Justice Action Response

Response to the Interim Report of the Mental Health and Suicide Prevention Agreement

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Justice Action

As a self-funded organisation, Justice Action (JA) has long advocated for the rights of marginalised populations, particularly those who are incarcerated or experiencing psychosocial challenges.

We are concerned with several shortcomings in the Interim Report and its failure to fully address crucial issues that affect mental health and suicide prevention, particularly for marginalised groups. To enhance the effectiveness of the National Mental Health and Suicide Prevention Agreement, we propose three key recommendations: improving service delivery through telecommunications and telehealth; incorporating lived experience through peer mentoring and co-design; and ensuring transparency in data collection related to coercive mental health practices.

The Interim Report acknowledges the lack of digital health services to supplement face-to-face care but provides no specific recommendations to address this gap. Implementing interactive tablets in youth justice cells, as already established in adult NSW prisons, would enable access to telehealth, counselling, education, and restorative programs. This approach supports social inclusion, reduces recidivism, and delivers person-centred, culturally appropriate care, especially for those in prolonged isolation.

In addition, peer mentoring from First Nations and other marginalised communities with lived experience would be a key solution in addressing the gaps in mental health services, and encourage engagement with minority groups. Co-design would reduce discrimination, build stronger social networks and improve inclusion in services, leading to better outcomes, such as enhanced wellbeing. However, it must go beyond consultation to involve genuine partnerships, shared decision-making, and ongoing collaboration with those who have lived or living experience.

Finally, data on coercive practices, especially involuntary medication, is currently incomplete. While seclusion is tracked, chemical restraint is often excluded, leading to underreporting and misuse. Transparent data collection is essential to uphold human rights, drive reforms, and ensure that all forms of coercion are openly and accurately reported.

We call on the Productivity Commission to take up these recommendations in the Final Report, and to ensure that mental health reform is grounded in lived experience, inclusive access, and robust accountability. These steps are necessary to build a more transparent, inclusive, and effective mental health system that delivers real outcomes for all, especially those who are the most affected.

Recommendations:

We propose three main recommendations to supplement and better achieve the underlying purpose and key objectives of the *National Mental Health and Suicide Prevention Agreement*.

These are:

1. Improved delivery of services through telecommunications and telehealth access.
2. The incorporation of lived experience in addressing mental health policies and practice through codesign and peer mentoring
3. Ensuring honesty in data collection, particularly in chemical restraint data so that all instances of involuntary medication are reported

1. Improved delivery of services

1.1 Telecommunications

The Interim Report recognised as a key theme from submissions that there is a lack of digital health services to supplement face-to-face services (p. 45, 47). However, the Report made no specific recommendation to rectify this nationwide issue. JA believes that improving the delivery of services through telecommunications is necessary to promote good mental health, particularly where there is a lack of access to resources such as for those in incarceration.

Implementing telecommunications in cells and in-patient rooms will fulfil the Report's 'Key Point' for **person-centred** and culturally supportive services (p. 14). Additionally, accessible telecommunications facilitates social inclusion, which is imperative for *quality mental health* and an *identified social determinant* (p. 229).

The Australian youth justice system provides a particularly stark illustration for the need to access telecommunications to support mental health. Across Australia, 63% of children in detention are First Nations, who have an 85% recidivism rate. Youth Justice NSW reports that 90% of their 222 children have mental illnesses, and that the cost of each child in detention is over $1 million annually. Despite this large

expenditure, no incarcerated children have access to services, such as for mental health support, in their cells where they are kept for 14 hours a day. See our evidence that was presented to the Youth Justice Senate Inquiry.

We call on the Productivity Commission to replace passive TV in cells with an interactive device, such as a tablet, that supports telecommunications with mental health and health professionals.

Transforming the TV screen that is currently present in youth justice cells to an interactive device would allow detainees to actively engage with the outside world, rather than passively consume unintelligent content.

In-cell access to external counselling, restorative justice, and education including art and music through the **'import model'** would be:

- Effective in providing trusted external counselling without a conflict of interest with a security role
- Efficient, as they are often already paid for by governments
- Existing through the detention and available after release
- Emotionally important, enabling detainees to feel connected to the outside community

Having computers in cells contributes to restorative justice, by providing access to Music, Education and Peer Mentoring Services. Restorative justice reduces crime charges by 38%, music and arts reduce recidivism rates by 60%, and improved education reduces recidivism rates by 35%.

JA has performed cost estimates that demonstrate that implementing interactive devices are simple and cost effective. As a result of JA's campaign, every adult in a NSW prison now has a computer tablet. Internationally, CURE is pursuing a campaign for United Nations recognition of the Nairobi Declaration for Detainee Telecommunications Rights.

1.2 Telehealth

In accordance with the *National Mental Health and Suicide Prevention Agreemment (20b),* telehealth is a sustainable and effective program that provides easy and efficient access to mental health services when needed. Research supports counselling online as being more effective than in person.

Facilitating telehealth in cells through interactive devices would allow those in detention to interact with counsellors in a more person-centred, integrated, and culturally appropriate system than the limited services of the detaining authority. Significantly, it enhances social inclusion by maintaining and establishing trust with

outside mainstream services, necessary to reduce recidivism and ensure ongoing mental wellbeing.

2. Incorporation of lived experiences

2.1 Peer mentoring (Scope d)

Peer Mentoring is proven to be an effective solution in addressing the gaps in mental health services, and encourages engagement with minority groups. It connects people with shared experiences to facilitate understanding, empathy and trust. Peer mentoring is a culturally responsive approach that provides effective mental health support to Indigenous Australians and other marginalised groups by fostering a sense of community and openness.

First Nations Australians are both a significantly overrepresented group in detention, and are most affected with mental health illnesses. Implementing peer mentoring programs would invite community connection and kinship, which supports mental wellbeing by strengthening Indigenous peoples' sense of belonging and identity; this is necessary to reduce rates of recidivism. In order to support peer mentoring programs, workers need to be properly trained, paid and have central status in support teams.

Peer mentoring is crucial to advancing the objectives of the *National Mental Health and Suicide Prevention Agreemment (20e)* as well as enhancing current mental health policies. Without sufficient funding, mentors will not be able to efficiently support their mentees and reach marginalised groups. Therefore, a national program that supports the infrastructure of peer mentoring programs is necessary.

2.2 Co-design

Co-design goes beyond traditional methods of consultation by forming authentic partnerships with consumers, carers, service providers and key stakeholders. The methodology is underpinned by principles of early engagement, inclusivity, transparency, shared power, equity of knowledge and responsibility, and ongoing feedback and evaluation.

In the context of mental health and suicide prevention services, co-design will improve attitudes, interactions and understanding between service users and providers. Also, it will reduce discrimination and build stronger social networks and better inclusion in services, leading to better outcomes, such as improved wellbeing. The National Mental Health Commission should oversee the development of co-designing and undertake its process with people for their lived and living experience, supporters, families, carers and kin. Simultaneously, the co-design

process will require government agencies to be genuinely willing to share decision-making power for mutual benefits.

Importantly, the Interim report recognised the importance of co-design with people with lived experiences for new policy architecture. Co-design with people with lived or living experiences requires a large amount of time and adequate resources, but it should provide both consumers and carers with improvements to attitudes, understandings, and inclusions in mental health services (p.25.) JA firmly supports the continuance of this in the Final Report.

3. Honesty in data collection: coercive measures

(Scope e & g, Agreement 20(i) and 27(d))

The Interim Report places very limited emphasis on reforming the involuntary practices and coercive measures that are currently used in the delivery of mental health services. Page 59 of the Report notes that involuntary practices can be a source of distress, which is antithetical to objectives of mental health care.

Coercive measures are widely recognised as being against the principles of care and compassion. The law defends the rights of people to be different and the dignity of risk, unless there is a risk of serious harm to self or others.

The medical profession has “cloaked” its use of coercion - involuntary medication - with the more respectable term, “treatment”. In practice, eight nurses hold down a person and inject them with medication that causes the person to feel degraded and poisoned. Research indicates long term problems and more effective solutions if the person isn’t medicated, but medication allows easier, cheaper management.

Data collection for chemical restraint explicitly excludes involuntary “treatment” although it is used to alter a person’s behaviour.

After a series of National Forums on Reduction of Seclusion and Restraint, Justice Action wrote a report and has exposed the increase in involuntary medication following the data collection of the other form of coercion - seclusion. When the KPIs of Primary Health Networks include the reduction of seclusion, but another form of coercion doesn’t have data collection, the psychiatrists make the obvious decision to use involuntary medication. This is an unintended consequence of the current practice.

Although the Interim Report recognises the importance of improved data collection to promote the Agreement’s outputs (p. 18), we call upon the Productivity Commission to specifically ensure that coercion is openly reflected in data collection. Quality control in data collection is crucial to ensure that the information gathered is

accurate, transparent, and truly representative of lived experiences, particularly in cases involving coercion and involuntary treatment. Additionally, the data must include involuntary medication for which permission is only granted through legal intervention and a Tribunal hearing. Our paper on the issue is continuing to develop.