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Roads to Recovery: Building a Better System for People Experiencing Mental Health Issues in Victoria

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

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Executive Summary

Now is the time for a total rethink and genuine culture shift. We need more services, better services and importantly, we also need alternative services. Let those of us most impacted by the system lead the way in designing a new system that works for us. We want services that are amazing – that you would consider good enough for yourself or your families and friends (**Wanda Bennetts, Senior Consumer Consultant, Victoria Legal Aid**).

The Royal Commission into Victoria's Mental Health System (**Royal Commission**) provides a once-in-a-lifetime opportunity to look at a system that is not currently working to support people's personal recovery and is at times harmful.

Through our work, Victoria Legal Aid (**VLA**) sees the intersection between people's mental health and other social, economic and legal issues. For example, we see the way a lack of access to housing, disability services, employment, income support and/or mental health services in the community, and experiences of isolation, family violence and/or discrimination, can damage people's mental health and undermine their recovery.

Support and service gaps and failures also contribute to escalating issues, which can include family breakdown, homelessness, criminal offending, removal of children, loss of income and employment or hospitalisation. Once people have entered crisis-based systems, their exit, reintegration and recovery are again dependent on access to adequate housing and supports in the community.

This submission highlights the stories of 24 people.¹ Their stories paint a picture of diverse lives, strengths and challenges. The experience that unifies them is that, at points in their lives, the mental health system – and the systems that intersect with it – have failed to understand and meet their needs. The hardship that our clients and consumers have experienced as a result of these system failures remind us all that widescale, systemic change is essential and urgent.

These 24 people's stories also highlight the importance of the Royal Commission being informed by the social determinants of health and framed within a social model of health rather than a purely medical model. This will allow for a system-wide review with the person at the centre and will encourage consideration of the different social, economic and legal factors that affect a person's wellbeing. It will also move from a deficit model focused on symptoms to a focus on people's strengths.

Recognition of the importance of consumer co-production and leadership should be at the foundation of the Royal Commission and the system it helps redesign.

We are optimistic about the potential of the Royal Commission to inform a system that responds to people's physical, mental, emotional, economic and social needs. As a community, we need a system that supports people's choices and their recovery in ways that enable them to live the best lives they can, as determined by them.

Informed by the experiences and expertise of our clients and consumers, this submission identifies that we are far from being at this point and what the priorities for reform should be to help us get there.

¹ Unless otherwise indicated, names and some small details have been changed to preserve confidentiality. All of the clients and consumers have consented to the sharing of their stories.

Six priority areas for reform

Informed by our work, and the experiences and expertise of clients and consumers, here are **six priority areas for reform** to build a system that promotes people's rights and recovery and reduces the negative impact of the justice system.

1. Building a recovery-focused mental health system

The mental health system is not currently focused on rights, recovery and self-determination. Compulsory, rather than voluntary, treatment continues to be higher in Victoria than other states and territories and we have low rates of advocacy and representation for people facing compulsory treatment. The Royal Commission should not miss the opportunity to change this. Three priority areas for building a recovery-focused mental health system are:

- Supporting people to manage their own health in the way that they have identified works for them, including flexibility for support and treatment to be 'flexed' up and down to maintain a person's health.
- Realising the rights and recovery focus of the *Mental Health Act 2014* (Vic) (**Mental Health Act**), including embedding the principles of least restriction and supported decision-making, where rights are maximised and compulsory treatment is truly a last resort.
- Regulating treatment and intervention to support autonomy and dignity and reduce as far as possible the negative impact of compulsory treatment when it does happen.

2. Embedding consumer leadership and advocacy as part of a rights-focused system

People whose lives are directly affected by the mental health system should shape and have influence over the re-imagined mental health system that emerges from the Royal Commission.

More work is needed to embed consumer leadership, at all levels, for it to be truly influential and realise its potential in improving services. Importantly, this must extend beyond mental health services, and all systems that are dealing with people experiencing mental health issues should commit to consumer leadership so that their services are relevant and responsive to the people using them.

The Independent Mental Health Advocacy (**IMHA**) service is an example of a service model that includes individual and systemic advocacy with consumers at the centre. As an organisation, VLA has seen the value of consumer leadership and the depth and diversity of expertise it provides. We are committed to continuing to strengthen consumer leadership and this must also be a priority for the Royal Commission and its recommendations for genuine reform.

3. Reducing the harm of criminal justice involvement for people experiencing mental health issues

There is an over-representation in the criminal justice system of people, including young people, with mental health issues. The justice system must not be the default mental health service provider. Based on our experience working with people across the justice system, there are some essential steps that must be taken to reduce the rates and intensity of criminal justice involvement for people experiencing mental health issues. These include:

- Reducing the number of people with mental health issues entering the criminal and youth justice systems.
- Increasing access to diversion, therapeutic courts and community-based sentencing options.
- Recognising that people with mental health issues may not be criminally responsible for their conduct.

- Reducing the harm associated with imprisonment, including access to appropriate forensic mental health facilities.
- Supporting people towards rehabilitation, recovery and life in the community.

4. Improving responses of other systems and services to mental health

Through our work, VLA sees the intersection between people's mental health and other life and legal issues. For example, we see the way a lack of access to housing, disability services, employment, income support and/or mental health services in the community, and experiences of isolation, family violence and/or discrimination, can cause damage to people's mental health and undermine their recovery. We also see the way in which this can lead to other service systems adopting a deficits-focused view of people experiencing mental health issues, failing to focus on and support their strengths to recover and address issues, for example in the child protection system.

The Royal Commission is an opportunity to undertake a system-wide review with the person at the centre, including:

- Adopting a social model of health to analyse the social, economic and legal factors that affect a person's wellbeing.
- Recognising that people have overlapping family, health, housing, NDIS, justice and social issues and need access to coordinated, integrated services in the community before they reach crisis point.
- Ensuring that people experiencing mental health issues are treated fairly in other systems and services and that the impacts of family violence or other trauma are properly recognised and responded to.

5. Reducing inequalities and developing tailored, culturally safe services

Currently, people get different treatment and services depending on where they live and there are insufficient and inadequate services tailored for particular groups within our community.

A person's postcode should not affect the treatment and services available to them. The Royal Commission is an opportunity for Victoria to work toward a service and legal landscape where people are not disadvantaged by where they live and where we invest in models that work right across the State.

Services should be tailored and culturally safe for groups within our community, including Aboriginal and Torres Strait Islander people, CALD communities, LGBTIQ people, older people, women and young people. The service needs of these priority groups should be informed by engagement with consumers who are members of these communities.

6. Strengthening governance, accountability, data and transparency

Stronger governance, oversight and accountability mechanisms are a crucial component of bridging the current gap between the rights and recovery focused system the Mental Health Act promises, and the reality on the ground for consumers.

There is very limited publicly available data regarding the mental health system, including data on how many people are subject to compulsory treatment, and their geographical location, age, gender, cultural background, type and length of order, and complaints. Data is critical to service design, evaluation and consumer choice, and a key part of ensuring accountability.

The Royal Commission should form a view about what a good system looks like. This is an opportunity to make sure that the necessary systems and processes are put in place to measure and monitor whether the system is meeting the needs of consumers, as identified by them, and to respond when it is not.

Victoria Legal Aid, our clients and consumers, and mental health

VLA is a statutory agency responsible for providing information, advice, and assistance in response to a broad range of legal problems. Working alongside our partners in the private profession, community legal centres, and Aboriginal legal services, we help people with legal problems such as criminal matters, family separation, child protection, family violence, fines, social security, mental health, immigration, discrimination, guardianship and administration, tenancy, and debt.

Our Legal Help telephone line is a resource for all Victorians to seek information, advice and assistance with legal problems. We also deliver specialist non-legal services, including our Family Dispute Resolution Service (**FDRS**), Independent Mental Health Advocacy and Independent Family Advocacy and Support (**IFAS**), as well as providing community legal education, and contributing to policy and law reform.

Our contribution to this Royal Commission is informed by our work with clients and consumers experiencing mental health issues, including:

- **Over one-quarter of our clients.** During 2017–18, VLA provided assistance to 94,485 unique clients: 26% disclosed having a disability or mental health issue and 11% were in custody, detention or psychiatric care.² In our recent Client Satisfaction Survey, 33% of clients reported that they experienced mental health issues. While some of VLA's work with people experiencing mental health issues is specifically within the mental health system, much of it is VLA's other day-to-day work across summary crime, indictable crime, child protection, family law, family violence, discrimination, social security, migration, tenancy, and legal help for people in prison.
- **Specialist mental health legal practice.** The Mental Health and Disability Law (**MHDL**) program provides advice and representation to people with a mental health diagnosis or cognitive disability. We work to realise people's rights and autonomy, and to help make sure the justice and health systems operate fairly. In 2017–18, we provided representation to people in over 1000 hearings before the Victorian Mental Health Tribunal. We also appeared for clients in 93 *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997 (Vic)* (**CMIA**) hearings in the County Court and Supreme Court, as well as at the Forensic Leave Panel for clients on supervision orders seeking access to leave.
- **Non-legal advocates and consumer experts.** The IMHA service, a non-legal advocacy service, supports people who are receiving compulsory mental health treatment to have as much say as possible about their assessment, treatment, and recovery. IMHA's *Speaking from Experience* advisory group is made up of people who have lived experience of mental health issues and the public mental health system. IMHA is included in Victoria's *10-Year Mental Health Plan* as a service that will 'strengthen a rights-based framework for the delivery of treatment and support, and help embed person-directed assessment, treatment and recovery as the norm for service delivery'. IMHA has been the subject of a favourable three-year external evaluation, providing

² See Victoria Legal Aid, *Annual Report 2017–18* (2018) <<https://www.legalaid.vic.gov.au/about-us/our-organisation/annual-report-2017-18>> (**VLA Annual Report**). This includes clients seen by a private practitioner duty lawyer. Unique clients are individual clients who accessed one or more of Victoria Legal Aid's legal services. This does not include people for whom a client-lawyer relationship was not formed, who received telephone, website or in-person information at court or at public counters or participated in community legal education—we do not create an individual client record for these people. Neither does this client count include people assisted by our Independent Mental Health Advocacy service. We note that, because this figure relies on clients disclosing their disability or mental health issue at the time of receiving legal assistance, the actual number of clients experiencing mental health issues is likely to be significantly higher. We also note that, because of the way our data is collected and recorded, we are not able to accurately separate out mental health from other disability.

insights into current issues within the mental health system and the importance of advocacy, as well as mechanisms to ensure coordinated oversight and safeguards.³

- **Assistance for people in the criminal justice system.** Our Criminal Law program provides support for people involved in the criminal justice system, including those with mental health issues that may be relevant to their offending or their experience of criminal justice processes. This includes our specialist Therapeutic Courts and Programs team, comprising lawyers working in the Assessment and Referral Court (ARC) List in the Magistrates' Court,⁴ our specialist practice with clients who fall under the CMIA as well as duty lawyers assisting people with mental health issues whose matters are dealt with through mainstream criminal justice processes.
- **Child protection, family violence and family law.** Our Family, Youth and Children's Law program provides help to children, young people and families to keep people safe, resolve family disputes, and achieve safe, workable and child-focused parenting and care arrangements. We support families involved in matters across the state child protection and family violence jurisdictions and federal family law jurisdiction, many of which involve complex issues such as family violence, mental health issues, or problematic substance use. VLA also recently commenced the IFAS, a three-year pilot service providing non-legal advocacy to families engaged with the child protection system, focusing on matters before they go to court.

People experiencing mental health issues and in detention are priority clients across all our services.

The following image shows a snapshot of VLA's clients in 2017–18 who identified as having a mental health issue or disability

³ Dr Chris Maylea, Susan Alvarez-Vasquez, Matthew Dale, Dr Nicholas Hill, Brendan Johnson, Professor Jennifer Martin, Professor Stuart Thomas, Professor Penelope Weller, *Evaluation of the Independent Mental Health Advocacy Service (IMHA)* (Final Report, November 2018) (IMHA Evaluation Report).

⁴ See also Law and Justice Foundation of New South Wales, *In Summary: Evaluation of the appropriateness and sustainability of Victoria Legal Aid's Summary Crime Program* (June 2017) <<http://www.legalaid.vic.gov.au/about-us/research-and-analysis/summary-crime-evaluation-report>>, which identified that, of 14,591 grants of legal assistance made in the review period, 64% related to family violence, mental ill-health and offending-driven by drug addiction.

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23,842

of our clients identified as **having a mental health issue** or disability



1. Building a recovery-focused mental health system

In 2014, a new Mental Health Act was introduced with the promise of improving the autonomy, protections, and health and social outcomes for people who use mental health services in Victoria.⁵

This year, the Mental Health Act will have been in operation for five years. The Royal Commission provides an opportunity to consider whether the principles and provisions of the Act, including a rights-based and recovery-oriented framework for the delivery of treatment and support, are operating as intended and if not, how to change this.

VLA's specialist mental health lawyers and non-legal IMHA advocates from work with people facing or subject to compulsory mental health treatment in every designated mental health service in Victoria,⁶ including at adolescent, adult and aged, and long-term secure extended care units (**SECUs**), as well as at Thomas Embling Hospital.

In 2017–18:

- VLA lawyers provided representation to people in over 1000 hearings before the Victorian Mental Health Tribunal.
- VLA lawyers provided over 3,000 advices to people subject to compulsory mental health treatment regarding their Mental Health Tribunal hearings.
- IMHA advocates provided 8,399 high intensity services (advocacy and self-advocacy) and 17,349 low intensity services (information and referral).

Through this work with thousands of people facing or subject to compulsory mental health treatment each year, we see that the fundamental shift towards rights and recovery that the Mental Health Act intended to bring about has not yet occurred in practice.⁷

There is still heavy reliance on crisis-based, compulsory treatment that takes away people's self-determination and the cultural change needed to support recovery and focus on rights has not taken place.

This part sets out three priorities to help build a recovery-focused mental health system:

- Supporting people to manage their own health in the way that they have identified works for them, including flexibility for support and treatment to be 'flexed' up and down to maintain a person's health.
- Realising the rights and recovery focus of the Mental Health, including embedding the principles of least restriction and supported decision-making, where rights are maximised and compulsory treatment is truly a last resort.
- Regulating treatment and intervention to support autonomy and dignity and reduce as far as possible the negative impact of compulsory treatment when it does happen.

⁵ Minister Wooldridge (Minister for Mental Health), Mental Health Bill 2014, Second Reading Speech (20 February 2014) (**Minister Wooldridge, Second Reading Speech**), Hansard, 470, 473.

⁶ A designated mental health service is a health service that may provide compulsory assessment and treatment to people in accordance with the Mental Health Act 2014 (Act).

⁷ IMHA Evaluation Report, above n 3, which found that mental health services are not consistently operating in compliance with the Mental Health Act.

1.1 Understanding recovery

In the mental health context, ‘recovery’ is not synonymous with ‘cure’. In the recent case of *PBU v Mental Health Tribunal*, a test case brought by VLA on behalf of two compulsory mental health patients, Justice Bell said:

In the mental health context, ‘recovery’ is a term of art. It reflects a contemporary understanding of ‘health’ that is broad — one that requires the social and personal circumstances of the person to be considered and one that is not focused exclusively on preventing and curing illness or disease as such. It emphasises the significance of respecting and promoting patients’ self-determination over time and ensuring that patients avoid dependency and institutionalisation.⁸

Our Senior Consumer Consultant, Wanda Bennetts, explains that we need to work toward:

a system that supports people's choices and their recovery in ways that enable them to live the best lives they can, as determined by them.⁹

Informed by the experiences and expertise of our clients and consumers, this submission identifies that we are far from being at this point and what the priorities for reform should be to help us get there.

1.2 Supporting mental health in the community

1.2.1 Moving away from a system geared for crisis

Despite the Mental Health Act’s commitment to least restrictive and voluntary treatment, the current mental health system holds few options for people who need an intermediate level of support. There are virtually no services available between the 10 sessions with a psychologist subsidised by Medicare, and crisis-based services, which may rapidly lead to a person’s loss of liberty and autonomy. The system does not support people to manage their own health in the way that they have identified works for them and there is limited flexibility for support and treatment to be ‘flexed’ up and down to maintain a person’s health.

This is captured by [REDACTED], a member of our lived experience advisory group, Speaking from Experience:

There is a widespread evidence base of the importance of social and psychological factors involved in mental health recovery. However, in practical terms, the focus is solely on medication. My own mental health treatment involved a serious lack of holistic services.

It got to the point my medication was being doubled at every appointment without any offer of therapy or social supports. The increases in dose were doing nothing to support my mental wellbeing and the side effects were actually causing harm. I’ve found now that the best thing for my mental health is having opportunities to make meaningful social connections. This has been far more helpful than high doses of medication.

The mental health system would be greatly improved by a focus on reducing isolation and improving coping skills rather than just relying on medication.

⁸ (*PBU v MHT*) *PBU v Mental Health Tribunal* [2018] VSC 564 (1 November 2018) [103] (citations omitted).

⁹ See also Victorian Department of Health, *Framework for recover-oriented practice* (August 2011)

<https://recoverylibrary.unimelb.edu.au/_data/assets/pdf_file/0010/1379116/framework-recovery-oriented-practice.pdf>.

■■■■'s experience highlights a failure to work with consumers starting from a presumption of autonomy and decision-making capacity to genuinely attempt to identify viable treatment options and enable the consumer to make their own decisions in relation to them. Our experience is that it is common for mental health services to instead approach such a situation with the goal of seeking a consumer's compliance with treatment the service has already identified is the best option.

■■■■'s reflections remind us that the over-reliance on medication to treat people's mental health issues not only undermines the intention of the Mental Health Act, but also the effectiveness of our mental health system and its ability to make a positive difference in the lives of Victorians experiencing mental health issues.

We note the finding of the 2014 review by the National Mental Health Commission that resources were concentrated in costly acute and crisis care, 'despite evidence that mental health services in community settings can be more effective in preventing pain and suffering, facilitating recovery, and keeping people in the community with their families and participating in employment or education'.¹⁰

We reiterate the ongoing relevance and importance of this finding. If people cannot get the support they want and need in the community, they are more likely to end up in crisis-based services – mental health or justice – which can further set back wellbeing and recovery.

Despite this, there is a lack of investment in less restrictive, co-produced, holistic services and supports and as a result, people continue to end up in crisis and in acute inpatient services, often on compulsory orders.

■■■■, one of the members of Speaking from Experience, explained this reliance on emergency departments at hospitals and acute wards:

It's often the first stop that people make to access services and they are intensely traumatic experiences for people as they do not receive a level of care that assists with recovery. The focus is on medicating and evacuating, as there is no time and space for any non-pharmaceutical therapy.

■■■■'s reflections are strongly supported by evidence that the allocation of funding to mental health services has focused on acute and crisis treatment at the expense of earlier intervention and preventative support services in the community, resulting in area mental health services having limited capacity to intervene early in a person's experience of mental health issues to promote recovery in the community. The decrease in community mental health contacts and increase in acute admissions was recently documented by the Victorian Auditor General:

Despite mental health system growth funding allocation over the last three state budgets, the lack of funding for more than 10 years has forced [area mental health services] to focus on acute and crisis treatment at the expense of earlier intervention services in the community ... Because [area mental health services] often redirect resources from community to hospital settings to support consumers who need a higher level of care, [area mental health services] have limited capacity to intervene in the earlier stages of mental illness or deliver high quality interventions in the community to promote recovery. This limitation contributes to an increase in the number of people admitted to acute care without prior community contact.¹¹

¹⁰ National Mental Health Commission, *Contributing Lives, Thriving Communities: Report of the National Review of Mental Health Programs and Services* (2014) <<http://www.mentalhealthcommission.gov.au/our-reports/our-national-report-cards/2014-contributing-lives-review.aspx>>.

¹¹ Victorian Auditor General's Office, 'Funding', *Access to Mental Health Services* (March, 2019) <<https://www.audit.vic.gov.au/report/access-mental-health-services?section=33107--3-understanding-and-meeting-demand>>, s 3.2. Between 2009 to 2016 acute admissions grew by 19 per cent, while community mental health contacts decreased by 17 per cent, which contributes to a cycle of increasing demand for costly

Through our work, VLA sees people who end up in crisis, and consequently in an inpatient mental health unit or the justice system because of a breakdown in services in the community – in both mental health and interdependent systems, such as rehabilitation services, housing, drug and alcohol, and the NDIS. Once people have entered these crisis-based systems, their exit, reintegration and/or recovery is again dependent on access to adequate housing and supports in the community.

As a result, people can then become stuck in these systems, including being indefinitely detained (for example, in SECUs or Thomas Embling Hospital), because of a lack of support and services to enable discharge back into the community.

1.2.2 Supporting discharge or release and recovery in the community

In addition to supporting people to avoid crisis, availability of appropriate support in the community is essential to successful and sustainable discharge. A lack of access or delays in accessing community supports frequently result in consumers being subjected to a longer admission than is necessary. Consumers in SECUs are particularly at risk of prolonged detention and a delay in discharge despite otherwise being clinically ready for community treatment.

The scope and availability of community-based support and treatment services varies markedly in different areas of Victoria, which is discussed further in part 5. Consumers in rural and regional areas and those with specialised needs arising from drug use or co-occurring disabilities such as intellectual disability, acquired brain injury (**ABI**), personality disorders and autism are particularly likely to face difficulties in accessing the services they need. The current siloed nature of services makes them ill-equipped to deal with people with intersecting and overlapping needs, especially dual disability and dual diagnosis.

The transition to NDIS, which is discussed further in part 4, has significantly complicated this process. It has multiplied the number of organisations that may need to be involved, leading to increased confusion and reduced accountability. Lack of access to appropriate accommodation, generally the first thing that needs to be in place for referral to be made to community based mental health providers, is widespread.

Jamal's story shows how consumers are being held for prolonged periods in more restrictive environments than necessary. It also shows the way in which failures in services in the community – particularly housing and the NDIS – are putting pressure on crisis-based services, including Thomas Embling and SECUs.

Jamal: Lack of housing and NDIS funded supports delay discharge for four years

Jamal arrived in Australia at the age of 17 as a refugee. Soon after arriving he was imprisoned. While in prison he was assessed as needing mental health treatment and transferred to a forensic mental health unit. He was released after two years and then admitted to a public psychiatric hospital. In 2014 Jamal damaged some property and assaulted a staff member at the hospital. He was arrested and charged. Jamal declined to seek bail as he did not want to return to the hospital.

After some time in Melbourne Assessment Prison he was transferred to Thomas Embling Hospital. In January 2015 Jamal received a sentence of imprisonment for time already served meaning he was eligible for immediate release. He was immediately placed on a civil mental health order detaining him at Thomas Embling Hospital, where he remains.

emergency and inpatient services and further impacts AMHSs' ability to provide effective interventions during earlier stages of illness. Recent increases in funding for community services, however, have seen more people have preadmission contact, which begins to address this problem.

The treating team at Thomas Embling Hospital determined that it was not a clinically appropriate environment for Jamal and attempted to have him transferred to a SECU. However, the SECU at which Jamal had previously been treated refused to take him back, and other SECUs refused him because he was not in their geographical 'catchment' area. Other services to which Jamal might have been discharged, such as community care units or supported residential services, also refused to take him.

Jamal has remained detained in an inappropriate forensic facility more than four years after his sentence finished, notwithstanding the clinical evidence that such an environment is neither necessary nor suitable to his needs. Due to Jamal's institutionalisation, his guardian was only prepared to approve Jamal's discharge if he receives significant mental health and disability support, and graduated leave to accommodation, from the hospital.

The transition to the NDIS significantly delayed Jamal's discharge planning. Jamal first applied for the NDIS in 2017, however, there were a number of delays in the application process and in securing the supports that were funded in the plan and confusion about the role of the NDIA, the hospital and the provider.

A public housing property was located for Jamal by his guardian in 2017. The hospital was prepared to grant leave for Jamal to spend some time in the house as part of his reintegration to the community. However, for some time, the house had no furniture or appliances so Jamal could not spend any extended period there. At one of many Mental Health Tribunal hearings, where Jamal's further compulsory treatment at Thomas Embling Hospital was ordered, it became clear that none of the agencies engaged with Jamal including his specialist support coordinator had communicated about the importance of, or taken responsibility for, furnishing his house. Jamal's family were horrified and explained that they would immediately furnish it, but were told that it was not their responsibility.

Given the critical importance of a gradual transition back to the community for Jamal, he will continue to be held at Thomas Embling Hospital until there is progress with his transitional steps.

Jamal has spent over four years in a restrictive environment. With appropriate housing and supports in place, he could have been continuing his recovery in the community. The inability of the system to meet his needs puts extra pressure on the scarce resources of Thomas Embling Hospital, limits his quality of life and undermines his long-term recovery.

1.3 Realising the rights and recovery focus of Victoria's Mental Health Act

The enactment of the Mental Health Act was intended to move toward a more rights and recovery-focused model. This is captured in the principles of the Act, which include:

- A focus on least restrictive assessment and treatment, with the least possible restrictions on human rights and dignity.¹²
- A preference for voluntary assessment and treatment.¹³
- Supported decision-making i.e. people receiving mental health services should be involved in all decisions about their assessment, treatment and recovery and supported to make, or participate in, those decisions, and their views and preferences should be respected.¹⁴

¹² *Mental Health Act 2014* (Vic) s 10.

¹³ *Mental Health Act 2014* (Vic) s 11(a).

¹⁴ *Mental Health Act 2014* (Vic) s 11(c).

- Choice and respect and promotion of the rights, dignity and autonomy of people receiving mental health services.¹⁵
- Providing mental health services ‘with the aim of bringing about the best possible therapeutic outcomes and promoting recovery and full participation in community life’.¹⁶
- Responding to people’s individual needs (including their health, culture, language, age, disability, religion, sexuality and gender).¹⁷

When the Mental Health Act was introduced, recovery was described as being about ‘maximising individual choice, autonomy, opportunity and wellbeing during a person’s life and accordingly is a self-defined process that is highly individual’.¹⁸

Justice Bell articulated the change that had been intended through the introduction of the Mental Health Act in *PBU v Mental Health Tribunal*:

*[the] regime represents a paradigm shift from best-interests paternalism to the least-restrictive kind of treatment, which draws upon elementary human rights concepts ... The regime gives effect to the support and participation objective and principle which reflect the right to self-determination.*¹⁹

Although having a recovery-focused legislative regime is one part of building a recovery-focused system, in the absence of changes in resourcing, training, governance and culture, the reality on the ground for consumers does not match the objectives and principles of the Mental Health Act.

This part sets out key principles and protections in the Mental Health Act aimed at delivering a rights and recovery-focused mental health system. We discuss what we see in practice, and what our clients and consumers tell us, about whether these principles are being complied with, and outline what it would look like in practice if they were.

1.3.1 Compulsory treatment as a last resort

There is a tension between a recovery-focused mental health system and a system that allows for compulsory treatment. In our view, compulsory treatment should only be used where absolutely necessary and as a last resort. This is not currently the case in Victoria. Compulsory treatment continues to be heavily relied on and rates are higher in Victoria than other states and territories.²⁰

Over-reliance on compulsory treatment

We see the following examples of over-use of compulsory treatment in Victoria:

¹⁵ *Mental Health Act 2014* (Vic) s 11(d) and (e).

¹⁶ *Mental Health Act 2014* (Vic) s 11(b).

¹⁷ *Mental Health Act 2014* (Vic) s 11(f), (g) and (h).

¹⁸ Minister Wooldridge Second Reading Speech, 470, 473, above n 5.

¹⁹ *PBU v MHT* above n 8[101] (references omitted). Although the case was about the interpretation of the law around compulsory electro-convulsive treatment, Justice Bell provides context about the broader compulsory treatment regime under the Mental Health Act, the first time the Supreme Court had considered this law.

²⁰ See Edwina Light et al, ‘Community Treatment Orders in Australia: Rates and Patterns of Use’ (2012) 20(6) *Australasian Psychiatry* 478, 480. Victoria has the highest rate of people **subject to Community Treatment Orders** (98.8 per 100,000). This is compared with 61.3 per 100,000 in QLD, 48.6 per 100,000 in WA, 46.4 per 100,000 in NSW, and 30.2 per 100,000 in Tasmania. There was no data available for SA or NT. See also Piers Gooding and Yvette Maker, ‘Why are the rates of restrictive practices in Victoria’s mental health services so high?’ (Article, 2019) <<https://pursuit.unimelb.edu.au/articles/why-are-the-rates-of-restrictive-practices-in-victoria-s-mental-health-services-so-high>> (**Restrictive practices in Victoria**). Victoria is also higher than the national average for people **admitted involuntarily to inpatient units** (the percentage of people admitted to an inpatient unit involuntarily (as opposed to voluntarily) is 52% in Victoria, compared to a national average of 45.4%)

- **Number and duration of orders.** Noting that compulsory treatment should only be used where absolutely necessary and as a last resort, we see over-use of compulsory treatment orders, both in terms of the number of orders made,²¹ and the duration of these orders. Data from the Mental Health Tribunal shows that in 2017–18 over two thirds of inpatient treatment orders were made for a duration of between 21–26 weeks (a 26 week inpatient treatment order being the longest, most restrictive order the Tribunal can make).²² This gives the treating mental health service a wide discretion when it comes to determining when the consumer can be discharged from hospital, reducing independent oversight of the consumer's treatment and detention.²³
- **Limited offering of voluntary treatment.** One of the intentions of the Mental Health Act was that, even where patients were made subject to compulsory treatment, they would still be able to receive treatment on a voluntary basis, to the maximum extent possible. We do not see evidence of this in practice. Instead we see an over-reliance on coercion and orders, rather than considering the possibility of voluntary treatment, for example by exploring alternative treatments that the person may be willing to engage with.²⁴
- **Restrictive practices.** Victoria has high rates of restrictive practices, such as seclusion and restraint, relative to other Australian jurisdictions (discussed further below in relation to inpatient treatment).²⁵

The impact of over-reliance on compulsory treatment

The consequences of the over-use of compulsory treatment and lack of adherence to a recovery focused approach include that consumers are less likely to seek assistance from mental health services and past experiences of trauma may be compounded. We often see consumers who have presented to mental health services voluntarily and have subsequently been made compulsory patients and subject to unwanted and restrictive treatment. These consumers report to us that this experience makes them less likely to seek out support from mental health services in the future. Our client *PBU* is an example of a consumer who initially sought out services on a voluntary basis only to be subsequently made subject to a compulsory order and subjected to highly restrictive treatment in the form of compulsory electroconvulsive treatment (**ECT**).

In *PBU*, the Supreme Court considered how the concepts of capacity and consent under the Mental Health Act are applied when determining whether a person should be subjected to compulsory ECT.²⁶ Our client's comments and the comments of the judge highlight the potential impact of compulsory treatment on people and their recovery, dignity and autonomy.

²¹ Ibid.

²² Mental Health Tribunal, *2017-2018 Annual Report* (July 2018) <<https://www.mht.vic.gov.au/sites/default/files/documents/201904/MHT-2017-2018-Annual-Report.pdf>> (**MHT Annual Report**).

²³ While consumers have the right to apply to the Tribunal at any time to challenge their order, as we discuss in this part, this right alone does not provide sufficient safeguards for consumer's dignity and autonomy. Importantly, as discussed, Victoria has low rates of advocacy and representation for people facing compulsory treatment, making reliance on this right as a safeguard problematic.

²⁴ Examples of this include: (1) for voluntary patients there is a concerning use of coercion, for example, services require that consumers voluntarily comply with the service's preferred treatment regime (rather than what the consumer wants) and advise the consumer that if they do not voluntarily comply with it, then they will be at risk of compulsory treatment; (2) claims by mental health services that a consumer can only be assured of receiving treatment from their service if they are subject to a compulsory treatment order. Despite this being inconsistent with the principles of the Mental Health Act, which favour voluntary treatment, the Mental Health Tribunal can often be persuaded to make a compulsory treatment order based on these representations (even where the consumer's evidence is that they will voluntarily comply with all necessary treatment).

²⁵ Restrictive practices in Victoria, above n 20.

²⁶ See, eg, Victoria Legal Aid, *Landmark judgment strengthens patients' rights in compulsory electroconvulsive treatment cases* (2018) <<https://www.legalaid.vic.gov.au/about-us/news/landmark-judgment-strengthens-patients-rights-in-compulsory-electroconvulsive-treatment-cases>>.

PBU and NJE:²⁷ Capacity to consent to or refuse treatment and the impact of this

VLA appealed to the Supreme Court of Victoria on behalf of clients 'PBU' and 'NJE' to clarify when ECT can be performed without a person's consent. Both had ECT ordered against their will by the Mental Health Tribunal. The Victorian Civil and Administrative Appeals Tribunal (VCAT) affirmed those decisions.

Describing the impact of compulsory ECT for him, PBU said:

'It was one of the most traumatic days of my life, when I was taken into the ECT room and held down on the bed. I didn't know I was going to have ECT ... The most terrifying aspect of having ECT is that I didn't know what state I would be in after.'

This case is the first time the court considered laws that govern the use of compulsory ECT in Victoria. The court was asked to consider important criteria governing the administration of compulsory ECT, including a person's capacity to consent to or refuse treatment.

In his judgment, Supreme Court Justice Kevin Bell found that VCAT had misapplied the law in relation to whether PBU and NJE had the capacity to decide if they wanted ECT, and had breached their human rights.

Justice Bell ruled that people experiencing mental health issues should face the same standard as all other people when their capacity to consent is assessed and said:

'The issue is closely connected with the need to respect the human rights of persons with mental disability by avoiding discriminatory application of the capacity test. More should not be expected of them, explicitly or implicitly, than ordinary patients.' (at [173])

'When respect is afforded to the choice of the person to consent to or refuse medical treatment, the person is recognised for who they are.' (at [199])

1.3.2 Supported decision-making: People participating in decisions that affect them

As the Mental Health Act Handbook explains:

*The Mental Health Act 2014 establishes **a supported decision-making model that will enable and support compulsory patients to make or participate in decisions about their treatment and determine their individual path to recovery.** Legal mechanisms in the Act that enable supported decision making include a presumption of capacity, advance statements, nominated persons and the right to seek a second psychiatric opinion.*

These mechanisms will promote best practice and facilitate optimal communication between practitioners and people with mental illness and their families and carers, leading to improved treatment outcomes and recovery. The Act also provides a legislative framework that supports the ongoing development of recovery-oriented practice in the public mental health service system.²⁸

VLA's specialist mental health lawyers and IMHA advocates report that these mechanisms do not appear to be achieving the objective of enabling supported decision-making. The overall extent of the use and effectiveness of these tools is unclear as, to our knowledge, very little state-wide data is

²⁷ *PBU v MHT*, above n 8.

²⁸ The Mental Health Act Handbook is a resource created to assist with the implementation and interpretation of the Act (emphasis added) <<https://www2.health.vic.gov.au/mental-health/practice-and-service-quality/mental-health-act-2014-handbook>> (emphasis added).

available in relation to their uptake and use. However, our evidence based on our practice experience is:

- **Presumption of capacity.** This reform was intended to reduce involuntary treatment, including for people on compulsory orders. However, we have not seen evidence that it has led to this outcome. In practice, consumers are treated on a voluntary basis if they acquiesce to treatment proposed by the mental health service. If they decline treatment, we frequently see people are compelled to have it, without a capacity assessment being conducted, or the presumption of capacity being considered.
- **Advance statements and nominated persons.** In VLA's advocacy work in designated mental health services and the Mental Health Tribunal, we rarely see clients who have made an advance statement or selected a nominated person. On the rare occasions when we do see them, the views of nominated persons and preferences expressed in advance statements are often disregarded, both by mental health services and the Mental Health Tribunal.
- **Second psychiatric opinions.** The ability to obtain a second opinion, and accompanying rights to review of treatment decisions by an authorised psychiatrist and the chief psychiatrist was an important reform. We frequently advise clients of their rights to access the second opinion scheme. However, our clients often report that the process is too slow, particularly if they are detained in an inpatient unit. We are not aware of any instances of the chief psychiatrist exercising their powers under these sections.

More promisingly, the establishment of IMHA (discussed in part 2 below) has been a key reform to support the objectives of a rights and recovery-orientated system. This was the stated purpose of IMHA in Victoria's 10 Year Mental Health Plan, including through supported decision-making.

Informed by consumers, IMHA has developed a supported decision-making training package for mental health services, in recognition of low levels of understanding amongst clinicians, which aims to contribute to a more rights-oriented and recovery-focused mental health system.

IMHA training significantly increases mental health staff's understanding of supported decision-making and confidence to integrate it into their services

IMHA's training about supported decision-making under the Mental Health Act is being rolled out to all designated mental health services in Victoria. Twenty sessions have been carried out across the State to date.

Outcomes reported from participants demonstrate:

- 85% report an increase in knowledge of supported decision-making.
- 85% report an increase in knowledge of how to put supported decision-making into practice.
- 80% report an increase in understanding of the benefits of supported decision-making.

The limited use of, and regard for, advance statements and nominated persons is a clear example of the way the systems, processes and culture in the mental health system have not developed to realise the intention of the Mental Health Act and the change it promised. IMHA's role and supported decision-making training are examples of the kinds of initiatives and investments that are required to translate the well-intentioned legislation into meaningful change for consumers seeking to be actively involved in decisions about their treatment, discharge planning, risk assessment or recovery.²⁹

²⁹ IMHA's supported decision-making training does not have ongoing funding.

1.3.3 Prioritising least restrictive treatment and choice

Justice Bell, in *PBU v Mental Health Tribunal*, emphasised how important the ‘least restrictive’ principle is in the compulsory treatment regime to ensure it is rights and recovery-focused:

Enactment of the no less restrictive treatment test, along with the requirement to take the views and preferences of the patient into account ... and the provisions that promote supported decision-making represents a paradigm shift in the design of the mental health legislation.... [It is] intended to operate under the Mental Health Act in a quite different way to the former best-interests test. It involves a different conception of the relationship between medical authority and the patient: it is one that respects, to a much greater degree, the patient’s right to self-determination, to be free of non-consensual medical treatment ...; one that is intended positively to promote patient participation and supported decision-making; and one that, in appropriate cases, incorporates recovery (and not simply cure) as an important therapeutic purpose in a holistic consideration of the person’s health (broadly understood).³⁰

The mental health system must ensure that the least restrictive principles are embedded into the practice of mental health services and exist in reality, not just in theory.

Clients and consumers often tell us that their treating team does not listen to them, or that their views and preferences are ignored or not genuinely considered as part of the decision-making process. The factors that contribute to this include:

- Mental health service staff not having **sufficient time** to spend with consumers to understand their preferences, what is important to them and shared treatment and recovery plans (this is a particular issue for consultations with psychiatrists on inpatient units).
- The **reliance on medication** and treatment of symptoms, rather than access to other kinds of therapies and support (and diverse professionals to deliver these), including access to psychologists, to help address underlying trauma or causes of mental distress.
- Failure to proactively provide consumers with **information and choices regarding medications** (including whether medication is administered orally, or by intra-muscular injection), supports, or other treatments including therapeutic approaches.
- Inconsistent, ad hoc **documentation** by mental health services of a person’s treatment plan, including documenting capacity assessments, the person’s views, preferences and recovery goals, and how these have been considered as part of the decision-making process.
- Failure to appropriately address **psychosocial issues** such as poverty, family violence, and homelessness, which can compound mental distress and impact a person’s ability to participate as effectively as possible in decision-making.

IMHA advocates see the negative impact of mental health services failing to maximise choice and participation for people, which Claudia’s story highlights.

Claudia: Lack of involvement in decisions about treatment

Claudia is a professional artist from a culturally and linguistically diverse background.

³⁰ *PBU v MHT* at [250] and [252], above n 8.

In 2016 Claudia's university life was stressful, a romantic relationship had broken down, and her housing situation was becoming insecure and uncomfortable. Claudia's goal was to simplify things, and slowly work out her issues from home. Without her knowledge, a friend made contact with a mental health service and she was involuntarily admitted to an inpatient unit.

Hospitalised against her will and incapacitated by high-levels of medication administered by the hospital, Claudia said the experience was harrowing and demoralising. She didn't feel safe in the hospital environment, the treating team disregarded her advance statement and continued to prescribe higher doses of medication.

Her culture and artistic abilities were not understood as an expression of herself, but rather viewed as an expression of a mental health issue. How she communicated what she wanted, in a way consistent with her culture, was considered to be evidence of deterioration, and thought to require more treatment. Without proper investigation, her disclosures of artistic achievements were assumed to be "grandiose delusions of self-importance".

Claudia contacted IMHA, with the goal of regaining some power over herself and her situation. With an advocate in her corner, she worked on her advance statement, met with the treating team, and worked on a complaint about her experiences.

After working with IMHA, Claudia felt that services took her more seriously, and she felt validated that there was a witness for her experiences. However, Claudia also felt that the system placed all of the responsibility on her to resolve mistakes that they had made.

Claudia's story demonstrates how strict medical models can undermine a person's personal recovery. Claudia was not involved in the decisions about her care or treatment, her advance statement was disregarded, she was administered high doses of medication, she was not assisted to cope with the stressful aspects of her life, and her cultural and artistic strengths were not taken into account.

In addition to failing to protect her rights, Claudia's treatment was a set-back in her recovery, rather than part of it.

1.3.4 Maximising consumers' exercise of their rights and contributing to systemic reform

The articulation of rights and existence of safeguards alone are not sufficient to ensure the rights of people receiving compulsory mental health treatment in Victoria are protected and promoted.

As the Law Council of Australia has identified, '[l]egal representation for people facing the Mental Health Tribunal can make a noticeable difference to the outcome achieved', noting that the Victorian Mental Health Tribunal approves applications for electro-convulsive treatment in 85% of cases where a consumer was not legally represented. This approval rate drops to 50% if the person is legally represented.³¹

Rates of legal representation at Mental Health Tribunal hearings are extremely low in Victoria, with 15% of people represented,³² compared to 80% in NSW.³³

Through the regular attendance of VLA's specialist mental health lawyers at mental health inpatient units, we see the impact that independent legal advice and instructions-based legal representation can

³¹ Law Council of Australia, *The Justice Project Final Report: People with Disability* (2018) 60; citing the Victorian Mental Health Tribunal, *Annual Report 2016–17*.

³² MHT Annual Report, above n 22, 30.

³³ NSW Mental Health Review Tribunal, *2017-2018 Annual Report*, 31.

have not only on the outcome of our clients' Mental Health Tribunal hearings, but the exercise of their rights under the Mental Health Act more generally, including:

- Assisting people to **understand proposed treatment and reasons for treatment** (the lawyer going through the report prepared by the service can sometimes be the first time the person has seen, in writing, what treatment and support their doctor thinks they need and why).
- **Making people aware of their rights** in relation to:
 - Communicating with lawyers, advocates and the Tribunal
 - Access to avenues of appeal against treatment orders
 - Participating in treatment decisions, even when subject to compulsory treatment.
- **Liaising with the treating team** on the progress of leave, discharge plans, treatment options or referrals for supports, including IMHA or regarding other legal issues.
- **Accessing information** in a way people can understand, for example, using interpreters and explanations of reports with consumers who cannot read.
- **Exploring less restrictive treatment options** based on a person's preferences.

In addition to improving individual outcomes for people and increasing their ability to engage with decisions and processes that affect them, lawyers and advocates have a role to play in identifying and addressing systemic issues that are apparent through high volume work with clients.

For example, VLA has observed the below examples of systemic non-compliance with the Mental Health Act.

Failure to provide reports in time to prepare for hearings

The Mental Health Act requires that consumers be provided with a report prepared by the mental health service at least 48 hours prior to their hearing at the Mental Health Tribunal. This requirement is important to ensure consumers have enough information to understand the application and prepare for their hearing. Neither the Mental Health Tribunal, or any other relevant body, has any formal role in ensuring compliance with this obligation, and this requirement is routinely breached by services.

We collected data on hospitals' compliance with this obligation, which revealed very poor and inconsistent compliance. In 2016, only around 44% of consumers were given their reports within the required timeframe. In 2017, the rate was 68%, and in 2018, it was 47%.³⁴

The consequence of this non-compliance for consumers is unfair or delayed hearings, which can result in prolonged periods in detention. There are no adverse consequences for mental health services.

Practices in relation to compulsory electroconvulsive treatment (ECT)

Important changes to the process for authorisation of compulsory ECT (principally the requirement for prior authorisation by the Mental Health Tribunal) were introduced by the Mental Health Act. The changes were driven by community concern in relation to the compulsory use of ECT.

These changes to the Mental Health Act were widely regarded as a progressive reform that would deliver greater protection of consumers' rights. VLA quickly observed, however, that the greater protection intended by the legislative reform was not being fully realised in practice. In 2015, VLA

³⁴ In 2016 we collected data from the hearings of 227 consumers across 21 hospitals, in 2017, the data sample was 68 consumers across 13 hospitals, and again in 2018, 45 consumers across 14 hospitals.

observed three main issues that were preventing the new process from operating in a way that was protective of consumers' rights:

- **Over-use of urgent hearings.** There was an overuse of the provisions enabling the request for an urgent hearing. Services were requesting an urgent hearing in 60% of cases, with the result that over 50% of hearings were being conducted within 24 hours of an ECT application being made, and 25% were occurring on the same day that the application was made.³⁵ This gave patients insufficient time to prepare for the hearing or to seek legal advice or representation.
- **Low rates of legal representation.** Because of the urgent listings, and because no extra funding was provided to service the new ECT jurisdiction, rates of legal representation were very low at below 10%.³⁶ This compared unfavourably to other states, such as NSW where the representation rate was 70%, and to Queensland where there is a statutory requirement for legal representation in all hearings related to the compulsory administration of ECT.
- **Difference in outcomes.** There was a large discrepancy between the outcomes for represented and unrepresented patients. As noted above, the Mental Health Tribunal approved 85% of ECT applications overall, but only 50% where the patient was represented. This indicated to us that the Mental Health Tribunal was not consistently correctly applying the legal criteria in the absence of legal representation to support accountability.

Based on this data, VLA prioritised improving practices in relation to ECT and consumer rights as part of our systemic reform work. The *PBU v Mental Health Tribunal* test case was one part of this. In addition, the Mental Health and Disability Law team have provided training to mental health service staff and used the precedent from *PBU* in providing duty lawyer services in the Mental Health Tribunal (i.e. incorporating it into day-to-day decision-making practices). This has led to a reduction in urgent ECT hearings. The Mental Health Tribunal's most recent quarterly report showed that the proportion of ECT hearings conducted within 24 hours has reduced from 54% to 22%. The number of same day hearings has reduced from 25% to 2%. The Mental Health Tribunal has attributed these changes to its practice to the *PBU* decision.

The Chief Psychiatrist's Guideline on ECT was also updated in April 2019 to include guidance on capacity to give informed consent, documentation in the file, rights-promoting statements on urgent ECT and referrals to VLA and IMHA.³⁷

The Mental Health Tribunal recently developed an ECT guideline, which includes reference to *PBU*.

These examples highlight that a progressive legislative framework is not enough to bring about reform. It highlights the role for oversight and advocacy and legal representation as part of the picture of improved accountability.

The positive changes that have been brought about since *PBU v Mental Health Tribunal*, including through the work of mental health services, the Mental Health Tribunal, the Office of the Chief

³⁵ Mental Health Tribunal, *Quarterly Report* (January – March 2015). It is notable that at the time of the introduction of the legislation to Parliament, same day ECT was described in the Second Reading Speech as being for an 'emergency' and 'extremely rare'. See Minister Wooldridge, Second Reading Speech, above n 5.

³⁶ The Mental Health Tribunal publishes overall rates of legal representation, but does not publish data on the rate of representation for different hearings types (eg, ECT, inpatient or community treatment order hearings). VLA's analysis of our internal data indicates however that, between 2014–2017 our lawyers provided representation at, on average, 40 ECT hearings each financial year. When compared with ECT hearings data published by the MHT (see MHT Annual Report 2017, 24, Table 17), this indicates that consumers were represented by VLA in 6% of hearings. This figure does not take into account legal representation by non-VLA lawyers.

³⁷ Department of Health and Human Services, *Chief Psychiatrist's Guideline on electroconvulsive treatment* (12 January 2016). <<https://www2.health.vic.gov.au/about/publications/policiesandguidelines/chief-psychiatrist-guideline-on-electroconvulsive-treatment>>.

Psychiatrist and VLA, remind us of the kinds of multi-party, systemic efforts require to embed rights and recovery-focused practices.

1.4 Maximising dignity and reducing the harm caused by compulsory treatment

Through our work in inpatient units across Victoria, we see the impact that detention in these environments can have on people's hope, wellbeing and recovery. The Royal Commission should consider the immediate and longer-term costs of the conditions, physical environment, culture, safety, and treatment of people who are hospitalised for their diagnosis or experience of a mental health issue or mental distress.

1.4.1 Conditions, physical environment, culture, safety and treatment

A recovery-focused system should be therapeutic and trauma informed. At present, the physical environment of inpatient units and the conditions placed on inpatients inhibit the ability of the system to be therapeutic and can undermine people's wellbeing and recovery.

Factors that we observe contributing to consumers feeling unsafe, or to feelings of hopelessness and disempowerment in inpatient settings, include:

- **Physical environment and ward culture**, including poor ward design, lack of outdoor spaces, lack of safe spaces for women³⁸ and gender non-binary people, lack of opportunities for meaningful therapeutic activities, and inadequate staffing levels.
- The length of involuntary detention and treatment in **SECUs**. VLA has clients who have been in a SECU for over 10 years.
- The use of **violence or unnecessary and disproportionate force** by staff and security personnel in inpatient facilities.
- The **lack of availability of holistic services** that address trauma and other social issues, including psychologists, social workers, peer support workers and occupational therapists, in clinical services.
- The **lack of availability of gender-specific areas of the unit**, both private and communal (for example, women's only lounges).³⁹
- Inflexible or 'blanket' policies such as in relation to **leave**, which result in leave or other restrictive practices being used as a behaviour management tool or form of punishment.
- **Risk management practices** based on a person's history, which may not accurately reflect their current circumstances, resulting in restrictions on their liberty and autonomy that may not be justified.
- **Lack of continuity of care** by inpatient treating teams, including a reluctance to contact or liaise with private practitioners in the community.
- Service models which do not cater for the **individual needs** of members of CALD, Aboriginal and Torres Strait Islander and LGBTIQ communities, or of younger or older consumers (discussed further in part 5 below).

³⁸ The need for services to be provided in ways that respond to an individual's specific needs, including their gender, are considered further in part 5.

³⁹ Ibid.

Feelings of hopelessness or disempowerment are reinforced when decisions are made to further restrict people's freedom in circumstances where it is not necessary or proportionate.

██████⁴⁰ **Strict conditions and leave cancellation**

██████ is a woman in her early 30s, currently living in a Secure Extended Care Unit in an outer suburban hospital. The service has noted that they feel there is no therapeutic benefit to ██████ remaining at the SECU, but they have not developed a discharge plan for her due to perceived risk involved in her diagnosis of a severe eating disorder, and lack of an NDIS plan in place.

██████ frequently has her leave cancelled at the SECU, sometimes due to concerns about risk, but other times for 'behavioural modification'. ██████ states that if she is rude to a nurse and raises her voice, then her leave is cancelled. This can be for a period of a few days, or sometimes for a period of a fortnight. ██████ feels that when her leave is taken away, it is a form of punishment.

As a young woman with limited freedom, detained without an immediate prospect of discharge, ██████ explains:

"They do not allow me chewing gum on the ward and when I can't go out and have a cigarette, that's one of my main comforts".

"They are reducing all my PRN [as needed] medications which actually help me, and they are not allowing me, when I have low blood sugar, to have the treatment I prefer. They force me to have a glucose injection which I hate, instead of glucose gel."

1.4.2 Restrictive practices – seclusion and restraint

In addition to the culture, environment and conditions in inpatient units in Victoria, the use of restrictive practices such as seclusion and restraint – and the impact these have on people's wellbeing and recovery – must also be examined (noting the high rates of these practices in Victoria relative to other jurisdictions).⁴¹

In relation to the use of restrictive practices in inpatient units, our experience is that consumers with dual disabilities or complex needs are particularly susceptible to being subjected to coercive or restrictive practices. This includes:

- Detention in high dependency or intensive care areas of the unit. This is often done to ensure safety from co-patients but has the problematic consequence of being restrictive or preventing the person's access to leave.
- Restraint and seclusion. These are often used in an attempt to address problematic behaviours that do not arise from the person's mental health, and staff often lack training to respond appropriately in other ways.

The principles underpinning the Mental Health Act provide for a last resort approach to the use of restrictive practices on people receiving mental health services. The Act provides that a person may only be placed in seclusion to prevent imminent and serious harm to themselves or another, and only after all reasonable and less restrictive options have been tried or are considered unsuitable.⁴² This

⁴⁰ Client's real name has been used.

⁴¹ Victorian Mental Illness Awareness Council, Seclusion Report: Accessible information on seclusion in Victorian mental health services (April 2019) 4-5, 11.

⁴² Department of Health and Human Services, Chief Psychiatrist's Annual Report 2017-18 (2018) 22.

approach is supported by the Australian Institute of Health and Welfare, which encourages alternative, less restrictive ways of managing patient behaviour wherever possible.⁴³

A recovery and trauma-informed approach would recognise that whilst the use of seclusion and restraint may be effective in containing the risk in the short term, the impact of it in the longer term may be to exacerbate the factors that drive risk to self and others through re-traumatisation and lack of emotional safety.⁴⁴ The Victorian Mental Illness Awareness Council's position is that seclusion and restraint are inherently harmful as they contribute to feelings of disempowerment, fear, vulnerability, anger, loneliness, humiliation, dependence, impaired trust, sadness and shame.⁴⁵ This impact was captured by [REDACTED], a member of our lived experience advisory group, Speaking from Experience:

In the 10 years I have been a service user of public mental health services ... I have had over 60 inpatient admissions and have lost count of the amount of times that I have been secluded and restrained (both mechanically and medically). This has caused me much trauma and distrust in the system.

The Royal Commission should consider the use of seclusion and restraint in mental health settings, particularly the factors leading to seclusion and the impact this has on people. It is also important to examine whether seclusion is being used as a last resort in practice, and how this varies across mental health services. The positive work that has been done to reduce its use could also be recognised and encouraged,⁴⁶ as well as the barriers to the effectiveness of this work and the need for further improvement in inpatient settings.

Priority area for reform 1: Building a recovery-focused mental health system

The mental health system is not currently focused on rights, recovery and self-determination. Compulsory, rather than voluntary, treatment continues to be higher in Victoria than other states and territories and we have low rates of advocacy and representation for people facing compulsory treatment. The Royal Commission should not miss the opportunity to change this. Three priority areas for building a recovery-focused mental health system are:

- Supporting people to manage their own health in the way that they have identified works for them, including flexibility for support and treatment to be 'flexed' up and down to maintain a person's health.
- Realising the rights and recovery focus of the Mental Health Act, including embedding the principles of least restriction and supported decision-making, where rights are maximised and compulsory treatment is truly a last resort.
- Regulating treatment and intervention to support autonomy and dignity and reduce as far as possible the negative impact of compulsory treatment when it does happen.

⁴³ Australian Institute of Health and Welfare, Mental health services: In brief 2018 (2019) <<https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/restrictive-practices/seclusion>>.

⁴⁴ Department of Health, Chief Psychiatrist's Guideline on Restrictive interventions in designated mental health services (<<https://www2.health.vic.gov.au/about/key-staff/chief-psychiatrist/chief-psychiatrist-guidelines/reducing-restrictive-interventions>>.

⁴⁵ Above n 41, 7.

⁴⁶ In recent years, there have been significant government efforts at both the State and Federal level to reduce the use of restrictive practices such as patient seclusion in mental health services. See, Department of Health and Human Services framework for reducing restrictive interventions; guidelines from the Chief Psychiatrist to reduce the use of restrictive interventions; and standards established by the Australia Commission on Safety and Quality in Health Care.

2. Embedding consumer leadership and advocacy as part of a rights-focused system

People whose lives are directly affected by the mental health system should shape and have influence over the re-imagined mental health system that emerges from the Royal Commission. In examining and reforming Victoria's mental health system, consumers must be central, not just as users of the services, but in co-producing, delivering and evaluating them.

The importance of consumer leadership is recognised as part of *Victoria's 10-Year Mental Health Plan*. Lived experience leadership adds value to services and communities by changing cultures, informing practice and redressing traditional power imbalances.⁴⁷

VLA defines consumer leadership as the leadership provided by consumers at a systemic level which privileges the voices of consumers so that they shape professional and organisational practice. It is based on emerging evidence that services designed, delivered and evaluated by the people who use them are more likely to achieve better outcomes and improve satisfaction.

The Recovery Library (developed by the Centre for Psychiatric Nursing of the University of Melbourne with funding from Victorian Government) identifies key capabilities for growing consumer leadership as including the attitudes of being 'open to seeing things in a new way ... trust[ing] consumer leadership ... [and] accepting and encouraging consumer leadership for the expertise it brings'. It also identifies being 'critically attuned to power' as good practice.⁴⁸

Although there have been consumer positions in the mental health system for a long time, much more must be done to embed consumer leadership, at all levels, in order for it to be truly influential and to realise its potential in improving services.

In other service systems with significant interactions with people experiencing mental health issues, particularly in the justice system, consumer engagement and leadership is much less developed. For example, specialist mental health programs such as the Assessment and Referral Court List in the Magistrates' Court (including VLA's services in these settings) do not have systematic consumer input. In our view, all service systems that are dealing with people experiencing mental health issues should commit to consumer leadership so that their services are relevant and responsive to the people using them. Processes to support this must be embedded.

This part discusses:

- VLA's IMHA service as an example of how consumer leadership can help create a service that consumers value.
- VLA's work toward embedding consumer leadership, the value of this and the need to continue embedding and extending this leadership across sectors.

⁴⁷ B Scholz, S Gordon and B Happell, 'Consumers in mental health service leadership: a systematic review' *International journal of mental health nursing* (2017), 26(1), 20-31; B Scholz, J Bocking and B Happell, 'How do consumer leaders co-create value in mental health organisations?' *Australian Health Review* (2017), 41(5), 505-510; B Happell, W Bennetts, J Tohotoa, D Wynaden and C Platania-Phung, 'Promoting recovery-oriented mental health nursing practice through consumer participation in mental health nursing education' *Journal of Mental Health* (2017) 1-7.

⁴⁸ Department of Health Victoria, *Framework for Recovery – Oriented Practice*, Tools for Change Recovery Library, 'Growing Consumer Leadership' (2015), <<https://recoverylibrary.unimelb.edu.au/>>.

2.1 IMHA: An example of mental health advocacy with consumers at the centre

IMHA was established in 2015 as part of the Victorian Government's commitment to a human rights-based mental health system and funded by the Department of Health and Human Services (DHHS) as part of the implementation of the Mental Health Act.

In launching IMHA, Minister Foley said services needed to have people at their heart, and their voices must be heard, understood, acted on, and taken seriously. He explained that IMHA would help clinical services understand:

They [consumers] are not just case notes, but people and citizens, and their best chance to recover is if they are centrally involved.⁴⁹

IMHA's primary purpose is to ensure that consumers are supported to make and participate in all decisions about their assessment, treatment and recovery. To do this, IMHA advocates regularly visit every public mental health service in Victoria to advocate, promote human rights and supported decision-making, support self-advocacy, and actively refer consumers to services they request to support their recovery.

A recent independent evaluation of IMHA highlighted its successes in maintaining consumers' rights using a supported decision-making approach informed by the principles of self-determination and recovery.⁵⁰

The impact is summarised by a consumer who provided feedback as part of the evaluation:

There has been clamour for change in the mental health sector for 30 years, and while change is still very slow, IMHA have adopted a model which has proved effective and efficient at changing culture and practices for the better. Other players also need to play their part, and resourcing restraints limit all serious action, but IMHA is showing the sector that things can be done differently.⁵¹

IMHA uses a model that includes individual and systemic advocacy with consumers at the centre, including through consumer leadership and co-production.

IMHA adopts a representational model of advocacy, which means that its advocates directly represent the views, wishes, and concerns of consumers. This is distinct from a best-interests approach, which is still common within mental health treatment and care practices and is informed by clinical staff decisions about what is best for the consumer. IMHA also connects and coordinates with Victoria's peak consumer body, the Victorian Mental Illness Awareness Council (VMIAC), to address systems issues, and elevates the consumer voice in conversations with stakeholders and safeguarding bodies such as the Mental Health Complaints Commissioner.

⁴⁹ Independent Mental Health Advocacy, 'Our service is officially launched' (1 October 2015) <<https://www.imha.vic.gov.au/about-us/news/our-service-is-officially-launched>>.

⁵⁰ IMHA Evaluation Report, above n 3.

IMHA's co-produced Self-Advocacy and Information Project

In 2018, in response to consumer feedback about the need for more self-advocacy resources, IMHA initiated the Self-Advocacy and Information Project.⁵² Self-advocacy aligns with recovery principles that focus on people's strengths and self-determination.

The Project co-produced self-advocacy resources to support consumers to speak up and protect their rights. Consistent with co-production principles, IMHA:

- Ensured consumers were involved in the decision-making from the beginning.
- Supported consumers' capacity to participate through information, support and time.
- Addressed power imbalances by making clear the decision-making processes and opportunities for feedback.

Through this process, IMHA co-produced: fact sheets on the most important issues to consumers; videos on self-advocacy; a wallet-card that provides advocacy information if someone later receives compulsory treatment; and an online web application that helps consumers make their own self-advocacy plans.⁵³

Independent evaluation

An independent evaluation was undertaken of IMHA's first three years of operation.⁵⁴ The evaluation team included experts in mental health law, service delivery and research, and was co-produced with people with lived experience of the mental health system. RMIT consulted 69 consumers who had used IMHA, 40 consumers who were eligible for but had not used IMHA, nine stakeholder body representatives, 292 mental health professionals, 31 mental health lawyers and 16 IMHA staff.

Overall, the independent evaluation of IMHA identified IMHA is a service model that helps protect and promote the rights of consumers, including through consumer leadership, advocacy and self-advocacy, a regional presence and a commitment to rights and recovery.

The key findings of the evaluation included:

- IMHA was overwhelmingly positively received by consumers who had used the service.
- IMHA is instrumental to the maintenance of the rights of people who are subject to compulsory treatment.
- Mental health services are not consistently operating in compliance with the Mental Health Act, and where IMHA services are utilised it is effective at assisting them to do so.
- For IMHA to continue to be successful in maintaining the rights of people subject to compulsory mental health treatment, it needs to be accessible to all who require it. This requires an opt-out system where every person who is eligible is offered advocacy, and an increase in funding to be able to provide services to all those who are eligible for IMHA.

⁵² In 2016 IMHA worked closely with the Victorian Mental Illness Awareness Council to co-produce the *What consumers want report*, detailing what consumers groups across Victoria want from IMHA's service. IMHA took advice from 49 consumers across six consultations, focusing on young people and those who had experienced homelessness or who identified as being from an LGBTIQ or Culturally and Linguistically Diverse background.

⁵³ Independent Mental Health Advocacy, *New resources help consumers speak up and protect their rights* (April 2019) <<https://www.imha.vic.gov.au/about-us/news/new-resources-help-consumers-speak-up-and-protect-their-rights>>.

⁵⁴ The evaluation was undertaken by RMIT University's Social and Global Studies Centre, see IMHA Evaluation Report, above n 3.

- There is a lack of available accurate data about how many Victorians are subject to compulsory treatment to assist with service planning and delivery.
- Stakeholder bodies and mental health professionals who had worked with IMHA held it in high regard.
- The sector including government, mental health services and oversight bodies, such as the Mental Health Complaints Commissioner, Office of the Public Advocate, and VLA need to come together and ensure that services are operating in compliance with the Mental Health Act. IMHA is working towards this goal but is hindered by lack of coordination and mechanisms in the sector.

The graph below provides an indication of the impact of IMHA's services for consumers in terms of building capacity and confidence.

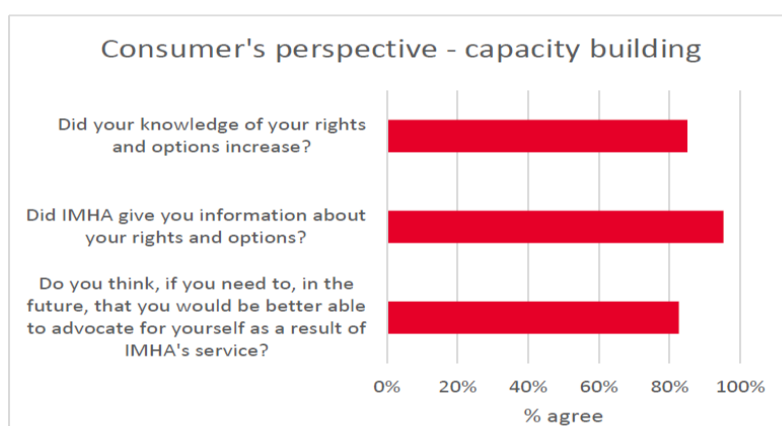


Figure 1 - Do we build capacity and confidence? (n=22)

Recommendations for the future of IMHA and the mental health system

The independent evaluation report made four key recommendations:

1. Referral to IMHA must be automatic for any person subject to compulsory treatment through an 'opt-out' system.⁵⁵
2. IMHA must be adequately resourced to meet demand.
3. IMHA must continue to improve sector awareness and understanding of advocacy.
4. Oversight and funding bodies must coordinate and adequately invest to ensure that services comply with legislation, are recovery-oriented and least-restrictive, and that consumers are supported to make decisions.

IMHA is an example of a model that is working well, and its effective implementation of consumer leadership and co-production can be learnt from and expanded.

2.2 A consumer workforce and consumer leadership

From the outset, consumer leadership and co-production was central for IMHA, and people with lived experience of the mental health system advised on its development, including co-production of IMHA's program logic and evaluation framework. Consumers are part of IMHA's work, and they are also part of its workforce. As part of IMHA, VLA employs a Senior Consumer Consultant to oversee and

⁵⁵ The Western Australian non legal advocacy service operates on the basis of an opt out system so all consumers are aware of their right to an advocate and can make decisions about accessing one.

promote consumer leadership, and two-thirds of IMHA's advocacy workforce identify as having a lived experience of mental health issues.

IMHA's Senior Consumer Consultant informs and assists with client engagement and participation in programs delivered, and supports IMHA's mental health lived experience advisory group, Speaking from Experience, to inform service design, delivery, and evaluation for IMHA and VLA. The Senior Consumer Consultant and Speaking from Experience have also assisted VLA by contributing to policy development, being on staff recruitment panels, and developing accessible resources for client groups.⁵⁶

Speaking from Experience was established in 2016 and has become an integral part of IMHA and VLA's work. The vision for Speaking from Experience is:

Speaking from Experience (SFE) envisions a community where people who engage with mental health services are free from harm, are supported to be actively involved in decision making and are respected and heard. This includes having Advance Directives legally recognised. SFE envisions that human rights are upheld; that people are never forced to engage with mental health services; that people have access to timely legal representation; and are provided with the services they need to keep them safe.

Practical aspects of the model used to develop sustainable consumer leadership include: payment guidelines for remuneration of consumers, a policy for consumers to sit on interview panels for recruitment, and orientation and media training.

VLA has been working toward embedding consumer leadership in its organisational culture and this has moved a long way in the four years since consumer leadership was first introduced. It has opened the organisation's eyes to different ways of providing services and undertaking systemic advocacy. We still have a long way to go – the role consumer leadership has played in IMHA was unprecedented for VLA or any other legal aid commission in Australia – but we see the value of this leadership and the depth and diversity of expertise it provides. We are committed to continuing to strengthen consumer leadership. This must also be a priority for the Royal Commission and its recommendations for genuine reform.

Priority area for reform 2: Embedding consumer leadership and advocacy as part of a rights-focused system

People whose lives are directly affected by the mental health system should shape and have influence over the re-imagined mental health system that emerges from the Royal Commission.

More work is needed to embed consumer leadership, at all levels, for it to be truly influential and realise its potential in improving services. Importantly, this must extend beyond mental health services, and all systems that are dealing with people experiencing mental health issues should commit to consumer leadership so that their services are relevant and responsive to the people using them.

The IMHA service is an example of a service model that includes individual and systemic advocacy with consumers at the centre. As an organisation, VLA has seen the value of consumer leadership and the depth and diversity of expertise it provides. We are committed to continuing to strengthen consumer leadership and this must also be a priority for the Royal Commission and its recommendations for genuine reform.

⁵⁶ See also Cath Roper, Flick Grey and Emma Cadogan, *Co-Production: Putting principles into practice in mental health contexts* (5 April 2018) <<https://healthsciences.unimelb.edu.au/departments/nursing/about-us/centre-for-psychiatric-nursing/news-and-events/test>> 4; Wanda Bennetts, Wendy Cross & Melissa Bloomer, 'Understanding consumer participation in mental health: Issues of power and change' (2011) 20(3) *International Journal of Mental Health Nursing*, 155–64, 2.

3. Reducing the harm of criminal justice involvement for people experiencing mental health issues

Most people experiencing mental health issues are not violent and are not involved in criminal activity. However, people experiencing mental health issues are at greater risk of contact with the justice system and are overrepresented in the prison and youth justice populations. Improvements to the quality and availability of mental health support in the community are a critical precursor to reducing criminal justice involvement for people experiencing mental health issues.

The circumstances and pathways of the clients we see across our spectrum of criminal law services often feature common contextual factors – flawed or inadequate mental health support in the community, substance use and addiction, housing instability, and involvement in multiple layered but ultimately disjointed service responses. In addition, there is an established link between mental health issues and social disadvantage, including homelessness, and between social disadvantage, race and police contact that contributes to increased rates of justice involvement.

In some cases, people are tipped into the justice system because of low level offending related to their mental health issues. In other cases, the challenges associated with accessing and remaining connected to mental health support in the community may have contributed to serious offending with significant consequences for the individual, their families and the community.

There are also other factors that may contribute to the increased risk of justice system involvement – including the particular vulnerability of people with mental health issues when they are in contact with enforcement and prosecution agencies. For example, people experiencing homelessness and living in public spaces are, due to their visibility, subject to additional police attention when compared to the rest of the population and are therefore more likely to receive fines or other enforcement action.⁵⁷

People experiencing mental health issues may also find it more difficult to understand and comply with police directions or court orders, such as bail conditions or the conditions of a Family Violence Intervention Order (**FVIO**), which increases the likely contact with criminal justice system. Intersecting issues such as access to housing in the community can also influence the level of their movement through the system.

Based on our experience working with people across the justice system, there are some essential steps that must be taken to reduce the rates and intensity of criminal justice involvement for people experiencing mental health issues. These steps include:

- Reducing the number of people with mental health issues entering the criminal and youth justice systems.
- Increasing access to diversion, therapeutic courts and community-based sentencing options.
- Recognising that people with mental health issues may not be criminally responsible for their conduct.
- Reducing the harm associated with imprisonment, including access to appropriate forensic mental health facilities.
- Supporting people towards rehabilitation, recovery and life in the community.

⁵⁷ The link between fines and enforcement action and a person's mental health is discussed further in Part 5

Supporting people to remain in the community also assists to reduce the harsh impact of imprisonment on particular groups in the community, including Aboriginal and Torres Strait Islander people, women and young people.

3.1 Reducing the number of people with mental health issues entering the criminal and youth justice systems

There are multiple opportunities to reduce the flow of people with mental health issues into the criminal justice system. We have been increasingly concerned about the high number of disadvantaged people entering the criminal justice system for low level or trivial offending. Over the past 12 months this has included:

- a person with ongoing mental health issues being arrested and bailed for begging, and then rearrested and remanded for a small value theft while on bail;
- a person on a disability support pension being arrested and remanded in custody for possession of a small amount of cannabis used to self-manage their mental health;
- a young person with mental health issues being charged and remanded for being drunk in a public place and breaching a bail condition (by consuming alcohol) for matters that were being managed through the Assessment and Referral Court.

Each of these examples results from a decision by Victoria Police to charge someone in vulnerable circumstances with a criminal offence where there would be a better outcome for the individual and the community if the person was referred to a social or welfare agency for support. The crisis orientation of the current mental health system contributes to the first responder to a mental health event being an enforcement agency rather than a mental health service.

In our view, preventing people from entering the criminal justice system, particularly in circumstances where the offending is low level, is the best way to limit ongoing and entrenched involvement in justice processes.

For this reason, VLA supports measures to reduce the entry points in the criminal justice system in circumstances where a welfare response would be a more effective use of public resources. This should include:

- **Reorientation of enforcement practices** including increased and consistent use of cautions and diversions by Victoria Police, or if charges are required, to proceed with these by way of summons rather than arrest and bail, to ensure people experiencing mental health issues can remain connected to treatment and support in the community.
- **Summary Offences Reform** to reduce the involvement of people in the criminal justice system in circumstances where a social or welfare response would be more appropriate. This should include summary offences reform, including the abolition of the offences of public drunkenness, begging and other offences that disproportionately impact some of the most disadvantaged people in the community.
- **Summary System Reform** to improve Magistrates' Court processes and make time and space for a more therapeutic summary justice system that respond to the individual needs of people entering the criminal justice system.
- **Further Bail Reform** to reduce the growing remand and prison population and ensure that people have access to programs and supports through a supported bail program where appropriate,

particularly in circumstances where they are unlikely to be sentenced to a term of imprisonment for their offending.⁵⁸

- **Raising the Age of Criminal Responsibility** to 14 years old to reduce the criminalisation of children and early contact and involvement with the harmful effects of the justice system.
- **Care Not Custody** to ensure that vulnerable children living in residential care units do not end up being charged with criminal offences for conduct that would not be criminalised in the family home, and that often has a grounding in previous experiences of trauma, abuse or neglect.⁵⁹

The potential for a person to experience negative consequences due to the compounding impact of involvement in criminal justice processes (particularly for people with mental health issues) is demonstrated by the recent experience of Jude whose story continues through this part.

Jude – Part One: Jude is remanded in custody by Victoria Police

Jude is a woman in her early 40s living in regional Victoria. She has a history of childhood trauma and has been involved with mental health services since her teenage years. Jude has had years of experience of treatment under the Mental Health Act. Jude has spent periods of time living in supported accommodation and has also lived in private rental accommodation with the support of a partner, her family and intensive case management through her area mental health service.

Jude experienced a relapse in her condition and allegedly assaulted her partner. She was admitted to an acute inpatient mental health unit which treated her over a number of weeks and stabilised her on medication. Jude was discharged back into the community.

After she was discharged, Jude voluntarily attended the local police station to be interviewed in relation to the alleged assault on her partner. Jude was charged and refused bail. She then appeared before a Magistrate and was remanded in custody for two weeks.

3.2 Increasing access to therapeutic courts and community-based sentencing options

Many of our clients are marginalised, experiencing acute disadvantage and may have a range of undiagnosed and diagnosed mental health, social and legal needs, making it difficult for them to engage with mainstream services. When these clients are sentenced in the community there is an opportunity to support them to engage in programs that will support positive changes and move towards rehabilitation and recovery. However, the capacity to pursue more therapeutic pathways is constrained by the architecture of the summary jurisdiction.

⁵⁸ The Hon. P Coghlan, 'Chapter 2 – Removing minor offences from the bail and remand system' *Bail Review: Second Advice to the Victorian Government* (May 2017) 14–28; Royal Commission into Family Violence, 'Recommendation 62', *Summary and Recommendations* (March 2016) 63.

⁵⁹ VLA continues to advocate for a new approach to reduce the contact kids in out-of-home care have with the criminal justice system. This is crucial to supporting the mental health of young people in residential care and making sure their futures are not undermined by preventable engagement with the criminal justice system. VLA's Care not Custody report findings are consistent with other studies of children in out-of-home care in Victoria being significantly overrepresented in the youth justice system. See further; Victoria Legal Aid, *Care Not Custody* (2016); Sentencing Advisory Council, *Crossover Kids: Vulnerable children in the youth justice system*, (June 2019). NSW and Queensland have now implemented specific protocols or agreements between the government, police and residential care sector, based on the UK approach, to reduce this unnecessary contact.

3.2.1 The summary jurisdiction is a flawed gateway to the criminal justice system

Most people entering the criminal justice system do not receive a specialist response that addresses their individual needs and circumstances. The majority of people have their criminal matters listed and finalised through the ordinary summary processes of the Magistrates' Court.

The Magistrates' Court is a busy and chaotic place. The processes must move quickly because of the sheer volume of matters in the court on a daily basis. It can feel rushed, confusing and stressful for all people involved in the summary jurisdiction.

People appearing before the Magistrates' Court frequently have a range of intersecting and layered issues in their lives. When our duty lawyers meet with someone who needs assistance we usually have little or no background information about their circumstances. It is often the first time a person has been at court or in custody and can be very distressing for most people, but particularly people who experience mental health issues.

Our lawyers frequently report:

- people who are experiencing a mental health crisis but have not had prior contact with mental health services;
- people who have drug or other substance dependency that may be linked to a mental health issue;
- people in the cells who require urgent access to mental health support;
- people expressing thoughts about wanting to end their lives;
- non-attendance or delayed attendance by CAT teams;
- people who have disengaged from community mental health services and have experienced a deterioration in their condition or circumstances;
- people who need access to assessment and treatment at court but the service is not available (for example, people whose matters are listed in the evening Bail and Remand Court and some regional courts do not have access to support from Forensicare).

These issues are often compounded by a court environment that does not have the resources to assess and respond to a person's circumstances and deliver a justice outcome that supports them towards recovery and rehabilitation.⁶⁰ Where these underlying circumstances are contributing to their offending, there remains a high risk of further and deeper involvement in the justice system.

Summary crime system reform has an important role to play in delivering a better response to people experiencing mental health issues. VLA is currently working on a prototype for a new model for dealing with summary crime matters in conjunction with Victoria Police and the Magistrates Court. The model would be tested at a single location, evaluated, and rolled out state-wide if successful. The new model would include:

- Increasing the continuity of service by lawyers, prosecutors and court staff throughout a matter.
- Early assessment and preparation of matters out of court, including through better use of technology.

⁶⁰ Opportunities to improve the operation of the summary jurisdiction have been identified by the Law and Justice Foundation who made a number of recommendations for procedural reforms to the Victorian summary crime jurisdiction that will help to facilitate better outcomes though reducing congestion in the summary jurisdiction. See generally, Law and Justice Foundation of New South Wales, (2016) In Summary, above n 4.

- Reduction in the number of court events while ensuring that at each court event there was more time and space to provide meaningful accountability and access to services that address the causes of offending.

If the proposed new approach is supported to meet these objectives, we would expect this service to significantly improve the experience of people experiencing mental health issues whose matters are dealt with in the mainstream summary jurisdiction.

3.2.2 Therapeutic courts: addressing the underlying circumstances of offending through therapeutic interventions

A small number of people with mental health issues have access to an alternative pathway for resolving their criminal law issues. In stark contrast to the mainstream summary jurisdiction, therapeutic courts work to identify, respond to and address the underlying circumstances of offending to support rehabilitation and recovery.

Specialist and problem-solving courts such as the Drug Court and the Assessment and Referral Court (**ARC**) shift the focus of the court from determining a legal contest between opposing sides to being actively engaged in addressing the underlying causes of offending and the therapeutic needs of the individual. Therapeutic courts have the common benefit of more time and stronger relationships between the client, the participant, the prosecution, support workers and the legal team. This can have strong therapeutic benefits for participants.

However, access to these community-based options (and the availability of related programs and supports) is highly dependent on where a person lives. People from regional and remote communities do not have the same options as those in metropolitan areas. For example, the geographical catchment of the Neighbourhood Justice Centre (**NJC**), ARC and Drug Court are highly restricted, despite these programs having high rates of success compared to less therapeutic alternatives.

For those who are eligible, ARC provides a dedicated justice pathway for a small number of people with mental health conditions and cognitive or neurological impairments. It focusses on addressing the underlying causes of offending through a collaborative and multidisciplinary approach. The environment of ARC is less formal than mainstream courts and hearings are conducted in plain language.⁶¹ The Magistrate is seated at a table with the participant, their lawyer, the prosecutor and an ARC Case Manager. Family members, support workers and other support people are also welcome to attend these hearings.

ARC recognises that recovery takes time and requires a collaborative and multidisciplinary approach that works towards a common goal. When a person enters ARC, an Individual Support Plan (**ISP**) is created that sets out the participant's goals. These plans may also include longer term goals such as study and work, community participation, and access and reconnection with family members. This provides a common vision and framework to guide the therapeutic response over a person's involvement in the program (which usually lasts for 12 months).

The benefits of this approach are demonstrated by the recent experiences of two of our clients.

Edwin: Therapeutic Courts breaking cycle of hospitalisation and offending

Edwin is a man in his early 40s living in Melbourne's inner suburbs. He was diagnosed with schizophrenia in his 20s and has had several hospitalisations over the years.

⁶¹ *Magistrates' Court Act 1989* (Vic) s 4U(3).

In 2016, Edwin experienced a prolonged mental health crisis, involving increasingly unusual behaviour and ultimately criminal offending.

After a period in custody, Edwin was referred into the Assessment and Referral Court, where he was allocated a case manager and linked him in with other community support services.

While participating in ARC, Edwin reconnected with his mother, and she attended his monthly court appearances with him.

Edwin and his mother see his participation in ARC as a turning point in his life. “It was a lot more personal, one on one experience” recalls Edwin, “you feel as though you are understood a lot more, you’re heard with what you’re saying. The extra time the judges [sic] put in for you really gives you the motivation to do the right thing”.

Edwin’s mother appreciated how the magistrate addressed the participants with professional care and encouragement. “The programme provided him with a different pathway that was not adversarial; but one of encouragement and respect permitting an alternative to one of decline into habitual anti-social behaviours and possible criminality”.

“The ARC program provided us with hope”.

Edwin feels ARC has provided him an opportunity to move on with his life and work towards achieving his goals and aspirations.

Although evaluations demonstrate that therapeutic courts are effective in achieving their aims,⁶² they have limited geographic reach. VLA supports more consistent access across Victoria to the proven benefits of therapeutic courts, particularly for people with mental health issues.

Therapeutic courts also have the potential to assist in the resolution of other intersecting legal and social issues. This is demonstrated by the experience of Belinda.

Belinda: ARC helped to overcome a history of trauma, reunite with her children and plan for her future

Belinda is a young woman in her mid-20s with a history of childhood neglect, family violence and trauma. She was placed in out of home care as a child. She experienced mental health issues arising from her history of trauma, including self harming and suicide attempts from her early teenage years.

Belinda developed a dependency on ice and cannabis. As an adult, she continued to experience family violence. She had two children, who were removed from her care by child protection services. She became homeless. She was caught up in a cycle of offending, had breached a Community Corrections Order, spent short periods in custody on remand and faced the real prospect of a jail sentence. “I was in a really bad scene. No hope at all.”

ARC helped her to positively transform her life.

At the start of the program, Belinda still grappled with ice use and struggled with her mental health issues. She again attempted suicide.

⁶² KPMG, *Evaluation of the Drug Court of Victoria* (Final Report, Magistrates’ Court of Victoria, 18 December 2014); Department of Justice, *The Drug Court: an Evaluation of the Victorian Pilot Program* (2005); Zoe Dawkins et al, *County Koori Court* (Final Evaluation Report, County Court of Victoria and the Department of Justice, 27 September 2011); Mark Harris, *A Sentencing Conversation: Evaluation of the Koori Courts Pilot Program, October 2002–October 2004* (Department of Justice Victoria, 2006); Stuart Ross, Evaluating neighbourhood justice: Measuring and attributing outcomes for a community justice program, *Trends and Issues in Crime and Criminal Justice*, No 499, Australian Institute of Criminology (2015); Anthony Morgan and Rick Brown, ‘Estimating the costs associated with community justice’, *Trends and Issues in Crime and Criminal Justice*, 507, Australian Institute of Criminology (2015). See also Victorian Ombudsman, *Investigation into the reintegration and rehabilitation of prisoners in Victoria* (September 2015).

She became aware that she was pregnant with her third child while on ARC. Fortunately, through ARC, there was specialist help available to her. She felt buoyed by the encouragement of the ARC team. “They believed in me and wanted to help me. The court helped me get back into community and assisted me to build a better life.” It wasn’t always easy, but Belinda stayed on the program for two years, returning to court every month for ongoing support and supervision.

Life is very different for Belinda now. Having finished ARC, she continues to be drug free. She is living in stable transitional housing and has her infant daughter in her care. She is seeing her two other children weekly and is working towards further increasing contact with them.

When reflecting on the past and on her life now, Belinda comments that “Things are a lot different now. My life has changed completely. Basically, ARC gave me a second opportunity at life again. I’ve got my life back and the prospects of a good future. I’m making plans and goals.”

Belinda’s case demonstrates the intersections between mental health, child protection, housing, family violence and problematic drug use, and the benefits of supporting women experiencing these issues in the criminal justice system to receive support in the community to address them. It also highlights the difference therapeutic courts can make in positively altering trajectories, and reducing intergenerational impacts.

As demonstrated by Belinda’s experience, the availability of sufficient social supports in the community is fundamental to the effectiveness of the therapeutic justice model.⁶³

There are also examples of therapeutic programs delivering positive benefit to people involved in the criminal justice system and the local community, such as those based at the Visy Cares Hub in Sunshine.

Spotlight on the Visy Cares Hub

The Visy Cares Hub (the Hub) in Sunshine houses a number of youth specific services for young people aged 12–25 years, including Orygen Youth Health and Headspace. The Youth Junction Inc operate a number of therapeutically oriented youth crime prevention programs from the Hub, including the Youth, Community and Law Program and the Youth Umbrella Project. Magistrates frequently refer young people to these programs on a pre-sentence deferral. These programs provide important therapeutic and diversionary options for young people, including a significant number who have not positively responded to other sentencing orders including Community Corrections Orders.

The Victorian Ombudsman is supportive of therapeutic approaches and noted that the spending on these community-based interventions has been low in comparison to spending on the wider correctional system. The Ombudsman supported investment in therapeutic courts such as ARC (and other alternatives to incarceration) to expand their operation as required to all offenders, regardless of their location.⁶⁴

VLA supports consideration by the Royal Commission of the important therapeutic and diversionary function of these programs in supporting people with mental health issues involved in justice processes.

⁶³ Issues associated with access to community-based supports, such as housing, are discussed further at Part 4.

⁶⁴ Victorian Ombudsman, *Investigation into the rehabilitation and reintegration of prisoners in Victoria* (September 2015) (**Victorian Ombudsman’s investigation into reintegration of prisoners**), 153.

3.2.3 Improving the operation of community-based sentencing options to support people with mental health conditions

People with mental health issues should be supported to remain in the community where possible. Ideally, this will occur through the exercise of police discretion or agreement to diversion or access to a therapeutic court to resolve criminal law issues. For people whose matters have progressed through the mainstream criminal justice system, there is scope for a deferral of sentence or a Community Corrections Order (CCO) to be used for therapeutic purposes.

The introduction of CCOs was intended to provide a genuine alternative to imprisonment that enables a person to be sentenced in the community and maintain connections to supports that are essential to recovery and wellbeing, including housing, education, employment, mental health support, community and family.

There is evidence that people who are sentenced to and complete a community-based order are less likely to reoffend than those on custodial orders. Of the offenders who were discharged from CCOs in 2014–15, 26.7% had returned with a new community correctional sanction within two years. Of the prisoners who were released in 2014–15, 43.6% had returned to prison under sentence within two years of release.⁶⁵ CCOs also have the additional therapeutic benefits and value associated with avoiding imprisonment which can be highly detrimental for people with mental health issues.

Our clients frequently present with a range of therapeutic needs with a background of complex and chaotic lives. In our experience, people with mental health issues sentenced in the community may require additional support to comply with the conditions of a CCO. Without more intensive case management and support, they may not be able to comply with treatment or other conditions. This carries the risk of a person moving deeper into the justice system for breaching the conditions of their order, rather than as a consequence of new offending. If a person is not supported to manage related issues, such as drug or alcohol dependence, there is also a risk of further offending if they remain in the community with limited support. Legal assistance is a key element supporting understanding of the requirements of court orders and supporting compliance.

There are also issues with waiting times to access therapeutic programs and support services for those sentenced in the community. Issues associated with timely access to programs was noted during a recent audit of Community Corrections by the Victorian Auditor-General.⁶⁶ VLA supports recent work by Corrections Victoria to improve the management and effectiveness of CCOs and supports investment from government to support the growing volume of CCOs. However, we consider there is still more that needs to be done to ensure CCOs provide a therapeutic response to offending by reorienting the approach of Community Corrections away from the monitoring of compliance and identification of breaches to supporting compliance through active case management.

3.3 Recognising that people with a mental impairment may not be criminally responsible for their conduct

Recognition that people with mental impairment may not be criminally responsible for their conduct is one of the essential features of a fair and compassionate justice system.

The principle that a person whose offending arises from a mental impairment should not be criminally responsible for their conduct is long-established in our criminal justice system. The *Crimes (Mental*

⁶⁵ Of the offenders who were discharged from Community Corrections orders in 2015–16, 13.9% had returned with a new community correctional sanction within two years. Of the prisoners who were released in 2015–16, 43.7% had returned to prison under sentence within two years of release. Source: Corrections Victoria, 'Corrections Statistics: Quick Reference' (2019) <<http://www.corrections.vic.gov.au/utility/publications+manuals+and+statistics/corrections+statistics+quick+reference>>.

⁶⁶ Victorian Auditor General, *Managing Community Corrections Orders* (February 2017) <<https://www.audit.vic.gov.au/sites/default/files/20170208-Community-Corrections.pdf>>.

Impairment and Unfitness to be Tried) Act 1997 (Vic) (**CMIA**) provides a legislative framework for those who, but for their mental impairment (frequently a serious mental health condition), would not have offended. The CMIA sets a high threshold for the mental impairment defence and diverts the very small number of people who come within it from punishment to treatment in recognition of this principle and in order to manage future risk. This policy intention is supported by a system that manages those that come within the CMIA because of their mental health issues in a designated mental health service or Thomas Embling Hospital, rather than prison.⁶⁷ However, as a risk driven regime, the CMIA is highly onerous and restrictive.

Despite the therapeutic benefits of this alternative pathway for offenders with mental health issues, it is not available to people in the Magistrates' Court and children and young people in the Children's Court do not have access to a dedicated forensic facility.

This has resulted in a range of consequences for clients with mental health issues including:

- People entering the system who would likely be found to be unfit to be tried, but have little choice but to plead guilty to charges that result in extended time in custody where they are likely to struggle to access appropriate support and experience harm to their wellbeing; and
- People who are unfit returning to the Magistrates' Court on a series of low-level matters but not being able to have these matters dealt with by the court in a timely manner due to issues of fitness to be tried being uplifted to the County Court.

The Victorian Law Reform Commission identified a number of these, and other, shortcomings in its major review of the CMIA and made some recommendations to improve the operation of the scheme as well as the services provided to people under supervision.⁶⁸ VLA considers that the implementation of many of these recommendations will improve the outcomes of people with mental health issues who come into contact with the criminal justice system. This should include:

- improving the processes for assessing fitness to stand trial;
- extending the operation of the CMIA to the Magistrates' Court;
- enhancing the range of orders available after a finding, including consideration of less restrictive civil orders as an alternative to a supervision order under the CMIA; and
- better processes for review, leave and management of people subject to supervision.

A number of these changes were supported by VLA in our detailed submission to the VLRC.⁶⁹

3.4 Reducing the harm associated with imprisonment

There continue to be significant issues for the significant number of people with disability and/or mental health issues in custody. The Victorian Ombudsman's *Investigation into the rehabilitation and reintegration of prisoners in Victoria* found that 40% of prisoners in Victoria had been identified as having a mental health condition, two to three times higher than the reported rates in the general community, and found that prisoners are also 10 to 15 times more likely to have a psychotic disorder than someone in the general community.⁷⁰ According to data from the Youth Parole Board, over 50% of young people entering detention have a mental health issue..⁷¹

⁶⁷ The Disability Forensic Assessment and Treatment Service provides supervision and treatment for people who fall under the CMIA because of disability. Forensicare, provides treatment and supervision of people on orders under the CMIA because of mental health issues, including providing inpatient services at Thomas Embling Hospital.

⁶⁸ Victorian Law Reform Commission, 'Review of the Crimes (Mental Impairment and Unfitness to be Tried) Act 1997' (2014) Chapter 5

⁶⁹ Victoria Legal Aid, 'Submission to the VLRC Review of the Crimes (Mental Impairment and Unfitness to be Tried) Act 1997' (2013).

⁷⁰ Victorian Ombudsman, 'Investigation into the rehabilitation and reintegration of prisoners in Victoria' (September 2015) 6, 34 (**Ombudsman's Prison Report**).

⁷¹ Youth Parole Board *Annual Report 2017-18*.

Entering custody is likely to cause further harm to people experiencing mental health issues. The punitive custodial environment, lack of timely access to mental health treatment and support, and issues associated with the management of complex needs and behaviours in custody, make imprisonment particularly harmful for people with mental health issues. The increasing prison population has had a significant impact on these issues.

There are many reasons why a person in the mainstream prison population may need to access forensic mental health services while in custody. Some people may not have been identified, or diagnosed, as having a mental health issue before entering custody. Others may become unwell due to their experience of the criminal justice system and the custodial environment.

Prisoners with mental health conditions that require intensive treatment have access to specialised mental health beds. For prisoners that require a transfer to Thomas Embling Hospital for more intensive or involuntary treatment there are usually significant delays before a person is transferred for treatment due to the number of forensic beds not meeting demand in the system.

3.4.1 The impact of Victoria's growing prison population

There has been a significant increase in the number of people held in Victorian prisons. This number has more than tripled since 2008. These increases can be broadly linked to government policy settings that have reduced access to bail, tightened laws relating to parole, increased custodial sentences and reduced the availability of community-based sentencing options. We consider that this development will have a negative impact on people experiencing mental health issues entering the justice system and highlights the importance of seeking community based and therapeutic alternatives to imprisonment.

The data relating to women is particularly significant, with approximately half of the women in custody being held on remand, and 60% of those women on remand there for less than four weeks.⁷² Ten years ago, only a quarter of women in custody were unsentenced. In the last five years there has been a 184% increase in women being remanded to custody over this period, and a 103% increase in Aboriginal people being remanded to custody (320% for Aboriginal women).⁷³ A significant proportion of those remanded in custody are released to bail, non-custodial sentences or are sentenced only to the time already served on remand. Corrections reports that when women are on remand, it is harder to deliver and engage them with mental health services.

The growing number of people in custody has had a number of impacts across the entire prison population, but issues that are likely to make the experience of imprisonment more challenging for people with mental health issues.

- **Deteriorating conditions in custody.** Some of VLA's clients are held in unsatisfactory conditions for extended periods in regional and rural police cells, or in the Melbourne Custody Centre, with limited access to fresh air or natural light, limited telephone calls or visits from family or legal practitioners; inappropriate bedding; and without appropriate supports or supervision. Clients are shuffled between police cells limiting their access to family and legal representation. Clients are often subject to lengthy lockdowns (with reports of 23-hour lockdowns at the MRC). Current delays in transportation have exacerbated this issue. People held on remand have limited (if any) access to programs and supports.
- **Delays due to prisoner non-transportation** has caused significant issues with the timely resolution of matters, access to legal advice and assistance and assessment by support services,

⁷² See Department of Justice and Community Safety – Corrections Victoria, 'Women in the Victorian Prison System' (January 2019) <<https://www.corrections.vic.gov.au/publications-manuals-and-statistics/women-in-the-victorian-prison-system>>.

⁷³ Ibid.

such as the Court Integrated Services Program (**CISP**). Moreover, audio-visual links (**AVL**) are not always available following non-transportation. There is increased court congestion, backlog and expenditure because of the unpredictable nature of prisoner movements. We have particular concerns about the harmful impact of transportation delays on vulnerable prisoners. There are also direct impacts on victims, family members and supports when matters do not proceed on the allocated hearing date.

- **Growing female remand population resulting in harmful impacts on women and their families**, when most women are unlikely to receive a period of imprisonment. This is particularly concerning given the high rates of victimisation, addiction issues, family violence and caring responsibilities within this cohort. Other jurisdictions are moving towards abolishing short periods of imprisonment for women in favour of community options, given the evidence of harmful and long-term impacts on women, their families and the community.⁷⁴
- **Disproportionate impacts of increased rates of imprisonment on Aboriginal and Torres Strait Islander people** who are already overrepresented in the criminal justice system. These impacts require system-wide collaboration to develop culturally appropriate programs, including diversion programs, bail programs, community-based sentence options, sentencing forums, and prison and post-release programs that will reduce the rates of indigenous imprisonment.⁷⁵

3.4.2 Access to mental health assessment, treatment and support

Once a person is in the criminal justice system it is more difficult to access health care, treatment and support. This can have significant consequences for their mental health issues and can cause instability, impact their recovery, lead to longer periods of imprisonment, and increase the chance of reoffending. A number of investigations have highlighted the deficiencies in access to mental health treatment and support in Victorian prisons.⁷⁶

The growing prison population in Victoria has added to the challenges of health care and support for people experiencing mental health issues involved in the criminal justice system.⁷⁷ The need for mental health treatment facilities for prisoners currently exceeds the number of available beds due to investment in the system not keeping pace with the increase in the prison population. These shortages impact across the criminal justice and forensic mental health systems (whether a person is on remand, sentenced, or found not guilty by reason of mental impairment)⁷⁸ and can also result in the prolonged detention in prison of people who have been found unfit to be tried.⁷⁹ The policy intention that those who should not be held criminally responsible should be diverted from prison to hospital is being undermined by lack of access to appropriate services, with people found not guilty by reason of mental impairment commonly spending up to 12 months in prison awaiting transfer to Thomas Embling Hospital to commence the process of treatment and rehabilitation required by their order.

Issues associated with continuity of care and treatment once a person enters custody, particularly for

⁷⁴ See, for example Scotland introduced a presumption against short sentences of up to three months. The United Kingdom is also considering a recommendation to abolish sentences of less than twelve months for women. See further, All Party Parliamentary Group on Women in the Penal System (UK) *Women in the penal system – Final Report* (2018).
<<https://howardleague.org/wp-content/uploads/2018/10/APPG-report-on-sentencing-31-October-2018.pdf>>.

⁷⁵ The need for services that take into account the specific needs of Aboriginal and Torres Strait Islander people is discussed in part 5.

⁷⁶ See Ombudsman's Prison Report above n 70; Victorian Ombudsman, 'Investigation into deaths and harm in custody' (Report, March 2014) 111.

⁷⁷ There were 7,666 prisoners in the Victorian prison system on 30 June 2018. This represents an increase of 81.5% on the 30 June 2008 figure of 4,223: Corrections Victoria, *Corrections Statistics: Quick Reference* (June, 2018)
<<http://www.corrections.vic.gov.au/utility/publications+manuals+and+statistics/corrections+statistics+quick+reference>>.

⁷⁸ Department of Health and Human Services, *Targeting Zero: Supporting the Victorian hospital system to eliminate avoidable harm and strengthen quality of care* (2016). (**Targeting Zero Report**).

⁷⁹ Ombudsman, Investigation into the imprisonment of a woman found unfit to stand trial (Report, October 2018)
<<https://www.ombudsman.vic.gov.au/News/Media-Releases/imprisonment-of-woman-found-unfit-to-stand-trial>> (**Ombudsman's Report on Imprisonment of a Woman Found Unfit to Stand Trial**).

people on remand, are demonstrated by Jude's experience.

Jude – Part 2: Being held in restrictive conditions due to lack of access to appropriate forensic mental health care

When Jude was remanded in custody, the remand warrant included brief information about her need to receive ongoing mental health treatment. For the time that Jude remained in custody in the cells at her local police station, her daily administration of medication continued without interruption.

Eventually the time arrived for Jude to be transported to Dame Phyllis Frost Centre (**DPFC**). When Jude was placed into prisoner transport for the 3+ hour journey to DPFC, her medications were transferred with her. However, Jude was moved in and out of police cells along the way where it is unknown whether her medication was administered. At some point, the medications were lost in the system and when Jude arrived at DPFC it was recorded that they did not have any information about her medications, but they were aware of her forensic history. The conditions in custody and lack of access to medication contributed to a deterioration in Jude's wellbeing. Crucially, Jude was not given her prescribed medication and she experienced a major relapse in psychosis. Jude's condition continued to worsen.

While at DPFC, Jude was subject to 23-hour lockdown as no beds were available at Thomas Embling Hospital. Unsurprisingly, Jude's condition deteriorated, and she underwent an emergency transfer to a hospital when she was observed to be catatonic. Upon release from hospital, Jude was returned to 23-hour lock down in the Marrmak unit at DPFC.

Jude remained in lockdown for some time. Jude continued to experience issues with her medications (including not being administered some of her prescribed medications) and wellbeing over that period.

Unfortunately, Jude's experience is typical of some of the issues observed by the Victorian Ombudsman when she conducted a pilot inspection of DPFC under the Optional Protocol to the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (**OPCAT**). The Victorian Ombudsman made a number of recommendations to improve the support for women at DPFC and prisoner rehabilitation and support more generally, including better mental health supports.⁸⁰

Jude's story highlights the extreme disadvantage people with mental health issues experience when they enter the criminal justice system in Victoria, and particularly during transfer of custody from police to Corrections Victoria. The protections afforded Jude under the *Corrections Act 1986* (Vic) were not sufficient to guarantee her access to crucial medical treatment during her transition to prison and did not protect her from avoidable and unnecessary harm. Similarly, the fundamental protections afforded her by the *Charter of Human Rights and Responsibilities Act 2006* (Vic) (**Charter**) appear to have done nothing to guarantee her "humane treatment when deprived of liberty".⁸¹

We are also concerned about the further criminalisation of people in custody where conduct is linked to a mental health issue or the management of that mental health issue within the custodial environment. For example, we have had clients charged with property damage for damage to their cells or possession of unauthorised property or for assault when acting out against restraint or other restrictive practices.

⁸⁰ Ombudsman's Prison Report, above n 70.

⁸¹ *Charter of Human Rights and Responsibilities Act 2006* (Vic).

3.4.3 Eliminating the use of solitary confinement and other restrictive practices to manage complex needs, including mental health issues

One of the consequences of the growing prison population in Victoria is the impact of overcrowding on the management of people in custody. Some of the custodial management practices, such as lockdowns and rotations, the use of solitary confinement, and irregular access to programs and support can have a direct and harmful impact on people with mental health conditions.

We also see people with disability or mental health issues being placed in more restrictive settings or being subject to highly restrictive management conditions due to their needs and behaviour. This includes extended solitary confinement, 23-hour lockdown, restraint and deprivation of movement and strip searches. This is closely linked to lack of appropriate resourcing of supports and facilities in the forensic mental health and disability system and the use of inappropriate facilities within prison to manage mental health needs.⁸²

These practices are connected to the lack of appropriate mental health support within the custodial environment, as well as issues associated with staffing numbers, training and capability to manage the complex needs and behaviours of people in custody, especially those with mental health issues. These issues have been particularly prominent in youth justice facilities, as demonstrated by the loneliness and isolation experience by our client Leo, documented in our recent submission to the Victorian Ombudsman.⁸³

Leo: The impact of solitary confinement on young people

Leo is an aspiring musician. Leo is currently living at Malmsbury Youth Justice Precinct. Leo told his lawyer that they seem to spend every second day on rotations. Leo has been in custody before and says that things are “the worst they have ever been.”

“(I) come out feeling angry.”

Leo told his lawyer that he spends most of his time locked in. Being locked in makes Leo feel angry. He says that when he is feeling this way there is nobody to talk to.

Leo has also observed the impact of lockdowns and rotations on other young people living at Malmsbury. He says they are “always angry or expressing suicidal thoughts” when they come out of lockdown and rotations.

Leo knows he should ask for help when he needs extra support. But the support doesn’t come very quickly. When Leo requested to see a psychologist he had to see the doctor first to get a referral. It was six weeks before he actually got to speak with a psychologist. Leo has only seen a psychologist twice in the three months he has been living at Malmsbury despite entering Malmsbury with a diagnosed need for mental health support.

There have been times when Leo hasn’t asked for help because he is afraid of the consequences. He says that they often get locked back in when they are feeling angry or have expressed thoughts of self-harm. He was told this is to protect his safety and the safety of the staff.

“I just want someone to talk to.”

⁸² These issues are especially acute for those with coexisting mental health issues and other issues, including acquired brain injuries, autism and intellectual disability.

⁸³ Victoria Legal Aid, “*I just want someone to talk to*”: Submission to the Victorian Ombudsman investigation into solitary confinement involving young people’ (2019).

Leo often feels lonely and just wants someone to talk to. His family can't come to see him very often due to the distance between their home and Malmsbury. If they can manage it, staff will come and have a chat but he has noticed that this doesn't happen much as there are not enough staff at Malmsbury. Often he just relies on the other boys in his unit for emotional support. When they are stuck in their cells this can't happen. He doesn't feel like he has enough support at Malmsbury. Sometimes he hasn't even been able to speak with his lawyer as there have not been enough staff to accommodate the video conference.

The use of solitary confinement and other management practices are a consequence of the youth justice system not having the processes or facilities to support young people experiencing mental health issues. There is currently no dedicated forensic mental health facility for young people in Victoria.⁸⁴ There are also delays in the assessment and screening for mental health issues when people are received into custodial facilities. For example, a recent report by the Victorian Auditor-General found that there were issues with the timely completion of assessment, planning and service delivery for young people entering detention.⁸⁵ The resulting delays can have a detrimental impact on mental health and the continuity of care people require to manage their conditions, which can increase the likelihood that management conditions will be used.

Our clients have also reported a lack of culturally appropriate mental health support in the youth justice system. Many of the children in the youth justice system have histories of trauma and disadvantage. The lack of access to mental health care and the damaging impact of custodial management practices are causing harm to young people. The importance of tailored and culturally safe services for young people and culturally and linguistically diverse people is further explored in part 5.

3.5 Supporting people towards rehabilitation, recovery and life in the community

People with mental health issues are at risk of longer involvement in criminal justice and forensic mental health systems due to inadequate support and services to facilitate their transition into back into the community.⁸⁶

These issues are more prominent and complex for people who have other issues, including intellectual disability, acquired brain injury, autism and personality disorders.⁸⁷ Few support services are designed to respond to these intersecting needs. These issues have been part of the criminal justice landscape for some time.

3.5.1 People transitioning from prison and youth justice facilities

Most people in prison will be released back into the community after completing their sentence. Ensuring that people receive access to health support and programs during their sentence is essential to making this transition back to the community successful. Access to transition planning and support is also necessary. In 2015, the Victorian Ombudsman completed an investigation into prisoner rehabilitation and reintegration. The Ombudsman found that transition support is essential to reduce the risk of a person returning to prison. According to the Ombudsman,

⁸⁴ The establishment of a youth facility was recommended by Penny Armytage and James Ogloff, *Youth Justice Review and Strategy: meeting needs and reducing offending* (Report, 2017) at [6.14].

⁸⁵ Victorian Auditor-General's Office, 'Managing Rehabilitation Services in Youth Detention' (Parliamentary Report, August 2018) <<https://www.audit.vic.gov.au/sites/default/files/2018-08/20180808-Youth-Detention.pdf>>.

⁸⁶ The particular impact of the NDIS in supporting or obstructing remaining in, or returning to, the community is discussed in part 4.

⁸⁷ The lack of responsive supports for people with dual diagnosis or dual disability are also discussed in part 1.

The evidence is strong that transitional support for prisoners is effective: 10.4% of prisoners discharged from Victoria's single transitional facility return to prison within two years compared to 44% of all prisoners. However this option is only available to male prisoners and is limited to 25 places.⁸⁸

A person's transition out of custody can be more difficult after longer sentences. A Commonwealth Parliamentary Inquiry found:

mental health problems can be compounded by sentencing practices. Longer sentences inevitably mean a greater habituation to prison environments and a diminished capacity to reintegrate into the external community, especially for those already facing problems of social competence. In this sense longer sentences contribute to the problem of recidivism – thus the endless cycle starts.⁸⁹

Providing transitional support is essential to reduce the risk of a mental health impact upon release to the community. As noted elsewhere, people experiencing mental health issues can experience barriers to participation in community life, such as access to housing and employment. Access to housing and employment are significant protective factors against reoffending. This makes support to transition back into the community essential to reduce risk of re-entry back into the justice system.

Jude – Part 3: Spending longer in custody due to inadequate access to health support and a worsening of mental health issues

One of the consequences of the deterioration of Jude's condition while on remand was that she spent longer in custody and it took longer to finalise her charges.

Jude was finally released from prison once her condition stabilised sufficiently to instruct her lawyer. Her criminal charges were finalised by the Magistrates' Court with an undertaking to be of good behaviour for 24 months. Jude did not receive a term of imprisonment.

On release, Jude was returned to an acute inpatient unit at her regional area mental health service where she has now effectively become a permanent patient.

3.5.2 People transitioning from custodial supervision under the CMIA

Following a finding of not guilty by reason of mental impairment or unfitness to be tried under the CMIA, the court must either declare that a person is liable for supervision or order their unconditional release. The most common order under the CMIA is for a court to declare a person is liable for supervision.⁹⁰ The court must then make a custodial or non-custodial supervision order. Supervision orders under the CMIA are indefinite orders and can only be brought to an end by a court determining that to do so would not present a risk of harm to the person on the order or anyone else.

Once a person is in the CMIA system, our lawyers see it can be difficult to access appropriate supports to facilitate their integration into the community and gradual exit from the system. This can have significant consequences for a person's rehabilitation and recovery. Our experience is that this often leads to longer and at times clinically unnecessary periods of detention at Thomas Embling Hospital and we frequently see people remaining under custodial supervision under the CMIA for longer than any term of imprisonment they would have received through ordinary criminal justice processes.

⁸⁸ Victorian Ombudsman's investigation into reintegration of prisoners, above n 64.

⁸⁹ Senate Select Committee on Mental Health, Parliament of Australia 'A national approach to mental health – from crisis to community First Report' (2006) 13.44.

⁹⁰ Unconditional release is very rare once a person is found unfit to plead or not guilty by reason of mental impairment under the CMIA.

There are three drivers that impede community transition.

- **Processes.** There are limitations created by Forensicare's ability to prepare the person for transition. Forensicare approaches all discharges in the same way, with the same discharge pathway, regardless of the individual's circumstances.
- **Availability of supports in the community.** There are delays that arise from difficulties putting supports in place in the community. Mainstream rehabilitation, mental health, housing and aged care services may not want to accommodate people with forensic histories, which are further complicated by the intersection with the NDIS.⁹¹
- **Public perceptions.** A negative public perception of the outcomes for mental impairment and unfitness to be tried matters underlies many of these issues, resulting in significant stigma for forensic patients and their families which impacts upon their reintegration into the community. This includes the challenges people with a forensic history face in finding appropriate accommodation which is suitable for discharge due to a range of factors. For example, there is an acute shortage of affordable housing, discrimination and a lack of appropriate services including step-down services such as SECUs and Continuing Care Units.

Further, a lack of coordination results in SECUs refusing to accept transfers of people who no longer need to remain at Thomas Embling Hospital, but may continue to require long-term inpatient rehabilitation services. There are limited mechanisms to compel SECUs to accept these patient transfers.

These issues do not require a new policy or legislative response. They simply require additional investment in transitional support and forensic mental health services to match increased demand and overall population growth to ensure that the service response gives effect to the current legislation and clinical framework.

Priority area for reform 3: Reducing the harm of criminal justice involvement for people experiencing mental health issues

There is an over-representation in the criminal justice system of people, including young people, with mental health issues. The justice system must not be the default mental health service provider. Based on our experience working with people across the justice system, there are some essential steps that must be taken to reduce the rates and intensity of criminal justice involvement for people experiencing mental health issues. These include:

- Reducing the number of people with mental health issues entering the criminal and youth justice systems.
- Increasing access to diversion, therapeutic courts and community-based sentencing options.
- Recognising that people with mental health issues may not be criminally responsible for their conduct.
- Reducing the harm associated with imprisonment, including access to appropriate forensic mental health facilities.
- Supporting people towards rehabilitation, recovery and life in the community.

⁹¹ The intersection between the NDIS and mental health services is discussed further at part 4.

4. Improving the responses of other services and systems to mental health

Through our work, VLA sees the intersection between people's mental health – and the systems, supports, and services that impact on mental health – with other life and legal issues. We see the way a lack of access to housing, disability services, employment, income support, and/or mental health services in the community, can be influenced by a person's experience of mental health issues, and can cause damage to people's mental health and undermine their recovery. Our practice experience also reveals the potential for these systems to treat people unfairly because of their mental health issues.

Difficulty in accessing support and services may escalate issues such as family breakdown, removal of children, homelessness, criminal offending, loss of income, loss of employment, or hospitalisation. Once people have entered crisis-based systems, their exit, reintegration, and recovery are again dependent on access to adequate housing and supports in the community.

This part highlights the way in which people experiencing mental health issues can experience laws, services, and systems in a way that:

- limits their access to the service and supports they need to support recovery;
- makes assumptions about their capacity and capabilities;
- fails to understand mental health issues, or to meet the needs of people in ways which are fair and promote people's rights and recovery;
- limits their opportunities to participate in decisions that affect their lives; and
- actively contributes to deterioration in their mental health.

We focus on:

- increasing access to **housing**, and reducing evictions, for people experiencing mental health issues;
- improving the interface between the **NDIS** and other services;
- **reducing unfairness in administrative and legal processes** for people experiencing mental health issues, including in relation to child protection, guardianship and administration, and Working with Children Checks;
- improving the understanding of, and responses to, mental health in the **family violence and adolescent family violence systems**;
- preventing and addressing the harm associated with **discrimination**, including discrimination on the basis of a person's mental health issue and the mental health impacts of discrimination and sexual harassment; and
- reducing the impact of **compliance and enforcement processes** on people experiencing mental health issues, including fines and social security.

The way in which these related systems operate can also lead to unfairness and reduced life opportunities for people in ways which carry heavy personal, social, and economic costs. In this context, we also discuss the benefits of early access to legal assistance as part of a community-wide response to mental health.

4.1 Increasing access to housing, and reducing evictions, for people experiencing mental health issues

In 2017-18, VLA assisted over 1,000 people who were experiencing homelessness and identified as having a mental health issue or disability. Through our work with clients at risk of or experiencing homelessness, we see the impact of housing instability and homelessness on people's mental health treatment and recovery.⁹² This includes people being discharged from hospital or released from prison into rooming houses, unstable housing, or onto the streets, and the consequent risk of readmission into hospital or re-entry into the criminal justice system. We also see circumstances where people are unable to be discharged from inpatient units or released from prison because of a lack of housing, leading to prolonged detention that negatively impacts their long-term wellbeing and recovery.

We see the particular challenges experienced by people with mental health issues living in the community getting access to safe, affordable housing, including because of low incomes, discrimination, and an acute shortage of affordable housing, as well as a heightened risk of eviction into homelessness for people experiencing mental health issues.⁹³

Lydia's story highlights the two-way relationship between a person's housing and their mental health: Lydia's hoarding – directly related to her mental health – placed her at risk of eviction, and the stress of facing eviction exacerbated her mental health issues.

Lydia: Threat of eviction for hoarding behaviours

Lydia is a 53-year-old woman living in suburban Melbourne in a property managed by a social housing provider. She identifies as Aboriginal and regularly travels to regional Victoria to help care for her ageing parents. Lydia has had some involvement with the criminal justice system and has spent some time in prison. She has been a victim of family violence.

Lydia has been affected by complex trauma and this manifests in hoarding behaviours. This has caused issues throughout her 12-year tenancy. Her relationships with some of the other occupants of the apartment building have broken down and they complain frequently to the housing provider about Lydia's hoarding. The housing provider has issued Lydia with numerous breach of duty notices over the years, and has applied to VCAT for possession of the property on multiple occasions. Lydia has defended many of these eviction applications and negotiated with respect to others, such that she has been able to remain in the property until now.

In 2018 Lydia was again issued with breach of duty notices and a new application was made to evict her from the property.

Lydia sought VLA's assistance to oppose the application for possession of the property. Lydia's mental health was adversely affected by the proceedings: her mental health is inextricably entwined with her housing, and a threat to the one is a threat to the other. Despite her best efforts, including consistent therapeutic engagement, her hoarding behaviours increased due to the stress.

At present, the VCAT proceedings are adjourned indefinitely while VLA negotiates an appropriate outcome with the housing provider. Lydia is, however, overwhelmed by the knowledge that the

⁹² In 2017-18, 5% of VLA's clients reported experiencing homelessness. In 2017-18, VLA's tenancy assistance included: 4,296 information services; 2,372 advices; 79 casework files; and 301 appearances at the Victorian Civil and Administrative Tribunal.

⁹³ In 2011, the Victorian Department of Health and Human Services estimated that it costs around \$34,000 in publicly funded support services to rehouse someone following eviction from public housing: Victorian Department of Human Services, *'Human Services: The Case for Change'* (Report, 2011) 12 <https://www.thelookout.org.au/sites/default/files/1_iwas_human_services_case_for_change_0412.pdf>.

proceedings could recommence at any time, and she could again face the threat of eviction into homelessness due to compulsions she has been unable to control.

Lydia's case highlights how community and public housing providers continue to resort to eviction as the mechanism for managing tenants with complex behaviours directly linked to their mental health.⁹⁴

While acknowledging the challenges of landlords and the competing obligations social housing landlords face managing multiple tenants, it is vital that we build a legal and services system that makes eviction for conduct related to a person's mental health a last resort. In the current housing environment, long waiting lists for social housing and an unaffordable private rental market mean homelessness is almost inevitable for low income people after eviction. Given the personal and economic costs of homelessness are well-known, legal protections, alternatives to eviction, and effective tenancy sustainment programs must be prioritised.

In addition to maintaining existing tenancies, it is crucial that all levels of government invest in increasing the supply of social housing and supports for people experiencing mental health issues. Safe, affordable housing is a critical foundation for improving health, supporting mental health, keeping families together, avoiding offending, and promoting social and economic participation.⁹⁵

4.2 Improving the interface between the NDIS and other services

The implementation of the NDIS has had (and will continue to have) a significant impact on Victoria's mental health system. Through our work with clients who are eligible for funding through the NDIS, we see a number of practices and experiences that can have negative consequences for a person's mental health, participation, and wellbeing. These include:

- **'Market failure' or 'thin markets'**, whereby people are not able to access services and supports they are funded to receive. This is particularly acute for people engaged with the justice system and people with complex needs.⁹⁶
- **Plans and supports that do not adequately meet people's needs** and the implications this has for their community engagement and wellbeing.
- **Responsibility shifting.** Tensions between the NDIA and State- and Territory-funded services result in people falling through the gaps. One clear example of this is where there is no agreement on whether supports relate to a person's disability needs or to their offending. As such, agreement cannot be reached on which agency is responsible for the provision of services.
- **Transition from inpatient or custodial environments.** There are ongoing challenges with discharge and release planning for people in prisons or inpatient units. In the absence of proactive discharge and pre-release planning, discharge or release can be: (a) delayed, causing people to be stuck in prison or inpatient units; or (b) ineffective, because poor planning means a person exits with inadequate supports and is more vulnerable to re-offending and/or readmission.
- **People experiencing restrictive conditions** such as not being released on bail or parole because of a lack of housing or supports in the community, and the consequences of extended periods of imprisonment on a person's ability to recover and reintegrate into the community.

⁹⁴ See, eg, C Martin, D Hab bis, L Burns, and H Pawson (2019) *Social housing legal responses to crime and anti-social behaviour: impacts on vulnerable families*, AHURI Final Report 314, Australian Housing and Urban Research Institute Limited, Melbourne <<http://www.ahuri.edu.au/research/final-reports/314>>.

⁹⁵ See *Everybody's Home* (2018) <<https://everybodyshome.com.au/>>.

⁹⁶ Victoria Legal Aid, *Ten Stories of NDIS 'Thin Markets': Reforming the NDIS to meet people's needs*, (Unpublished Report, June 2019) (**'Thin Markets' Submission**).

A number of these issues, together with the difficult interface between the NDIS and the housing and justice systems, are highlighted through John's story below.

John: The costly maze of NDIS, housing and the justice system

John has an ABI and a diagnosis of schizophrenia, and his disabilities have contributed to past problematic substance use, lack of employment, and limited community engagement. He has a history of mostly low-level offending. His disabilities have a significant impact on his everyday functioning, and his behaviours of concern limit his housing options. When he has received consistent community supports, John has been most successful in retaining accommodation and avoiding reoffending.

When John transitioned to the NDIS, his plan was not sufficient to support him to live well in the community. Without the supports he needed, John committed further offences and was taken into custody.

John could be placed on the waiting lists for community and public housing providers, but any housing option was unlikely to be sustainable for John without intensive daily support.

At John's hearing, the Magistrate indicated she would be satisfied that John had spent sufficient time in custody in relation to his offences but would only release him if appropriate supports were in place. A supported residential service said it could hold a room for him pending further planning, but it could not hold John's housing indefinitely if the support was not confirmed.

A new NDIS planner was allocated to John's case just before his next hearing date, and indicated a further three months would be needed make a decision about John's NDIS plan. This planner raised concerns regarding the relationship between John's offending and his disability support needs. While reports suggested some proposed supports could reduce John's risk of re-offending, the planner indicated that risk of re-offending was a justice, not disability issue, and therefore those supports may not be eligible for NDIS funding.

VLA escalated John's case with the DHHS Intensive Support Team, noting that John was facing further unnecessary time in custody if his pre-release planning was delayed. The Intensive Support Team contacted the NDIA and arranged for the planning to be undertaken promptly.

The plan was reviewed, and John's supports were increased to provide 24/7 support for him in his home. These supports made living at the supported residential service feasible for John.

It took 10 months for an NDIS plan review, which led to a sustainable post-release package of supports. For the majority of this time, John was in custody.

As John's case shows, a common theme that arises across VLA's work with people who are – or should be – engaged with the NDIS is the lack of systemic coordination; that is, no one agency or worker is responsible for a person's matter and for navigating the system, particularly for people in prisons or other restrictive environments or who face other additional barriers to doing that themselves.

The NDIS is a potential source of optimism and may be able to meet the support needs of people with psychosocial disability to strengthen their ability to live well and independently. However, in its current form it has added another layer to an already complex system, and in some cases is exacerbating rather than resolving problems. VLA has made a number of recommendations for improvements to support the operation of the NDIS and its intersection with other service systems.⁹⁷

⁹⁷ Ibid.

At present, the transition to the NDIS is part of a system that is having long-term negative impacts on people's mental health and wellbeing. People have lost access to services they previously had and are subjected to assessment processes that are stressful and damaging. Without the services and supports they need to live well and independently, people are spending protracted periods in prison or mental health units and are facing homelessness and family breakdown. Those with multiple intersecting issues, like John, are especially vulnerable to losing appropriate support services in the transition to the NDIS.

4.3 Reducing unfairness in administrative and legal processes for people experiencing mental health issues

The intersection of the mental health system with the legal system is not limited to criminal justice or the mental health legal jurisdiction. People who experience mental health issues are also vulnerable to having decisions made about them, their families, and their lives that are influenced by assumptions about their mental health. We have seen this occur in the context of child protection, guardianship and administration, and Working with Children Checks.

4.3.1 Child protection

In 2017-18, VLA assisted 1,954 clients with child protection legal matters who identified as having a disability or mental health issue.

In the child protection system, we have seen that a mental health diagnosis can be cause for a pre-judgement or assumption that parenting capacity is low. Where a parent has a disability, particularly a cognitive disability or mental health issue(s), children are removed from their family at a rate greater than where parents do not have a disability.⁹⁸

Parental mental health concerns are one of the key risk factors for children going into Out of Home Care, particularly when co-occurring with family violence or substance abuse.⁹⁹ Where a mental health issue is present, it is important to understand the basis on which it may present a current or future risk of abuse or neglect and, wherever possible, to determine what supports could be put in place for the parent and/or children to keep the parents and children together as a family unit.

Despite mental health issues often being episodic or the parent being in remission, we have seen that previous experience of mental health issues can pose a risk of the removal of children from a parent's care.

The stories of Charlotte and Sarah highlight the unfairness in how people with mental health issues can be treated in the child protection system, including having judgements made about capacity and barriers to participating in decisions that affect them. Sarah's story highlights the difference where adequate supports are put in place (in her case through VLA's IFAS service).

⁹⁸ Office of the Public Advocate *Rebuilding the village: Supporting families where a parent has a disability* (Report 2, 2015) <<https://www.publicadvocate.vic.gov.au/our-services/publications-forms/241-rebuilding-the-village-supporting-families-where-a-parent-has-a-disability-report-2-child-protection-2015?path=>> (OPA **Rebuilding the Village**).

⁹⁹ As a signatory to the United Nations Convention on the Rights of the Child (CRC) and *Convention on the Rights of Persons with Disabilities* (CRPD) children should not be separated from their parents against their will unless this is in the best interests of the child as determined by a Court and subject to judicial review. Under these conventions, the disability of a parent is not justification for the separation of children from parents and the State is committed to providing the supports necessary for parents with disability to meet their parenting responsibilities. These rights are reflected in the *Children, Youth and Families Act 2005* (Vic).

Charlotte: Child removed despite engagement in mental health supports

Our client Charlotte had experienced periods of acute mental health crisis in her early 20s, but had since enjoyed good mental health for seven years when she fell pregnant with her first child. After a medical assessment, Charlotte was placed on an involuntary order for treatment. With the support of a VLA mental health lawyer, she was later assessed by the Mental Health Tribunal, which found that she did not meet the criteria to be an involuntary patient as her symptoms had reduced.

Charlotte understood she had mental health issues and she was prepared to cooperate with her treating mental health workers. Despite being in remission, at the time of her child's birth she and her baby were moved to a specialised ward for mothers with mental health issues.

Based in regional Victoria, the ward closed over the weekend and DHHS Child Protection was not satisfied with Charlotte and her baby staying in a hotel, so Charlotte's baby was removed from her and placed on a temporary protection order in out-of-home care. Charlotte then needed to go through a lengthy court process to have her child placed back in her care, which ultimately happened after glowing reports from her support services.

Sarah: Advocacy and support helps mother navigate the child protection system

Sarah is a single mother in her 40s with several children, some of whom are still dependents. Sarah had been the victim of family violence perpetrated by her partner and had developed a safety plan with her family violence worker. She also experienced recurring mental health issues. When hospitalisation was required, she had an arrangement that her adult children and sister provided support and care for the younger children.

Last year, while Sarah was an inpatient at a hospital due to her mental health, DHHS Child Protection opened an investigation. A child protection worker spoke with Sarah and requested meetings with her support people and her children. After these meetings, the child protection worker requested that Sarah apply for an FVIO against her partner. Sarah did not want to do this as she was concerned that it would escalate the violence.

Sarah was frustrated with Child Protection, and it wasn't clear to her what steps she needed to take in order to have the investigation closed.

A few months later Sarah was referred to an advocate from VLA's IFAS service. The IFAS advocate was able to assist with communication between Sarah and her allocated child protection worker. This included clarifying the support that Sarah had to manage the care of the children when she was in hospital and explaining Sarah's concerns about the intervention order to Child Protection. The advocate was also able to explain to Sarah the outstanding requirements of the investigation, so Sarah could comply with these, including arranging for the family violence safety plan to be provided to child protection services.

Through this advocacy and communication, Child Protection was satisfied, and the investigation was closed.

Consultations undertaken for our Child Protection Legal Aid Services Review¹⁰⁰ also identified that people in mental health inpatient units may be further disadvantaged by our traditional court-based child protection system as they often are unable to attend court. This may be because they: have not

¹⁰⁰ Victoria Legal Aid, *Child Protection Legal Services Review* (2017) 53.

been notified; do not have phone access; are not granted leave; are not supported by appropriate services; or, as noted above, are assessed or assumed not to have capacity.

As a consequence, parents are frequently absent from proceedings involving their children.¹⁰¹ In addition, while under the *Children, Youth and Families Act 2005* (Vic) a parent is a party to proceedings, where a parent is deemed not to have capacity to instruct a lawyer, they currently go unrepresented.

Without parental participation in proceedings there is a risk that a court may not have all the information necessary to make a determination in the best interests of the child. There is also a risk that the parent's rights are not being upheld.

Victorian law is currently unclear about the court's ability to appoint litigation guardians in child protection matters, and very few litigation guardians are appointed for parents in Children's Court proceedings.¹⁰² Further, no agency is tasked with providing or supporting provision of litigation guardians, so few are available in any case. The *Children, Youth and Families Act* also provides no mechanisms for supported decision-making in child protection proceedings, in contrast to, for example, the principles under the *Mental Health Act* discussed in part 1.¹⁰³

4.3.2 Guardianship and administration

People who experience mental health issues are more vulnerable to having their right to make decisions about their finances removed.¹⁰⁴ The appointment of a guardian or administrator to manage a person's health, lifestyle, legal, or financial decisions involves a significant restriction on a person's rights, autonomy, and dignity.

As the Ombudsman states in her recent report on the Investigation into State Trustees:

*There can be few more potent examples of the imbalance of power between the individual and the state than when the state assumes control over someone's financial affairs.*¹⁰⁵

Our report to the Ombudsman, *State of Trust: Making sure State Trustees protects and promotes the rights of Victorians with disability*, showed how our clients were prevented from participating in activities or spending their funds in ways that they enjoy and that contribute to their quality of life because of the impact of an administration order.¹⁰⁶

¹⁰¹ VLA has taken steps in our Duty Lawyer Guidelines to state that people are eligible for services even if they do not physically attend Court, and VLA is committed to improving ways for lawyers to access parties who are in mental health facilities. VLA's new intake processes will also go some way to providing data that is currently not available from the Court or DHHS regarding the frequency with which people do not participate in proceedings due to being in a mental health facility. Solutions may be time- and resource-intensive as technology-enabled access methods (such as video conferencing) may be required, and lawyers may need to undertake capacity assessments in person and over a period of time to determine if the person can instruct, but they need to be explored and enacted.

¹⁰² The Australian Law Reform Commission, 'Equality, capacity and Disability in Commonwealth Laws', *ALRC report 124*, (November 2014) <<https://www.alrc.gov.au/publications/equality-capacity-disability-report-124>>; The Victorian Law Reform Commission, *Guardianship: Final Report*, (Report, April 2012).

¹⁰³ See also Australian Law Reform Commission, 'Family Law for the Future — An Inquiry into the Family Law System: Final Report', *ALRC Report 135*, (March 2019), recommendations 46-48. The Australian Law Reform Commission's recent final report on its inquiry into the family law system made three relevant and similar recommendations, namely, that the *Family Law Act 1975* (Cth) should be amended to include a supported decision-making framework for people with disability and to include provisions for the appointment of a litigation representative where a person with disability is unable to conduct the litigation; and that the Australian Government should work with State and Territory governments to facilitate the appointment of statutory authorities as litigation representatives in family law proceedings.

¹⁰⁴ In the 2017–18 financial year we provided nearly 500 advices to over 250 individual clients about administration orders; and legal information about administration orders in over 300 cases.

¹⁰⁵ Victorian Ombudsman, *Investigation into State Trustees* (Parliamentary Report, June 2019) <<https://www.ombudsman.vic.gov.au/getattachment/Publications/Parliamentary-Reports/Investigation-into-State-Trustees/Investigation-into-State-Trustees-web-copy.pdf.aspx>>.

¹⁰⁶ Victoria Legal Aid, *State of Trust: Making sure State Trustees protects and promotes the rights of Victorians with disability* (September 2018) <<https://www.legalaid.vic.gov.au/sites/www.legalaid.vic.gov.au/files/vla-submission-state-of-trust-making-sure-state-trustees-protects-and-promotes-the-rights-of-victorians-with-disability-september-2018.docx>>.

In her report, the Ombudsman noted the ‘overwhelming sense of powerlessness’, indignity, and frustration that people on administration orders experienced.¹⁰⁷

The new *Guardianship and Administration Act 2019* (Vic) – which is due to come into effect in March 2020 – is a move in the right direction towards a focus on supported decision-making. This Royal Commission is well-placed to consider whether the substitute decision-making regime established in the Act will genuinely improve the rights, autonomy, and recovery journey of people experiencing mental health issues. As we have seen with the Mental Health Act, training, accountability, and oversight must accompany legislative reform if genuine cultural and practice-based change is to be achieved.

4.3.3 Working with Children Checks

The way in which mental health is considered by decision-makers under Victoria’s Working with Children Check (**WWCC**) scheme also highlights the need for rigorous and proper training, support, and understanding of mental health by legal-decision makers. Through our work, we see that people with mental health issues are more likely to be refused working with children checks due to these issues, even where it is unrelated to an actual risk to the safety of children.

Adina: Required to explain her mental health issues to get a working with children check

In 2017, following the birth of first child, Adina experienced a mental health crisis for the first time, which resulted in her becoming an involuntary patient for three months. Around that time, Adina was charged with a criminal offence which resulted in a review of her working with children check. The working with children check was cancelled as a result. After Adina’s charge had been dismissed without any finding of guilt, she was able to re-apply for a working with children check. When she applied, the WWCC Unit responded by asking a significant number of questions regarding her mental health, including the particular symptoms exhibited over time, Adina’s experience of her mental health issues generally, details of any medication Adina had been prescribed, the effect of that medication, and any side effects.

These questions were asked without reference to how they were relevant to an assessment of the risk that Adina posed to the safety of children. Adina’s lawyer made submissions about Adina’s eligibility to get a working with children check without reference to her mental health, but the WWCC Unit continued to demand details about Adina’s mental health and indicated that, in absence of that material, her working with children check would be refused.

At this point Adina’s recovery journey was progressing well: she was engaged with treatment and had been so for over three years. Adina, a mother of two young children, could not understand why she had to respond to such invasive questions regarding her mental health.

VLA was ultimately able to obtain a working with children check by providing information regarding Adina’s mental health. However, the experience and significant barriers that Adina faced, including assumptions that her earlier period of poor mental health was relevant to whether she posed a risk to the safety of children, highlights the lack of broad understanding of mental health issues within the justice system.

VLA has also represented clients where the WWCC Unit has written to the applicant requesting (among other things) information about whether they have had recurring urges to self-harm and how they responded to those urges. Such questions – and the questions asked in Adina’s case – came without warning and run the risk of retriggering or exacerbating a person’s mental health issues. This

¹⁰⁷ Above n 105.

practice of requiring a person to explain their mental health, without any explanation as to the relevance of their mental health to the assessment of whether they pose an unjustifiable risk to the safety of children, serves to further contribute to the stigma associated with mental health issues.

4.4 Improving the understanding of, and responses to, mental health in the family violence and adolescent family violence systems

Through our work, we see inadequate understanding of the ways in which family violence and mental health issues can intersect, which means victims often do not get support and services suited to their needs.

In relation to adolescent family violence, we see that mental health issues often go un-identified, and are addressed through the legal system rather than through supports and services.

4.4.1 Family violence

We know from extensive research that women with a disability (including those experiencing mental health issues) are disproportionately victims of family violence.¹⁰⁸ Consequently, they are more likely to have contact with the family law, family violence, and/or child protection systems if not appropriately supported at an early stage.

A limited understanding of mental health and the way that mental health issues intersect with family violence can lead to clients missing out on early access to legal and non-legal support services. This can cause or exacerbate mental health issues, putting women in particular at greater risk of experiencing legal problems. While supports may be provided for mental health issues, those supports often do not address the underlying issue of family violence.

For example, while mental health treatment may be one part of the response required, a client experiencing mental health issues may also require a family violence safety response (including a risk assessment and safety planning). The lack of a holistic response to the multiple factors a victim of family violence – predominantly women – may be experiencing can be the cause of ongoing trauma and/or continuation of family violence.¹⁰⁹

VLA's lawyers also see people detained as compulsory patients based on reports about the person's mental health from someone who is alleged to be using family violence against them. Without adequate assessment of the veracity and basis of such claims, there is a risk that the mental health system inadvertently perpetuates a cycle of control or abuse against a victim of family violence.

IMHA advocates report experiences where mental health treating teams have put consumers – particularly women – at greater risk by involving an alleged perpetrator in their care plan, such as giving them a role in administering medication and being informed about the consumer's treatment. This is often despite a disclosure of family violence by the consumer and the consumer clearly not consenting to the involvement of the alleged perpetrator in their treatment.

Jenny's and Adele's stories below both show the need for services to be better equipped to understand and respond to disclosures of family violence. Disclosures of family violence can be disbelieved by treating teams and/or seen as evidence of mental health issues. Trauma-informed responses across mental health services and child protection are needed to avoid victims of violence being the subject of damaging responses by services.

¹⁰⁸ Women with Disabilities Victoria, *Royal Commission into Family Violence Submission* (June 2015) 4.

<[¹⁰⁹ VLA notes that men also experience family violence, and require safe and responsive services, but acknowledge that family violence overwhelming impacts on women and children.](http://www.rcfv.com.au/getattachment/204CC2CA-1899-483F-925E-3DA0F0F348C9/Women-with-Disabilities-Victoria-(WDV)></p>
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Jenny: Allegations of mental health issues by perpetrator of family violence

When Jenny threatened to leave her partner Oscar again, he tried to wrest their baby from her arms, causing the baby injury and distress. Police notified the Department of Health and Human Services, who took the baby into protective care and began an investigation. Oscar claimed Jenny was the violent one, but the extensive bruising she had told a different story.

During this time, her baby was put in multiple placements in different locations which made it difficult for Jenny to see her child regularly. Jenny was also asked to undergo a full psychological assessment after her former partner Oscar made allegations about her mental health. Jenny did so and was given a positive report.

With support, Jenny was able to separate from her abusive former partner which, in turn, allowed to her to provide a safe home for her baby. Her lawyer noticed significant differences in the person she first met and the one who had come through the challenging child protection intervention.

Adele: Role of family violence in mental health decline not considered in child protection process

As a baby, Mia was taken from her mother, Adele, through the intervention of the DHHS. Adele had been juggling parenting and a successful career when she began to experience serious family violence, including threats to kill, perpetrated by her partner. After some time, she was diagnosed with Post Traumatic Stress Disorder (**PTSD**) and separated from her partner.

However, the continuation of family violence after separation, including physical assault, threats to take her children away, and false claims to DHHS Child Protection, combined with single parenting and PTSD saw Adele's life spiral into a mix of problematic alcohol and drug use, further mental health issues, and homelessness.

After Mia was removed from her care, Adele actively engaged in a plan to have Mia returned to her care. She engaged with her psychologist and undertook drug treatment, despite continuing to experience family violence by Mia's father. Disregarding the claims of family violence, DHHS shared information about Adele with the father which further antagonised him. When the matter went to court, Adele had demonstrated that she was no longer using drugs but that without support to address the family violence she was struggling to stabilise her mental health.

Without identifying the family violence as an ongoing issue, DHHS argued in Court that Adele's mental health continued to pose a risk to Mia. DHHS then made an application for Mia to be placed with a family member, on an order that only allowed Adele four contact visits a year with her daughter.

Adele has since commenced a new relationship and has had another baby that DHHS has assessed is safe in her care

Ai's story in part 5 also shows how people from CALD backgrounds can be even more vulnerable to some of these systems issues.

Conversely, where a perpetrator of family violence is experiencing mental health issues, both a justice and a therapeutic response may be required (depending on the circumstances) to better ensure safety for the victim and fair treatment for the perpetrator.

As noted in Part 3, people experiencing mental health issues may find it more difficult to understand and comply with court orders, including conditions on an FVIO. In particular, Family Violence Safety Notices (issued by police) and interim FVIOs are generally served on respondents without legal advice about the nature of the order and the conditions it imposes, as well as the criminal repercussions of breaching the order. Not understanding an order can increase the risk that a respondent breaches it.

It is important to recognise that mental health is not a cause of family violence. However, where a perpetrator does experience mental health issues, systems and interventions that ensure they understand what is occurring and how they can start to engage with and take accountability for their behaviour are important to reduce risks of further family violence and ensure a fair process. A recent analysis of VLA's family violence legal services found that clients who were charged with breaching intervention orders showed a higher rate of disability (including those who experience a mental health issue). A requirement, as is the case for Personal Safety Intervention Orders, that the court consider the respondent's capacity to understand and comply with the conditions of the order, would ensure fairer treatment and reduce safety risks.

4.4.2 Adolescent family violence

As stated in our submission to the Royal Commission into Family Violence,¹¹⁰ VLA's practice experience confirms that children and young people who use violence usually present with a range of complex behavioural, mental, physical, and emotional issues. There is usually, but not always, at least one of the following factors involved: neurological harm caused by developmental trauma (exposure to family violence or neglect); emotional harm caused by recent exposure to family violence or abuse; abandonment or chronic neglect; substance abuse; family breakdown; unresolved grief; and loss.

These experiences may manifest themselves in challenging adolescent behaviours. Children and young people are still developing and can be experiencing undiagnosed mental health issues. The young person's use of violence may then result in one or multiple legal issues such as criminal charges, child protection intervention, or personal safety or family violence intervention orders.

Currently the family violence system struggles with how best to juggle the competing needs of protecting the best interests of young people and the safety of their family when an adolescent is using violence in the home. Adolescent violence has some similarities with adult family violence, but adolescent violence in the home also has unique characteristics and requires different responses.¹¹¹

The Royal Commission into Family Violence made six recommendations (123–128) for establishing a specialised response for adolescents. While implementation of the recommendations is in progress, it is crucial that family violence responses for young people are resourced to identify and respond to the complexity of behavioural, development, and mental health needs of young people.

All too frequently we are seeing FVIOs being used as a form of first response for adolescents who use family violence, and that an FVIO is also used to manage mental health and disability issues. We expect that this will be raised in a forthcoming report from the Centre for Innovative Justice (CIJ).¹¹²

The use of an FVIO does not in itself provide the range of supports a young person may need, and can lead to the removal of the respondent child to protect other children in the family. The presence of an FVIO creates a risk of involving Child Protection to assess whether parents are deemed able to care safely for a child with complex mental health needs. Through fear that it could lead to criminal penalties for the young person, an FVIO may also prevent a protected person from seeking help, increasing risk to them rather than decreasing it.

The use of an FVIO does not in itself provide the range of supports a young person may need, and can lead to the removal of the respondent child to protect other children in the family. The presence of an FVIO creates a risk of involving Child Protection to assess whether parents are deemed able to

¹¹⁰ Victoria Legal Aid, *Submission to the Royal Commission into Family Violence* (June 2015), 40.

¹¹¹ Victorian Government, 'Chapter 23', *Royal Commission into Family Violence, Volume 4, Report and Recommendations*. 2016, 165.

¹¹² E Campbell, J Richter, J Howard & H Cockburn *Legal responses to family violence: doing more harm than good? Findings from the Positive Interventions with Perpetrators of Adolescent violence in the home (PIPA) Project* ANROWS, Sydney, Australia (forthcoming).

care safely for a child with complex mental health needs.

Through fear that it could lead to criminal penalties for the young person, an FVIO may also prevent a protected person from seeking help, increasing risk to them rather than decreasing it.

4.5 Preventing and addressing the harm associated with discrimination

VLA provides advice and representation to clients who experience discrimination, victimisation, sexual harassment, and vilification in all areas of public life. Through this work, we see both:

- people experiencing mental health issues and/or disabilities who have experienced discrimination in seeking access to housing services, health services, public transport services, and aged care services; and
- the impacts of discrimination, victimisation, sexual harassment or vilification on people's mental health.

■■■■: ¹¹³ Insurance discrimination

As a 17 year old, based on medical advice ■■■■ had to cancel an overseas school trip. ■■■■ had no pre-existing illness when first diagnosed with major depression, but the insurer rejected ■■■■'s travel insurance claim.

VCAT found that QBE directly discriminated against ■■■■ by providing a travel insurance policy that had a blanket exclusion for claims relating to all mental illnesses, and by relying on this clause to reject ■■■■'s claim to reimburse travel expenses.¹¹⁴

■■■■'s case was a contributing factor to the Victorian Equal Opportunity and Human Rights Commission initiating an investigation into the Travel Insurance industry. This investigation found that in an eight-month period, Australian travel insurers sold more than 365,000 policies that contained terms that discriminated against people with mental health conditions.¹¹⁵

■■■■'s case highlights that punitive or exclusionary measures are often taken by service providers when interacting with clients who have mental health issues, rather than proactively seeking to support and include them in service provision.

■■■■: ¹¹⁶ Banned by local council

Manningham City Council banned ■■■■, 67, from all buildings that it owned, operated, or managed, in part because it alleged he was disruptive at local council meetings and abusive towards staff. ■■■■ has bipolar disorder, post-traumatic stress disorder, compulsive disorder, an acquired brain injury, and a hearing impairment.

Although the Council had concerns about ■■■■'s behaviour, it had other options than simply banning him from more than 200 council-owned, operated, or managed buildings in the City of Manningham. ■■■■ couldn't even take his grandchildren to the local swimming pool.

¹¹³ Client's real name has been used.

¹¹⁴ *Ingram v QBE Insurance (Australia) Ltd* (Human Rights) [2015] VCAT 1936.

¹¹⁵ Victorian Equal Opportunity and Human Rights Commission, *Fair-minded cover: Investigation into Mental Health Discrimination in Travel Insurance*, (2019), 2, 11.

¹¹⁶ Client's real name has been used.

VLA helped █████ take his case to VCAT. VCAT found that the Council had discriminated against █████ and ordered compulsory training on the Charter of Human Rights and Responsibilities for Manningham City councillors, chief executive and directors, and ordered the Council to pay him \$14,000 in compensation.¹¹⁷

█████ said going before VCAT was very cathartic and helped him move on with his life.

“I felt demeaned and embarrassed by the ban, and I wanted to fight it to highlight discrimination and help other people in similar situations”, he said. “I’m really proud that this decision is a landmark in establishing the rights of other people like myself who have a disability”.

In addition to discrimination on the basis of a person’s mental health issue, the experience of discrimination and sexual harassment can also have negative consequences on a person’s mental health. Studies have shown that experiencing discrimination can cause stress and anxiety and increase the risk of mental health issues, as well as lead to other forms of social disadvantage, such as unemployment, poor education, and social isolation,¹¹⁸ and an increased risk of physical illness.¹¹⁹

A study by VicHealth of the ‘mental health impacts of racial discrimination in Victorian Aboriginal communities’ found:

*Racism is associated with poorer mental health and reduced life chances for Aboriginal Victorians. Reducing the experience of racism is an important approach to improving health in this population.*¹²⁰

Recently, as part of VLA’s submission to the National Inquiry into Sexual Harassment in Australian Workplaces run by the Australian Human Rights Commission,¹²¹ we highlighted the common experience of sexual harassment causing significant harm to individuals and their mental health.¹²² People who experience sexual harassment along with other forms of discrimination can have their experiences compounded and the impacts on them can therefore be significant, as our client █████ explained:

The interplay of bullying, sexual harassment and the subsequent impact this had on my health resulted in a debilitating post-traumatic stress disorder and other related ill health that affects every facet of my life. After 25-years as a confident successful career woman, my health, personal life and career have all been impacted. I’ve gone from someone who wouldn’t think twice of travelling solo around the world to someone who fears walking down my own street after dark.

Situations like mine would occur less in the workplace if companies, management and employees were made more accountable for harassment, homophobia and bullying. The

¹¹⁷ *Slattery v Manningham CC (Human Rights)* [2013] VCAT 1869.

¹¹⁸ M Kelaher et al, ‘Discrimination and Health in an English Study’ 66(7) *Social Science and Medicine* (2008) 1627–36; AD Otiniano and GC Gee, ‘Self-Reported Discrimination and Health-Related Quality of Life among Whites, Blacks, Mexicans and Central Americans’ 14(2) *Immigration Minor Health* (2012) 189–97; CA Okechukwu et al, ‘Discrimination, Harassment, Abuse and Bullying in the Workplace: Contribution of Workplace Injustice to Occupational Health Disparities’ 57(5) *American Journal of Industrial Medicine* (2013) 578–9.

¹¹⁹ Richard Delgado, ‘Words that Wound: A Tort Action for Racial Insults, Epithets and Name Calling’ in Mari J Matsuda (ed), *Words that Wound: Critical Race Theory, Assaultive Speech and the First Amendments* (New York: Routledge, 2018) 89, 92–3.

¹²⁰ VicHealth, *Mental health impacts of racial discrimination in Victorian Aboriginal communities* (2012)

<<https://www.vichealth.vic.gov.au/media-and-resources/publications/mental-health-impacts-of-racial-discrimination-in-victorian-aboriginal-communities>>.

¹²¹ Victoria Legal Aid, *Change the culture, change the system: urgent action needed to end sexual harassment at work*, Submission: Australian Human Rights National Inquiry into Sexual Harassment in Australian Workplaces (Submission, 2018) (**VLA Sexual Harassment Submission**).

¹²² Australian Human Rights Commission, *Everyone’s Business: Fourth national survey on sexual harassment in Australian Workplaces*(Report, 2018) 9.

<https://www.humanrights.gov.au/sites/default/files/document/publication/AHRC_WORKPLACE_SH_2018.pdf>.

*stigma, methods and systems associated with raising complaints doesn't work to protect injured workers, it only causes more damage to workers' health.*¹²³

The experience of discrimination has ongoing impacts on people and communities in various multiple ways, including affecting people's mental and physical health, financial security, job security, and social relationships. In many cases, the impacts are significant and long lasting.

4.6 Reducing the impact of compliance and enforcement processes on people experiencing mental health issues

There are some systems that operate across the community but may have higher rates of involvement by people experiencing mental health issues.

These include:

- **Access to social security** including qualifying for the Disability Support Pension, and the widening gap between the DSP and the Newstart Allowance, which place people under significant personal and financial pressure.¹²⁴
- **Robodebt** and the automated enforcement processes used by Centrelink to pursue people for alleged overpayments. We know from what our clients tell us that suddenly being told they owe a significant debt, and having to spend large amounts of time and energy to disprove it, is causing pain and hardship.¹²⁵ One client said, 'I was an emotional and physical wreck' and 'I didn't want to get up and face the day'. People have reported taking time off work to try to resolve their debt or because of the stress. Parents talk about not being able to afford uniforms for their children because their income has been reduced to pay an alleged debt. In these ways, in our view, robodebt is actively undermining the mental health of past and present recipients of social security.
- **Fines and infringements** and the disproportionate impact of the enforcement of public space and transport offences on people experiencing mental health issues, including the challenges associated with non-payment of these fines and the distressing impact of escalating enforcement action.

In addition to disproportionately affecting people experiencing mental health issues (for example, because their mental health makes compliance more challenging), these systems can negatively affect people's mental health and wellbeing.

4.7 Recognising the value of early access to legal assistance as part of a community-wide response to mental health

This part has identified the many ways in which people experiencing mental health issues can be negatively affected by laws, services, and systems.

This is consistent with research showing that people experiencing mental health issues are significantly more likely to experience legal problems and be involved in multiple service systems.¹²⁶

¹²³ VLA Sexual Harassment Submission, above n 121.

¹²⁴ See, eg, 'Over several years, governments have tightened DSP eligibility requirements ... Successful [DSP] claims have dropped from 63 per cent in 2010 to just 25 per cent in 2015'. Australian Council of Social Service, 'Disability Support Pension cuts bad news for people affected' (21 February 2018) <https://www.acoss.org.au/media_release/disability-support-pension-cuts-bad-news-for-people-affected/>

¹²⁵ See, eg, Shalailah Medhora, 'More than 77,500 Centrelink robo-debts have been reduced or waived' (28 March 2019) <<https://www.abc.net.au/triplej/programs/hack/more-than-77500-centrelink-robodebts-waived-or-reduced/10948942>>.

¹²⁶ Christine Coumarelos on behalf of the Law and Justice Foundation of New South Wales, 'Legal Australia-Wide Survey: Legal Need in Victoria' *Access to justice and legal needs*, v. 14, 28; Pascoe Pleasence and Nigel Balmer, *Mental Health and the Experience of Social Problems Involving Rights: Findings from the United Kingdom and New Zealand* *Psychiatry, Psychology and Law* (2009) 16(1).

The LAW Survey showed that over 60% of people who reported experiencing six or more legal problems also reported experiencing a mental health issue.¹²⁷ The existence of legal problems can be both a cause and a consequence of experiencing mental health issues. A 2015 UK study by Pleasence et al found that the experience of legal problems is a key predictor of mental health problems for young people.¹²⁸

A system-wide analysis should consider the role legal assistance has to play in supporting mental health, including through:

- protecting and promoting people's rights and building understanding of rights and options;
- preventing the escalation of legal issues; and
- reducing the stress that often accompanies legal issues.

Legal assistance, together with essential health and community services, has a role to play in the prevention of avoidable homelessness, incarceration, and involuntary treatment, keeping people safe and deescalating disputes and issues, all of which carry heavy costs for people and communities.¹²⁹

Priority area for reform 4: Improving responses of other systems and services to mental health

Through our work, VLA sees the intersection between people's mental health and other life and legal issues. For example, we see the way a lack of access to housing, disability services, employment, income support and/or mental health services in the community, and experiences of isolation, family violence and/or discrimination, can cause damage to people's mental health and undermine their recovery. We also see the way in which this can lead to other service systems adopting a deficits-focused view of people experiencing mental health issues, failing to focus on and support their strengths to recover and address issues, for example in the child protection system.

The Royal Commission is an opportunity to undertake a system-wide review with the person at the centre, including:

- Adopting a social model of health to analyse the social, economic and legal factors that affect a person's wellbeing.
- Recognising that people have overlapping family, health, housing, NDIS, justice and social issues and need access to coordinated, integrated services in the community before they reach crisis point.
- Ensuring that people experiencing mental health issues are treated fairly in other systems and services and that the impacts of family violence or other trauma are properly recognised and responded to.

¹²⁷ Ibid 25.

¹²⁸ Law Council of Australia, *The Justice Project Final Report: Children and Young People* (2018) 9 <<https://www.lawcouncil.asn.au/files/web-pdf/Justice%20Project/Final%20Report/Children%20and%20Young%20People%20%28Part%201%29.pdf>>; Pascoe Pleasence, Nigel Balmer and Ann Hagell, *Youth Access, Health Inequality and Access to Justice: Young People, Mental Health and Legal Issues* *Youth Access UK* (June 2015).

¹²⁹ See eg, Health Justice Australia, *Mapping a New Path: The Health Justice Landscape* (2018) <<https://www.healthjustice.org.au/wp-content/uploads/2018/08/Health-Justice-Australia-Mapping-a-new-path.pdf>>; State Government of Victoria, *Access to Justice Review Report and Recommendations* (2016) <<https://engage.vic.gov.au/accesstojustice>>; Victoria Legal Aid, *Mallee region to benefit from health justice partnership* (2016) <<https://www.legalaid.vic.gov.au/about-us/news/mallee-region-to-benefit-from-health-justice-partnership>>; Mental Health Legal Centre, *Bolton Clark: Project Summary* <<https://mhlc.org.au/our-programs/bolton-clarke/>>; Inner Melbourne Community Legal, *Partners in Care: The benefits of community lawyers working in a hospital setting* (2018) <https://imcl.org.au/assets/downloads/IMCL_report_FA_web.pdf>; Justice Connect, *A Just Life: The role for legal help in building fairer, safer and healthier communities* (2018) <<https://justiceconnect.org.au/wp-content/uploads/2018/06/AJustLifeReport.pdf>>.

5 Reducing inequalities and developing tailored, culturally safe services

Mental health issues affect the whole community, but focused and targeted responses for groups within our community are needed to ensure that everybody has equality of access to the care and support they need to recover.

The Royal Commission presents a crucial opportunity to analyse and address regional inequalities and develop tailored and culturally safe services for groups within our community, including Aboriginal and Torres Strait Islander people, CALD communities, LGBTIQ people, older Victorians, women and young people.

Our services and systems must be accessible and responsive to our diverse communities to support recovery, and a person's postcode should have no bearing on the services they can access.

5.1 Reducing regional inequalities

VLA has offices in regional communities in Ballarat, Bairnsdale, Bendigo, Geelong, Horsham, Mildura, Morwell, Shepparton and Warrnambool. In 2017–18, 29% of our total clients were living in regional or rural areas. Of our clients who identified as having a disability or mental health issue 34% lived in regional or remote Victoria.

Through our work, we see the way in which unmet support needs in regional communities intersect with legal issues to undermine personal and community wellbeing. For example, the recent report of the Gippsland Legal Assistance Forum (comprised of VLA, Djirra, VALS and Gippsland Community Legal Centre) found:

[F]amilies cannot access housing or emergency accommodation to prevent homelessness. Parents wanting to address their mental health, disability, or drug and alcohol issues so they can provide a safe home for their children, cannot access services and resolve the concerns of the child protection agency. There are long wait lists for hearings in the local Magistrates' Court. This is forcing clients to make difficult decisions to forgo their rights to procedural fairness to resolve their problems more quickly. Isolation and public transport difficulties exacerbate these issues.¹³⁰

■■■■■, one of the members of our lived experience advisory group, Speaking from Experience, explained his experience of getting access to mental health services in a regional area:

I've experienced, as I know others have, lengthy delays from discharge to then receiving further clinical support. I live in Ballarat and after being discharged from a suburban Melbourne acute ward, found that I couldn't access assistance from a psychiatrist for 9 months. I'd flagged previous issues I'd had with continuity of care, but it led to nothing. I realise also that there is a peer worker lead program in place now, but resources in regional areas are so small, that waiting times are unavoidable, even though you are acutely at risk.

Through our work, we see that there are disparities between metropolitan and regional areas with respect to treatment and services available to consumers in three respects:

- **Access to services, including specialist services.** It is more difficult to access mental health services including second opinions, and specialist services such as youth mental health and mother-baby units in regional areas. There are fewer treatment options available and people are

¹³⁰ Gippsland Legal Assistance Forum, *Equal justice for a strong, healthy and resilient Latrobe Valley* (February 2019) <<https://www.legalaid.vic.gov.au/about-us/news/addressing-legal-problems-crucial-for-strong-healthy-and-resilient-latrobe-valley>>.

less likely to be able to access their treatment of choice (including because of zoning and service boundaries), contributing to escalation of mental health issues and associated conduct (for example, offending), and impacting on people's recovery. Barriers to access to specialists to address physical health needs of consumers is also an issue, given the higher morbidity and mortality rates for people with mental health issues who are being treated with medications.¹³¹

- **Isolation and separation from family and community.** Admission to a mental health unit is more likely to involve separation from family and supports that are important to the person, sometimes for significant periods of time. VLA is aware of situations of consumers being transferred significant distances from their home or community to receive treatment. Being admitted to a unit far from family may also impact on a person's ability to access leave while an inpatient and may impede discharge. Further, we regularly hear from people in regional areas who have been transported significant distances by ambulance for mental health assessment, only to be told they do not require hospital admission. These people then have no way to get back to their homes, sometimes over two hours away.
- **Access to justice.** People in regional areas face particular barriers to access to justice. It is more likely that their hearings in the Mental Health Tribunal will be conducted via videolink, rather than face to face, impacting on their ability to participate and the Tribunal's ability to build a rapport during the hearing. As discussed in part 3, they will not have access to the therapeutic court models that are available for people with mental health issues in Melbourne, most notably the Assessment and Referral Court list (and the availability of related programs and supports), the Neighbourhood Justice Centre and the Drug Court in the Magistrates' Court.

Betty's story highlights the issue of distance and the way it impacts on a person's service access, recovery and quality of life.

Betty: Travelling 300 kilometres each month to receive mental health services

Betty is an Irish woman in her 60s currently living in regional Victoria. Her adult children live interstate. She is a retired professional and is accessing NDIS. Betty self-referred to IMHA after learning about the service during a recent compulsory admission to the Adult Inpatient Psychiatric Unit in her regional area. She was then discharged on a 52-week community treatment order.

Due to living in a regional area, Betty had to travel over 300 kilometres each month to receive her treatment and wished to access another clinic closer to home. The preferred mental health service provider she identified refused the referral due to complaints she had lodged against that service years earlier.

Betty was offered an alternative, however she still had to travel unnecessary distances for compulsory treatment at her own cost.

In addition to the lack of service availability and choice in regional areas, there is inconsistency in practice and service experience across regions. This is discussed further in part 6 in relation to data and accountability.

Ultimately, Victoria should work towards a service and legal landscape in which people are not disadvantaged by where they live, and in which we invest in models that work right across the State.

¹³¹ Equally Well, *Improving the physical health and wellbeing of people living with mental illness in Australia* (May 2016) <<https://www.equallywell.org.au/wp-content/uploads/2018/12/Equally-Well-National-Consensus-Booklet-47537.pdf>>.

5.2 Tailored and culturally safe services

The principles in the Mental Health Act state that people receiving mental health services should have their individual needs recognised and responded to.¹³² It is fundamentally important that mental health services, together with other services working with people who experience mental health issues, provide tailored and culturally safe services for groups within our community. This ensures that the system is accessible and responsive to the needs of diverse communities while respecting and promoting consumers' rights, dignity and autonomy.

We note earlier in our submission that mental health services are often inflexible and do not respond to consumers' individual needs. These issues are magnified for people with diverse needs. Victoria is a widely diverse community, and this diversity is reflected in those who engage with the mental health system. Through VLA's work we see that many mental health services, particularly inpatient units, are poorly equipped to deal with the multidimensional needs of consumers.

Consistent with principles of self-determination and recovery, the Royal Commission's consideration of the service needs of these priority groups should be informed by engagement with consumers who are members of these communities.

5.2.1 Aboriginal and Torres Strait Islander people

In 2017–18, 19% of the Aboriginal and Torres Strait Islander clients VLA assisted identified as having a disability or mental health issue.

Services and system responses must recognise the importance of:

- cultural competency to ensure cultural safety, responsiveness and inclusion;
- being trauma-informed; and
- cultural strengthening for healing.

There must also be an understanding that government policies can cause harm and contribute to trauma, especially in relation to the over-representation of Aboriginal and Torres Strait Islander children in out of home care.

We emphasise the importance of having community inform the Royal Commission of their needs. Self-determination is fundamental to Aboriginal and Torres Strait Islander social and emotional wellbeing. In enabling self-determination, government action should be consistent with the 11 guiding principles set out in the *Victorian Aboriginal Affairs Framework 2018-2023*: human rights, cultural integrity, commitment, Aboriginal expertise, partnership, decision-making, empowerment, cultural safety, investment, equity and accountability.¹³³

Aboriginal Community Controlled Organisations (**ACCos**) must be adequately resourced to meet demand and provide a genuine choice to Aboriginal and Torres Strait Islander people.¹³⁴ We highlight the need for investment across the sector to achieve cultural safety.

¹³² *Mental Health Act 2014* (Vic) s 11(g).

¹³³ These guiding principles set the minimum standards for all existing and future work with Aboriginal Victorians and will guide all government work to progress self-determination going forward, and are set out in Victorian Government, *Victorian Aboriginal Affairs Framework 2018-2023* (2018) <https://www.vic.gov.au/system/user_files/Documents/av/VAAF%20FINAL.pdf>.

¹³⁴ VLA acknowledges the critical role that Djirra and VALS play in providing culturally safe and trauma informed legal services to Aboriginal and Torres Strait Islander Victorians.

Aboriginal self-determination should include personal self-determination in choosing which services to access, including both ACCOs and mainstream services. To fully realise this, both ACCOs and mainstream services must be available and accessible.

Sandra: Appropriate consideration of Aboriginal identity

Sandra is a young Aboriginal woman who was receiving compulsory treatment in hospital. She had a strong connection with her Aboriginal identity and no longer wanted to remain in hospital to engage with her treatment. Sandra wanted to return home to receive care from her GP and the local area mental health service, who had a better understanding of Aboriginal culture and health.

VLA represented Sandra at her Mental Health Tribunal hearing. Although the Tribunal decided that Sandra met the criteria for compulsory treatment, it made a community treatment order, rather than an inpatient treatment order, which is what the treating team were seeking.

In reaching its decision, the Tribunal acknowledged that release from hospital might risk a worsening of Sandra's mental health. However, in considering her Aboriginal cultural rights under the *Charter of Human Rights and Responsibilities Act 2006* (Vic) and the mental health principles, the potential risks associated with discharge were not sufficiently imminent or serious enough to justify her continued detention in hospital.

Important factors in the decision were Sandra's cultural identity, her preference for community treatment and the high rate of Aboriginal incarceration.

Sandra's story is a good example of mental health services being responsive to individual needs and making decisions that take a person's culture and connection to country into account.

Unfortunately this is not consistently the case, and IMHA regularly works with Aboriginal or Torres Strait Islander consumers who have not been referred to Aboriginal Liaison Officers or given the option of accessing an ACCO, despite the stated need for Aboriginal people to have their distinct culture and identity recognised and responded to.¹³⁵

5.2.1 Women

The need for female-only treatment spaces and services, consistent with trauma-informed practice is set out in the Mental Health Complaints Commissioner's report, *'The Right to be Safe: Ensuring sexual safety in acute mental health inpatient units.'*¹³⁶ We note the Mental Health Complaints Commissioner recommended gender-specific wards¹³⁷ as one means of responding to the safety needs of women in inpatient units.

As we discuss in part 4 above, we also see the limited understanding of mental health and the way mental health issues intersect with family law, family violence and child protection. We see the way in which these services and systems often misunderstand the woman's needs. For example, a woman may be unable to get a holistic, trauma-informed response to her experience of family violence or may be detained as a compulsory patient or have children removed from her care based on reports about

¹³⁵ MHA s 11(h).

¹³⁶ Mental Health Complaints Commissioner, *Right to be safe: Ensuring sexual safety in acute mental health units* (March 2018) <<https://www.mhcc.vic.gov.au/Api/downloadmedia/%7B76BF660A-3A27-4B20-A30C-448376D319C0%7D>>.

¹³⁷ Mental Health Complaints Commissioner, *Annual Report* (2018) 45, 49 and 51. The Mental Health Complaints Commissioner's 2017–18 Annual Report recommends: Gender-sensitive and trauma-informed practice; piloting and evaluating single-gender units, prioritising the piloting of women-only units; and support services to implement trauma-informed care and supported decision making as primary prevention strategies to prevent sexual safety breaches.

her mental health from the perpetrator of violence (and see Ai's case below in section 5.2.3 for one example).

5.2.2 CALD communities

In 2017–18, 22% of VLA's clients were from culturally and linguistically diverse backgrounds. Of our clients who identified as having a disability or mental health issue, 17% were from culturally and linguistically diverse backgrounds. VLA's Legal Help telephone service is staffed by bilingual lawyers, providing advice and information in 23 languages other than English.¹³⁸

The diversity of the Victorian community necessitates the availability of culturally appropriate mental health services, including interpreters, bicultural workers and approaches that engage with community including community leaders.

The principles in the Mental Health Act include that people should have their individual needs, including culture and language, recognised and responded to.¹³⁹ Despite this, IMHA and our mental health lawyers commonly see consumers who have been reviewed by psychiatrists without an interpreter present.

As Ai's story shows, issues accessing culturally safe and appropriate health care can be more acute in regional areas, including lack of specialised or holistic support and limited access to in-person.

Ai: Family violence, mental health and linguistic diversity

Ai was a VLA client from a Culturally and Linguistically Diverse community living in regional Victoria. Ai had her child removed from her care when her partner accused her of having a mental health issue following an incident of family violence. While her husband spoke to police, she spoke limited English so was unable to explain her situation.

Ai then had to wait several months to access mental health support services in a regional area. Language and cultural barriers made other mental health assessments and treatment very challenging for Ai, which a psychologist assessed as a situational crisis. It wasn't until Ai was supported by a translator and interpreter that she could demonstrate she was fit to have her child returned to her.

VLA's migration sub-program provides advice and representation to people seeking asylum and other vulnerable non-citizens. In 2017–18, we provided almost 1500 specialist migration legal services.

Through this work we are exposed to the treatment of people seeking asylum, refugees and migrants in Australia's immigration detention centres and communities. We see that people are frequently subject to long periods of detention while awaiting an outcome, and we see the corrosive impact of indefinite detention on people's mental health.

We also work with young people whose mental health is seriously affected after protracted detention in immigration detention centres. The effect of mental health issues among people seeking asylum has immediate and long-term consequences. When a person seeking asylum is experiencing mental health issues, the demands of the protection visa application process are made even more daunting and the likelihood of an unfair outcome is increased because the applicant's ability to articulate their claims will be compromised. In the longer term the capacity of the successful applicant to adapt and integrate into the Australian community will be made considerably more challenging by a lack of psychological well-being.

¹³⁸ VLA Annual Report, above n 2, 48.

¹³⁹ *Mental Health Act 2014* (Vic) s 11(g).

It is essential that people with an experience of pre-arrival trauma have access to appropriate, culturally responsive mental health support to address their trauma.

5.2.3 LGBTIQ people

Inclusive and appropriate services must be available for lesbian, gay, bisexual, transgender, gender diverse and intersex members of the community. We also encourage the Royal Commission to have regard to the impact of discriminatory service provision on these groups.

The principles in the Mental Health Act state that regard must be had to a person's gender and sexuality in the provision of mental health services.¹⁴⁰

Alanna: Assaulted in mixed gender ward

I am a transgender woman who was receiving treatment in a psychiatric unit of a public hospital. I self-admitted myself to the hospital because I was highly stressed at the time. I was stressed because of the Marriage Equality, YES Campaign. I was one of the only representatives of the trans community in my community at the time and I felt a lot of pressure from my community to be their voice and advocate.

I was admitted into a mixed gender ward at the hospital. The hospital also had a closed male ward and a closed female ward.

During my stay on the mixed ward, I heard another male patient talking in a threatening way about the YES Campaign and the LGBTI community. He was opposed to marriage equality and said things like: "I want to cave in the heads of all the YES supporters". On hearing these comments, I became worried about my safety and so I raised my concerns with hospital staff. I also requested to be moved to the female only ward at the hospital.

I was told I couldn't be relocated to a female only ward due to a bed shortage. The male patient continued his inappropriate behaviour towards me and I became increasingly fearful of him. I continued to raise my concerns with hospital staff.

Within days of my initial complaint to hospital staff, the male patient attacked me in the common area of the hospital. He grabbed me on my arm and around my throat and verbally threatened me. He threatened to slit my throat.

In response to the incident, the male patient was moved to another unit. But the day after the attack, I saw him in my ward without any security or staff and he made a gesture towards me which mimicked slitting my throat. I was provided some debriefing support by the hospital and told to speak to the police to take out an intervention order against the male patient.

I remained in the ward for about two days after the attack. I was never transferred to a female only ward even after this incident. Before I went into the hospital I was suffering from stress and depression, but I didn't have a diagnosis. Following the attack at the hospital, I was diagnosed with PTSD and I experience severe panic attacks, anxiety, paranoia and live in a chronic state of fear.

My relationship has also broken down and I've been unable to work or study full time due to the post traumatic impacts of the incident.

When I entered the psychiatric ward, I believed it was a place I would be safe and get support, and the hospital would be resourced to respond to my gender specific needs. I now fear that there is no safe place for members of the LGBTI community.

¹⁴⁰ Ibid.

Alanna's story highlights the importance of safe, responsive services that are able to meet the needs of all people in need of mental health supports. Her story also shows the detrimental impact on people's safety, mental health, and willingness to continue engaging with mental health services, when services are not provided safely and appropriately.

5.2.4 Older people

As Victoria's population ages, the need for appropriate services for older Victorians who experience mental health issues and neurological diseases increases. Of particular concern are conditions in aged care psychiatric services (including capacity, use of coercion and rights-based frameworks).¹⁴¹

People with dual diagnoses, or coexistent health conditions are often unable to receive appropriate services for their various health or other needs during inpatient admissions.

As Sally's case shows, this is especially the case for older Victorians with complex medical issues.

Sally: Physical health deteriorated in hospital

Sally is 67 years old and lives in a remote regional town. She was on an inpatient treatment order for three months. Sally was treated for her mental health issues during her stay, but not her physical illnesses. Sally has various complex health conditions, including type 2 diabetes, carpal tunnel and glaucoma. During her stay, Sally had two falls because she is unsteady on her feet and vision impaired.

Sally said it felt like "forever" until someone came to help her after she fell over. Sally found it difficult to wake up in time to request her meal and was given the meal the hospital staff chose for her. She frequently could not eat this food and would rely on hospital staff to buy her food in the hospital cafeteria, which was detrimental to her blood sugar requirements and stress levels.

Sally wanted to visit an ophthalmologist to discuss her glaucoma and deteriorating sight, but was told the hospital could not facilitate an appointment and she had to wait until she was discharged from hospital. During her three-month admission, Sally was unable to access appropriate healthcare and found the focus on her mental health frustrating given her age and complex health needs. As Sally's physical health deteriorated she became increasingly stressed, which aggravated her mental health.

Sally wants to tell her story to "make sure that old and sick people are taken care of properly".

As Sally's story shows, failure to provide appropriately for people's multifaceted needs during their mental health treatment can have detrimental consequences on their quality of life.

5.2.5 Young people

Of our clients who identified as having a disability or mental health issue, 15% were under 18 years of age.

We see the significant impacts across VLA's different practice areas if young people do not receive the right supports at the right time. This is especially the case in the mental health, child protection, family violence, and criminal justice systems. Young people should be able to access age-appropriate mental health services, as well as other targeted services to prevent homelessness and engagement with youth justice, and later adult criminal justice systems. This is especially true for young people in state care, who are otherwise at increased risk of contact with the criminal justice system.¹⁴²

¹⁴¹ Royal Commission into Aged Care Quality and Safety, *Terms of Reference* (December 2018) <<https://agedcare.royalcommission.gov.au/Pages/default.aspx>>.

¹⁴² Sentencing Advisory Council, *Crossover Kids: Vulnerable children in the youth justice system* (June 2019).

The principles in the Mental Health Act state that children and young people receiving mental health services should have their best interests recognised and promoted as a primary consideration, including receiving services separately from adults.¹⁴³ Despite this, appropriate youth-specific services are not available throughout Victoria.

VLA is also concerned that this lack of responsive, available services extends to children in Secure Welfare Services despite being amongst the most vulnerable and disadvantaged children in the state. Our experience raises concerns that DHHS Child Protection does not always take a coordinated or informed approach to assessing a young person's mental health.

We have seen young people, who already had a treating psychologist who they had an established relationship with, but DHHS sought new psychiatrist/psychologist assessments once the young person was in Secure Welfare. On other occasions a mental health assessment is not arranged at all, even when a young person's mental health was one of the issues that placed them in immediate and substantial risk causing their placement in Secure Welfare.

Young people are also affected by the differential funding levels for adults and youth services, and the consequential experience of service drop-off for those reaching adulthood. Mental health services should have regard to facilitating continuity of access to services for young people who turn 21, the impact of being cut off from youth services without adult services or case management planned, and the need for more flexible transition processes. The importance of access to tailored, responsive forensic mental health services for young people is discussed above in part 3.

We are pleased to see the establishment of the Children's Court Mental Health Advice and Response Service (**MHARS**) at Melbourne Children's Court, a specialist mental health service delivered by Orygen Youth Health that will help to identify if a mental health issue is present and inform when it is necessary to go beyond a justice response to also or instead use a therapeutic response. However, there are no similar services in other children's or family violence courts throughout the state.

Priority area for reform 5: Reducing inequalities and developing tailored, culturally safe services

Currently, people get different treatment and services depending on where they live and there are insufficient and inadequate services tailored for particular groups within our community.

A person's postcode should not affect the treatment and services available to them. The Royal Commission is an opportunity for Victoria to work toward a service and legal landscape where people are not disadvantaged by where they live and where we invest in models that work right across the State.

Services should be tailored and culturally safe for groups within our community, including Aboriginal and Torres Strait Islander people, CALD communities, LGBTIQ people, older people, women and young people. The service needs of these priority groups should be informed by engagement with consumers who are members of these communities.

¹⁴³ *Mental Health Act 2014* (Vic) s 11(i).

6 Strengthening governance, accountability, data and transparency

As we discussed in detail in part 1, Victoria's Mental Health Act – and the greater focus on recovery, choice, rights and better outcomes that it sought to introduce – has not lived up to its promise.

Despite carefully thought out legislation, the mechanisms that are required to bring about genuine cultural and systemic change have not been established.

This part discusses the elements we think are necessary for an improved system for people experiencing mental health issues in Victoria:

- Training to support changes in culture and practice.
- Transparent data and increased accountability.
- Enhanced oversight and governance.

6.2 Training to support changes in culture and practice

At the time that the new Mental Health Act was introduced in 2014, limited support was provided to designated mental health services to make the cultural change necessary to achieve the intended reform.

Building the capacity of staff through training, education and ongoing professional development has a crucial role to play in improving compliance and embedding cultural change. Staff should be trained to understand and implement the requirements of the Mental Health Act, the Victorian Charter and the United Nations Convention on the Rights of Persons with Disabilities (**CPRD**).

The independent evaluation of IMHA undertaken by RMIT identified training about the Mental Health Act as a systems gap which may contribute to non-compliance with the principles in the Act.¹⁴⁴ The supported decision-making training for services, discussed in part 1, has been an important part of IMHA's systemic reform work and senior management of all designated mental health services have now agreed for IMHA to deliver this training. As noted by RMIT in the evaluation report, the responsibility for ensuring that clinical decision-makers complete training on mental health legislation so that they understand their legal obligations does not sit with IMHA alone. In some other jurisdictions such training is mandated prior to practice.¹⁴⁵ Such training programs are not currently required by services or the Department of Health and Human Services – the system funder and regulator – in order to practise as a mental health clinician in Victoria.

People with a lived experience of mental health issues should have a leading role in designing and delivering a training strategy for mental health services.

¹⁴⁴ IMHA Evaluation Report, above n 3, 35.

¹⁴⁵ Ibid.

6.3 Transparent data and increased accountability

6.3.1 The role of data in Victoria's mental health system

Data is critical in helping to improve quality, reach and consistency of service provision, as well as informing consumer choice and ensuring accountability.

This experience was recognised and recommended in the health context in the 2016 Duckett Review *Targeting Zero: Supporting the Victorian hospital system to eliminate avoidable harm and strengthen quality of care*, Report of the Review of Hospital Safety and Quality Assurance in Victoria. As noted in that report, the lack of data in the public health system undermines the ability of health services to assure the quality of their own services through benchmarking.¹⁴⁶

Access to data is supported by the Victorian Government's DataVic Access Policy, which aims to 'mak(e) datasets freely available to the public (as) the State's default position and where possible (for) agencies (to) make datasets available with minimum restrictions, including the proactive removal of cost barriers.' The intent of the Policy is to:

- Enable public access to government data to support research and education;
- Promote innovation;
- Support improvements in productivity and stimulate growth in the Victorian economy; and
- Enhance sharing of, and access to information rich resources to support evidence-based decision making in the public sector.¹⁴⁷

This kind of information, together with demographic information such as geographical location, age, gender, disability, cultural background, type and length of order would assist in benchmarking and understanding whether interventions used by mental health services are being used appropriately. It would assist to determine whether variation in practice between services is explicable on a clinical basis.

6.3.2 Gaps in current data on Victoria's mental health system

Despite the policy and the recommendations made in the Targeting Zero report, data to measure the performance of clinical mental health services is inadequate. Currently there are few publicly available mental health performance measures that are outcome based or that include consumer feedback. Much of the data is episode based, without the ability to track trends or to understand the full picture of consumer experience, the efficacy of programs or the use of restrictive interventions.

One of the key aims of the Mental Health Act at the time of its introduction was to reduce the use of compulsory treatment, with a preference for voluntary treatment.¹⁴⁸ In practice, however, it is not clear how the drivers of system practice, such as performance measures and transparent data, align with the intention of the Act.

For example, data is not publicly available on how many people are subject to compulsory treatment. Whilst the Mental Health Tribunal publishes data about the number of orders it makes and their

¹⁴⁶ Targeting Zero Report, above n 78.

¹⁴⁷ Victorian Government, *DataVic Access Policy* <<https://data.vic.gov.au/datavic-access-policy>>.

¹⁴⁸ See, eg, Minister Woodridge, Second Reading Speech, above n 5.

duration, it is not possible to tell how many people are subject to orders or for what length of time people remain on orders continuously. Similarly, the Mental Health Tribunal publishes the number of orders it makes authorising compulsory ECT and how many ECT treatments are approved under each order. However, there is no data published by services or DHHS about the number of ECT treatments that are actually delivered and to how many people, as opposed to the number authorised.¹⁴⁹ There are also no measures to assess how services determine urgency for ECT applications or what has been done to gain informed consent as required by the Mental Health Act or build capacity to consent.

It is notable that the most recent publication of comparison of seclusion data across services has been undertaken by VMIAC, the peak consumer body, rather than the Chief Psychiatrist, the Mental Health Complaints Commissioner or DHHS.¹⁵⁰

It is also unclear whether the data being collected is meaningful to consumers and their experience of the system. Evaluations of service effectiveness could draw on consumer feedback and include an assessment of rights protection and a focus on recovery to help inform a mental health strategy that drives a system to better respond to people with mental health issues and their social situations. This could be co-produced and have mechanisms for review, quality improvement and improved accountability and regulation.

While designated mental health services have obligations to report some data to DHHS, this data is not available publicly, even to funded agencies like IMHA and the MHDL program within VLA.¹⁵¹ There is service data published in the Chief Psychiatrist's Annual Reports, but this is limited and not readily accessible to the public and mental health consumers or their advocates, families and carers.

As noted in the Targeting Zero report, improved data is critical to achieving:

- A rigorous evidence-based approach to improvement;
- A culture of candour; and
- A patient-centred hospital system.

Lack of data also limits the ability to design and implement evidence-based, tailored and culturally safe services for groups within our community, including Aboriginal and Torres Strait Islander people, CALD communities, LGBTIQ people, older people, women and young people.¹⁵² This is particularly important in an environment of growing demand and limited additional resources to address demand.

6.4 Enhanced oversight and governance

The need for effective regulation to protect people and to identify conduct that breaches applicable norms was highlighted in the Hayne Royal Commission into Banking and Financial Services.¹⁵³

¹⁴⁹ The number of treatments that is delivered may be less than what has been approved, for example if a person regains capacity so that ECT ceases or continues voluntarily, or if the person's condition changes so that fewer treatments are necessary.

¹⁵⁰ Victorian Mental Illness Awareness Council, *Seclusion Report: How safe is my hospital?* (April 2015) <<https://www.vmiac.org.au/blog/seclusion-report-how-safe-is-my-hospital/>>.

¹⁵¹ For example, it has not been possible for IMHA to compare its service user data against data of people on compulsory orders to determine whether the people the service is reaching are proportionately representative of this target group. The Mental Health and Disability Law program has similarly been unable to obtain data about the number of applications to the Tribunal for ECT in order to direct its resources to areas of greatest demand and to target its strategic advocacy.

¹⁵² The need for targeted, culturally safe and responsive services for groups within our community is discussed in part 5.

¹⁵³ Royal Commission into Misconduct in the Banking, Superannuation and Financial Services Industry, *Final Report*, v 1 (February 2019) 211.

In the Victorian mental health system, there is a lack of effective regulation and independent oversight mechanisms to drive compliance with Mental Health Act obligations. We see the impact of this through our legal and non-legal advocacy work supporting people subject to or at risk of compulsory treatment.

The experiences of our clients and consumers have been that mental health services are not consistently operating in compliance with the Mental Health Act obligations to provide ‘recovery-oriented, least-restrictive treatment and care where people are supported to make their own decisions.’¹⁵⁴

An example of this was discussed in part 1 regarding VLA’s data collection of mental health service compliance with Mental Health Act obligation to provide consumers with information and reports 48 hours prior to their Mental Health Tribunal hearings. In 2016, the average rate of compliance with this obligation across 21 services surveyed was 44%.

The results of this data collection have been shared with DHHS and with some services. Importantly, VLA is not best placed to collect and share this data to drive system improvement.

IMHA faces similar limitations in attempting to create system change in isolation. It is in this context, that the independent evaluation of IMHA recommended that oversight and funding bodies coordinate and adequately invest to ensure that services meet their legislative obligations.¹⁵⁵

All the existing oversight mechanisms are funded by and report to the Mental Health Branch of DHHS, including the Office of the Chief Psychiatrist, the Mental Health Complaints Commissioner and the Mental Health Tribunal.

This is in the context of the findings of the Targeting Zero report that ‘the Department has not been fully exercising its leadership of the system to drive improvement or to create economies of scale in centralised data analysis, performance benchmarking and common improvement resources.’¹⁵⁶ The Royal Commission should consider whether there is unnecessary fragmentation of oversight bodies under current arrangements.

It is notable that improvements to the functioning of the UK Mental Health Tribunal, including becoming more rigorous and rights-focused have been attributed in part to its move out of the Department of Health into the Ministry of Justice.¹⁵⁷

In our view, improved systems for oversight would lead to better understanding and implementation of the Mental Health Act and its safeguards, including supported decision-making, least restrictive assessment and treatment and a recovery-focus.

This should include embedding consumer leadership and self-advocacy as part of systems and services, including opportunities, funding and support for co-produced services and programs.¹⁵⁸

¹⁵⁴ As discussed throughout this submission, this was a key finding of the IMHA Evaluation Report, above n 3.

¹⁵⁵ Ibid.

¹⁵⁶ Targeting Zero Report, above n 78.

¹⁵⁷ Eleanore Fritze, *Shining a Light Behind Closed Doors. Report of the Jack Brockhoff Foundation Churchill Fellowship to better protect the human rights and dignity of people with disabilities, detained in closed environments for compulsory treatment, through the use of innovative legal services* (December 2015) 58–9.

¹⁵⁸ Independent Mental Health Advocacy, *New resources help consumers speak up and protect their rights* (April 2019) <<https://www.imha.vic.gov.au/about-us/news/new-resources-help-consumers-speak-up-and-protect-their-rights>>.

Priority area for reform 6: Strengthening governance, accountability, data and transparency

Stronger governance, oversight and accountability mechanisms are a crucial component of bridging the current gap between the rights and recovery focused system the Mental Health Act promises, and the reality on the ground for consumers.

There is very limited publicly available data regarding the mental health system, including data on how many people are subject to compulsory treatment, and their geographical location, age, gender, cultural background, type and length of order, and complaints. Data is critical to service design, evaluation and consumer choice, and a key part of ensuring accountability.

The Royal Commission should form a view about what a good system looks like. This is an opportunity to make sure that the necessary systems and processes are put in place to measure and monitor whether the system is meeting the needs of consumers, as identified by them, and to respond when it is not.

Appendix: Notes on Language

VLA recognises the diversity of views and experiences of those with lived experience of mental health services. We have attempted to be conscious of our use of language and have sought to avoid unnecessarily medical or legal language throughout this submission. There may be examples of clinical or technical language being used for clarity, despite negative connotations.

Informed by IMHA and consumer experts, we have primarily used the term ‘mental health issues’ throughout. ‘Mental illness’ is only used in direct quotes, or when referring to organisations or reports.

We have used ‘mental impairment’ where it relates to that concept as set out in the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic).

We note that ‘appropriate’, ‘specialised’ or ‘therapeutic’ services or programs are subjective terms in the mental health context and should be used carefully, keeping in mind self-determination and safeguards to promote safe and least restrictive treatment. What a clinician considers ‘appropriate’ supports or services may differ significantly to the supports that person would seek and consider appropriate for themselves. ‘Therapeutic’ has a different specific meaning in relation to the criminal justice system, where ‘therapeutic responses, programs and Courts’ refers to justice system approaches which respond to an individual’s needs and circumstances, including mental health issues.

We have used the term ‘consumer’ to refer to people with a lived experience of mental health services, and to people who have used IMHA services. ‘Clients’ generally refers to clients of VLA.

Our understanding of ‘recovery’ is set out in part 1. We recognise that many consumers see the Mental Health Act as incompatible with the concept of recovery, as it facilitates compulsory treatment, which is inconsistent with self-determination, a fundamental aspect of recovery.