Queensland Advocacy Incorporated

Our mission is to promote, protect and defend, through advocacy, the fundamental needs and rights and lives of the most vulnerable people with disability in Queensland.

Systems and Legal Advocacy for vulnerable people with Disability

Mental Health Inquiry
Productivity Commission
GPO Box 1428
Canberra City ACT 2601

4 April 2019

By online submission: www://pc.gov.au/inquiries/current/mental-health/submissions

Dear Commission,

Inquiry into the economic impacts of mental ill-health

We refer to the above inquiry and enclose:

- Submission by Queensland Advocacy Incorporated.

Thank you for the opportunity to make a submission.

We are happy to provide further information or clarification upon request.

Yours Faithfully,

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Director

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The Social and Economic Benefits of Improving Mental Health

Submission by Queensland Advocacy Incorporated

Productivity Commission

4 April 2019

About Queensland Advocacy Incorporated

Queensland Advocacy Incorporated (**QAI**) is an independent, community-based systems and individual advocacy organisation and a community legal service for people with disability. Our mission is to promote, protect and defend, through systems and individual advocacy, the fundamental needs and rights and lives of the most vulnerable people with disability in Queensland.

QAI has an exemplary track record of effective systems advocacy, with thirty years' experience advocating for systems change, through campaigns directed to attitudinal, law and policy reform and by supporting the development of a range of advocacy initiatives in this state. We have provided, for almost a decade, highly in-demand individual advocacy through our individual advocacy services – the Human Rights Legal Service, the Mental Health Legal Service and the Justice Support Program and more recently the National Disability Insurance Scheme Appeals Support Program and Decision Support Pilot Program.

QAI's Mental Health Legal Service (**MHLS**) is a specialist legal service dedicated to providing free and independent information, advice, referrals and representation in relation to mental health law in Queensland. From time to time, the MHLS also works on law reform issues and provides continuing legal education services to the legal profession and the community. The focus of the service is to provide advice and representation to people who have matters before the Mental Health Review Tribunal, including a review of a treatment authority, a review of a forensic order, an application for electroconvulsive therapy or an application to have an involuntary patient move out of Queensland.

QAI was extensively involved in the review of the Queensland mental health legislation that culminated in passage of the *Mental Health Act 2016* (Qld). Subsequent to this, we have made submissions to the review of this legislation and the evaluation of mental health services operating under this Act.

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Introduction

The focus of this inquiry is on the link between mental health and economic participation, productivity and growth. The Productivity Commission Issues Paper (**Issues Paper**) notes that mental health is a key driver of economic participation and productivity in Australia, with the potential to impact incomes and living standards as well as social engagement and connectedness. The reduced economic costs associated with improved mental health are stated and it is recognised that improvements in mental health can benefit both individuals and the wider community. The significant occurrence of mental health issues experienced by Australians are noted and it is recognised that, notwithstanding 'a plethora of past reviews and inquiries into mental health in Australia', and related positive service delivery and service reforms, there are significant problems with mental health in Australia.

QAI agrees with this starting point – our experience is that there are significant, unaddressed mental health problems in Australia. We also agree that addressing these problems requires holistic reform encompassing innovations not only within the healthcare system, but also in the areas of work, education, justice, housing and social services.

QAI's response to key issues of inquiry:

Below, we respond to questions posed in the Issues Paper. We will confine our submission to those questions of which we have direct knowledge and expertise.

Assessment approach

What suggestions, if any, do you have on the Commission's proposed assessment approach for the inquiry?

QAI supports the proposed approach to assessment and in particular, we agree that both qualitative and quantitative analysis is appropriate, with qualitative inquiry necessary to hear the voices of those with lived experience of mental illness or mental health concerns and to help us to understand the statistical findings. We emphasise that this research should be primarily informed by the many and varied voices of people with lived experience of mental illness and mental health concerns as they are the experts on the impact of mental ill-health and the types of measures and initiatives that are genuinely helpful. It should also hear from families, carers, health and allied health professionals and relevant service providers (including of employment services). In seeking to document their views and experiences, the inquiry must extend beyond receiving input from those who step forward and must actively seek to engage with people from a broad range of backgrounds and living in a diversity of situations. We note that some people, such as those with mental illness living in boarding homes and hostels, may be more difficult to reach and are unlikely to be aware of this inquiry unless active steps are taken to engage with them. It must also be recognised that many consumers of mental health services, particularly current in-patients, may be reticent to speak freely for fear of repercussions (actual or perceived).

We also agree with the Productivity Commission exploring best practice in Australia and other countries to inform recommendations for reform.

Health care

Structural weaknesses

Why have past reform efforts by governments over many years had limited effectiveness in removing the structural weaknesses in healthcare for people with a mental illness? How would you overcome the barriers which governments have faced

in implementing effective reforms?

QAI considers that much of the reforms undertaken by Government over preceding years have had limited effectiveness for reasons including the following:

1. The reforms have at times been token and have not addressed ingrained systemic problems. QAI considers that the human rights of people with mental illness are under-protected by the law in Queensland and until now have received comparatively little attention compared to the rights of some other vulnerable groups, perhaps reflective of the ongoing stigma in our society that attaches to people with mental illness. People with disability and mental illness, as a group, have been significantly adversely affected by damaging stereotypes about the nature of particular types of disability and mental illness. Historically, there have been negative connotations associated with mental illness that have created a stigma about mental illness and drawn a correlation between mental illness and a predisposition to violence.[1] While this stigma has been substantially overcome in recent decades, scholars such as Salzman attribute the historical perspective on psychosocial disability as explaining in part the differential treatment of people with a mental illness within the legal system, which can result in an unjustified assumption of general incapacity based on stereotypes of behaviour.[2] As Caivano notes:[3]

   People with disabilities, particularly those with intellectual and psychosocial disabilities, have long been subject to limitations on their right to legal capacity. They have endured arbitrary detention and have been deprived of access to basic health interventions. They have faced cruel, inhumane, and degrading treatment, including physical abuse, confinement in squalid institutions, and subjection to restraint and seclusion. Due to stigma and discrimination, people with disabilities in many parts of the world continue to be deprived of legal capacity despite being able to make and communicate decisions, either by themselves or with support.

2. To date, the Government has not authentically consulted with people with mental illness, their families and carers in designing the reform agenda. Instead, a paternalistic approach is often taken which does not consider the views and wishes of people with mental illness.

3. Proposed reforms have generally not been supported by an appropriate funding investment, which makes them difficult to realise.

4. There is a lack of understanding of mental illness. There has been a lack of clarity in differentiating mental illness from intellectual or cognitive disability. The Carter Report, published in 2006,[4] documented significant problems with the conflation of treatment provided to persons with mental illness and persons with an intellectual or cognitive disability. It noted the need to develop a differentiated response to persons with a sole diagnosis of intellectual or cognitive disability (that is, persons who do not have a mental illness). This delineation challenged the accepted practice of accommodating persons with an intellectual or cognitive disability who were diverted

[1] Leslie Salzman, 'Guardianship for Persons with Mental Illness – A Legal and Appropriate Alternative?' (20102011) 4 St Louis University Journal of Health Law & Policy 279, 286.
[2] Leslie Salzman, 'Guardianship for Persons with Mental Illness – A Legal and Appropriate Alternative?' (20102011) 4 St Louis University Journal of Health Law & Policy 279, 288-9.
[3] Nicholas Caivano, 'Conceptualizing Capacity: Interpreting Canada's Qualified Ratification of Article 12 of the UN Disability Rights Convention' (2014) 4(1) Western Journal of Legal Studies 1, 2-3.
[4] The Hon Justice Carter QC. Challenging Behaviour and Disability: A Targeted Response. Report to Honourable Warren Pitt MP, Minister for Communities, Disability Services and Seniors, July 2006 ('Carter Report').

from the criminal justice system in authorised mental health services (**AMHS**). Yet there remain issues at this interface. This is clearly illustrated in the case of people under Forensic Orders (Mental Health) and Forensic Orders (Disability).[5] In essence, the distinction between the two orders pertains to both the treatment and/or care of the person and the type of facility they are detained in. Persons under a Forensic Order (Disability) can be subjected to involuntary care, but not treatment, whilst persons under a Forensic Order (Mental Health) can be subjected to both involuntary treatment and care for their mental illness. The treatment and care under Forensic Orders (Mental Health) is provided through the mental health system and monitored and reviewed by the Mental Health Review Tribunal (**MHRT**). The care provided under a Forensic Order (Disability) is coordinated between the disability and mental health systems, depending on whether the AMHS or the Forensic Disability Service (**FDS**), a 10 bed service, is accountable for management of the order.[6] Any other disability services and supports that may be available to a person are considered, but cannot be compelled.[7] Where the person has a dual diagnosis – that is, they have a co-existing mental illness and an intellectual or cognitive disability – a Forensic Order (Mental Health) must be made and treatment provided in an AMHS, not the FDS.[8] The MHA defines 'care' to include the provision of rehabilitation, the development of living skills, and the giving of support, assistance, information and other services.[9] 'Treatment' of a person with a mental illness is defined as anything done, or to be done, with the intention of having a therapeutic effect on the person's illness.[10] Persons with an intellectual or cognitive disability have a lifelong condition that cannot be 'treated'. Rather, their habilitation, rehabilitation and successful inclusion in society is dependent on a positive, supportive response that also focuses on helping others within society to understand their behaviours. Where a person has a dual diagnosis of an intellectual or cognitive disability and a mental illness, there is the potential for their mental health treating team, who hold responsibility under the Forensic Order, to focus largely or solely on their mental illness, at the expense of any consideration given to their needs based on disability.

A problematic approach has been taken under the National Disability Insurance Scheme (**NDIS**), which attempts to fit mental illness ('psychosocial disability') into a framework designed for physical or intellectual disability. This has been problematic for many reasons. Firstly, the National Disability Insurance Scheme Act 2013 (Cth) (**NDIS Act**) imposes the requirement that the condition is or is likely to be permanent as part of the disability test.[11] This is problematic for mental illness as, in contrast to disabilities, they can respond to treatment. It is also therapeutically counter-productive for many people with mental illness to feel that their illness is permanent. These important issues are discussed further, below.

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[5] There is provision for the Mental Health Court to make two types of Forensic Orders: Forensic Orders (Mental Condition) (also referred to as general Forensic Orders) and Forensic Orders (Disability). The former can be made for persons with a mental health condition; the latter can only be made for persons with an intellectual or cognitive disability.

[6] Queensland Health, *Review of the Mental Health Act 2000: Background Paper: Forensic Disability*, May 2014, 1.

[7] Queensland Health, *Review of the Mental Health Act 2000: Background Paper: Forensic Disability*, May 2014, 1-2.

[8] Queensland Health, *Review of the Mental Health Act 2000: Background Paper: Forensic Disability*, May 2014, 1-2.

[9] MHA 2016, Schedule 3.

[10] MHA 2016, Schedule 3.

[11] NDIS Act, s 24(1)(b).

What, if any, structural weaknesses in healthcare are not being targeted by the most recent and foreshadowed reforms by governments? How should they be addressed and what would be the improvements in population mental health, participation and productivity?

In practice, QAI sees people kept on involuntary orders, not because the client requires compulsion to engage with treatment, but because mental health teams are unable to provide the level of support needed without the client being designated as a Treatment Authority or Forensic Order client.

QAI supports the introduction of a 'stepped model of care', an outcome of the decision to redirect Commonwealth funding for primary mental health programs to a new flexible funding pool to be used by its regional primary health networks (PHNs) to plan and commission primary care, in concert with State and Territory Government local health networks and others. We consider this model recognises that all of the population require some degree of support to achieve and/or maintain mental health and in this way, helps to reduce the stigma potentially associated with investments in mental health supports.

There are a number of structural weakness in healthcare that are yet to be addressed. These include the siloing of different forms of treatment, therapy and support, with the potential for real issues in a person's life to be left unaddressed. There is a need for greater integration of medical/pharmacology and non-medical/holistic interventions. Support for people with non-acute mental illness is also problematic (these issues are discussed in further detail below).

Specific health concerns

Should there be any changes to mental illness prevention and early intervention by healthcare providers? If so, what changes do you propose and to what extent would this reduce the prevalence and/or severity of mental illness? What is the supporting evidence and what would be some of the other benefits and costs?

QAI considers that there should be changes to mental illness prevention and early intervention by healthcare providers. These changes should include:

1. **Education**, including in the areas of:
    - types of mental health issues individuals should be aware of that may require intervention or that they should seek support for;
    - early warning signs (pre-mental health diagnosis);
    - wellness – initiatives (eg good sleep patterns, stress reduction techniques, nutrition, work/life/study balance, etc);
    - trauma informed responses;
    - promoting autonomy/awareness in identifying mental health issues;
    - psychology/counselling in schools;
    - integration of holistic modalities – non-pharmacological approach or integration of pharmacology and holistic supports;
    - for families and support networks.
2. An expanded range of **services**, including:
    - services to assist people to access mental health services;

- services that enable people to access supports for mental health issues without a diagnosis of mental illness;
- services available to address early warning signs, so that further deterioration and inpatient care can be avoided.

Which forms of mental health promotion are effective in improving population mental health in either the short or longer term? What evidence supports this?

QAI considers that the following forms of mental health promotion are effective in improving population mental health in both the short and longer term:

- education, which should be available in medical surgeries, health care providers and educational institutions via school counsellors, as well as being built into the school curriculum (such as within Health and Physical Education);
- advertising – billboards, public events, social media, etc.

What changes do you recommend to healthcare to address the specific issues of suicides and comorbidities among people with a mental illness? What evidence is there to support your suggested actions and what types of improvements would you expect in terms of population mental health, participation and productivity?

QAI proposes the following changes:

1. campaigns targeted to stamp out bullying and create awareness of depression and other conditions with high rates of suicidal ideation;
2. campaigns targeted at reducing the stigma of mental illness;
3. increased education in schools and targeting 'at risk' groups;
4. wide-spread media attention across a multitude of forums.

What healthcare reforms do you propose to address other specific health concerns related to mental ill-health? What is the supporting evidence and what would be some of the benefits and costs?

A regular concern raised by consumers of mental health is the lack of available health care/treatment options available to them. They are diagnosed ('labelled') and treatment is singularly directed towards this diagnosed illness, rather than holistic support and treatment. For example, in mental health, psychiatry only focusses on the 'bandaid' of pharmacological intervention and does not address the root cause or identify the basis of trauma. This is so notwithstanding that the person may be suffering from mental health issues that need treatment whilst also having issues that have created or attributed to the illness that are not investigated.

There is a significant gap in the system that impacts the range of supports available. More funding is required for social workers, psychologists and other allied health professionals, to work in mental health settings to provide alternatives to pharmacological intervention alone, as well as more support groups and services that are recovery-driven.

Health workforce and informal carers

Does the configuration and capabilities of the professional health workforce need to change to improve where and how care is delivered? If so, how should the workforce differ from current arrangements? How would this improve population mental health, participation and productivity?

QAI considers that intervention strategies need to be considered before incidents progress to a crisis point. This might include:

- supports for front-line agencies to identify issues and develop solutions with people experiencing mental ill health;
- engaging with people before crisis;
- identifying supports, such as community legal centres, who may be able to assist in identifying legal issues that may impact on a person's recovery or to prevent the escalation of a legal issue;
- sharing of information is a crucial factor. If agencies have limited information about the person they are supporting it is likely that assistance will be reactive rather than proactive. The limited resources of community agencies can mean that the best outcomes are not achieved as a result of these restraints;
- better accountability;
- team-based approaches that focus on access as well as quality;
- development of specialist worker roles to address acute mental health issues (complex cases may require a multi-faceted team approach);
- a focus on the views, wishes and preferences of the person being treated and their support network.

The management of patients with an intellectual disability on Forensic Orders needs to be re-evaluated. The current system in which they are monitored by mental health workers, who often do not have the knowledge or skills to work with people with intellectual disability, but are managed in the community by service providers, who have no accountability to the forensic system, with no fall back other than mental health services at times of crisis, does not provide for suitable care. The focus on treatment in this setting is not appropriate and the desired outcome is unlikely to be achieved.

What can be done to address health workforce shortages in regional and remote areas? In which areas or circumstances would greater use of technology and tele-health services be suitable? What prevents greater remote provision of services to address the shortages?

QAI proposes the following strategies:

- identification of 'on the ground' support in regional areas;
- recognition of the importance of building trust with the community. The issues facing regional Australia can start with access to services. Lack of access and choice with respect to vital services can mean that issues develop and escalate to require multi-agency/ department solutions;
- technology is able to bridge some of the tyranny of distance and isolation;
- better systems and education that are accessible is required in the long term.

What restrictions exist on the scope of practice for different professions, such as GPs, nurses, clinical versus other psychologists, and social workers? Are these restrictions unwarranted and, if so, how could they be addressed and what would be some of the costs and benefits?

QAI notes the following restrictions:

- accessibility of information;
- lack of recognition of the importance of allied health in the treatment and recovery of a person with mental illness;
- lack of recognition of informal supports that could assist various professionals;
- realisation that individuals are diverse and will not always fit a pro forma response. An empathetic response that acknowledges the validity of different experiences, and different emotional responses to similar experiences, is vital.

What could be done to reduce stress and turnover among mental health workers?

Mental health workers can be adversely affected by the culture of the workplace, heavy workloads and lack of mentoring and support. Appropriate supervision and support, with the opportunity to debrief and reflect on practice improvements, manageable targets and education and training on current trends is required.

How could training and continuing professional development be improved for health professionals and peer workers caring for people with a mental illness? What can be done to increase its take up?

QAI proposes the following:

- focus on developing empathy reserves;
- promote sustainable empathy balanced with sustainable self care;
- address issues of isolation;
- introduce community focus initiatives, building on existing structures.

What changes should be made to how informal carers are supported (other than financially) to carry out their role? What would be some of the benefits and costs, including in terms of the mental health, participation and productivity of informal carers and the people they care for?

Carers can experience both emotional and practical challenges. They can be very isolated in their role and lack the support they need. They can face significant economic penalties as a consequence of the care they provide for a person with mental illness. The difficulties faced by carers in terms of workforce participation are not only relevant during the period of caregiving; many carers experience significant adverse career impact after a period of care-giving ends in circumstances where the care-giving has caused a lengthy absence from, or scaled down participation in, the labour market. In this situation, many care-givers may have been unable to maintain a strong attachment to the labour market, or to maintain the training and skills required for a smooth re-entry to the workforce. There can be scant value placed by employers and prospective employers on the significant physical and emotional work provided by the care-givers in their caring role and consequently, carers can find it more difficult to obtain appropriate employment than non-carers. The difficulties for carers are compounded in circumstances where they have experienced adverse physical and/or emotional effects associated with their care-giving, or where they are experiencing grief from a bereavement that has brought the care-giving role to an end.

QAI considers that the following strategies can be effective:

- opportunities for debriefing;
- access to new trends and education;
- holistic practices.

Housing and homelessness

In QAI's experience of providing support to people with mental illness, a significant barrier to community care, or discharge into the community, is the lack of appropriate accommodation options for people with mental illness. There is a gap in the system in providing support housing for vulnerable people, including those on Forensic Orders, transitioning from mental health wards to community living. More funding for purpose-built housing in a safe and supportive environment to fill this purpose is urgently needed, to support people in this situation and ensure their rehabilitation and integration is successful whilst monitoring risk. In the absence of this support, people without family or friendship networks who can fill this gap unnecessarily stay longer in inpatient facilities, or are at greater risk of relapse and return to hospital.

In this regard, we note:

- People are often forced to rely on hostels and boarding houses, which do not provide the security or support needed for someone recently discharged from hospital after an acute episode or for someone who has been institutionalised for some time.
- Community care units are available, but end up being a long-term housing solution for people with high support needs.
- There are not enough beds to support people in transition.
- People are forced to give up commission housing, or placed at risk of losing commission housing, due to long-term admission to hospital. They then have nowhere to go upon discharge.

Prisoners

'Up to 28 per cent of exiting prisoners find themselves on the street'.[12] The most serious problem for ex-prisoners with disability is the lack of adequate accommodation on release,[13] which 'makes their chances of integration slim'.[14] Ex-prisoners have disproportionately high rates of homelessness – about one per cent of the general population is homeless yet for ex-prisoners the figure is around 28 per cent.[15] A visit to any of the larger men's homeless shelters in Brisbane will confirm that people with psycho-social disability are disproportionately represented amongst homeless ex-prisoners.

Australian governments have a responsibility to provide 'appropriate and affordable accommodation to all individuals'.[16] In order to gain parole, the prisoner must provide the Parole Board with an address which the Board then assesses for suitability. Many prisoners with mental illness have no home to go to. Many do not own their own homes and cannot afford the up-front cost to get into the private rental market. Housing is not just a necessity for its own sake: it is the foundation for the ex-prisoner's future prospects.

Private rentals and even mortgages rarely survive a prison term. Prior to February 2014 a person could retain their Queensland Department of Housing property if they were absent for

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[12] E Baldry & Australian Housing Urban Research Institute. 2003. *Ex-prisoners, and accommodation what bearing do different forms of housing have on social reintegration?* Canberra.
.[13] V Catherine Riches, T Parmenter, M Wiese & R Stancliffe. 2006. 'Intellectual disability and mental illness in the NSW criminal justice system'. *International Journal of Law and Psychiatry* 29: 386–396.
[14] E Baldry, L Dowse & M Clarence. 2011. *People with Mental Health and Cognitive Disability: Pathways into and out of the criminal justice system*. Background Paper for the National Legal Aid Conference, Darwin, 6-7.
[15] E Baldry & M Borzycki. 2003. *Promoting integration: the provision of prisoner post-release services: Trends and issues in crime and criminal justice*. Canberra: Australian Institute of Criminology.
[16] Ibid.

up to 12 months on the condition they continued to pay a reduced amount of rent. This is no longer the case.[17]

The private rental market is difficult to access for those without employment and references. Defaulting private tenants, such as prisoners whose lease was interrupted by jail, will usually be 'blacklisted' on the TICA database (national tenants database). The listings are permanent and the majority of agents Australia-wide will not accept an offer from an applicant on the TICA database. The only solution is to move into state or non-government housing, to purchase if this is financially feasible, to stay with friends or family or to move into a boarding house.

Anyone seeking to enter a residential tenancy agreement must be able to afford a bond and two weeks rent in advance – amounting to six weeks' rent. That is beyond most, so the alternative is rooming accommodation – hardly a suitable alternative for a person wanting to avoid old drug and/or alcohol habits. Recent research confirms a correlation between persons who struggle to find accommodation or who are homeless upon their release and the likelihood that they will later commit another crime.[18] For those without a job or money and with no palatable explanation for their recent whereabouts, the only options are boarding houses, hostels and the street, where they are likely encounter other ex-prisoners and drug users, making it difficult for them to avoid further offending.

In Queensland, the Ozcare Supported Parole Program has two facilities that accept male ex-prisoners in South Brisbane and in Townsville, but supply does not approach demand.[19] It is not uncommon for parole applications to be approved but not activated until a vacancy arises at an Ozcare facility – which can sometimes be a matter of years.[20]

If Ozcare is deemed unsuitable as a release address, either by the parole board or by Ozcare itself, the prisoner is left with no options. For someone serving a long sentence the result may be years in prison instead of release and supervision on parole. Ozcare does not accept women prisoners and lack of appropriate housing options results in prisoners remaining imprisoned past their possible release date.

- QAI recommends:
  - The NDIA, Corrections and Housing authorities cooperate to pilot comprehensive programs of housing and support for exiting prisoners with disabilities (the NSW Justice Support Program may provide a useful example).
  - Prisoners who apply for public or community housing must be eligible for priority housing on release from prison.
  - Corrections and Housing authorities should cooperate to give prisoners the option to maintain public or community housing for a reasonable time while they serve in prison.

Social services

How could non-clinical mental health support services be better coordinated with clinical mental health services?

QAI submits that non-clinical mental health support services could be better coordinated with clinical mental health services by:

[17] Prisoners Legal Service. 2014. *Queensland Prisons Report 2013.*
[18] A Mills, D Gofkovic, R Meek & D Mullins. 2013. 'Housing Ex-Prisoners: The Role of the Third Sector'. *Safer Communities* 12: 38-49.
[19] Prisoners Legal Service and Catholic Prisons Ministry. 2013. *Queensland Prisons Report.*
[20] Ibid.

- better communication - formal channels for communication between the treating teams and NGOs who deliver services to the client should be established (at present, it is mostly an ad hoc arrangement dependent on the person's case manager or the support organisation making contact). We note that information sharing would have to consider privacy issues;
- clinical MH services could provide education to NGOs about mental illness, conditions on involuntary orders, early warning signs;
- implementing measures to make it easier for people with mental illness to access support under the NDIS. The NDIS does not properly fill the gap left by Disability Services Qld – for example, DSQ would provide programs for sex offenders with an intellectual impairment and would modify the program to suit the individual. QAI's Mental Health Legal Service has found it difficult for clients and/or treating teams to find providers who do similar work, especially in regional areas (even Townsville).

Case study – Highlighting the trickiness of treating teams working with NGO support workers

QAI recently supported a client who was on a Forensic Order and who had obtained illicit substances while out in the community with a support worker. The support worker was supervising him but didn't realise 'supervision' meant he was supposed to have him in view at all times and accompany him everywhere. At the MHRT hearing, the Tribunal members urged the treating team to educate the support workers about what the exact requirements are for a client under a Forensic Order.

This is not a singular occurrence and support workers are frequently expected to monitor and report on the behaviour of their clients, including monitoring text messages and internet activity. It would be good for NGOs and treating teams to work together to get the best outcomes for clients but issues of privacy, rapport and building trust are often difficult to navigate.

Are there significant service gaps for people with psychosocial disability who do not qualify for the NDIS? If so, what are they?

Yes. To get Continuity of Care, people who are unlikely to get NDIS access must nevertheless apply, to gain evidence of rejection (the first step in qualifying for CoC). The process is expensive, time consuming, involves long waits of up to nine months or more, and is emotionally exhausting, if not psychologically damaging.

The NDIS has not been well developed to meet the needs of people with psychosocial disability. The development of the access criteria has been developed with a primary focus on people with physical or intellectual or cognitive, rather than psychosocial disabilities.

For example, the requirement to show permanency of impairment (see s 24(1)(b) of the *National Disability Insurance Scheme Act 2013* (Cth)) can be problematic. The nature of psychosocial disability, which can respond to treatment, can mean that it is therapeutically counterproductive for a person to consider that their psychosocial disability is, or is likely to be, permanent. For people with fluctuating mental health conditions, the permanency requirement is also problematic. Many people with psychosocial disability also don't qualify for support under the NDIS as they lack medical records or reports necessary for access. The cost to undertake assessments for reports can be crippling for many people, and that actually becomes a real gamble that for too many people doesn't pay off. Even where a person has a

very good claim to become an NDIS participant and can afford the appropriate assessments, if the report writer has limited understanding of the NDIS, the way in which their report portrays the individual's functional capacities could be much less convincing than if they had simply written the report with a greater understanding of what was being sought by the NDIS to prove they meet the disability requirements.

The problems are compounded for people deemed ineligible for the NDIS, as there has been a shrinking of state-based services, many of which were very effective. Community mental health programs that do exist are over capacity and unable to meet demand. Prior to the NDIS, people with psycho-social disabilities could receive block-funded services under the Commonwealth funded Personal Helpers and Mentors, Day to Day Living, and Partners in Recovery programs. Some are NDIS-eligible and get funded support packages, while those who are not eligible so far receive nothing.

In the 2017-18 Budget the Australian Government committed $80 million over four years for the National Psychosocial Support (NPS) measure. The purpose of the NPS measure is to provide psychosocial support services to assist people with severe mental illness resulting in reduced psychosocial functional capacity who are not more appropriately funded through the National Disability Insurance Scheme (NDIS).

The rollout of the NDIS has created many gaps and uncertainties, and left certain groups at risk of disadvantage, and this must be addressed. The Government must develop and implement a plan to address these gaps and uncertainties.

Support for young people with mental health is also lacking. The main programs available are Children and Youth Mental Health or Headspace, again underfunded and the NDIS is reluctant to give access to a young person due to their MH not being permanent.

Case study

Mary* has been diagnosed with autism, fibromyalgia, anxiety and depression. She has been attempting to access mental health services for over two decades, since her teenage years. Mary has tried different forms of cognitive behavioural therapy and medications, none of which have stabilised her condition and her mental health continues to deteriorate. She has attempted to self-harm and has suicidal tendencies.

Co-morbidity is not accepted by NDIA for access purposes and Mary has been informed that she does not meet the NDIS access criteria for any of her disabilities when considered separately. Her three NDIS access requests have been rejected on this basis.

There are no services available through the Department of Health that meet Mary's needs, as she has difficulty leaving her home, can experience extreme anxiety and paranoia and has difficulty interacting with people she does not know. It is very difficult for Mary to form an ongoing relationship with a psychologist, which takes time and trust.

Mary has accessed a mental health unit at a hospital and been prescribed medication, but no other form of assistance. She has been informed by Partners in Recovery that they are no longer taking on new clients. Mary has utilised mental health plans over many years to access psychology services, but these are not sufficient to meet her need for ongoing assistance.

A recent acute episode led to Mary accessing a psychologist and a psychiatrist through the above services and a possible referral to Partners in Recovery worker. This demonstrates that mental health services are reactive when people have deteriorated to a critical point but not before; and that services are inadequate to the needs and volume of people with mental

health issues. Mary's experience was also that staff do not always treat people respectfully or take into account their condition.

** name has been changed to protect identity*

What continuity of support are State and Territory Governments providing (or plan to provide) for people with a psychosocial disability who are ineligible for the NDIS?

At present, there is no continuity of support. There is also a lack of support for people with disability and mental illness who have access to the NDIS for their disability but not their mental illness – in these cases, the NDIA have advised that they will not fund mental health as it is not directly related to the primary disability. The recently released Progress Report of the Joint Standing Committee on the National Disability Insurance Scheme (March 2019) has made key recommendations for people under the NDIS with psychosocial disability,[21] but those without access will not have the benefit of these recommendations, if implemented.

The Queensland Government is replacing Queensland Community Care (QCC) with the Queensland Community Support Scheme from 1 July 2019, which is designed to meet the support needs of persons not under the NDIS following full NDIS roll-out. It is predominantly directed to meeting the needs of those with low level support needs, with the expectation that those with high level support needs will transition to the NDIS. QAI is concerned that the requirement that a person prove they are not eligible for the NDIS (which, in the case of new participants, requires that an NDIS application is made and rejected) will cause undue delay and hardship for participants, who may be in limbo pending a decision of the NDIA. This is particularly so given that people are already experiencing lengthy delays receiving an outcome from the NDIA, with delays expected to increase with the increased demands associated with this transition.

Are the disability support pension, carer payment and carer allowance providing income support to those people with a mental illness, and their carers, who most need support? If not, what changes are needed?

Families which include a person with disability can be subject to considerable additional financial expenses when compared to families which do not include a person with disability. We consider that it is appropriate to ensure that families which include a person with disability are adequately financially supported. As discussed above, carers can face significant economic penalties as a consequence of being a carer.

Welfare reforms in Australia have resulted in many people being transitioned from the Disability Support Pension to Newstart Allowance. QAI strenuously objected to this transition, as the transfer from pension to allowance is inappropriate, increased financial hardship due to the lower payments and increased bureaucratic requirements (such as requiring a person to prove they were actively seeking work).

The 2017 Senate Inquiry into the design, scope, cost-benefit analysis, contracts awarded and implementation associated with the Better Management of the Social Welfare System

[21] That the NDIA immediately commit resources to work with the mental health sector to refine the psychosocial disability stream before it is rolled out nationally to ensure it is fit-for-purpose; that the NDIA immediately commit resources to provide additional training in mental health to staff and planners to rollout the psychosocial disability stream nationally during 2019; that the Australian Government extend funding for PIR, PHaMs and D2DL programs until 30 June 2021 and make public by 30 June 2020 how it intends to deliver longer-term arrangements for existing program clients not eligible for the NDIS; and that the Council of Australian Government conduct an audit of all Australian, state and territory services, programs and associated funding available for mental health.

initiative exposed significant flaws in systems used by the Federal Government to identify and seek to recover welfare 'overpayments', at significant cost to people. Indeed, it has recently been reported that over 2,000 deaths have been attributed to the 'Robo-Debt' debacle.[22] There remain significant structural issues in this space that are disproportionately impacting people with disability and mental illness and their carers.

Is there evidence that mental illness-related income support payments reduce the propensity of some recipients to seek employment? AND How could mental illness-related income support payments better meet the needs of people whose capacity to work fluctuates over time?

We are not aware of evidence that mental illness-related income support payments reduce the propensity of some recipients to seek employment. However, we are aware that the interface between earnings and support payments can be a source of confusion and concern for many recipients. It is important that the interface between earnings and welfare payments are designed to ensure people are not penalised for fluctuations in their income. It is important that the system is transparent and easily understood to ensure that there are no financial disincentives for working, whether actual or perceived.

Social participation and inclusion

In what ways are governments (at any level) seeking to improve mental health by encouraging social participation and inclusion? What evidence is there that public investments in social participation and inclusion are delivering benefits that outweigh the costs?

In recent times, there appears to be a greater preparedness by many people to talk about mental health issues in public, which may be attributed to campaigns (often funded by government) aimed at heightening people's awareness of mental illness. On the surface these attempts appear positive, but there does not yet appear to be evidence that these campaigns are translating into real improvements for people living with mental illness.

Mental Health is an area of disability where it's often vital to straddle the medical and the social models of disability because regular treatment is important to maintain or reclaim stability, so the distance between mental health treatment facilities and practitioners, and those who operate in the social services sector needs to be breached. It still remains very wide to this day, even though both paradigms have been operating almost in parallel for decades.

Our growing understanding of the issue of loneliness and the possible attendant mental health issues that can ensue is an emerging issue of importance, with consideration required of the sort of public health responses might be put in place to address this issue. This is becoming a major area of research across the tertiary education sectors in many countries around the world, so perhaps the absence of a precursor of mental ill health being the cause, may auger well for this important factor to get some traction with the attention it warrants.

The work of the office of the Qld Mental Health Commissioner, including the 2018-2023 Strategic Plan and the comprehensive web-based resources offered, is evidence that a genuine effort is being invested in Queensland.

[22] Data provided by the Department of Human Services in response to questioning from the Senate Community Affairs References Committee: https://www.abc.net.au/triplej/programs/hack/2030-people-have-died-after-receiving-centrelink-robodebt-notice/10821272; https://www.abc.net.au/triplej/programs/hack/2030-people-have-died-after-receiving-centrelink-robodebt-notice/10821272.

For people with complex needs, such as people with severe and persistent mental health conditions, there should be "wrap around" services that assist them to stabilise their lives and engage in education, work and social activities. The welfare system should offer the right support to people with complex needs, such as mental health conditions. This might include supporting people with mental health conditions to take part in the community and to find work. However, measures designed to help people find work must be more than tokenistic and that concerted effort must be directed to challenging mindsets and preconceptions that can act as barriers to the employment of people with mental illness.

What role do non-government organisations play in supporting mental health through social inclusion and participation, and what more should they do?

A key ingredient to consumer control is having a voice. Many people find it difficult to speak up about their views, wishes and preferences to their doctors, hospital staff and other services. Non-government organisations, including advocacy organisations, play a vital role in supporting people to make decisions about key aspects of their lives, communicate their decisions and connect with appropriate social supports and services. A key issue limiting the impact of many of these NGOs is limited funding, which limits their capacity to respond to the significant need in this area.

Pre-NDIS there were a number of programs which had an exclusive mental health focus (e.g. Personal Helpers and Mentors (PHAMS) program, Partners in Recovery (PIR) and Day to Day Living (D2DL). Most of those programs have either fully closed their doors, or will soon do so as their funding transitions to the NDIS. There are a number of very large mental health focussed organisations that enjoy a very high public profile (e.g. Headspace and Beyond Blue), but while they provide a vast range of resources, some clinical or in-house services, as well as telephone counselling services, they don't necessarily facilitate direct social inclusion and participation. Many people living with mental illness know enormous amounts about their diagnosis and treatment, so they don't really benefit much from that.

Many people do however need and greatly benefit from reliable 1:1 assistance with basic day-to-day tasks related to self management, so that they can maintain their commitments, continue to operate reasonably well when they are in an unwell phase of their illness but not hospitalised, and have someone who will sensitively and professionally guide them through some basic decision-making when needed. Things such as having someone take them to do their shopping, to attend appointments, perhaps attend a community event or visit a public venue like a park are simple and relatively undemanding instances of social inclusion that many people simply don't have in their lives. It's a dream to think that this could potentially develop into having someone go on the journey to prepare to re-enter the workforce and to provide ongoing encouragement and positive support to do so; or to help with bridging the divide that often occurs in families of people with mental illness.

Once full roll-out has occurred across the country, the "divvying up" of funding that has been ongoing since the advent of the NDIS is something that should be thoroughly researched (and audited) to examine exactly what gains and losses have occurred in the social participation arena, solely because of this new scheme.

Are there particular population sub-groups that are more at risk of mental ill-health due to inadequate social participation and inclusion? What, if anything, should be done to specifically target those groups?

QAI considers the following sub-groups to be most at risk:

1. Those with multiple vulnerabilities, including disability, homelessness, unemployment, etc.
2. People in rural, regional and remote localities, due to the lack of appropriate supports and services in these areas. QAI supports the development of a decentralised 'hub and spoke' model, with regional hubs dispersed throughout Queensland, for the delivery of outreach services throughout Queensland that support people with mental illness to remain living in their community. This should take the form of service outreach and capacity-building.
3. People who are engaged with the justice system, including those in prisons - more needs to be done to identify, and where desirable, provide the chance for diagnosis and treatment whilst incarcerated.
4. People with mental illness and substance abuse issues who are incarcerated for that reason alone - decriminalisation to allow those persons to be diverted to treatment (mandatory instead of jail) would be a more logical and cost effective response. Ongoing substance abuse by people even while under the care of mental health services is a significant issue – mental health services do not have the skills or resources to both treat mental illness and substance abuse. This results in treating teams and even the MHRT resorting to punitive measures to try and achieve a change in behaviour. There is a pressing need to rethink how we address substance misuse.
5. People who are socially isolated, including older people – their risk of exploitation is heightened. Friendly visitation programs (or phone calls such as the Red Cross Tele-link service) can be effective in situations like this, but these services are often reliant on volunteers and are becoming less available.
6. Younger Aboriginal and Torres Strait Islander people, particularly those who may be engaging in risky behaviour, have been known to 'copy cat' suicides of their peers who have died.

Targeted support measures must be designed and implemented that are co-designed by people with mental illness.

What indicators are most useful to monitor progress in improving mental health outcomes through improved social participation and inclusion?

The following indicia are relevant:

- hospitalisation statistics;
- statistics from the Anti-Discrimination Commissions and Human Rights Commissions – annual trends can be informative;
- rates of participation in mainstream education and open employment. We note that there is still a significant reluctance to disclose mental illness during recruitment for fear of a discriminatory response;
- community policing statistics – better mental health through constructive community participation impacts the likelihood of police involvement in disputes, presentations to Emergency Departments, etc;
- levels of unemployment;
- levels of homelessness;
- rates of suicide;

- ‘good news’ stories.

Justice

What mental health supports earlier in life are most effective in reducing contact with the justice system?

Early holistic supports are crucial for the development and well-being of children and young people with mental health disorders, particularly Aboriginal and Torres Strait Islander children, young people and others from disadvantaged backgrounds. Without such early intervention and diversion, the costs to individuals with mental illness, to their families and communities and to government are high. These costs increase over time as people with mental illness become entrenched in the criminal justice system and become further marginalised from the community. Case studies presented in Baldry’s cost/benefit analysis of different life paths of NSW residents with capacity impairments, illustrate that the lifetime costs of prison and crisis supports can be as high as $1 million per annum per person.[23]

Support, employment, housing, training and educational opportunities that integrate people with their communities and break down the barriers between ‘them’ and ‘us’ are the most effective way of breaking the criminal justice cycle.

To what extent does inadequate identification of mental health and individual needs in different parts of the justice system increase the likelihood, and extent, of peoples’ future interactions with that system?

As QAI noted in our 2015 publication *dis-Abled Justice: Reforms to Justice for Persons with Disability in Queensland*,[24] the 2010 national prisoner health census determined that 33% of people in Australian prisons had a mental illness.[25]

People with intellectual and psychiatric impairments are in watch houses, courts, remand centres, jails and forensic facilities because they are disadvantaged in myriad ways. International[26] and Australian research[27] confirms that offenders with intellectual and psychiatric impairments are more likely to have experienced childhood neglect or abuse, to be unemployed (see text box), poor and/or from an indigenous minority, to have limited social and communication skills and behavioural and/or psychiatric conditions.

Where are the gaps in mental health services for people in the justice system including while incarcerated? AND What interventions in the justice system most effectively reduce the likelihood of re-offending, improve mental health and increase prospects for re-establishing contributing lives? What evidence is there about the long-term benefits and costs of these interventions? AND What are the main barriers to lowering the over-representation of people living with a mental illness in the justice system and what strategies would best overcome them?

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[23] Ruth McCausland, Sarah Johnson, Eileen Baldry & Anna Cohen. 2013. *People with mental health disorders and cognitive impairment in the criminal justice system Cost-benefit analysis of early support and diversion.* University of New South Wales.
[24] Queensland Advocacy Incorporated. *Dis-Abled Justice: Reforms to Justice for Persons with Disability in Queensland.* 2015.
[25] Australian Institute of Health and Welfare. 2011. The Health of Australia’s Prisoners 2010. Australian Institute of Health and Welfare.
[26] William Glaser & Kristen Deane. 1999. ‘Normalisation in an Abnormal World: A Study of Prisoners with an Intellectual Disability’ International Journal of Offender Therapy and Comparative Criminology. 43(3): 338.
[27] See, for example, S Hayes. 2005. Prison Services and offenders with intellectual disability – the current state of knowledge and future directions. 4th International Conference on the Care and Treatment of Offenders with a Learning Disability, 2005 April 6-8, University of Central Lancashire, Preston, UK.

A significant issue is the over-representation of people with mental illness in the criminal justice system and in our prisons. In Queensland, this is addressed by:

- special circumstances court – allowing for the diversion of non-indictable offences;
- the expansion of the Court Liaison Service, to support amendments to the *Mental Health Act 2016* (Qld), which expressly enables Magistrates to dismiss simple offences on the basis that a person was of unsound mind or is currently unfit for trial;
- Mental Health Court, which deals with questions of unsoundness of mind and unfitness for trial for indictable offences, and can make Forensic Orders in cases where charges are discontinued.

There are also systems before and after the court process which need to be considered, and are discussed in more detail, below.

QAI's experience through our Justice Support Program is that when a person in the criminal justice system is supported holistically, not just simply providing legal support for the criminal charge, but also taking time to listen to their story, help them to better understand their situation, and identify their other social and legal needs, the likelihood of recidivism is vastly reduced.

Police

Police officers encounter people with mental illness every day - as suspects, victims and witnesses of crime, or because the police have been called for assistance by concerned members of the public. A survey of Sydney police officers determined that police on average spend around ten percent of their time dealing with people who appear to be mentally ill.[28]

Research commissioned by the NSW Law Reform Commission in 2012 examined policing and mental health, and that research confirmed the 2010 finding that police in NSW spend approximately 10 percent of their time with people with mental health impairments.[29]

In 2010, Victorian police reported that around one-fifth of potential offenders they encountered appeared to have a mental illness.[30] Another Victorian study showed that people with mental illnesses are overrepresented among those taken into police custody:

- More than half had prior contact with the public mental health system.
- One-third of detainees reported current psychiatric symptoms (most commonly anxiety and depression) at the time of detention.
- One-third of detainees were receiving psychiatric treatment in the community at the time of arrest. [31]

In a follow-up Victorian study, the authors assessed 150 people in police cells to identify current and lifetime mental illness:

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[28] Godfredson JW, Ogloff JP, Thomas SDM & Luebbers S. 2010. 'Police discretion and encounters with people experiencing mental illness'. *Criminal Justice and Behaviour* 37(12): 1392. Three-quarters of police participants reported that they had dealt with people in this category in the past month.

[29] New South Wales Law Reform Commission. 2012. *People with cognitive and mental health impairments in the criminal justice system- Diversion*. Report 135. www.lawlink.nsw.gov.au/lrc.

[30] Kesic D, Thomas SDM & Ogloff JP. 2010. 'Mental illness among police fatalities in Victoria 1982-2007: Case linkage study'. *Australian and New Zealand Journal of Psychiatrists* 44(5): 463.

[31] G Baksheev, S Thomas & J Ogloff. 2010. 'Psychiatric disorders and unmet needs in Australian police cells'. *Australian and New Zealand Journal of Psychiatry.* 44: 1043-1051. These results are an underestimate due to the nature of police screening and because the samples did not include those people with mental illnesses taken by the police to hospital.

- Three-quarters of the detainees met diagnostic criteria for at least one mental disorder.
- Over half of the detainees had a history of contact with public mental health services.
- A quarter of detainees had been admitted to psychiatric hospitals on at least one occasion
- The majority of detainees had committed non-violent offences. [32]

More recent research explored the relationship between offending, mental health and experiences of abuse among a sample of police detainees in New South Wales, Queensland, South Australia and Western Australia. It found high levels of mental illness symptoms, particularly among women.[33] The 2012 'Gateway study' established that:[34]

- 41 percent of detainees had been previously diagnosed with a mental health problem.
- 64 percent of women and 46 percent of men were screened and identified as having a mental disorder.

In 2013 alone, NSW police responded to more than 40 000 mental health incidents,[35] while in Victoria, the police apprehend an average of one person every two hours and take them to hospital for assessment. The figures demonstrate that police work *is* largely work with people with various forms of intellectual and mental health impairment.

Qualitative data from interviews with mental health consumers uncovered a perception that police fear this group, and fear prompts police to pre-emptively escalate conflict.[36] Like the general community, those with mental health issues are also likely aware, through the extensive media coverage of this issue, that police have been involved in, if not responsible for, a number of gunshot and Taser deaths.

The perception amongst some mental health consumers is that police are afraid of them and that this fear can lead to pre-emptive aggressive/defence responses in crisis situations. That police can lawfully kill in self-defence when they have a reasonable apprehension of death or grievous bodily harm[37] is no consolation.

Surprisingly few police are provided with knowledge and skills to deal with mentally ill people in crisis. Fewer than 10 percent of frontline officers in New South Wales, for example, have

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[32] G Baksheev, S Thomas & J Ogloff. 2011. 'Identification of mental illness in police cells: a comparison of police processes, the Brief Jail Mental Health Screen and the Jail Screening Assessment Tool'. *Psychology, Crime and Law.* 18(6): 529–542.

[33] L Forsythe, K Adams. 2009. 'Mental health, abuse, drug use and crime: does gender matter?'. *Trends & issues in crime and criminal justice No. 384.* Australian Institute of Criminology.

[34] L Forsythe & A Gaffney. 2012. 'Mental disorder prevalence at the gateway to the criminal justice system'. *Trends & issues in crime and criminal justice No. 438.* Canberra: Australian Institute of Criminology. In addition, they found that:
43 percent of male detainees and 55 percent of female detainees self-reported as having been previously diagnosed with a mental disorder.
28 percent of male detainees and 42 percent of female detainees who had not previously been diagnosed met the criteria for a diagnosable mental illness.

[35] LR Steele, L Dowse & J Trofimovs. 2013. *Section 32: A Report on the Human Service and Criminal Pathways of People Diagnosed with Mental Health Disorder and Cognitive Disability in the Criminal Justice System Who Have Received Orders Under the Mental Health (Forensic Provisions) Act 1990 (NSW).*

[36] V Herrington *et al* 2009. 'The Impact of the NSW Police Force Mental Health Intervention Team: Final Evaluation Report'
Charles Sturt University Centre for Inland Health Australian Graduate School of Policing.
http://www.police.nsw.gov.au/__data/assets/pdf_file/0006/174246/MHIT_Evaluation_Final_Report_241209.pdf

[37] *Criminal Code 1899* (Qld) s 271.

had mental health training. The findings of these studies are broadly consistent with comparative studies internationally.[38]

The Police Federation of Australia (**PFA**) has encouraged better mental health incident training for police but has also expressed concern that training will be counter–productive if mental health professionals defer incidents to better-trained police.[39] According to the PFA, the public might take the view that the police were thoroughly trained when in fact they could not be expected to be mental health experts.

Government allocation of more resources including beds in hospitals, better trained mental health staff and more responsive community programs would relieve police of responsibility for the mentally ill and divert it to where it best can be managed - by family members and mental health professionals.

QAI recommends:

- early and repeated police training in mental health awareness and crisis de-escalation
- communication between front-line services.

Mental Health Crisis Intervention

The Queensland Government established Mental Health Crisis Intervention Teams - emergency services personnel acting together to de-escalate crisis situations with a view to resolving situations safely and humanely. In 2014, the QPS and the Department of Health, including the Queensland Ambulance Service and Queensland Hospital and Health Services, signed an agreement[40] that outlines processes for transporting mental health patients which:

- defines a state-wide interagency approach to the safe transport of people with a known or suspected mental illness who require, or may require, mental health assessment, treatment or care;
- clarifies the roles and responsibilities of each agency involved;
- provides a broad framework to guide the development of local interagency agreements;
- facilitates collaboration and coordination between key agencies in providing transport and treatment/care that address the safety of individuals, service providers and the community.

Police are more confident about de-escalation techniques following the Mental Health Intervention (Project) training.[41] We are not aware of any independent assessment of its effectiveness, but an evaluation of the NSW Police Force Mental Health Intervention Team's four-day and one-day training programs reports that the strategy, in place since 2008, has been successful in:

- improving the risk awareness of frontline police;
- reducing the risk of injury to police and people they attended during crisis events;

[38] Kesic D, Thomas SDM & Ogloff JP. 2010. 'Mental illness among police fatalities in Victoria 1982-2007: Case linkage study'. *Australian and New Zealand Journal of Psychiatrists* 44(5): 463.
[39] PFA reporting to The Senate, Select Committee on Mental Health. 2006. *A national approach to mental health – from crisis to community First Report. A national approach to mental health – from crisis to community. First Report.* 30 March 2006. Commonwealth of Australia.

[40] June 2014
[41] Ibid.

- improving collaboration with government and non-government agencies;
- reducing the police time consumed in mental health transfers;
- increasing police use of de-escalation techniques and greater police confidence when communicating with people experiencing mental health crisis and drug induced psychosis.

The literature and anecdotal evidence overwhelmingly stresses the need for early and repeated police training in mental health awareness and crisis de-escalation, together with the need for communication between front-line services, in that order.

QAI recommends:

- that all frontline police receive regularly updated training in mental health first aid such as that provided through the Mental Health Intervention Project (MHIT), and in the de-escalation of conflict situations involving people manifesting acute psychosis.[42]
- that Australian police forces assesse and revise their disability engagement plans for consistency with current best practice in police mental health and disability service delivery, including:
  - the need for early and repeated police training in mental health awareness and crisis de-escalation
  - the need for communication between front-line services.

Responding to the Queensland Coroner's recommendations in relation to the five shooting deaths of people with mental illness at the hands of police in late 2014, the Queensland Police Force has made a number of policy and operational improvements to its engagement with people who have mental illness.

Mental Health Court Liaison Services

Mental Health Court Liaison Services are presently operative in Victoria, Queensland, New South Wales and Tasmania.

Court Liaison Officers provide assistance for people with mental health issues required to attend court. The scope of their work can include:

- providing assistance and support for individuals and family members;
- explaining court processes;
- providing advice on contacting a lawyer;
- undertaking psychiatric assessments upon request by magistrates and judges;
- providing assessments and recommendations to the court.

In Victoria, the Mental Health Court Liaison Service provides assessment and advice to persons with a mental illness at the court, aimed at diverting appropriate offenders into mental health treatment programs, reducing recidivism and reducing the frequency and length of custodial remands.[43] The service seeks to identify and assess people suspected of suffering

[42] See, for example, the coronial findings into the death of Carmelo Galeano, released in November 2012: http://www.courts.qld.gov.au/__data/assets/pdf_file/0003/168357/cif-galeano-ac-20121114.pdf.
[43] Magistrates Court of Victoria. *Mental Health Court Liaison Service*. <https://www.magistratescourt.vic.gov.au/jurisdictions/specialist-jurisdictions/court-support-services/mental-health-court-liaison-service>.

from a mental illness and put them in contact with appropriate treatment and support, as well as determining their capacity for the purposes of the court proceedings.[44]

Select local districts within New South Wales also offer court liaison services for people with mental health issues, with the objective of providing assistance to people who have, or have had, mental illness and for conducting urgent mental health assessments for individuals before court.[45]

As described above, Queensland's Court Liaison Service has greatly expanded since 2016, to support their function to provide psychiatric assessment in simple offence matters, so that Magistrates can, in appropriate cases, dismiss the charge and divert the person to relevant mental health and other support services. The implementation of the *Mental Health Act 2016* (Qld), responsible for these changes, is currently under review by the Office of the Chief Psychiatrist. We hope that a report will be published soon and will include an assessment of the impact of the Court Liaison Service and the powers of Magistrates.

Diversion - Tasmania's Mental Health Diversion List

Tasmania's Mental Health Diversion List was established in 2007, and now operates within the Hobart and Launceston registries of the Magistrates Court. It uses existing provisions in the *Bail Act 1994* (Tas) and the *Sentencing Act 1997* (Tas) to divert offenders into treatment.

The list is open to defendants who have impaired intellectual or mental functioning as a result of a mental illness. People with intellectual disabilities are accepted if they also have a mental illness.[46] The list is open to people charged with summary offences, or offences capable of being tried summarily, with the exception of sexual offences and serious offences to the person, such as grievous bodily harm or murder.

There are many similarities with the South Australian program, for example, the preparation of a personalised treatment plan, monitoring of progress and the implications of non-compliance. Yet unlike the South Australian program, in the first 12 months of operation, the majority of participants left the program without a conviction.

Early evaluations provide preliminary support for the conclusion that participation in the program leads to a reduction in reoffending rates in the first six months after participating in the program, and anecdotal evidence is that participants have higher levels of engagement with treatment.[47]

Under the *Criminal Justice (Mental Impairment) Act 1999* (Tas) mental illness, dysfunction or intellectual disability is determined as a fitness-to-be-tried issue in courts of summary jurisdiction.[48] Since February 2006, the Forensic Tribunal has dealt with all forensic matters (these were previously within the jurisdiction of the Mental Health Tribunal), including

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[44] Ibid.
[45] New South Wales Department of Health. <http://www.hnehealth.nsw.gov.au/mh/services/mhsf/prs/courtliaisonservice>.
[46] Magistrates Court of Tasmania. 2007. *Magistrates Court Mental Health Diversion Program*. <http://www.magistratescourt.tas.gov.au/divisions/criminal_and_general/mental_health_diversion>. Mental illness is defined by the Act.
[47] H Graham. 2007. *A foot in the (revolving) door? A preliminary evaluation of Tasmania's mental health diversion list*. Hobart: University of Tasmania. <http://eprints.utas.edu.au/7186/1/MHCT_Thesis_MC_Report_Version.pdf>.
[48] Law Society of New South Wales. 2007. *NSW Young Lawyers Criminal Law Committee Submission relating to the determination of Fitness to be Tried in the Local Court and Children's Court*. <http://www.lawsociety.com.au/uploads/filelibrary/1060046713640_0.4795290956364408.pdf>.

reviewing orders made under the *Criminal Justice (Mental Impairment) Act 1999* (Tas) relating to persons who have been found mentally unfit to stand trial.[49]

Western Australia's Mental Health Diversion Program

In May 2012, the Western Australian government announced that it would introduce a Mental Health Court Diversion Program at Perth Magistrates' Court and Children's Court, aimed at diverting people with mental illness facing criminal charges into treatment and services. There are separate programs for adults and children:

- The Start Court - adult program
- Links - children program

The Program is a partnership between the Mental Health Commission and the Department of the Attorney General. The other agencies that contribute to the Program are:

- The Department of Health
- The Department of Corrective Services
- WA Police
- Legal Aid WA
- Outcare Inc. (a Non-Government service provider)

The Program was independently evaluated in 2014. The evaluation made a number of positive findings, including that the Program is operating in accordance with good practice and is highly valued by participants, their families and carers, and stakeholders within the justice system. A summary of the 2014 evaluation can be found here. A further review in 2015 found positive outcomes and can be found here.

Post-Sentencing and Corrections

Prisons are *de facto* mental institutions according to Australian Institute of Health and Welfare figures. An estimated one-third of Australian prisoners were already mentally ill when they entered prison - a rate 2.5 times that of the general population.

About 33% of Australian prisoners have a mental illness and 10% have an intellectual disability, of whom half have a mental illness – making a total of 38% of prisoners in these two categories alone.[50] 16 percent of the prison population was on medication for a mental health disorder; 14 percent of prison entrants experienced a high level of mental distress. Female prisoners were more likely to have a history of mental illness than men upon entering prison (41 percent of women compared to 30 percent of men) but this may be an underestimate as it does not account for prisoners with mental illness whose disability might not have been identified or recognised but who nevertheless require support and legal safeguards.[51] Many *should* receive NDIS supports while in prison, and while transitioning from prison, but do not.

[49] Department of Justice. *The forensic tribunal*. 2007. <http://www.justice.tas.gov.au/_data/assets/pdf_file/0006/80934/FT.pdf>.
[50] (Australian Institute of Health and Welfare. 2011. *The Health of Australia's Prisoners 2010*)
[51] Australian Institute of Health and Welfare. 2011. The Health of Australia's Prisoners 2010. Australian Institute of Health and Welfare.

Young People

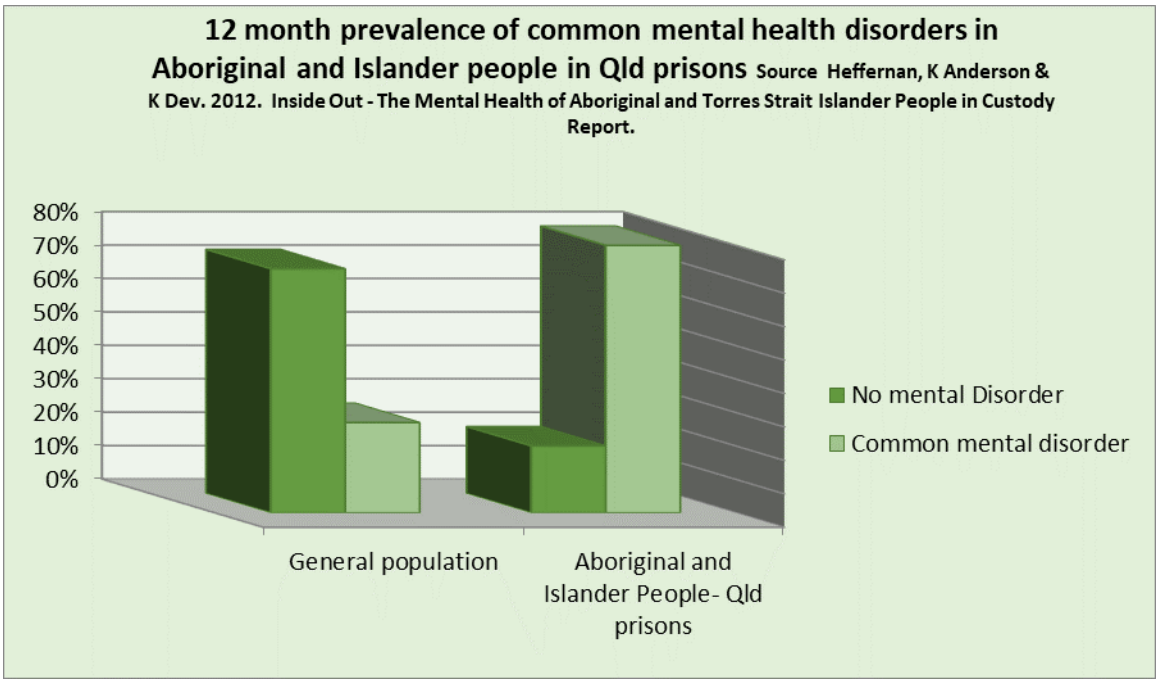
The *Young People in Custody Health Survey* and *Young People on Community Based Orders Health Survey* both found a high level of mental illness amongst their population sample:

- 88% reported mild, moderate or severe symptoms consistent with a clinical disorder;[52]
- 8% of males and 12% of females in custody reported that they had attempted suicide.[53]

Aboriginal and Islander People in Prisons and Mental Illness

A Queensland sample of Aboriginal and Torres Strait Islander prisoners in nine prisons revealed that a staggering 72.8 percent of Aboriginal and Torres Strait Islander men and 86.1 percent of Aboriginal and Torres Strait Islander women had at least one mental health episode in the preceding twelve months, against a 20 percent rate in the general community.[54] The remand sample was even higher - 84.4 percent compared with 70.4 percent overall.

The graphs below show the respective 12 month prevalence of anxiety, psychotic, depressive and substance misuse disorders experienced by the general population and by Queensland Indigenous prisoners.[55]



Prison Mental Health Services

Prisoners are more likely than the general public to have a mental health disorder before and during their incarceration,[56] yet people in prison receive minimal mental health support. The

[52] NSW Department of Juvenile Justice, 2003. *NSW Young People in Custody Health Survey Key Findings Report,* Haymarket, p19.
[53] Ibid. p 27.
[54] Queensland Forensic Mental Health Service. 2013.
[55] E Heffernan, K Andersen, A Dev, S Kinner. 2012. 'Prevalence of mental illness among Aboriginal and Torres Strait Islander people in Queensland prisons'. *Medical Journal of Australia.* 197(1):37-41.

absence of in-prison psychological/counselling services[57] is one of the principal gaps identified by Eileen Baldry in 'Pathways into Prison',[58] particularly special supports for those with intellectual impairments[59] and mental illness.[60]

The European Court of Human Rights (ECHR) has held[61] that a failure to provide adequate mental health care to prisoners in circumstances which do not adequately accommodate, or result in the deterioration of, a person's mental health, may amount to a violation of the prohibition on torture and ill-treatment.[62] Australia is not a signatory to the European Convention Against Torture but is to the *Universal Declaration of Human Rights*, the *International Covenant on Civil and Political Rights* and the *Convention Against Torture*, all of which provide that no-one may be subjected to torture or to cruel, inhuman or degrading treatment or punishment in Articles #5, #7 and #16 respectively.

The *Convention Against Torture* implies that all prisoners have a right to adequate treatment and support, and this applies in principle if not substantively to Queensland prisoners with intellectual impairments. There is scant Queensland case law on this issue. A Victorian court has ruled in a way that is consistent with the ECHR, warning that the imprisonment of a person with a severe psychiatric illness may be contrary to the spirit, if not the letter, of the Victorian Charter of Human Rights.[63] Queensland's new *Human Rights Act 2019* (Qld) may be similarly utilised.

Effects of incarceration

Prison in general and seclusion in particular may harm prisoners who already have a mental illness.[64] Institutionalisation and the control mechanisms such as segregation units and safe cells adversely affect inmates' mental health. Solitary confinement is a known cause of psychotic behaviour. The experience of solitary is 'psychologically painful, can be traumatic and harmful, and puts many of those who have been subjected to it at risk of long-term emotional and even physical damage'.[65]

Parole and post-parole options (denial of parole – lack of suitable accommodation, support)

The major problem is the absence of affordable and secure post-prison accommodation. Persons with mental illness are often segregated from the rest of the prison population or are

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[56] P Mullen, 2001. 'A Review of the relationship between mental disorders and offending behaviours on the management of mentally abnormal offenders in the health and criminal justice system'. Criminology Research Council. Canberra; T Butler & S Allnut. 2003. 'Mental Health among NSW prisoners'. Corrections Health Service. Sydney.

[57] S Hayes. 2005. 'Prison Services and offenders with intellectual disability – the current state of knowledge and future directions'. Paper presented at the 4th International Conference on the Care and Treatment of Offenders with a Learning Disability, 6-8 April 2005, University of Central Lancashire, Preston, UK.

[58] E Baldry, L Dowse & M Clarence. 2011. 'Background Paper for the National Legal Aid Conference Darwin 2011 People with mental and cognitive disabilities: pathways into prison'.

[59] IDRS 2008, *op cit.*

[60] Hayes et al 2007 *op cit;*

[61] *Dybeku v Albania* [2007] ECHR 41153/06.

[62] Violation of Article 3 (prohibition of inhuman or degrading treatment) of the European Convention on Human Rights.

[63] *R v White* [2007] VSC 142. There Bongiorno J had no choice but to send a man with a severe psychiatric disability to prison because there was no room for him in a psychiatric unit.

[64] Michelle Tanin. 2005. *Committee Hansard*, 4 August 2005, 77–87 reporting to The Senate, Select Committee on Mental Health> 2006. A national approach to mental health – from crisis to community First Report. Commonwealth of Australia.

[65] CJS Haney & M Lynch. 1997. 'Regulating Prisons of the Future: A Psychological Analysis of Supermax and Solitary Confinement'. *New York University Review of Law and Social Change*> 23: 477-570.

under protection and may therefore have restricted access to programs and services. The parole board may be disinclined to release people because they have not participated in appropriate prison programs.

Parole authorities often will not release offenders unless they are convinced that the person is not a threat to the community - a problem for persons with a mental illness in respect of whom psychiatrists are reluctant to make conclusive prognoses. People with mental illness and other capacity impairments tend to have fewer social supports than most, and what supports they do have are likely to drop away through the course of a term of imprisonment.

Recommendations pertaining to in-prison services

QAI recommends:

- Programs for rehabilitation should be tailored to be inclusive of persons with mental illness.
- The Forensic Mental Health Service (FMHS) should be funded to provide additional psychological services, including therapeutic services to people with intellectual disability and other capacity impairments with mental illness in prison.
- The FMHS or another service should be funded to provide addiction treatment services in prisons and to others subject to correctional orders.
- Corrective Services and the National Disability Insurance Agency (NDIA) should establish prison-based support and conduct a pilot project to compare prison-based support against prison without support.
- The NDIA should provide funding for supports beyond reasonable adjustments to people subject to custodial orders.

Leaving prison

Upon release, offenders with psycho-social disabilities who are re-entering the community face a number of prejudices to community placement that may result in re-institutionalisation.[66] One source has described prison release as comparable to the soldier returning from battle.[67] Reintegration is more challenging for ex-prisoners who have intellectual as well as psycho-social disability.

Barriers include poverty, inferior levels of education, unemployment, homelessness and personal issues including drug or alcohol dependency, lack of social support or loss of family ties.[68] The risk of recidivism increases when services are not available. Commonwealth and state government services are difficult to access, in part because they are poorly coordinated at the policy level.[69]

About half of offenders with intellectual disability also have a mental illness. Positive developments include Interact's offender reintegration services 'Bridging the Gap', which involves working with offenders and ex-offenders with cognitive impairments for up to six

[66] J Cleur & D Coyne. 1994. *Behaviour, crime and life: Issues for people with an intellectual disability in contact with the criminal justice system in NSW.* Paper presented to the Third Inter Jurisdictional Conference on Guardianship and Administration. Western Australia.
[67] E Ogilvie. 2001. *Post-release: the current predicament and the potential strategies*. Canberra: Criminology Research Council.
http://www.aic.gov.au/crc/reports/ogilvie-html.html.
[68] E Baldry & M Borzycki. 2003. *Promoting integration: the provision of prisoner post-release services. trends and issues in crime and criminal justice*. Canberra: Australian Institute of Criminology.
[69] V Catherine Riches, T Parmenter, M Wiese & R Stancliffe. 2006. 'Intellectual disability and mental illness in the NSW criminal justice system'. *International Journal of Law and Psychiatry* 29: 386–396.

months while in custody and then up to another nine months post-release on establishing social supports, housing, legal, financial and personal support systems.

Indefinite detention

QAI holds significant concerns about the incarceration of people with intellectual or cognitive disability and/or mental illness within the Forensic Disability Service Unit or in an Authorised Mental Health Service. The indefinite detention of vulnerable people is a significant human rights concern. Invariably, these are tragic stories of wasted lives. The clients share a number of similarities:

- the presence of a disability or mental illness that significantly impacts on the person's ability to understand the consequences of their behaviour;
- a lifetime of disempowerment and disadvantage and lack of support to overcome their life history;
- vulnerability and lack of appropriate support throughout the continuum of contact with the criminal justice system;
- generally the offences that led to the indefinite detention are not the 'horrific' offences that would be expected to result in indefinite imprisonment, but rather public order offences or offences of a minor or summary nature. The law breaking of people with intellectual impairments is inextricably linked to their disability and is determined by the social and familial circumstances that shaped them - and, more urgently, by the person's present circumstances and behaviours that attract police attention.

QAI considers that the indefinite detention of persons within the Forensic Disability Service Unit:

1. contravenes our commitments under international humanitarian law, including under the Convention on the Rights of Persons with Disabilities (**CRPD**) and the United Nations Convention Against Torture and other Cruel, Inhuman and Degrading Treatment or Punishment (**CAT**);
2. contravenes the requirements of natural justice;
3. is not carried out in a way that is consistent with the spirit and intent of the relevant Queensland legislation;
4. violates the human rights and dignities of the persons detained;
5. further marginalises and disempowers already highly vulnerable persons in our society.

The need for a coordinated approach to exit

The critical time is at about five weeks out. In Queensland, the work of the Prisoners' Legal Service, the Catholic Prison Ministry[70] and the Queensland Centre for Intellectual and Developmental Disability demonstrates that ex-prisoners are most likely to reoffend in those first fraught weeks out of jail. Ex-prisoners often have nowhere to live, little money, few

[70] M Alexander & D Martin. 2013. *Queensland Prison Report 2013.* Prisoners' Legal Service & Catholic Prison Ministry.

friends or supporters and scant prospects. For some, a return to prison is an alternative to poverty, loneliness and homelessness.

- Piecemeal changes are not enough: the first step is for corrective services to ensure that inmates have support to seek access to NDIS while they are in prison, and for transition.
- The second step is for government to initiate a coordinated cross-government approach to post-release services to ex-offenders with disabilities so that they are better equipped to reintegrate and live fulfilling lives.

Post-release other - health and drug dependency

Drug use is common post-release.[71] An Australian study determined that of 372 post-prison deaths, 50.8 percent were caused by drug overdoses within 12 months of release. Homelessness or housing transience, domestic violence, unemployment and loss of social opportunities are associated with drug use soon after exiting prison. Ex-prisoners who died of drug-related causes commonly experienced social and economic disadvantage: most were unemployed (81.8 percent) and one-third were homeless (33.8 percent). According to coronial records, 25.1 percent had a general health condition and 32.6 percent had a mental health problem.[72]

If prisoners are not supported to radically change their pre-prison lifestyle they may resume that lifestyle.[73] Life stresses such as homelessness or housing transience, domestic violence, poverty, unemployment and a loss of other 'social opportunities' can all be precursors to drug abuse.

In 2012 drug courts were closed in Queensland after 12 years of diverting people from prison. The court operated under the *Drug Rehabilitation (Court Diversion) Act 2000*. Drug court participants had their sentencing suspended for up to eighteen months while they were given intensive drug treatment. Completion of the program was taken into account at sentencing. Drug Courts have saved resources equivalent to 588 years of actual prison time.[74]

QAI recommends:

- Expand specialist treatment for young people with severe and complex mental health and substance use problems in detention to reduce the likelihood of re-offending and readmission.
- Expand child and youth forensic outreach services to provide multidisciplinary services to young people in the community up to 18 years of age, with severe and complex mental health and substance use problems, who are involved or at risk of becoming involved with the juvenile justice system.
- Expand the police communications centre mental health intervention co-ordinator initiative.
- Expand services to support people transitioning from prison back into the community.

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[71] CJS Carcach, & Australian Institute of Criminology. 1999. *Imprisonment in Australia: Trends in Populations & Imprisonment Rates 1982-1998.*

[72] J Andrews & S Kinner. 2012. *Understanding drug-related mortality in released prisoners: a review of national coronial records*. http://www.biomedcentral.com/1471-2458/12/270.

[73] E Ogilvie. 2001. *Post-release: the current predicament and the potential strategies*. Canberra: Criminology Research Council. http://www.aic.gov.au/crc/reports/ogilvie-html.html.

[74] B Butler. 2011. *Magistrate Courts of Queensland Annual Report*. Queensland Courts.

- Implement the indigenous mental health intervention program in male correctional centres.
- Consider the outcomes of the reviews of diversion and court referral programs in Queensland.
- Support people who are eligible for services through the national disability insurance agency to transition successfully and receive supports **while in prison, and while transitioning from prison.**
- Support alcohol and other drug treatment services to help meet immediate demand.
- Expand the capacity of existing state-funded services to provide psychosocial interventions and rehabilitation, including pre-treatment, service transition and post-treatment support.
- Increase access to withdrawal management and support across our public hospitals and in outpatient and community settings.
- Expand access to support programs and services for families and significant others affected by substance use increase access to, and expand the range of alcohol and other drug service options.
- Provide residential and non-residential rehabilitation including structured and intensive day programs.
- Offer psychosocial interventions including increasing access through flexible modes of delivery.
- Offer residential and non-residential withdrawal management.
- Provide family support programs and services.
- Provide tailored services for vulnerable population groups.
- Offer pre and post-treatment and transition support services.
- Provide culturally safe alcohol and other drug treatment for aboriginal and Torres Strait Islander peoples.

Child safety

The statistics paint an alarming picture of the extent of the overrepresentation of parents with mental illness and/or disability who have children removed from their care. Research considering the prevalence and outcomes for parents with disabilities and their children in Australian court proceedings presents a similar picture, highlighting that despite evidence that abuse and maltreatment is rare among the children of people with disabilities, high rates of child removal from parents with psychiatric disability or intellectual disability are reported.[75]

The perpetuation of this stereotype is particularly alarming when we consider that the child of a parent with a disability is far more vulnerable to abuse and neglect when placed in state or foster care. While the research does not show a correlation between parental disability and parental abuse, the disproportionate rates of abuse and neglect of children in state or foster

[75] Gwynnyth Llewellyn, David McConnell and Luisa Ferronato, 'Prevalence and outcomes for parents with disabilities and their children in an Australian court sample' (2003) Child Abuse & Neglect 27: 235-251, 236.

care is well documented.[76] The impact on children of this double trauma on children – separation from their parents and subsequent abusive treatment – is of high economic and social cost to society. If the approach and accompanying mindsets are changed, there will be benefits for all concerned. In the context of the ultimate socio-economic costs associated with failing to respect the human rights of all involved, the cost of providing appropriate support are insignificant. Refreshingly, in the New South Wales Supreme Court case of *Re Georgia and Luke [No. 2]*,[77] the Court specifically confronted an officer of the Department of Children's' Services who referred to a 'history of mental health issues', noting the inappropriateness of this submission given that there was 'not the slightest evidence before this Court of a "history of mental health issues", whatever that vague phrase is intended to mean.' Yet this case is the exception rather than the rule. It is inappropriate to leave the fate of families that include a parent with a disability to the hands of a Magistrate or Judge who is deciding in light of precedents heavily weighted against parents with disability, with insufficient legislative or policy guidance to protect the parents' rights.

In her report, *Rebuilding the village: Supporting families where a parent has a disability*,[78] Victorian Public Advocate Colleen Pearce documents the alarming reality that the intellectual disability or mental illness of a parent is categorised as a major risk for their children by the Department of Health and Human Services. A key rationale behind the report was concern to bring about systems change and develop adequate human rights protections to override false, prejudicial assumptions about the unsuitability of people with an intellectual or cognitive disability or mental illness to be fit parents and help them to retain custody of their children. A core concern of this report is that, rather than the fact of the disability being something that triggers the provision of additional support for the parent, particularly in the initial stages of parenting where they are learning the basic skills involved, the disability becomes a reason to remove the child from the parent, in the absence of any other circumstances justifying this.

The small body of research that does exist on these issues reports mothers' feelings of grief, sadness, loss, emptiness and at times anger.[79] It also documents their sense of powerlessness in the child protection system, in terms of their inability to influence, alter or control their situation. Yet this is where our knowledge base ends. There has been inadequate attention on ways to support these mothers, either to retain custody of their children or to support them in other ways to maintain relationships with their children.

This discrimination seems particularly unjust given the strong evidence-base that shows that parenting skills of mothers with disability can be improved by support and training in parenting skills. This is essentially a double failure – this vulnerable group is a subset of society that we fail to adequately support in the first place; we then also fail to support them to care for their children, perpetuating a cycle of disempowerment.[80]

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[76] Philip Menes and Badal Moslehuddin. Transitioning from state care to state prison: a critical analysis of the relationship between leaving out of home care and involvement in the criminal justice system. Social Alternatives, Volume 28, No.3, 2009, pp.51-56.
[77] [2008] NSWSC 1897 (19 December 2008), at 200.
[78] Office of the Public Advocate. (2015) Rebuilding the village: Supporting families where a parent has a disability. Report 2: Child Protection.
[79] Rachel Mayes and Gwynnyth Llewellyn, 'Mothering differently: Narratives of mothers with intellectual disability whose children have been compulsorily removed' (2012) Journal of Intellectual and Developmental Disability 37 (2): 121-130.
[80] Tim Booth, Wendy Booth and David McConnell, 'Care proceedings and parents with learning difficulties: comparative prevalence and outcomes in an English and Australian court sample'.

Education and training

In Queensland, there are currently significant problems in the education system, stemming from the failure to offer all students an inclusive education. Inclusion is a right, not a gift, concession or benefit. Australia-wide, more than 70 per cent of students with disabilities (including psyco-social disability) have had their enrolment discouraged by principals of mainstream schools.[81] While there has been a modest drop in the proportion of students with disability in special schools, enrolment in special schools still outstrips general population growth.

The enrolment process itself reinforces stigma and marginalisation. While students may have learning and other support needs, it is more important that schools are well equipped with well-skilled teachers who can teach to all rather than a cast of 1000's that are brought into the school as a student with disability enrolls. [82] It communicates to the families and school community that including a student with disability is difficult - 'this is hard' rather than 'we are skilled and we can do this because good teaching is good teaching'.

Education systems have not kept pace with changes in communities. Motherhood statements and minor adjustments to policy or practice have not addressed discrimination or segregation and poor learning outcomes for students with disability or mental illness.

The United Nations Committee on the Rights of Persons with Disabilities recently issued a General Comment that sets out clear definitions of inclusive education, segregation and the need for all signatory states, including Australia, to set a clear path towards a fully inclusive education system. Contrary to the UN charter, Queensland's education system resists inclusion, and the biggest barrier is active enrolment gatekeeping by school principals.[83] Principals advise parents to send their child to another school that could better support them. Concessionary allowances for a child to attend a school on the days that funding is available, or extortive requests for parents to pay extra to employ support school staff or purchase equipment, and/or coercion for parents to accept a place in a separate support class or special school.[84] For decades students have been consigned to part-time placements, dual enrolments, and/or relegated to separate "learning settings" such as special classes or education units.

When children are given a place, teachers often refuse them, or are reluctant to make adjustments, due to poor attitudes towards students with disability or mental illness, bemoaning extra workloads to create adjustments, having little expectation of success for the student or themselves.

In addition to these issues, there were accounts of bullying by staff, of support teachers not having appropriate training and qualifications, and school principals not being held accountable for ensuring adjustments were made for students.

The dual system reinforces the model of segregation and second-class status for students with disability or mental illness.

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[81] Kathy Cologon and Robert Jackson. 2017. Gatekeeping and restrictive practices with students with disability: results of an Australian survey: Paper delivered at the Inclusive Education Summit, Adelaide.
[82] Figure ii, Page xv Review of education for students with disability in Queensland state schools – Executive Summary
[83] Committee on the Rights of Persons with Disabilities. A guide to Article 24: The Right to Inclusive Education
[84] How schools avoid enrolling children with disabilities, by Associate Professor Helen Proctor, first published in *The Conversation*, 28 January 2016.

All schools must be well resourced to teach to a diversity of learning styles and needs, with talent to adapt and modify (not differentiate) curriculum according to the individual needs of many students.

Government-funded employment support

How cost effective have the Australian Government's Disability Employment Service (DES) and Personal Helpers and Mentors service (PHaMs) been in enabling people with a mental illness to find and keep a job? Have the DES and PHaMs been targeted at the right populations?

Only one-third of people assisted by Disability Employment Service (**DES**) currently achieve an effective employment outcome. This suggests that improvement is necessary. Focus should be placed on training, job suitability and job satisfaction and increased flexibility, with key areas for improvement include increasing choice and control for jobseekers, greater focus on employer-employee compatibility, providing continuing support following job placement, dispelling myths about the employment of people with mental illness and a holistic approach to service provision.

DES participants should, at least, be more easily able to choose which DES provider to go to and to have greater choice and control about the scope and content of their job plans. People should have greater choice and control over all decisions relating to their employment, and ensure they are appropriately supported to exercise these rights. This includes decisions about finding and transferring between providers.

People should be fully informed, including about where they can go to obtain assistance in gaining employment; what services are available from various providers; the funding attached to the participant; provider performance in achieving employment outcomes; any ratings or comments pertaining to the provider's service delivery; the balance of individualised funding and processes and principles for accessing it; eligibility information; full job search and employment information; information on barriers to employment a person may face; information on how to make a complaint about a provider. Employers should be fully informed about the benefits of employing workers with mental illness.

QAI recommend that those DES who demonstrate fidelity to a client base with the most significant disabilities and work to further their employment aspirations deserve recognition and support with heavier weighting for the star ratings.

In order for those services to deliver optimal service response to the clients with higher support needs to deliver training to the worker and to develop good relationships with employers and other co-workers DES that have demonstrated commitment to such a clientele should be afforded extra resources and time to enable good outcomes.

People with mental illness should expect to get the same quality of service delivery no matter where they live. DES should be compelled to operate with best practice measures and move beyond the standard generic employment service response.

What alternative approaches would better support people with a mental illness (whether episodic or not) to find and keep a job?

The Government should:

- prioritise diversity amongst service providers, to increase choice of provider;
- publicise relevant information to help people make informed choices about providers;

- provide incentives for providers to engage with rural, regional and remove areas, to ensure there is a healthy and competitive market for service delivery in these areas. This could be done by providing bursaries for the establishment of new services in areas. where there is a need, or by supporting existing services to provide outreach services;
- focus on reducing bureaucratic requirements.

What will the transition to the NDIS mean for those receiving employment support?

Current indicators predict little overlap in service delivery between the NDIS and DES System – the New Disability Employment Services from 2018 Discussion Paper noted that approximately five percent of NDIS participants (upon full roll-out of the scheme) will also be DES participants; this proportion is expected to increase if the NDIS vision of increased social and economic participation is realised.

How could employment outcomes for people experiencing mental ill-health be further improved?

Unemployment for people with psychological disabilities is high compared with other disability groups, regardless of severity, according to ABS data. Those with psychological disability (18.9%) had higher unemployment rates than those with moderate or mild physical disability (8.8%) or the general population (5.5%). These figures reflect the unique barriers that people with intellectual or psychological disabilities face in accessing education and work.[85]

There is a need to improve the effectiveness of employee assistance programs. QAI submits there is a need for greater, and more appropriate and individually-tailored, continuing support for people with mental illness within the workplace.

QAI welcomes the notion of 'affirmative action and quotas' within larger businesses and recommends the adoption of such measures as soon as possible. We recommend that smaller businesses be encouraged to review the work of other employees and determine if niche roles could be created for someone with mental illness. Governments should be setting the example for all employers and lead the way in employing people with mental illness and by applying affirmative action.

QAI recommends that both post school services and DES be compelled to develop programs that support nurture relationships with employers for opportunities for workplace training/experiences/volunteering roles for workers with mental illness.

Volunteer work can potentially be an effective means by which people with mental illness can make a valuable contribution to the workplace, demonstrate their capabilities and simultaneously develop skills that are valuable to the workplace. To foster and support the involvement of people with mental illness in the labour market in a voluntary capacity, funding incentives should be developed for people with mental illness who contribute to society through unpaid work. However, it is vitally important that safeguards are implemented to ensure that people with disability are not exploited, by remaining engaged in a voluntary capacity where their role could, but ultimately does not, lead to paid employment.

The importance of adequate and appropriate support for people with mental illness must be recognised. Furthermore, the timing of support is critical – supporting people sooner rather than later can help people become more independent over time. The Australian welfare system needs to develop as its foundation a strong supportive framework whereby the right support is made available to people, including people with complex needs, including mental

[85] Australian Bureau of Statistics. Australian Social Trends. 4102.0; March Quarter 2012.

illness. This might include supporting people with mental health conditions to take part in the community and to find work. All measures designed to help people to find work must be genuine and that concerted effort must be directed to challenging mindsets and preconceptions that can act as barriers to the employment of people with mental illness.

QAI submits that government should take proactive steps to increase employer awareness of the benefits of employing people with mental illness. In the face of negative employer attitudes to employing people with disability and mental illness, founded upon incorrect assumptions and stereotypes, positive action is required. We propose that DEEWR and the Australian Taxation office provide information to employers at BAS and Tax time on the benefits of employing persons with mental illness.

People with mental illness can be adversely affected by stereotypes. To combat this, inclusive strategies designed to raise awareness about the benefits of workplace diversity and to encourage outreach activities within corporate culture are needed.

The state and federal governments need to take leadership in this regard and model by example, significantly increasing their rates of employment of people with mental illness. All government bodies should be required to implement and comply with affirmative action quotas and policies.

All medium and large companies should also be required to implement and comply with affirmative action quotas and policies. The government should set appropriate targets for companies to meet and publicly reward and promote success in meeting these targets and impose sanctions for the failure to do so.

While it is not feasible to impose affirmative action policies or quotas on small businesses, mandatory requirements to review recruitment practices and assess whether there is potential to employ workers with disability should be implemented. Many people work extremely well within niche roles created within a small business, and often work compatibly for more than one company at a time. This often proves to be beneficial for the worker and for the business.

Post-release income

The immediate payment from Centrelink on release from prison is equivalent to two weeks of the eligible payment, usually the 'Newstart' Allowance, or if the ex-prisoner has a diagnosed disability, possibly the Disability Support Pension. (Rent assistance is available if the prisoner is able to secure accommodation.) From that the ex-prisoner must pay for accommodation, food, medication, clothing and sundry expenses.

Prisoners who received the Disability Support Pension before their incarceration have the DSP suspended for up to 2 years during their time in jail. The Morrison government in late 2018 introduced a policy measure that would have reduced the suspension period to 13 weeks, which would have required exiting prisoners to reapply, and more than likely be refused. The government responded to disability concerns and withdrew the policy measure.

Post-release Employment

There is a well-established link between unemployment and recidivism,[86] but for ex-prisoners with capacity impairments the need to get a job is as urgent as the prospect is low. The interruption to a person's life that results from their incarceration is abrupt and absolute, presenting challenges to inmates who had responsibilities to an employer. For those

[86] L Gideon. 2010. *Substance Abusing Inmates: Experiences of Recovering Drug Addicts on their Way Back Home.*

remanded in custody there may be no opportunity to tie up loose ends or part on amicable terms with an employer.

Prison impacts on the ability of an ex-prisoner to secure employment once released. Prisoners who disclose their prison history are acutely aware that it will likely have a negative impact on their employment prospects, but also know that failing to explain their absence from the workforce will be counterproductive too. For some ex-prisoners, disclosing their criminal history is both a condition of their parole and a condition of job applications.

Discrimination on the basis of an inmate's prior criminal record is a major cause of unemployment among ex-prisoners in the UK.[87] Almost 60 percent of British employers would 'probably not' employ a person with a criminal history; another survey established that only 12 percent of employers would knowingly hire ex-prisoners.[88] This is particularly true in small towns, even if a job application form does not require that an ex-prisoner discloses their record. (Under the *Criminal Law (Rehabilitation of Offenders) Act 1986* (Qld), a person is not required to disclose a conviction once the rehabilitation period of ten years[89] has passed).[90]

Ex-prisoners face numerous contradictory challenges. They cannot secure accommodation because they have no employment and they cannot get a job because they have no fixed address (and cannot explain their absence from the workforce). Exiting prisoners are of course unemployed and there are few programs to assist ex-prisoners to find work.

Mentally healthy workplaces

Inclusive, diverse workplaces are the most mentally healthy workplaces. With appropriate support and opportunity, many people with disability and mental illness have significant, untapped potential to contribute to the labour market. What is required is a shift in mindset that embraces the opportunities for flexible working arrangements that accommodate the varying needs of people with mental illness. At present, negative employer attitudes to people with mental illness is a significant obstacle to their labour market participation. Dismantling negative mindsets towards people with mental illness in the employment context is particularly important given the considerable obstacles they face well before labour market participation becomes possible (such as within the educational system, discussed above)

Some companies are leading the way in modelling an alternative work paradigm that does not merely tolerate but embraces the significant groups of workers that require very flexible or atypical working arrangements yet have a significant amount to contribute to the workplace. The Westpac and IBM corporate examples of developing collaborative links with the Australian Network on Disability prototype a successful, contemporary approach to fostering a diverse, inclusive and productive workforce whilst maintaining commercial success in a

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[87] H Metcalf, T Anderson & Rolfe. 2001. *Barriers to Employment for Offenders and Ex-offenders.* Department of Work and Pensions Report No. 155. Leeds: CDS

[88] C Visher, S Debus-Sherrill & J Yahner. 2010. 'Employment After Prison: A Longitudinal Study of Former Prisoners'. *Justice Quarterly* 28: 698-718; J Graffam, A Shinkfield & L Hardcastle. 2008. 'The Perceived Employability of Ex-Prisoners and Offenders'. *International Journal of Offender Therapy and Comparative Criminology* 52: 673-685.

[89] Section 3 of the Act defines rehabilitation period, in relation to a conviction upon indictment recorded against a person who in relation to that conviction was not dealt with as a child:
(i) a period of 10 years commencing on the date the conviction is recorded; or
(ii) where an order of a court made in relation to the conviction has not been satisfied within that period of 10 years—a period terminating on the date the order is satisfied; whichever period is the later.

[90] *Criminal Law (Rehabilitation of Offenders) Act 1986* (Qld), s 6. Discrimination on the basis of a criminal record is unlawful under the *Australian Human Rights Commission Act 1986* (Cth). The *Australian Human Rights Commission Regulations 1989* (Cth) extended the definition of discrimination in the Act to include criminal record (reg. 4(a)(iii)).

competitive market. These models not only highlight the possibilities but also provide industrial leadership in exemplifying the viability of such changes for other workplace organisations. QAI submits that government should take proactive steps to increase employer awareness of the benefits of employing people with mental illness. In the face of negative employer attitudes to employing people with mental illness, founded upon incorrect assumptions and stereotypes, positive action is required. We propose that the Australian Taxation office provide information to employers at BAS and tax time on the benefits of employing persons with mental illness.

Coordination and integration

To what extent do current governance and institutional arrangements promote coordination and integration of mental health services and supports across health and non-health sectors and different levels of government?

QAI's practice experience working across mental health, justice and disability sectors has revealed frequent difficulties with the 'siloed' attitude to service provision between different government departments. Many people with multiple vulnerabilities (including comorbid mental illness and intellectual disabilities, prejudicial and traumatic backgrounds) need coordinated health and other social services to live in the community and reduce risks to themselves and others. Siloed attitudes to services can see a person refused or referred elsewhere until the person reaches crisis point, leading to significantly greater complexity, cost and distress.

Common examples QAI sees in practice include:

- lengthy in-patient stays while a person awaits housing of disability support packages;
- insufficient disability support packages leading to further contacts with the criminal justice system;
- lack of post-discharge supports and follow-up leading to further rebounding in patient stays.

The courts have commented on the systemic failures that result in costly matters before them, as follows:

Attorney-General for the State of Queensland v McCann [2018] QSC 115

A recent case in Queensland concerned Mr McCann, a 31 year-old Indigenous man who suffered a prejudicial childhood and a history of inhalant abuse and chronic schizophrenia. He was convicted of a number of charges, and spent most of the last 12 years in custody. His time in custody was particularly difficult given his chronic mental illness, and the Judge noted that for all intents and purposes he was in solitary confinement with inadequate mental health treatment.

In 2016, the Court made a continuing detention order with the expectation that Mr McCann would receive a lengthy period of active psychiatric treatment for his illness in a medium secure facility that was necessary to address his risk of reoffending. He spent five months in a mental health facility before being returned to prison because of the 'need to create a bed'. When the matter came before the Court again to consider continuing a detention or supervision order, the Judge was scathing of the systemic issues which led to the adverse situation Mr McCann found himself in and the lack of cooperation between corrective services and the mental health system. His Honour Mr Justice Applegarth commented that it was

'easier to find a bed in prison than in a mental health facility'.

Re N: Office of the Public Guardian v Department of Queensland Health, Office of the Chief Psychiatrist and Anor

A young man was charged with a number of relatively minor offences, which were referred to the Mental Health Court to determine whether he had a mental health defence and whether he was fit for trial. Justice Dalton became concerned that whilst he was awaiting resolution of the reference, he had spent 200 days in the high dependency unit of the hospital, and was likely to continue to spend time there as no arrangements had been made for him to move into the community. It appeared that all parties concerned considered that his detention in the HDU was preferable to prison, which suspended the need to seek accommodation so that he could receive bail and meant his situation continued. Justice Dalton made a number of findings and comments on the systemic issues that contributed to N's situation:

- the Office of the Public Guardian, as N's guardian, had failed to advocate for him and make necessary enquiries about his situation and had neglected his interests;
- that N was placed on an involuntary treatment order (called a "treatment authority") by a medical officer not qualified to do so, and there was no evidence to substantiate the treatment authority as he posted no imminent risk of harm and there was a less restrictive way for him to be treated;
- N's detention in the HDU which would otherwise be for people with acute needs was not necessary, was unjustified and was harmful to him;
- there were systemic misunderstandings about classified patients (a patient who would be in prison, but for their needing to be treated as an inpatient), how they should be treated and their entitlement to leave from hospital.

Monitoring and reporting outcomes

Are decision-making forums for mental health receiving high quality and timely information on which to base strategic decisions?

No. There is an alarming lack of transparency in relation to mental health. This does not allow for high quality and timely information to be provided to decision-making bodies.

Does Australia have adequate monitoring and reporting processes to assure compliance with national standards and international obligations?

QAI considers that further oversight is required. We note that the impending implementation of the Optional Protocol to the Convention Against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT) will provide additional layers of oversight in this regard.[91]

[91] The Australian Government ratified OPCAT in December 2017. The Government made a declaration under Article 24 of OPCAT, postponing implementation of its obligations under OPCAT for period of up to three years. Australia must therefore achieve OPCAT compliance by December 2020. This requires that, by December 2020, Australia establish an effective National Preventive Mechanism(s) (NPM) to conduct independent inspections of places of detention within Australia, as well as facilitating periodic monitoring of Australian places of detention by the United Nations' Subcommittee on Prevention of Torture (SPT). The second stage of consultations around OPCAT implementation in Australia is currently in progress, with matters including the scope of the treaty and the conduct of inspections currently under consideration.

Is there sufficient independence given to monitoring, reporting and analysing the performance of mental health services?

No. There is presently no clear independent body to monitor performance. QAI is hopeful that implementation of OPCAT, discussed above, with the National Preventive Mechanisms established as independent inspectorates, will provide this independent monitoring that is presently lacking.

Further, the decision-making bodies in Queensland also lack adequate independence and accountability. The Mental Health Review Tribunal (**MHRT**) is within Queensland Health and therefore lacks independence. The Mental Health Court (**MHC**) generally does not publish its decisions and often courts are closed.

What does improved participation, productivity and economic growth mean for consumers and carers? What outcomes should be measured and reported on?

QAI considers that outcomes measured and reported on could include:

- rates of employment and return to work for people with mental illness;
- lessening of service provision over time with positive mental health outcomes – when needs are met in a timely fashion, people's needs decrease;
- a decrease in hospital admissions and re-admissions – when people experience better care from front-line health services (GP's etc), it can lead to a decrease in hospital admissions.

What approaches to monitoring and reporting are implemented internationally? What can Australia learn from developments in other countries?

Since the drafting of OPCAT, a strong body of knowledge and understanding of monitoring and reporting of closed environments has been developed within the international community. Australia can benefit from this body of knowledge.

Conclusion

QAI thanks the Productivity Commission for the opportunity to make a submission to this inquiry.