Clinician's Guide & Code of Practice

Mental Health Act 2009

Government of South Australia
SA Health

Disclaimer

The information contained in this publication is intended to assist in the interpretation of the Mental Health Act 2009 and is not a substitute for the Mental Health Act 2009. No responsibility is accepted by the Minister for Mental Health or the Department of Health for any errors or omissions contained within this publication. The information contained within the publication is for general information only. Readers should refer to the Mental Health Act 2009 where appropriate, and no liability will be accepted for any loss or damage arising from reliance upon any information in this publication.

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Contents

Introduction To The Mental Health Act 2009

The Mental Health Act 2009 ('MHA 2009' or 'the Act') will come into operation on 1 July 2010. For a mental health professional working in South Australia (SA), the Act will have a considerable impact on clinical practice.

The Guide has been developed to help 'front line staff' understand the MHA 2009. It is anticipated that the Guide will be used, not only to increase awareness of the new legislation, but as a tool to influence practice.

It is important to recognise that this is a Guide and not a substitute for the Act.

'Front line staff' refers to all those who may or may not have statutory legislative functions under the Act, but by virtue of their work need to be aware of the implications of the Act. This group consists of a wide range of disciplines within SA.

How Can The Guide Be Used?

This Guide can be used in conjunction with the ***Plain Language Guide*** to the Act:

- As a training resource within organisations or for inter agency education and training.
- On an individual basis where clinicians wish or need to have a more in-depth knowledge of the Act.

The Guide is designed to be self–directed and has an Introduction followed by six Sections:

Introduction to the MHA 2009
Section 1 Foundations of the MHA 2009
Section 2 Key Reforms and Features of the Act
Section 3 Roles and Function
Section 4 Treatment and Care
Section 5 Voluntary or Involuntary Treatment
Section 6 Frequently Asked Questions

How Is The Guide Structured?

The Guide comprises:

- Learning outcomes for each Section;
- Activities, scenarios, questions and reflection;
- Frequently Asked Questions.

What Are The Goals Of The Guide?

- Identify the issues that influenced the development of the MHA 2009;
- Discuss the Guiding Principles of the MHA 2009 and the influence these will have on mental health practice;
- Explain the roles and responsibilities of key individuals as defined by the Act;
- Discuss the purpose and use of the safeguards, rights, and the provisions for appeal in the Act;
- Develop an understanding of the different processes involved and the various roles and responsibilities in relation to applying a community treatment order (CTO) or a detention and treatment order (DTO) under the Act.

Each Section of the Guide can be worked through at your own pace and in whatever order you wish.

Acknowledgement

This Guide has been facilitated and developed by the Mental Health Unit of the Department of Health, SA Health, in collaboration with a wide range of stakeholders from across SA including practitioners, managers, consumers and carers.

Section 1 Foundations Of The Mental Health Act 2009

In this Section the key reforms to mental health law as implemented by the MHA 2009 are considered.

There is also an expectation that everyone involved in mental health practice should be aware of the **Code of Practice (COP)**.

The COP applicable to the MHA 2009 is the National Practice Standards for the Mental Health Workforce.

The principles of the National Practice Standards for the Mental Health Workforce and how they fit with the Act will be discussed in some detail.

In brief, the MHA 2009:

- Has key differences from the Mental Health Act 1993 (MHA 1993);
- Introduces Guiding Principles;
- Outlines the legal status of individuals with specific roles, powers and responsibilities.

How Do The MHA 2009, The COP And The Guiding Principles Fit Together?

This can be summarised as follows:

- The MHA 2009 tells us what to do;
- The COP explains how to do it;
- The Guiding Principles guide us in how to apply the Act and the COP.

A key point to remember is that the MHA 2009 is a Law providing a legal framework about what can and cannot be done. The purpose of the Guiding Principles is to guide the application of the Law.

On completion of this Section of the Guide you should be able to:

- Identify the issues that influenced the development of the MHA 2009;
- Discuss the Guiding Principles of the MHA 2009 and the effect these have on mental health practice;
- Understand the key differences between the MHA 1993 and the MHA 2009.

Need For Change

This Section of the Guide will outline the legal and political background that influenced the development of the Act.

Background

A review of the MHA 1993 and related legislation began in 2004. The (then) Minister for Health, Lea Stevens, and Justice Minister, Michael Atkinson, commissioned Legal Policy Consultant and Solicitor, Ian Bidmeade, to audit and recommend improvements to the MHA 1993 and related legislation, for example, the Guardianship and Administration Act 1993 (GAA 1993).

Ian was assisted by a small Review Committee made up of practitioners from both law and mental health practice. The Review Committee included a consumer (and a deputy) and a carer representative. The inclusion of consumers and carers in the Review reflected the recognition of these key stakeholders since the last major review of mental health legislation.

Modernising Mental Health Law In South Australia

The Review Committee undertook wide consultation and received submissions before making recommendations as to what the new legislation should contain.

Informing these activities was a concern to modernise mental health law in SA including:

- the application of involuntary treatment orders;
- the need to improve protection of individual rights;
- the need for new legislation to reflect contemporary developments in relation to the involvement of consumers and carers;
- the need for alignment with legislation in other Australian jurisdictions.

After six months of consultation, research and consideration the Review Committee published its recommendations in April 2005. The recommendations of the ***Paving the Way Review of Mental Legislation in South Australia Report April 2005*** can be accessed on the Department of Health's website:
http://www.health.sa.gov.au/mentalhealth

Progress Towards The Final Bill

Widespread consultations were conducted with other agencies and the community about the draft mental health legislation which was introduced into Parliament.

After a number of amendments, the Mental Health Bill 2009 was passed by Parliament on 3 June 2009 and assented to by the Governor in Executive Council on 11 June 2009, when it became an Act.

It was later determined that the Act should be proclaimed (come into operation) on 1 July 2010.

On the day the Bill was passed, the Honourable Jane Lomax Smith (then Minister for Mental Health and Substance Abuse) said:

'The Mental Health Act 2009 has been heralded as the start of a new era in mental health practice in South Australia. Some have suggested that this legislation does not just introduce new forms of detention powers and safeguards but will also change the very culture of mental health practice in South Australia to a more just and progressive one.'

Main Purpose Of The Mental Health Act 2009

The MHA 2009 is largely concerned with the circumstances in which a person with a serious mental illness can receive early assessment and/or care and treatment for that illness, in an appropriate facility or in the community, on a voluntary or involuntary basis.

The Act also sets out the processes that must be followed and the safeguards to ensure people with a mental illness receive care and treatment in the least restrictive manner and environment.

The Objectives of the MHA 2009 are to ensure that people with a serious mental illness:

- receive a comprehensive range of services of the highest standard for their treatment, care and rehabilitation;
- retain their freedom, rights, dignity and self respect as far as is consistent with their protection, the protection of the public and the proper delivery of services; and
- for that purpose, confer appropriate limited powers to make orders for community treatment, or detention and treatment, where required.

Reading The Mental Health Act 2009

The Act is divided into 13 Parts plus two Schedules (Schedule 1 and Schedule 2). Some Parts are subdivided into Divisions. Each of the 13 Parts of the Act has a number, a title and two or more Sections and Sub-sections. The Sections are numbered from the beginning to the end of the Act, that is, Parts 1 to 13 of the Act consist of Sections 1 to 111 of the Act.

The header on each page of the Act lists the Part, the title and, where applicable, the Division and title of the provisions on that page. You may find the headers helpful when searching for a topic. When referring to a specific provision in the Act, it is usual to quote the Section and Sub-section numbers.

The Act contains two Schedules after the main text. Schedule 1 details certain conducts which, in and of themselves, do not indicate mental illness. Schedule 2 repeals the MHA 1993 and makes provision for the translation of existing orders under the MHA 1993 to similar orders under the MHA 2009.

The Guiding Principles

The MHA 2009 comprehensively reforms and modernises the legal framework for involuntary care and treatment. It introduces 'Guiding Principles' to mental health law in SA.

Why Are Guiding Principles Needed?

The MHA 2009 contains a set of Guiding Principles which are designed to provide guidance to all persons and bodies involved in the administration of the Act. The Guiding Principles should assist health professionals in decision-making and undertaking actions.

The Guiding Principles set the tone of the Act and guide its interpretation. The Guiding Principles are consistent with and should be read alongside the principles underpinning the *South Australia's Mental Health and Wellbeing Policy 2010 – 2015*, and the principles of the *National Practice Standards for the Mental Health Workforce 2002*.

The Guiding Principles of the Act are designed to inform decisions, not to determine them. The context will be the all-deciding factor as to which of the Guiding Principles of the Act are employed in a particular case. It is imperative that all the Guiding Principles inform every decision or action under the MHA 2009.

The Guiding Principles of the Act are designed primarily to safeguard the rights of patients. The Guiding Principles aim to reflect a shared vision between patients and the many different provider groups in both government and non-government sectors and are concerned with best practice and involuntary treatment and care.

As a general rule, anyone who takes any action under the Act has to take account of the Guiding Principles.

The challenge is that every decision taken involves unique individuals in unique situations. However carefully the Law and the COP spell out what to do and how to do it, the Law and the COP cannot cover all situations in sufficient detail.

The Guiding Principles provide guidance by providing a framework of important considerations that should be kept in mind when making decisions under the MHA 2009.

For example, the COP talks about rights, responsibilities, safety and privacy of patients. The COP suggests mental health professionals should uphold the rights of people affected by mental health problems, maintaining their privacy, dignity and confidentiality.

However, professionals will need to rely on the Guiding Principles of the Act in deciding whether they may need to share information without consent in order to facilitate optimal care and treatment, to promote a person's recovery.

The idea behind the Guiding Principles of the Act is that there are some things that are so important, like treating people with respect, which should always be observed whatever the situation.

Activities, Scenarios And Self Assessment

As you work through this Section of the Guide you will find that as well as reading the text you are asked to undertake various activities.

The activities are designed to develop your understanding of the areas under discussion and to think about how the MHA 2009 will impact on your practice.

The activities include looking at scenarios and a series of self assessment questions at the end of this Section of the Guide.

Activity 1

Before reading further please take a few moments to reflect on your personal principles by answering the following three questions:

Do personal principles inform your practice?

Does your professional discipline advocate certain principles?

Do these personal and professional principles make a difference to your practice?

Comment

The notes you have made for this activity will depend very much on your individual beliefs and where you work.

If you are a nurse you may have listed some of the elements of the ***Code of Professional Conduct*** as the principles that inform your work. On the other hand if you work in a General Practice, your organisation's mission statement or aims may indicate the principles of your practice.

The advantage of having such written statements or codes is that everyone in the organisation or profession knows what is expected of them, as do the public.

Therefore, having the Guiding Principles laid out at the beginning of the Act means that all practitioners (irrespective of professional background) know what is expected of them, and the community (consumers, carers and others) know what to expect from practitioners.

Guiding Principles In Practice

Having established the purpose and benefits of the Guiding Principles of the Act, we shall now consider them.

The Guiding Principles are linked to case examples throughout this Guide to offer an increased understanding of how they will be best applied in practice.

Box 1.1 below contains a list of Guiding Principles and how they should be applied in practice.

Box 1.1 Guiding Principles and how they should be applied in practice

Guiding Principle	What does this mean in practice?
Therapeutic	Any intervention under the Act should be intended to produce a benefit for a person with a mental illness that cannot reasonably be achieved other than by the intervention.
Least restrictive alternative	A person with a mental illness should be provided with any necessary care, treatment and support in the least restrictive manner and environment compatible with the delivery of safe and effective care, taking account, where appropriate, of the safety of others.
Collaboration	A person with a mental illness should be fully involved, so far as they are able to be, in all aspects of their assessment, care, treatment and support. Their past and present wishes should be taken into account. They should have a comprehensive treatment and care plan and be provided with all the information and support necessary to enable them to participate fully. Information should be presented in a way the patient can understand it.
Culturally Appropriate	A person with a mental illness should receive care, treatment and support in a manner that affords respect for their individual qualities, abilities and diverse backgrounds, and properly takes into account their age, gender, sexual orientation, ethnic group and social, cultural and religious background.
Informal care	Wherever possible, care, treatment and support should be provided to people with mental illness without the use of involuntary powers.
Respect for carers	Carers/families should be respected for their role and experience and receive appropriate information and advice, and have their views and needs taken into account.

There will be times when the Guiding Principles cannot all have equal status and a prioritisation process may need to occur. For example, in the case where the carer/family of a person may be in denial of a person's illness and do not want intervention. The person with a mental illness may be unwell and at high risk to themselves and need involuntary treatment. The Guiding Principle **'Therapeutic Intervention'** will take priority over other principles.

Activity 2

Having read the Guiding Principles of the MHA 2009, consider the list you made earlier during Activity 1.

Do any of the Guiding Principles of the Act match any of your own personal and professional principles that guide your practice? If so, which ones?

Activity 3

This is a three part activity.

It has been designed for practitioners who have experience working with consumers who are or have been subject to involuntary treatment.

> Think about someone you know who received involuntary treatment under the MHA 1993. Consider the situation and circumstances leading up to the order being made.

Now reflect on the Guiding Principles of the MHA 2009 and answer the following two questions:

> Using an example from your practice, which of the Guiding Principles of the MHA 2009 would have applied in this instance?

> With the Guiding Principles of the Act in mind and using an example from your practice, do you think the professionals involved might have come to a different decision if they had been required to consider the Guiding Principles?

Comment

Your response to Activity 1 depends to some extent on the situation you have selected and the environment you work in.

It is likely that in all situations, however, some or all of the Guiding Principles are relevant and need to be considered.

For example, the Guiding Principle of 'collaboration' will always be relevant as will the Guiding Principles of **'culturally appropriate'** and **'respect for carers/family'**.

Did you think that the decision might have been altered had those involved had regard to these Guiding Principles?

If we consider the Guiding Principle of **'least restrictive alternative'** for example, then it may be that professionals in consultation with the person and his/her carers/family would decide not to detain someone in a treatment centre, but to provide intensive support delivered in the person's own home instead.

In this instance we could say that paying regard to the Guiding Principles can alter decision-making and create a different outcome which could be more suitable for the consumer.

In practice, however, it could become more complicated.

What if the person's carer is adamant that they want the person to be detained in an appropriate treatment centre and does not feel that they can cope if the person is to return home?

The professionals involved have to also have regard to the Guiding Principle of **'respect for carers'** when making decisions.

Having regard to the Guiding Principles may not be as straightforward as it initially seems. It will be important, therefore, that all professionals are able to carefully weigh up each of the Guiding Principles as they apply to a situation in order to ascertain the best course of action.

However, it should be noted that in some situations and communities, especially in the remote localities, that the range of service provision options currently available may limit the choice of therapeutic interventions.

In the example above intensive support delivered in the person's own home was identified as the least restrictive alternative, but it is an option that requires resources which might not always be available uniformly across SA.

Section 2 Key Reforms And Features Of The Act

There is an expectation that everyone involved in mental health practice should be aware of the key reforms and the differences between the MHA 1993 and the MHA 2009 with its Guiding Principles.

Box 2.1 below lists the key reforms implemented by the MHA 2009 that are discussed in the Guide.

Box 2.1 Key reforms of the MHA 2009

Key Reform 1	Clarifying the definition of mental illness (by adding Schedule 1).
Key Reform 2	Including Guiding Principles to assist health professionals in decision-making and undertaking actions.
Key Reform 3	Providing greater protection of consumer rights and provisions for review.
Key Reform 4	Providing for age appropriate services.
Key Reform 5	Reforming and modernising the legal framework for involuntary treatment.
Key Reform 6	Establishing the statutory position of a Chief Psychiatrist to govern the implementation of the Act and ensure accountability of the mental health system.
Key Reform 7	Enabling a broader range of professional groups to make orders and exercise other responsibilities.
Key Reform 8	Promoting earlier intervention and access to appropriate care and treatment.
Key Reform 9	Providing a framework of safeguards for involuntary treatment for mental illness.
Key Reform 10	Providing a framework for interstate transfers.
Key Reform 11	Enabling information to be shared with carers and family in certain circumstances.
Key Reform 12	Allowing individuals to be transported by Authorised Officers to reduce police involvement.
Key Reform 13	Recognising the different and broader concepts of mental health within Aboriginal culture and Torres Strait Island culture.

In order to have a deeper understanding of the key reforms to the MHA 2009 we shall discuss some of the differences between the MHA 1993 and the MHA 2009.

Mental Illness Defined

The definition of mental illness used in the MHA 2009 is very broad. The definition remains unchanged from its predecessor and is deliberately broad so that people are not precluded from a service on the basis of diagnosis. Its breadth means that people who need even a short term intervention will not be excluded because they do not fall within a narrower definition of mental illness.

Below is the definition of mental illness as it appears in Part 1 of the Act.

'Mental Illness means any illness or disorder of the mind;
see also Schedule 1 (Certain conduct may not indicate mental illness)'

The definition does not prevent the treatment of co-morbidity or personality disorders, with clinical decisions about the need for an order being made on a case by case basis, according to the needs of the individual at that time.

Schedule 1 of the Act clarifies the definition of mental illness by specifying some behaviours, which, in and of themselves, do not constitute mental illness. Schedule 1 is outlined in Box 2.2 below.

Box 2.2 Schedule 1 - Certain conduct may not indicate mental illness

A person does not have a mental illness merely because of any 1 or more of the following:

(a) the person expresses or refuses or fails to express, or has expressed or refused or failed to express, a particular political opinion or belief;

(b) the person expresses or refuses or fails to express, or has expressed or refused or failed to express, a particular religious opinion or belief;

(c) the person expresses or refuses or fails to express, or has expressed or refused or failed to express, a particular philosophy;

(d) the person expresses or refuses or fails to express, or has expressed or refused or failed to express, a particular sexual preference or sexual orientation;

(e) the person engages in or refuses or fails to engage in, or has engaged in or refused or failed to engage in, a particular political activity;

(f) the person engages in or refuses or fails to engage in, or has engaged in or refused or failed to engage in, a particular religious activity;

(g) the person engages in or has engaged in a particular sexual activity or sexual promiscuity;

(h) the person engages in or has engaged in immoral conduct;

(i) the person engages in or has engaged in illegal conduct;

(j) the person has developmental disability of mind;

(k) the person takes or has taken alcohol or any other drug;

(l) the person engages in or has engaged in anti social behaviour;

(m) the person has a particular economic or social status or is a member of a particular cultural or racial group.

However, nothing prevents, in relation to a person who takes or has taken alcohol or any other drug, the serious or permanent physiological, biochemical or psychological effects of drug taking from being regarded as an indication that a person is suffering from mental illness.

Rights Of Individuals

People with a mental illness enjoy the same rights as anyone else in the community. However, at times, a mental illness may result in behaviour that leads to those rights being curtailed. The new Act builds on the old Act and provides for greater protection of the legal rights of a person with a mental illness. It articulates additional rights for both voluntary and involuntary patients.

These rights include:

- Providing a copy of orders and a statement of rights to the person;
- Providing a copy of orders to a guardian, medical agent, relative, carer or friend of the person with a mental illness (if the order is confirmed, revoked or changed) as well as to the person;
- Providing for the use of interpreters where available and practicable;
- Entitling the person with a mental illness to have another person's support;
- Entitling the person with a mental illness to communicate with people outside of a treatment centre;
- Person with a mental illness has a right to a treatment and care plan and to have input into the plan and for their carer or other person providing support to them to be involved.

The SA Health booklet *'Your Rights and Responsibilities'* provides general information about the rights of a person with a mental illness. This includes rights to information, treatment, rights to receive appropriate care and to a second opinion.

The rights of carers/families extend to information that is reasonably required for the treatment, care or rehabilitation of the person who is receiving involuntary treatment. Such information may be shared with a relative, carer or friend of the person, where the disclosure is not contrary to the person's best interest.

Confidentiality And Information Sharing

It is acknowledged that staff in Mental Health Services frequently deal with important and complex information-sharing issues in the course of their daily activities.

Health workers have professional and legal obligations to keep client information confidential. However, there are circumstances when it will be appropriate to disclose information without consent.

The Act increases provision for the appropriate disclosure of relevant information and clarifies conditions when information can be shared with and without consent of the person to whom the information relates.

Information about a person can be shared at any time when the person concerned has given informed consent. Even when consent has not been given, information about a person can still be received by staff.

If a person is on either a CTO or a DTO then information can be shared where the disclosure is necessary to provide appropriate care and treatment. Any issues of risk either to the person concerned or to any other person must also be considered as grounds for disclosure of the relevant information.

The SA Health/Health Consumers Alliance of South Australia booklet 'Privacy, Confidentiality and Getting the Best Care and Treatment, Achieving The Balance' (commonly referred to as: 'Achieving the Balance') was written for the MHA 1993. However, the booklet contains some general information and principles that clinicians may still find useful until the booklet is updated and/or replaced.

The MHA 2009 clarifies when information can be disclosed and the Guiding Principles should be considered to assist decision-making when confidentiality and information sharing issues arise. The need to share/disclose information must be taken into account when considering issues of clinical risk.

Scenario 1

The following scenario is designed to demonstrate when it is appropriate to disclose information.

Mary lives amicably with her sister Carol. Over the last two weeks, Mary has become increasingly manic with heightened activity and agitated conversations lasting well into the night. Carol finally persuades Mary that she needs professional help. By now both of them are stressed, exhausted and angry. Mary tells the doctor she wants no further contact with her sister and doesn't want her involved in any discussions about her care.

Mary is placed on a Level 1 Detention and Treatment Order (L1 DTO). There is a note in Mary's records stating that, when she was well, she had given permission for information and decisions to be shared with her sister if she became ill again.

a) Should information about Mary's treatment and care be shared with her sister?

Comment

Issues around confidentiality should not be used as reasons to withhold information about Mary's treatment from her sister, nor for not discussing fully with Mary the need for her sister to receive information so that she can continue to support her. Carol should be given sufficient information, in a way she can readily understand, to help her provide care and support.

The Act provides for information to be shared, if a person is on an order when it is reasonably required for the treatment, care or rehabilitation of the person and not contrary to the person's best interests.

The provisions in Section 106 of the MHA 2009 for confidentiality and disclosure of information are consistent with the provisions of Section 93 of the Health Care Act 2008.

Support Person

It is recognised that people may lack the confidence or the skills to express their own views when they are unwell, especially in some settings such as a General Practitioner (GP) clinic or a hospital.

This may be exacerbated in the case of a person who is experiencing mental distress and confusion and the Act recognises the importance of supporting a person in these circumstances.

The Act states that a person with a mental illness is entitled to have another person's support, wherever practicable, to exercise rights under the Act or in any communications between that person and the treating team.

A support person can be a guardian, medical agent, relative, carer or friend of the person who has been nominated by them for the purpose or someone who has or is assuming responsibility for the care of the person.

The support person should be consulted in regard to the care and treatment of the person.

Advocacy

An advocate may be defined as a person who helps the patient find their voice and express their views. In order to achieve this it is preferable that the advocacy service is independent of the formal care giving services.

Advocacy recognises a person's right to express their views in formal settings and formal processes. Part 8 of the Act provides for the use of support persons, including persons who provide advocacy services on a professional or voluntary basis, to all patients with a mental illness.

The MHA 2009 provides for advocacy services through the creation of the Community Visitor Scheme.

The Community Visitor Scheme must be implemented no later than 11 June 2011.

Existing Services that provide advocacy, advice and/or information include:

The **Office of the Public Advocate**
Tel: (08) 8342 8200, Toll Free: 1800 066 969
Web: www.opa.sa.gov.au

The **Legal Services Commission**
Tel: (legal advisory service): 1300 366 424
Web: www.lsc.sa.gov.au

The **Health and Community Services Complaints Commissioner** (HCSCC)
helps people resolve complaints about health and community services.
Tel: (08) 8226 8666, Toll Free: 1800 232 007
Web: www.hcscc.sa.gov.au

The **Aboriginal Legal Rights Movement** (ALRM).
Tel: (08) 8113 3777, Toll Free: 1800 643 222
Web: www.alrm.org.au

The **Office of the Guardian for Children and Young People**
Tel: (08) 226 8570, Toll Free: 1800 275 668 (or 1800 ask oot)
Web: www.gcyp.sa.gov.au

Activity 4

Can you think of a situation where the presence of an advocate would have been of benefit to a person with a mental illness?

Is there ever a situation where the presence of an advocate may be seen as a hindrance?

Comment

In relation to the second question above, the answer should be 'no'.

However, if the advocate was not reflecting the feelings and wishes of the person with a mental illness, but was following his/her own agenda, not only would he/she not be a true advocate but might be a hindrance to ensuring that the wishes of the person were heard.

It is the duty of mental health service providers to ensure that people with a mental illness receive information about advocacy, information and support services. It is the responsibility of every health professional to ensure that the person is aware of and is provided with information and assistance to contact advocacy services.

In this Section of the Guide we have covered some of the provisions of the Act.

We have looked at the support person, advocacy, and some of the safeguards that have been put in place to protect the rights of people with a mental illness.

It is not possible to cover everything in detail but it is to be hoped that having completed this Section of the Guide, you will be better equipped to deal with some of the issues encountered in your workplace, and feel more confident in your knowledge of the Act.

Self Assessment

Now test yourself to see how much you have learned from undertaking this Section of the Guide and to see if you can apply your knowledge to practice.

The scenarios in the next few pages are designed to ascertain whether you have met the learning outcomes for this Section of the Guide.

You should now complete the following self assessment activities.

Scenario 2

Jo is a 25 year old Sudanese woman who, with her husband, lives with her older brother's family and her 60 year old mother in law in a large unit in Murray Bridge. Jo has two children aged three years and nine months. Jo accessed mental health services once in her late teens. She has a diagnosis of depression and continues to take medication. Jo says: 'I like to take the tablets but forget to take them from time to time – who doesn't?'

The main support comes from the local GP. While Jo's English is good, she feels that she can better express what she is experiencing in her mother tongue.

Jo's mental health has been steadily deteriorating and she is referred for a psychiatric assessment. It is considered necessary for her to receive treatment in a treatment centre.

Jo refuses to be admitted on a voluntary basis and is admitted under a L1 DTO. On admission to a treatment centre she expresses concern regarding the care of her children while she is receiving treatment in the treatment centre, as she does not believe they will be safe without her.

We would now like to ask you questions based on this scenario.

a) How can staff ensure they are meeting Jo's cultural and spiritual needs?

Comment

The SA Mental Health and Wellbeing Policy 2010-2015 provides a strategic vision for whole of government mental health reform.

One of the aims of the policy is to protect the rights of people and to ensure that services are provided in a way that meet the cultural and spiritual needs of people.

It is important that staff working in Mental Health Services receive training and have an understanding of cultural diversity, respond in accordance with this training and are familiar with the key cultural and religious needs of a person with a mental illness of a different ethnic origin.

In this scenario, Jo may require an interpreter to assist with identifying her cultural and spiritual needs and/or requirements.

b) How can the child care issues be managed?

Comment

As Jo has been admitted under an order, a member of the treating team could liaise with the GP. The GP may know the family well enough and be satisfied that the father and mother are competent to cope with the children's care in general and that the father is able to competently cope with the children's care while Jo is in a treatment centre.

However, if not and/or if there are suspected child abuse issues, any health professional concerned, has an obligation to involve Families SA. The number for Crisis Care is 131 611. The child abuse report line is 131 478.

It is also important to note there are considerable variations in parenting skills and behaviours across cultures and within cultures.

1c) What are the relevant Guiding Principles to be considered?

The Guiding Principles that should be considered include: **'Culturally appropriate'**, **'carers needs'** and **'collaboration'**. The rights, welfare and safety of any children and other dependants of the patient should also be considered and protected as far as possible.

Scenario 3

Katy is 30 years old, and has had a diagnosis of schizophrenia since she was 20 years old. She also has a moderate learning disability.

Katy has recently been admitted as a voluntary patient to a treatment centre to be commenced on new medication (clozapine).

On admission, Katy verbally states that she wishes Bob, her support person, to act on her behalf, to be involved in all aspects of her care and to receive full information relating to her treatment.

Katy's current medication is gradually decreased in preparation for commencement of a new drug regime. Katy's mental state rapidly deteriorates and she displays symptoms of persecutory delusions, paranoid beliefs and auditory hallucinations. She is also irritable and aggressive.

Katy is unwilling to remain in hospital and following assessment by a psychiatrist she is detained on a L1 DTO.

Katy states she no longer wishes Bob to be involved or receive information about her care. Bob subsequently visits the ward and requests information in respect of Katy's detention.

The nurse in charge informs Bob that Katy no longer wants him to be involved in her care or to act as advocate and she cannot discuss any aspect of Katy's care with him.

Bob demands to receive information and states that when Katy was well she signed a consent form that he can receive information about her care and therefore he should be considered as advocate and continue to be involved.

Should information be divulged to Bob?

Comment

Where a valid consent form or an advanced directive or even an informal written Ulysses Agreement is in place it should be taken into account when decisions are taken about the care and treatment of a person with a mental illness. The decision to disclose or withhold information will depend on the individual circumstances in each case.

A person is not incapable of making a decision because they have a mental illness and therefore the fact that Katy has changed her mind may be valid. However, if a decision is made because of a person's mental illness then it may be in their best interest to uphold their written instructions.

Decisions made together with an accurate clinical record of presentation and actions carried out must be documented in a patient's clinical notes in accordance with the *'National Practice Standards of the Mental Health Workforce',* statement *'Mental Health professionals maintain a high standard of documentation and information systems on clinical interventions'.*

It is important to note that each case should be considered on its own merit.

Provisions For Review By The Guardianship Board And Appeal To The Guardianship Board

The MHA 2009 establishes processes of review and appeal for people whose liberty or rights are impacted as a result of their mental illness.

The Guardianship Board (the Board) was established pursuant to the GAA 1993.

The GAA 1993 provides for a Board President, deputy Presidents and members appointed by the Governor to one of two panels. One of the panels consists of members from professions that the Governor considers relevant, for example, lawyers or psychiatrists. The second panel consists of general members made up of people with relevant areas of expertise including representing or promoting the interests of people with mental illness or mental incapacity.

The Board has a role in making Level 2 (L2) CTOs and Level 3 (L3) DTOs.

Only the Board can make a L2 CTO (on application). The Board can make a L2 CTO for a person on a L1 or on a L2 CTO. The Board can also make a L2 CTO (on application) for a person who is not currently on a CTO or on a DTO (providing the criteria for a L2 CTO are met).

Two months prior to the expiry of a L2 CTO with a duration of more than six months, the Registrar of the Board must send a written reminder of the expiry date to the applicant, the Public Advocate and any other person who has a proper interest in the welfare of the patient.

The Board also has a role in hearing appeals against orders made/confirmed by psychiatrists/authorised medical practitioners (AMPs). For example, on hearing an appeal against a L2 DTO, the Board may confirm, vary or revoke the L2 DTO. The Board has the option of revoking the L2 DTO and making a L2 CTO instead. The Board may also order that a person's treatment and care plan be reviewed.

Board hearings take place in a range of venues and ideally will be undertaken by panels of three, with each of the member groups represented, although on occasions a hearing might have only one Board member.

The Act entitles a person with a mental illness to have another person's support, wherever practicable, to exercise rights under the Act, for example, when appealing to the Board or for any communications between the person and the treating team.

Guardianship Board Reviews

The legislation makes provision for the person with a mental illness, or others acting on their behalf, to apply to the Board to review an order with the aim of revoking or changing the order made in relation to the patient. The various orders are discussed in depth in Section 5 of the Guide.

The Board will review L1 CTOs before expiry to consider if a L2 CTO should be made. If the Board considers the criteria for a L2 CTO are not met, the Board must revoke the L1 CTO.

If a L1 CTO is revoked by an AMP or psychiatrist prior to review by the Board, then the Board must still conduct a (paper) review of the circumstances involved in the making and revocation of the L1 CTO.

The Board is not required to review a L2 CTO made in relation to persons of 18 years or older. However, the Board must review a L2 CTO made in respect of a child/young person under 18 years of age if the L2 CTO still applies to the child/young person after three months of the order being made.

The Board must also review the circumstances involved when a L1 DTO is made within 7 days after the expiry or revocation of a previous DTO.

The Board must ensure that a person with a mental illness is given, as soon as practicable after making an order or a decision, a written statement of the person's rights. The Board must also ensure that a copy of the order or decision and the statement of rights are sent or given to a support person, carer or guardian of the person as soon as practicable.

Appeal To The Guardianship Board

The person or a support person has the right to appeal to the Board for revocation of an order made/confirmed by a psychiatrist or an AMP. Before a decision is made, the Board must allow representation from people acting on the patient's behalf. The representation can be made orally or in writing.

Any of the following people may appeal to the Board against an order:

- a person to whom the order applies;
- the Public Advocate;
- a guardian, medical agent, relative, carer or friend of the person; or
- any other person who satisfies the Board that he or she has a proper interest in the matter and who is dissatisfied with an order (other than an order made by the Board).

Determining An Appeal

In determining an appeal, the Board must be satisfied that the criteria of the order continue to be met. The onus is not on the person with a mental illness to demonstrate that the criteria do not continue to be met. Rather, the onus is on the professionals to prove the necessity of continuing involuntary treatment.

Groups With Particular Needs

As we have discussed earlier, the MHA 2009 allows for new and expanded Guiding Principles to safeguard people's rights, recognising and respecting them as individuals. This is particularly so when we consider various community groups including Aboriginal people and Torres Strait Islander people, people from culturally and linguistically diverse backgrounds and children/young people.

Let us take into account how the MHA 2009 provides for these groups.

Aboriginal People And Torres Strait Islander People

The MHA 2009 recognises the different and broader concepts of mental health within Aboriginal culture and Torres Strait Islander culture. Guiding Principles have been included in the Act that services should take into account their traditional beliefs and practices, and where practicable and appropriate, to involve collaboration with health workers and traditional healers from the relevant communities.

The establishment of Limited Treatment Centres (LTCs) will benefit some South Australians who live in country areas including Aboriginal people and Torres Strait Islander people. The enhancement of video-conferencing technology will improve access to specialist services for rural and remote areas, and will extend to services for people living on the Anangu Pitjantjatjara Yankunytjatjara (APY) Lands.

People From Culturally And Linguistically Diverse Backgrounds

The Guiding Principles of the Act state that the different cultural backgrounds of people should be taken into account. This aligns with the Mental Health and Wellbeing Policy, whereby services aim to be delivered which are culturally appropriate and that meet the distinct and complex needs of consumers from culturally and linguistically diverse backgrounds across their lifespan and facilitate the provision of specialist services.

The Special Circumstances Of Children

The Act clarifies that it applies to children and includes a number of provisions designed to protect their interests. This is reflected in the following Guiding Principles:

- Children and young persons should be cared for and treated separately from other patients as necessary to enable the care and treatment to be tailored to their different developmental stages; and
- The rights, welfare and safety of the children and other dependants of patients should always be considered and protected as far as possible.

The latter principle is designed to ensure that the needs of children and young people are considered and responded to when they live with or care for an adult with a serious mental illness.

The Act recognises that a child may consent to their own treatment at 16 years of age. However, the Act extends protection in terms of shorter orders and review by the Board of L2 CTOs and L3 DTOs for children/young people under 18 years of age.

The maximum duration of a L2 CTO or a L3 DTO for a child/young person under 18 years of age is six months. The Board must review a L2 CTO/L3 DTO for a child/young person if the order is still in place three months after being made.

Reflection

What Have We Learnt So Far?

In this Section of the Guide we have considered:

- the background to the MHA 2009;
- the manner in which decisions should be made under the MHA 2009 (the Guiding Principles);
- the key differences between the MHA 2009 & MHA 1993; and
- some of the key reforms.

In doing so, some issues have been identified in relation to the realities of practice and the context in which you work.

The Act is generally seen as facilitating a culture that is more conducive to the rights of and collaboration with people who access our services to receive care and treatment for a mental illness.

However, we must not forget that for most people, involuntary treatment can be a difficult experience. It is important that all practitioners are aware of this and consider how to work in respectful and sensitive ways, especially when making an order for involuntary treatment.

The aim is to ensure that people with a serious mental illness:

- receive comprehensive services of a high standard in the least restrictive environment/manner; and
- retain their freedom, rights, dignity and self respect whilst ensuring their/others' safety.

Self Assessment

Now test yourself to see how much you have learned from undertaking this Section of the Guide and to see if you can apply your knowledge to practice.

You should complete the following self assessment activities.

Scenario 4

Edward is a man in his late 50s who lives alone and is not known to Mental Health Services. Recently he has been making 'odd' telephone calls to his GP clinic, and his GP has become increasingly concerned about his mental state.

Despite being offered numerous appointments Edward has not attended the clinic.

Following the most recent telephone call, Edward's GP decides to visit him at home.

When the GP arrives, Edward opens the door and although a bit excited and perhaps confused, he appears to show no obvious signs of mental illness. On entering Edward's house the GP sees that the gas appliances have been removed from their permanent fixtures and various electrical wires have been disconnected from light switches and sockets.

When asked about this, Edward states that he has had to do this to stop 'them' listening in on him. There is a strong smell of gas in the house.

We will now ask you three questions regarding this scenario.

a) Which of the Guiding Principles of the Act need to be taken into account in this scenario?

Comment

One of the challenges in this scenario is that you don't actually have much information to go on (as is sometimes the case in practice).

The Guiding Principles in relation to **'Collaboration'**, **'Least Restrictive Alternative'** and **'Therapeutic'** will need to be considered if the GP is considering using the Act.

At this time, however, we do not know if Edward has any family or friends, but this will need to be ascertained.

b) Does Edward fit within the definition of 'mental illness' as it is given in Part 3 of the MHA 2009 (taking into account the clarification provided by Schedule 1)?

Comment

Although there is some evidence of mental illness, in this case is this enough to convince us that Edward has or appears to have a mental illness and that he may require assessment, care and treatment?

It might be that Edward is a heavy cannabis user who is experiencing paranoia or is experiencing an alcohol withdrawal.

c) Based on the previous two answers in this scenario what actions if any should the GP take?

Comment

The GP would need to undertake further assessment in order to demonstrate that Edward meets the criteria for intervention before proceeding with making an order (and we shall be revisiting Edward's situation in Section 5 of the Guide).

Meantime there are some more immediate concerns in relation to the safety of Edward and any other nearby residents. The priority for the GP must be the safety of Edward and his property.

The best course of action, therefore, would be for the GP to contact the local Social Work Team or Mental Health Services for assessment and monitoring of the situation. In addition, the electricity and gas authorities are alerted of the high risk situation.

You have now completed Section 2 of the Guide.

What you have learned in this Section will equip you to undertake the remaining Sections of the Guide.

Section 3 Roles And Functions

Administration Of The Mental Health Act 2009

One of the most significant changes in the Act is the creation of a structure which supports its effective implementation.

The position of a Chief Psychiatrist with statutory powers and functions has been established. The functions of the Chief Psychiatrist include monitoring to ensure accountability and the safety and quality of mental health services.

In this Section of the Guide you will learn about the new statutory roles and functions and safeguards in the Act.

On completion of this Section of the Guide you should be able to demonstrate an understanding of:

- new statutory roles and functions;
- police powers;
- treatment centres;
- the role/use of audio-visual conferencing.

Specific Roles And Functions Under The Mental Health Act 2009

The Act describes new groups of health workers who have specific functions and powers under the legislation.

Even if you do not have statutory powers in relation to this legislation you are still likely to come into contact with the MHA 2009 in some way. We will discuss briefly some of these roles and responsibilities.

If you have a particular interest in the various roles and responsibilities and want to know more than is presented in the Guide as a whole, then you should consult the Act. Further descriptions are outlined in the ***Plain Language Guide***.

A summary of the powers and responsibilities under the Act is provided by Appendix 1 at the end of this Guide.

Summary Of Specific Roles, Powers And Duties

The Minister

The Minister refers to the Minister for Mental Health and Substance Abuse. The Minister has the responsibility to develop and/or promote a strong and viable system of treatment and care, and a full range of services and facilities, for persons with mental illness.

The Minister may appoint a specific medical practitioner or a health practitioner to perform particular duties, to hold or to act in a position.

The Minister will ensure effective systems of accountability are in place for people delivering mental health services. The Minister will table the Chief Psychiatrist's report in Parliament.

Chief Executive

The Chief Executive (of SA Health) may also delegate power in order to perform particular duties, to hold a position or to act in a position to perform particular duties.

Chief Psychiatrist

The Chief Psychiatrist has a function to ensure there is greater accountability, reporting and monitoring of mental health treatment. The Chief Psychiatrist will develop a framework for the governance of the treatment of voluntary patients, legal orders and restraint and seclusion.

The Chief Psychiatrist has a range of responsibilities with the power to discharge them. These powers are provided to the Chief Psychiatrist to ensure safety and quality in the delivery of mental health services.

The Chief Psychiatrist will ensure a system of care is developed to manage and monitor the use of the MHA 2009. In addition, the Chief Psychiatrist will hold a record of all Authorised Health Professionals (AHPs), AMPs, and govern the statutory powers of specific roles.

The Chief Psychiatrist will monitor operations and report annually to the Minister on the Act's application.

Authorised Medical Practitioners

Within the MHA 2009 reference is made to AMPs who are authorised by the Minister to carry out statutory functions under the Act.

An AMP is a medical practitioner (MP) that has undergone significant psychiatric training at a reputable training institute and who has extensive experience working in the area of psychiatry in the diagnosis and treatment of mental illness.

The AMPs have a range of responsibilities including confirming orders. In practice an AMP is most likely to be a psychiatric registrar in the later years of training.

Authorised Health Professionals

The new role of an AHP created under the MHA 2009 will meet the needs of modern community based Mental Health Services, particularly when involuntary treatment is involved or being considered.

The AHP can facilitate earlier access to care and treatment. The AHP is a professional with specialist training and experience in mental health. They are appointed by the Minister.

The Act gives AHPs powers to make both L1 CTOs and L1 DTOs. An AHP will be a specified individual and is likely to be a nurse, psychologist, an occupational therapist, social worker or an Aboriginal Health Worker.

Community Visitors

Part 8, Division 2, provides for a Community Visitor Scheme. This scheme must be introduced by 11 June 2011. There will be a Principal Community Visitor and community visitors appointed for a period not exceeding three years.

Community visitors will conduct visits and inspections of treatment centres at least once every month and as required and will refer matters of concern regarding the care, treatment, or control of consumers to the Chief Psychiatrist and the Minister.

A patient in a treatment centre or a guardian, medical agent, relative, carer or friend of a patient or another support person may request to see a community visitor and the Director must advise a community visitor of the request within two days after receiving such a request.

Community visitors will also advocate for the rights of consumers and their carers and promote resolution of issues in relation to care and treatment raised by a consumer or their nominated representative.

The Guardianship Board

The Guardianship Board (the Board) has a wide range of powers.

The Board has the power to vary, review, revoke, and make treatment orders under the MHA 2009 and the GAA 1993.

The Board makes important decisions affecting the lives and property of vulnerable people over whom it has jurisdiction.

The Board may order that the treatment and care plan of a person be reviewed.

Authorised Officers

Mental Health Clinicians, ambulance officers, Royal Flying Doctors Service (RFDS) medical officers and flight nurses are designated as Authorised Officers. There is also provision to classify other classes of person as Authorised Officers in the regulations.

Under the Act, an Authorised Officer will be able to take a person who appears to have a mental illness to a person/place for medical examination. An Authorised Officer will be able to use reasonable force if necessary for this purpose.

The MHA 2009 repeals the MHA 1993. The powers in Section 23 of the MHA 1993 will be replaced by the powers set out in Part 9, Section 57, of the MHA 2009 for police officers. Part 9, Section 56, provides similar powers and functions for Authorised Officers.

The differences and similarities in the powers for Authorised Officers and police officers are highlighted in Boxes 3.1 and 3.2 below.

Health professionals involved in the care and treatment of people with mental illness have clinical expertise that inform their opinion of a person's current or potential future needs for assessment, care or treatment.

Enabling Authorised Officers to exercise powers in regard to the transportation of people will reduce the need for police involvement.

Box 3.1 below provides a summary of the provisions for Authorised Officers set out in Part 9 (Section 56) of the Act.

Box 3.1 Summary of powers for Authorised Officers in Part 9, Section 56

Authorised Officers include: Mental Health Clinicians, ambulance officers[1], RFDS medical officers & flight nurses and persons of a class prescribed by the Regulations (if any).

Section 56 – If a person has or appears to have a mental illness (and has caused or there is significant risk of the person causing harm to self/others/property OR if the person otherwise requires medical examination) Authorised Officers may:

- take the person into care and control;
- transport the person from place to place;
- restrain the person and otherwise use force in relation to the person as reasonably required in the circumstances (for transport & to enable medical examination and/or treatment);
- restrain the person by means of the administration of a drug when that is reasonably required in the circumstances (but only if authorised to do so under the Controlled Substances Act 1984 – see Section 56 (6));
- enter and remain in a place where the Authorised Officer reasonably suspects the person may be found;
- search the clothing or possessions of the person that has been taken into care/control and take possession of anything in the person's possession that the person may use to cause harm to himself or herself or others or property;
- transport the person, or arrange for the person to be transported by another Authorised Officer or a police officer to a treatment centre or other place for medical examination in accordance with the Mental Health and Emergency Services Memorandum of Understanding (MoU).

[1] Ambulance officer means a person who is (a) employed as an ambulance officer, or engaged as a volunteer ambulance officer, with an organisation that provides ambulance services; and (b) authorised by the chief executive officer of SA Ambulance Service Inc to exercise the powers conferred by this Act on Authorised Officers.

Police Powers

In the community, it is often a police officer who has initial contact with a person who has or who appears to have a mental illness and whose behaviour is putting themselves or others at risk. The MHA 2009 recognises the necessity of enabling a police officer to take action, where appropriate, to divert people to Health from the judicial system.

Police officers are not expected to form an opinion about a person's future assessment, care or treatment needs, that is, police officers can only act if the person or others are at significant risk of harm at the present time.

The MHA 2009 clarifies the circumstances under which a police officer may apprehend someone and take them for assessment.

Box 3.2 below provides a summary of the provisions for police officers in Part 9, Section 57.

Box 3.2 Summary of powers for police officers in Part 9, Section 57

Section 57 (1) – If a police officer believes on reasonable grounds a person is:

- a patient in respect of whom a Patient Transport Request has been issued;
  or
- a patient at large (from a treatment centre)

or it appears to the police officer the person has a mental illness & has caused or there is significant risk of the person causing harm to self/others/property AND the person requires medical examination) the police officer may:

- take the person into care and control;
- transport the person from place to place;
- restrain the person and otherwise use force in relation to the person as reasonably required in the circumstances (for transport & to enable medical examination and/or treatment);
- enter and remain in a place where the police officer reasonably suspects the person may be found;
- use reasonable force to break into a place when that is reasonably required to take the person into care/control;
- search the clothing or possessions of the person that has been taken into care/control and take possession of anything in the person's possession that the person may use to cause harm to himself or herself or others or property.
- transport the person, or arrange for the person to be transported by another Authorised Officer or a police officer to a treatment centre or other place for medical examination (in accordance with the Mental Health and Emergency Services MoU).
- may arrest a person for an offence or apprehend under another law & release the person from police custody for the purpose of medical examination or treatment.
- Section 57 (2) - police officers are excluded from inter-hospital/ATC transfers unless the person has become a patient at large.
- Section 57 (3) - police officers are not required to exercise any medical expertise informing an opinion about a person appearing to have a mental illness.

Police involvement should only be requested if there is a possibility of significant risk of harm or violence, as police involvement may unnecessarily add to the tension of the situation and cause fear and distress to the consumer and family.

Treatment Centres

The MHA 2009 is enabling and will allow some short term admissions for involuntary treatment to be managed closer to someone's home in country areas. This will minimise the disruption experienced by a person and/or their families and carers when a person is transported to Adelaide for assessment or care and treatment.

Limited Treatment Centres

The MHA makes provision for a facility, such as a country general hospital, to be declared by the Minister as a Limited Treatment Centre (LTC) in which a person on a L1 DTO may receive involuntary treatment for up to seven days.

In order for a facility like a country general hospital to be declared an LTC, it will be required to have access to resources and infrastructure to provide professional and appropriate clinical care to a person who is subject to a L1 DTO.

Four LTCs will be established in country areas over the next few years reducing the number of transfers made from country regions to metropolitan areas and thus responding to consumer and carers needs more adequately.

Approved Treatment Centres

An Approved Treatment Centre (ATC) is a facility, usually a large metropolitan hospital, declared by the Minister to be an ATC for the purpose of the Act. An ATC will be an inpatient treatment facility. ATCs are considered to have conditions and staffing levels to provide an appropriate standard of treatment and care to patients receiving treatment and care under the Act for longer periods of time.

Medical Examination Via Audio-visual Conferencing

The MHA 2009 clarifies that audio-visual conferencing can be used for an examination by a MP or an AHP as the basis for making orders when it is not practicable for this to take place in the physical presence of the patient.

Audio-visual conferencing can also be used for an examination by a psychiatrist or an AMP as the basis for making, confirming, extending, reviewing and revoking orders, when it is not practicable for this to take place in the physical presence of the patient.

The Act makes it clear that audio-visual conferencing can be used in the initial or ongoing care and treatment of patients.

This will reduce the need for people from rural and remote areas to be transported to Adelaide or a regional treatment centre for assessment or care and treatment, and fits with the Guiding Principles of **'Early access to treatment and care'** and **'Least restrictive manner'**.

Reflection

In this Section of the Guide we have covered some of the statutory roles and powers in the Act including the Chief Psychiatrist, psychiatrists, AMPs, AHPs, Authorised Officers, police officers, community visitors and the Guardianship Board.

Having completed this Section of the Guide, you should be better equipped to deal with some of the issues that arise in the workplace and feel more confident in your knowledge of the MHA 2009.

Section 4 Treatment And Care

Treatment And Care Plans

Treatment and care plans are a key mechanism by which a person's individual care and treatment can be developed, documented and shared with all those who are involved.

Implemented well, and in accordance with the Guiding Principles of the MHA 2009, treatment and care plans provide a participatory framework for agreeing and reviewing the benefits of a given programme of treatment and care with an individual in the context of his or her recovery.

On completion of this Section of the Guide you should have an understanding of:

- 'treatment and care' as cited in the Act;
- the importance of a treatment and care plan;
- arrangements for transport;
- provisions for ministerial agreements between SA and other jurisdictions.

The MHA 2009 provides a specific definition of 'treatment' or 'medical treatment'. Part 1, Section 3, defines 'treatment' or 'medical treatment' as:

'...treatment or procedures administered or carried out by a medical practitioner or other health professional in the course of professional practice, and includes the prescription and supply of drugs.'

The SA *Mental Health Care Plan* information booklet provides a step-by-step guide to assist staff working in public Mental Health Services in completing a treatment and care plan in consultation with the consumer, their family and/or carer.

In line with best practice, the Act states that a patient's treatment and care should be governed by a comprehensive treatment and care plan that is developed in a multi-disciplinary framework. For example, where 'treatment' includes 'nursing care' or 'psychological intervention', those disciplines will have contributed to the design of the plan, in consultation with the patient and their family or others that support them.

It is expected that treatment and care plans will be commenced from the time that care and treatment commences and that all patients will have a treatment and care plan. However, for those people on L2 or L3 DTOs, or a L2 CTO, it is a mandated requirement that a documented treatment and care plan is prepared.

There are various points in time, throughout the life of a CTO or a DTO, where there is a formal requirement for a care plan to be produced to the Board. The Act requires a copy of an individual's treatment and care plan to be provided to the Board prior to or at a review or an appeal hearing.

Below is a summary of the information that must be reflected in the treatment and care plan as set out in Part 6, Section 39, of the Act.

A patient's treatment and care plan must:

- describe the treatment and care that will be provided to the patient under the requirements of the order and should describe any rehabilitation services that will be provided or available to the patient whether under requirements of the order or through the patient's voluntary participation; and
- as far as practicable, be prepared and revised in consultation with the patient and, any guardian, medical agent, relative, carer or friend who is providing support to the patient under the Act; and
- comply with any requirements of the regulations as to the making or content of such plans.

Clinical Reviews

The Act specifies that there should be a regular medical examination of every patient's mental and physical health and regular medical review of any order applying to the patient. The requirement is consistent with the National Standards for Mental Health Services.

Transport

The MHA 2009 regulates the conditions under which a person with a mental illness can be transported or transferred for medical examination or treatment, including in circumstances where that person is unable to or does not consent to be transported/transferred.

A person can consent to have any other person or officer transport or transfer them for medical treatment. Under the Act, Authorised Officers and police officers may legally transport someone who has or who appears to have a mental illness without their consent for the purpose of assessment.

An Authorised Officer or a police officer is able to transport a person to a treatment centre for assessment or treatment when:

- The officer believes on reasonable grounds that the person is a person for whom a Patient Transport Request has been issued;
- It appears to the officer that the person has a mental illness and the person either requires medical examination or has caused, or there is a significant risk of the person causing, harm to himself or herself, others or property.

A Patient Transport Request (PTR) is a specific request directed to Authorised Officers and police officers generally for the transport of a patient who is subject to a CTO or DTO.

While the primary responsibility for transporting people with a mental illness rests with health staff, police officers will be involved, when appropriate, in accordance with the provisions of the Mental Health and Emergency Services MoU.

Patients with a mental illness who require urgent assessment and treatment may need to be transferred to another place. In the majority of cases an ambulance will be required, but under certain circumstances transport may be with an Authorised Officer, a relative or carer, in a Mental Health Service vehicle or a taxi.

Arranging mental health admissions and transfers is sometimes unpredictable and case by case judgement will be required.

The new provisions will enable a reduction in police officers transporting people who have, or who appear to have a mental illness.

Box 4.1 below gives a summary of the circumstances in which a PTR can be issued, and who is legally able to issue the request.

Box 4.1 Patient Transport Requests

Circumstance in which a Patient Transport Request can be issued	Class of person with the power to issue a Patient Transport Request
A patient subject to a CTO does not comply with the order and needs to be transported for treatment in accordance with the CTO.	A MP or Mental Health Clinician.
A L1 DTO is made by a MP or an AHP at a place other than a treatment centre. Transport request is issued for the purpose of transporting the person to receive treatment at a treatment centre.	The MP or an AHP making the DTO or Mental Health Clinician.
A patient, subject to a DTO is at large from a treatment centre and needs to be transported to a treatment centre.	The Director of the treatment centre, a MP or Mental Health Clinician.
The patient is subject to a DTO and the Director of a treatment centre has directed that the patient be transferred to another treatment centre or hospital.	The Director of a treatment centre or a Mental Health Clinician.

Any person who is the subject of a PTR should be given a copy of the PTR as soon as possible after the PTR is made.

Police involvement may increase the level of fear and distress to patients and their families. Police should only be involved if there is a significant risk of harm to the person or others in accordance with the Mental Health and Emergency Services MoU.

In line with best practice and the Guiding Principles of the MHA 2009, the procedures of managing transport should be developed in a collaborative manner between all services at a local level who may potentially be involved in transporting involuntary patients with a mental illness. This will allow for local difficulties to be addressed and contingency procedures to be put in place before they arise in practice.

The revised Mental Health and Emergency Services MoU is an interagency framework to assist this process. The existence of Local Liaison Groups has created a forum for collaborative practice to be clarified.

Transport To And From South Australia

The MHA 2009 has extensive provisions to facilitate early access to assessment and appropriate care and treatment for people with mental illness.

The interstate provisions in the Act can only be used in respect of another Australian jurisdiction if SA has a signed ministerial agreement with the jurisdiction and if the agreement specifically contemplates/provides for the proposed action to occur.

For example, a ministerial agreement made under the MHA 2009 between SA and the Northern Territory (NT) would allow a Director of a treatment centre (if the transfer is in a patient's best interest and only if approved by the Chief Psychiatrist) to arrange the return of the patient who is usually resident in the NT, to the NT, if the person is admitted on a DTO to a treatment centre in SA.

The MHA provides that Authorised Officers and police officers may transport or arrange for a person who appears to have a mental illness to be transported for mental health assessment across the border or for care and treatment (prior to admission to a treatment centre in SA).

The intent is to reduce the distances that people have to travel for specialist mental health assessment or care and treatment. A person may be transported without consent.

The Act provides for the recognition of interstate orders. For example, if a person who is subject to an interstate CTO comes to SA, the Chief Psychiatrist can make - without examining the person - a L1 CTO based on the requirements of the interstate CTO. This will ensure the person continues to receive mental health care and treatment whilst in SA. The Act's provisions for review by the Board apply to L1 CTOs made by the Chief Psychiatrist.

The Act provides for the transport or transfer of patients who are subject to orders for involuntary mental health treatment in:

- the community (that is, a person on a CTO) - to facilitate treatment;
- a treatment centre (that is, a person subject to a DTO).

A person in respect of whom a L1 DTO has been made in SA may be taken to an interstate facility for admission and treatment (prior to admission to a treatment centre in SA).

After admission to a treatment centre in SA for involuntary treatment (that is, a person subject to a L1, L2 or L3 DTO) only the Chief Psychiatrist can approve a transfer. The person can appeal against the decision and the proposed transfer will not be able to occur:

(i) until the appeal period of 14 days has expired without an appeal being lodged; or

(ii) if an appeal is lodged, until the outcome of the appeal is known.

The Chief Psychiatrist's annual report has to report on all interstate activity.

Section 5 Voluntary And Involuntary Treatment

The MHA 2009 comprehensively reforms and modernises the legal framework for voluntary and involuntary treatment and sets out clear conditions which must be met before an order can be made as well as the detailed procedures which must be followed.

This Section of the Guide will examine the range of CTOs and DTOs contained within the Act.

In undertaking this Section of the Guide it is imperative that you have already completed the earlier Sections as you will need to be able to apply aspects of your learning from earlier Sections.

On completion of this Section of the Guide you should be able to:

- Define the orders as described in the MHA 2009;
- Discuss the details of each of the types of order in relation to the criteria, application, duration, authorisation of treatment and rights to appeal.

Please remember as you read through the details of the various orders that in carrying out any function under the Act, practitioners must have regard to the Guiding Principles of the Act (see Section 1 of the Guide) and that in considering the use of orders the criteria for intervention must be met.

Voluntary Assessment

The pursuit of voluntary admission and treatment is in line with the **'least restrictive'** Guiding Principle and this is the preferred approach providing it is safe and appropriate.

Any person, who is 16 years of age or over may request voluntary admission to a treatment centre.

Usually the initial assessment will be conducted by a mental health professional, who may explore alternatives to inpatient admission and if required, refer the person to a psychiatrist or AMP for examination.

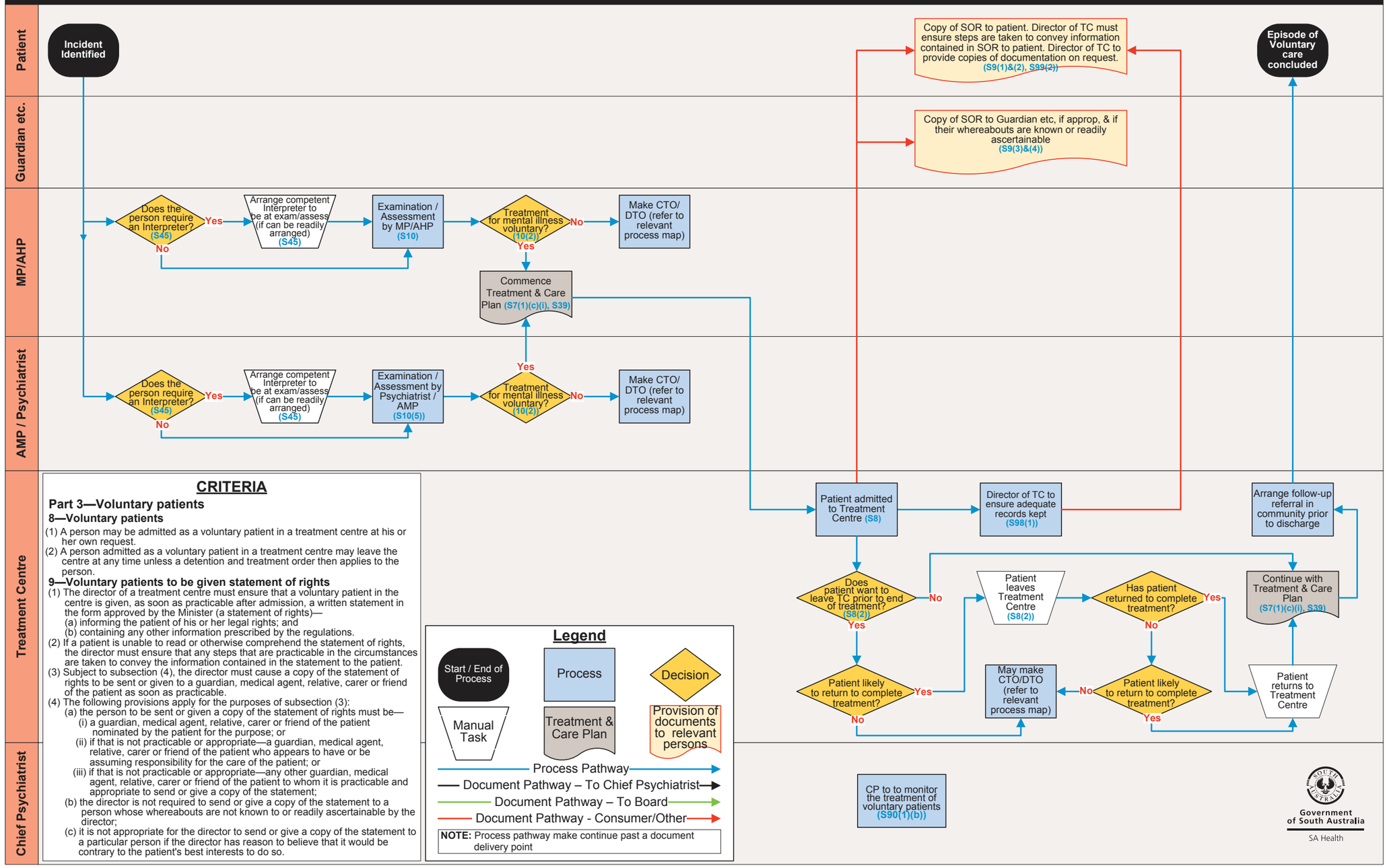
A psychiatrist or AMP must then examine the person and may admit the person as a voluntary patient if satisfied that the person has given informed consent to admission and treatment. The psychiatrist or AMP may refuse to admit a person as a voluntary patient unless satisfied that the person is likely to benefit from being admitted. An alternative management plan may be recommended.

The following map gives an overview of the pathway of care of a person receiving voluntary treatment in a treatment centre.

Voluntary Patients

REV. 1.1	Voluntary Patients	4 Mar 2010	E. Wiszniewski

Criteria: Person has a mental illness & requires treatment. Person admitted as a voluntary patient in a treatment centre at his or her own request.



Involuntary Assessment

If a person requires assessment, a MP (including a psychiatrist or an AMP) or an AHP may assess or arrange for the person to be assessed as soon as practicable. The assessment does not have to occur at a treatment centre.

A L1 order for psychiatric treatment and care may be made by the assessing clinician and must specify the basis on which the order is being made. In addition to the assessment, collateral information must be considered when forming an opinion as to whether the criteria for the making of an order have been met.

An AHP/MP may issue a PTR for the transport of a person who is subject to a L1 DTO to a treatment centre (if the L1 DTO was not made at a treatment centre).

If the L1 DTO made in respect of a patient has been confirmed, the patient can be treated on an involuntary basis in an LTC or an ATC for up to 7 days.

Orders For Involuntary Treatment

The MHA 2009 deals with several types of orders for involuntary treatment:

- L1 CTO (up to 28 days);
- L2 CTO (up to 6 months for children, up to 12 months for adults);
- L1 DTO (up to 7 days);
- L2 DTO (up to 42 days);
- L3 DTO (up to 6 months for children, up to 12 months for adults).

Please note no order can be 'renewed', 'rolled-over' or 'extended'.

Community Treatment Orders

A CTO enables a person who needs treatment for a mental illness and who will not accept services voluntarily, to be treated in the community. A CTO can only be made if the person requires care and treatment for a mental illness and if a CTO is the least restrictive way in which the care and treatment can be provided.

A person on a CTO can only be treated for a mental illness without consent (except in a medical or life-threatening emergency).

Treatment for the mental illness of a person on a CTO must be authorised by a psychiatrist or an AMP who has examined the person.

A CTO provides a framework to protect a person's rights and to assist people who might otherwise not comply with treatment or who might lose contact with services on discharge from hospital and subsequently relapse, leading to a cycle of involuntary admissions. Part 4 and Part 5 of the Act provides a number of ways in which the process of involuntary treatment can be initiated.

A CTO sets out conditions the person must adhere to in order to ensure they receive the required treatment for their mental illness.

Level 1 Community Treatment Orders

The MHA 2009 enables a MP or an AHP to make a L1 CTO. A L1 CTO made by a MP or an AHP must be confirmed by a psychiatrist or an AMP within 24 hours (hrs) or as soon as practicable, and is valid for a maximum of 28 days.

A L1 CTO made by a psychiatrist or an AMP does not need to be confirmed by a different psychiatrist or an AMP.

A L1 CTO, unless earlier revoked by a psychiatrist or an AMP, must/will expire at 2pm on a business day not later than 28 days after the day on which it was made. A psychiatrist or an AMP making, confirming or varying a L1 CTO must set the date of expiry to be on a business day.

A patient on a L1 CTO may be admitted to a treatment centre on a L1 DTO and in this situation, the requirements of the L1 CTO do not apply for the period in which a DTO applies to the patient. If the L1 CTO remains in force once any DTO that applies to the patient is revoked or expires, then the requirements of the L1 CTO will once again apply.

Any MP or AHP may examine a patient and issue a L1 CTO if it appears that:

- the person has a mental illness; and
- because of the illness, the person requires treatment for the person's own protection from harm (including harm involved in the continuation or deterioration of the person's condition) or for the protection of others from harm;
- there are facilities and services available for appropriate treatment of the illness and there is no less restrictive means of ensuring appropriate treatment of that person's illness.

Consideration must be given to the possibility of the person receiving the treatment on a voluntary basis.

The psychiatrist or AMP must ensure notification of the order is made to the Board and Chief Psychiatrist within 1 business day if making, revoking, or varying the order.

Table 5.1 below gives an overview of a L1 CTO and its conditions.

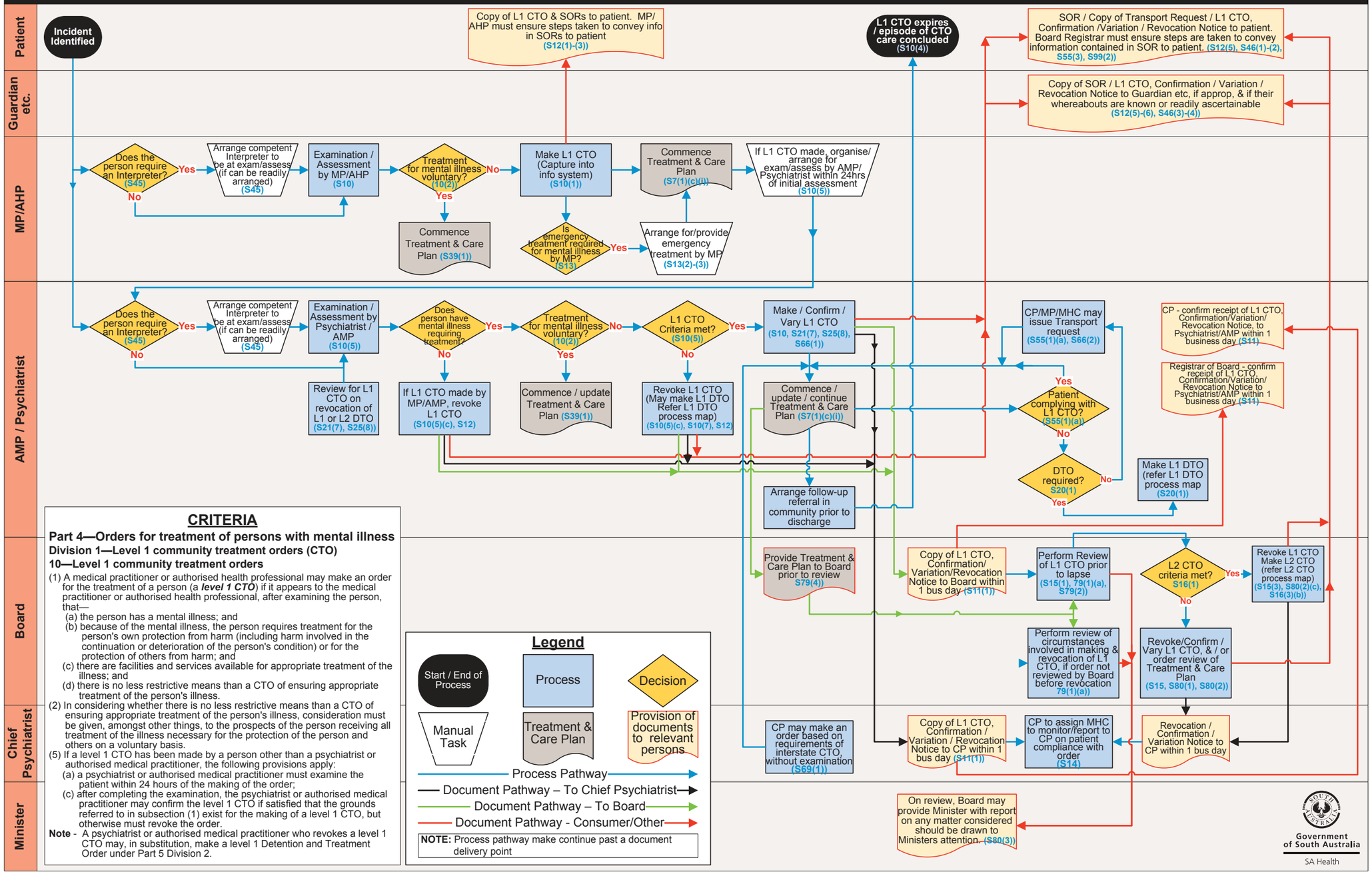
Table 5.1 L1 CTO

Part 4 of the Act	L1 CTO
Who authorises?	MP (including a psychiatrist or an AMP) or an AHP
What conditions must be met?	A MP or an AHP may make a L1 CTO if it appears to the MP or AHP, after examining the person, that: > the person has a mental illness; and > because of the illness, the person requires treatment for the person's own protection from harm (including harm involved in the continuation or deterioration of the person's condition) or for the protection of others from harm; and > there are facilities and services available for appropriate treatment of the illness, & there is no less restrictive means of ensuring appropriate treatment of that person's illness; and > there is no less restrictive means than a CTO of ensuring appropriate treatment of the person's illness. In considering whether there is no less restrictive means than a CTO of ensuring appropriate treatment of the person's mental illness, consideration must be given, amongst other things, to the prospect of the person receiving all treatment of the mental illness necessary for the protection of the person and others on a voluntary basis. For L1 CTOs that are NOT made by a psychiatrist or an AMP, the MP or AHP must make arrangements for an examination by a psychiatrist/AMP within 24 hrs or as soon as practicable. The psychiatrist/AMP must notify the Board and Chief Psychiatrist within 1 business day if making, revoking, varying a L1 CTO.
Duration and location?	Up to 28 days. The psychiatrist/AMP making, confirming or varying a L1 CTO must set the date of expiry to be on a business day.
Treatment?	The treatment and care of the person's mental illness, must, as far as practicable, be governed by a treatment and care plan. Treatment for the patient's mental illness must be authorised by a psychiatrist or AMP who has examined the patient. A person on a L1 CTO can only be treated for a mental illness without consent not any other illness (except in a medical or life-threatening emergency when patient authorisation is not required, or in the circumstances it is not practicable to obtain authorisation). The Chief Psychiatrist must ensure that for each patient to whom a L1 CTO applies there is a Mental Health Clinician who has ongoing responsibility for monitoring and reporting to the Chief Psychiatrist on the patient's compliance with the order.
Board Review?	The Board must conduct a review before expiry of the order. If the L1 CTO is revoked prior to the review by the Board, the Board must still conduct a (paper) review of the circumstances involved in the making and revocation of the L1 CTO.
Appeal?	Any of the following persons who is dissatisfied with a L1 CTO may appeal to the Board against the order: (a) the person to whom the order applies; (b) the Public Advocate; (c) a guardian, medical agent, relative, carer or friend of the person to whom the order applies; (d) any other person who satisfies the Board that he or she has a proper interest in the matter.

L1 Community Treatment Order (CTO) Process Flow Diagram (up to 28 Days)

REV. 1.1	L1 CTO	4 Mar 2010	E. Wiszniewski

Criteria: person appears to have a mental illness & requires treatment for the person's own protection or protection of others from harm, there are facilities and services available for appropriate treatment of the illness, and there is no less restrictive means of ensuring appropriate treatment of the person's illness



CRITERIA

Part 4—Orders for treatment of persons with mental illness

Division 1—Level 1 community treatment orders (CTO)

10—Level 1 community treatment orders

(1) A medical practitioner or authorised health professional may make an order for the treatment of a person (a ***level 1 CTO***) if it appears to the medical practitioner or authorised health professional, after examining the person, that—
- (a) the person has a mental illness; and
- (b) because of the mental illness, the person requires treatment for the person's own protection from harm (including harm involved in the continuation or deterioration of the person's condition) or for the protection of others from harm; and
- (c) there are facilities and services available for appropriate treatment of the illness; and
- (d) there is no less restrictive means than a CTO of ensuring appropriate treatment of the person's illness.

(2) In considering whether there is no less restrictive means than a CTO of ensuring appropriate treatment of the person's illness, consideration must be given, amongst other things, to the prospects of the person receiving all treatment of the illness necessary for the protection of the person and others on a voluntary basis.

(5) If a level 1 CTO has been made by a person other than a psychiatrist or authorised medical practitioner, the following provisions apply:
- (a) a psychiatrist or authorised medical practitioner must examine the patient within 24 hours of the making of the order;
- (c) after completing the examination, the psychiatrist or authorised medical practitioner may confirm the level 1 CTO if satisfied that the grounds referred to in subsection (1) exist for the making of a level 1 CTO, but otherwise must revoke the order.

Note - A psychiatrist or authorised medical practitioner who revokes a level 1 CTO may, in substitution, make a level 1 Detention and Treatment Order under Part 5 Division 2.

Legend

Level 2 Community Treatment Orders

A L2 CTO is made only by the Board and is valid for a maximum of:

- 6 months for a child;
- 12 months for all other patients.

An application for a L2 CTO order may be made to the Board by:

- The Public Advocate;
- A MP;
- A Mental Health Clinician;
- A guardian, carer, relative, friend or medical agent of the patient;
- Any other person who has a proper interest in the welfare of the patient.

If the Board is satisfied that the criteria for the making of a L2 CTO are met, the Board may make a L2 CTO.

The Board can make a L2 CTO in respect of a person who is:

- not currently on any order, that is, not on a CTO or a DTO;
- on a L1 CTO made/confirmed by a psychiatrist/AMP;
- on a L2 CTO made by the Board, for example, if the L2 CTO is due to expire;
- on application to the Board for the revocation of a L3 DTO.

The Board must notify the Chief Psychiatrist when a L2 CTO is made, varied or revoked within 1 business day.

A L2 CTO, unless earlier revoked, expires at a time in the order which must be 2pm on a business day no later than 6 months for children/young people under 18 years of age and no later than 12 months for adults. The Board may on review, vary or revoke a L2 CTO. The Board may also order a review of the person's treatment and care plan.

A L2 CTO can only be made if the person requires care and treatment for a mental illness and if a L2 CTO is the least restrictive way in which the care and treatment can be provided.

A person on a L2 CTO can only be treated for a mental illness without consent (except in a medical or life-threatening emergency when patient authorisation is not required, or in the circumstances it is not practical to obtain authorisation).

The Chief Psychiatrist must ensure that a Mental Health Clinician has the ongoing responsibility for monitoring the person and reporting to the Chief Psychiatrist on the patient's compliance with a L2 CTO.

The treatment and care of a patient with a L2 CTO must be governed by a treatment and care plan. A patient on a L2 CTO can only be treated for a mental illness and treatment for the patient's mental illness must be authorised by a psychiatrist or an AMP who has examined the patient.

If the L2 CTO remains in force once any DTO that applies to the patient is revoked or expires, then the requirements of the L2 CTO will once again apply.

Table 5.2 below gives an overview of a L2 CTO and its conditions.

Table 5.2 L2 CTO

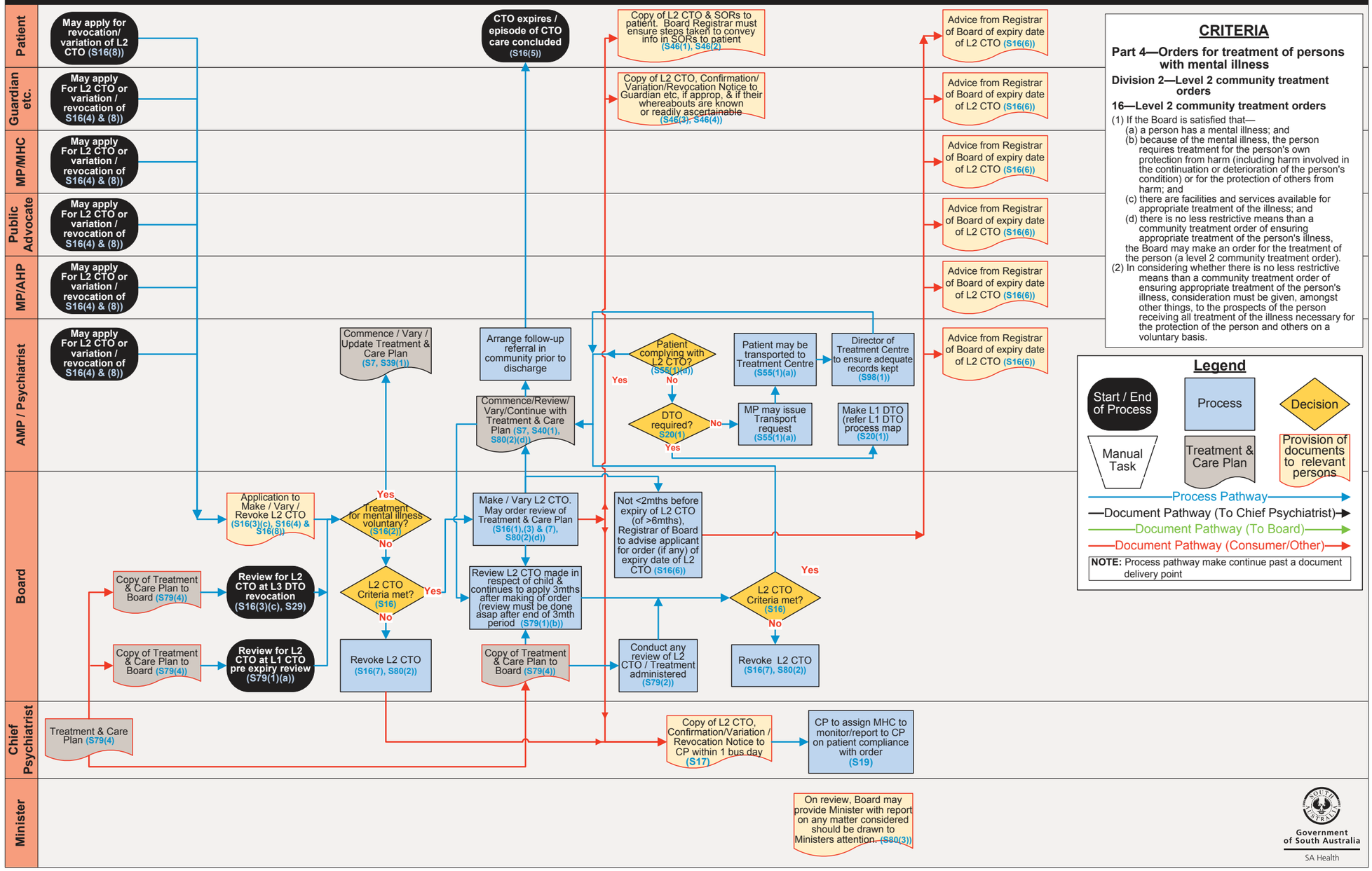
Part 4 of the Act	L2 CTO
Who authorises?	The Board
What conditions must be met?	If the Board is satisfied that: > the person has a mental illness; and > because of the illness, the person requires treatment for the person's own protection from harm (including harm involved in the continuation or deterioration of the person's condition) or for the protection of others from harm; and > there are facilities and services available for appropriate treatment of the illness, & there is no less restrictive means of ensuring appropriate treatment of that person's illness; and > there is no less restrictive means than a CTO of ensuring appropriate treatment of the person's mental illness. Consideration must be given to the possibility of the person receiving the treatment for their mental illness on a voluntary basis.
Duration and location?	Up to 6 months for children/young people under 18 years of age and up to 12 months for adults.
Treatment?	The treatment and care of the person's mental illness must, as far as practicable, be governed by a treatment and care plan. A person on a L2 CTO can only be treated for a mental illness without consent (except in a medical or life-threatening emergency when patient authorisation is not required or in the circumstances it is not practical to obtain authorisation). A person on a L2 CTO may be given treatment for their mental illness if the treatment has been authorised by a psychiatrist or an AMP who has examined the patient. The Chief Psychiatrist must ensure that for each patient to whom a L2 CTO applies there is a Mental Health Clinician who has ongoing responsibility for monitoring and reporting to the Chief Psychiatrist on the patient's compliance with the order.
The Board Review	The Board must review a L2 CTO that has been made in respect of a child/young person and continues to apply to the child/young person 3 months after making the L2 CTO. The Board is not required to review L2 CTOs for adults.
Appeal?	Any of the following persons who is dissatisfied with a L2 CTO made by the Board may appeal to the District Court against the order: (a) the person to whom the order applies; (b) the Public Advocate; (c) a guardian, medical agent, relative, carer or friend of the person to whom the order applies; (d) any other person who satisfies the Board that he or she has a proper interest in the matter.

Following is a flowchart to aid decision-making for the making of a L2 CTO by the Board.

L2 Community Treatment Order Process Flow Diagram (up to 6mths for children, 12 mths for adults)

REV. 1.1	L2 CTO	4 Mar 2010	E. Wiszniewski

Criteria: Board is satisfied the person has mental illness & requires treatment for the person's own protection or protection of others from harm, there are facilities & services available for appropriate treatment of the illness, and there is no less restrictive means of ensuring appropriate treatment of the person's illness



Detention And Treatment Orders

The criteria for CTOs and DTOs are similar in that care should be provided in the least restrictive way and in the least restrictive environment.

Level 1 Detention And Treatment Orders

Any MP (including a psychiatrist or an AMP) or an AHP may make a L1 DTO that, once confirmed by a (different) psychiatrist or an AMP, authorises involuntary inpatient treatment in an LTC or an ATC for a maximum period of 7 days.

A L1 DTO can only be made if the following criteria are met:

- the person has a mental illness; and
- because of the illness, the person requires treatment for the person's own protection from harm (including harm involved in the continuation or deterioration of the person's condition) or for the protection of others from harm; and
- there is no less restrictive means than a DTO of ensuring appropriate treatment of the person's illness.

Consideration must be given to the possibility of the person receiving the treatment on a voluntary basis or on a CTO.

The MP (including a psychiatrist/AMP) making a L1 DTO must arrange for the person to be examined by a (different) psychiatrist/AMP within 24 hrs or as soon as practicable.

A person on a L1 DTO who has been examined by a MP may be given treatment for a mental illness or any other illness without consent.

A L1 DTO, unless earlier revoked, will expire at 2pm on a business day not later than 7 days after the day on which it is made.

The psychiatrist or AMP confirming, revoking or varying a L1 DTO must ensure notification of the order is made to the Board and Chief Psychiatrist within 1 business day .

Table 5.3 below gives an overview of a L1 DTO and its conditions.

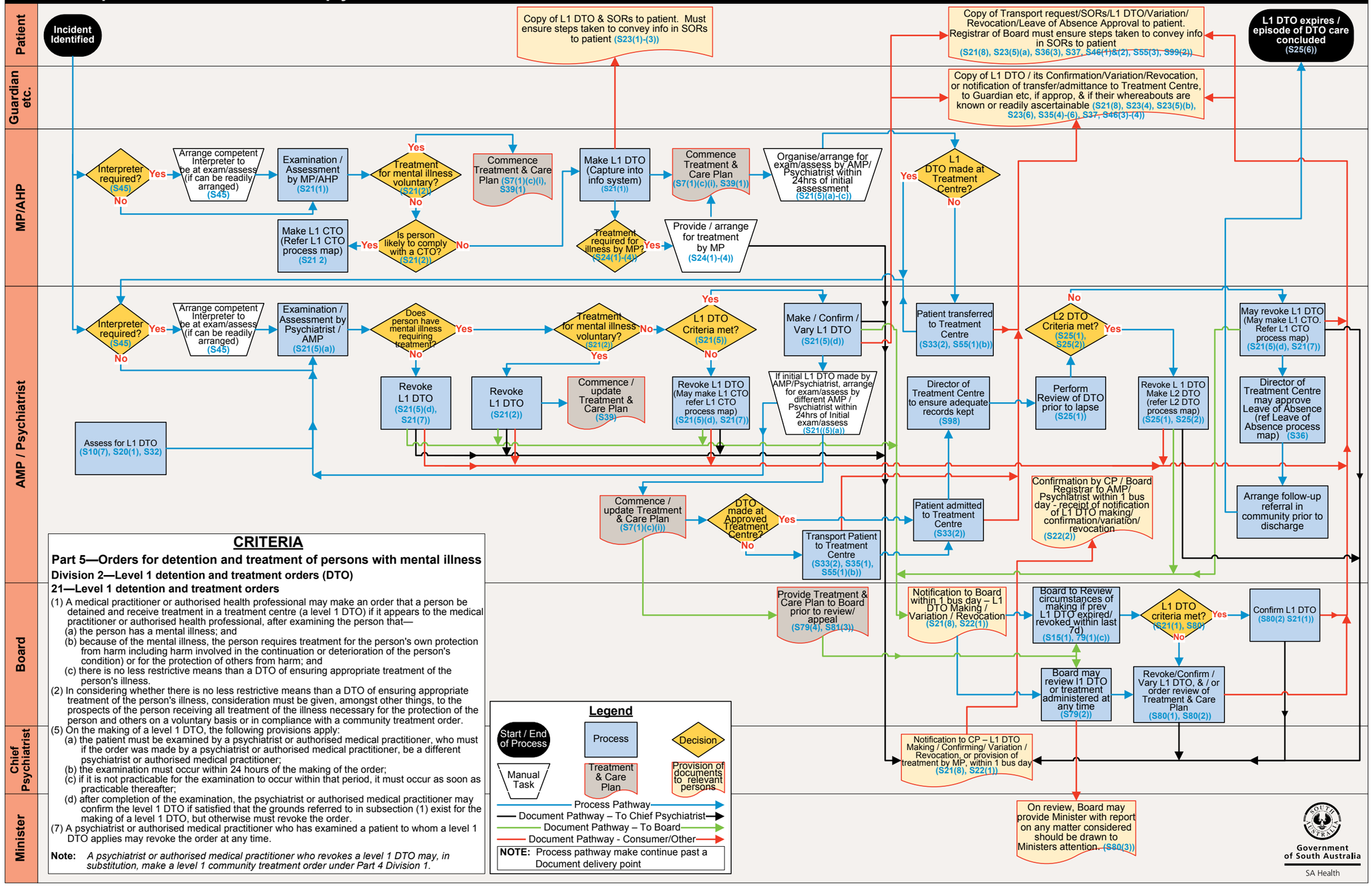
Table 5.3 L1 DTO

Part 5 of the Act	L1 DTO
Who authorises?	MP (including psychiatrist or AMP) or AHP
What conditions must be met?	The MP or AHP may make an L1 DTO if after examining the person, it appears to the MP or AHP that: > the person has a mental illness; and > because of the illness, the person requires treatment for the person's own protection from harm (including harm involved in the continuation or deterioration of the person's condition) or for the protection of others from harm; > there is no less restrictive means than a DTO of ensuring appropriate treatment of the person's illness. Consideration must be given to the possibility of the person receiving the treatment on a voluntary basis or on a CTO. The MP (including a psychiatrist/AMP) or AHP making the L1 DTO must make arrangements for examination by a psychiatrist/AMP within 24 hrs or as soon as practicable. If the L1 DTO has been made by a psychiatrist/AMP, the subsequent examination must be carried out by a different psychiatrist/AMP. The psychiatrist or AMP making, confirming, varying or revoking a L1 DTO must notify the Board and Chief Psychiatrist within 1 business day.
Duration and location?	Up to 7 days in an LTC or an ATC.
Treatment?	Treatment for a mental illness or any other illness authorised by a MP who has examined the patient can be given without consent. This does not include prescribed treatment (ECT or neurosurgery). If treatment of a kind that is prescribed by the Regulations is given (currently none) the Chief Psychiatrist must be notified within 1 business day.
Board Review?	The Board is not required to review a L1 DTO except if the order has been made within 7 days after the expiry or revocation of a previous DTO applying to the same person. On reviewing a L1 DTO, the Board has the option of revoking the L1 DTO and making a L2 CTO instead. The Board may order a review of a person's treatment & care plan.
Appeal?	Any of the following persons who is dissatisfied with a L1 DTO may appeal to the Board against the order: (a) the person to whom the order Applies; (b) the Public Advocate; (c) a guardian, medical agent, relative, carer or friend of the person to whom the order applies; (d) any other person who satisfies the Board that he or she has a proper interest in the matter.

L1 Detention & Treatment Order (DTO) Process Flow Diagram (up to 7 Days)

REV. 1.2	L1 DTO	4 Mar 2010	E. Wiszniewski

Criteria: person has a mental illness & requires treatment for person's own protection from harm or for protection of others from harm (incl. harm involved in continuation/deterioration of person's condition) & there is no less restrictive means than a DTO of ensuring appropriate treatment of the person's illness, or person refuses/fails to comply with a CTO.



CRITERIA

Part 5—Orders for detention and treatment of persons with mental illness

Division 2—Level 1 detention and treatment orders (DTO)

21—Level 1 detention and treatment orders

(1) A medical practitioner or authorised health professional may make an order that a person be detained and receive treatment in a treatment centre (a level 1 DTO) if it appears to the medical practitioner or authorised health professional, after examining the person that—
- (a) the person has a mental illness; and
- (b) because of the mental illness, the person requires treatment for the person's own protection from harm including harm involved in the continuation or deterioration of the person's condition) or for the protection of others from harm; and
- (c) there is no less restrictive means than a DTO of ensuring appropriate treatment of the person's illness.

(2) In considering whether there is no less restrictive means than a DTO of ensuring appropriate treatment of the person's illness, consideration must be given, amongst other things, to the prospects of the person receiving all treatment of the illness necessary for the protection of the person and others on a voluntary basis or in compliance with a community treatment order.

(5) On the making of a level 1 DTO, the following provisions apply:
- (a) the patient must be examined by a psychiatrist or authorised medical practitioner, who must if the order was made by a psychiatrist or authorised medical practitioner, be a different psychiatrist or authorised medical practitioner;
- (b) the examination must occur within 24 hours of the making of the order;
- (c) if it is not practicable for the examination to occur within that period, it must occur as soon as practicable thereafter;
- (d) after completion of the examination, the psychiatrist or authorised medical practitioner may confirm the level 1 DTO if satisfied that the grounds referred to in subsection (1) exist for the making of a level 1 DTO, but otherwise must revoke the order.

(7) A psychiatrist or authorised medical practitioner who has examined a patient to whom a level 1 DTO applies may revoke the order at any time.

Note: *A psychiatrist or authorised medical practitioner who revokes a level 1 DTO may, in substitution, make a level 1 community treatment order under Part 4 Division 1.*

Legend

Start / End of Process | Process | Decision

Manual Task | Treatment & Care Plan | Provision of documents to relevant persons

Process Pathway

Document Pathway – To Chief Psychiatrist

Document Pathway – To Board

Document Pathway - Consumer/Other

NOTE: Process pathway make continue past a Document delivery point

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Level 2 Detention And Treatment Orders

A L2 DTO can be made by an AMP or a psychiatrist.

A L2 DTO must be made before expiry of a L1 DTO and after further examination of the patient.

A L2 DTO, unless earlier revoked, expires at 2pm on a business day not later than 42 days after the day on which it is made.

The psychiatrist/AMP making a L2 DTO must set the date of expiry to be on a business day.

The psychiatrist or AMP must ensure notification is made to the Chief Psychiatrist and the Board within 1 business day if making, revoking or varying the order.

The treatment and care of a patient with a L2 DTO must be governed by a treatment and care plan.

A MP (including a psychiatrist/AMP) who has examined the patient may authorise treatment for the patient's mental illness or any other illness and the patient may be treated without consent.

Table 5.4 below gives an overview of a L2 DTO and its conditions.

Table 5.4 L2 DTO

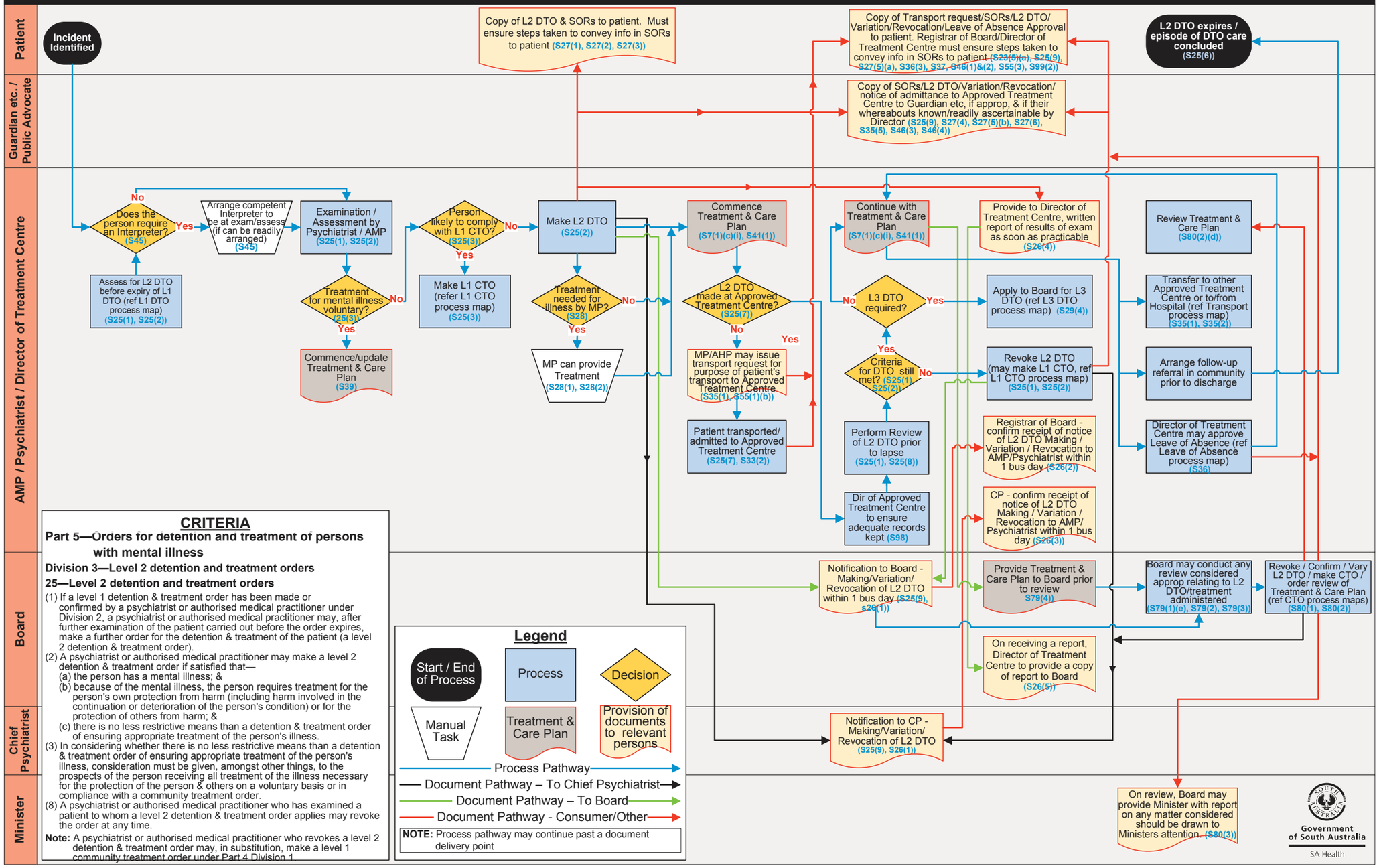
Part 5 of the Act	L2 DTO
Who authorises?	Psychiatrist or AMP
What conditions must be met?	If the psychiatrist or AMP is satisfied that: > the person has a mental illness; and > because of the illness, the person requires treatment for the person's own protection from harm (including harm involved in the continuation or deterioration of the person's condition) or for the protection of others from harm; and > there is no less restrictive means than a DTO of ensuring appropriate treatment of the person's illness. Consideration must be given to the possibility of the person receiving the treatment on a voluntary basis or on a CTO. A L2 DTO may be made for a person on a L1 DTO (that has been confirmed by a psychiatrist or AMP) and after further examination of the patient and before the L1 DTO expires. Notification must be made to the Board and Chief Psychiatrist within 1 business day if making, revoking, varying a DTO.
Duration and location?	Up to 42 days in an ATC only. The psychiatrist/ AMP making a L2 DTO must set the date of expiry to be on a business day.
Treatment?	Treatment for mental illness and other illness authorised by a MP who has examined the patient can be given without consent. This does not include prescribed treatment (ECT or neurosurgery). If treatment of a kind that is prescribed by the Regulations is given (currently none) the Chief Psychiatrist must be notified within 1 business day.
Board Review?	There is no requirement to review a L2 DTO, however, the Board may review any order including a L2 DTO. On review, the Board has the option of revoking a DTO and making a L2 CTO instead. The Board may order a review of a person's treatment & care plan.
Appeal?	Any of the following persons who is dissatisfied with a L2 DTO may appeal to the Board against the order: (a) the person to whom the order applies; (b) the Public Advocate; (c)a guardian, medical agent, relative, carer or friend of the person to whom the order applies; (d) any other person who satisfies the Board that he or she has a proper interest in the matter.

Following is a flowchart to aid decision-making for the making of a L2 DTO.

L2 Detention & Treatment Order Process Flow Diagram (up to 42 days)

REV. 1.1	L2 DTO	4 Mar 2010	E. Wiszniewski

Criteria: Board is satisfied the person has a mental illness, requires treatment for the person's own protection or protection of others from harm, there are facilities & services available for appropriate treatment of the illness, & there is no less restrictive means of ensuring appropriate treatment of the person's illness



Level 3 Detention And Treatment Orders

A L3 DTO may be made only by the Board, on application, to the Board in respect of a person to whom a L2 or L3 DTO applies.

A L3 DTO, unless earlier revoked, expires at 2pm on a business day, no later than 6 months for children/young people under 18 years of age and no later than 12 months for adults.

An application may be made to the Board for a L3 DTO in respect of a person by the Public Advocate, the Director of an ATC or an employee in an ATC authorised by the Director of the ATC.

On review or appeal the Board may revoke a L3 DTO and may, in substitution, make a L2 CTO.

A MP who has examined a person can authorise treatment of a patient to whom a L3 DTO applies for any illness including a mental illness, without consent. This does not apply to prescribed psychiatric treatment such as ECT or neurosurgery.

The treatment and care of a patient with a L3 DTO must be governed by a treatment and care plan.

Revoking A L3 Detention And Treatment Order

The patient or their support person, the Public Advocate, a MP, a Mental Health Clinician or any other person who has a proper interest in the welfare of the person, can apply to the Board to revoke a L3 DTO.

The Board will consider the views of all parties involved in order to consider whether the conditions for the order continue to apply. If the Board considers that the conditions no longer apply then the L3 DTO must be revoked.

Finally, the psychiatrist or AMP has a duty to keep under review, the need for detention, and must apply to the Board to revoke the order if the criteria for a L3 DTO are no longer met.

Table 5.5 below gives an overview of a L3 DTO and its conditions.

Table 5.5 L3 DTO

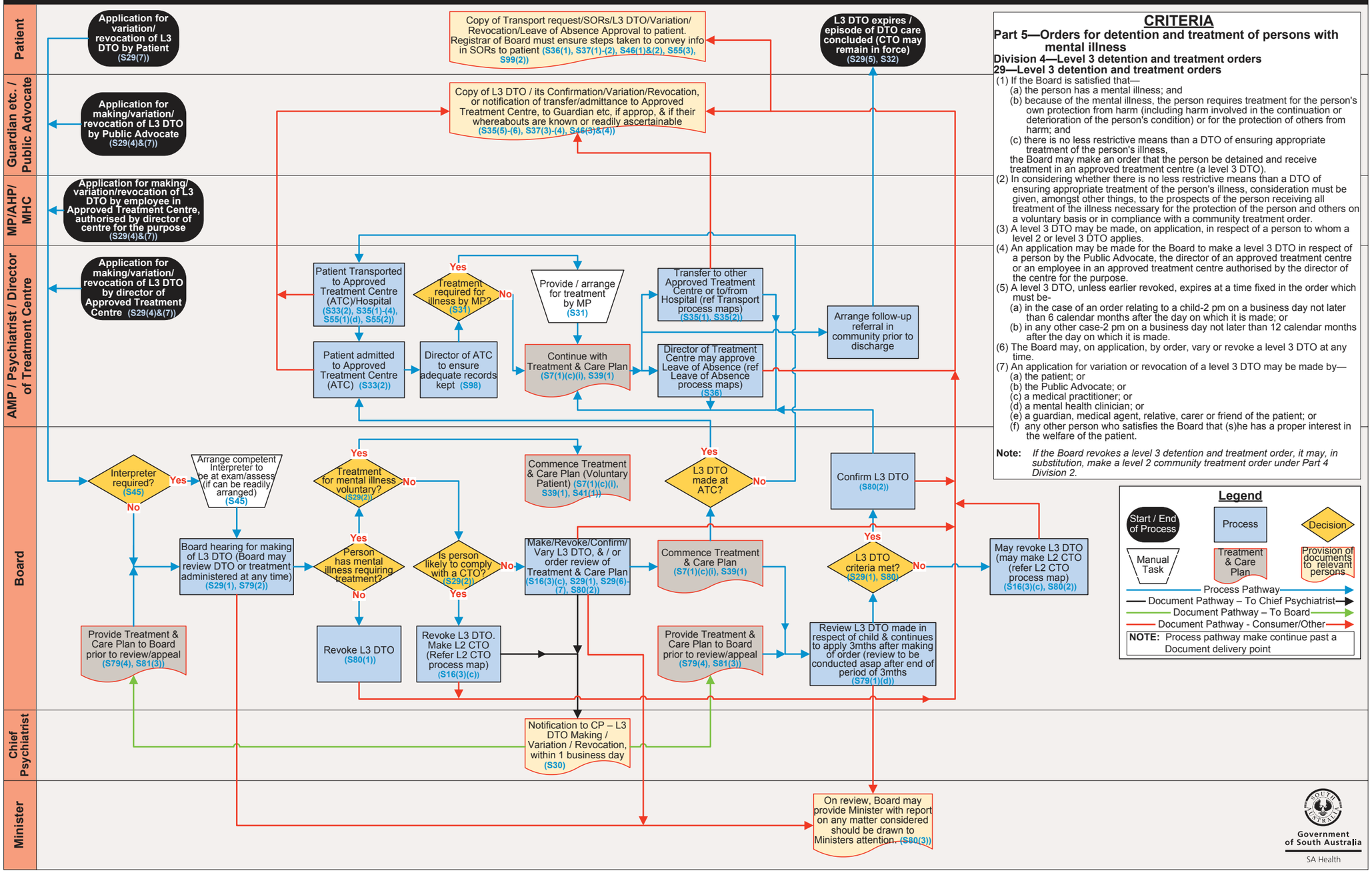
Part 5 of the Act	L3 DTO
Who authorises?	The Board
What conditions must be met?	If the Board is satisfied that: > the person has a mental illness; and > because of the illness, the person requires treatment for the person's own protection from harm (including harm involved in the continuation or deterioration of the person's condition) or for the protection of others from harm; and > there is no less restrictive means than a DTO of ensuring appropriate treatment of the person's illness. Consideration must be given to the possibility of the person receiving the care and treatment required on a CTO or on a voluntary basis. The Board must notify the Chief Psychiatrist within 1 business day if making, revoking, varying a L3 DTO.
Duration and location?	Up to 6 months for children/young people under 18 years of age and up to 12 months for adults.
Treatment?	The treatment and care of a person on a L3 DTO must as far as practicable, be governed by a treatment and care plan directed towards the patient's recovery. Treatment for a person's mental illness or any other illness may be authorised or given by a MP (including a psychiatrist/AMP) who has examined the patient. This does not include prescribed treatment (ECT & neurosurgery). If treatment of a kind that is prescribed by the Regulations is given (currently none), the Chief Psychiatrist must be notified within 1 business day.
Board Review?	The Board must review a L3 DTO that has been made in respect of a child/young person under 18 years of age and that continues to apply to the child/young person after 3 months. There are no requirements for the Board to review L3 DTOs for adults. However, the Board may review any order, including a L3 DTO. On reviewing a L3 DTO the Board has the option of revoking the L3 DTO and making a L2 CTO instead. The Board may order a review of a person's treatment and care plan.
Appeal?	Any of the following persons who is dissatisfied with a L3 DTO made by the Board may appeal to the District Court against the L3 DTO: (a) the person to whom the order applies; (b) the Public Advocate; (c) a guardian, medical agent, relative, carer or friend of the person to whom the order applies; (d) any other person who satisfies the Board that he or she has a proper interest in the matter.

Following is a flowchart to aid decision-making for making a Level 3 DTO

L3 Detention & Treatment Order - Process Flow Diagram (up to 6 months for children, 12 months for adults)

REV. 1.1	L3 DTO	4 Mar 2009	E. Wiszniewski

Criteria: Board is satisfied the person has a mental illness, requires treatment for the person's own protection or protection of others from harm, there are facilities & services available for appropriate treatment of the illness, & there is no less restrictive means of ensuring appropriate treatment of the person's illness



CRITERIA

Part 5—Orders for detention and treatment of persons with mental illness

Division 4—Level 3 detention and treatment orders

29—Level 3 detention and treatment orders

(1) If the Board is satisfied that—
- (a) the person has a mental illness; and
- (b) because of the mental illness, the person requires treatment for the person's own protection from harm (including harm involved in the continuation or deterioration of the person's condition) or for the protection of others from harm; and
- (c) there is no less restrictive means than a DTO of ensuring appropriate treatment of the person's illness,

the Board may make an order that the person be detained and receive treatment in an approved treatment centre (a level 3 DTO).

(2) In considering whether there is no less restrictive means than a DTO of ensuring appropriate treatment of the person's illness, consideration must be given, amongst other things, to the prospects of the person receiving all treatment of the illness necessary for the protection of the person and others on a voluntary basis or in compliance with a community treatment order.

(3) A level 3 DTO may be made, on application, in respect of a person to whom a level 2 or level 3 DTO applies.

(4) An application may be made for the Board to make a level 3 DTO in respect of a person by the Public Advocate, the director of an approved treatment centre or an employee in an approved treatment centre authorised by the director of the centre for the purpose.

(5) A level 3 DTO, unless earlier revoked, expires at a time fixed in the order which must be-
- (a) in the case of an order relating to a child-2 pm on a business day not later than 6 calendar months after the day on which it is made; or
- (b) in any other case-2 pm on a business day not later than 12 calendar months after the day on which it is made.

(6) The Board may, on application, by order, vary or revoke a level 3 DTO at any time.

(7) An application for variation or revocation of a level 3 DTO may be made by—
- (a) the patient; or
- (b) the Public Advocate; or
- (c) a medical practitioner; or
- (d) a mental health clinician; or
- (e) a guardian, medical agent, relative, carer or friend of the patient; or
- (f) any other person who satisfies the Board that (s)he has a proper interest in the welfare of the patient.

Note: *If the Board revokes a level 3 detention and treatment order, it may, in substitution, make a level 2 community treatment order under Part 4 Division 2.*

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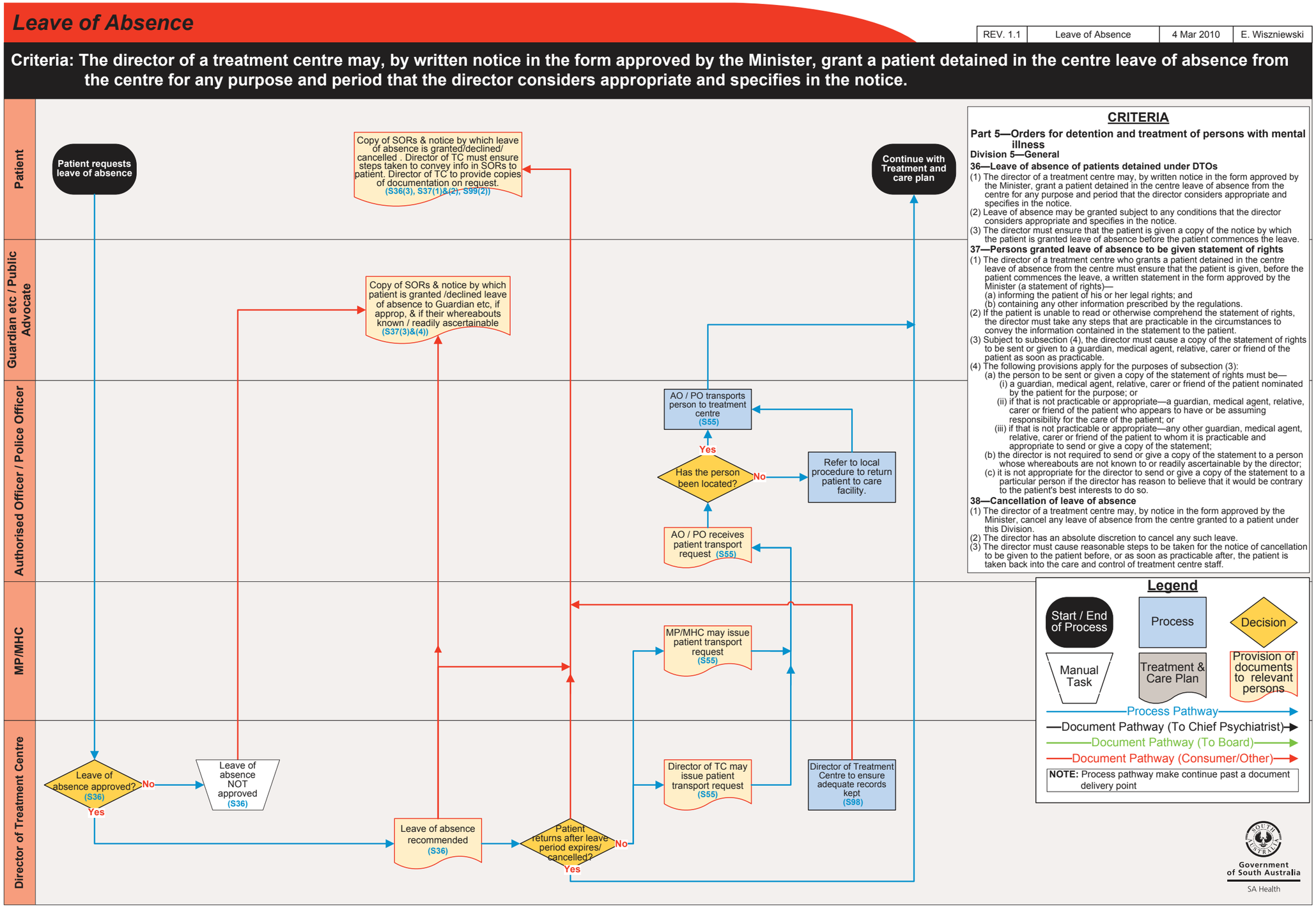
The following is a flow chart outlining the process for leave of absence from a treatment centre.



Activity 5

Please take a few moments to reflect on the criteria and arrangements for DTOs and CTOs by answering the following questions.

One of the criteria is that:

> '*The person has a mental illness and because of the illness, the person requires treatment for the person's own protection from harm (including harm involved in the continuation or deterioration of the person's condition) or for the protection of others from harm.*'

How would you go about finding out if someone requires treatment for the person's own protection from harm?

Comment

In the first instance clinical assessment and discussion with a person regarding treatment may indicate if the person is at risk of harming himself/herself or others. In discussion, the person may express views that indicate reasons why he/she is not complying or is unwilling to comply with a treatment and care plan.

However, before making an order the practitioner must be of the opinion, after examining the person, that the person has a mental illness and requires treatment for his/her own protection.

For example, a man with a diagnosis of depression may refuse anti-depressant medication while intoxicated but agree to take it when sober. In this instance, we would conclude that it was the alcohol consumption that affected his attitude to treatment and not mental illness.

Non-compliance with treatment for physical health issues can also be affected by the mental illness for example, diabetes management which might be life threatening.

Other sources of information, notably family or carers, may also be helpful in relation to these conditions. If it is clear that the patient has accepted treatment in the past on a voluntary basis this might suggest that the patient's view has changed. If this is thought to be as a result of mental illness then the condition is met.

Activity 6

One of the criteria for an order is that:

'The person has a mental illness and because of the illness, the person requires treatment for the person's own protection from harm (including harm involved in the continuation or deterioration of the person's condition) or for the protection of others from harm.'

What do you think might count as harm to a person's wellbeing?

Comment

Instead of 'condition', we might think of a patient's 'wellbeing'. Wellbeing is a broad concept and a definition is not actually provided in the Act. There are many aspects of our lives (social, financial, work) that we might identify as being linked to our overall wellbeing.

It has been suggested by some that this broader consideration will allow for the involuntary treatment and care of people who become 'impulsive' as a result of mental illness.

For example, if someone with a diagnosis of bi-polar affective disorder becomes unwell and as a result decides impulsively to give their life savings to a charity leaving them with no income at all, then this behaviour could be interpreted as posing harm to the person's wellbeing.

It must be stressed, however, that giving one's savings to charity in itself would not be grounds for involuntary treatment or detention.

Other situations might involve poor self-care or poor home environments (again provided there is a link between these factors and mental illness).

You have probably been able to identify other situations from your own experience or practice. It is important to ensure we do not perceive 'harm' on the basis of lifestyle choices that do not match our own, or make assumptions about how people ought to live.

Activity 7

Please take a few moments to reflect on involuntary treatment by answering the following question.

What effect do you think the new provisions for CTOs and DTOs will have on your practice?

Comment

It is difficult to predict what the future might hold and the impact these orders will have.

At the time of reviewing the MHA 1993, the making of initial orders by a range of professionals in addition to MPs and the Board was widely supported.

It facilitates consumers having earlier access to expert assessment, care and treatment. The practice also reflects contemporary approaches to the delivery of mental health services which emphasises the provision of care in the community as the preferred approach where possible.

When the Mental Health Bill was introduced into Parliament, the Minister stated that CTOs and DTOs were not intended to be used frequently and that, wherever possible, services would be delivered on a voluntary basis.

Activity 8

How do you think the making of L1 CTOs by MPs (including psychiatrists/AMPs) and AHPs will affect relationships between consumers and Mental Health Services?

Comment

Whether used infrequently or not, the making of L1 CTOs are likely to have an impact on relationships and services. Compliance with an order will need to be monitored by those providing services specified in the order. For some staff this will create an additional role.

Services too may be impacted. If, for example, you work in a government sector day service the attendance of one or more consumers who are required to be there may have a significant effect on the atmosphere and operation of your service. Good multi-disciplinary working at all stages may help to minimise negative effects and put in place clear roles for staff involved.

Reflection

In this Section of the Guide we have discussed the range of involuntary orders. You have examined the conditions that must be met, the process of issuing orders and the application process for them.

You have also become aware of the duration of and the appeal process for the various orders. Additionally, you have had an opportunity to reflect on your own practice and how this might be impacted when the new orders are implemented.

Now test yourself to see how much you have learned from this Section to see if you can apply your knowledge to practice.

The scenarios in the next few pages are designed to enable you to ascertain whether you have met the learning outcomes for this Section of the Guide. If not, you may wish to revisit some Sections of the Guide.

You should now complete the following self assessment activities:

Scenario 4 (continued)

In Section 2 of the Guide you were asked to look at a scenario involving a person called Edward and the scenario is continued below.

Having discovered Edward's house to be unsafe, Edward's GP has telephoned the local CMHT and has requested that an AHP attend. The gas and electricity authorities have also been alerted.

When the utility companies arrive the GP suggests to Edward that they go to the Surgery while the work is done at Edward's house. Edward agrees to go with the GP but does ask if there are any of 'them' in the Surgery.

Once in the Surgery the GP tries to find out more about Edward's current situation. Edward is generally happy to answer the GP's questions but becomes visibly distressed when asked about why he removed the gas appliances and tampered with the electric wiring in his house.

At times he attributes this to a dispute with his neighbours and at other times he blames the utility companies and on one or two occasions he hints at the presence of 'evil forces' at work in his house.

The GP suggests to Edward that he appears to be confused and may be unwell. Edward dismisses this and says he has always enjoyed good health. He refuses the offer of medication.

As the discussion comes to a halt the GP receives a telephone call, informing him that no mental health staff are available to attend.

Based on the information you have about Edward's situation what options do you think the GP has?

Comment

It is difficult to make judgements based on limited information and this can be the case in practice also. Firstly, the GP really only has two options, that is, to treat Edward or not.

The GP may consider the Guiding Principles **'Respect for Carers'** and **'Collaboration'** and contact Edward's nearest family member/carer when deciding whether and/or how to treat Edward. A close family member/carer may well be able to provide relevant information as to whether Edward's behaviour is unusual, or if there have been any previous occurrences.

With more information, the GP may try and convince Edward of his need for treatment with a view to gaining his consent.

If Edward consents, then the GP would need to consider engaging other supports that Edward might require (in addition to any prescribed medication) to remain at home. This might involve making a referral to the community mental health team (CMHT).

The CMHT could help establish a rapport, build trust and engage Edward in the broader community. A member of the CMHT could negotiate with the GP, to be the key agent to gain a collateral history of Edward's wellbeing, by liaising with Edward's family, carer and/or friends.

This would coordinate dialogue between all stakeholders, avoiding processes being duplicated and enable information to be shared between the GP and the CMHT. This would assist the GP with decision-making in how best to treat and care for Edward.

Involving the CMHT could be difficult to arrange at short notice. Therefore, the GP may decide to issue a CTO or DTO in order to ensure Edward receives the treatment and care required to aid his recovery.

Do you think that Edward meets the criteria for the making of a L1 DTO?

Comment

It isn't entirely clear is it? Remember though that the GP is allowed a certain degree of doubt. It need only appear that Edward has a mental illness which is significantly impairing his ability to make a decision about treatment.

This instance is perhaps complicated by the fact that Edward has had no contact with Mental Health Services before so it is difficult to deduce what his 'past and present' wishes are in relation to treatment for mental illness.

In relation to the health and safety conditions it would appear that Edward and others have already been placed at potential risk of harm as a result of his tampering with gas and electricity supplies.

The GP may want to conduct further examination (physical and mental) of Edward before reaching a decision but it seems likely that if an alternative option cannot be agreed and no physical explanation is found for Edward's confusion then a L1 DTO could be issued.

How do you think Edward might react if involuntary admission is mentioned?

Comment

Edward may become quite alarmed at the thought of detention in a treatment centre. We know that Edward has not previously received mental health services and he may not have visited a treatment centre before.

Admission to any hospital is a frightening and often bewildering experience but even more so if you do not know what to expect. Edward will therefore need considerable reassurance and support from both his GP and staff at the treatment centre.

Scenario 5

Caroline is 22 years old and currently detained in an ATC on a L3 DTO. Application is being made to the Board to revoke the L3 DTO and to make a L2 CTO.

Caroline has had one previous admission to hospital 18 months ago when she was not detained (as her psychotic symptoms were believed to be related to drug and alcohol use).

Caroline has rejected the idea that she has a mental illness that requires care and treatment and she has refused medication. She has been in the ATC for two months during which time she has been given medication by depot injection against her will.

Over the past three weeks there has been no evidence of psychotic symptoms, but Caroline is still reluctant to comply with her depot. Caroline has not had access to drugs or alcohol during her stay in the ATC.

Caroline continues to insist she does not have a mental illness and recently has attributed her difficulties to having too good a time at clubs. She states that when she is discharged she intends to give up clubbing and to find a job.

The Board revokes the L3 DTO and makes a L2 CTO. Caroline indicates that she intends to appeal to the District Court against the Board's decision to make a L2 CTO.

How often should a clinical review take place in a treatment centre?

The Act does not specify how often reviews might be. However, the National Standards for Mental Health Services that all consumers, whether voluntary or involuntary, are reviewed at least every three months.

It is generally the case that in most instances patients in treatment centres are reviewed on a daily basis by mental health professionals.

Should Caroline continue to receive medication against her will?

Comment

As we discussed earlier, the MHA 2009 specifies a psychiatrist/AMP who has examined a patient can authorise treatment of a patient's mental illness on a CTO for a mental illness without consent. This does not apply to prescribed psychiatric treatment such as ECT or neurosurgery.

The Chief Psychiatrist must arrange for a copy of the treatment and care plan to be provided to the Board at or before any appeal hearing commences. The Board is required to take into account the Guiding Principles of the Act and, in particular, the views of the patient. The Board may order a review of a patient's treatment and care plan.

Who has a duty to review Caroline's L2 CTO?

Comment

The treating team/practitioner must evaluate the need for the involuntary treatment order on a regular basis. This should also involve regular consultation with others involved in supporting Caroline and, of course, Caroline herself.

In line with best practice, the treating team/practitioner should undertake a review every three months and before the L2 CTO expires with a view to considering whether an application should be made to the Board for the L2 CTO to be revoked or varied.

In undertaking all of these reviews the treating team/practitioner must bear in mind the Guiding Principles of the Act.

Caroline's past and present wishes, the views of any carers, the benefit being derived from the order being in place and whether the order continues to be the **'least restrictive alternative'** should also be considered.

Section 6 Frequently Asked Questions

Changes to SA's mental health legislation will come into force on 1 July 2010. The following questions and answers have been compiled to assist with queries about the MHA 2009.

The recommendations bring SA's Act into line with modern service provision, and strengthen patient safeguards and remedy incompatibilities with Human Rights legislation.

What Will The Act Do?

The Act makes a range of important changes to existing legislation to modernise and improve it. The Act:

- retains the same broad definition of mental illness as in the MHA 1993. However, Schedule 1 has been added to the Act to clarify that certain conduct (beliefs, activities or actions) in and of themselves, do not constitute a mental illness;
- introduces a specific new requirement for CTOs that there must be services and facilities available before a CTO can be made, for example, in a country area;
- establishes the statutory position of Chief Psychiatrist to govern the implementation of the Act and to ensure accountability of the mental health system;
- recognises the different and broader concepts of mental health within Aboriginal culture and Torres Strait Islander culture;
- introduces L1 CTOs made by MPs and AHPs as a first treatment option to allow for early access to care and treatment and with the aim of reducing incidences where a person deteriorates to the point where admission is the only option.

The Act provides greater flexibility about which professionals may perform certain key statutory roles under the Act, reflecting modern mental health practices.

The Act allows individuals under orders to be transported by Authorised Officers to reduce police involvement in transport.

The MHA 2009 contains a set of Guiding Principles to inform decisions made under the Act.

What Is The Definition Of Mental Illness In The MHA 2009?

In the Act mental illness means: *'any illness or disorder of the mind; see also Schedule 1 (Certain conduct may not indicate mental illness).'*

The definition is the same as in the MHA 1993, but with the clarification that the certain conduct alone (as specified in Schedule 1 of the Act) does not constitute mental illness.

What Is A CTO?

A CTO is an order that enables involuntary treatment to be provided to a person in the community (if a person has a mental illness that requires care and treatment to prevent harm to themselves or others and/or to avoid relapses/ readmissions to a treatment centre). A CTO can only be made if it is the least restrictive way/manner of providing the person with the required care and treatment.

The provisions in the Act for CTOs fit with contemporary service provision to ensure that people with mental illness can be treated in the least restrictive environment, that is, in the community (closer to home and support networks) according to individual needs and circumstances.

A person on a CTO will usually be transported to a treatment centre or a facility for treatment. A person on a CTO will not be subject to forcible treatment in their own homes (except in an emergency and if the person lacks the capacity to consent).

Who Is Responsible For Implementing The Changes?

The changes provide new opportunities for the provision of services locally. It is up to Mental Health Services to make the best use of the changes. The Chief Psychiatrist will monitor the operation of the Act.

How Can The MHA 2009 Provide More Treatment In The Community And Still Protect The Public Effectively?

People with serious mental illness are much more likely to pose a risk to themselves than to the public at large.

When necessary, a person may be detained in a treatment centre, however, some people will receive treatment for a mental illness on a CTO in the community.

The new provisions should assist in breaking the so-called 'revolving door' cycle of people being discharged from treatment centres, losing contact with services and having to be readmitted as a result.

Won't CTOs Simply Be Abused / Overused?

No. A CTO can only be made if a person has a mental illness that requires treatment and the person cannot receive treatment on a voluntary basis and if all the other criteria for the making of a CTO are met.

It will be a matter of clinical judgement whether a CTO is required for a specific individual at a particular point in time.

The Chief Psychiatrist will monitor the use of CTOs and report to the Minister via an annual report.

Aren't CTOs Simply Ineffective?

No. A review of research evidence commissioned in the UK by DH (Churchill et al 2007) found that there was a lack of conclusive evidence about the effects of CTOs internationally.

A lack of evidence should not be confused with a lack of efficacy. The lack of evidence is not surprising due to the nature of these interventions.

There are many practical and methodological problems in research in this area. Interestingly, the study did show that many stakeholders had positive views about CTOs. Three similar reviews have been published over the last few years on this topic (Dawson 2005; Ridgely et al, 2001; NASMHPD, 2001).

If People Have Serious Mental Health Problems, Shouldn't They Just Be In Hospital?

People are entitled to receive care and treatment in the least restrictive environment and manner, having regard to the individual and their circumstances.

Won't The MHA 2009 Result In More People Being Placed On DTOs?

No. The purpose of the Act is to protect the rights of people with serious mental illness when it is necessary to take action without a person's consent in order to protect them, or other people. Detentions under mental health legislation in SA have remained fairly stable over several years. The changes made by the MHA 2009 are unlikely to change that. The Chief Psychiatrist will monitor the impact of the Act.

What Will Community Visitors do?

Community Visitors will visit and inspect treatment centres and will be able to advocate on behalf of patients.

Who Will Appoint Community Visitors?

The Act empowers the Governor of SA to appoint community visitors.

When Will The Community Visitor Scheme Come Into Operation?

The provisions of Division 2, Part 8, of the Act must come into effect no later than 11 June 2011 and this allows time for appropriate planning, consultation and funding of the community visitor scheme.

Does This Mean That Mental Health Patients Will Be Without Access To Support/ Advocacy Until 2011?

There are existing Agencies/Services in SA that provide information, support and advocacy and these arrangements will continue. In addition, the Act provides for a person with a mental illness to be supported by a medical agent, guardian, relative, carer or friend of the person.

What Flexibility Does The Act Introduce Around Which Professionals Can Perform Particular Roles?

The MHA 2009 removes rigid demarcation of professional roles and introduces a new approach which ensures that practitioners with the right skills, expertise and training can carry out important functions not currently open to them.

The role of AHPs will be open to mental health nurses, occupational therapists, social workers, psychologists and Aboriginal Health Workers. Any person who is selected to become an AHP will be individually appointed by the Minister as an AHP.

The role of AMPs is most likely to be restricted to psychiatric registrars in the later years of training.

The Act does not require AHPs or AMPs to be appointed in SA.

The Minister will only appoint an individual as an AHP or an AMP if the Chief Psychiatrist is satisfied that the particular individual has the qualifications, skills and experience required of the role.

Does That Mean There Is A Danger That The Person In Charge Of Care May Not Be Qualified For The Job?

No. The professionals undertaking the new functions of AHPs and AMPs under the Act must be registered with their professional bodies. They will also have to demonstrate that they have undergone appropriate training and meet the relevant competencies of the role.

It is envisaged that only experienced, senior professionals will be able to demonstrate that they meet the competencies needed to have statutory powers.

All AMPs and AHPs are employees of SA Health and are subject to terms and conditions of appointment and/or dismissal.

The Minister may attach conditions/limitations to an appointment and may revoke an appointment.

Psychiatrists Are Concerned That When They Detain Someone, They Will Be Responsible For Finding A Bed And Must Know In Advance Where The Patient Should Be Admitted, When This Isn't Always Possible.

The basic procedures for detention are not changing.

Professionals need to work collaboratively to ensure a good outcome for the patient. It is up to Mental Health Services to put in place the systems and structures to assist in that process. One example of this is central bed coordination/management.

Useful Resources Available On The Department Of Health website: www.health.sa.gov.au

National Practice Standards for Mental Health Workforce 2004

National Standards for Mental Health Services 2010

Paving the Way, Review of Mental Legislation in South Australia Report, April 2005, Ian Bidmeade

Stepping Up: A Social Inclusion Plan for Mental Health Reform 2007-2012

Mental Health Act 2009

Mental Health Act 1993

South Australia's Mental Health and Wellbeing Policy 2010-2015

Fourth National Mental Health Plan

SA Health and Health Consumers Alliance of South Australia Privacy, Confidentiality and Getting the Best Care and Treatment, Achieving The Balance

SA Health Rights and Responsibilities

Health Care Act 2008

SA Health The Mental Health Care Plan Information book

Mental Health and Emergency Services Memorandum of Understanding

Plain Language Guide

Guardianship and Administration Act 1993

Code of Professional Conduct for Nurses

References

Northern Territory Government, *Mental Health Clinicians Guide 1st Edition 2009*

Mental Health Act Guide Book, Institute of Psychiatry NSW

NIMHE (2009) The Legal Aspects of Care and Treatment of Children and Young People with a Mental Disorder: *A guide for Professionals*, London NIMHE

National Education for Scotland, *Implementing the Mental Health Act, 2009*

Dawson J. Community Treatment Orders: *International Comparisons*. The Law Foundation, New Zealand. 2005

National Association of State Mental Health Program Directors (NASMHPD) Medical Directors Council. Technical Report on *Involuntary Outpatient Commitment*. Sixth in a Series of Technical Reports. 2001

Ridgely MS, Borum R, Petrila J. *The effectiveness of involuntary outpatient treatment: empirical evidence and the experience of eight states.* Santa Monica, CA: RAND Corporation. 2001

Appendix 1 Comparison of powers to transport, issue transport requests, correct errors, make L1 orders, monitor people on CTOs

(This table does not include information about powers to administer treatment or drugs under the Controlled Substances Act 1984)

MENTAL HEALTH ACT 2009	PROVISION	Take a person who **appears to have a mental illness** into 'care & control' (eg in order to transport)	Transport a person who **appears to have a mental illness** to a person/ place for a mental health examination	Arrange for another authorised/ police officer to transport person who **appears to have a mental illness**	**Issue a patient transport request** regarding a person in respect of whom a DTO has been made	**Issue a patient transport request** for person subject to a DTO (at large from a Treatment Centre)	**Issue a patient transport request** for a person on a CTO (who is not compliant with the CTO)	**Correct errors in a written document** of which the clinician is the author (taken to have effect from issue)	**Make a L1** Community Treatment Order (**CTO**) or a L1 Detention & Treatment Order (**DTO**) – if criteria are met	May be appointed by the CP to **monitor a person on a CTO**
CATEGORY										
Mental health clinicians		Yes	Yes	Yes	Yes	Yes	Yes	Yes	N/A	Yes
Ambulance officers1		Yes	Yes	Yes	N/A	N/A	N/A	N/A	N/A	N/A
RFDS Flight nurses		Yes	Yes	Yes	N/A	N/A	N/A	N/A	N/A	N/A
RFDS Medical officers		Yes	Yes	Yes	^	^	^	^	^	^+
Person prescribed by the Regulations		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Police officers		Yes	Yes#	Yes	No	No	No	No	No	No
Authorised Health Professionals		Yes*+	Yes*+	Yes*+	Yes (if the AHP made the L1 DTO)	Yes (if the AHP is a MH clinician)	Yes (if the AHP is a MH clinician)	Yes	Yes	+
Medical practitioners		+	+	+	Yes	Yes	Yes	Yes	Yes	+
Authorised Medical Practitioners		+	+	+	Yes	Yes	Yes	Yes	Yes (& L2 DTOs)	+
Psychiatrists		+	+	+	Yes	Yes	Yes	Yes	Yes (& L2 DTOs)	+
Chief Psychiatrist		+	+	+	+	+	Yes	Yes	Yes	N/A
Director of a Treatment Centre		+	+	+	+	Yes	N/A	Yes	N/A	N/A

* If an Authorised Officer / MH clinician

\+ Not expressly provided for in the Act, but not specifically excluded either.

^ If a medical practitioner registered on the general register under the Medical Practitioners Act 2004.

\# Under S55(1)(d), police officers are excluded from inter-hospital/ATC transfers unless the person has become a patient at large as per S57(2).

* If an Authorised Officer / mental health clinician.

[2] **Ambulance officer** means a person who is (a) employed as an ambulance officer, or engaged as a volunteer ambulance officer, with an organisation that provides ambulance services; **and (b) authorised by the chief executive officer of SA Ambulance Service Inc to exercise the powers conferred by this Act on Authorised Officers.**

For more information

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Non-English speaking: for information in languages other than English, call the Interpreting and Translating Centre and ask them to call the Department of Health. This service is available at no cost to you, contact (08) 8226 1990.

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