Review of the *Mental Health Act 2009*

The following summarises suggested key areas for review in Part 7 of the *Mental Health Act 2009* (SA) (**the Act**):

1. Revising the functions of the Panel and the "review triggers";
2. Clarifying the obligation of psychiatrists to supply a progress report to the Panel;
3. Considering the circumstances (if any) in which the use of restrictive practices to administer ECT might be reasonable.

1. Functions of the Panel: Involvement in "Complex Cases" – Original Intent vs. Actual Operation

Issues to consider

- The triggers for referring ECT cases to the Panel for review are too broad and are therefore ineffective in identifying clinically complex cases or cases which merit Panel oversight.
- "Complex cases" needs to be defined to delineate only those cases which ought to be brought to the attention of the Panel.
- Alternatively, how to adjust the trigger mechanisms to better capture "complex cases" of Panel interest.

Discussion

History of Part 7 of the Act

The Panel was established following recommendation by the Chief Psychiatrist in *The Review of the Mental Health Act 2009* completed in May 2014 (**2014 Review**).

Relevantly, Recommendation 44 of the 2014 Review was as follows:

> *44. That a Prescribed Psychiatric Treatment Panel section should be introduced to the Act, to consider applications for neurosurgery for mental illness, the introduction or amendment of regulations relating to prescribed psychiatric treatment and complex ECT cases referred to the Panel…*[Emphasis added.]

The term "complex cases" insofar as it applied to ECT was discussed earlier in the 2014 Review in Part 13.1, "Prescribed Psychiatric Treatment, Electro-Convulsive Therapy":

> *Complex Cases*
> *Complex ECT treatment and consent matters are currently considered by treatment sites and the Guardianship Board. It is recommended that the option for referring complex cases to the Prescribed Psychiatric Treatment Panel be added, for example:*
>
> > *42(1)(c)(iv) by the Prescribed Psychiatric Treatment Panel on application by the patient, a parent or guardian, a medical practitioner or the Board under this section.* [Emphasis added.]

Accordingly, Recommendation 39 of the 2014 Review provided:

> *39. Complex ECT clinical or consent matters should be considered by a Prescribed Psychiatric Treatment Panel convened by the Chief Psychiatrist.*

Discussion in the 2014 Review surrounding the introduction of the Panel under Recommendation 44 includes proposed drafting of a new section in the Act to describe the Panel's proposed functions:

> *44B-Prescribed Psychiatric Treatment Panel*
>
> *(1) The Chief Psychiatrist may convene a Prescribed Psychiatric Treatment Panel to consider matters relating to –*
>
> *i. Applications for neurosurgery for mental illness; or*
> *ii. The introduction or amendment of regulations relating to prescribed psychiatric treatment; or*
> *iii. Complex ECT cases referred to the Panel.*
>
> *(2) The Prescribed Psychiatric Treatment Panel will comprise members including but not restricted to –*
>
> *i. A patient; and*
> *ii. A carer; and*
> *iii. A psychiatrist; and*
> *iv. A neurosurgeon, if relevant; and*
> *v. A lawyer; and*
> *vi. A member of the South Australian Civil and Administrative Tribunal; and*
> *vii. A bioethicist.*
>
> *(3) The Prescribed Psychiatric Treatment Panel may conduct proceedings as it sees fit, including receiving testimony from the patient, a carer, the treating psychiatrist or other person with a proper interest in the matter.*
>
> *(4) The Prescribed Psychiatric Treatment Panel will make records of submissions and deliberations and make a recommendation to the Chief Psychiatrist to authorise or not the proposed psychiatric treatment.*
>
> *(5) A decision of the Prescribed Psychiatric Treatment Panel is final and further consideration of a matter will only be undertaken as a new application if additional supporting evidence is submitted.*
>
> [Emphasis added.]

Two matters are apparent from the proposed drafting: first, it was originally envisaged the Panel would authorise complex ECT (i.e., the Panel would consider complex ECT clinical or consent matters *prior to* the administration of the treatment), and second, the convening of the Panel to consider such matters would be at the discretion of the Chief Psychiatrist.

Ultimately, although Recommendation 44 and the introduction of the Panel as envisaged by the proposed drafting was supported by the Office of the Public Advocate, the Ethics Health Advisory Council and the Office of the Chief Psychiatrist, it was strongly opposed by the Disability Rights Advocacy Service (DRAS) and the Royal Australian & New Zealand College of Psychiatrists (RANZCP). The opposition of DRAS was due to concerns the Panel may replace the appeal functions of the South Australian Civil and Administrative Tribunal (SACAT), while RANZCP criticised the

potential of the Panel's authorisation of treatment function to delay medically urgent treatment.

Current operation of Part 7 of the Act

Part 7 of the Act, as enacted by the *Mental Health (Review) Amendment Act 2016*, deviated from the apparent original intent of the 2014 Review with respect to the Panel's functions and operation in two ways:

First, the 2014 Review appears to leave open the meaning of "complex ECT case" and does not attempt any definition beyond "complex ECT clinical or consent matter". Conversely, Part 7 of the Act operationalises what is meant by "complex ECT cases" by defining the Panel's functions as follows (relevantly):

> *41C – Functions of Panel*
> *The Prescribed Psychiatric Treatment Panel has the following functions in relation to the regulation of prescribed psychiatric treatments:*
> *(a) To conduct a review of the progress of a patient who has, in the course of any 12-month period, received 3 or more courses of ECT treatment;*
> *(b) To conduct a review of the progress of a patient to whom, in the course of any 12 months period, 2 or more episodes of ECT have been administered without consent in reliance on section 42(6);*
> *(c) …*
> [Emphasis added.]

(**Section 41C Review Triggers**)

Second, section 41D of the Act, concerning the proceedings of the Panel, provides (relevantly):

> *41D – Constitution and proceedings of Panel*
> *(1) The following provisions apply in proceedings before the Prescribed Psychiatric Treatment Panel under this Act:*
> *(a) Subject to this section, the Panel may decide its own proceedings;*
> *(b) The Chief Psychiatrist is the presiding member of the Panel;*
> *(c) The Panel will meet at such times and places as required by the Chief Psychiatrist for the purposes of carrying out its functions;*
> *(d) …*
> [Emphasis added.]

The effect of sections 41C and 41D of the Act is to prescribe the Panel's oversight of ECT as a post hoc review of cases that fall within the Section 41C Review Triggers, and to limit the discretion of the Panel with respect to its workload due to the volume of ECT cases captured by the Section 41C Review Triggers. Currently, the legislation requires the Panel to review ECT cases that fall within the Section 41C Review Triggers, rather than relying upon an application for review (as envisaged by the 2014 Review).

It is the opinion of the Panel that the Section 41C Review Triggers are not working effectively and do not always capture the "complex ECT cases" that are appropriate for Panel review. One reason for this is that section 41C (a) (*review of patient with 3 or more courses of ECT in 12 months*) captures cases of maintenance ECT, the large majority of which is routine and uncontroversial. There has also been at least one instance of the Section 41C Review Triggers being enlivened, and the Panel seeking a case report, when the treating medical practitioner sought a third consent from the patient only out of an abundance of caution, despite an earlier consent remaining valid.

Case example: Patient X presented with severe depression following cancer surgery. The first course of ECT was 14 treatments, necessitating a second consent form, and a second course was 5 bifrontal treatments. In between the two courses of ECT, the patient underwent inpatient treatment for another issue. The treating doctor obtained a third consent for the second course, given the interruption to ECT treatment, despite the second consent still being valid. This resulted in 3 consents to treatment within 12 months and triggered Panel review. The Panel considered ECT treatment was appropriate. The treating doctor queried the necessity of the report in this instance where, in fact, the patient only underwent 2 courses of ECT.

Similarly, section 41C(b) of the Act (*review of patient with 2 or more episodes of emergency ECT*) often captures cases that are no more complex than cases where there has been only one emergency consent to ECT, but multiple consents have been required due to scheduling limitations of SACAT (i.e., consent applications are made on Thursday but cannot be heard by SACAT until the following Tuesday). Further, cases which fall within section 41C(b) where emergency treatment has been required are also often those involving the most unwell ECT consumers, and therefore, while their cases may be clinically complex, the clinical requirement for and benefit of ECT is often most clear and, therefore, uncontroversial in these cases.

The Panel considers the functions of the Panel in the Act should be reconsidered to ensure the mechanism of Panel review is reserved for ECT cases which are truly complex for clinical or consent reasons.

"Complex Cases" of Panel interest

Cases which the Panel considers may be appropriate for review include those where any of the following issues arise:

- Concerns regarding consent to ECT treatment;
- Any use of restraint or restrictive practices;
- Where a significant medical adverse event in relation to an episode of ECT has been notified on the SLS;
- Three or more acute courses of treatment per year;
- Instances of very prolonged courses of treatment (e.g., where a course of treatment exceeds a threshold of (for example) 20 episodes);
- Cases of maintenance ECT that have continued for 3+ years;
- Cases featuring clinically complex treatment-resistance;
- Cases featuring clinically complex comorbidities;
- The use of ECT on children and young people aged under 18; and

- Cases where ECT-naïve patients are prescribed bitemporal ECT as a first treatment.

Recommendations for review

Suggested options for amending the Act to limit the functions of the Panel to reviewing only those 'complex cases' of interest:

1) Revising the Section 41C Review Triggers such that the Panel may conduct a review of a "complex case". A "complex case" is defined as cases such as those listed above, to be determined by the Chief Psychiatrist in consultation with the Panel.

   The Panel will review cases identified by the Office of the Chief Psychiatrist, based upon information sourced from, but not limited to:
   - Safety Learning System reports
   - advice from clinicians
   - advice from consumers
   - advice from carers/guardians
   - advice from SACAT
   - Clinical Incident Reports
   - ECT Consent Forms

   This approach would require cooperation with ECT clinical coordinators and treating psychiatrists to filter and identify cases meeting the criteria for referral to the Panel.

2. Inclusion of legislative obligation upon treating medical practitioners to supply a report to the Panel

Issues to consider

- The functions of the Panel under the Act – to review the progress of ECT cases meeting the criteria for review – are reliant upon treating psychiatrists supplying a patient progress report to the Panel. There is currently no legislative obligation upon the treating psychiatrist to do so. Query whether the Act should clarify this obligation.

Discussion

The work of the Panel is dependent upon the cooperation of treating psychiatrists to supply progress reports for patients whose treatment meets the criteria for Panel review under the Act.

There is significant goodwill between the Panel and ECT treatment staff and specialists, such that reports have almost always been forthcoming upon the Panel's

request. However, the review of the Act provides an opportunity to clarify the Panel's reliance upon these patient reports to fulfill its statutory functions, and to clarify the legislative obligation of treating staff to supply them.

Recommendation

The Act be amended to clarify that a psychiatrist who authorises or administers ECT treatment to a patient such that the patient's treatment triggers the Panel review mechanisms, has an obligation to supply a patient progress report to the Panel upon request.

3. Section 42(4) - Reasonable use of force to provide ECT treatment

Issues to consider

- Clarification required as to whether section 42(4)(b) of the Act is intended to restrict the use of reasonable force to administer the ECT treatment when the patient is the subject of an Inpatient Treatment Order under the Act.

Discussion

It is unclear whether the Act as currently framed allows for the use of reasonable force to administer an ECT treatment where the patient is subject to an ITO.

Section 34A of the Act allows for treatment staff to restrain the patient and otherwise use reasonably required force for the purposes of carrying into effect the ITO applying to the patient.

However, section 42(4)(b) of the Act provides that consent to ECT does not extend to the use of any force for the purposes of administering the ECT treatment.

Currently, in the limited cases where patients are the subject of guardianship or administration orders under the *Guardianship and Administration Act 1993* (SA) (**GA**), treatment staff rely upon powers in section 32 of the GA to use reasonable force to administer ECT. Section 32 of the GA allows SACAT to make orders authorising treatment staff to use "such force as may be reasonably necessary for the purpose of ensuring the proper medical … treatment … of the person".

Whether reasonable use of force is permissible for the purposes of administering ECT to patients subject to an ITO is the subject of regular enquiries to the OCP, and should be clarified in any review of the Act.

Recommendation

Consideration should be given to whether there are circumstances in which the use of force to administer ECT might be reasonable, how this force should be used, what limitations should be put in place, and how such restrictive practices are to be reviewed post treatment.

4. Section 41A – Prescribed Psychiatric Treatment Panel composition

Issues to consider

- Potential need to incorporate more diverse views into Panel membership, e.g., Aboriginal and Torres Strait Islander, CALD, LGBTIQA+ voices.

Discussion

Section 41A(2) of the Act States:

The Panel consists of—
(a) the Chief Psychiatrist; and
(b) no more than 8 other persons appointed by the Governor on the recommendation of the Minister, of whom at least—
(i) 1 must be a patient or former patient; and
(ii) 1 must be a carer or former carer; and
(iii) 1 must be a senior psychiatrist; and
(iv) 1 must be a neurosurgeon; and
(v) 1 must be a legal practitioner in this State; and
(vi) 1 must be a person with credentials and experience in bioethics.

The Panel suggests that there is benefit in enabling further specialist input to ensure that Aboriginal and Torres Strait Islander, CALD, LGBTIQA+ representatives can contribute on an as needs basis for specific cases.

It is suggested that the Chief Psychiatrist be provided with authority to assign specialists to individual cases, who can attend Panel meetings to provide advice to the Panel.