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Submitted via email: salri_mha@adelaide.edu.au

Dear Professor Williams

RE: Review of the Mental Health Act 2009 (SA)

The Australian Psychological Society (APS) welcomes the opportunity to respond to the Review of the *Mental Health Act 2009* (SA) (MHA).

The APS considers the current review timely in terms of the growing demand for mental health services, and the need to ensure their quality and safety — as evidenced by several recent Royal Commissions and government inquiries across Australia. This submission from the APS does not make comment on all questions raised in the fact sheets. Rather, we have endeavoured to provide a response that highlights the most salient issues from a psychological perspective.

As with all our work at the APS, we consider this in light of the Sustainable Development Goals (SDGs).¹ Of particular relevance is SDG 3: Good health and wellbeing; SDG 10: Reduced inequalities,¹ and SDG 16 which aims to “provide justice for all, and build effective, accountable and inclusive institutions at all levels”².

Thank you for the opportunity to provide a response to the current review of the MHA. If any further information is required from the APS, I would be happy to be contacted through my office on (03) 8662 3300 or by email at z.burgess@psychology.org.au

Yours sincerely

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Chief Executive Officer

Review of the Mental Health Act 2009 (SA)

The Australian Psychological Society (APS) is pleased to provide the following response to the Review of the *Mental Health Act 2009* (SA) being undertaken by the South Australian Law Reform Institute (SALRI).

The APS commends the South Australian Government's intention to revise the MHA. We note that the fact sheets cover a breadth of topics related to the MHA. For the purposes of our response, the APS has only focussed on areas where we believe we have the relevant expertise and/or experience. Therefore, we have not provided input to all questions, but to those where we believe we can make a useful contribution.

Fact Sheet 2: Capacity and Supported Decision-Making

Question 1: Should the MHA include a clearer definition of 'impaired decision-making capacity' for treatment orders?

1. The APS recommends that the *Mental Health Act 2009* (MHA) be amended to recognise supported decision-making as a way of enabling people to have the capacity to make decisions in relation to their treatment.
2. The research evidence shows that the vast majority of people with severe mental illness have the mental capacity to make treatment decisions, especially if they are provided with support to do so.³ As such, the APS believes that section 5A of the MHA should be reviewed to affirm, rather than limit, decision-making capacity.
3. In its present form, section 5A sets out a functional approach to assessing decision-making capacity.⁴ Notably, many Australian jurisdictions have provided extra-legislative guidance on how this functional test is applied in clinical practice, often adding psychological and psychosocial factors, including the use of decision support, to balance the highly individualistic and cognitive focus of the statutory criteria.⁵
4. The South Australian Office of the Chief Psychiatrist has recently clarified that '[a]n assessment of decision-making capacity should assess the capacity a person with mental illness is able to exercise *with support from others*' (emphasis in original).⁶ We believe that this principle should be codified in the MHA. Otherwise, assessments of decision-making capacity can be made in ways which are far removed from the person and their social context, often to negate the presumption of capacity.⁷ This is contrary to the aims of a capacity-oriented and patient-centred approach to mental health.
5. Reducing decision-making capacity to a 'checklist' of cognitive abilities is also discordant with our understanding of the nature and dynamics of human decision-making, which has been informed by decades of theory and research in psychological science.⁸ Consistent with a psychological understanding of decision-making, the World Health Organization notes that functional approaches to decision-making capacity are:

... flawed because the way we make decisions cannot be measured scientifically. Sometimes we make decisions on the basis of very rational reasons and sometimes they are based on our emotions and feelings. There is no universal process of decision-making and no right or wrong way to make decisions. All persons have their own process of thinking and it is not possible to fully know, understand or assess what is going on in another person's mind.⁹

6. The proposed Victorian approach in clause 87 of the Mental Health and Wellbeing Bill 2022 (Vic) (MHWB) offers a practical solution that can be followed in the MHA. This provision combines the functional approach with principles that must be considered when assessing decision-making capacity.
7. Importantly, sub-clauses 87(2)(e) and (3)(b) of the MHWB recognise that decision-making capacity can be present through appropriate decision supports, which must be available to the person as far as is reasonable. This formulation rightly recognises decision-making, and decision-making capacity, as a relational, contextually-sensitive and dynamic process which is not easily negated.
8. Within this principle-based approach, the MHA should also clarify that the assessment of decision-making capacity is not primarily a medical test. Rather, the MHA should explicitly recognise the role of other mental health professionals in not only assessing but maximising a person's decision-making capacity through decision supports.

9. Psychologists, in particular, have expertise in the social, cognitive and relational dimensions of decision-making. We believe that psychologists therefore have an important but currently underutilised role in facilitating supported decision-making at both the patient and systems level. This should be recognised in the MHA.
10. The MHA should recognise that our understanding of (supported) decision-making and decision-making capacity continues to evolve, and is influenced by ongoing developments in psychological science. We recommend that the MHA allow for the adaptive and evidence-based implementation of a principle-based approach to decision-making capacity through standards issued by the Chief Psychologist, a new statutory role that we propose be established under the MHA (see our response to Fact Sheet 9 below).
11. We suggest that any amendment to the section 5A should preserve section 5A(2)(b), which helpfully states that a person's Advance Care Directive (ACD) may state when they have impaired decision-making capacity. This provision could be extended by allowing an ACD to state what supports they need to maximise their decision-making capacity. To do so would better value a person's experience, preferences and relationships, which all shape the psychological contours of decision-making.
12. Finally, to be consistent with these proposed amendments to the MHA, section 15 of the ACDA needs to be amended to allow people making an ACD to do so with appropriate decision-making support, in order to satisfy the standard of competence in section 15(1)(b).

Question 2: How can the law better protect the human rights of persons with a lived experience of mental illness and provide supported decision-making?

Advance Care Directives and the MHA

13. The APS believes that increasing the integration of ACDs into the MHA will help to promote and protect the rights of people with a lived experience of mental illness.
14. One review of the research evidence found that the use of ACDs in a mental health setting reduced the likelihood of involuntary adult psychiatric admissions by an average of 23%,¹⁰ and that ACDs were far more effective than other mechanisms designed to reduce involuntary inpatient care, including community treatment orders. ACDs also facilitate recovery, empowerment and symptom improvement.¹¹ The process of creating an ACD can itself be a therapeutic process, and could be integrated into psychological therapy that is directed towards recovery, empowerment and strengthening interpersonal relationships.¹²
15. The realisation of these benefits depend on ACDs being implemented effectively across the mental health system.¹³ However, the MHA is almost completely silent about the operation of ACDs, which may lead to ACDs being overlooked or downplayed in everyday clinical decision-making. Although the *Advance Care Directives Act 2013* (ACDA) applies to treatment decisions under the MHA, we submit that including direct references to ACDs within the MHA would provide greater procedural clarity and also reinforce the importance of ACDs as part of a rights and capacity-oriented mental health system.
16. For instance, although section 35 of the ACDA requires clinicians to give effect to an ACD as far as is reasonably practicable, this provision is substantively weak. It only applies where a clinician is 'making a decision under an advance care directive', which assumes that clinicians are aware that an ACD is in effect.
17. Unlike most other Australian jurisdictions, there is no positive obligation in the MHA for decision-makers to check for the presence of an ACD or to consider its contents before making treatment decisions.¹⁴ This is a significant gap which needs to be remedied in the MHA. The requirement to check for, and give effect to, an ACD should extend to all situations where involuntary treatment is being considered or where coercive powers may be exercised, including Care and Control, Patient Assistance Requests, and Patient Transport Requests.
18. The MHA also does not impose a requirement for patients to be given an opportunity to make an ACD or to be provided with information about making an ACD as part of treatment planning or recovery.¹⁵ Including this requirement would allow psychologists and others to work closely with the patient in this important therapeutic process.

As such, if such a provision were added, psychologists should be expressly named in the MHA as part of the category of persons who can provide the required information and support in relation to the creation of an ACD.

19. One additional opportunity for reform is to follow the ACT and Victorian position to allow an ACD to contain a binding refusal of mental health treatment, which can be overridden in limited circumstances.¹⁶ This would require amending section 12 of the ACDA, which presently operates to invalidate provisions in an ACD which 'comprise a refusal of mandatory medical treatment' (including under a treatment order or care and control).
20. At the very least, we recommend that the scope of the section 12 prohibition be revised to allow for an ACD to include provisions about the *type* of treatment to be received or not received (e.g., not consenting to a particular type of medication, but consenting to another appropriate medication or psychological intervention) where this does not amount to a complete refusal of treatment under the MHA.

Supported Decision-Making

21. As we have outlined above, the effective use of supported decision-making in mental health services is essential to promote and protect the rights of patients. We recommend that the MHA should establish a framework for recognising decision support persons.
22. Similar frameworks are already in place in other Australian states and territories, with nominated decision supporters known as *nominated persons* (e.g., ACT, Victoria and WA) or *nominated support person* (e.g., Queensland, and proposed in the Victorian MHWB). A nominated person or nominated support person is appointed to support the patient with their treatment decisions. In practice, this means notifying the nominated (support) person if certain decisions are proposed to be made and allowing them to communicate with the patient.
23. This must be carefully distinguished from a system that merely notifies the nominated person after the fact, or consults with them as a *de facto* substitute decision-maker. A system of nominated (support) persons must also continue to recognise informal or *ad hoc* decision supports.
24. The APS acknowledges that being nominated as a decision support person can be a psychologically demanding role which often involves navigating conflicting priorities and values.¹⁷ We would therefore recommend the inclusion of provisions in the MHA allowing nominated (support) persons to access subsidised and independent psychological support. This would allow the mental health system to support the wellbeing of people who are supporting others under the MHA.

Access to Psychological Therapy

25. The APS strongly recommends that access to psychological treatment be promoted and protected in the MHA on an equal basis with psychiatric treatment.
26. There is clear evidence of the effectiveness of psychological therapy for a wide range of mental disorders for which treatment under the MHA may be provided.¹⁸ Moreover, psychological therapy in an acute inpatient setting leads to an improvement in patients' symptoms, a reduction in readmissions, lower levels of depression and anxiety,¹⁹ and increased hope and empowerment.²⁰ Despite this evidence, there are significant barriers to the delivery and integration of psychological therapy within the mental health system,²¹ in part due to the privileging of psychiatric treatment.
27. We therefore propose that the MHA recognise the provision of psychological therapies as part of treatment orders. The current definition of 'treatment' in section 3 of the MHA technically encompasses psychological treatment but is heavily weighted towards medical and psychiatric treatment. By contrast, the *Mental Health Act 2015* (ACT) uses the broader term 'treatment, care and support' throughout the Act, which means:
 - (a) ... things done in the course of the exercise of professional skills to remedy the disorder or illness or lessen its ill effects or the pain or suffering it causes; and
 - (b) includes the giving of medication and counselling, training, therapeutic and rehabilitation programs, care or support.²²

28. We suggest that a similar definition should be adopted in the MHA to recognise the multidisciplinary actions and interventions which bring about therapeutic outcomes in the mental health system. Specifically, we recommend going beyond the ACT definition to expressly include psychological therapy within the meaning of 'treatment'.

Fact Sheet 3. Inpatient Treatment Order

Question 2: Should the MHA allow powers to detain and use force? If so, who should be allowed to detain and use force?

Note: This response also applies to:

- *Fact Sheet 4, Community Treatment Order, consultation question 2 (Should the MHA be changed to include a power to use reasonable force in cases involving noncompliance with a CTO?);*
 - *Fact Sheet 5: Restrictive Practice and Control Powers; and*
 - *Fact Sheet 6. ECT, consultation question 1 (Should the law allow reasonable force to ensure a person receives ECT? If so, when?)*
29. Coercive powers (including detention, the use of force and restrictive practices) cannot be considered to be a desirable feature of contemporary mental health legislation. Coercive powers are not only incompatible with a rights-oriented mental health framework but can also undermine the psychological, therapeutic and relational factors which promote recovery.²³ The goal should be to have a mental health system that does not require coercive powers and restrictive practices.
30. Having said this, the elimination of coercive powers cannot be achieved through legislative amendment alone. As recognised by the Royal Commission into Victoria's Mental Health System, what is needed is a fundamental redesign of mental health services, funding and regulation with a view to creating a range of non-coercive alternatives which are readily accessible by the entire community.²⁴
31. Such reforms must consider improving the utilisation of the highly-qualified psychological workforce across all parts of the South Australian mental health system. These include developing psychological preventative interventions and services,²⁵ providing psychological treatment on an equal basis with psychiatric interventions, and establishing psychologists as leaders in clinical service design, governance and oversight and engagement.
32. In the meantime, any consideration of powers to detain and use force in the MHA should be particularly attentive to the psychological impact of these powers not only on patients, but also on the organisational culture of the mental health service. We therefore recommend:
- Inserting a requirement in the MHA to offer trauma-informed psychological support or therapy by an independent psychologist to a patient following the use of coercive powers;
 - Including in the objectives of the MHA a statement that preventative psychological interventions should be available to all patients as a way of minimising coercive powers;
 - Amending the MHA to create the statutory role of Chief Psychologist, who can issue binding standards based on psychological research and evidence on preventing or minimising the use of coercive powers (see our submissions on Fact Sheet 9 below).

Fact sheet 4: Community Treatment Order

Question 1: Should the law and practice be re-framed to limit or reduce the number of CTOs? Why or why not?

33. Our shared goal should be to reduce the number of CTOs in favour of voluntary and non-coercive options which are accessible, appropriate and sustainable. The research on CTOs both in Australia and overseas is consistent in finding that they are generally ineffective in reducing involuntary inpatient admissions,²⁶ and therefore may be used too frequently relative to their questionable impact on outcomes.²⁷
34. To the extent that CTOs still remain a part of the MHA, our previous recommendations are relevant:

- Amendments to the MHA which promote the full use of supported decision-making may also help to reduce rates of CTO use;²⁸ and
- CTOs should be more than a legal mechanism for the involuntary administration of psychiatric medication in a community setting. Providing responsive, appropriate and evidence-based interventions led by psychologists in the community would increase the effectiveness of CTOs in bringing about recovery as far as is possible, with the overall aim of reducing their use.

35. In addition, we recommend that amendments to the MHA could afford greater recognition to voluntary or preventative treatment – especially psychological interventions – as a way of reducing the need for treatment orders, including CTOs. As a starting point, the MHA could again follow the proposed Victorian MHWB, which states in its objectives that mental health services should:

*... include a broad range of treatment options with the aim of providing access to the same treatment and support irrespective of whether a person is receiving voluntary or compulsory treatment [and] include a broad and accessible range of voluntary treatment and support options ... to enable a reduction in the use of compulsory assessment and treatment.*²⁹

Fact Sheet 6. Electroconvulsive Therapy

Question 2: How can the rights of a consumer be better protected in cases of emergency ECT?

36. See our responses to Fact Sheet 2 above. Promoting the effective and consistent use of supported decision-making and ACDs would help to protect the rights of patients in relation to emergency ECT. Our proposed reforms to require information to be provided about ACDs and for patients to be given opportunities to make an ACD may also encourage patients to express their preferences and consents about ECT, especially if they have previously received ECT.
37. In addition, we propose that the MHA be amended to require patients to be provided with the opportunity to consult with a psychologist before and after the administration of ECT. Before ECT is administered, a psychological consultation may help to address the patient's ECT-related anxiety, provide psychoeducation, and to activate any supports identified by the patient that minimise the loss of control or disruption to therapeutic alliances which are associated with ECT.³⁰ Noting that the process of receiving ECT can often be experienced as a traumatic event, providing voluntary, trauma-informed psychological support at an appropriate time after the administration of ECT can minimise the psychological distress associated with this psychiatric treatment.³¹

Question 3: Should the PPTP provide more or less oversight of ECT (including maintenance ECT) and/or other treatments?

38. We believe that the psychological impacts of ECT and other prescribed psychiatric treatments need to be considered fully by the PPTP. These impacts include the neuropsychological effects of ECT,³² patients' ECT-related anxiety,³³ and the disruptions to patients' sense of self and relationships following ECT which can alter the person's recovery journey.³⁴
39. As such, we propose that section 41A(2)(b) be amended to require the PPTP to include a clinical neuropsychologist and another psychologist. The inclusion of these professionals on the PPTP would protect the rights and interests of patients by ensuring that the psychological considerations and effects of prescribed psychiatric treatments are not overlooked.

Fact Sheet 9. Guiding Principles

Question 4: What, if any, measures for accountability and monitoring should be included in the MHA?

40. The APS advocates for the creation of the position of Chief Psychologist as a statutory appointment under the MHA. We propose that the appointed Chief Psychologist would work collaboratively with the Chief Psychiatrist to give effect to the exercise the functions set out in section 90, including the promotion of continuous improvement in the organisation and delivery of mental health services and the monitoring of treatment and coercive practices under the MHA.

41. We recommend that the Chief Psychologist should have the authority, in the same way as the Chief Psychiatrist, to issue binding standards on matters within the scope of practice of psychologists (see s 90(2)). These standards would be an important way to provide authoritative clinical guidance on matters relevant to psychological treatment or assessment, supported decision-making and decision-making capacity, and where the contemporary psychological research evidence or practice-based evidence is instructive on the provision of recovery-oriented and rights-promoting mental health services of the highest quality.³⁵

Concluding comments

- The APS again expresses our appreciation for the opportunity to provide a submission to the Review of the Mental Health Act 2009 (SA). We underscore the need for the South Australian Government to continue to recognise, support and promote human rights and best practices in the mental health system in South Australia.
- The APS recommends the appointment of a Chief Psychologist to work alongside the Chief Psychiatrist to ensure that state of the art psychological and psychiatric interventions are implemented to produce best practice outcomes for individuals receiving treatment under the MHA.
- Further, we encourage the South Australian Government to actively seek to partner with peak bodies in the mental health field, and the APS in particular, so that best practice services can be delivered in partnerships that will lead to enhanced mental health care for all South Australians.

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- ¹⁵ Cf *Mental Health Act 2015* (ACT) s 25.
- ¹⁶ See *Mental Health Act 2015* (ACT) s 28(4) and (5); *Mental Health Act 2014* (Vic) s 73; Mental Health and Wellbeing Bill 2022 (Vic) cl 90.
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