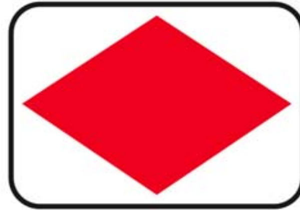

OFFICE OF THE
PUBLIC ADVOCATE

Submission to the Human Rights and Equal Opportunity Commission's and Mental Health Council of Australia's review of mental illness and human rights, 11 years on from the "Burdekin Report"

September, 2004

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This submission is endorsed by the Public Advocate, Julian Gardner.

Executive Summary

The Victorian Office of the Public Advocate (OPA) has had a longstanding concern about the accessibility and responsiveness of the public mental health system in Victoria, and welcomes the opportunity to comment on key issues in this area of service delivery. This submission address five main areas of the public mental health system that OPA, from its involvement with persons with a mental illness across the various programs of the Office, has identified as being in need of attention:

- Issues pertaining to the general operation of the mental health system
- The lack of suitable accommodation options available to people with a severe mental illness
- The inadequacy and paucity of existing services for people with multiple disabilities and/or complex needs
- The over-representation and under-servicing of people with mental illness involved in the criminal justice system
- The lack of support for parents with a mental illness.

Summary of Recommendations

The Victorian Office of the Public Advocate makes the following recommendations to the Human Rights and Equal Opportunity Commission's and the Mental Health Council of Australia's national review of the mental health system. There should be:

General Systemic Issues

1. Accountability mechanisms should be developed and implemented across the mental health system at both a Federal and state level to ensure that the progressive policies and philosophies contained in plans such as the National Mental Health Plan (NMHP) 2003-08 are actually delivered in practice.

2. A significant increase in funding to the mental health sector so that resourcing is proportionate to the growing number of people experiencing a mental illness.

3. The provision of more acute beds as well as prevention and recovery beds to:

    - provide care to people who are currently unwell but who are refused inpatient treatment and,

- to prevent long waits in the emergency departments of hospitals and avoid unnecessary transfers between services.

4. An increase in the number of community-based programs that contribute to reducing the demand for inpatient services.

5. Planning should commence for the care of people with dementia in line with projected increases in the prevalence of dementia in the community.

6. There should be increased mental health promotion to people from CALD backgrounds. Mainstream services should seek to achieve an appropriate mix of cultural backgrounds amongst staff.

7. Greater acceptance of responsibility by the mental health sector for the provision of services for people with diagnoses of personality disorder.

Accommodation options

8. The establishment of a greater range of accommodation and support options for people with psychiatric disabilities including:

   - An increased number of community care units
   - The establishment of government sponsored mental health specific SRSs
   - Accommodation facilities for younger people who need intensive long-term/ongoing support
   - Step-down, step-up accommodation facilities for people moving in and out of acute care
   - An increased number of secure extended care facilities

People with complex needs/multiple disabilities

9. Increased funding to mental health and intellectual disability services in such a way that encourages and enables them to provide a service to individuals with complex needs, and which militates against the tendency towards service ‘silos’.

10. The establishment of services for people with complex needs that cater for those with limited capacity for compliance with treatment and care plans.

11. Improved service options for people with Huntington’s Disease, and the clarification of the obligation of mental health, intellectual disability and aged care services to service individuals with Huntington’s Disease.

People with mental illness in the criminal justice system

12. Enhanced services for the identification and appropriate treatment of mental illness amongst people in custody.

13. Rehabilitation and treatment programs should be made readily available to people with mental illness in prisons and should account for the complex needs of some prisoners, including varying levels of cognitive capacity and of the ability to provide informed consent to participation.

14. Enhanced information sharing between the mental health and criminal justice sectors.

15. The establishment of thorough pre-release planning protocols for individuals with mental illness and or complex needs, and appropriate follow-up mechanisms.

16. Training of prison staff regarding appropriate responses to the symptomatology of Huntington's Disease, dementia, and mental illness generally.

17. Increased access to intensive care for acutely unwell prisoners by improving psychiatric services generally, including the opening of additional beds to meet a growing need, especially for female prisoners.

18. The establishment of step-down accommodation facilities for people with mental illness upon their release from prison.

Parents with mental illness

19. The development of national parenting support guidelines for all parents, which also recognise the needs of specific groups. This has the potential to normalise the issues faced by parents from these groups and reduce the risk of them being further stigmatised by being singled out in specific guidelines.

20. As part of a broader national strategy to address child abuse, government needs to resource integrated and varied supports to families throughout the different stages of planning. There needs to be a systemic shift to a parent support focus.

21. There should be an emphasis on cross training of child protection and mental health workers so that there is an increased understanding of both mental health from the child protection workers' perspective, and the child protection system by the mental health workers. Such cross training can help broaden the understanding of mental illness enabling the child protection system to be more responsive to the needs of this group.

22. The establishment of clear links between child protection and adult mental health support services, disability, and drug and alcohol support services. The role of adult mental health services in supporting parents with a mental illness should also be strengthened as part of broader psychosocial rehabilitation approach within mental health, which is consistent with the NMHP 2003-2008.

23. A comprehensive and strengths-based assessment of the family situation should be the basis of intervention. This should minimise the extent to which presumptions are made about the person's capacity to parent often before they have had the opportunity to parent.

About the Public Advocate

The Victorian Public Advocate is appointed by the Governor in Council pursuant to the *Guardianship and Administration Act* 1986 (Vic). The Office of the Public Advocate (OPA) represents the interests of people with a disability, aiming to promote their rights and dignity and to strengthen their position in society. It is a statutory office, independent of government and government services, and can highlight situations in which people with disabilities are exploited, neglected or abused. Further material on the role of the office can be provided if required by consulting the Office of the Public Advocate's (OPA's) website: **www.publicadvocate.vic.gov.au**.

OPA's involvement with people with a mental illness

The Office of the Public Advocate (OPA) welcomes the review by the Human Rights and Equal Opportunity Commission and the Mental Health Council of Australia of the status of the mental health system in Australia. OPA has had a longstanding concern with the adequacy of the mental health service system and is pleased to have the opportunity to present this submission to the present nationwide review.

Statistics on OPA's involvement with people with a mental illness

- In the last financial year, approximately 17% of all calls made to OPA's telephone advice service were made in relation to a person with a mental illness. Of these, 3% were made by people with a mental illness who were involuntary patients and who wished to access the Community Visitors Program. These figures represent a conservative estimate as they do not include calls made in relation to people with multiple disabilities, for whom mental illness is often present.

- People with psychiatric disability comprised 25% of the total number of new guardianship orders in 2003 in which the Public Advocate was appointed statutory guardian. Nineteen percent of new advocacy cases in 2003-04 involved people with psychiatric illness.

- In 2003-04, Community Visitors made 1447 visits to 107 mental health facilities. In addition, 306 police interviews involving people with a mental illness were attended by Independent Third Person Program volunteers in 2003-04.

From its involvement with persons with a mental illness across the various programs of the Office, the Public Advocate wishes to highlight the issues considered to be particularly relevant to this submission: These key issues are:

- Issues pertaining to the general operation of the mental health system
- The lack of suitable accommodation options available to people with a severe mental illness
- The inadequacy and paucity of existing services for people with multiple disabilities and/or complex needs
- The over-representation and under-servicing of people with mental illness involved in the criminal justice system
- The lack of support for parents with a mental illness.

Part 1: General systemic issues

An example of the need for a more community care focus from OPA's case files
(N.B. Pseudonyms are used to protect privacy and confidentiality.)

Geoff is a 42 year old man who has a chronic mental illness and lives in rural Victoria. He has been placed on a Community Treatment Order because, due to poor insight into his illness, he does not comply readily with treatment regimes. Despite the existence of the order, Geoff at times does not attend his local mental health clinic for his scheduled treatment. The mental health clinic does not follow up clients when they miss treatment appointments and consequently, Geoff has had three major relapses. Geoff's relapses have led to hospital admissions, often up to two and half hours ambulance ride away from his home town. While Geoff's treating clinic maintains an inflexible service response to Geoff's needs by insisting on only providing centre-based treatment, it is likely that Geoff will continue to relapse and require resource intensive, and personally distressing crisis support.

Although OPA acknowledges Government initiatives in the areas of prevention, community education and research, OPA identifies the following general systemic issues continuing to face consumers of Victoria's public mental health services:

Mental Health Policy

In line with the priority themes espoused in the *National Mental Health Plan* (NMHP) 2003-2008, OPA affirms its belief in the right of people with mental illness to have access to mental health care, primary health care, recovery and rehabilitation programs and appropriate accommodation. The Public Advocate endorses the NMHP's attention to issues of continuity of care, including the development of an integrated specialist mental health system with appropriate intra-sectoral and inter-sectoral linkages. The timely transfer of information with adherence to privacy principles, and the commitment to reducing service system gaps are central to a more integrated service system for people with mental illness.

Proposed new directions in mental health policy reflect a departure from the dominant medical paradigm, within which mental health care has hitherto been situated, to a more individualistic and social model of mental health care. The Public Advocate observes that despite this clear direction of the previous two NMHPs, and the current NMHP 2003-2008, this policy is not reflected in the services provided. For example, people in non-acute phases of mental illness and people with high prevalence disorders continue to have difficulty accessing the public mental health system. This may be due to continued inadequate funding of the mental health sector, which has contributed to its entrenched crisis-driven response which has not always served these groups well.

Growing Demand for Mental Health Services

- Between 1997 and 2001, the total number of registered Area Mental Health Service consumers increased by 20 per cent. However, the overall number of designated acute psychiatric inpatient beds in Victoria has remained relatively constant since 1996, despite a 20 per cent increase in overall service demand. When the Auditor-General's Office reported in 2002, Victoria had 21.8 acute beds per 100 000 adults; 2.6 beds below the national average. Since then the figure per capita has fallen further and is now believed to be the lowest in Australia.

- Studies undertaken by the Australian Bureau of Statistics and the Victorian Department of Sustainability and Environment on the ageing of the Victorian population have predicted that the number of persons aged less than 60 years will grow by a total of 2.8% in the 4 years to 2006 whereas the number aged over 80 will grow by 19.1 %. The relevance of this dramatic growth in older Victorians is that with age the increase in dementia is exponential. Over age 60 the prevalence of dementia doubles every 5 years of age – from 2% prevalence at age 65 to 32% at age 85. (Access Economics Report for Alzheimer's Australia, 2003). This is reflected in the experience of the Office which has seen the number of guardianship cases involving dementia increase by an average of 13.3% a year over the last two years.

Resourcing of the System

The Public Advocate believes that it is unacceptable that the Federal Government spends only 7% of its dedicated health budget on mental health services, compared with the 12-15% that other OECD countries spend on mental health (von Doussa, 2003).

In Victoria, mental disorders account for 26 per cent of the non-fatal health burden, however only 8% of the state's total health budget is allocated to mental health services (Victorian Burden of Disease study 1999, cited in Auditor-General's Office, 2002). This is at odds with the current policy direction towards early intervention, enhanced pre-acute service responsiveness, and continuity of care (NMHP 2003-2008). It also highlights the continued failure of funds to be redirected to the community sector to provide appropriate and adequate community care services.

Recommendations:

1. Accountability mechanisms should be developed and implemented across the mental health system at both a Federal and state level to ensure that the progressive policies and philosophies contained in plans such as the National Mental Health Plan 2003-08 are actually delivered in practice.

2. A significant increase in funding to the mental health sector so that resourcing is proportionate to the growing number of people experiencing a mental illness.

3. The provision of more acute beds as well as prevention and recovery beds to:

- provide care to people who are currently unwell but who are refused inpatient treatment and,
- to prevent long waits in the emergency departments of hospitals and avoid unnecessary transfers between services.

4. An increase in the capacity of community-based programs that contribute to reducing the demand for inpatient services.

Appropriate Individual Planning

The 2002 Auditor-General's Office's review of clinical files found that 31 per cent of consumers treated in the community did not receive either an individual service plan or an inpatient management plan. None of the 402 individual service plans examined addressed all of the criteria as recommended by Department of Human Services' clinical guidelines (DHS, 1996 cited in Auditor-General's Report, 2002). In addition, 30 per cent of hospital discharge plans reviewed included no evidence that consumers had been linked into appropriate community-based services for ongoing treatment following discharge (Auditor-General's Office, 2002). OPA's experience is that even when a mental health service has applied for the appointment of a guardian, patients have been discharged inappropriately without consulting the guardian. Community Visitors report ongoing cases of patients discharged into Supported Residential Services without adequate planning or sharing of information needed for the provision of care.

Continuity of Care / Service Coordination

The issue of continuity of care for consumers of mental health services has been targeted for improvement in state and federal mental health policy since the development of the First NMHP in 1992. Despite the particular emphasis given to continuity of care in the 2003-2008 NMHP, there is evidence of the continued failure of the mental health sector, primary health sector and other human service providers to provide an integrated, 'continuous' response to the needs of mental health consumers.

- Poor consistency of care, including the lack of transfer of case information across area boundaries – particularly in rural/regional areas

- Inadequate integration and linkage across mental health, primary health, and other human service sectors

- Inconsistent diagnostic classification by psychiatrists of mental disorders as mental illnesses, for example, different classification approaches to dementia

and Huntington's disease do determine which, if any, mental health services are made available.

Service Accessibility

- Poor accessibility of mental health services for people in non-acute phases of mental illness, people with high prevalence disorders, and people with non-psychotic mental illnesses.

- Unwillingness of psychiatric services to re-engage with people with long-term mental illness.

- Unwillingness of community health/mental health centres to make home visits to administer medication to low-functioning/poorly supported clients on community treatment orders.

Jason is a 40 year old man of Greek orthodox background with dual disability. Jason has an intellectual disability, and chronic epilepsy which, if he has a fit, induces psychosis and brain tissue scarring. Jason lives at home with his overprotective mother, with whom he sometimes argues after which he leaves home for several days without his psychotropic medications. Jason was placed on a Community Treatment Order (CTO) by a psychiatrist at a mental health clinic, but another mental health clinic is responsible for the delivery of Jason's treatment. At Mental Health Review Board hearings, Jason's OPA Advocate/Guardian has advocated for the continuation of Jason's order, however has met with much resistance from the treating clinic in this matter. Jason's Advocate has argued that the treating clinic has a legislative obligation to provide treatment to Jason, as set out in the 1994 Department of Human Services Protocol between (intellectual) Disability Services and Psychiatric Services.

Dominance of the Medical Model

- It is the experience of the OPA that there is an over-valuing of 'clinical judgement' and an over-reliance on medical/pharmacological interventions and chemical restraint.

- OPA is also concerned about the lack of counselling and therapeutic approaches to treatment, which indicates the failure of mental health professionals to account for the historical bio-psycho-social context of mental illness.

- People's experience of hospital treatment is often depersonalising and dehumanising.

Example of a more holistic response to care

Kathryn is a 56 year old woman who experiences overwhelming bouts of loneliness, compounded by protracted grief issues. Across a twelve month period, Kathryn has had 65 admissions to the acute psychiatric unit of a public hospital in Melbourne; 37 of which were via ambulance. When she felt terribly lonely, Kathryn would take overdoses of an analgesic, in part so she could go to the hospital where there were people who would listen to her. In between her bouts of suicidality, Kathryn would take some home-baked biscuits to the nursing staff and other in-patients, such was the nature of her relationship and familiarity with people at the hospital. After 12 months of Kathryn's presentation pattern, the health and welfare professionals involved in Kathryn's care came together and talked about the factors contributing to Kathryn's behaviour. It was decided that a case manager would phone/visit Kathryn every week, and that Kathryn's apartment would get a good clean and a new television to make her home more comfortable for her. Kathryn has had no further admissions since her care plan was instigated 3 months ago.

Groups Poorly Served by the Mental Health System

- There is little evidence that the projected dramatic increase in the incidence of dementia (see figures on page 8) is matched with preparedness in the mental health system in terms of infrastructure and expertise. There is potential for a considerable negative impact upon services already over-stretched and supported accommodation already in critical under-supply.

- It is the experience of the office that culturally and linguistically diverse (CALD) people have difficulty accessing mental health services due to a lack of knowledge about mental illness and mental health services, and to the non-specificity of some mental health services with respect to their cultural target group.

- People with personality disorders are often excluded from the system through clinical judgements.

Recommendations:

5. Planning should commence for the care of people with dementia in line with projected increases in the prevalence of dementia in the community.

6. There should be increased mental health promotion to people from CALD backgrounds. Mainstream services should seek to achieve an appropriate mix of cultural backgrounds amongst staff.

7. Greater acceptance of responsibility by the mental health sector for the provision of services for people with diagnoses of personality disorder.

Part 2: Accommodation shortage

Private Supported Residential Services (SRSs) are an important part of the supply of supported accommodation for people with a disability. This is particularly true for people with a severe mental illness. The 2003 Supported Residential Services (SRS) Census Facility Snapshot (Department of Human Services [DHS], 2003a) reported that 49% of people residing in pension-level SRSs in Victoria have a psychiatric disability, plus another 8% with dementia.

OPA has expressed the view that pension-level SRSs in their current form are not viable. That is, we do not consider that an SRS can provide accommodation, meals and adequate levels of personal care for the price of the pension (or 90% of it) plus rent assistance and with no other subsidy. In particular, it cannot do so when the profile of the residents has changed dramatically from the frail elderly to a mix of people with significant levels of disability.

The Government has announced a pilot project designed to partly address these problems. Initially the pilot will cost $600,000 to support a small number of pension-level supported residential services (6-8 of the 209 SRSs in Victoria). The pilot will provide the funding through non-government organisations to work with the proprietors to deliver care packages to low-income residents with medium and high-level care requirements. The intention is that after testing the pilot, more substantial funding will be provided to ensure the viability of a number of supported residential services and to improve the care of their residents. As small as the pilot may be, the Government accepting a financial role for the public sector in what is at present a private industry, represents a significant philosophical shift. Unfortunately, at the end of 2003-04 the pilot had not yet commenced.

Despite the shortcomings, SRSs provide an important supply of information to people with a mental illness. However, the supply has been decreasing for several years. In 2003-04 alone, 15 pension level SRSs have closed with a net loss of 222 beds. The overall decrease in accommodation options for people with mental illness on low incomes without the active creation of quality alternatives is of serious concern.

Chantelle is a 49 year old woman who suffers from schizophrenia, has a mild intellectual disability, and is unable to adequately take care of her activities of daily living. She has a 25 year history of involvement with psychiatric services and has frequently been subject to the involuntary provisions of the *Mental Health Act (1986)*. Chantelle has been an inpatient at a suburban public mental health facility for over 7 months and has been refused accommodation and support by the Area Community Care Unit, the supported residential service, and the low care hostel local to Chantelle's parents' home. The reasoning offered by these services for not re-admitting Chantelle was that she was 'unsuitable' for the services because of her poor rehabilitation potential, and behavioural difficulties. The Public Advocate wrote to the Chief Psychiatrist about this matter. The Chief Psychiatrist, expressing disappointment at the exclusionary policies of the mental health services, directed the Community Care Unit to admit Chantelle as soon as possible. It was only at a point of crisis, following intervention at a senior level, that accommodation was found.

The shortage of accommodation options for people with long term support needs is the most pressing need observed by guardians and Community Visitors. Community Visitors are aware of people with mental illness living in accommodation where there is inadequate support for their needs and an inappropriate mix of residents. The stress inherent in these types of living environments heightens the potential risk of relapse into acute phases of mental illness and hence, more admissions to acute inpatient facilities. In the financial year 2003-04, OPA received several complaints from relatives of people in community care units being asked to move to alternate community living facilities that relatives believed could not provide the level of support required by their mentally ill family member. The lengthy delay in the establishment of the sub-acute beds announced in the 2002 budget is of serious concern to OPA. The 20 beds to be established in metropolitan Melbourne - 12 in Springvale and eight in Box Hill - are still not yet operational. However, Community Visitors have reported very favourably regarding the new 24-hour prevention and recovery unit in Shepparton which has eight beds and two day clients. Sixty-six clients have accessed the service since 22 September 2003, when the first participant was accepted.

There is a limited availability of specialist accommodation for people with a severe mental illness who require long term support. For example, few long term accommodation options outside of secure extended care exist for this group. The secure extended care that does exist is limited to hostels, nursing homes, or Thomas Embling Forensic Hospital. The specific long term care needs of people with mental illness assessed as having a 'low rehabilitation potential' are not being catered for by

the service system. The Willows program in Beechworth is a successful example of an appropriate accommodation option that could be provided.

Recommendations:

8. The establishment of a greater range of accommodation and support options for people with psychiatric disabilities including:

    - increased number of community care units
    - the establishment of government sponsored mental health specific SRSs
    - accommodation facilities for younger people who need intensive long-term/ongoing support
    - step-down, step up accommodation facilities for people moving in and out of acute care
    - increased number of secure extended care facilities

Part 3: People with multiple disabilities and complex needs

In recent years, OPA, and other support organisations and service providers have raised concerns about the failure of the existing service system to meet the needs of people with dual/multiple disabilities. Among such concerns were poor service outcomes for multiple needs clients associated with the "crisis-driven, unplanned, and uncoordinated" nature of the existing service response (Department of Human Services, 2003:3), the expense of such a crisis-oriented service system, and the creation of service "silos". The Department of Human Services (DHS) responded to such concerns by establishing the *Responding to People with Multiple and Complex Needs Project* (DHS, 2003b). The project highlighted the need for a new targeted, cross-sector service response predicated on a specialist 12-15 month intervention that aims to stabilise housing, health, safety, and social connection, and to pursue individualised, long term therapeutic plans.

Whilst this program is commencing operation, OPA observes the following continuing difficulties:

- Despite the existence of substantial research data to indicate that people with intellectual disabilities are more at risk of developing mental illness than the general population (Hudson & Chan, 2002), gaps in service provision for people with intellectual disability and mental illness remain. People who have an intellectual disability are less likely to receive assistance from mental health services because they are considered to have behavioural problems attributed to their intellectual disability rather than to their co-existing mental illness.

- Service boundary issues; people with dual intellectual disability/psychiatric disability have difficulty accessing the mental health system, and intellectual disability services are often left to support people with dual/multiple disabilities without funding and with non-specialist staff.

- People with presentations that cross behavioural, psychiatric and intellectual disability boundaries are often the subjects of service boundary disputes about which service should provide 'the' service to these clients.

- Poor accessibility of drug and alcohol services for people with mental illness and few services which treat drug and alcohol abuse and mental health issues simultaneously.

- Service deficits for people with Huntington's disease - behavioural issues associated with the illness can preclude people with Huntington's disease from accessing nursing homes and other disability services.

- Few service provisions for people with multiple disabilities who, as a result of their mental illness are unable to 'comply' with treatment and care plans.

Recommendations:

9. Increased funding to mental health and intellectual disability services in such a way that encourages and enables them to provide a service to individuals with complex needs, and which militates against the tendency towards service 'silos'.

10. The establishment of services for people with complex needs that cater for those with limited capacity for compliance with treatment and care plans.

11. Improved service options for people with Huntington's Disease, and the clarification of the obligation of mental health, intellectual disability and aged care services to service individuals with Huntington's Disease.

Part 4: People with a mental illness in the criminal justice system

Peter is a 75 year old man who has been imprisoned for child sex offences. During his prison sentence, Peter developed dementia and has deteriorated quite rapidly. In his current state, Peter is a highly vulnerable individual with high level care needs. Peter's OPA Advocate/Guardian has negotiated Peter's release to a dementia-specific nursing home where there are locked key pads.

Joan is an 80 year old woman, who while residing in a nursing home, stabbed and killed another resident with whom she had ongoing conflict. Joan was sent to prison where she subsequently developed dementia. Joan was transferred to a forensic psychiatric hospital where she was assaulted by another inpatient. Short of alternative accommodation options, Joan has been transferred to a hospital inside a men's prison. Joan's OPA Advocate/Guardian is attempting to have her placed in a nursing home, but is unsurprisingly having difficulty with this.

OPA is concerned about the over-representation of people with a mental illness in the criminal justice system. The Department of Justice (2004) reports that the incidence of mental illness in the corrections system is thought to be between 3 and 5 times that of the general community. The Victorian Prisoner Health Study (Department of Justice, 2003:25) reported that 28% of the prisoners involved in the study had received a psychiatric diagnosis. Almost half of prisoners had contemplated suicide and 60% of these had made an attempt. Half of prisoners had been determined to have alcohol dependence issues and over 70% had used illegal drugs. OPA believes that people with a mental illness are poorly dealt with at all stages of the criminal justice system, and that efforts towards better-accommodating the needs of people with mental illness have been piecemeal and fragmented. If the true test of a civil society is the manner in which it treats its most vulnerable members, the continued 'punishment' of people with mental illness and/or mental impairment by incarceration may be tantamount to institutional abuse.

In response to the high recidivism rates of offenders with mental illness, and the resource-intensive nature of existing criminal justice interventions for this group, new initiatives have been developed towards a more coherent service response. Whilst these are welcomed, OPA believes that initiatives towards enhancing justice at the criminal justice end of the service spectrum should form only one part of an all-of-system approach to better responding to the needs of people with mental illness. A danger of an over-emphasis on service improvement at the criminal justice end of the service spectrum, is the creation of a service access hierarchy, favouring those who engage in offending behaviour, and reinforcing an already crisis-driven mental health service system. The question to be debated is whether the court process should be a chief mechanism by which service provision to people with mental illness is determined. OPA believes that this is not the most appropriate mechanism for ensuring equitable access to services for people with mental illness. A fragmented service system is partly responsible for the degeneration of some mentally ill people into offending behaviour, and therefore, improved access to timely, quality and appropriate services for people with mental illness is a critical element of reducing the prevalence of people with mental illness in the corrections system.

The following are some additional issues observed by OPA concerning people with mental illness involved in the criminal justice system.

Assessment and Treatment

- Procedures for detecting and treating mental illness in the criminal justice system are inadequate and psychiatric services in custody and prisons do not adequately address the extent of need. OPA acknowledges the work currently being undertaken by Corrections Victoria to improve their initial assessment processes.

Rehabilitation

- The incarceration of people with non-acute psychiatric illness rarely leads to concurrent treatment/rehabilitation. Psychosocial rehabilitation programs in prisons are inadequate, and presuppose a cognitive capacity. OPA acknowledges the work currently being undertaken by Corrections Victoria to improve their rehabilitation programs.

Information Sharing

- Inadequate transfer of psychiatric information to custodial settings.

Post-Release Planning and Service Provision

- Lack of post-release planning, rehabilitation programs, and referral to community-based social services, in absence of a parole plan. Also, inadequate follow-up of prisoners with mental illness after release. OPA acknowledges the work currently being undertaken by Corrections Victoria to improve their post-release planning and services.

- Prisoners with Huntington's disease are poorly served. A lack of understanding of Huntington's Disease symptomatology can result in the behaviour being assumed to be premeditated.

- Thomas Embling Forensic Hospital is not able to meet the demand for treatment for which it was designed. Half of the beds are now occupied by security patients (people found unfit to plead or not guilty because of mental impairment who are generally long term) and therefore there is an inadequate capacity to admit and treat acutely ill prisoners. The situation then spills over to prisons with unacceptable waiting lists to access the Adult Assessment Unit.

Recommendations:

12. Enhanced services for the identification and appropriate treatment of mental illness amongst people in custody.

13. Rehabilitation and treatment programs should be made readily available to people with mental illness in prisons and should account for the complex

needs of some prisoners, including varying levels of cognitive capacity and of capacity to provide informed consent to participation.

14. Enhanced information sharing between the mental health and criminal justice sectors.

15. The establishment of thorough pre-release planning protocols for individuals with mental illness and or complex needs, and appropriate follow-up mechanisms.

16. Training of prison staff around responding to the symptomatology of Huntington's Disease and mental illness generally.

17. Increased access to intensive care for acutely unwell prisoners by improving psychiatric services generally, including the opening of additional beds to meet growing need, especially for female prisoners.

18. The establishment of step-down accommodation facilities for people with mental illness upon their release from prison.

Part 4: Parents with a mental illness

Lucy is a 36 year old woman who has schizophrenia. During her first hospitalisation, Lucy absconded from the inpatient unit, and became pregnant. Lucy's baby was born and eventually placed with a foster family. Two years later after a major relapse, Lucy was hospitalised and absconded from inpatient care again. Without reference to Lucy's history, the hospital failed to test Lucy for pregnancy upon her return, and Lucy had a second baby. Prior to the birth, an OPA Advocate/Guardian was appointed. When the child was born, the hospital made a notification to Child Protective Services without consulting Lucy's guardian. The hospital claimed that Lucy had refused to consent to the standard inoculations for her baby and that she had also refused to breastfeed her child. Actually, Lucy had decided not to breastfeed her baby because of the risks associated with the transference of antipsychotic medication through breast-milk. Lucy's guardian argued that although the guardian could not consent to the baby's inoculation, the hospital had a duty of care to the child to administer the vaccines. The guardian contested the grounds of notification on the basis of misrepresentation, so that Lucy's second child would know that her mother had not refused her care, but rather, had suffered a disability that prevented her from consenting to care.

In 2001-02, the Department of Human Services (DHS) reported that in 15% of its investigated cases, parents had a mental illness. This was double the figure reported in 1996-97 (DHS, 2003c).

The Public Advocate observes a general lack of appropriate support to families where a parent has a mental illness. Often parents with mental illness 'need' to be formally notified to child protection services if they are to have access to the limited range of support services currently available to families. The limited availability of specialist parenting programs directly impacts upon the opportunities many parents with a

mental illness have to undertake the parenting role. Linked to this is the problem of respite services not being available to parents with mental illness in need of respite from parenting. Given the often-episodic nature of mental illness, support needs to be provided in ways which accommodate this aspect. An important part of this is having a clear plan of action in instances where the parent is unwell. This would help to minimise the extent to which situations develop into crisis before there is a response, and indeed the extent to which protective concerns arise.

The Public Advocate notes a possible bias against parents with mental illness in the current child protection assessment framework. For example, the presumption that mental illness is in itself a key determinant of parenting ability is discriminatory, particularly when the definition of 'effective parenting' is so unclear.

The current emphasis on 'risk management' means that the mere presence of parental mental illness is automatically presumed to be a risk factor, and such deficits-focused assessment practices can have particularly damaging consequences for parents.

Deficit assessments fail to consider the possible effect of multiple care placements upon the child, which is often the alternative to remaining in the care of the parents. A more comprehensive and sophisticated risk assessment approach is to be encouraged, as this makes it less likely that assumptions will be made based upon disability.

The experience of OPA is that the level of understanding of mental illness by the professional undertaking the assessment has implications for the accuracy of the assessment. Unfortunately there area limited number of professionals with this expertise. Consideration should be given to training and mentoring programs in this specialised area. The need for child protection workers to have clear standards in relation to understanding issues of parental mental illness is critical, particularly given that 32% of cases coming before the Children's Court in 2000-01 involved a parent with a disability (DHS, 2003c).

OPA affirms the right of **both parent and child** to maintain personal contact, except if it has been determined to be contrary to the child's best interests. Too often in this area, rights are perceived and pursued in isolation of parent-child relationships. Often the approach is characterised by an exclusive focus upon the needs of the child, without considering the importance of attachment issues and relationships with parents in seeking to meet these needs.

Recommendations:

19. The development of national parenting guidelines which recognise the needs of specific groups within a broader framework of general parenting support. This has the potential to normalise the issues faced by parents from these groups and reduce the risk of them being further stigmatised by being singled out in specific guidelines.

20. As part of a broader national strategy to address child abuse, government needs to resource integrated and varied supports to families throughout the different stages of planning. There needs to be a systemic shift to a parent support focus.

21. There should be an emphasis on cross training of child protection and mental health workers so that there is an increased understanding of both mental health from the child protection workers' perspective, and the child protection system by the mental health workers. Such cross training can help broaden the understanding of mental illness enabling the child protection system to be more responsive to the needs of this group.

22. The establishment of clear links between child protection and adult mental health support services, disability, and drug and alcohol support services. The role of adult mental health services in supporting parents should also be strengthened as part of broader psychosocial rehabilitation approach.

23. Intervention should be based on comprehensive and strengths-based assessments of the family situation. This should minimise the extent to which presumptions are made about the person's capacity to parent often before they have had the opportunity to parent.

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