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5 July 2019

Royal Commission into Victoria's Mental Health System
PO Box 12079
A'Beckett Street
VICTORIA 8006

By email: contact@rcvmhs.vic.gov.au

Dear Sir/Madam,

We welcome the opportunity to provide a submission to the Royal Commission into Victoria's mental health system.

We agree that our submission may be published or referred to in any public document prepared by the Royal Commission. There is no need to anonymise this submission.

We would welcome the opportunity to discuss any of the matters in our submission in more detail with the Royal Commission.

Please do not hesitate to contact me and my colleagues on (03) 9605 2864 or via ddubrow@mauriceblackburn.com.au if we can further assist with the Royal Commission's important work.

Yours faithfully,

Dimitra Dubrow
Principal
National Head of Medical Negligence

MAURICE BLACKBURN

Emily Hart
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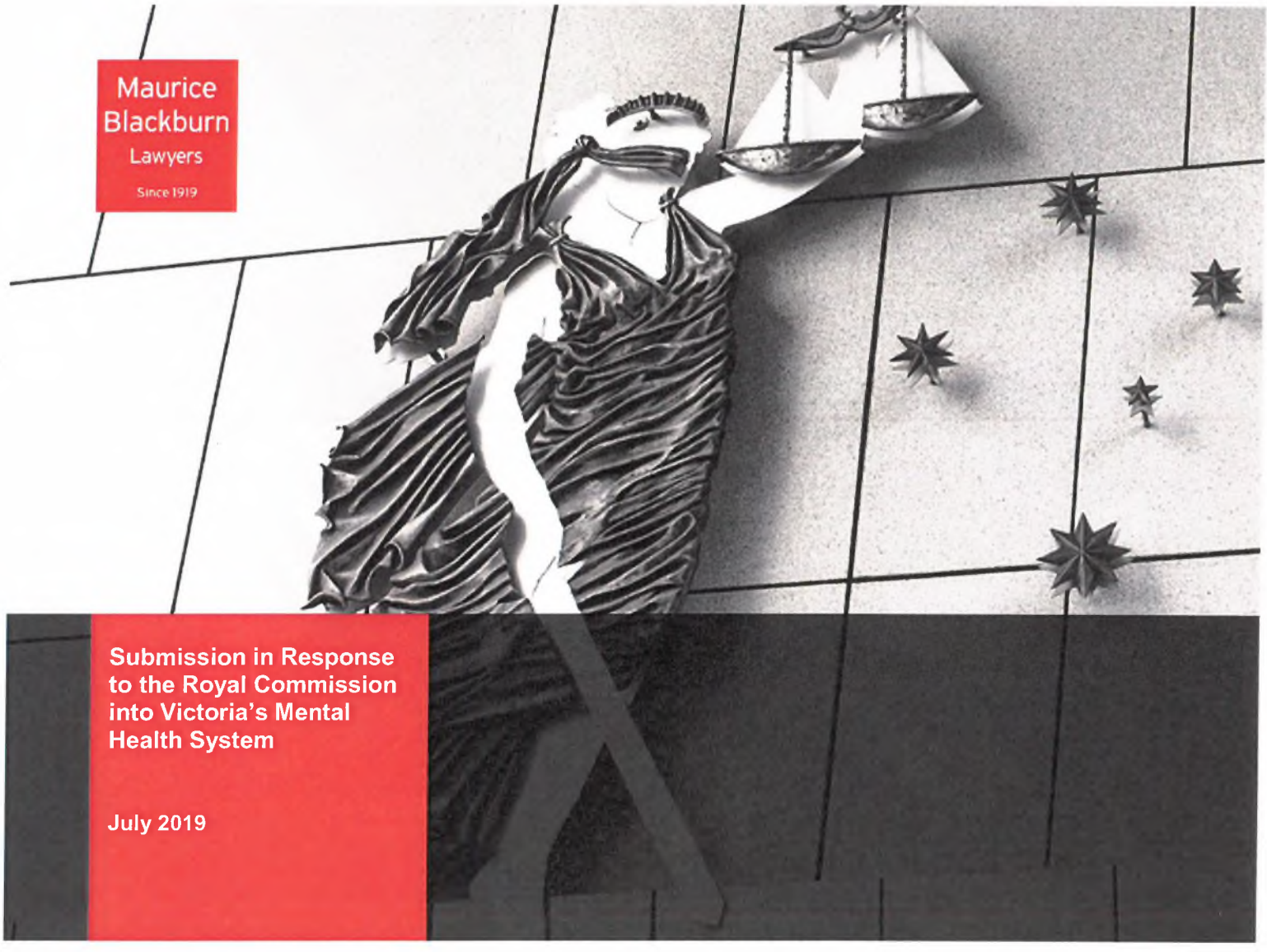

Submission in Response to the Royal Commission into Victoria's Mental Health System

July 2019

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Introduction

Maurice Blackburn is a plaintiff litigation firm with 32 permanent offices and 31 visiting offices throughout all mainland states and territories. We employ more than 1,000 staff nationally, including approximately 330 lawyers who provide advice and legal assistance to thousands of clients each year.

In addition to specialised practice areas in personal injuries, employment and industrial law, dust diseases, superannuation, financial advice disputes and class actions, Maurice Blackburn has the largest team of medical negligence lawyers exclusively dedicated to representing injured patients and their families in Australia.

We have successfully resolved hundreds of complex and sensitive medical negligence cases, including many claims involving treatment provided to patients under Victoria's mental health system. Through the experiences of our clients and their families, we have had the opportunity to gain valuable insight into the operation of the mental health system and, in particular, areas for improvement to ensure that patients receive the most appropriate treatment, care and support.

Our Submission

Maurice Blackburn is encouraged by the extent of the current focus on mental health in a number of public policy discussions across a number of jurisdictions. It shows that people suffering mental illness have been treated poorly by current systems and processes.

We have based our submission on our experiences working with clients and families that have had extensive contact with the mental health system in Victoria.

We have sought to address a number of key issues in relation to the delivery of and access to the mental health system, improved mental health outcomes for those at risk, and a number of other matters necessary to address the Terms of Reference arising in the scope of our work.

A summary of our recommendations to the Royal Commission can be found on page 22 of this document.

Responses to Terms of Reference

Maurice Blackburn notes that the Letters Patent specify six Terms of Reference for investigation and report by the Royal Commission.

Maurice Blackburn provides its responses to the Terms of Reference in the sections below.

1. How to most effectively prevent mental illness and suicide, and support people to recover from mental illness, early in life, early in illness and early in episode, through Victoria's mental health system, and in close partnership with other services.

Maurice Blackburn acknowledges that seeking to identify preventative means to reduce Victorians' experience of mental health has primacy in the Royal Commission's work. The importance of finding early intervention measures that work cannot be overstated.

Broadly speaking we support any efforts by the Royal Commission to enhance focus on early intervention and integration with other services, which we consider to be essential to the prevention of chronic mental illness and suicide.

Unfortunately, by the time we find ourselves in contact with people experiencing mental health issues, we are past the point where prevention and early intervention processes have impact.

We can, however, offer some observations as to what would have helped prevent our clients from accessing the mental health system.

i. Access to information.

In our experience, accessing quality information at the right time can help to reduce the exacerbation of mental health issues. There are several areas where we believe this can have a very beneficial effect:

General Practitioners (GPs) are often the first point of contact for a patient or a concerned family member or carer. An early intervention pack or information booklet could be provided to patients and/or carers with contact numbers and guidelines for appropriate contacts at various stages of mental illness would be of assistance.

In particular, we consider provision of information about community services, GP mental health treatment plans, the role of the CAT team, and links to local private mental health services and practitioners would be of use.

It is often the case for our clients that their first experience with the mental health system occurs during a period of acute illness. It may be that they lack legal and/or medical decision making capacity. We believe that access to information about the use of instruments like Powers of Attorney or the appointment Medical Treatment Decision Makers in managing recovery is invaluable. This is particularly the case where confidentiality concerns would otherwise limit clinician's engagement with families and carers.

As set out in our response to term of reference 3, we consider integration with families and carers to be essential in the prevention of mental illness and suicide. Ensuring that families and carers have access to appropriate and timely information is critical.

We also consider it is essential to strengthen the sharing of information and learnings from poor outcomes. The outcomes of Coroner's Court and the Office of the Chief Psychiatrist investigations should be perceived as valuable preventative assets in preventing future recurrence.

We consider the Commission will be in a position to recommend public education initiatives, following the completion of the Inquiry, which we consider would be of benefit in the prevention of mental illness and suicide.

ii. Removing causes of mental harm

In our response to Term of Reference 6, we detail how some current pieces of Victorian legislation, which are aimed at helping provide recourse for injury, can actually *create* rather than relieve mental illness.

Through the administration and interpretation of these pieces of legislation, and stress caused by delays in achieving outcomes, secondary diagnoses of mental health issues are, unfortunately, not uncommon.

We believe that the Royal Commission is well placed to provide recommendations that can fix this.

2. How to deliver the best mental health outcomes and improve access to and the navigation of Victoria's mental health system for people of all ages.

Maurice Blackburn notes that the Royal Commission seeks comment on how to deliver the best mental health outcomes and improve access to and the navigation of Victoria's mental health system for people of all ages, including through:

(a) Best practice treatment and care models that are safe and person-centred;

(b) Strategies to attract, train, develop and retain a highly skilled mental health workforce, including peer support workers;

(c) Strengthened pathways and interfaces between Victoria's mental health system and other services;

(d) Better service and infrastructure planning, governance, accountability, funding, commissioning and information sharing arrangements; and

(e) Improved data collection and research strategies to advance continuity of care and monitor the impact of any reforms.

These are specifically addressed below:

(a) Best practice treatment and care models that are safe and person-centred

i. The need to reconcile human rights principles with treatment and care models

Maurice Blackburn considers that there are inconsistencies in the application of the 'least restrictive' principles as set out as an objective of

the *Mental Health Act* 2014 (Vic) (the Act) and the standards of care imposed on medical practitioners by the *Wrongs Act 1958 (Vic)* and at Common Law.

There is a compelling need to reconcile human rights concepts and the 'least restrictive' language of the *Victorian Charter of Human Rights and Responsibilities Act* 2006 (Vic) (Victorian Charter) with leading cases defining the least restrictive care model by the Courts. (See, for example, *Hunter v New England Local Health District v McKenna* [2014] HCA 44.)

For example, Section 10(b) states that it is an objective of the Act to provide for persons to receive assessment and treatment in the least restrictive way possible with the least restrictions on human rights and human dignity. This is an apparent reference to s.7 of the Victorian Charter which sets out the basis under which human rights can be reasonably and proportionally limited including rights such as the right to equality, liberty and consent.

Maurice Blackburn recognises that this is an important objective directed to upholding the fundamental human rights of patients, particularly in relation to involuntary treatment orders, where there is the potential for limitation of these rights.

However, the lack of definition and clarity around this term and its application, especially when juxtaposed against the similar language used by the Courts in respect of the duty of care placed on medical practitioners to patients at common law, is unhelpful.

The 'least restrictive' language of the Act, when not clearly defined, creates confusion for medical practitioners both in terms of the language and requisite standards and decision making processes under the Act.

In our experience, this can lead directly to harm to both patients and members of the public. Ultimately, mental health care is about more than just the patient. It is about providing safety for their families, circle of friends and the wider community. Whilst there is a clear need to balance patients' rights and dignity with these considerations, an application of the 'least restrictive ' consideration in a vacuum is inappropriate.

We are of the view that a comprehensive review of the practical application of 'least restrictive' care that appropriately distinguishes this model from important human rights concepts is required to ensure that the principle is applied consistently across facilities and by medical practitioners.

Greater guidance for medical practitioners is required to ensure they can make decisions under the *Mental Health Act* that have appropriate regard to human rights principles *and* common law principles of duty of care. For example, guidance could be provided on how to discharge the objectives of 10(b) of the act by way of a proper consideration decision making framework.

Recommendation 1:
That the Royal Commission recommend that a comprehensive review of the practical application of 'least restrictive' care be instigated to ensure that the principle is applied consistently across facilities and medical practitioners.

Recommendation 2:
That the Royal Commission recommend greater guidance for medical practitioners to ensure they can make decisions under the Mental Health Act that have appropriate regard to both human rights principles and common law principles of duty of care.

ii. Treatment and care models

Maurice Blackburn also considers that, based on a number of cases we have been involved in, there are particular inconsistencies in the development and application of approved leave policies within inpatient mental health services.

We submit that the Royal Commission should consider the need for the development of consistent standards for the consideration of granting leave, monitoring of leave and responses to failure to return from leave.

Whilst most mental health facilities have policies that set out the appropriate steps to be taken should a patient fail to return from leave, we have seen a number of cases where such policies were not followed. In part, this is reported to be the result of interaction with Victoria Police, and their ability to take action where a patient is considered 'missing'.

In addition, it exposes members of emergency services to an increased number of distressing and difficult interactions.

Maurice Blackburn further notes inconsistencies in the application of building standards to facilities which are utilised for the treatment of mental health. For example, we are aware of issues that have arisen in relation to patient entry and exit points and nursing monitoring areas such that patients have been able to abscond while admitted as involuntary inpatients.

We consider that this issue should be addressed through the development of a consistent regulation regime for the design and layout of inpatient mental health facilities.

Further, Maurice Blackburn has identified capacity and assessment issues within the Critical Assessment and Treatment Team (CAT Team) system.

In particular, we note cases where the CAT Team has been unavailable to provide support, and has failed to provide adequate follow up support to clients. This issue is especially pronounced in rural and regional contexts.

We submit that the Royal Commission should consider conducting a review of the role and function of the CAT Team and, in particular, whether the current level of funding and resourcing requires amendment.

Maurice Blackburn is aware of multiple incidents involving ligature points in patient rooms and we consider that access to ligature points in inpatient mental health facilities is of concern, specifically in relation to patients with suicide risk.

We submit that the Royal Commission consider the development of a consistent regulation system for inpatient accommodation to protect against patient access to ligature fixture points. This may include audits of inpatient units to identify potential ligature points and modifications to features in bathrooms and wardrobes to prevent use as ligature fixture points.

Recommendation 3:
That the Royal Commission consider the need for the development of consistent standards for the consideration of granting leave, monitoring of leave and responses to failure to return from leave.
Recommendation 4:
That the Royal Commission recommend the development of a consistent regulation regime for the design and layout of inpatient mental health facilities.

Recommendation 5:
That any regulation regime for the design and layout of inpatient mental health facilities should specifically protect against patient access to ligature fixture points.

Recommendation 6:
That the Royal Commission recommend a review of the role and function of the CAT Team and, in particular, whether the current level of funding and resourcing requires amendment

(b) Strategies to attract, train, develop and retain a highly skilled mental health workforce, including peer support workers

Maurice Blackburn has also identified inconsistencies within the mental health workforce, including a lack of consistent training, on the job support, system failures, funding discrepancies and staff burnout.

We note particular concerns in relation to the engagement of agency staff in public inpatient units, where the patient care needs are complex, and there are differences across facilities and Health Service providers that can impact on patient safety.

Maurice Blackburn is also concerned about the increasing utilisation of precarious employment arrangements within the health sector.

We submit that these issues should be addressed through a review of current credentialing requirements for mental health staff and the development of consistent training requirements across mental health services.

Recommendation 7:
That the Royal Commission recommend a review of current credentialing requirements for mental health staff and the development of consistent training requirements across mental health services.

Recommendation 8:
That the Royal Commission consider the role of precarious work arrangements on worker mental health.

(c) Strengthened pathways and interfaces between Victoria's mental health system and other services

i. Interface with the health system

Maurice Blackburn has identified inconsistencies between providers and a lack of clarity around role responsibility for discharge, community transition and criteria for voluntary and involuntary admissions.

This is particularly problematic in the context of mental health patients that may be at risk of suicide or violence, as a lack of care and family support may increase the risk of injury or death for patients and the wider community.

We consider that there should be a review of the expectations, documentation and responsibilities of mental health service providers with a view to ensuring consistency regarding:

- Discharge planning;
- Continuity of care between inpatient and community services; and
- Clarity around the criteria for voluntary and involuntary status, keeping in mind consideration of the 'least restrictive care' principle.

It is apparent from a number of cases Maurice Blackburn has been involved in that medical practitioners are forced to make 'hybrid' admission status decisions where a patient meets criteria for involuntary admission but it is considered that voluntary treatment is the least restrictive option.

For example, we often see notes that a patient is to be admitted as a voluntary patient, but that their admission status is to be changed to involuntary should the patient attempt to leave the facility.

In circumstances where ward staff have no capacity to restrain a voluntary patient, and indeed where facilities are not set up to include a locked/monitored entry or exit point, the practical capacity for a patient's admission status to be converted is significantly limited.

Maurice Blackburn has also identified capacity and assessment issues within emergency departments across state health services.

We have identified that Victoria Police are placed under significant strain in the management of mental health incidents, particularly where families have been advised that the local public health service (including the CAT team) does not have capacity to manage an acute mental health incident.

A lack of mental health resourcing has resulted in some of our clients being turned away from emergency departments when requesting treatment. In some cases this has led to further injuries to our clients and in other cases, significant injury or worse still suicide.

The impact of this lack of acute resourcing is compounded where patients have not been able to access community services, or have not been supported to identify suitable services on discharge from acute care.

We have seen many cases where a patient is discharged from an inpatient psychiatric unit and no notification is provided to the patient's General Practitioner (GP) or psychologist/psychiatrist.

Similarly, we have seen cases where patients with serious mental health conditions are discharged with no plan for review by the health service, a GP or any community service. In many cases this leads to readmission, grave social and health outcomes, and in some cases serious injury and suicide.

Recommendation 9:
That the Royal Commission recommend a review of the expectations, documentation and responsibilities of mental health service providers regarding discharge planning and continuity of care between inpatient and community services.

Recommendation 10:
That the Royal Commission recommend a review of the expectations, documentation and responsibilities of mental health service providers with a view to ensuring clarity around the criteria for voluntary and involuntary status, keeping in mind consideration of the 'least restrictive care' principle.

ii. Interface with the National Disability Insurance Scheme (NDIS)

In recent times, Maurice Blackburn has noted a lack of clarity around access to the NDIS for Victorians with mental health conditions. In particular, we have consistently argued that the national roll-out process is leaving vulnerable groups and people behind.

The ideal of the transition to a free market model has not, in our experience, been grounded in the reality of the change process. The NDIA is now trying to cope with burgeoning demand and an underdeveloped supply market.

In our experience, the roll out of the NDIS has left many people with psychosocial disability without the supports they were receiving under pre-NDIS funding arrangements.

This is supported by evidence provided to the Productivity Commission, in their January 2019 Review of the National Disability Agreement.[1] The report from that review notes "Supports for people with psychosocial disability" as one of the areas where there is a lack of clarity around funding arrangements since the introduction of the NDIS. The report reads:

> *There is potentially a large gap in the number of people with severe psychosocial disability not eligible for the NDIS. Psychosocial disability relates to the effects (through impairments or restrictions) on someone's ability to participate fully in life as a*

[1] https://www.pc.gov.au/inquiries/completed/disability-agreement/report/disability-agreement.pdf.

> *result of mental ill-health. About 282 000 people aged up to 65 are estimated to have severe psychosocial disability requiring supports. Once the NDIS is fully implemented, approximately 64 000 people are estimated to be covered on the basis of a primary disability of psychosocial disability. Funding of some services used by non-NDIS participants is being transferred to the NDIS from existing Australian Government programs, including the Personal Helpers and Mentors, Day to Day Living, Partners in Recovery and Mental Health Carer Respite programs. Participants also raised concerns about gaps caused by the transfer of (already underfunded) community mental health programs to the NDIS.* (p.14)

This is in line with our experience.

There are fundamental issues with the perception of the role of the NDIS in relation to psychosocial disability. These include:

- NDIS systems and philosophies are not equipped to deal with the episodic nature of mental illness. The need for support is real at the times when the disability is impacting the person's life.
- The NDIS classifies mental health treatment as a medical condition, as opposed to a disability, meaning participants are unable to access integrated services to support improved outcomes.
- Representative bodies of groups with mental illness struggle to equate the NDIS requirement that "the person's impairment or impairments are, or are likely to be, permanent".[2]

Whilst the above issues, plus the shift from a state-based bloc funded model are playing out, it is the clients that are missing out on services.

A number of inquiries have concluded that the frameworks adopted by the NDIS in relation to mental health issues are failing to provide clarity or certainty in these issues.

The Joint Standing Committee on the National Disability Insurance Scheme's recent inquiry (September 2018) into market readiness highlighted the same thing. Recommendation 6 of their report notes:

"*[t]he committee recommends the NDIA urgently implement the tailored pathways designed to support … participants with psychosocial disability.*"[3]

Maurice Blackburn would support this finding.

We encourage the Royal Commission to prioritise any actions that, under current procedures for access to and assessment under the NDIS, allow state-based services to continue to provide consistent information and

[2] https://www.legislation.gov.au/Details/F2018C00165. Part 5, s 5.1(b).
[3] https://www.childabuseroyalcommission.gov.au/.
https://www.aph.gov.au/Parliamentary_Business/Committees/Joint/National_Disability_Insurance_Scheme/MarketReadiness/~/media/Committees/ndis_ctte/MarketReadiness/report.pdf

support for NDIS applicants. Cost shifting during this transition phase is putting people with mental health issues at risk.

iii. Interface with the National Redress Scheme for Survivors of Childhood Sexual Abuse

Through Maurice Blackburn's work in abuse law, we have also identified concerns with the National Redress Scheme for survivors of childhood sexual abuse.

The Royal Commission into Institutional Responses to Child Sexual Abuse heard the stories of more than 8,000 abuse survivors. The Royal Commission made almost 2,500 referrals to the police.[4] The final report puts the number of abuse Australians in the tens of thousands. Further, despite a legislated cap of $150,000, the average payout made through the Redress Scheme so far is under $80,000.[5]

The main reason that so few of the applications have been finalised is that institutions have failed to sign up to the scheme.

Maurice Blackburn is concerned about the potential for these delays to exacerbate the impacts of survivors living with mental health conditions as a result of the abuse suffered as children.

A $5,000 cap has been placed on counselling provision, despite this being contrary to the recommendations of the Royal Commission.

Questions have also been asked about the resourcing of the Scheme in terms of its capacity to urge institutions to sign up. This concern is shared by the Victorian Attorney General, who is quoted as saying:

…the federal government could increase resources to the scheme to speed up claims, because delays risk re-traumatising victims. Many people don't report that they were victims of child sex abuse for a long period of time and the scars of that emotional and physical trauma often play out in a range of ways.[6]

Maurice Blackburn submits that the Royal Commission should consider the impacts of the development, continuation or worsening of mental health conditions due to an inability to access appropriate redress, and consider how the mental health system can respond to the need for psychological services for survivors.

Recommendation 11:
That the Royal Commission consider the impacts of the development, continuation or worsening of mental health conditions for survivors of childhood sexual abuse due to an inability to access appropriate redress, and consider how the mental health system can respond to the need for support services for survivors.

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[4] https://www.childabuseroyalcommission.gov.au/.
[5] https://www.sbs.com.au/news/institutions-not-in-redress-scheme-named.
[6] https://www.9news.com.au/2019/03/06/19/45/news-melbourne-national-redress-scheme-delays-victorian-government-politics.

(e) Improved Data collection

Maurice Blackburn is concerned about inconsistencies in the efficiency and efficacy of data collection processes following critical incidents.

Over many years we have continued to see the same issues in mental health service provision that lead to death, disability and injury.

It is apparent that there is no consistent approach to communicating learnings amongst mental health service providers, or that there is insufficient oversight to ensure recommendations and learnings are implemented consistently.

We submit that there should be a review of the role and function of various government bodies, including the Coroner's Court and the Chief Psychiatrist, in providing data and learnings arising from critical incidents and the consequences for Victorians with mental illness.

Recommendation 12:
That the Royal Commission recommend a review of the role and function of various government bodies, including the Coroner's Court and the Chief Psychiatrist, in providing data and learnings arising from critical incidents and the consequences for Victorians with mental illness.

3. How to best support the needs of family members and carers of people living with mental illness.

We consider the support needs of family and carers to be a central theme to this inquiry.

Maurice Blackburn submits that there are two important factors which needs to be balanced – the need for privacy for the person with a mental health issue, and the importance of families and carers in the development and implementation of treatment plans.

From our experience working with patients, families and carers we provide the following for the consideration of the Royal Commission:

- Whilst treatment centres and practitioners must be aware of patient privacy, we believe it is essential that family members and carers are informed of treatment plans – particularly during episodes of crisis or transition (for example, on discharge from acute mental health services, on a change of medications, after involvement of emergency services such as police or ambulance call outs).

  This is particularly pertinent in circumstances where the patient may not have legal capacity to make decisions, including circumstances where a patient is refusing treatment or a clinician has determined not to provide a formal care plan.

- Maurice Blackburn believes that it is preferable that family members and carers have opportunities to engage in the development of treatment plans, and be empowered to ask questions about care planning.

- Patients and their families require more information about the variety of services available to them – and the implications of such options. For example, if a patient is being admitted to a private psychiatric facility, both the patient and their family/carer should understand that there is no capacity to involuntarily admit the patient, or to prevent a patient from leaving.

- Carers and family members should be given information about accessing community based mental health services, and crisis management plans, following acute mental health episodes and/or hospitalisation.

To this end, we consider that public health education, targeting issues associated with navigating the mental health system, would be of significant assistance to families and carers. For example, a crisis management website, with instructions/prompts for management of acute episodes and contact details for local services would be of considerable value.

We also consider it would be of value for the mental health sector to engage further with GPs in relation to the provision of information for families and carers. This would include a review of the funding and resourcing for GP services, and the availability to patients and their carers/families.

As discussed above, in our response to Term of Reference #1, we consider there is opportunity to empower GPs to take a more active role in early intervention.

4. How to improve mental health outcomes, taking into account best practice and person-centred treatment and care models.

As mentioned above, we note Recommendation 6 of the Joint Standing Committee on the National Disability Insurance Scheme's inquiry into market readiness, highlighting the need for urgent implementation of tailored pathways to support participants with psychosocial disability, and those from culturally and linguistically diverse backgrounds, Aboriginal and Torres Strait Islander communities, and remote and very remote communities, amongst others.

We encourage the Royal Commissioners to be mindful of the outcomes of that inquiry.

We provide specific comment below on what, in our experience, are particular areas of need in mental health.

(a) Rural and regional communities

Maurice Blackburn notes that there are differences in support for people with mental illness when provided in metropolitan, urban fringe, regional, rural and remote areas.

In particular, Maurice Blackburn's medical negligence department has dealt with multiple cases involving regional mental health services lacking sufficient facilities to effectively treat patients.

Major issues we have identified include a lack of beds in public facilities, inadequately trained staff for triage, diagnosis and treatment, and a failure to provide adequate follow up and community care services.

In addition, there is a lack of understanding about entitlement and access to transfer to a tertiary facility in a metropolitan area, and the practicalities of such a transfer taking place.

It is readily apparent from our cases that the ability to access support in rural and regional communities is significantly lower than access in Melbourne.

Maurice Blackburn is of the view that, in a regional and remote context, there needs to be a greater focus on discharge planning and ensuring that families have adequate support when patients receiving mental health treatment are released into their care.

We also note that our regional clients report that local GPs are struggling to cope with the number of patients requesting mental health services. With mental health now being reported as the number one reason why people are going to their GP[7], there are often not enough local specialists to which a GP can refer a patient, leaving GPs with limited treatment options.

In a recent case, we were instructed that the waiting list for a regional patient to see a public psychiatrist was between 12 – 18 months. The patient had been advised that, until a psychiatrist had reviewed him, he was unable to access appropriate psychotropic medications. Unfortunately, that patient did not survive to attend the appointment.

We submit that there should be a review of systemic issues in service provision in different geographic areas including, but not limited to:

- Workforce planning;
- Resourcing;
- Response to changes in population and geographically specific issues; and
- Remote supervision and access to services, including increasing technological capacities.

Recommendation 13:
That the Royal Commission recommend a review of systemic issues in service provision in different geographic areas including workforce planning, resourcing, response to changes in population, and remote access to services, including increasing technological capacities.

[7] https://www.abc.net.au/news/2018-09-19/number-one-reason-why-people-see-their-gps-mental-health/10281134.

(b) Asylum seekers

Maurice Blackburn also draws the Royal Commission's attention to mental health issues experienced by asylum seekers in the Victorian community, particularly given that many asylum seekers have experienced torture and trauma.

The Federal Government's National Mental Health Commission's Statement on the mental health of refugees and asylum seekers notes the following:[8]

Asylum seekers and refugees should have access to effective support for their mental health and wellbeing, irrespective of where they are located. Priority should be given to providing support that is trauma informed and culturally appropriate. Maintaining connections should be a key consideration, particularly the connections between children and parents.

Everyone has a right to live a contributing life, including asylum seekers and refugees protected under Australia's Refugee and Humanitarian Program. Effective support, care and treatment; connections with family, friends, culture and community; and feeling safe, stable and secure are some of the foundations for enabling people to live a contributing life.

Maurice Blackburn submits that the Royal Commission should consider a review of access to services for refugees and asylum seekers in Victoria, including ensuring a consistent approach to referring individuals for appropriate care within their local communities and taking into account cultural and religious considerations.

Recommendation 14:
That the Royal Commission recommend a review of access to services for refugees and asylum seekers in Victoria, including ensuring a consistent approach to referring individuals for appropriate care within their local communities and taking into account cultural and religious considerations.

5. How to best support those in the Victorian community who are living with both mental illness and problematic alcohol and drug use, including through evidence-based harm minimisation approaches.

No response to this Term of Reference

6. Any other matters necessary to satisfactorily resolve the matters set out in paragraphs 1-5.

The Royal Commission seeks comment on any other matters necessary to satisfactorily resolve the preceding matters.

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[8]http://www.mentalhealthcommission.gov.au/central.health/dfsuserenv/Users/User_01/TowiIm/Desktop/Statement%20on%20asylum%20seekers%20and%20refugees.pdf.

Maurice Blackburn draws the Royal Commission's attention to two matters drawn from our experience which are not covered by the other Terms of Reference, namely:

(a) Public and private mental healthcare, and

(b) Inequality in Exposure to Statutory Compensation and Insurance Schemes

(a) Public and private mental healthcare

Maurice Blackburn acknowledges that there are differences in support for people with mental illness when provided through the public and private healthcare systems.

In particular, we note that facilities for involuntary patients are only available within public health services, which can lead to significant management difficulties for clinicians working in the private system.

As identified in our response to Term of Reference 2, there is an inconsistency between the legal framework for conversion to involuntary status, and the practical considerations where a patient may be volatile, irrational and violent.

Maurice Blackburn submits that there should be a review of the interaction between public and private mental health services aimed at ensuring that patients are not negatively affected by the often prohibitive waiting times for access to public mental health services.

The issue of excessive wait times for public patients is particularly prevalent in rural locations.

Maurice Blackburn has been instructed that some clients have been advised of wait times in excess of 18 months to consult a psychiatrist under the public healthcare system, which is unacceptable and dangerous for patients experiencing acute mental health issues requiring immediate treatment.

Recommendation 15:
That the Royal Commission recommend a review of the interaction between public and private mental health services, aimed at ensuring that patients are not negatively affected by the often prohibitive waiting times for access to public mental health services

(b) Inequality in Exposure to Statutory Compensation and Insurance Schemes

Maurice Blackburn submits that the core issue in relation to the adequacy of statutory compensation schemes in dealing with mental health problems is that, in our experience, claimants with mental health claims are treated very differently from those with physical health claims.

Maurice Blackburn submits that there should be no difference.

Maurice Blackburn has several concerns in relation to how statutory compensation schemes respond to claims involving mental health issues. Those concerns can be articulated under the following main headings:

i. Compensation Scheme treatment of people with mental health claims

ii. Workplace attitudes to mental health

i. Compensation Scheme treatment of people with mental health claims:

Every day, Maurice Blackburn staff assist people with injuries to achieve compensation through various statutory schemes – be it for a road related injury, a workplace injury and return to work process or some other statutory process.

It is evident that those who are working through the system due to a mental health claim are treated differently than those with a physical injury.

Often these differences are entrenched in the explicit wordings of the legislation. Sometimes the inequity is more about the implicit interpretation of the legislation.

An example of explicitly entrenched inequity can be found in Victorian Workcover legislation. In order to claim a Permanent Impairment benefit, the following minimum thresholds apply:

- For a physical injury[9], the injury threshold is 10% impairment.
- For a psychiatric impairment[10], the injury threshold is 30% impairment.

Such a difference does not apply in other Victorian statutory compensation schemes, such as the TAC scheme.

Maurice Blackburn submits that the Royal Commission should identify where such differences exist in legislation, and determine why such explicit differences exist.

Some inequities in statutory compensation schemes' treatment of people with mental health claims are more implicit in the legislation, or have come about through interpretation.

As an example, a number of statutory compensation schemes, contain a clause restricting compensation mental health claims if the worker has been subject to management action – such as performance management or disciplinary action.

In our experience, it is not uncommon in these situations for witnesses to be reluctant to come forward to support a worker suffering a psychological injury such as the above, for a fear of reprisal by their co-workers or their employer.

[9]http://www1.worksafe.vic.gov.au/vwa/claimsmanual/Content/6Specialised_Payments/PDFs/Compensation%20Table%20for%20Physical%20Impairment%202018.pdf
[10]http://www1.worksafe.vic.gov.au/vwa/claimsmanual/Content/6Specialised_Payments/PDFs/Compensation%20Tables%20for%20Psychiatric%20Impairment%202018.pdf

Appeals processes for injured people who have fallen foul of 'management action' clauses are complex, and the costs are prohibitive for most claimants.

The imposition of the additional barrier of 'management action' obviously treats people with a psychological claim differently from those making a claim for physical injury.

Maurice Blackburn submits that the Royal Commission should identify where such differences exist in the application of legislation and determine why such differences exist.

To make matters worse, after liability for a claim has been accepted by Workcover, workers are often continuously subjected to medical assessments and ongoing disputes with respect to the extent of their weekly entitlements. This aspect of compensation schemes can have significant impacts on the mental health of workers who are seriously injured.

In this way, in our experience, it is not unusual for the delays, administration and legislation of statutory compensations schemes to generate mental health issues, not resolve them.

Another way that statutory compensation schemes indirectly disadvantage workers with psychological injury claims is in legislated time limits.

Most jurisdictions have strict time limits for lodging a workers' compensation statutory claim, such as a strict time limit to lodge a claim, from first being assessed by a Doctor.

Many mental health conditions can take a long period of time to develop, or go underdiagnosed for lengthy periods of time. They are seen as taboo and not discussed especially in the workplace. For those suffering, they often seek medical treatment confidentially, and are reluctant share their experiences, especially at work, in the hope it will go away.

This often means that by the time their condition gets to the stage where they cannot work, or they finally feel comfortable advising their employer, insurers having gained access to medical records will claim that their time limit to lodge a claim has passed.

A failure to meet this time limit without reasonable cause, means the claim is statute barred, denying access to entitlements.

A 2015 report released by Safe Work Australia titled *Work-related mental disorders profile*[11] revealed that between 2008-09 and 2012-13, on average, around 90 per cent of workers' compensation claims involving a mental condition were linked to mental stress. Exposure to trauma was identified among these conditions.

There is no doubt that this impacts workers with a mental health related claim far more than those claiming for physical injury. In most cases, it is easy to attribute the cause of a physical injury. This is not the case with psychological injury. We have seen cases where insurers have trawled back through a claimant's history in order

[11] https://www.safeworkaustralia.gov.au/system/files/documents/1702/work-related-mental-disorders-profile.pdf

to find life events which *may* have caused the psychological injury, rather than accept that it is work related.

In short, people with claims for psychological injury are being treated differently from those suffering physical injury through statutory compensation schemes and their insurers.

The statutory legal test for psychological injury includes complicated explicit and implicit legal exceptions that can apply to exclude a psychological injury claim from being accepted as a workers' compensation injury. This is a higher test than for physical injury, across jurisdictions.

ii. Workplace attitudes to mental health:

In our experience, mental health is widely misunderstood in the workplace – and, in fact, in the wider community. This leads to a number of potential cultural issues in the workplace, such as:

- A culture which implicitly or explicitly encourages ongoing stigmatisation of a worker who has sustained psychological injury
- A culture where toxic masculinity leads to an unwillingness to come forward with a health concern
- A culture which engenders fear of potential discrimination, harassment or reduced opportunities for career progression

Maurice Blackburn notes that work site inspections are common occurrences for physical health and safety checks – especially following major incidents or identifiable trends of poor process in a workplace.

We suggest that the same level of scrutiny does not exist following identifiable trends of poor mental health practices in a workplace.

Once again, this represents a clear difference in workplace attitude to physical injury, compared to psychological injury. Thus, people with mental health issues in the workplace are treated differently to those with physical injuries.

Maurice Blackburn also notes that workers may be exposed to bullying, cyberbullying, sexual harassment and other social interactions in the workplace that, in some instances, may have a deleterious impact on the worker's mental health.

Maurice Blackburn is of the view that one of the significant failings of the current legislative protections for people with mental illness in the workplace is the onus it places on victims to seek redress for the harm they have suffered.

We submit to the Royal Commission that there should be a review of the interaction between workplace mental health policies and access to mental health services for workers, such that the onus on employees to seek help is reversed.

Recommendation 16:

That the Royal Commission should seek a review of the interaction between workplace mental health policies and access to mental health services for workers, such that the onus on employees to seek help is reversed.

Maurice Blackburn has similar concerns in relation to how mental health issues are processed by the insurance industry.

There are two main areas for concern in this regard:

i. Making **access** to insurance unattainable for people with a history of mental health issues through blanket and limited exclusions in insurance policies, and

ii. Concerns about disadvantage experienced by people with mental health issues being able to **claim** on insurance

i. Access to insurance.

Some insurance policies, particularly travel insurance policies and injury/accident policies, will not provide cover for any claim arising from a mental health condition. That means that even if a consumer has no history of mental health problems, if something were to happen in the future and he/she needed to take time off work or otherwise claim for a mental health condition claim, it would not be covered.

This represents a fundamental difference between access to insurance against physical injury or illness compared to mental health issues.

Recent research has found more than half of Australian travel insurers do not cover people with mental health conditions[12].

The impact of the denial of access to insurance due to mental health conditions can be devastating. It could lead to:

- People postponing treatment, often at the times when they most need it, in order to satisfy their insurers' requirements[13]
- People choosing to, or being forced to remain uninsured
- People not discussing potential mental health issues with their GP for fear of negative consequences, thereby remaining undiagnosed.

With mental health now being reported as the number one reason why people are going to their GP[14], and the rate increasing, it makes no sense for these blanket exclusions to exist.

ii. Insurance Claims:

[12] https://www.smh.com.au/business/consumer-affairs/an-absolute-minefield-why-darryl-couldn-t-get-travel-insurance-20180801-p4zuth.html
[13] https://www.abc.net.au/news/2018-10-31/mental-health-treatment-excluding-people-from-insurance/10382532
[14] https://www.abc.net.au/news/2018-09-19/number-one-reason-why-people-see-their-gps-mental-health/10281134

Failure to fully disclose a mental health condition, or even a past mental health condition, can allow insurers to not only deny a claim but also to 'avoid' the insurance cover, as if it never existed.

This means an insurer could refuse to cover any claim under the insurance policy, even if it's completely unrelated to the matter that was not disclosed. This can happen even if the non-disclosure was an innocent oversight.

Maurice Blackburn had a client, for example, who stopped work due to an inner ear imbalance caused by a failed operation. He made an income protection claim, only to have his policy avoided by the insurer because he'd been diagnosed with a mental health problem many years ago, which he hadn't disclosed.

The fact that he considered his mental health condition had long since recovered did not stop the insurer from rejecting the claim.

In many cases such as this one, the mental health condition which has been used by the insurer as the basis for avoiding the claim, has nothing to do with the nature of the claim itself.

In our experience, this is not uncommon. A lot of people going through an insurance application process are mindful of their current health, but not so much of their entire medical history.

Recommendation 17:
That the Royal Commission recommend the establishment of a formal review of the inequalities experienced by people with mental health issues in gaining access to insurances, and in claims management processes.

Summary and Recommendations

Maurice Blackburn welcomes the Royal Commission's broad focus and commitment to improve the mental health system in Victoria.

As can be seen above, mental health services interact with many areas of law, and across many parts of the Victorian community.

Should the Commission require clarification as to any aspect of our submission, or wish to seek further information from our lawyers or clients, please do not hesitate in contacting us.

Recommendations:

Recommendation 1:
That the Royal Commission recommend that a comprehensive review of the practical application of 'least restrictive' care be instigated to ensure that the principle is applied consistently across facilities and medical practitioners.

Recommendation 2:
That the Royal Commission recommend greater guidance for medical practitioners to ensure they can make decisions under the Mental Health Act that have appropriate regard to human rights principles and common law principles of duty of care.

Recommendation 3:
That the Royal Commission consider the need for the development of consistent standards for the consideration of granting leave, monitoring of leave and responses to failure to return from leave.

Recommendation 4:
That the Royal Commission recommend the development of a consistent regulation regime for the design and layout of inpatient mental health facilities.

Recommendation 5:
That any regulation regime for the design and layout of inpatient mental health facilities should specifically protect against patient access to ligature fixture points.

Recommendation 6:
That the Royal Commission recommend a review of the role and function of the CAT Team and, in particular, whether the current level of funding and resourcing requires amendment

Recommendation 7:
That the Royal Commission recommend a review of current credentialing requirements for mental health staff and the development of consistent training requirements across mental health services.

Recommendation 8:
That the Royal Commission consider the role of precarious work arrangements on worker mental health.

Recommendation 9:
That the Royal Commission recommend a review of the expectations, documentation and responsibilities of mental health service providers regarding discharge planning and continuity of care between inpatient and community services.

Recommendation 10:
That the Royal Commission recommend a review of the expectations, documentation and responsibilities of mental health service providers to ensure clarity around the criteria for voluntary and involuntary status, with consideration of the 'least restrictive care' principle.

Recommendation 11:
That the Royal Commission consider the impacts of the development, continuation or worsening of mental health conditions for survivors of childhood sexual abuse due to an inability to access appropriate redress, and consider how the mental health system can respond to the need for support services for survivors.

Recommendation 12:
That the Royal Commission recommend a review of the role and function of various government bodies, including the Coroner's Court and the Chief Psychiatrist, in providing data and learnings arising from critical incidents and the consequences for Victorians with mental illness.

Recommendation 13:
That the Royal Commission recommend a review of systemic issues in service provision in different geographic areas including workforce planning, resourcing, response to changes in population, and remote access to services, including increasing technological capacities.

Recommendation 14:
That the Royal Commission recommend a review of access to services for refugees and asylum seekers in Victoria, including ensuring a consistent approach to referring individuals for appropriate care within their local communities and taking into account cultural and religious considerations.

Recommendation 15:
That the Royal Commission recommend a review of the interaction between public and private mental health services, aimed at ensuring that patients are not negatively affected by the often prohibitive waiting times for access to public mental health services.

Recommendation 16:
That the Royal Commission should seek a review of the interaction between workplace mental health policies and access to mental health services for workers, such that the onus on employees to seek help is reversed.

Recommendation 17:
That the Royal Commission recommend the establishment of a formal review of the inequalities experienced by people with mental health issues in gaining access to insurances, and through claims management processes.