FORMAL SUBMISSION TO THE ROYAL COMMISSION INTO VICTORIA'S MENTAL HEALTH SYSTEM

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INTRODUCTION

The Law Institute of Victoria ('LIV') welcomes the opportunity to provide a formal submission to the Royal Commission into Victoria's Mental Health System ('Commission'). The LIV considers that the Commission represents a unique and vital opportunity to ensure best practice, prevention, treatment and support for Victorians experiencing mental illness. In addition to the issues facing the broader population, the LIV hopes the Commission will also take the opportunity to consider the unique impacts the current mental health system has on Aboriginal and Torres Strait Islander people and children, especially those who may be experiencing intersecting forms of disadvantage or discrimination, on the basis of race, mental illness and/or disability.

The LIV, founded in 1859, is the peak membership body for the Victorian legal profession, representing more than 19,000 lawyers and people working in the law in Victoria, interstate and overseas. Its members are legal professionals from all practice areas, and work in the courts, academia, policy, state and federal government, community legal centres and private practice.

The LIV's membership includes expert lawyers who specialise in assisting people with mental illness and psychiatric disability to exercise their legal rights. Every day, our members experience the ways in which the shortcomings of Victoria's current mental health system contribute to disproportionate entanglement with its justice system. The LIV's submission draws from this vast pool of expertise, experience and relevant case studies from its expert membership base.

The initial part of this submission will discuss ancillary health and medical law, administrative law and human rights law issues. The primary focus of the LIV's submission will then be on addressing the ways mental health intersects with the criminal justice system. There is a clear correlation between untreated mental illness and a heightened risk of criminal offending. For people who do not have stable housing, the risk of offending is further exacerbated. Accommodation intersects across every issue discussed in this submission, and while it may not always be 'the answer', without stable and safe accommodation every juncture, intervention and step towards mental health treatment becomes infinitely more difficult, if not impossible. At present the Victorian public housing and mental health care systems are chronically under-resourced. For some people, the first time they have access to housing and mental health programs is when they enter the court system. But not everyone entering the criminal justice system can access the support they need due to similarly significant under-resourcing of the court system; particularly a lack of mental health services in prison and the limited availability of rehabilitative and diversionary programs. Once released from custody, individuals all too often return to homelessness or volatile living situations and discontinue their mental health treatment. These factors are the

most significant contributors to the fact that from 2014-2015, Victoria's reoffending rate (individuals that were returned to corrective services, including prison sentences and community orders) was 53.4 per cent.[1]

The reform of Victoria's mental health system should be approached by the Commission in a holistic, systems-wide manner. The Commission should acknowledge the intersectionality of a wide range of services that can contribute to improving mental health. These supports include services in housing and homelessness, drug and alcohol treatment, family violence, employment, disability and access to justice.

When these services are inadequate, the consequence all too often is an escalation in mental illness which has a number of negative consequences for the individual and society, such as the deterioration of relationships, unemployment, homelessness and criminal offending.

It is the LIV's hope that this Royal Commission will result in a fundamental review of the criminal justice, health and public housing systems in Victoria. The result being a reduced crime rate and an increase in stable, functioning, mentally well Victorians who are able to better contribute to their families and the community as a whole.

[1] Sentencing Council, *Released Prisoners Returning to Prison, 2014-2015* (Web Page) <https://www.sentencingcouncil.vic.gov.au/statistics/sentencing-statistics/released-prisoners-returning-to-prison>

RECOMMENDATIONS

Legislative Frameworks

1. The Commission should conduct its own review of the provisions and operation of the *Mental Health Act 2014* (Vic).

2. There should be legislative consistency between the *Mental Health Act 2014* (Vic), the *Medical Treatment Planning and Decisions Act 2016* (Vic) and the *Guardianship and Administration Act 2019* (Vic).

Human Rights

3. A comprehensive education strategy for Mental Health Tribunal members, users, and health practitioners that ensures greater understanding of, and improved compliance with, the relevant legislative regimes and human rights principles.

4. Framework reforms (either through new legislation or ensuring improved compliance with existing legislation) recommended by the Commission should be developed with human rights principles and 'least intrusive treatment' objectives in mind.

5. The Mental Health Complaints Commissioner should be given the capacity and resourcing to receive reports under a mandatory reporting scheme, and to prosecute breaches of the *Mental Health Act 2014* (Vic).

Culture, Education and Training

6. Access to training, such as mental health first aid courses and access to supports, including employee assistance programs, be rolled out to emergency services staff, publicly funded health service workers, and community legal workers.

7. The introduction of specialised mental health training to Victoria Police officers to ensure that police interactions with people with mental illness are safe, appropriate and respectful.

Mental Health Services

8. The Victorian Government vastly increase the quantum of funding for mental health services required in order to fulfil its promise of implementing the Commission's recommendations.

9. The Victorian Government negotiate improved funding partnership agreements with the Commonwealth Government for federally funded services.

10. Investment in intervention supports that reflects and addresses the proportionally larger cohort of individuals with sub-acute mental health needs.

11. Targeted investment in rural, regional and remote Victoria to increase the number, quality and accessibility of mental health services and treatment options in those areas.

12. Lowering the relatively high legislative threshold in s 351 of the *Mental Health Act 2014* (Vic), to allow appropriate treatment to be provided to a larger cohort of individuals suffering from mental illness.

13. Improved training and resourcing of mental health treatment facilities to deliver treatment for individuals with a dual diagnosis (particularly addiction), including National Disability and Insurance Scheme treatment providers.

14. Sufficient funding of emergency service mental health clinicians such as Crisis Assessment and Treatment teams to the extent that mental health clinicians are present at all mental health welfare checks, including those also attended by police.

15. The centralisation of Crisis Assessment and Treatment team dispatch and coordination, together with improved information sharing between geographically disperse Crisis Assessment and Treatment teams.

16. The introduction of women-only units and improved sexual-safety measures in mental health inpatient facilities.

17. Measures that incentivise health practitioners to offer bulk-billed mental health services, especially in Victoria's rural, regional and remote areas.

18. Measures that improve the accessibility, efficiency and interaction of Victorian-based mental health services with the National Disability Insurance Scheme.

Offending

19. More opportunities for diversion should be built into all stages of the criminal justice process, with a focus on addiction and therapeutic treatment that addresses underlying health factors that contribute to offending.

20. Creating a protocol between Victoria Police and the Department of Health and Human Services to prioritise keeping child offenders, particularly those who may have a mental illness, in caring environments and outside of youth detention centres.

21. Raising the age of criminal responsibility in Victoria from 10 to 14 years of age.

22. The creation of diversionary treatment programs for low level offenders with mental illness that allow individuals to avoid charges or have their sentence reduced by successful completion of a treatment program.

23. Resourcing to support the implementation of diversion programs, such as the Court Integrated Services Program, in all Magistrates' Courts in rural, regional and remote areas of Victoria.

24. The abolition of the offence of public intoxication in Victoria.

25. The *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) be amended to allow for a judge alone to determine fitness for trial, without the need to empanel a jury.

26. The Magistrates' Court be given similar powers to the higher courts to determine an individual's fitness to be tried.

27. The Assessment and Referral Court intake be expanded to include persons who intend to plead not guilty on the grounds of mental impairment.

28. Expanding the remit of the Drug Court, together with increased and timely access to drug and alcohol rehabilitation facilities, to divert offenders away from remand and into therapeutic treatment.

29. Further research into the prevalence and appropriate treatment of acquired brain injury and similar conditions within the criminal justice system.

Bail

30. The Commission review Victoria's current presumptive bail laws, with the aim of promoting therapeutic justice programs as the preferred response to accused persons suffering mental illness.

Remand

31. Resourcing to address the significant delays in accessing mental health assessments, diagnosis, medication and treatment for remandees.

32. Increasing the intervention opportunities for remandees to access therapeutic facilities and treatment programs whilst they are on remand, rather than being held without treatment within the general prison population.

33. For persons charged with terrorism offences as a result of radicalisation that stems from untreated mental illness, making holistic, de-radicalisation programs available while on bail or remand (which can often be a significant period of time, due to the nature of terrorism charges).

Courts

34. The Assessment and Referral Court and Drug Court be expanded to provide wraparound services to more offenders and over an increased geographic area, rather than intakes being catchment area based.

35. Increased resourcing to allow a formal mental health diagnosis to take place in time for an offender to be accepted onto the Assessment and Referral Court list.

36. Judicial education that facilitates recognition of lower level mental illnesses, such as borderline personality disorder, so that these illnesses are given appropriate weight during court proceedings and sentencing.

Sentencing

37. Investment to increase the number of Court Integrated Services Program placements that are available, in order to meet demand for this service.

38. Measures that improve the safety and standard of accommodation provided to individuals whilst they are subject to a Drug Treatment Order.

Prisons

39. Significant funding and resourcing investment in Forensicare to improve the availability of mental health treatment facilities in all Victorian prisons.

40. Victoria's prisons adopt more stringent policies regarding the cell allocation of prisoners who have been identified to have a serious mental illness, to prevent harm being caused to themselves or other inmates that may arise when they are held as part of the general prison population.

41. Culturally appropriate and safe mental health treatment for Aboriginal and Torres Strait Islander Victorians in prison, that recognises the protective value of culture, identity, kinship and community.

42. Ending routine strip searching in prisons through legislative provisions that mandate that strip searching be completed on a 'reasonable suspicion' basis only.

43. Reducing the use of solitary confinement in prisons to where it is strictly necessary only, especially in youth detention facilities.

Post-Prison Services

44. The resourcing and expansion of prison release programs that pair a prisoner with a case worker who is familiar with their particular needs and can liaise with the wide range of relevant services and stakeholders to ensure that holistic and comprehensive support is provided from the day of release.

45. That safe and appropriate transitional housing arrangements be made available for prisoners upon their release.

Accommodation

46. The creation of more public housing to remedy the multifaceted issues that arise from long-term homelessness and housing instability.

47. The development of holistic programs and commensurate funding and investment initiatives that work towards eliminating postcode injustice in accessing mental health services, and ancillary support services, in rural, regional and remote areas.

Employment

48. The introduction of a spent convictions scheme in Victoria.

Families

49. Exploring ways in which to reduce the disproportionate number of children being removed from their parents with disability and mental illness.

50. Improving the availability and funding of, and referrals to, mental health supports and services in a family law context.

1. Legislative Frameworks

1.1. The Mental Health Act 2014 (Vic) ('*MHA*') is the legislative foundation for mental health treatment and decision-making in Victoria. In 2019 the *MHA* in its current form will have been in operation for five years and is due for review. Whilst it is not currently clear to what extent the Commission's work will encompass a review of the *MHA*, the LIV submits that it is critical to the effectiveness of the Commission in delivering meaningful change that the Commission conduct its own evaluation of the effectiveness and operation of the *MHA*. Should the Commission not conduct its own review and evaluation of the *MHA*, the LIV is concerned that the Commission's inquiry and recommendations will be incomplete.

1.2. In analysing the *MHA*, the Commission will also need to explore the way in which the *MHA* interacts (whether successfully or otherwise) with other legislation, in particular *the Crimes Mental Impairment and Unfitness to be Tried Act 1997* (Vic) ('*CMIA*'), the *Medical Treatment Planning and Decisions Act 2016* (Vic) ('*MTPDA*'), the *Guardianship and Administration Act 2019* (Vic), the *Charter of Human Rights and Responsibilities Act 2006* (Vic) ('*Charter*') and the *Convention on the Rights of Persons with Disabilities* ('*CRPD*'), which are discussed in the first part of this submission.

Mental Health Act 2014 (Vic)

1.3. Being cognisant of the economic, social and cultural rights enshrined in the *CRPD*, the LIV supports legislative protections that both ensure funding for mental health services is commensurate with the burden of the disease, and that focus on developing least intrusive treatments that promote engagement as well as best therapeutic outcomes. Least intrusive treatment includes considerations such as the side effects of treatment, and the use of restrictive practices.

1.4. The LIV also supports strengthening the civil and political rights of people with mental illness, and encourages the Commission to recommend the introduction of mechanisms which facilitate enforcement of an individual's rights (either through new legislative provisions, or improving compliance with existing legislation), including:

(a) Reinstatement of some of the processes that previously existed under the Mental Health Act 1986 (Vic). In particular, providing those processes such as the revision of treatment plans,[2] and the capacity to make orders that a person be placed on a Community Treatment Order within a certain time,[3] that optimise accountability value from the Mental Health Tribunal ('MHT') process;

[2] Mental Health Act 1986 (Vic) s 35A.
[3] Ibid s 36(4).

(b) Introducing a capacity to appeal to the MHT if a clinician is not following the requirements of s 71 of the *MHA*. This would ensure that clinicians in fact implement an individual's entitlement to have their most preferred, least intrusive treatment, even if that individual is subject to compulsory treatment by virtue of an Inpatient Treatment Order or Community Treatment Order;

(c) Adoption of the non-discriminatory approach which exists in some other jurisdictions whereby individuals who are able to consent to general psychiatric treatment cannot be subject to other treatment without their consent;

(d) That a mandatory reporting body, such as the Mental Health Complaints Commission, be empowered and resourced to both receive reports where a client's advance statement (a statement of their clients' treatment preferences in the event they become involuntary mental health patients and are unable to effectively communicate their wishes) has not been followed, and to prosecute breaches of *MHA* provisions. In some jurisdictions (other than Victoria), advance directives are enforceable. LIV members have reported situations in Victoria where their client's advance statement has not been followed by treating practitioners. The LIV understands that a mandatory reporting and prosecution body was included in a draft version of the *MHA*, though was ultimately not adopted.

Medical Treatment Planning and Decisions Act (Vic)

1.5. There is inconsistency and unnecessary complexity in the interaction of the *MHA* with the *MTPDA*. The different legal tests and frameworks invoked by the two acts causes difficulty for medical and legal practitioners alike. It is all the more complicated for those suffering mental illness wanting to understand their rights.

1.6. Ordinarily, substitute medical treatment decision-making is covered by the *MTPDA*. However, for mental health patients that are subject to compulsory treatment orders, their substitute medical treatment decision-making framework is governed by the *MHA*.

1.7. Section 75 of the *MHA* provides a list of medical treatment decision makers that is inconsistent with the list provided in the *MTPDA*. The hierarchy of substitute decision makers provided by the *MHA* does not include spouse, partner, primary carer, adult child, parent or sibling (unless they have been appointed by the person or VCAT). These substitute decision makers are all provided for in the *MTPDA* and are arguably the relations that most people would ordinarily choose to make decisions on their behalf or assume have default substitute decision making authority as their 'next of kin' (as they would under the *MTPDA* and the person were not subject to the *MHA*). If a person has not already appointed a medical treatment decision maker, or does not have a guardian, then the

authorised psychiatrist can make decisions on their behalf. These decisions may not be the same as those that may have been made by a family member.

Case Study:

Sue (a pseudonym) has a brother, Roger (a pseudonym), who has a history of mental illness. Sue is his medical treatment decision maker, under the hierarchy set out in s 55(3)(iii) of the MTPDA. Roger has previously had electroconvulsive treatment (ECT). Roger became unwell and it was recommended that he have ECT. However, due to his illness, Roger was not capable of making the decision. Sue consents on Roger's behalf to having ECT, because she feels it is consistent with Roger's values and preferences. The matter goes to the Mental Health Tribunal, which is standard practice.

Later, Roger's condition deteriorates further, and he is made an involuntary patient under the MHA. Whilst Roger is in hospital and receiving treatment under the MHA, he develops pneumonia. Sue is not able to make a decision about treatment for Roger's pneumonia, because under the MHA, Sue is not a person who can make a decision about medical treatment. Under s 75 of the MHA, it is the authorised psychiatrist who can make a treatment decision about Roger's pneumonia. Sue is astounded that she can make decisions about mental health matters such as ECT when Roger is not able, but not other decision that affect Roger's health such as treating his pneumonia. The only option for Sue to be able to make a decision for Roger in this situation is the lengthy process of applying to VCAT to be appointed Roger's guardian.

1.8. This system is unnecessarily complex, places great responsibility on vulnerable individuals and is inconsistent from a policy perspective. The inconsistency in substitute decision makers between the two acts is illogical, and creates much unnecessary confusion among patients, and their families, as well as with medical practitioners as to who is authorised to make medical treatment decisions on behalf of another. This is an unnecessary layer of legal complexity that reduces the autonomy of people suffering from mental illness.

Aged Care

1.9. The LIV is also concerned that a similar lack of understanding amongst medical practitioners about the appropriate legislative regimes risks psychogeriatric facilities effectively operating as places of detention, without any lawful authority to do so. From LIV members' experience, few residents in these facilities are subject to the orders under the *MHA* that authorise their detention for the purposes of treatment.

1.10. These residents are officially classified as 'voluntary patients' by the facility, however, they are not free to come and go and are kept in locked wards. If these residents are not subject to an order under the *MHA*, but lack decision making capacity, then decisions about their treatment for mental illness

should be made by their medical treatment decision maker in accordance with the *MTPDA* (rather than by a practitioner who has 'assumed' authority to make medical treatment decisions for the resident). Members have however observed poor compliance with this requirement in practice.

1.11. It remains poorly understood by some medical practitioners that, as a result of recent legislative changes, medication is a medical treatment decision requiring the consent of a medical treatment decision maker in accordance with the *MTPDA*. Members have submitted that, in their experience, practitioners often prefer patients to be moved off compulsory treatment orders and transitioned to 'voluntary' patients, as this means the provisions of the *MHA* do not apply, without those practitioners understanding that this means that another legislative regime (the *MTPDA*) applies.

1.12. As a result, aged care facilities risk residents being treated for mental illness without appropriate legislative compliance. As such it risks inappropriate deprivation of liberty and/or poor health outcomes for patients.

1.13. The LIV recommends that a comprehensive education program be undertaken to ensure that health practitioners are aware of the different legislation regarding medical treatment and consent and their legal obligations under the relevant acts, to ensure legislative compliance and the protection of patients' rights.

2. Human Rights

2.1. The LIV submits that the Commission should give priority to prioritising human rights principles, conventions and treaties in determining a new framework for Victoria's mental health system. An increased focus on the human rights of individuals experiencing mental illness will facilitate and underpin a cultural and legislative shift towards a 'least intrusive treatment' model for mental illness, as well as mitigating stigma *(refer to Chapter 3: 'Stigma').*

2.2. The replacement of the *Mental Health Act 1986* (Vic) with the *MHA* was in part informed by the *CRPD* and the *Charter.* The LIV commends this step towards a human-rights based approach, however more reform is required, particularly in areas of compulsory treatment and involuntary detention regimes. The LIV recognises that practices of compulsory treatment have the potential to limit the human rights of individuals with mental illnesses, which results in a legislative and clinical preference for treatment over autonomy. It is important to recognise the ongoing tension between the fundamental human rights of an individual, especially the rights of equality, self-determination, freedom from non-consensual medical treatment and personal inviolability under the *CRPD* and the *Charter* and the need for the provision least intrusive medical care in the context of mental health treatment.[4]

2.3. The Commission should consider the compatibility of any proposed reforms with Victorian and international best practices. This would include the *Charter*, *CRPD* and the *UN Principles for the Protection of Persons with Mental Illness and for the improvement of Mental Health Care* ('*UN Principles*').[5] The LIV believes that these frameworks are important to consider when reforming the *MHA*. Treatment used for mental health illnesses demonstrate a real risk of undue encroachment on an individual's rights. For example, this may occur when there is a clinical assumption of lack of capacity of a patient. Additionally, the risk of limiting human rights is relevant in the practice of compulsory treatment such as ECT. These international and domestic frameworks mentioned above can provide guidance on how decisions regarding capacity should be made and further identify areas where balancing issues are complex and further mitigate risk.

2.4. Both the *Charter* and the *CRPD* assert that equal recognition before the law is a fundamental right. Equality before the law includes the universal right to legal capacity. This right should be upheld for persons with a disability on an equal basis. [6] As such, it is exceptionally important to remember that

[4] PBU [83]
[5] *UN Principles for the Protection of Persons with Mental Illness and for the improvement of Mental Health Care,* GAOR A/RES/46/119 (17 December 1991)
[6] Convention on the Rights of Persons with Disabilities, opened for signature 13 December 2006, 1577 UNTS 3 (entered into force 3 May 2008), Art 12.

the diagnosis of a mental impairment does not have any automatic bearing on the human right to the recognition of legal capacity and the person's right to exercise that capacity.[7]

2.5. The need for greater regard of the *Charter* by decision makers (both MHT and VCAT members in conducting hearings and making Orders under the MHA, and treating medical practitioners in administering compulsory treatment pursuant to those orders) is highlighted in the 2018 case *PBU & NJE v Mental Health Tribunal ('PBU'),*[8]*.* In that case, the Court found that mental health patients were being unlawfully provided ECT against their will, in breach of the *Charter*. It was held that VCAT erred in law by determining that the applicants were unable to give informed consent, and therefore applied the *MHA* incompatibly with the *Charter*. The provision of ECT without consent in the circumstances of these individuals represented a breach of the *Charter* and was therefore unlawful. This decision highlights the need for clearer guidance on how human rights principles should be centrally incorporated at all stages of decision making in order to better protect the rights of mental health patients.

2.6. The LIV notes the new guidelines for MHT users on ECT hearings and Orders released by the MHT in May 2019, in response to the landmark decision in *PBU*. Regarding the development of future guidelines, the LIV encourages the Commission to give thought as to how guidance is provided practically as well as legally. For example, when drafting new guidelines, clarifying the decision-making framework that decision makers should have regard to, in an effort to ensure that appropriate reference is had to human rights-based principles as well as clinical assessment guidelines. The Commission should consider how human rights principles can be incorporated into decision making criteria in any legislative and policy responses.

2.7. In any new mental health determinative system, decision makers and treating teams would benefit from guidance as to how to properly implement a human rights centric approach to providing treatment and making decisions about compulsory treatment. This should involve a comprehensive education strategy that includes treating medical professionals, and MHT and VCAT users and members, to ensure that they are compliant with relevant medical treatment and consent laws, the *UN Principles*, the *CRPD* and the *Charter*. This will improve accountability for decision makers at all levels. It will also strengthen the human rights protections afforded to some of our most vulnerable Victorians.

[7] Charters and Disability by Rosemary Kayess and Belinda Smith, Australia Charters of Rights a Decade on by Matthew Groves and Colin Campbell

[8] *PBU and NJE v Mental Health Tribunal* [2018] VSC 564.

3. Culture, Education and Training

Stigma

3.1. Mental illness remains surrounded by stigma within the community. It is widely reported that approximately three quarters of people living with mental illness have experienced stigma. Many consumers report that the stigma they experience is as distressing as the symptoms of their mental health condition. Discrimination, harassment and vilification are key drivers of poor mental health and can therefore further exacerbate an individual's mental illness.

3.2. Stigma has a number of negative impacts on those experiencing mental illness, for example when it results in discrimination that can impact an individual's career, or cause a reluctance to seek treatment. A 2012 study by the Mental Health Council of Australia found that doctors and practitioners in mental health were equally as likely to attach stigma to mental health patients as the general population.[9] Of those consumers who visited a health practitioner, 29 per cent felt that they had been avoided or shunned by the professional; 34 per cent had been told by the professional to lower their expectations for what they could achieve in their life while living with mental illness; and 44 per cent felt that the professional had behaved differently once mental illness was disclosed to them.[10]

3.3. From 2015 to 2018, mental health related issues comprised a significant proportion of both enquiries and complaints to the Victorian Equal Opportunity and Human Rights Commission.[11] Of those complainants, the most commonly reported area of discrimination was employment, including failure to make reasonable adjustments, or increased scrutiny of their work performance (*see also Chapter 14: Employment*).

3.4. Anecdotally, there appears to be less understanding and sympathy in circumstances where an individual has acquired a mental illness either from or triggered by drug use, despite the net result (living with a mental illness) being the same. There is a growing push in Australian social, legal and health policy to change the way addiction and treatment is viewed, from a criminal issue to a health issue. A 2018 Victorian Parliamentary Committee report recommended that drug addiction be reoriented towards a health-based framework, rather than a criminal justice one.[12] The focus would then be on providing support, treatment and rehabilitation, rather than taking a purely punitive approach through court and prison systems, which does little to treat the medical aspects of addiction. Transitioning the treatment of drug addiction in Australia from a punitive paradigm to an

[9] Mental Health Council of Australia, *Consumer and carer experiences of stigma from mental health and other health professionals* (2011) 2.
[10] Ibid 16.
[11] Victorian Equal Opportunity and Human Rights Commission correspondence to the Mental Health Royal Commission Establishment (18 January 2019) 2.
[12] Law Reform, Road and Community Safety Committee, Parliament of Victoria, *Inquiry Into Drug Law Reform* (March 2018).

addiction treatment paradigm, would go some way to reducing the negative impacts of stigma on mental health consumers. The Commission should consider ways in which corrective services are simultaneously matched with treatment services.

3.5. Reducing existing stigma surrounding mental illness, in both the wider community and in those professions who work with mentally ill patients, will require a change in cultural and social attitudes, underpinned by investment in research and education to improve the positive visibility and social perception of mental illness within our communities.

3.6. In working to reduce stigma, the Commission should consider recommendations in these areas, with a priority focus on occupations that interact most with persons experiencing mental illness. Considerable focus should be given to ways in which to promote and implement education, training and support resources such as mental health first aid courses, and employee assistance programs. This would serve the dual purpose of reducing stigma that individuals might feel about the mental health of others, and addresses stigma that individuals might feel in coming forward about their own mental health such as compassion fatigue, stress, burnout, and workforce attrition.

Frontline Services: Compassion Fatigue

3.7. Frontline service workers such as those in emergency services, health practitioners and lawyers, play a critical role in de-escalating mental health crisis situations and providing immediate care for people experiencing mental illness. As these workers are often the first point of contact for a person experiencing a mental health crisis, it is vital that they are both educated in understanding and responding to mental illness, and are supported by their workplaces to care for their own mental health and manage the risks of vicarious trauma. For example, the LIV has conducted several education offerings for its members on the risks and management of vicarious trauma (particularly for duty, criminal, family and dedicated mental health lawyers).

3.8. Professions and individuals with frontline exposure to mental illness are at a high risk of developing compassion fatigue: a gradual reduction in compassion over time as a result of prolonged exposure to stress in a care-giving context. Compassion fatigue contributes to exhaustion and burnout in those who continue to work in the area. This in turn can lead to a reduction in the quality of care provided and contribute to workforce attrition. Building resilience in the mental health of these workers should therefore be considered a priority in order to improve workforce retention, and outcomes for mental health consumers.

3.9. The LIV welcomes the recent announcement of a 12 month pilot program to cover the reasonable medical expenses of both current and former emergency workers and volunteers who are awaiting

compensation claims for work-related mental health injuries.[13] To the extent that any existing services are considered by the Commission to be inadequate, the Commission should recommend that access to training, such as mental health first aid course and access to supports, such as employee assistance programs, be rolled out to emergency services staff, publicly funded health service workers, and community legal workers.

Education and Training for Police

3.10. Where a person appears to be suffering from mental illness, Victoria Police are empowered to apprehend them if necessary, to prevent serious and imminent harm either to that person, or to others.[14] Ideally, when performing mental health welfare checks, police are accompanied by a mental health clinician. There have been various iterations and trials of this arrangement in Victoria since approximately 2011, such as the Police, Ambulance and Clinical Early Response (PACER) unit, and more recent partnerships with CAT (Crisis Assessment and Treatment) teams.

3.11. Currently, largely due to the lack of sufficient resourcing of CAT teams, mental health welfare checks are unfortunately often conducted by police officers without a mental health clinician being present (*see also 4.22-4.24*)

3.12. LIV members practising in police misconduct and excessive force claims report a notable correlation between police attending non-violent welfare checks without a clinician present and a tendency for such visits to escalate, often into violence. This is especially the case where police responses are not appropriate or proportionate, such as when multiple units of uniformed officers attend for one individual with no prior reports of violence. This can appear threatening to the individual and thus exacerbate the situation.

3.13. Members expressed the view that where police respond, this reinforces the notion that mentally ill people are sometimes treated with a presumption of being dangerous criminals, rather than people suffering from an illness. This characterisation is problematic and may have the effect of discouraging individuals from seeking help during a time of crisis.

Case Study:

3.14. *The Commission will undoubtedly be familiar with the 2018 case of John, a Victorian disability pensioner whose psychologist, worried about his mental health, requested police conduct a mental health welfare check. John's home was then attended by six uniformed police officers. Having been forcibly removed from inside his home by the attending officers, in the front yard of his home John was pinned to the ground, stomach down. He was struck with a baton by an officer. Another officer*

[13] Premier of Victoria, 'Improving mental health support for emergency workers' (Media Release, 12 June 2019) <https://www.premier.vic.gov.au/improving-mental-health-support-for-emergency-workers/>
[14] Ibid n 6, s 351.

pepper sprayed John in the face. A second officer sprayed John whilst he was sitting and immobile with his head down and hands cuffed behind his back. John had not committed an offence. The incident was referred to the Independent Broad-based Anti-Corruption Commission for investigation.

3.15. Though John's case was well reported in the media, members of the LIV who practice in police misconduct matters note that the mistreatment experienced by John is, unfortunately, not an uncommon outcome from mental health welfare checks being conducted by police without a mental health clinician present.

Case Study:

3.16. *Brendan (a pseudonym), a male in his 30s, suffered from serious mental illness and regularly had episodes of paranoia which may be described as mild psychosis. An interim Personal Safety Intervention Order (PSIO) had been taken out against Brendan by his neighbour, Nora (a pseudonym) who lived in his apartment block.*

One evening, Brendan experienced a severe episode involving paranoia and psychosis. He called 000 to request a welfare check, however due to his confused mental state, he could not articulate himself and was difficult to communicate with.

A police officer was recorded laughing and saying to Nora "I don't think he's done anything wrong but trust me I'd love to arrest him". The police then discussed amongst themselves ways in which Brendan could potentially breach the order. Brendan was left alone in his apartment while the police spoke to Nora.

The police arrested Brendan for breaching the PSIO after he knocked on Nora's door to get the police's attention, as he was afraid to be in his apartment alone. The police took Brendan to the police station where he was held in a cell for several hours. They interviewed him at 4am. Despite Brendan's reports of hallucinations, his inability to recall events from that evening and his fear of self-harm, the police charged him and released him without presenting him to a hospital for assessment. At Court, the prosecutor was deeply disturbed by how Brendan was treated and withdrew the charge.

3.17. The above case studies demonstrate a lack of education, training and compassion when dealing with people with mental illness, who are often criminalised instead of supported.

3.18. The Commission should recommend that police not be permitted to attend mental health welfare checks as first responders unless there are reports of violence, or a trained mental health professional is also present at the attendance. Any such recommendation would, however, need to be matched with appropriate resourcing of CAT teams to eliminate mental health welfare checks being attended by police without a clinician present due to a lack of resourcing.

3.19. The Commission should also recommend the introduction of specialised mental health training to Victoria Police officers, similar to the Victoria Police Family Violence Centre of Learning model.[15] Members in the program would be provided with specialist training to identify and understand mental illness and assess the risk of harm to the individual and others. They should be taught to treat individuals in mental health crisis with dignity and respect. Such a program should be sufficiently funded to ensure any shortfall in CAT team capacity to attend events involving mentally ill persons, can be filled with a mental health officer. The success of similar projects in other jurisdictions, such as the Mental Health Intervention Team in New South Wales,[16] or Crisis Intervention Training (CIT) in Miami-Dade, Florida in the United States, should be considered *(refer to 4.25: 'The Miami Model')*.

[15] Victorian Government, 'Family Violence Rolling Action Plan 2017-2020' (Web Page) <https://w.www.vic.gov.au/familyviolence/rolling-action-plan/safety-and-support/victim-centred-justice.html>
[16] Office of Police Integrity, *Policing People Who Appear to be Mentally Ill* (*November* 2012).

4. Mental Health Services

Funding

4.1. One of the key challenges for the Commission in considering its recommendations, and for the Victorian Government in the implementation stage, will be addressing a history of chronic underinvestment in mental health services. Notwithstanding a record investment in mental health announced in the 2018/19 Victorian Budget,[17] the Victorian Government has failed to invest an adequate quantum of funding that addresses the existing imbalance between demand and supply.[18]

4.2. Despite the standing commitment of the Victorian Government to implement all recommendations to be made by the Commission,[19] the LIV remains concerned that the implementation and efficacy of the Commission's recommendations will be curtailed unless matched by a proportionate investment of funding, resourcing and infrastructure across both mental health and ancillary services.

4.3. The LIV strongly echoes the observation made by the Federal Senate Select Committee on Mental Health:

> '*There is an urgent need for more mental health services. Whatever debates there are about what those services should be, there is consensus that at present there is simply not enough mental health care. … in no other sector of health care would it be regarded as acceptable that 60 per cent of people with needs received no service.'*[20]

4.4. The Commission should recommend that that the Victorian Government consider redirecting existing revenue sources and identifying new sources of revenue that will facilitate the necessary spending required to achieve meaningful system reform. To the extent that existing or recommended mental health service delivery is an area of responsibility shared with the Commonwealth Government, and relies on federal funding, this should be complemented by a recommendation that the Victorian Government explore improved funding partnership agreements with the Commonwealth Government.

[17] Premier of Victoria, 'Record Investment for Mental Health' (Media Release) (1 May 2018) <https://www.premier.vic.gov.au/record-investment-for-mental-health/>

[18] Victorian Auditor-General's Office, *Access to Mental Health Services* (Independent assurance report to Parliament 2018-19: 16, March 2019) 8.

[19] Premier of Victoria, 'Experts to Lead the Mental Health Royal Commission' (Media Release) *(*24 February 2019) <https://www.premier.vic.gov.au/experts-to-lead-the-mental-health-royal-commission/>

[20] Senate Select Committee on Mental Health, *A national approach to mental health - from crisis to community,* March 2006, 2.11

Existing Focus on Acute Illness

4.5. The current mental health framework focuses almost exclusively on the most seriously ill, despite the fact that 'lower level' mental illnesses like anxiety and depression affect almost 30 per cent of the general population.[21] Largely as a result of the overemphasis on acute care arising from the National Mental Health Strategy,[22] other conditions such as self-harming, post-natal depression and eating disorders become lost in the attention given to 'traditional' psychotic mental illnesses. This is despite the prediction that by 2030, depression will be the leading cause of disease burden globally.[23]

4.6. Anxiety disorders, for example, affect 12.6 per cent of the population yet it is difficult to access the necessary care until the individual is at a level of acute suffering.[24] For 'lower level' disorders, early intervention can be highly beneficial, resulting in an individual never experiencing acute symptoms and learning to long-term manage or overcome their illness. Conversely, if left untreated, these disorders can escalate and become more acute. Preventative and longer-term investment is therefore critical.

4.7. While the LIV of course recognises the need to prioritise acute mental illness, in an under-resourced mental health system this results in those with the most severe conditions being able to secure treatment, whilst the majority of Victorians living with the far more common but 'lower level' mental illnesses such as moderate anxiety disorders or depression receive no treatment.

4.8. The Commission should therefore recommend investment in intervention supports such as outpatient mood disorder clinics to address the relatively larger cohort with sub-acute mental health needs.

Personality Disorders

4.9. LIV members have found that it is hard to obtain support for people with complex illnesses such as borderline personality disorder. These clients often come to the attention of police through offences related to their illness, for example carrying weapons used for self-harm in public places, making repeated nuisance phone calls to emergency services, repeatedly breaching intervention orders or causing danger to the public through suicide or self-harm attempts such as walking in front of cars or trespassing onto train lines. The fact that it is challenging and difficult to treat should not preclude the criminal justice system from expanding its understanding of an illness that is most commonly rooted in early childhood trauma.

[21] Ibid, 1.23.
[22] Ibid, 2.28; and see, for example, Australian Health Ministers, National Mental Health Plan 1992, April 1992, Section 2.
[23] World Health Organisation, *Global burden of mental disorders and the need for a comprehensive, coordinated response from health and social sectors at the country level* (December 2011).
[24] Ibid n 21, 5.68.

4.10. Due to the nature of their illness, such clients are unlikely to get an admission to hospital or to be linked in with an area mental health service. In some cases, services have started treating these people but have developed compassion fatigue and do not want to continue treatment or have restricted treatment. LIV members have reported that clients suffering borderline personality disorders often commit offences after being turned away from services such as emergency departments or mental health treatment providers. This can be particularly frustrating for police and lawyers for whom it is apparent they need accommodation and ongoing care. Further, it is a significant drain on the resources of lawyers, courts and police *(refer to 4.13-4.18: 'Section 351 Mental Health Act 2014')*.

Case Study:

4.11. *Beth (a pseudonym) was a young woman who had been diagnosed with borderline personality disorder. She frequently presented to Sunshine Hospital seeking assistance but was often sent away because she was not deemed an acute risk to herself or others. She would then make thousands of nuisance phone calls to police, emergency services and the hospital to try to get attention. Police charged her with using a carriage service to harass. She ultimately spent time on remand for these offences, which was extremely distressing for her.*

4.12. The Commission should review creating clearer pathways for these individuals to receive the treatment they require, for example through recommending a broadening and increase of funding for the services offered by organisations such as Spectrum.[25] It is hoped that in doing so, this may keep these people out of the criminal justice system.

Section 351 Mental Health Act 2014

4.13. The focus of Victoria's health system on acute mental health needs is mirrored in the operation of the apprehension powers of police under s 351 of the *MHA* ('being sectioned'), which allows for apprehension to prevent harm only when an individual is deemed to be acutely unwell to the extent that they qualify for an inpatient Assessment Order (AO) within s 28 of the *MHA*.[26]

4.14. If they are found to be suitable for an AO then an individual can be taken to, and detained in, a designated mental health service such as a secure psychiatric ward in a public hospital and be examined by an authorised psychiatrist. If the individual either refuses to, or cannot give, informed consent to treatment while subject to an AO, treatment cannot be provided unless a registered medical practitioner employed by the treating service is satisfied that urgent compulsory treatment is

[25] Spectrum is a Victorian state-wide service that supports and works with local mental health services to provide treatment for people with personality disorder.
[26] Ibid n 6, s 28.

necessary to prevent serious deterioration in their mental or physical health, or serious harm to themselves or another person.[27]

4.15. The procedure of being sectioned requires the apprehending police officers to remain with the individual until they have been assessed by the medical practitioner, most commonly in a public hospital. Due to a lack of beds and resourcing in public hospital psychiatric wards generally, Victoria Police officers report they are often kept off the road with wait times of three to six hours for the individual to be assessed by a medical practitioner. As such, this compounds resourcing issues for police, in addition to the public hospital system.

4.16. Due to the lack of beds in these units, clinicians typically appropriately consider the relatively high threshold that must be met for an individual to be compulsorily detained for treatment, that being a 'serious' risk of either mental or physical health deterioration or harm to themselves or another person. As a result, these individuals are often promptly discharged either without treatment or without sufficient treatment. This however, typically in no way reflects their need for mental health treatment. These may be people who, for example, have self-harmed but only leave superficial wounds, or who are experiencing vivid hallucinations due to schizophrenia. LIV members have reported that, in conversations with Victoria Police officers, officers have noted that it is often the case that within hours of such individuals being discharged as not sufficiently 'serious', they need to be detained and sectioned for assessment once again.

Case Study:

4.17. *David (a pseudonym), is a 40-year-old long-term homeless male. He suffers a combination of mental health issues, compounded by drug addiction, which he has battled for most of his adult life. David has never received substantive treatment for these issues. He regularly self-harms, and being homeless, this typically happens in public places. On a semi-regular occasion, David is known to take a sharp object such as a broken glass bottle and superficially slash his arms. Members of the public notify ambulance to attend, who do so with police in attendance due to the risk involved with a person armed with a sharp object. David is then apprehended by police under section 351 of the MHA, to prevent him from serious and imminent harm. He is then transferred to hospital for examination of his suitability for an AO. Police officers, who know David on a first name basis due to his frequent transfers, have reported waiting at times up to six hours for David to be assessed.*

David typically refuses referrals and treatment. Due to the superficiality of David's injuries and the shortage of beds, his condition is commonly determined as not being sufficiently serious enough to apprehend under an inpatient AO. He is therefore promptly discharged from hospital, his physical

[27] Ibid n 6, ss 38(2) and (69).

injuries bandaged, yet his mental illness, being the primary cause of his physical injuries, entirely untreated.

Within hours, David returns to the same location and re-commences self-harming. Police and paramedics are then tied up once again apprehending David and transporting him to hospital. David once again refuses treatment. The cycle repeats.

4.18. The Commission should evaluate the focus of the *MHA* on acute illness thresholds, with a view to increase the accessibility of treatment for individuals, such as 'David', who are unable to meet the current requirements to obtain the mental health treatment they need.

Dual-Diagnosis

4.19. Those with dual-diagnosis, commonly arising where an individual is experiencing mental illness and substance abuse simultaneously, present another challenge for an under-resourced and siloed mental health system. Individuals with a dual diagnosis will often be on waiting lists for an array of specialist services, without being a priority for any. Alternatively, some mental health services may refuse to treat dual-diagnosed patients. In evidence to the Senate Select Committee on Mental Health, one psychiatrist observed:

> *"In a rural area, the local psychiatrist once refused my referral of an actively suicidal patient with major depression. She was drinking, and he didn't see drinkers…"*[28]

Dual diagnosis is one of the most prevalent mental health issues in the justice system, where individuals struggling with mental health and addiction are shuffled between services that are either unable or unwilling to treat both conditions. The Commission should make recommendations that support the availability of services that are appropriately trained and resourced to provide simultaneous treatment for dual-diagnosis.

Case Study:

4.20. *Nick (a pseudonym) was remanded for assaults and aggravated burglary whilst floridly psychotic. He had attacked a homeless person and broken into a public building. The lawyer representing him struggled to find details about who Nick was and his personal circumstances and noted:*

> *"with clients like this sometimes it appears like they have come out of black holes, it looks like they have no history when of course they have a whole life story."*

[28] Ibid n 21, 14.126, citing Dr A Gunn, Submission 52, p1.

The lawyer also indicated that very unwell clients like Nick sometimes actively work against lawyers attempting to ascertain their history.

Eventually, it was identified that he had previously been on a Community Treatment Order and had a long history of psychiatric treatment for schizophrenia in Victoria. Nick's form of schizophrenia had been identified as 'medication resistant'.

An evidentiary report was obtained which expressed that he could not reason with the wrongfulness of his conduct and therefore he potentially had a complete defence. However, ultimately a forensic decision was made to rely upon his psychiatric material in mitigation rather than as a defence.

Shortly prior to the plea hearing, Nick became seriously unwell and was being held in a secure psych unit. The plea was adjourned briefly to ensure he was sufficiently fit to plead.

At the plea hearing, it was proposed that a submission be made that he be sentenced to "time served" at which point he would be taken directly from remand to hospital by ambulance and sectioned under s 351 either by Forensicare or by the hospital. The judge and prosecution agreed with this submission and orders were made to this effect.

The bed which had been arranged at Sunshine hospital the previous day had become unavailable and thus the plan changed to take him to Royal Melbourne Hospital. After the plea hearing, the lawyer rang Royal Melbourne Hospital to confirm that all would go smoothly but that bed had also become unavailable and the plan changed again to take him to Box Hill hospital.

Nick had spent over 200 days in custody, for the most part in a secure psychiatric unit, for serious violent offending. Nick was transferred to hospital by ambulance as planned, held overnight and discharged the next morning. He has not been seen since. Nick is known to be violent and unwell and to the best of our knowledge is at large in the community without treatment, housing or support of any kind.

4.21. As discussed in greater detail below, (*refer to Chapter 12: 'Accommodation'),* it is of upmost importance that mentally ill people who do not meet the high threshold to receive treatment under s 351 of the *MHA* are not discharged into homelessness. There needs to be sufficient safe and appropriate public housing made available which intersects with facilitating ongoing mental health treatment.

CAT Teams

4.22. Many mental health services throughout the state of Victoria often operate in geographic isolation, with little resourcing for information sharing, which creates significant barriers for people moving between different 'catchment' areas. This geographic zoning is an area of frequent frustration for mental health consumers, and those treating or supporting them.

4.23. For example, LIV members report particular difficulty with this issue when attempting to contact the CAT team for urgent support for someone experiencing a mental health crisis. The various CAT teams operate in specified catchment areas and often those seeking their services find they are referred back and forth between services trying to obtain assistance. (*see also 3.11).*

4.24. The LIV recommends that the straightforward solution of a central CAT Team dispatch agency be recommended by the Commission. This would place the onus on the expert CAT Team operator, rather than the caller, to ensure that the correct assistance is located and provided.

The Miami Model

4.25. The LIV recommends the Commission consider the implementation of measures similar to those adopted in the Criminal Mental Health Project (CMHP), founded in Miami-Dade County, Florida in 2000, which is being heralded in the U.S. as a 'national model for decriminalising mental illness.'[29] As of 2016, the CMHP has resulted in a 44 per cent decrease in the County's prison population, achieved by diverting people with mental illnesses away from the criminal justice system and into community-based mental health services.[30] This decrease was so sharp that a detention centre was closed, saving the County USD$12 million a year.

4.26. People with serious mental illness who commit minor or less serious non-violent offences are transferred through a Crisis Intervention Team (CIT), to an involuntary treatment unit for up to 72 hours. The CIT are police officers who have undergone a specialist training program to identify and appropriately respond to mental illness. As the treatment units are properly resourced and specifically designed for this purpose, CIT units do not have protracted wait times at the facility.

4.27. Once the individual's condition stabilises, providing they meet the criteria, they are given the option to consent to continuing in a mental health program. On average, 80 per cent of participants agree to continue in the program.[31] Those who refuse have their criminal matters treated as normal. The project runs diversion programs, requiring adherence to ongoing treatment. If the individual completes the program, often criminal charges are avoided, or sentences reduced, further incentivising compliance. The program requires adherence to strict rules, similar to those of a Drug Treatment Order (DTO) such as staying on psychiatric medications, attending support groups and submitting to drug tests. Compliance is monitored by the court, who have the authority to dismiss the charges if the individual completes the program. The recidivism rate of those who stay on the

[29] John K. Inglehart, Decriminalizing Mental Illness — the Miami Model, *The New England Journal of Medicine*, Vol 374, no.18, 5 May 2016, 1701
[30] Ibid 1702.
[31] Ibid.

program is around 20 per cent, whilst those who decline the program reoffend at a rate of 75 per cent.[32]

4.28. In 2021, the program will expand to include a treatment centre specifically catering to the chronically homeless with severe mental illness, whose conditions have resulted in frequent rotations through the prison and the health care systems.

Sexual Safety in Mental Health Inpatient Units

4.29. In both 2017 and earlier this year, the LIV wrote to the Hon. Martin Foley MP, Minister for Mental Health, to advocate for improved sexual safety in mental health inpatient units and express its support for the recommendations made in the 2018 report of the Mental Health Complaints Commissioner: *The Right to be Safe - Ensuring Sexual Safety in Mental Health Inpatient Unit*s: *Sexual Safety Project Report*, particularly the introduction of women-only units.

4.30. The LIV is of the view that this could be achieved relatively practically by utilising separate wards that already exist in many Victorian mental health units, with the aim of moving towards single-gender services. An alternative option may be to introduce more flexibility for out-of-area admissions, so that particular services could focus on women-only access. In a city the size of Melbourne, a possible option would be to allow for someone from Footscray, for example, to be admitted to a service in Dandenong which better met their needs; provided that consideration of the person's needs includes consideration of the ability of their family or support persons being able to continue to visit them in a new location. An arrangement facilitating voluntary out-of-area admission could provide access to women-only services without significant investment in new infrastructure.

4.31. Further progress on this issue would be consistent with the rights under international instruments to which Australia is a signatory,[33] as well as the following sections of the *Charter*:

(a) effective protection against discrimination.[34]

Requiring women and girls to receive inpatient psychiatric treatment where they are at risk of, or worried about, sexual assault may constitute an unreasonable discriminatory requirement or condition. The LIV submits that the exacerbation of impact of histories of sexual assault by such environments could fall into the same category; and

[32] Ibid.
[33] That is, UN General Assembly, Article 12, *Convention on the Elimination of all Forms of Discrimination Against Women* 18 December 1979, United Nations, Treaty Series, vol.1249.
[34] Ibid n 6, s 8(3).

(b) humane treatment of persons deprived of liberty.[35]

Around half of inpatients in inpatient units are compulsory patients and are, therefore, deprived of liberty. Exposure to these issues might well be categorised as inhumane.

4.32. In response to the LIV's correspondence, the Minister for Mental Health has advised of a number of recent developments towards improving sexual safety for mental health patients: an audit partnership between the Victorian Health and Human Services Building Authority, Mental Health Branch and DHHS to identify improvements to existing built environments; mandatory reporting of suspected sexual activity, harassment or assault occurring in mental health inpatient units to the Chief Psychiatrist; and the creation of women's only inpatient units at Werribee Mercy and Eastern Health. The LIV welcomes these developments.

4.33. The LIV submits that the Royal Commission make recommendations that further build on work currently underway to improve sexual safety in mental health inpatient units, in particular prioritising the implementation of women-only wards.

Mental Health and Medicare

4.34. The introduction of general practitioner mental health treatment plans has allowed people with mental illness to access services that they would not otherwise be able to afford, which is a positive step towards expanding the reach of mental health treatment throughout the community. LIV members report that they refer a number of clients to this scheme. However, the number of subsidised visits is capped, which makes long-term treatment difficult. Further, it can be difficult for clients to find practitioners who are willing to bulk-bill and for those that do there can be significant waitlist delays to secure an appointment.

4.35. The LIV suggests that the Commission consider making recommendations that incentivise practitioners, particularly in rural and regional areas, to offer bulk-billed mental health services in order to expand and improve access to the mental health treatment plan scheme. The LIV also recommends the introduction of a separate specialisation for addiction, and longer sessions for dual-diagnosis consultations, which are not currently available.

Mental Health and the NDIS

4.36. The LIV welcomes the inclusion of psychosocial disability stream into the National Disability Insurance Scheme ('NDIS'), as it recognises and facilitates addressing the detrimental impact mental illness has on a person's life. However, some members have raised concerns about delays their NDIS clients are experiencing in having their applications processed, which in turn is leading to longer

[35] Ibid n 6, s 22.

treatment admissions. The LIV understands that treatment is not provided where addiction is also present, despite members reporting that this issue is commonplace. Further, there are concerns regarding the funding model for mental health service providers under the NDIS. Presently, contracts for these services are largely limited to 12 months. This short-term approach puts a constant cloud of uncertainty over the future of these vital services.

4.37. The LIV recommends the Commission explore ways in which the Commonwealth NDIS rollout can be best integrated with Victorian mental health services, to support funding certainty, increased efficiency and accessibility, and the ability to treat dual diagnosis clients.

5. Offending

5.1. Mental illness is a significant contributory factor to criminal offending. Nationwide, almost half (49 per cent) of all prisoners have at some time in their life been advised by a medical professional that they have a mental illness.[36]

5.2. The highest rate of incarceration in Victoria is of offenders aged in their 20s and 30s.[37] Of this prisoner population, one-third (32 per cent) have been diagnosed with a psychiatric illness within a 10-year period of their arrest.[38] It is not uncommon for the first contact these prisoners have with mental health services to occur after they have been arrested. It is therefore a crucial period in an individual's life for meaningful mental health intervention. Given that mental health and addiction are so often contributory factors to offending, intervention is also the greatest opportunity to prevent reoffending. Successful intervention requires properly resourced support services to address mental health and addiction issues, including treatment in terms of medications, in addition to therapeutic and psychosocial supports. For example, evidence indicates that adherence to antipsychotic medication reduces criminal recidivism amongst persons diagnosed with schizophrenia.[39]

Keeping Children Out of the Criminal Justice System

5.3. For children that live at home, misbehaviour that is often regarded as a youthful act of defiance, such as verbal threats, marijuana possession or minor property damage, is usually dealt with internally within the family, most commonly by the child's parents or guardian. However, for children who reside in out of home care, such behaviour is instead often referred to police in the first instance. It is unsurprising that children who reside in Department of Health and Human Services (DHHS) care arrangements are especially vulnerable to coming into contact with the criminal justice system from an early age.[40] This is even more likely to be the case if the child has a mental illness.

5.4. Research by the Sentencing Advisory Council found that with each one-year increase in a child's age at the time of their first sentence, there is an 18 per cent reduction in the likelihood of

[36] This statistic is inclusive of drug and alcohol misuse; Australian Institute of Health and Welfare, *The health of Australia's prisoners 2015,* 37; the Youth Parole Board recorded in the 2017-18 period 53 per cent of detainees had presented with mental illness - Department of Justice and Regulation (VIC), *Youth Parole Board Annual Report*, 2018, 15; The Victorian Ombudsman identified this figure to be 40 per cent in the Victorian prison population which was non-inclusive of drug and alcohol misuse Victorian Ombudsman, Investigation into the Rehabilitation and Reintegration of Prisoners in Victoria, September 2015, 6

[37] 20-39 year olds make up 63 per cent of the Victorian prison population as of 2018 - Corrections Victoria, Annual Prisoner Statistical Profile 2006-07 to 2017-18.

[38] V.A. Morgan et al, *A whole-of-population study of the prevalence and patterns of criminal offending in people with schizophrenia and other mental illness*, Psychological Medicine Vol 43, 2013

[39] Stefanie Rezansoff et al, *Adherence to Antipsychotic Medication and Criminal Recidivism in a Canadian Provincial Offender Population*, *Schizophrenia Bulletin,* Vol. 43, 5, 2017, 1002-1010

[40] Victoria Legal Aid, *Care Not Custody - A new approach to keep kids in residential care out of the criminal justice system* (2016).

reoffending.[41] To this end, the Commission should recommend the development of a protocol between DHHS, police and other relevant stakeholders, that aims to minimise the interaction of young people with the criminal justice system and keep them in a care environment for longer.

Raising the Age

5.5. In Victoria, the age at which a child is deemed capable of committing an offence is 10 years old.[42] In 2017-18, 1,033 young people aged 10 or older were under youth justice supervision.[43] From 2016 to 2017, 35 children incarcerated in Victorian prisons were aged between 10 and 13.[44]

5.6. The negative impacts of incarceration on the mental health of prisoners is well established. The effect on children is equally, if not more significant, with youth imprisonment being associated with higher risks of depression and suicide.[45] Of the number of imprisoned children diagnosed with depression, one third had not experienced the onset of depression until they were imprisoned.[46]

5.7. To this end the LIV submits that the Commission should recommend raising the age of criminal responsibility to 14 years of age, to divert children out of the criminal justice system, and keep them connected to the family and community support structures that underpin their mental health.

Mental Health and Intervention Orders

5.8. People with mental illness are prone to having intervention orders taken out against them by people unable or unwilling to tolerate their behaviour. This can particularly be the case where the person also experiences a substance use issue. LIV members have reported it is common to have clients whose family members (such as their siblings, or parents) have taken intervention orders out against them as they were unable to cope with the problematic behaviour caused by that person's mental illness. When these orders are breached for low level offending, police are called, and charges filed. The person with the mental illness is then facing the prospect of a criminal record being created, which may impact on their employment and future wellbeing. This can cause distress to their family who in fact only applied for the order as a means of trying to get help for the unwell person. This raises two issues that need addressing, the first being a clearer understanding of legal processes, to ensure that these orders are only being taken out by applicants with the full understanding of the ramifications if the defendant breaches them. The second issue being that applicants are aware of and consider options that are outside of the criminal justice system, and so pursue an Intervention

[41] Sentencing Advisory Council, Reoffending by Children and Young People in Victoria, 2016
[42] *Children, Youth and Families Act 2005* (Vic), s 344.
[43] Australian Institute of Health and Welfare 2019. Youth justice in Victoria 2017–18. Cat. no. JUV 129. Canberra: AIHW.
[44] Based on Australian Institute of Health and Welfare figures, 2018. Youth Justice in Australia 2016–17. Cat. no. JUV 116. Canberra: AIHW, tables s74b, s140b and s1b.
[45] Commonwealth Royal Commission into the Protection and Detention of Children in the Northern Territory, *Final Report* (2017).
[46] Barry Holman and Jason Ziedenberg, *The Dangers of Detention: The Impact of Incarcerating Youth in Detention and Other Secure Facilities* (28 November 2006) Justice Policy Institute.

Order only where it is truly appropriate. This requires a mental health system that is properly resourced, so that people do not have to seek the assistance of the Court in caring for their loved ones.

Case Study:

5.9. *Adam (a pseudonym) is a 19 year old man who had been diagnosed with a psychotic illness. He had become paranoid and verbally aggressive towards his parents and damaged some of the property in the family home. In desperation, his parents took out an intervention order against him which prevented him from perpetrating family violence against them. A week later, Adam got into an argument with his father and threatened to kill him. He then smashed the television and left the house. Adam was charged with breaching the intervention order. By the time the matter reached court, Adam had been linked in with an area mental health service, and his condition had stabilised from being appropriately medicated. His parents did not want the matter to proceed and were horrified that their son might end up with a criminal record because of their actions in taking out an intervention order.*

Diversion

5.10. The LIV strongly advocates for an increased focus on early intervention that creates additional diversion options and makes diversion available at all stages of the criminal legal process. The LIV's view is that diversions should not necessarily be a 'one-time' offering, especially for young or mentally ill people who are more at risk of having a number of interactions with the criminal justice system throughout their life.

5.11. Victoria presently has a number of early intervention and diversion programs. One such program is known as a 'drug caution'. When an individual is caught in possession of a small amount of drugs, instead of going to court they can be given a diversion response such as a cannabis caution. This requires the person to attend a short course and upon completion, they avoid being charged.

5.12. LIV members have proposed that a similar diversion exist, whereby if a minor offence is committed by a person suffering mental illness, they can be diverted away from the criminal justice system by undertaking to complete mental health treatment. If the person provides evidence to police that they have completed the treatment, they can avoid being charged. This keeps these individuals out of the court system entirely and provides a means for early mental health intervention *(refer to 4.25: 'The Miami Model')*.

Diversion and Postcode Injustice

5.13. Reports from LIV members, supported by research, indicate that where a person lives has a direct impact on the accessibility of mental health and supporting services. This is particularly felt in rural, regional and remote ('RRR') communities, where the availability of both general mental health

services and therapeutic justice pathways (such as court diversion programs) is limited. This postcode injustice can result in the escalation of both mental illness, and associated conduct such as offending, as well as inhibiting recovery.

5.14. In 2011, a report by Deakin University Australia highlighted the extent to which justice outcomes were affected by the identifiable lack of services for mental health, youth, disability, Indigenous, family, domestic violence, supervised accommodation and counselling in RRR communities.[47] This inequality of access continues to exist for Victorians living in RRR communities today.

5.15. LIV members have reported that when representing clients in RRR communities, diversions and other forms of therapeutic justice can be harder to access. Obtaining a placement in a Court Integrated Services Program ('CISP') for example is not offered through all courts in RRR communities.

5.16. The Mental Health Advice and Response Services (formerly the Mental Health Court Liaison Service), provided by Forensicare, provides clinical mental health advice to the Magistrates' Courts on individuals appearing before the court who may be experiencing mental illness. This vital program aims to intervene in the criminal justice process to provide advice and referrals to treatment providers, as well as supporting the courts to understand mental health issues.

5.17. The Deakin University report concluded:

> *"Given the demonstrated inadequacy of mental health services in regional Australia and the relationship between mental illness and criminal offences, either as a victim or offender, the limited regional roll-out of the Victorian government's Mental Health Court Liaison Service Program, now established for the last 16 years, is disappointing. Much greater resources are required in regional areas to rectify this issue."*[48]

5.18. At the time, the service operated in seven metropolitan courts. As of 2019, the service has only been expanded to one additional location, to now operate in eight of the 10 metropolitan courts. It does not currently operate in any of the 41 RRR Magistrates' Courts.

5.19. The LIV recommends that the Commission review ways in which all Magistrates' Courts can be resourced to provide the same opportunities for accessing therapeutic justice as metropolitan courts. These programs have been shown to work and should therefore be rolled out across the state.

Acquired Brain Injury

5.20. Another complexity in forensic mental health is the prevalence of cognitive impairments such as acquired brain injury (ABI). The prevalence of such disorders within the criminal justice system is

[47] Deakin University, *Postcode Justice: Rural and Regional Disadvantage in the Administration of the Law in Victoria* (2011).
[48] Ibid, 80.

difficult to ascertain, in part due to a lack of self-identification and the difficulty in differentiating it from other mental illnesses or behaviours. Once identified, there are considerable issues in how to manage such a condition, given a cognitive impairment is permanent and often difficult to treat with medication or therapy.

5.21. In Victoria in 2010, five per cent (approximately 500) of the 10,032 total referrals to CISP were for 'ABI issues', with 'mental health' also making up another five per cent of referrals.[49] A 2009 review of the Victorian Magistrates' Court CISP program found that:

> *'The rate of suspected Acquired Brain Injury (ABI) in program clients is much higher than allowed for in the demand modelling for CISP. This points to a high rate of ABI in justice client populations generally and indicates that a comprehensive strategy to address this issue is required.'*[50]

5.22. Given the commensurate prevalence of these disorders within criminal justice populations, and a lack of services or defined strategies to meet those needs, the Commission should recommend the completion of further research into, and formation of strategies to address, the justice needs of persons with ABI and similar cognitive impairments.

Public Intoxication

5.23. Presently in Victoria, a person can be charged for public intoxication.[51] These laws have a disproportionate impact on people with mental health and addiction issues, particularly people of Aboriginal and Torres Strait Islander background.[52]

5.24. The LIV wishes to state its strong support for the abolition of the offence of public drunkenness, which is consistent with the recommendations of numerous inquiries.[53] Victoria and Queensland remain the only Australian jurisdictions that have failed to implement this recommendation.

5.25. In addition, the LIV proposes that recommendations 80 and 81 of the Royal Commission into Aboriginal Deaths in Custody be implemented. These are:

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[49] Court Integrated Services Program, *Tackling the Causes of Crime, Executive Summary Evaluation Report* (June 2010)
[50] Stuart Ross, Melbourne University - Melbourne Consulting & Custom Programs, Evaluation of the Court Integrated Services Program – Final Report (December 2009) 19.
[51] *Summary Offences Act 1966* (Vic) s 13-16.
[52] ABS *Prisoners in Australia (2018)* (Table 14, 18).
[53] See, for example: the *Royal Commission into Aboriginal Deaths in Custody* (1991); Drugs and Crime Prevention Committee, Parliament of Victoria, *Inquiry into Public Drunkenness* (2000). This has also been foreshadowed by Coroner Kate English in the current coronial inquest into the death in custody of Aboriginal woman Tanya Day: see, for example, Calla Wahlquist 'Death in custody prompts push to change Victoria's public drunkenness laws', *The Guardian Australia,* (6 December 2018).

(80) That the abolition of the offence of drunkenness should be accompanied by adequately funded programs to establish and maintain non-custodial facilities for the care and treatment of intoxicated persons; and

(81) That legislation decriminalising drunkenness should place a statutory duty upon police to consider and utilise alternatives to the detention of intoxicated persons in police cells. Alternatives should include the options of taking the intoxicated person home or to a facility established for the care of intoxicated persons.

5.26. The LIV commends the Victorian Government for providing seven Koori Community Alcohol and Drug Resource Centres, such as the Sober Up Shelter in St Kilda. This is the type of service that appropriately meets recommendation 81. Such a service needs to be expanded across the state and be made available to all persons picked up for public intoxication. These services provide non-custodial facilities to ensure intoxicated persons receive care and treatment during their state of intoxication. Once sober, they provide an opportunity to assess and refer the individual to appropriate mental health and rehabilitation services.

Crimes (Mental Impairment and Unfitness to be Tried) Act 1997 (Vic)

5.27. The LIV submits that the Commission make recommendations aimed at improving the compatibility of the *CMIA* with the with the *CRPD* and other human rights principles. This should include:

(a) Revival and review of the Crimes (Mental Impairment and Unfitness to be Tried) Amendment Bill 2016 (Vic);

(b) Allowing for the imposition of terms that limit an order made under the *CMIA*, which currently exist in other jurisdictions such as the Australian Capital Territory; and

(c) Introducing measures that encourage the consistent application of s 39 of the *CMIA*. That being the Court must apply the principle that restrictions on a person's freedom and personal autonomy should be kept to the minimum, consistent with the safety of the community, particularly in the case of applications to the Forensic Leave Panel.

Ability for Unfitness to be Determined by Judge Alone

5.28. In the event the defence, prosecution and the trial judge all reach agreement that on the evidence, the defendant satisfies the defence of mental impairment, the *CMIA* allows for the trial judge to direct a verdict of not guilty be recorded on the grounds of mental impairment.[54] However, this is only available if the ruling of mental impairment relates to the evidence of the accused's mental state at *the time of offending*.

[54] *Crimes (Mental Impairment and Unfitness to be Tried Act) 1997* (Vic), s 21(4).

5.29. LIV members have reported difficulties in circumstances where there is insufficient evidence as to the defendant's mental state at the time they committed the offence, however since the offence was committed, yet prior to the trial commencing, the defendant's mental state has deteriorated to an extent they are not fit for trial. These difficulties arise due to the presumption at law that a person is fit to stand trial,[55] which is a question of fact to be determined on the balance of probabilities, by a jury empanelled for that purpose.[56]

5.30. In these circumstances, a defendant may be unable to understand why they are in a courtroom. Nevertheless, as a result of having to overcome the legal presumption that they are fit to stand trial, the defendant is put before the spectacle of jury selection. When that jury is empanelled, it will then hear from the prosecution, defence and expert witnesses who, in such circumstances, will all state to the jury that the defendant is mentally unfit for trial. This process wastes precious courtroom resources, and the stress of the procedure can serve to exacerbate the defendant's mental condition which results in further delays to the defendant's treatment and potential for rehabilitation. Additionally, this prolongs the process for the victim and the families of both the victim and the defendant.

Case Study:

5.31. *Joshua (a pseudonym), who had significant issues with mental illness, murdered his partner. Whilst there was insufficient evidence of his mental state at the time, by the time the matter came to court it was clear to both the prosecution and defence that Joshua was unfit to be tried on the grounds of mental impairment.*

Such was Joshua's mental state that the deceased partner's family were supporting him through the court process. Despite complete agreement between the prosecution, defence, the experts and the court that, based on extensive medical material, Joshua was unfit at the time of the hearing and had open a defence of mental impairment; the matter still had to go before a jury.

The victim's family found the drawn-out court proceedings a further traumatising experience. Two juries were empanelled, a number of hearings were held, interpreters were required, and the family members sat through it. Joshua also sat through these proceedings, without the mental awareness to understand why he was even there. He was eventually found unfit for trial after this drawn out process.

5.32. The LIV therefore recommends that a section 7(4) be introduced to mirror section 21(4) of the *CMIA*, whereby in situations where both the prosecution and defence are in agreement as to the unfitness

[55] Ibid s 7(1).
[56] Ibid ss 7(3)(a)-(b).

of a defendant to stand trial due to mental impairment, this can be determined by the trial judge alone, without the unnecessary empanelment of a jury.

Case Study:

5.33. *Gerard (a pseudonym), is a 78-year-old man with no prior convictions, who suffers from dementia. He had been receiving respite care at the time of the offending. Whilst sitting at a bus stop, Gerard touched a 17-year-old girl on the thigh and asked if she was cold. The police apprehended him, however due to his dementia he was deemed not fit for interview*

However, Gerard was still charged with sexual assault. Given Gerard's limitations, there was a lot of debate as to whether the prosecution would proceed with the matter. Following this, Gerard was placed in a home which provided 24-hour care and did not permit him to go outside unaccompanied. The prosecution persisted and refused to withdraw the charges. Ultimately, Gerard received a bond from the Magistrates' Court.

5.34. There are a number of issues demonstrated by this case study that should be addressed. The Magistrates' Court of Victoria (Magistrates' Court) has inadequate powers to deal with fitness to be tried and mental impairment. The LIV supports the *CMIA* being amended to equip the Magistrates' Court with similar powers to those of the higher courts regarding matters of determining fitness to be tried and mental impairment; including the proposed amendment discussed in 5.37. In matters such as this one, for conduct that only resulted in a bond, it was not worth those in Gerard's family's situation going through the costly and protracted ordeal of pursuing the issues of fitness and mental impairment in the County Court. This was despite having strong grounds for such an argument on account of his dementia.

5.35. Further, the Magistrates' Court should be able to impose both custodial and non-custodial supervision orders. In this matter, the prosecution held the belief that Gerard was a risk to the community. A better outcome would have been if the Magistrates' Court had the power to impose a supervisory order, without having the finding of guilt.

5.36. Although there is the Assessment and Referral Court (ARC) within the Magistrates' Court, which offers an intensive approach for people with a mental or intellectual disability, the ARC does not typically deal with sexual offending. The ARC is also restricted to dealing with people who plead guilty. Therefore, those wanting to plead not guilty for reasons of mental impairment are not able to access the ARC. The LIV believes it would be appropriate for the ARC to be extended to include persons who plead not guilty on the grounds of mental impairment. Especially given pleas are not made until the end, the individual, regardless of the finding of the court, would still be able to obtain the benefit of the months of intensive work on the underlying factors that contribute to their offending. This would work in a similar way to how the CISP currently works.

5.37. The fact that Gerard's case was prosecuted reflects a general lack of awareness and understanding of the impact of dementia. The recommendation relating to judicial and legal profession education on sub-acute conditions should include dementia and Alzheimer's where the cognitive impairment symptoms extend beyond simply memory loss and include disinhibited behaviour which can result in criminal offending.

6. Bail

6.1. Recent changes to Victoria's bail laws have expanded the number of offences for which there is a presumption against the granting of bail.[57] This has resulted in individuals being held on remand for minor breaches of bail conditions, such as curfews, contacting prohibited persons, failing to report for bail, shop theft, marijuana possession or missing court hearings.

6.2. The presumption against bail has resulted in a 22 per cent increase in unsentenced prisoners since 30 June 2017.[58] Australia's percentage of unsentenced individuals being held on remand is currently higher than in the United Kingdom, United States and New Zealand. LIV members have reported subsequent court delays with the consequence being their clients being held on remanded for minor offending for weeks and sometimes months. These remand periods are often longer than any sentence the person would have received for the offences for which they were charged. In fact, 40 per cent of those held on remand have either been found not guilty or were sentenced to a period equal to or less than the period of time they served on remand.[59]

6.3. Remand has a significant impact on people struggling with mental illness. Remand removes normalcy and stability from an individual's life. Factors that assist in mitigating mental illness such as employment, education, family and support services, are needlessly interrupted for offences that do not warrant incarceration. Whilst the prison system has some support services for mental illness, the record increase in unsentenced incarcerated persons means these services are at capacity, limiting access to assessments, programs and treatments.

Case Study:

6.4. *Dominic (a pseudonym) was diagnosed with schizophrenia at the age of 12, and also has heart issues and weight problems. Dominic has been hospitalised twice in the last two months. His lawyer has obtained reports that outline that he was unfit.*

Dominic has recently been charged with a number of offences. Most recently, the alleged sexual assault of a teen on a tram, and an allegation that, upon mental health workers attending at his residence, he produced a knife. Dominic denies it was a knife and states it was his vape. Dominic's lawyer attended his weekend out of hours bail justice hearing. The lawyer was not permitted to speak, despite having advised their view that Dominic was unfit to be interviewed. Dominic was refused bail, and was bailed at the next available court day.

[57] Paul Coghlan, *Bail review: first advice to the Victorian government*, State Government of Victoria, 2017; Paul Coghlan, *Bail review: second advice to the Victorian government*, State Government of Victoria, 2017
[58] Australian Bureau of Statistics, *Unsentenced prisoners and sentenced prisoners*, 4517.0 - Prisoners in Australia, 2018
[59] Matthew Ericson & Tony Vinson, *Young People on Remand in Victoria: Balancing Individual and Community Interests,* Jesuit Social Services (2010) 20.

The conditions of Dominic's bail include that he not travel on public transport. Due to the allegation Dominic produced a knife during his last mental health attendance, mental health workers will no longer attend Dominic's house to pick him up and transport him to get his depot injection. Due to Dominic's obesity and heart issues, he is not capable of walking to his treating nurse to get his medication. Dominic relies on his mother leaving her employment during work hours to transport him to and from his appointments. His mother is at risk of losing her job due to the amount of time she needs to take off to care for Dominic. Dominic is isolated and unable to access supports to leave the house or engage in social activities.

Dominic's lawyer applied to vary his bail to allow him to travel to and from appointments or activities, but this was denied. The matter has been adjourned for three months. Dominic does not fall within the ARC catchment area and so cannot be placed in that program. He is now likely to have to go to the County Court on a fitness issue. The delay will see him on bail for some time. Until the issue in relation to the most recent case has resolved it's unlikely anyone from his area mental health service will assist with transportation. Dominic's lawyer will continue to attempt to vary his bail, but it remains opposed.

6.5. The LIV recommends the Commission review the current bail laws and promote therapeutic justice programs as the preferred response to accused persons suffering mental illness.

6.6. The other issue preventing people getting bail is a lack of accommodation. LIV members have reported the difficulty their clients face when trying to obtain bail. It is reportedly quite difficult for a person without fixed accommodation to be granted bail, comply with their bail conditions or to perform responsibilities such as reporting for bail or attending court hearings. This again raises the issue of a lack of housing resulting in persons being needlessly held in prison (*refer to Chapter 13: 'Accommodation').*

7. On Remand

7.1. The changes to bail laws in Victoria have consequently increased the number of accused persons being held on remand. As of 2018, 42 per cent of women being held in prison were on remand.[60] In addition to the LIV advocating for changes to the bail laws to ensure those on remand are only held when it is appropriate to do so, the LIV also recommends that remand be utilised as an opportunity for early intervention. Currently, when a person is on remand there are limited opportunities to access early intervention programs to address the underlying issues that have resulted in that person's offending. This is a missed opportunity.

7.2. Due to a lack of Forensic Mental Health Unit beds for individuals on remand, people suffering mental illness are held within the broader prison population. Therapeutic facilities are specially designed to assist in reducing substance abuse, mental illness and other behavioural problems that are linked to offending and should therefore be readily accessible for appropriate remandees.

7.3. In addition to a lack of secure therapeutic facilities, the LIV is further concerned with the lack of resources to address significant delays and lack of access to risk and mental health assessments, diagnosis and appropriate medication and medical treatment of remandees. As stated, a considerable number of offenders initially learn of their mental health diagnosis after coming into contact with the criminal justice system. Appropriately diagnosing and equipping individuals with the tools to manage their diagnosis could significantly reduce the risk of reoffending.

7.4. As the number of remandees continues to grow to record numbers, the burden on these key areas is further exacerbated. The LIV wishes to reiterate the importance of diversions. Instead of remanding mentally ill people they should be receiving treatment through CISP, ARC, and Drug Court, or the proposal in 5.12 and *The Miami Model* within this submission.

Case Study:

7.5. *Jill (a pseudonym), who has no prior convictions, was refused bail until a psychological report was made available to the Magistrate. There was only one psychologist available that was prepared to undertake a Victorian Legal Aid funded evidentiary report of a person in custody. The earliest date for assessment was eight weeks away. Given her lack criminal history, Jill may not ultimately receive a jail sentence. However, she will be held in custody for eight weeks.*

De-radicalisation Programs

7.6. LIV members have reported that there appears to be a correlation between their clients who have been charged with terrorism offences and the prevalence of mental illness and drug abuse issues,

[60] Corrections Victoria, *Prisoner Profile,* 2018

often compounded by social isolation. Research indicates that drug use, mental illnesses such as depression, anxiety, various psychoses, developmental disorders such as autism and social isolation, can all be contributory risk factors for radicalisation.[61]

7.7. Often terrorism cases are protracted and can take years. However, persons detained for terrorism offences do not have access to programs related to their offending, such as de-radicalisation programs, until after they are convicted and sentenced. In such cases, it is often much easier to identify that an individual has been radicalised, than it is to secure a conviction for a terrorism offence. As such, in the event these individuals are found not guilty, they will be released back into the community without having received any form of de-radicalisation treatment. Due to the nature of their charges these individuals are often remanded away from other prisoners. The social isolation can further deteriorate their mental health prior to release, making them a danger to themselves and the community *(refer to Chapter 10: 'Prisons')*.

7.8. The Commission should recommend that for individuals remanded on terrorism charges, they should receive holistic de-radicalisation treatment as soon as practicable, which also addresses any underlying mental illness and/or drug abuse issues.

Case Study:

7.9. *Khaled (a pseudonym), was detained for doing acts in preparation for, or planning, a terrorist act. His lawyer maintained that Khaled was psychiatrically unwell and that treatment should be prioritised. He was instead held in maximum security and frequently isolated in solitary confinement. The deterioration of his mental health was apparent. Khaled was then acquitted after a long period on remand and released without treatment or support. A few months later he committed an egregious family violence related crime. It is believed his mental state was a contributing factor. Had he received some form of mental health treatment prior to his release, it is far more likely this tragedy could have been averted.*

[61] Bhui Kamaldeep, 'Radicalisation and Mental Health' (2018) 72(1) *Nordic Journal of Psychiatry*,16-19.

8. Courts

Mental Health Assessments

8.1. At all stages of a defendant's interaction with the criminal justice system, access to a mental health assessment is all too frequently problematic due to a lack of allocated resources. Legal aid funding is limited and it can be difficult to find experts willing to do reports for meagre fees. This becomes particularly relevant once a matter commences in court. In the absence of a mental health assessment, fitness to be tried and mental health factors to be considered during sentencing, are not able to be properly explored. Mental health assessments have a significant role in court proceedings and need to be made more readily accessible for individuals before their trial commences, in order to ensure just and appropriate outcomes.

Family Court

8.2. In addition to the evident interaction between mental illness and the criminal justice system, LIV members have reported experiences of the effects of mental illness in family law matters. Mental illness can often result in relationship breakdowns, and, in turn, people with mental illness may find it difficult to participate in negotiation and reach an agreed outcome. For judges working with such litigants, who are often self-represented, it can be very difficult, with the process being slow, fraught, and stressful. The focus is often on resolving the issues of contention within a family law context, with no focus given to making appropriate referrals for the parents or guardians mental health issues which are often at the core of the initial relationship breakdown.

Case Study:

8.3. *Sonya (a pseudonym), suffers mental illness and was involved in a family law matter. The other party was seeking orders against Sonya on behalf of themselves and their child. During proceedings Sonya threatened suicide if the court orders were made unfavourably against her. It was discussed whether a case guardian was appropriate and discussion of whether Sonya was making vexatious threats. There were additional concerns common in such proceedings, as to how the rights of the other parties were compromised and how such threats open the ruling to appeals.*

8.4. The Commission should review ways in which the referral processes can be improved within the family law context. Similarly to early intervention within the criminal justice system, this too should be seen as a prime opportunity for mental health intervention. Appropriate referrals to treat mental illness can be tailored to the desired outcomes of the parties in family law matters.

Specialised Courts: A Holistic Approach

8.5. One of the greatest challenges to providing effective treatment for people with mental health issues in the criminal justice system is the complexity of issues facing these individuals. Seldom are mentally

ill offenders dealing with an isolated issue. Rather, they typically have complex and intersecting issues, most notably addiction and homelessness. These individuals typically lack the motivation, money and/or organisational capacity to navigate the mental health system and get the support they need. Many have burned their bridges with friends, family and service providers. They require a holistic approach to treatment which motivates them and assists them to attend available services, also known as a 'wraparound' model of care. Unless these issues are addressed holistically, there is little prospect for these individuals to break the cycle of offending and incarceration.

8.6. The LIV believes that investment in services which go towards addressing these complex issues is vital. Such services include evidence-based and Medicare-funded rehabilitation services, public housing, mental health treatment and case managers to support the client attending these services.

8.7. As discussed above, these wraparound model services can be provided through the specialist court programs such as the Assessment and Referral Court (ARC) and Drug Court. Although, it is noted that these courts are not available to all people entering the criminal justice system, particularly those outside of Greater Melbourne *(refer to 5.13: 'Diversion and Postcode Injustice')*.

8.8. Participants in these programs have a plan developed for them which provides practical steps to address their needs and which reflects the individual's challenges and limitations. This may include providing housing, drug and alcohol treatment and mental health treatment. These specialised courts have been proven to be effective interventions to assist people to improve their mental health and refrain from reoffending.[62]

8.9. LIV members have reported that in their experience these specialised courts have resulted in better outcomes for their clients and in turn reduced the rate of reoffending. However, as these courts are catchment based, the LIV recommends they be expanded so that they are available to all people in Victoria charged with criminal offences and meeting the eligibility requirements.

8.10. LIV members have raised concerns that the criteria for the ARC are applied overly restrictively, resulting in a number of their clients with long histories of mental health, addiction and homelessness issues struggling to be accepted onto the list. One of the significant issues is that those who come into contact with the criminal justice system do not have a formal diagnosis of mental illness from a clinician, as they have been untreated for most of their lives. Often there are insufficient resources to have a formal diagnosis take place in time to be accepted onto the ARC list.

[62] Jason Payne 'Specialty courts: current issues and future prospects' *Trends & issues in crime and criminal justice* (317) Australian Institute of Criminology.

8.11. The Commission should look into ways in which remandees who are believed to have an undiagnosed mental illness can be assessed as soon as practicable, to better inform the courts of any potential mental illness and to allow access to specialist court programs such as the ARC list.

8.12. The LIV also supports the expansion of the Drug Court to include less serious offending that is not likely to receive an extensive term of imprisonment (for example, low level shoplifting committed during a period of drug use). This would increase the opportunities for early intervention for drug users before their behaviour deteriorates and the seriousness of their offending increases.

9. Sentencing

9.1. In the context of sentencing, the LIV wishes to restate its strong support for the current therapeutic justice programs such as the CISP, the Drug Court, the ARC, bail referral programs and the Neighbourhood Justice Centre.

9.2. However, members report that there is a need for a wider range of programs to cover the breadth of issues facing their clients. In addition, the availability of programs currently in place is insufficient to meet the demand. Members have reported the lack of resources has on occasion resulted in appropriate candidates for therapeutic programs being excluded, for no other reason than there was no availability.

9.3. Often bail is dependent on the availability of a CISP placement. Sometimes there is a significant waiting period for these programs, particularly in the suburban courts. Failure to find a program which has capacity for the defendant results in appropriate therapeutic justice candidates being remanded instead. If a CISP placement is unavailable sometimes lawyers will take on the role of case worker, trying to put therapeutic programs such as counselling, accommodation and drug treatment in place. This is a significant drain on the resources of lawyers who already experience heavy workloads.

9.4. Similar issues arise for those wanting to use the ARC, which is not available in high volume courts such as Sunshine, Werribee or Dandenong or in rural, regional and remote courts *(refer to 5.13-5.19: 'Diversion and Postcode Injustice').*

Case Study:

9.5. Nathan (a pseudonym), is a mildly intellectually disabled male in his mid-40s. He had lived with his mother who had managed and coordinated his mental health care and provided him with housing. He had a limited criminal history but had recently taken up drug use which resulted in serious aggression towards his mother. When Nathan was charged with criminal offences and remanded in custody, his mother was no longer willing and able to have him live with her, particularly as she was a victim of some of his offending. Without accommodation and a person to organise and coordinate support for Nathan, he had no prospect of being released on bail.

However, a CISP worker engaged with Nathan and through the CISP program, they organised housing and coordinated mental health services, drug treatment and other medical services. Without someone to connect Nathan to these services and coordinate his involvement with them, he had no prospect of being released on bail and therefore no likelihood of commencing the process to stabilise and rehabilitate himself. The service provided by CISP was therefore crucial to Nathan's ability to be released on bail and, therefore, his recovery.

Drug Treatment Orders

9.6. As outlined above, the LIV strongly supports the Drug Court and the use of Drug Treatment Orders (DTO), which both research and LIV members indicate are an invaluable opportunity for diversion, treatment and rehabilitation. However, there are serious concerns as to the appropriateness of some of the accommodation provided throughout the DTO program. It is promising that Magistrates within the Drug Court commonly state to defendants that, providing they adhere to their DTO conditions, they will not be homeless. However, our members report that the accommodation their clients are given on a DTO can often increase the risk of drug use.

9.7. Often the first accommodation provided on a DTO is in a temporary lodgement such as the Coburg Motor Inn or the Palms Motel in Footscray. Clients have reported to LIV members that due to the common knowledge that drug users are housed in these locations with no supervision, they are often targeted by drug dealers. It has been reported by clients that drug dealers are known to go door to door at these locations offering to sell the occupants drugs. LIV members report that if their clients manage to get through the initial phase of the DTO in this accommodation, the next stage of accommodation is a shared lodgement. In these properties, it is widely reported that drug use is commonplace amongst the occupants.

9.8. The LIV understands initial accommodation for a person on a DTO is only temporary. However, the LIV recommends that the safety and security of these lodgings be improved. The use of security, similar to that presently used in public housing commission flats would be an example of such an improvement. Alternatively, government owned and controlled housing be used, providing stability and avoiding individuals having to move throughout their DTO.

10. Prisons

10.1. The prison population has a disproportionate number of people with mental illness, however the only place that compulsory treatment can be provided is in the Thomas Embling Hospital. Being a single facility, there are only a finite number of beds that are available and thus there is a significant waiting period. Often people with acute mental health issues, particularly people experiencing psychosis, are deemed inappropriate for bail or are unfit to be tried or resolve their matter. Due to the wait times at Thomas Embling Hospital, they are therefore held on remand in ordinary prison environments for long periods awaiting treatment. As a result, people with mental illness are held in custody, untreated, for longer periods than necessary due to their mental illness.

10.2. Through casework, LIV members have reported that often these individuals with severe mental illness, despite posing a threat to themselves and others, are nevertheless allocated to mainstream cells with other inmates. Unfortunately, this has created circumstances where the mentally ill prisoner has seriously harmed a cellmate. This has occurred despite there being single cells available in those prisons, as well as specific units for prisoners with mental illness.

Case Study:

10.3. *Jim (a pseudonym) arrived at the Melbourne Assessment Prison ('MAP'), where Forensicare staff conducted a mental health intake, which identified Jim as having a "P1" psychiatric rating, being a "serious psychiatric condition requiring intensive or immediate care." MAP staff also observed Jim as exhibiting signs and symptoms of mental instability and acute disturbance. Staff noted that Jim presented with indicators of psychosis, irritability, grandiose beliefs and paranoia. He was assessed as requiring hourly observation.*

After his mental health intake assessment, and the above behaviour having been observed by MAP staff, Jim was allocated into a mainstream cell with Duncan (a pseudonym) and one other inmate.

When previously in remand at the MAP in late 2013, Jim had been diagnosed with acute psychotic symptoms, including thought disorder persecutory delusions. Despite Jim's prior history and presentation and assessment in this instance, he was placed in a shared cell with other inmates in a mainstream unit of the prison.

The morning after he had been allocated to the shared cell, Jim pressed the duress intercom in the cell and requested to see a nurse. He was not provided with any medical attention. Shortly thereafter, Jim attacked Duncan with a butter knife while Duncan was sleeping, causing injuries to Duncan's face, head and arm. Duncan was taken to hospital where he was kept for several days and required multiple stitches. Duncan suffered ongoing nerve damage, scarring and PTSD.

It is unclear why Jim was not allocated to a cell in a unit with psychiatric care facilities, or at the very least a single-person cell, despite his psychiatric condition having been identified as "serious" and requiring "intensive" care.

10.4. In addition to the requirement of additional mental health unit beds within prisons, the LIV recommends that Victoria's prisons adopt more stringent policies regarding the cell allocation of prisoners who have been identified to have serious mental illness, such that they pose a risk to themselves, are seriously vulnerable, or pose a threat to others.

Case Study:

10.5. *Paul (a pseudonym), the client of a LIV member, was found not guilty due to mental impairment. Nine months after this finding, he still remains in a general prison because he is deemed to be too mentally unwell to be released into the community and there are no beds available at Thomas Embling Hospital. Other LIV members have advised that Paul is not the only person in this situation. As of 20 June 2019, there are no available beds and will not be in the immediate future.*

Paul's lawyer received the following correspondence from Forensicare in December 2018 explaining the situation:

> *'In determining whether a bed will be available, we have taken into account the fact that there are 7 other male prisoners remanded in prison under the CMIA, awaiting admission to the Thomas Embling Hospital through the making of a CSO (forensic patient) by the court. These matters have been adjourned until a bed becomes available. We anticipate the beds will be allocated according to the order in which the person was recommended for a CSO (subject to clinical need).*
>
> *'In addition, we currently have 27 male prisoners waiting for a bed who are certified under the Mental Health Act 2014 (security patients) as requiring compulsory treatment at Thomas Embling Hospital. We currently have 18 beds available for the entire male prison population and these beds are currently full. Although prisoners are able to access voluntary treatment for mental illness within the prison system, they can only receive compulsory treatment at Thomas Embling Hospital. This remains true, even if the prisoner is placed in a Forensic Mental Health Unit within the prison system.'*

10.6. Such waiting times for individuals who have been clinically diagnosed as having serious mental illness requiring placement in a secure psychiatric unit is deeply troubling. Anecdotally, our members advise that the shortage of beds at Thomas Embling Hospital and the consequent delays in remandees and sentenced prisoners accessing appropriate services has been occurring for a period of years. The current facility is chronically under-resourced. A single acute psychiatric hospital is clearly insufficient for a state that is growing in excess of 100,000 people per annum. This is particularly so in light of the ever-increasing number of remanded and sentenced prisoners.

Case Study:

10.7. *Dan (a pseudonym), was an indigenous man who came to Melbourne from Western Australia and had no family or friends in the area. Whilst experiencing a psychotic episode, he entered an apartment and was found sleeping on a couch by one of the residents. He was arrested and found unfit to be interviewed. He was charged with burglary, but the police conceded that they could not prove that he had intended to steal anything. He was remanded in custody. His lawyer saw him at MAP and was unable to obtain instructions due to Dan's apparent delusional state. The lawyer spoke to his family in WA who advised that he suffered from schizophrenia.*

Dan refused treatment and was held in MAP for three months, without bail, waiting to be transferred to the Thomas Embling Hospital. He was not a candidate for bail as he had no accommodation and no Area Mental Health Service would accept him as he did not have a fixed address in the community and did not fit within their catchment. Once he eventually arrived at Thomas Embling Hospital, he was treated with antipsychotic medication and his condition promptly stabilised. He pleaded guilty to one charge of trespass and was sentenced to two weeks imprisonment. He had served seven months on remand.

Sub-Acute Mental Illness in Prison

10.8. As with the issues discussed from '*4.9: Personality Disorders',* people with mental health issues that do not fall into an Axis 1 diagnosis of a clinical syndrome, or those whose issues do have an Axis 1 diagnosis but whose symptoms are sub-acute, have very limited access to psychologists and psychiatrists in prison. Only the most acutely unwell people are likely to receive such services. LIV members report that they have many clients with sub-acute mental illness who request appointments to speak with the prison's psychiatric nurse, and must wait several weeks for an appointment to become available.

10.9. These individuals' mental illness, whilst not acute, can still be a leading contributory factor to their offending. In not taking this as an opportunity to treat them, these risk factors persist, and serve as fertile grounds for reoffending. The LIV recommends additional resourcing be provided for mental health and medical treatment for remandees and sentenced prisoners to facilitate timely access to assistance, to prevent their condition deteriorating in custody.

Indigenous Prisoners

10.10. There is a disproportionate number of Indigenous people in the prison population. Mental health care tailored to their specific cultural needs should be prioritised. This is particularly important given the vulnerability of Indigenous people in custody, as highlighted during the Royal Commission into Aboriginal Deaths in Custody.

10.11. There are existing frameworks that provide for the cultural rights of Indigenous people, such as s 19(2) of the *Charter* and the Victorian Government's *Balit Murrup: Aboriginal social and emotional wellbeing framework 2017–2027.* However, despite these existing safeguards, cultural rights are not being sufficiently considered in the treatment and care of Indigenous people.

10.12. The LIV recommends that recognition of the cultural rights of Aboriginals and Torres Strait Islanders be reflected to a greater extent in Victoria's mental health frameworks. The Commission should consider the role of culture, spirituality, kinship, and community as protective factors for Aboriginal and Torres Strait Islander prisoners, and must ensure that culturally appropriate and competent care is provided within the mental health and criminal justice systems.

Strip searches

10.13. The continued use of frequent strip searching of women in Victoria's prisons is a practice that unnecessarily negatively impacts the mental health of prisoners. Clients have reported to LIV members they find the experience to be humiliating, dehumanising and, particularly for survivors of physical and sexual violence, re-traumatising.[63] This latter category of women account for between 57 per cent and 90 per cent of all female prisoners.[64] Survivors describe strip searches cause them feelings of humiliation, violation, powerlessness, fear, and of having been abused, similar to that they experienced as a result of sexual violence and abuse.[65]

10.14. For their 2017 report, the Human Rights Law Centre interviewed female prisoners about the impacts of frequent strip searches on their mental health.[66] Similarly, those women described feeling stressed, anxious, humiliated and upset as a result of strip searches. They further revealed experiencing long-term mental health impacts and consequential physical health issues, which in some cases extended many years post-release.[67]

10.15. Over a six-month period in 2015, over 6,200 strip searches were performed on women in Victoria's prisons. These 6,200 strip searches resulted in only six instances of contraband material being located: four tobacco or nicotine products, chewing gum and one unidentified object.[68] Routine strip searches are clearly an ineffective security practice, that unnecessarily traumatises and re-traumatises prisoners. The use of routine strip searching is arguably not reasonable or proportionate, and violates the rights of individuals to privacy, humate treatment in detention, and freedom from cruel, degrading or humiliating treatment. These rights are protected by the *Charter.*

[63] See also Human Rights Law Centre, *Total control: Ending the routine strip searching of Women in Victoria's prisons,* December 2017, 2.
[64] Ibid, 6.
[65] Ibid n 52, citing Anna Bogdanic, Strip-Searching of Women in Queensland Prisons (Report, 2007).
[66] Ibid
[67] Ibid n 52, 13.
[68] Ibid n 52, 2.

10.16. The LIV notes that the Australian Capital Territory introduced legislation in 2008 to permit strip searches only on the basis of reasonable suspicion,[69] rather than on a routine basis. The new provisions also clearly articulate the circumstances in which a strip search can take place. People in prison should only be strip searched as a last resort, in circumstances where there is reasonable intelligence which indicates that they are carrying dangerous contraband. If it is determined that a strip search is required, it should only be undertaken after all other less intrusive search alternatives have been exhausted such as pat down searches and the use of safe-scanning technologies like scanners and wands. The reasons for undertaking the strip search, and the basis of the reasonable intelligence, must be documented, to ensure transparency and accountability.

10.17. The LIV submits that the ACT model is an example of best practice in Australia, which the Commission should have regard to when considering making recommendations in this area.

Solitary Confinement

10.18. The LIV has concerns about the punitive use of solitary confinement in prisons and its impact on the mental health of inmates, particularly in the youth justice system.

10.19. Aboriginal and Torres Strait Islander children interviewed by the Koori Youth Council as part of the *Ngaga-dji* project[70] reported incidents where they had been isolated in "the slot". Children reported being left in the slot for hours and days and being fed through a hole in the door. Being held in the slot was described as being the worst experience of their life.[71] A Victorian Children's Commissioner's report found that the unacceptable incidence of lockdowns had a detrimental effect on both young people in detention and staff, noting:

> '*Efforts must be made to mitigate the harmful effects of isolation, particularly for highly vulnerable young people. As a matter of priority, this includes ensuring compliance with policies directed at minimising the acute risks associated with isolation of Koori children and young people, a review into processes and responsibilities for young people who are at risk of self-harm, and expressly prohibiting the use of isolation within separation plans for young people who are at risk of being, or have been, attacked in custody. Specialised needs and vulnerabilities should be addressed through clinical support and appropriate accommodation arrangements, rather than by segregation and confinement.*'[72]

10.20. The Commission should recommend the introduction of laws similar to those introduced in the Northern Territory, following the Royal Commission into the Detention and Protection of Children in the Northern Territory, which prohibit solitary confinement and strictly regulate the separation of

[69] *Corrections Management Act 2007* (ACT), ss 113A-113C.
[70] Koori Youth Council, *Ngaga-dji (hear me): young voices creating change for justice* (2018), 33.
[71] Victorian Ombudsman, 'Ombudsman to investigate the use of 'solitary confinement' and young people' (Media Release) (6 December 2018)
[72] Commission for Children and Young People, *The Same Four Walls: Inquiry into the Use of Isolation, Separation and Lockdowns in the Victorian Youth Justice System,* (March 2017) 17.

children from other people detained in prisons. In particular, the Government should enact provisions such as s 155A and 155B of the *Youth Justice Act 2018* (NT).

10.21. Section 155A provides that a child must not be separated from others unless they request it, the child is suffering from an infectious disease or if separation is reasonably necessary for the child's protection or the protection of another person or property. Authorisation under the latter section can only be given in specific circumstances. That being, if an emergency situation exists and all reasonable behavioural or therapeutic measures to resolve the situation have been attempted and failed, and that no other course of action is reasonably practicable. Section 155B sets out the obligations placed on members of staff at detention centres to ensure that children are treated appropriately whilst separated.

11. Post-Prison Services

11.1. Upon release from prison, a significant number of offenders are released into homelessness. As of 2015, for example, the Victorian Ombudsman found 40 per cent of female prisoners were released into homelessness.[73] As discussed below *(refer to Chapter 12: 'Accommodation')*, a deficiency of secure and appropriate accommodation is a significant risk factor for reoffending. In addition, prisoners who have at some point been diagnosed with a mental illness have an increased likelihood of experiencing substance abuse issues, reoffending and poorer health outcomes in the six months post-release from prison.[74]

11.2. Evidence indicates that the availability of transitional support for prisoners in Victoria is four times more likely to reduce reoffending within the first two years post-release from prison.[75] However, despite these positive outcomes and the clear correlation of accommodation and reducing offending, only 1.7 per cent of those released from prison are granted access to public housing.[76]

11.3. The transition of people with mental illness from prison to the community can be especially problematic. Whilst individuals may receive treatment in prison, there is little oversight to ensure that referrals made for the prisoner to continue treatment upon release into the community are followed up. This is primarily so when the prisoner is not released on a Community Based Order, which often has supervision and treatment as a condition of the Order.

11.4. The LIV therefore recommends that the supported transition of ex-prisoners back into the community is given considerable attention, with a holistic approach in mind, by the Commission. Preparing a prisoner for release should commence well in advance of their release date, to allow the best chance of making appropriate housing, employment and health arrangements, along with minimising the risk that prisoners are released into temporary or emergency structures. Transitional support services should be streamlined for the individual as much as possible. Many LIV members have reported that many former prisoners find their return to the community an overwhelming experience.

11.5. To this end, the LIV recommends the resourcing and expansion of prison release programs that pair a prisoner with a case worker who is familiar with their particular needs and can liaise with the wide range of relevant services and stakeholders to ensure that holistic and comprehensive support is provided from the day of release.

[73] Victorian Ombudsman, *Investigation into the Rehabilitation and Reintegration of Prisoners in Victoria* (September 2015) 5.
[74] Z Cutcher et al, 'Poor health and social outcomes for ex-prisoners with a history of mental disorder: a longitudinal study' (2014) (38), *Australia and New Zealand Journal of Public Health,* 424–9.
[75] Ibid n 67, 7.
[76] Ibid.

Parole

11.6. Securing parole is also family difficult for those without secure housing. Many people with mental illness face economic and familial issues, meaning affording their own place or staying with loved ones are not viable options. In refusing parole due to a lack of accommodation, these people remain as prisoners costing taxpayers on average $391.18 per prisoner per day or $142,780 per prisoner annually.[77] This is in contrast to ex-prisoners living in public housing, with a case manager ensuring they are receiving appropriate mental health and rehabilitation. In such circumstances, they would be expected to pay subsidised rent and would be far more likely to return to the workforce and commence a path to rehabilitation and independence.

11.7. In 2017-18, of the Adult Parole Board's ('the Board') 1,267 decisions to grant or deny parole, 464 (or 37 per cent) were denied.[78] Of the denied applications, 297 (or 64 per cent) were denied on the grounds of precarious or unsuitable accommodation, which is viewed by the Board as being a major risk factor for re-offending. The Board stated in their annual report that their 'requirement to treat the safety and protection of the community as its paramount consideration means that the Board cannot grant parole in such cases.' Prisoners who are already disadvantaged and marginalised, by not having appropriate accommodation, are further disadvantaged by losing the opportunity to be supported in the community through the parole system.

11.8. There is a clear disconnect when the Board consider a lack of accommodation to be a major risk factor for re-offending, whilst the Department of Health and Human Services (DHHS) is insufficiently funded to the extent that as of March 2018, there were 82,499 people waiting on the Victorian Housing Register for public or community housing.[79]

Post-Prison Accommodation

11.9. It is deeply concerning that prisoners who meet the parole criteria in all ways other than accommodation, are refused parole and must therefore serve the remainder of their sentence. However, once their sentence is served, they are released without any accommodation arrangements in place. As stated by the Board, this is a major risk factor for re-offending. The Corrections Victoria website openly acknowledges the shortcomings in housing and accommodation for prisoners upon release:

[77] Australian Institute of Criminology*, Executive Summary*, Research Report 05, 2018, x

[78] In total 1,509 decisions were made to grant or deny; however, 242 denials were procedural after the prisoner withdrew their application prior to being decided by the board therefore for accuracy these 242 denials have been subtracted from the total number of decisions, thus the figure 1,267 is referenced as the total figure. There is no data available as to the reasons behind the 242 withdrawals, however it is assumed through anecdotal evidence that a significant number of these are due to prisoners realising they will not meet the accommodation requirement; Adult Parole Board, *Annual Report 2017-18*, September 2018, 29.

[79] Legal and Social Issues Committee, Parliament of Victoria, *Inquiry into the Public Housing Renewal Program* (June 2018) 17.

> *'Many prisoners being released experience issues with housing and homelessness on release. Public and social housing resources are limited, in high demand and have long waiting lists. Support is available in prison from visiting housing workers who can provide information about housing options and make referrals to housing support services on release. Prisoners are advised to begin considering housing options well before leaving prison.'*[80]

11.10. Once released without accommodation or a case manager, these prisoners often become uncontactable, meaning there is likely to be no supervision, support or ability to connect with services until they next come into contact with authorities, usually through police or ambulance.

Case Study

11.11. *Chris (a pseudonym), suffers from schizophrenia and was living in a boarding house. He was engaging with mental health services following a schizophrenic episode. During this time, Chris was sentenced to a brief period of incarceration for drug related offending. Chris was homeless upon his release because an Intervention Order had been taken out against him by occupants of the boarding house. Chris was incapable of managing his own affairs and without a case manager to co-ordinate his treatment he did not continue taking his medication. Homeless and unmedicated, it was not long before Chris re-offended and was returned to custody.*

Case Study:

11.12. *Jane (a pseudonym), had serious mental health issues which included longstanding schizophrenia with symptoms such as hearing voices. She committed arson of her public housing which was in connection to her delusions. Jane was remanded in custody in which she had a defence of mental impairment available. By consent, Jane was eligible for release on a supervision order. However, there was no appropriate supervised accommodation available. As a result, Jane remains in prison despite being eligible for release under supervision.*

Case Study:

11.13. *Jayden (a pseudonym), a prisoner, applied for parole which was refused due to the non-existence of secure accommodation. Jayden suffers from bipolar and an acquired brain injury, which results in erratic behaviour and poor impulse control. Although diagnosed, Jayden has never received treatment for these issues. Prior to entering prison, Jayden was unable to hold down employment and was homeless after becoming estranged from his family, who were unable to cope with his erratic and at times violent behaviour.*

Jayden had been living in an unregistered vehicle and committed a number of theft and robbery related offences to support his drug addiction, for which he was eventually caught. After being

[80] Corrections Victoria, *Housing & accommodation* (Web Page) <https://www.corrections.vic.gov.au/release>.

released from prison, he returned to homelessness and no interaction with support services. Jayden was soon arrested again by police for driving the unregistered vehicle, driving whilst unlicensed and for stealing petrol. Jayden received fines for the driving offences which he has no means to pay. Returning to living on the street, Jayden returns to using drugs and his criminal offending escalates. He soon returns to prison.

Case Study:

11.14. *Tran (a pseudonym), is a 35-year-old male who has struggled with chronic schizophrenia since the age of 16. His family are unable to care for him as only his mother and younger brother remain. His father and sister both committed suicide when he was younger. His funds are managed by State Trustees and he receives a depot injection once per fortnight. He is not on a Community Treatment Order nor does he have a regular case worker to manage his needs. He has been homeless for over 10 years. He has no belongings, no supports and no hope. He rotates between the streets and prisons on a monthly, sometimes weekly basis. When unwell he may spend 6-8 months in custody while the services in custody try to stabilise his mental health. During this time, he is deemed unfit by the professionals to appear before the court to finalise his matters. When due for release he is placed on an "In-Custody Assessment Order" requiring his immediate transfer from the prison to hospital by ambulance for a psychiatric assessment where he is immediately deemed to be fit to return to the community. He is discharged from hospital onto the street, without supports, without food, without accommodation. The cycle repeats.*

11.15. The LIV recommends that safe and appropriate transitional housing be made available for prisoners upon their release. Such housing is to intersect with health, long-term accommodation and employment services to better integrate ex-prisoners back into society and ensure these individuals are equipped with the means and knowledge to maintain their mental health and stay off the streets.

12. Accommodation

12.1. Of the many issues facing mental illness, LIV members have found accommodation to be the single biggest contributory factor to improving the mental health of their clients. Inversely, accommodation issues such as homelessness, insecure or hostile living environments and housing stresses such as affordability, reduce psychological wellbeing and exacerbate mental illness.[81] In November 2015, the Victorian Government launched 'Victoria's 10-year mental health plan', which identifies the role of accommodation in mental health. Unfortunately, of the policy priorities outlined in the plan to improve mental health, expanding public housing was not mentioned.

Homelessness

12.2. Homelessness, in which an individual lives without security or privacy, including being subject to CCTV surveillance and frequent police checks, creates fertile grounds for criminal offending. Offences committed in order to cope with these circumstances, such as trespassing, theft and substance abuse, are commonplace. As the evidence indicates, stable housing has a clear correlation with reducing crime and improving health and the likelihood of maintaining employment.[82] As stated, as of 31 March 2018, there are 82,499 people, including 24,622 children, waiting on the Victorian Housing Register for public or community housing.[83]

12.3. Typically, homelessness is the result of a considerable number of structural and individual factors. Two of the significant structural factors relate to employment and accommodation. Primarily, a weak jobs market and unaffordable housing with a lack of accessibility to public housing. The primary individual risk factors include mental illness, substance abuse, family violence and relationship breakdown, unemployment, poor education and long-term institutionalisation. It is far easier for an individual to focus on improving their personal circumstances when they have the stability of fixed accommodation.

12.4. The LIV urges the Commission to recommend the creation of more public housing to remedy the multifaceted issues that arise from long-term homelessness or housing instability.

Rental Stress

12.5. The impact of market factors contributing to higher private housing prices has a particularly detrimental impact on low income earners. The Productivity Commission measures housing affordability in terms of 'rental stress', which is defined as when more than 30 per cent of gross

[81] National Mental Health Commission, A Contributing Life: the 2012 National Report Card on Mental Health and Suicide Prevention, Australian Government, 2013

[82] , Legal and Social Issues Committee, Parliament of Victoria, *Inquiry into the Public Housing Renewal Program* (June 2018) 17.

[83] Ibid.

household income is spent on rent. In 2015-16, of the 25.3 per cent of Australian households renting in the private sector, 42.5 per cent were low income earners and 52.9 per cent were experiencing rental stress.[84]

12.6. In 2019, the Commonwealth Government announced a $1.45 billion funding model 'shake-up' to address primary health network mental health reform.[85] The LIV recommends the Commission capitalise on this promising indication from the Federal Government that they intend on investing in the improvement of the nation's mental health. As such, recommendations should be made to the Federal Government to view housing subsidies such as Commonwealth Rent Assistance to be viewed through a mental health lens, highlighting how improved accessibility to affordable accommodation will contribute to improving mental health outcomes.

Postcode Discrimination

12.7. As the Victorian population continues to grow in excess of 100,000 people a year, the price of housing remains an issue. Issues of undersupply, gentrification and general market trends compound the issue of affordability, particularly in the inner suburbs. Affordability is a significant driver of people moving from metropolitan to non-metropolitan areas, which the evidence indicates such a move can improve not only affordability, but wellbeing.[86] The wellbeing benefits of moving to non-metropolitan areas however can be jeopardised when crucial services are inaccessible.

12.8. By 2051, the population of regional Victoria is expected to grow from 1.5 million to 2.2 million, with Greater Geelong, Bendigo and Ballarat expected to account for 50 per cent of this growth. It is promising that the Victorian Government's 'Plan Melbourne 2017-2050' guide for sustainable growth states it intends to avoid urban sprawl to ensure essential services are widely accessible. However, the guide for the sustainable growth of the city over the next three decades, makes no substantive reference to mental health services.[87] Following this Commission, it is hoped that is promptly rectified.

12.9. There is a clear correlation between the increase in geographical remoteness and an increased risk of suicide. Males in regional areas aged 15-24 years old are almost twice as likely to suicide than

[84] Productivity Commission, *Table GA.3*, Report on Government Services 2019, January 2019

[85] Department of Health, $1.45 billion to strengthen mental health services and support job security, 16 January 2019 https://beta.health.gov.au/ministers/the-hon-greg-hunt-mp/media/145-billion-to-strengthen-mental-health-services-and-support-job-security

[86] Rowland Atkinson et al, *Gentrification and displacement: the household impacts of neighbourhood change*, Australian Housing and Urban Research Institute, AHURI Final Report No. 160, 2011; Wendy Stone et al, *Accessing and sustaining private rental tenancies: critical life events, housing shocks and insurances*, AHURI Final Report No. 259, Australian Housing and Urban Research Institute Limited, 2015

[87] The only mention in the seven-part plan regarding mental health is that one benefit of making Melbourne greener it will improve mental and physical health - Victorian Government, *Direction 6.4 Make Melbourne Cooler and Greener figure 17*, Plan Melbourne 2017-2050

their urban counterparts.[88] This can increase to six times more likely for those in particularly remote areas. Across all age demographics, those in non-metropolitan areas are at a higher risk of suicide.

12.10. There are both structural and personal factors in RRR communities that contribute to this alarming disparity. Structural factors include unemployment or a lack of desirable and fulfilling work, geographical barriers to mental health services, and inadequate mental health education and awareness. Personal factors include isolation and loneliness, undiagnosed and/or untreated mental health issues, alcohol and substance abuse and a culture of stoic and masculine individualism which prevents seeking help. There are also external factors such as drought and bushfires which have a devastating impact on the mental health of those affected.

12.11. The Commission must therefore once again take a holistic approach to improving mental health in RRR communities, taking into full consideration these wide-ranging structural and personal factors.

12.12. Despite the high rates of mental illness and suicide in RRR communities, the Medicare expenditure per capita on mental health services in these areas is below 15 per cent of that of major cities.[89] The number of psychiatrists, mental health nurses and psychologists in RRR communities is particularly limited, resulting in considerable wait times for patients.[90]

12.13. The Victorian Government identified to a Federal Senate Committee inquiry into mental health services in RRR communities, that 'the availability of appropriately skilled staff can be the single biggest contributing factor limiting the ability to provide a broader range of services in rural communities, particularly where around-the-clock care is required.'[91]

12.14. The LIV supports the findings of the Community Affairs References Committee (Cth) *Accessibility and Quality of Mental Health Services in Rural and Remote Australia* inquiry, which acknowledged that if practitioners and community members from RRR communities are trained in these areas, they are more likely to continue working in an RRR community.[92] As such, investment in regional training facilities for mental health practitioners is vital.

12.15. In recognising the need to resolve the widespread skills shortage in RRR communities, from November 2019, the Federal Government will introduce subclass 491 – Skilled Work Regional (Provisional) visas and provisional subclass 494 – Skilled Employer Sponsored Regional (Provisional) visas.[93] In November 2022, holders of a 491 or 494 visa will become eligible for

[88] Margaret Alston, Rural male suicide in Australia, *Social Science and Medicine*, (2012), 74(4), 515–22.
[89] Australian Institute of Health and Welfare, *Mental health services in Australia,* (Cth) (2018).
[90] Ibid.
[91] Victorian Government, Submission No 100 to Senate Community Affairs References Committee (Cth) *Accessibility and Quality of Mental Health Services in Rural and Remote Australia* (2018) 4.
[92] Commonwealth Senate Community Affairs References Committee (Cth) *Accessibility and Quality of Mental Health Services in Rural and Remote Australia* (2018).
[93] Migration Amendment (New Skilled Regional Visas) Regulations 2019 (Cth)

permanent residence through a subclass 191 – Permanent Residence (Skilled Regional) visa. Mental health professionals such as Registered Nurse (Mental Health) and Registered Nurse (Developmental Disability) will be eligible to obtain these visas, with the requirement they work in RRR communities. These visas create an opportunity to ease the long-term resourcing issues mental health services face in these communities. It should therefore be recommended to the Victorian Government that they secure an appropriate allocation of these skilled mental health workers to service Victoria's RRR communities.

Addressing Isolation in RRR Communities

12.16. The detrimental impact of loneliness and isolation is well documented.[94] By way of illustration, the most severe punishment prisoners can receive is solitary confinement. Loneliness and isolation are linked to mental health issues such as depression, alcohol and substance abuse, personality disorders and Alzheimer's disease.[95] Whilst this is a universal issue, isolation is particularly prevalent in RRR communities due to geographical and population realities.

12.17. The announcement in November 2018 of the funding for 11 unfunded neighbourhood houses and the establishment of 16 new neighbourhood houses, primarily in regional areas, provides an opportunity to address issues of isolation. Their ongoing funding should very much be viewed as part of the Victorian Government's mental health plan. Whilst neighbourhood houses do not necessarily address mental illness directly, they promote mental wellness, which builds resilience and serves to prevent deteriorating mental health. Neighbourhood houses promote mental wellness through group activities that combat isolation, exercise and various education initiatives.

12.18. The LIV supports the use of already established infrastructure and services to provide community-led support. Such services should be viewed as beneficial to the long-term health of RRR communities. As such, they should be further rolled out and, once it is established they are providing the services for which they are funded, resourced with block funding to guarantee their longevity,

[94] See for example Raheel Mushtaq et al, 'Relationship Between Loneliness, Psychiatric Disorders and Physical Health? A Review on the Psychological Aspects of Loneliness' (2014) 8(9) *Journal of Clinical and Diagnostic Research*.
[95] Ibid.

13. Employment

13.1. The links between employment and mental illness are well established. Gainful employment is critical to secure housing, living standards, providing a sense of community and building structure and purpose into a person's life. Conversely, unemployment can trigger or exacerbate mental illness, which itself can then make it more difficult to gain re-employment.

13.2. There are legal protections in place for employees who disclose their mental illness: discrimination against someone on the basis of their mental illness is an offence under the *Disability Discrimination Act 1992* (Cth). Employers also have obligations to employees with mental illness under the *Fair Work Act 2009* (Cth) and the *Occupational Health and Safety Act 2004* (Vic).

13.3. However, this does not remedy the situation of individuals who find themselves unable to continue to work, or to obtain employment, because they are unable to access the treatment and supports to meet their mental health needs *(refer to Chapter 4: 'Mental Health Services')* or secure accommodation (*refer to Chapter 12: 'Accommodation')*.

Criminal Records

13.4. The Spent Convictions Bill 2019 (Vic) is currently before the Victorian Parliament. The LIV has long advocated for a spent convictions scheme to be legislated in Victoria. All other Australian states and territories, as well as the Commonwealth, have spent convictions legislation in place. Victoria is the only state in Australia without spent conviction provisions.

13.5. Currently, any crime of which a person has been found guilty, even in cases of non-conviction, remains on their record indefinitely. With the continued growth of criminal history checks, those with minor convictions on their records are subjected to discrimination that job seekers in other states are not subject to. This is particularly the case for young and indigenous Victorians, who are disproportionately represented in the criminal justice system. This is often for minor offences such as possession of cannabis, minor shop stealing, or using a concession Myki card without possessing a concession card, which is treated as fraud.

13.6. A spent convictions scheme would help prevent discrimination and remove obstacles which prevent some former offenders from seeking rehabilitation, gaining employment and participating in their communities.

13.7. The Commission should recommend that Victoria establish a spent convictions scheme. In the event that the current Bill is not passed, a recommendation by the Commission will add impetus to future legislative change in this area.

14. Families

14.1. Consideration should be given to the impacts of mental illness within the family context, particularly family breakdown, family violence and child protection. Inadequate access to appropriate mental health supports and services, particularly for victims, is a contributing factor to an increased risk of family violence. Where family breakdown reaches the Family Court or Federal Circuit Court, mental illness can add significantly to the complexity, length and costs of a case. In improving the availability of mental health supports, services and referrals for victims of family violence where mental illness is involved, the frequency of such court proceedings can be reduced.

14.2. The Commission should also review the extent to which a limited understanding of mental illness, coupled with a general lack of services and supports, can result in the removal of children from the care of their parent. As identified by the Office of the Public Advocate, children are removed from parents with disability and mental illness at a disproportionate rate.[96] The Commission needs to explore the reasons as to why this is occurring and how this number can be reduced, whilst upholding the best interests of the child as paramount.

14.3. The LIV recommends that a parent's diagnosis in relation to mental illness be assessed when deciding to remove a child from their custody or when making orders in family law matters, so that the individual's parenting capacity is assessed against their capacity to deal with their diagnosis on a daily basis, rather than being influenced by assumptions or stigma about their illness.

[96] Office of the Public Advocate, *Whatever happened to the village? The removal of children from parents with a disability,* 2013, 3.

CONCLUSION

This submission is informed by the expertise and experience of lawyers who, every day, assist people with mental illness and psychiatric disability to exercise their legal rights and, every day, see the ways in which the shortcomings of Victoria's current mental health system contribute to disproportionate entanglement with the justice system.

The Royal Commission into Victoria's Mental Health System is an invaluable opportunity for Victoria to overcome the institutional and systemic issues facing its current mental health system, and to move towards a world leading, best practice mental health care model that meets the mental health needs of all Victorians.

The LIV would welcome the opportunity to discuss any of the issues raised in this submission further with the Commission, or to provide oral evidence to the Commission at hearing.

Should the Commission wish to discuss any aspect of this submission further, please do not hesitate to contact Maurice Stuckey, Policy Officer, at mstuckey@liv.asn.au or (03) 9607 9311.

Yours sincerely

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