Submission

To	Office of the Chief Psychiatrist
Topic	Supplementary consultation on Mental Health Act 2009
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UNITING COMMUNITIES

About

We are an inclusive not-for-profit organisation working alongside more than 80,000 South Australians each year and have been creating positive change for South Australian communities for more than 120 years. We advocate for systems change across diverse social justice issues to shape public and social policy that delivers better outcomes for marginalised communities.

We support those in need to find the courage to move forward through enriching their lives and uniting the communities in which they live. By tackling the deep-seated challenges that affect people's lives, we are working to create systemic change and brighter futures for all South Australians.

Chrysalis Forensic Mental Health Service

Chrysalis is a transitional accommodation and case management service for clients transitioning from extended stays in inpatient mental health wards (including James Nash House) into the community. The aim of this nine-bedroom program is to support residents with sourcing long-term accommodation, build independent living skills, support with maintaining good mental health and to make connections in their community.

All residents of the Chrysalis service:

- Live with a mental illness
- Have ongoing psychosocial support needs
- Display low risk behaviour
- Have no alternate safe housing options
- Are able to reside independently
- Are medically stable
- Have no acute care needs

Family Mental Health Support Onkaparinga/ Southern Fleurieu, Kangaroo Island

This service provides support for people caring for a young person with mental health issues. We offer free counselling and information to families concerned about a young person aged under 18. Our goal is to help children and families to improve mental health, resilience and confidence.

Headspace Mount Gambier

Headspace provides information, support and services for young people aged 12-25 to work through mental health, physical health, work and study and alcohol and other drugs. We can connect clients with health workers to work through a range of issues.

Lifeline

Lifeline is committed to preventing suicide, supporting people in crisis, and promoting good mental health and emotional wellbeing. Every year, the service answers more than 36,000 calls from people experiencing crisis. Many of them are thinking about taking their lives. Our dedicated team of Crisis

Supporters are here to listen and offer support and, where appropriate, refer people to other services that can help.

Psychosocial disability services (NDIS)

We provide recovery support services for people experiencing long-term mental health issues who would like support to live the best life they can.

Services include:

- skills development
- help to participate in the community and in areas of interest
- feedback and coaching
- support with daily tasks.

Submission to supplementary consultation on Mental Health Act 2009

Uniting Communities thanks the Office of the Chief Psychiatrist for the opportunity to provide input into this supplementary consultation. We provided a submission to the initial consultation and look forward to the opportunity to provide input on the draft legislation.

We understand this additional consultation has come about due to recent safety concerns. While we are largely supportive of the proposals, we provide further commentary on how these additions can better support consumers.

Our key recommendations:

1. **A prevention of harm principle be explicit in the wording that this is to be applied to broader support (including clinical and non-clinical therapy) rather than solely decisions regarding involuntary care.**
2. **The Chief Psychiatrist be required to create a Standard for all the principles (currently only required for two of the proposed principles).**
3. **Both the Suicide Prevention Principle, and the accompanying Suicide Prevention Standard should be explicit about the need for interventions to be more than an administrative assessment of a person's risk of suicide but should also include follow up support as well, including referrals and the creation of a safety plan.**
4. **More support services, particularly non-clinical support must be made available as part of the implementation of the new legislation to implement the proposed principles effectively (to address long waitlists for support).**
5. **That an understanding of the consumers low risk to others (such as during psychosis) be incorporated into the wording of the 'principle that considers the needs of people with severe mental health conditions' to help address barriers for support.**
6. **That the Co-Morbidity principle is incorporated and the 'specific care plan requirements' are explicit about the need for collaboration, so that 'needs are identified, the offer made AND mental health services collaborate with AOD services co-currently' (where the consumer has voluntarily accepted the treatment).**
7. **That a Compassionate Care Principle should be clear about what this looks like in practice and include the role of peer support workers in ensuring compassionate care is implemented.**
8. **Action is taken to address the factors that contribute to prolonged use of care and control powers.**
9. **Regular reviews of involuntary orders are legislatively required where such an order is required for the safety of the consumer (so that assessments during a moment of crisis are not dictating ongoing treatment).**

Additional Comments

Do you consider that a prevention of harm to persons principle is required What key elements should be included in this principle?

We are supportive of the proposed principle and believe this addition would place a greater level of responsibility on mental health services and staff, to keep this principle central to their practice. We agree that such a principle in relation to prevention of harm to persons should include more than the risk of suicide, we believe such a principle should also include risk of harm as a result of a lack of support or therapy.

As referred to in the discussion paper this principle would be broader than a decision about involuntary care. We think this principle would need to be carefully worded to make this explicit, allowing for this principle to be used more broadly in relation to services and care that involves voluntary non-clinical treatment, rather than just initial assessments. It is vital that a 'prevention of harm,' principle is not solely implicated in decisions to impose involuntary treatment but must consider the potentially adverse impact of involuntary treatment on the recipient and the alternative options that are available to support that person (voluntary/non-clinical).

Do you support the inclusion of a Suicide Prevention Principle in the Act, and the associated requirement that the Chief Psychiatrist maintain a Suicide Prevention Standard?

We believe this would be a positive addition to the Act. We would expect that such a standard would ensure suicide prevention is being delivered by mental health services to ensure consumers get access to support (beyond the initial assessment). In our experience suicide prevention interventions are primarily focused on the initial assessment of risk. Both the principle, and the accompanying Suicide Prevention Standard should be explicit about the need for interventions to be more than an administrative assessment of a person's risk of suicide but should also include follow up support as well, including referrals and the creation of a safety plan (ensuring a more thorough process). This will lead to more effective outcomes.

For our Chrysalis mental health service, we do risk management strategy and safety planning which is a lengthy process rather than a once off assessment. We acknowledge that sometimes there are lengthy waitlists for support (sometimes months) which is why the provision of more support services, particularly non-clinical support must be made available as part of the implementation of the new legislation to implement principles such as this, effectively.

Given there are various stakeholders that will interact with consumers in many crisis situations, consideration could be made to including other staff such as police officers, practitioners, emergency department nurses etc. in the Principle within the Act and/or the Suicide Prevention Standard so that the roles of others in the system are made clear in how this principle looks in implementation (rather than limiting this to mental health staff specifically).

Do you agree that there is a need for a principle that considers the needs of people with severe mental health conditions?

We welcome this additional principle, recognising the unique support required for consumers with severe mental health conditions who need tailored support and care. We agree that "most people who experience either psychosis or other severe mental illness are not a risk to other people and are more likely to be at risk of being a victim of assault from others." We believe this is not widely understood within the mental health sector and often less so across the broader community. The current misconceptions

around risk of safety to staff result in significant barriers to support for people with severe mental health conditions. Often consumers experiencing severe mental health conditions, such as psychosis, who are showing signs of distress, are actually angry about the situation they are in and lack of support and understanding rather than the staff involved, while some may believe the anger is directed at them.

For example, we have witnessed instances where a clinician or psychiatrist has been fearful of a consumer, in circumstances such as psychosis, even though our staff have been safe with the consumer at the time. In these situations, we have attempted to reassure the clinician/psychiatrist, but sometimes they have not attended (no assessment is conducted), or involved police officers, which has escalated the situation.

Therefore, we think it is very important that an understanding of this risk is framed within the principle, to address the stigma for people experiencing these mental health conditions and ensure this understanding is incorporated into service design and practice. Ultimately, this will help ensure the needs of people with severe mental health conditions are considered in practice. We believe alongside the inclusion of this principle, the Act should also require that the Chief Psychiatrist develop an accompanying Standard to aid in the implementation of this principle.

Do you consider that the issue of mental health and drug and alcohol co-morbidity merits a specific principle in the Act?
Do you support the specific care plan requirement to formalise the offer of treatment for drug and alcohol use disorders when needed?

As an organisation with a significant history of providing both mental health support services and alcohol and other drug support services we understand firsthand the crucial need for this principle, as this issue has been witnessed by our services over many years. It is very common for both mental health conditions and alcohol and drug use to occur concurrently. Historically this issue has resulted in some mental health services referring a client to AOD services rather than working collaboratively, and in conjunction to address both issues.

We support the proposal of a specific care plan to formalise treatment. We believe this requirement should also be explicit about the need for collaboration, instead of just requiring 'that needs are identified and the offer made,' mental health services should also be required to collaborate with AOD services to co-currently provide treatment (where the consumer has voluntarily accepted the treatment). Whilst we acknowledge that alcohol and drug use does not constitute a mental health condition, we believe it is unacceptable for consumers to be refused mental health services on the basis they also have a drug and alcohol condition. In addition, we believe that a standard should also be included, similar to the requirements proposed for the other principles to provide guidance for implementing the principle in practice.

Do you support a Neurodevelopmental Disorders Co-Morbidity principle?
What should the principle include?

We are supportive of this principle; co-morbidity needs to be factored into complex presentations involving both neurodivergence and mental health. In our mental health services for youth, we have seen the emergence of young people with neurodevelopmental disorders who are at risk of long term chronic mental health conditions due to a lack of appropriate support. As a result we believe there needs to be a greater focus in policy and practice on this issue. Greater access to preventative support could avoid long term chronic conditions from occurring. We agree that further training would be beneficial across the sector, to improve outcomes for consumers. Such a principle would benefit from an accompanying Standard as proposed in some of the previous principles.

Is a compassionate care principle a proposal that should be supported?
What ideas do you have for the framing of what would be an innovative principle?

We are supportive of this proposed principle. We believe compassionate care should be a part of all practice for services and staff supporting people with severe mental health conditions. Demonstrating compassion enables staff to understand and help the consumer better. Similarly, if you have a better relationship with the consumer (which often stems from showing compassion) this will improve outcomes.

We believe a compassionate care principle should be explicit on what compassionate care looks like in practice (or within an accompanying Standard). Compassionate care, at a minimum, involves providing adequate care despite any preconceptions about the consumer staff may have, recognising their right to care and support regardless of their actions.

We note in the discussion paper was the inclusion, 'it has also been noted in initial discussions that this will be supported by moves to expand the peer workforce.' We believe that a compassionate care principle should include the role of peer support workers in ensuring compassionate care is implemented, recognising the crucial role a peer support worker provides for consumers with severe mental health conditions. Uniting Communities provided specific recommendations for implementing a right to a peer support worker within the Act in our submission to the SALRI review of supported decision making. We also think this principle could benefit from an accompanied standard for staff and services to adhere to in practice. This would in turn support any reporting requirements for the Mental Health Commissioner, Principal Community Visitor and Chief Psychiatrist (as proposed in the discussion paper).

Do you agree that assessments of people held under care and control powers should be timely?
Is the proposed reporting requirement supported?
Any other comments?

We agree with this proposal, it is important that assessments are timely. In our previous submission we proposed that where reasonable, care and control powers should be exercised in a manner that is as least restrictive as possible, and the authorised officer must actively seek to minimise the potential traumatic impacts to the consumer.

If care and control powers are used for more than 6 hours, we believe this is indicative of greater issues and shortcomings in the system. Any legislative changes must be accompanied by action to address the various barriers that are contributing to this (once circumstances have been identified) e.g. not enough support, resourcing and staff with the qualifications to make the assessments.

The discussion paper highlights that, 'there may be situations where the need for an order may not be clear and a longer use of s56 powers would be preferable and in the persons interests." While we recognise that such care and control powers should be temporary, we also agree with the concerns highlighted in the discussion paper that the imposition of a mental health order can have greater future legal significance. We strongly believe in the need to move away from involuntary treatment orders where such orders are used as a last resort. We believe that the implementation of thorough assessments alongside regular reviews of orders would create better outcomes for situations where quick assessments are required for the safety of the consumer. It is vital that assessments during a time of crisis do not dedicate long term treatment which may no longer be required (as decision making capacity fluctuates).

What is your view of this proposed "local psychiatrist review by telehealth" provision that would permit assessment before transport except if there is a clinical reason to transfer earlier?

We agree with this proposal as this could avoid unnecessary transfers where the order is no longer required. Particularly in regional areas where there is already an overburdened system. This would avoid unnecessary transfers, that are at the detriment of the consumer and the staff supporting this transfer.

Sometimes there are worse impacts because of transport, where it is unnecessary and can be avoided, this can escalate issues and make the consumers condition worse.

Do you support the inclusion of this provision in the South Australian Act? (consulting family and carers)
Under what circumstances should such consultation with family and carers not occur?

We are supportive of this new proposal and believe this would benefit the consumer, family and carers overall, but provisions to safeguard consumers should be provided. We agree that exclusions should apply when it is not in a consumer's best interests and when the consumers requests would need to be taken into consideration, such as situations of family and domestic violence. This is why consultation with the consumer is so important in these circumstances. Unfortunately, some families and carers are not always acting in the best interest of the consumer. We have witnessed many situations where the carers/family's response is not in the consumers best interest but instead coming from a place of misplaced fear and perception of risk.

A new requirement for the completion of a Statement of Reasons and a Report to Director be put in place when a treatment order is not made (to discharge order or not make a further order). This requirement would be limited only to situations where a person has been a risk to others because of threats or a concern that they might harm others.

We understand the reasoning behind this proposal and believe it could create improved accountability. However, we do echo the concerns raised in the paper that this could lead to less revoking of orders even when needed due to the hesitancy that may arise from having to provide a formal reason. We are concerned this may result in more risk adverse decision making when it may be at the detriment of the consumer. We strongly believe that ultimately, the legislative requirements need to move towards less involuntary treatment orders. Although it is intended to apply, 'where a person has said that they may harm others, fear that they might harm others or has otherwise been considered at risk due to their behaviour, where such statements or behaviours have arisen at any time during their referrals, assessment, or treatment,' this is very broad and is likely to implicate many consumers. As highlighted in our previous submission, there is a need for regular and thorough reviews of involuntary orders to ensure they are not being used unnecessarily or could be avoided with a more appropriate response. More reviews will be crucial if this Statement of Reason Is implemented to ensure regular oversight.

Duty to warn - Do you support a move to a mandatory approach rather than a permissive one to the "duty to warn"? Under what circumstances should the duty to warn apply? What exclusions should be considered?

We recognise that in practice this often occurs already. However, by making it a requirement we are concerned this might happen more often than it needs to. Confidentiality is a concern, as highlighted in the discussion paper, 'people may not confide their thoughts to their practitioners if they are concerned that they might be passed on to others, and they see this as unnecessary.' Provisions in the Act will need to carefully consider this and how it will affect patient outcomes.

Statutory establishment of a Human Rights and Coercion Reduction Committee
Do you support the statutory establishment of such a committee?

We are supportive of this proposal and the focus on 'rights-based issues.' We hope this will result in an increased focus on supported rather than substituted decision making.

Future work:

The development of non-Mental Health Act powers for the detention and restraint of people who require acute care due to a delirium, dementia and/or intoxication
Do you support the development of such powers in other legislation separate to the Mental Health Act, such as in the Consent to Medical Treatment and Palliative Care Act?

We believe this question would require an additional consultation, that involves consulting with a broad range of services that wouldn't necessarily be providing input on this *Mental Health Act 2009* consult, which could include aged care and alcohol and other drug support services. We think that it is important that provisions in the *Mental Health Act 2009* are not used in circumstances that are outside the scope of the legislation. Dedicated legislation will be vital to supporting people in these circumstances.

The development of limited powers to require people who have co-morbid drug and alcohol conditions to mental illness to receive involuntary treatment.

We believe this proposal will require additional consultation, to ensure any provisions have robust safeguards in place.

Conclusion

We appreciate the opportunity to provide a submission to the supplementary consultation on the *Mental Health Act 2009.* Wherever possible, we believe it is crucial that the new legislation focuses on moving away from involuntary treatment towards therapeutic interventions and supported decision making. We look forward to any additional consultation on the proposed new Bill.