



Submission

MENTAL HEALTH Productivity Commission Draft Report

Date: 23 January 2020

Contact: Charlotte Jones, Manager

Ann Jorgensen, Principal Solicitor

(03) 9629 4422

Overview

The MHLC welcomes the Productivity Commission's draft report on mental health and commends the comprehensive approach it has taken to considering mental health care and the social and economic context of mental illness. We support many of the draft recommendations contained in the report.

This submission focuses on the areas in which we have specific expertise or where we have comments on individual recommendations.

About the Mental Health Legal Centre

The MHLC is a community legal centre based in Melbourne that has been providing legal services for more than 30 years to people who have experienced mental illness. We provide a range of innovative services in the community, in treatment facilities and in prisons. We work in partnership with other agencies to provide integrated services that address the needs of the most complex and vulnerable members of our community.

The services of the MHLC are broken down into a number of specific areas and these are all separate access points for consumers. MHLC consumers often move between the services and many of the lawyers are able to provide services across a number of areas enabling continuity of service. Our different programs are set out below.

Day Service

Our telephone lines are open from Tuesday to Friday 9am-5pm. Our highly experienced and well trained administrators answer our calls and provide support and information to anyone who calls. As we are a generalist service we are often the last port of call for people who have been endlessly referred on throughout the system. We take the time to speak to people and identify their needs and endeavour to provide warm referrals and realistic information. Our administrators refer clients to our night service or individual MHLC programs where appropriate and can also utilise our social worker. We currently receive over 5000 calls per year.

Many of the calls we receive relate to requests to provide representation at upcoming Mental Health Tribunal (MHT) hearings. Representation is provided through our lawyers and a network of over 50 pro bono lawyers who work with us. We train and support all of our pro bono lawyers.

Night Service

People who call during the day seeking legal advice are referred to our telephone night service (unless the matter is urgent). The night service is staffed by an administrator, an experienced community lawyer and up to 12 pro bono lawyers and law students. The service runs every Tuesday and Thursday evening. We receive calls from people who are inpatients across the state. We operate a 1800 number for people outside the metro area. From these calls we are also able to provide ongoing case work for a limited number of clients across a number of different areas of law. One of the areas we seek to assist is minor

criminal matters where a person will struggle to represent themselves but legal aid is unavailable.

Advance Statements Project

The MHLC has spent over 12 years campaigning for and promoting advance statements which were introduced in the Mental Health Act 2014. We were concerned that the Department of Health and Human Services were not funding practical supports for people to prepare advance statements and sought philanthropic backing to support this critical service. The MHLC ensured that the outputs and outcomes were fully evaluated and continues to provide evidence of the importance of advance statements.

Bolton Clarke Homeless Persons Project

The MHLC has worked with the team of dedicated nurses at Bolton Clarke for the past four years building a Health Justice Partnership. This fully evaluated project has high satisfaction ratings from clients and our partner nurses. With clinics in Frankston and Glenroy working alongside nursing teams funded through the Rough Sleepers Initiative, we are able to provide meaningful legal support for people with complex mental health needs and insecure housing.

This service also combines an embedded education component which enables clinical staff to easily identify legal issues and make effective referrals.

Inside Access Project

The MHLC provides a unique service to women prisoners at the Dame Phyllis Frost Centre (DPFC). The project continues to evolve to meet the needs of a changing prison population and we have developed education sessions and clinic-based legal and social work services to provide holistic services to women in prison. The team consists of a general lawyer and co-ordinator, a child protection lawyer, a family violence and victims of crime lawyer, a specialist fines lawyer and a social worker. This unique suite of services is possible due to funding from the Department of Corrections, the Attorney General and philanthropic organisations.

At Ravenhall Correctional Centre we also provide a generalist lawyer providing one to one clinics along with education services and a fines clinic. This work is funded by GEO. This service has been online for 2 years and has expanded to meet the growing demands within the prison.

We have recently developed two pilot projects with GEO supporting people transitioning out of Ravenhall and in the early stages post release. More detailed information about these is included below.

Health care – improvements for receiving care in hospitals

Draft recommendation 8.1 – Improve emergency mental health service experiences

The MHLC strongly supports the recommendations to provide more and improved alternatives to hospital emergency departments for people with acute mental illness and to provide paramedics with access to mental health resources.

In Victoria the PROMPT trial (Prehospital Response of Mental Health and Paramedic Teams) is a model that meets both of these recommendations. The trial has been extended with initial reports indicating that it had been effective in diverting people from the emergency department and providing a more effective community based response to people experiencing an acute mental health episode.¹

The MHLC also recommends that additional supports and avenues be developed to avoid the need for people to be transported to emergency departments. Community based drop-in centres that incorporate mental health workers and other services could be a more effective way of supporting people through difficult periods and dealing holistically with their issues. The Safe Have Café profiled in the Commission's report is well regarded by our clients that have used it but, as identified, find its opening hours to be limited.

The MHLC also recommends that consideration be given to fully integrating advance statements at this stage. This could allow for clinicians or paramedics to obtain a copy of a person's advance statement (if the person had given consent for it to be used in this way). The advance statement could contain important information that would assist with de-escalation and identifying appropriate supports for the person.

The MHLC notes that, in Victoria, police are often acting as first responders in mental health crisis situations. Although police responses are dealt with separately in the Justice chapter of the draft report, it is important to recognise the role that police play in conducting welfare checks, responding to people in public spaces and taking people to hospital for assessment. While a police response may be necessary in some circumstances, they should not be routinely involved in responding to people needing mental health care. People experiencing an acute mental health episode can find interactions with the police frightening and distressing. Such interactions frequently escalate with a heavy handed approach taken to perceived resistance and individuals being charged for resisting arrest and similar offences.

Case study – welfare check by police

We assisted a client who had been visited by police to conduct a welfare check. There had been no concerns raised about violence. Family members present said he was not violent towards the police but ended up handcuffed and placed in the police van. He was later charged on summons for assaulting police. This is an unacceptable outcome of a process that seeks to be protective. As a result of this interaction, our

¹ <https://www.premier.vic.gov.au/geelong-mental-health-support-trial-extended/>

client's mental health deteriorated and his family are hesitant to seek support in the future. We were able to negotiate for the matter to be dealt with by diversion, avoiding a conviction on his record.

Enabling coordination and continuity of care

Draft finding 10.1 - Digital records would facilitate information sharing

The MHLC agrees that better use of digital records would facilitate information sharing. In particular we believe that there is a need for consumer preferences (in the form of an advance statement or similar consumer directed document) to be included in digital records so that they can be readily accessed when a person presents needing mental health treatment.

Advance statements have enormous potential to facilitate communication between an individual needing mental health treatment and their treatment team. If used effectively, they can quickly provide a clinician with important information that facilitates appropriate treatment and consumer engagement. A challenge is ensuring that the existence of an advance statement is able to be ascertained and a copy obtained promptly. At present in Victoria, the existence of an advance statement can be noted on a person's state wide mental health record but a copy of the actual advance statement itself is not centrally located. This is problematic when a person presents at, or is taken to, a different mental health service. There is also a strong onus for consumers to ensure that their advance statement is provided to all health care providers that might need it. In a crisis, people are unlikely to have a copy of their advance statement with them and without a centralised record system it can be a matter of luck if the advance statement is provided to the treating team.

While we see benefits to the use of My Health Record, we note there has been significant consumer disquiet around it. During the opt out period for My Health Record, peak mental health consumer bodies in Victoria, New South Wales and Western Australia ran a campaign encouraging consumers to carefully consider whether they wished to be a part of the system given the risks involved.²

These concerns are consistent with reports from some of our clients that they feel stigmatised by their mental health diagnoses within the health system. Symptoms of poor physical health or responses to trauma are often dismissed or downplayed. People are therefore reluctant to have details of their mental health history shared across services and providers.

MHLC recommends that the perspectives of consumers be obtained and taken into account in considering an expansion of the use of digital records.

² http://being.org.au/wp-content/uploads/2018/07/MR_If-in-doubt-opt-out_My-Health-Record_Jul2018.pdf

Income support

General comments

Income support is an area that has a significant impact on people experiencing mental illness. The MHLC commends the Commission's consideration of how to best tailor employment support services to people with mental illness. The MHLC is however of the view that greater consideration needs to be given to the issues people with mental illness face in accessing appropriate income support.

The MHLC notes that the Commission does not see the adequacy of Newstart payments as within the scope of its report. We acknowledge that the adequacy of Newstart payments is not an issue that only affects people with mental illness. It is certainly the MHLC's view that Newstart rates need to be raised for all recipients. However given the enormous impact that living in poverty has on people with mental illness, we are of the view that it should be explored further in the Commission's report.

People experiencing mental illness find themselves on Newstart for significant periods of time for reasons such as:

- They are waiting for their disability support pension (DSP) claim to be finalised or for a rejection to be reviewed (in some cases for more than 2 years)
- The processing of their application is delayed because they are unable to provide the evidence required in support of their claim for DSP
- They are undertaking a program of support for 18 months in order to be eligible for the DSP
- They have been found not to meet the eligibility criteria for the DSP despite having significant mental illness.

The rates of Newstart are so low that they make living with a mental illness a constant struggle. Accessing treatment, maintaining social connections, eating healthy food and engaging in exercise all support a person's recovery. However, many people on Newstart have very little money to pay for such things after their housing costs are accounted for. This is exacerbated for people living in rural and regional areas where transport costs are high and it is more difficult to access bulk billed medical and mental health supports.

The MHLC respectfully suggests that the Commission consider at least acknowledging in its report that the inadequacy of payments has a detrimental impact on people experiencing serious mental ill health.

Other options that may address some of the negative effects of low Newstart rates for this particular cohort could include:

- Improving the process and timeliness of assessment and review of claims for DSP so that errors are less likely to be made and that applicants are not waiting for significant periods of time to have their matters finalised

- An increased level of payment (greater than Newstart but less than the DSP) for people undertaking a program of support
- Properly funded advocacy and support services to enable individuals to navigate the application process and ensure that the best possible evidence is provided at the outset
- Adequate funding to legal services providing representation to individuals seeking to review Centrelink decisions around DSP eligibility to ensure that individuals who should be eligible are able to present their case.

It is important to acknowledge that there is a significant drive from the government to reduce the number of people on the DSP. This inevitably has an impact on those who have a role in assessing eligibility both within Centrelink and as contracted providers. Our clients report feeling as though the people they deal with throughout their application process are actively seeking to find them ineligible for payments. The Commission notes that review processes provide a safety valve for addressing errors. However given that Administrative Appeals Tribunal members are appointed on contracts, in some cases have a close relationship with the government of the day, and are increasingly not legally qualified does not provide a great deal of assurance that Centrelink decisions will be robustly scrutinised and errors corrected.

As lawyers, we often find it difficult to navigate Centrelink's processes and documentation. For many of our clients it is a frustrating impossibility. We strongly recommend that increased funding be made available for legal and non-legal support and advocacy for people applying for the DSP.

The MHLC also requests that the Commission give more detailed consideration to the impact of eligibility criteria for the DSP on access for people with mental illness. The discussion in the draft report is brief and does not seem to comprehensively respond to the concerns raised by a number of organisations dealing with these issues on the ground. Whether it is a matter of the criteria themselves or the application of them, the impact is that the criteria can be very difficult to navigate and are inconsistently applied. Mental health conditions are often more complicated than physical conditions not just because they can be episodic but because they complicate engagement with treatment. What constitutes reasonable treatment is also often less clear for mental illnesses than for physical illnesses. The application of the impairment tables is not as straightforward as when assessing physical disabilities.

Case study – DSP rejection

We acted for a client who had refused to attend a particular type of group therapy that she found intensely distressing and also, on occasion, refused to be weighed by her GP (she had a 30 year history of anorexia). Centrelink saw these factors as refusal of treatment which meant that the condition could not be considered fully treated and stabilised. In reality they were inherently linked to her mental illnesses and severe post-traumatic stress disorder. It took Centrelink 42 weeks to make a decision on her initial application. Centrelink provided different reasoning at the first

instance and at the authorised review officer stage. Ultimately the AAT found in her favour nearly 2 years after she first applied.

Better training for people assessing DSP applications for people with mental illness and improved guidance on the application of the relevant impairment table may improve Centrelink's service delivery in this area.

MHLC Recommendation: More detailed consideration needs to be given by the Commission to the difficulties faced by people with serious mental illnesses in navigating access to the DSP and identifying the cause of these difficulties.

The Australian Government should fund support services for people making applications for the DSP and also adequately fund legal advocacy services for people seeking to challenge Centrelink decisions.

Draft recommendation 14.4 – Income support recipients mutual obligation requirements

The MHLC supports increased flexibility in mutual obligation requirements for jobseekers experiencing mental illness.

Preventing housing issues from arising

Draft recommendation 15.1 – Housing security for people with mental illness

The MHLC strongly supports the Commission's recommendations regarding housing security for people with mental illness. In particular we support the recommendations for mental health training for social housing workers and for social housing authorities to review their policies relating to anti-social behaviour. We regularly act for clients who have been given notices to vacate for behaviours that are intrinsically linked to their mental illness which can be addressed in a constructive manner. Eviction should be a last resort, initiated only when other avenues to resolve issues have been exhausted.

Legal assistance is important in preventing people with mental illness from losing their housing. Specialist tenancy legal services and other community legal centres play an important role in challenging inappropriate evictions and protecting tenancies.

Case study – lawyer helping to maintain housing

Peter suffered from several serious health conditions that had an impact on his cognitive function. He also had a long history of depression. He lived in a community housing property that contained a mix of community housing tenants and private renters. Peter's housing had been stable for 4 years and he received a range of supports there including home care and nursing visits. Peter started to have some issues with bureaucracy that were causing him a lot of frustration. On two occasions he came home from dealing with these issues in an angry state and damaged a neighbour's property. The community housing organisation issued him with an immediate notice to vacate for danger.

Peter was referred to the MHLC by his outreach nurse at Bolton Clarke who had been working with him for many years. Peter was difficult to get a hold of by phone and our lawyer left many messages for him. While more traditional services may have been forced to give up, we were able to work with his nursing team to contact him when they were conducting a home visit. Our lawyer liaised with Peter's nurse, his GP and his support worker to prepare for the eviction hearing and opened discussions with the housing provider. We represented Peter at his tribunal hearing and his nurse and support worker attended with him.

The Tribunal accepted that Peter's actions were out of character and that he did not present an ongoing danger to other tenants. As a result of a multi-disciplinary team working together, he avoided the devastating consequences of immediate homelessness and the attendant loss of services.

Peter was also charged by the police in relation to the incidents. He had no criminal record and our lawyer was also able to represent him at court where he was granted diversion.

MHLC Recommendation: The role of legal services in supporting housing security should be recognised by State and Territory Governments and should be funded appropriately. Funding should be directed to specialist tenancy services as well as services that specialise in working with clients with mental illness.

In our earlier submission we raised the issue of the large number of people with mental illness living in private rooming houses. We are disappointed that this type of housing has not received attention in the Commission's draft response. While it is hoped that in the long term the Commission's recommendations for increased housing supply would minimise the need for private rooming houses, at present they are a very real issue for people with complex mental illnesses.

Private rooming house accommodation is often expensive, unsafe and run by unaccountable, private operators. In Victoria, a handful of operators working through constantly shifting shelf companies, control a large share of the rooming house market. Their activities distort the market and they receive significant public funds through crisis housing services and residents paying rent directly from their Centrelink payments through Centrepay. Due to a major shortage of short-term or crisis housing, housing services feel forced to continue to use these providers even though many of our clients would actually be safer on the streets. While some services have indicated they will stop using these providers, at present there is such enormous demand for housing that they continue to operate.

The other type of housing not addressed by the Commission is supported residential services. SRSs are privately operated businesses that provide accommodation and support for people who need help with everyday activities. They set their own fees and charges which cover accommodation, food and other support services. In many cases individuals pay the majority of their income to the SRS. The standard of care and services provided by SRSs

vary greatly. Our partners, the Bolton Clark Homeless Persons Program prepared a review of SRSs in Victoria which set out some serious concerns about how some were operating.

Housing supply

Draft recommendation 15.2 – Support people to find and maintain housing

We support the Commission’s draft recommendations relating to housing supply.

In our Bolton Clark Homeless Persons Program health justice partnership we frequently see clients that have been discharged from hospital care to homelessness once their condition has stabilised. Through our Inside Access programs we are aware of the large number of prisoners who leave prison without any arrangements for ongoing housing. We therefore strongly support the recommendation for a formal nationally consistent policy of no exits into homelessness for people discharged from institutional care.

We agree with the Commission that stable housing is a fundamental first step in dealing with a range of other issues that people with severe mental illness experience. We support the scaling up of Housing First programs targeting people with severe and complex mental illness who experience persistent homelessness and government investment in long term housing for these programs.

Justice system

Draft recommendation 16.1 – Support for police

The MHLC supports the recommendations to support police to respond to mental health crisis situations. However, it is our view that police should not be considered a standard first response to people experiencing a mental health crisis.

The first response provided to a person in a mental health crisis is crucial and has a lasting impact on their experience of, and willingness to engage with, treatment. Police should only be used as a last resort where there is a clear risk of serious harm to others. Police should not be routinely used for welfare checks or to transport a person to a mental health service or emergency department for assessment or admission where there is no risk of harm to others.

The MHLC hears from many clients who have found their interaction with the police at a time of being acutely unwell to be terrifying and traumatising. Clients have reported having armed police burst through their door, having guns pointed at them, being handcuffed and in the worst cases being assaulted and/or arrested. The capture on CCTV of six police officers assaulting ‘John’, a mentally ill disability support pensioner outside of his home in Preston in August 2018 validated an experience that a number of clients have reported through our telephone advice service.

Case study – police interacting with people with mental illness

Frank's nurse contacted our centre when he got a summons for charges for assaulting an emergency worker and criminal damage.

Frank was kicking a garbage bin on the footpath of a main road when he was approached by two police officers. When approached he allegedly raised his fists. The police sprayed him with pepper spray. He then walked away from police with his back towards them. As he was not following their instructions – they sprayed him with pepper spray again.

The police officers returned him to his home – an SRS for older people with mental health issues. Later that day, police were called to the property. Frank was found naked in the yard spraying his eyes with a garden hose and in the words of the police “suffering from a severe mental health episode”. Prior to this he had sprayed a fire extinguisher in his eyes to relieve the burning from the pepper spray. This caused flooding to the SRS.

The police apprehended him under section 351 of the Mental Health Act and transported him to hospital where he was a psychiatric inpatient for 6 weeks.

Frank was later charged with assaulting police and wilful and intentional damage to property. The owner of the accommodation service also sought restitution for the damage to the property.

Our lawyer tried to negotiate with the police to have the charges withdrawn prior to hearing. This was not possible. At court the Magistrate agreed to dismiss the charges given Frank's mental illness, that he was unwell at the time and had no priors. The Magistrate did not make the order for restitution.

Initiatives that pair police with mental health workers, such as PACER (Police, Ambulance and Clinical Early Response) in Victoria, are a significant improvement on a police only response. However, where a police response is unnecessary, MHLC supports the development of a system of first response for people experiencing a mental health episode (or suspected to be) that is entirely separate from a law enforcement response. The PROMPT trial (Prehospital Response of Mental Health and Paramedic Teams) in Victoria provides a potential model for this.

Where a police response is necessary, the MHLC agrees that initiatives that enable police, mental health and ambulance services to collectively respond to mental health crisis situations should be implemented. The MHLC submits that a key component of any co-response model must be multi-agency review of complex cases with the opportunity to reflect on outcomes and identify areas for improvement. The Mental Health Intervention Project component of the Queensland model appears to provide an example of this.

MHLC Recommendation: Police should not be used as first responders in mental health crisis situations unless there is a need for their involvement. The primary response for people in mental

health crisis should be appropriately trained mental health clinicians in partnership with paramedics where required.

For situations where a police response is warranted, co-response models should be implemented. An essential component of this should be shared governance models with regular opportunities to review complex cases and develop and disseminate best practice guidance.

As police officers will inevitably come across people experiencing mental illness in their day to day policing work training about mental illness and how to respond to people experiencing it should be a core part of the education and training of officers.

Draft recommendation 16.2 – Mental healthcare standards in correctional facilities

The MHLC supports this draft recommendation and sees it as an important step in improving the safety and quality of mental health care in prisons.

The MHLC also recommends that consistent national data regarding mental health service provision and performance within prisons should be collected and made publicly available. This would allow benchmarking against other jurisdictions and ensure best practice clinical care and service delivery models. There is at present minimal publicly available information and data around the provision of mental health care (and general healthcare) within Victoria's prisons. We note that Victoria withdrew its participation from the first ever national survey of mental health service provision for prisons in Australia (Clugston et al. 2017) meaning we are unable to see how Victoria performs against other jurisdictions and identify priorities for improvement.

Draft recommendation 16.3 – Mental healthcare in correctional facilities and on release

The MHLC supports this recommendation. We suggest that it be amended to provide that the mental health screening should be undertaken by clinicians with specialist mental health training.

Where a person has been receiving mental health treatment in the community prior to incarceration contact should be made with their treatment team to ensure continuity of treatment and consistency of medications.

Mental health care in Victorian prisons

As in non-prison settings, people with mental illness would benefit from integrated, personalised services that comprehensively address the issues underlying their offending. At present program delivery is disjointed and treatment within prison is not integrated with that in the community upon incarceration or release. The frontline delivery of mental health treatment in Victorian prisons is through mental health nurses. Prisoners have irregular visits from psychiatrists and regular psychological treatment is almost impossible to access. Many people within prison have a history of severe trauma and this is not well understood or treated within the prison system.

In Victoria Justice Health, a business unit of the Department of Justice and Community Safety, is responsible for the delivery of health services to prisoners. Health services are contracted out to a number of organisations. Correct Care Australasia delivers primary health care services (including mental health services) to all prisons in Victoria. Victoria is unique among Australian states and territories in having primary health care services provided by a private sector company. Forensicare is contracted to provide secondary mental health services at all public prisons and provides direct services within a number of prisons.

Prisoners have a medical review on arrival but some report that, while they are assessed, they do not feel like they receive appropriate treatment. It can be a long wait to access an appointment with Correct Care clinical staff. Correct Care staff are effectively the gatekeepers to secondary mental health treatment and it can be extremely difficult for prisoners to access a higher level of care.

It is difficult to obtain information from outside the prison regarding a person's health prior to entry and very little information is provided on exit. This must be reviewed with a full and complete handover of information and current medications. We are aware of a woman not being advised that she had cancer as a failure to communicate post release.

Our lawyers assist people with access to medical and mental health treatment or to escalate issues that cannot be resolved with Correct Care. Dealing with Correct Care can sometimes be difficult. Our lawyers are unable to contact the medical centre at DPFC directly to raise issues on behalf of clients. They are required to go through Correct Care's head office. Correct Care have 21 business days to respond. This is a problem when inquiries are being made about appointments or acute situations. This contrasts with our ability to contact other units in the prison to resolve issues quickly. It is also very difficult for prisoners or their representatives to obtain medical information or access medical records. Information will only be provided through a freedom of information request which involves a wait of at least 30 days, often significantly longer. This inability to obtain information limits the ability of prisoners to understand their mental and physical health and actively participate in decisions about their health care.

Medication issues arise throughout the period of incarceration from first arrest to release. Twenty-three percent of prison entrants reported that they were currently taking medication for a mental health condition (Australian Institute of Health and Welfare 2018).

If a prisoner has been held in police cells or in the cells at the Magistrates' Court prior to prison they may have had a number of days without any medication including opiate substitution medication. Medication does not follow people into prison. Once a medical assessment has been conducted medications can be prescribed but these may differ from the medications people were taking in the community or they may no longer receive any medication. Some medications are not available in prison or the prison based clinicians may not be prepared to prescribe certain medications.

Mental health treatment in prison is heavily reliant on psychiatric medication but prisoners are, for the most part, excluded from the Pharmaceutical Benefits Scheme (PBS). This limits

the range of medications available (due to cost restraints) and the Australian Medical Association has identified that exclusion from the PBS means that prisoners “are frequently prescribed psychiatric medications in a manner that would not attract a PBS subsidy in the community. As such, adherence to these medications after release from prison is likely to be poor, with the result being recurrence of psychiatric symptoms and, for some, an avoidable relapse to self-medication with illicit substances.” (Johnson and Tatz 2017).

Clients report that it can be difficult to have medications changed and that there is limited monitoring of side effects and whether the need for medication continues. One prisoner reported to our lawyer that she had not had her medication reviewed by a psychiatrist for more than 4 years.

Upon release, prisoners face the sudden return to managing their own medication. They will be given a prescription to be filled at a pharmacy. Medication looks different to that provided in prison and for clients taking medication for multiple issues this can be extremely confusing and risky.

Many of our clients identify psychological treatment as something that would be of enormous benefit to them. However psychological treatment is extremely difficult to access within prison. There are some excellent programs within prisons for trauma based counselling or drug and alcohol counselling but they often have long waiting lists.

Prisoners are able to privately access health care but must cover the cost, making it an impractical option. Prisoners cannot access the Medical Benefits Schedule (MBS) which means that they cannot utilise the subsidised services of private psychologists or psychiatrists. If the Federal Government were to remove the limitation on prisoners accessing MBS subsidised service, more options for telehealth would be available which could address some of the shortages in the system.

Prisoners with behavioural issues, suicidal prisoners, and prisoners awaiting transfer to a forensic bed are sometimes held in management units. This involves remaining in a cell for 23 hours each day with limited access to programs and services within the prison such as the gym or the library. Management units are an inappropriate placement option for people with mental health issues. The issues in regard to seclusion not being of benefit to people who are unwell is well documented but this is often the only response in the prison environment.

[Information request 16.1 - Transition support for those with mental illness released from correctional facilities](#)

The support provided to prisoners transitioning out of prison falls short of the level required to have a meaningful impact and to help people re-engage with society and break cycles of poverty, drug use and incarceration. The services available to prisoners are overwhelmed due to a lack of resourcing and only able to provide limited services. After a period (sometimes many years) of not making their own decisions and living a highly regulated life, people exiting prison are suddenly expected to get themselves to appointments, identify and articulate their needs, access housing and income support and manage their own healthcare. The failure to adequately invest in transition support is a false economy. While

intensive, long term support to people transitioning out of prison is a costly model, it is significantly cheaper than the costs of incarcerating people. Effective post release support reduces the risk of recidivism and the cost to the community and the state of offending.

MHLC Recommendation: Intensive, wrap-around, post-release support should be provided for all prisoners commencing at least 3 months prior to release and continuing for up to 12 months after release. This service should provide case managers to co-ordinate the range of supports needed for people re-entering the community including housing, income support, access to NDIS if relevant, health care (including mental health care) and psycho-social supports. In the first 28 days post release people should be actively supported to physically attend appointments and engage with Centrelink, housing agencies and other priority services.

At the MHLC we have developed two pilot programs to support prisoners at Ravenhall Correctional Centre transition out of prison and reduce their risk of re-incarceration.

The Ravenhall NDIS Pilot Program delivers a weekly NDIS support service directly to men within the Ravenhall Correctional Centre. Our experienced social worker and an administrator work to streamline access to NDIS for men returning to the community.

The project aims to ensure that an NDIS package is available to prisoners on exit from Ravenhall Correctional Centre to support their reintegration into the community and facilitate their rehabilitation.

Each client receives a tailored service designed to provide assistance in completing the NDIS Access Request Form, including collecting and collating supporting evidence and any additional evidence required by the NDIS. The MHLC also liaises with NDIS planners and support coordinators in the community to facilitate contact with clients who are already on an NDIS package.

Outcomes for clients include increased capacity to navigate NDIS processes and increased knowledge and information related to their NDIS package.

The Bridge Program delivers an on-call civil legal service to clients of the Bridge Centre, a community reintegration facility for prisoners released from Ravenhall. The Bridge Program is overseen by a senior lawyer and an experienced administrator. They work to assist men on exit from Ravenhall Correctional Centre who either have minor legal matters yet to be resolved, or have warrants issued due to a lack of support. The legal matters may include fines and infringements, housing matters, Centrelink issues, family law matters, victims of crime, and minor criminal matters such as driving offences.

The Bridge Program also trains staff to identify legal needs and make appropriate referrals. We have identified that having a lawyer immediately on hand results in increased engagement of clients with services.

Information request 16.2 - Appropriate treatment for forensic patients

The draft report defines a forensic patient in box 16.2 as an individual who is alleged to have committed a crime but is deemed unfit to plead or to unfit to stand trial. This accords with the definition used in Victoria and elsewhere. Forensic mental health care however usually refers to a broader group than forensic patients and includes the treatment of prisoners needing inpatient treatment. Some of the discussion on forensic services in the draft report seems to conflate forensic patients with individuals in correctional facilities who are not forensic patients, but are extremely unwell and in need of intensive mental health treatment.

Forensicare is the state-wide specialist provider of forensic mental health services in Victoria. It operates at the Thomas Embling Hospital, a secure mental health hospital where forensic patients and prisoners with serious mental illness in need of inpatient care are treated. It also delivers mental health services across prisons in Victoria through a range of outpatient and inpatient services. Compulsory mental health treatment cannot be provided in prisons because they are not designated mental health services under the Mental Health Act. Prisoners requiring compulsory treatment who are unable to access a bed at Thomas Embling Hospital can be waiting for significant periods of time without any treatment in the general prison system. Due to difficulties in managing prisoners with a serious, untreated mental illness they are often placed in management units with severe limitations placed on their movement.

It has been clearly identified by numerous reports that there is a lack of capacity within the Victorian prison system for dealing with prisoners with acute mental health conditions.³ Despite investment in this area and the opening of Ravenhall Correctional Centre, there remain extremely unwell individuals within the general prison population who are not being appropriately treated. This is a problem for the individuals involved but also puts a heavy strain on the prison system more broadly and prison staff who are not trained or resourced to be delivering frontline care to acutely unwell people.

The Report of the Review of Hospital Safety and Quality Assurance in Victoria (the 'Targeting Zero' report) has some useful discussion and analysis of the pressures on forensic mental health care in Victoria which may be of interest to the Commission.⁴

Draft finding 16.4 - Health justice partnerships

The MHLC welcomes the recognition of the potential of health justice partnerships (HJPs) in helping people access legal support early and reduce risks to mental health. We understand the Commission's concerns around the lack of rigorous evaluations assessing the impact of HJPs in Australia.

³ <https://www.audit.vic.gov.au/sites/default/files/20141015-MH-Strategies-Justice.pdf>;
[https://www.ombudsman.vic.gov.au/getattachment/5188692a-35b6-411f-907e-3e7704f45e17](https://www.ombudsman.vic.gov.au/getattachment/5188692a-35b6-411f-907e-3e7704f45e17;);
<https://www.dhhs.vic.gov.au/sites/default/files/documents/201610/Hospital%20Safety%20and%20Quality%20Assurance%20in%20Victoria.pdf>

The MHLC has embedded independent evaluation in the two HJPs we have been a partner in. This enables us to understand how the project is working as it progresses and to make any changes needed in a timely manner.

A particular frustration for the MHLC has been the difficulties in obtaining government funding for our MHLC and Bolton Clarke Homeless Persons Program HJP which has operated very successfully for more than four years, been fully evaluated and demonstrated excellent outcomes.

MHLC Recommendation: The Australian Government should provide dedicated funding grants for HJPs with transparent selection criteria and processes. Funding for existing HJPs should only be provided to programs that have been fully evaluated and can demonstrate impact. Funding of new programs should require an evaluation plan. An additional component of funding should be given for evaluation of projects. The funds should be administered separately to the National Partnership Agreement on Legal Assistance Services.

MHLC and Bolton Clarke Homeless Persons Program Health Justice Partnership

The health justice partnership focusses on people experiencing, or at risk of, homelessness. The MHLC worked in partnership with the Bolton Clarke HPP nurses to develop a project to address the legal needs of patients. The nurses recognised that legal issues were having a significant impact on the mental and physical health of their patients.

The lawyers in the team partner with the nurses to provide assertive outreach services to some of the most vulnerable members of our community. These include people who are street homeless, living in crisis accommodation or in rooming houses and caravan parks. It also includes people at risk of homelessness and those who are newly placed in housing. An important aspect of the program is that the lawyers meet the clients where they are rather than expecting them to access formal appointments and centre-based services. The clients already have a relationship of trust with their nurses and MHLC can build on that relationship to quickly establish rapport and identify how to most effectively assist clients. The nurses facilitate contact with the client, in many cases attend client interviews, prepare support letters and help the lawyer to link into other service providers if needed.

The lawyers assist with a broad range of legal issues and endeavour to address multiple issues for a client rather than having strict guidelines for assistance. The main areas of law are fines, debt, housing, access to health services, minor criminal matters not covered by legal aid, social security, MHT, family violence and crimes compensation.

The lawyers provide regular education sessions to the nursing team. The education topics are selected in consultation with the nurses. The sessions are practical in nature and highly interactive. The sessions help the nurses to recognise when a client has a legal issue so that

prompt referrals can be made and the nurses can focus on providing clinical care and other supports.

An independent evaluator was appointed at the commencement of the project and has been key to ensuring that the project is effective, responsive and constantly improving. The independent evaluation also allows us to clearly see the evidence of impact.

Since the project began in 2016 it has assisted more than 332 clients with 526 legal matters. During the evaluation of the project a large number of clients (30%) completed evaluation forms giving a clear insight into their experience of the service. Client satisfaction ratings are high (90%) and 95% of clients said that they would use the service again. 85.7% of clients reported that using the legal team had an impact on their wellbeing including less worry, sleeping better and improved mental health. The nurses also rate the program highly and 75% of them had referred clients to the lawyers. Nurses referring to the project had a 94% satisfaction score.

The project has been funded for 5 years by the Legal Services Board and Commission but the funding ceases at the end of this year. Without sustainable government funding this service will be unable to continue and our clients, who simply do not access other legal services, will return to a situation where their legal needs are not met.

The project also demonstrates the need for innovative, outreach based, integrated service delivery models in order to effectively deliver services to the most complex individuals within our community.

From the MHLC's perspective the elements required for success of a health justice partnership addressing the legal needs of clients with complex legal, social and health issues are:

1. A genuine partnership between the health and legal service across all aspects of project design, delivery and evaluation.
2. Recognition that both partners bring vital skills and expertise to the project and a commitment to learning from each other.
3. A shared commitment to delivering services in an outreach model recognising that standard appointment based services do not work for clients with complex needs.
4. Embedded evaluation allowing for client and clinician feedback to drive the service delivery model and to ensure that the model continues to meet the needs of clients.
5. Regular education sessions for clinicians helping them to identify legal issues for referral.

[Health justice partnership case studies](#)

We include a number of case studies here to demonstrate the importance of dealing with a person's legal problems alongside their health and social needs.

[Case study – lawyer assisting client to have more control over finances](#)

Liam had been under an administration order for nearly 20 years and was finding that it was very restrictive and stopping him from living life as he wanted

to particularly in relation to travelling to different parts of Australia. He had a part-time gig that gave him a small income which he managed independently. After speaking to his nurse about this she referred him to our outreach lawyer. We worked with Liam and his nurse to obtain the reports he needed to challenge the administration order and represented him at the Victorian Civil and Administrative Tribunal. The Tribunal found that Liam could manage all of his own money for the first time in two decades. The decision made an enormous difference to Liam's sense of dignity and self-worth.

Case study – lawyer assisting client to resolve conflict with her family

Samantha was a young women living in crisis accommodation whose relationship with her family had broken down. Her parents and siblings had applied for intervention orders and she had made cross-applications. The situation had been going on for years.

The situation was causing enormous distress to Samantha who felt isolated from her family and unsupported in a time of poor mental health. Her nurse contacted our service and our lawyer was able to visit the client with her nurse at her temporary housing. Our lawyer was able to contact Samantha's family and worked hard to negotiate between the parties for consent orders that provided everyone with a sense of safety but also allowed for the possibility of reconciliation. Our lawyer provided representation at two hearings before the matter was resolved by consent orders. The legal process which threatened to further harm the relationship between the parties instead paved the way for resumed contact. This supported Samantha's ongoing recovery. Samantha's sibling contacted our lawyer after the matter finished to thank her for her role in de-escalating the conflict between everyone.

Case study – lawyer assisting client to deal with debt collectors and large debt

Kim was referred to the MHLC by her nurse. Kim had lived an itinerant lifestyle, travelling between states. She had experienced intermittent homelessness and had spent time in and out of jail as a result of her drug addiction. Kim also had significant mental health issues. On referral Kim was reasonably settled in a boarding house in Melbourne and engaging with treatment. She was however being pursued by a debt collection company for nearly \$20,000.00 in court fines and infringements that she had incurred while living interstate.

After seeking advice from interstate community legal centre colleagues and the state's debt recovery body we put in an application to have the fines written off. The application was made on the basis of Kim's financial hardship, her mental health issues (all of which were being exacerbated by the anxiety of the debt and the debt collectors), her substance dependence and homelessness. We also showed how Kim was progressing with her rehabilitation and the stability she had achieved in her life.

Ten days after we had submitted the application we received a response that write-off had been approved. Kim was very happy with the outcome which bolstered her

With the positive relationship Kim has built with her treating team and the resulting stability in treatment and, without the added anxiety of this debt, her mental health remains stable.

Draft recommendation 16.5 Disability justice strategies

The MHLC supports the recommendation for all State and Territory Governments to continue to develop disability justice strategies.

These strategies must recognise the complexity of the legal assistance sector and recognise the complementary roles that legal aid commissions and community legal centres play. CLCs play a vital role in addressing gaps in legal aid service delivery but also in providing flexible legal responses to clients with complex needs.

The service delivery model of legal aid commissions is effective in dealing with a large volume of clients with serious legal needs in discreet areas (for example those charged with crimes warranting imprisonment or people with unresolved family law disputes). Clients with complex mental illnesses (and co-morbidities) will often not actively seek out legal assistance through standard avenues. In order to reach these clients different models of service delivery must be utilised. CLCs are uniquely placed to deliver the type of flexible outreach services that best meet the needs of this client group.

Draft recommendation 16.6 Legal representation at Mental Health Tribunals

The MHLC strongly supports the recommendation for adequate resourcing for people to be represented before mental health tribunals. We do however suggest that the recommendation be worded to refer to the adequate resourcing of legal assistance services to account for the fact that it is not only legal aid commissions that provide representation in this setting. In Victoria and Western Australia specialist mental health community legal centres provide tribunal representation (in addition to other legal services).

The decisions made by Mental Health Tribunals impact on some of the most fundamental rights of individuals – liberty, the freedom to make their own decisions and not to be forced to have medical treatment. In such a setting the legal representation should be an automatic right.

Rates of legal representation at Mental Health Tribunals vary widely across Australia. Victoria has low rates of legal representation for people appearing before the Mental Health Tribunal (MHT). In 2018/19 patients in Victoria were legally represented at only 13% of hearings.⁵ Patient attendance rates at the Tribunal are also low with patients being in attendance at only 56% of hearings in 2018/19.

⁵ <https://www.mht.vic.gov.au/sites/default/files/documents/201910/MHT-2018-2019-Annual-Report.pdf>

Victoria's figures compare unfavourably with some other states. In NSW in 2018/19 the attendance rate for civil hearings was 86%.⁶ In 83% of these cases the patient was legally represented. In the Northern Territory, the Mental Health and Review Tribunal ensures arrangements are in place for consumers to have legal representation in all cases. In 2018/19 87.4% of people appearing before the Tribunal had legal representation.⁷

In each of these states there is greater legislative and practical support for legal representation before the tribunal. In Victoria there is no automatic right to legal representation for MHT hearings and it is the responsibility of individual patients to access legal assistance. This is a particularly onerous burden to place on someone who is unwell enough to be subject to a treatment order or in a confined environment where access to any kind of communication device is fraught. In Victoria hearing notifications are provided to patients by the mental health service not the MHT. Patients often do not receive hearing notifications in a timely manner and as such struggle even more to obtain legal representation.

At present there is limited capacity for legal service providers (Victoria Legal Aid and ourselves) to provide a higher level of legal representation and demand exceeds supply across both organisations. Victoria Legal Aid operates a duty lawyer style scheme at some inpatient facilities but is often unable to assist people on inpatient orders and rarely assist in relation to community treatment orders. The MHLC used to be funded to provide representation for community treatment orders but this funding is now directed to Victoria Legal Aid. Despite receiving no government funding to support our MHT representation, we represented 169 clients in the year to 30 June 2019 (not all matters resulted in a hearing). We were able to do this only with the support of an extensive network of pro bono lawyers. We were unable to represent a further 159 people at their hearings although we always endeavoured to provide phone advice prior to their hearings.

The MHT does not view the low levels of legal representation as a problem. In its 2017/18 Annual Report it stated that it was vital to avoid "creating a misconception that having a lawyer is necessary to ensure a fair hearing or that it determines outcomes". The solution focussed approach that the MHT takes to hearings is said to take place whether or not an individual is legally represented. The emphasis on solution focussed hearings, while worthy, does not adequately recognise the system that the MHT is operating within. If recovery oriented practice was embedded throughout the system, solution focussed hearings would be an ideal mechanism for supporting individuals in their hearings. We currently however have a system where only 44% of patients in Victoria attend their hearings – a significant minority of patients do not appear to be convinced that their attendance will make a difference to the outcome.

It is important to understand that attending an MHT hearing is overwhelming and many consumers feel that there is a significant power imbalance. Although the MHT is of course

⁶ <https://www.mhrt.nsw.gov.au/files/mhrt/pdf/MHRT%20Annual%20Report%202018%2019%20-%20Final.pdf>

⁷

<https://www.territorystories.nt.gov.au/jspui/bitstream/10070/754955/1/1387%20-%20Annual%20Report%202018-2019%20Northern%20Territory%20Mental%20Health%20Review%20Tribunal.pdf>

independent, hearings take place at mental health services and consumers perceive themselves as the outsider in a room with clinicians from their service, another psychiatrist or doctor, a lawyer and a community member. This is unquestionably intimidating particularly at a time of acute mental illness. Being asked questions by a panel of three members and having to articulate your views and address the legal criteria that decisions are based on is difficult. The presence of a lawyer is very comforting for people, they feel that there is someone specifically there for them.

Impact of representation on hearing outcomes

Legal representation before Mental Health Tribunals is not only a matter of human rights, it has a meaningful impact on outcomes.

An audit of 759 Victorian MHT hearings conducted by Dr Michael Gardner during 2014-2015 revealed that patients with legal representation were given longer hearings and shorter periods of compulsory treatment orders compared to those that were unrepresented.⁸ Patients without legal representation were placed on community treatment orders that were on average three months longer than the orders for legally represented patients. The audit indicated that hearings where a lawyer were present lasted an average of one hour. Without legal representation, the time for hearings fell to an average of 38 minutes.

The audit also revealed that patients had legal representation in less than a quarter of 128 Electroconvulsive Treatment (ECT) applications. In cases where a person was represented 41 per cent of the hearings resulted in no order for ECT being made. When the patient was unrepresented only five per cent of applications resulted in no order being made.

These figures align with the experience of our legal service in providing representation to people appearing before the MHT. In 2018/19 the MHT made 6794 treatment order determinations. It revoked the treatment order in 497 of these determinations (7.32%). In 2019 the MHLC appeared at 91 hearings in which treatment order determinations were made. The treatment order was revoked in 25 of these determinations (27.5%). In cases where a treatment order was made, we were able to have a shorter order than requested by the treating team in an additional 43 cases.

Consumers have very polarised views on ECT. While some consumers find it a positive treatment, many find the prospect of receiving it deeply distressing and are adamant they do not want it under any circumstances. The Mental Health Act 2014 recognises that ECT is a unique category of treatment and as such the criteria for an ECT order are more stringent than for treatment orders generally. The MHT can only make an order for ECT where a patient does not have capacity to give informed consent. Patients coming before the MHT on ECT applications are therefore in a position where it is very difficult to represent themselves. Legal representation for ECT applications is vitally important.

Although the MHLC only appeared at four hearings in relation to an ECT application in 2019, three of these applications (75%) were refused by the MHT. The MHT heard 680 ECT applications in 2018/19 and refused 98 (14.42%). Electroconvulsive treatment remains a

⁸ <https://www.legalaid.vic.gov.au/about-us/news/compulsory-treatment-ordered-for-shorter-periods-when-lawyers-involved-in-hearings>

treatment that consumers have very polarised views on. Some consumers see it as an effective treatment that they are happy to receive. Many others find the prospect of it deeply distressing and are adamant that they do not want it. The Mental Health Act 2014 recognises that ECT is in a different category of treatment.

This discussion demonstrates the importance of ensuring legal representation for people appearing before the MHT and the need for adequate resourcing to make sure that it is readily available.

Governance, responsibilities and consumer participation

Draft recommendation 22.3 – Enhancing consumer and carer participation

The experience and expertise of people with a lived experience of mental illness must be central to any consideration of reforms to our mental health system. The role of peak mental health consumer bodies must be recognised and their work must be adequately funded. In Victoria, the Victorian Mental Illness Awareness Council does important work in representing and supporting mental health consumers. While advocacy services such as Independent Mental Health Advocacy (IMHA) play an important role, they are not a substitute for consumer led organisations providing individual and systemic advocacy and peer support.

The MHLC strongly supports the Commission's recommendations in relation peak representative bodies.