7th Feb 2025

Review of the Mental Health Act 2009 South Australia

Supplementary Consultation:

Additional proposals for further legislative change to prevent incidents and respond to mental health emergencies.

Submitted to the South Australian Office of the Chief Psychiatrist: healthocp@sa.gov.au

Lived Experience Australia Ltd
Contact: Sharon Lawn
Executive Director
slawn@livedexperienceaustralia.com.au
PO Box 98, Brighton SA 5048
Phone 1300 620 042
ABN: 44 613 210 889

Contents

Introduction

Lived Experience Australia Ltd (LEA) is a national representative organisation for Australian mental health consumers and carers, families and kin, formed in 2002. Our 'friends' include more than 10,000 people with lived experience of mental health concerns across Australia. This includes lived experiences with all parts of the mental health care system, NDIS, psychosocial disability support outside the NDIS, PHN commissioned services, public and private service options, and service provision across urban, regional, rural and remote Australia. All members of our Board and staff have mental health lived experience as either a consumer, family/carer/kin/supporter, or both.

Lived Experience is core to our advocacy, recognising that the impacts of policy and practice are felt not only by individuals, but also by families and whole communities. Our core business is to advocate for effective policies and systemic change to improve mental health care and psychosocial disability support services and support across the lifespan, across the whole Australian health and social care system, including within State and Territory jurisdictions.

We welcome the opportunity to provide our feedback to this Supplementary Consultations on the SA Mental Health Act 2009, particularly given the significant opportunity to enhance human rights, reduce coercive practices, and improve the culture and practice of mental health service delivery in South Australia. This will have clear positive impacts for individuals with mental ill-health and distress, and their families, carers and kin in the South Australian community.

Background

This supplementary consultation follows earlier South Australian Law Reform Institute (SALRI) consultations and their 2023 report to the SA Government. The ideas contained in the consultation discussion paper evolved following critical incidents in both South Australia and elsewhere in Australia that have brought into focus the need for further review of South Australia's Mental Health Act and also services for people who experience mental health conditions. The discussion paper contains a number of proposed changes to principles that are designed to improve the delivery of quality care and that could offer a positive benefit to many more people, beyond the initial focus on risk that is inherent in the current Mental Health Act. Conversely the risk of unintended consequences on a wider population needs to be considered.

The South Australian Office of the Chief Psychiatrist formed a dedicated Human Rights and Coercion Reduction Committee in early 2022 as part of the SA Mental Health Services Plan. This committee has engaged closely with the SALRI and this reform process, and the range of principles being considered in this consultation. Lived Experience Australia's Executive Director, Sharon Lawn, is a member of this committee.

Purpose of this Consultation

This consultation, as cited in the Discussion paper (https://yoursay.sa.gov.au/96919/widgets/448848/documents/300681) arose in response to a request from the Minister for Health and Wellbeing to consider and consult on what further changes could be made to the Mental Health Act that might prevent critical incidents and improve mental health care.

This discussion paper is structured to consider:

- New proposed principles of the Act.
- Proposals to facilitate emergency mental health responses.
- Further proposals that might improve personal and community safety.
- An additional proposal regarding the establishment of a Human Rights Committee in mental health.

In these sections, the topics covered include new principles related to risk, and suicide prevention. There are new principles related to groups who may experience gaps in care including people who have a severe mental illness, people who have both a mental illness and drug and alcohol condition at the same time, and people who experience neurodevelopmental conditions. There is also a new principle of compassionate care.

Specific changes are also suggested to the use of powers of care and control used within health services, and a new requirement proposed for documenting decisions related to involuntary care when other people may be at risk. There are changes proposed to the "duty to warn" potential victims. The paper concludes with a proposed Human Rights Committee to be added to the Act. Our Response to the Consultation

1. A new Prevention of Harm to Persons Principle – including prevention of harm to self and to others.

This proposal is to add a new principle that emphasises a role for mental health services in preventing harm– this applies to risk of harm to self or others.

Proposal: The principle would (1) acknowledge this role of mental health services broadly in preventing harm to persons, (2) recognise the rights of other people who may be affected in some situations including those of carers, family, friends, and community members and in particular the right to personal safety and (3) refer to the provision of assessment and therapies that can reduce risk to the person themselves or to other people.

Further Proposal: To assist in the implementation of this Principle, it is proposed that the Act should include a requirement that the Chief Psychiatrist is to maintain a standard on Prevention of Harm to Persons that considers risk identification and response in mental health services.

Questions: Do you consider that a Prevention of Harm to Persons principle is required? What key elements should be included in this principle?

Our Response: A Prevention of Harm principle would be useful. However, we believe that a wider understanding of harm is needed as part of how prevention of harm is then defined and acted on. In particular, we wonder why the 3rd point in the proposal above is so clinically focused on 'assessment and therapies'. Our experience is that many of the harms arise from services not listening to the person or their family, carers and kin, and not including them in care. That is, services are not simply responding as part of the one-way process; the issues are two-way and services and workforce are not bystanders delivering a response. Sometimes, they are part of 'the problem'. Further to our concerns, we know that prevention of harm also involves the context in which people live and the social determinants of their lives, not only the clinical realm. A prevention of harm principle must acknowledge the social context, not only the bio-psycho contexts. We refer you to a project undertaken by Tandem in collaboration with Lived Experience Australia and others on Carers Human Rights which involved consultation with approximately 100 family carers at the 2023 TheMHS Conference. Among the many rights that they raised were: the right to feel safe in your own home, to right to be listened to, and the right to have a mental health service than does its job.

We also wish to raise the complexity and challenge inherent in applying a prevention of harm principle, particularly when considering how this must be balanced with dignity of risk; the choices and actions of an individual will arguably always have some consequences for themselves or others. Mental health workforce struggle to apply dignity of risk in practice. Workforce training in both of these concepts is strongly indicated, otherwise, systems will put both in the 'too hard' basket', making the principles meaningless.

2. Suicide Prevention Principle – a broad principle to inform all aspects of clinical policy, planning, design, and delivery

The discussion about risk to self and others has highlighted the lack of focus on suicide prevention in the existing *Mental Health Act.*

Proposal: That a new Suicide Prevention Principle be added to the Act to underpin suicide prevention in the design and delivery of mental health services, extending beyond hospital.

Further proposal: That a requirement be made that the Chief Psychiatrist develop and maintain a Suicide Prevention Standard for Mental Health Services.

Question: 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?

Our Response: Many people with lived experience of mental health challenges 'live with' levels of suicidality as part of their everyday experience. We support inclusion of this principle, so long as it prompts more holistic assessment and support and does not have the unintended consequence of mental health staff then being pushed even further towards a risk driven process of assessment and response. An opportunity for meaningful upstream suicide prevention is what is needed, and inclusion of the principle within the Mental Health Act could reflect this.

3. A Principle that Services will consider the needs of People with Severe Mental Health Conditions

There has been recent public discussion that our mental health systems need to ensure that they are focused on the care of people with the highest needs and that nationally the needs of people in these groups requires more focus in policy and planning.

Proposal: A new principle states that services will consider the needs of people with severe and complex mental health conditions and people who require emergency assessment and care. This is intended to support the provision and design of services for people who have service needs.

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

Our Response: We are concerned about the level of rhetoric and service-centric discussions associated with many reforms and new initiatives. Most begin with promising person-centred care, then rapidly sink into a discussion about building a service for people to come to, focusing on commissioning and competing for funding to set up services that arguably serve those with greater agency and resources to make contact with those services. If only it was that simple. Such an approach ignores the reality that many people with severe and complex mental health conditions do not seek help; they don't 'go to' services; services must go to them, literally. Neither should services expect that people in this group will eventually come to the attention of mental health services via a crisis or hospital admission, i.e. That they or their families will eventually find that door to that service. There are likely many people with severe and complex mental health issues who are completely outside of the radar of services. I spoke with a family just last week in this situation: the parents were in the 80s and their adult son who lived with them had never had contact with mental health services (only a GP), and refused to leave the house, and did not recognize the need for any further support, despite his parents becoming increasingly frail. Family carers provide care until they can't provide care, but then what happens? This person is one of the 19,000 in SA with unmet need.

4. A new Mental Health and Substance Use Co-morbidity Principle and associated new care plan requirements

The *Mental Health Act 2009* also does not always address the needs of people who have both a mental health condition and a drug and/or alcohol use disorder – a common combination.

Proposal: A Drug and Alcohol and Mental Health Co-morbidity Principle will recognise the need to plan effective intervention that address both mental health care and drug and alcohol care together, the role of mental health services in this area and the need for collaboration with drug and alcohol services.

Related proposal: Mental Health Care plans should refer to therapies for a substance use disorder when this disorder is co-morbid to a person's mental health condition and needs to be addressed to prevent deterioration and relapse of this condition. Care plans should include the offer of treatment for drug and alcohol use disorders available on a voluntary basis.

Questions: 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?

Our Response: Yes to both questions. This principle is long overdue, and system silos have led to the needs of people with mental health AND alcohol and other drug use to be neglected. It's time to fix this siloing of care; it has led to each of these sectors abrogating responsibility for providing support. The evidence for mental health and AOD interacting adversely on each other has been well-known for decades. It's time.

5. A Neurodevelopmental Disorders Co-Morbidity Principle

This principle would consider the needs of (1) people who experience autism spectrum disorders (with or without intellectual disability), (2) people who experience an intellectual disability.

Proposal: A Neurodevelopmental Disorders and Mental Health Co-morbidity Principle be added to the Act requiring that the needs of people who experience these co-morbid conditions be considered when setting policy and designing services that are responsive to those needs.

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

Our Response: We support this principle but suggest that it also include the broader issue of people who require communication assistance (Complex Community Needs). Mental health services are currently very 'traditional' and anyone who falls outside of service-led ways of communicating don't experience equity with services; their basic human rights can also be undermined when services lack flexibility in if and how they engage and respond. Sometimes, they don't receive a service at all, are excluded, or told that they are not eligible. This includes the above groups but also people from the deaf/blind community and people with conditions such as cerebral palsy who may need to express their needs and experiences with the help of communication aids or trained communication partners.

6. A Principle to deliver compassionate care

In this initial proposal, the focus is on the organisation of services. The proposal that is included in this paper has a focus on emergencies and risk, because a compassionate response will improve the quality of care delivered in emergency situations (as well as having benefits across the full range of services delivered).

Proposal: The Compassionate Care Principle. A new principle would be added to the Act that the Mental Health and Wellbeing services will be designed to support the provision of compassionate care based on empathy, respect, and dignity, with organisational support given to staff delivering this care.

Further proposal: That a report on the delivery of compassionate care by our systems be required in the Annual Reports of the Mental Health Commissioner, Principal Community Visitor, and Chief Psychiatrist.

Questions: 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?

Our Response: We support the inclusion of this principle. Reporting on delivery of compassionate care and what it looks like in practice provides a positive counterbalance to mental health services and staff within systems of care that focus so much on risk and coercion. They need models and role models of how to do things better, not just for emergency situations but also in everyday contact with people. Framing that could be considered is to be person-first as if it was themselves or their own family member in contact with services.

7. Ensuring that the use of care and control powers to enable assessments is timely and that the use of the powers are monitored.

In discussion with services in South Australia there was concern about unintended consequences of a time limit and the focus of this proposal is on monitoring rather than a strict time limit.

Hence this proposal would require the Chief Psychiatrist to (1) monitor and report on the use of section 56 powers and (2) report specifically on the use of powers for a period greater than 6 hours.

Proposal: A new monitoring requirement be introduced of the use of temporary care and control powers to support SALRIs recommendation that assessments are timely. The Chief Psychiatrist would be asked to report on (i) the use of such powers (ii) instances and the circumstances where powers are used for greater than 6 hours. This monitoring will use clinical data sources and will not impose a reporting burden on services.

Questions: 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?

Our Response: Yes, these assessment circumstances should always be timely to avoid further distress, harm or acute physical health issues being overlooked or responded to too late. We support this principle so long as reporting is accurately capturing what occurs in practice and is actively used to inform service improvement.

8. Provisions to support psychiatric review of people who are on involuntary treatment orders prior to interhospital transfer.

Legislation has been written with the expectation that people who are placed on Inpatient Treatment Orders need to be transported to an approved treatment centre at the earliest opportunity.

Proposal: That people placed on an ITO in rural settings can be held in a rural setting to have their psychiatrist review by telehealth, rather than transported for the review. The Act would refer to local reviews and require reporting on these provisions in the Chief Psychiatrist Annual Report.

Question: 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?

Our response: We recognise that this provision may have particular benefit for people in rural areas awaiting transport to metropolitan centres, people experiencing drug intoxication, and so forth. Therefore, we support this proposal, though we have some concerns about the training required at local level, and the reliance on telehealth options which may not be sufficient to make a full assessment of the person's circumstances or ensure the involvement of family or friends, where relevant to the situation at hand. Conversely, this option may be beneficial in enabling family or friends to corroborate important information about the person and their needs and preferences in some situations, especially where they may not then be present when the person is transported to a new location (e.g. family left in rural area and person transported to city emergency department by Royal Flying Doctors service).

9. A requirement to consult family members when a decision is made about involuntary care.

Discussions about risk to others led to further consideration of consultation with families and carers.

Proposal: A consultation requirement for consulting family and carers be added to the Act similar in intent to the provisions of the New Zealand Mental Health (Compulsory Assessment and Treatment Act) 1992.

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

Our Response: This is a complex consideration needing a more nuanced response; making this a 'requirement' may not suite all circumstances. Some families may wish to not be involved in this process because they do not want to damage their relationship or trust with the person. This is especially important when it is the person and their families who must pick up the piece after such a hospital admission. For some people, involving their family may lead to greater harm, especially where their relationship with family is strained (e.g. where family and domestic violence of abuse has occurred, where they experience coercive control from family).

10. Increased accountability in mental capacity assessment when there is a risk of harm to another person.

SALRI recommended that measures to enforce accountability following a clinical capacity assessment, particularly in the making of a treatment order, such as providing written reasons, should be considered further and, where appropriate, implemented (SALRI Recommendation 16).

Proposal: 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. 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. It would not apply where the concern is a risk to self.

Questions: Is this new proposed requirement supported? Under what circumstances should the requirement be applied?

Our Response: This proposed requirement is fraught and difficult to envisage how it would be applied, given assessment of risk is a fraught process and well-recognised to lack an evidence base for prediction of risk. Applying the requirement in the case of others but then not when the concern is about risk to self sends an ambiguous message about care of the person and care afforded to others. We also wonder whether this requirement could devolve into a 'butt covering' mindset by the service. The purpose of this proposed requirement remains unclear; it should already occur as part of good practice and compassionate care and communication with the person.

11. Enshrining in legislation a "duty to warn" other people at risk

In clinical practice, there is a widely accepted "duty to warn" other parties who may be harmed by the actions of a person receiving care. This is a well-accepted ethical practice supported by legislation. While maintaining confidentiality is a duty, it is also expected that other parties be warned.

Proposal: Inclusion of a new provision within section 106 of the Act which describes a duty to warn. These circumstances would be in situations where a person is a serious threat to others, and there is foreseeable risk of harm. The expectation would be accompanied by exclusion criteria that might be applied, for example if a person is unable to act on these actions as they are in hospital.

Questions: 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?

Our Response: Our understanding is that this is already a full recognised ethical principle internationally, made so by the Tarasoff Case, which has informed ethics training received by the diverse health disciplines for decades. And that not applying this has legal consequences. Again, this is a difficult principle to operationalise in practice unless it involves a very clear and immediate threat made to harm another person. Better training and ongoing professional development about ethical issues, and more reflective practice as a standard expectation for all mental health staff, may be an alternative approach here.

12. Additional proposal regarding a statutory Mental Health Human Rights Committee and Coercion Reduction Committee

Since the release of the SALRI review, the concept of a statutory Human Rights and Coercion Reduction Committee has been raised. Such a committee could support the careful consideration of rights-based issues, such as those in this paper where the rights of different parties need to be upheld and report their deliberations to parliament.
A non-statutory committee with the same name currently exists (*The OCP Human Rights and Coercion Reduction Committee noted earlier*), with members including relevant statutory officers, lawyers, advocates, academics, clinicians and lived experience representatives.

Proposal: Provide for the statutory establishment of a Human Rights and Coercion Reduction Committee, with defined terms of reference and report of work. It would monitor application of relevant human rights instruments, promote human rights initiatives in mental health, and provide the Minister with advice area.

Question: Do you support the statutory establishment of such a committee?

Our Response: We support this proposal. The current committee has demonstrated already that it can have real impact within the mental health system in South Australia. It's development of a Human Rights Tool is evidence of this benefit. Human rights cannot be left to services to 'do the right thing'; monitoring and reporting is needed to maintain focus on it, otherwise, the rhetoric of policy does not translate to practice improvement.

13.A proposal for 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

Currently the *Mental Health Act 2009* is used to provide involuntary care for people who have a mental incapacity, that is not related to the mental health conditions usually treated by mental health services.

Proposal for future work: That amendments to alternative legislation (most likely the *Consent to Medical Treatment and Palliative Care Act 1993)* be developed to provide an alternative to the *Mental Health Act 2009* when detention or restrictive practices are required for the care of people who have a delirium, dementia, substance intoxication and withdrawal, and for other situations where people are not usually treated by mental health services.

Questions: 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*? What human rights protections should be provided when such powers are used?

Our Response: We do not know enough about the legal implications of this proposal and therefore defer to others who are more informed and expert in this matter.

14. A proposal for future work – the development of limited powers to require people who have co-morbid drug and alcohol conditions to mental illness to receive involuntary treatment

Earlier in this document there are proposals to include a drug and alcohol co-morbidity mental health principle in the Act, and they also refer to the inclusion of drug and alcohol treatment in care plans. The latter would be delivered on a ***voluntary*** basis.

Proposal for future work: That developmental work occurs for a concept to provide in limited circumstances involuntary drug and alcohol treatment for people who have a mental illness that deteriorates due to substance use and have not wished to address this. This would apply if the deterioration places the person or others at serious risk

Questions: Do you support the use of involuntary treatment for drug and alcohol use that leads to relapse or deterioration of mental illness as a last resort option?
If you support this concept should such legislative provisions sit in a Mental Health Act, drug and alcohol Act, or other legislation? In general, what treatment should such involuntary provisions be limited to for a range of substance use disorder? For people who experience relapse of mental illness due to methamphetamine use what interventions might be considered in scope? What human rights protections should be provided when such powers are used?

Our Response: We believe this is a topic that requires further time, thinking and consultation with relevant stakeholders with expertise. It would be one that could be well-suited to consideration by a statutory Human Rights and Coercion Reduction Committee, in future.

15. Proposal for further work: seeking to address a gap in legislation coverage related to the involuntary care of people who have a neurodevelopmental disorder when the Mental Health Act does not apply

Earlier in this paper is a proposed principal related to the care of people who experience a neurodevelopmental disorder (e.g. children or adolescents with Autism Spectrum Disorder) who also need mental health care.

Proposal for future work: That work occurs to provide for the use of restrictive practices for people with neurodevelopmental conditions in situations where the Mental Health Act does not apply. This work would seek to minimise and prevent the use of such practices where possible but provide for lawful authority when needed.

Questions: Do you agree with the need for this work? What limits should be placed on any new powers in this area? What human rights protections should be provided when such powers are used?

Our response: We are aware that this has been a significant and distressing issue for a number of families whose children and adolescents have experienced significant distressing coercive care, and this has been a particular focus of advocacy for the 'Parents for Change' group in South Australia. We support further work that seeks to help improve this issue and hope that such a solution involves more comprehensive training and education of the mental health workforce. Equity of access to good mental health care and support for people with neurodevelopmental conditions should occur, just like it should for anyone.

Contact

We thank you for the opportunity to put our views forward. We wish you well with the next steps and would be pleased to contribute our Lived Experience perspectives to any future discussions about this important topic.

Your sincerely

Sharon Lawn

Professor Sharon Lawn, Executive Director
Lived Experience Australia Ltd
Email: slawn@livedexperienceaustralia.com.au
Mobile: 0459 098 772