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Dr John Brayley
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VIA E-mail: **HealthOCP@sa.gov.au**

Dear Dr Brayley

Thank you for the opportunity to provide feedback on the Supplementary Consultation regarding the Mental Health Act 2009 (SA)- Government Review. Staff from my office had the privilege of attending the online briefing for this consultation on 9 January 2025.

I note the tight time frames for this consultation created by the need to insert amendments into the Bill which is currently being drafted. I understand that further consultation on the Bill will occur before its intended introduction to Parliament by June 2025.

In 2022, my offices made a submission to the SALRI review of the *Mental Health Act 2009* (SA) which is available on the OPA website. At times I refer to my earlier submission in this submission.

I provide this response in my capacity as the South Australian Public Advocate (PA), and as the South Australian Principal Community Visitor (PCV) appointed under this Act.

While the impetus for this consultation follows critical incidents in South Australia and other jurisdictions, it is positive that other amendments are being considered. I am supportive of the addition of six principles and proposal of a statutory Metal Health Human Rights Committee as they maintain the focus on the individual and their rights.

Part A: Additional principles and related amendments.

Prevention of harm and suicide prevention

The elevation of prevention of harm (to self and others) along with suicide prevention to the principles focuses the legislation on the role of mental health services on not just the impact on the individual experiencing mental health, but also those around them.

Severe mental health conditions

A principle that services will consider the needs of people with severe mental health conditions elevates the need for appropriate timely responses. While some of these people are in receipt of other services funded via the National Disability Insurance Scheme (NDIS) a timely clinical response for acute presenting mental health will complement other support services and contribute to the maintenance of a person's mental health and wellbeing.

Mental health and substance use co-morbidity

Many of the people for whom I am appointed as guardian, and those I visit in my capacity as the PCV, experience mental health and substance use co-morbidity. Historically there has been a tendency to separate mental health from other comorbidities such as substance misuse. The inclusion of this principle acknowledges the interplay and impacts of comorbidities and will assist various services to work more collaboratively to support the person holistically when addressing their presenting issues. This will contribute to harm minimisation which is an earlier suggested principle for the Act.

Neurodevelopmental disorder co-morbidity

A neurodevelopmental disorders co- morbidity principle is welcome and long overdue. Currently, people who have autism spectrum disorders (with or without intellectual disability) and people who have an intellectual disability are excluded from the definition of mental illness and this has an impact on access to care for these patients. While neurodevelopmental disorders are not mental health, it is well documented that people who have neurodevelopmental disorders have increased rates of mental health and lower rates of diagnosis and treatment. In my submission to the SALRI review I described 'Overshadowing' which refers to when symptoms arising from physical or mental illness are misattributed to an individual's disability. This has the effect of delaying treatment, can result in multiple 'failed' presentations without clear treatment plans and contributes to poor long-term outcomes and significant distress for people with complex needs and their carers.[1] Alternatively, misattribution of a person's intellectual disability with mental

[1] Department of Health and Wellbeing - SA Intellectual Disability Health Service Model of Care 2020, p. 23

illness can also occur, which can have an impact on the treatment and support provided. For example, a person with intellectual disability may be subject to chemical restraint to manage behaviour mis-diagnosed as mental illness, when they would more appropriately benefit from positive behaviour support interventions. The new principle responding to the needs of people in these groups would reinforce the need to consider access to care for these groups when co-morbid conditions exit.

The discussion paper also notes that *'services may need to make specific arrangements to make their clinics and units accessible for people with these needs and ensure that staff have access to relevant training'.* As PCV, this issue is often raised in visits to Child and Adolescent Mental Health Services (CAMHS) and the Women's and Children's Hospital. Staff report feeling ill-equipped to care for this cohort and additional training could help them better support these patients. Such training could also be documented in the Disability Access and Inclusion Plan.

<u>The principle to deliver compassionate care.</u>

The inclusion of a principle to deliver compassionate care is supported. Measuring the delivery of compassionate care to meet the further proposal of reporting on this in the annual reports of the Mental Health Commissioner, Principal Community Visitor and the Chief Psychiatrist will require further thought and consideration. Indicators of what compassionate care is and how it is measured and evaluated would assist and need to be developed. Compassionate care is not currently reported on in the Community Visitor Annual Report and this information is not routinely gathered by Community Visitors during visits. Further information is required concerning the parameters for collection of this information as community visitor reporting templates and training will need to be updated to accommodate for this requirement.

Part B: Proposal to facilitate emergency mental health responses.

I support the new monitoring and reporting requirement for the use of temporary care and control powers under Sec 56 of the Act. It sets expected timeframes for assessment expediting people towards an appropriate response. Reporting requirements make services accountable while protecting the rights of patients and reducing the risk of prolonged wait times for assessment.

I support the psychiatric review of people who haves involuntary treatment orders prior to interhospital transfer where safe to do so. A review by a psychiatrist via telehealth and the ability to delay transport has many benefits including reducing the trauma and risk to the patient and transporting health staff and costs. Avoiding unnecessary transportation reduces the need for the use of restrictive practices like chemical or mechanical restraints and ultimately will be less distressing for the patient and those around them.

Part C: Other Proposals that might improve personal and community safety

The requirement to consult family members when a decision is made about involuntary care is supported noting that this was also coronial recommendation. Exemptions for not consulting family and considering others who might need to be consulted such as a nominated person in an Advance Care Directive as a right to exercise legal capacity are also supported.

Increased accountability in mental capacity assessments when there is a risk of harm to another person and enshrining in legislation a 'duty to warn' other people at risk are also supported as both aim to minimise the risk of harm.

Part D: Additional proposal regarding a statutory Mental Health Human Rights Committee and Coercion Reduction Committee

As noted in the discussion paper, the PA/PCV is a member of the current non-statutory Mental Health Human Rights Committee and Coercion Reduction Committee. Moving this to a statutory committee is supported as it is a commitment in the legislation to the focus on practical application and upholding of human rights of those who access mental health services.

Part E: Further areas of work

I am also interested to read the proposal for future work which seeks to address the use of powers within the MHA for involuntary care when the presenting issue may not primarily be mental health. These include people who experience delirium, dementia, or substance withdrawal, and co morbid drug and alcohol use for people who have mental health conditions which are exacerbated by substance use. This future work aims to address current gaps and provide for involuntary care via other legislative instruments. Involuntary care/ detention is a restrictive practice, and all efforts should be afforded to eliminate the use of restrictive practices where safe and practicable to do so.

People interacting with mental health services may also be National Disability Insurance Scheme (NDIS) participants or Aged Care service recipients. While the state has established the Restrictive Practices Authorisation scheme for NDIS participants under the *Disability Inclusion Act 2018* (SA), we are yet to see the Rules relating to restrictive practices under the new *Aged Care Act 2024* which commences on 1 July 2025. As Public Advocate, along with other jurisdictions, I advocated for a Senior Practitioner role for the aged care sector. This has not eventuated in the new *Aged Care Act 2024,* therefore this places additional responsibility on states and territories to consider and respond to the use of restrictive practices for South Australian citizens in aged care. The various restrictive practices consent and authorisation schemes across sectors can be complicating for service providers and those subject to restrictive practices. This creates a risk to the protection of individuals rights. I continue to advocate for consistent

definitions and consent/ authorisation regimes restrictive practices across sectors. I advocated for consistent definitions in my earlier submission to SALRI.

I look forward to seeing the draft Bill as part of the next consultations.

Yours sincerely

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Principal Community Visitor