Office of the Public Advocate

Safeguarding the rights and interests of people with disability

Submission to the Royal Commission into Victoria's mental health system

July 2019

Dr Colleen Pearce
Public Advocate
Office of the Public Advocate

Dr John Chesterman
03 9603 9567
John.Chesterman@justice.vic.gov.au

Office of the Public Advocate
Level 1, 204 Lygon Street, Carlton, Victoria, 3053
Tel: 1300 309 337
www.publicadvocate.vic.gov.au

Contents

Abbreviations

AHRC	Australian Human Rights Commission
CAT	Crisis Assessment and Treatment
CCU	Community Care Unit
CISO	Corrections Independent Support Officer
UN Convention	United Nations *Convention on the Rights of People with Disabilities*
DHHS	Department of Health and Human Services
ECT	Electroconvulsive treatment
IMHA	Independent Mental Health Advocacy
ITP	Independent Third Person
MTPD Act	*Medical Treatment Planning and Decisions Act 2016* (Vic)
NDIS	National Disability Insurance Scheme
OPA	Office of the Public Advocate
OPCAT	Optional Protocol to the Convention Against Torture
PARC	Prevention and Recovery Care
SECU	Secure Extended Care Unit
SRS	Supported Residential Services
TSU	Transition Support Unit
Tribunal	Mental Health Tribunal
VAGO	Victorian Auditor General's Office

VCAT	Victorian Civil and Administrative Tribunal
Victorian Charter	*Charter of Human Rights and Responsibilities Act 2006* (Vic)
VLRC	Victorian Law Reform Commission

Recommendations

Recommendation 1
The Victorian Government should review the *Mental Health Act 2014* and continue to monitor its implementation to assess, among other things:

- the standard of care offered to all persons seeking mental health services, not just those who are assessed and may be treated compulsorily
- the impact of supported decision-making practices on the delivery and success of treatment and care
- the interaction of the Mental Health Act with other relevant legislation, such as the *Medical Treatment Planning and Decision Making Act 2016*, the *National Disability Insurance Scheme 2013*, the *Crimes Mental Impairment and Unfitness to be Tried Act 1997*
- the comprehensiveness of the oversight provided by monitoring bodies, namely the Chief Psychiatrist, the Mental Health Complaints Commissioner, and the Mental Health Tribunal.

The Victorian Government should ensure that future amendments to the *Mental Health Act 2014* (Vic) include:

- a legislated therapeutic approach to treatment plans
- more comprehensive oversight of the use of electroconvulsive treatment in all mental health services
- provisions that enhance access to advocacy for all people receiving mental health services.

Recommendation 2
The Victorian Government should review and amend the *Framework for recovery-oriented practice* to include an additional domain on recovery-oriented practice at a systemic level.

Recommendation 3
The Victorian Government should ensure meaningful therapeutic activities are available seven days a week in all mental health facilities as a minimum standard.

Recommendation 4
The Victorian Government should publicly report on the following in their quarterly mental health performance data report:

- deaths (all causes) within mental health facilities
- deaths of people under the Mental Health Act in the community within a month of discharge from a mental health facility
- the number of incidents of aggression and violence within mental health facilities
- the number of times people under the mental health act leave an inpatient facility without authorisation from the authorised psychiatrist

Recommendation 5
The Victorian Government should implement the recommendations of the Mental Health Complaints Commissioner's report *The right to be safe* to ensure sexual safety in acute mental health inpatient units.

Recommendation 6
The Victorian Government should publish and implement a commitment to reduce and eliminate the use of seclusion and restraint in the mental health sector.

Recommendation 7
The following settings, among others, should fall within the deprivation of liberty and places of detention under OPCAT:

- detention in a mental health service, residential treatment facility or prison following a finding of unfitness to be tried and/or not guilty because of mental impairment
- detention in a mental health service for compulsory mental health treatment under mental health laws, such as the *Mental Health Act 2014* (Vic)
- detention in a treatment centre for compulsory detoxification, withdrawal and/or substance dependence treatment, such as pursuant to a detention and treatment order under the *Severe Substance Dependence and Treatment Act 2010* (Vic).

Recommendation 8
The Victorian Government should publish guidelines to ensure open air access is available to all mental health patients for a minimum of two hours daily.

Recommendation 9
Public designated mental health facilities should be required to report sustained failure to provide patients with access to open air to the Chief Psychiatrist.

Recommendation 10
The Victorian Government should complete a thorough system map that documents its capacity, including capital and workforce infrastructure, geographical spread of services, and estimated current and future demand, including current unmet demand. This should include a map of NDIS and non-NDIS mental health programs and populations to assess the impact of the NDIS on the mental health landscape and identify any emerging gaps.

Recommendation 11
The Victorian Government should use this map to inform a detailed, public, state-wide investment plan that integrates service, capital and workforce planning, setting out deliverable timeframes.

Recommendation 12
The Victorian Government, in its system wide infrastructure design, should plan for short stay units to be available in all catchment areas.

Recommendation 13
The Victorian Government, in its system wide infrastructure design, should specifically plan for more individualised accommodation options with 24-hour support for people with mental illness living in the community.

Recommendation 14
The Victorian Government should audit Supported Residential Services staff attendance at mental health training against the potential staff attendance pool.

Recommendation 15
The Victorian Government should fund staff training in Supported Residential Services to manage excessive alcohol and illicit drug use effectively.

Recommendation 16
The Victorian Government should develop a Disability Justice Strategy, as proposed in the Australian Human Rights Commission report *Equal before the law,* to reduce the number of people with disability and/or mental illness who are incarcerated due to inadequate support for their needs.

Recommendation 17
The Victorian Government should publish human rights principles and guidelines for Corrections Victoria.

Recommendation 18
The Victorian Government should fund the expansion of transition and community based mental health services for former prisoners.

Recommendation 19
A new medium-secure forensic mental health facility should be established as an approved mental health service for adults with a mental illness who are subject to supervision orders under the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic).

Recommendation 20
The Victorian Government should prioritise reforms to the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* on its parliamentary legislative agenda.

Recommendation 21
The Victorian Government should fund an expansion of the Victoria Police PACER program to operate 24/7.

Recommendation 22
The Victorian Government should adequately fund the Crisis Assessment and Treatment (CAT) program.

Recommendation 23
The Victorian Government should introduce legislative reform to require Victoria Police to have an Independent Third Person present when interviewing a person with a cognitive impairment or mental illness.

Recommendation 24
Corrections Victoria should expand and resource the Corrections Independent Support Officers Program to support people with mental illness.

Recommendation 25
The Chief Psychiatrist and the Chief Mental Health Nurse should review the clinical governance, referral pathways, and model of care of aged mental health residential care facilities across Victoria to ensure care is consistent across all aged mental health facilities.

Recommendation 26
The Victorian Government should ensure mental health practitioners undertake professional education of the possibility of autism as an underlying cause of some mental illnesses, particularly anxiety and depression, and particularly in females.

Recommendation 27
The Victorian Government should provide necessary evidence-based services for both adult women and men with autism to help prevent the development of mental illnesses and the resulting cost in lives lost or compromised as well as system resources.

Recommendation 28
The Victorian Government should provide free access to autism diagnoses, which are currently very costly.

1. About the Office of the Public Advocate

The Office of the Public Advocate (OPA) is a Victorian statutory office, independent of government and government services that works to safeguard the rights and interests of people with disability[1]. The Public Advocate is appointed by the Governor in Council and is answerable to Parliament.

OPA provides a range of services for people with cognitive impairment or mental illness, including guardianship, advocacy, and investigation services. In 2017-18, OPA was involved in 1,806 guardianship matters (963 of which were new), 389 investigations and 320 cases requiring advocacy.

Under the *Guardianship and Administration Act 1986* (Vic), OPA is required to arrange, coordinate and promote informed public awareness and understanding about substitute decision making laws and any other legislation dealing with or affecting persons with disability.[2] OPA provides an advice and education service that offers information and advice on a diverse range of topics affecting people with disability. Last financial year, the telephone advice line provided advice in 11,752 instances, a substantial proportion of which related to powers of attorney (approximately 30 per cent). OPA coordinates a community education program where staff address both professional and community audiences across Victoria on a range of topics including the role of OPA, guardianship and administration, enduring powers of attorney, and medical decision making.

OPA is also supported by more than 600 volunteers across four volunteer programs: the Community Visitors Program, the Community Guardian Program, the Independent Third Person Program (ITP Program) and the Corrections Independent Support Officer (CISO) Program.

Community Visitors are empowered by law to visit Victorian accommodation facilities for people with disability or mental illness at any time, unannounced. They monitor and report on the adequacy of services provided, in the interests of residents and patients. They ensure that the human rights of residents or patients are being upheld and that residents are not subject to abuse, neglect or exploitation.[3]

There are more than 400 Community Visitors who visit across three streams: disability services, supported residential services and mental health services. Under the *Mental Health Act 2014* (Vic), Community Visitors visit mental health services, including acute and secure extended care units. Community Visitors conducted 5,261 statutory visits across all three streams in 2017-18, 1,601 of which were to 143 mental health units across Victoria.[4] In their annual report, Community Visitors report to parliament on the quality and safety of the mental health services they visit.

[1] *Guardianship and Administration Act 1986* (Vic) pt 3.
[2] *Guardianship and Administration Act 1986* (Vic) s 15(e).
[3] Office of the Public Advocate (Vic), *Annual Report* (2017-18) 26.
[4] *Community Visitors Annual Report* (2017-18).

2. About this submission

2.1. A human rights approach

This submission applies a human rights approach that:

- holds that all people with disabilities have the right to enjoy equality of opportunity and to effectively participate in, and be fully included in, society
- recognises that the challenges experienced by many people with disabilities are a result of disabling systems and environments, rather than being due to an inherent 'lack' in the individual
- does not deny the reality of impairment or its impact on the individual
- seeks to challenge physical and social environments to accommodate impairment as an expected dimension of human diversity.

In writing this submission, OPA is guided by the following legislative instruments that promote and protect the human rights of people with mental illness and/or disability:

- the United Nations Convention on the Rights of Persons with Disabilities
- the Optional Protocol to the Convention Against Torture
- Disability Discrimination Act 1992 (Cth)
- National Disability Insurance Scheme Act 2013 (Cth)
- Guardianship and Administration Act 1986 (Vic)
- Charter of Human Rights and Responsibilities Act 2006 (Vic)
- Mental Health Act 2014 (Vic).

OPA applies a person-centred approach to its conceptualisation and understanding of mental illness. OPA repeats key statements made in its submission to the terms of reference of this Royal Commission:

- People with mental illness should not be represented as depictions of their circumstances.
- Care should be tailored to a person's life circumstances, personal aspirations, and preferences.
- The focus of the Royal Commission should be on outcomes for people and how they can be individually supported to have the best possible life they can.

2.2. Terms of reference

This submission includes observations from across all OPA program areas, including Community Visitors and other volunteer programs. It addresses the terms of reference that are most directly relevant to OPA's unique experience in safeguarding the rights of people with cognitive impairment. Many of the topics raised are relevant to multiple of the terms of reference. Consequently, this submission is organised thematically rather than according to each term of reference.

3. Person-centred care

There is strong evidence in the literature on the social determinants of health and mental health that overall wellbeing contributes to good mental health. As a result, a person's recovery is necessarily underpinned by factors and services that lie outside the realm of mental health, such as health, housing, employment, or disability. Mental health services should accordingly encourage and facilitate access to a range of services that, while provided by other sectors, can lead to good mental health.

OPA has concerns that reforms in human service delivery struggle to meaningfully apply a person-centred approach and fully recognise the intersecting needs of service users. Social service sectors are being increasingly silo-ed and separated, which imposes bureaucratic challenges for both service users and providers. For example, the *Principles to determine the responsibilities of the NDIS and other service systems* attempts to distinguish disability services from other human services in order to determine the source of funding for the relevant service. This approach demands that consumers clearly delineate aspects of their life that cannot be so easily untangled. For instance, the principles for the NDIS - mental health interface list 'intensive case coordination operated by the mental health system where a significant component of case coordination is related to the mental illness'[5] as the responsibility of the mental health system. For someone with a psychosocial disability, the distinction can seem meaningless when mental illness and its disabling factors are bound up with one another. The difficulty of this exercise places consumers and providers in funding disputes between sectors, resulting in consumers awaiting resolution without the services they need.

Legislation, policies, and procedures are essential to operationalise a holistic and person-centred approach to care. In this section, OPA analyses the effectiveness of the implementation of mental health legislation and practice frameworks in effecting person-centred care.

3.1. The *Mental Health Act 2014* (Vic)

The *Mental Health Act 2014* (Mental Health Act) is the starting point for setting the standard of care within the mental health sector.

The initial intention of the 2010 review of Victorian mental health legislation, as stated by the then Minister of Mental Health, was to ensure a new act could effectively protect the rights articulated in the Victorian *Charter of Human Rights and Responsibilities 2006* (Victorian Charter) and the United Nations' *Convention on the Rights of Persons with Disabilities* (UN Convention). It was envisaged that the amended legislation would more genuinely align with a contemporary service context.

In line with this intention, OPA hoped that the new Mental Health Act would provide a legislative framework for *all* people with mental illness, not just patients subject to compulsory treatment. In OPA's view, the Mental Health Act remains too narrowly centred on situations of civil detention. By doing so, it fails to fulfil the intention to promote the universal right of all Victorians to be supported in achieving good mental health.

[5] Council of Australian Governments, *Principles to determine the responsibilities of the NDIS and other service systems* (November 2015) 6.

While patients on an assessment or treatment order undeniably require additional protections due to the intrusion on their human rights, they represent only a portion of mental health consumers. The Mental Health Act could do more to prescribe a rights enhancing model for all mental health services and users.

OPA draws comparisons to the *Disability Act 2006* (Vic; Disability Act) whereby an individual who meets the criteria for disability (which excludes mental illness) is granted a range of legislated rights to access funded supports. The objectives (s 4) and principles (s 5) of the Disability Act cover all people with disability and the legislation directs providers on the parameters for service delivery. The *National Disability Insurance Scheme Act 2013* (Cth), while not as comprehensive, articulates similar intentions. In contrast, the objectives and principles of Mental Health Act are for the most part limited to people with mental illness who are subject to assessment. Among the objectives, only one speaks universally to the need to 'promote the recovery of persons who have mental illness'.[6] Yet, article 25 of the UN Convention recognises that all 'persons with disabilities have the right to the enjoyment of the highest attainable standard of health'.

Even within this narrow scope, OPA and Community Visitors have observed that limited funding impacts the ability of the mental health sector to fulfil the current objectives of the Act, as is described throughout this submission. For example, in 2017-18, Community Visitors recorded 319 issues related to legal/human rights and the provision of information. These include access to consumer rights information such as information about the Mental Health Tribunal (Tribunal) hearings, rights to appeal, and rights to second opinion.

Legislation entrenches the right of consumers to access services. When it is limited in scope, it materialises into a system that is too easily influenced by political change (and budgetary commitments). OPA advocates for a broadening of the Mental Health Act with the objective of ensuring that mental health services are accessible to all. This could also provide some security for the sector by ensuring it is adequately resourced to carry out its legislated functions.

The Mental Health Act is due for review in 2019; OPA expects that evidence provided to the Commission will reiterate the need for a review of the legislation. OPA will contribute to the review when it occurs but raises some preliminary recommendations and matters for consideration below.

Recommendation 1
The Victorian Government should review the *Mental Health Act 2014* and continue to monitor its implementation to assess, among other things:

- **the standard of care offered to all persons seeking mental health services, not just those who are assessed and may be treated compulsorily**
- **the impact of supported decision-making practices on the delivery and success of treatment and care**
- **the interaction of the Mental Health Act with other relevant legislation, such as the *Medical Treatment Planning and Decision Making Act 2016*, the *National Disability Insurance Scheme 2013*, the *Crimes Mental Impairment and Unfitness to be Tried Act 1997***

[6] *Mental Health Act 2014* (Vic) s 10(f).

- **the comprehensiveness of the oversight provided by monitoring bodies, namely the Chief Psychiatrist, the Mental Health Complaints Commissioner, and the Mental Health Tribunal.**

The Victorian Government should ensure that future amendments to the *Mental Health Act 2014* (Vic) include:

- **a legislated therapeutic approach to treatment plans**
- **more comprehensive oversight of the use of electroconvulsive treatment in all mental health services**
- **provisions that enhance access to advocacy for all people receiving mental health services.**

3.1.1. Treatment Plans

In its submission to the Mental Health Bill exposure draft 2010, OPA advocated for a model of therapeutic jurisprudence in relation to treatment plans, recommending a level of statutory vigilance comparable to that accorded in Part 4, Division 3 (Planning) of the Disability Act. That legislation prescribes the content of a plan, the process by which the plan is created, and the right of individuals to request a review. Individuals must also receive a copy of their plan. To OPA's disappointment, all mention of treatment plans was removed in the review of the Mental Health Act and the legislation was instead restricted to consumers subject to compulsory treatment.

The Chief Psychiatrist guideline on treatment plans incorporates some of these elements by mandating that treatment planning should be led by consumers and that a copy be provided to the consumer[7] but Community Visitors report that still very few consumers have a copy of their treatment plan. As mentioned at 3.1.4, guidelines from the Chief Psychiatrist are not enforceable in the same way as legislation, which restricts compliance options. OPA continues to advocate for provisions around treatment planning to be legislated to entrench recovery-oriented and consumer-led practice within the sector.

3.1.2. Electroconvulsive treatment

The previous mental health legislation required that the use of electroconvulsive treatment (ECT) across all services, including private mental health services, be reported to the Chief Psychiatrist. No similar provision was carried over into the current Act. Furthermore, the Act allows the authorised psychiatrist to proceed with an application to the Tribunal for an order authorising the use of ECT on a person who is refusing treatment if they are satisfied that there is 'no less restrictive way' for the patient to be treated.

Community Visitors lobbied for the inclusion of a provision requiring mental health services to report the use of ECT to the Chief Psychiatrist for some time. As a result, the Chief Psychiatrist has agreed to audit the usage of ECT across the state. These audits include private mental health services who voluntarily agreed to participate in this process after approaches from the Chief Psychiatrist. The audit team is multidisciplinary including psychiatrists, mental health nurses and consumers.

OPA and Community Visitors nonetheless maintain that higher thresholds for the use of ECT would provide more comprehensive safeguards.

[7] Office of the Chief Psychiatrist (Vic), *Chief Psychiatrist's guideline: treatment plans* (2018) 3.

3.1.3. Advance statements

Advance statements set out a person's treatment preference in case they become unwell and need compulsory mental health treatment. An authorised psychiatrist must have regard to a person's advance statement when making a treatment decision. Advance statements are an important mechanism to give effect to a person's will and preferences.

OPA and Community Visitors have observed that there has been a low uptake of advance statements by both mental health services and consumers. Data from the Department of Health and Human Services (DHHS) that is shared with Community Visitors show that on average 2 to 6 percent of mental health consumers have an advance statement. The best performing mental health service across the state had fifteen per cent of their clients with an advance statement, so there is still much work to be done here. OPA's medical treatment and decisions team has not seen any advance statements and suspect that consumers and possibly practitioners may lack confidence in the instrument.

3.1.4. Interaction with the *Medical Treatment Planning and Decisions Act 2016* (Vic)

The *Medical Treatment Planning and Decisions Act 2016* (Vic) (MTPD Act) provides for some forms of advance care planning: the appointment of a medical treatment decision maker, appointment of a support person and the making of an advance care directive (consisting of a values directive and/or instructional directive). The definition of 'medical treatment' under this Act includes treatment for mental illness or any other medical condition, yet OPA identifies some inconsistencies between the MTPD Act and the Mental Health Act.

Since the implementation of the MTPD Act, there appears to be limited understanding of, and compliance with, the requirement to obtain the consent of a medical treatment decision maker to administer medication to treat mental illness if the person is unable to consent to the treatment themselves.

Case study: Rona

Rona was an older woman with mental illness. When OPA was appointed guardian with authority for medical treatment decisions, Rona was living in an aged mental health residential care facility as a voluntary patient and was receiving a range of medications for both mental and physical conditions.

On occasion, the staff at the aged mental health residential care facility were unable to successfully manage behaviours related to her mental illness that placed her and others at risk.

The facility staff approached Rona's guardian to seek consent for the administration of psychotropic medication by intra muscular injection, as Rona was refusing treatment and was strongly opposed to receiving intra muscular injections which was being proposed. The guardian refused to consent due to Rona's preferences and values and the matter was resolved in a way that promoted Rona's wellbeing and quality of life. Given how unwell Rona was, OPA believes that the facility should have sought a compulsory order to bring the mental health treatment decisions under the Mental Health Act instead of seeking consent from her guardian under the Medical Treatment Planning and Decisions Act.

OPA has concerns about the application of the legislated decision-making framework under either Act. The MTPD Act "recognises that when decisions are made on behalf of a person, these decisions should be made in accordance with the person's preferences and values."[8] Similarly, the Mental Health Act speaks to a person's 'views and preferences'.[9] Despite this requirement, the mental health service involved in Rona's care seemed to expect the guardian (as a medical treatment decision maker under the MTPD Act) to make a decision without thorough consideration of Rona's preferences or of the broader implications. Indeed, it was unclear to OPA at the time whether the medication was proposed as a behaviour management strategy (to the benefit of other residents in the facility) or for Rona's wellbeing. This lack of information meant the guardian lacked the information required to make an informed decision about whether or not to consent under the MTPD Act.

If a patient is on an assessment or treatment order and does not have decision making capacity, the Mental Health Act determines the appropriate medical treatment decision maker. If a patient is a voluntary mental health patient, like Rona was, the MTDP Act prevails.

While both the MTPD and the Mental Health Acts determine a hierarchy of persons that can make medical treatment decisions on behalf of someone else who is unable to make the decision themselves, the hierarchies do not match. If a person is a voluntary mental health patient, as Rona was but perhaps ultimately should not have been, the medical treatment decision maker is identified through section 55 of the MTPD Act, which lists, in the following order: a medical treatment decision maker appointed under the MTDP Act, a VCAT appointed guardian with powers to make medical treatment decisions or a person 'who is in a close and continuing relationship with the person'. This last provision allows for a person's natural supporters to be involved in the decision-making process.

If instead a person is a compulsory mental health patient, section 75 of the Mental Health Act applies, which prescribes that the following persons may consent to medical treatment (not including mental health treatment) on behalf of someone lacking capacity: a medical treatment decision maker (appointed under the MTDP Act), a VCAT appointed guardian with power to make decisions concerning the proposed medical treatment or the authorised psychiatrist. It is thus likely that in many cases decisions will be made, by default, by the authorising psychiatrist. OPA considers that, by failing to replicate the hierarchy of the MTDP Act, the Mental Health Act excludes persons (i.e. natural and informal support people) who could be appropriate to act as medical treatment decision makers. In this way, the Mental Health Act imposes unnecessary limitations on persons who lack decision making capacity in regards to their medical treatment decisions.

As a result of the inconsistencies between the two Acts, OPA has observed a lack of understanding around the definitions of 'medical treatment' from practitioners using either Act, which can result in practice that is inconsistent with legislation. When using the Mental Health Act, services can fail to recognise that medical treatment decision makers can make decisions related to treatment for physical illnesses. The opposite is true under

[8] Department of Health and Human Service (Vic), *A guide to the Medical Treatment Planning and Decisions Act 2016 for health practitioners, Second edition* (January 2019) 5.
[9] *Mental Health Act 2014* (Vic) s76.

the MTPD Act, where services do not always recognise that the legislation provides for decisions to be made on the treatment of mental illness.

OPA questions whether the discrepancies between the two Acts may result in unintended consequences. For instance, mental health services may choose to place a patient on an order under the Mental Health Act to facilitate (or accelerate) medical treatment decision making. It is difficult for OPA to know whether this occurs, but nonetheless is a risk that merits flagging.

3.1.5. Monitoring bodies

OPA recognises the clinical leadership provided by the Chief Psychiatrist, which has contributed to raising the standard of care within the sector. The Office of the Chief Psychiatrist has engaged with the advocacy undertaken by OPA and Community Visitors and has provided valuable support to this office. However, OPA considers that legislative and policy reform could strengthen the role (see below).

For example, the Chief Psychiatrist produces practice guidelines that are imperative in providing clinical leadership to the sector but they are not enforceable through the Mental Health Act and in some cases, this poses a challenge to compliance (e.g. see 5.4). In addition, Community Visitors query whether the right information-sharing systems are in place to maximise the oversight of the Chief Psychiatrist. Community Visitors observe that systems are in place for data from designated mental health services to be shared with the DHHS, but not directly with the Office of the Chief Psychiatrist. This adds a layer of bureaucracy to the Chief Psychiatrist's access to that important data.

The jurisdiction of the monitoring bodies established in the Mental Health Act, namely the Chief Psychiatrist, the Mental Health Complaints Commissioner and the Mental Health Tribunal, is limited to publicly funded mental health services. There is no independent oversight of mental health services or restrictive practices employed in private settings, as the Mental Health Act obliges only 'designated mental health services' to report on the use of restrictive interventions.

3.1.6. Advocacy

Advocacy can play a crucial role for people with mental illness who are at risk of or who are receiving compulsory treatment. Some people who find themselves in these situations are socially isolated and without a network of support to assist them to navigate the system. Advocacy can also enable greater access to early intervention and other supports, such as diversion programs.

Victoria Legal Aid's Independent Mental Health Advocacy (IMHA) program supports people who are receiving compulsory treatment to have a voice in determining their assessment, treatment, and recovery.[10] OPA welcomes the IMHA, however, it is limited in scope in that the service is not available to consumers receiving psychiatric treatment on a voluntary basis or through the private sector.

[10] <https://www.imha.vic.gov.au/about-us>

Advocacy is a crucial safeguard, particularly in the forensic mental health system. It can be provided both through legal representation and independently to safeguard the rights of people on custodial and non-custodial supervision orders under the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic), for instance.

The Mental Health Act includes no provisions on advocacy. In the second reading speech, the then Minister made the commitment that "separate to the legislation, the government will also fund advocacy and support services for patients as an integral part of the reforms."[11]

OPA has called in the past for a legislated right for people on supervision orders to access advocacy at regular intervals, especially during reviews of supervision orders, for applications to vary orders, for decisions about leave and the determination of post-discharge placements. In an era where the concept of 'least restrictive' option is enshrined under the Victorian Charter and other legislation relating to compulsory orders, it is important that people who are at a risk of being or are indefinitely detained have access to advocacy to support them through this process and enhance protection of their human rights. OPA and Community Visitors continue to advocate for all mental health consumers to have a legislated right to access independent advocacy.

3.2. The Framework for recovery-oriented practice

Recovery-oriented practice in mental health is an evidence-based model that embeds the participation of consumers as equal agents in the delivery of mental health care. The framework is rooted in a human rights approach; its principles translate into practice that promotes and enhances the human and legal rights of consumers by giving effect to Victoria's obligations under the UN Convention.

In Victoria, DHHS prescribes the *Framework for Recovery-oriented Practice* as the clinical directive on recovery-oriented practice. It defines recovery as follows:

> "a unique personal experience, process or journey that is defined and led by each person with a mental illness. It is owned by, and unique to, the person. The role of mental health services is to create an environment that supports and does not impede people's recovery efforts."[12]

3.2.1. A system-wide commitment

The successful implementation of any clinical practice framework can only be possible if it is met with adequate funding, clinical leadership, and explicit processes to operationalise its core principles. Additionally, as argued at 3.1, legislated obligations ensure that any framework becomes entrenched within services.

[11] Victoria, *Parliamentary Debates,* Legislative Assembly, 20 February 2014, 470, (Wooldridge, Minister for Mental Health).
[12] Department of Health (Vic), *Framework for recovery-oriented practice* (2011) 1.

Looking to the international literature, some jurisdictions include a commitment to implement recovery-oriented practices at a systemic level. For example, the *Guidelines for Recovery-Oriented Practice* published by the Mental Health Commission of Canada dedicates four dimensions to 'transforming services and systems', with an explicit acknowledgment that a recovery orientation must permeate the system in order to be successful:

> "Supporting recovery cannot be reduced to a single program, model or service element. It involves reflecting on the way we think about mental health problems and considering the implications for the relationship between providers and those who seek access to supports and services. It entails reviewing how services are organized, how they connect to the broader community and who is involved in delivering services."[13]

Wrap around care, and the collaboration it begets from different sectors, needs to be facilitated at a systemic level. The Victorian *Framework for Recovery-oriented practice* encourages management within mental health services to "ensure staff are skilled at networking and building partnerships with other organisations and that this aspect of their work is recognised and supported by the organisation."[14] However, in OPA's view, the guideline does too little to encourage the contemporary funding and service models to fully realise recovery in the systemic landscape.

The Victorian Framework, across its nine domains, is silent on a systemic aspect to recovery. OPA makes the following recommendation.

Recommendation 2
The Victorian Government should review and amend the *Framework for recovery-oriented practice* to include an additional domain on recovery-oriented practice at a systemic level.

3.2.2. National standards

The Australian Government published the *National standards for mental health services* as guidelines for public, private, and community-based mental health services.

Standard 10.5 reiterates that a recovery-oriented approach is one that "provides access to a range of evidence-based treatments and facilitates access to rehabilitation and support programs which address the specific needs of consumers and promotes their recovery."[15]

Community Visitors note insufficient activities for patients in some services and regularly observe that those services providing meaningful activities have fewer patients experiencing boredom, less aggression between patients and therefore fewer incidents of patient on patient abuse. Also, more importantly, programs can teach people how to avoid episodes, by identifying triggers and developing strategies to stay well.

While the National Standards require meaningful activities, they do not define what this covers nor are there any minimum time standards required. OPA and Community Visitors

[13] Mental Health Commission of Canada, *Guidelines for Recovery-Oriented Practice* (2016) 78.
[14] Ibid 16.
[15] Department of Health (Commonwealth), *National Standards for Mental Health Services* (2010) 26.

repeat a recommendation for a minimum standard to be implemented in mental health services.

Recommendation 3
The Victorian Government should ensure meaningful therapeutic activities are available seven days a week in all mental health facilities as a minimum standard.[16]

4. Safety and abuse within mental health services

Under the Mental Health Act, Community Visitors have a legislated role to visit public mental health units across Victoria. The units include adult and aged person's acute inpatient units, aged mental health residential units, community care units (CCU), secure extended care units (SECU), child and adolescent units, eating disorder units, mother and baby units, prevention and recovery care (PARC) and transition support units (TSU). In the last financial year, 78 appointed Community Visitors in the mental health stream undertook 1,601 visits to 143 mental health units across the state.

Inpatient acute mental health services should be a place of healing, but for some they can be the cause of re-traumatisation. Trauma informed care should be the norm across the system and mental health services should be responsive to the vulnerabilities and histories of incoming consumers. Yet, Community Visitors consistently report on the high prevalence of avoidable harms experienced by consumers in inpatient mental health units. A failure to keep patients safe can rupture the trust they place in the mental health system as a whole and result in non-compliance and resistance to help seeking.

An analysis of Community Visitor data from 2015 to 2018 reveals a total of 891 issues recorded in relation to safety within mental health services. Table 1 breaks down the data on these issues.

Table 1: Safety issues in mental health facilities in Victoria, as recorded by Community Visitors (1 July 2015 to 30 June 2018).

Issue Type	Count
Hazards/safety	365
Assaults, including sexual assaults	170
Aggression, intimidation, harassment	166
Smoking provisions	70
Illicit drug and alcohol use	56
Self-harm	44
Suicide	20
TOTAL	891

In many instances, Community Visitors identify that incidents related to safety and assault (including sexual assault) are at least in part created by pressures placed on the mental health system (as described at 5.0). While funding for the improvement of individual

[16] *Community Visitors Annual Report* (2016-17) 17.

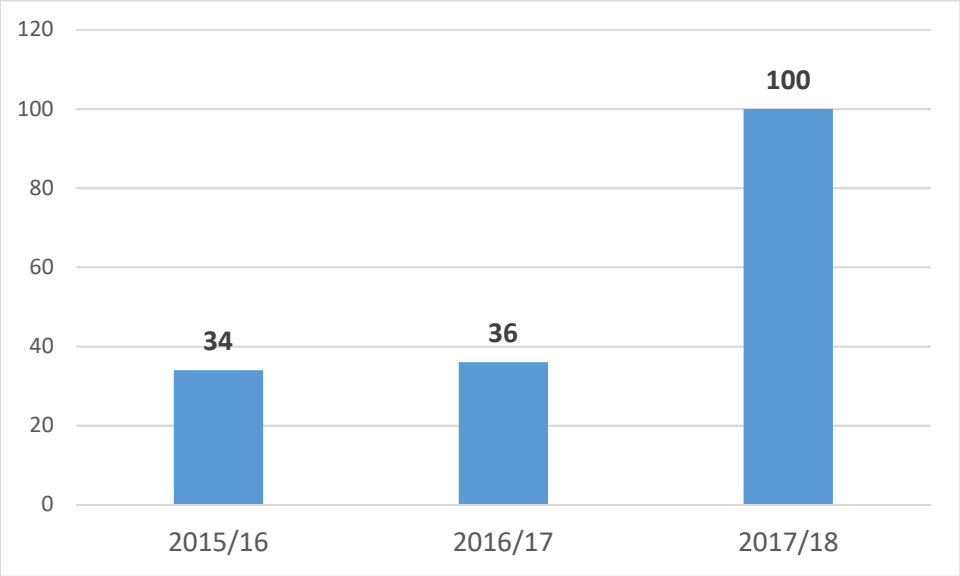
services is necessary, safety issues are likely to persist until systemic change is implemented.

4.1. Physical safety

The greatest safety concern identified by Community Visitors is the physical safety of consumers and staff in mental health facilities. Risks to physical safety include hazards such as falls, absconding, sharp objects in the possession of patients, aggression, and assaults.

Figure 1 depicts the yearly number of assaults including sexual assault recorded by Community Visitors in mental health services since 2015. The apparent increase in incidents could in part be explained by greater access by Community Visitors to incident reports over the years. Nonetheless, it remains troubling.

Figure 1. Assaults, including sexual assault incidents, reported by Community Visitors, mental health stream (2015 to 2018).[17]



Community Visitors report that aggression and assaults most frequently occur in adult acute inpatient units. Assaults occur between patients as well as between patients and staff. Both patients and staff experience verbal abuse, threats, and physical assault, which can be symptomatic of acute mental illness. Notwithstanding this, there are other factors contributing to decreased levels of safety such as staff shortages, drug and alcohol use, and mix of residents.

The Victorian Government publishes quarterly mental health performance reports on their website.[18] To enable greater transparency around the performance of mental health services, OPA calls for a wider range of incident data to be included in the reports: all categories of deaths, including those that occur in the community within a month of discharge; incidents of aggression, assault, violence, and self-harm in mental health units; and instances of absconding from inpatient units.

[17] *Community Visitors Annual Report* (2017-18) 69.
[18] < www2.health.vic.gov.au>

Recommendation 4
The Victorian Government should publicly report on the following in their quarterly mental health performance data report:

- **deaths (all causes) within mental health facilities**
- **deaths of people under the Mental Health Act in the community within a month of discharge from a mental health facility**
- **the number of incidents of aggression and violence within mental health facilities**
- **the number of times people under the mental health act leave an inpatient facility without authorisation from the authorised psychiatrist**

4.2. Sexual safety

OPA and Community Visitors have a long history of advocating for, and monitoring, the implementation of women-only areas within mental health services. In their 2017–18 annual report, Community Visitors note that "while women-only corridors have been established in most acute mental health units, due to high bed occupancies, they cannot always be used as intended and are instead repurposed to accommodate male patients."[19] This is a clear example where system-wide pressures (i.e. pressure on beds) stymie the quality and safety of the care provided to patients.

In 2018, the Mental Health Complaints Commissioner published *The Right to be Safe*, a thorough analysis of complaints related to sexual safety. The report aims to identify systemic threats to gender safety in Victorian mental health services and provides sound recommendations to improve the system's response. OPA endorses the report and reiterates a recommendation made by the Community Visitors Board.

Recommendation 5
The Victorian Government should implement the recommendations of the Mental Health Complaints Commissioner's report *The right to be safe* to ensure sexual safety in acute mental health inpatient units.[20]

4.3. Seclusion, restraint and compulsory treatment

Data from the Victorian Government's 2017-18 *Mental Health Services Annual Report* show no diminution in the use of seclusion, restraint, and compulsory treatment in the mental health system in the past three years.[21] Furthermore, Community Visitors point to Victorian Health Services performance data showing that seclusion events in child and adolescent units have doubled.

At a systems level, no explicit commitment is made to reduce and eliminate the use of restraints and seclusion within the sector. There are no provisions in the Mental Health Act to operationalise the objective of eliminating the use of seclusion and restraint, despite this being the objective stated in the second reading speech of the Act. In the Mental Health Services Annual Report, measures on restrictive practices are indicators of a broader outcome of services that are 'safe, of high quality, offer choice and provide a positive

[19] Ibid 70.
[20] Ibid 67.
[21] Department of Health and Human Services (Vic), *Mental Health Services Annual Report* (2017-18) 54.

experience'.[22] The absence of a more meaningful commitment stands in stark contrast with the disability sector where the Commonwealth Government has established a *National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Service Sector.* The national framework gives effect to Australia's obligations under the UN Convention.

OPA recommends a similar sector-wide goal of eliminating the use of seclusion and restraint should be adopted in the mental health sector. This would do more to place limits on the use of seclusion and restraint and emphasise the need to train mental health staff to implement alternative interventions (e.g. teaching staff de-escalation techniques, developing patient management plans, the provision of comfort rooms).

Recommendation 6
The Victorian Government should publish and implement a commitment to reduce and eliminate the use of seclusion and restraint in the mental health sector.

OPA continues to explore options for legal and practice reform to give effect to additional international human rights obligations since Australia ratified the Optional Protocol to the Convention against Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment (OPCAT).

Article 4(1) of OPCAT defines a 'place of detention' as 'any place under [a State's] jurisdiction and control where persons are or may be deprived of their liberty, either by virtue of an order given by a public authority or at its instigation or with its consent or acquiescence'. 'Deprivation of liberty' is in turn defined in article 4(2) as 'any form of detention or imprisonment or the placement of a person in a public or private custodial setting which that person is not permitted to leave at will by order of any judicial, administrative or other authority.'

OPA repeats a recommendation made to the Australian Human Rights Commission on Australia's implementation of the OPCAT.

[22] Ibid 62.

Recommendation 7
The following settings, among others, should fall within the deprivation of liberty and places of detention under OPCAT:

- **detention in a mental health service, residential treatment facility or prison following a finding of unfitness to be tried and/or not guilty because of mental impairment**
- **detention in a mental health service for compulsory mental health treatment under mental health laws, such as the *Mental Health Act 2014* (Vic)**
- **detention in a treatment centre for compulsory detoxification, withdrawal and/or substance dependence treatment, such as pursuant to a detention and treatment order under the *Severe Substance Dependence and Treatment Act 2010* (Vic).[23]**

4.4. Open air

In 2015-16, the Community Visitors Board recommended that "State Government publish guidelines to ensure open air access for a minimum of 2 hours daily is available to all patients".[24]

In response, the government conducted a review of all outdoor spaces within designated public mental health facilities and the Chief Psychiatrist led an audit of access to open courtyards in inpatient facilities (including a request for immediate notification if Community Visitors find courtyards locked). Since the review, government has funded the refurbishment of outdoor spaces but has failed to endorse a more meaningful requirement for daily access to open air within mental health services, with the reasoning that:

> "A patient's access to these spaces and the duration of access is dependent on a number of multidimensional clinical factors that are taken into account by the service on a daily basis. This is based on the individual needs of the patient and their mental health risks and assessment at the time."[25]

Community Visitors continue to report restrictions on access to open air in some mental health services.

OPA points to Article 21(1) of the United Nations *Standard Minimum Rules for the Treatment of Prisoners* that 'every prisoner who is not employed in outdoor work shall have at least one hour of suitable exercise in the open air daily if the weather permits.'

It is concerning that mental health services (i.e. places of voluntary or civil detention) operate with lower minimum standards than places of criminal detention. To impose such strict restrictions on mental health patients is a breach of human rights obligations under the Victorian Charter and the UN Convention. OPA repeats the following recommendation made by the Community Visitors Board.

[23] Office of the Public Advocate (Vic), *Submission to Australian Human Rights Commission – Australia's implementation of the Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* (July 2017) 4.
[24] *Community Visitors Annual Report* (2015-16) 82.
[25] Department of Health and Human Services (Vic), *The Victorian Government Response to the Community Visitors Annual Report 2015-16* (2016) 19.

Recommendation 8
The Victorian Government should publish guidelines to ensure open air access is available to all mental health patients for a minimum of two hours daily.

Recommendation 9
Public designated mental health facilities should be required to report sustained failure to provide patients with access to open air to the Chief Psychiatrist.

5. A system in perpetual crisis

In OPA's view, the most endemic and costly of all issues in Victoria's mental health system are shortages in both inpatient beds and community-based accommodation. The two are intrinsically linked and when combined, they create a system that operates in a state of perpetual crisis due to its inability to meet the needs of consumers. In this section, OPA further explains the impact of shortages of mental health services.

5.1. Bed shortages

There are 2,471 publicly funded mental health beds in Victoria. According to Victorian Health Services data, most facilities maintain an occupancy rate over 90 per cent and some areas operate at more than 100 per cent occupancy.[26] Bed shortages are not a recent development: Community Visitors annual reports show evidence that bed shortages in the areas of acute, sub-acute, and secure extended care have been ongoing for decades. The impact on consumers, staff, and the mental health system as a whole has been unremitting, yet there has been no comprehensive response to this system-wide issue.

The discrepancy between demand and supply for mental health inpatient beds has ripple effects on the recovery and wellbeing of all consumers. OPA and Community Visitors witness firsthand how bed shortages result in premature discharges, consumers being inappropriately kept in general hospital wards or emergency departments for extended periods of time, people in crisis not being able to gain admission, the locking of wards due to limited numbers of high dependency beds in acute units, and beds in underutilised specialist units (e.g. Transition Support Units (TSU); aged mental health residential care facilities) being repurposed to take in clients in crisis.

The reduced availability of beds means admission into acute units can be determined by the acuteness of a person's symptoms, disadvantaging individuals with less severe presentations. This inability to admit consumers with less severe symptoms creates a system that is unable to intervene at an early enough stage to prevent the escalation of symptoms. Those who gain admission are typically very heightened and agitated, creating a high-pressure environment within units that is not necessarily conducive to recovery. Operating at capacity with waiting lists places pressure on inpatient mental health services to discharge people earlier than may be clinically advisable, sometimes before their medication may have taken effect or to inappropriate settings.

[26] *Community Visitors Annual Report* (2017-18) 70.

In 2015, DHHS published *Victoria's 10-year mental health plan*, which explicitly acknowledges the pressures on beds:

> "…increasing and sustained demand pressure on services has not been matched with increasing resources. Shifting population and growth has left some services under even greater pressure. The result is longer waiting times to access services and higher thresholds for entry. The increased pressure on services creates a risk that people may receive treatment that is less timely, less intensive and shorter in duration than they want or need."[27]

In March 2019, the Victorian Auditor General's Office (VAGO) released a timely report entitled *Access to mental health services.* It presents the findings from an audit conducted to "determine if people with mental illness have timely access to appropriate treatment and support services"[28] as required by *Victoria's 10-year mental health plan*.

The VAGO audit concluded that the actions proposed in the 10-year plan will be insufficient to reduce the gap between demand and supply:

> "While DHHS understands the extent of the problem well and has been informed by multiple external reviews, the 10-year plan outlines few actions that demonstrate how DHHS will address the demand challenge that the 10-year plan articulates."[29]

OPA has in the past recommended a thorough approach to system planning for the mental health sector, most recently in the context of funding commitments made in the transition to the NDIS (discussed at 5.4 and 8.3 of this submission). The VAGO proposes a more comprehensive exercise that OPA endorses and OPA further qualifies the recommendation to ensure that the system mapping proposed captures any gaps emerging as a result of the NDIS reforms.

Recommendation 10
The Victorian Government should complete a thorough system map that documents its capacity, including capital and workforce infrastructure, geographical spread of services, and estimated current and future demand, including current unmet demand.[30] This should include a map of NDIS and non-NDIS mental health programs and populations to assess the impact of the NDIS on the mental health landscape and identify any emerging gaps.

Recommendation 11
The Victorian Government should use this map to inform a detailed, public, state-wide investment plan that integrates service, capital and workforce planning, setting out deliverable timeframes.[31]

[27] Department of Health and Human Services (Vic), *Victoria's ten-year mental health plan* (2015) 9.
[28] Victorian Auditor General's Office (Vic), *Access to Mental Health Services* (2019) 7.
[29] Ibid 8.
[30] Ibid 14.
[31] Ibid.

Good practice: Short stay units

Community Visitors observe that Psychiatric Assessment and Planning Units (PAPU), where available, contribute to good outcomes for mental health patients. PAPUs are a dedicated treatment and assessment service that can admit patients for up to 72 hours. During this time, practitioners work towards the goal of discharging patients to a community setting with the required supports.

PAPUs bring much needed relief to emergency departments and acute units, all the while providing an intermediary setting to manage acute symptoms. Community Visitors estimate that up to 80 per cent of patients are appropriately discharged from PAPUs within the 72-hour time frame.

OPA welcomes the Victorian Government's funding commitment to six emergency department crisis hubs, that will provide a 24-hour short stay option for patients admitted for mental illness and/or drug and alcohol problems.[32] To OPA's knowledge, the hubs have not yet been rolled out, but it is expected that they will provide further relief to acute units, similarly to PAPUs. Likewise, Community Visitors welcome the expansion of Prevention and Recovery Centres (PARCs).

Short stay units are unfortunately not available in every catchment area and, as is the case in most mental health services, some have limited availability. OPA encourages the expansion of the network of short stay units.

Recommendation 12
The Victorian Government, in its system wide infrastructure design, should plan for short stay units to be available in all catchment areas.

5.2. Accommodation shortages

While much reform has occurred in mental health policy and service delivery over the last three decades in Australia, the process of deinstitutionalisation has failed to adequately address the need of many people with enduring mental illness to access long-term accommodation and support. Despite the adoption of the policy of deinstitutionalisation in the 1990s and the closure of the remaining standalone institutions, OPA and Community Visitors report that without adequate housing supports some people with long-term mental illness are still not afforded the same opportunity to live and participate fully in the life of their community.

Evidence from Community Visitors' reports and OPA clients shows that the move from institutions to community-based mental health care has been executed with large shortfalls in government funding commitments for supported accommodation options that could provide varying levels of mental health support (both step-up and step-down) outside of inpatient units. When coupled with a state-wide shortage in affordable housing, consumers who could benefit from outpatient care are faced with very limited options.

Housing is one of the key social determinants of health; without stable housing, the recovery, wellbeing, and safety of mental health consumers are all jeopardised. Shortages in accommodation limit the range of discharge options, thus compromising the ability of acute inpatient mental health services to ensure consumers are safe upon discharge. In the

[32] < https://www.premier.vic.gov.au/new-mental-health-hubs-to-treat-more-victorians-sooner/>

absence of suitable accommodation options, some consumers unnecessarily cycle in and out of hospital or the justice system and/or situations of homelessness, as is the case with Harriet (see below) or Stephanie (Case Study on page 47). In other cases, patients remain in unnecessary detention in the mental health (see 5.3) or justice systems (see 7.1).

Case study: Harriet

Harriet, of no fixed abode, spent time in a country SECU before her transfer to an acute mental health unit. She was non-compliant with her medication regime and irritable, aggressive and assaultive on the ward. The unit tried to find her suitable discharge accommodation, of which there were very limited options in that country area. Harriet refused the proposed options and so, after four months with the service, was facing discharge into homelessness having been supplied with a warm coat and a sleeping bag purchased by the acute mental health service.

The Community Visitors raised this matter with the Office of the Chief Psychiatrist for review, as they were concerned about Harriet's wellbeing should she be discharged into homelessness.

The service's view was that there was nothing to be gained by insisting that Harriet stay any longer on the ward. She would be discharged on a Community Treatment Order (CTO) and prescribed regular depot antipsychotic injections, provided she was able to be contacted once discharged to homelessness. The Office of the Chief Psychiatrist review found that the service had made reasonable efforts to engage with Harriet, to find the optimal treatment for her and to assist with discharge planning. Because of the review sought by the Community Visitors, Harriet was funded to stay in a motel for a few days post-discharge.

Harriet would very likely have benefitted from the availability of additional supported accommodation options in her local community, this would have promoted her recovery under a CTO.

The UN Convention's article 14 (the right to liberty and security of person), article 19 (the right to live independently and be included in the community), and article 26 (the right to habilitation and rehabilitation) are all relevant. OPA calls upon government to intervene to fully realise the rights of people with mental illness to be supported to live independently within their communities.

Recommendation 13
The Victorian Government, in its system wide infrastructure design, should specifically plan for more individualised accommodation options with 24-hour support for people with mental illness living in the community.

Good practice: Supported long-term accommodation

OPA turns once more to the disability sector, where supported long-term accommodation is available to some clients.

OPA observed one particularly successful model funded by the Transport Accident Commission (TAC) where consumers each have their own unit on a shared lot with access to a 'core' unit where staff are present 24/7. Each resident has their own

individual support plan, but outside of this, on site staff remain available to them. Independence is encouraged with residents paying their own utilities and groceries and residents can have guests and pets. Social activities are organised for all but are not compulsory. This service has no time limit and while it can be challenging to access, provides a sustainable level of support to people with disability.

In the mental health sector, OPA notes that Community Care Units provide a similar service. However, CCUs have a two year stay limit. Longer term options are required.

5.3. Unnecessary detention: long stay patients

OPA's long stay patient project involves the collection and analysis of data by Community Visitors to identify patients who are detained in mental health units for extended periods of time. Community Visitors request long stay patient data from staff for publication in their annual report.

'Long stay patients' are defined as patients spending more than three months in an adult acute unit or more than two years in a Community Care Unit (CCU), Secure Extended Care Unit (SECU) or other units such as Thomas Embling Hospital and Mary Guthrie House.

Since 2008, Community Visitors have identified an important number of patients who appear to be indefinitely involuntarily detained under the Mental Health Act. OPA appreciates that mental health units are not intended to provide lifelong accommodation and/or support. Yet, many involuntary patients spend protracted periods of time in these restricted settings because there is nowhere else for them to go.

Figure 2 presents the data from the long stay patient project since 2008. At the last data collection point in 2015-16, Community Visitors identified 65 long stay patients in Victoria. Figure 3 below illustrates the distribution of these patients across clinical settings.

Figure 2. Long stay patients identified by Community Visitors, mental health stream (2008 to 2015).

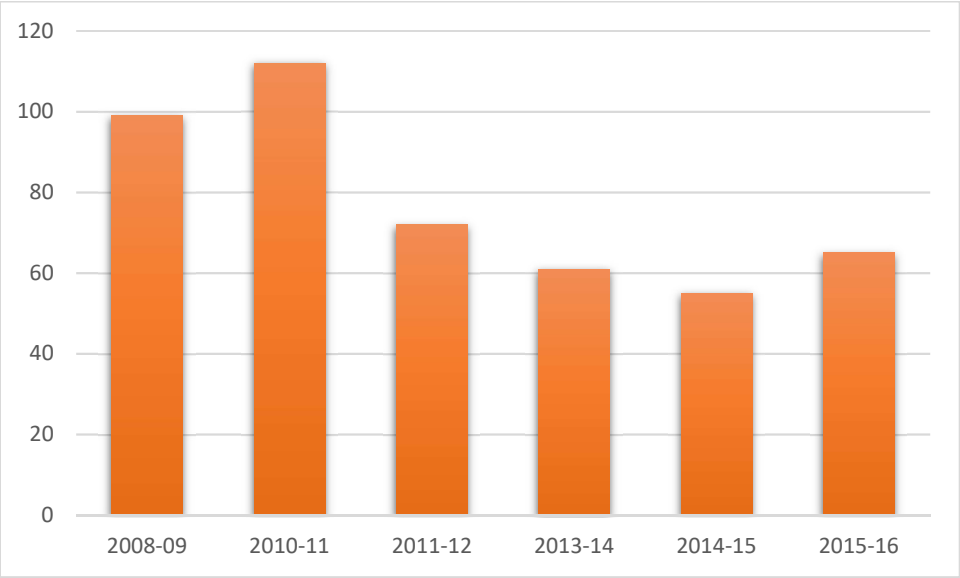
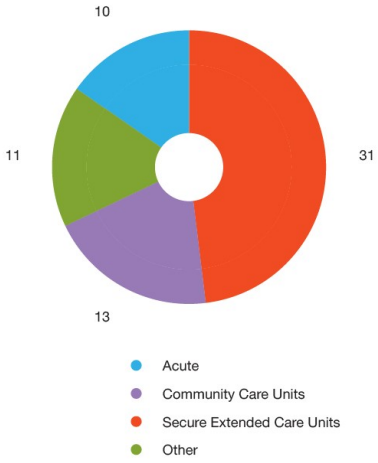


Figure 3. Current accommodation for identified long stay patients, as recorded by Community Visitors, mental health stream (2015-16).



The most recent data shows that the length of stay was commonly between two to three years for patients who were in SECU, CCU and units categorised as 'other'.[33] However, eleven individuals had been in mental health units for far longer (between nine and 24 years), most of whom were 'unable to be discharged due to serious mental illness and complex needs'.

The most frequently cited factor preventing discharge for long stay patients with serious mental illness was a shortage of appropriate accommodation and support that could ensure a transition into a less restrictive setting that would provide the required level of care.[34] In other words, some long stay patients are involuntarily detained in restrictive environments for lack of alternative step-down options.

While the number of identified long stay patients remains high, figure 2 nonetheless demonstrates a slow and steady reduction in numbers over the last ten years. In 2013-14, Community Visitors noted:

> "Since the commencement of the [long stay patient] project in 2007, many long-term, former-institutionalised patients have been discharged to more appropriate accommodation. Many current long-stay patients in SECU and CCU settings have been there for relatively shorter periods of time than the original cohort of long-stay patients. These successes are in large part due to Community Visitors work in identifying them and OPA's advocacy on their behalf."[35]

The reduction in the number of long stay patients may be attributable to a range of policy and funding factors, including the provision of intensive in-reach for long-stay patients (funded originally through the Intensive Rehabilitation Recovery Care Project, then through the SECU diversion project and the Intensive Home Based Outreach Service) and the development and expansion of PARC facilities. Together, these initiatives contribute to diverting consumers from sub-acute settings and provide intensive support for their recovery as they transition to a community setting.

[33] Thomas Embling and Mary Guthrie House.
[34] *Community Visitors Annual Report* (2015-16) 49.
[35] *Community Visitors Annual Report* (2013-14) 43.

Notwithstanding these improvements, Community Visitors and OPA continue to identify a serious deficiency in the availability of less restrictive, home-like, community-based accommodation options for people with chronic mental health issues. The capacity of the mental health system to meet its human rights obligations in line with the Victorian Charter and the UN Convention is severely compromised by shortages in community-based accommodation. It is not reasonable to limit a person's rights where their circumstances are dictated by the failure of the service system to provide less restrictive options.

5.4. System navigation and discharge planning

Discharge planning is an information sharing clinical practice that enables collaboration between services with the aim of providing effective and comprehensive care to consumers. When well executed, discharge planning and referrals facilitate system navigation and secure continuity of care for consumers transitioning from one service to the other.

Empirical evidence demonstrates that the days following discharge are a period of particularly high risk for patients leaving acute mental health care. OPA is aware that clinicians are required to contact consumers in the seven days following their discharge, however evidence from OPA suggests there is a need for a wider range of supports to better manage the post-discharge risk.

OPA observes that it can take some time, a week or more on some occasions, for outreach services to be in touch with a consumer after discharge. In the wait, consumers are not well supported, resulting in greater likelihood of readmission. The same is true for services such as addiction services where individuals who have been forced into a period of sobriety due to detention under the Mental Health Act are then released into the community without the necessary supports to continue the recovery pathway. They are consequently much more likely to overdose in the days post discharge as they will have difficulties judging the potency of substances following a period of abstinence.

Case Study: Lucy

OPA was appointed as a guardian for a young woman named Lucy. Lucy was able to live independently, with regular visits to and from her family who supported her with some daily activities.

Lucy had a long-standing history of self-harm, suicidal ideation, and violent behaviours. She received a dual diagnosis of borderline personality disorder and intellectual disability.

One evening, Lucy contacted a helpline and disclosed suicidal ideation, with the specific plan of jumping off the balcony of her apartment. She agreed to be taken into hospital for assessment where she remained for several days. She was eventually discharged with a discharge plan to 'take medication and engage with a psychologist or psychiatrist through a general practitioner referral'.

Several weeks later, a case manager was appointed for her. The case manager supported her in engaging with individual and family-oriented supports. Lucy also maintained an ongoing care relationship with her family doctor and psychiatrist.

Some months following the psychiatric admission, Lucy had difficult day with her family. Police attended her apartment and found her sitting on the ledge of her balcony. They attempted to talk her down, but she tragically fell from the balcony. The coroner's inquiry determined the fall was an accident.

The coroner's report acknowledges an 'information transfer failure' but concludes a different practice may not have led to a better outcome. Nonetheless, upon discharge from the mental health service, neither Lucy's family, guardian or the services involved in her care were made aware of the suicidal ideation and the attempt that led to her admission to hospital some months prior to the accident.

OPA recognises that DHHS and the Chief Psychiatrist have guidelines that are relevant to responding to suicidal ideation, planning for discharge and involving family and carers. Under these guidelines, services are expected to engage with families, carers, guardians, and any other relevant persons/agencies that are in a care relationship with the person. Lucy's story illustrates there can be serious short falls in the implementation of these guidelines, and that they may lack the authority to be consistently and effectively translated into a comprehensive transfer of information.

To be clear, OPA does not interpret inadequate discharge as a lack of vigilance or good will, but rather as one of the more harmful consequences of limited funding and infrastructure required to meet the demand for mental health services (both inpatient and community-based). Practitioners have little control on the number of beds available within their services. OPA appreciates that they are tasked with the seemingly impossible act of simultaneously balancing duties of care for both the patients being discharged and those awaiting admission.

OPA understands that the Chief Psychiatrist is undertaking a review of the guidelines on discharge planning to address the issues raised by this matter.

Services are instructed to facilitate housing arrangements if necessary.[36] Section 6 of this submission describes SRS as one of the discharge options that is regularly presented to patients leaving an acute mental health service. Often, OPA finds SRS to be inappropriate for people with mental illness. Despite advocate guardians raising this with mental health services, they are used as a fall-back option or a last resort due to lack of alternatives.

Most recently, the pressure on mental health services has increased while the availability of suitable SRSs has become even more limited. Community Visitors and OPA advocate guardians have recorded instances where patients are discharged without long-term housing arrangements, into unsafe or inappropriate accommodation (e.g. into a motel or couch surfing with three days paid accommodation) due to a lack of more sustainable options. OPA is concerned that the situation is worsening.

Ensuring patients access appropriate supports (including accommodation, where necessary) upon leaving a service is one of many components of discharge planning. Discharge practices give effect to a clinical obligation to share and coordinate critical health information between services. While this is reflected in the Chief Psychiatrist's guideline on the topic, OPA observes that information sharing practices do not always meet the

[36] Office of the Chief Psychiatrist (Vic), *Chief Psychiatrist's guideline: discharge planning* (2002).

standards. Often, key information is not shared with other service providers, carers or guardians. OPA queries whether the concern for privacy overrides the duty of care towards consumers.

Furthermore, there is a growing gap in community mental health support services, as funding cuts in the transition to the NDIS have forced several community mental health support providers into voluntary administration.

Recommendation 10 of this submission addresses the needs for a more thorough approach to be applied in mapping the mental health system in the light of NDIS reforms. That recommendation updates a recommendation made in the OPA submission to the Joint Standing Committee on the NDIS.

6. Supported Residential Services

Supported Residential Services (SRS) are privately operated residences that provide accommodation and support for individuals who need help with everyday activities. Each SRS differs in services, residents, and fees.

There are two primary types of SRS. Above-pension SRS are for individuals who receive income outside of a pension and tend to be over the age of 60. Pension-level SRS charge lower fees (i.e. no more than the disability or aged pension plus Commonwealth rent assistance) as an affordable accommodation option for people with limited income. Residents in pension-level SRS are generally younger.

DHHS provides oversight and support to the SRS sector by registering SRS, administering and monitoring compliance with the *Supported Residential Services (Private Proprietors) Act 2010* (SRS Act) and its regulations, and providing education and general assistance to SRS facilities.[37] SRS are private properties and thus do not receive government funding, although some pension-level facilities receive DHHS program funding to remain viable and improve outcomes for their residents. No funding is provided to improve the fabric and infrastructure of SRS; therefore, the quality of the build is variable across the sector.

Community Visitors are legislated and empowered under the SRS Act to make visits, both announced and unannounced, to SRS to make enquiries of residents and staff and examine selected documentation in relation to the care of residents. Many of OPA's guardianship clients reside in SRS.

SRS residents have varying levels of support needs, but most have health conditions that require some level of daily care.[38] In OPA's experience, the SRS sector is often asked to fill the gap left in the absence of step-up/step-down community-based accommodation for people with mental illness.

Every five years, DHHS publishes a *Census of Supported Residential Services (SRS) in Victoria* (SRS census) providing a snapshot of resident and staffing profiles. The 2018 SRS Census identifies the prevalence of mental illness amongst SRS residents:

[37] <https://www2.health.vic.gov.au/ageing-and-aged-care/supported-residential-services>
[38] Department of Health and Human Services (Vic), *Supported Residential Services Census 2018* (2019).

- Mental illness/psychiatric disability is the most common recorded type of disability: an average of 47 per cent of SRS residents across facility types present with some form of mental illness or psychiatric disability.
- The prevalence of mental illness is highest in government assisted pension-level SRS: between 59 and 69 per cent.
- The most commonly noted form of mental illness is 'psychotic disorder', followed by 'mood disorder'.
- Approximately 25 per cent of pension-level SRS residents are NDIS participants.
- Mental health services are the most common source of referral for government assisted pension level SRS. [39]

While the 2018 SRS census identifies a decrease in the prevalence of mental illness in SRS residents, DHHS has amended its definitions of disability since the last data collection point, which limits the reliability of this claim. Moreover, data is obtained only from proprietors; no data is obtained directly from residents. This methodology increases the likelihood of an underestimation of the prevalence of mental illness, as proprietors may not always be made aware of the psychiatric condition of their residents.

Anecdotally, Community Visitors notice an increasing number of SRS residents with chronic mental illness. OPA guardians witness SRS being used to warehouse people with mental health issues whilst they wait to turn 65 and obtain entry into an aged care facility. At this point, they are institutionalised to the SRS model (e.g. drug and alcohol use or behaviour) and can have difficulties transitioning over to the aged care model.

Community Visitors' reports show that SRS with higher rates of mental illness among residents are those with the highest incident rates (i.e. self-harm, aggression, suicide attempts, and assaults).

6.1. Resident mix and safety

Community Visitors report on the severity of aggression that occurs between SRS residents, as well as between SRS residents and staff. The prevalence of mental illness in combination with drug and alcohol use create incompatibilities between residents and can often heighten tensions within an SRS.

Since 2013, Community Visitors have reported 453 issues related to abuse, violence, and neglect within SRS. The number of incidents related to resident safety has steadily increased in the past five years. Community Visitors also report a high number of sexual assaults, with more than fifty per cent of pension-level SRS having incidences of one or more sexual assaults.

Sometimes police are called, and in many instances, violent episodes lead to resident evictions, adding pressure on residents to find alternate accommodation and placing them in a precarious situation that may result in homelessness. To this point, the 2018 SRS Census data shows that the most commonly cited reason for the issue of a notice to vacate is 'a resident endangering the safety of other persons.'[40]

[39] Ibid.
[40] Ibid 40.

6.2. Lack of supports

Community Visitors have concerns of a misperception in the mental health sector that clinical staff are employed in SRS or that SRS are step-down mental health facilities. SRS provide minimal levels of supports to enable people to live in the community. While they meet the needs of some residents, they are not usually suitable for individuals with more complex presentations of disability and/or mental illness.

Issues related to staffing and support in SRS are the third most commonly reported by Community Visitors who express concerns around minimum qualification requirements for SRS staff and how this translates into an ability (or inability) to keep residents safe. In comparison with mental health and disability services, SRS operate with regulations that are less protective than those that apply to mental health services: the minimum staff-to-resident ratio is 1:30. At facilities with residents with complex needs, staff members are often occupied supporting high need residents, compromising the overall hygiene and cleanliness of the facilities.

SRS regulations impose no prerequisite for formal mental health training. The 2018 SRS census indicates that the most common qualification held by SRS staff is a Certificate III in Individual Support (Aged Care); still, only 51 percent of staff across all facility types have this qualification.[41] Staff seldom have qualifications in disability or mental health. The 2018 SRS census also specifies that pension-level SRS rarely operate with an 'activities coordinator' or a registered nurse. It is hard to imagine how residents can be supported in their recovery without these minimal services.[42]

These minimal requirements create a discrepancy between staff qualifications and resident profiles. For example, Community Visitors note one SRS where more than 60 per cent of residents have a diagnosis of chronic mental health, yet no coordinated training plan is in place to upskill staff to respond to the needs of their residents.

The consequences can be major. Community Visitors report the number of unexpected and premature deaths in SRS to be high, especially in pension-level SRS where a higher proportion of residents have complex support needs. The most common causes of death are due to medical conditions or rapid deterioration of health, and on some rare occasions, drug-related or violence between residents.

In 2017, a coronial inquiry investigated the death of an SRS resident at the hand of their roommate who was having a psychotic episode. A coronial recommendation was made for all SRS staff to be trained in mental health. Community Visitors are pleased that DHHS has developed and implemented a one-day mental health training for the sector. However, DHHS figures demonstrate that only two thirds of the pension-level SRS staff who enrolled to do this course had attended the training in 2018. There were no figures for pension plus SRS staff attendance at this training. Community Visitors query whether DHHS has taken sufficient action to monitor compliance with the coronial inquiry recommendation that it accepted, particularly in light of the high staff turnover rate in SRS.

OPA repeats two recommendation made by the Community Visitors Board.

[41] Ibid 35.
[42] Ibid 28.

Recommendation 14
The Victorian Government should audit Supported Residential Services staff attendance at mental health training against the potential staff attendance pool.[43]

Recommendation 15
The Victorian Government should fund staff training in Supported Residential Services to manage excessive alcohol and illicit drug use effectively.[44]

Good practice: Alma House model

OPA and Community Visitors observe that a small number of SRS operate with a model of care that integrates residential services and mental health supports under one roof.

The Alma House is a pension-level SRS where all residents have a mental illness. Most have been referred from the adjacent Alfred hospital. The two services have a well-established relationship and referral procedure, so that every resident arrives with a referral form that details their diagnosis and support needs. Staff from the Alfred and other mental health professionals come directly into the SRS to provide treatment, when necessary. The residence is set up to facilitate the transition of consumers into a community-based setting. For instance, there is a board with the name of all residents as well as the names of staff from the Alfred that support them.

The Alma House model is an example of cross sector collaboration that places consumers at the centre of service delivery and provides continuous care and support.

6.3. Bed loss

OPA and Community Visitors identify a rising number of threats to the financial viability of pension-level SRS. There has been a significant loss of beds in recent years: since 2013 when the sector counted 5,400 beds, Community Visitors have identified fourteen SRS closures, bringing the number of beds in the sector down to 4,399 (i.e. a 20 percent decrease). Community Visitors and OPA have ongoing concerns about bed losses in the sector when no additional accommodation options are being funded to fill the gap.

Despite a high need for supported accommodation, SRS operate with empty beds. In the 2018 SRS Census, proprietors cite the following reasons for empty beds: lack of suitable residents, residents moving to higher care, and residents not being able to afford to stay.

Newer pressures are affecting the sector as well; Community Visitors have recently been informed by SRS proprietors that the NDIS roll out is compromising the financial viability of their services given that SRS residents are not eligible to be funded under the NDIS for supports they already receive through the SRS. This impacts the ability of SRS to fill their beds with NDIS participants.

OPA fears that an increasing reliance on SRS to make up the dearth of community-based mental health supports and accommodation may not be the most appropriate or effective systemic response. As illustrated in the examples above, few SRS are designed or equipped to meet the support needs of people with chronic or complex mental illness.

[43] *Community Visitors Annual Report* (2017-18) 15.
[44] Ibid.

There remains a dire need for community-based accommodation to provide higher levels of supports to individuals with mental illness.

7. Mental health and the criminal justice system

There is strong evidence that, due to the range of systemic disadvantages they can face, people with cognitive disabilities and mental illness are overrepresented in the justice system. In 2015, the Victorian Ombudsman investigated the rehabilitation and reintegration of prisoners and reported the following statistics:

- Forty per cent of prisoners in Victoria have a mental health condition, a figure two to three times higher than the rates reported in the general community.
- Prisoners are ten to fifteen times more likely to have a psychotic disorder than someone in the general community. [45]

The cumulative effect of social and economic disadvantages imparted on people with mental illness can result in involvement with the criminal justice system. There are many contributing factors: people with disability and/or mental illness often have limited opportunities for education and work, are more likely to be poor, are disproportionately subject to all forms of abuse, and their access to advocacy and legal representation is limited. People with mental illness thus can sometimes be imprisoned or detained as a result of factors not directly related to their crime.

The persistence of systemic discrimination within the justice system gives rise to a renewed form of institutionalisation of people with disability and mental illness. This is largely due to the lack of adequate recognition of their needs and the failure to provide comprehensive supports. For example, there is often a lack of appropriate accommodation and/or supervision arrangements contributing to delays in releasing prisoners to less restrictive and more rehabilitative environments.

The Australian Human Rights Commission's (AHRC) *Equal Before the Law* report (2014) is a significant document for people with disability and all Australians. In conducting its research and consultation, the AHRC heard stories of where the criminal justice system had failed people with disabilities and had compounded disadvantage, in addition to some positive examples of where best practice was occurring.[46] The report proposed possible actions towards the development of a state or territory administered disability justice strategy as a beneficial approach to address some of the inequities faced by people with disability. The AHRC recommended the development of a Disability Justice Strategy to reduce the number of people with disability and/or mental illness who are incarcerated due to inadequate support for their needs. OPA endorses this recommendation.

[45] Victorian Ombudsman (Vic), *Investigation into the rehabilitation and reintegration of prisoners in Victoria* (September 2015) 61.
[46] Graeme Innes, Australian Human Rights Commission, *Towards Disability Justice Strategies* <https://www.humanrights.gov.au/our-work/disability-rights/publications/equal-law> accessed 4 April 2016.

Recommendation 16
The Victorian Government should develop a Disability Justice Strategy, as proposed in the Australian Human Rights Commission report *Equal before the law,* to reduce the number of people with disability and/or mental illness who are incarcerated due to inadequate support for their needs.[47]

7.1. Correctional facilities

7.1.1. A human rights framework

OPA turns to the Australian Capital Territory (ACT) Justice and Community Safety Directorate, which published *Human Rights Principles for ACT Correctional Centers* in January 2019. The principles are articulated in line with Australia's obligations under international human rights commitments and give effect to commitments under the territory's *Human Rights Act 2004* (ACT).

The document in its entirety is commendable but principle 11 on mental health is most relevant to this submission:

> "ACT Corrective Services must make appropriate and adequate provision to meet the mental health care needs of detainees in a correctional centre.
>
> Persons found not criminally responsible due to mental impairment or those assessed as requiring inpatient mental health care should be transferred to mental health facilities, where available, where appropriate mental health supports and responses can be provided.
>
> Community equivalent mental health care is provided within a correctional centre by Canberra Health Services. If inpatient mental health care is required, Canberra Health Services must provide treatment, care or support in the most appropriate facility based on the clinical assessment, requirements of the person and operational demands."[48]

Evidence provided in this section of OPA's submission shows that similar human rights principles could lead to improvements in Victoria's justice system.

Recommendation 17
The Victorian Government should publish human rights principles and guidelines for Corrections Victoria.

7.1.2. Thomas Embling Hospital

Case study: Damian

OPA is guardian for Damian who is detained at Thomas Embling Hospital under the *Mental Health Act* (2014), with decision making powers related to accommodation and

[47] Office of the Public Advocate (Victoria), *Submission to Senate Community Affairs Reference Committee: indefinite detention of people with cognitive and psychiatric impairment in Australia* (April 2016) 13.
[48] Justice and Community Safety Directorate (ACT), *Human Rights Principles for ACT Correctional Centres* (January 2019) 11.

access to services. Damian is a young man with a history of schizophrenia, substance abuse, significant self-harm and violence to others. He also has an intellectual disability.

Damian's custodial sentence concluded more than 12 months ago, however due to his mental health issues and the absence of available suitable community accommodation and services, he continues to be detained at Thomas Embling.

Prior to being admitted to Thomas Embling, Damian was incarcerated in mainstream prison for around three years. In his time in prison and at Thomas Embling, he has spent most of his time in seclusion, due to the risk he poses to himself and others. Staff have trialled him in less restrictive settings, but he has not tolerated this well for more than a few hours.

Damian receives direct one-on-one support visits from an NDIS service provider, although these have sometimes been restricted due to risk. At this stage, his NDIS plan only provides minimal funding limited to the one on one support and support coordination. His NDIS plan progression is limited by being detained in Thomas Embling.

The main factor hindering his release is a lack of suitable community accommodation options being available. Damian has been assessed to require a robust build residential setting and would require 24 hour a day supervision from multiple care staff who are specially qualified and trained to manage his known behaviours and mental health issues.

The OPA guardian continues to seek the involvement of services that are specialised in supporting clients with complex needs, but none has agreed to accept him as a client. There have also been some disputes about whether Damian would be best supported by the mental health or the disability sector. Senior practitioners from different services are involved in case conferencing, however until they can agree on an appropriate step-down option, there is nowhere for Damian to go safely.

Thomas Embling Hospital is Victoria's only forensic mental health facility and it faces the same pressures as other inpatient mental health services across the state, most notably a shortage of beds. The 2015 Victorian Ombudsman's report states that:

> "Several agencies […] have previously highlighted the inadequacy of the number of mental health beds and services available to prisoners in Victoria. A report by the Victorian Auditor-General found that the number of secure mental health beds has not kept pace with growing demand and wait times have increased significantly." [49]

Community Visitors note in their most recent annual report that thirteen forensic patients are detained in prison without the specialist mental health care they require because there were no beds available at Thomas Embling Hospital. Increases in wait times for admission at Thomas Embling impact prisoners who are detained in alternative settings, where mental health supports are not as specialised. The impacts can be long lasting:

> "failure to properly treat a prisoner's mental health condition during their imprisonment can have adverse effects on their health and wellbeing and in turn, their rehabilitation and ability to effectively reintegrate into the community."[50]

The fact that the justice system is often unable to meet the needs of a person with mental illness who is imprisoned, at risk of being indefinitely detained, or released from their

[49] Ibid 62.
[50] Ibid 6.

services is a failure of the system. OPA welcomes funding to increase the number of beds at Thomas Embling Hospital, but considers it is not likely to be enough to meet the demand.

7.1.3. Therapeutic model

In OPA's experience, risk averse tendencies continue to dominate in the care provided to patients in the forensic mental health system, undermining therapeutic and recovery-based initiatives.

Damian's story illustrates how seclusion can sometimes be used to manage behavior with minimal regard to its lack of therapeutic benefit. Community Visitors report that high levels of aggression between patients at Thomas Embling Hospital can lead to seclusion (with the authorisation of the Chief Psychiatrist), despite the introduction of the safe wards approach. In practice, the number of residents with violent behaviors or heightened symptoms compromises the capacity of the service to apply an effective therapeutic model, instead restricting intervention options to behavior management and risk averse strategies.

7.1.4. Transition planning

The Ombudsman report shows that housing insecurity is one of the factors that predicts return to prison. It also identifies a high risk of death post release, with the two most frequent causes being related to mental health, namely drug overdose and suicide. The Ombudsman links this to a failure to organise wrap around supports at a time when individuals are rebuilding their lives and simultaneously learning to manage their mental health in a starkly different setting.

Providing continued care from prison into the community is known as 'through care', it involves pre-release planning beginning in the weeks before a prisoner's release. Through care is critical in the rehabilitation of prisoners; it can prevent further custody by supporting individuals throughout a critical transition in their lives. However, to be successful, community-based specialised supports need to be available post release.

Case study: Mark

OPA received a letter from a prisoner, Mark, who is in a maximum-security correctional center. He identifies as having autism, mental health, and substance abuse. For many years, he has cycled in and out of prison.

Mark has insight into the risk he can pose if he is not well supported when released into the community. He is clear on his intention to contribute positively in his community, but acknowledges that to enact this, he needs supports. In preparation for his most recent release from prison, he requested a prison support worker to establish a transition support plan in which he planned to request assistance with housing, Centrelink, mental health, and substance use.

In the days preceding his release, he reminded the prison of his request but never received an answer. Mark was released in the evening, with none of the supports he identified and nowhere to go.

He is now again in custody; this is where he was when he contacted OPA. He was hopeful that his next release from prison would be more successful but was eager to obtain assistance in connecting with services.

Mark's story illustrates the very real impacts of limited dedicated mental health support programs specifically for prisoners transitioning from prison to the community.[51] Shortages may be due to limited funding as well as growth in the prevalence of mental illness among prisoners.

Some people await admission to the forensic mental health system while others are overstaying their sentence for lack of suitable and secure community-based accommodation options. OPA guardians who have clients in the forensic mental health system have observed that some discrimination exists for people who have limited informal supports. Anecdotally, they are more likely to remain in restrictive environments unless they have supports outside of prison.

Better integration of services and coordination between the justice and mental health systems ensures a person is fully supported, while in detention and upon release.

It is the justice system's responsibility to regulate correctional services, but government more broadly has a duty of care to adequately fund and resource human services, such as mental health services, to prevent injustice and support people to avoid detention. The need to protect the community is valid but it should be met with rigorous and best practice treatment approaches, adequately priced services offered by skilled workers, and perhaps most importantly, secure community accommodation options. OPA endorses the following recommendation made by the Ombudsman.

Recommendation 18
The Victorian Government should fund the expansion of transition and community based mental health services for former prisoners.[52]

7.1.5. NDIS and justice interface

Prisoners with mental illness and/or disability are some of society's most disadvantaged individuals. The NDIS is a promising initiative for this cohort but thus far OPA observes that its interface with the justice system has not operated smoothly.

The dearth of post release supports is one of many issues for NDIS participants who interact with the mental health and justice systems. In the move towards a market-based model, OPA has found service and accommodation providers to be reluctant to take on individuals leaving Thomas Embling Hospital and other settings of criminal detention. The work can be demanding, and this cohort of individuals can seem 'unattractive' or high risk for providers.

Before the NDIS, DHHS exercised its duty of care by providing services without discrimination to individuals with complex needs and challenging behaviours. In the NDIS private market, choice and control are granted not only to participants, but also to providers

[51] Ibid 115.
[52] Victorian Ombudsman (Vic), *Investigation into the rehabilitation and reintegration of prisoners in Victoria* (September 2015).

who have no obligation to provide or maintain services to participants if and when problems arise. While there may be a financial incentive to take on participants with substantial NDIS funding, OPA has seen that for many providers, the perceived risks outweigh the monetary benefits.[53]

Participants with complex needs continue to be disadvantaged by the scheme; their safety and wellbeing are compromised by thin markets. While some NDIS funded services are providing in-reach supports to participants who are in Thomas Embling, the current NDIS pricing framework is not conducive to attracting the highly specialized mental health workforce that is required for this cohort. Damian's story illustrates this issue, and unfortunately is a situation that is not unfamiliar to OPA. OPA's report *The Illusion of Choice and Control* speaks to the problems appearing at the NDIS and justice system interface and makes a number of recommendations that are applicable to people with mental illness who are in contact with the justice system. OPA encourages the Commission to read the report in conjunction with this submission (it is attached).

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

In June 2014, the Victorian Law Reform Commission (VLRC) reviewed the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (CMIA). The CMIA operates across government departments, criminal courts, and mental health and disability service sectors. The review confirmed that the majority of people under the CMIA have a history of mental health:

"Of the 146 participants detained under CMIA

- 72.4 per cent had previous contact with psychiatric services
- 58.2 per cent had prior psychiatric hospitalisation
- 65.1 per cent had a primary diagnosis of schizophrenia
- 10.3 per cent had another psychotic disorder
- Only 10 participants had a primary diagnosis of intellectual disability."[54]

Most individuals on a custodial order under the CMIA are detained at Thomas Embling Hospital. Bed shortages, however, mean that some CMIA clients who would be best placed at Thomas Embling are kept in prisons where they are not receiving appropriate mental health supports.

Treatments provided to persons with mental illness on orders under the Mental Health Act are relatively well established based on the notion that the illness may respond to treatment and psychosocial supports over time. The same does not exist for people under the CMIA, which lacks provisions relating to treatment planning and review.

OPA repeats the following recommendation made by the VLRC to address the gap in forensic mental health services for people subject to a supervision order under the CMIA:

[53] Office of the Public Advocate (Vic.) *Submission to NDIS Thin Markets Project* (May 2019)
[54] Victorian Law Reform Commission (Vic), *Review of the Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (2014) 22.

Recommendation 19
A new medium-secure forensic mental health facility should be established as an approved mental health service for adults with a mental illness who are subject to supervision orders under the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic).

The VLRC recommended amendments to the CMIA but OPA understands the review of the legislation has recently lapsed and it may take years before it is again debated in parliament. OPA stresses the urgency of reviewing the legislation.

Recommendation 20
The Victorian Government should prioritise reforms to the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* on its parliamentary legislative agenda.

7.3. Victoria Police

Police and emergency services are often at the frontline of responding to crises involving people with mental illness in the community. Recent statistics from Victoria Police show that police respond to a mental health incident every twelve minutes.[55]

OPA welcomes recent initiatives where mental health services and police work together to respond to high risk situations (e.g. PACER and RAPID programs). Community Visitors observe that PACER units are well skilled in de-escalation and can relieve hospitals and emergency departments by assessing individuals to determine whether ongoing mental health support should be provided to them when clinically indicated.

PACER teams are only available in the evening, OPA recommends they be extended into all hours.

Recommendation 21
The Victorian Government should fund an expansion of the Victoria Police PACER program to operate 24/7.

Recommendation 22
The Victorian Government should adequately fund the Crisis Assessment and Treatment (CAT) program.

7.3.1. The Independent Third Person Program

The Independent Third Person's (ITP) Program trains volunteers to support alleged offenders, victims and witnesses of any age with disability or mental illness at a Victoria Police Interview. Police interviews often require people to comprehend complex information quickly, understand their legal rights, and be able to communicate with people in positions of authority.

ITPs are available 24 hours, 7 days a week to attend any police station throughout Victoria. They are independent of the police and the investigation. ITP support is a safeguard that

[55] Jeff Kennett, Tragic deaths causing trauma for our first responders. *Herald Sun* (Melbourne) 29 May 2019. < https://amp.heraldsun.com.au/news/opinion/jeff-kennett-tragic-deaths-causing-trauma-for-our-first-responders/news-story/b65bd218aae447cc5ae7b7b27f65890a>

helps ensure the person with disability is not disadvantaged when communicating with police. The primary role of the ITP is to facilitate communication between the alleged offender or victim and the police. It is also part of their role to ensure that the person understands and can exercise their rights if they so wish.

In 2017-18, 192 ITPs attended 2537 interviews, an average of 211 per month. Almost half (48.1 per cent) of the clients who required ITPs were recorded as having an intellectual disability. Data shared by Victoria Police reveals that nearly 50 per cent of the people they come into contact with have a mental illness, however ITP Program data shows that only 21.4 per cent of their client base reported a mental illness. This suggests that police are more likely to seek ITP services for people with an intellectual disability than for people with a mental illness.

OPA and the ITP team raise with Victoria Police any cases that come to their notice where a person with a mental illness had a police interview without the benefit of an ITP being called. This information sharing pathway aims to increase the visibility and awareness amongst police of the impact of mental illness on people coming into contact with the criminal justice system and to demonstrate the need for an ITP for this group to be increased to the level that currently occurs for people with an intellectual disability.

The ITP Program assists police in their interviews with people with cognitive impairment through training and co-development of resources. Over recent years, OPA has welcomed the positive working relationship it has developed with Victoria Police and their previous and current work to expand staff mental health training, including over the next four years to all frontline police.

OPA's report *Breaking the Cycle: Using Advocacy-Based Referrals to Assist People with Disabilities in the Criminal Justice System* states that:

> "not involving an ITP could compromise the integrity of the evidence raised in the interview. On this point, case law recognises the importance of ITPs in protecting the rights of people with disabilities during the police interview. For example, the Supreme Court of Victoria has held that the failure of police to use an ITP when one is required may diminish the credibility of any evidence obtained in that interview. This is because the absence of an ITP raises serious questions regarding the 'propriety, reliability and fairness' of the police interview. Accordingly, Victoria Police policy requires that members arrange for an ITP to be present during the interview with any person whom they believe may have a cognitive impairment or mental illness."[56]

OPA believes that the ability of people with disability and/or mental illness to communicate their experience and understand their rights increases with the assistance of an ITP. Article 13 of the UN Convention recognises that people with disability have a right to access to justice, which includes the 'provision of procedural accommodations in order to facilitate their effective role as direct and indirect participants, including as witnesses, in all legal proceedings, including at investigative and other preliminary stages'. The ITP Program is one that gives effect to this right and a person's right to an ITP should be legislated. This would result in consistent application of the use of ITPs across Victoria and would ensure the program is appropriately resourced to unfailingly deliver its intended purpose.

[56] Office of the Public Advocate (Vic), *Breaking the Cycle* (2012) 19.

This level of legislative protection for people needing an ITP would be consistent with the legislative right for young people to have access to the support of an Independent Person in police interviews.[57]

Recommendation 23
The Victorian Government should introduce legislative reform to require Victoria Police to have an Independent Third Person present when interviewing a person with a cognitive impairment or mental illness.

7.4. Corrections Independent Support Officers

Corrections Independent Support Officers (CISO) are experienced ITP volunteers or OPA staff who provide assistance and support to prisoners with a diagnosed intellectual disability during Governors' Disciplinary Hearings at all adult prisons in Victoria. CISOs explain their rights to prisoners, check that they understand them and are freely able to exercise them throughout the process.

During the year, CISOs were requested to attend 297 hearings in seven of Victoria's thirteen prisons (excluding the Judy Lazarus Transition Centre).

The CISO program is limited to prisoners with a diagnosed intellectual disability and excludes those with cognitive impairment caused by other conditions, such a mental illness or an Acquired Brain Injury (ABI).

A 2015 Australian Institute of Health and Welfare report found that almost half of those entering prison have a mental health issue, compared with 18 per cent of the general population. The figures are even starker for Indigenous prisoners with 73 per cent of Aboriginal and Torres Strait Islander men and 86 per cent of Aboriginal and Torres Strait Islander women in prison having a diagnosed mental health condition.

Recommendation 24
Corrections Victoria should expand and resource the Corrections Independent Support Officers Program to support people with mental illness.

8. Specialist mental health services

8.1. Aged mental health residential care facilities

Older people with mental illness are confronted with unique challenges in accessing mental health supports. Individuals over the age of 65 are ineligible for the NDIS and thus cannot access disability supports, while residents in aged care facilities are not consistently provided with comprehensive mental health supports. Thus, older people are often directed to acute mental health services, where they are predominantly referred to aged mental health residential care facilities by reason of their age.

[57] *Crimes Act 1958* (Vic) s 464E.

8.1.1. Recovery and prevention in older populations

By virtue of its investigation and guardianship functions, OPA is in contact with many older persons who are living with mental illness and/or caring for someone (e.g. an adult child or a life partner) with mental illness.

OPA guardians note that with this population, there is a predominantly medical approach to the treatment of mental illness, which highlights a need to adapt the recovery-oriented practice framework in a way that is responsive to the challenges that are unique to people in this stage of life.

Human services will be increasingly called upon to support an ageing population. OPA considers there is an additional need to implement prevention initiatives that could support people to thrive in their old age and maintain good mental health for as long as possible.

8.1.2. Referral pathway

Aged mental health residential care facilities include acute units and aged mental health nursing homes and hostels. Community Visitors visit the 32 aged mental health residential care facilities across Victoria that provide inpatient mental health services to older people.

Aged mental health residential facilities are a needed specialised service, but OPA observes that they are also sometimes used less appropriately for more fit and able older people with mental illness for lack of alternative placements. These facilities are generally well suited to individuals with severe and complex cognitive impairments; individuals who are admitted are typically those with complicated presentations of dementia that include challenging behaviours and a limited ability to communicate. For an older person with a symptomatology that is less acute or not related to dementia, an acute aged mental health unit can be a distressing place that is unfit to support their recovery and wellbeing.

Upon investigation, OPA could find no objective admission criteria for referrals made into acute aged mental health units. Rather, intake decisions are seemingly dependent upon the clinician making the referral. OPA questions whether age is being used to limit the range of mental health services made accessible to people in this age group. OPA suspects that it may be that some older people with mental illness are experiencing discrimination and restricted choice in the mental health services that are made available to them.

8.1.3. Model of care

Aged mental health residential care facilities are funded to provide specialist mental health care . It is therefore expected that their staff have appropriate specialist training and knowledge on the provision of mental health care for older people. For the most part, OPA and Community Visitors find this to be the case. However, OPA is aware of one unit that does not have any trained mental health staff, which raises questions as to whether the care being provided there is optimal and, more broadly, whether the quality of care is consistent across these facilities.

OPA questions whether an agreed model of care is used across these facilities and makes the following recommendation.

Recommendation 25
The Chief Psychiatrist and the Chief Mental Health Nurse should review the clinical governance, referral pathways, and model of care of aged mental health residential care facilities across Victoria to ensure care is consistent across all aged mental health facilities.

8.1.4. Design

OPA and Community Visitors also identify some issues in the design of aged mental health residential care facilities. For instance, some are in older buildings, some offer only shared rooms, and others are laid out in a way that does not allow the adequate line of sight for nursing staff to observe patients and ensure safety. Some facilities have shared toilets and showers, adding to the challenges of providing optimal care for this cohort of patients.

8.1.5. Seclusion and restraint

All acute aged mental health residential care facilities have built-in seclusion rooms, despite OPA and Community Visitors finding low reports of seclusion within these services. OPA observes one example of a unit that has creatively converted the seclusion room into a quiet room that could also serve as a sensory room. New facilities continue to be designed with seclusion rooms and OPA questions whether this is conducive to optimal care.

OPA is aware of one aged mental health nursing home where the funded beds are collocated within a general nursing home unit. It is unclear how specialist mental health care can be provided when there is no separate physical space dedicated to providing a specialist mental health model of care. Furthermore, OPA understands that within this unit there are no specialist mental health trained staff working within this facility.

Residential aged mental health care facilities must comply with the *Aged Care Act 1997* (Cth). At this point in time, Commonwealth funded aged care services have no legislated requirement to report on the use of restrictive intervention, creating a significant gap in the safeguarding of aged mental health consumers. OPA will engage with the Royal Commission into aged care quality and safety to recommend the legislated regulation and oversight of restrictive practices within residential aged care facilities.

8.2. Dual Disability Transition Support Units

In its long stay patient project, Community Visitors identified longer lengths of stay in acute units for patients with dual disability caused by the dearth of specialist services for this cohort. Community Visitors and OPA have long advocated for a service that could respond to both mental health and disability needs and welcomed the establishment of two Transition Support Units (TSUs) to fill this critical gap. TSUs are designed as long-term accommodation (i.e. up to two years) for individuals with dual disability who require a sustainable plan to manage their mental health.

Unfortunately, the units have not operated as successfully as expected. Community Visitors report that the profiles of current residents do not reflect the proposed targeted group, despite there being a high need for this specialised service. Community Visitors note that both units are operating below capacity and that referral and access to these units has been difficult, as illustrated in the story below.

Case study: Stephanie

OPA is the appointed guardian of a woman who was receiving services from an inpatient mental health service. Stephanie has no family support. She has been incarcerated numerous times due to her behaviours of concern and has lived in many different types of accommodation over the years, most have been unsuccessful because she does not cope well in group settings. Her dual disability requires very specific supports to manage her behaviour as well as a low stimulus environment to prevent her becoming agitated and aggressive.

Stephanie's treating team encouraged a referral to a TSU as the best discharge option available at the time. The TSU initially supported the referral, but, weeks later, the TSU withdrew its offer of a place: most likely due to staffing issues. At this point the facility discharged her to an SRS, disregarding the guardian's concerns about the risk this accommodation option posed to both Stephanie and those around her.

Stephanie did not cope well in the SRS and two days later her support staff took her to an emergency department. Stephanie was readmitted to the inpatient mental health unit.

She was later discharged to disability residential accommodation with NDIS funded support workers. Being a group setting, this unit was ill suited to Stephanie's needs. She committed an offence and was remanded in custody due to lack of appropriate accommodation. She was sentenced and having been in remand for longer than her sentence, was released to an SRS, which was the only supported accommodation available to her at the time.

Had Stephanie been able to access the TSU, her repeated contact with the criminal justice system may have been avoided. Stephanie's guardian continues to advocate for more suitable accommodation for Stephanie.

Community Visitors and Advocate Guardians have in many instances advocated for consumers to be admitted to TSU, but the eligibility criteria are seemingly applied in a way that denies access to consumers with behavioural issues and other intensive support needs, notwithstanding that these can often be characteristic of dual disability. Community Visitors report that direct referrals from disability services are not accepted and patients to date in one of the TSU have only come from within the catchment of the managing hospital, despite TSUs being funded to operate as state wide facilities.

The TSU referral and service model needs urgent review, and OPA understands the Chief Psychiatrist has agreed to take on this work. Nonetheless, it is disappointing that a newly established service is not operating as planned.

8.3. NDIS

The NDIS is creating noticeable shifts in the mental health service landscape. Perhaps the most distressing consequence has been funding cuts to community based mental health services to redirect resources into the scheme. OPA and Community Visitors have seen community mental health support providers declare voluntary administration and heard accounts of larger community mental health support providers operating NDIS programs at a loss (pro-bono) in order to meet the needs of their clients. The loss of mental health services has consequences that extend beyond the NDIS, given that most people with mental illness are not eligible for the scheme but are nonetheless being disadvantaged by the shrinking market.

In its most recent budget, the Victorian Government made substantial funding commitments to the community mental health support sector, but funding continuity remains uncertain at a time where community based mental health services must learn to operate within a new service delivery model. It is uncertain how long, if ever, it will take the community mental health support sector to recover in this unstable environment.

At the same time, as in the case of Stephanie above, the eligibility criteria for the NDIS are not articulated in terms of a specific disability. This means that a person can be found eligible for NDIS supports where they previously would have faced service exclusion (often because disability services and mental health would each have denied responsibility and sought to shift it to the other sector). In OPA's experience, the NDIS has in many cases been a reliable safety net for individuals who would have previously fallen in the crack between the two systems.

Notwithstanding this positive outcome, OPA notes that services for individuals with complex needs is an increasingly thin market (within and outside of NDIS funded supports). Most consistently, the difficulties are in engaging an NDIS provider or worker with not only the skills but also the willingness to engage with this cohort.

In 2014-15, Community Visitors noted that several very long stay patients could not be discharged "because of dual disability, behavioural problems that are difficult to manage and a shortage of suitable accommodation for people with complex needs."[58] This submission has presented ample evidence of these ongoing issues. In OPA's experience, the transition to the NDIS has exacerbated the situation. *The Illusion of Choice and Control* describes this quite well:

> "the difficulty of engaging and retaining suitable service providers, including competent support coordinators, hinders people being released from criminal justice or mental health detention at the earliest opportunity. Aside from the financial cost, the harm and distress caused in these circumstances is clearly a tremendous human cost. Delays in being able to engage a suitable service provider, as well as receiving unsuitable or poor-quality supports in the interim, often results in challenging or high-risk behaviours which in turn lead to the withdrawal of services and/or accommodation. Quite a number of stories presented in this report show that emergency and mental health services are often prevailed upon to manage a person in the absence of appropriate supports. This can result in lengthy periods of

[58] *Community Visitors Annual Report* (2014-15) 26.

detention under the Mental Health Act 2014 (Vic) pending the arrangement of suitable supports.

Such prolonged admissions are often not clinically or legally justified, as is evident from the mental health services themselves sometimes becoming uncomfortable facilitating the person's detention, and they significantly infringe on the person's human rights. Prolonged detention and the associated trauma can also contribute to further challenging behaviours and compromise the person's ability to engage with and benefit from support services once released. In some cases, this leads to people being set up in extremely restrictive, individualised (and isolative) arrangements in the community in an attempt to manage their support needs outside a formal detention environment."[59]

8.4. Guardianship

Under the *Guardianship and Administration Act 1986* (Vic), the Public Advocate can be appointed by VCAT as a guardian of last resort. In recent years, OPA has seen an increase in guardianship applications and has grappled with an increasing number of clients waiting for a guardian to be appointed.

OPA believes that the increase in guardianship applications is partly related to complexities associated with obtaining and organising supports. On the one part, access to services is becoming more complex, especially in the transition to the NDIS. This is in addition to the limited accommodation options available to persons with mental illness, as described in this submission. As a result, guardians are frequently involved in advocating for improved discharge destinations but often there are very limited options.

There can often be delays for guardians while they aim to fulfil their legislative obligations of making decisions in the best interests of clients. Guardians cannot compel a mental health facility to maintain a person within their services, particularly if they no longer satisfy the criteria for admission. However, the lack of safe and suitable discharge options makes agreement by a guardian difficult.

To this point, guardians remark that they are often asked to perform duties that would usually fall to case managers, such as finding service providers. These tasks fall outside the resourcing of a guardian, but they point to a real need for people with limited capacity to be supported in navigating a changing service landscape.

Good practice: Multidisciplinary teams

The mental health system is complicated to navigate, and with the relentless pressures placed on clinicians, support is not always provided to accompany a consumer from one service to another. Navigation can be extremely difficult for someone with a cognitive impairment, especially if they have limited informal supports.

One way to assist with system navigation and access to services is the multidisciplinary model, which OPA has found to be effective for people with dual disability or consumers whose needs cut across many sectors. A multidisciplinary team allows for care to be

[59] Office of the Public Advocate (Vic), *The Illusion of Choice and Control* (September 2018) 31.

delivered in a more holistic way, taking into account the complexities that make up any individual life. It also capitalises on the expertise of several clinicians and places the client at the centre of care.

OPA has found the multidisciplinary model to be effective in providing longitudinal care, to ensure a person has ongoing contact with known clinicians as they move from one sector to another. OPA commends the following teams for their implementation of the model: Multiple and Complex Needs Initiative (MACNI), the Intensive Support Team (IST) at DHHS, and the Justice team at DHHS.

However, like most mental health services, the supports provided by these teams can be hard to access and often necessitate a consumer to be severely unwell before they can gain admission to them. As well, the dearth of community-based supports can be an obstacle to the activation of supports for these teams, and in some cases, while sound recommendations are made by the clinicians, it is impossible to find services that will take on consumers with complex needs.

9. Autism Spectrum Disorder and mental health

The prevalence of Autism is growing throughout the Western world due, in part, to better diagnoses. Autism Spectrum Australia (Aspect) has revised its autism prevalence rates from 1 in 100 to an estimated 1 in 70 people in Australia. That is an estimated 40% increase or around an extra 353,880 people nationally. This includes adults who missed out on a diagnosis as children and seek one after their own children have been diagnosed.

However, there are also significant numbers of adults who still do not have a diagnosis, particularly females, as their symptoms are less overt than those of males. Two issues result from this: for those adults with a diagnosis, there are not yet any autism specific services which could help offset the development of mental illnesses; and, for those adults without a diagnosis who experience mental illnesses, mental health treatment is being provided without an awareness of the underlying autism. This is akin to being treated for the symptoms of cancer without treating the cancer itself.

The most common mental illnesses experienced by people with autism are depression and anxiety. Hospital readmissions can result from not treating the underlying cause, putting considerable strain on the mental health system as well as families and carers who struggle to help the person they care for get well. For the person, it can result in self-harm or suicide as they become more and more hopeless of improvement in their lives. Adult females are affected disproportionately, too, as their symptoms are not the same as those for males and they are, therefore, under-recognised and under-diagnosed.

The costs to the community of failing to appreciate the underlying cause of the psycho-social distress of people with autism can also escalate exponentially. In recent OPA research, the NDIS represented an ‘illusion of choice’ including for seven out of 12 who had suspected or confirmed autism. In some cases, the solution eventually funded by the NDIS involved the development of purpose-built accommodation for one person.

Recommendation 26
The Victorian Government should ensure mental health practitioners undertake professional education of the possibility of autism as an underlying cause of some mental illnesses, particularly anxiety and depression, and particularly in females.

Recommendation 27
The Victorian Government should provide necessary evidence-based services for both adult women and men with autism to help prevent the development of mental illnesses and the resulting cost in lives lost or compromised as well as system resources.

OPA also supports the recommendation from Amaze to improve accessibility to autism diagnoses.

Recommendation 28
The Victorian Government should provide free access to autism diagnoses, which are currently very costly.