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

Discussion Paper

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Acknowledgments

Acknowledgement of Country

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

Further, that 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 that Aboriginal peoples have endured past injustice and dispossession of their traditional lands and waters.

Introduction

Purpose

In this document, the Office of the Chief Psychiatrist sets out further discussion to the SA Law Reform Institute (SALRI) review, which will inform the drafting of the Bill for the update of the Act. The paper highlights where clarification is sought, and seeks feedback for topics from people, including those with lived experience and clinical expertise, to provide further input to the legislative reform process.

Background to the *Mental Health Act 2009*

The *Mental Health Act 2009* (MHA) was proclaimed in July 2010, repealing the *Mental Health Act 1993*. The 2009 Act provided South Australia with the legislative framework to ensure that people with severe mental illness were receiving a comprehensive range of services to facilitate, to the greatest extent possible, their recovery from mental illness and the resumption of their participation in and contribution to community life.

Section 111 of the MHA requires that a report on the operation of the Act be tabled in Parliament within five years of commencement. A review of the MHA was tabled in Parliament in July 2014 with amendments resulting from the review commencing in June 2017.

The OCP welcomes the opportunity to reflect on a further five years of operation of the Act, which has been independently reviewed by the South Australian Law Reform Institute (SALRI) at the University of Adelaide.

The SALRI Report advanced 61 recommendations and 11 suggestions ('suggestions' fell outside the terms of reference of the review). Many of the recommendations are for specific statutory amendments to the Act. The remaining recommendations require service provision, policy and training commitments. The focus of this paper is to explore the changes required to the Act.

The OCP welcomes the opportunity to align mental health legislation with contemporary mental health and human rights-based practice.

2023 SA Law Reform Institute Report on the Review of the *Mental Health Act 2009*

In April 2022, SALRI commenced its review of the *Mental Health Act 2009*, starting with community and sector consultation including the publication of a series of "issues Fact Sheets" and feedback on the YourSay website. In addition to the YourSay survey, interested parties could complete a formal or informal written submission.

Input was received 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 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 consulted with several 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 holding 19 Roundtables.

SALRI also had consultation with Aboriginal communities. As part of this review, SALRI spoke to Elders and members of community, Aboriginal Health Services and practitioners working closely with Aboriginal communities. SALRI also held consultation sessions, including private meetings with interested parties in Adelaide and regional centres.

The review reflected that since the MHA was last considered, the Australian and international landscape of mental health legislation has evolved, and there is a momentum for mental health law reform to better safeguard the human rights of mental health consumers and carers, and uphold Australia's international treaty obligations, most notably the Convention on the Rights of Persons with Disabilities (CRPD). This approach requires a shift away from involuntary treatment models towards a model of "supported decision-making".

Assisting the formation of the SALRI report were findings of the Royal Commission into Victoria's Mental Health System, released February 2021, which made recommendations advocating a legislative shift towards support-decision making and recovery-oriented practice.

An interim report was tabled in Parliament on 31 May 2022. The Final Report was tabled in Parliament 2 May 2023 with 61 recommendations and 11 suggestions that arose from the review but fell outside of the scope of the Terms of Reference.

The Office of the Chief Psychiatrist thanks the many individuals and groups who participated in the SALRI review. This discussion paper seeks to reflect on some key issues raised in the SALRI report that require further discussion. Feedback on these issues will be used to inform the development of a draft Bill to make amendments to the *Mental Health Act 2009*. Changes to the Act will need to be agreed by Cabinet and both houses of Parliament. Any changes with resource implications will be subject to government budget processes.

Statutory objects of the Act

Greater focus on promotion of wellbeing and prevention strategies

The SALRI report recommended that the objects of the Act be amended to reflect a greater focus on the promotion of wellbeing and prevention strategies, to help facilitate a shift from a crisis focussed approach to one of wellbeing (SALRI Recommendation 7).

New system-wide aspirations will build on and extend objectives in the current legislation. The objectives should be appropriately honoured and acted upon. Decision-makers, clinicians and services seeking to employ a human rights-oriented approach can use these objectives to justify their approach.

The current objects of the MHA are:

6—Objects

The objects of this Act are—

(a) to ensure that persons with severe mental illness—

(i) 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; and

(ii) 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; and

(b) for that purpose, to confer appropriately limited powers to make orders for community treatment, or inpatient treatment, of such persons where required.

A recent example of objectives that include a focus on wellbeing can be found in the Victorian Mental Health and Wellbeing Act (MHWa):

This Act has the following objectives—

(a) to promote conditions in which people can—

(i) experience good mental health and wellbeing; and

(ii) recover from mental illness or psychological distress;

(b) to reduce inequities in access to, and the delivery of, mental health and wellbeing services;

(c) to provide for comprehensive, compassionate, safe and high-quality mental health and wellbeing services that promote the health and wellbeing of people living with mental illness or psychological distress and that—

(i) are accessible; and

(ii) respond in a timely way to people's needs and recognise that these needs may vary over time; and

(iii) are consistent with a person's treatment, care, support and recovery preferences wherever possible; and

(iv) are available early in life, early in onset and early in episode; and

(v) recognise and respond to the diverse backgrounds and needs of the people who use them; and

(vi) provide culturally safe and responsive services to Aboriginal and Torres Strait Islander people in order to support and strengthen connection to culture, family, community and Country; and

(vii) connect and coordinate with other support services to respond to the broad range of circumstances that influence mental health and wellbeing including alcohol and other drug support services and treatment; and

(viii) include a broad range of treatment options with the aim of providing access to the same treatment and support irrespective of whether a person is receiving voluntary or compulsory treatment; and

(ix) include a broad and accessible range of voluntary treatment and support options—

(A) to enable a reduction in the use of compulsory assessment and treatment; and

(B) to enable a reduction in the use of seclusion and restraint with the aim of eliminating its use;

(d) to promote continuous improvement in the quality and safety of mental health and wellbeing services including by ensuring that the experiences of people living with mental illness or psychological distress, and the people receiving treatment, their carers, families and supporters, are at the centre of changes in practices and service delivery and the design and evaluation of systems;

(e) 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;

(f) to recognise and respect the right of people with mental illness or psychological distress to speak and be heard in their own voices, from their own experiences and from within their own communities and cultures;

(g) to recognise, promote and actively support the role of families, carers and supporters in the care, support and recovery of people living with mental illness or psychological distress;

(h) to promote and support the health and wellbeing of families, carers and supporters of people living with mental illness or psychological distress;

(i) to recognise and value the critical role of the clinical and non-clinical mental health and wellbeing workforce and to support and promote the health and wellbeing of members of that workforce;

(j) to promote the mental health and wellbeing principles.

Question 1: What is important to include in the objects of the Act if we are to move to a focus on wellbeing?

Guiding Principles

The SALRI report noted that the current list of guiding principles in South Australia's Mental Health Act is extensive, representing distinct human rights, best practice and desired outcomes for consumers. The report suggested that guiding principles will be most effective when they are able to be translated into practice and are supported by effective accountability mechanisms.

The SALRI report recommended that assertive positive rights-based language be used in the guiding principles (SALRI Recommendation 56), that the guiding principles be restructured to emphasise mental health, wellbeing and prevention (SALRI Recommendation 58) and that a Statement of Recognition similar to s13 of the *Mental Health and Wellbeing Act 2022* (Vic) be included (SALRI Recommendation 57). Further discussion on the Statement of Recognition can be found below in the discussion on Aboriginal Mental Health.

The current guiding principles place emphasis on what mental health services need to provide. It is proposed that updated principles are restructured to be person-centred and rights-based. The proposed principles below are examples borrowing from:

- the Victorian MHWa,
- a reframing of the current SA principles
- the Substance Abuse and Mental Health Services Administration (SAMHSA) six key principles to a trauma informed approach, and
- Article 3 of the Convention on the Rights of Persons with Disabilities (CRPD).

New 7—Guiding principles

(1) The following principles are to be actively considered by the Minister, the Tribunal, the Chief Psychiatrist, health professionals and other persons and bodies involved in the administration of this Act in the performance of their functions:

Dignity and autonomy principle

The rights, dignity and autonomy of a person living with mental illness or psychological distress is to be promoted and protected and the person is to be supported to exercise those rights.

Least restrictive principle

Mental health and wellbeing services are to be provided to a person living with mental illness or psychological distress with the least possible restriction of their rights, dignity and autonomy with the aim of promoting their recovery and full participation in community life. The views and preferences of the person should be key determinants of the nature of this recovery and participation.

Medication and restrictive practices should be used only for therapeutic purposes or safety reasons and not as a punishment or for the convenience of others;

Diversity principle

(1) The diverse needs and experiences of a person receiving mental health and wellbeing services are to be actively considered noting that such diversity may be due to a variety of attributes including any of the following—

- (a) gender identity;
- (b) sexual orientation;
- (c) sex;
- (d) ethnicity;
- (e) language;
- (f) race;
- (g) religion, faith or spirituality;

- (h) class;
- (i) socioeconomic status;
- (j) age;
- (k) disability;
- (l) neurodiversity;
- (m) culture;
- (n) residency status;
- (o) geographic disadvantage.

(2) Mental health and wellbeing services are to be provided in a manner that—

- (a) is safe, sensitive and responsive to the diverse abilities, needs and experiences of the person including any experience of trauma; and
- (b) considers how those needs and experiences intersect with each other and with the person's mental health.

Choice and control principle

A person living with mental illness or psychological distress is to be provided with access to a choice of care and support services. This is to be determined, as much as possible, by the needs and preferences of the person living with mental illness or psychological distress including their accessibility requirements, relationships, living situation, any experience of trauma, level of education, financial circumstances and employment status.

Supported decision making principle

Supported decision making practices are to be respected, protected and fulfilled. Persons receiving mental health and wellbeing services are to be supported to make decisions and to be involved in decisions about their assessment, treatment and recovery including when they are receiving compulsory treatment. The views and preferences of the person receiving mental health and wellbeing services are to be given priority.

Trustworthiness and transparency principle

Decisions are made with transparency with the goal of building and maintaining trust.

Family and carers principle

Families, carers and supporters (including children) of a person receiving mental health and wellbeing services are to be supported in their role in decisions about the person's assessment, treatment and recovery.

Lived experience principle

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.

Health needs principle

The medical and other health needs of people living with mental illness or psychological distress are to be identified and responded to, including any medical or health needs that are related to the use of alcohol or other drugs. In doing so, the ways in which a person's physical and mental health needs may intersect should be considered.

Dignity of risk principle

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.

Wellbeing of young people principle

The health, wellbeing and autonomy of children and young people receiving mental health and wellbeing services are to be promoted and supported, including by providing treatment and support in age and developmentally appropriate settings and ways. It is recognised that their lived experience makes them valuable leaders and active partners in the mental health and wellbeing service system.

Safety principle

People feel physically and psychologically safe, the physical settings are safe and the interpersonal interactions promote a sense of safety.

Gender safety principle

People receiving mental health and wellbeing services may have specific safety needs or concerns based on their gender. Consideration is therefore to be given to these needs and concerns and access is to be provided to services that—

- (a) are safe; and
- (b) are responsive to any current experience of family violence and trauma or any history of family violence and trauma; and
- (c) recognise and respond to the ways gender dynamics may affect service delivery, treatment and recovery; and
- (d) recognise and respond to the ways in which gender intersects with other types of discrimination and disadvantage.

Cultural safety principle

- (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) Treatment and care is to be appropriate for, and consistent with, the cultural and spiritual beliefs and practices of a person living with mental illness or psychological distress. Regard is to be given to the views of the person's family and, to the extent that it is practicable and appropriate to do so, the views of significant members of the person's community. 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.

Wellbeing of dependents principle

The needs, wellbeing and safety of children, young people and other dependents of people receiving mental health and wellbeing services are to be protected.

Recovery principle

People are supported through a process of change through which individuals improve their health and wellness, live a self-directed life and strive to reach their full potential.

In addition, mental health services should meet the highest levels of quality and safety; and (subject to this Act or any other Act) be provided in accordance with international treaties and agreements to which Australia is a signatory.

Question 2: What is important to include in the guiding principles of the MHA if we are to move to a focus on mental health, wellbeing and prevention?

Question 3: How would the principles be reflected in practice?

SALRI recommended that the Office of the Chief Psychiatrist convene a working group to develop and monitor standards that would see the guiding principles put into action. Progress on the operationalisation of the guiding principles can be published in the Chief Psychiatrist's annual report each year. (SALRI Recommendations 59-60)

Decision making capacity

Decision-making capacity refers to an individual's ability to make their own decisions. The SALRI report noted that when the law interferes with a person's ability to make their own decisions, it is important to ensure that this interference is reasonable, proportionate, and necessary in the circumstances.

Treatment can only be carried out under the MHA without the consumer's consent when specific criteria are satisfied. One of these criteria relates to impaired decision-making capacity. The implications of a finding that a consumer does or does not have capacity under the MHA are significant.

SALRI recommended that the current definition of 'decision-making capacity' in s 5A (2) of the MHA should be retained. SALRI recommended that s 5A (3) should be amended to endorse a supported decision-making framework, giving consideration to s 8(1) and (d) of the *Mental Health Act 2015* (ACT) to provide that: a. A person who does not have decision-making capacity should 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 (SALRI Recommendation 12).

Note the proposed changes are likely to assist in upholding the 'supported decision-making' principle proposed in the Guiding Principles section above.

Definition of decision-making capacity

Taking this suggestion on board would result in the decision-making capacity section being amended to:

5A—Decision-making capacity

(1) A person is, 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 his or her health care, residential and accommodation arrangements and personal affairs.

(2) For the purposes of this Act, 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) For the purposes of this Act—

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

(b) [new] A person must not be treated as not having decision-making capacity unless all practicable steps to support the person to make decisions have been taken;

(c) a person will not be taken to be incapable of understanding information merely because the person is not able to understand matters of a technical or trivial nature; and

(d) a person will not be taken to be incapable of retaining information merely because the person can only retain the information for a limited time; and

(e) a person may fluctuate between having impaired decision-making capacity and full decision-making capacity; and

(f) a person's decision-making capacity will not be taken to be impaired merely because a decision made by the person results, or may result, in an adverse outcome for the person.

SALRI further recommended that a capacity assessment toolkit or guidelines be developed to be used as a non-legislative, educative tool for anyone to use. It was recommended that the toolkit or guidelines address implications of capacity and its assessment for Aboriginal communities and culturally and linguistically diverse communities.

Question 4: Do you support the proposed updates to the decision-making capacity section of the Act? Can you explain any benefits and / or complexities?

Capacity as a Criterion for Treatment Orders

The MHA was last reviewed in 2014 with the resulting amendments enacted in 2017. One of the significant amendments to the Act was the inclusion of a decision-making capacity criterion for all involuntary treatment orders which requires a person to have “impaired decision-making capacity relating to appropriate treatment of their mental illness” for a treatment order to be made.

A Term of Reference for the SA Law Reform Institute Review was to consider the decision-making capacity criterion following a recommendation made by Deputy State Coroner Anthony Schapel that the criterion be removed. This recommendation was made in the Inquest into the Death of Theo Papageorgiou released in November 2021.

Following careful consideration of the criterion, SALRI recommended that the ‘impaired decision-making capacity’ criterion for community treatment orders and inpatient treatment orders in ss 10(1)(c), 16(1)(c), 21(1)(ba), 25(2)(ba) and 29(1)(ba) should be retained.

Question 5: Do you agree that the ‘impaired decision-making capacity’ criterion be retained?

Accountability following a clinical capacity assessment

The SALRI report found that there was support for providing clarification on how an assessment of capacity should be made and that documentation on how decisions on capacity are made would assist consumers to better understand decisions being made about them. SALRI recommended that measures to enforce accountability such as providing written reasons should be considered further (Recommendation 16). A possible outcome would be that the process of assessment could be defined by the Chief Psychiatrist, through the publication of Standards.

Question 6: How can capacity assessments be improved?

Removal of the term ‘appropriate’ in relation to treatment

SALRI recommended that the term ‘appropriate’ 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. SALRI’s consultation revealed wide support to remove the term ‘appropriate’.

The Office of the Chief Psychiatrist intends to recommend that this change be made to the legislation.

Example Section 10—Level 1 community treatment orders

(1) A medical practitioner or authorised mental health professional may make an order for the treatment of a person (a level 1 community treatment order) if it appears to the medical practitioner or authorised mental health professional, after examining the person, 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

(c) the person has impaired decision-making capacity relating to ~~appropriate~~ treatment of the person's mental illness; and

(d) there is no less restrictive means than a community treatment order of ensuring appropriate treatment of the person's illness.

Aboriginal Mental Health

Statement of Recognition

Strengthening the ways mental health services and regulatory bodies engage with Aboriginal people and communities, to promote social and emotional wellbeing, must be a priority. To build on the current good work and commit to a better experience for Aboriginal consumers, family and carers, two specific statutory amendments are proposed.

The SALRI report recommended that a Statement of Recognition with regard to the National Strategic Framework and the Victorian Mental Health and Wellbeing Act 2022 be included as a guiding principle in the MHA (Recommendation 57).

The Guiding Principles from the National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing are:

1. Aboriginal and Torres Strait Islander health is viewed in a holistic context, that encompasses mental health and physical, cultural and spiritual health. Land is central to wellbeing. Crucially, it must be understood that when the harmony of these interrelations is disrupted, Aboriginal and Torres Strait Islander ill health will persist.
2. Self-determination is central to the provision of Aboriginal and Torres Strait Islander health services.
3. Culturally valid understandings must shape the provision of services and must guide assessment, care and management of Aboriginal and Torres Strait Islander people's health problems generally, and mental health problems, in particular.
4. It must be recognised that the experiences of trauma and loss, present since European invasion, are a direct outcome of the disruption to cultural wellbeing. Trauma and loss of this magnitude continues to have inter-generational effects.
5. The human rights of Aboriginal and Torres Strait Islander people must be recognised and respected. Failure to respect these human rights constitutes continuous disruption to mental health. Human rights relevant to mental illness must be specifically addressed.
6. Racism, stigma, environmental adversity and social disadvantage constitute ongoing stressors and have negative impacts on Aboriginal and Torres Strait Islander peoples' mental health and wellbeing.
7. The centrality of Aboriginal and Torres Strait Islander family and kinship must be recognised as well as the broader concepts of family and the bonds of reciprocal affection, responsibility and sharing.
8. There is no single Aboriginal or Torres Strait Islander culture or group, but numerous groupings, languages, kinships, and tribes, as well as ways of living. Furthermore, Aboriginal and Torres Strait

Islander people may currently live in urban, rural or remote settings, in traditional or other lifestyles, and frequently move between these ways of living.

9. It must be recognised that Aboriginal and Torres Strait Islander people have great strengths, creativity and endurance and a deep understanding of the relationships between human beings and their environment.

The Victorian Statement of Recognition is below:

13 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—

(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.

Amendment to 'Patients' right to be supported by guardian etc' section

SALRI recommended 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.

(Recommendation 19). It is intended that this amendment will be made to the MHA.

SALRI further recommended that appropriate measures to promote Aboriginal mental health and culturally responsive and appropriate services are considered and progressed. SALRI further

recommends that measures to implement a Social and Emotional Wellbeing model should be examined.

Question 7: What is important to include in a South Australian Statement of Recognition for Aboriginal and Torres Strait Islanders in the Act?

Children and Young People

Include specific provisions to safeguard children subject to Treatment Orders

SALRI recommends that the Act be amended to include specific provisions to safeguard children subject to an Inpatient Treatment Order (Recommendation 27) or a Community Treatment Order (Recommendation 34)

This could be achieved through the development of a Statement of Rights appropriate to the developmental age of the young person, and ensuring young people had access to an independent children's lawyer. There may also be a role for the Commissioner for Children and Young People, the Commissioner for Aboriginal Children and Young People and the Guardian for Children and Young People.

SALRI further recommended that a Child and Adolescent Mental Health Committee be established by the Office of the Chief Psychiatrist (Recommendation 50).

Question 8: What's important in providing extra safeguards for children and young people under treatment orders?

Restrictive Practices

The MHA defines restrictive practice as the use of physical, mechanical or chemical means to restrain a patient or the seclusion or confinement of a patient in an area from which the person cannot leave of their own volition. The SALRI found that the role and use of restrictive practices was a prominent theme in consultation. Restrictive practices can be used under the MHA when a person is placed under 'care and control' or placed under an involuntary treatment order.

Many submissions called for a prohibition on the use of restrictive practices, and there were divergent views on their use and effectiveness. It is acknowledged that restrictive practices can cause distress and trauma and may constitute an interference with a person's human rights.

The *Chief Psychiatrist Standard to Reduce and Eliminate where possible the use of Restraint and Seclusion applied under the Mental Health Act 2009* provides for the use of restrictive practices and reasonable force under the MHA.

Restrictive practices have also been considered in the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability.

No changes to the Act are proposed for restrictive practices, however changes to the authorisation of restrictive practices for prescribed psychiatric treatment (including ECT) are discussed later in this paper.

Use of care and control powers (Section 56 and 57 powers)

Care and control powers allow a person to be lawfully detained for a medical examination where certain criteria are met. Care and control powers allow for the use of reasonable force. Restrictive practices can be used on an individual who is under care and control if the criteria are met.

Overall, SALRI found that the current legislation be retained and that there be an emphasis on adequate training, expertise and experience in exercising care and control powers.

Powers should be used to facilitate assessment within a timely manner

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) the MHA (Recommendation 26)

The proposed changes to section 56 (3) are shown below:

(3) An authorised officer may, subject to this section, exercise the following powers in relation to a person to whom this section applies:

(a) the authorised officer may take the person into his or her care and control;

(b) the authorised officer may transport the person from place to place;

(c) the authorised officer may restrain the person and otherwise use force in relation to the person [for an assessment for a treatment order] as reasonably required in the circumstances;

(d) the authorised officer may restrain the person by means of the administration of a drug [for an assessment for a treatment order] when that is reasonably required in the circumstances;

(e) the authorised officer may enter and remain in a place where the authorised officer reasonably suspects the person may be found;

(f) the authorised officer may search the person's clothing or possessions and take possession of anything in the person's possession that the person may use to cause harm to himself or herself or others or property

The Act current wording at s56 (5) is "The powers conferred by this section continue to be exercisable as reasonably required for the purposes of enabling or facilitating the medical examination or treatment of the person"

Question 9: Do you support the proposed changes to make it clear that s56 powers are used to facilitate assessment for a treatment order?

Power to use reasonable force to hold someone to return to police custody

SALRI found there were differing views relating to the ability of hospital staff to use reasonable force to 'hold' a person until SAPOL arrives. Some consumers and consumer advocacy groups opposed the suggestions. Other parties, including some health practitioners and RANZCP, whilst supportive in principle, identified having reservations about the policy and practice. Some parties were supportive, noting the need for the power to be carefully used by suitably trained staff.

SALRI note the view of the Legal Services Commission that in some extreme circumstances, SAPOL is best placed to manage a patient the subject of an order under the MHA to protect the patient or others from the risk of harm. There may be some circumstances where SAPOL have left or are on their way where protective measures may be necessary. This may require use of lawful restrictive practices by hospital staff for the protection of the patient, other patients and their own safety.

OCP has previously sought legal advice on this topic and considers that the current wording of s 57(10) is clear that a person must be held and returned to police custody in the event that an inpatient treatment order is not made for that person.

SALRI recommended that where a person has committed an offence, and is in police custody and requires treatment, that 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 (Recommendation 47).

Question 10: Is the power to use reasonable force to 'hold' a person until police arrive sufficiently described in the Act?

Community Treatment Orders

The role and use of community treatment orders was a prominent theme in SALRI's consultation and research, attracting much debate and discussion. The use of CTOs in South Australia is relatively high compared with other Australian jurisdictions and there is debate about whether this is desirable.

Recommendations relating to community treatment orders included:

- Amending the Act to:
 - include 'serious harm' as a threshold criterion for the imposition of a CTO (Recommendation 29)
 - ensure that Directors of Mental Health Services hold the duty to ensure that a mental health clinician is appointed for each consumer on a CTO to ensure monitoring and compliance, rather than the Chief Psychiatrist (Recommendation 30)
 - provide one universal CTO rather than the current CTO1 and CTO2 (Recommendation 31)
- Addressing non-compliance within the Act (Recommendation 32)
- Including a power for AMHPs and authorised officers to use 'reasonable force' in the administration and enforcement of a CTO where there is non-compliance (Recommendation 33)
- Including specific provisions when CTOs are applied to children (Recommendation 34)
- That consideration be given to the introduction of a Forensic Community Treatment Order (Recommendation 36).

'Serious harm' as a threshold criterion

One of the criteria for imposing inpatient treatment orders and community treatment orders is that:

(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

SALRI have recommended that 'harm' be amended to 'serious harm' as a threshold criterion for the imposition of a CTO (Recommendation 29). A similar recommendation is made for inpatient treatment orders (Recommendation 21).

In comparing South Australian legislation to other jurisdictions, SALRI found that Victoria uses a 'balancing of harm' principle which provides that 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.

SALRI indicated support for 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 themselves or someone else; or is suffering, or is likely to suffer, serious mental or physical deterioration'.

Directors of Mental Health Services hold the duty to ensure a mental health clinician is allocated (Recommendation 30)

SALRI noted 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. These obligations are currently in sections 14 (CTO1) and 19 (CTO2) of the MHA. The Chief Psychiatrist Standard: Monitoring of Compliance with Community Treatment Orders which was released in October 2022 outlines the responsibilities of Local Health Networks and private hospitals to have an assigned mental health clinician responsible for the care and treatment of people under the care of a CTO. The OCP intends to recommend that this change be made to the legislation.

Levels for Community Treatment Orders (Recommendation 31)

SALRI found that most consultees agreed that there should be regular reviews but also noted widespread acknowledgment that SACAT was not resourced to conduct regular reviews. SALRI have suggested that a specific mental health stream be established by SACAT to undertake this function.

SALRI found that administrative burdens placed upon clinicians may contribute to a lack of transparency with consumers and their support networks as well as difficulties and delays with the review and revocation or variation of orders. This may lead to orders remaining in place for longer than necessary where a less restrictive approach could have been taken.

SALRI recommended that the MHA 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

Question 11: How can the Act support the efficient and effective regular review of community treatment orders by an appropriate mechanism?

Non-compliance (Recommendation 32)

SALRI recommends that non-compliance with a Community Treatment Order should be explicitly addressed in the MHA, describing the absence as a 'significant omission'. 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.

Question 12: How can the Act support greater transparency for the requirements of a CTO so that the conduct that constitutes a breach or non-compliance with an order is clear?

Allow reasonable force in administration and enforcement of a CTO where there is non-compliance (Recommendation 33)

SALRI has recommended that the Act specifically allow for the use of reasonable force where there is non-compliance with a CTO.

Currently the Act allows for treatment to be given 'despite the absence or refusal of consent to the treatment' (ss13(3) and 18(3)).

S54A of the Act provides:

(1) If a community treatment order applies to a patient and the patient has not complied with the requirements of the order, a medical practitioner or mental health clinician may issue a patient assistance request for the purpose of treating the patient in accordance with the order at the place where the person is located.

(2) A patient assistance request must be— (a) directed to authorised officers and police officers generally; and (b) in writing in the form approved by the Chief Psychiatrist.

Where an authorised officer believes on reasonable grounds that a patient assistance request has been issued under s54A(1) they may exercise 'care and control' powers under s56.

Powers under s56(3) include: '(c) the authorised officer may restrain the person and otherwise use force in relation to the person as reasonably required in the circumstances'.

This recommendation must be read in conjunction with Recommendation 26 which is discussed above. Recommendation 26 suggests amending s56(3) of the Act so that it is clear that powers are used to facilitate an assessment for a treatment order.

Question 13: Do you agree that the power to use force where there is non-compliance with a community treatment order needs to be clarified within the Act?

Forensic Community Treatment Order (Recommendation 36)

SALRI has recommended that consideration 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 CTO under the current MHA. The NSW *Mental Health and Cognitive Impairment Provisions Act 2020* s99 allows for the Mental Health Review Tribunal to make a CTO for a forensic patient or persons in correctional or detention facilities. The Tribunal must carry out reviews of persons (other than forensic patients) who are subject to community treatment orders no later than 3 months after the CTO is made and at least once every 6 months during the term of each order. The *Mental Health and Cognitive Impairment Forensic Provisions Regulation* allow for any modifications of CTOs to apply to all forensic CTOs.

Inpatient Treatment Orders

Inpatient Treatment Orders allow for a person to receive treatment for their mental illness in a treatment centre despite the absence or refusal of consent to the treatment. In its review of the legislation relating to Inpatient Treatment Orders (ITOs) under the Act, SALRI recommended that the existing three levels be retained (Recommendation 21). The Act currently allows for the following in relation to ITOs:

- Level 1 – made by a medical practitioner or authorised medical health professional (AMHP) for up to seven days
- Level 2 – made by a psychiatrist or authorised medical practitioner (AMP) for up to 42 days
- Level 3 – made by the South Australian Civil and Administrative Tribunal (SACAT) for up to 12 months (six months for orders relating to children).

The changes recommended by SALRI to the current legislation for ITOs were:

- removal of the term ‘appropriate’ in relation to one of the criteria for making an order ‘the person has impaired decision-making capacity relating to appropriate treatment of the person’s mental illness’ (Recommendation 20) Note this recommendation also relates to the criteria for community treatment orders and is discussed above under ‘decision-making capacity’.
- ‘harm’ be amended to ‘serious harm’ as a threshold criterion for the imposition of an ITO (Recommendation 21). A similar recommendation is made for community treatment orders (Recommendation 29).
- that the definition of ‘treatment’ be amended to the treatment of mental illness that may be ‘causing, contributing *or connected to* the person’s mental illness (Recommendation 24).

‘Serious harm’ as a threshold criterion

One of the criteria for imposing inpatient treatment orders and community treatment orders is that:

(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

In comparing South Australian legislation to other jurisdictions, SALRI found that Victoria uses a ‘balancing of harm’ principle which provides that 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.

SALRI indicated support for 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 themselves or someone else; or is suffering, or is likely to suffer, serious mental or physical deterioration’.

Question 14: Do you support the change of threshold from ‘harm’ to ‘serious harm’?

Definition of ‘treatment’

SALRI examines the use of involuntary treatment orders and considers the definition of ‘treatment’ that can be given without consent under inpatient treatment orders. Currently the relevant parts of the Act (ss 24(1), 28(1) and 31(1) relating to Level 1, 2 and 3 Inpatient Treatment Orders respectively) provide that a patient may be given treatment ‘for his or her mental illness, or for any other illness that may be causing or contributing to the mental illness ...’. The SALRI report acknowledges that there were differing views on whether the definition should be changed:

“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.”

SALRI recommended that the definition of treatment be changed to treatment of mental illness that may be ‘causing, contributing *or connected to*’ the person’s mental illness (Recommendation 24). Alternatively, noting concerns raised about the right to autonomy and the avoidance of coercive practices the Act could be amended to treatment ‘causing, contributing or as a *consequence of* the person’s mental illness.

SALRI further recommended that the Chief Psychiatrist publish standards regarding the definition of ‘treatment’ (Recommendation 25)

Question 15: Do you agree that the definition of ‘treatment’ should be amended to the treatment of mental illness that may be causing, contributing or:

- ‘*connected to*’ the person’s mental illness, or
- ‘*as a consequence of*’ the person’s mental illness?

Electroconvulsive Therapy (ECT)

Consent for ECT and the use of restrictive practices

The MHA provides extra protections for patients relating to prescribed psychiatric treatment, including ECT. Under Section 42 of the MHA, ECT cannot be administered unless written consent has been given by:

- A patient who has attained 16 years of age and is capable of making their own decisions, or
- If over 16 years old and incapable of making their own decisions:
 - by each substitute decision-maker or the SACAT where an advance care directive is in place
 - by a medical agent, or guardian or by the SACAT on application
- If under 16 years of age – by a parent or guardian or by the SACAT on application.

An episode of ECT can be provided without consent if it is urgently required and it is not practicable to obtain consent (s 42(6)). This is often referred to as 'emergency ECT'.

Consent for the administration of ECT is considered separately from the authorisation to use force in administering the ECT. Section 42 of the MHA, which describes the powers and functions relating to ECT, specifically states under subsection 42(4)(b) that consent to ECT does not include consent to the use of restrictive practice (force).

The power to use restrictive practice under MHA subsections 24(4), 28(3), 31(3) and 34A when a patient is subject to an Inpatient Treatment Order does not extend to administering prescribed psychiatric treatment. The power to use restrictive practice under MHA section 56 care and control does not extend to administering prescribed psychiatric treatment.

The Office of the Chief Psychiatrist information sheet on the legal authority for use of restrictive practice (force) to administer ECT treatment notes that the use of such restraint should be rare, and that all steps should be taken to minimise and eliminate where possible the use of such practices. The expectation to minimise and eliminate the use of restrictive practices has been reinforced by the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability Final Report handed down in September 2023.

Currently the use of restrictive practices for ECT can only be authorised by the SACAT under section 32(1)(c) of the *Guardianship and Administration Act 1993*. Guardians and substitute decision-makers retain a role in decisions about the use of section 32(1)(c) special powers because it is only they who can apply to the Tribunal for an order. Once an order for special powers is made, the treating team can use force as reasonably necessary to ensure proper medical treatment.

The SALRI report notes that the process of applying to SACAT for the use of restrictive practices in emergency ECT can result in treatment delays and may be detrimental to the patient. There is a need to allow for the use of restrictive practices under the appropriate circumstances and with appropriate safeguards that does not put patient care at risk.

A recommendation of the SALRI review was that s42(4)(b) of the MHA be amended to authorise the use of reasonable restrictive practices to facilitate the provision of emergency ECT (Recommendation 37). Bringing the authority to use restrictive practices under the MHA rather than requiring authorisation for ECT under the MHA and consent to the use of force under the *Guardianship and Administration Act 1993* will reduce the likelihood of treatment delays where emergency ECT is required. An additional safeguard could be added to the MHA, such as a requirement that all occurrences of restrictive practice use in emergency ECT be notified to the Prescribed Psychiatric Treatment Panel who could monitor its use.

SALRI's recommendation was that the legislation should only allow the use of restrictive practices where there is a clear clinical harm to the person if they don't receive the ECT and all reasonable alternatives to carry out ECT without coercion have been attempted. SALRI further recommended that restrictive practices be allowed only in emergency treatment or where SACAT provides authorisation or where a substitute decision-maker or guardian provides consent. The use of restrictive practices would need to be documented and reported to the Office of the Chief Psychiatrist and subsequently reported through the OCP annual reporting process.

The Act could be amended so that authorisation for the use of restrictive practices in non-emergency situations was provided for in the MH Act rather than by reference to the *Guardianship and Administration Act 1993*.

Question 16: Do you agree that the Act be changed to authorise the use of restrictive practices for ECT under certain circumstances rather than seeking authorisation through the *Guardianship and Administration Act 1993*?

Changes to the Prescribed Psychiatric Treatment Panel

The Prescribed Psychiatric Treatment Panel was established in the previous review of the MHA to provide a level of oversight and safeguarding to prescribed psychiatric treatments (currently only ECT but could include neurosurgery).

Recommendations 38 to 40 were made in relation to the PPTP, these were:

- That the review triggers of the PPTP be amended to enable the Panel to review a 'complex case' rather than the current triggers which are based on the number of treatments in a 12 month period
- That the membership of a neurosurgeon be retained but the requirement to attend be based on the requirements of the case
- That consideration be given to allowing the Panel to invite specialist input from relevant persons, such as an Aboriginal, culturally and linguistically diverse or LGBTIQ representative, where a case so requires.

The Office of the Chief Psychiatrist intends to recommend these changes be made to the legislation.

Legal Representation Scheme / Consumer representation

In South Australia, the South Australian Civil and Administrative Tribunal (SACAT) is the body 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 (note the last of these does not presently occur in SA).

The present free of charge legal representation scheme for consumers under the MHA before SACAT is provided by the Legal Services Commission, funded by the Department for Health and Wellbeing, and only provides representation for consumers pursuing an appeal *not in the first instance or primary proceedings*.

Where the Tribunal makes an order, for example to impose a Level 2 Community Treatment Order (Level 2 CTO), 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 to order a Level 2 CTO in its original jurisdiction, 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. [Emphasis added.]

In the 2021-2022 financial year, there were 352 instances where legal representation was provided by the Legal Services Commission with almost all of these reviews relating to level 2 ITOs ('ITO 2').

Extend present scheme to all consumers in all appeal proceedings

SALRI noted that the South Australian Civil and Administrative Tribunal (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. Mental health review tribunals such as SACAT are required to balance the obligations of efficiency and accessibility with the obligation to promote active consumer participation and provision of procedural fairness. SALRI found that mental health review tribunals generally allow, but neither require nor provide, legal representation to consumers and that the absence of representation may create access to justice challenges for people.

S84 of the Act provides that the person who is the subject of appeal proceedings is entitled to be represented by counsel under a scheme established by the Minister. The Act allows for legal practitioners to receive fees for this service.

Currently the entitlement for legal representation does not apply for SACAT's 'original jurisdiction', that is where SACAT is making a decision (such as to place a Level 2 Community Treatment Order or a Level 3 Inpatient Treatment Order).

The entitlement does apply where SACAT is reviewing a decision that it has previously made such as reviewing its own decision to place a Level 2 CTO ("internal review jurisdiction").

SALRI has recommended that s84 of the MHA should be amended to provide for an extension of the present legal representation scheme to consumers in all proceedings under the Act in the SACAT (Recommendation 48). It is difficult to predict the uptake should this change occur. As noted in the introduction to this paper, changes to legislation that are likely to impacting resourcing will need to be approved by governmental budget processes. SALRI noted almost unanimous support for an extension of the scheme to cover proceedings in SACAT's original jurisdiction, namely ITO3, CTO2 and ECT applications.

Do not extend scheme to interested parties

SALRI recommended that s 84 of the MHA 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 MHA in the SACAT. (Recommendation 49)

The person subject to the MHA proceeding retains the right to engage counsel at their own expense, appear personally, or by the Public Advocate, or by a representative pursuant to any other provision of the Act. 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.

However, the absence of a scheme or framework for the provision of free of charge legal representation for consumers not in the first instance or primary proceedings in SACAT was widely seen in consultation as problematic. SALRI observed this gap in legal representation may create access to justice challenges for consumers.

Further, interested parties, including carers, noted to SALRI that they were left out of decision-making forums, and were not provided with access to legal representation schemes to participate in the SACAT hearings.

Question 17: Do you agree additional legal representation schemes should be offered to consumers in all SACAT proceedings? Should legal representation schemes be limited to consumers, and not extended to interested parties?

Mental Health Commissioner

Mental Health Commissioner should be added to Act

In 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 MHA.

Clarity and specificity in the roles and functions of a Mental Health Commissioner under the MHA will assist in oversight of mental health service. In designing the role, it may assist in holding the government to account, to improve the lives of people with lived experience of mental health issues and their families and carers.

The Commissioner will report to the Minister for Health and Wellbeing.

Functions of the Commissioner should include:

- To promote and advocate for the rights and interests of all people in relation to Mental Health and Wellbeing
- To promote the participation by those living with mental illness or lived experience in the design and delivery of services that affect their lives
- To promote the planning, development, implementation and evaluation of suicide prevention, intervention and postvention activities
- Support initiatives targeting suicide prevention, intervention and postvention conducted by key stakeholders
- To promote and support the planning and implementation of innovative best practice initiatives across all age-groups, but to also provide a specific focus on the needs of young people and older persons in relation to mental health issues
- To advise, and make recommendations to, Ministers, State authorities and other bodies (including non-Government bodies) on matters related to the rights, care and treatment of all people living with mental illness

- To prepare and publish reports on matters related to care and treatment of people with mental illness
- To consult with and engage people with mental illness and lived experience in the performance of the Commissioner's functions
- To consult and engage with those involved in the delivery of services to people with a mental illness.
- To advocate for continuous improvement of mental health related resources, information, and connection to support services for families and/or individuals impacted by mental illness and suicide

Question 18: What is important to include in the role and function of a Mental Health Commissioner?

Clarity of roles of regulatory bodies in broader mental health / Community Visitor Scheme

Clarity of roles Chief Psychiatrist / Commissioner / CVS / HCSCC

At Recommendation 51 SALRI recommends that greater clarity is necessary in the MHA as to the respective roles and functions of key agencies, notably the Office of the Chief Psychiatrist, the Mental Health Commissioner, the Community Visitor Scheme (CVS) and the Health and Community Services Complaints Commissioner.

At 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, consumers, Aboriginal, Culturally and Linguistically Diverse and LGBTIQ representatives, to engage in the development of appropriate standards.

SALRI has observed that 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 mental health services. However, the various bodies with oversight and regulatory functions 'overlap and cause complexity'. The SALRI report recommended statutory clarity in the respective roles and functions of those bodies, including the Office of the Chief Psychiatrist, the Mental Health Commissioner, the Health and Community Services Complaints Commissioner and the CVS. It is noted that not all of these bodies are under the MHA.

Strengthening whole-of-government mental health governance is supported. In working to improve outcomes for mental health consumers in South Australia, the task requires each agency to play their part. The Office of the Chief Psychiatrist looks forward to stronger collaboration, cooperation in continuous improvement with all agencies.

Clear delineation of the roles of each agency and an ongoing working group would assist in promoting raising and resolving of system-wide emerging issues and setting out whole-of-community education on specific issues.

Question 19: Should the Act be amended to clarify the role of legal and regulatory bodies involved in mental health, in an effort to enhance

coordination across government, or can this be done by another mechanism?

Remove inspection powers and focus on advocacy

At Recommendation 53, SALRI recommends that the present roles and functions of the Community Visitors in Part 9 of the MHA 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.

At 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 MHA, to standardise the role and function of Community Visitors.

The Principal Community Visitor and Community Visitors are independent statutory appointments, appointed by the Governor. The CVS is established under the MHA in 2009 to conduct visits and inspections of mental health facilities. Community visitors conduct visits to, and inspections of, treatment centres and authorised community mental health facilities (ACMHF). Originally, the scheme was designed around visits and inspections for institutional settings, such as hospitals. Under 2017 amendments to the MHA, visits and inspections to ACMHF were introduced.

Community visitors are trained to provide advocacy and support to the people in these facilities. Clients, carers and family members can speak freely to them, knowing they are not attached to service providers. The Principal Community Visitor can refer matters of concern to the Minister, Chief Psychiatrist or other appropriate person or body, such as the Health and Community Services Complaints Commissioner.

SALRI noted that the CVS was commended by several parties for their 'helpful and useful' advocacy role to consumers.

The Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability handed down 29 September 2023 recommended that states and territories should agree to make community visitor schemes consistent regarding people with disability including in relation to powers to visit people with disability, inspect records and provide information to other relevant bodies.

In consideration of the recommendations, the Office of the Chief Psychiatrist does not support the removal of inspection powers from the Principal Community Visitor. The Mental Health Commissioner role has to date not been established as a regulator or complaints agency so the suggestion to provide inspection powers is not likely to assist the Commissioner to undertake their functions. Further the OCP is not aware of concerns or complaints about the CVS.

Future appointments

At 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.

The Principal Community Visitor has expressed support for the recommendation that appointment of Community Visitors be done by the Minister rather than the Governor on the recommendation of Cabinet.

Language, terminology and definitions

Since the MHA was last amended, inclusive language which promotes a broader understanding of lived experiences and recovery, a rights-based approach, and which reduces discrimination and stigma, has come into use. As a key exemplar of this approach, the SALRI report recommended that the title of the *Mental Health Act 2009* be amended to the *Mental Health and Wellbeing Act* to reflect the shift from a crisis focused approach to one of wellbeing.

Updated terminology

Replace the term ‘patient’ with ‘consumer’

The Office of the Chief Psychiatrist intends to recommend that the term ‘patient’ be replaced with the term ‘consumer’ in the MHA except where a person is admitted to a treatment centre such as a hospital. The SA Law Reform Institute recommended this change (Recommendation 4) noting that although there was debate, this was the preferred term arising from the consultation. A definition of ‘consumer’ would be added to s3 of the MHA.

It is proposed that “consumer” be added to the MHA and be defined as “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.”*

Mental Health and Wellbeing Service

The SA Law Reform institute further recommended that a definition of a ‘mental health and wellbeing service’ should be added to s3 of the MHA. This could be based on the definition found in the Victorian *Mental Health and Wellbeing Act 2022* (SALRI recommendation 6).

“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;

Question 20: Do you agree with the proposed changes to the terminology for ‘patient’ ‘consumer’ and ‘mental health and wellbeing service’?

Definition of ‘consent’

SALRI has recommended 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 *Mental Health and Wellbeing Act 2022* (Vic) (SALRI recommendation 10).

References to ‘consent’ in the Act are largely to note that treatment can be carried out under treatment orders without consent. There are requirements for consent to be obtained in relation to prescribed psychiatric treatments such as ECT and neurosurgery (noting a substitute decision maker can provide this consent where a person is unable to due to lack of capacity).

The current definition of ‘consent’ in the MHA is:

consent to treatment means effective consent to the treatment

‘Effective consent’ is not further defined. It is proposed that ‘consent’ be replaced with ‘valid consent’ with a definition as follows:

When does a person give informed consent?

(1) Informed consent may be given by a person if the person—

(a) has capacity to give informed consent; and

(b) has been given adequate information to enable the person to make an informed decision; and

(c) has been given a reasonable opportunity to decide whether or not to consent; and

(d) has given consent freely without undue pressure or coercion by any other person; and

(e) has not withdrawn their consent or indicated their intention to withdraw their consent.

(2) A person has been given adequate information to make an informed decision if the person has been given—

an explanation of the proposed treatment or medical treatment including—

(i) the purpose of the treatment or medical treatment; and

(ii) the type, method and likely duration of the treatment or medical treatment; and

(b) an explanation of the advantages and disadvantages of the treatment or medical treatment, including information about the associated discomfort, risks and common or expected side effects of the treatment or medical treatment; and

- (c) an explanation of any beneficial alternative treatments that are reasonable available, including any information about the advantages and disadvantages of these alternatives; and*
- (d) answers to any relevant questions that the person has asked; and*
- (e) an explanation of the advantages and disadvantages of not undergoing the treatment;*
- (f) any other relevant information that is likely to influence the person's decision; and*
- (g) in the case of proposed treatment, a statement of rights relevant to the person's situation.*
- (3) A person has been given a reasonable opportunity to make a decision if, in the circumstances, the person has been given—*
 - (a) a reasonable period of time in which to consider the matters involved in the decision; and*
 - (b) a reasonable opportunity to discuss these matters with the registered medical practitioner or other health practitioner who is proposing the treatment or medical treatment; and*
 - (c) the appropriate supports to make the decision; and*
 - (d) a reasonable opportunity to obtain any other advice or assistance in relation to the decision.*
- (4) Without limiting subsections (1), (2) or (3), for the purposes of medical treatment that is given under this Act, a person may give informed consent by instructional directive.*

Question 21: Do you agree that the proposed definition of ‘valid consent’ be added to the *Mental Health Act 2009*?

Mental illness not to include use of drugs and alcohol

SALRI recommended 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 Schedule1. (SALRI Recommendation 8)

SALRI noted that the intersection between mental illness and drug and/or alcohol use can be complex and nuanced and that it may take time to determine whether a person is self-medicating to cope and/or mask mental health symptoms and whether drug and/or alcohol addiction has caused a mental illness.

Current wording of Schedule 1.

Schedule 1—Certain conduct may not indicate 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.

It is proposed that the current (k) be moved to (a) to be more prominent.

Question 22: Do you agree that the taking of alcohol and drugs be moved to (a) in Schedule 1 which outlines certain conduct may not indicate mental illness?



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