SUBMISSION

TO | **Office of the Chief Psychiatrist**

TOPIC | **Review of the Mental Health Act 2009**

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Submission to the review of the Mental Health Act 2009

Uniting Communities welcomes the opportunity to provide input into the review of the *Mental Health Act 2009 (MHA).*

We recognise the work already completed as part of the independent review by the South Australian Law Reform Institute (SALRI). The report recommends that the MHA reflect a greater focus on the promotion of wellbeing and prevention strategies. We seek to make specific commentary on the questions and recommendations from SALRI's review.

We believe it is important that the MHA upholds human rights in international law including the Convention on the Rights of Persons with Disabilities (CRPD) which focuses on moving away from involuntary treatment models "towards a model of supported decision making". In addition, Victoria's Royal Commission into the Mental Health System recommends shifting towards supported-decision making and recovery-oriented practice.

It is vital that any changes made to the MHA are accompanied by the development of guidelines and training to ensure consistency in understanding of the legislation for those working in the sector.

It is also important that any changes made to the legislation (that impacts service delivery) are simultaneously met with increased resourcing. For example, the current MHA allows for those with a severe mental illness to have access to support services, whereas a report released by SA Health in July 2023, *Unmet Needs Report for Psychosocial Support Services in SA*, revealed that the number of South Australians living with acute and severe mental illness going without psychosocial support has increased to 19,000 people a year.

Key recommendations

Recommendations for the review of the MHA include:

- The name of the Act should be amended to include wellbeing in the title to reflect the greater focus on promoting mental health and wellbeing.
- That the objectives have a rights-based and recovery-orientated focus and recognise the role of both clinical and non-clinical support. We recommend an additional line is added that acknowledges the need for prevention. We broadly support the objectives in the Victorian MHWA but believe the word severe should be retained.
- We support the proposed guiding principles but believe the 'recovery principle' should be listed first in the Act.
- We recommend an additional guiding principle is added that focuses specifically on prevention, including preventative services and support.
- Further consultation is sought from both non-clinical and clinical support services on framework or guidelines for implementing the guiding principles into practice.
- We believe regular, ongoing accreditation/training should be implemented for clinical and non-clinical staff that outlines the principles and guidelines in practice to ensure all staff apply them in the daily work.
- Implement the proposed changes to the decision-making capacity section of the Act – (3) (a) and (3) (b). We believe this clause should also mandate that any person supporting the decisions of a consumer should be doing so in an unbiased way that is reflective of the new objectives and guiding principles of the MHA to protect the consumer.
- The impaired decision-making capacity criterion for involuntary treatment orders be retained.

- Where reasonable, a capacity assessment should be thorough and support the consumer to make decisions for themselves. Standard capacity assessment guidelines should be developed alongside a requirement to provide a written copy of all capacity assessments. Assessments should be regularly reviewed.
- We support the removal of the term 'appropriate' in relation to treatment for both CTOs and ITOs.
- Include an Aboriginal and Torres Strait Islander Statement of Recognition in the guiding principles.
- Provide legal representation for children and young people on treatment orders.
- Include a Statement of Rights appropriate to the developmental age of the young person to allow for additional provisions to safeguard children and young people's rights.
- Implement the proposed changes to make it clear that s56 powers are used to facilitate assessment for a treatment order and propose an additional clause is added that, where reasonable, care and control powers should be exercised in a manner that is as least restrictive as possible and the authorised officer must actively seek to minimise the potential traumatic impacts to the consumer.
- The Act require the automatic reviews of CTOs and ITOs and the SACAT establish a specific mental health stream with the capacity, resourcing and expertise to undertake this function.
- Non-compliance with a CTO should be explicitly addressed in the MHA and should include a requirement for the medical practitioner to educate themselves on the consumers perspective and rationale that is causing noncompliance and to accurately record the consumer's reasons for noncompliance.
- The Act require that every effort should be made to avoid the use of restrictive practices where there is non-compliance of a CTO by consulting with the consumer and providing appropriate support.
- That 'serious harm' be a threshold criterion for the imposition of a CTO and an ITO.
- Definition of treatment should be amended to the treatment of mental illness that may be causing, contributing or 'connected to' the persons mental illness.
- We believe that the present legal representation scheme should be extended to consumers in all proceedings (or a new advocacy service is created) under the MHA in the SACAT but not extended for interested parties.
- That the Commissioner and Mental Health Commission's role should primarily be to advocate for people with mental illness at a systems level with a particular focus on prevention and early intervention.

About Uniting Communities

We are an inclusive not-for-profit organisation working alongside more than 80,000 South Australians each year and have been creating positive change for South Australian communities for more than 120 years. We advocate for systems change across diverse social justice issues to shape public and social policy that delivers better outcomes for marginalised communities.

Uniting Communities provides services for people who experience mental health issues including:

Chrysalis Forensic Mental Health Service

Chrysalis is a transitional accommodation and case management service for clients moving from adult mental health services (such as James Nash House) and inpatient wards into the community. The aim of this 9-bedroom program is to support residents with sourcing long term accommodation, build independent living skills, support with maintaining good mental health and to make connections in their community.

All residents of the Chrysalis service:

- Live with a mental illness
- Have ongoing psychosocial support needs
- Display low risk behaviour
- Have no alternate safe housing options
- Are able to reside independently
- Are medically stable
- Have no acute care needs

Family Mental Health Support Onkaparinga/ Southern Fleurieu, Kangaroo Island

This service provides support for people caring for a young person with mental health issues. We offer free counselling and information to families concerned about a young person aged under 18. Our goal is to help children and families to improve mental health, resilience and confidence.

Individual Psychosocial Rehabilitation and Support Services (IPRSS)

Uniting Communities has specialised in providing IPRSS recovery services for clients of Older Persons Mental Health Services and people who are aged over 65 in Adult Services Mental Health Services. There is a range of mental health issues experienced by this client cohort, including anxiety disorders, isolation and depression.

Headspace Mount Gambier

Headspace provides information, support and services for young people aged 12-25 to work through mental health, physical health, work and study and alcohol and other drugs. We can connect clients with health workers to work through a range of issues.

Lifeline

Lifeline is committed to preventing suicide, supporting people in crisis, and promoting good mental health and emotional wellbeing.

Every year, the service answers more than 36,000 calls from people experiencing crisis. Many of them are thinking about taking their lives. Our dedicated team of Crisis

Supporters are here to listen and offer support and, where appropriate, refer people to other services that can help.

Psychosocial disability services (NDIS)

We provide recovery support services for people experiencing long-term mental health issues who would like support to live the best life they can.

Services include:

- skills development
- help to participate in the community and in areas of interest
- feedback and coaching
- support with daily tasks.

Additional comments

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

We believe the current objectives of the MHA are limited and should incorporate a comprehensive commitment to the rights, health, and wellbeing of people with a severe mental illness. We support the objectives detailed in the *Victorian Mental Health and Wellbeing Act 2022* (MHWA). The rights of people should be at the centre (including their voice) and incorporate a preventative, strength-based and recovery orientated focus. We recommend an additional line is added that acknowledges the need for prevention. This is not specifically outlined in the Victorian MHWA but should be included in the MHA.

The Victorian MHWA prioritises interventions that promote wellbeing and moves away from the need for compulsory treatment and restrictive practices. The Victorian MHWA objectives also provides for a broader range of support including (c) (vii) *alcohol and other drug support services and treatment* and (c) (ix) *includes a broad and accessible range of voluntary treatment and support options.*

We believe the inclusion of clause (d) (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* - is particularly important. Both the clinical and non-clinical support roles should be equally represented in the Act.

We recommend that the current first line of the objectives of the MHA- (a) *to ensure that persons with a* severe *mental illness*- be retained as well as expanding the objectives to incorporate those included in the Victorian MHWA.

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?

We agree with SALRI's recommendation that the guiding principles should emphasise mental health, wellbeing and prevention and are supportive of the New Guiding principles included in the discussion paper. The new principles focus on rights based and person-

centred language and the need for less involuntary orders and restrictive practices. We recommend an additional principle is added that focuses specifically on prevention, including preventative services and support.

Importantly, we believe the 'recovery principle,' 'least restrictive principle,' 'choice and control principle' and 'supported decision making principle' should be listed first in the Act, recognising that these are central principles that should be guiding all decision making and practices.

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

This question will require an additional consultation of its own, as it is a significant question and requires an in-depth response. How the principles are reflected in practice will depend on the situation and context.

Ensuring the guiding principles are reflected in practice will require a consistent interpretation of the legislation across the sector. To achieve consistency, every guiding principle in the Act should be incorporated into practice framework/guidelines, for example, the creation of consumer engagement guidelines. However, the framework alone will not ensure compliance, there needs to be a mechanism in place to keep staff accountable. For instance, there are currently varied interpretations of the Recovery Practice Framework in practice.

We believe regular, ongoing accreditation/training (for example online) should be implemented that unpacks the principles and guidelines by outlining what this looks like in practice. This will hold staff (including practitioners, clinicians, mental health nurses and psychiatrists) to account and ensure they are adhering to the standards by providing regular education. This accreditation should be for staff across both clinical and non-clinical support to unite the sectors but must be applicable to the roles of the practitioner and not create an unreasonable burden for practitioners.

We agree with the Office of Chief Psychiatrist (OCP) that a working group should develop and monitor standards (specifically frameworks) that would see the guiding principles put into action. We believe this working group should include representatives from both clinical and non-clinical support services. Further consultation on the principles, and what should be included in the framework and accreditation is important.

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?

We broadly support the changes to the decision-making capacity section of the Act. We recommend that clause (3) (a) is reworded for greater clarity. It is our understanding that clause (3) (a) is mandating that a consumer receives support to make decisions to the best of their ability. However, this could be complicated to apply given it relates to a consumer who has been deemed unable to make their own decisions. Importantly, this clause does not include safeguards to protect the consumer from a person inappropriately supporting them in this context. We believe this clause should mandate that any person supporting the decisions of a consumer should be doing so in an unbiased way that is reflective of the new objectives and guiding principles of the MHA.

Clause (3) (b) is beneficial as it ensures every effort has been made to support their decision-making capacity. Sometimes the consumer requires specific support or alternative ways of communicating, for example, communicating in a comfortable environment, to aid in their decision-making capacity.

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

We agree with SALRI's recommendation that the impaired decision-making capacity criterion for involuntary treatment orders be retained. The consequences of removing this as a criterion is that it puts more people at risk of involuntary treatment orders when they have the capacity to make their own decisions. The focus of the MHA should be rights-centred, therefore the consumers voice and their ability to make their own decisions should be paramount in decisions for involuntary orders.

Question 6: How can capacity assessments be improved?

There is an opportunity to improve how capacity assessments are conducted and managed. Currently the accuracy of these assessments can vary. Sometimes these assessments are rushed, therefore, it is possible for the assessment to be inaccurate about the persons decision making capacity.

Where reasonable, a capacity assessment should be thorough and support the consumer to make the highest-level possible decisions for themselves. To achieve this, a standard capacity assessment guideline should be developed alongside a requirement to provide a written copy of all capacity assessments. This guideline would provide clarity on how an assessment of capacity should be made and ensure consistent criterion is applied.

Providing a written copy of assessments will clarify the reasons behind the decision and will ensure accountability and oversight. Without the evidence to support these decisions, it will be difficult to ensure appropriate standards are being followed. A copy of these assessments is also useful information for the consumer to have when applying to SACAT for an order to be changed or revoked.

Regardless of whether the consumer applies to SACAT, it is important these capacity assessments are regularly reviewed as the consumer's decision-making capacity can change quickly.

We note SALRI's recommends a capacity assessment toolkit or guideline be developed to be used as a non-legislative, educative tool for anyone to use. However, we recommend this guideline be mandatory for all capacity assessments to ensure consistency.

Removal of the term 'appropriate' in relation to treatment

We support the removal of the term 'appropriate' in relation to treatment for both CTOs and ITOs. It is our understanding that the reasoning behind this change is that all forms of treatment will be considered in these clauses rather than be limited by the word appropriate, which is ambiguous.

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

We recognise the importance that an Aboriginal and Torres Strait Islander Statement of Recognition is included in the guiding principles of the MHA in order to strengthen the ways mental health services and regulatory bodies engage with Aboriginal and Torres Strait Islander people and communities. We support the guiding principles from the National Strategic Framework and the Victorian MHWA, in particular, the rights to self-determination in the provision of Aboriginal and Torres Strait Islander health services and that the human rights of Aboriginal and Torres Strait Islander people must be recognised and respected.

In addition, we support SALRI's recommendation to change section 47 of the MHA for 'Patients' right to be supported by guardian etc. 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.

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

Further safeguards for children and young people under treatment orders are important. Access to independent legal representation (children's lawyer) is a vital protection. There is a greater need for representation in these circumstances given the unique difficulties faced by people living with a severe mental illness, particularly young people, in navigating SACAT hearings. We agree that amending the MHA to include a Statement of Rights appropriate to the developmental age of the young person would allow for additional provisions to safeguard young people's rights.

We believe it is important to clarify the role of the Commissioner for Children and Young People, the Commissioner for Aboriginal Children and Young People and the Guardian for Children and Young People in supporting and safeguarding children subject to treatment orders. We agree that a Child and Adolescent Mental Health Committee that is run by the Office of the Chief Psychiatrist could be beneficial and should include members from non-clinical support services.

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

We broadly support the proposed changes, recognising that this will provide greater clarity that care and control powers can only be used for an assessment for a treatment order in this case.

We propose an additional clause is added that, where reasonable, care and control powers should be exercised in a manner that is as least restrictive as possible and the authorised officer must actively seek to minimise the potential traumatic impacts to the consumer.

We support SALRI's recommendation that authorised officers should receive improved training, expertise and experience in exercising care and control powers. Adequate training will help ensure these powers are used appropriately.

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

Regularity

It is essential that both CTOs and ITOs are reviewed on a regular basis as the consumers situation and their capacity, can change rapidly. Regular reviews, and subsequent revocation or variation of orders, may reduce the number of people on orders for longer than required and provide opportunities for consumers to transition to less restrictive approaches.

We are supportive of the proposed automatic reviews of treatment orders and the MHA should be amended to mandate this. We support SALRI's timeframes that will support efficient and regular reviews: initially, orders should be reviewed within 4 weeks of its making, upon six months of its imposition, then annually and each time another CTO or ITO is made or varied.

Resourcing

As acknowledged in the discussion paper, currently SACAT is not resourced to conduct regular reviews and if given this responsibility, SACAT would need to establish a specific mental health stream with the capacity, resourcing and expertise to undertake this function. The MHA should be amended to provide resourcing for this function. More staff resourcing will be needed to respond to the additional reviews.

Effective review process

The reviews need to be conducted in a manner that is conducive to the consumer's level of understanding and allows for the consumer to receive appropriate support to self-advocate and to have a voice over their treatment. Currently, there can be a lack of shared understanding and collaboration between the clinical staff and the consumer that impacts the consumers likelihood of recovery, adherence to the order and the effectiveness of the treatment provided. Reviews should be conducted with sufficient time, and all reasonable steps should be taken to inform consumers of the process and outcomes.

Other changes to the MHA discussed in this submission will support the efficient and effective review of CTOs and ITOs. This includes access to legal representation and the recording of non-compliance from a consumer's perspective which should be considered in these reviews (see further under question 12).

Recommendation 31 - Provide one universal CTO rather than the current CTO1 and CTO2 (n1)

We are supportive of recommendation 31 that one universal CTO is created.

Recommendation 30 - 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

We support recommendation 30 as the appointment of a mental health clinician provides consumers with support for their care and treatment plan. It is our understanding that this is currently policy but not in legislation. Incorporating this into the MHA may reduce non-

compliance. Like with other amendments to the MHA this will need to be supported with increased resourcing.

Recommendation 36 - That consideration be given to the introduction of a Forensic Community Treatment Order

We support SALRI's recommendation to introduce a Forensic Community Treatment Order (FCTO) due to the greater oversight and review of NSW's Forensic Community Treatment Orders compared to CTOs under the current MHA in South Australia.

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?

We agree that non-compliance with a CTO should be explicitly addressed in the MHA including a definition of non-compliance. We support the inclusion of points: 'i.' 'ii.' 'iii.' and 'iv' in provisions on non-compliance (on page 20 of the discussion paper). In addition, we recommend that point 'ii' - *responsibilities of medical practitioners and authorised mental health professionals in attempting to obtain compliance* - mandates that when obtaining compliance, where reasonable, the medical practitioner is required to educate themselves on the consumers perspective and rationale that is causing non-compliance (for example, the result of negative side effects) with the order and thoroughly explore alternative possibilities with the consumer. This ensures a recovery-oriented approach to the practice of clinicians.

Provision 'iii' - *Records of non-compliance to be kept by medical practitioners and authorised mental health professionals* - should include a record of the consumers reasons for why they were non-compliant. This evidence is also useful for any reviews of the order at SACAT hearings.

Training in trauma informed responses to non-compliance

Trauma informed response education should be incorporated into training for practitioners including responses such as motivational interviewing, and other person-centred methods of communication. This would help the practitioner to understand the consumer better, support their recovery and support the relationship between consumer and practitioner.

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?

We broadly support this recommendation and agree this needs to be clarified in the Act. However, we recommend the addition of a clause that requires that every effort should be made to avoid the use of restrictive practices by engaging and consulting with the consumer on their reasons for non-compliance and providing appropriate support. In addition, there should be a requirement to use the least amount of force as possible and the decision to use restrictive practices should consider the consumers history and be weighed against the risks to the consumer and others.

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

We are concerned about the high use of CTOs and ITOs in South Australia compared to other jurisdictions in Australia. We agree that the MHA should be amended to include 'serious harm' as a threshold criterion for the imposition of a CTO and ITO so that these orders are only enforced in appropriate circumstances. Changing the threshold limits when these orders can be used, reorientating the legislation to be rights-based. Consideration could be given to the Victorian MHWA's use of 'balancing of harm' 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*. This recognises the impact that these orders can have on the health and wellbeing of the consumer. The definition of 'serious harm' in ACT *Mental Health Act 2015* could be incorporated into the current definition in the MHA.

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 persons mental illness, or 'as a consequence of' the person's mental illness?

We support SALRI's recommendation to change the definition of 'treatment' to the treatment of mental illness that is causing, contributing or 'connected to' the persons mental illness. This incorporates a holistic understanding of treatment and provides opportunities to address other issues associated with the persons mental illness.

We support recommendation 25 that the Chief Psychiatrist should publish standards regarding the definition of 'treatment.'

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?

We are concerned about the absence of free legal representation for consumers in the first instance or primary proceedings of the SACAT. We believe that the present legal representation scheme should be extended to consumers in all proceedings (or a new advocacy service is created) under the MHA in the SACAT. The current scheme creates serious challenges for consumers during SACAT hearings. The Tribunal process can be difficult to navigate for consumers generally, but for a person with a severe mental illness this is extremely difficult or impossible to understand, creating unrealistic and unfair expectations for the consumer.

Consideration should also be had to ensuring all legal representation in these circumstances are given sufficient training on complex mental illness so they are providing appropriate support and representation.

We support SALRI's recommendation that 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 and should be limited to consumers.

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

Enshrining the role of the Mental Health Commissioner into the MHA is an important change. This will clarify the role and obligations of the Commissioner (and the Mental Health Commission) and ensure the longevity of the role. We note it is important that the role of the Commissioner does not overlap with the role of the Chief Psychiatrist but instead compliments and supports each other.

We support the suggested functions of the Commissioner. The Commissioner's role should be primarily to advocate for people with mental illness at a systems level with a particular focus on prevention. This can be directly incorporated into the new standalone division for the Mental Health Commissioner in the MHA.

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?

We support this recommendation and believe greater clarity will support effective implementation of the MHA.

We support SALRI's recommendation that the respective roles and functions of the Office of the Chief Psychiatrist, the Mental Health Commissioner, the Health and Community Services Complaints Commissioner and the CVS should be included under the MHA to improve clarity.

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

We support these changes to the terminology in the MHA. The word consumer is more appropriate outside the context of hospitalisation.

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

We support the proposed changes to 'effective consent.' The inclusion of 'valid consent' and reference to 'informed consent' are important amendments to the MHA as it provides vital parameters around ensuring consent is obtained appropriately.

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?

We support the inclusion of Schedule 1, '*certain conduct that does not indicate mental illness'* and agree that ***(k) the person takes or has taken alcohol or any other drug,*** should be prioritised and included first.

Conclusion

Amendments to the MHA are required to prioritise a rights-centred and recovery orientated approach to the legislation. Wherever possible the Act should move away from the need for involuntary treatment orders, community treatment orders and restrictive practices towards supported decision making and effective support services (both clinical and non-clinical).