The Provision of Mental Health Services in Australia

Submission

Senate Select Committee on Mental Health
Inquiry into Mental Health

May 2005

People with Disability Australia Incorporated

people with disability

1 About People with Disability Australia Incorporated

1.1 People with Disability Australia Incorporated (PWDA) is a national disability rights and advocacy organisation. Its primary membership is made up of people with disability and organisations mainly constituted by people with disability. PWDA also has a large associate membership of other individuals and organisations committed to the disability rights movement. PWDA was founded in 1981, the International Year of Disabled Persons, to provide people with disability with a voice of our own. We have a cross-disability focus - we represent the interests of people with all kinds of disability. PWDA is a non-profit, non-government organisation.

1.2 We have a vision of a socially just, accessible, and inclusive community, in which the human rights, citizenship, contribution, potential and diversity of all people with disability are respected and celebrated.

1.3 We believe that people with disability, irrespective of our age, gender, cultural or linguistic background, geographic location, sexuality, or the nature, origin, or degree of our disability

- Have a right to life, and to bodily integrity
- Are entitled to a decent standard of living, an adequate income, and to lead active and satisfying lives
- Are people first, with human, legal, and service user rights that must be recognised and respected
- Are entitled to the full enjoyment of our citizenship rights and responsibilities
- Are entitled to live free from prejudice, discrimination and vilification
- Are entitled to social support and adjustments as a right, and not as the result of pity, charity or the exercise of social control
- Contribute substantially to the intellectual, cultural, economic and social diversity and well-being of our community
- Possess many skills and abilities, and have enormous potential for life-long growth and development
- Are entitled to live in, and be a part of, the diversity of the community
- Have the right to participate in the formulation of those policies and programs that affect our lives
- Should be empowered to exercise our rights and responsibilities, without fear of retribution.

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3 Context of this Submission

3.1 This submission is based on the key issues that PWDA consistently addresses in our work with people with mental illness and psychiatric disability. We have restricted our responses to particular Terms of Reference that these key issues fall within.

3.2 Our work with people with disability, including people with mental illness and psychiatric disability includes:

3.2.1 **Individual and Group Advocacy**: PWDA provides extensive assistance to people with disability and their associates through its Individual and Group Advocacy service, which operates throughout NSW. Individual Advocates from this service deal on a daily basis with individuals with disability (including individuals with mental illness and psychiatric disability) and their families and carers. They assist by providing information, advice, referral and short-term, issue based, individual advocacy on a broad range of subject matters. Individual Advocates provide assistance across a wide range of issues, including abuse and neglect, discrimination, vilification, harassment, service quality, maladministration, unmet need, service development and reform.

3.2.2 **Systemic Advocacy**: PWDA is also extensively involved on an ongoing basis in systemic advocacy. Our systemic advocacy role covers local, national and international issues. It includes issues that relate to the rights of people with mental illness and psychiatric disability, the mental health service system, reform of mental health and criminal and juvenile justice legislation, specialist disability and mainstream accommodation systems and unmet need for a range of generic and specialist social assistance. Our systemic advocacy role also encompasses representation on government and non-government committees dealing with issues affecting people with mental illness and psychiatric disability.

3.2.3 **National Disability Services Abuse and Neglect Hotline (the Hotline)**: PWDA operates the National Disability Services Abuse and Neglect Hotline. The Australian Government Department of Family and Community Services (FACS) funds this service. It is an

Australia-wide hotline for reporting abuse and neglect of people with disability, including people with mental illness and psychiatric disability using Commonwealth, State or Territory funded disability services. Cases of abuse and neglect can include physical, sexual, psychological, legal and civil abuse, restraint and restrictive practices, systemic or financial abuse. It can also include the withholding of care and support that exposes an individual to harm. Allegations have been received from accommodation services, community and respite care services, immigration detention centres, hospital and mental health facilities and juvenile justice facilities. These allegations are referred to the appropriate authority for investigation. The Hotline provides statistical information to FACS for analysis.

3.2.4 **National Disability Complaints Resolution and Referral Service (CRRS)**: PWDA operates the National Disability Complaints Resolution and Referral Service. The Australian Government Department of Family and Community Services (FACS) funds this service. The CRRS assists with the resolution of complaints from users of disability employment and advocacy services funded by FACS and the Department of Employment and Workplace Relations (DEWR). It is a neutral party that investigates complaints and assists people with disability to find a resolution. CRRS provides statistical information to FACS for analysis.

3.2.5 **NSW Aboriginal Disability Network (ADN)**: PWDA provides policy and resource support to the ADN, an unfunded network of Aboriginal people with disability. The Network undertakes activities that enable the needs, issues and rights of Aboriginal people with disability to be highlighted and addressed.

4 Specific Issues

a. the extent to which the National Mental Health Strategy, the resources committed to it and the division of responsibility for policy and funding between all levels of government have achieved its aims and objectives, and the barriers to progress

4.1 Since the adoption of the National Mental Health Strategy (NMHS) in 1992, the mental health service system, mental health legislation and the rights of people with mental illness and psychiatric disability have been the subject of numerous national or State and Territory, government and non-government inquiries, reports, reviews and discussions. In particular, we draw attention to the following:

- Human Rights and Equal Opportunity Commission, *Report of the National Inquiry into the Human Rights of People with Mental Illness*, 1993.
- Human Rights and Equal Opportunity Commission, *Report of the Reconvened Inquiry into the Human Rights of People with Mental Illness (Victoria)*, 1995.
- Legislative Council Select Committee on Mental Health, *Final Report of the Inquiry into Mental Health Services in NSW*, 2002.
- NSW Mental Health Sentinel Events Review Committee, *Tracking Tragedy – A systemic look at suicides and homicides amongst mental health inpatients*, 2003.
- Corrections Health Service, *Mental Illness Among New South Wales Prisoners*, 2003
- SANE, *SANE Mental Health Report*, 2002-03.
- Mental Health Council of Australia, *Out of Hospital, Out of Mind*, 2003.

Despite the ten-year timeframe that these reports cover, PWDA observes that the same issues and themes are constantly identified in report findings. These findings provide consistent, stark evidence that the aims and objectives of the NMHS have not been achieved. This failure exists despite the evaluations of the NMHS and the development of new strategies and directions that are adopted for implementation by Commonwealth, State and Territory governments. PWDA argues that there is an urgent need for the NMHS to be reconfigured and revitalised.

4.2 There are a number of key issues that PWDA argues are essential to a reconfigured NMHS and its implementation:

4.2.1 The most current international and national benchmarks for recognising the rights of people with mental illness and for improving the quality of mental health care must be referenced and reflected throughout a NMHS. In particular, we draw your attention to:

- the United Nations *Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care* adopted by the United Nations General Assembly in December 1991;
- the United Nations *Standard Rules for the Equalisation of Opportunities for Persons with Disabilities,*1993;
- the proposed United Nations *Supplement to the Standard Rules for the Equalisation of Opportunities for Persons with Disabilities,* 2002;
- the proposed United Nations *Convention on the Rights and Dignity of Persons with Disability*, which is currently being developed;
- the *Disability Discrimination Act,* 1992;
- the *National Mental Health Standards*, the *National Model Mental Health Legislation* and the *National Statement of Principles for Forensic Mental Health*; and
- the *Disability Services Act,* 1986 (Cth).

4.2.2 A NMHS must reflect the social model of disability, which locates the problem of disability in social, economic, environmental and attitudinal barriers external to the individual. A medical model focuses on the individual's impairments or medical conditions in isolation to the relationship between the individual, their daily lives and their environment. Applying the social model of disability to service development and delivery is essential to ensuring that people with mental illness and psychiatric disability are viewed as people in their totality, and as members of families and communities, who require dignified, interconnected and seamless specialist and generic services to gain and maintain well-being and live successfully in the community.

4.2.3 The Australian Government must take a leadership role in the promotion and implementation of a NMHS. This would include developing a mechanism or process for ensuring ownership of a NMHS by all levels of government, consumers, carers, advocates, professionals and non-government service providers, as well as a public and transparent accountability mechanism for all levels of government.

4.2.4 Provide adequate resources and funding to the Human Rights and Equal Opportunity Commission to facilitate independent monitoring and review of the rights of people with mental illness and psychiatric disability.

4.2.5 A NMHS must incorporate participation of and consultation with independent mental health consumer groups as an essential

component of development and implementation. This will require mental health consumer groups to be adequately funded.

4.2.6 Funding for mental health at all levels of government must, at a minimum, be in line with the proportion of health budgets spent by other comparable countries, such as Canada and New Zealand.

4.2.7 Mental Health legislation must be reformed to incorporate a national regulatory framework for community-based mental health services, including non-government agencies. This should include clear funding arrangements linked to quality outcomes, standards for service delivery, and a robust system of accreditation, and ongoing monitoring and review. Quality outcomes, standards and accreditation must be linked to human rights indicators and outcomes for individuals.

4.2.8 Transparent complaints processes and grievance procedures need to be built into all levels of the service system, including in relation to the non-government mental health sector. This must include a tertiary complaint handling function that is external to and independent of the service system. Complaint handling mechanisms must recognise the role of advocates and other support people in assisting a person through the complaints process and contain mechanisms to prevent retribution. This should be viewed as an integral part of the mental health care system.

4.2.9 Independent, comprehensive, quality consumer mental health advocacy services, including legal advocacy services, need to be established and adequately funded.

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

4.3 The reports referred to in 4.1 provide comprehensive detail of unmet need for all modes of care for people with mental illness and psychiatric disability. PWDA has consistent direct experience of this in the following areas:

4.3.1 *No available services*: The lack of mental health services is a significant issue. Many people with mental illness and psychiatric disability use the Hotline (see 3.2.3) as a defacto counseling service as there is no other service available to them.

Families also frequently call for assistance in relation to obtaining services for their children with mental illness or psychiatric disability. In some of these cases, their children are suicidal but the family has not been able to get mental health support for a number of months.

4.3.2 *Lack of and inadequate case management*: PWDA has frequent calls about community mental health services and the lack of case management and inadequacies in case management. In particular, people with mental illness and psychiatric disability either do not have a caseworker assigned to them, or the caseworker has no time to properly assess the person's needs or monitor the person. Frequently caseworkers are untrained in specific issues, such as medication management and do not know how to assist or monitor a person, such as when they are changing medication.

4.3.3 *Inadequate community mental health services*: A number of individual advocacy (see 3. 2.1 above) cases involve the inadequacy of community mental health teams in providing preventative and ongoing support to people. In some cases, these people have been taken to hospital after being found in dangerous situations, such as on railway tracks, but have been discharged from hospital and have subsequently committed suicide.

4.3.4 Lack of mental health advocacy services: Through its services (see section 3.2 above), PWDA is aware of the significant unmet need for mental health advocacy services. In particular, the Hotline reports having to address serious issues by contracting advocates to undertake service liaison and networking to get community supports for people. This is not the role of the Hotline, but without this, a person's life issues cannot be addressed.

Consumer advocates that are available are often situated in the same location as mental health teams; funded by the same body; and may be supervised by a mental health worker. Clearly, this creates a conflict of interest that compromises the advocacy service as well as deterring people from using the service in the first place.

g. the extent to which unmet need in supported accommodation, employment, family and social support services, is a barrier to better mental health outcomes

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

4.4 The reports referred to in 4.1 provide comprehensive detail of the unmet need for a range of community, family and social support services and the serious lack of proficiency and accountability of agencies in dealing appropriately with people affected by mental illness. PWDA has consistent experience of this in the following areas:

4.4.1 *Boarding Houses*: Often, the only community accommodation options for people with mental illness are boarding houses. PWDA works extensively with people in boarding houses in NSW and

estimates that 95% of residents have a mental illness. Yet the majority of boarding houses provide no support in terms of health, recreation, community living or social skill development. Often health care is equated with providing medication to clients, and although Boarding House Review Teams are responsible for monitoring medication, PWDA has found that such monitoring is not always consistent or comprehensive. The reality is that boarding house owners have considerable influence over the medication of their clients.

Aside from the 'medication as health care' issue, boarding houses are often unsafe in terms of assault and abuse, with women being particularly vulnerable. Boarding houses are often unlicensed, despite funding bodies being aware of this situation.

4.4.2 *Supported Accommodation Options*: There is considerable unmet need for supported accommodation options for people with mental illness and psychiatric disability. Some options that are available are only available for limited time periods and in limited locations. Others are jointly funded group homes that have no clear regulatory frameworks, complaints mechanisms or operational processes for providing support. PWDA often experiences difficulties in obtaining support for people with mental illness from mainstream housing agencies.

The lack of housing options and supported accommodation in conjunction with a lack of support services to assist with maintaining tenancies and living in the community means that there are a significant number of people with a mental illness, who are at risk of homelessness or actually in a situation of homelessness[1].

There are some good supported accommodation models, but these are usually pilot models that receive one-off funding. One such pilot is the NSW Government's Housing and Accommodation Support Initiative (HASI) that aims at strengthening partnerships between Departments of Health, Housing, the non-government sector and consumers and carers in the delivery of accommodation support services.

PWDA is extremely concerned about recent NSW Government initiatives to offer limited tenancy to public housing tenants. Aspects of implementation have not been finalized. However, we have raised concerns regarding assessment, monitoring and the appeals process.

[1] For a comprehensive discussion of homelessness and people with mental illness, see research report, *Understanding Iterative Homelessness: The Case of People with Mental Disorders*, 2003, Catherine Robinson for the Australian Housing and Urban Research Institute.

4.4.3 *Employment Services*: Open employment services for people with disability have difficulty in providing services to people with mental illness because of a general lack of knowledge and skills. It is not uncommon for services to disclose confidential information, lack understanding of how specific illnesses affect people and dismiss symptoms of illness as the person being 'difficult'. PWDA is also not aware of any training programs available to employment services that focus on people with mental illness.

People with mental illness using open employment services report difficulties in pursuing complaints because of a lack of mental health advocacy (see 3.3.4) and case management (see 3.3.2). CRRS reports that it has taken on case management because of the dearth of services available.

PWDA is concerned about the reliance of people with mental illness on Job Network services. Minimal support is provided for people who have episodic illnesses, such as mental illness, who need more job flexibility and individual planning. This doesn't 'fit' with outcome measures based on moving people into employment within time limits, making Job Network service providers reluctant to provide their service to people with mental illness. In addition, the Personal Support Program is not sufficient to provide the ongoing support required to assist people with mental illnesses into employment.

4.4.3 *Interaction between service systems:* PWDA consistently experiences difficulties in people with mental illness and psychiatric disability being able to move between service systems, such as health and housing and disability and health, with jurisdictional divides creating barriers to obtaining services. This results in many people 'falling through' the significant gaps in services.

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

4.5 *People with Intellectual Disability and Mental Illness*: PWDA consistently finds that people with dual diagnosis (intellectual disability and mental illness) fall through service gaps. If intellectual disability is the primary diagnosis, then community mental health teams often will not provide services to the person. In some cases, this has resulted in the Hotline calling the ambulance service for a person with dual diagnosis, as the mental health team would not assist.

If the person's primary diagnosis is a mental illness, then the disability service system will not provide support services to the person. PWDA has found that to receive disability support services once a person is well

enough to move out of acute psychiatric care, it is advantageous for the person to have their primary diagnosis as intellectual disability.

In addition, PWDA has found that some mental illnesses, such as anxiety disorders and depression often go undiagnosed in people with intellectual disability.

This demonstrates a failure of the disability and health service systems to work in partnership to meet the support needs of individuals. The service systems do not generally share information about support needs or community treatment.

4.6 *Children and Young People*: Reports and inquiries demonstrate that children and young people with mental illness are often unable to obtain services, receive adequate and long-term treatment or be provided with support and assistance to effectively live in the community or with their families.[2] While there has been a policy and practice move away from residential facilities, there is still a serious lack of integrated community mental health services designed specifically for children and young people. The Human Rights and Equal Opportunity Commission (HREOC) inquiry conducted twelve years ago and a 2002 inquiry into mental health services in NSW both found that "initiatives in child and adolescent mental health services are just a fraction of what is required".[3]

Children with non-acute illnesses are often not viewed as requiring a mental health service and not given the necessary assistance to successfully live with their families or to prevent the escalation of their illness that can result in self-harming behaviours or suicide.[4] Those children with acute illnesses are often inappropriately admitted to adult units - creating serious risks for the child - or general wards of children's hospitals, which cannot provide appropriate care or prevent other children from being at risk of harm.[5] This situation is even worse in rural and remote areas where there may be no acute children's units for hundreds of miles or where there are, no beds available.[6]

Both inquiries also found that the mental health system is unable to effectively treat and assist children with a dual diagnosis, such as a child with intellectual disability and a mental illness.[7] Lack of skills in diagnosis of a mental illness in a person with disability, lack of mental health treatment options and programs for people with disability and the lack of interagency

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[2] see Human Rights and Equal Opportunity Commission, (1993) *Human Rights & Mental Illness – Report of the National Inquiry into the Human Rights of People with Mental Illness*; Legislative Council Select Committee on Mental Health, (2002) *Inquiry into Mental Heath Services in New South Wales – Final Report*

[3] Legislative Council Select Committee on Mental Health, ibid, p. 217

[4] Ibid, p. 218

[5] Ibid, p. 219; Human Rights and Opportunity Commission (1993), op. cit., Volume 2 p. 626

[6] Legislative Council Select Committee on Mental Health, ibid, p. 220

[7] Ibid, Chapter 11, pp. 187-198; Human Rights and Opportunity Commission (1993), op. cit., Volume 2 pp. 659-673

collaboration between disability services and mental health services means that many children with dual diagnosis fall through the system.

PWDA has also found that children with autism spectrum disorders and children with ADD or ADHD fall through service gaps between the disability and mental health service systems. This occurs when families need support services to deal with children's 'challenging behaviour' associated with these conditions. The disability service system doesn't provide ongoing, intensive behaviour support services, and usually refer families to the mental health service system. The mental health service system may only provide a service at the point of crisis but also don't provide intensive, specialised family support.

The lack of assistance for children with non-acute illnesses, the lack of acute children's units and the lack of services for children with dual diagnosis and 'challenging behaviour' often creates the risk that children with a mental illness will come into contact or enter the juvenile justice system.[8]

4.7 *Children and young people with disability in the juvenile justice system*: Reports show that children with disability, particularly those with mental illness and/or intellectual disability are over-represented in the juvenile justice system[9], with a recent survey indicating that the figure is as high as 80%[10].

These reports link failures in the mental health, child protection, disability and community service system with the increased risk of children entering the juvenile justice system. Once in the juvenile justice system, the emphasis is on punishment of the crime and rehabilitation rather than on appropriate assessment, intervention and support services.[11] Many children with disability are not even identified, which means their specific support needs are not addressed. The design of facilities and the environment can also contribute to a decreasing emotional and mental state.[12]

4.7 *Parents with Mental Illness*: Parents with disability, particularly those with intellectual disability and mental illness are significantly over represented in

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[8] Legislative Council Select Committee on Mental Health, ibid, p. 195; Human Rights and Opportunity Commission (1993), ibid, Volume 2 p. 627

[9] Community Services Commission (1996) *The Drift of Children in Care into the Juvenile Justice System – Turning Victims into Criminals*; Human Rights and Equal Opportunity Commission (1993) *Human Rights & Mental Illness – Report of the National Inquiry into the Human Rights of People with Mental Illness*.

[10] NSW Department of Juvenile Justice (2003) *2003 NSW Young People in Custody Health Survey* (online at www.djj.nsw.gov.au/pdf/publications/2003YoungPeopleInCustody.pdf)

[11] Community Services Commission (1996) ibid, p. 10; Forde Implementation Monitoring Committee, (2001) *Report to the Commission of Inquiry into Abuse of Children in Queensland Institutions,* pp. ix-x

[12] Human Rights and Equal Opportunity Commission, op. cit., Volume 2, p. 636

the child protection system.[13] The prejudicial assumptions about the parenting capacity of people with disability means that "(d)isability is constructed as a risk factor for abuse and neglect rather than as an indicator of possible support needs".[14] It is more likely that parents with disability will have at least one child, if not more removed early in life, and approximately "1 in 6 children in out-of-home care will have a parent who has a disability".[15]

However, evidence provided at the NSW Legislative Council inquiry into disability services and the inquiry into child protection services demonstrate that when family support programs and sufficient community-based mental health services are provided to parents with disability, the outcomes for their children are not significantly different from other children.[16] This is in direct contrast to the more negative outcomes of children who are in out-of-home care. Despite this, there are almost no services in Australia that recognise the need for intensive parenting support or that provide intensive parenting support to parents with disability.

4.8 *Aboriginal and Torres Strait Islander peoples:* Both the 1993 *Human Rights and Mental Illness* report and the 1997 *Bringing Them Home* report[17] found that mental health services failed to meet the needs of or provide services to Aboriginal and Torres Strait Islander peoples. This was despite the fact that "greater exposure to causal factors" made it more likely that Aboriginal and Torres Strait Islander peoples will "experience mental and emotional ill-health" than others[18].

In 2004, the ADN (see 3.2.5) conducted 33 meetings with Aboriginal people with disability throughout NSW, mainly in rural and remote areas. Their findings do not indicate that much has changed despite Federal and State and Territory policies developed to address the mental health situation of Aboriginal and Torres Strait Islanders. They found that a significant number of people with mental illness had never been diagnosed or provided with mental health services. They also found that suicide was a common occurrence in most communities[19].

Overall, the factors that have an adverse effect on mental health still exist in most Aboriginal communities. For instance, generally speaking Aboriginal

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[13] Legislative Council Standing Committee on Social Issues, (December 2002) *Care and Support – Final Report on Child Protection Services*, p. 144; Legislative Council Standing Committee on Social Issues, (November 2002) *Making it Happen – Final Report on Disability Services*, p. 126
[14] Legislative Council Standing Committee On Social Issues, (December 2002) *ibid.,* p. 145
[15] Legislative Council Standing Committee on Social Issues, (November 2002) op. cit., p. 126
[16] Legislative Council Standing Committee On Social Issues, (December 2002) op. cit., p. 147; Legislative Council Standing Committee on Social Issues, (November 2002) ibid., p. 126
[17] Human Rights and Equal Opportunity Commission, op. cit., Chapter 23, and Human Rights and Equal Opportunity Commission, *Bringing Them Home – National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from their Families*, 1997, Chapter 18
[18] Human Rights and Equal Opportunity Commission, 1997, ibid., p. 377.
[19] Report from consultations with Aboriginal people with disability in NSW conducted by the Aboriginal Disability Network, 2005, unpublished.

people remain at the margins of mainstream society and continue to be the subject of both direct and indirect racial discrimination. Furthermore, the ADN found that in many regional and remote communities the key cultural icons such as rivers or other natural resources are slowly dwindling or being polluted. This has a serious adverse effect on the mental health of Aboriginal people as so much of their identity is enshrined with such natural icons.[20]

j. the overrepresentation 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

4.9 Without adequate housing and supported accommodation options, community care, legal protection, advocacy, coordinated diversionary programs and community based sentencing options, people with a mental illness are more likely to come into contact, enter and re-offend or to some degree remain in contact with the criminal justice system. A 2003 report has found that "the prevalence of mental illness in the NSW correctional system is substantial and consistent with international findings", with 72% of male prisoners and 86% of female prisoners showing a twelve month prevalence of mental illness.[21]

4.10 PWDA has provided assistance to a number of people, who are unable to be released from prison because there are no community support options, including accommodation. Consequently, they serve out their parole period in prison.

4.11 There have also been recent reports[22] of prisoners with mental illness being placed in solitary confinement as punishment, highlighting serious human rights breaches caused by systemic failures in the mental health and correctional service systems.

4.12 PWDA argues that no person with a mental illness or psychiatric disability should be treated inside correctional facilities.

4.13 There is a lack of mental health advocacy services, including legal advocacy services. No legal aid office funds specialist legal services that would assist people with mental illness at the point of entry to the justice system, such as at police stations or in obtaining bail. Specialist legal assistants, acting as independent third persons could provide essential support to people with mental illness and have knowledge relating to criminal law that could assist with maximising diversion.

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[20] Ibid.
[21] Corrections Health Service, 2003, Mental Illness Among NSW Prisoners, p. 2 and 15.
[22] NSW Shadow Minister for Mental Health, *State Government must act to stop prisons being last resort for mentally ill*, Media Release, 16 May 2005; NSW Greens MLC, *Greens flag Parliamentary Inquiry for mentally ill prisoners*, Media Release, 16 May 2005.

4.14 In 1988 the Australian Law Reform Commission (ALRC) found that the interaction of people with mental illness with the criminal justice system as a whole needed to be examined in order to develop a comprehensive framework[23]. The ALRC recommended that it be given a separate reference to undertake such an examination, but this recommendation has never been implemented.

4.15 In 2004, the Productivity Commission recommended that the Attorney-General "commission an inquiry into access to justice for people with disabilities, with a focus on practical strategies for protecting their rights in the criminal and civil justice systems"[24]. The Attorney-General has not agreed to this recommendation.

4.16 The over-representation of people with mental illness in the criminal justice system warrants the development of a national, comprehensive framework to address this issue. *The Framework Report*[25] may be a useful model to consider in this regard. This 2001 Report provides recommendations to address the over-representation of people with intellectual disability in the criminal justice system. It takes a holistic approach to the issue, looking at a continuum of community support services and criminal justice services to maximise prevention of criminal justice contact and the diversion of people with intellectual disability from the criminal justice system.

A comprehensive framework that covers community support programs, legal support and assistance, diversionary programs and community based sentencing options may best be facilitated by an examination or inquiry as recommended by both the ALRC and the Productivity Commission.

4.17 PWDA welcomes initiatives announced in the NSW State Government budget on 24 May 2005 regarding the development of supported accommodation for people with disability transferring from Department of Corrective Services' facilities. PWDA believes that, if implemented with regard to the issues identified above, this initiative has some potential to redress some of the lack of services for people with mental illness.

[23] Australian Law Reform Commission, *Sentencing*, 1988, ALRC 44.
[24] Productivity Commission, *Review of the Disability Discrimination Act 1992*, 2004, Chapter 9.
[25] Intellectual Disability Rights Service and NSW Council for Intellectual Disability, 2001, *Framework Report*

5 Recommendations

5.1 Urgent action is required to address the serious unmet need for quality mental health and community support services, lack of appropriate services for specific groups of people and to address breaches of the human rights of people with mental illness.

5.2 PWDA makes the following recommendations to address the specific experiences we have outlined throughout our submission.

5.2.1 The National Mental Health Strategy (NMHS) should be reconfigured and revitalised to reflect a social model of disability, be based on current international and national human rights and service quality benchmarks and incorporate ongoing participation and consultation with mental health consumer groups.

5.2.2 The Australian Government must take a leadership role in the promotion and implementation of a NMHS, including developing a mechanism or process for ensuring ownership of a NMHS by all levels of government, consumers, carers, advocates, professionals and non-government service providers, as well as a public and transparent accountability mechanism for all levels of government.

5.2.3 Provide adequate resources and funding to the Human Rights and Equal Opportunity Commission to facilitate independent monitoring and review of the rights of people with mental illness and psychiatric disability.

5.2.4 Funding for mental health at all levels of government must, at a minimum, be in line with the proportion of health budgets spent by other comparable countries, such as Canada and New Zealand.

5.2.5 Increased funding needs to target, as a priority the unmet need for all modes of mental health care, community support services, supported accommodation and specialist employment services.

5.2.6 All levels of government need to collaborate on a whole of government framework that eliminates jurisdictional barriers and gaps in community and mental health service provision for people with mental illness, and includes consultation with mental health consumer groups.

5.2.7 Independent mental health consumer groups must be adequately funded.

5.2.8 Mental Health legislation must be reformed to incorporate a national regulatory framework for community-based mental health services, including non-government agencies. This should include clear funding arrangements linked to quality outcomes, standards for service delivery, and a robust system of accreditation, and ongoing monitoring and review. Quality outcomes, standards and accreditation must be linked to human rights indicators and outcomes for individuals.

5.2.9 Transparent complaints processes and grievance procedures need to be built into all levels of the service system, including in relation to the non-government mental health sector. This must include a tertiary complaint handling function that is external to and independent of the service system. Complaint handling mechanisms must recognise the role of advocates and other support people in assisting a person through the complaints process and contain mechanisms to prevent retribution. This should be viewed as an integral part of the mental health care system.

5.2.10 Independent, comprehensive, quality consumer mental health advocacy services, including legal advocacy services, need to be established and adequately funded.

5.2.11 All levels of government need to work collaboratively on the development of a comprehensive, integrated community support, disability and mental health service system that meets the specific needs of people with dual diagnosis (intellectual disability and mental illness).

5.2.12 The Australian government, in collaboration with key stakeholders develop a national mental health strategy for children and young people and their families that recognises the specific emotional and developmental needs of children and young people; addresses the needs of children with dual diagnosis; and provides for across government, integrated service provision to eliminate service gaps for specific groups of children.

5.2.13 All levels of government need to work collaboratively to develop comprehensive social support programs and service systems to prevent the circumstances that contribute to children with mental illness from entering the juvenile justice system.

5.2.14 All levels of government implement a range of diversionary programs and mechanisms and community based sentencing options for juvenile offenders that are integrated with social support programs.

5.2.15 All levels of government implement comprehensive, integrated and intensive parenting and family support and community mental health services for parents with mental illness.

5.2.16 In partnership with Aboriginal and Torres Strait Islander peoples, all levels of government need to develop a well funded culturally empowering strategy to address the mental health circumstances of Aboriginal and Torres Strait Islander peoples, including Aboriginal and Torres Strait Islander controlled qualitative research into the prevalence, circumstances and cultural understanding of mental health.

5.2.17 In partnership with Aboriginal and Torres Strait Islander peoples, all levels of government need to develop a comprehensive, integrated community support, disability and mental health service system that meets the specific needs of Aboriginal and Torres Strait Islander peoples.

5.2.18 The Australian Government should conduct an examination or inquiry into the over-representation of people with mental illness in the criminal justice system in line with the recommendations of the Australian Law Reform Commission and the Productivity Commission.

5.2.19 All levels of government need to work collaboratively to develop a national, comprehensive framework to address the over-representation of people with mental illness in the criminal justice system; and that covers community support programs, legal support and assistance, diversionary programs and community based sentencing options.