Att: Dr John Brayley
Office of the Chief Psychiatrist
c/- HealthOCP@sa.gov.au

Date: 10 January 2024

Dear John,

Re: SALRI Report 16: Review of the Mental Health Act 2009 (SA)

Congratulations on the quality of the Review of the Mental Health Act 2009 Report and, in particular, engaging an expert group (SALRI) to independently undertake the review. The feedback we have received regarding the process was highly positive and people felt that the consultations were respectful and encouraged the sharing their views.

The Report is very clear in presenting views of various stakeholders, practice in other jurisdictions and referencing relevant evidence making it easy to follow the logic to SALRI's conclusions and recommendations. The approach of making both instantly implementable recommendations as well as proposing future work to reconcile issues beyond the scope of the consultancy or the authors' expertise is also welcome.

However, since SALRI has completed this work, the World Health Organisation and the Office of the High Commissioner for Human Rights have jointly developed the publication, *Mental health, human rights and legislation: guidance and practice October 2023.* The WHO/ UNOHCHR document is clear that the scope of human rights focused mental health legislation should include greater scope than that of the SA review. This is quickly evident in the checklist on pp139-163. One example is question 1.3 - Does the legislation enable access to quality care and support that is person-centred and rights-based? Whilst the SALRI Report is clear on which issues are beyond the scope of this Review, this limitation means that the legislation will have a poor rating in some important areas covered by the WHO/UNOHCHR Report, and therefore fail to adequately meet contemporary international expectations to uphold human rights described in the UNCRPD and relevant UN conventions to which Australia is a signatory.

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The unmet need for psychosocial support is the largest gap in our ability to deliver holistic public mental health services in South Australia. The Unmet Needs Study highlights that 19 000 South Australians with severe mental ill health are going without necessary psychosocial support services that could be keeping them well in the community. We would firstly like to flag Recommendation 35 as a high priority for action to improve the capacity of our system to deliver least restrictive treatments and create a more trauma-informed system. The scope of Recommendation 35 must include consideration of access to holistic services, particularly with regards to the gap identified in the Unmet Needs Study. This would enable a balanced consideration of the use of involuntary treatment with the system goal of increasing the positive human rights outcomes for people with severe mental ill-health, especially those on or at risk of being placed on involuntary orders.

The authors' clearly state that making recommendations about resourcing holistic services is beyond the brief. This is understandable but frustrating, given that effective holistic treatment and support reduces the use of crisis and emergency services and hence the risk of involuntary treatment being used more frequently, including in response to system failure. The subsequent release of the WHO/UNOHCHR guide as referenced above, is clear that access to holistic services should be within scope of legislative reviews to ensure an appropriately balanced human rights focus.

We also highlight the urgent unmet need for community based youth mental health services, as identified by SA Police, Hospital Emergency Departments and the NGO sector including Youth Affairs Council of SA (YACSA) members as an area of high priority, including the underlying issues around suicidal ideation or attempt. Young people and service providers are calling for the resourcing of non-clinical, locally based support services and activities, access to timely age-appropriate therapeutic support, and mechanisms for intervening early.

Another high priority is Suggestion 1, which encourages further review and investigation into alternatives to the Emergency Department in public hospitals for mental health related attendances. The Australian College for Emergency Medicine State of Emergency Report November 2022, identified that South Australian emergency departments have the highest percentage of patients presenting with mental health or behavioural problems in Australia. From a human rights perspective, this is a high priority given the emerging role of 'urgent mental health' services in helping people to stay well in the community and reducing use of crisis settings which have the associated risks of trauma and involuntary treatments. Initiatives such as the Urgent Mental Health Care Centre and co-responder models combined with greater access to community psychosocial support have the potential

to completely reshape the experience and effectiveness of public mental health services to deliver holistic rights-based services.

The MHCSA strongly supports the clarifications on aspects of capacity assessment, increasing the threshold for imposing involuntary treatments, moving to supported decision-making and increasing access to legal representation. Expert discussions in the Human Rights and Coercion Reduction Committee highlighted that we can have the best legislation in the world to safeguard human rights, but to get the benefits of this for consumers and families requires ensuring our implementation is of high quality and continuously improving. The imposition of involuntary treatment must be a last resort, preceded by access to legal advice and advocacy, and there should be evidence that all other avenues have been exhausted, requiring a rigorous process of justification, strong accountability and mechanisms for review. The MHCSA therefore strongly supports Recommendation 16 to increase accountability regarding capacity assessment and imposition of involuntary treatment, Recommendation 48 re access to legal advice and also Suggestion 11 to increase access to advice and advocacy (beyond that identified in Recommendation 48)

There were some areas of the report where greater weight could have been given to arguments to improve the human rights outcomes relative to system factors. The discussion, findings and Recommendations regarding involuntary Community Treatment Orders (CTOs) are an example of this.

There were views from some stakeholders that a key benefit is that it gives the subject of the order a higher likelihood of obtaining treatment. If this is a key driver for some CTOs, then it is solving a system problem through imposition of involuntary treatment on individuals.

Other stakeholders highlighted the potential long-term trauma associated with involuntary treatment and the authors' analysis of the evidence found it mixed as to the effectiveness of CTOs. Given the strong views elsewhere in the Report, (for example substitute vs supported decision-making and capacity) the conclusions and recommendations are surprisingly neutral.

Another stakeholder view used as an argument to support CTOs is that they are less restrictive than an Inpatient Treatment Order. These arguments can be appropriate, however, they need to be tempered with the understanding that a key principle of the Mental Health Act is access to holistic services remains aspirational. The lack of access to community treatment and community psychosocial support is a critical system barrier to being able to deliver on principles in the Act such as holistic and least restrictive treatment – not just least restrictive involuntary treatment.

We support Recommendation 56-60 re Guiding Principles and Accountability. In addition we propose including a section in the Act, outlining human rights in line with relevant UN Conventions. This would provide an unambiguous reference point for a rights-based interpretation of other sections in the legislation. Also, as SA currently lacks overarching human rights legislation to provide guidance, adding a clear human rights based section in the Act will help make up for this gap in our legislative framework.

Suggestion 10 is strongly supported noting that the human rights focus of the mental health stream of South Australian Civil and Administrative Tribunal (SACAT) work could be improved through creating a less technical and disempowering environment by minimising the use of legalistic and medical/clinical jargon. The notion of Aboriginal people being experts in their own culture is also an interesting concept to consider in mental health legal processes. People with lived experience have said for a long time that they are experts in their own mental health and so the challenge is to balance this appropriately with legal and clinical expertise. Implementation of Suggestion 10 should be done using WHO/ UNOHCHR Report on human rights legislation for guidance.

The analysis of the various individual and systemic advocacy roles of the Chief Psychiatrist, Community Visitor Program, Public Advocate, HCSCC and the Mental Health Commissioner was generally supported. Recommendation 51 to clarify the respective roles and Recommendation 52 to define the Mental Health Commission(er) role in legislation are also supported.

However, the logic of Recommendation 53 to transfer some powers from Community Visitors to the Mental Health Commissioner (with as yet determined role and resourcing) is not clear. Whilst unfettered access to patient files by Community Visitors should not continue, access at the request of the patient should. Resulting advocacy should continue to be from a human rights or lived experience perspective, not a clinical perspective. The expectation should remain that some individual advocacy issues identified by Community Visitors could be system advocacy issues and should form part of the considerations for implementing Recommendations 53, 54 and 55.

A Mental Health Commission needs legislation so that the Mental Health Commissioner role is statutory, and this framing would ensure independence and define the role in broad terms. Additionally, the Commission needs its own resources to employ staff and develop and implement a strategic agenda. This agenda will need to be well-targeted, supported by an advisory committee and informed by robust consultation. Leadership and accountability for Commission performance needs to be clear, and the Commission must utilise key areas of advice available to

it, including LELAN, LEA and the MHCSA as organisations that the Commission could partner with to access lived experience and NGO networks.

A critical area of strategic reform that the Mental Health Commission could take on is to integrate a focus on human rights outcomes into all areas of mental health and wellbeing activity. Integral to this is growing the lived experience voice, leadership and workforce. Given current resourcing is low, the Mental Health Commissioner will need to focus on a small number of highly strategic priorities. Whilst there are a range of priorities and ways that this could happen, the statutory role could define some long term focus areas such as Legislation and Governance, Mental Health in All Policies and Capacity Building. Extra resourcing would be appropriate to enable, for example, whole of government approaches.

If the Mental Health Commissioner role was to be expanded, for example to deal with some individual complaints, then it would require the role to have significantly more resourcing. The Scottish Mental Welfare Commission for example undertakes extensive surveys which then inform priorities for strategic systems advocacy.

The Auditor General's Report was highly critical of the Department's funding accountability mechanisms, and the Report reflected their finance and governance expertise but not subject matter expertise. A Mental Health Commission with the kind of focus proposed could assist greatly in responding constructively with strategic policy advice (backed up with subject matter expertise and consultation with lived stakeholders) to these types of processes to assist in the development of robust solutions.

Additionally the MHCSA supports the following points (most of which are included above but were specifically identified by stakeholders in our consultation):

- The proposed change to move the reference to alcohol and drugs to the beginning of Schedule 1, and advocate for a comprehensive understanding that not only acknowledges the potential impact of substance use on mental health, but also promotes a nuanced assessment approach. This approach should encompass a thorough consideration of individual circumstances, acknowledging the interconnected nature of mental health and substance use challenges. Endorsing this perspective would contribute to a more holistic and tailored assessment process that better addresses the complexities of individuals facing substance use and mental health issues.
- The addition of the proposed definition of 'valid consent', and advocate for definitions that uphold principles of informed decision-making, autonomy, and protection of individuals' rights in mental health care.

- Changes to the terminology that reflect contemporary and inclusive language. We advocate for language that reduces stigma and promotes a person-centred approach to mental health and well-being.
- The amendments to clarify the roles of legal and regulatory bodies in mental health, and we advocate for the implementation of effective mechanisms that enhance coordination and collaboration among government agencies engaged in mental health initiatives including streamlined communication channels, interagency partnerships, and shared frameworks to ensure a cohesive and comprehensive approach.
- The focus on improved training and education for carers regarding legislative rights, and proposed transparency and accountability structures, as well as the inclusion of carers in various aspects of the mental health care process. These changes have the potential to strengthen connections within the support network, fostering collaborative decision-making, reducing coercion, and ultimately enhancing the overall quality of care.

Overall, the changes proposed are welcomed and supported (though with significant scope limitations compared to the contemporary international approach outlined in the WHO/ UNOHCHR Report), and we look forward to working with the Government and relevant departments on the implementation of the Recommendations and Suggestions.

Please note, we also support the HRCR Committee and LELAN responses to this Review.

Regards,

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