggestions by the new Mental Health Commissioner. The role and tenure of a Community Visitor should be subject to initial and ongoing appropriate training and oversight.
11	Community Visitors Scheme	51A	The Act allows the Principal Community Visitor to delegate a power or function to another community visitor. There is no power to delegate to a paid employee, such as an assistant. This would particularly assist in training. Consider change: enabling the Principal CV to delegate powers or functions to an employee or another community visitor.	Legal	Will enhance efficiency of CVS scheme	Accepted.
12	Community Visitors Scheme	53(2)	If a patient requests a visit from the Community Visitor Scheme (CVS) the director of a treatment centre must inform the CVS within 2 days. The wording excludes requested visits to authorised community mental health facilities. Add/change: If such a request is made to the director of an authorised community mental health facility or a director of a treatment centre where the patient is receiving treatment and care, the director must advise a community visitor of the request within 2 days after receipt of the request.	Legal	Enhanced rights	Supported.

13	Cross border Care and control	56(5a)	Section 56 does not explicitly allow the use of care and control powers to carry out cross border arrangements. Add: The powers conferred by this section can be exercised as reasonably required to facilitate arrangements between South Australia and other jurisdictions in accordance with Part 10 of this Act.	Legal	Will provide certainty for cross border arrangements	Accepted – provided ongoing appropriate training on behalf of the authorised officer is undertaken, with the use of reasonable force a last resort.
14	Cross border Care and control	57(6a)	Section 57 does not explicitly allow the use of care and control powers to carry out cross border arrangements. Add: The powers conferred by this section can be exercised as reasonably required to facilitate arrangements between South Australia and other jurisdictions in accordance with Part 10 of this Act.	Legal	Will provide certainty for cross border arrangements	Accepted – provided ongoing appropriate training on behalf of SAPOL is undertaken, with the use of reasonable force a last resort.
15	Cross border Language	68(2)(c)	A person subject to an interstate community treatment order in South Australia can be taken to an authorised community mental health facility, their home or another place (such as GP rooms) for community treatment in SA. The provision erroneously says for treatment as 'an involuntary community inpatient'. Change: 'treated as an involuntary community patient there'.	Administrative	Enhanced consistency	Declined – SALRI has recommended any person receiving mental health treatment in the community, whether voluntary or involuntary, should be referred to as a 'consumer'. Consequently, SALRI recommends this provision be amended to: 'treated as an involuntary community consumer there'.
16	Cross border Human rights	70(4)	If a patient is transferred from a South Australian treatment centre to an interstate treatment centre they do not receive a copy of the transfer form, but the carer does. Add: The patient should get a copy of the transfer form.	Notification	Enhanced rights	Accepted.
17	Cross border Human rights	71(2a)	If a patient is transferred from an interstate treatment centre to a South Australian treatment centre the patient must receive a copy of the order and a statement of rights. The patient does not receive a copy of the transfer form. Add: The patient should get a copy of the transfer form.	Notification	Enhanced rights	Accepted.
18	CTO Restrictive practices	13, 24	If a patient is subject to a Community Treatment Order and is non-compliant with the medication required by the order and a Patient Transport Request has been issued and the patient has been transported to a treatment centre, authorised community mental health facility or other place for treatment in accordance with the order, there are no explicit provisions for the use of reasonable force to ensure appropriate treatment.	Legal and clinical effectiveness	Will provide certainty about the use of restraint	Accepted – see SALRI Recommendation 33.

			Add: If a Community Treatment Order applies to a patient and the patient has not complied with the requirements of the order, and the patient has been transported to a treatment centre, authorised community mental health facility or other place in accordance with a patient transport request issued under section 55(1) for the purpose of treating the patient in accordance with the order; a medical practitioner, mental health clinician, authorised officer or staff of a treatment centre may restrain the patient and otherwise use force in relation to the patient as reasonably required in the circumstances.			
19	CTO	16	A level 2 Community Treatment Order when made by SACAT may overlap with an existing level 1 Community Treatment Order. Add: The automatic expiry of a level 1 Community Treatment Order when SACAT makes a level 2 Community Treatment Order.	Legal	Will provide certainty about which order is in force	Declined – SALRI has recommended the levels within CTOs should be removed and replaced by a single universal order with regular prescribed reviews. See SALRI Recommendation 31.
20	CTO ITO Human rights	40, 41	Patients subject to a level 2 Community Treatment Order or a level 2 or level 3 Inpatient Treatment Order must be treated in accordance with a treatment and care plan, which must be prepared and revised, as far as practicable, with the patient, their carer and any other agency involved with the care of the patient. Add: The patient and the carer (if appropriate) must be given a copy of the treatment and care plan.	Notification	Enhanced rights	Accepted – in the context of Level 2 & 3 ITOs. In the case of a CTO, the consumer and carer (if appropriate) may be given a copy of the treatment and care plan.
21	ECT ACD	42(1)(c)(ii)(A)	If a patient has an advance care directive that nominates multiple substitute decision makers, for any treatment other than ECT the substitute decision makers are jointly and severally responsible. However, for ECT all substitute decision makers must consent before treatment can proceed. This makes ECT different from decisions about general medical treatment, surgery and end-of-life. Change: Multiple substitute decision makers are jointly and severally responsible for consenting to ECT.	Legal	Enhanced consistency	Accepted.
22	ECT Forms	42(7)	Consent to ECT requires a form. Responsibility for approval of most forms has been transferred from the Minister to the Chief Psychiatrist. Approval for this form	Administrative	Enhanced consistency	Accepted.

			remains with the Minister. Change: The ECT forms should be approved by the Chief Psychiatrist.			
23	ECT Human rights	42(7)	Consent to ECT must be made using a form. Neither the patient (or the other person consenting) nor the carer receive a copy of the form. Add: The patient (or other person consenting) and the carer must receive a copy of the form.	Notification	Enhanced rights	Supported. SALRI recommends any such amendments should be made following consultation with clinicians.
24	ECT Forms	42(1)(c)(ii)(B) 42(2)	Under the *Guardianship and Administration Act*, Guardians are appointed jointly. This requires clinicians to obtain consent to ECT from all guardians. It is also unclear when 3-month consent period begins when multiple guardians sign on different dates. Change: update ECT consent form to add a continuity form to allow for multiple signatories (to avoid need for multiple forms). Change: update Act to clarify that 3-month consent period begins upon signature of final required guardian (as jointly appointed).	Administrative	Enhanced ease in use of Act	Accepted.
25	ECT Human rights Restrictive Practices	42(4)(b)	The Act explicitly states consent to ECT does not include consent to the use of force to administer ECT. But an ITO allows the use of reasonable force to provide treatment. It is unclear whether force/restrictive practices can be used on consumers under an ITO to administer ECT. This is being inconsistently applied currently and requires clarification. In cases where the GA applies, treatment teams will often rely on s 32 GA powers for authorisation for the use of force in administering ECT. Consider change: update Act to make it clear that reasonable force may be used to administer ECT to consumers under an ITO.	Legal	Enhanced consistency Will provide certainty regarding use restrictive practices	Accepted – SALRI has recommended that the *Mental Health Act 2009* (SA) be amended to allow use of reasonable restrictive practices to facilitate emergency ECT should be provided. This also aims to reduce reliance upon s 32 of the *Guardianship and Administration Act 1993* (SA).
26	ECT Human rights	42(6)	Emergency ECT can be administered without consent when a psychiatrist considers ECT is urgency needed. However, there is no time limit on this subsection. All other consent periods have limitations. Change: amend Act to limit 'emergency consent period' to (e.g.) 24 hours or to the nearest practicable occasion when ECT could be administered.	Legal	Enhanced rights	SALRI recommends any such amendments should be made following consultation with relevant stakeholders, such as the RANZCP.

27	ECT Human rights	42	There is a need to consider how Advance Care Directives are being applied when it comes to consent to ECT. A recent case reviewed by the Panel concerned a consumer with an ACD which refused ECT but the Tribunal allowed the consumer's later verbal consent to ECT.	Legal	Enhanced rights	SALRI has recommended that a valid Advance Care Directive should be binding, as much as is practicable.
28	ECT Human rights Forms	42	The Lived Experience team expressed a desire for ECT consent forms to specify: (a) the intended voltage and whether bilateral or unilateral, and that new consent be obtained where a change is required. (b) More details regarding the potential longer-term side effects of ECT. Consider change: Amend forms to include this requirement and specify in the Act.	Notification	Enhanced rights	Supported in part – intended voltage and nature of procedure are clinical matters, subject to change. The inclusion of long-term side effects within the consent form is supported, in addition to routine practice informing the consumer of risks prior to the procedure.
29	ECT Human rights	42(6)	The Act allows the administration of ECT without consent where a psychiatrist considers it is 'urgently needed for the patient's well-being'. There is no definition concerning what constitutes 'urgent need'. To better protect patient rights, the following changes are submitted (1) Emergency ECT only be authorised where two psychiatrists consider it necessary; (2) Emergency ECT only be authorised where it is considered to be life-saving. (3) Terms 'emergency ', 'urgent need', 'life-saving' be clearly defined. (NB: problematic to define matters of clinical judgment)	Legal	Enhanced rights	Supported. See SALRI Recommendation 37.
30	Human rights	47(1)	A patient is entitled to support from another person, wherever practicable, in exercising rights and in communication with clinicians. However, the clinicians listed only apply in limited circumstances, excluding support from many situations. Add/change: A patient is entitled to support in any communication between the patient and an examining or treating authorised officer, mental health clinician, authorised mental health professional, medical practitioner, authorised medical practitioner,	Legal	Enhanced Rights	Accepted.

			psychiatrist, the director of an authorised community mental health facility, and the director or staff of a treatment centre.			
31	Decision Making Capacity Human rights CTO ITO	10, 16, 21, 25, 26(4), 29 5A, 58A	There is uncertainty among clinicians and consumers about the assessment of 'Decision Making Capacity' for the purposes of making an involuntary treatment order. Consider change: rework criteria for treatment orders so OM Capacity is primary criterion to emphasise importance in maintaining rights-based approach. Consider change: add clear requirements for supported decision-making to give consumer best chance of meeting OM Capacity criterion. Consider change to forms: require treating doctor or AMHP to detail reasons why criterion met (though concern this has not worked in the past - see Dr Brayley's paper) Consider change: consumers to be given statement of reasons together with statement of rights.	Legal Notification	Enhanced Rights	Supported in principle – see SALRI's Recommendation.
32	Decision-making Capacity	10, 16, 21, 25, 29, 5A	In the context of the enhanced focus on the role of 'decision making capacity' as a criterion for the making of an involuntary treatment order under the Act (as above), consider the findings of the Deputy Coroner regarding the death of Theo Nicholas Papageorgiou, in particular Recommendation 4: *'I recommend that except in relation to electro-convulsive therapy and neurosurgery, the relevant provisions of the Mental Health Act 2009 be amended by deleting as a requirement for the imposition of any level of Inpatient Treatment Order or Community Treatment Order that the person in question has impaired decision-making capacity relating to appropriate treatment of the person 's mental illness.'*	Legal	Possible enhanced protection for persons with mental illness	Declined – SALRI has recommended that the impaired decision-making capacity criterion be retained.
33	Human rights	5A, 6, 7	There are broad human rights concerns that the operation of the Act, in practice, favours the imposition of involuntary treatment orders over consumer rights to refuse treatment and/or consider non-pharmacological treatment. The spirit and objectives of the Act are geared towards using the least restrictive approach, but concern this does not happen in practice (query whether number of involuntary treatment orders	Legal	Enhanced Rights	Supported in principle – SALRI has recommended legislative endorsement of supported decision-making. In relation to the number of treatment orders made, SALRI cannot be unduly speculative with respect to the interpretation of this data. However, consultation revealed a number of factors that may contribute to higher

			reduced after last review and creation of rights-based objectives). Consider: relational vs. clinical recovery (per Vic Royal Commission) Consider: higher requirements on services to discuss other treatment methods. Consider: renewed focus on supported decision making.			rates of treatment orders, in particular, CTOs.
34	Human rights	All	Consider the recommendations arising out of the Victorian Royal Commission, particularly those regarding: • Transitioning away from legislation that focuses on compulsory treatment towards a system that promotes good mental health and wellbeing; • Improved training and education about legislative rights. • Increased accountability structures regarding the guiding principles in the Act and positive steps taken to enhance human rights. • Increased transparency about the enforcement of the Act's objectives by regulatory bodies (e.g. OCP). Consider whether other South Australian legislation, such as the *Suicide Prevention Act 2021* could assist with moving towards a system that promotes good mental health and wellbeing and enhancing human rights.	Legal	Enhanced rights	Accepted. See SALRI Recommendations.
35	Human rights	All	Consider ways in which changes to the Act can better support the goals of the Mental Health Services Plan 2020-2025, particularly those concerning the reduction of coercion, and the reduction of CTO and ITO rates without causing increased hard to individuals or the community.	Legal	Enhanced rights	Supported. SALRI has explored the factors contributing to the rising levels of CTOs and has recommended that further research, analysis and interrogation of data concerning the general use and effectiveness of ITOs and CTOs is required, including the disproportionately high prevalence of treatment orders in

						South Australia for Aboriginal people and Culturally and Linguistically Diverse people.
36	ITO Powers	11(1)	Responsibility for notifying the Chief Psychiatrist when a level 1 Inpatient Treatment Order is made, confirmed, varied or revoked is not consistent with the officers who can carry out those actions. Add: Authorised Mental Health Professionals and Medical Practitioners to reflect all officers who can take actions that require notification.	Administrative	Enhanced consistency	Supported.
37	ITO Powers	12(4)	Responsibility for giving a patient a copy of the level 1 Inpatient Treatment Order and the Statement of Rights is not consistent with the officers who make an order. Add: Authorised Mental Health Professionals and Medical Practitioners to reflect all appropriate officers.	Administrative	Enhanced consistency	Supported.
38	ITO	24(1), 28(1), 31(1)	Inpatient Treatment Orders allow for treatment of mental illness and any other illness causing or contributing to the mental illness. This leaves a gap where illness or injury resulting from the mental illness (such as self-harm or overdose) cannot be treated under the Act. Add: The capacity to treatment an illness or injury 'caused by', 'resulting from' or 'consequent to' the mental illness. Strong concern in lived experience community over inability to use Act to treat physical health. E.g. diabetes caused by psychiatric medication. NB: the Consent to Medical Treatment and Palliative Care Act allows treatment of physical injury/illness where imminent risk to life.	Legal and clinical effectiveness	Will provide capacity for treatment of illness 'resulting from' the mental illness	Accepted in part. SALRI has recommended that the definition of 'treatment' in ss 24(1), 28(1) and 31(1) of the *Mental Health Act 2009* (SA) should be amended to the treatment of mental illness that may be 'causing, contributing or connected to' the person's mental illness.
39	ITO	25	A level 2 Inpatient Treatment Order when made by a psychiatrist may overlap with an existing level 1 Inpatient Treatment Order. Add: The automatic expiry of a level 1 Inpatient Treatment Order when a psychiatrist makes a level 2 Inpatient Treatment Order.	Legal	Will provide certainty about which order is in force	Supported.
40	ITO	26(1)	The extension of a level 2 Inpatient Treatment Order does not require notification to the Chief Psychiatrist, unlike the making or revocation of an order. Add: The Chief Psychiatrist must be notified when a	Notification	Enhanced monitoring	Accepted.

			level 2 Inpatient Treatment Order is extended.			
41	ITO Human rights	27(1)	The patient must be given a copy of the order when a level 2 Inpatient Treatment Order is made but not when the order is extended. Add: The patient must be given a copy when the order is made or extended.	Notification	Enhanced rights	Accepted.
42	ITO Human rights	27(2)	The patient must be given a copy of the Statement of Rights when a level 2 Inpatient Treatment Order is made but not when the order is extended. Add: The patient must be given a copy when the order is made or extended.	Notification	Enhanced rights	Accepted.
43	ITO	29	A level 3 Inpatient Treatment Order when made by SACAT may overlap with an existing level 1 or level 2 Inpatient Treatment Order. Add: The automatic expiry of a level 1 or level 2 Inpatient Treatment Order when SACAT makes a level 3 Inpatient Treatment Order.	Legal	Will provide certainty about which order is in force	Accepted.
44	ITO Powers	29(4)	Allows that only the Public Advocate and the director of a treatment centre (or someone authorised by them) can apply to SACAT for a level 3 Inpatient Treatment Order. This is different to the individuals who can apply to SACAT for a level 2 Community Treatment Order, who are the Public Advocate, a medical practitioner, a mental health clinician, a guardian or another person with a proper interest. Change: That applications to SACAT for level 3 Inpatient Treatment Orders should be made by the same individuals who can apply for a level 2 Community Treatment Order.	Legal	Enhanced consistency	Declined – SALRI supports a more limited number of parties who may apply for a Level 3 ITO.
45	ITO	35(3)(b)	A patient subject to an Inpatient Treatment Order can be transferred to a general hospital for specialist medical treatment. Staff of that hospital can uphold the inpatient treatment order during the patient's stay. This subsection erroneously confers section 34 powers (a patient cannot leave a treatment centre or the company of treatment centre staff) to hospital staff, rather than section 34A powers (treatment centre staff can carry the Inpatient Treatment Order into effect, use restraint etc). Change: The reference to 'section 34' powers should	Legal	Will provide certainty for powers available to hospital staff	Accepted.

			be corrected to be 'section 34A' powers.			
46	ITO Forms	35(4)	The transfer of an involuntary inpatient requires a form. Responsibility for approval of most forms has been transferred from the Minister to the Chief Psychiatrist. Approval for this form remains with the Minister. Change: Transfer forms to be approved by the Chief Psychiatrist.	Administrative	Enhanced consistency	Accepted.
47	ITO Human rights	35(5)	When an involuntary inpatient is transferred from one treatment centre or hospital to another, the carer must be given a copy of the transfer form but not the patient. Add: The patient must be given a copy of the transfer form.	Notification	Enhanced rights	Accepted.
48	ITO Human rights	36	When an involuntary inpatient is given a leave of absence from a treatment centre, the patient receives a copy of the form and the statement of rights. The carer only gets a copy of the statement of rights. Add: The carer must get a copy of the form.	Notification	Enhanced rights	Accepted.
49	ITO Capacity to treat	76(1)(e)	This subsection allows for treatment of mental illness and any other illness. At a minimum, this subsection should be updated to be consistent with amended sections to allow treatment for mental illness and any other illness causing or contributing to the mental illness. It is recommended, if the changes to 24(1), 28(1) and 31(1) described above are made, that this subsection also include treating illness or injury 'resulting from' the mental illness. Add: The capacity to treatment an illness or injury 'caused by', 'resulting from' or 'consequent to' the mental illness.	Legal and clinical effectiveness	Will provide capacity for treatment of illness 'resulting from' the mental illness	Accepted in part. SALRI has recommended that the definition of 'treatment' in ss 24(1), 28(1) and 31(1) of the *Mental Health Act 2009* (SA) should be amended to the treatment of mental illness that may be 'causing, contributing or connected to' the person's mental illness.
50	ITO Care and control Human rights	21, 25, 56	It is known that an ITO or use of s 56 'care and control powers' under the Act is currently the only legal basis to hold patients high on drugs, alcohol or with delirium or deteriorating dementia for assessment in hospital. It is believed this accounts for a large number of treatment orders. There are clear rights concerns about doing this, and long-term consequences for patients placed on mental health orders under the Act (e.g. on permanent record). AGO was working on amendments to the Consent to Medical Treatment Act to allow for the involuntary	Legal	Enhanced rights Will clarify appropriate use of powers	Supported in principle. SALRI has recommended that a separate review should be conducted into the use of the *Mental Health Act 2009* (SA) for: 1. Persons with drug and/or alcohol addiction; and 2. Older persons, especially those with a cognitive impairment or neurocognitive disorder; and 3. Children and adolescents.

			holding of these patients. Amendments currently on hold due to complaints from Law Society among others. OCP team to follow up status of these amendments. Consider consequential change to *MHA* to prevent use of the Act for these purposes.			
51	ITO CTO Human rights	16(7), 29(6)	Level 2 CTOs or Level 3 ITOs are only by order of the Tribunal. However, the only way of varying or revoking these orders once made is by application to the Tribunal. Consider more efficient way for these orders to be varied, e.g., where a level 2 CTO consumer becomes a voluntary patient; or where a level 3 ITO consumer responds well to ECT treatment. Currently consumers under treatment orders longer than necessary because of this legal requirement.	Legal	Enhanced rights	Supported in principle. Please see SALRI's recommendation to remove the levels within CTOs, subject to automatic reviews by SACAT at specific review periods. This will attempt to ensure a consumer does not remain on a CTO longer than required. SALRI has recommended the provisions relating to ITOs currently enumerated in the Act should be retained.
52	ITO Human rights DM capacity Forms	21 26(4)	Under the Act, when a psychiatrist confirms a level 2 ITO, s26(4) requires a statement of reasons be provided (detailing the evidence for the decision, including decision-making capacity). This statement is in the form of Form MRMHA-E. However, there is no similar provision for the confirmation of a level 1 ITO in section 21. Change: Amend the Act to include in s21 a similar provision as s26(4) (or alternatively, a new section titled 'Notices and reports relating to level 1 orders').	Notification	Enhanced rights	Supported in principle. SALRI notes this change must be made in consultation with clinicians, to ensure it does not place undue administrative burdens that may hinder service delivery.
53	ITO Definitions	3, 24(1), 28(1)	The Act allows medical practitioners to provide 'treatment for his or her mental illness, or for any other illness that may be causing or contributing to the mental illness ...' It is unclear whether the definition of 'treatment' includes 'assessment for the purposes of determining correct treatment'. The question arose in the context of a psychiatrist wishing to do a CT scan of a level 2 ITO patient to determine eligibility for ECT treatment. Consider change: Amend the Act to include assessment within the definition of treatment.	Legal	Enhanced clarity regarding clinicians' treatment powers	See above SALRI's Recommendation relating to the definition of 'treatment'. SALRI recognises that many concerns pertaining to the definition of 'treatment' are clinical matters. As such, SALRI has recommended that the Office of the Chief Psychiatrist consider the publication of, or amendments to, existing standards or directives clarifying and offering consistency regarding the definition of the term 'treatment', pursuant to s 90(2) of the *Mental Health Act 2009* (SA).
54	Language	3(1)	Add: Director of an authorised community mental health facility means the person for the time being in charge of the mental health services of the facility.	Administrative	Enhanced consistency	Supported. SALRI notes the term 'Director' is currently defined. The definition can be amended to refer to a Director of a mental

						health service within a treatment centre or authorised community mental health facility.
55	Language Human rights	Entire Act	Change use of 'patient' to 'consumer' (or other more appropriate term reflecting a person with lived experience of mental illness). Remove reference to Mental Health Guidelines of Care 1991 (UN) which are no longer used and encourage a biomedical approach.	Administrative	Enhanced rights	Accepted. SALRI has recommended that all references to 'patient' in the *Mental Health Act 2009* (SA) should be amended to 'consumer', except in the circumstances where a person is admitted to a treatment centre, such as a hospital. SALRI has further recommended that the term 'voluntary community patient' in the *Mental Health Act 2009* (SA) should be amended to 'voluntary community consumer'.
56	MOU	59	The Act currently requires any Memorandum of Understanding between emergency services providers to be approved by the Minister. This causes administrative delays and allows more regular amendments where required and agreed upon. Change: amend the Act to remove the reference to the Minister ('the Minister may approve ...') to reduce the level of seniority required for changes to the MOU, such that the MOU can be approved by the Chief Executive and the Police Commissioner and remove from ministerial level.	Administrative	Will provide capacity for MOU to be updated more regularly	Supported.
57	Powers Restrictive practices Human rights	57(10)	Where a person in police custody has been transferred to a hospital for treatment, the Act requires the hospital to 'hold' a person until they can be transferred back to Police (if an ITO not made or expires). It is unclear whether the Act legally empowers hospital staff to detain someone not on an ITO until Police arrive. Use of the word 'hold' includes an implied power to use reasonable force to detain. However, 'Legislative amendment of the *MHA* providing for the use of force in these situations would remedy any doubt about whether such a power exists and the extent of that power' Change: Amend the Act to clarify that hospital staff have an express power to use reasonable force to detain a person until care can be transferred back to SAPOL.	Legal	Enhanced clarity of powers to detain	Accepted. SALRI has recommended that, where a person has committed an offence, and is in police custody and requires treatment, the *Mental Health Act 2009* (SA) should be amended to allow authorised mental health practitioners and officers to use reasonable force to 'hold' a person until police arrive.

58	Powers	100(3)(a)	With the addition of directors of authorised community mental health facilities, delegation powers for those directors are required. Add: Delegation powers for directors of authorised community mental health facilities.	Administrative	Enhanced consistency	Supported.
59	Powers	102(1)	Medical practitioners or authorised mental health professionals must examine a person before making an order etc, or face a penalty. However, the Chief Psychiatrist provides authorisations and orders without examining a person in accordance with the Act. This offence should have an exemption for the Chief Psychiatrist. Change: This offence should have an exemption for the Chief Psychiatrist when using the powers of Part 10.	Legal	Enhanced consistency	Supported.
60	PPTP Language	41B(4)(d)	Provisions detailing the functioning of the Prescribed Psychiatric Treatment Panel refer to the 'Tribunal' where they should refer to the 'Panel'. Change: Reference to 'Tribunal' to say 'Panel'.	Administrative effectiveness	Enhanced consistency	Accepted.
61	PPTP	41A	The Act establishes the Prescribed Psychiatric Treatment Panel to oversee ECT and other 'prescribed treatments'. The Panel consumes considerable OCP administrative resources, Panel members are appointed by the Governor. Question: is a statutory Panel is needed, or could the oversight functions be performed by a more informal Committee (e.g. OCP Clinical Management Committee which oversees and issues guidelines relating to use of Clozapine) with more flexible functions.	Legal and administrative effectiveness	Would increase flexibility of oversight Panel	Declined. SALRI recommends that the Prescribed Psychiatric Treatment Panel remain a statutory body.
62	PPTP	41C, 42	The Act includes ECT as a prescribed psychiatric treatment, and states as the Panel's function, the oversight of ECT treatments. Question: should ECT still be considered a prescribed psychiatric treatment or is its enhanced monitoring a historical relic? (given some equally serious psychiatric drugs are not similarly monitored by a statutory panel). OCP Lived Experience team: strongly in favour retaining greater monitoring of ECT.	Legal and administrative effectiveness	Would increase capacity of the Panel to consider other issues	Supported. SALRI recommends that Division 1 of the *Mental Health Act 2009* (SA) should be retained. SALRI notes the continued negative rhetoric surrounding ECT and acknowledges it is a sophisticated treatment for mental illness.

63	PPTP	41C	The Act prescribes the functions of the Panel and prescribes 'triggers' for cases that require Panel review. These are not working. They catch many cases of uncontroversial maintenance ECT and do not capture the complex cases involving consent issues and other matters the Panel is interested in reviewing. This leads to an unmanageable workload for the Panel and very large administrative burden. The Lived Experience Team suggests a function of the Panel should be reviewing ECT data from a systemic perspective, e.g. is ECT use increasing, why? Are certain providers using it more, why? Change: Consider change to prescribed Panel.	Legal	Enhanced rights by ensuring complex cases are reviewed by the Panel	Accepted. SALRI has recommended a revision to section 41C *Mental Health Act 2009* (SA) identifying the review triggers of the Prescribed Psychiatric Treatment Panel should be considered, to enable the Panel to review a 'complex case'. This term should be defined, in consultation with the Panel, the Chief Psychiatrist and other relevant stakeholders.
64	PPTP	41C, 41D	The Act requires the Panel to review ECT cases that fall within the s 41C 'review triggers' but there is no corresponding obligation upon treating psychiatrists to supply the patient report required for this review. The Panel has relied on considerable goodwill in the profession. Change: Amend the Act to clarify the obligation of treating psychiatrists to supply a patient progress report to the Panel upon request.	Administrative	Clarity around obligation to provide information	Supported in principle. SALRI notes any change must be made in consultation with clinicians, to ensure it does not place undue administrative burdens that may hinder service delivery.
65	Representation Human rights	84, 85	The Act entitles consumers to legal representation under the legal representation scheme in review or appeal proceedings before the Tribunal (review of psychiatrist-imposed order; or internal review of SACAT order) The Act does not currently entitle consumers to legal representation in the Tribunal's original jurisdiction (level 2 CTO, level 3 ITO or ECT) meaning wishes of vulnerable consumers are often not before the Tribunal. This Act currently relies on consumers (a) knowing their rights to appeal and (b) knowing they are then entitled to a lawyer, (c) those vulnerable people presenting all relevant evidence at first instance without legal support. Consider change: Amend the Act to entitle consumers to legal representation under the scheme in the Tribunal's original jurisdiction. This would better support vulnerable people and	Legal	Enhanced rights	SALRI has recommended that s 84 of the *Mental Health Act 2009* (SA) should be amended to provide for an extension of the present legal representation scheme to consumers in all proceedings under the Act in the South Australian Civil and Administrative Tribunal.

			increase Tribunal efficiencies.			
66	Representation Human rights	12, 23, 27	The Act requires clinicians to provide consumers under treatment orders with a statement of rights (e.g. rights to appeal the orders). The Lived Experience suggests (a) the rights should be explained to consumers by a person with lived experience (e.g. a video); (b) the rights should be explained a second time 1-2 days into treatment once consumers are generally more calm; (c) consider access issues (language, comprehension, reading level) of statements of rights. Consider: amending statements of rights; consider funding for non-legal advocates in treatment centres to assist consumers to be aware of their rights; imposing obligation on clinicians to advise consumers of their rights twice (at start and during their treatment period).	Legal	Enhanced rights	Supported in principle. SALRI supports the implementation of measures to assist a consumer to understand their rights and recognises the importance of a peer worker in this process. SALRI has recommended that the CVS retain an advocacy-based role and suggests that assistance in explaining and enhancing a consumer's understanding of their rights would fall within the remit of this role.
67	Restrictive practices Human rights	47(3)	Reasonable limits can be made to the support a patient can receive. The officers responsible and settings described are relevant only to inpatient settings, which should be expanded to include care and control and community patient circumstances. Add/change: Reasonable limits to support can be made by an authorised officer during use of section 56 care and control powers, and by a mental health clinician or medical practitioner or director of an authorised community mental health facility in community settings.	Legal	Enhanced consistency	Supported in principle. SALRI has suggested that further review and investigation into the allocation of resourcing, staffing, infrastructure and funding of Community Mental Health Teams is explored. This would include efforts to provide a consumer with ongoing support.
68	ITO	29(3), 29(4a)	Level 3 ITOs can only be made by the Tribunal in respect of persons who whom a level 2 or 3 ITO applies (not level 1). Change: Amend s29(3) to say, 'in respect of a person to whom a. ..level 2 or level 3 inpatient treatment order applies' Amend s 4a to say 'A level ... 2 inpatient treatment order ...'	Administrative	Provides clarity that a person cannot go from a level 1 ITO to level 3 ITO.	Accepted.
69	Mental Health Commissioners	n/a	Mental Health Commissioners are appointed for 3-year terms to the SA Mental Health Commission to aid in the implementation of the South Australian Mental Health Strategic Plan. Consider: the role of Mental Health Commissioners. In particular, should their roles be statutory under the	Administrative	Enhanced clarity	Accepted. SALRI has noted that particular clarity is necessary as to the role and functions of the Mental Health Commissioner(s) and has therefore recommended that the role, functions, constitution, appointment and removal of

			Mental Health Act? Consider in the context of a discussion around shifting the focus of the Act towards encouraging good mental health and wellbeing, in addition to a regulatory framework for the involuntary treatment of mentally ill consumers.			the Mental Health Commissioner should be added as a new Division in the *Mental Health Act 2009* (SA). The role and powers of the new Mental Health Commissioner have also been raised in SALRI's recommendations.

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