



OFFICIAL

Review of the *Mental Health Act* 2009

*Supplementary
Consultation:*

*Additional proposals for
further legislative change
to prevent incidents and
respond to mental health
emergencies.*

Consultation Paper

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of South Australia

SA Health

Contents

Acknowledgements	4
Advice about content and support services	5
Preface	6
Introduction	7
Background	7
Process for consultation	9
Part A: Additional Principles and related amendments	10
1. A new Prevention of Harm to Persons Principle – including prevention of harm to self and to others.	11
2. Suicide Prevention Principle – a broad principle to inform all aspects of clinical policy, planning, design and delivery	14
3. A Principle that Services will consider the needs of People with Severe Mental Health Conditions	16
4. A new Mental Health and Substance Use Co-morbidity Principle and associated new care plan requirements	17
5. A Neurodevelopmental Disorders Co-Morbidity Principle	19
6. A Principle to deliver compassionate care	21
Part B: Proposals to facilitate emergency mental health responses	22
7. Ensuring that the use of care and control powers to enable assessments is timely and that the use of the powers are monitored.	22
8. Provisions to support psychiatric review of people who are on involuntary treatment orders prior to interhospital transfer	24
9. Use of non Mental Health Act powers for the detention and restraint of people who require acute care due to a delirium, dementia and/or intoxication	25
Part C: Other Proposals that Might Improve Personal and Community Safety	26
9. A requirement to consult family members when a decision is made about involuntary care	26
10. Increased accountability in mental capacity assessment when there is a risk of harm to another person.	28
11. Enshrining in legislation a “duty to warn” other people at risk	30
Part D: Additional proposal regarding a statutory Mental Health Human Rights Committee and Coercion Reduction Committee	31
Part E: Further areas of work	32
13. A proposal for future work – the development of non Mental Health Act powers for the detention and restraint of people who require acute care due to a delirium, dementia and/or intoxication	32
13. A proposal for future work – the development of limited powers to require people who have co-morbid drug and alcohol conditions to mental illness to receive involuntary treatment	35

14. Proposal for further work: seeking to address a gap in legislation coverage related to the involuntary care of people who have a neurodevelopmental disorder when the Mental Health Act does not apply 37

Consultation 38

Acknowledgements

Acknowledgement of Country

The Office of the Chief Psychiatrist acknowledges and respects Aboriginal peoples as the State's first peoples and nations and recognises Aboriginal peoples as traditional owners and occupants of the land and waters in South Australia.

Further, their spiritual, social, cultural, and economic practices come from their traditional lands and waters; and that they maintain their cultural heritage beliefs, languages and laws which are of ongoing importance; and that they have made and continue to make a unique and irreplaceable contribution to the State.

We acknowledge Aboriginal peoples have endured past injustice and dispossession of their traditional lands and waters.

Advice about content and support services

This paper considers topics that may lead to distress for some people based on past experiences. If this occurs, please speak to a person you know, support person or professional.

Service options include:

Lifeline	13 11 14
Lived Experience Telephone Support	1 800 013 755
Mental Health Triage For Mental Health Emergencies	13 14 65
Urgent Mental Health Care Centre	08 8448 9100 215 Grenfell St Adelaide
Kid's Helpline	1 800 55 1800
Beyond Blue	1 300 224 636
Rebuild (provides trauma-based counselling and peer support to adult and child victims of crime as they move through the criminal justice process)	1 800 310 310
1800RESPECT (National domestic family and sexual violence counselling service)	1 800 737 732

Preface

We wish to thank the reader for considering this supplementary consultation, that follows earlier South Australian Law Reform Institute (SALRI) consultations and their 2023 report.

The ideas in this paper have evolved this year following critical incidents in both South Australia and elsewhere in Australia that have brought into focus our services for people who experience mental health conditions.

There were two strengths of the SALRI approach that have assisted us with this task.

The first is the human rights approach. This can be applied to the human rights of all parties; the person who has a mental health condition, their family, friends, and members of the community. This can enable complex topics to be broached and then subsequently reviewed.

The second is the focus on principles of a proposed Mental Health and Wellbeing Act that underpin the delivery of the broad system. When rare events do occur, it is not uncommon for recommendations to focus on the system of care to enable assessment, therapy, and intervention, rather than finding the answer in specific technical changes to the operation of the Act. While this discussion paper does have some of those technical changes that we have considered are worthy of discussion, it is the section on new principles that may be most relevant, and many of these principles relate to both incidents and near-miss incidents that have been reviewed.

Because these proposed changes to principles are designed to improve the delivery of quality care, they could offer a positive benefit to many more people, beyond the initial focus on risk.

Conversely the risk of unintended consequences on a wider population needs to be considered. In addition to consulting on proposals there will be a further consultation on a draft Act so that the sector and community can see the draft Act in its final form before it is considered by Parliament.

In addition, alongside this work, further discussions, and proposals arose related to the delivery of emergency care. These are also included in this document.

We also appreciate that elements of the existing SALRI proposals have been positively received by people with lived experience of mental ill-health and their carers. The broad focus on the proposed Act on both mental health and wellbeing, and the delivery of quality services, has been positively received. The proposed Act is to benefit people broadly, not just focus on involuntary care. This needs to be retained with any new changes.

One further addition in this vein has been the principle of compassionate care. Is it possible to legislate for compassion? We thought yes, as there is now sufficient evidence of the benefits of compassion in both mental health care delivery and suicide prevention, and strategies that can be used to care for people using services, and for the staff delivering them. We look forward to comments on this new idea as well.

Thank you for your views about the proposals and ideas in this discussion paper.

John Brayley

Chief Psychiatrist

Introduction

This paper has been developed in response to a request from the Minister for Health and Wellbeing to consider and consult on what further changes could be made to the Mental Health Act that might prevent critical incidents and improve mental health care.

This discussion paper is structured to consider:

- New proposed principles of the Act.
- Proposals to facilitate emergency mental health responses.
- Further proposals that might improve personal and community safety.
- An additional proposal regarding the establishment of a Human Rights Committee in mental health.

In these sections, the topics covered include new principles related to risk, and suicide prevention. There are new principles related to groups who may experience gaps in care including people who have a severe mental illness, people who have both a mental illness and drug and alcohol condition at the same time, and people who experience neurodevelopmental conditions. There is also a new principle of compassionate care.

Specific changes are also suggested to the use of powers of care and control used within health services, and a new requirement proposed for documenting decisions related to involuntary care when other people may be at risk. There are changes proposed to the “duty to warn” potential victims.

The paper concludes with a proposed Human Rights Committee to be added to the Act. In considering topics such as the application of human rights principles and the need to uphold the rights of all parties, including those who may be affected by the actions of another, it is suggested that it would be beneficial to have a Human Rights Committee established on a statutory basis to provide ongoing advice on these matters. There is an existing Committee in operation that is not a statutory committee that has already developed a Human Rights Analysis Tool to consider new mental health initiatives, and this work could be extended. A Human Rights committee would have a much broader role in considering human rights in mental health care than the specific issue that led to this paper, and this is discussed.

Background

In November 2023 the Office of the Chief Psychiatrist (OCP) released a discussion paper in response to the review of the *Mental Health Act 2009* (“the Act”). This was based on the review of the *Mental Health Act 2009* undertaken by the South Australian Law Reform Institute (SALRI). The recommendations from SALRI were generally positively received with a proposed new *Mental Health and Wellbeing Act* informed by international human rights and greater breadth than historical acts welcomed. A new Act will have principles that underpin the SA Government work in mental health across prevention, early intervention, treatment, and rehabilitation and apply to both operated and funded services, supporting future planning and delivery. The principles will also inform the application of those sections of the Act that relate to both voluntary and involuntary care. It is expected that the new Act will have updated principles stated in assertive language to guide the planning, commissioning, and delivery of services as well as care for individuals.

While this work has been underway, there has been a nationwide concern that mental health services should be able to better identify and respond to circumstances where there have been critical incidents involving people who have received mental health care that affects the

safety of others. Some of this response stems from tragic events interstate, but there have also been local incidents and concerns¹.

In addressing this topic, it is important to note that such incidents are rare, and the discussion about such matters should not lead to increased stigma. Necessary service responses are broad and not limited to involuntary care – this includes early access to care for people who have first episodes or relapses, access to adequate time with professionals for assessment, the delivery of therapies, and effective engagement. Key interventions can include non-clinical support such as psychosocial support, peer support, and housing. For this reason, proposals relate to not only the sections of the Act concerned with involuntary care, but the principles which will underpin the operation of the broader mental health system.

While the process has commenced with the consideration of incidents where other people are at risk, it highlights a gap in traditional mental health legislation in how it considers the broader issue of risk including risk to self, and the topic of suicide prevention. There are opportunities to strengthen the Act in this regard and suicide prevention is also addressed in this paper.

A rights-based approach provides a platform for the careful consideration of this topic. The rights of all parties can be considered – not only the rights of a person who has a mental health problem, but also by recognising more effectively the rights of the carers and acquaintances of the person and members of the wider community, and particularly a right to personal safety.

Lived experience

In preparing this discussion paper, we recognise that it will be carefully considered by all groups potentially affected by the proposals. This includes people with lived experience of mental ill-health and their families who are impacted by stigma related to rare incidents. In seeking feedback, we wish to check that proposals have benefits and not unintended consequences.

This paper will also be read by people who have been either directly or indirectly affected by an incident where another person has been harmed. The support agency list on page 4 also includes victim support groups.

It is recognised that there is a significant overlap between mental health lived experience groups and victim support groups. People who experience a mental health condition are more likely to be the victims of violence. People who have experienced crime are at risk of conditions such as post-traumatic stress disorder and may then need mental health counselling from professionals and support from peers.

Should this paper raise any personal concerns do not hesitate to talk with a support person or contact a service such as those listed on page 4.

If you have questions and concerns about the legal and policy implications stemming from this paper, please do not hesitate to contact this Office.

¹ As a clarifying note it should be noted that while awareness of concerns has stemmed from incidents, the inclusion of proposals in this paper should not be used to infer information about any person's case. It should not be inferred that any of these proposals are linked to any specific incident. Each year the OCP receives many reports where risk is reported, and proposals can also be informed by near miss reports. .

Process for consultation

Feedback to this paper is welcomed.

A draft exposure Bill is under preparation based on the original review. This feedback will be added to the draft exposure bill.

This means that there will be a further chance to comment on any new provisions either based on the original SALRI review or based on the consultation from this revised paper after the exposure bill is circulated.

A short series of Webinar discussions will also be convened to gain feedback. Details will be on the Office of the Chief Psychiatrist website.

Comments on this paper can be made via the YourSAy website or sent direct to the Office of the Chief Psychiatrist at healthocp@sa.gov.au .

Part A: Additional Principles and related amendments

The proposed new principles for a South Australian Mental Health and Wellbeing Act were described in the SALRI report and previous consultation document. These can be read on the Office of the Chief Psychiatrist website. The following principles were previously proposed based on the principles in the Victorian *Mental Health and Wellbeing Act 2022* which was prepared following a Royal Commission into mental health in that state.

Table 1: Proposed Principles of a South Australian Mental Health and Wellbeing Act

The guiding principles to be restructured to emphasise mental health, wellbeing, and prevention with assertive positive rights-based language. The guiding principles should include reference to:

- Dignity and autonomy principle
- Least restrictive principle
- Diversity principle
- Choice and control principle
- Supported decision-making principle
- Trustworthiness and transparency principle
- Family and carers principle
- Lived experience principle
- Health needs principle
- Dignity of risk principle
- Wellbeing of young people principle
- Safety principle
- Gender safety principle
- Cultural safety principle
- Wellbeing of dependents principle
- Recovery principle

Points of reference include the Victorian Mental Health and Wellbeing Act 2022 (MHWa), the current SA principles, the Substance Abuse and Mental Health Services Administration (SAMSHA) key principles to a trauma informed approach, and Article 3 of the UN Convention on the Rights of Persons with Disabilities (CRPD).

This paper proposes additional principles for inclusion in the next draft of the Act. At times there may need to be balancing between principles, so the addition of the new principles needs to be considered in the context of the existing proposed principles above.

1. A new Prevention of Harm to Persons Principle – including prevention of harm to self and to others.

This proposal is to add a new principle that emphasises a role for mental health services in preventing harm– this applies to risk of harm to self or others.

The potential benefit of a new principle

While this role for mental health services is contained in the criteria for involuntary treatment that refer to “the protection of harm to others”, it is not in the principles of the Act.

There is a brief reference to “protection of the public” in the current Objects of the current Act which does explain a goal of this law, but the principles can give added guidance about the underlying values of the law, inform its interpretation, and influence a broader range of actions, whether it be policies, plans or service design that is developed under the law.

For the same reason that there are other principles already proposed that are related to safety and risk, this can be expanded to a broader prevention of harm to all persons principle.

This new proposed principle is written in a broad way as it also refers to the risks of harm to a person receiving care, that may be broader than the risk of suicide and include risks due to poor self-care.

This raises the question of how prevention of harm to persons principles is read in the context of the current human rights approach in mental health.

A human rights approach can consider the rights of all parties – the person who experiences an illness, their family and friends and community, and staff of services; recognising that at times rights can be competing, and solutions required that uphold the rights of all parties. This is the basis of the proposal that considers preventing harm to others.

Preventing harm can benefit all parties, including the person who might be at risk to others when experiencing an episode of mental distress. If an incident occurs, they then will have interaction with the justice system that could be avoided.

The broader impact of a principle on policy, plans, and service design

A prevention of harm principle would underpin work to design interventions to avoid incidents occurring and benefit the rights of the person who may need care, as well as others who may be harmed.

To reiterate, this is broader than a decision about involuntary care. It can support action to design services that engage with people, identify risks, deliver follow up and provide therapies and treatment.

Recent Australian research using New South Wales data describes how most patients who have been found not guilty of an offence by reason of mental illness had contact with services prior to the offence, and although it is possible that symptoms have emerged between the time of contact and the offence, it was suggested that key emerging and underlying conditions have been missed². While there is already improvement work to

² Goodhand, C., Lyons, G., Johnson, A., Nielssen, O., Large, M., & Dean, K. (2024). Patterns and correlates of health service contact prior to serious offences by people with severe mental illness. *Australian and New Zealand Journal of Psychiatry*, 58(9), 775-786. <https://doi.org/10.1177/00048674241254213>

change systems to improve assessments in emergency departments, a new principle would provide a broader underpinning into the future.

A mandatory “risk” standard

Another way to operationalise such a principle in clinical practice is to develop a relevant Standard and guideline on Prevention of Harm. It is proposed that it be a requirement of the new Act for the Chief Psychiatrist to maintain a standard on Prevention of Harm to Persons that would consider risk identification and response to risk in mental health services.

Interface with the currently proposed “dignity of risk” principle

The only principle related to risk currently proposed for the new Act is the Dignity of Risk principle taken from the new Victorian Act. The Victorian wording is as follows:

A person receiving mental health and wellbeing services has the right to take reasonable risks 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.

This principle underpins the need for some risks to be taken for people to recover and resume their life. The Victorian principle balances this with the duty of care to the individual. If a prevention of harm principle is added to the Act in South Australia, then this new principle, as it applies to risk of harm to self, would need to be balanced with the Dignity of Risk principle when applied to the care of individual people.

The Victorian principle does not refer to duties to other people which would need to be considered when preventing harm to others. If similar considerations were applied in South Australia, “dignity of risk” would not apply to risk of harm to others and the new “prevention of harm” principle alone would be considered in these situations.

Proposal:

A Prevention of Harm to Persons Principle be added to the Act.

The principle would (1) acknowledge this role of mental health services broadly in preventing harm to persons, (2) recognise the rights of other people who may be affected in some situations including those of carers, family, friends, and community members and in particular the right to personal safety and (3) refer to the provision of assessment and therapies that can reduce risk to the person themselves or to other people.

Further Proposal:

To assist in the implementation of this Principle, it is proposed that the Act should include a requirement that the Chief Psychiatrist is to maintain a standard on Prevention of Harm to Persons that considers risk identification and response in mental health services.

Questions:

Do you consider that a Prevention of Harm to Persons principle is required?

What key elements should be included in this principle?

2. Suicide Prevention Principle – a broad principle to inform all aspects of clinical policy, planning, design, and delivery

The discussion about risk to self and others has highlighted the lack of focus on suicide prevention in the existing *Mental Health Act*.

South Australia's *Suicide Prevention Act 2021* considers suicide prevention across government and across our community. This includes mental health services.

It is proposed that in addition to this, there is merit in placing a suicide prevention principle in the *Mental Health and Wellbeing Act* with a specific focus on mental health services linked with the broader community-wide requirements of the *Suicide Prevention Act 2021*.

The benefit of an additional Suicide Prevention principle

While there is no Suicide Prevention principle in the Act as it now stands. The Act does contain criteria for involuntary care in response to a risk of self-harm. However involuntary care is only one small part of a suicide prevention response. It is an anomaly that while much of the use of the *Mental Health Act* relates to keeping people safe who might be at risk of suicide, there is no explicit statement in the Act of the Act's purpose in preventing suicide.

To make such a principle explicit would then acknowledge the breadth of suicide prevention work undertaken by mental health services the majority of which is delivered to people who seek this care on a voluntary basis.

A Suicide Prevention principle would support best practice suicide prevention in areas such as engagement with persons at risk, identification of risks, safety planning, follow-up support, and therapy. As mentioned, most suicide prevention interventions are voluntary ones. To assist with recovery, a person needs to take risks as part of a therapeutic and supportive approach. A principle would be consistent with existing work to develop Suicide Prevention Pathways – an approach being used across Australia.

A suicide prevention standard

To support operational implementation, it is also proposed that the Chief Psychiatrist should develop and maintain a Suicide Prevention Standard for Mental Health Services. Any standard would be consistent with the requirements of the *Suicide Prevention Act 2021*, which mandate a Suicide Prevention Action Plan for the Department and the proposed new principle of the *Mental Health Act*.

Such a standard would describe the requirements of suicide prevention interventions to be delivered by mental health services. Progress is to be reported in the Chief Psychiatrist's Annual Report to Parliament.

Proposal:

That a new Suicide Prevention Principle be added to the Act to underpin suicide prevention in the design and delivery of mental health services, extending beyond hospital.

Further proposal:

That a requirement be made that the Chief Psychiatrist develop and maintain a Suicide Prevention Standard for Mental Health Services.

Question.

Do you support the inclusion of a Suicide Prevention Principle in the Act, and the associated requirement that the Chief Psychiatrist maintain a Suicide Prevention Standard?

3. A Principle that Services will consider the needs of People with Severe Mental Health Conditions

There has been recent public discussion that our mental health systems need to ensure that they are focused on the care of people with the highest needs and that nationally the needs of people in these groups requires more focus in policy and planning.

Most people who experience either psychosis or other severe mental illness are not a risk to other people and are more likely to be at risk of being a victim of assault from others. However, situations can arise, for example when a person experiencing mental distress is frightened of others because of their symptoms, where there is a risk of incidents. Risks are more common if an illness is severe.

Severity of a condition can be defined in a number of ways. It could be linked to a specific diagnosis but can also be defined by a person's level of need, regardless of diagnosis, for services such as specialist therapy, and clinical rehabilitation. For some people "tertiary" care is needed for their condition, and this is usually delivered by state services. People in this group are often also eligible for NDIS psychosocial supports, but this principle relates to the care delivered by the state which is usually clinical assessment, review, and therapies.

It is proposed that a principle related to severe mental health conditions and responding to high acuity be included in the Act. Because there may be a range of situations and diagnoses that could be considered "severe", no particular condition is mentioned in the proposal. It is not intended that this principle would lead to a diminution of effort in other areas for conditions and presentations that are considered to be less severe, or reduce a focus in early intervention, but it would seek to ensure that the needs of those who have high and complex needs or require emergency responses for those in crisis are considered in policy development, service planning, and operational management of services.

Proposal:

A new principle states that services will consider the needs of people with severe and complex mental health conditions and people who require emergency assessment and care. This is intended to support the provision and design of services for people who have service needs.

Question:

Do you agree that there is a need for a principle that considers the needs of people with severe mental health conditions?

4. A new Mental Health and Substance Use Co-morbidity Principle and associated new care plan requirements

The *Mental Health Act 2009* also does not always address the needs of people who have both a mental health condition and a drug and/or alcohol use disorder – a common combination.

The need to break down divisions between drug and alcohol and mental health responses.

In Australia there has been a historical division between mental health and drug and alcohol services. Yet it is understood that mental health and drug and alcohol conditions can commonly co-occur. Each can make the other condition worse, and therapies for each condition need to be delivered at the same time not sequentially.

Addressing alcohol and drug use can not only prevent relapse it can also reduce the risk of harm to self and others due to the altered mental state created by substances. Alcohol use is the most common problem leading to impulsive actions, but a range of other substances can create or worsen mental health conditions resulting in potential harm to a person or others.

There has been general agreement in both the mental health and drug and alcohol sectors about the need to achieve improved collaboration, however the pace over many years has been slow.

There is significant interest in this area. For example, in August 2024 the Office of the Chief Psychiatrist and SA Police co-hosted a Professional Development Day on the topic of co-morbidity and emergency mental health care and over 300 mental health workers, ambulance officers and police attended.

Carers and family have also expressed significant concerns about the lack of services for drug use that can have fatal consequences.

Any substance, including alcohol, can increase the risks of harm to self either by themselves or in the context of co-morbidity. Health services grapple with assisting people who are users of specific substances that create risks of violence to others – notably alcohol and methamphetamine, that also worsen underlying mental illness.

A new co-morbidity principle

Schedule 1 of the current *Mental Health Act* makes it clear that substance use disorders are not to be considered mental illnesses for the purposes of the Act. It is not proposed to change this stipulation which is related to the imposition of involuntary care. Historically it has been problematic when mental health legislation has been used to treat addictions when an addiction is the only presentation. It is not intended to return to these practices, but this schedule 1 requirement should not be a barrier to mental health services delivering care for people's substance use and working closely with Drug and Alcohol services when needed.

A broad "co-morbidity" principle will influence the design and operation of services, and proactively support future collaboration and integration between mental health and drug and alcohol services.

While the existing response to the SALRI review would make a mention of the needs of this group with both conditions in the principles, this new proposal would make the principle more prominent and with broad intent to influence future developments in mental health care in the direction of integrated and collaborative responses.

Inclusion of drug and alcohol treatments within care plans

A second proposed addition would further enable treatment for drug and alcohol problems when they are related to a person's mental health care.

This proposed requirement would be for the care plans for people who are either receiving mental health care on a voluntary or involuntary basis. The inclusion of such drug and alcohol therapies in plans can occur now, but this new proposal would make it a requirement that needs are identified and the offer made. The delivery of the drug and alcohol intervention would remain voluntary.

While it is possible already to include voluntary drug and alcohol treatment in care plans, the extent of the documentation of this can vary.

A legislative statement would signify the importance of doing this and would enable a range of interventions whether they be group programs, individual counselling, or pharmacological treatment to be considered and offered.

Proposal:

A Drug and Alcohol and Mental Health Co-morbidity Principle will recognise the need to plan effective intervention that address both mental health care and drug and alcohol care together, the role of mental health services in this area and the need for collaboration with drug and alcohol services.

Related proposal:

Mental Health Care plans should refer to therapies for a substance use disorder when this disorder is co-morbid to a person's mental health condition and needs to be addressed to prevent deterioration and relapse of this condition. Care plans should include the offer of treatment for drug and alcohol use disorders available on a voluntary basis.

Questions:

Do you consider that the issue of mental health and drug and alcohol co-morbidity merits a specific principle in the Act?

Do you support the specific care plan requirement to formalise the offer of treatment for drug and alcohol use disorders when needed?

5. A Neurodevelopmental Disorders Co-Morbidity Principle

This principle would consider the needs of (1) people who experience autism spectrum disorders (with or without intellectual disability), (2) people who experience an intellectual disability.

Background to the proposal

There have been similar issues in addressing neurodevelopmental disorders co-morbidity and drug and alcohol co-morbidity. Neurodevelopmental disorders are also included in Schedule 1 of the *Mental Health Act* as conditions that are not mental illness. Historically the separation of general disability and mental health services has been an approach in place for over 60 years in South Australia, and it is not intended to change this, or expect that mental health services fulfil duties that are expected of disability providers funded by the National Disability Insurance Scheme.

However, people with these neurodevelopmental conditions have a greater risk of developing a mental health condition and can be at greater risk of experiencing suicidal thinking. The Royal Australian and New Zealand College of Psychiatrists statement on Addressing the Mental Health Needs of Autistic People summarises the significant challenges and unmet mental health needs for this group that can experience higher rates of psychiatric disorders, including depression and schizophrenia, and have a rate of deaths by suicide that is 3 to 9 times of the general population³.

Schedule 1 of the current *Mental Health Act* specifically excludes neurodevelopmental disorders from the definition of mental illness as it might apply to involuntary care. This exclusion in the schedule should not prevent people with those conditions accessing voluntary mental health services when required. However, a new principle responding to the needs of people in these groups would reinforce the need to consider access to care for these groups when co-morbid conditions exist.

At the current time there has been considerable interest within mental health professions to have better training and improved systems to better meet the needs of people in this group. It has also been recognised that services for people with a developmental disability have been better developed in countries such as the UK. It is hoped that a clearer principle will better lay foundations for the future and practitioners developing sub-specialist skills in this area.

Services may need to make specific arrangements to make their clinics and units accessible for people with these needs and ensure that staff have access to relevant training.

Once again while these groups are to be mentioned in the existing principles as already proposed, this new proposal would create a more prominent focus for these groups.

This new principle is more specifically related to assessment of co-morbid conditions and the assessment of risk to self or others and considering environments that are supportive of neurodiverse people.

The question can be asked why people in other diagnostic groups should not also have a principle. In the case of neurodevelopmental disorders there is a long standing systemic gap, and an inclusion of a principle “balances” the Schedule 1 exclusion of these conditions.

³ RANZCP, Autism Position Statement 2022 Autism: Addressing the mental health needs of Autistic people | RANZCP

Proposal:

A Neurodevelopmental Disorders and Mental Health Co-morbidity Principle be added to the Act requiring that the needs of people who experience these co-morbid conditions be considered when setting policy and designing services that are responsive to those needs.

Questions:

Do you support a Neurodevelopmental Disorders Co-Morbidity principle?

What should the principle include?

6. A Principle to deliver compassionate care

Compassion in health care defines how care is given through relationships based on empathy, respect, and dignity⁴. It has been identified over the last 10 years as a significant element in suicide prevention care, mental health care, and the delivery of health care more generally. Organisational compassion can be defined as “the proactive, systematic, and continuous identification, alleviation, and prevention of all sources of suffering”⁵. For this to be delivered it also needs care for staff, as part of the approach. While focussed on people who need care, the approach is seen as one to prevent burnout and support resilience in staff.⁶

This is part of a values-based approach, one that can be measured and observed, and could appropriately be defined in legislation.

It has also been noted in initial discussions that this will be supported by moves to expand the peer workforce.

The question is how best a principle for compassionate care be written in legislation in a supportive way for all involved. Ideas about this are welcomed for this innovative principle.

In this initial proposal the focus is on the organisation of services.

The proposal that is included in this paper has a focus on emergencies and risk, because a compassionate response will improve the quality of care delivered in emergency situations (as well as having benefits across the full range of services delivered).

Proposal:

The Compassionate Care Principle. A new principle would be added to the Act that the Mental Health and Wellbeing services will be designed to support the provision of compassionate care based on empathy, respect, and dignity, with organisational support given to staff delivering this care.

Further proposal:

That a report on the delivery of compassionate care by our systems be required in the Annual Reports of the Mental Health Commissioner, Principal Community Visitor, and Chief Psychiatrist.

Questions:

Is a compassionate care principle a proposal that should be supported?

What ideas do you have for the framing of what would be an innovative principle?

⁴ NHS England (2015) 6 Cs presentation, <https://www.england.nhs.uk/6cs/wp-content/uploads/sites/25/2015/03/cip-6cs.pdf>

⁵ Pestian T, Awtrey E, Kanov J, Winick N, Thienprayoon R. The impact of organizational compassion in health care on clinicians: A scoping review. *Worldviews Evid Based Nurs*. 2023 Aug;20(4):290-305. doi: 10.1111/wvn.12664. Epub 2023 Jun 20. PMID: 37340547.

⁶ *Nurs Health Sci* 2021 Sep;23(3):565-569. doi: 10.1111/nhs.12843. Epub 2021 May 13.

Part B: Proposals to facilitate emergency mental health responses

7. Ensuring that the use of care and control powers to enable assessments is timely and that the use of the powers are monitored.

Section 56 of the current Act provides powers to facilitate the transport and assessment of a person who appears to have a mental illness, is at risk, and requires a medical examination. The latter includes assessment by either medical practitioners, or mental health professionals of other disciplines who have undergone extra training.

Concerns have been expressed that the prolonged application of these powers in emergency departments may have unintended consequences on care delivery, particularly as there is no time limit for formal review and the provision of a definitive assessment and plan can be delayed.

In addition, section 56, has been designed for assessment only and treatment cannot be provided. The purpose of these powers is to enable transport and assessment. Authorised officers can administer chemical restraint but not therapeutic treatment. Extended periods under such care and control powers may delay the commencement of treatment.

There was extensive consideration of the use of these powers in the SALRI Mental Health Review from 2023. SALRI recommended that the Act should be amended to clarify the scope of section 56 to ensure this power is reasonably used to facilitate an assessment within a timely manner. SALRI further recommended that reference to an 'assessment' should be added within section 56(3)(c) and (d) (SALRI Recommendation 26).

Following consultation this recommendation has been accepted and wording to require an assessment in a timely manner is being incorporated in the draft Act without specifying a duration.

In this situation what is deemed a reasonable duration will depend on the individual circumstances of each situation and accountability for "reasonableness" can be a matter of judgement.

In considering this issue for this latest consultation it was first considered that we should go one step further and provide a time limit of 6 hours. The time limit would only commence after the person has arrived at an acute treatment centre, avoiding the uncertainty of travel time. Many jurisdictions expect early assessment and would use a more formal assessment order rather than the use of care and control power. A 6-hour limit for similar powers (with a further 6-hour extension) applies in at least one other jurisdiction.

In discussion with services in South Australia there was concern about unintended consequences of a time limit and the focus of this proposal is on monitoring rather than a strict time limit.

Hence this proposal would require the Chief Psychiatrist to (1) monitor and report on the use of section 56 powers and (2) report specifically on the use of powers for a period greater than 6 hours.

The recent roll out of Statewide Electronic Medical Records would facilitate this monitoring and any subsequent auditing.

There are rights perspectives for and against this work seeking early assessment and consideration of whether a person should be a voluntary patient or placed on an Inpatient Treatment Order. If a formal inpatient treatment order is applied a person, then has appeal rights, and a range of other rights protections are invoked as the person is on an order as

opposed to being held under powers. They can also be administered treatment for their condition. For this reason, it can be considered preferable to use a formal order for involuntary care rather than s56 “powers” which have less rights protections and only allow for assessment.

A converse argument is that the imposition of a mental health order may have greater future legal significance than the temporary use of powers. For example questions about significant mental health history are asked when people apply for insurance or visas to visit foreign countries, and that if a person reports that they have been placed on an involuntary order this might have negative implications for the granting of a visa or insurance. Because of this concern, the use of s56 powers in a crisis situation might be preferred than an ITO as it may not have to be declared in the future, depending on what questions are asked.

There may be situations where the need for an order may not be clear and a longer use of s56 powers would be preferable and in the persons interests.

There is currently work to improve pathways and flow in emergency departments. These initiatives will support earlier assessment and decision making and should reduce the use of prolonged care and control powers. This new monitoring requirement would provide an additional safeguard.

Proposal:

A new monitoring requirement be introduced of the use of temporary care and control powers to support SALRIs recommendation that assessments are timely. The Chief Psychiatrist would be asked to report on (i) the use of such powers (ii) instances and the circumstances where powers are used for greater than 6 hours.

This monitoring will use clinical data sources and will not impose a reporting burden on services.

Questions:

Do you agree that assessments of people held under care and control powers should be timely?

Is the proposed reporting requirement supported?

Any other comments?

8. Provisions to support psychiatric review of people who are on involuntary treatment orders prior to interhospital transfer.

Legislation has been written with the expectation that people who are placed on Inpatient Treatment Orders need to be transported to an approved treatment centre at the earliest opportunity.

For people in country locations this can be a long ambulance or Flying Doctor trip, and for those people who are moved to Adelaide, if a bed is not available, there may be a further stay in an emergency department.

Many people may only need a short order, which is not renewed at the 24-hour review by a psychiatrist.

Services have identified that there are clinical benefits for the patient if a telemedicine psychiatrist review can occur *before* travel, and that for some people when those reviews occur, orders may be lifted because a crisis is settling, and community treatment can be recommended.

This can benefit people in crisis. It can also benefit people who have drug intoxication or a drug induced psychosis who have conditions that can improve within days and may not need a longer hospital stay.

While in practice this can happen now – for example when waiting for a plane – it does not always occur, and people can be transported for hospital care that is ultimately not required.

The legislation would be modified to allow for a delay in transport so that a psychiatrist assessment can occur for patients referred for inpatient care who are waiting in incorporated hospitals or other designated clinic sites that can provide care and observation of people waiting transfer.

These requirements would only be invoked when clinical oversight is available. It is expected that rural and remote hospital staff may need extra training and telehealth support to care for patients in these circumstances. In high-risk clinical situations an immediate referral for transport would still occur. The change in this proposal from the current practice, is that automatic transfer would not be required.

The benefits put forward in this proposal include (i) to the person receiving care might avoid a transfer which for some people (e.g. those with drug induced psychosis) can be associated with the use of restraint and significant sedation, (ii) to the Medstar and Flying Doctor teams who will not undertake transfers without clinical benefit or risk to themselves. Flying to deliver immediate transfers in poor weather creates risks for the crew for transfers that may not be needed and (iii) to metropolitan services who will not need to provide an otherwise avoidable service.

There are risks in this proposal as many country sites are small, with minimal staffing and the use of locums. Telehealth support would mitigate this risk and clinical thresholds for immediate transfer would still need to be considered. This process would also apply to peri-urban hospitals such as Mount Barker, Murray Bridge, Gawler and Victor Harbor as well as those further afield. It would also apply to inter-rural transfers when a person is transferred from a country hospital to one of the three country approved treatment centres at Whyalla, Berri, or Mount Gambier.

The operation of the process would be reported on in the Chief Psychiatrist Annual Reports.

This proposed change would be to the provisions in the Act requesting transport. As a new procedure it is suggested that the use of such provisions be monitored and reported on.

Proposal:

That people placed on an ITO in rural settings can be held in a rural setting to have their psychiatrist review by telehealth, rather than transported for the review.

The Act would refer to local reviews and require reporting on these provisions in the Chief Psychiatrist Annual Report.

Question:

What is your view of this proposed "local psychiatrist review by telehealth" provision that would permit assessment before transport except if there is a clinical reason to transfer earlier?

9. Use of non-Mental Health Act powers for the detention and restraint of people who require acute care due to a delirium, dementia and/or intoxication

This proposal has arisen out of emergency service planning. It was also a proposed topic of a future review by SALRI. More specific details of this proposal are included in Section E of this document "proposals for future work".

Part C: Other Proposals that Might Improve Personal and Community Safety

As noted above, these changes are proposed based on observations from a number of situations.

9. A requirement to consult family members when a decision is made about involuntary care.

Discussions about risk to others led to further consideration of consultation with families and carers.

The need to contact families and carers and obtain collateral history has been the subject of previous Coronial recommendations as a measure to prevent suicide. Such contact may also prevent harm to others. If a person is at risk, family and carers may have valuable background history, and at times can also be at risk themselves as the persons who can be closest to the person who is in need of care.

The New Zealand Mental Health Act (1992) has a requirement to consult with family members.

NZ MHA (1992) 7A(2) states: A practitioner must consult the family or whanau of the proposed patient or patient.

There are also relevant exclusions to such consultations when it is not in a person's best interests and when the person's requests would need to be taken into consideration. For example, this could be relevant if a person is subject to domestic violence.

Consultation occurs now as part of good clinical practice; however, carers and family contact the Office of the Chief Psychiatrist with concerns that they have not been engaged. This provision has broad benefits beyond the issue of risk to others. On most occasions when a person's order is reviewed family will be concerned for that person's health and wish to assist.

For those lesser number of occasions when a family member or carer is at risk, such consultation could better inform a decision and acknowledges the rights of carers.

While this is focussed on family, it is also possible to consider others who might need to be consulted if affected by a decision, such as a nominated person in an Advanced Care Directive. This will protect the right to exercise legal capacity.

The New Zealand Act requires practitioners to apply relevant guidelines produced by the Director General. There are extensive guidelines to support practitioners in this task⁸ and it is expected that local guidelines would need to be produced in similar form. This could be done by the Office of the Chief Psychiatrist in this state.

The wording of the NZ Act provision is as follows:

Practitioner or responsible clinician to consult

(1) In this section, practitioner means—

⁸ New Zealand Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992, published 2022: Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992

(a) a mental health practitioner conducting an assessment examination of a proposed patient under section 9; and

(b) a responsible clinician providing an assessment of, or treatment to, a patient.

(2) A practitioner must consult the family or whanau of the proposed patient or patient. This subsection is subject to subsection (3).

(3) Subsection (2) does not apply if the practitioner has reasonable grounds for deciding that consultation—

(a) is not reasonably practicable; or

(b) is not in the best interests of the proposed patient or patient.

(4) In deciding whether or not consultation with the family or whanau is in the best interests of a proposed patient or patient, the practitioner must consult the proposed patient or patient.

(5) A practitioner must apply any relevant guidelines and standards of care and treatment issued by the Director-General of Health under section 130, when—

(a) deciding when and how to consult the family or whanau, or the proposed patient or patient; and

(b) deciding whether or not consultation with the family or whanau is reasonably practicable; and

(c) deciding whether or not consultation with the family or whanau is in the best interests of the proposed patient or patient.

Proposal:

A consultation requirement for consulting family and carers be added to the Act similar in intent to the provisions of the New Zealand Mental Health (Compulsory Assessment and Treatment Act) 1992.

Question:

Do you support the inclusion of this provision in the South Australian Act?

Under what circumstances should such consultation with family and carers not occur?

10. Increased accountability in mental capacity assessment when there is a risk of harm to another person.

SALRI recommended 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 (SALRI Recommendation 16).

This was a broad recommendation not necessarily focussed on the situation of risk to others, but the principle can be applied.

Current legislation requires that reasons for decision are written when psychiatrists confirm treatment orders but not when they discharge an order or do not make a further order.

New requirements are proposed to require the same formal process to provide written reasons for the revoking of treatment orders or for not making a new order. This process currently applies to the confirming of all treatment orders, but it is proposed that this be extended to the revocation of treatment orders where there is a risk of harm to other people because threats have been made, or there is a concern that a person may harm others.

The current formal requirements are for either a Statement of Reasons (for level 1 Inpatient treatment orders which are up to 7 days duration) or a Report to the Director of a Treatment Centre (for level 2 inpatient treatment orders which are up to 42 days) when treatment orders are confirmed.

The Statement of Reasons or Report to Director asks the psychiatrist to consider each criterion for involuntary treatment and why it is met, including that the practitioner has concluded that the person has impaired decision-making capacity.

When doing so, the guiding principles of the Act must also be considered ensuring there is no less restrictive means to provide treatment.

A formal document such as this provides an explanation as to how the Act is complied with and provides a record for review which also helps uphold the rights of a person placed on an order.

Currently, if an order is not made there is no requirement to make a Statement of Reasons or Report to Director. Standard practice would be to make a note in case-notes as to why an order has not been considered necessary.

This new proposed expectation would not apply to treatment orders where the concern is a risk to self. It would apply in any instance where a person has said that they may harm others, fear that they might harm others or has otherwise been considered at risk due to their behaviour, where such statements or behaviours have arisen at any time during their referrals, assessment, or treatment.

The implementation of the new requirements will ensure clinicians appropriately turn their mind to these considerations as part of the medical assessment. It is a preventative measure for the safety of other persons who may be impacted by the decision.

In preliminary discussions about this idea there was mostly support. In discussing with psychiatrists, they noted that this type of information is often documented in case notes already and represents good practice. In some discussion a concern was expressed that this might lead to more people having orders upheld, but if this was clinically appropriate this should not be an issue.

While in some instances this may lead to a change in the decision to revoke, in other circumstances it may not change the decision about an order but lead to further consideration of follow up plans and supports. Overall, this should benefit individual patient care as well as flow in the mental health system because experience related to many different situations suggests that unaddressed conditions and risk can lead to multiple re-presentations to emergency departments and acute admissions.

Proposal:

A new requirement for the completion of a Statement of Reasons and a Report to Director be put in place when a treatment order is not made.

This requirement would be limited only to situations where a person has been a risk to others because of threats or a concern that they might harm others.

Questions:

Is this new proposed requirement supported?

Under what circumstances should the requirement be applied?

11. Enshrining in legislation a “duty to warn” other people at risk

In clinical practice, there is a widely accepted “duty to warn” other parties who may be harmed by the actions of a person receiving care. This is a well-accepted ethical practice supported by legislation. While maintaining confidentiality is a duty, it is also expected that other parties be warned.

Warning others is facilitated in section 106 (2)(e) of the Act which enables the disclosure of information when there is a serious threat to life. This permits such communication but does not expect it.

Victims expect that appropriate warnings are given and wish to see robust systems for this to occur.

In the area of duty to warn legislation can be either *permissive* or *mandatory*. Currently the South Australian legislation is permissive as it provides for disclosure if the need for this is identified and acted on.

This proposal is to move towards a mandatory model. Disclosure would be an expectation when there is a serious threat to life unless there is a reason not to disclose. Reasons not to disclose could include a person’s admission to hospital as a way of managing this risk.

This duty would apply if there is a risk to a specific person, group of persons or a general risk to community members.

Care would be required to avoid unintended consequences of such a provision, because concerns could be raised that people may not confide their thoughts to their practitioners if they are concerned that they might be passed on to others, and they see this as unnecessary. The provision would require careful drafting to define the risk and what exceptions should be considered and how information is managed.

The provision would need to be worded in a way that does not inhibit people from disclosing thoughts of harming others to their mental health professionals and requires careful consideration of balancing privacy and confidentiality with public safety.

The expectation of disclosure would be independent of the person’s capacity and be based on the presumption that in a therapeutic relationship such thoughts and intent may be shared, and regardless of the reasons behind those thoughts if there is a risk to others, action should be taken.

It is recognised that these provisions will also need to account for situations of fluctuating risk, where a person may not be at an immediate risk but there is a concern that it could re-emerge.

Proposal:

Inclusion of a new provision within section 106 of the Act which describes a duty to warn. These circumstances would be in situations where a person is a serious threat to others, and there is foreseeable risk of harm. The expectation would be accompanied by exclusion criteria that might be applied, for example if a person is unable to act on these actions as they are in hospital.

Questions:

Do you support a move to a mandatory approach rather than a permissive one to the “duty to warn”?

Under what circumstances should the duty to warn apply?

What exclusions should be considered?

Part D: Additional proposal regarding a statutory Mental Health Human Rights Committee and Coercion Reduction Committee

Since the release of the SALRI review, the concept of a statutory Human Rights and Coercion Reduction Committee has been raised.

Such a committee could support the careful consideration of rights-based issues, such as those in this paper where the rights of different parties need to be upheld and report their deliberations to parliament.

A non-statutory committee with the same name currently exists, with members including relevant statutory officers, lawyers, advocates, academics, clinicians and lived experience representatives. Statutory Officers who are members of the committee currently include the Commissioner for Children and Young People and the Principal Community Visitor/Public Advocate. The Mental Health Commissioner is also a member. This Committee has focused on the practical application and upholding of human rights. It has overseen the development of a Human Rights Analysis tool that can support the development of new services and programs. The Chief Psychiatrist chairs the current committee.

A proposed statutory committee would oversee this ongoing work, consider the rights of consumers, carers and others, and monitor work to uphold the expectation of key international instruments that underpin the work of the mental health sector including the UN Convention on the Rights of Persons with Disabilities, the Optional Protocol to the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT), and the UN Convention on the Rights of the Child.

Proposal:

Provide for the statutory establishment of a Human Rights and Coercion Reduction Committee, defining its terms of reference and reporting of work. It would monitor the application of relevant human rights instruments, promote human rights initiatives in mental health, and provide the Minister with advice in this area.

Question:

Do you support the statutory establishment of such a committee?

Part E: Further areas of work

Two areas related to the boundaries of Mental Health legislation have been raised. One is to find alternatives to the current use of the *Mental Health Act* for people who experience delirium, dementia, or substance withdrawal.

The second is the potential use of involuntary powers to address co-morbid drug and alcohol use for people who have mental health conditions that are made worse by substance use, that then place themselves or others at risk, and where involuntary care may assist. This may not necessarily be in the Mental Health Act.

SALRI noted in their review 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, and children and adolescents. As a result, SALRI is of the view that a separate review should be conducted into the use of the MHA for these cohorts.”

This is summarised in their recommendation 11.

This section of the discussion paper relates to potential further areas of work that might occur as the Mental Health Act is revised – not necessarily delaying the existing changes to the Act, but for later consideration.

13. A proposal for future work – the development of non-*Mental Health Act* powers for the detention and restraint of people who require acute care due to a delirium, dementia and/or intoxication

Currently the *Mental Health Act 2009* is used to provide involuntary care for people who have a mental incapacity, that is not related to the mental health conditions usually treated by mental health services.

This relates to the lack of alternative legislation to the *Mental Health Act* for such situations in South Australia.

Mental Health Services have noted that in other states patients are treated either under common law powers or other legislation and that past work to include detention and restraint powers in the *Consent to Medical Treatment and Palliative Care Act 1995* that was not completed would be beneficial if it were restarted.

The broader current use of the *Mental Health Act* applies to both the use of short-term care and control powers (under s56) and Inpatient Treatment Orders.’

An example is use of section 56 powers by paramedics to bring people who are intoxicated and refusing care for an injury to hospital. *Mental Health Act* section 56 powers may be the only power available to bring the person to hospital.

For a longer period in hospital the placement of an inpatient treatment order may be the only readily available power to keep a person who is confused in hospital (e.g. after an anaesthetic, physical illness, or substance withdrawal).

In some other jurisdictions, common law powers are used to require people in this group to stay in hospital instead of using the *Mental Health Act*, but in South Australia our laws do not permit the routine use of common law powers in this way and for this reason a statutory solution is required.

Mental Health Services have noted that mental health teams have then had to review these clinical orders, and this can take mental health teams away from the care of other mental health patients contributing to avoidable delays. If there was not a legal requirement to review all such patients more time would be available for other work. The mental health teams would still be available for consultation if needed and patients could still be referred for opinion, but the teams would not automatically be required to review all patients in this group.

An example of the use of alternative legislation is the use of “Emergency Examination Authorities” in Queensland. These authorities are outside the *Mental Health Act*, in that state sitting within the Queensland *Public Health Act 2005* but if similar powers were established here would most likely sit within the *Consent to Medical Treatment and Palliative Care Act 1995*.

An EEA in Queensland enables a person to be taken against their will to a public sector health facility if there is a disturbance in their mental capacity or there is a risk of harm. Reasons for at risk behaviour may include illness, disability, injury, intoxication or another reason and are not limited to mental illness. A person may be detained in hospital for up to 6 hours and an extension of up to 12 hours (maximum) can be granted⁹. If this model existed in SA, it might potentially replace the use of section 56, or alternatively a modified model could be designed to complement section 56.

In addition to powers similar to a Queensland EEA, law reform would also need to enable a longer duration power so that people who are inpatients and are confused, or affected by substances, could also stay.

It is understood that if new powers were to be incorporated into the *Consent Act* or other legislation, that rights protections would be required. Previously when this was considered it was seen that there would be benefit in using similar definitions of restrictive practice across different legislation (disability, mental health, and general health), providing similar rights protections and seeking to ensure that the use of coercion be minimised where possible.

This consultation question is not a specific issue for change to the *Mental Health Act*, as it relates to making changes to other legislation such as the *Consent Act*, or alternative legislation. If there is a need to consequential amendments to the *Mental Health Act*, these would be minimal so if this extra work were to proceed it is not expected that this should delay any of the other unrelated *Mental Health Act* changes proposed.

⁹ Queensland Government, Emergency Examination Authority FAQs, https://www.health.qld.gov.au/data/assets/pdf_file/0038/998840/eea-faqs.pdf

Proposal for future work:

That amendments to alternative legislation (most likely the *Consent to Medical Treatment and Palliative Care Act 1993*) be developed to provide an alternative to the *Mental Health Act 2009* when detention or restrictive practices are required for the care of people who have a delirium, dementia, substance intoxication and withdrawal, and for other situations where people are not usually treated by mental health services.

Questions:

Do you support the development of such powers in other legislation separate to the *Mental Health Act*, such as in the *Consent to Medical Treatment and Palliative Care Act*?

What human rights protections should be provided when such powers are used?

14. A proposal for future work – the development of limited powers to require people who have co-morbid drug and alcohol conditions to mental illness to receive involuntary treatment

This was also an area of future work recommended in the SALRI report.

Earlier in this document there are proposals to include a drug and alcohol co-morbidity mental health principle in the Act, and they also refer to the inclusion of drug and alcohol treatment in care plans. The latter would be delivered on a **voluntary** basis.

This section refers to a limited involuntary option. It is included in this “for future work” section because in initial discussions there were differing views about the role of involuntary care, and what Act it should be included in – Mental Health or Drug and Alcohol legislation. There was also a view that more work would need to be done to define what therapies could be provided on an involuntary basis if such a proposal were to proceed.

Further work could consider the role, if any, of permitting **involuntary** substance use treatment in some circumstances. In particular when treatment to address a substance use disorder that is co-morbid to a mental health condition, is considered to be necessary as part of a person’s recovery from their mental health problem.

A possible concept for limited involuntary treatment of co-morbid drug and alcohol conditions

If drug and alcohol services are declined, should the person be required to participate? An example may be a person who uses methamphetamine that leads to a relapse of a mental health condition and may have no interest in addressing their methamphetamine use at this time.

In this concept if a person were under a community treatment order the person who may not have otherwise engaged in drug and alcohol treatment, may be required to attend a service. This might include attendance at an education session, therapy group, a requirement to meet a drug and alcohol worker, or alternatively to accepting substitute medication if a suitable treatment is available.

Similarly, if a person were under an inpatient treatment order (for their mental illness not substance use) they might similarly be expected to attend similar sessions while in hospital.

A decision about involuntary mental health treatment would be based on the usual criteria related to a person’s mental health condition not their substance use condition. It would not be intended in this concept that a person be subject to an ITO or CTO primarily for the basis of a substance use disorder. In initial discussions there were different opinions about whether such a power should be included in the Mental Health Act or other legislation so it is also possible that if powers related to drug and alcohol treatment were put in place that this would rest in alternative legislation. For this reason views are sought to inform further work.

Another consideration is that much of the evidence for the use of involuntary treatment of drug and alcohol conditions comes from Court programs in drug diversion courts or drink driving programs. There can be consequences for not attending treatment in such programs in that the matter will return to Court. If changes were made to civil legislation (which ever Act is used) this would not have consequences for the individual, should they decline. While this might appear to be a significant limitation there can be many instances where a person might accept such a decision and attend a session even if they may not have wished to otherwise do so.

Given that this is a new concept, the range of potential involuntary treatments included would be defined and published in the gazette. Consumers could also be provided with a specific appeal right about a requirement to attend drug and alcohol treatment if it were implemented.

This provision would need review of its impact.

In preliminary discussions the proposal for a principle regarding co-morbidity and a requirement for care plans to include voluntary treatment have been broadly well received. There are differing views about the involuntary proposal and its potential scope, and it is expected that the consultation will be helpful in clarifying this. On one hand there is uncertainty about involuntary powers in any legislation, noting that there is still much work to do to improve access to voluntarily received therapies addressing drug and alcohol treatment. As noted, the appropriateness of placing such powers in a Mental Health Act rather than other legislation has also been raised. On the other hand, there is another view that can be expressed by family members that any step that might save a life after other attempts have failed should be available and be delivered involuntarily if needed.

Proposal for future work:

That developmental work occurs for a concept to provide in limited circumstances involuntary drug and alcohol treatment for people who have a mental illness that deteriorates due to substance use and have not wished to address this. This would apply if the deterioration places the person or others at serious risk

Questions:

Do you support the use of involuntary treatment for drug and alcohol use that leads to relapse or deterioration of mental illness as a last resort option?

If you support this concept should such legislative provisions sit in a Mental Health Act, drug and alcohol Act, or other legislation?

In general, what treatment should such involuntary provisions be limited to for a range of substance use disorder?

For people who experience relapse of mental illness due to methamphetamine use what interventions might be considered in scope?

What human rights protections should be provided when such powers are used?

14. Proposal for further work: seeking to address a gap in legislation coverage related to the involuntary care of people who have a neurodevelopmental disorder when the Mental Health Act does not apply

Earlier in this paper is a proposed principal related to the care of people who experience a neurodevelopmental disorder who also need mental health care.

This section relates to a gap in coverage in the Act. The exclusion of neurodevelopmental disorders as a mental illness in Schedule 1 in the Act can lead to uncertainty in crisis situations, and the need to identify a solution.

It can have a significant impact when children and adolescents who experience a disability, often autism spectrum disorders, present to the emergency department or are admitted to hospital following a behavioural disturbance that can place carers and families at risk.

If the behavioural disturbance cannot be linked to another co-morbid mental illness and is considered to be due to a neurodevelopmental condition alone, the *Mental Health Act* cannot be used to keep that young person in hospital.

This can create problems for young people, their families, carers and clinical staff. If clinicians consider that behavioural symptoms are linked to underlying anxiety the Act might apply. If it is considered that the symptoms should be seen as a symptom of a person's underlying neurodevelopmental disorder and the Act cannot be used.

If the Act does not apply, restraint and detention may need to occur without a statutory authority in emergency situations that can expose staff to allegations of assault. Common law defences including the defence of necessity were abolished in South Australia in 2021. Further statutory defences may apply – e.g. self-defence, defence of property etc, duress, or sudden or extraordinary emergency, but relying on these defences is not ideal.

Guardianship and Administration Act special powers can be sought but these powers can also have limitations in where they are used.

For this reason, work to address this gap is proposed. Although the focus is on health care settings it would need to be done in conjunction with the disability sector for all options to be considered.

Proposal for future work:

That work occurs to provide for the use of restrictive practices for people with neurodevelopmental conditions in situations where the Mental Health Act does not apply. This work would seek to minimise and prevent the use of such practices where possible but provide for lawful authority when needed.

Questions:

Do you agree with the need for this work?

What limits should be placed on any new powers in this area?

What human rights protections should be provided when such powers are used?

Consultation

Consultation on these proposals will occur in December 2024 and January 2025.

A second round of consultation will occur on a draft exposure Bill expected subsequently



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For more information

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