



Office of the Public Advocate South Australia

Submission

Review of the Mental Health Act

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Review of the Mental Health Act 2009

1. Introduction

The Public Advocate welcomes the opportunity to provide a submission to the review of the *Mental Health Act 2009* (the MHA).

The Office of the Public Advocate (OPA) supports the promotion of self-determination for South Australians with a mental illness. All South Australians should be empowered to make decisions about their mental health care to the greatest extent possible, in line with the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD).

Whilst most people who require treatment for mental illness will receive support through voluntary means, there are a small number of people who are acutely unwell and have impaired capacity to understand their treatment needs. The MHA establishes the legal framework for the compulsory (involuntary) treatment of mental illness in these cases, either in community-based or inpatient settings. Given the MHA sets out circumstances where treatment can be provided without consent, it is essential that the legislation protects the rights of people with mental illness and that effective safeguards are in place to ensure its powers are only ever used where necessary, to protect them or the community from harm.

The MHA intersects with the role of the Public Advocate in various ways. This includes the Public Advocate's responsibility to speak for and promote the rights and interests of people with impaired decision-making capacity and the role as guardian of last resort for adults with complex needs and who can be at risk of harm. Many of OPA's clients have a mental illness or psychosocial disability, often with other comorbidities, trauma and issues such as social isolation or homelessness.

This submission will focus on the discussion questions which relate to matters within the scope of the OPA's role and expertise.

The Public Advocate is also currently appointed as the Principal Community Visitor (PCV). The Community Visitor Scheme (CVS), and the PCV's role, is established under the MHA. Through its independent oversight and advocacy, the CVS provides an important safeguarding function for people receiving care in a mental health treatment centre or hospital, or attending a community mental health facility.

The Public Advocate will be making a separate submission in her capacity as Principal Community Visitor to explore the important issues arising from this program and to provide feedback on the operations of the CVS under the MHA.

2. Terms of reference

The Act must be reviewed every five years. The South Australian Law Reform Institute (SALRI) has been asked by the State Government to review the Act and, as part of this review, to:

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- Consult with relevant parties, such as experts, interested groups and persons with lived experience of mental illness.
- Recommend appropriate changes to the current law which promote human rights and best practices.
- Consider the findings of the Royal Commission into Victoria's Mental Health System.
- Consider the meaning and practice of decision-making capacity.
- Determine the effectiveness of establishing the role of Mental Health Commissioners under the Act.
- Any other relevant issues raised by the Office of the Chief Psychiatrist.

3. The Public Advocate

The South Australian Public Advocate promotes the rights and interests of people with impaired decision-making capacity. The Public Advocate is supported by the Office of the Public Advocate (OPA) to provide guardianship services, systemic advocacy, dispute resolution (for matters relating to advance care directives and consent to medical treatment), and information to support people who need assistance with decision making.

The Public Advocate can be appointed by the South Australian Civil and Administrative Tribunal (SACAT) as a guardian of last resort if a person has impaired decision-making capacity, if there are health or welfare decisions to be made and if there is no other appropriate person willing or able to be appointed.

What this means in practice is that the Public Advocate will only be appointed if there is no one else in a person's life able or willing to make necessary decisions, or if there is family conflict meaning that agreement on decisions is not possible. Consequently, the Public Advocate often must make decisions for people who have complex needs or situations and who may be without support networks.

4. Disability Advocate

The Disability Advocate is a position located within the Office of the Public Advocate and was established in November 2018. The purpose of the role of the Disability Advocate is to "ensure that South Australians with a disability and their families are getting a good deal from the National Disability Insurance Scheme (NDIS)."

Throughout 2019 the Disability Advocate attended over 150 meetings with people with disability, family, advocates, and carers to speak with people about their experiences with the NDIS, what was working well and areas for improvement. Regular reports were presented to Ministers and senior State and NDIA officers.

All reports are available on the OPA website at opa.sa.gov.au.

5. Responses to the Review

5.1 Capacity and Supported Decision-Making

The issue of capacity is critical because involuntary treatment is only permitted under the MHA if the patient has impaired decision-making capacity relating to decisions about appropriate treatment of their mental illness.

Should the MHA include a clearer definition of 'impaired decision-making capacity' for treatment orders?

The current definition of impaired decision-making capacity in the MHA is consistent that in some other South Australian laws, including the *Advance Care Directives Act 2013* and the *Consent to Medical Treatment and Palliative Care Act 1995*. The MHA importantly includes a presumption of decision-making capacity unless there is evidence to the contrary.

The OPA notes that the current definition of impaired decision-making capacity in the MHA better reflects contemporary values and expectations when compared, for example, to the definition of 'mental incapacity' in the *Guardianship and Administration Act 1993 (GAA)*. The GAA does not expressly refer to a presumption of capacity nor does it acknowledge that capacity can be decision-specific.

The concepts reflected in the current MHA definition, if properly and consistently applied, go a long way in promoting the rights of people with impaired decision-making capacity to make their own decisions in line with Article 12 of the UNCRPD.

The OPA notes that the new Victorian Mental Health and Wellbeing Bill includes a comprehensive section on defining capacity, as well as principles relating to supported decision-making and dignity of risk. Whilst the current definition of impaired decision-making capacity in the MHA could be strengthened to more clearly articulate some of these important concepts, any proposed changes should also be considered with respect to other Acts in South Australia to ensure harmonisation.

How can the law better protect the human rights of persons with a lived experience of mental illness and provide supported decision-making?

The Office of the Chief Psychiatrist (OCP) plays an important role in supporting mental health professionals to comply with the requirements of the MHA and upholding the rights of people with mental illness through education and oversight. The OPA notes that the OCP has published a range of fact-sheets to help guide practitioners in the application of the MHA.

The OCP's fact-sheet on decision-making capacity covers important practical points, some of which might be suitable to include in the MHA or its regulations, because they go to the protection of people's right to autonomy. For example, a requirement to document the capacity assessment by summarising the evidence and reasoning used to reach the conclusion could be included in the MHA. Similarly, the MHA could set out the requirement for ongoing re-assessment of decision-making capacity

throughout the duration of the community treatment order (CTO) or in-patient treatment order (ITO), as is currently a matter of policy.

Supported Decision-Making (SDM) is an emerging and increasingly accepted practice whereby people with a disability or cognitive impairment are assisted to exercise their legal rights to the greatest extent possible. It is driven by the UNCRPD. Moving away from a focus on individual capacity, to the right to be supported in the decision-making process, requires a paradigm shift in thinking about decision-making by people with cognitive impairment. SDM may have a place in the MHA and/or the regulations or guidelines for its operation.

Section 47 of the MHA provides that a person is entitled to have another person's support in exercising their rights or communicating with medical staff. This is important but does not represent SDM of itself.

SDM refers to a range of processes and approaches that assist people to exercise their legal capacity by supporting them to make decisions about their lives according to their own will and preference. Examples of such support include using modified language or visual aids, breaking down one complex decision into a series of smaller ones, taking additional time, or engaging a supporter who assists by discussing information or helping to communicate the person's decision.

SDM is not yet expressly enshrined in other relevant South Australian legislation. In terms of the MHA, it is acknowledged that in circumstances of high risk or urgency (when a person is acutely unwell), SDM will not always be practicable or possible. However, the MHA could include requirements around the steps that must be taken to facilitate SDM for the person's ongoing care and treatment, and to recognise any past expressed wishes a person has documented or been supported to document. This would recognise a person's right to access support for decision-making as well as considering a person's will and preferences. These rights may be appropriate to include in the principles of the MHA or in the existing Part 6 (care and treatment plans).

Importantly, any requirements for SDM would need to be appropriately resourced and monitored to ensure it is translated into practice. Further, SDM takes time and skill because it involves an iterative process and is different for each individual. In addition, medical and health care professionals would require specific education and training.

Recommendation 1: *That the MHA be amended to include principles of supported decision-making and recognition of a person's will and preferences when making ongoing care and treatment decisions.*

Building on this, provisions to undertake 'advance planning' is another way to ensure that decisions in relation to care and treatment are guided by a person's 'will and preference'. The ability for will and preferences expressed in an advance document (e.g. an advance care directive) to be considered by medical professionals when enforcing treatment under a compulsory order is something that could be further considered and explored. The UN Committee on the Rights of Persons with

Disabilities supports the broad notion that the ability to plan in advance is important in enabling a person to state their will and preferences.¹ An Australian example is that the mental health legislation in the Australian Capital Territory (ACT) sets out a comprehensive scheme for developing an advance agreement between the person and their treatment team (see section 27 of the *Mental Health Act 2015 (ACT)* for the types of directions that can be made). Similarly, the Mental Health and Wellbeing Bill in Victoria includes provisions to make an advance statement of preference.

Recommendation 2: *That the ability for people to develop advance plans to capture will and preferences for treatment and care whilst subject to a CTO or ITO be considered. This may need to consider how it would interact with existing arrangements under the Advance Care Directives Act 2013.*

5.2 Inpatient Treatment Order

An Inpatient Treatment Order (ITO) authorises the compulsory treatment of a person in a treatment centre. ITOs make up most compulsory orders under the MHA. OPA notes that of the 12,476 active treatment orders in 2020-21, 80.2% (10,005) were ITOs.²

Should the MHA allow powers to detain and use force? If so, who should be allowed to detain and use force?

Section 34 of the MHA authorises the detention of a person under an ITO given that they must stay in a treatment centre unless they are granted a leave of absence or permission to leave with staff. Further, section 34A authorises the use of confinement, restraint and use of force in order to carry out treatment or to maintain order and security at the centre for ‘the prevention of harm or nuisance to others.’

The OPA acknowledges that there are circumstances that justify the exercise of these powers because of serious risk of harm to a person and/or the community. These are, however, significant powers that carry with them serious human rights considerations.

Under the current legislation, Level 1 and Level 2 ITOs can be made by psychiatrists or medical practitioners, subject to review. A Level 3 ITO can only be made by the South Australian Civil and Administrative Tribunal (SACAT). The question arises as to whether there are sufficient checks and balances in the exercise of these powers to detain, given that most other similar powers can only be exercised following decision of a court or tribunal. As an example, the Victorian Office of the Public Advocate, in its submission on the new Mental Health and Wellbeing Bill, has recommended that the legislation ensure people are not subject to compulsory detention for more than 14 days without tribunal approval. It is important to note that

¹ CALLAGHAN, S. & RYAN, C. 2016. An Evolving Revolution: Evaluating Australia's compliance with the Convention on the Rights of Person's with Disabilities in mental health law. *University of New South Wales Law Journal*, 39, 596–624.

² It is noted that some people can be subject to more than 1 order.

there would be resource implications for the SACAT should there be changes to the timeframes or circumstances in which it must review ITOs.

Feedback on confinement and use of force is explored in more detail under section 5.4 below (*restrictive practices and control orders*).

Should the definition of ‘treatment’ be expanded to include an assessment of other medical/health issues?

Sections 24, 28 and 31 authorise the treatment of mental illness as part of an ITO, or for any other illness that may be causing or contributing to the mental illness.

Prior to changes brought about by the *Mental Health (Review) Amendment Act 2016*, a person subject to an ITO could be given treatment for their mental illness ‘or any other illness’. However, these amendments (which permit treatment of other illnesses which are causing or contributing to the person’s mental illness), in practice, may be too narrow. For example, the OPA understands that self-inflicted and other injuries to a person’s body in the course of a mental health episode cannot be treated under the powers of an ITO. Consent must be sought, and processes followed under the *Consent to Medical Treatment and Palliative Care Act 1995*, as well as the need to consider special powers orders under the GAA if the person is resisting treatment.

While consent to medical treatment should be sought wherever possible, the result now is that, where a person is incapable of consenting due to impaired decision-making capacity and there is no person responsible available to consent, an application to the SACAT will be required. This is so that either the SACAT can consent to treatment, or the Public Advocate appointed as guardian for that purpose. As well as having potential to cause treatment delays, a situation which results in a guardianship order may add an extra layer of restriction to a person’s legal autonomy, in addition to the ITO. The OPA submits that 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.

Recommendation 3: *That consideration be given to amending sections 24, 28 and 31 so that the treatment of injuries or illnesses ‘causing, contributing or connected to’ the person’s mental illness is permitted as part of an ITO.*

5.3 Community Treatment Orders

A Community Treatment Order (CTO) authorises the compulsory treatment of a person at a particular place in the community and at regular intervals. As noted by SALRI, the number of active CTOs has been rising in South Australia from 1,704 in 2015-16 to 2,471 in 2020-21.³

Studies have shown that Australia has high rates of CTOs by international standards. Whilst it is difficult to make comparisons across jurisdictions due to

³ Office of the Chief Psychiatrist South Australia, *Annual Report 2020-12*.

differences in legislation and reporting practices, South Australia has among the highest rates of CTOs in Australia.⁴

Should the law and practice be re-framed to limit or reduce the number of CTOs? Why or why not?

Compulsory treatment raises important human rights considerations and should be limited to circumstances where there is no less restrictive means of ensuring appropriate treatment for people with mental illness.

The Royal Commission into Victoria's Mental Health System observed that the emphasis of mental health laws on compulsory treatment contributes to the dominance of a deficit, medical model of care. It recommended that a new Mental Health and Wellbeing Act be established to broaden the focus beyond compulsory treatment towards the attainment of good mental health and wellbeing. Similar lessons could be learnt here in South Australia to establish a legislative framework that promotes the universal right of everyone to be supported to achieve good mental health.

Early access to mental health support, advocacy and other community-based mental health measures, may lead to a greater emphasis on prevention and voluntary treatment. This, in turn, may assist in reducing the number of compulsory orders.

In the OPA's experience, there are times when a CTO provides a less restrictive alternative to compulsory inpatient treatment and, in that sense, CTOs are an important mechanism for the treatment of people with serious mental illness. However, the rising numbers of CTOs is worthy of noting and the reasons for this should be better understood to inform legislative reform and policymaking.

Should the MHA be changed to include a power to use reasonable force in cases involving non-compliance with a CTO?

Part 5, Division 2 of the MHA allows for refusal or failure to comply with a CTO to form part of a decision as to whether an ITO should be made. Where an ITO is made, this then allows for use of force and detention to carry out treatment. Similarly, Sections 56 and 57 provide appropriate authorities with the power to bring a person into their 'care and control' through such means as use of force, if they suspect a person has a mental illness and they have caused, or are at risk of causing, harm to themselves, others or property.

However, the OPA submits that consideration should be given to whether serious non-compliance with a CTO could be addressed in a way that is less restrictive than using an ITO or care and control powers. For example, an option might be to empower the SACAT to make orders similar to those under Section 32(1)(c) of the GAA, authorising the use of reasonable force to provide treatment in the community where safe, appropriate and the least restrictive alternative. This could prevent people from requiring detention in hospital under an ITO which is, arguably, more

⁴ LIGHT, E. M. 2019. Rates of use of community treatment orders in Australia. *International Journal of Law and Psychiatry*, 64, 83-87.

restrictive. Such a change would need to have appropriate safeguards in place, such as oversight and review by the SACAT or other appropriate, expert bodies.

Another, similar example, is the recent enactment of Part 6A of the *Disability Inclusion Act 2018*, in which the SA Senior Authorising Officer has the power to authorise the physical restraint of NDIS participants in accordance with recommendations in a behaviour support plan and subject to relevant safeguards and guidance.

5.4 Restrictive Practice and Control Powers

OPA acknowledges the work being undertaken by the OCP to reduce and eliminate the use of restrictive practices. Efforts have included improvements to reporting and trauma-informed care strategies through a community of practice. The introduction of the Chief Psychiatrist's Restraint and Seclusion Standard⁵ in February 2021 is also a welcome development.

The MHA could also benefit from incorporating other safeguards, such as clearly prohibited practices and a requirement for a positive behaviour support plan to reduce and aim to eliminate the need for restrictive practices, where appropriate. The *National Disability Insurance Scheme Act 2013* (Cwlth) and *Disability Inclusion Act 2018* (SA) provide good examples of comprehensive legislative schemes governing the authorisation and use of restrictive practices.

As well as disability and mental health, this particular area of policy and practice has application in many other fields, including health, corrections, child protection and education. Ideally, regulation of restrictive practices should therefore be addressed consistently across government to provide for common definitions, authorisation, use and safeguards.

Recommendation 4: *That the MHA provide a more comprehensive definition of restrictive practices, aligned where possible with definitions in other Acts, including the Disability Inclusion Act 2018, to support a common understanding across government.*

The MHA could be clearer about the reporting, recording and monitoring requirements relating to the use of powers under Section 56 and 57. Whilst Section 58A already requires that officers must keep records relating to the exercise of powers, the OCP fact-sheet on Section 56 is far more comprehensive. It requires that use of Section 56(3) powers be documented in the patient's records and cover any handover information, reasons for using the powers, assessments, action taken, start and finish times, as well as any other information relevant to the specific circumstances.

⁵ [Restraint-and-Seclusion-Standard-28-May21_FINAL-005.pdf](#)

Recommendation 5: *That additional safeguarding mechanisms already in place through policy in relation to the use of restrictive practices be included in the MHA, particularly in regard to the reporting and recording requirements for the use of powers under sections 56 and 57, under section 58A.*

Should the MHA allow use of reasonable force and control powers? If so, when?

It is acknowledged that use of reasonable force and control powers is sometimes necessary in circumstances where a person's safety or wellbeing, or that of the community, is at risk. However, this should only ever be used as a last resort in emergency situations and only for as long as necessary, in order to protect the rights of persons with mental illness. Use of these powers should also be subject to review and reporting requirements.

5.5 Electroconvulsive Therapy (ECT)

Should the law allow reasonable force to ensure a person receives ECT? If so, when?

ECT has special status under the MHA, in that it cannot be given as a compulsory treatment without the written consent of either a substitute decision-maker, guardian or the SACAT (s42(1) of the MHA). As outlined in s42(4)(b), consent to ECT does not extend to use of force for the purposes of administering the treatment. In addition, the OPA understands that an ITO cannot be used to authorise reasonable force to ensure that ECT is administered. Currently, a special powers order from SACAT (s32(1)(c) GAA) is required to use reasonable force to ensure that a person receives ECT. Only a substitute decision-maker under an advance care directive or a guardian can apply to the SACAT for such special powers orders.

The need for an order authorising the use of reasonable force, as well as the consent requirements for ECT, provides additional regulation and safeguards recognising the special status of this treatment. However, it appears that there are some unintended consequences of the system as it currently works, particularly for patients who do not already have a guardian or substitute decision-maker. In particular, the need for a special powers order under s32(1)(c) GAA to use reasonable force has resulted in the appointment of guardians (including the Public Advocate where the patient has no other support people) for the purpose of making that application, even where there is no other need for substitute decision-making.

Given that the guardian does not themselves authorise or approve the use of force (authorisation is given to the treating team by the SACAT), and that the SACAT has the power to consent to ECT, the need for a guardianship order in addition to the oversight of the SACAT (and often on top of an ITO), is a duplication. In some cases, the SACAT will be satisfied of the need for ECT and make the special powers order, but will appoint the Public Advocate as guardian to provide the written consent to ECT. In practice, this can mean that the treating psychiatrists must go through the process of explaining the risks and benefits of ECT again to an OPA staff member who has delegations to consent to ECT, if that staff member has not been present at

the SACAT hearing. In addition, the insertion of a guardianship order can result in the person experiencing more limitations on their decision-making control.

In practice, when the OPA becomes guardian for this specific purpose, there may be no additional decisions that are required and often the OPA does not receive an update about the patient's treatment before the order lapses. It is difficult to see how the OPA, or a private guardian, adds value to the process or provides a genuine safeguard in such circumstances.

The OPA submits that the process for authorisation of the use of reasonable force to administer ECT should be managed separately from guardianship and substitute decision-making schemes. For example, if it is still considered that ECT should have special status under the MHA, a system for authorisation for the use of reasonable force by the SACAT (or other expert authority, if there is provision to seek a review by a court or tribunal) could be established under the MHA. Psychiatrists who have examined a patient should then have standing to apply for such authorisation.

Recommendation 6: *That the process for authorising the use of force in relation to ECT be managed separately from guardianship and substitute decision-making schemes, for example by empowering SACAT to provide authority directly to the treatment team.*

How can the rights of a consumer be better protected in cases of emergency ECT?

Given that ECT has been identified as requiring special consideration before being undertaken, greater scrutiny of emergency ECT could be provided in the MHA to monitor this practice closely to ensure it is being used appropriately and that all other alternative, less restrictive methods are being considered. While the OPA recommends separating the process for authorising the use of force to administer ECT, where a guardian is already appointed, this system could include a duty to consult with the guardian when seeking to make an application for the use of force, so that the views of the guardian may be heard and taken into consideration by the body charged with authorising the use of force.

Should the PPTP provide more or less oversight of ECT (including maintenance ECT) and/or other treatments?

The Prescribed Psychiatric Treatment Panel (PPTP) currently provides oversight of people receiving ECT by conducting a review of the progress of a patient who has, in the course of any 12-month period:

- received 3 or more courses of ECT treatment; or
- received 2 or more episodes of emergency ECT without consent

In terms of the overall role, function and composition of the PPTP, there is scope to provide greater clarity in the MHA. It may be appropriate to consider, for example, whether the PPTP should review all cases where force has been used to administer ECT. The Panel could also provide an oversight and monitoring role of ECT more generally, including emergency ECT discussed above.

The OPA has itself referred three cases to the PPTP since its inception in 2016. However, Division A1 of Part 7 does not explicitly outline referral mechanisms so it may be worthwhile clarifying this process in the MHA or regulations. Under section 41D(1)(a), the Panel may decide its own proceedings. A sub-section could be added allowing for referrals to be made to the Panel. Consideration could also be given to the appropriateness of the outcome of the Panel's review being made available to the person subject to the proceedings, or their guardian, to contribute to their decision-making for consent to ECT.

Finally, consideration should be given to the composition of the PPTP in relation to issues about receipt of highly personal and confidential medical information about patients being treated with ECT.

Recommendation 7: *That provisions relating to the PPTP be strengthened to clarify referral pathways, panel processes and information sharing.*

5.6 SACAT and Legal Representation

Should the MHA be amended to entitle consumers to legal representation under the scheme in cases where SACAT reviews its own decision?

People under guardianship orders (referred to in the GAA as 'protected persons') are entitled to legal representation in SACAT internal reviews, and the Legal Services Commission administers a scheme providing protected persons with free legal representation. This can be an important mechanism for access to justice for protected people. Similarly, there might be greater access to justice for people under compulsory orders if they were also entitled to legal representation for internal reviews.

Should the MHA legal representation scheme be extended to provide representation to families and carers who apply for review of treatment orders?

As above, free legal representation can improve access to justice for people with impaired decision-making capacity and mental illness. The OPA submits that decisions about allocation of resources for the purpose of legal representation should primarily focus on the patient.

5.7 Role of SAPOL

Should SAPOL be involved in the enforcement of the MHA? If not, who should be given these powers?

Whilst sometimes necessary in the circumstances where a person's safety or the safety of others is at risk, the involvement of police in a mental health crisis is not always the best solution to enforcement of the MHA. It can have the effect of criminalising and stigmatising people with a mental illness and can exacerbate trauma.

As highlighted in the Royal Commission into Victoria's mental health system, there can be over-reliance on police to respond to mental health crises. It noted that police are not, and should not be expected to be, experts in responding to people experiencing mental illness or psychological distress. It also noted that police often have limited options besides transporting people to an emergency department.

An expanded crisis response capacity should be considered, so that emergencies are health-led wherever possible and safe, rather than police-led. SAAS and SAPOL sometimes provide a joint response, which can be an effective collaboration. This would also require appropriate resourcing of police and mental health clinical partnership models, which have been shown to improve outcomes in other jurisdictions (for example the Police Force Mental Health Co-Response Commissioning trial in Western Australia).

Other initiatives, like the development of 'safe spaces', as recommended by the Victorian Royal Commission, and the new 'Urgent Mental Health Treatment Centre' in Adelaide's CBD are important in providing alternative avenues for people to get help without it becoming a crisis situation requiring police involvement.

Should the law allow hospital staff to use reasonable force to 'hold' a person until SAPOL arrives?

Under section 57(9), a person who has been arrested may be released from police custody for the purposes of medical examination or treatment under the MHA. If an ITO is not subsequently made, or ceases to apply, in respect to the person, they must be 'held and returned' to police custody. If there is a brief time lapse between hospital staff determining that an ITO is not required, or no longer applies, and SAPOL arriving to take custody of the person, then the ability to safely and securely 'hold' the person would potentially avoid the need to apply to the SACAT to seek special powers orders of detention under the GAA. Short-term 'holding' powers would need to be subject to appropriate authority and safeguards, including time-limits, recording and oversight requirements.

5.8 Principles

Section 7 of the MHA includes a range of principles that guide its administration, including that mental health services should be designed to bring about the best therapeutic outcomes for patients, be recovery-orientated and of the highest levels of quality and safety. It also requires that services should be provided on a voluntary basis to the greatest extent possible and that use of restrictive practices should be a last resort.

Principles play an important role in legislation, in that they seek to clarify the fundamental values and beliefs that underpin a legislative regime. If properly embedded and understood, principles should influence the day-to-day decisions and practices under the MHA. The principles should also recognise the lived experience

of people with mental illness and acknowledge the value that this experience brings to the mental health system.

Recommendation 8: *That principles should recognise the lived experience of people with mental illness, the right to legal autonomy and support for decision-making.*

How can these guiding principles be enforced into practice?

Currently, those involved in the administration of the MHA are 'guided by' the principles. This language could be strengthened to ensure that the principles are observed in the performance of functions under the MHA. For the principles to be truly effective, there needs to also be appropriate guidance, training and resources to enable them to be implemented. Equally, there needs to be effective and transparent accountability mechanisms in place to ensure the principles do in fact inform practice (see below).

If applied or not in practice, do these guiding principles impact access to services?

In the OPA's experience, the non-application of guiding principles can have an adverse impact on access to services. For example, Section 7 includes a principle (ca) that recognises a range of different groups and requires that mental health services take into account individual needs and circumstances, including the particular needs of people with disability.

For a number of clients with dual diagnosis there can be challenges with accessing assessment of mental health needs and associated treatment. For example, the Public Advocate is appointed guardian of Client A who has a complex presentation attributable to an interaction between diagnosed autism spectrum disorder, borderline intellectual disability, a history of trauma; and mental health issues including PTSD and depression. Client A has a history of presenting to hospital as a result of engaging in self-injurious behaviour as well as challenges in sustaining support arrangements due to behaviours of concern. OPA has been unable to secure mental health support for Client A on the basis that the mental health presentations have been attributed to behaviour/disability and therefore diagnostic requirements for access to Mental Health Services are not met.

'Overshadowing' refers to when symptoms arising from physical or mental illness are misattributed to an individual's disability. This has the effect of delaying treatment, can result in multiple 'failed' presentations without clear treatment plans and contributes to poor long-term outcomes and significant distress for people with complex needs and their carers.⁶ Alternatively, misattribution of a person's intellectual disability with mental illness can also occur, which can have an impact on the treatment and support provided. For example, a person with intellectual disability may be subject to chemical restraint to manage behaviour mis-diagnosed as mental illness, when they would more appropriately benefit from positive behaviour support interventions.

⁶ Department of Health and Wellbeing - SA Intellectual Disability Health Service Model of Care 2020, p. 23

Many OPA clients have dual or multiple diagnosis of disability and mental illness, as well as challenging behaviours. It requires careful diagnosis to determine whether behaviour is related to disability or mental illness, as well as a specialised and coordinated response.

Whilst there are examples of good practice in addressing these issues, including the Department for Health and Wellbeing's 'Challenging Behaviour Strategic Framework', people with intellectual disability or complex needs can experience barriers to accessing mental health services. Mainstream mental health services should be accessible to people with dual diagnosis of mental illness and intellectual disability. However, services for this group of people are often limited.⁷ SA Intellectual Disability Health Service provides an important linkage but services are not at the scale required.

Although the MHA already recognises that mental health services should take into account the particular needs of people with disability, the challenges faced by people with dual diagnosis in accessing appropriate support highlights the need for this principle to be strengthened, and for a specialised service response to be available.

Recommendation 9: *That the guiding principle requiring that services take into account the particular needs of people with disability be strengthened to ensure mental health support is accessible and made available to people with a dual diagnosis of disability and mental illness.*

What, if any, measures for accountability and monitoring should be included in the MHA?

Accountability and monitoring mechanisms are important for the administration of the MHA, which deals with significant limitations on the rights and freedoms of people with mental illness as well as their treatment.

Some accountability and monitoring measures that might be considered are:

- Guidance, policies and procedures for adhering to the principles;
- Services could be required to report on compliance with the MHA principles through their service plans or annual reports;
- A complaints mechanism could be established which confirms that consumers have the right to complain about non-compliance with the principles;
- Clear and transparent performance measures that are easily accessible to consumers and the public.

Recommendation 10: *That a range of accountability and monitoring measures be considered and included in the MHA to ensure services are complying with the guiding principles set out in Section 7.*

⁷ Department of Health and Wellbeing - SA Intellectual Disability Health Service Model of Care 2020, p. 24

5.9 Other Issues

Should the role of a Mental Health Commissioner be clearly defined under the MHA?

Commissioner roles are usually statutory officers and, therefore, a mental health commissioner should be included in the MHA. The scope, role, and responsibilities (particularly with respect to its interface with the Chief Psychiatrist and the Department of Health and Wellbeing) must be clear.

6. Conclusion

This review presents opportunities to strengthen protections in the MHA to ensure the rights of people with mental illness are upheld and that services are provided in a way that maximises legal autonomy to the greatest extent possible. This includes incorporating supported decision-making and a will and preference approach; increased accountability mechanisms to ensure the guiding principles are translated into practice; and enhanced oversight and regulation of restrictive practices in line with other sectors.

7. Recommendations

Recommendation 1: *That the MHA be amended to include principles of supported decision-making and recognition of a person's will and preferences when making ongoing care and treatment decisions.*

Recommendation 2: *That the ability for people to develop advance plans to capture will and preferences for treatment and care whilst subject to a CTO or ITO be considered. This may need to consider how it would interact with existing arrangements under the Advance Care Directives Act 2013.*

Recommendation 3: *That consideration be given to amending sections 24, 28 and 31 so that the treatment of injuries or illnesses 'causing, contributing or connected to' the person's mental illness is permitted as part of an ITO.*

Recommendation 4: *That the MHA provide a more comprehensive definition of restrictive practices, aligned where possible with definitions in other Acts, including the Disability Inclusion Act 2018, to support a common understanding across government.*

Recommendation 5: *That additional safeguarding mechanism already in place through policy in relation to the use of restrictive practices be elevated to the MHA or Regulations to strengthen these important protections.*

Recommendation 6: *That the process for authorising the use of force in relation to ECT be managed separately from guardianship and substitute decision-making schemes, for example by empowering SACAT to provide authority directly to the treatment team.*

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Recommendation 7: *That provisions relating to the PPTP be strengthened to clarify referral pathways, panel processes and information sharing*

Recommendation 8: *That principles should recognise the lived experience of people with mental illness, the right to legal autonomy and support for decision-making.*

Recommendation 9: *That the guiding principle requiring that services take into account the particular needs of people with disability be strengthened to ensure mental health support is accessible and made available to people with a dual diagnosis of disability and mental illness.*

Recommendation 10: *That a range of accountability and monitoring measures be considered and included in the MHA to ensure services are complying with the guiding principles set out in Section 7.*