



# Disability Rights Advocacy Service Inc

Safeguarding and promoting the rights and  
interests of people with disability, their families

## SUBMISSION INTO THE *MENTAL HEALTH ACT 2009* (SA) REVIEW

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### SALRI REVIEW

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# Disability Rights Advocacy Service Inc

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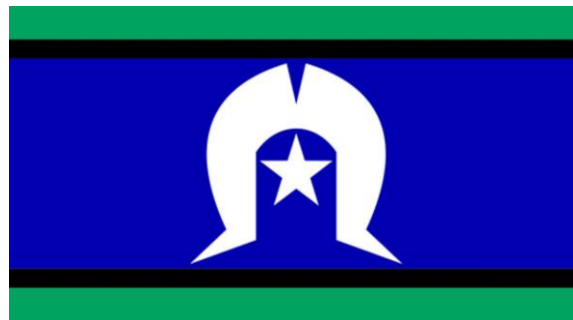




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## Acknowledgement of Country



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The Disability Rights Advocacy Service Inc acknowledges that this submission was completed on Koorina Land. We pay our respects to Elders past, present and emerging. We recognise the continuing relationship with the lands and seas and connection to culture.

Koorina Miyurna yaitya yarta-mathanya Wama Tarntanyaku, parnaku yailtya, parnaku tapa puru purruna. Koorina Miyurna ithu yailtya purruna, yarta kuma puru martinthi, puru warri-apinthe, puru tangka martulayinthe.

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## **Background**

Disability Rights Advocacy Service is part of a national network of disability advocacy organisations funded by the Australian Government Department of Social Services to provide individual advocacy, individual capacity-building and systemic advocacy for persons with disability. We service three areas in South Australia, representing people who reside within greater metropolitan Adelaide, the Adelaide Hills and Murray Bridge, the South-East and Coorong region, and the Riverland.

As part of our work our advocates assist clients who are on Inpatient or Community Treatment Orders, including assisting clients to challenge orders at the Tribunal level. In putting together this submission we have reviewed key research and interviewed advocates and clients about their experiences.

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## Capacity and supported decision-making

1. Should the *MHA* include a clearer definition of 'impaired decision-making capacity' for treatment orders?
2. How can the law better protect the human rights of persons with a lived experience of mental illness and provide supported decision-making?

As an advocacy service we prefer the rights-based approach of supported decision-making. This means that people with disabilities and mental health conditions are provided with support and have genuine input into decisions being made about their health and bodies. The United Nations Committee on the Rights of Persons with Disabilities advocates for supported decision-making and the ability for persons with disabilities to uphold their legal capacity. The rights-based approach of legal capacity under Article 12(2) of the CRPD is preferred rather than the concept of mental incapacity or impaired decision-making capacity. Under legal capacity, persons have legal standing where they have the right to hold duties and rights, and legal agency where they have the right to exercise said rights. Legal capacity is preferred because it centres consent in decision-making, rather than the concept of mental capacity under which the right to make decisions may be taken away through a narrow test of a person's capabilities or understanding. We understand that a rights-based approach must be balanced with the ability for health services to safeguard patients against risk or harm to themselves or others.

Section 7 of the *MHA* Guiding Principles outlines that mental health services should be governed by comprehensive treatment and care plans that are developed in a multi-disciplinary framework in consultation with patients and their families, carers or supporters. It also outlines that patients should be provided with comprehensive information about their illnesses, orders, their legal rights, treatments and other services that will be provided or offered to them, or other alternatives. However, it is the experience of our clients that this is often not the case. Many clients come to us either with limited understanding of or knowledge of their legal rights, alternative treatment options, or 'comprehensive information' about their illness. It can be the case that they disagree with a diagnosis they have received, or have not been provided with information about it. For example, in the making of an Inpatient Treatment Order (ITO) or Community Treatment Order (CTO), clients are often not allowed to see the medical reports or information that has been provided to the South Australian Civil and Administrative Tribunal (SACAT) due to concerns about patient/doctor confidentiality or trust. As advocates we believe that in the creation of a treatment order, persons subject to treatment orders and their supports should be consulted as much as is practically possible about the treatment options available. The *MHA* should be strengthened so that any enforcement of a treatment order should consider:

- What treatments a person has tried in the past and what the outcome or effect was;

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- Consulting with current treating professionals about past and current treatments and how effective they were;
- Explaining to the person what benefits, risks and side-effects treatments proposed by a treatment order may bring;
- Liaising with family or caregivers about what supports can be provided (includes health and social supports);
- Ongoing assessments of capacity with the acknowledgement that capacity can fluctuate, and should not be based solely on a 'point-in-time';
- Allowing persons subject to treatment orders the option to view the medical reports or information that justify the order, unless this would cause serious risk to the person, so they can have the information they need to challenge an order if they want to do so.

We also have concerns about historical medical information being used to provide justification for a treatment order. It may be difficult to overcome historical information about a person's past behaviour or capacity, even if it may not be relevant at the time of making a treatment order. Records may also not be accurate and there are often no independent reviews of a client's file. We note with concern our experience as advocates that there can be a misrepresentation of events or incidents that may build a narrative that goes against a vulnerable person's best interests. Therefore, we recommend that where a client has concerns about potential misuse of historical information, the *MHA* should provide a right to request an independent review of their case file before a treatment order is adopted.

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## Inpatient Treatment Orders

3. Should the definition of 'treatment' be expanded to include an assessment of other medical/health issues?
4. Should the *MHA* allow powers to detain and use force? If so, who should be allowed to detain and use force?

Under sections 23 and 27 of the *MHA*, the copy of the relevant order, any notices and a statement of rights are required to be provided to inpatients on Level 1 and Level 2 Inpatient Treatment Orders. However, these are not required to be provided to inpatients on Level 3 Inpatient Treatment Orders. It is our position that everyone under an Inpatient Treatment Order should be provided with a copy of the order made, any relevant notices and a statement of rights.

It is our position that powers to detain and use force should be used as a last resort and that this should be more heavily emphasised in the *MHA* and in practice. Currently s 7(h) of the *MHA* outlines that 'restrictive practices should be used only as a last resort for safety reasons and not as a punishment or for the convenience of others'. However, using restrictive practices for 'safety reasons'

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could be widely interpreted and is at the discretion of individual workers. Safeguards should be included in the *MHA* so that the Act reflects alternatives approaches that can be taken as opposed to restrictive practice. This includes:

- An emphasis on de-escalation techniques to support the well-being of inpatients;
- The provision of wrap-around supports that are personalised to inpatients, such as access and/or referral to medical services, social workers, mental health counselling, financial counselling, accommodation services, advocacy support or legal aid;
- An emphasis on trauma-informed practice with the acknowledgement that persons detained in mental health facilities often have complex historical backgrounds, which may include child sexual abuse, domestic and family violence, socio-economic insecurity, among other things. Clients have told us that being detained as an inpatient is a triggering and traumatic experience.

Our clients have relayed the following about their experiences as an inpatient. Their experiences include:

- A feeling that paramedics called out to mental health emergencies are more understanding and have more training
- Concern that as inpatients they were forced to do injection treatments without consent, sometimes in front of family
- Feeling like there wasn't any opportunity to ask questions or provide feedback about treatment
- Feeling like mental health staff had preconceived notions about the 'label' of the mental illness and drawing off connotations attached to that label
- That hospital staff were forceful and sometimes condescending in the way they spoke to patients
- That the amount of security guards in the ward they were in was intimidating – particularly in cases where women inpatients were in wards with mostly male guards
- Feeling as though it didn't matter what they did or said, they were not given input into treatment, feeling like they were misheard and there was no point in saying anything or speaking up for themselves because they weren't being listened to
- They had their mobile phones taken away and they weren't allowed to make phone calls
- Being denied access to advocacy support, even over the phone
- Feeling like they didn't have a chance to speak or ask questions if moving wards and just being told to do so
- Feeling like they had no dignity and were 'dragged' to different wards even though they did not feel they were being resistant to moving

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- Women inpatients getting bruises from where male security guards handled them
- Feeling like they were being 'threatened' or 'intimidated' by the prospect of injections
- Being administered injections by staff without them telling the patient what was about to happen
- Miscommunication between the staff about 'leave' times leading to patients being told they were absconding
- Some staff members didn't seem equipped to assist people with physical disabilities
- Conclusions drawn that staff need more training across the board
- Different cultures at different hospitals meaning a lack of consistency between approaches
- Patients being administered ECT without their consent
- A lack of understanding about cultural differences leading to mental health facilities that are not culturally safe
- Feeling like their rights were not being respected, feeling 'degraded' and 'worthless' due to human rights being violated, and that the Office of the Chief Psychiatrist was not contactable despite having so much power over their lives

It is our position that the *MHA* must mandate adequate oversight and transparency of mental health facilities where inpatients are detained. The Community Visitor Scheme must be expanded so that advocates have a right of entry to mental health institutions to ensure that inpatients rights are respected.

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We are also concerned that a shortage of doctors, nurses, clinical psychologists and psychiatrists is leading to overstretched workloads and tick-box solutions. Being detained in a mental health facility as an inpatient is a crisis point. We advocate for a focus on early intervention, health promotion and public awareness. As a society we are facing an epidemic of mental illness, particularly with the onset of the COVID-19 pandemic. However, we are not seeing governments place an urgent priority on funding or resourcing equitable access to mental health services. This means that clients who did not receive support at the early onset of mental illness are only being offered support by an ambulance when they are at the bottom of a cliff. While this may be outside the scope of what the *MHA* can offer, it is important to note that any changes to the *MHA* framework must be supported by a whole-of-government approach to holistic supports and a well-funded healthcare system, so people do not 'fall through the cracks' without being offered adequate mental health support from the beginning. Staff should also be supported with adequate training and resources to help them help patients.

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## Community Treatment Orders

5. Should the law and practice be re-framed to limit or reduce the number of Community Treatment Orders? Why or why not?
6. Should the *MHA* be changed to include a power to use reasonable force in cases involving non-compliance with a Community Treatment Order?

Under s 12 of the *MHA*, the copy of the relevant order, any notices and a statement of rights are required to be provided to individuals on Level 1 Community Treatment Orders. However, these are not required to be provided to individuals on Level 2 Community Treatment Orders. It is our position that everyone under a Community Treatment Order should be provided with a copy of the order made, any relevant notices and a statement of rights.

Our position is that the law and practice should be re-framed to limit or reduce the number of CTOs. As with our suggestions for ITOs above, persons subject to CTOs must be able to have access to wrap-around supports and a trauma-informed approach that are personalised to their individual circumstances. Persons must be involved in decision-making about the kinds of treatment options available to them. Often it seems that treatment options and outcomes are not adequately explained to persons with disabilities. For people who often feel that they are unheard, treatment orders can further away take away their voice.

There should also be a broader focus on health promotion and prevention through our public healthcare system, so people do not get to the crisis point of being put onto a CTO. There may be a series of failures along the way by our healthcare system to intervene early on in a person's experience of poor mental health meaning that they are left unsupported. The reasoning behind a CTO is also often not explained to a person, particularly at the SACAT stage, and medical information is not provided to the person being put on a CTO due to confidentiality reasons from a treating doctors' perspective. While there may be some rationale for this, it also means that a person goes into a SACAT hearing about a CTO without all the information they need and cannot adequately challenge the CTO if they do not think it is in their best interests.

The Chief Psychiatrist has the primary responsibility under the *MHA* to assess whether a CTO is necessary and monitors the enforcement and compliance of orders. While the *MHA* does refer to offering individuals a multidisciplinary team, we are concerned that this is not happening in practice, as this has been the experience of our clients. We note that there should be increased oversight and transparency around the treatment teams offered to individuals on treatment orders. This could include mandating under the *MHA* that individuals *must* be provided a multidisciplinary treatment team of psychiatry, clinical psychology, counselling, nursing, or social workers, among other things – subject to their personal circumstances and conditions and what supports are appropriate.

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## **Restrictive Practice and Control Powers**

7. Should the *MHA* allow use of reasonable force and control powers? If so, when?
8. Who should be allowed to use force and exercise control powers?
9. What is 'reasonable' and how should this be defined?

The *MHA* should only allow use of reasonable force and control powers as a last resort. Staff should be trained in de-escalation responses and trauma-informed approaches. As already mentioned, individuals under all types of treatment orders should be provided with a statement of rights, comprehensive information about their condition, treatment options available and ongoing communication about what is happening and why through all steps of the process. Individuals should be provided with communication assistance if they require to assist their understanding of processes throughout treatment orders and when being detained as an inpatient.

It is also important that individuals be able to develop and maintain trusting relationships with healthcare professionals and providers. We have had clients come to us after being on treatment orders that have developed a distrusting relationship with healthcare professionals and providers, police and tribunals as a result of orders being made against them that they believe are a breach of their trust and human rights. It is also important to note that the use of restrictive practices and force can have long-term detrimental impacts on the health and well-being of individuals and therefore should be measured and limited in scope.

## **Electroconvulsive Therapy**

10. Should the law allow reasonable force to ensure a person receives Electroconvulsive Therapy? If so, when?
11. How can the rights of a consumer be better protected in cases of emergency Electroconvulsive Therapy?
12. Should the Prescribed Psychiatric Treatment Panel provide more or less oversight of Electroconvulsive Therapy (including maintenance Electroconvulsive Therapy) and/or other treatments?

The use of electroconvulsive therapy (ECT) has historically been controversial, indicated by surveys of public opinion, patient testimonials, and differing opinions in the psychiatric and medical community. Internationally ECT has been viewed as a 'high-risk' device. The World Health Organisation outlines that ECT should only be used with the informed consent of the patient or their guardian. However, under the *MHA* treatment of ECT can be provided without the consent of a patient or guardian and can be ordered by a psychiatrist or other health professional. In this case patients are not entitled to express consent over whether the procedure occurs. There does not appear to be a legal obligation to explain to the patient the reason for treatment or any risks or

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benefits of receiving or denying the ECT. Adverse side effects of ECT include risk of brain injury or permanent and severe memory loss.

Currently under section 41 of the *MHA*, written consent must be given for ECT if the patient is 16 years or older if they are capable of making decisions on their own behalf. In situations where a person is 16 years or older and are deemed as being incapable of making their own decisions, a psychiatrist can assess whether another agency or individual can make the decision to administer consent to the patient. This includes a substitute decision-maker appointed by an advance care directive at SACAT, a medical agent, a guardian, or SACAT themselves. It is our position that individuals who are being considered for ECT must have all opportunities to consent to the treatment, including access to supported decision-making. The *MHA* should be amended in this respect.

### **SACAT and Legal Representation**

13. Should the *MHA* be amended to entitle consumers to legal representation under the scheme in cases where the South Australian Civil and Administrative Tribunal reviews its own decision?
14. Should the *MHA* legal representation scheme be extended to provide representation to families and carers who apply for review of treatment orders?

Individuals should be entitled to legal representation for internal reviews under the *MHA*. It is important that people with disability are supported throughout this process so their rights are upheld. SACAT should have the responsibility of referring people to legal representation or advocacy support. Families and carers should be provided information about the options for legal representation and advice under the *MHA*, although we see no reason as to why this should be mandated under the *MHA*. The rights and interests of the person impacted by a treatment order must be the primary consideration.

### **The role of the South Australia Police**

15. Should the South Australia Police be involved in the enforcement of the *MHA*? If not, who should be given these powers?
16. Should the law allow hospital staff to use reasonable force to 'hold' a person until South Australian Police arrives?
17. Should the law allow the use of care and control powers to enforce cross border arrangements?

Police must be given training on disability awareness and mental health first aid training if they are given enforcement powers. Otherwise their actions may exacerbate the situation and cause

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significant harm. Social workers or mental health nurses who work alongside police may provide a better health or social support response, however, they would need to be equipped with the necessary training to assist in these circumstances.

Persons with mental health conditions must not be criminalised for having such conditions. If they are 'held' in hospital they must be given access to legal representation or advocacy support. The *MHA* must be amended to include and define supported decision-making and communication assistance in circumstances where police are involved.

## Guiding Principles and Accountability Mechanisms

18. How can these guiding principles be enforced into practice?
19. If applied or not in practice, do these guiding principles impact access to services?
20. How might the *MHA* provisions be changed to improve consumer's access to service?
21. What, if any, measures for accountability and monitoring should be included in the *MHA*?

Supported decision-making and recovery-oriented practice is pivotal - we must ensure that vulnerable people are not leaving these treatment orders or control powers worse off than when they went in. They must be given care, support and access to transparent complaint services, advocacy and/or legal representation if they are not provided with best practice or trauma-informed care.

The Guiding Principles under s 7 of the *MHA* impact access to services by making services more accessible only if they are applied in practice – otherwise they are meaningless. Treatment should be rights-based, enforce accountability and operate with transparency and oversight mechanisms, and ongoing client feedback. Mental health services should provide consumer's access to advocacy support, and ensure they are aware of their legal rights. The Mental Health Commissioner should also be given the power to conduct audits of mental health facilities to ensure that they are upholding the rights as outlined under the *MHA*. Expanding the Community Visitor Scheme as discussed below will also provide increased advocacy and oversight.

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## Other Issues

22. How can the Community Visitors Scheme be improved to enhance access to Community Visitors and its efficiency?
23. Should the director of an authorised community mental health facility inform the Community Visitors Scheme of a request within 2 days?
24. Should the role of a Mental Health Commissioner be clearly defined under the *MHA*?

Our position is that there should be a clear complaints process, mandatory reviews of mental health institutions and hospitals by an Ombudsman or equivalent, and a right of entry by Advocates under the Community Visitor Scheme. The role of the Mental Health Commissioner should also be more clearly defined so that they are responsible for upholding the rights of persons with disability and mental health conditions. We advocate for the following updates to sections 50-54 of the *MHA*, in reference to the Community Visitor Scheme:

- Expansion of sections to incorporate advocates as community visitors to provide advocacy support and information.
- Expansion to enable community visitors to have additional functions and powers for advocacy support and information or to include disability advocates to work alongside the community visitors in a co-partnership arrangement.
- Expansion of scope of legislation and powers of entry to include other NGO facilities.
- Keep safeguarding and inspection powers – look at greater legislative cohesion and aligning legislation with NDIS Act/ NDISQSC powers (i.e. in conjunction with NDIS Quality and Safeguards Commission regulatory, safeguarding, visitation & inspection powers in the NDIS Act).
- Legislative recognition and procedural establishment of multi-agency, across-government approaches to the Community Visitor Scheme, such as rights of entry, patient visitation and communication and sharing of information.
- Review of the CVS sections for access and entry of advocates as based upon the provisions in the *Aged Care Act 1997* s56.1 and *User Rights Principles 2014*- Div 2, s 8.
- Clarity on the principal piece of legislation which delegates power to the Principal Community Visitor and Community Visitor Scheme
- Consideration of overarching or standalone legislation for the Community Visitor Scheme (outside of the *MHA*).

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## Recommendations

1. The Community Visitor Scheme (CVS) should be expanded under the *MHA* sections 50-54 as outlined above so that advocates have a right of entry to mental health facilities to support clients and advocate on their behalf. This includes adequate telecommunication contact and visiting inpatients in facilities.
2. State Government may also wish to legislate stand-alone CVS legislation to provide consistency across the application of a Scheme across mental health facilities, disability care facilities, aged care, supported independent living or specialist disability accommodation, among other things.
3. Section 5A of the *MHA* should be amended to allow for the option of supported decision-making if a person is considered to have an 'impaired decision-making capacity'. For example, this would mean allowing a person access to support from family, carers, advocates or legal aid when making decisions about treatment, before a treatment order begins, or in the establishment of a treatment order. The Objects and Guiding Principles under the *MHA* should be updated to outline that supported decision-making is preferred and that substitute decision-making should be an option of last resort where there are significant concerns about risks the person poses to themselves or others. Supported decision-making must be an option for both inpatient and community treatment orders.
4. Strengthening the *MHA* so that the individuals personal circumstances are more adequately considered in the making of an order. This includes consideration of past and current treatment and its outcomes, a focus on offering the least restrictive practice possible, explaining the benefits and risks of treatments to an individual, and liaising with families and carers. Only the Guiding Principles of the *MHA* point to offering mental health services in the least restrictive way in the least restrictive environment. The *MHA* should embed this throughout the legislation so that the least restrictive option is considered at every point of an inpatient or community treatment order.
5. The *MHA* must be updated to include more transparency and oversight measures. The legislation should provide the ability for the Mental Health Commissioner to conduct five yearly audits of mental health facilities to ensure they are following the *MHA* adequately and that the rights and interests of inpatients are respected as per the Objects and Principles of the Act. A report of the audit must be tabled in Parliament and be made publicly available.
6. The *MHA* must include, or adopt regulations to include, a comprehensive and transparent complaints procedure that individuals on inpatient or community treatment orders can follow.
7. The Government should consider adopting a right in the *MHA* for persons subject to inpatient or community treatment orders (and/or their support persons) to have copies of the medical evidence and justification for the orders. We have concerns that individuals subject to these orders are not given sufficient opportunity to know and understand why orders are being made

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# Disability Rights Advocacy Service Inc

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against them and what evidence SACAT is considering in justifying the order. This should be done as long as it would not pose a significant risk to the well-being of the individual.

8. A copy of the order made, any relevant notices and a statement of rights must be provided to individuals on inpatient and community treatment orders on all Levels. These documents must be adequately explained to an individual as they often contain legalistic language that is not accessible for laypeople. There should also be easy-read copies made available and copies made available in a variety of languages.
9. There should be more efforts made both in legislation and policy practice to ensure that people of Aboriginal or Torres Strait Islander backgrounds, or people from culturally and linguistically diverse backgrounds, are given the support they need. This includes culturally-safe services, access to interpreters who understand and are given training on the system, copies of documents given in their native language, and access to cultural supports.
10. There should be a broader emphasis in the *MHA* and policy practice for trauma-informed services. Past trauma should be a consideration in whether to impose restrictive practices such as seclusion, isolation or forced treatment because of their re-traumatising effects and potential for long-term harm.
11. We advocate that the *MHA* should be amended to adopt the following in reference to Electroconvulsive Therapy (ECT):
  - ECT should be administered with the written consent of a patient, and without the written consent of a patient as a last resort;
  - If a patient's capacity to consent is in question, supported decision-making must be explored to help a patient make the decision to have ECT administered or not;
  - In all cases – whether there is capacity to consent to ECT or not - patients must have the benefits and risks of ECT explained to them;
  - Any provision of ECT must be documented and reported to the Prescribed Psychiatric Treatment Panel in a comprehensive way, including justification for the treatment, the consent status of the patient, whether supported decision-making was involved, the risks or benefits for the particular patient, and any adverse side effects that were recorded as a result of ECT.
  - There should be increased oversight and transparency of ECT, particularly in documenting and investigating its long-term effects. Consumer's must be given the rights to provide feedback about the treatment, especially in cases of 'emergency' ECT. Counselling post-ECT should be offered to provide supports to the patient.
12. Amend the *MHA* so that if SAPOL are involved, individuals must have access to advocacy support, communication assistance, legal aid, or family/carer support. Police also need to be trained adequately in disability awareness training and mental health first aid training.
13. Amend the *MHA* to mandate a multidisciplinary treatment team at all points rather than the Chief Psychiatrist.

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