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Committee Secretary
Senate Select Committee on Mental Health
Department of the Senate
Parliament House
CANBERRA ACT 2600

By email: mental.health@aph.gov.au

Dear Committee Secretary

Senate Inquiry into the Provision of Mental Health Services in Australia

Thank you for the opportunity to comment on the Senate Inquiry into Mental Health Services in Australia. I attach Victoria Legal Aid's comments in relation to the Terms of Reference for the Committee's consideration.

If you would like further information about any of our comments please contact Llewellyn Prain (Senior Policy Officer) on (03) 9269 0138.

Yours faithfully,

TONY PARSONS
Managing Director

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1. Introduction

Victoria Legal Aid (VLA) welcomes the opportunity to comment on the state of mental health services in Australia, and strongly supports reform and an increase in resources in this area.

VLA has the largest in-house mental health practice in Australia. It operates the only duty lawyer service in the country that is based on client instructions. The service provides assistance and where appropriate, representation before the Mental Health Review Board for clients in most of Melbourne's psychiatric inpatient facilities. It also provides a regular visiting service to the Thomas Embling Forensic Centre.

In 2003-04 VLA provided the following legal services in criminal, family and civil law:

- 37,677 grants of assistance for legal representation by VLA staff and private practitioners
- 54,481 duty lawyer services by VLA staff and private practitioners
- 1,643 legal advice services in relation to the Mental Health Review Board

VLA has had the opportunity to read the submission by Philip Lynch on behalf of the PILCH Homeless Persons' Legal Clinic. We endorse Mr Lynch's comments and encourage the Committee to adopt his recommendations. VLA also wishes to make further comments on Terms of Reference b, f, I, j, k and m.

2. Response to Terms of Reference

The law relating to the provision of mental health services is complex. The law attempts to balance the rights of persons suffering from a mental illness with general community expectations and interests. As a result sometimes treatment is imposed upon those who do not believe treatment is required or who, due to their underlying condition, are unwilling to voluntarily accept treatment. The current resource crisis in mental health makes this balance far more difficult to achieve.

2.1 Term of Reference b: The adequacy of various modes of care for people with a mental illness, in particular, prevention, early intervention, acute care, community care, after hours crisis services and respite care.

2.1.1 Prevention and Early Intervention

At present prevention and early intervention facilities and the information provided to patients and families is largely inadequate. The term prevention indicates that a mental illness in itself can be prevented, which is simply not the case. As a community, we are still a long way away from being able to prevent mental illness. However, increased education starting from childhood, would reduce the stigma of mental illness within the community, particularly amongst younger people, as mental illnesses are likely to develop during the late teens and early twenties.

Further education in relation to drug use and mental illness should also be undertaken, particularly in the teenage age group, as there is a strong link between mental illness and substance abuse. In relation to early intervention, Victoria's main program is Orygen Youth Services run by Professor Pat McGorrie. This program provides intensive support and treatment for episodes of first psychosis. It is limited,

however, to a small catchment area situated mainly in the Western suburbs. The program attempts to work intensively with young people and their families in their first episodes to give them appropriate treatment and care, with a view to either reducing the likelihood of a relapse or easing their way into mainstream mental health services. VLA suggests an expansion of services similar to this model to ensure that young people across the state receive appropriate support.

2.1.2 Acute care

Acute care for the purposes of this submission is defined as an adult inpatient unit that specialises in the immediate treatment and care of persons in an acute situation. Acute care facilities cater for youth, adults and the elderly. Present funding and facilities are inadequate at all levels, particularly for adults. This means that patients tend to be discharged earlier than is medically preferable, leading in some cases to relapse. An identified area of particular concern is the transition between youth services and adult services, which occurs at the age of 18. Youth services are generally well staffed and seek to provide the young person with intensive support and care. It is often distressing for a young person to be placed in adult mental health services with older sufferers of mental illness, leading to great despair for the young person and a grave concern for their future, ultimately resulting in a rejection of their condition.

2.1.3 Community care – after hours crisis services

Community care in the state of Victoria is provided by Community Mental Health Services, by the Crisis Assessment and Treatment Team (CATT) and Multi Systemic Therapy (MST) support. CATT also provides after hours services. Due to funding issues, after hours services can be haphazard. A good example of this is the Maroondah catchment area where there is only one after hours crisis service for a very large area. VLA suggests the expansion of after hours services to ensure that mentally ill people across the state receive appropriate support.

2.2 Term of Reference f: The special needs of groups such as children, adolescents, the aged, Indigenous Australians, the socially and geographically isolated and of people with complex and co-morbid conditions and drug and alcohol dependence.

VLA's Human Rights and Civil Law Service often deals with children and young people. Lawyers in this service see children and young people in the context of hospital admissions to Victoria's various child and adolescent units. Young people can be admitted as young as age 15 or 16. While the units do attempt to keep young people as voluntary patients, quite often young people are made involuntary under the *Mental Health Act* 1986 (Vic). This can be a distressing time for a young person who often does not understand why they have been placed in hospital, their illness, and the need for treatment and care. We refer to the comments made under Term of Reference b in relation to child and adolescent facilities.

Children and first time admissions have complex needs, frequently in the context of drug dependency. Often, drugs are used to self medicate – a young person would often prefer to have a drug addiction as opposed to a mental illness, and will usually fight a mental illness diagnosis for this reason. Ultimately, there needs to be:

- More funding for first time admissions to provide them with education and support, particularly in the late teens and early twenties when the transition from child and adolescent units is undertaken.
- More drug and alcohol education, particularly within hospital units. To rely upon drug and alcohol units within the community is not satisfactory. Treatment of mental health issues should be undertaken in the context of the person receiving the treatment, with a holistic approach by treating teams.

2.3 Term of Reference i: Opportunities for reducing the effects of iatrogenesis and promoting recovery-focussed care through consumer involvement, peer support and education of the mental health workforce, and for services to be consumer-operated.

VLA lawyers provide duty lawyer services and advice to Victoria's psychiatric inpatient facilities, and through these experiences have found that consumers tend to feel that events, including their mental illness, their finances and day to day decision-making, are taken out of their control. This occurs primarily due to the appointment of administrators to manage finances, and guardians to assist with health care and accommodation. This can cause anxiety and stress to someone who is already vulnerable after a diagnosis and hospitalisation, and can also make the person feel like they are being punished. The idea of promoting recovery focused care through consumer involvement, peer support and education to the mental health workforce would, in an ideal world, assist a person with a mental illness. The reality is that there are not enough resources currently available to do this.

Often, a person with a mental illness is brought into the system against their will and there is little understanding as to why they have been hospitalised. It is common for the person to feel that they have lost control due to forced medication, and they will usually not understand why they are being medicated. Peer support is also often non-existent.

Most mental health services in Victoria have a consumer representative and are regularly visited by both VLA, the Mental Health Legal Service and the Office of the Public Advocate. An enhanced consumer focus, and consumer involvement in ward policy may assist persons to recover from a mental illness, and to understand the reasons for hospitalisation. To ensure this works effectively an overall education program would benefit mental health professionals (nurses, doctors and social workers) so that consumer opinions and consumer support are better used.

2.4 Term of Reference j: The over-representation of people with a mental illness in the criminal justice system and in custody, the extent to which these environments give rise to mental illness, the adequacy of legislation and processes in protecting their human rights and the use of diversion programs for such people.

2.4.1 The over representation of people with mental illness in the criminal justice system, and in custody

Mentally ill people are currently over-represented in the criminal justice system, and are much more likely to keep reoffending until they receive treatment. Studies have found that 60% of admissions to prison

have an active mental illness.[1] In 2002 it was found that 85% of inmates received into correctional centres and 70% of sentenced inmates had a psychotic, mood, anxiety, substance use or personality disorder or a combination of these disorders.[2]

One of the key reasons mentally ill people are overrepresented in the criminal justice system is due to the diversion of resources from mental health into criminal justice. The policy of de-institutionalisation in the 1990's was based on the premise that there would be intense and appropriate community and government funded support for mentally ill patients rejoining the community. Instead, mental health resources are scarce and the mentally ill have found themselves unsupported and untreated and ultimately in the criminal justice system.

Unfortunately, this trend entrenches the view that criminal justice system is an appropriate forum for dealing with undesirable behaviour by mentally ill people. The upshot of this is that the community in general sees this behaviour (such as begging or prostitution) as a criminal rather than a social or mental health issue, and will report the behaviour to the police, rather than a welfare worker. Sometimes, this behaviour may even be precipitated by the mental health system. For example: a person on an administration order is limited to $5 per day spending money by the administrator. In order to buy cigarettes, the person begs on the street.

In practice it is also often the case that mentally ill people find themselves in custody awaiting trial or a hearing for far longer than people without mental illness. For a minor offence, an accused in Victoria has the right to be granted bail[3]. Yet mentally ill people are more likely to have a lack of financial resources and family or social support, restricting their opportunity to access mental health services, and therefore make bail.

If an accused with a mental illness has been charged with a serious offence and is in remand, by law they should be transferred to a psychiatric facility under a hospital order [4]. In practice however, hospital orders are very hard to obtain, as there are often no beds at the facilities. The result is that mentally ill accused are kept in the prisons until a bed becomes available.

2.4.2 The extent to which criminal justice system environments give rise to mental illness

Being mentally ill in prison is clearly not going to improve a person's mental condition. In fact the prison environment will almost certainly exacerbate it. Many prisoners fear physical and sexual assault, and are exposed to overcrowding, drug abuse and the prospect of infection with diseases such as Hepatitis C. In the Victorian prison system there is no dedicated psychiatric unit, and psychiatric treatment is *ad hoc*. There are no full time psychiatrists, only nurses and consultant psychiatrists. It is VLA's belief that putting mentally ill people into prisons without adequate treatment facilities, or in prison *per se*, exacerbates their condition and is likely to cause even greater mental illness.

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[1] See *Fact Sheet 1 Criminal Justice and Mental Health*, Mental Health Coordinating Council, NSW:http://www.mhcc.org.au/index1.htm
[2] See *Fact Sheet 1 Criminal Justice and Mental Health*, Mental Health Coordinating Council, NSW:http://www.mhcc.org.au/index1.htm
[3] A person 'shall be granted bail' - s.4 *Bail Act 1977 (VIC).*
[4] Section 17, Mental Health Act 1986.

2.4.3 The adequacy of legislation and legal processes in protecting the human rights of mentally ill people

As discussed in the PILCH submission, mentally ill people have rights to the highest attainable standard of health[5], and the right to non-discrimination[6]. In the criminal context a mentally ill accused also has the right to a fair trial, specifically the right to a legal remedy or the right to utilise an available defence[7]. Most importantly all citizens share a fundamental right to liberty[8], which may only be interfered with in exceptional circumstances. In practice, however, the impact of legislation and processes in the criminal justice system may have the effect of impinging upon these basic rights. The legislative framework for dealing with criminal offences by mentally ill offenders is complex. Essentially there are three main options:

Guilty plea: If a mentally ill defendant pleads guilty, the judge or magistrate can take the illness into account and give the defendant a lower penalty than usual for the offence. If the court considers the defendant requires treatment, it can make an order for treatment or hospitalisation under the *Sentencing Act* 1991.

Not guilty plea (less serious offences): s.5 of the *Crimes Mental Impairment and Unfitness to be Tried Act* 1997 (CMIUTA) provides the defence of 'not guilty by reason of mental impairment' for both summary offences and indictable offences that can be heard summarily in the Magistrates' Court. The test for this defence is more stringent. If the defence is established in the Magistrates' Court, the defendant is found 'not guilty' and discharged into the community without any restrictions.

Not guilty plea (more serious offences): Part 4 of the CMIUTA also provides the mental impairment defence for indictable offences heard in the County or Supreme Courts. If the defence is established in these Courts, the defendant is found 'not guilty' but the judge can release the defendant or make a supervision order. A supervision order can commit the defendant to detention in a mental health facility or (if there is no practical alternative) to a prison.

VLA has anecdotal evidence that when the defence raises mental impairment, the prosecution sometimes attempts to escalate the case into the higher courts (where the defendant may be subject to a supervision order instead of being discharged). This strategy is clearly inappropriate. Further, it can result in inconsistent outcomes for similar offences.

Deciding whether to plead guilty or not guilty

A mentally ill defendant has the right to rely on any appropriate defence. Therefore, in theory, a defendant who commits an offence whilst mentally impaired, should plead not guilty. Their actions should not be labelled 'criminal', with all the legal and social consequences of that label. However, in practice, it

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[5] See Article 12 of the *International Covenant on Economic, Social and Cultural Rights* G.A. res. 2200A (XXI), 21 U.N.GAOR Supp. (No. 16) at 49, U.N. Doc. A/6316 (1966), 993 U.N.T.S. 3, *entered into force* Jan. 3, 1976.

[6] See ICCPR Articles 2(1) and 26, and ICESCR Article 2(2).

[7] See Articles 8, 10 and 11 of the *Universal Declaration of Human Rights* G.A. res. 217A (III), U.N. Doc A/810 at 71 (1948); Article 14 of *the International Covenant on Civil and Political Rights* G.A. res. 2200A (XXI), 21 U.N. GAOR Supp. (No. 16) at 52, U.N. Doc. A/6316 (1966), 999 U.N.T.S. 171, *entered into force* Mar. 23, 1976.

[8] See ICCPR Article 9.

can be difficult to decide whether to plead guilty or not guilty because the outcome may be 'better' if the defendant pleads guilty. This is illustrated in the following examples:

***1. Guilty plea (less serious offence)*:** The defence calls a psychiatrist to explain that the mental illness deprived the defendant of the reasoning ability to refrain from the offending behaviour. The magistrate finds the defendant guilty and imposes a fine - a lower penalty than would normally be given for this offence.

***2. Not guilty plea (less serious offence)*:** The defence of mental impairment is difficult to establish and it is unclear whether it will succeed. Ultimately, the magistrate finds the defendant not guilty by reason of mental impairment and the defendant is discharged.

***3. Guilty plea (more serious offence)*:** The court accepts the evidence of the defence psychiatrist. The judge makes a hospital order for psychiatric treatment. After treatment, the defendant is discharged – much earlier than the usual prison term for this offence.

***4. Not guilty plea (more serious offence)*:** The defence of mental impairment succeeds. The judge makes a supervision order for a nominal term of 25 years – more than the usual prison term for this offence. The defendant is detained in a psychiatric hospital. After many years, the Court grants the defendant extended leave from the hospital. However, the defendant may be returned to detention at any time during the term, if the safety of the defendant or public is endangered.

Best interests of the client v. wishes of the client

The defendant's perception of what is a 'good' outcome may differ from the lawyer's perception of what is 'in the best interests' of their client. Clients may not be as concerned about the legal ramifications of being found 'guilty'. Their main concern may be to avoid involuntary treatment or to minimise the nominal term of the order.

According to Arie Freiberg, defence counsel face a very real conflict in such matters:

> Counsel's role in the dispositional issue is contentious. Should defence counsel seek the least restrictive alternative open to the court in the light of the gravity of the offence and the background of the offender, or should they seek a…process, which is in their client's 'best interests', a phrase which conjures issues of paternalism, coercion and role conflict[9].

That conflict can be minimised by ensuring that the client is fully informed and understands the legal and practical ramifications of their decision. However, it presents an ethical difficulty for lawyers working in this field.

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[9] Freiberg, Arie, 'Problem-Oriented Courts: Innovative Solutions to Intractable Problems' (Speech delivered at the Australian Institute of Judicial Administration Magistrates' Conference, 20 – 21 July 2001, Melbourne Australia) at pp. 13 – 14, available @ http://www.aija.org.au/Mag01/FREIBERG.pdf.

2.4.4 The use of diversion programs for mentally ill people

As discussed in the PILCH submission, the term ‘therapeutic jurisprudence’ refers to the link between misdemeanour adjudication and social service intervention, along with the coercive power of the law. Included in this is the idea of problem-solving or specialist courts.

The South Australian Magistrates Court Diversion Program[10] is the first comprehensive mental health court in Australia[11]. Under this model, a person who has been charged with a minor offence and who shows signs of being mentally ill or impaired is assessed for the diversion program, and can elect to have their matter heard in a Diversion Court while their matter is adjourned. If the individual is not found to be eligible for the program they retain the option of pursuing a defence of mental impairment.

The program considers only summary or certain minor indictable offences. This process operates most effectively if an individual was referred at the time charges were laid. Under this program there is no formal requirement for the accused to plead guilty to any offence, but the Court needs to know that the matter is not under dispute or likely to be contested. The program facilitates health and other services to assist individuals with mental health or impairment problems. At the end of the program all participants are required to appear for a final determination at the end of the adjournment period. This is reported back to the Magistrate who will make a determination taking into account the participant’s involvement in the program.

One of the major advantages of this sort of process is the improved link between the health and justice systems. It is more likely to ensure mentally ill people undergo appropriate treatment and therefore reduce rates of recidivism in the mentally ill. However, there are some practical and ethical issues that need to be considered.

An ethical implication of diversion programs such as this is that an accused is likely to forgo pursuing a valid defence for the easier option of pleading guilty, as discussed in the previous section. If the accused undertakes a diversion program they will in all probability receive a lenient sentence, and be able to get on with their lives, rather than run the risk of a harsher penalty if their defence was unsuccessful. It could essentially be seen as an inducement to waive their rights.

Another problem is that an accused will usually only be eligible for a diversion program if it is their first offence, and they have no prior convictions or even cautions. As a result, a large number of mentally ill offenders would not be eligible for a mental health diversion program due to the fact that they will probably reoffend until they receive treatment. VLA believes that diversion programs should accept offenders that may have committed minor offences previously, and should not be restricted to first-time offenders.

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[10] For more information go please go to Magistrates Court Diversion Program information site, available @ <http://www.courts.sa.gov.au/courts/magistrates/court_diversion.html>

[11] Jelena Popovich, Deputy Chief Magistrate of the Melbourne Magistrates Court, is currently working to establish a mental health specialist court list at the Melbourne Magistrates Court, which is yet to get off the ground.

2.5 Term of Reference k: The practice of detention and seclusion within mental health facilities and the extent to which it is compatible with human rights instruments, humane treatment and care standards, and proven practice in promoting engagement and minimising treatment refusal and coercion.

To understand the practices of detention and seclusion within mental health facilities, particularly in Victoria, an understanding of the facilities themselves is first required. Most of Victoria's major metropolitan hospitals have psychiatric inpatient facilities. These facilities are broken into two units, being low dependency and high dependency. In the high dependency unit there is at least one seclusion unit. High dependency units are locked units and are often extremely inhospitable environments with little furniture and little outdoor space. Patients often sleep on a mattress in small, stuffy rooms.

Persons who are in high dependency often feel isolated from their peers, and believe that they are being detained and punished for no reason. Seclusion for most involuntary inpatients is seen as the ultimate punishment. Patients are brought into the high dependency unit from the low dependency unit (often dragged by security guards), and placed in a very small room with a mattress on the floor and simply left to their own devices. Seclusion is used by nursing staff as a punishment if a patient refuses to cooperate with the ward regime, although medical staff would say that seclusion is required for treatment and for the health and safety of the patient, and other patients.

If the aim of seclusion is to calm a person down so that they can re-enter the ward environment, it must be questioned as to whether a small cell-like room is the best way to achieve this. If a person has to be separated from the ward, this can be done more humanely.

2.6 Term of Reference M: The proficiency and accountability of agencies, such as housing, employment, law enforcement and general health services, in dealing appropriately with people affected by mental illness.

Unfortunately there are limited facilities to assist people affected by mental illness. In Victoria people often receive the minimum amount of care possible in a psychiatric inpatient facility. They are then discharged on early discharge planning which involves regular attendance by the CATT team to monitor mental state and medication. After a number of admissions, persons often return to less than desirable accommodation such as rooming houses or caravan parks. Returning to this environment destroys self-esteem and often leads a mentally ill person to participate in the behaviour that led to the hospitalisation in the first place: drug taking, failure to take medication, violence etc. Rapid readmission and potentially a long term acute stay often follows.

It is essential that government examine housing needs for persons with a mental illness to ensure satisfactory accommodation on discharge. Similarly, although agencies do specialise in employment for persons with a mental illness, there is often resistance from employers who are reluctant to commit to employing someone who they see as being far from an optimal employee. Accordingly, further education and employment incentives are needed to ensure ongoing employment for persons with mental illnesses. Ideally, this proposal would form part of the government's strategy of encouraging people to enter the workforce on at least a part-time basis.

In the criminal law context inadequate facilities for people with mental illness means an increased reliance on police for crisis management. Rather than social workers assisting the mentally ill, police end up dealing with "the problem" by charging them with offences. VLA has found that police frequently confuse mental illness with drunkenness. Police also tend not to believe a person who claims to be ill or on medication, and they are not assessed as quickly as they should be. With this in mind, along with more resources, there is a need for more intensive training programs to be provided to police to avoid unnecessary arrests and conflict with mentally ill people.

3. Key issues for consideration

1. The community requires ongoing education in relation to people with mental illnesses.
2. Government should examine investment in both hospitals and in community facilities to ensure ongoing optimal care for persons with mental illnesses, particularly in supported accommodation. This should result in a saving to the resources required for the criminal justice system.
3. There should be a focus to improve the agency and dignity of persons with mental illnesses wherever possible.
4. More support in the transition from child-adolescent facilities to adult facilities is required, as well as more support for persons suffering from mental illnesses in the early years of the illness so that a greater understanding of the illness can be obtained.
5. A mental illness cannot be treated by itself. Other factors need to be addressed, particularly during early admissions, such as drug and alcohol dependency.
6. The practice of seclusion needs to be reformed.
7. The increased use of diversion programs like specialised courts for mentally ill offenders needs to be further explored.
8. Professionals working in mental health are hampered by inadequate facilities, forcing them to process clients quickly, and without optimal therapeutic levels of treatment in place.
9. More training for police would go some way to eliminating discrimination against the mentally ill, and would reduce unnecessary contact with the criminal justice system.

4. Further Information

For further information please contact:

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