

PAVING THE WAY

REVIEW OF MENTAL HEALTH LEGISLATION IN SOUTH AUSTRALIA REPORT

April 2005



**Government
of South Australia**

Department of Health

**This Report was prepared by:
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on behalf of the
Review Committee on Mental Health Legislation
for the Mental Health Unit
Department of Health**

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PART I

MENTAL HEALTH AND GUARDIANSHIP

1. INTRODUCTION

This Report has been prepared for the Department of Health by the Review Committee on Mental Health Legislation with the following Terms of Reference:

To ensure that mental health and other relevant legislation in South Australia:

- **Affirms the rights, dignity and civil liberties of mental health consumers and their carers;**
- **Balances these rights with the community's legitimate expectations that it be protected from harm;**
- **Ensures that procedures facilitate care and treatment appropriately;**
- **Establishes clear principles, which enable mental health consumers to receive appropriate services in either hospitals or in the community;**
- **Provides a legislative framework for a modern mental health service system in South Australia.**

Of necessity, the Review will involve not only a focus on the Mental Health Act 1993, but also related legislation, which impacts on mental health consumers, including but not limited to:

- **Guardianship and Administration Act 1993;**
- **Criminal Law Consolidation Act 1935;**
- **Criminal Law (Sentencing) Act 1988.**

This Report follows on the Issues Paper prepared for the Committee both to identify issues needing attention and as a basis for consultation. It also follows reports focusing on detention procedures under the Mental Health Act 1993 by Peter Brennan in November 2000 and the Detention Review Working Party in July 2002.

Consultation has been extensive and has involved consumer and carer groups in both city and country, a public meeting and meetings with Aboriginal organisations, professional organisations and government agencies.

The assistance of those consulted or who have written to us is gratefully acknowledged. (See **Appendix I**).

It is more than 10 years since the mental health legislation has been comprehensively reviewed. In that same period (generally speaking), there have been significant initiatives:

- The United Nations (UN) Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health 1991;
- National Mental Health Statement of Rights and Responsibilities 1991;
- The National Mental Health Strategy 1992 calling amongst other things for modern consistent mental health legislation;
- The Human Rights and Equal Opportunity Commission (HREOC) Report of the National Inquiry into the Human Rights of People with Mental Illness, 1993 (the Burdekin Report);
- Model Mental Health Legislation 1994, reflecting the United Nations Principles and the recommendations of the HREOC Report;
- A Rights Analysis Instrument 1996 to indicate how mental health laws in Australia measure up in protecting consumers' rights;
- Legislative change in most other States, enacted or proposed, reflecting these developments.

Several broad themes have emerged from this Review:

- The rights of carers and consumers should be articulated more clearly in the legislation, as other States have recently done;
- Confidentiality should not be interpreted as a barrier to proper sharing of information in the best interests of consumers;
- The particular needs of Aboriginal people need to be recognised as a matter of principle;
- There must be an emphasis on community care, and not just hospital services;

- There should be more flexibility as to who can intervene to assist someone in need of care, or make initial orders for admission and detention;
- Greater flexibility with orders to suit the individual is needed (for example, short-term detention orders to avoid inappropriate transfer of consumers from the country to the city);
- The treatment plan as a pivotal requirement of involuntary orders;
- The Guardianship Board needs to be humanised from arrival at the door (eg through social work assistance, or consumer representation);
- A specialist appeal body should replace the Court to ensure appeals and procedural fairness arguments are considered in a therapeutic context.

A summary of recommendations appears at the end of Part I of this Report.

The consultation process revealed an expectation and momentum for change, and it is hoped that this Report can assist that to occur.

2. HISTORY OF CURRENT MENTAL HEALTH LEGISLATIVE FRAMEWORK

2.1 Mental Health Act and Guardianship Legislation

The beginning of modern mental health legislation in Australia can be traced back to the South Australian Mental Health Act 1977. Key features of the 1977 Act were the creation of a Guardianship Board and Mental Health Review Tribunal.

Decisions about guardianship and administration and long-term restrictions on a person's freedom or property (in most cases) became the province of a multi-disciplinary board, rather than a court or psychiatrist.

A second independent multi-disciplinary body, the Mental Health Review Tribunal, was established to review orders of the Guardianship Board and to hear appeals on decisions made by psychiatrists.

In 1985, amendments allowed for simpler procedures for consent to medical and dental procedures. Next of kin of mental health consumers (and persons with an intellectual disability) were empowered to consent to routine procedures, rather than having to go to the Guardianship Board.

In 1993, changes saw:

- The splitting of the Mental Health Act into separate mental health and guardianship legislation;
- The creation of a Public Advocate to be amongst other things a public guardian – a role previously handled by the Guardianship Board;
- The abolition of the Mental Health Review Tribunal;
- The Guardianship Board empowered to review and hear appeals on initial detention orders made by psychiatrists, in addition to its general jurisdiction;
- The establishment of an Administrative and Disciplinary Division (ADD) of the District Court to hear appeals from decisions of the Board including continuing detention orders (CDOs).

3. THE NEED FOR A MODERN PHILOSOPHICAL FRAMEWORK

3.1 Reflecting New Service Directions – Community Care

The current Mental Health Act has some laudable objectives, which include:

- ensuring that patients receive the best possible treatment and care;
- minimising restrictions and interference with rights, dignity and self-respect, consistent with protection of the patient and the public;
- working towards ameliorating the adverse effects of mental illness upon family life;
- rationalising and coordinating services;
- encouraging voluntary agencies;
- research;
- training;
- promoting informed public opinion.

The Guardianship and Administration Act states some significant principles to be observed in making decisions under this Act, including:

- the wishes of the person being sought and considered;
- the least restrictive alternative being preferred where possible.

However, the approach taken is minimalist when compared with the statements of objectives and principles included in the Model Mental Health Legislation, and which most States have adopted more fully.

In particular, the objectives of the Act say nothing specifically or directly about **new service directions** to keep people in the community, as close to home as possible.

This can be compared with the United Nations Resolution of the Principles for the Protection of Persons with Mental Illness, and the Improvement of Mental Health Care as well as Model Mental Health Legislation principles, and nearly all other jurisdictions, which more explicitly recognise the importance of **care in the community**:

- “As far as is possible, people with mental illness are to be treated in the community”;
- “The provision of treatment and care is to be designed to assist people with mental illness to as much as is possible live, work, and participate in the community”;
- “People with mental illness are wherever possible to be treated near their home or the home of relatives or friends”.¹

4.2 Consumer and Carer Rights

As discussed below in greater detail, there does need to be further clarity in the legislation as to consumer and carer rights. To quote the National Mental Health Plan, “*The rights of consumers and their families and carers must shape reform*”.²

The Act needs to acknowledge these rights as fundamental, and the importance of family and carers in the care and treatment of people with mental illness.

In Part II of this Report, we also emphasise the need for the Act to acknowledge that the rights of forensic patients should be as close as possible to those enjoyed by other patients.

¹ See Principle 4, Model Mental Health Legislation Report to AHMAC National Working Group on Mental Health Policy, The University of Newcastle, Centre for Health Law, Ethics and Policy, December 1994.

² National Mental Health Plan 2003-2008, Australian Health Ministers, July 2003, at p.10.

4.3 The Concept of Recovery

It was indicated to us in consultation that the Act should reflect the concept of recovery at least in its objectives. As the National Mental Health Plan puts it, “A recovery orientation should drive service delivery”.³

The concept of recovery acknowledges that having a mental illness does not necessarily mean life-long (or continued) deterioration. This is supported by research which confirms that even people severely affected by mental illness can and do recover. It is seen as involving hope and empowerment of the individual – a sense of self apart from the illness. Family involvement is important as is employment. The service provider is seen as facilitating the process of the individual’s journey of recovery rather than determining its direction.

4.4 Reflecting the Broad Directions of the National Mental Health Plan and the Generational Health Review

Many of the suggestions raised so far and in this Report reflect the directions of both these core documents. As a matter of general principle, the philosophical framework of the Mental Health Act should reflect these directions.

4.5 Service Standards

The Act is also silent on **service standards**. Several submissions have suggested that the Act should be about services and the standards and principles which services should follow, and not just compulsory orders. We agree with this. As in the disability sector, national standards, in particular the National Standards for Mental Health Services (NSMHS), are becoming crucial benchmarks for funding of mental health services.⁴

Whether the NSMHS should be prescribed under the Mental Health Act needs further consideration. We note that Section 66 of the South Australian Commission Act 1976 enables standards and conditions to be prescribed in relation to prescribed health services generally.

³ *ibid*, at p.11

⁴ National Standards for Mental Health Services 1996, endorsed by National Mental Health Working Group, Department of Health and Ageing, Canberra, 2601.

The Mental Health Act should at least refer to the need for mental health service providers to meet standards of care.

Recommendations:

3.1 Among other things, the philosophical framework of the Mental Health Act needs to:

- 3.1.1 Specifically recognise the importance of care in the community as close to home as possible, as well as hospital care.**
- 3.1.2 Acknowledge the rights of consumers and their carers as fundamental and the importance of family and carers in the care and treatment of people with a mental illness.**
- 3.1.3 Emphasise the concept of recovery as a goal of assisting consumers.**
- 3.1.4 Reflect the broad directions of the National Mental Health Plan and Health Reform emanating from the Generational Health Review.**
- 3.1.5 Provide for providers of mental health services to meet standards of care, such as the National Standards for Mental Health Services.**

4. CONSUMER RIGHTS

4.1 Articulating Rights

The South Australian legislation again is minimalist in articulating consumer rights. It was criticised for this when A Rights Analysis Instrument ⁵ was applied to all jurisdictions during 1998 – 1999.

Apart from the objectives and principles already mentioned, the South Australian Act provides for a statement of rights to be given to detained patients on initial admission. It also provides special provisions for the use of electro-convulsive therapy (ECT), and together with the guardianship legislation, provides procedures for compulsory orders and appeal mechanisms.

This brevity can be compared with the UN Principles for the Protection of and for the Improvement of Mental Health Care, the National Mental Health Statement of Rights and Responsibilities, the Model Mental Health Legislation, and statements in other Australian mental health legislation.

Most jurisdictions have felt it appropriate to be specific about rights or principles in relation to treatment and care, and not leave this purely to professional discretion. In an environment where consumers are highly vulnerable and dependent, this does seem appropriate. Certainly, consultation indicates an impatience amongst carers and consumers for a similar clarity here.

Areas where other States have gone further in articulating rights include:

- information on rights being given to all consumers in mental health facilities, not just detained patients, and persons subject to community treatment orders (CTOs);
- information in relation to medication, including side effects;
- the rights of voluntary patients in relation to their rights to leave;

⁵ Application of Rights Analysis Instrument for Use in Evaluating Mental Health Legislation, prepared by the Human Rights Branch, Attorney-General's Department, Canberra, for AHMAC National Mental Health Working Group, December 2000.

- treatment plans and discharge plans;
- disclosure of information to others;
- internal complaints procedures;
- involvement of carers in decision-making;
- treatment being culturally appropriate.

Perhaps the most comprehensive provisions are provided by the Northern Territory Mental Health and Related Services Act although some other States are similar.⁶

The Northern Territory Act contains detailed and fundamental principles, which apply to the provision of treatment and care, involuntary admission and treatment, and rights and conditions in approved treatment facilities among other things. These provisions are set out in **Appendix II** of this Report.

These principles are in turn supported by detailed specific requirements in relation to information to be provided to patients, information concerning medication, discharge plan requirements, and internal complaints procedures.

Even if that degree of prescription is not preferred, the Committee does support an expansion of fundamental principles for the South Australian Act. This issue is further developed in subsequent chapters.

4.6 Terminology

Several submissions have indicated a preference for the term “patient”, which appears frequently in the current legislation, being replaced by “consumer”, or “mental health consumer”. “Patient” is seen as outmoded terminology, which reflects hospital care, and not someone who may need different services from time to time. “Consumer” is also the term preferred by people in receipt of the services.

Another option preferred in submissions was “client”.

⁶ See for example, Mental Health Act 2000 (Qld).

Recommendations:

- 4.1 The Act should include an expanded statement of principles in relation to the provisions of treatment and care, involuntary admission and treatment, and rights of consumers in approved treatment facilities.**
- 4.2 The term “consumer” or “mental health consumer” should replace “patient” in the legislation.**

5. THE TREATMENT PLAN AS A PIVOTAL REQUIREMENT

Recent legislation elsewhere emphasises the treatment plan of a consumer as crucial to proper treatment and involvement of both hospital and community services as appropriate. It is also the cornerstone of compulsory orders for detention or community treatment. There is an emphasis on the plans being individualised and comprehensive and not just focusing on medication.

For example, the Victorian Act was amended in 2004 to require an authorised psychiatrist to prepare, regularly review and revise as required, a treatment plan for each involuntary patient. The plan needs to take into account the wishes of the patient, the wishes of carers involved in ongoing care or support (unless the patient objects), beneficial alternative treatments, and risks involved.

In the case of CTOs, it must also spell out who is to monitor the treatment, the case manager, and place and times of treatment.

In Queensland, there is a similar focus on a treatment plan as a priority before considering whether involuntary treatment should take place in a facility or in the community.⁷

Recommendation:

5.1 The South Australian Act should emphasise an individual and comprehensive treatment plan as crucial to continuity of treatment and services. It should also be the cornerstone of compulsory orders for detention or community treatment.

⁷ See s6A, Mental Health Act 1986 (Vic), and s124, Mental Health Act 2000 (Qld).

6. CARER RIGHTS

Carers and their organisations expressed a number of concerns about the lack of recognition of their role in supporting consumers, and the need for legislation to address this.

A particular concern was that while they were often expected to provide the major support for a family member, they were not necessarily included in discussions about treatment, or given the information they needed to provide the support (for example, information about medication side-effects).

The Carers' Ministerial Advisory Committee reflected views from their own forums, which were very similar to those expressed to us:

“Forum participants spoke of significant levels of distress dealing with mental health providers both on behalf of the person they are caring for and on their own behalf. They spoke of often feeling powerless, patronised, disregarded, marginalised, blamed, ignored and pathologised by service providers. Often carers were left to care for family members with a mental illness after they had left in-patient care, but were not provided with information critical in providing that support.”⁸

Confidentiality was often cited as a reason for this. That is certainly understandable if a consumer does not want the carer(s) involved, or if there are concerns about involving them, but as we discuss below, confidentiality should not be seen as a barrier as a norm.

We note with approval the approach taken by the Northern Territory legislation in including the following guiding principles:

- *“Principles relating to rights of carers*

When treatment and care is provided to a person the following principles apply:

- i. As far as practicable and appropriate, a carer of the person is to be provided with relevant information about the person's rights and entitlements under this Act, how those rights and entitlements may be accessed and exercised, the grounds for the person's admission, the*

⁸ Submission to Committee.

section under which the person was admitted, any proposed or alternative treatment and the services available to meet the person's needs;

- ii. As far as practicable, a carer of the person must be consulted and involved in the development of any ongoing treatment plan and any discharge planning for the person.”⁹*

We note that the Guardianship and Administration Act includes as a function of the Public Advocate “*to give support to and promote the interests of carers of mentally incapacitated persons*”.¹⁰

During consultation, we found that this provision was little, if at all, known by carers and their organisations. It is important that this be rectified, as the Public Advocate can play an important role in supporting carers through systems advocacy and the provision of information about requirements under the Guardianship and Administration and Mental Health legislation.

It needs to be clear that the role of the Public Advocate in relation to carers is to assist in a general way with information and systems rather than individual advocacy. The Public Advocate, in advocating for consumers under his guardianship, can be at odds with individual carers.

Both carers and consumers also need support through the processes of the Guardianship Board and this needs to be better resourced than at present.

Carers need and should have access to advocacy in their own right. During consultation the lack of advocacy services for carers was raised on several occasions.

The legislation also needs to recognise directly carers as able to consent to treatment on behalf of a consumer who cannot. At present, the Guardianship and Administration Act allows for relatives to be able to do so, and the definition includes people acting in loco parentis, but carers are not yet recognised in their own right.

⁹ See s12, Mental Health and Related Services Act (NT).

¹⁰ See s21, Guardianship and Administration Act 1993 (SA).

The Equal Opportunity Amendment Bill 2003 (introduced to cover mental illness as a ground for discrimination) usefully defined a carer as one whose responsibilities “were to provide care or support (other than on a commercial or voluntary basis) for another who is wholly or substantially dependent on the person for provision of that care or support and a member of the person’s family or household or a close acquaintance”.¹¹

Recommendations:

- 6.1 As indicated in 3.1, the philosophical framework of the Mental Health Act needs to recognise the importance of the role of family and friends who are carers.**
- 6.2 The Act should establish as a matter of principle a carer’s right to information and to be consulted in the development of treatment and discharge plans for a consumer, where practical and appropriate.**
- 6.3 The role of the Public Advocate in assisting the interests of carers should be made better known. It needs to be clear that it involves information and systems advocacy, rather than individual advocacy, to avoid conflicts of interest in assisting consumers under the guardianship of the Public Advocate.**
- 6.4 Carers should be recognised in their own right as able to consent to treatment on behalf of a consumer who cannot.**
- 6.5 The Act should include a definition of a carer.**
- 6.6 Any evaluation of advocacy needs in the mental health area must include advocacy for carers and families of people with a mental illness.**

¹¹ This Bill has now lapsed.

7. THE CONFIDENTIALITY BARRIER TO SHARING OF INFORMATION

This issue was raised on numerous occasions by carers and consumers, and professionals. It is one which has bedevilled the mental health system for years and needs to be addressed specifically by legislative change. More seriously, the Coroner has in the past identified that deaths may have been avoided by sharing information which was withheld because of unfounded fears about confidentiality duties.

It has always been the case that sharing of confidential information is perfectly proper in some situations.

The courts have over the years developed the common law to the point where disclosure of confidential information is permitted:

- to the client;
- to others with the consent of the client or guardian;
- where there is a legal requirement to disclose (for example, mandatory reporting of child abuse, or court order);
- in the public interest (for example, information to the police about a serious crime).

There is also an accepted practice of sharing information with other professionals or agencies where the basis may be seen as implied consent, or simply because it is in the best interests of the client.

It is likely that the courts would also recognise the duty of care to warn another person about serious or imminent dangers, which their client may present to that other person.

At common law, the remedies for breach of confidentiality are damages or an injunction to prevent further occurrences. The Court would have a discretion about an injunction and would have to be satisfied that there had been some loss (such as to reputation) worth compensating.

It is very difficult to see that the courts would ever be concerned about a disclosure, which is clearly in the interests of the client, and to which the client has no objection.

If there is doubt about information being given to carers, the National Privacy Principles (NPPs) have certainly clarified that in relation to non-government organisations (NGOs).¹²

Apart from reiterating and strengthening the common law, principle 2.4 of the NPPs expressly permits a health service to disclose health information to relatives and other carers responsible for an individual who is unable to consent properly, if the disclosure is necessary to provide appropriate care or treatment of the individual, or the disclosure is for compassionate reasons, and is not contrary to any wish expressed before the person became unwell.

With respect to the State Government, the Department of Health has developed a Code of Fair Information Practice, which is in exactly the same terms as principle 2.4 of the NPPs.¹³

A departmental document “Achieving the Balance” is being finalised to roll out the Code in the mental health area. The situation would therefore seem to be clear apart from two legislative interventions.

Section 34 of the Mental Health Act 1993 provides an offence for a person engaged in the administration of the Act to divulge any personal information relating to a person in respect of whom any proceedings or other action has been taken. This does not prevent statistical data or information being divulged if **authorised or required to do so by law or by his or her employer.**

Section 64 of the South Australian Health Commission Act 1976 is a provision in similar terms applying to employees of the Commission, an incorporated hospital or health centre.

¹² The National Privacy Principles in the Privacy Amendment (Privacy Sector) Act 2000.

¹³ Code of Fair Information Practice for the Department of Human Services, South Australia, 3rd October 2003.

These sections are seen by some as a barrier to disclosure, even if it is in the interests of clients to do so, and there is no objection. Section 34 is frequently quoted as a reason not to disclose. This is despite Crown Law advice that the objects of the Mental Health Act to provide the best possible treatment and care will allow disclosure in the interests of clients.

It is seen that there should be an authorisation under the sections to fill any gaps that are perceived to exist (for example in relation to informing carers).

The Committee considers that legislative amendment should also occur to spell out that information can be shared with the consent of a client, or to carers where it is in the best interests of the client or on compassionate grounds. Other States have similar provisions.

The legislation itself needs to be clear rather than depend on an administrative authorisation. Such a fundamental problem needs a fundamental solution.

Indeed, consideration should be given to the repeal of Section 34, given the barrier it presents to cultural change within mental health services. Any person involved in the administration of the Act who discloses when it is inappropriate to do so should face disciplinary action (including dismissal).

There is also a need for mental health staff to have accurate information about duties of care and confidentiality. There appears to be a lack of clarity, which should not be the case.

Recommendations:

- 7.1 Barriers to proper disclosure of information should be removed as a matter of urgency by legislative change.**
- 7.2 There should also be professional development of mental health staff on mental health law, and duties of care and confidentiality.**

8. COMMUNICATION AND EXCHANGE OF INFORMATION GENERALLY

This Report has already highlighted specific issues which relate to communication and exchange of information, the use of treatment plans as a crucial element of proper care - including involuntary treatment - and confidentiality as a barrier to proper sharing of information.

Critical incident investigations and coronial inquiries have highlighted the systemic nature of communication problems in the mental health area. We understand that many of these issues have been addressed through the Emergency Demand Management Policy and Procedures series that was developed by the Department in 2003 and implementation of the NSMHS at an operational level. That is not to say that issues do not remain.

Communication issues in various areas have been a theme in many submissions to the Committee.

The need for better electronic records and rapid exchange of information has been highlighted.

We provide further information indicating the extent and nature of communication issues in **Appendix III**.

On one information issue previous reports have suggested that, as a routine matter, the Guardianship Board should be notified of changes in status of patients being detained or otherwise restricted by the Act, such as revocation of trial leave. The Board is already notified of some orders so that it can perform its review function. The Board does need information consistent with that function.

However, as the Board itself has indicated the collection of data for analysis or monitoring of trends, or general research purposes, is not really a suitable role for the Board. That function would be better performed by the Department of Health, with the Board and others providing information (such as orders made under the Mental Health Act) to the Department of Health.

Recommendation:

- 8.1 The Guardianship Board and the Department of Health should clarify their respective roles in relation to the collection of data.**

9. ABORIGINAL CONSUMERS AND CARERS

The Committee undertook considerable consultation with Aboriginal organisations to understand the unique perspective of Aboriginal families experiencing mental illness.

Several issues stood out:

- Aboriginal culture has a different, broader concept of mental illness. In essence, health is seen not just as the well-being of the individual, but also involves the extended family, and indeed, the social, emotional, spiritual, and cultural well-being of the whole community. Kinship ties, responsibilities and obligations place a strong emphasis on sharing and mutual support. Dispossession and racism have had a profound effect on families. Drug and alcohol abuse, depression and other forms of mental illness have followed.¹⁴
- With this holistic multi-layered view of health and mental health, Aboriginal families find it difficult to relate to the specialisation and “silo” approach of different mainstream services.
- Traditional healers are commonly and increasingly used in conjunction with mainstream services.
- It is particularly distressing for Aboriginal consumers to be transported away from near where they live to the city. There is strong support for hospitals such as Whyalla and Port Augusta having the authority to hold Aboriginal consumers as long as possible if involuntary admission is needed.
- Hospitals themselves can be daunting places both for their physical environment, and cultural concerns about being places where people have died.

¹⁴ See for example, [Aboriginal Health – Everybody’s Business, Social and Emotional Well-Being](#), A South Australian Strategy for Aboriginal and Torres Strait Islander People 2005-2010, South Australian Aboriginal Health Partnership.

- There is acceptance that professionals other than medical practitioners should have power to admit and detain, but in the country, there can be concerns about retribution if an Aboriginal person from the same community makes this order.
- One particular concern is the control of money by the Public Trustee. Some families have difficulty in accessing funds, particularly because the Public Trustee no longer has local offices in country areas. Some have had difficulty tracking funds left by family members who have died without a will.
- There is a need for legislation, mainstream information and services to be culturally appropriate.
- Community education is vitally needed about mental health measures such as apprehension and conveyance and the power of the courts to refer people to the mental health system.
- The training of Aboriginal health workers regarding mental health is vitally needed.
- Documents such as the Statement of Appeal Rights should be in Aboriginal languages in common use in South Australia.
- Aboriginal people need support and advocacy from family when they are receiving care, particularly in the case of involuntary treatment.

A number of these issues are indeed relevant to all carers and consumers and acutely so in the case of Aboriginal carers and consumers.

One submission suggested that a Mental Health Act, which is sensitive to Aboriginal consumers and carers, would reflect the principle of reconciliation.

Again we note with approval, the Northern Territory Act in providing:

“When providing treatment and care to a person of Aboriginal background, the following principles apply:

- i. As far as possible, the person’s treatment and care is to be appropriate to and consistent with the person’s cultural beliefs, practices and mores, taking into account the views of the person’s family and community;*
- ii. The involuntary treatment is, where possible, to be provided in collaboration with an Aboriginal health worker.”*¹⁵

It was pointed out during consultation that processes at the service level need to be in place to make sure these principles are implemented in practice. Mental health workers need training on Aboriginal cultural beliefs and views of mental health, and indeed facilities need Aboriginal social and emotional well-being workers to provide appropriate treatment and care directly, where possible. Police also need cultural awareness training from indigenous trainers.

Recommendations:

- 9.1 The Mental Health Act should establish the principle that, as far as possible, treatment and care of a person of Aboriginal background must be culturally appropriate, and take into account the views of the person’s family and community.**
- 9.2 Documents such as the Statement of Appeal Rights should be in Aboriginal languages in common use in South Australia.**
- 9.3 Wherever possible, a person of Aboriginal background should have the support of family or friends when they are receiving care, particularly in the case of involuntary treatment.**
- 9.4 Empowering and resourcing country hospitals to hold consumers for short periods (see 17.4) will be of particular benefit to Aboriginal consumers.**

¹⁵ s11, Mental Health and Related Services Act (NT).

10. PEOPLE FROM DIFFERENT CULTURAL BACKGROUNDS

As with Aboriginal consumers and carers, people from different cultural backgrounds can have a number of issues in dealing with the mental health system:

- They may have difficulties in understanding explanations about treatment or decisions affecting their freedom;
- They may have a different perspective about what is mental illness, and prefer traditional treatment to a reliance on psychotropic drugs;
- Some may want family involvement, others may see mental illness as something to be kept from family.

Treatment and care needs to be culturally appropriate, and objectives and principles of the Act need to express this. Once again, the South Australian Act is currently silent on this. As one submission puts it, the Mental Health Act needs to be *“responsive, sensitive and culturally appropriate”*.

“Culture” needs to include religious and spiritual views as well.

Authorities like the Guardianship Board or psychiatrists, in making orders for involuntary treatment or admission which affect a person’s freedom, should be obliged to take into account any cultural factors which may be relevant to the determination.

Before making such orders they should also be obliged to use accredited interpreters, where possible, if the Board or psychiatrist is not sufficiently conversant with the language or mode of communication that the patient is most familiar with, uses and is likely to understand.

Mode of communication may include sign language or Braille. Other States have similar provisions.

The Acts already provide for a statement of rights on initial admission and on appeal, whenever possible, in the language with which the patient is most familiar.

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It was suggested in a submission to the Committee that this should be expanded as follows:

“Wherever possible, the statement should be in plain language and the language or mode of communication with which the patient is most familiar, uses and is likely to understand”.

It was put to us that familiarity does not necessarily mean understanding. Plain language (English) and translated versions of plain language will be generally helpful. Again, this amended provision will cover Braille users.

It was suggested that the Mental Health Unit should provide information about where to find psychiatrists with cultural expertise, and the Public Advocate should provide similar information in relation to suitable independent advocates.

Recommendations:

- 10.1 The Mental Health Act should set as a goal or principle that treatment and care is culturally appropriate.**
- 10.2 Authorities such as psychiatrists or the Guardianship Board in making involuntary orders should be obliged to take into account any cultural factors, which may be relevant to the determination.**
- 10.3 Authorities should be obliged to use accredited interpreters, where possible and necessary, before making such orders.**
- 10.4 The Acts should be amended to provide that statements of rights on admission and for appeals are, wherever possible, in plain language and the language or mode of communication with which the patient is most familiar, uses and is likely to understand.**
- 10.5 The Mental Health Unit should provide information about where to find psychiatrists with cultural expertise, and the Public Advocate should provide similar information in relation to suitable independent advocates.**

¹⁶ See ss 15 and 29, Mental Health Act 1993 (SA), and s55, Guardianship and Administration Act 1993 (SA).

11. THE SPECIAL NEEDS OF CHILDREN

11.1 Introduction

Several submissions spoke of the special needs and vulnerability of children both as people with mental health problems, or as people who may live with someone with a mental illness, whether a parent or sibling. The need for their wishes to be taken into account was also stressed.

In the first situation, a child with a mental illness may need mental health services, and come under the Mental Health Act.

In the second, they may be at risk. Risks may include abuse and neglect. If they are a carer, they may be at risk of social exclusion (including absence from school or community activities) because of the demands on them.

11.2 Children who are mentally ill

Both the Mental Health Act and the Guardianship and Administration Act are silent as to whether they apply to children. It has been assumed as a matter of interpretation that they do, and in practice, this does occur.

However, if possible, it should be made explicit that the Acts do apply to children. We note recent Crown Law advice that raises possible constitutional problems in clarifying that the Guardianship and Administration Act applies to children. This is because South Australia has referred powers relating to custody and guardianship of children to the Commonwealth. Assuming that can be overcome, the application of both Acts to children should be clarified. There should also be a principle, which establishes that in providing care to children, the special needs and vulnerability of children should be taken into account. Other States have similar but less detailed statements of principle.

The National Mental Health Statement of Rights and Responsibilities 1991 suggests that:

- children and adolescents admitted to a mental health facility or community programme have the right to be separated from adult patients and be provided with programmes suited to their developmental needs;

- they should also have available to them a person who will represent them and whose task it is to protect their rights.

Submissions indicate that children rarely seek review or appeal against involuntary orders. Certainly, advocates are particularly important to ensure children do exercise their legal rights.

Some additional external protection also seems important. We note that the Queensland Act requires the Mental Health Review Tribunal to review the detention of children on a regular basis.¹⁷ South Australia should have a similar provision.

The Act should also place priority on placement and treatment of minors in the community wherever possible.

11.3 Children at Risk because of the Mental Illness of Others

In some circumstances, this situation may involve the need for a risk assessment of a child under the Children's Protection Act 1993.

The risk to the child may also be an issue in determining whether the parent or sibling should be under a mental health order.

There will be a need for a close working relationship between mental health and child protection services.

We also note concern that parents who are mentally ill are not discriminated against arbitrarily. They may well be able to take care of their children, notwithstanding their illness, or be able to do so with some practical support. They may need their own advocates.

Where children are the carers, they certainly need support services and advocacy.

¹⁷ See s194, Mental Health Act 2000 (Qld).

11.4 Removal of Confidentiality Barriers

We note that the Layton Child Protection Review Report refers to the need for the removal of barriers that prevent the appropriate exchange of information about children, young people and families that are involved with the child protection system.¹⁸

Section 58 of the Children's Protection Act is in similar terms to Section 34 of the Mental Health Act.

We would agree with this change.

Recommendations:

- 11.1 If possible, it should be clarified that the Mental Health Act and the Guardianship and Administration Act apply to children. There should be a legislative principle clarifying that in providing care, the special needs and vulnerabilities of children should be taken into account.**
- 11.2 Wherever possible, children who are involved with mental health services, particularly as involuntary patients, should have support from family carers or advocates.**
- 11.3 The Guardianship Board should review the detention of children within 28 days of the first order, and every 3 months thereafter. The legislation should place priority on treatment and placement of the minors in the community wherever possible.**
- 11.4 Barriers to the appropriate exchange of information about children, young people and families that are involved with the child protection system should be removed.**

¹⁸ See Recommendation 27, Robyn A. Layton, Our Best Investment: A State Plan to Protect and Advance the Interests of Children, Child Protection Review, South Australia, 2003.

12. ADVANCED DIRECTIVES (ULYSSES AGREEMENTS) – TEMPORARY INCAPACITY

The term, Ulysses Agreement, has been used to cover various ways in which consumers can empower others to make treatment decisions for them when they are unwell, or initiate their treatment preferences directly (eg noting adverse drug reactions). Both the report on A Rights' Analysis Instrument for Use in evaluating Mental Health Legislation 1996¹⁹ and the Model Mental Health Legislation 1994²⁰ refer to consumers' wishes in this regard.

In the last decade or more, South Australia has been progressive in developing various mechanisms to empower people to indicate their wishes for future treatment including:

- the appointment of a medical agent under a medical power of attorney to make decisions about treatment during **both temporary and permanent incapacity**;
- advanced directives (anticipatory directions) effective when a person is in the terminal phase of a terminal illness or in a persistent vegetative state and incapable of making medical treatment decisions at the time;
- an enduring power of guardianship appointing an enduring guardian to make decisions relating to lifestyle and medical decisions when an individual becomes **permanently incapacitated**.

The one significant gap is that consumers are not empowered, by law, to express their wishes about particular treatment(s) and actions in *the event that they become temporarily incapacitated*, for example as a result of a mental illness.

¹⁹ At p. 11.

²⁰ At pp 10-14.

The Department of Health's Emergency Demand Management Policy and Procedure Series policy on Mental Health Emergency Management Best Practice for South Australia states that every consumer should have:

- a crisis management plan, and
- a relapse prevention plan.

The latter in particular appears to fulfil a similar function to a Ulysses agreement (advance directive) during temporary incapacity (see **proforma in Appendix IV**).

It would seem that Ulysses Agreements are being utilised in practice in metropolitan and country areas by some consumers and services in South Australia but their use is not widespread.

Consumers have strongly argued in discussions with the Committee for legislative recognition of this concept.

The Committee supports legal recognition by the planned Advanced Directives Act for advanced directives by consumers to cover the times when they are temporarily incapacitated.

Ulysses Agreements were also seen as a means by which wishes about the care of children can be expressed when a parent is unable to make rational decisions because of temporary mental illness.

Recommendation:

12.1 Advanced directives by consumers to cover the times when they are temporarily incapacitated should be given legal recognition by the planned Advanced Directives Act.

13. PRESCRIBED TREATMENTS

13.1 Electro-Convulsive Therapy

13.1.1 Introduction

Electro-convulsive therapy (ECT) is a prescribed Category B treatment under the Mental Health Act, which means special safeguards apply. They provide that ECT can be administered by a psychiatrist who has personally examined the person when the treatment is authorised or is part of a course of treatment that has been authorised and has been consented to in writing.

The written consent (in the presence of a witness) must be given by a patient capable of giving effective and informed consent **or** the guardian of a patient under 16 years of age **or**, for a person over 18 who is incapable of giving consent, either a medical agent or the Guardianship Board.

The only exception is if an episode of ECT treatment is urgently required for the protection of the patient or other persons and in circumstances where it is not practicable to obtain consent.

The consultation for the review of mental health legislation has revealed starkly different views about these provisions.

Professional and clinical stakeholders have questioned the need for ECT to have special safeguards. They have defended ECT as a safe and, at times, lifesaving procedure and have said that ECT's public image as a dangerous, unsafe treatment is regrettable. As one clinician put it, "*It is regrettable that it should be given special status in the consent process. This perpetuates rather than diminishes the status associated with its use*".²¹

On the other hand, stakeholders representative of consumer views have generally submitted that the safeguards regarding ECT should remain and indeed that there should be greater accountability in relation to authorising (involuntary) ECT.

²¹ Submission to Committee.

13.1.2 Discussion

A major concern for clinicians is having to frequently go to the Guardianship Board for authorisation.

As one submission put it, *"Currently a detained patient does not need to give consent for any medical or surgical treatment nor does the Guardianship Board need to be consulted. The exceptions are sterilisation, ECT or psycho-surgery. For example, it is quite possible to detain a patient and amputate their leg without their consent and without review by the Guardianship Board..."*

And another: *"As ECT is now imposed by the Board, any appeal must be made to the District Court. This is, in practice, a cruel imposition upon floridly ill patients. The fact that a clinical matter of some urgency is being dealt with in a highly legalistic setting is inappropriate and at times had led to some curious decisions, which have not, from a clinical viewpoint, been either justifiable or helpful to the patient."*

Crown Law has recently advised that in the absence of informed consent an initial and / or subsequent episode of emergency ECT may only be administered if, on each occasion, the pre-requisites can be satisfied ie:

- the mental illness is still present;
- the danger to the patient or others remains; and
- it is not practicable to obtain the consent of the Board.

In other words, an emergency is an emergency. However, the emergency clause does not allow ongoing treatment without Guardianship Board approval unless the emergency remains.

From consumers, there is a different perspective. One submission recommends legislative safeguards to regulate the frequency at which this treatment is administered, with specific boundaries established in relation to time between treatments *"because of disturbing evidence regarding the*

frequency with which this treatment is used. There have been occasions where 6-10 treatments are given within the space of 2-3 weeks". Increased involvement of family and carers during treatment is also urged.

Certainly, the Committee agrees with previous reviews, there must be certainty about what is authorised in relation to ECT. An authorisation should not be open-ended. We do think that a maximum number of 12 treatments and a maximum duration of 3 months should be prescribed for which an authorisation is valid. Forms should require psychiatrists to outline the clinical reasons why a course of ECT is necessary, the likely number of treatments and the proposed end date of treatment.

To change the special status of ECT (with the safeguard of the Board's approval in most cases) would need further discussion, in particular, a dialogue involving psychiatrists and consumer groups.

In all States except Victoria and Western Australia, external Board/Tribunal approval is required for ECT where the patient is involuntary or unable to consent (or no one else is authorised) and it is not an emergency. In Victoria, an authorised psychiatrist may order ECT if all reasonable efforts have been made to notify the guardian or primary carer before ECT, unless there is a valid reason not to notify them. In Western Australia, two psychiatrists may authorise ECT. If they cannot agree, the matter may be referred to the Board. This Board in Western Australia can refer the person to another psychiatrist but not substitute its decision.

It is worth noting that similar debates are occurring elsewhere. A New South Wales Health Discussion Paper notes that "*whilst ECT is controversial in the community, many clinicians see it as a useful and necessary form of treatment for some intractable conditions...with modern improved equipment, better monitoring and more sophisticated techniques and safety measures, ECT offers a safe, reasonable alternative to other therapies*".²²

²² Discussion Paper 2: The Mental Health Act 1990, July 2004, at p. 45.

The New South Wales paper seeks comments on whether current processes for ECT remain relevant and appropriate, or whether they should be changed.

In Western Australia, a 2003 report has recommended that there be no emergency exceptions.²³ In that State, this means two psychiatrists have to agree on all occasions. It does not make reference to the Board.

Another issue is whether **notification** of ECT use in an emergency should occur. This is required in the Northern Territory and Western Australia (at least at present).²⁴ If the present scheme is retained, it does seem logical to indicate the extent of the use of ECT as an emergency treatment.

Finally, it is notable that while a medical agent can consent to ECT, a guardian can only do so in relation to a child. A guardian appointed by the Guardianship Board should also be able to do so in relation to adults, as should a primary carer.

Also, this is something that a consumer, while well, should be able to indicate through an advanced directive.

These steps would lessen the need to go to the Guardianship Board. It is worth noting that South Australia has more options than most States for consent without going to the Board. The changes would increase these options.

Recommendations elsewhere in this Report would also see a more accessible appeal body than the District Court hearing appeals from the Guardianship Board.

13.2 Psychosurgery

Concern was expressed in submissions that ECT should need special safeguards placing it in a similar category to psychosurgery.

Psychosurgery is a Category A prescribed psychiatric treatment, which means that it can only be administered with the authorisation of the person

²³ Holman, CDJ, The Way Forward, Recommendations of the Review of the Mental Health Act 1996, Perth, Government of Western Australia, 2003.

²⁴ See s66, Mental Health and Related Services Act (NT) for examples.

who is to administer it, and by 2 psychiatrists (one of whom is a senior psychiatrist), each of whom has separately examined the patient.

The patient must also be capable of giving effective consent and must consent in writing. It was also suggested by some that, rather than have special safeguards, psychosurgery should simply be banned, given that it is not used in practice.

The Section has never been used in South Australia.

If it is decided to ban psychosurgery, care needs to be taken not to prohibit accepted neurosurgery for such purposes as control of epilepsy.

Recommendations:

13.1 Authorisation for ECT should specify the number of treatments and duration of time. A maximum number of 12 treatments and a maximum duration of 3 months should be prescribed for which an authorisation is valid.

13.2 Given the differing views between clinicians and consumers, there would need to be further dialogue involving both, before current safeguards in relation to ECT (in particular the involvement of the Guardianship Board) could be changed.

13.3 The emergency use of ECT should be notified.

13.4 The categories of people, who can consent to ECT on behalf of a consumer who cannot, should be extended to include a guardian appointed by the Guardianship Board, and a primary carer. A consumer should be able to indicate their wishes through an advanced directive. These steps would lessen the need to go to the Guardianship Board.

13.5 Consideration should be given as to whether psychosurgery should be banned, rather than have special safeguards.

14. CRITERIA FOR COMPULSORY INTERVENTION

14.1 The Definition of Mental Illness

Section 3 of the South Australian Mental Health Act defines mental illness as including: "*any illness or disorder of the mind*". This does mean that (depending on the risks and other criteria being satisfied) a person may be treated or detained on the basis of psychosis, or personality disorder. Psychosis may also be drug or alcohol induced, rather than an ongoing condition. Others may simply have behavioural problems, which do not readily fall within the definition.

The Model Mental Health Legislation suggests a distinction be drawn between mental illness and personality disorder so that detention for the former may be longer, while intervention for issues related to personality disorder is time-limited (eg 10 days).²⁵

It also lists a number of conditions such as promiscuity, religion, immoral or illegal conduct, intellectual disability, which are not by themselves considered to be mental illness.

The Committee received different views, but the majority opinion was that the present definition should remain.

We note the comments of one submission: "*The issue... will always be vexed. Both the community and the profession vary in their attitudes to the boundaries of psychiatry. It is tempting for the community at times to say that anyone who behaves in such and such a fashion must be 'crazy' and warrant enforced treatment, and it is similarly tempting for members of the profession to become overly rigid in defining what is and isn't disorder*".

A significant concern was that people in need of help might be excluded from assistance with too much definition.

We note that there has been continual concern about people being denied services on the basis of diagnosis over the years, and various committees addressing the problem of people falling between the gaps.

²⁵ See discussion on p. 60 thereof.

The Coroner was strongly critical of this occurring in the Strangways Case (2000), and urged a review of the services to persons with mental illness, with a view to:

- ceasing the denial of care to patients who need it on the basis of diagnosis;
- providing services to those with multiple diagnoses;
- providing mental health services to Aboriginal people.

We tend to the view that the definition of mental illness should not be over-prescriptive. The most significant issue is the need for intervention, wherever possible on a voluntary basis, and where some restriction is required, it is in the least restrictive form or alternative.

14.2 Health and Safety

Apart from mental illness, a crucial basis for compulsory orders such as detention or treatment orders, is that the person is unable to look after his/her own health and safety. Some doubts about what this means have been raised. Does it allow intervention not only at a point of crisis such as attempts at suicide, but also to prevent deterioration to that point?

The Victorian Act was amended in 1995 to deal with this issue. It provides for a person to be detained or ordered to have treatment *“for his or her own health and safety (whether to prevent a serious deterioration in the person’s physical or mental condition or otherwise) or for the protection of members of the public”*.²⁶

We support a clarification along these lines for South Australia. There is little point in waiting until someone is seriously unwell if some form of earlier intervention can assist. It is also consistent with the provisions of the Model Mental Health Legislation.²⁷

²⁶ See s8, Mental Health Act 1986 (Vic).

²⁷ See p. 56 thereof.

Another suggestion is that “health and safety” should be “health or safety”, so that it is clear that intervention can be on either basis. It can be argued that “health and safety” requires a higher level of risk before intervention. If there is the ability to intervene to prevent serious deterioration, this may be sufficient change.

We note that Brennan and others have suggested “*health and safety and protection of others*” should encompass “*concepts of financial security, social standing and risk to reputation*”.²⁸

The Detention Review Working Party Report also suggests new definitions of “*danger, safety, health and the protection of others*” should cover concepts of “*financial security, social standing and risk to reputation*”.

We do not agree with this. As the Law Society of South Australia puts it: “*It is difficult to envisage circumstances where it would be consistent with basic civil liberties to detain and treat a person against their will on the basis that their mental illness might cause risk to their social standing or reputation or the social standing and reputation of their family or others with whom they associate*”.

We also raise the question whether the criteria preferred by the UN Principles, the Model Mental Health Legislation and some States may be preferable to the South Australian concept of “health and safety”.

Principle 16 of the UN Principles states that involuntary detention should only be on the basis that, because of the illness, there is a serious likelihood of immediate or imminent harm to the person or others, or serious deterioration.

The concept of “imminent harm” does seem clearer than “health and safety”, which has been a phrase vexing those trying to work with it.

²⁸ Recommendation No. 5 of the Brennan Review, supported by the Detention Review Working Party 2002.

Apart from issues of criteria, one submission makes the point that a decision, which may restrict a person's freedom must rely on careful assessment of the individual (of personal history, what is best for the patient, specialist medical assessment) "*rather than generalist speculation of the worst case scenario*".

Recommendations:

14.1 The definition of mental illness in the Act should remain the same.

14.2 It should be clarified that a mentally ill person can be detained or ordered to have treatment where there is a serious likelihood of immediate or imminent harm to the person or others, or serious deterioration in the person's physical or mental condition.

15. APPREHENSION AND CONVEYANCE

Section 23 of the Mental Health Act sets out the powers of members of the police force and ambulance officers to apprehend and convey people with a mental illness to a hospital for examination or to an approved treatment centre (ATC).

This issue is the subject of separate examination with a Memorandum of Understanding (MOU) that has been developed between the Department of Health, South Australia Police (SAPOL), Royal Flying Doctor Service (RFDS) and the SA Ambulance Service (SAAS).

The use of police in conveying consumers to hospital is a vexed issue, and was the subject of much discussion during consultation. It can be traumatic for consumers and their families to have police involvement, particularly if they are in uniform or in a police car or wagon. The police are also concerned about this issue, for these reasons and because of resourcing concerns. Yet in practice they are frequently asked to play this role and indeed, particularly in country areas, are often the only option.

We note that Section 5 of the Act provides a general objective of ensuring minimal interference with the rights, dignity and self-respect of consumers, so far as is consistent with the proper protection and care of the patient themselves, and with the protection of the public.

We support the application of this principle in relation to the apprehension and conveyance of consumers by anyone and it should be reiterated in Section 23. We are pleased that it has been emphasised in the MOU.

The section does not provide for community mental health workers to convey consumers when that is appropriate (for example, low risk situations) nor does it expressly provide for such workers to request police or ambulance assistance.

While a member of the police can intervene if they have reasonable cause to believe it is necessary, strictly speaking, an ambulance officer is empowered only if summoned by a person exercising powers under the section.

The section ought to empower mental health workers, ambulance officers and police officers to convey people with a mental illness. Mental health workers and ambulance officers ought to be able to request police assistance when needed.

As with other jurisdictions, police involvement should be indicated as a last resort at least where that is practicable.

While others should be able to convey consumers , as a general rule, we think only police should be able to exercise police-type powers such as “break and enter”.

We would support explicit powers of restraint by SAAS officers or the RFDS to put beyond doubt any uncertainties in that regard.

We note also the need to be clear that staff including security staff at emergency departments can restrain a person where necessary before an order for admission and detention has been made. This would also assist police who are often delayed in emergency departments to provide security. Both the Ombudsman and the Crown Solicitor’s Office have indicated it would be preferable for the power to restrain to be included expressly in legislation.

As a final comment, Section 23 has been criticised as not being as specific or clear as some interstate models. We note for example the Western Australian Mental Health Act 1996, which has separate provisions for different situations. For example, police powers of apprehension or use of police for transport in different situations are spelt out. The Western Australian Act also specifically allows for an individual arrested for an offence to be taken for appropriate examination, including at an ATC. It is also specific about powers of search and seizure. It would seem to give clear guidance to those using the provisions. It is suggested that reference be made to the Western Australian provisions during drafting.

Recommendations:

- 15.1 Section 23 of the Act should reiterate the need to minimise interference with the rights, dignity and self-respect of consumers during apprehension and conveyance.**
- 15.2 Mental health workers, ambulance officers and police officers should all be empowered to convey people with a mental illness. Mental health workers and ambulance officers ought to be able to request police assistance when needed.**
- 15.3 Police involvement should be indicated as a last resort at least where that is practicable.**
- 15.4 Powers of restraint by ambulance officers, the Royal Flying Doctor Service (RFDS) and security staff at emergency departments should be explicit to remove any uncertainties about them.**

16. AUDIO-VISUAL CONFERENCING

The importance of audio-visual conferencing to ensure mental health consumers can be assessed expeditiously, particularly in remote areas, by psychiatrists or the Guardianship Board was emphasised during consultation.

It was acknowledged that such assessment was not necessarily as effective as face-to-face assessment. There can also be technical problems with equipment and quality can be a problem. Operators need to be competent. It is not yet readily available in some remote areas (for example through parts of the Anangu Pitjantjatjara Yankunytjatjara Lands (APY lands)). The person involved may need support.

However, audio-visual conferencing was seen as vital given the lack of psychiatrists in country areas, and the need for early assessment, particularly if it can avoid the trauma of a person having to be transferred to the city.

The Mental Health Act requires examination of a patient before orders can be made. This implies that assessment must be face to face. The Act needs amendment to clarify that audio-visual conferencing can be used as a basis for orders, as other States have done.

Section 46 of the Queensland Mental Health Act, for example, provides specifically that initial assessments to confirm whether involuntary treatment criteria apply to a patient may be carried out using audio-visual link facilities.

Similarly, Section 39 of the Northern Territory Mental Health and Related Services Act provides that a psychiatrist may confirm an initial order by examination conducted through the use of tele-conferencing or other forms of interactive audio-visual conferencing.

Recommendation:

16.1 The Act should clarify that audio-visual conferencing can be used as a basis for orders.

17. ADMISSION AND DETENTION

17.1 Who Can Admit and Detain?

In South Australia it is only a medical practitioner who can make an order for the immediate admission and detention of a person in an ATC.

It may mean that a General Practitioner (GP) who has little to do with the person has to be asked to make such an order.

It is notable that all other States and Territories, apart from Tasmania and South Australia, provide for a person other than a medical practitioner to make such an initial order.

For example, the provisions enable a nurse practitioner or a community team member to be authorised for the purpose.

This option was seen as particularly useful in the country where a medical practitioner may be some distance away.

There has been strong support for a similar change in South Australia.

We would envisage that such a person would be approved by the Minister (or delegate) based on the individual and the need for such appointment in a particular area. There could be some accreditation process if seen as necessary.

17.2 Criteria for Admission and Detention Order

The Coroner pointed out in consultation that Section 12 in relation to admission and detention requires that a medical practitioner is “satisfied” that the criteria for an order are fulfilled. He suggests that “*believes*” is preferable. Police and the Coroner have expressed frustration that people clearly in need of intervention are turned away because the doctor cannot be sure as to the diagnosis or need. We support this change, particularly given the short term nature of this first order. It might be qualified so that the belief is on reasonable grounds.

17.3 Revocation of Initial Admission and Detention Order

Once confirmed by a psychiatrist, there is no ability to revoke an initial order. This needs to be clarified. At the moment, trial leave is used as a means of releasing patients who no longer need care. It is inappropriate to use trial leave provisions in this way. As suggested by Brennan, this revocation could be done by the director of a facility.

17.4 The Country Dilemma

At present, the only option for detention is for a person to be transferred to an ATC. The dilemma for people living in rural and remote areas is that there are no ATCs in the country. During country consultations, carers, consumers, professional staff and Aboriginal families spoke of the trauma of dislocating consumers to the city via the RFDS with medication and restraint. The situation can then become farcical when the person is diagnosed not to be mentally ill, or recovers and is bussed back to their home within 1 or 2 days. The cost of all this, both personal and financial, is considerable.

Certainly, audio-visual conferencing should be able to reduce the need for inappropriate transfers.

As well, some hospitals have an improved capacity to deal with consumers who are mentally ill (notably Port Augusta and Whyalla). Patients are treated as voluntary patients. Anecdotally, it seems that this has reduced the level of unnecessary transfers.

However, there were consistent views expressed to the Review that there are consumers who do need some restriction for a few days in order to recover. They are not necessarily amenable to negotiation.

In practice, it seems that consumers are sometimes “encouraged” to stay under the threat of being detained and transferred or the police are asked to bring them back. It was felt that it would be much better if there were clear power to detain such consumers for a few days in facilities other than ATCs.

The Rural and Remote Mental Health Service at Glenside Campus expressed it this way in a submission to the Committee:

“The forced dislocation from community, informal and formal supports can create added difficulties for people recovering from mental illness. For the system to be consistent with the principle of least restrictive care, graded responses for assessment and treatment need to be developed. This would involve centres or facilities being approved as providing specific levels of clinical support. For example, a person who requires detention for assessment and treatment but who poses minimal risk to others may be appropriately managed in a regional hospital which has been accredited to provide this level of care. Such a system would also facilitate the expedient transfer of persons back to their region of origin for ongoing treatment post their admission to a metropolitan based facility.”

More specifically, we think it ought to be possible to detain a person for a period not exceeding 7 days to deal with a short term crisis in places approved for that purpose, other than ATCs. As with current arrangements, that order should be subject to confirmation by a psychiatrist as soon as practicable, using audio-visual conferencing if necessary. If a person still needs restriction after that period, or the risks increase, then they should be transferred to an ATC.

We realise that there are resourcing implications which need to be investigated, including suitably trained staff. Risk assessment will also be important.

But there must be savings both in human and financial terms if there is more flexibility in the system, particularly in relation to country clients.

It was suggested that even if a person could be held for a day or two in a hospital with limited resources that could be helpful.

Other suggestions have included managing clients in their homes for a short period before transfer is considered but under an involuntary order.

We also note that Broken Hill provides an example of a small unit which is gazetted in the same way as other ATCs. It opens and shuts according to need. It is run by a community team, with support from a psychiatrist either through audio-visual conferencing or fortnightly visits. A person can be detained there when needed or appropriate.

It appears like South Australia, New South Wales has no prescribed standards or criteria for ATCs which prevent other facilities being prescribed.

17.5 Making the Initial Order 7 rather than 3 days

One suggestion is that the initial order should be able to be confirmed generally for a period of up to 7 days rather than 3 days and not just to deal with the country dilemma. This was seen as allowing time for a person to recover from psychosis caused or exacerbated by amphetamine abuse, non-compliance with medication or an acute exacerbation of personality disorder. In other words, the order fits the actual pattern of many psychiatric crises. Seven day orders were seen as more practical and allowing the psychiatrist of the actual treating team to do the review, rather than someone on call on week-ends and public holidays, who may not necessarily know the patient.

Concerns about extending this period should be seen against the continuing shortage of mental health beds and the pressure to discharge patients in the shortest possible time to accommodate acutely ill patients waiting for a bed in emergency departments. Orders can be revoked at any time.

It is arguable that having a longer period for the first order will lessen the number of 21 day orders. It seems that these are often made because it is not clear whether the person is well enough after 3 days (some of which may have been spent in transit).

17.6 Further Detention by Psychiatrist Order

At present, it is possible for a person to be detained for 21 days by a psychiatrist, and then for a further 21 days, by 2 psychiatrists. Beyond that, only the Guardianship Board can make a long-term order. The history of the two 21 day orders is not based on any particular medical grounds.

Originally, the legislation provided for one 21 day order, but it was found that it was not always possible to get a Guardianship Board order quickly or not always clear whether it was going to be necessary. A second 21 day order was then added.

One option is for these 2 orders to be replaced by one which allows extension for up to 6 weeks. This was again seen as fitting in with the time courses of illnesses likely to warrant detention such as major depression, or episodes of major psychosis such as schizophrenia and the manic phase of bipolar mood disorder. It would be subject to revocation and appeal at any time.

Beyond that, any further orders should only be made by the Guardianship Board.

It must be said that consumers have generally expressed concerns about moving away from the current 21 + 21 day scheme, which encourages caution in consideration of extending detention. Its critics say it is bureaucratic and cumbersome, and not meaningful.

It is worth comparing South Australia with other States (see **Appendix V**).

While there is considerable variation, Victoria, Tasmania, Western Australia and Queensland provide for indefinite orders by psychiatrists, subject to review by a Tribunal, rather than a series of orders as in South Australia. In Victoria, the first review must take place within 8 weeks. Queensland, for example, has an involuntary treatment order concept, which allows for a treatment plan to be followed in either the community or in a facility.

If the second 21 day order is retained, another issue is whether it should be made by two psychiatrists as at present, or could be made by a psychiatrist and one other professional, such as a senior psychiatric registrar (given the lack of availability of psychiatrists).

However, we do agree that there needs to be simplification. There is no incentive to keep patients longer than is needed and indeed the pressure, given demand for beds, is otherwise.

Orders can be revoked at any time. Orders can be made for shorter periods than the maximum. Patients can appeal at any time.

This Report makes a number of suggestions to strengthen treatment plans and involve carers and consumers in those plans. We also argue that advocacy support should be strengthened for involuntary patients.

On balance, with these changes, we consider that the second order should be able to be made by a psychiatrist for a period not exceeding 42 days.

Thereafter, we agree that further orders should only be made by the Guardianship Board.

17.7 Expiry of Orders

It needs to be possible for orders to be made to expire at a certain time (such as 4.00pm) rather than at the end of the day, at midnight, as a matter of practical convenience for consumers and staff.

17.8 Transfer of Patients

Section 16 of the Act currently provides for the director of an ATC to authorise transfer of patients from one ATC to another, upon the certificate of a psychiatrist, where the other ATC is better equipped for the care and treatment of the patient.

Submissions and previous reviews have expressed the view that this power ought to be able to be exercised by the director without necessarily waiting for a psychiatrist to certify, in order to avoid unnecessary delays which are not in the interests of the consumer.

17.9 Terminology

It was submitted during consultation that the terminology “detained” or “detention” should be replaced by “involuntary” admission to reduce the stigmatising effect of the current label. As mentioned, we note that Victoria and Queensland use the term “involuntary treatment order” in relation to both hospital and community care.

We certainly support a move away from “detention” because it emphasises restriction alone, and not the treatment or care component. As one submission indicated, “*assessment and treatment [should] be the primary focus of the process and detention ... a secondary or associated consideration*”.

Recommendations:

17.1 An approved person other than a medical practitioner also ought to be able to make an order for admission and detention.

17.2 A person making the order should be required to “believe on reasonable grounds” rather than be “satisfied” that the criteria for the order are fulfilled.

17.3 An admission and detention order, once confirmed, should be able to be revoked.

17.4 It should be possible for a person to be detained under the initial order for up to 7 days rather than 3 days to allow time for recovery from a short-term crisis.

The Act should enable such initial detention to occur in places other than ATCs approved for that purpose, so that people from country areas can be saved the trauma of dislocation to ATCs in the city where possible. If a person still needs restriction after that period, or the risks increase, then they should be transferred to an ATC.

17.5 A psychiatrist should be able to make a further order for detention for a period not exceeding 42 days.

17.6 Any further long-term orders should only be made by the Guardianship Board.

17.7 Orders ought to be able to expire at a time during the day rather than at the end of the day (midnight).

17.8 The director of an ATC should be able to transfer patients from one ATC to another where the other ATC can better care and treat the patient, without needing to wait for a psychiatrist’s certificate.

17.9 The term “detention” should be replaced by language, which reflects treatment or care, as well as the involuntary provision of it.

18. COMMUNITY TREATMENT ORDERS

18.1 Introduction

Community treatment orders (CTOs) are a means of enabling people to live in the community but subject to some direction to ensure their health does not deteriorate. They offer a less restrictive alternative to admission and detention in an ATC.

At present, CTOs can only be made and revoked by the Guardianship Board.

A number of criticisms have been made about the South Australian provisions in relation to CTOs.

Some commentators have also raised issues about CTOs. As Mclvor argues, if a person is well enough to be in the community, then he or she may be well enough to make their own decisions regarding treatment. He asks who responds best to CTOs? Would improvement in assertive outreach services obviate the need for CTOs? Has the erosion of civil liberties been counter-balanced by improvement in service? He sees the need to audit their use.²⁹

Others have seen the need for CTOs to be integrated into best clinical practice, with the order being a means of maintaining an ongoing therapeutic alliance with the patient and his/her family, more than a policing tool. Treatment and care is based on a treatment plan which is reviewed regularly and revised as necessary. CTOs should be seen as part of the ongoing treatment plan, in which the patient participates.³⁰

18.2 The Preferred Choice over Detention

A number of submissions indicated that the Act should expressly state that a community treatment order should be preferred to detention where possible. CTOs are seen as the least restrictive option and less disruptive to a person's life.

²⁹ Ronan Mclvor, The Community Treatment Order: Clinical and Ethical Issues, Australian and New Zealand Journal of Psychiatry 1998, 32 : 223-228.

³⁰ Sol Jaworowski and Rumiana Guneva, Integrating Community Treatment Orders into Best Clinical Practice, Australian Psychiatry, Vol. 8, No. 1, March 2000.

The Act should also specifically refer to a **community** treatment order. It does not at present.

18.3 The Need for a Broader Focus

The South Australian provisions are seen as having a narrow focus on medication and medical treatment. Unlike other States (collectively at least), they do not, for example, provide for:

- a treatment plan to be prepared and regularly reviewed and revised as required;
- the wishes of the person and carers to be indicated;
- beneficial alternative treatments to be indicated;
- options such as counselling, training and education, therapeutic or rehabilitation programmes;
- treatment agencies or providers specified;
- where a person should reside if it is necessary for the treatment;
- goals for recovery.

As one submission stated; *“In this State, we need CTOs that are not just about medication and medical treatment, but the best possible treatment, eg have a plan for naming personal goals as a focus for the consumer and the family”*.

A broader based CTO could also be a way of meeting the particular needs of Aboriginal people, by requiring attendance at a health centre on Aboriginal lands for regular treatment, or to see a traditional healer, rather than a disruptive option like hospitalisation.

18.4 Accountability

Submissions were also critical of practices at times in obtaining and implementing CTOs. The person applying for the CTO has not always seen

the consumer. There is a lack of accountability at times in following up orders, particularly if the person moves. There is certainly a need for CTOs to be specific about who is responsible for monitoring and follow up. It was suggested that should often be a community team leader. It was also said that GPs tend to be consulted, rather than a community worker who is more directly involved with the case.

18.5 The Role of the Guardianship Board

We discuss the Board in more detail later in this Report, but the question arises as to what should be the role of the Board in relation to CTOs?

Several persons consulted felt that the Board should continue to make these orders, given they do place restrictions on consumers.

However, the majority of submissions or persons consulted who commented on this issue were of the view that the treating team or psychiatrist should make such orders subject to review by the Guardianship Board and rights of appeal.

This follows the approach taken in Victoria, Queensland, Western Australia and Tasmania. The Northern Territory allows for a 7 day community management order before the Tribunal makes an ongoing order. (See **Appendix VI**)

The submissions generally considered that local treating professionals should make the order because the Guardianship Board processes were traumatic, open to manipulation, or too slow and bureaucratic. The fact that CTOs are granted by the Board was seen as causing substantial delays in treatment of people in the community, and discharge from hospital. It was also seen as ironic that it was easier to detain someone than to keep him or her in the community. Having this power with professionals allows a choice as to treatment in the community, or in an acute facility, at a critical early stage.

In fairness to the Board as we discuss later, the Board has a difficult task in balancing procedural requirements imposed by legislation with the need for expedient hearings or decision-making.

It must also be said that at times there will be advantages in having an external body make these decisions rather than a treating professional, who may have to maintain an ongoing therapeutic relationship with a consumer.

Another alternative may be for greater use of the Board's power to make interim orders in urgent cases without the need for a hearing and other procedural requirements. At present, the Board can only make such orders for 7 days. There may be advantages in having such orders for a longer period such as 21 days to allow the CTO arrangement to settle into place before any formal Board hearing.

However, the question needs to be asked whether the Board's involvement at the beginning is always necessary.

This is particularly so if the Act spells out more protections for the consumer such as the need for a detailed treatment plan which indicates the wishes of the person or carers where possible.

The Board can then review the arrangement.

Various periods are specified for the first review in different States:

- ✦ Victoria – within 8 weeks
- ✦ Western Australia – within 8 weeks
- ✦ Tasmania – within 28 days
- ✦ Queensland – within 6 weeks

(See **Appendix VI** for these details).

We would suggest that the period in South Australia be 28 days.

If the power to make CTOs is given to treating professionals, they should also be able to revoke the order. This allows for a quick response when a person no longer needs such an order, or there is a need for the person to be in hospital.

There should be a safeguard against revoking orders simply to avoid review by the Guardianship Board.

Treating professionals could include a medical practitioner, a mental health practitioner or a psychiatrist.

Another option is to allow both the professional and the Board to make a CTO. In some complex situations, where the solution is not clear, it may be valuable to apply to the Board as an independent body to make the decision. It will also be useful for the Board to be able to make a CTO as part of an overall plan for a person, which includes management of the person's finances, guardianship and so on.

A similar range of people to those who can make a CTO should be able to apply to the Board for a CTO. Section 20 of the Mental Health Act empowers the Public Advocate, a medical practitioner, or a guardian, relative or medical agent of the person the subject of the application. This list also ought to include mental health practitioners, nurses and psychiatrists. The Guardianship Board stressed the need for nurses to be able to make such an application.

18.6 The Need for Services

A number of submissions made the point that CTOs can only be effective if there are adequate community services. This was particularly a concern in the country, where community services are lacking.

Recommendations:

- 18.1 The Act should indicate that a community treatment order is to be preferred to detention where possible.**
- 18.2 The Act should enable CTOs to spell out a detailed treatment plan with a range of options to assist the person, as well as the wishes of the consumer and carers where possible.**
- 18.3 CTOs need to be specific about who is responsible for monitoring and follow-up.**
- 18.4 The treating professional should be able to make a CTO, subject to review by the Guardianship Board within 28 days, and thereafter 6 monthly.**
- 18.5 The Guardianship Board should also continue to be empowered to make a CTO.**
- 18.6 Those who can apply to the Board for a CTO should include mental health practitioners, nurses and psychiatrists.**

19. GUARDIANSHIP BOARD

19.1 Introduction

The Guardianship Board is unique in Australian mental health law as a multi-disciplinary body which can make not only mental health orders, but also a range of guardianship and administration orders. At its best, it is a one-stop shop where various expertise can be brought to bear on major life decisions affecting a person who lacks capacity.

We make some suggestions in this Report which would affect its jurisdiction. At the conceptual level, it has much to praise. At an operational level, several people consulted found the Board most helpful but generally it drew criticism.

Criticisms include:

- *“Unnecessarily bureaucratic – there is a need for social workers”;*
- *“A lack of information given to the consumer and their family about the process”;*
- *“No publicly funded provision for legal representation (cf appeals)”;*
- *“Going before the Board is traumatic”;*
- *“System is too formal, a more accessible flexible consumer friendly, approach is needed”;*
- *“Families feel physically and emotionally unsafe to reveal violence of family member at hearings”;*
- *“The process is open to manipulation, input inaccuracies and is slow”;*
- *“There is a need for more consumer support at Guardianship Board procedures and automatic advocacy, free of charge”;*
- *“Applications often heard by one sitting member when the [Act] provides for a multi-disciplinary panel of members”;*

- *“There is a lack of preparation and contextual information to assist the application as there is an absence of social background reports”;*
- *“Reliance by the Board on the professional applicants’ information alone, regardless of whether it is factually correct or not. It is considered that the Board – because of the pressure and the time – tends to take the word of professionals”;*
- *“There is a view that the Board sides with anybody who is a professional and the family carers are looked down on and their views disregarded”.*

19.2 Procedural Fairness in the Board

It must be said that the Board has a difficult task balancing competing pressures. The Board often has a single member rather than multi-disciplinary hearings to reduce delays and work within its budget. Giving interested parties an opportunity to give evidence can also delay procedures. Having legal representation can protect a consumer but lead to formality.

It is also the case that the issues dealt with by the Board are themselves often traumatic and serious. They can involve a person’s personal freedom, or some loss of control over decisions affecting them. It is appropriate that there be some formality and process, and that in turn can be harrowing, particularly for people unfamiliar with what is involved.

The Board also has requirements under its Act, which affect how it must operate.

The Guardianship Act provides that the Board is not bound by the rules of evidence, and may inform itself on any matter in such manner as it thinks fit.

However, the 1993 Act has introduced formal traditional procedural fairness requirements as well. Section 46(6) of the Guardianship Act provides:

“The Board:

- (a) must give the applicant and the person to whom the proceedings relate a reasonable opportunity to call or give evidence, to examine or cross-examine witnesses and to make submissions to the Board; and*

(b) must give any other person:

- (i) to whom notice of the proceedings was given; or*
- (ii) who satisfies the Board that he or she has a proper interest in the matter, a reasonable opportunity to make submissions to the Board.”*

These rights can only be dispensed with in the case of urgent interim orders which last for up to 7 days.

The Act also establishes a person’s entitlement to be represented by counsel, or by the Public Advocate, or a recognised advocate.

The Board can direct a particular person not be present in the room while the proceedings are being heard. But this does not include the person to whom the proceedings relate and his or her representative.

These provisions assume a formal and traditional approach to procedural fairness. They also do not allow for the Board to hear from a family member without the consumer being present. The end result of this can be damaging for both in the long term. On the face of it, they do not allow a person to be detained when they are so ill that they cannot cross-examine a witness, or instruct a representative to do so. Presumably, common sense will generally prevail in such cases, but these provisions do emphasise a legalistic rather than therapeutic approach. They also invite appeals to the Court on procedural fairness arguments, rather than core issues about what is best for the consumer.

One suggestion made by the Chairman of the Guardianship Board is the formulation of principles of procedural fairness within the therapeutic context of the Board. These could be guidelines developed by the Board, and modifying the current provisions of the Act.

One obvious principle is giving the person concerned the opportunity to have his/her say wherever possible, even if represented. As some commentators have put it, *“Patients experience procedural fairness when they feel they are able to express their views (‘voice’) and that these views are seriously considered (‘validation’).”*³¹ Another is to reaffirm that the Board can make its own inquiries, rather than wait for evidence to be presented to it.

Another is that the Board must ensure that its hearings are conducted in a manner, which emphasises what is best for the person from a therapeutic point of view.

19.3 Humanising the Guardianship Board

In many respects, complaints about the Board indicate a need for personal support for those involved in Guardianship Board hearings.

This used to be the case and it was intended that it still be the case. Prior to 1993, the Board was both a guardian and tribunal. It employed a number of social workers to investigate applications to the Board, support those involved when they came to Board hearings and maintain some involvement with consumers while they were subject to Board orders.

In 1993, the “guardian” role of the Board was given to the Public Advocate. It was intended that these functions would, generally speaking be carried out by the Public Advocate, but resourcing has made this difficult.

There does seem to be a need for a “friendly face” at the door of the Board – ideally someone with social work experience, who is provided by the Public Advocate to provide support for people coming to the Board.

The Board is also missing a capacity for information to be gathered by social workers. This in turn places a load on others to provide reports or attend hearings, including GPs, who are concerned that they receive no payment for this assistance.

³¹ Brian G. McKenna, Alexander I.F. Simpson, John H. Coverdale, What is the Role of Procedural Fairness in Civil Commitment, Australian and New Zealand Journal of Psychiatry 2000, 34 : 671 – 676.

We note also that while the provisions of legal aid through private solicitors at appeal level is commendable, there is no such arrangement for legal aid before Board hearings.

There is a need to explore the possibility of a duty solicitor provided by the Legal Services Commission being on call to assist.

It is also worth noting community legal centre initiatives in New South Wales and Victoria where legal assistance in mental health matters can be provided. In South Australia, assistance on disability discrimination issues is already provided by Central Community Legal Centre and one can envisage a similar role in relation to guardianship and mental health matters.

Section 14 of the Guardianship and Administration Act also assumes that an advocate recognised in writing by the Board as qualified to act as an advocate in proceedings before the Board can do so. This provision has never been implemented. It should be.

19.4 Amendments to assist Board Operations

There are a number of specific operational changes which should be made:

19.4.1 Two Member Boards

While the Board can sit with 3 members, or one, it is not clear that it can sit with 2. Yet 2 provide the opportunity to have both a community and professional member which can ensure a balance of views, as well as some resourcing savings.

19.4.2 The Option of a Single Member for Simple Guardianship and Administration Hearings

Guardianship or administration applications can be quite straightforward at times (for example, to assist a person with Alzheimer's disease where there is no family conflict). Yet, at present a full Board is necessary. It ought to be possible for a single member to hear such matters. The Registrar could be guided by internal criteria to decide when this should occur, and a full Board hearing could be possible if matters turn out to be more complex or contentious than first thought.

19.4.3 Registrar's Powers

It has also been suggested that the regulations under the two Acts be reviewed to see if there are straightforward matters which the Registrar can deal with or complete.

19.4.4 Single Professional Member

At present, it is not clear that a single member Board can be constituted by a professional member who is not a psychiatrist (eg psychologist, social worker). Yet a community member can sit alone.

There will be many circumstances where it is desirable to have a psychiatrist sitting, but this will not always be the case. A psychologist for example will be more appropriate in the case of people with an intellectual disability.

19.4.5 Extending Terms of Board Members

At present, Board members can only be appointed for two consecutive terms. This is seen as depriving the Board of useful and experienced membership.

19.4.6 Interim Orders

It is not widely known that the Board can make interim orders for up to 7 days, without a formal hearing. This is a short period in which to give notice of a hearing, organise Board members and for consumers to organise legal representation. The Board suggests that this period could be up to 21 days.

This is a way in which urgent orders can be obtained, such as CTOs, without initially having to go to a Board hearing. Elsewhere in this Report, we have raised the possibility of CTOs being made either by a professional, subject to review by the Board, or by way of an interim order by the Board, and then a longer term order.

Whichever way that debate goes, it is arguable that interim orders should have a longer period of operation where necessary, both to meet an emergency and allow time for proper consideration by the Board.

19.5 Amendment to Assist Operations of Public Advocate

While the Public Advocate must investigate the affairs of a person subject to an application if so directed by the Board, the Public Advocate has no general power of investigation or powers to obtain documents or answers in relation to services provided to people with mental incapacity. Yet the Public Advocate is asked to investigate serious matters such as physical and sexual abuse, and cannot always get answers for example from the police, because the police have no obligation to provide information. The Public Advocate does need powers of investigation like similar statutory authorities.

Recommendations:

- 19.1 The Guardianship Board should be able to formulate its own principles of procedural fairness to ensure the therapeutic context is taken into account.**
- 19.2 A number of steps need to be taken to humanise the Guardianship Board, including a social worker provided by the Public Advocate to provide support for people coming to the Board.**
- 19.3 The recognition of advocates needs to occur as contemplated already by the Act.**
- 19.4 Increased legal assistance also needs to be looked at including the possibility of a duty solicitor provided by Legal Services, being on call to assist, and community legal centres playing a role.**
- 19.5 There are a number of changes which should be made to assist the operations of the Board:**
 - 19.5.1 Two member Boards should be possible.**
 - 19.5.2 A single member should be able to hear simple guardianship and administration hearings.**
 - 19.5.3 The regulations under the Mental Health and Guardianship Acts should be removed to see what matters the Registrar can deal with.**
 - 19.5.4 It should be possible to have a single professional member hearing a matter other than a psychiatrist.**
 - 19.5.5 Board members should be able to be appointed beyond 2 terms.**
 - 19.5.6 The Board should be able to make interim orders for up to 21 days (rather than 7).**
- 19.6 The Public Advocate should have a general power of investigation and to obtain documents and answers while assisting persons with mental incapacity.**

20. THE APPEAL PROCESS

20.1 Introduction

As mentioned, the Guardianship Board hears appeals on decisions made by psychiatrists, (as well as making CDOs or CTOs, and Guardianship and Administration orders) while appeals lie from the Board's orders to the Administrative and Disciplinary Division (ADD) of the District Court.

In 1993, this appeal system replaced the previous Mental Health Review Tribunal, which was a specialist body to hear appeals and review decisions of psychiatrists and the Guardianship Board.

The Mental Health Review Tribunal heard appeals de novo (afresh). The ADD hears appeals based on transcripts, submissions and reasons given by the Board. The emphasis is therefore on the original decision rather than what is best for the person at the time of appeal.

The Tribunal had the same person as chair. The ADD is led by the judge who is rotating through cases on the short notice list (which includes mental health appeals but not exclusively). Each month the particular judge changes.

The ADD hears some 160 appeals per year in the mental health/guardianship area (approximately 65% relate to mental health orders, and 5-8% relate to both mental health and guardianship. These numbers are similar to the past 4 years). In other States, the appeals heard at a court level are a handful each year.

The difference would seem to be due to the following:

- In other States, a specialist tribunal takes care of most appeals before they get to court. They also review cases, which reduces the number of appeals.
- The Guardianship Board has detailed procedural fairness requirements to meet. It is difficult always to meet them. A court not operating in a therapeutic environment will be likely to allow appeals on these grounds, and this encourages appeals.

- The Board is not necessarily providing consumers with a sense that they have a chance to have their say.
- The Board often has to use single member hearings because of resourcing issues. Competence will vary, and appeals can follow.
- There is a panel of private legal practitioners paid prescribed fees (albeit modest) by the Mental Health Unit of the Department of Health, who have developed expertise in handling these appeals.

The demise of the Mental Health Review Tribunal in 1993 appears to owe much to a philosophical view that appeal issues should be matters for a court with its judicial independence rather than an administrative body.

20.2 Criticisms of the Present System

It must be said that submissions and consultations reflect overwhelming support for moving away from the Court and a return to a specialist appeal body, which understands the therapeutic context in which it is operating. This view was expressed across the board as well – by consumers, carers, courts, barristers with experience in the area, the Law Society, service providers (both government and non-government), the Ombudsman, individual psychiatrists (including one who is a member of the ADD).

Comments included:

- *“The present appeal system is too formal and too cumbersome”.*
- *“A more accessible, flexible and informal consumer friendly approach would be preferable”.*
- *“The District Court is the wrong venue”.*
- *“It is too daunting and judges hate the area”.*
- *“Judges are not really suited to the general mental health area”.*

- *“The court system is cumbersome, bogged down in legalistic ideas and must be horrendously expensive. The judges hearing cases rotate after short periods of time. Many have no interest or knowledge of mental health matters. Whilst they do therefore use the assessors to provide them with clinical input, it still means the outcome is a judicial one. In my experience of sitting on the District Court for the last 4 years, I do not believe that this process is efficient, nor in the patient’s best interests. The only good thing about it is that patients have the right to be represented by a lawyer at no cost to them, something they cannot do when appealing to the Guardianship Board”.*
- *“... the present appeal system is a legal response to a treatment need. We believe that judging the appropriateness of an appeal purely on the basis of the adherence to administrative requirements as per the Act, leaves open the possibility that an appeal can be upheld and the person may be released into the community at a time when they are of extreme risk to themselves or others... We have heard instances of an appeal being upheld to an administrative error and the person released at a time of deep psychosis and resulting in self-harm”. [it is understood the error was a slightly incorrect naming of the ATC in a detention order]”.*
- *“[There is] support for a specialist appeal body rather than a court process ... understanding mental health issues and therapeutic principles ... with least bureaucratic processes to function”.*

Another criticism made of the Court is that Section 42 of the District Court Act requires the Court to have urgent reasons to change orders (yet it does not seem to give this much credence).

20.3 Discussion

In fairness, it must be said the Court has given useful guidance at times in its deliberations. As well, while it is generally criticised for being too inflexible regarding procedural fairness arguments, a judgment by Judge Clayton in relation to PJM on 3 September 2004, acknowledges that the Guardianship Board (from which appeals may come) does operate in a different context:

“Because of the nature of its function and the illnesses from which the persons who come before the Guardianship Board may suffer, the Board is required to carry out a very difficult task. The applications which go before the Board and the orders which it is required to make, involve very practical considerations. It would be inappropriate to require the same rigid adherence to formal procedures and strict compliance with the rules of natural justice that may be appropriate in other circumstances.”

This kind of recognition or awareness of the special issues of mental health would be further enhanced if judges sat longer in this area. One suggestion made is that *“selected judges with interest in the area should be chosen to sit in the jurisdiction on a semi-permanent basis, thereby developing expertise and a consistent body of jurisprudence. Such judges with the assistance of other members of the ADD and other interested parties could develop appropriate pre-trial procedures to make the process more amenable”*.

This does however run counter to the views of the Chief Judge of the District Court, who sees judges as having judicial expertise to be used in whatever matter comes before them. It may also still be an environment, which is more formal and daunting than needs to be the case.

Another suggestion was that the appeal body could be either a specially constituted Magistrates Court (a Magistrate and 2 Assessors), or a specially constituted tribunal.

The Chief Judge expressed the view that a specialist mental health appeal body should be chaired by neither a judge nor a magistrate, but by a lawyer with expertise in the mental health area.

It has to be said that the call is strong for a specialist tribunal. The crucial issue is to ensure that the appeal body operates in a way which achieves a balance between legal rights and therapeutic need, and is not so formal as to intimidate consumers, carers and service providers from having their say.

Freckleton in Mental Health Review Tribunal - A Therapeutic Jurisprudence Lens concludes that the challenge is to combine legal rigour with informality, humanity and therapeutic awareness so as to ensure that the patient's condition is not worsened by their experience of appearing before a tribunal.

In his view, decision-making demands qualities additional to those exhibited traditionally by incumbents of the judicial benches. There needs to be a *“creativity and flexibility about processes, and a commitment to making hearings a pro-therapeutic as well as a legally rigorous environment”*.³²

The appeal body should focus on the needs of the consumer at the time of the appeal, rather than procedural deficiencies of the initial decision. This means the hearing should be de novo (afresh), and should be conducted in an inquisitorial manner.

We would see it as an opportunity to bring together appeals against orders from psychiatrists, currently heard by the Guardianship Board, and appeals now heard by the Court from Guardianship Board decisions.

This would end the hybrid nature of the Board, leaving it to make original decisions, rather than also handle appeals.

From a resourcing point of view, that is not to say that some persons could not sit on both the Board and the Appeal Tribunal, as long as they had not been involved in hearing the same matter.

A number of submissions suggest that the Appeal Tribunal need not necessarily have a review function. They suggest that it could remain a role of the Guardianship Board to review its own decisions. The Board in particular reviews its decisions on application from interested people, especially when the circumstances of the person have changed. We agree with this role being retained by the Board.

It should be possible for the Appeal Tribunal to refer questions of law to the Supreme Court for consideration when necessary.

³² Psychiatry, Psychology and the Law, Vol. 10, Issue 1, August 2003.

The Appeal Tribunal should have a name, which reflects the fact that it will hear appeals involving, not only people with mental illness, but also people with brain injury or intellectual disability. The “Mental Capacity Tribunal” may be a suitable name.

It will be important for the Tribunal to hear matters expeditiously.

Current delays in appeals against detention to the Guardianship Board can mean that a person may have spent the majority of the days for which the order is made in detention before an appeal is heard. One suggestion made by the Law Society is that appeals against detention orders must be heard within a set number of working days. The Law Society suggests 3 days.

20.4 Treatment pending Appeal

It was submitted by some, including the Law Society that while an appeal against a detention or a treatment order is pending, treatment should not be given, without the consent of the patient. This does raise a number of issues including the civil liberties of the person.

If the person is treated against their will while an appeal is pending, and that appeal is ultimately successful, the victory may be somewhat futile.

On the other hand, there may be serious questions about the capacity of the person, and there may be risks of deterioration of the person, if they are not treated while an appeal is pending. There may be delays in hearing the appeal.

Recommendations:

- 20.1 A specialist Appeal Tribunal should be established to hear appeals currently heard by the Guardianship Board, and by the ADD of the District Court. It could be called the “Mental Capacity Tribunal”.**
- 20.2 Appeals should be heard de novo (afresh).**
- 20.3 The Guardianship Board should continue to be able to review its own decisions.**
- 20.4 The Tribunal should be able to refer questions of law to the Supreme Court for consideration when necessary.**
- 20.5 In relation to both the Guardianship Board and the Appeal Tribunal, there needs to be a legislative provision which encourages recognition of the therapeutic context in which both bodies are operating.**
- 20.6 To reduce appeals on minor administration errors, there should be a provision in the Act clarifying that substantial compliance with forms is sufficient if the intention is reasonably clear.**
- 20.7 Further consideration should be given to the implications of treatment not being given pending an appeal being heard against involuntary treatment or detention. Consideration should also be given to whether a requirement for a set number of working days be set in which appeals must be heard.**

21. ADVOCACY AND COMMUNITY VISITORS

21.1 Advocacy

In this Report we refer to advocacy on a number of occasions and particularly in the context of the Guardianship Board.

We have identified the need for advocates to be recognised for the purposes of Board hearings as the Act already contemplates. We also have noted the need for increased legal assistance for consumers before the Board, and for social work support for consumers and carers coming to the Board.

There is also a need for the Public Advocate's role in supporting carers through systems advocacy and the provision of information about legislative requirements to be better known.

We have noted that children have particular need for advocacy support when involved in mental health services.

The submissions and consultation also identified other needs:

- independent advocates to follow a consumer through the system, and particularly when detained;
- the particular need of Aboriginal people to navigate the system;
- the need for carers and families to have individual support and advocacy.

The Rights Analysis Instrument recommends that every person admitted to a mental health facility or community programme must have available to them a person who will represent them and whose task it is to advise and protect their rights as long as that person wishes to have such representation.

The NSMHS require that independent advocacy services and support persons must be actively promoted by the mental health service and consumers are made aware of their right to have an independent advocate or support person with them at any time during their involvement with the service.³³

³³ See Standard 1.6 – Rights.

Some submissions call for the Act to enshrine independent advocacy for consumers.

We note that the Queensland Mental Health Act 2000 makes provision for nominated allied persons to help an involuntary patient represent his/her views, wishes and interests relating to assessment, detention and treatment. Allied persons can be a relative, friend, carer or guardian. If the patient does not have capacity to choose someone, the administration must choose an allied person (who is not an employee).

One submission makes the point that any increased use of advocacy needs to be carefully considered with regard to the availability of appropriately skilled advocacy services, specific funding, skills set and experience, the role of the primary caregiver and their access to advocacy services, and the role of the treating agency in ensuring advocacy is provided.

It certainly does seem the case that there are limited advocacy supports in South Australia at present for people with a mental illness.

At a government level, the Public Advocate has a general role to promote the rights and interests of people with reduced mental capacity, and where appropriate, their carers. As a guardian of last resort, the Public Advocate advocates for the person who is protected. The Public Advocate also has an important information role.

The State Ombudsman can investigate complaints about government agencies.

The new Health and Community Services Complaints Commissioner will have a broader role to investigate complaints in the public and private sector services.

In terms of independent individual advocacy there are several advocacy bodies, but they have limited resources to provide assistance in the mental health area.

There does seem a need to evaluate further how the advocacy needs identified in this Report can be met.

The Queensland provision is a means of establishing the right of a patient to be supported by a suitable person or advocate at crucial times, and should be followed here.

21.2 Community Visitors

All States, apart from South Australia, have community visitor schemes to provide external monitoring of mental health and disability services. While the Health and Community Services Complaints Commissioner (recently established by legislation but not yet in operation) will be able to investigate complaints, community visitor schemes offer the opportunity for ongoing checking of what is happening on the ground.

The Victorian Mental Health Act 1986 for example empowers community visitors to inquire into:

- the adequacy of services for assessment and treatment;
- facilities;
- opportunities for recreation, training, etc;
- the best possible care in the least possible restrictive environment;
- complaints made by consumers to a community visitor.

The scheme in Victoria is administered by the Public Advocate.

A similar scheme of official visitors in New South Wales is administered by the New South Wales Ombudsman (Community Services Division).

Similar schemes for South Australia have been suggested in the past and have been endorsed in submissions to the Committee.

An inter-departmental committee administered by the Mental Health Unit of the Department of Health is investigating the concept at the present time in relation to people with a mental illness, or intellectual disability.

One obvious issue in a small State like South Australia is whether people involved in such schemes could play other roles, such as advocacy, or assistance to consumers coming before the Guardianship Board. Another is whether the visitors should be looking at standards of care, or be more focused on a personal supportive relationship with individual consumers. We support any such scheme being housed with the Public Advocate to emphasise advocacy and synergy with other advocacy roles.

Recommendations:

- 21.1 The Act should provide for an involuntary patient to be supported by a relative, friend, carer, guardian or advocate during assessment, detention, treatment where possible.**
- 21.2 There is a need to evaluate further how the advocacy needs identified in this report can be met. It should involve advocacy agencies and the Commonwealth as a principal funder.**
- 21.3 The Committee supports work being done to establish a community visitor scheme in the mental health area.**

22. DISCRIMINATION ON BASIS OF MENTAL ILLNESS

It is notable that while mental health consumers are protected from discrimination in other jurisdictions, South Australia has not yet legislated for this.

The former government had introduced a Bill to amend the Equal Opportunity Act in a number of areas, including clarifying that mental illness is covered by the Act. The Bill was debated in the Legislative Council but debate was not completed and lapsed on the calling of the election.

Subsequently, further work has been done to develop new proposals for change, which again aim to ensure that mental illness is covered.

Submissions to the Committee strongly support such a change. South Australia is the only State yet to legislate in this way. It is an important step in shifting attitudes towards mental illness.

Recommendation:

22.1 The Equal Opportunity Act should be amended to ensure persons with mental illness are protected from discrimination in South Australia.

23. CROSS-BORDER RECOGNITION OF ORDERS

Most States have moved to legislate to facilitate cross-border recognition of orders made in relation to mental health consumers. South Australia has yet to do so although work on this is proceeding.

The South Australian Act provides for the Governor to make regulations “*in relation to the transfer of persons who are, as a result of mental illness, subject to orders for detention or treatment or who have been apprehended on suspicion of being mentally ill*”.³⁴

Some concern was expressed during consultation as to whether this power was adequate to implement the scheme. It was also suggested that any new provisions should echo those in other States to optimise interaction between the States.

We note that the Australian Health Ministers Conference agreed in 1996 to principles for cross-border issues in mental health.³⁵

Issues to be covered include:

- the absconding patient where emergency apprehension may be necessary;
- planned transfers (relocation);
- planned treatment in another State;
- transfer of forensic patients.

CTOs as well as detention orders need to be taken into account.

Recommendation:

23.1 The Mental Health Act should be amended to facilitate cross-border recognition of orders made in relation to mental health consumers.

³⁴ See s37, Mental Health Act 1993 (SA).

³⁵ Australian Health Ministers' Conference, 2002

24. MISCELLANEOUS

24.1 Regulations and Forms

The regulations and forms under the Mental Health Act and Guardianship and Administration Act need to be revised in the light of issues previously identified and this review. Work on this has commenced. Issues include:

- **Incorrect completion of forms in relation to gazetted names of ATCs**

The Act or the regulations need to be amended to ensure that a minor discrepancy does not render a form invalid.

- **The need to simplify the forms for users/to improve the quality of the information collected**

Feedback from the Guardianship Board and others has indicated that forms are filled out inconsistently with varying quality and detail of information.

- **The need to amend forms to minimise the likelihood that patients may be released after hours or on week-ends when little support is available.**

- **A number of unrelated administrative issues**

For example, making sure forms for ECT specify the reasons for the proposed course of treatment, the number of treatments required and the proposed end date of treatments.

24.2 In Loco Parentis

We have already discussed several consent to treatment issues, including the need to clarify the rights of carers to consent to treatment in their own right, when the consumer cannot.

The Guardianship and Administration Act currently provides for relatives to be able to consent to treatment. Relatives include a person acting in loco parentis.

Recognising the rights of carers will lessen the need to rely on the concept of a person acting in loco parentis as able to consent. However, there will be situations where there are no relatives or carers available to consent.

As a matter of practice, directors of accommodation services (rather than direct care staff) have been seen as acting in loco parentis in some instances and have been able to consent on behalf of clients who cannot.

A recent Crown Law opinion has cast doubt on whether they are acting in loco parentis. Crown Law has also questioned whether a person can act in loco parentis in relation to an adult person. In reality, most people in long-term accommodation who lack capacity to consent are adults. The Guardianship and Administration Act needs to be amended to clarify these issues.

24.3 Fire Arms Notification

The Coroner has raised the issue with this Committee about firearms notification in relation to detained patients. We understand this matter is being addressed with a view to amending the Firearms legislation. We agree that it is the appropriate legislation.

24.4 Duty to Notify Registrar of Motor Vehicles

During consultation, some uncertainty was expressed about whether there was an obligation to notify the Registrar of Motor Vehicles about dangers presented by patients if they drive motor vehicles. Section 148 of the Motor Vehicles Act 1959 places a clear obligation on a health professional to do so where the health professional has reasonable cause to believe that the person is suffering from a physical or mental illness, disability or deficiency such that, if the person drove a motor vehicle, he or she would be likely to endanger the public.

24.5 Ensuring Physical Health

The Coroner has also expressed concern that patients can have health problems, which are undetected, with fatal consequences, when the emphasis of treatment is on mental health. We note that Section 87 of the Victorian Mental Health Act requires that every patient must at least once every year be examined as to the patient's mental and general health. This issue may not necessarily be a matter for legislation, but we note it as a significant issue for proper treatment and care.

Recommendation:

24.1 The Guardianship and Administration Act should be amended to clarify in loco parentis issues.

25. THE LEGISLATIVE SCHEME

During consultation, the suggestion was made by several people that the Mental Health Act and the Guardianship and Administration Act should be combined to avoid the need for continual cross-referencing, and to simplify the legislative scheme.

The two areas were under a single Mental Health Act until 1993. There was concern at that time that people with intellectual disability were being covered by a Mental Health Act, and therefore the distinct difference between intellectual disability and mental illness was continuing to be blurred. (Courts and lawyers for example do not always understand the differences).

There is also separate Guardianship legislation in other States.

However, the Guardianship Boards in other States have nothing to do with the making of mental health orders.

An argument could be mounted in the South Australian context for a single comprehensive Act called the Mental Capacity Act.

The common issue after all in areas such as mental illness and intellectual disability is a lack of mental capacity, requiring substituted decision-making and as a last resort, compulsory orders.

The two Acts are also ones which need to be read by a wide range of people including consumers, carers, service providers, lawyers, boards and so on.

Anything, which makes the legislation more readily accessible needs to be given careful consideration.

For the same reason, plain English is also important.

Recommendations:

25.1 The benefits or otherwise of combining the Mental Health and Guardianship and Administration Acts into a single Mental Capacity Act should be considered during the drafting stage.

25.2 The legislation needs to be in plain English, given the wide range of people who read it, and the issues affecting people's lives which it covers.

26. RESOURCES

This Report does not focus upon resources or services because that is not the brief of the Committee, but we have been asked to provide recommendations for a legislative framework for a modern mental health service system in South Australia.

However, we think it is important to indicate that funding issues have frequently been raised during consultation, and resources are needed if the framework we are suggesting is to be implemented effectively. There are clearly acute needs in relation to community services and the country generally.

We have been mindful of resource limitations in our suggestions that community visitors may also be able to provide some advocacy for consumers before the Guardianship Board. We also see the suggested Appeal Tribunal drawing some membership from those who are Guardianship Board Members, when that is appropriate. It will also save the costs and delays of the existing court appeal system and replace appeal to the Guardianship Board.

Ultimately, there must also be some savings in having more acute services near where people live, particularly in the country. The costs, not to mention the trauma, of transporting detained patients by air to metropolitan facilities, only to have them bussed back a few days later, will certainly be saved if such facilities are established even to allow short-term stays.

One price of a lack of resources is likely to be more restriction in unsuitable environments, and fewer options for consumers. Restrictions or removal of civil liberties for the purpose of care should be matched by adequate, quality services.

27. SUMMARY OF RECOMMENDATIONS

Chapter 3 – The Need for a Modern Philosophical Framework:

3.1 Among other things, the philosophical framework of the Mental Health Act needs to:

3.1.1 Specifically recognise the importance of care in the community as close to home as possible, as well as hospital care.

3.1.2 Acknowledge the rights of consumers and their carers as fundamental and the importance of family and carers in the care and treatment of people with a mental illness.

3.1.3 Emphasise the concept of recovery as a goal of assisting consumers.

3.1.4 Reflect the broad directions of the National Mental Health Plan and Health Reform emanating from the Generational Health Review.

3.1.5 Provide for providers of mental health services to meet standards of care, such as the National Standards for Mental Health Services.

Chapter 4 – Consumer Rights:

4.1 The Act should include an expanded statement of principles in relation to the provisions of treatment and care, involuntary admission and treatment, and rights of consumers in approved treatment facilities.

4.2 The term “consumer” or “mental health consumer” should replace “patient” in the legislation.

Chapter 5 – The Treatment Plan as a Pivotal Requirement:

5.1 The South Australian Act should emphasise an individual and comprehensive treatment plan as crucial to continuity of treatment and services. It should also be the cornerstone of compulsory orders for detention or community treatment.

Chapter 6 – Carer Rights:

- 6.1 As indicated in 3.1, the philosophical frameworks of the Mental Health Act needs to recognise the importance of the role of family and friends who are carers.**
- 6.2 The Act should establish as a matter of principle a carer’s right to information and to be consulted in the development of treatment and discharge plans for a consumer, where practical and appropriate.**
- 6.3 The role of the Public Advocate in assisting the interests of carers should be made better known. It needs to be clear that it involves information and systems advocacy, rather than individual advocacy, to avoid conflicts of interest in assisting consumers under the guardianship of the Public Advocate.**
- 6.4 Carers should be recognised in their own right as able to consent to treatment on behalf of a consumer who cannot.**
- 6.5 The Act should include a definition of a carer.**
- 6.6 Any evaluation of advocacy needs in the mental health area must include advocacy for carers and families of people with a mental illness.**

Chapter 7 – The Confidentiality Barrier to Sharing Information:

- 7.1 Barriers to proper disclosure of information should be removed as a matter of urgency by legislative change.**
- 7.2 There should also be professional development of mental health staff on mental health law, and duties of care and confidentiality.**

Chapter 8 – Communication and Exchange of Information:

- 8.1 The Guardianship Board and the Department of Health should clarify their respective roles in relation to the collection of data.**

Chapter 9 – Aboriginal Consumers and Carers:

- 9.1 The Mental Health Act should establish the principle that, as far as possible, treatment and care of a person of Aboriginal background must be culturally appropriate, and take into account the views of the person's family and community.**
- 9.2 Documents such as the Statement of Appeal Rights should be in Aboriginal languages in common use in South Australia.**
- 9.3 Wherever possible, a person of Aboriginal background should have the support of family or friends when they are receiving care, particularly in the case of involuntary treatment.**
- 9.4 Empowering and resourcing country hospitals to hold consumers for short periods (see 17.4) will be of particular benefit to Aboriginal consumers.**

Chapter 10 – People from Different Cultural Backgrounds:

- 10.1 The Mental Health Act should set as a goal or principle that treatment and care is culturally appropriate.**
- 10.2 Authorities such as psychiatrists or the Guardianship Board in making involuntary orders should be obliged to take into account any cultural factors, which may be relevant to the determination.**
- 10.3 Authorities should be obliged to use accredited interpreters where possible and necessary before making such orders.**
- 10.4 The Acts should be amended to provide that statements of rights on admission and for appeals are wherever possible, in plain language and the language or mode of communication with which the patient is most familiar, uses and is likely to understand.**
- 10.5 The Mental Health Unit should provide information about where to find psychiatrists with cultural expertise, and the Public Advocate should provide similar information in relation to suitable independent advocates.**

Chapter 11 – The Special Needs of Children:

- 11.1** If possible, it should be clarified that the Mental Health Act and the Guardianship and Administration Act apply to children. There should be a legislative principle clarifying that in providing care, the special needs and vulnerabilities of children should be taken into account.
- 11.2** Wherever possible, children who are involved with mental health services, particularly as involuntary patients, should have support from family carers or advocates.
- 11.3** The Guardianship Board should review the detention of children within 28 days of the first order, and every 3 months thereafter. The legislation should place priority on treatment and placement of the minors in the community wherever possible.
- 11.4** Barriers to the appropriate exchange of information about children, young people and families that are involved with the child protection system should be removed.

Chapter 12 – Advanced Directives (Ulysses Agreements) – Temporary Incapacity:

- 12.1** Advanced directives by consumers to cover the time when they are temporarily incapacitated should be given legal recognition by the planned Advanced Directives Act.

Chapter 13 – Electro-Convulsive Therapy:

- 13.1** Authorisation for electro-convulsive therapy (ECT) should specify the number of treatments and duration of time. A maximum number of 12 treatments and a maximum duration of 3 months should be prescribed for which an authorisation is valid.
- 13.2** Given the differing views between clinicians and consumers, there would need to be further dialogue involving both, before current safeguards in relation to ECT (in particular the involvement of the Guardianship Board) could be changed.
- 13.3** The emergency use of ECT should be notified to the Board.
- 13.4** The categories of people, who can consent to ECT on behalf of a consumer who cannot, should be extended to include a guardian appointed by the Guardianship Board, and a primary carer. A consumer should be able to indicate their wishes through an advanced directive. These steps would lessen the need to go to the Guardianship Board.
- 13.5** Consideration should be given as to whether psychosurgery should be banned, rather than have special safeguards.

Chapter 14 – Criteria for Compulsory Intervention:

- 14.1** The definition of mental illness in the Act should remain the same.
- 14.2** It should be clarified that a mentally ill person can be detained or ordered to have treatment where there is a serious likelihood of immediate or imminent harm to the person or others, or serious deterioration in the person's physical or mental condition.

Chapter 15 – Apprehension and Conveyance:

- 15.1** Section 23 of the Act should reiterate the need to minimise interference with the rights, dignity and self-respect of consumers during apprehension and conveyance.
- 15.2** Mental health workers, ambulance officers and police officers should all be empowered to convey people with a mental illness. Mental health workers and ambulance officers ought to be able to request police assistance when needed.
- 15.3** Police involvement should be indicated as a last resort at least where that is practicable.
- 15.4** Powers of restraint by ambulance officers, the Royal Flying Doctor Service (RFDS) and security staff at emergency departments should be explicit to remove any uncertainties about them.

Chapter 16 – Audio-Visual Conferencing:

- 16.1** The Act should clarify that audio-visual conferencing can be used as a basis for orders.

Chapter 17 – Admission and Detention:

17.1 An approved person other than a medical practitioner also ought to be able to make an order for admission and detention.

17.2 A person making the order should be required to “believe on reasonable grounds” rather than be “satisfied” that the criteria for the order are fulfilled.

17.3 An admission and detention order, once confirmed, should be able to be revoked.

17.4 It should be possible for a person to be detained under the initial order for up to 7 days rather than 3 days to allow time for recovery from a short-term crisis.

The Act should enable such initial detention to occur in places other than ATCs approved for that purpose, so that people from country areas can be saved the trauma of dislocation to ATCs in the city where possible. If a person still needs restriction after that period, or the risks increase, then they should be transferred to an ATC.

17.5 A psychiatrist should be able to make a further order for detention for a period not exceeding 42 days.

17.6 Any further long-term orders should only be made by the Guardianship Board.

17.7 Orders ought to be able to expire at a time during the day rather than at the end of the day (midnight).

17.8 The director of an ATC should be able to transfer patients from one ATC to another where the other ATC can better care and treat the patient, without needing to wait for a psychiatrist’s certificate.

17.9 The term “detention” should be replaced by language, which reflects treatment or care, as well as the involuntary provision of it.

Chapter 18 – Community Treatment Orders:

- 18.1 The Act should indicate that a community treatment order (CTO) is to be preferred to detention where possible.**
- 18.2 The Act should enable CTOs to spell out a detailed treatment plan with a range of options to assist the person, as well as the wishes of the consumer and carers where possible.**
- 18.3 CTOs need to be specific about who is responsible for monitoring and follow-up.**
- 18.4 The treating professional should be able to make a CTO, subject to review by the Guardianship Board within 28 days, and thereafter 6 monthly.**
- 18.5 The Guardianship Board should also continue to be empowered to make a CTO.**
- 18.6 Those who can apply to the Board for a CTO should include mental health practitioners, nurses and psychiatrists.**

Chapter 19 – Guardianship Board

- 19.1** The Guardianship Board should be able to formulate its own principles of procedural fairness to ensure the therapeutic context is taken into account.
- 19.2** A number of steps need to be taken to humanise the Guardianship Board, including a social worker provided by the Public Advocate to provide support for people coming to the Board.
- 19.3** The recognition of advocates needs to occur as contemplated already by the Act.
- 19.4** Increased legal assistance also needs to be looked at including the possibility of a duty solicitor provided by Legal Services, being on call to assist, and community legal centres playing a role.
- 19.5** There are a number of changes which should be made to assist the operations of the Board:
- 19.5.1** Two member Boards should be possible.
 - 19.5.2** A single member should be able to hear simple guardianship and administration hearings.
 - 19.5.3** The regulations under the Mental Health and Guardianship Acts should be removed to see what matters the Registrar can deal with.
 - 19.5.4** It should be possible to have a single professional member hearing a matter other than a psychiatrist.
 - 19.5.5** Board members should be able to be appointed beyond 2 appointments.
 - 19.5.6** The Board should be able to make interim orders for up to 21 days (rather than 7).
- 19.6** The Public Advocate should have a general power of investigation and to obtain documents and answers while assisting persons with mental incapacity.

Chapter 20 – The Appeal Process:

- 20.1 A specialist Appeal Tribunal should be established to hear appeals currently heard by the Guardianship Board, and by the ADD of the District Court. It could be called the “Mental Capacity Tribunal”.**
- 20.2 Appeals should be heard de novo (afresh).**
- 20.3 The Guardianship Board should continue to be able to review its own decisions.**
- 20.4 The Tribunal should be able to refer questions of law to the Supreme Court for consideration when necessary.**
- 20.5 In relation to both the Guardianship Board and the Appeal Tribunal, there needs to be a legislative provision which encourages recognition of the therapeutic context in which both bodies are operating.**
- 20.6 To reduce appeals on minor administration errors, there should be a provision in the Act clarifying that substantial compliance with forms is sufficient, if the intention is reasonably clear.**
- 20.7 Further consideration should be given to the implications of treatment not being given pending an appeal being heard against involuntary treatment or detention. Consideration should also be given to whether a requirement for a set number of working days be set in which appeals must be heard.**

Chapter 21 - Advocacy and Community Visitors:

- 21.1 The Act should provide for an involuntary patient to be supported by a relative, friend, carer, guardian or advocate during assessment, detention, treatment where possible.**
- 21.2 There is a need to evaluate further how the advocacy needs identified in this report can be met. It should involve advocacy agencies and the Commonwealth as a principal funder.**
- 21.3 The Committee supports work being done to establish a community visitor scheme in the mental health area.**

Chapter 22 – Discrimination on Basis of Mental Illness:

- 22.1 The Equal Opportunity Act should be amended to ensure persons with mental illness are protected from discrimination in South Australia.**

Chapter 23 – Cross-Border Recognition of Orders:

23.1 The Mental Health Act should be amended to facilitate cross-border recognition of orders made in relation to mental health consumers.

Chapter 24 - Miscellaneous:

24.1 The Guardianship and Administration Act should be amended to clarify in loco parentis issues.

Chapter 25 – The Legislative Scheme:

25.1 The benefits or otherwise of combining the Mental Health and Guardianship and Administration Acts into a single Mental Capacity Act should be considered during the drafting stage.

25.2 The legislation needs to be in plain English, given the wide range of people who read it, and the issues affecting people's lives which it covers.

PART II

CRIMINAL JUSTICE

SYSTEM

1. INTRODUCTION

The Terms of Reference of this Review require the Committee to focus not only on the Mental Health Act 1993, but also related legislation, including the Guardianship and Administration Act 1993, and the Criminal Justice Legislation, such as the Criminal Law (Sentencing) Act 1988.

The criminal justice area has seen significant changes made (or intended) to legislation relating to people with mental health or disability problems.

The changes have not been without their operational difficulties, and a series of reviews have taken place. It is hoped that this Paper assists in future directions.

Key changes recommended in this Part call for:

- A simplification of the provisions relating to the mental impairment defence;
- Supervision and variation of court orders relating to mental impairment being the responsibility of the proposed multi-disciplinary Mental Capacity Tribunal, rather than the Court;
- A range of options to assist offenders with mental impairment, rather than rely only upon the formal mental impairment defence;
- More straightforward ministerial and departmental arrangements to assist offenders with mental impairment.

A summary of recommendations appears at the end of Part II of this Report.

2. LEGISLATIVE FRAMEWORK

2.1 Mental Impairment Defence

Over recent years, there have been significant changes made to legislation to enable defendants to argue their lack of mental competence as a defence to criminal proceedings.

For many years, people who lacked mental competence could argue they were unfit to stand trial or were not guilty by reason of insanity. They were then held at the Governor's Pleasure. These defences were only attractive to avoid capital punishment.

This position was modified by the introduction of licence arrangements overseen by the Parole Board.

In 1992, amendments to the Criminal Law Consolidation Act (CLCA) 1935 abolished the Governor's Pleasure system, and shifted decision-making to the courts to set a limiting term commensurate with the nature of the offence.

In 1995, Part 8A of the CLCA (Sections 269A and 269 ZB) further refined these changes. These provisions now enable the courts to make both custodial and non-custodial supervision orders for people who are mentally incompetent to stand trial or commit an offence.

Custodial orders place the defendant in the custody of the Minister who may give directions as to the appropriate custody, supervision and care of the defendant.

In the case of a non-custodial supervision order, supervisory responsibilities are divided between the Minister (treatment and monitoring of the mental condition) and the Parole Board (all other supervision).

When setting conditions of licence, the Court must apply the principle that restrictions on the defendant's freedom and personal autonomy should be kept to the minimum consistent with the safety of the community.

The Court sets a limiting term for its orders based on the term of imprisonment which would have been given to the defendant if found guilty. This allows the Court to consider not only the nature of the offence but also the previous record of the defendant. This makes the plea of mental incompetence attractive for defendants to use in the full range of offences and courts.

The Section 269 defences are available not just for indictable (more serious) offences, but also for summary offences (lesser offences dealt with by the Magistrates Courts).

A range of people may also argue mental impairment. Mental impairment includes mental illness, intellectual disability, or a disability or impairment of the mind resulting from senility but does not include intoxication.

The defence involves a number of steps:

- Objective elements of the offence must be found and considered separately from the issue of competence/fitness to plead.
- Once deemed incompetent or unfit a person is found not guilty and is considered liable to supervision for a limiting term, equivalent to the penalty that would have applied if a guilty verdict had been found.
- The Court considers reports from the Minister for Health and the Crown before determining the nature of supervision or the orders to be imposed. The Health report provides information regarding the person's prognosis and treatment and the Crown report regarding the views of the victim and next of kin of the defendant. These reports must be provided within 30 days of the determination of mental competence being made.
- If the person is being considered for release into the community on licence, or for a significant reduction in the degree of supervision to which the person is subject, the Court must, in most cases, also consider at least 3 expert reports, each prepared by a different specialist.

- Not more than every 12 months for the period of the limiting term, the Court must receive from the Minister a report on the person's prognosis, the treatment received since the last report and the treatment and care planned for the next period of the limiting term.

In summary, the changes have provided the courts with more options and flexibility to make orders in relation to people who lack mental competence. In particular, they allow more opportunities to keep people in the community and under restriction for periods appropriate to the individual.

As discussed later, the implementation of the changes has not been without operational difficulties.

2.2 Sentencing Options

The Criminal Law (Sentencing) Act 1988 has a number of provisions of relevance to people with a mental illness or disability.

A Court is empowered to take into account the physical and mental condition of the defendant in determining a sentence.

The Court can also set as a condition of bond that the defendant undergoes medical or psychiatric treatment in accordance with the terms of the bond. The Court must be satisfied that the treatment has been recommended for the defendant by a legally qualified medical practitioner and is available to the defendant.

2.3 Statute Amendment (Intervention Programs and Sentencing Procedures) Bill 2005

The changes proposed in this Bill would increase options for defendants who lack mental competence.

It would provide a legislative basis for diversion or intervention schemes and give the Magistrates Court or Youth Court options to release a person on bail, or without conviction or penalty, or on an undertaking if such a scheme is completed to a satisfactory extent.

2.4 Bail Options

Proposed amendments to the Bail Act 1985 have been developed to allow appropriate agencies to enter into agreements on behalf of consumers with cognitive impairment. This is an important proposal aimed at ensuring vulnerable people are not kept in remand inappropriately. As yet the legislation has not been passed.

Recommendation:

2.1 The Statute Amendment (Intervention Programs and Sentencing Procedures) Bill 2005 should be passed to provide a legislative basis for current diversion schemes, and to allow consumers with cognitive impairment to have bail.

3. OPERATIONAL REVIEWS

In 2000, the report, *Operational Review, The Criminal Law Consolidation Act, Mental Impairment Provisions 1995*, undertaken by the Justice Strategy Unit, looked at how the criminal legislative system was working in practice and how to achieve the best possible interface between justice and treatment and support services.

It made a number of recommendations, under several themes:

3.1 Provision of 24 hour responses and services for accused persons with mental impairment who come into contact with the criminal justice system

This included amendments to the Bail Act to allow agencies to enter into bail agreements on behalf of consumers with cognitive impairment. As already indicated, the legislation has yet to be passed.

3.2 Diversion from the Formal Court Process

The report noted that for minor offences, Part 8A (Section 269) was a cumbersome and costly process.

It recommended the development of a Magistrates Court Diversion Programme as an alternative for minor offences.

Such a programme has since been established. It operates by sentencing being delayed while the person is diverted into treatment and service options. The intention has been that, if successful, the charge should be withdrawn. If unsuccessful, the matter is returned to court for sentencing under the Criminal Law Sentencing Act.

At present, there is no legislative basis for the diversion scheme. The Statute Amendment (Intervention Programs and Sentencing Procedures) Bill 2005 referred to would, if passed, provide that.

3.3 Clarifying and Supporting the Statutory Requirements

This has included a number of issues including proposals for protocols, guidelines and processes for the reports needed by the Court, allocation of work to a panel of experts, membership of the panel, and court expectations in relation to the quality of reports.

Some work has been done on these issues by the Justice Strategy Unit in 2003, with its report, ***The requirement of the justice system for expert health opinion in cases of mental impairment when release on licence or lessening of supervision is being considered.***

The operational review also questioned whether 3 expert opinions were always necessary before release or significant reduction in the degree of supervision.

As a result, Section 269T now provides that, for summary offences, 1 or 2 reports may be sufficient if the Court considers they adequately cover the matters on which the Court needs expert advice.

3.4 Ministerial Responsibilities for Treatment and Monitoring of the Mental Condition, or for Custody, Supervision and Care

One key issue is the responsibilities of the Minister and ensuring that they are carried out properly.

The Operational Review recommended that delegations should be made by the Minister to appropriate agencies to ensure proper authority to make decisions and take action under the Act.

They include, for example, the annual review report to the Court on care or treatment of the defendant and ensuring counselling services are made available to next of kin and victims.

The situation has been compounded by the fact that there are now separate Ministers for Health and for Disability Services.

3.5 Cross-Jurisdiction Processes

As with the mainstream system, the Operational Review identified the need for cross-border inter-jurisdictional arrangements to be clarified.

Recommendations:

- 3.1 Ensure ministerial arrangements for carrying out functions under Section 269 CLCA are in place in both health and disability services.**
- 3.2 Ensure cross-border inter-jurisdictional arrangements for persons under Section 269 orders are in place with such legislative amendments as may be necessary.**

4. JOINT STAKEHOLDER SURVEY

Since the Operational Reviews, there has also been a Joint Stakeholder Survey by Ms Margaret Bonesmo on current knowledge of CLCA Mental Impairment Provisions and of the Magistrates Court Diversion Programme.³⁶ Among other things it provides a summary of key issues and proposed strategies to improve the purpose and operation of the Section 269 defence and the diversion programme.

The Survey Report is extensive and highlights legislative issues and strategies for improving court outcomes, case management for clients, victims and next of kin, as well as community confidence and awareness. It also indicates a number of infrastructure and resource issues.

We set out below key recommendations of the Survey Report in relation to legislative issues and court outcomes – areas of most relevance to our legislative review.

“5.1 Recommendations for legislative clarity

1. Action: Clarify the interplay between s269 of the CLCA and the Mental Health Act to clearly identify the basis upon which the Minister is to provide supervision and treatment to a mentally impaired defendant (ie a defendant who is suspected to have or is found to have a mental impairment and is subject to an order for detention, release on licence, or in interim custody.)

Reason: There is duplication occurring. Mental health personnel at inpatient and out patient levels are commonly resorting to powers under the Mental Health Act (and as authorised by the Guardianship Board) to treat and monitor a patient’s mental condition. It is unclear whether this was intended under Part 8A. The duplication has produced confusion and a widespread ‘lack of comfort’ for non-forensic mental health staff who have responsibilities to treat or supervise a defendant under Part 8A.

2. Action: Review the sufficiency of the definition of ‘Minister’ in relation to the provision of facilities, services and supervision for mentally impaired defendants with an intellectual incapacity or brain injury under Part 8A.

Reason: Only the Minister responsible for the administration of the Mental Health Act has direct standing to provide and supervise treatment under Part 8A. Under current portfolio arrangements, defendants with intellectual disability / brain injury are falling through ‘service gaps’. Facilities and services designed for people with mental illness are not appropriate for this group. Current disability service providers require a client’s consent to intervention. They consider they are not

³⁶ Justice Strategy Unit, Attorney-General’s Department, 2005.

able to enforce compliance with licence terms under Part 8A. Consequently this group of mentally impaired offenders is compromised during detention and release on licence.

3. Action: Clarify the role of the Parole Board in relation to the setting of licence terms and breach of licence (s269 T and 269U).

Reason: The Parole Board is responsible to supervise all licence terms other than the treatment and monitoring of a defendant's mental condition. At times, the Board has not been notified of applications / orders and does not have direct input into conditions. Some conditions have suggested the court lacked all relevant information when setting the licence conditions.

4. Action: Review various sections of Part 8A as suggested in paragraphs 3.1.5 – 3.1.10 (of the Joint Stakeholder Survey Report).

Reason: Aspects of these provisions have been queried in the survey.

5.2 Recommendations to strengthen court outcomes

5. Action: Consider removing the requirement for 3 expert reports to replace it with a discretionary power in the court. If it is thought desirable for the requirement for 3 reports to remain, then clarity is needed as to who is responsible to commission the reports.

Reason: A number of s269 defences or variation applications are uncontested. In these cases 3 reports are not warranted. The court's function under the legislation appears to include an inquisitorial responsibility such that it could seek further opinion if necessary. In contested matters adversarial processes adequately protect the interests of the parties and the community. There are insufficient numbers of forensic experts to sustain the reporting obligations under the present legislation.

6. Action: Review the role and function of the Court Assessment Service (CAS) in the provision of expert reports under s269. If it is thought desirable to continue to provide expert reports through CAS, then protocols defining its role are needed. Give consideration to whether there is justification to appoint a coordinator who is independent.

Reason: There are no protocols defining the role of CAS or panel members providing expert reports to the court, to say on whose behalf the reports are provided. There is confusion as to whether the experts are 'court appointed' and truly independent of the parties or whether they are called on behalf of one or other party. Concerns were raised in relation to the potential for conflict in the event that a treating psychiatrist is asked to provide an independent report.

7. Action: Review the range of expert reports now available to the court to determine whether comprehensive information is provided for the purposes of s269S (ie to assist the court determine whether to order detention or release on licence, and if the latter, on what conditions.)

Reason: The court is not always receiving adequate information in relation to an appropriate treatment and support plan for the defendant, or supervision that might be made available in the community, in lieu of detention. In particular the view was expressed that the court is not now receiving adequate information in relation to community services that may be available to the defendant by comparison to other members of the community, or people with exceptional needs. Adequate cultural information for Aboriginal people (and possibly other cultural groups) was thought to be deficient.

8. Action: Develop guidelines to improve the quality of expert reports and ensure they address the statutory provisions for which they are provided.

Reason: The quality of reports was thought to be inconsistent and some did not address the necessary issues. Survey input suggests that instructions to CAS panel members may not be provided through the parties' legal representatives in all cases. There are few recognised forensic experts and guidelines might assist to draw on a wider range of experts and produce greater consistency. They would also be necessary if a 'multi-disciplinary report' was thought desirable.

9. Action: Review current licence variation processes to determine whether they achieve legislative objectives and in particular whether a statutory panel could provide more flexible and appropriate outcomes.

Reason: Current legislative processes require an application to vary a licence to be considered by the court. Applications are costly, cumbersome and slow. Delays in the reports are causing adjournments, due to heavy demand. Defendants in custody remain so held while applications are pending. Applications are made even for minor variations. Survey input was to the effect that interstate models, which establish a statutory board or tribunal to make variation decisions and issue orders in relation to supervision and ongoing management of a mentally impaired defendant in the community may be more appropriate. More accessible processes, such as now occur with the Parole and Guardianship Boards, may improve access, provide greater flexibility for clinical / supervisory management, and be more appropriate (as the issue of criminal responsibility for the offence has already been determined by the court.)

10. Action: Extend the Diversion Program to provide equitable access to it across the state. Expedite proclamation of the underpinning legislation to provide certainty. Continue to address victim concerns and processes for their engagement in the process.

Reason: Participants gave overwhelming support to the Diversion Program. Without the underpinning legislation, current sentencing options are inadequate to achieve the Program's full potential. This increases the number of s269 defences and can result in a duplication of diversion and s269 processes. Victims' concerns about the sufficiency of their engagement in the diversion process are being addressed.

11. Action: Consider the WA model 'Court Liaison Service' for possible application in SA.

Reason: There may be scope to further filter out very low level offences (not involving a public safety issue) to transfer a defendant on bail from justice to health for treatment / services.

12. Action: Consider whether eligibility for the Diversion Program should be extended to a second level, for offenders who have committed middle level offences, but indicate a genuine desire to participate.

Reason: Participants consider treatment is more effective than punishment in achieving community safety. Some offenders are now excluded under Program eligibility criteria and are not receiving adequate treatment or rehabilitation in prisons, which increases the risks of recidivism.

13. Action: Consider the ongoing application of s269 to summary offences.

Reason: Participants raised concerns about a serious deficiency in forensic mental health infrastructure to support the legislation at this level. This was said to produce more adverse outcomes for mentally impaired offenders in that jurisdiction than may otherwise have applied under ordinary criminal processes. The record numbers of defendants under s269 orders are resulting in withdrawal of specialist forensic treatment and inpatient services to prisoners and of services to clients in the wider community. The working group expressed concern to ensure that the application of s269 in the Magistrates Court be strengthened.

14. Action: Consult with the Youth Court and service providers to children, adolescents and young offenders concerning the application of s269 in that jurisdiction.

Reason: Some participants raised concerns that s269 was inappropriate for Youth Court objectives and lacked back-up services and facilities. The survey sample did not include sufficient input from participants with specialist knowledge of the area and accordingly further consultation is desirable.

15. Action: Review standard licence terms / orders in the Court Administration Authority (CAA) Procedure Manual to ensure they are appropriate, balance the need for flexible clinical treatment against the need for supervision and clearly define agency responsibility areas. Provide targeted training to personnel involved in the drafting of proposed terms, particularly those conducting summary matters, to provide greater assistance to the court in accordance with the principles in s269S.

Reason: Feedback was received that licence terms were of inconsistent standard – either too vague or too restrictive. Some are not monitored. There is a need to ensure that proposed licence terms accurately reflect the individual case management requirements of an offender (and the public) in accordance with s269S, yet at the same time provide appropriate flexibility for treatment providers. (Unclear administrative arrangements are also impacting on this aspect and this is picked up in the next group of recommendations.)

16. Action: Ensure that adequate consultation has occurred with all agencies nominated to provide services under a licence before the proposed terms are approved by the court. If several agencies are involved, consider whether a coordinator or team leader should be nominated in the case plan. Consider whether agencies nominated to provide treatment or supervision under a licence should be required to demonstrate acceptance of the proposed responsibilities before approval is given by the court.

Reason: *There are instances when external agencies (ie other than Mental Health Services or Parole Board) have been nominated in treatment plans without consultation and have been unwilling / unable to provide the service.*

17(a) Action: *Review the current processes for preparing statutory victim reports and consider whether legislative objectives may be better served by resourcing the Director of Public Prosecutions (DPP) to take over responsibility for their preparation.*

17(b) Action: *Develop guidelines for the content of victim reports.*

Reason: *There is a perception that James Nash House (JNH) has a conflict of interest preparing these reports as they are treating the defendant. There is a need to improve the consistent quality, timing and process for obtaining the reports and the understanding of victims in the purpose of the legislation. There are no guidelines to assist on the desirable content or format of the reports.*

18 (a) Action: *Review the current processes for preparing the statutory reports from the next of kin of a defendant to ensure they are of a high standard.*

18 (b) Action: *Provide guidelines for the content of reports.*

Reason: *A defendant's next of kin often have the most insight into the defendant's mental condition and can provide important feedback on steps needed to properly manage a defendant in the community. There are no guidelines in place to assist on the desirable content or format of the reports.*

19. Action: *Review current processes to ensure the opportunity is provided to victims and next of kin to receive effective counselling at an early time.*

Reason: *Feedback from victim advocates and next of kin suggests adequate counselling may not be occurring as is envisaged by the legislation.*

20. Action: *Develop targeted training and professional development courses for police prosecutors, private legal practitioners and Magistrates involved in s269 for summary matters. Consult with the Law Society to increase the size of the private practitioners who have expertise in the area. Consult with the Commissioner of Police to determine whether a small pool of specialised prosecutors for s269 matters may be worthwhile pending further training for all prosecutors.*

Reason: *Section 269 is widely acknowledged to be a complex area of law. Workforce expertise has not caught up with the amendments to Part 8A in 1996, or the large volume of s269 matters now listed before the Magistrates Court. Participants consider further training is needed to address the deficiency.*

Recommendation:

4.1 That the Joint Stakeholder Survey Report be read in conjunction with this Report.

5. APPLICATION OF THE MENTAL IMPAIRMENT DEFENCE

Notwithstanding previous reviews and some changes, operational problems continue with the mental impairment provisions of the CLCA and their application, and related issues. The Bonesmo Report is testimony to that. Our own consultation confirms the ongoing dilemmas.

5.1 Clogging up the Courts and Services

The application of the mental impairment defence to minor offences in the Magistrates Court is seen by many as clogging up the courts and as a flow-on effect mental health services as well. This means that priorities for services are being distorted, and people are being cared for inappropriately.

In a submission to the Committee, Dr Shane Gill summarises the impact well:

“There are several problems associated with the Section 269 provisions. The intention was good – to allow persons who were mentally impaired at the time of an offence to use this defence for all offences and not just capital offences. However, Section 269 has made these persons subject to much stronger restrictions than persons detained under the Mental Health Act. They are neither prisoners (they have, by definition, been acquitted of charges), nor are they patients in the same way as other mental health patients. They are subject to Parole Board overview when discharged, can only be released by order of a court and tend to spend much longer in hospital, even when recovered from their illness, than other patients under the Mental Health Act. They are housed in special forensic mental health facilities that are often much more restrictive than their current mental state requires, alongside patients who are indeed prisoners in correctional custody. They are technically (according to the Act) under the supervision of the Minister for Health, yet they cannot be transferred from one health facility to another, or move to community care, without approval from the Court.

The mental impairment defence is now much more widely used (its intention) but resources in terms of forensic and extended care beds have not kept pace with this demand. Often now, severely mentally ill prisoners are denied

access to forensic mental health beds in JNH because they are filled with extended detainees who are well, not in need of acute psychiatric care, but unable to be discharged until the Court approves. The Court tends to be conservative, and often uses transfer from JNH to Glenside Campus as a form of pseudo-discharge. If someone is recovered they should be discharged to the community, not to another institution.”

Suggestions for dealing with this dilemma include cutting back the Section 269 defence to more serious offences.

5.2 Cutting back the Defence to more Serious Offences

An obvious threshold response is to cut back this formal defence to more serious offences. It is clear from current Mental Health Unit statistics that Magistrates Court matters dominate. There are 143 mental impairment clients at present, 66 from the Magistrates Court, 39 from the District Court and 38 from the Supreme Court. The defence is not available in lower courts in New South Wales for example at least in this form³⁷ and Western Australia provides that only offences with imprisonment as a penalty attract the defence.³⁸

5.3 Developing the Magistrates Court Diversion Scheme

An alternative view is that it is too early to make major changes to the scope of application of Section 269. According to this view, it is better to expand the Magistrates Court Diversion Scheme so that it offers a less complex option for people with mental impairment.

There is criticism that the scheme is only available for use in some courts in South Australia and not everywhere. It currently operates in Adelaide, Christies Beach, Holden Hill, Elizabeth, Port Adelaide, Port Augusta, Whyalla and Berri.

³⁷ Parts 2 and 3, Mental Health (Criminal Procedure) Act 1990 (NSW).

³⁸ Criminal Law (Mentally Impaired Defendants) Act 1996 (WA).

It is only a voluntary scheme at present. Some defendants are also ineligible for diversion. For example, it does not include:

- parolees;
- regulatory offences;
- major indictable offences;
- people with a significant history of violent or sexual offending;
- offences against minors or other vulnerable groups.

These exclusions could usefully be reviewed.

Another dilemma with the scheme is that, at present, the scheme operates with withdrawal of charges being at the discretion of SAPOL prosecutions. In recent times, SAPOL have been less willing to withdraw charges, even after the person has completed a diversion programme, with the consequence of more Section 269 applications to the courts.

There is a need for the Statute Amendment (Intervention Programs and Sentencing Procedures) Bill 2005 to be passed by Parliament.

The Bill has recently been introduced. It closely follows a 2003 Bill, which lapsed.

The legislation would provide the judiciary with the authority to withdraw charges upon successful completion of the diversion programme. Before releasing the defendant, the Court will have to be satisfied that the defendant understands that he or she has a mental impairment, understands that it affects his or her behaviour, and has made a conscientious effort to address this by completing or participating to a satisfactory extent in an intervention programme.

The Court must also be satisfied that the release or dismissal of the charge will not endanger the safety of a particular person or the public. It may not dismiss charges if this would have the effect of denying a victim compensation under the Criminal Law (Sentencing) Act 1988.

Significantly, the concept of mental impairment will be broader than that required by Section 269 CLCA. For the purposes of intervention, a person's mental impairment must be such as to explain and extenuate at least to some extent, the conduct that forms the subject matter of the offence.

5.4. Power to Deal with Trivial Matters

Another suggestion made was that in addition to the mental impairment defence and diversion schemes, South Australia should have a provision similar to Section 20BQ of the Crimes Act 1994 (Commonwealth) and Section 32 Mental Health (Criminal Procedures) Act 1998 (NSW).

These sections enable a Magistrate hearing a matter to dismiss a charge against a person who is mentally ill or has an intellectual disability, where it is more appropriate than to deal with them in accordance with the law.

The dismissal can be unconditional. The Magistrate can also make an order referring the person for treatment.

In other words, a trivial matter involving a person with a significant mental impairment, could attract this approach, rather than the more formal process of establishing the elements of an offence, limiting term, suitable care and supervision involved in a Section 269 defence.

We note concern expressed by SAPOL in another context about legislative provisions empowering a court to dismiss a charge on the ground of mental illness when the current legislative provisions on mental competence are not made out. SAPOL sees this as inconsistent with the general provisions of criminal liability and offering no constructive way of dealing with the behaviour.

However, the benefits of ready referral for treatment or rehabilitation for minor matters will, in our view, on occasions outweigh these concerns.

5.5 Informal Diversion before Getting to Court

In practice, police will often refer people with a mental impairment to services, without taking the court route, particularly when the offence is minor and the impairment serious.

5.6 Court Liaison – The Western Australian Approach

Western Australia seems to have a particularly responsive court liaison service under which authorised mental health practitioners visit the Central and Fremantle Courts each day and metropolitan courts weekly to make early assessments of people arrested. The Magistrate is then advised and can bail the person while they are referred to the appropriate mental health service for treatment until the matter is heard. This keeps defendants out of remand and ensures prompt treatment.

South Australia needs a similarly responsive system.

5.7 Summary of Approaches

A four-pronged scheme can be seen as emerging:

- (1) Informal referral by police without going to court where appropriate;
- (2) Power in Magistrates to deal with minor matters without resorting to diversion or formal mental impairment defences;
- (3) Use of diversion programmes in more serious matters where the person is willing to undertake such programmes;
- (4) The use of the mental impairment defence in higher order contested matters.

It can be seen that there is the potential to develop pathways other than the formal mental impairment defence to ensure matters are dealt with more appropriately and expeditiously.

All of these pathways are of course dependent on mental health resources being available.

The question remains whether the availability of the formal mental impairment defence should be restricted in some way. There is a philosophical view that the defence should be available as a matter of right to defendants to avail themselves of it when appropriate. The availability of Section 269 for minor matters is seen as important while decisions about

proceeding with prosecutions even after diversion remains at police discretion. This is because repetition of minor offences can lead to gaol and a police record.

The alternative view is that some pragmatism is needed, that Section 269 is inappropriate for minor offences and the legislation should make that clear, particularly given the impact on services.

It is worth noting that the Magistrates Court deals with a range of offences from serious to minor. The Magistrates Court deals with minor indictable offences and summary offences. Minor indictable offences can include offences with a maximum imprisonment of 5 years (or more in some instances) such as malicious wounding or assault causing actual bodily harm). Summary offences can involve imprisonment of up to 2 years.

One suggestion made to the Joint Stakeholder Survey was that coupled with extension of the diversion options, Section 269 should be preserved for serious offences involving a potential term of imprisonment of one year or more. That will still mean Section 269 matters being heard in the Magistrates Court, but only more serious matters.

This would certainly make sense once the diversion programme has legislative backing empowering Magistrates to withdraw charges upon successful completion of a programme, or empower Magistrates to dismiss trivial matters and refer a person informally for treatment.

There should also be regular review of this area to appreciate the impact of the provisions and to make necessary legislative adjustments.

Recommendations:

- 5.1 The Magistrates Court Diversion Scheme should be expanded where possible and mandated by legislation.**
- 5.2 There should be a four-pronged approach to offenders with mental impairment:**
 - 5.2.1 Informal referral by police without going to Court where appropriate.**
 - 5.2.2 Power in Magistrates to deal with minor matters without resort to diversion or formal mental impairment defences.**
 - 5.2.3 Use of diversion programmes in more serious matters where the person is willing to undertake such programmes.**
 - 5.2.4 Use of the formal mental impairment defence in higher order contested matters.**
- 5.3 The formal mental impairment defence should be preserved for serious matters involving a potential term of imprisonment of one year or more. This change should be made when there is legislative backing empowering Magistrates to withdraw charges upon successful completion of a programme, or Magistrates have power to dismiss trivial matters and refer a person informally for treatment.**

6. THE PROCESSES

As well as the question of what should be the scope of application of Section 269, there remain process issues. As one experienced Magistrate expressed it: *“The provisions of Part 8A of the CLCA relating to defendants with mental impairment are unduly complicated. There are inbuilt delays in moving from one step to another and the plethora of reports in many cases is difficult to justify. Some defendants spend longer in custody awaiting determination under Part 8A than they would if they had entered a plea of guilty under normal court procedure.”*

6.1 The Reports

Both the number and range of expert reports required by the courts continue to be matters of debate and concern. The Joint Stakeholder Survey Report deals with this in some detail, which we will not repeat, but the following seems worth emphasising.

In most cases of releasing a defendant or significantly reducing the degree of supervision to which the defendant is subject, 3 reports are needed, prepared by a different psychiatrist or other appropriate expert who has personally examined the defendant. As well the Court must consider next of kin and victim reports.

The expert reports focus on the mental condition of the defendant and the possible effects of the proposed action on the behaviour of the defendant.

This number of reports was seen as often being excessive and repetitious, particularly in uncontested matters.

They also focus on organic and diagnostic factors rather than information on the options and availability of community services, which might include information from workers in community corrections or health teams.

In most States, there is not the same specificity as to the number of reports. It is generally left to the Court to inform itself as it sees fit. Victoria has a similar provision to South Australia with only 1 expert report definitely required.³⁹

It does seem preferable that there is a discretion to make decisions having regard to such expert reports as are requested. It would be better to specify areas such as psychiatric, psychological or community service, than any particular number of reports.

6.2 When to Go Back to Court?

There is also concern as to when it is necessary to go back to Court, and just what variations in reducing security can be made by the Minister as part of his or her responsibility for the care of the person.

If the Court refuses a variation or revocation of a supervision order, in most cases, a further application cannot be made to the Court for 6 months. This too has attracted concern because of its inflexibility. This could mean someone remaining in JNH longer than they need to, when they are clearly well enough to be in a less restricted environment.

6.3 Formal Report to the Court

The courts must receive a 12 monthly report from the Minister in relation to people under supervision orders. Some have questioned the utility of this given the courts do not in practice play a monitoring role.

As we discuss in the next chapter, there is in fact some fundamental questioning of the role of the courts and the need for other structures to provide supervision with respect to the mental health of the person.

6.4 Information and Training

The Joint Stakeholder Survey Report raised the need for information and training for judicial officers and lawyers in relation to Section 269, report requirements and mental health and other relevant services.⁴⁰ Our

³⁹ s41, Crimes (Mental Impairment and Unfitness to be Tried) Act 1997 (Vic).

⁴⁰ See Recommendation 20 of the Joint Stakeholder Survey Report.

consultation also indicated the same need. There is a Procedure Manual, which provides information about some of these matters, but any information and training, which can assist those working in the courts or the mental health area regarding Section 269 should be supported.

Recommendations:

- 6.1 There should be a discretion in the courts or supervising body as to the number of expert reports required. It would be better to specify areas such as psychiatric, psychological or community services, from which reports could be obtained rather than any particular number of reports.**
- 6.2 The current restriction on seeking a variation or revocation of a supervision order for 6 months after a refusal should be removed.**
- 6.3 The Committee supports the development of information and training for those working in the courts or the mental health area regarding Section 269 matters.**

7. SUPERVISION – AN ALTERNATIVE APPROACH

7.1 Introduction

The Chief Judge of the District Court put the issue this way: *“One of the questions raised in the Issues Paper is what part, if any, the Court should play once a person has been committed to detention or released on licence. This raises the threshold question of whether the Court’s function should cease once orders have been made under Section 269O, eg setting a limiting term, and that thereafter the person is subject to supervision and management by experts in the mental health area without the Court playing any further part. In some respects, this would be similar to the Court’s function ceasing once sentence has been passed and prisoners then being managed by the Department for Correctional Services and the Parole Board. The competing issue is whether, given that the person’s liberty is at stake, the Court should have an ongoing supervisory role”.*

Amongst others, the Chair of the Parole Board, Ms Frances Nelson, QC, has questioned the need for the Court to remain involved once it has determined that mental impairment and the elements of the offence existed. The Public Advocate expressed similar conclusions in a submission to the Committee.

The Joint Stakeholder Survey Report also recommended that consideration be given to *“whether a statutory panel could provide more flexible and appropriate outcomes.”*

The report noted that *“survey input was to the effect that interstate models, which establish a statutory body or tribunal to make variation decisions and issue orders in relation to supervision and ongoing management of a mentally impaired defendant in the community may be more appropriate. More accessible processes, such as now occur with the Parole and Guardianship Boards, may improve access, provide greater flexibility for clinical / supervisory management, and be more appropriate (as the issue of criminal responsibility for the offence has already been determined by the Court).”*

It is important to realise that in most Australian jurisdictions, the Court shares responsibilities for forensic patients with a mental health board or tribunal.

Forensic patients are treated quite differently from mainstream patients by the law in South Australia. The criminal justice legislation deals with forensic patients. The mainstream Mental Health Act is silent about them.

7.2 Some Other States

7.2.1 New South Wales

In New South Wales, the Supreme Court and District Court refer questions of mental competence to the Mental Health Review Tribunal for determination. The courts then make appropriate orders, including limiting terms and detention.

The Tribunal is then obliged to review each forensic patient on an ongoing basis, and make recommendations to the Minister as to the patient's continued detention or care arrangements, fitness to be tried, or release (either unconditionally or subject to conditions).

The Minister can then act upon the recommendations of the Tribunal without needing to go back to the Court.

In the Magistrates Court, there are less formal provisions enabling a Magistrate to make orders in relation to a person who appears to be mentally ill or developmentally disabled, in similar fashion to the Commonwealth Crimes Act mentioned previously. This includes release unconditionally or into the care of a responsible person.⁴¹

7.2.2 Victoria

In Victoria, the mental impairment defence does apply to the Magistrates Court, but if the Magistrates Court finds the person not guilty because of mental impairment of a summary offence, or an indictable offence tried summarily, the Magistrates Court must discharge the person. The higher courts have similar provisions to South Australia, with provision for supervision orders. These courts cannot make a supervision order unless

⁴¹ Mental Health (Criminal Procedure) Act 1990 (NSW).

the Department of Human Services has certified that the facilities or services necessary for the order are available.

The Court can release a person or significantly reduce the degree of supervision, on the basis of one specialist report.

The legislation also establishes a forensic leave panel, which includes judicial and psychiatric members, to hear applications for leave of absence. Leave of absence includes on-ground leave, limited off-ground leave and special leave. Special leave cannot exceed 7 days for medical treatment, or 24 hours in other cases. Extended leave is for leave not exceeding 12 months.

Extended leave applications must go back to court.⁴²

In practice, Magistrates divert people with mental impairment into counselling treatment, but like South Australia, there is no formal legislative basis for diversion.

7.2.3 Western Australia

A court can make a custody order or release a person found not fit to stand trial without determining the guilt or innocence of the defendant.

In the case of offences tried summarily, a custody order cannot be made unless the statutory penalty includes imprisonment.

A specialist Mentally Impaired Defendants Review Board determines where custody orders are to take place.

It also reviews the orders within 8 weeks after they are made and at least once a year and when requested by the Attorney-General, and reports to the Attorney-General on such orders.

The Board can make leave of absence recommendations to the Attorney-General for the Governor to grant.

⁴² Crimes (Mental Impairment and Unfitness to be Tried) Act 1997 (Vic).

The Board can also make release recommendations to the Attorney-General for the Governor to grant.⁴³

7.2.4 Queensland

In Queensland, questions as to a person's mental condition relating to an indictable offence may be referred to a Mental Health Court, constituted by a Supreme Court Judge and 2 psychiatrists.

The Court has inquisitorial powers of investigation. It may order the person to be examined.

The Court denotes whether, when an offence was allegedly committed, a person was:

- of unsound mind;
- of diminished responsibility (where the charge is murder); and
- if the person was not of unsound mind, whether he or she is fit for trial.

If the Mental Health Court decides the person was of unsound mind, or is unfit for trial, it may make a forensic order. Under this order a person may be detained in an authorised mental health service, or a high security unit, for treatment or care. The Court also has the power to order limited community treatment, which enables the person to reside in the community with active monitoring by a mental health service.

Review of the patient is then conducted by the Mental Health Review Tribunal every 6 months or on application. The Tribunal has the power to discharge the patient, approve limited community treatment and order the patient's transfer to another hospital or removal from Queensland. The Tribunal is required to take into account factors such as the patient's treatment and security needs and the safety of the community.⁴⁴

⁴³ Criminal Law (Mentally Impaired Defendants) Act 1996 (WA).

⁴⁴ Mental Health Act 2000 (Qld).

7.3 Options for a Board or Tribunal

A number of issues need to be considered:

- Should it be an existing body like the Guardianship Board, or the proposed Mental Capacity Appeal/Review Tribunal, or a stand-alone body?
- In either case, should it have a membership, which includes Parole Board/ Corrections or other representation and expertise?
- Should it monitor, grant leave, be able to vary security, terminate orders?
- Should it be able to do all these things or make recommendations to the Minister on some?
- Does the Minister retain his/her supervisory roles if such a body or Tribunal exists?
- Does anything go back to the Court after responsibility has passed to the Tribunal, for example, an annual report?
- Does it simply create another mechanism?

In the South Australian context, it certainly seems preferable for this forensic review body to be an existing body like the Guardianship Board, or the proposed Mental Capacity Tribunal, or to be closely associated operationally, sharing administrative supports.

If the Guardianship Board has the review functions suggested elsewhere in this Report, there would be a synergy with the forensic review role. The Tribunal may offer a higher level in status, which is commensurate with a function previously performed by all the courts.

In either case, while the same chairperson could sit, there would be a need to be able to call upon members with a range of expertise and backgrounds for serious forensic cases, just as the Guardianship Board now has a range of members to call upon for particular matters.

There would seem little point in giving only a limited leave of absence role to the body. Ideally, it would have responsibility for regular review, varying supervision, granting leave and release on licence. Supervision of some kind would remain until expiry of the limiting term of the original court order.

The Tribunal should have power to make its own decisions rather than merely recommend to the Minister.

Given the transfer of functions from the courts to the Tribunal, there does not seem to be a need for an annual report from either the Tribunal or the Minister to the relevant court. Rather, the Tribunal should review cases of people under supervision at least once a year and seek reports as needed from those providing care.

The Tribunal should provide an annual report to Parliament on its forensic supervisory role (in addition to any other role) via the relevant Ministers.

It is important that careful thought be given to the procedures of the Tribunal so that it can provide a more expeditious consideration of issues than the courts have done.

Recommendations:

- 7.1 The Mental Capacity Tribunal proposed in this Report should also provide a supervisory role for offenders with mental impairment, instead of the courts.**
- 7.2 The Tribunal should be able to make its own decisions rather than merely recommend to the Minister.**
- 7.3 It should have responsibility for regular review, varying supervision, granting leave and release on licence.**
- 7.4 The Tribunal should provide an annual report to Parliament on its forensic supervisory role (in addition to any other role) via the relevant Ministers.**

8. LINKS BETWEEN THE COURTS AND MENTAL HEALTH SERVICES

There have been a number of suggestions made to strengthen links between the criminal justice and mental health areas.

8.1 The Status of Section 269 Patients in the Mental Health System

One area of uncertainty is the status of Section 269 patients in the mental health system. Legally, they derive their status from the supervision orders made under the CLCA (detention, or release on licence).

In practice, because the situation is not clear, they are commonly detained at JNH or released on CTOs under the Mental Health Act. There is a doubling up of orders to clarify where they stand. It does mean, for example, that they must be given a statement of patient rights like other detained persons.

It has been suggested that they should be regarded as voluntary patients under the Mental Health Act, presumably so that any restrictions derive from the original court orders.

Another suggestion is that the Mental Health Act should articulate their status. The Victorian Mental Health Act, for example, clarifies that upon admission to an approved mental health service, a forensic patient (including a person under a custodial supervision order) is to be detained and treated for his or her condition. If he or she refuses to consent to necessary treatment or is not capable, then a psychiatrist can authorise treatment. Patients are defined to include forensic patients, and as such are entitled to statements of rights and treatment plans.⁴⁵

In Queensland, as already indicated, the Mental Health Court can make orders with immediate operation in the mental health system and under the Mental Health Act.

Dr Shane Gill makes an interesting suggestion that would see a court make a forensic detention order lasting 30 days to enable initial mental health

⁴⁵ s17A, Mental Health Act 1986 (Vic)

assessment and treatment at an Approved Forensic Treatment Centre (eg JNH) and then be transferred into the mainstream system subject to the provisions of the Mental Health Act, and its options for detention and community treatment.

He would see this reducing the need for specialist forensic beds, as well as integrating people into the mainstream system.

“If we were to persist with this process of treating persons acquitted because of mental impairment in some sort of twilight zone between prisoner and patient, and require they be kept in hospital for much longer periods than their illness dictates, then we will need to build many more forensic beds than we have. A better approach is to move their care into the mainstream mental health system and make them subject to the same processes (Mental Health Act, inpatient care and community care) as other mental health consumers. This is my preferred choice, as these people have much more in common with psychiatric patients than they do prisoners.”

Another view is that the current practice of making orders under the Mental Health Act or the Guardianship and Administration Act after a person is referred by court order is not a serious problem. In fact, it can be seen as a way of bringing specific treatment requirements or plans and patients' rights to individual offenders, within the outer perimeter of the court order and its requirements for supervision.

Orders under the Mental Health Act may include orders for detention or community treatment. Under the Guardianship and Administration Act, a person who is mentally incapacitated may be ordered to reside in particular places or with a particular person or have a guardian or administrator appointed. In other words, once referred by the courts subject to some general conditions, which relate to risk, the further needs of the person are considered in a therapeutic context.

We are inclined to think that this approach should prevail for the time being because of its flexibility.

If other solutions emerge in the future, they should be considered.

8.2 Relationship between the Court and the Guardianship Board

People with mental illness, intellectual disability or brain injury can find themselves before the courts or bodies like the Guardianship Board at different times.

The Chief Magistrate has expressed the view that there should be a mechanism for information to be shared between the courts and the Board.

It is often important for the Court to know the outcome of guardianship, treatment and detention orders in determining what orders it should make. It appears that when the Magistrates Court Diversion Programme is involved, the Court is notified of progress. However, for others before the Court who are subject to Board orders, there is no mechanism to inform the Court of progress.

The Court is seen as a possible avenue both to refer defendants to the Board, and assist with compliance of offenders, where appropriate.

The possibility of court officers making application to the Board for appropriate orders was raised during consultation. At this point, such officers would be unlikely to fit the criteria as applicants before the Board.

The Guardianship Board does have concerns about being used as a means of enforcement when an offence has been committed. Its charter is seen as making orders for therapeutic or public safety ends, rather than compliance for offenders.

Recommendations:

8.1 The Committee considers there are advantages in the current approach, where the courts set general requirements for supervision of defendants with mental impairment under Section 269, and orders are made under the Mental Health Act or Guardianship and Administration Act to meet their specific therapeutic needs and clarify their status and rights as patients.

8.2 The potential for information and referral between the courts and the Guardianship Board should be further explored.

9. CORRECTIONS AND MENTAL HEALTH

9.1 Department for Correctional Services Submission

As the Department for Correctional Services (DCS) noted in a submission to the Review Committee, the Department has a central role in the criminal justice process in South Australia.

It intersects with Mental Health Services in the case of offenders with a mental illness or other relevant services in the case of intellectual disability or brain injury.

The Department notes among other things:

- Difficulties in operationalising joint arrangements under Section 269, partly because of confusion over respective roles.
- The need for the status of offenders referred for mental health treatment to be clear.
- Treatment of offenders dually served by DCS and the Department of Health to be in accordance with the draft National Statement of Principles for Forensic Mental Health.⁴⁶ The National Statement in particular calls for equivalence to the non-offender, so that prisoners and detainees have the same right to access equity and quality of mental health care as the general population.

The submission also proposes that specific DCS staff be credentialed to make orders for immediate admission and assessment of prisoners and detainees to an ATC, and not just medical practitioners, as at present. Prison nurses or senior staff in Community Corrections are suggested.

Elsewhere in this Report, we recommend that persons other than medical practitioners be able to make this order.

⁴⁶ Commonwealth Department of Health and Ageing, 2002.

The submission stresses the need for the South Australian Health Commission (SAHC) Act (and the Mental Health Act) not to be a barrier to appropriate sharing of information between agencies.

It supports the establishment of an expert panel or body to supervise offenders, especially for offenders under Section 269, without having to go back to court.

The submission asserts the need for the forensic patient and their status and rights under the Mental Health Act to be defined.

It also supports a pamphlet on their rights as patients to be provided to all forensic patients on admission.

9.2 SA Review of Health Services and Programmes for Prisoners and Young People in Custody

This 2005 Review by consultants Jocelyn Auer and Belinda Chaplin has been taking place at the same time as the Joint Stakeholder Survey and our legislative review.

It aims to describe current health services and programmes and the legal framework, management and governance arrangements for their provision to prisoners and young people in custody. It also seeks to make recommendations for improvement and set strategic directions for the future.

Its focus is not particularly on mental health, but it notes the extent of mental health problems among prisoners and young people in custody. It highlights the Memorandum of Understanding between the Minister for Health and Correctional Services under which health care is provided to people in custody.

It recommends that consideration be given to amending Corrections legislation to set out (amongst other things):

- inmates' right of access to medical attention, treatment and medicine;
- health care functions of the custodial health service;
- access by providers to offenders in order to provide services.

With respect to mental health, it recommends a specific work group to report on strategies to improve mental health assessment and referral pathways and seamless care from and back into the community where possible.

It highlights “*the smooth and legally appropriate flow of confidential information*” as important.

It recommends a project to clarify principles of information rights as a guide to staff.

This project sits comfortably alongside the Review of Mental Health Legislation.

Recommendations:

- 9.1 The Committee supports implementation of the National Statement of Principles for Forensic Mental Health.**
- 9.2 Forensic patients should be given a pamphlet on their rights on admission.**
- 9.3 Barriers to appropriate sharing of information between Corrections and Health and between health units should be removed.**

10. ROLES OF THE MINISTER AND PAROLE BOARD

Under the present provisions, the Minister responsible for the administration of the Mental Health Act has custody of a defendant detained under Section 269 and may give directions for the custody, supervision and care of the defendant. It is understood the intention was to provide a higher level of ministerial accountability for vulnerable people. Supervision responsibilities for people on licence are exercised by the Minister in relation to the mental condition of the person, and other responsibilities by the Parole Board.

It is worth considering these roles having regard to several issues, which have arisen during this Review:

- (1) There are now separate Ministers for Health and Disability Services.
- (2) The ministerial responsibility requires a series of delegations to be made to those working in the system – there has been some confusion and delay in making this happen.
- (3) The Parole Board in practice is not being notified of applications or orders and does not have direct input into conditions.
- (4) The respective roles of the Minister and the Parole Board are not always clear. What is meant by “the mental condition” is not always clear.
- (5) There is a strong impetus to have a statutory body with Health and Parole Board / Corrections membership to supervise orders that have been made.
- (6) There is the view that people under mental impairment orders should have the same protections as other patients under the Mental Health Act.
- (7) There are initiatives to achieve cooperation between Health and Corrections at the departmental level.

It seems timely to consider whether a simplification should be considered. Given the possibility of a Tribunal with a supervisory role, and the protection of the Mental Health Act, is there a need for the Minister or the Parole Board to continue to have their current supervisory or custodial roles? Is it not simpler for the Minister (or Ministers) to have their normal roles of ministerial accountability rather

than special roles, with day-to-day supervision of orders carried out by Health and Community Corrections as departmental functions, and not based on ministerial or Parole Board delegations? An MOU between Health and Corrections would help to make things happen on the ground.

If a higher order obligation is seen as needed, it seems preferable to oblige the Minister under the Mental Health Act to ensure that the rights of forensic patients are as close as possible to those enjoyed by other patients. There could also be objectives to ensure that forensic patients get the services, treatment and care they need. This would be consistent with the draft National Statement of Principles for Forensic Mental Health.

Recommendations:

- 10.1 The current supervisory or custodial roles of the Minister and the Parole Board should no longer continue, if a Tribunal is empowered to have a supervisory role. The Minister (or Ministers) then should have their normal roles of ministerial accountability, rather than special roles, with day-to-day supervision of orders carried out by Health and Corrections as departmental functions, supported by an MOU.**
- 10.2 The Minister should be obliged instead under the Mental Health Act to ensure that the rights of forensic patients are as close as possible to those enjoyed by other patients. There could also be objectives to ensure forensic patients obtain the services they need.**

11. CHILDREN AND YOUTH

We have already discussed the special vulnerabilities of children and youths in the mental health system.

The same can be said for the criminal justice system.

The Youth Offenders Act 1993 is testament to the need for special protections, with limits on the circumstances in which courts can sentence a youth to imprisonment and with preference being given to training centres and home detention, rather than prison.

The Magistrates Court Diversion Scheme has been introduced into the Youth Court and the legislative amendments before parliament will confirm the availability of diversion schemes there.

We note concerns expressed by the Department of Families and Communities that the introduction of mental health intervention programmes into justice legislation has the potential to result in delays in finalising justice matters which can, in turn, lead to prolonged and unnecessary management of youth in the justice system.

The Department also indicates that legislative change is only as good as the programmes and services in place to cater for the needs of those referred to them.

We note that Section 269 is sometimes used as a defence to charges against youths.

We would support a clarification to Part 8A of the CLCA that, in the case of minors, priority be given to community placement and treatment wherever possible.

It would seem crucial for children and youths with mental impairment that a full range of options exist, from Section 269 to informal dismissal of charges.

12. MENTAL HEALTH AND DRUG AND ALCOHOL ABUSE

12.1 Introduction

It is not surprising that people may have a range of problems, which manifest themselves in different ways. For example, a person may have an alcohol or drug abuse problem that can lead to drug induced psychosis at times, or it may mask serious underlying mental health problems such as depression or schizophrenia.

Statistically, 1 in 5 adults in Australia has a mental disorder.⁴⁷ Studies indicate that 60% of people with schizophrenia also engage in problematic substance use.⁴⁸

Service and legislative responses, which focus rigidly on a single morbidity are unlikely alone to meet the needs of people with complex needs.

As well, particularly in the case of legislative intervention, dilemmas can arise about restrictions or limitations, and their basis.

12.2 Consultation.

Consultation with those involved with the courts and in service provision saw co-morbidity as a major issue.

For Aboriginal organisations *“there is a lack of facilities for people who may have co-morbid conditions. Many of them are turned away at shelters and have nowhere to go”*.

For the courts, there was a lack of services to which to refer people both specialising in substance abuse, or dealing with co-morbidity. *“If one treats only a mental illness eg stabilise the illness but we don’t address the other factors eg drug and alcohol abuse, major problems remain as use of illicit substances is often resumed as soon as a person is in the community. Mental illness is only one aspect”*.

⁴⁷ National Survey of Mental Health and Well-being of Adults in Australia, ABS, 1997.

⁴⁸ Discussion Paper, The Management of People with a co-existing Mental Health and Substance Use Disorder, NSW Health, 2000.

Mental health services saw a moral dilemma in responding to patients with co-morbidity at times. To what extent should services respond to patients who have abused drugs and alcohol? Where do the responsibilities of service providers end and the responsibilities of individual consumers begin?

As one community mental health team expressed it; *“those with drug psychosis and borderline personality disorders block the system”*.

In the country, given the lack of facilities, assisting can mean involving the RFDS to fly someone down to a metropolitan ATC only to have the person bussed back a couple of days later.

With respect to the criminal justice area, there was concern within mental health services that while mental impairment under the CLCA does not include intoxication per se, drug or alcohol induced psychosis is being used as a ground for arguing the mental impairment defence. There is a view that there is an element of choice, that if people are psychotic due to drug or alcohol abuse, they should be treated in a similar way to those who are intoxicated, and that if an offence is committed during a drug induced psychosis, the person should be charged and not be able to make use of the mental impairment defence. Section 269 is also seen as inappropriate, given the formality and time involved in proceedings and the fact the person may only need a few days for the psychosis to be resolved.

12.3 The Need for Legislative Options

What emerges again is the importance of a range of flexible and appropriate legislative options as well as services.

12.3.1 The Magistrates Court Diversion Scheme

Again, the passing of the Statute Amendment (Intervention Programs and Sentencing Procedures) Bill 2005 is important to affirm the power of the courts to deal appropriately with people with a range of problems. The Bill defines intervention programmes to include supervised treatment, rehabilitation, behaviour management, access to support services or a combination of these, designed to address behavioural problems, substance abuse or mental impairment.

An appropriate expansion of eligibility will also help to reduce reliance on Section 269 in this area.

12.3.2 Diversion under the Controlled Substances Act 1985

For more than 15 years, a multi-disciplinary Drug Assessment and Aid Panel provided a diversion scheme for people found in possession of hard drugs (excluding cannabis) under the Controlled Substances Act 1985.

For 6 months, offenders undertook to receive counselling or other services, and not to use drugs. The Panel either saw offenders 3 or 4 times itself and/or referred offenders to other services. If offenders fulfilled the undertaking the Court was advised and charges dropped.

Many had mental health problems as well and the scheme ensured that people with co-morbidity issues were kept out of the courts while at the same time receiving some assistance.

This scheme was replaced by a police and service based diversion scheme 3 years ago. It is understood that it is not serving the same number of people as the previous scheme.

It would be timely to review its effectiveness.

12.3.3 Public Intoxication Act 1984

This little known Act empowers police officers to detain people under the influence of alcohol or drugs and take them home, to a police station or to a sobering up centre. They can be held at a sobering up centre for up to 18 hours.

Again, it would be interesting to know its effectiveness in intervening to assist people with co-morbidity problems and whether legislative change is needed. In fact, it does seem to have potential as a means of intervening, for example, to assist people with drug induced psychosis.

12.3.4 Mental Health Act 1993

Elsewhere in this Report, we have suggested that the initial admission and detention order should be for up to 7 days, and be able to be carried out in places other than authorised treatment centres. This is particularly aimed at people who may need short-term intervention, such as people with drug induced psychosis, and to ensure that country hospitals can hold them while they recover without the disruption of moving them to the city.

12.3.5 Mental Impairment Defence under the CLCA

Given views held, consideration should be given to whether the defence should continue to be available for drug-induced psychosis.

However, this is an issue needing further debate. It is an area of fine distinctions and dangers of moralistic judgments, as well as finite resources.

Recommendations:

- 12.1 The mandating of the Magistrates Court Diversion Program by legislation, and the expansion of the scheme is important for people with co-morbidity problems.**
- 12.2 The effectiveness of the diversion scheme under the Controlled Substances Act 1985 should be reviewed.**
- 12.3 The potential for the Public Intoxication Act 1984 to be used to assist people with co-morbidity problems should be investigated.**
- 12.4 The Mental Health Act 1993 should be amended to enable short-term detention for problems such as drug-induced psychosis to be resolved, without having to transfer people to metropolitan hospitals.**
- 12.5 There should be further debate as to whether the mental impairment defence under the CLCA should continue to be available for drug-induced psychosis.**

13. ABORIGINAL OFFENDERS WITH MENTAL HEALTH PROBLEMS

In our discussion on Aboriginal consumers and carers in Part I, we detail a number of issues of particular relevance to Aboriginal people, including cultural differences and a lack of services near where they live.

In a submission to the Committee, Fred Field, SM, makes it clear that these issues are also relevant in the criminal justice area. He notes, for example, that Section 269 is of limited use to most Aboriginal people because the delays involved may mean the defendant spends more time in remand than a prison sentence is likely to be and there are few services suitable as an alternative. He indicated that Aboriginal people often preferred to accept time in prison rather than look to Section 269 or diversion schemes.

Richard Balfour, Senior Psychologist, JNH, notes in a survey summary for the Joint Stakeholder Survey Report that 17% of the gaol population in South Australia is Aboriginal, compared to 1% representation in the general population.

In Port Augusta gaol, 80% to 90% of prisoners are Aboriginal, with approximately 50% of these being traditional Aboriginal people.

This means simply as a matter of percentages, that a large number of these people will have some form of mental illness or disability, apart from cultural differences.

These issues are discussed in detail by Margaret Bonesmo in her Joint Stakeholder Survey Report, and we suggest that it be read particularly in this area, in conjunction with our Report.

The Bonesmo Report stresses the importance of mental health and forensic services for Aboriginal people being developed in consultation with those people.

We also note the Statute Amendment (Intervention Programs and Sentencing Procedures) Bill 2005, which would introduce a series of protections for Aboriginal defendants when being sentenced, including:

- the assistance of an Aboriginal Justice Officer;

- the use of sentencing conferences;
- involvement of an Aboriginal Elder, and a person qualified to provide relevant cultural advice from the defendant's community.

We also suggest that forensic patients who are Aboriginal should have the protection of the principle regarding culturally appropriate treatment suggested in Recommendation 9.1 of Part I of this Report.

Recommendations:

13.1 Similar issues of cultural differences and lack of services apply to Aboriginal people in the criminal justice area as in the mental health area.

13.2 The discussions and recommendations in the Joint Stakeholders Survey Report regarding Aboriginal offenders in particular should be read in conjunction with this Report.

13.3 The passing of the Statute Amendment (Intervention Programmes and Sentencing Procedures) Bill 2005 will be important in protecting Aboriginal defendants, when being sentenced.

13.4 Forensic patients who are Aboriginal should have the protection of the principle that, as far as possible, treatment and care of a person of Aboriginal background must be culturally appropriate, and take into account the views of the person's family and community.

14. RESOURCES

Again, in the criminal justice area, the issue of resources has been a significant one, which can affect the best of legislative intentions. The Joint Stakeholder Survey Report deals in considerable detail with resource and infrastructure concerns and we do not propose to repeat that discussion.

However, it would be remiss of us not to indicate again that a lack of resources or service options affects the kinds of orders that a court can make. It is a constant theme when talking to judicial officers. If there is a lack of community options or services in the country, it is more likely that people are held longer in inappropriate settings often away from where they live. It can mean gaol instead of a service.

It can affect the value of diversion schemes if there are no diversion programmes.

A lack of resources or service options can particularly affect marginalised groups such as Aboriginal people, people with personality disorders, people with drug and alcohol problems, and those with an intellectual disability or brain injury.

It is not just a question of money or resources. As one submission to the Committee put it: "*We do need a large injection of money*", but it also needs to be "*combined with a greater injection of intelligence, imagination and compassion*".

15. SUMMARY OF RECOMMENDATIONS

Chapter 2 – Legislative Framework:

- 2.1 The Statute Amendment (Intervention Programs and Sentencing Procedures) Bill 2005 should be passed to provide a legislative basis for current diversion schemes, and to allow consumers with cognitive impairment to have bail.**

Chapter 3 - Operational Reviews:

- 3.1 Ensure Ministerial arrangements for carrying out functions under Section 269 CLCA are in place in both health and disability services.**
- 3.2 Ensure cross-border inter-jurisdictional arrangements for persons under Section 269 orders are in place with such legislative amendments as may be necessary.**

Chapter 4 - Joint Stakeholder Survey:

- 4.1 That the Joint Stakeholder Survey Report be read in conjunction with this Report.**

Chapter 5 - Application of the Mental Impairment Defence:

- 5.1 The Magistrates Court Diversion Scheme should be expanded where possible and mandated by legislation.**
- 5.2 There should be a four-pronged approach to offenders with mental impairment:**
 - 5.2.1 Informal referral by police without going to court where appropriate.**
 - 5.2.2 Power in Magistrates to deal with minor matters without resort to diversion or formal mental impairment defences.**
 - 5.2.3 Use of diversion programmes in more serious matters where the person is willing to undertake such programmes.**
 - 5.2.4 Use of the formal mental impairment defence in higher order contested matters.**
- 5.3 The formal mental impairment defence should be preserved for serious matters involving a potential term of imprisonment of one year or more. This change should be made when there is legislative backing empowering Magistrates to withdraw charges upon successful completion of a programme, or Magistrates have power to dismiss trivial matters and refer a person informally for treatment.**

Chapter 6 – The Processes:

- 6.1 There should be a discretion in the courts or supervising body as to the number of expert reports required. It would be better to specify areas such as psychiatric, psychological or community services, from where reports could be obtained, rather than any particular number of reports.**
- 6.2 The current restriction on seeking a variation or revocation of a supervision order for 6 months after a refusal should be removed.**
- 6.3 The Committee supports the development of information and training for those working in the courts or the mental health area regarding Section 269 matters.**

Chapter 7 - Supervision – An Alternative Approach:

- 7.1 The Mental Capacity Tribunal proposed in this Report should also provide a supervisory role for offenders with mental impairment, instead of the courts.**
- 7.2 The Tribunal should be able to make its own decisions rather than merely recommend to the Minister.**
- 7.3 It should have responsibility for regular review, varying supervision, granting leave and release on licence.**
- 7.4 The Tribunal should provide an annual report to Parliament on its forensic supervisory role (in addition to any other role) via the relevant Ministers.**

Chapter 8 – Links between the Courts and Mental Health Services:

- 8.1 The Committee considers there are advantages in the current approach, where the courts set general requirements for supervision of defendants with mental impairment under Section 269, and orders are made under the Mental Health Act or Guardianship and Administration Act to meet their specific therapeutic needs and clarify their status and rights as patients.**
- 8.2 The potential for information and referral between the courts and the Guardianship Board should be further explored.**

Chapter 9 - Corrections and Mental Health:

- 9.1 The Committee supports implementation of the National Statement of Principles for Forensic Mental Health.**
- 9.2 Forensic patients should be given a pamphlet on their rights on admission.**
- 9.3 Barriers to appropriate sharing of information between Corrections and Health and between health units should be removed.**

Chapter 10 - Role of the Minister and Parole Board:

- 10.1** The current supervisory or custodial roles of the Minister and the Parole Board should no longer continue if a Tribunal is empowered to have a supervisory role. The Minister (or Ministers) then should have their normal roles of ministerial accountability rather than special roles, with day-to-day supervision of orders carried out by Health and Corrections as departmental functions, supported by an MOU.
- 10.2** The Minister should be obliged instead under the Mental Health Act to ensure that the rights of forensic patients are as close as possible to those enjoyed by other patients. There could also be objectives to ensure forensic patients obtain the services they need.

Chapter 12 - Mental Health and Drug and Alcohol Abuse:

- 12.1** The mandating of the Magistrates Diversion Scheme by legislation, and the expansion of the scheme is important for people with co-morbidity problems.
- 12.2** The effectiveness of the diversion scheme under the Controlled Substances Act 1985 should be reviewed.
- 12.3** The potential for the Public Intoxication Act 1984 to be used to assist people with co-morbidity problems should be investigated.
- 12.4** The Mental Health Act 1993 should be amended to enable short-term detention for problems such as drug-induced psychosis to be resolved, without having to transfer people to metropolitan hospitals.
- 12.5** There should be further debate as to whether the mental impairment defence under the CLCA should continue to be available for drug-induced psychosis.

Chapter 13 - Aboriginal Offenders with Mental Health Problems:

- 13.1 Similar issues of cultural differences and lack of services apply to Aboriginal people in the criminal justice area as in the mental health area.**
- 13.2 The discussions and recommendations in the Joint Stakeholders Survey Report regarding Aboriginal offenders in particular should be read in conjunction with this Report.**
- 13.3 The passing of the Statute Amendment (Intervention Programs and Sentencing Procedures) Bill 2005 will be important in protecting Aboriginal defendants, when being sentenced.**
- 13.4 Forensic patients who are Aboriginal should have the protection of the principle that, as far as possible, treatment and care of a person of Aboriginal background must be culturally appropriate and take into account the views of the person's family and community.**

GLOSSARY

ADD	Administrative and Disciplinary Division (of the District Court)
APY Lands	Anangu Pitjantjatjara Yankunytjatjara Lands
ATC	Approved Treatment Centre
CAA	Court Administration Authority
CAS	Court Assessment Service
CDO	Continuing Detention Order
CLCA	Criminal Law Consolidation Act
CTO	Community Treatment Order
DCS	Department of Correctional Services
DPP	Director of Public Prosecutions
ECT	Electro-Convulsive Therapy
GP	General Practitioner
HREOC	Human Rights and Equal Opportunity Commission
JNH	James Nash House
MOU	Memorandum of Understanding
NGO	Non-Government Organisation
NPPs	National Privacy Principles
NSMHS	National Standards for Mental Health Service
RFDS	Royal Flying Doctor Service
SAAS	SA Ambulance Service
SAHC	South Australian Health Commission
SAPOL	South Australia Police
UN	United Nations

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Aboriginal Health Advisory Committees Chairs (AHAC)

Aboriginal Health Council of South Australia - (Annual General Meeting)

Aboriginal Health Council of South Australia - (Aboriginal Primary Health Care Workers Forum and Aboriginal Health Council Secretariat)

Aboriginal Sobriety Group and **Nunkawarrin Yunti** (Joint meeting)

Agius, Leona - Muna Paiendi (Lyell McEwin Health Service)

Ashton, Maxie - Tobacco & Mental Illness Project, North Western Adelaide Health Service

Assessment Crisis Intervention Service (ACIS) Team and other Mental Health Community Team Leaders (Joint meeting)

Baker, Andrew - Manager Services, Oak Valley Health and Aged Care

Ballantyne, Melissa - Senior Solicitor, Women's Legal Service SA Inc.

Beckwith, Andrew (Dr) - Senior Consultant Psychiatrist, Community Mental Health Service, Royal Adelaide Hospital

Beltchev, George - Director, Major Projects Unit & Office of Health Reform, Department of Health

Berzins, Inga - Lawyer

Betterman, Cynthia - Executive Officer, Parent Advocacy Inc.

Biganovsky, Eugene - State Ombudsman, **Hale, Meg** – Investigating Officer, and **Hamilton, Pauline** - Investigation Officer, State Ombudsman Office

Bonesmo, Margaret - Barrister

Boswell, Michael - Michael Boswell & Associates

Bristow, Wayne (Superintendent) - SA Police, Port Augusta

Bruggenmann, Richard - Chief Executive Officer, and **Butler, Chris** - State Development Officer, Intellectual Disability Services Council

Butler, Brian - Chairperson, Carers Ministerial Advisory Committee

Carroll, Louise - Executive Officer, Health Consumers Alliance of South Australia Inc.

Caseleyr, Alice H (Dr) - Mount Pleasant

Ceduna/Koonibba Aboriginal Health Service - Ceduna

Chappell, Duncan (Professor) - President, Mental Health Review Tribunal (NSW)

Chivell, Mr Wayne - State Coroner

Clark, Margaret - Federal Representative, Christian Science Committee on Publication of South Australia

Consumers, Child, Youth and Family Service (CYFS) and Clubhouse Staff - Whyalla (Joint meeting)

Country Mental Health Program Managers - Department of Health

Crabtree, Marilyn - Manager, Aged Rights Advocacy Service Inc.

Dawson, Robin - Adult Mental Health Worker, Ceduna District Health Service

Denley, Lou - Acting Chief Executive, Department for Families and Communities

Dignam, Paul (Dr) - Psychiatrist, Women's & Children's Hospital

DiSisto, Nino - Regional General Manager, Riverland Regional Hospitals & Health Centres

Durrington, Learne – Deputy Director, Mental Health Unit, Department of Health

Dusmohamed, Sue - Manager, Specialist Courts, Magistrates Court

Edwards, Audrey

Emergency Department Staff - Port Augusta Hospital

Fairlamb, Judith - Murray Mallee Community Health Service, (Murray Bridge)

Felke, Ken (Dr) - Clinical Director, Rural & Remote, Glenside Campus

Field, Fred - Local Magistrate, Port Augusta

Fogarty, Marcia (Dr) - Clinical Director, Mental Health Division, Noarlunga Health Service

Forwood, Michael – Chief Executive Officer, Royal College of General Practitioners (South Australia / Northern Territory)

Francis, Theresa - Manager, and **Clark, Ms Christine** - Aboriginal Mental Health Worker, Aboriginal & Torres Strait Islander Community Health Services (ATSI), Noarlunga Health Service

Galleguillos-Pozo, Jorge - Executive Officer, Disability Action Inc.

Gaughwin, Matt (Dr) - Drug & Alcohol Resource Unit, **Beckwith, Andrew (Dr)** - Department of Psychiatry, Royal Adelaide Hospital, and **Koopowitz, Les (Dr)** - Consultant Psychiatrist

Gawler Mental Health Support Group

Gibbs, Helen (Dr) - Clinical Psychologist, Beaufort Clinic, North Western Adelaide Health Service

Gill, Shane (Dr) - Director of Clinical Services, Community Mental Health Service, Royal Adelaide Hospital

Guha, Sabil (Dr) - Psychiatrist, **Mental Health Community Team** and **SA Police** - Nunyara Wellbeing Centre, Whyalla (Joint meeting)

Gunter, Zane – Manager, Transitional Accommodation Program, AHA, Ceduna

Harley, John - Public Advocate

Harris, Geoff - Executive Officer, Mental Health Coalition of South Australia

Haythorpe, Ingrid - Acting Director, Office of the Chief Executive, Department of Health

Health Consumers Alliance of South Australia

Heddle, William (Dr) - President, Australian Medical Association (AMA)

Henderson, Kay

Hickey, John - Senior Project Officer, Legislative Policy and Review Team, Victorian Department of Health, Melbourne, Victoria

Hope, Vivien - Executive Officer, Multi-cultural Advocacy Liaison Services of South Australia (MALSSA) and Multi-cultural Communities Council of South Australia (MCCSA)

Horgan, Rebecca - Senior Policy Officer, Ethics & Privacy Policy Unit, Strategic Planning and Population Health, Department of Health

Horsnell, Jan - Chief Executive, Anglicare SA

Hyde, Malcolm (Commissioner) - Commissioner of Police, SA Police

James, Norman (Professor) - Clinical Director, Glenside Campus, Mental Health Service

Jones, Denis

Kanck, The Hon. Sandra, MLC - Health Spokesperson, Parliamentary Leader, South Australian Democrats

Kelly, Fiona - Director, Rural and Remote Mental Health Service, Glenside Campus

Kuchel, Brian

Lemmer, Chris - Chief Executive, South Australian Ambulance Service

Lesser, John - President, Victorian Mental Health Review Board, Melbourne, Victoria

Malone, Mary – Director, Glenside Services, Glenside Campus

Matta, Sandra - Acting Director, Community Mental Health Service, Royal Adelaide Hospital

McCulloch, Mandy - Acting Manager, Country Mental Health, Country Division, Department of Health

McKenny, Brian (Dr) - Consultant Psychiatrist, Rural & Remote Inpatient Service, Glenside Campus

McPheal, Ruth - Riverland Mental Health Service, Berri

Mental Health Advisory Group - Northern & Far Western Regional Mental Health Services, Port Augusta

Mental Health Directors' Forum - Department of Health

Miller, Harry - Chair, Wangka Wilurrara Regional Council of ATSIC, Ceduna

Moore, Gwen - General Manager Services, Uniting Care Wesley Adelaide

Mullen, Paul (Professor) - Forensicare, Melbourne, Victoria

Nelson, Ms Frances QC - Chairperson, Parole Board

Newchurch, Ann - Representative, Wakefield Aboriginal Health Advisory Forum and Aboriginal Family Practitioner, Child, Youth & Family Services, Kadina - (Port Pirie)

Norman, Ingrid - Managing Solicitor, Department of Health and Department of Families and Communities

Osborn, Thomas (Chief Superintendent) - Holden Hill Police Station, SA Police

O'Keefe, Karen - Lawyer, C.M. Tucker & Associates

O'Loughlin, Kate - Public Trustee

O'Shannessy, Leane - Manager, and **Sterry, Mr Michael** - Project Officer - New South Wales Department of Health, Sydney, New South Wales

Panter, David (Dr) - Chief Executive, Central Northern Adelaide Health Service

Park, Robert - President, Guardianship Board

Phillips, Jonathan (Dr) - Clinical Associate Professor / Director Mental Health Unit, Department of Health

Pika Wiya Aboriginal Carers - Port Augusta

Pika Wiya Aboriginal Health Service Staff - Port Augusta

Prescott, Kelvyn - Chief Magistrate, Magistrates Court

Public Meeting in Adelaide - Consumers, their families, carers and advocates

Ramsey, Roxanne - Executive Director, Country Division, Department of Health

Regional General Managers (Country) - Department of Health

Rendall, Viv

Robinson, Philip - Chief Executive, Division of Mental Health, Women's & Children's

Robinson, Philip - Chair Board of Directors, Australian Infant, Child, Adolescent and Family Mental Health Association Ltd (AICAFMHA)

Royal Australian and New Zealand College of Psychiatrists

Rozenbilds, Ute (Dr) - Consultant Psychiatrist, Repatriation General Hospital

Samuel, Brian & Rhonda

Scanlon, Maureen - Southern Regional Mental Health Advisory Group, Mount Gambier

Schmerl, Eric - Chief Executive Officer, Repatriation General Hospital

Seith, Francesca - Principal Policy Analyst (Carers), Health & Policy Reform, Department of Health

Setchell, John (Dr) - Health Services Manager, Royal Flying Doctor Service

Severin, Peter - Chief Executive, Department for Correctional Services

Sinor, Sally - Chief Program Officer, Mental Health Unit, Department of Health

Smith, Ann - Flinders Mental Health Consumer Advisory Group and Noarlunga Consumer Advisory Group

Smyth, Val - Principal Consultant, Acute Care & Clinical, Department of Health

Stewart, Harold - Senior Policy & Planning Officer, Aboriginal Health Division, Department of Health

Stewart, Terry - Adelaide Central Community Health Services, Aboriginal Consultation

Swan, David - Chief Executive, Mental Health Division, Southern Adelaide Health Centre

Tesoriero, Sandra - Chief Executive Officer, and **Lane, Andrew** - DON, Ceduna District Health Services

Tomaino, John - Principal Policy Officer, Justice Portfolio Services Division, Attorney-General's Office

Tustin, Don (Dr) - Psychologist, Division of Mental Health, Noarlunga Health Service

Udy, Terry - Chair, Murray Mallee Consumer Advisory Group, Murray Bridge

Vukovich, David - Social Worker and Volunteer Advocate

Wade, Victoria (Dr) - Medical Director, South Australian Divisions of General Practice (SADI)

Waldron, Bronwyn - Solicitor, Legal Services Commission

Wangka Wilurrara Accommodation Centre - Aboriginal Consumers, Carers and Service Provider Staff, Ceduna

Ward, Alexander - President, Law Society of South Australia

Warmington, Rosemary - Executive Director, Carers' Association of South Australia

Watson, Darryl (Dr) - Psychiatrist, Lyell McEwin Hospital

Wightman, Lee - Acting Manager, Health Policy & Reform, Department of Health

Worthington, Terry - Chief Judge, Chambers of Chief Judge, District Court of South Australia

PRINCIPLES UNDER NORTHERN TERRITORY ACT

- Principles relating to the provision of treatment and care:

When providing treatment and care to a person who has a mental illness the following principles apply:

- i. The person is to be provided with timely and high quality treatment and care in accordance with professionally accepted standards;
- ii. Where possible, the person is to be treated in the community;
- iii. As far as possible, the person's treatment and care is to be designed to assist the person to live, work and participate in the community and to promote and assist self-reliance;
- iv. The person is to be provided with appropriate and comprehensive information about his or her mental illness, proposed/alternative treatment and services available to meet the person's needs;
- v. Where possible, the person is to be treated near where he or she ordinarily resides or where relatives or friends of the person reside;
- vi. As far as possible, the person's treatment and any service to be developed for the person are appropriate having regard to the age and gender of the person.
- vii. As far as possible, the person is to be involved in the development of any ongoing treatment plan or any discharge planning;
- viii. The person is to be given medication only for therapeutic or diagnostic purposes and not as a punishment or for the convenience of others;
- ix. Except as provided by this Act, the person is not to be given treatment without his/her consent.
- x. The person's treatment is to be carried out, wherever practicable, within a multi-disciplinary framework;
- xi. The person's treatment and care is to be based on an individually developed plan that is discussed with the person, reviewed regularly and revised, as necessary, and is provided by qualified professional persons;
- xii. Where the person is from a non-English speaking background, the person's treatment and care is, as far as possible, to be appropriate to and consistent with the person's cultural beliefs, practices and mores, taking into account the views of the person's family and community;
- xiii. Any assessment of the person to determine whether he or she needs to be admitted to an approved treatment facility is to be conducted in the least restrictive manner and environment possible.

- Principles relating to involuntary admission and treatment

When admitting and treating a person as an involuntary patient the following principles apply:

The person should only be admitted after every effort to avoid the person being admitted as an involuntary patient has been taken;

Where the person needs to be taken to an approved treatment facilities or into custody for assessment, the assistance of a member of the Police Force is to be sought only as a last resort and there is no other means of taking the person to the approved treatment facility or into custody;

Involuntary treatment is to be for a brief period, reviewed regularly and is to cease as soon as the person no longer meets the criteria for involuntary admission;

Where the person is from a non-English speaking background, involuntary treatment is, where possible, to be provided by health service providers who are from the same non-English speaking background.

- Principles relating to rights and conditions in approved treatment facilities

When a person who has a mental illness is being treated in an approved treatment facility the principles include:

- i. The person's legal rights and his/her right to privacy and to religious freedom are to be respected;
- ii. The confidentiality of information relating to the person is to be respected;
- iii. Subject to this Act, the person's freedom of lawful communication should be protected;
- iv. The person's living conditions are to be as close as practicable to those usually experienced by people of a similar age living in the general community;
- v. Subject to this Act, the person is to have access to his or her personal records;
- vi. The person's right to make a complaint under an Act in respect of his or her treatment under this Act is not affected.

COMMUNICATION, EXCHANGE OF INFORMATION, STANDARDS OF RECORD KEEPING

1. Communication, exchange of information - Extract of submissions and/ consultations for the review of mental health legislation

1.1 Information sharing involving service providers / electronic database

- Improve communication of information between MH units, agencies and hospitals.
- Hospitals should provide immediate access to patient records to proper authorised staff.
- Police to provide written information why a person is conveyed to an ED for assessment.
- If SAAS, SAPOL & a community MH team are required, it should be coordinated.
- A communications (electronic information) system that preserves confidentiality is required.
- Recommendation 36 in the Layton Child Protection Review Report refers to the removal of barriers that prevent the appropriate exchange of information about children, young people and families that are involved with the child protection system and recommends that requirements under the Children's Protection Act should be referred to within the MH Act to enable improvements in appropriate, relevant information sharing.
- MHU should keep a register of approved psychiatrists with cultural expertise.
- Need better data collection and a central repository.
- Link EDs and GPs – Promote information sharing.
- The MOU with SAPOL should address the interaction between regions and agencies and should clarify powers to request police assistance.
- After hours there are issues in the country if a client needs assessment in the ED who is not known to the GP who attends or to the staff.
- GPs don't want to disclose information re medication etc.
- Psychiatrists should use accredited interpreters when examining persons.

1.2 Information sharing involving carers/consumers

- Treatment centres should immediately inform nominated relatives or carers of admission.
- When treatment plans are devised carer / consumer should be informed of the plan.
- Social workers should be used as they have better communication skills in talking to carers.
- Service providers should listen to carers/consumers.
- Treatment should include provision of education to enable a client to learn to self-manage.
- Facilitate a flexible range of interventions that empower clients to participate in decisions.
- Consumers and carers do not get enough information.
- The rights of carers and service providers to information must be stated in legislation.
- Consultation is required with children and young people who are consumers or carers of parents with mental illness.
- Families and carers should have more opportunity to provide relevant information.
- Carers & advocates should play a more a significant part in decision-making.
- Statements should be available in Braille.
- Carer assessments and perspectives are required in community care plans.
- Sharing of information for ongoing care with carers is necessary.
- Strengthen a commitment to participation and involvement of carers in treatment plans.
- Provide ongoing education about where people can go for help.
- Information provided by carers to services should be given higher priority.
- Information from carers/family not taken seriously- yet they have to "pick up the pieces".

- Communication, communication, communication!!!!
- Include carers from the start when formulating total care packages; they provide ongoing support.
- The main carer should have relevant information.
- Carers are not given explanations when someone is detained, the medical practitioners do not have collateral history, which the carer can provide.

1.3 Discharge planning

- Documents should be provided on discharge.
- Carers should be involved in discharge planning and should be consulted.
- What is required is good discharge planning, collaboration / support with appropriate exchange of information.
- Carers, relatives & support people should be involved in assessment/discharge processes.
- The family is to be given adequate information upon discharge to facilitate ongoing care.
- Consumers are currently not being given information on discharge.
- Notify carers prior to discharge.
- There's a lack of notification to community teams about discharges.

1.4 Education, access to/provision of general and de-identified information

- The Act should be easy to read.
- Create education and awareness programmes about mental illness.
- Decisions of the appeal body should be published to inform the interested community.
- The GB should provide de-identified reports about both administrative topics and rulings made by the Board.
- The OPA leaflets should be distributed in hospital wards.
- People in the community need easier access to information from the PA's office.
- The critical need for effective community education re mental illness should be recognised.
- The need for effective community education about mental illness should be recognised.
- More transparency is needed from the Guardianship Board.
- Accredited interpreters should be provided free of charge to consumer, guardian, relative or other person with proper interest (for GB hearings).
- Families feel physically and emotionally unsafe to reveal violence and threats of violence to the GB. These issues should be able to be offered in a confidential document.
- Consumers' representatives should be available to explain GB/court processes and to assist clients going before the Board.

1.5 Confidentiality

- Proposed amendment to confidentiality provisions is supported.
- S64D of the SAHC Act renders certain information absolutely secret...change this.
- Access to information without consent if in the patient's best interest should be facilitated.
- Staff are protective of positions and are hesitant of carer and consumer involvement.
- Privacy/confidentiality requirements around roles of carers should be clarified.
- Further clarification is necessary of situations in which either the consumer lacks capacity to consent to information being shared or where a consumer has not consented to information sharing but there is a serious risk of harm to the consumer or others.
- Health care workers should be able to provide relevant information to families and carers.
- Confidentiality is used as a reason for not providing an older person with information that would assist them to support the adult child's MH treatment, medication and appointments.

- Address services' interaction with carers re privacy/confidentiality requirements.
- Privacy laws are currently used to block provision of essential information to carers.
- Privacy and confidentiality provisions should be written to facilitate best possible outcomes.
- Protect individuals' privacy but also provide information to carers and other care providers.
- Confidentiality is a major barrier for families.
- Carers are not recognised properly – they are expected to assist but are often not given information. Confidentiality is wrongly given as reason.
- Carers are not listened to and are not given information about the consumer.
- Confidentiality has been used as an excuse for information not being given.
- Confidentiality is used as a barrier or excuse to not inform relevant others – Staff hide behind privacy and confidentiality provisions.
- Confidentiality and the disclosure of information is a major issue eg disclosure of financial information to other organisations to make health related decisions.

2 Mental Health Unit, Department of Health: An overview of trends from coronial recommendations and adverse events in August 2004

2.1 Coroner's Inquest into six homicides and/or suicides and aggregate recommendations in 1997

Some issues highlighted by the Coroner in his findings related to the quality of record-keeping and liaison with the patient's family. The Coroner's recommendations included:

- The role of family members in the monitoring of a patient's mental state...should not be underestimated. They are often in a position to provide information which the patient is unable or unwilling to disclose, which is relevant to a diagnosis or...re-emerging psychosis;
- The standard of record-keeping should be sufficient to enable the assessments referred to in these recommendations to take place. In particular, regular and accurate recording of the patient's mental state, including a note of the presence or absence of both positive and negative symptoms, should occur;
- Consideration should be given to the computerisation of psychiatric casenotes...;
- ...one member of the treatment team is specifically allocated the task of liaison with the family and supporters of the patient, should be considered for general application.

2.2 Coroner's Inquests & Adverse Events (2000 – 2004)

An in-depth review of 58 coronial inquests and/or adverse event files in the Mental Health Unit identified areas of service improvements including:

2.2.1 Standards of record keeping / Information sharing across service sectors and borders / one shared medical record

- Establishment of a system where knowledge of all patients admitted to non-MH wards is communicated to the relevant MH community team.
- Upon discharge the MH registrar at the ACIS team should be informed if there are incompletely resolved medical problems.
- Where patients present with a MH issue all available information should be made known to the medical officer responsible for diagnosis and treatment;
- Mental Health Services and public hospitals should examine ways in which staff can access a combined medical record of a patient when both are involved in treatment.

2.2.2 Database

- The forensic MH system has little or no control over and/or knowledge of an individual's movements between (and in and out of) correctional facilities and the duration of stay. MH and correctional systems should work in concert with

an automatic feedback system to inform relevant community care teams of the whereabouts of their client/patient at all times.

2.2.3 Referral systems

- In January 2003, a client on a Continuing Detention Order (CDOs) absconded from on 30/12/02 and on 2/1/03 presented to a GP in Melbourne, requesting medication for a medical condition. CDOs do not apply across state borders and a discharge summary was faxed interstate with the intention that interstate MH services should provide follow up. Unfortunately the client committed suicide on 3/1/03. The CDO was not clearly communicated to the interstate GP ie that the client was at serious risk of self-harm/suicide.

3. Electronic Records – Mental Health Unit Report as at 2 December 2004

This report highlights progress in improving the use and exchange of electronic data.

3.1 Community Based Information System (CBIS)

- The issue about staff in an ED having access to historical information is a prime example of why a statewide information system is needed for mental health (MH) services.
- The CBIS community based information system is due for implementation in the first part of 2005 to cover all mental health services in the metropolitan area.
- CBIS will allow Assessment Crisis Intervention Service (ACIS) staff in hospital EDs to view historical information and clients' movements. If the client has been seen in the community and has some alerts recorded, these will be visible which will be a significant improvement on the current situation.
- Because of privacy and confidentiality safeguards, not all staff will have this level of access, only those who need the information in order to provide appropriate care to the individual.

3.2 Open Architecture Clinical Information Service (OACIS) – as at December 2004

- OACIS is a clinical information system within the major metropolitan hospitals.
- OACIS links the clinical data across the hospitals into a single cohesive patient record which makes available to the treating clinician a comprehensive view of recent activity.
- If a patient then attends another participating site and has a unit record number the summaries are available to the treating clinicians.
- OACIS does not at present include alert data eg in regard to violent behaviour because there is no standard by which this data is collected and/or maintained.

3.3 HealthConnect – as at December 2004

- A key theme in health care reform is the integration and coordination of the delivery of care across the full range of health care providers. Achieving such integration depends upon relevant information being readily available at every point of care. Usually, this information is already on record somewhere in different formats and in a wide range of organisations.
- HealthConnect is a proposed new national system that will enable service providers in the public and private health sectors to seamlessly exchange consumer health information easily and safely. Rather than replacing the existing computer systems used by these providers across the health care sector HealthConnect will work in conjunction with them.
- Privacy protection underpins HealthConnect and participation will be voluntary.

4. Legislative Models

4.1 The Application of Rights Analysis Instrument to Australian Mental Health Legislation - Extracts relating to communication and exchange of information

The Application of Rights Analysis Instrument to Australian Mental Health legislation includes:

- Carers and advocates have the right to put information concerning family relationships and any matters relating to the mental state of the consumer to health service providers.
- The patient shall also be entitled to the assistance, if necessary, of an interpreter.
- The consumer has a right to information on and access to mechanism of complaint and redress and to appeal decisions made regarding their treatment and care.

4.2 The Model Mental Health Legislation (1994) - Extracts relating to communication, exchange of information

The model mental health legislation provides that:

- the information about rights and entitlements, and the notice of grounds of admission, must be provided to the person in the appropriate language.
- a written copy of the explanation and information shall be given to the representative of the patient or person subject to a CTO.
- the Director of a health care agency responsible for treating a person subject to a CTO must ensure that all steps as are reasonably practicable are taken to provide the person or his or her representative with particulars of the types of medication, the dosages, expected benefits and side effects of each medication that is administered to the person.
- Information about complaints procedures and advocacy services should be repeated at reasonable intervals.

**ULYSSES AGREEMENT (Example)
CARE, TREATMENT AND PERSONAL MANAGEMENT AGREEMENT**

This is an agreement between William (Bill) Edward Smith, of 111 Main Street, Elizabeth and the following people:

Dr Wong, my psychiatrist, 8555-8626
Julie Long, my mental health nurse, 8555-8626
Carrie Black, 8555-8078
Dr Stephen White, 8555-1843
Sam Thomas my probation officer, (see CARE), 8555-8834
Kerry Green, 8555-3273
Tim Ross, 8555-7626

These people are trusted friends or people who have experience with me and my illness. They have agreed to be members of my support team and to follow the guidelines set out below. The Elizabeth & Districts Police have been informed of my wishes as set out below.

PURPOSE

The purpose of this Ulysses Agreement is to provide a clear set of guidelines for actions to be taken by members of my support team in the event that I exhibit signs or symptoms of mania or serious depression.

SYMPTOMS OF MANIA

The following are my symptoms of mania:

1. Decreased sleeping with increased activity.
2. Excessive energy.
3. Grandiosity, inflated self-esteem, thinking I am better or more powerful than others.
4. Increased interest in activities, overspending, incurring heavy debts.
5. Extreme irritability, very demanding and angry when others do not jump to my commands.
6. Unpredictable emotional changes.
7. Talking more and faster than usual, shouting people down.
8. Thought processes speeded up, jumping from one topic to another, racing thoughts, flight of ideas.
9. Denying that I have manic depression, refusing treatment, denying that I need lithium.

Any four of the symptoms require action, as outlined below, to be taken.

PLAN OF ACTION FOR MANIA AND DIRECTIONS FOR POLICE INVOLVEMENT

For symptoms of mania, the following action should be taken by members of my support team:

- As many members of the team as possible shall consult each other and contact Carrie, as she has experience with my mania. If Carrie is not available, Stephen should be contacted.
- Carrie will alert Dr Wong re what action is going to be taken as set out in this Ulysses Agreement.
- Carrie will contact the Director of the Mental Health Centre.
- The Director of the Mental Health Centre will contact the police and request that they pick me up for 72 hour observation in hospital, preferably the Lyell McEwin Health Service.
- If possible, any one of my support team or a worker from the mental health centre should go with the police to pick me up as I have experienced difficulty with the police in the past.

SYMPTOMS OF DEPRESSION

The following are my symptoms of depression:

1. Feeling of uselessness, hopelessness, excessive guilt.
2. Slowed thinking, forgetfulness, difficulty in concentrating and in making decisions.
3. Not responding, to the phone or to messages.
4. Too tired and weak to do anything.
5. Increase in appetite and weight.
6. Decreased sex drive.
7. Suicidal thoughts.

Several of the symptoms require action, as outlined below, to be taken.

PLAN OF ACTION FOR DEPRESSION

For symptoms of depression the following actions should be taken by members of my support team:

- As many members as possible of the team will consult each other and contact Carrie
- If Carrie is not available, Stephen should be contacted.
- Carrie will alert Dr Wong that action should be taken as set out in this Ulysses Agreement.
- Dr Wong will instruct a mental health nurse to go to my apartment at 111 Main Street, Elizabeth to assess the situation. If there is a need for treatment I trust my psychiatrist to decide whether to treat me at home or in hospital. I usually do not need to be hospitalised when I am depressed.

I do not need the police involved if I am depressed.

CARE

I will see my psychiatrist two times per week during any medication changes and have my lithium level checked weekly. Once the medication is stabilised I will see my psychiatrist once a week and get my lithium level checked once a month.

The results of the blood test should be given to Dr Wong, my probation officer Sam Thomas and I. The purpose of Sam Thomas receiving the results of the lithium level is to ensure that the lithium levels are maintained, not to monitor the results of the lithium levels.

MEDICAL RECORDS

I authorise the release of the following information to my support team or people responsible for my care: The attached medical history and medical information during which this agreement is activated.

TREATMENT WHILE IN HOSPITAL

I am allergic to chlorpromazine so while in hospital I SHOULD NOT BE GIVEN CHLORPROMAZINE under any circumstances. My normal course of treatment for mania is to take Haldol and to be re-established on Lithium. I am sensitive to Haldol.

Otherwise, I hereby authorise Dr Wong to provide the treatment that he believes to be in my best interests even though I may at that time withhold my consent to such treatment or state that I do not want to be treated.

FAMILY, HOME AND DISSEMINATION OF INFORMATION

My mother and stepfather, Ann and Adam Edwards, should be informed if I become hospitalised or leave town.

**ADMISSION AND DETENTION PROCEDURES – A COMPARISON BETWEEN
AUSTRALIAN STATES AND TERRITORIES**

South Australia

- (1) 3 day admission and detention order by medical practitioner.
- (2) Confirmation or revocation of 3 day order by a psychiatrist.
- (3) 21 day detention order by a psychiatrist.
- (4) Further 21 day detention order by 2 psychiatrists.
- (5) Appeal to Guardianship Board.
- (6) Continuing detention order by Board for 12 months.
- (7) Review of that order by Board within 6 months.
- (8) Appeal to Administration and Disciplinary Division of District Court from Board order.

Victoria

- (1) Recommendation and request for involuntary admission within 3 days by medical practitioner, or by mental health practitioner in absence of medical practitioner.
- (2) Confirmation or revocation by psychiatrist.
- (3) Indefinite detention.
- (4) Review by Mental Health Review Board within 8 weeks, or thereafter at intervals not exceeding 12 months.
- (5) Appeal at any time to Board.
- (6) Board can reserve questions of law for Supreme Court. Review of Board determinations on application to Civil and Administrative Tribunal Board.

New South Wales

- (1) Initial detention within 5 days on certificate of medical practitioner or accredited person.
- (2) Certification by medical superintendent that person is mentally ill.
- (3) Further examination by psychiatrist as soon as practicable.
- (4) Order by Magistrate for detention not exceeding 3 months as temporary client.
- (5) Mental Health Review Tribunal can then order person to be a continued treatment patient.
- (6) Tribunal must review every 6 months.
- (7) Tribunal hears appeal from Magistrate, Supreme Court (with assessors) from Tribunal.

ACT

- (1) Doctor or mental health officer may take a person to approval health facility for emergency care.
- (2) Person can be detained there by person in charge of facility. Doctor must examine within 4 hours.
- (3) Doctor can authorise up to 3 days detention.
- (4) The Mental Health Review Tribunal can make a range of mental health orders including a restriction order for a person to reside at a particular place for up to 3 months.
- (5) Tribunal reviews on application or of its own motion. Can order a fresh assessment and (presumably) further restriction as in (4).

Northern Territory

- (1) Assessment by medical practitioner, authorised psychiatric practitioner or designated mental health practitioner and recommendation for psychiatric examination.
- (2) Detention up to 7 days (appeal lies to Mental Health Review Tribunal).
- (3) Mental Health Review Tribunal must review in that time.
- (4) Tribunal can then detain up to 3 months and then review, and renew.
- (5) Appeal to Supreme Court from Tribunal.

Western Australia

- (1) Referral by medical practitioner or an authorised mental health practitioner for examination by a psychiatrist.
- (2) Detention for examination for up to 24 hours from time of reception within 7 days of referral.
- (3) Psychiatrist may detain for up to 28 days.
- (4) Another psychiatrist may then detain up to 6 months and this order can be renewed.
- (5) Review by Mental Health Review Board within 8 weeks of initial detention and thereafter every 6 months or less. Patient can also apply for review.
- (6) Appeal lies to Supreme Court.

Tasmania

- (1) Initial order by medical practitioner for admission and detention – 72 hour limit – confirmation.
- (2) Continuing care order by 2 medical practitioners (one of whom is approved for purposes of Act) for period not exceeding 6 months.
- (3) Order may be renewed in same day.
- (4) Review by Mental Health Review Tribunal within 28 days of order or renewal of order, and on application of patient.

Queensland

- (1) Recommendation for assessment made by a medical practitioner or an authorised mental health practitioner – in force for 7 days.
- (2) Detention for 24 hours with power to extend further 24 hours for assessment.
- (3) Involuntary treatment plan may be outcome – can include detention.
- (4) Mental Health Review Tribunal review within 6 weeks and thereafter every 6 months.
- (5) Can confirm or revoke, or vary to community order or different place of detention.
- (6) Appeal lies to Mental Health Court.

COMMUNITY CARE PROVISIONS – A COMPARISON BETWEEN AUSTRALIAN STATES AND TERRITORIES

South Australia

- (1) Treatment order by Board (S20) for up to 12 months. Board may revoke on application.
- (2) Special powers of the Board to place and detain persons under guardianship or administration in places other than approved treatment centres (ATCs) (S32 Guardianship and Administration Act).

Victoria

- (1) Objects include:
 - Support people with a mental disorder in the community and coordinate with other community services.
 - Promote establishment of community health services...which are conducive of continued participation in community life wherever possible.
- (2) Principles include:
 - Wherever possible people with a mental illness should be treated in the community.
 - Provision of treatment and care should be designed to assist people with a mental disorder to wherever possible live, work and participate in the community.
- (3) Community treatment order can be made by authorised psychiatrist instead of confirming admission or continuing to detain person – among other things, the order can specify where the patient must live if necessary for the treatment.

New South Wales

- (1) Objects include:
 - Care through community care facilities.
 - Promoting the establishment of community mental health services in the community.
- (2) The Tribunal or Magistrate can make community counselling order, or a community treatment order.

ACT

- (1) Objects include:
 - Services that support people in the community and coordinate with other community services.
 - Services that are designed to reduce mental illness in the community.
- (2) In making a mental health order, the Tribunal has to take into account that as far as possible the person should live in the general community and join in community activities.
- (3) Mental health orders include:
 - Psychiatric treatment orders.
 - Community care orders.
- (4) In the case of a community care order, the order may specify that the person is to be given or provided care and support or undertake a counselling, training, therapeutic or rehabilitation programme.

Northern Territory

- (1) Objects include:
 - Treatment in the community where possible.
 - As far as possible, the person's treatment and care is to be designed to assist the person to live, work and participate in community and to promote and assist self-reliance.
 - Where possible, person treated near where he or she ordinarily resides or relatives or friends reside.
- (2) Provisions for interim community management order by authorised psychiatric practitioner for 7 days.

- (3) Tribunal can then make a community management order – sets out treatment agencies, treatment, obligations, and rehabilitation, support and other services.
- (4) Community management order must be regularly reviewed by authorised psychiatric practitioner who can revoke order.

Western Australia

- (1) Functions of Minister include:
 - Encourage development within the community of services to prevent mental illness and its early detection and treatment.
 - Promote development of community agencies.
- (2) Psychiatrist can make community treatment order instead of detention, or release person from detention on a community treatment order.
- (3) Psychiatrist obliged to consider whether objects of Act better achieved by making a community treatment order than detain or continue detention.
- (4) Psychiatrist also has general power to make a community treatment order.
- (5) Order under this general power must be confirmed within 72 hours by another psychiatrist or medical practitioner where psychiatrist not available.
- (6) Order can be extended.
- (7) Order subject to review by Mental Health Review Board within 8 weeks and 6 monthly thereafter.

Tasmania

- (1) Objects include:
 - Encouraging care and treatment in community.
 - Integration of community support in community.
- (2) Community treatment order may be made by approved medical practitioners who have examined person separately.
- (3) Term can be up to a year, and can be extended.
- (4) Tribunal must review within 28 days of order being made or renewed.

Queensland

- (1) Principles include:
 - Maintenance of supportive relationships, community participation and treatment in the community.
- (2) Concept of involuntary treatment order with inpatient, and community categories. Made by authorised doctor. Must be confirmed within 72 hours by an authorised psychiatrist examining the person if order made by non-psychiatrist or using audio visual links.
- (3) Non-compliance twice and a health practitioner can arrange for the person to be taken to a health service for detention and treatment.
- (4) Order remains until revoked by doctor, or authorised doctor and confirmed by a psychiatrist, or on review by Tribunal.

Tribunal must review within 6 weeks and afterwards at intervals of no more than 6 weeks.

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