Lived Experience AUSTRALIA

National Secretariat
PO Box 542 Marden SA 5070
Phone 1300 620 042
admin@LivedExperienceAustralia.com.au
ABN 44 613 210 889
Patrons: Professor Alan Fels AO | Mr John McGrath AM

Ms Marina Bowshall
State Director
Drug and Alcohol Services SA
75 Magill Road
Stepney SA 5069 sent via email: DASSAHealthPolicy@sa.gov.au

3 February 2021

Dear Ms Bowshall,

SUBMISSION

Draft Model of Care of Phase 1 - Youth Treatment Orders 2020

Lived Experience Australia (LEA) is the representative organisation for Australian mental health consumers and carers and the only organisation with a focus on the private mental health sector. Our core business is to advocate for systemic change, empowerment of consumers in their own care, promoting engagement and inclusion of consumers and carers within system design, planning and evaluation and most importantly, advocating for consumer choice and family and carer inclusion.

LEA appreciates the opportunity to provide this Submission. LEA has concerns around aspects of the Draft Model of Care (DMoC) in its current draft state but even greater concerns about the transition to Phase 2 for application to children and youth in the community.

For this Submission, LEA will concentrate on Phase 1, in respect to children/youth who are currently subject to detention in a training centre at the time the order is made, currently identified as Kurlana Tapa Youth Justice Centre (KTYJC)

Concerns

1) At present LEA does not believe the DMOC contains sufficient detail around a number of aspects and we note there seems to be an absence of independent advocates/advocacy organisations for children, or young people themselves with drug dependency or mental health issues, that have been consulted or collaborated with in regard to the development of this DMoC.

2) Increasingly, other jurisdictions are integrating drug and alcohol services with mental health and proceed to treat, assist, and support people with both.

3) Much research has indicated drug dependence and mental illness are interchangeable. Additionally, many mental illness diagnoses develop in mid-teens or earlier. Part of this process MUST be the establishment of a forensic mental health facility specifically for children/youth. This should be co-located within the current James Nash House environ where access to mental health clinicians (including psychiatrists and allied health) are readily available to attend to:

- Withdrawal processes
- Monitoring 24/7 of deterioration in mental health and wellbeing
- Crises
- Oversight of treatment programs
- Medications
- Access to mental health clinicians 24/7

4) The DMoC notes the age for the order is applicable to children under the age of 18. We know that young people these days are well developed in these later parts of teenage years. It will be critical that their choices are respected with the ability to make their own choices, and that they understand the implication of those choices.

5) LEA acknowledged the importance of the right of children/youth to access legal representation. This needs to be discussed with them face to face not simply providing them with a Statement of their Rights given so much can depend on their understanding.

6) LEA has very great concerns regarding the role of the legal representative. The DMOC states that if a child cannot or is unwilling to provide instructions, the legal representative can make decisions to what they believe is in the best interests of the child. LEA strongly opposes this, it should be a person familiar with the child, ie a GP, social worker, guardian, parent or family member who knows the child, and knows their background, personal issues, familial, environment issues including child abuse or neglect.

   The essence of this concern is how a legal representative can demonstrate that the child cannot provide instructions.

7) LEA notes the Assessment process involved 3 medical practitioners. Whilst we agree these are the appropriate clinicians, will the child be seen independently or before the clinicians collectively. If as a panel, this will not be acceptable, given concern that this would likely heighten their anxiety and actual or perceived coercive care and disempowerment of the children.

8) Children can be subject to the order and undergo treatment, but on returning to their usual environments, could very easily start taking drugs again. The transition back into the community will be an essential component, and LEA believes this is perhaps the most important aspect of this initiative. The community context in which the child returns to live must be recognised as a vital part of sustaining any benefits that may arise from being on the order and beyond.

9) Related to the above concern, we are also concerned that the Draft Model of Care has a strong focus on the coercive elements of mandatory drug treatment and there appears to be an absence of a focus on building and supporting capacity to consent and to positively engage with treatment. This appears to be at risk of producing similar problems to those we know exist for adults with mental health conditions who are placed on Community Treatment Orders. That is, the focus seems to be primarily on the coercive elements of imposing treatment, and waiting for the person to develop insight and compliance, rather than striving to build trust and collaboration with the person so that they don't need the order at the end of the enforced treatment period. We see these cycles often where people

may be on such orders over and over again, and the main outcome from the research evidence is that their engagement and trust in services worsens rather than improves.[1]

10) Statement of Rights (SoR): LEA believes this is written in a bureaucratic manner and in its current form does not relate well to children. LEA also believes that a discussion with the child is required on providing the SoR as opposed to just handing to the child. Secondly a signature must be attached to provide evidence the child has actually received face to face instruction about their rights and they fully understand.

11) In terms of a child's rights, part of the process must be access to an advocate for a face to face meeting to ensure, where possible, that the child fully understands the implications of their choices.

12) The element which mostly concerns LEA is the applicability that a child can be subject to the assessment and Youth Treatment Order based in part on 'risk to self or others'. This is a very contentious issue with involuntary admission or community treatment orders in the mental health area, and we believe that it will be equally complex in this area when determining and applying Youth Treatment Orders.

    There must be the same determinants in terms of protection under this DMoC that are reflected in the rights of people under these existing orders, as above.

    This DMoC is in essence the same institutional confinement, but in this case affects children, therefore greater protection of their rights including human rights must be protected.

Lived Experience Australia would welcome the involvement in discussions and representation going forward in this initiative. For the sake of protecting our children who are the community's future, we believe we have a lot to offer.

I would be very happy to further discuss any aspects of this Submission with you.

Kind regards

Ms Janne McMahon OAM
Founder and Executive Director
Email: jmcmahon@livedexperienceaustralia.com.au
Phone: Mobile 0417 893 741

[1] McMillan, J., **Lawn, S.,** Delany-Crowe, T. (2019) Trust and community treatment orders. Frontiers in Psychiatry. https://doi.org/10.3389/fpsyt.2019.00349