Public Health Association
AUSTRALIA

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Submission to the South Australian Law Review Institute (SALRI) in response to the Review of the Mental Health Act 2009 (SA)

The Public Health Association of Australia (PHAA) is recognised as the principal non-government organisation for public health in Australia working to promote the health and well-being of all Australians. It is the pre-eminent voice for the public's health in Australia and seeks to drive better health outcomes through increased knowledge, better access and equity, evidence informed policy and effective population-based practice in public health. PHAA has clear policy position statements on Mental Health[1] and Suicide Prevention[2] and welcomes this review of the Mental Health Act 2009 (SA).

Consideration of human rights, a person-centred lens and trauma-informed care, are required in this review of the Mental Health Act 2009. We commend the focus on recommending appropriate changes to promote human rights and best practices in the terms of reference of this review, the consideration of the meaning and practice of decision-making capacity with specific reference to providing supported decision-making, and the inclusion of determination of effectiveness of establishing the role of Mental Health Commissioners under the Mental Health Act.

Capacity and Supported Decision Making

It is suggested in Fact Sheet 2 for the Review that SARLI will consider whether the Mental Health Act upholds human rights, and the role and assessment of decision-making capacity for treatment orders. It is also suggested that the Mental Health Act could be changed to include specific criteria defining capacity and supported decision making.

The United Nations' Convention on the Rights of Persons with Disabilities (CRPD) is underpinned by a human-rights based model of disability and represents a paradigm shift from substitute decision-making to supported decision-making (Fact Sheet 2).[3] Article 12 of the CRPD does not permit the discriminatory denial of legal capacity on the basis of disability status or impairment (including psychosocial disability), and requires the provision of support to enable people with disability to exercise legal capacity, including in relation to decisions on mental health treatment. Such support must respect 'the rights, will and preferences' of people with disability.[3] Where the will and preferences of an individual cannot be practicably determined, the Committee on the CRPD recommend that a 'best interpretation' should be achieved, involving those who know the person.[3,4]

Key provisions of supported decision-making regimes to better protect human rights include that[3]:

- support must be available to all; high level of support needs or non-conventional communication must not serve as barriers to accessing support.
- support must be available at nominal or no cost; lack of financial resources must not be a barrier to accessing support.
- an individual has the right to refuse support, cease or change support arrangements or relationships at any time.
- facilitation to create support should be provided for people who are isolated and without naturally occurring support.
- safeguards mechanisms must ensure that the individual's will and preferences are respected and protect against undue influence.
- reasonable accommodations may be required to enable people with disability to engage in the supported decision-making process on an equal basis with others. Examples of such accommodations include access to buildings and the provision of information in accessible formats.
- supported decision-making systems should not overregulate the lives of people with disability.

The recent *Royal Commission into Victoria's Mental Health System* recommended the alignment of mental health laws with other decision-making laws, and workforce training on non-coercive treatment options underpinned by principles of human rights and supported decision-making (Fact Sheet 2).[5]

Support for decision-making encompasses both formal and informal support arrangements. Examples include: assistance of a trusted support person(s); peer support; advocacy; assistance with communication; universal design and accessibility (e.g. provision of sign language interpretation or information in an accessible format); development and recognition of diverse non-conventional methods of communication; and advanced planning.[3]

The PHAA recommends that the guardianship system and substituted decision-making regime should be replaced by a supported decision-making framework incorporating provisions set out by the Committee for the CRPD, particularly with respect to decisions concerning forced psychiatric treatment (Fact Sheet 2). This would implement recommendations in the 2014 Australian Law Reform Commission report, *Equality, Capacity and Disability in Commonwealth Laws.*[6]

The PHAA was consulted by the then Opposition in regard of the Advance Care Directives (Review) Amendment Bill 2021. In that submission the PHAA supported the maintenance of autonomy of individuals with an Advance Care Directive and their choice to refuse medical assistance.

The PHAA recommends that previously developed Advanced Care Directives should be considered and honoured in accordance with an individual's directions, irrespective of perceptions of their capacity to make decisions (Fact Sheet 2). Families and informal carers should be involved in this process, with exceptions where there are grounds to suspect domestic violence.

Inpatient Treatment Orders

The Committee on the Rights of Persons with Disabilities has raised concerns about the involuntary detention of people with disabilities in psychiatric hospitals and forced psychiatric treatment in Australia.[6] The law should be changed to implement the recommendations in the Senate Community Affairs References Committee 2016 report *Indefinite Detention of People with Cognitive and Psychiatric Impairment in Australia*.[6]

PHAA recommends that people with disability, particularly Aboriginal and Torres Strait Islander persons with disabilities and persons with intellectual or psychosocial disabilities, should not be deprived of liberty

on the basis of impairment, in accordance with the recommendations in the Senate Community Affairs Reference Committee 2015 report.

Community Treatment Orders

The Committee on the Rights of Persons with Disabilities has raised concerns about the ongoing practice of obliging persons with "cognitive and mental impairment" to undergo forced treatment and has urged the repeal of law that enables such forced medical interventions.[6]

The PHAA recommends that people with disability (including psychosocial disability), and particularly Aboriginal and Torres Strait Islander people with disability, should not be subject to forced medical interventions including forced treatment.

Restrictive Practice and Control Powers

Serious concerns have been raised about restrictive practices since at least 1993.[7] Seclusion and restraint in mental health settings have been associated with trauma, isolation, dehumanisation, 'othering' and being anti-recovery.[7] The 2008 National Mental Health Policy adopted the position that Australian mental health services should use a recovery-oriented approach.[8] This is further supported by the 2013 National Framework for Recovery-Oriented Mental Health Services.[9]

The PHAA recommends that the Mental Health Act 2009 should incorporate recovery-oriented strategies to ensure that individuals receive the treatment that they need to improve or maintain their physical and mental wellbeing, without being forced to undergo treatments that are restrictive in practice and that contribute to further traumatising the individual.

Electroconvulsive Therapy

The Committee on the Rights of Persons with Disabilities expressly urges the prohibition of non-consensual electroconvulsive therapy on the basis of any form of impairment (including mental impairment) (Fact Sheet 6).[6]

The PHAA recommends the prohibition of non-consensual electroconvulsive therapy on the basis of impairment.

The Role of the South Australia Police

The involvement of SAPOL in enforcing the Mental Health Act 2009 (Fact Sheet 8), contributes to stigma associated with mental ill health.[19, 11] Restraint of people living with mental ill health is associated with trauma, dehumanisation and 'othering'.[7] Further, police often lack the necessary training to act as first responders to people in mental health crises.[12] In cases where SAPOL involvement is necessary, strategies to ensure police are appropriately trained to work with people experiencing mental health issues could incorporate the implementation of programs that see police officers accompanied by trained mental health support workers. Similar approaches have been trialled, with success, in Western Australia,[13] New South Wales and Queensland.[14]

The PHAA recommends that people living with mental ill health should not be forcibly restrained unless their condition presents a danger to themselves or others.

The PHAA recommends that police officers be accompanied by trained mental health support workers for cases where SAPOL involvement in enforcing the Mental Health Act is necessary.

Guiding Principles and Accountability Mechanisms

The MHA provisions (Fact sheet 9) currently do not appear to apply to refugees and asylum seekers. The PHAA has a policy statement on Refugee and Asylum Seeker Health which states that refugees and asylum seekers should be offered the same level and type of health care as the general population (https://www.phaa.net.au/documents/item/5218).[15] Refugees are more likely to have mental health conditions compared with the general population due to experiences of trauma[16] and prolonged immigration detention continues to have a detrimental impact on the mental health of asylum seekers.[17]

Further, prisoners do not appear to be considered in the Mental Health Act 2009, yet recent data reflect that 40% of prisoners in Australia are living with mental health conditions.[18] The PHAA's Policy Position Statement on Prisoner Health[19], reiterates the UN's Standard Minimum Rules for the Treatment of Prisoners (2015): '*Prisoners should enjoy the same standards of health care that are available in the community, and should have access to necessary health-care services free of charge without discrimination on the grounds of their legal status.*'. This extends to appropriate access to treatment for mental health issues and ensuring that prisoners receive medication, as prescribed.

In addition, the Mental Health Act 2009 does not appear to take into account experience of domestic violence or situations where there are any grounds to suspect domestic violence. Negative mental health outcomes are common amongst victim-survivors of domestic violence[20], and if there are grounds to suspect ongoing domestic violence this has implications both for considering experiences of trauma in personalised care and how this abuse impacts on mental health, and confidentiality and sharing of information with carers.

The PHAA recommends amendments to the provisions in the Mental Health Act to take into account treatment needs of refugees and asylum seekers, prisoners in Australia, and to account for past or ongoing experiences of domestic violence.

Other Issues

The PHAA supports the suggested change for Community Visitors to be notified of a request at an absolute maximum of two days, and further, recommends that paid employees should be able to act in place of the PVC as a means of enhancing the efficiency of the process (Fact Sheet 10).

The PHAA previously advocated to retain the independence of the Mental Health Commissioners and what was the South Australian Mental Health Commission (SAMHC); however, the activities of the SAMHC now occur within Wellbeing SA. Mental Health Commissioners play an important role in holding the 'government to account for the performance and quality and safety of the mental health and wellbeing system'.[5]

The PHAA recommends that the role of the Mental Health Commissioners (Fact Sheet 10) should be defined in the Mental Health Act 2009, and the Commissioners provided the ability to implement the Mental Health Strategic Plan as originally intended.

The PHAA appreciate the opportunity to make this submission. Please do not hesitate to contact us should you require additional information or have any queries.

Sincerely,

Professor Jacquie Bowden
PHAA Branch President (SA)
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