# PROPOSAL FOR WITHDRAWAL OF THE CHIEF PSYCHIATRIST'S COMMUNIQUE

**Prepared by Justice Action**

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# EXECUTIVE SUMMARY

The withdrawal of the Chief Psychiatrist's 2014 Communique is necessary for effective change due to several critical reasons. Firstly, the role of Chief Psychiatrist in NSW, currently held by Dr. Murray Wright since October 2014, lacks legislative definition and suffers from vague information. While Dr. Wright's position is described as a leadership and advisory role that shapes NSW policy and advises the Executive Director of Mental Health Branch, Sally Lee, the absence of official government sources outlining the role hinders clarity.

The lack of transparency, accessibility, and meaningful contact with the Chief Psychiatrist, free from Ministerial intervention, places a burden on individuals and organisations seeking direct changes related to the Chief Psychiatrist. To legitimise the enforcement of the 2014 Communique, there is a pressing need for a clear legislative definition that outlines the Chief Psychiatrist's powers. Additionally, establishing an Office of the Chief Psychiatrist would enhance public accountability, an essential aspect of good governance that seems to have been lacking.

Another document prepared by Justice Action on the 'Limits to Forced Medication' undertakes a meticulous examination of the powers held by health authorities in relation to forced medication, with the primary objective of preventing situations similar to that experienced by Kerry O'Malley from recurring in the future. A critical aspect that necessitates attention is the problematic nature of the NSW Chief Psychiatrist's Communique of 2014 (Appendix 2), which lacks clarity in providing guidance to clinicians regarding the quantification of harm. By adopting a broad interpretation of 'serious harm' as outlined in section 14 of the *Mental Health Act 2007* (NSW), the communique fails to address the direct impact it has on individuals, rendering it misleading and ultimately illegal.

To address this issue effectively, it is essential to challenge and nullify the misleading communique. The courts have already imposed stringent restrictions on the use of Community Treatment Orders (CTOs) and the powers of the Health Department in forcibly administering medication. These restrictions necessitate the fulfillment of highly specific requirements before an order for forced medication can be lawfully issued.

The NSW Chief Psychiatrist's communique (2014)[1] that was written in response to the Waterlow inquest, was never justified. It set out misleading definitions of 'serious harm' with the result being that it was followed by practitioners in the field. While the broad consideration of 'serious harm' provided more nuances to the implications of harm, the implementations of a communique in the form of a fact sheet rather than legislative amendments misled clinicians to make decisions of involuntary treatment.[2]

[1] NSW Government Department of Health, 'Amendments to the NSW Mental Health Act (2007)', *NSW Government* (Web Page) <https://www.health.nsw.gov.au/mentalhealth/resources/Factsheets/community-medical-practitioners.pdf>.
[2] Ibid; Christopher James Ryan, Sascha Callaghan and Matthew Large, 'Better laws for coercive psychiatric treatment: Lessons from the Waterlow case' (2012), 20(4) *Australasian Psychiatry* 283-6.

Mental health is a key matter of concern in Australia with 1 in 5 Australians living with a mental health condition.[3] Despite the prevalence of this issue, mental health care systems across Australia continue to remain dysfunctional and negligent towards consumers. NSW has not responded to the changes that have been adopted by other states such as the recent Victorian Royal Commission into Mental Health. Critical issues include the disrespect and disempowerment of mental health consumers, forced medication, the lack of peer workers in the mental health workforce, and poor funding for mental health services. These issues have been further exacerbated by the COVID-19 pandemic.

The impact of this failure is disproportionate and discriminatory. Groups at higher risk of experiencing mental health issues include persons who are most vulnerable; the incarcerated, Aboriginal and Torres Strait Islander people, women, youth, and people with disabilities. The consequences of this systemic failure are significant resulting in NSW having the highest number of deaths by suicide in Australia.

The four NSW case studies explored in this paper, Nathan Chetty, Miriam Merten, Antony Waterlow, and Kerry O'Malley, are examples of the cultural and systemic issues to which mental health consumers are subjected. It is important to note the timeline in these cases. Whilst the Miriam Merten case happened years ago, Nathan Chetty's has only just recently been resolved. These cases illustrate the continuous failure of the NSW Health Department to provide respectful support and appropriate care in the delivery of their key services. The experiences found in the aforementioned cases present a tragic story of brutalisation and degradation by the NSW health care system. This maltreatment is exacerbated by the system's current reliance on medication as a low-cost and low-effort response to distress, rather than updating itself to the current scientific consensus on methods of effective care.

The picture that emerges is disturbing, but sadly not surprising. These issues have been highlighted in the Federal Royal Commission into Disability (2019), the Victorian Royal Commission into Mental Health (2019) (VRC) and the National Suicide Strategy which have all exposed the failure of the mental health system to recognise and uphold the basic human rights of those suffering distress. Urgent reform and cultural change is required to reduce rates of coercive treatment and medication as consumers continue to be marginalised throughout their mental health battles.[4]

Globally, there have been mental health system policy changes that have been implemented to ensure consumers' human rights are upheld. The World Health Organisation (WHO) has recognised that mental health reforms need to eliminate coercive practices, adopt holistic processes and engage consumers with informed models of recovery. Reforms of the NSW mental health system must address both cultural and systemic policies in order to develop a recovery-focused, trauma-informed model that is led by culturally diverse and informed practitioners. Furthermore, mental health laws must also be aligned with consumer-centred decision-making principles. This must include increased access to peer workers, social workers and independent legal representation within the mental health system. Mechanisms for accountability will drive this reform, including a

[3] Australian Bureau of Statistics, *Mental Health, 2017-18* (Catalogue No 4364.005.001, 12 December 2018).
[4] Martin Zinkler and Sebastian von Peter, 'End Coercion in Mental Health Services - Towards a System Based on Support Only' (2019) 8(3) *Laws* 19.

regular collection of data from consumers as to their choice of medication and/or psychological counselling.

The application of the *Mental Health Act 2007* (NSW) is a critical legal issue that supports the involuntary detaining of persons who, by reason of mental illness, are likely to cause serious harm to themselves or others. "Serious harm", according to the decisions of the courts, is threatening to life or bodily integrity. The NSW Chief Psychiatrist's Communique (2014) that was written in response to the Waterlow inquest resulted in setting out a broad scope of what constitutes 'serious harm,' with this being misleading to clinicians. The consequence of this has been that in practice the provisions have been loosely applied and done so on the basis of lesser risks, such as harm to reputation, fraught personal relationships, and the potential of not being able to take care of oneself.[5] Under this legislation, mentally ill people are subject to forced treatment in accordance with Community Treatment Orders (CTO). The use of forced medication raises serious concerns regarding ethical, legal and human rights violations.

Far more effective and humane alternative methods exist to these coercive practices.[6] They include cognitive behavioural therapy, the transferral from prisons into appropriate mental health care, peer mentoring programs and social support services. These more holistic practices can help to create an environment where human rights, including disability rights, are respected, in which the path to recovery is far easier for these Australian citizens.

The NSW government needs to follow the expert guidance provided by the World Health Organisation,[7] its own 'Living Well Strategy',[8] and the Victorian Royal Commission. NSW must legislate to eliminate abusive and inhumane practices, coercive treatments and unnecessary involuntary admissions which violate individuals' power, dignity, and autonomy. In response to the current model, consumers are deterred from seeking treatment or support and are driven further into alienation, isolation, despair and hopelessness, subsequently impacting not only their own lives but the wider community as well.

Reform of the NSW mental health system is needed, with the first step being a withdrawal of the Chief Psychiatrist's 2014 Communique. A more precise definition of 'serious harm' would help to reduce the number of individuals placed under involuntary treatment and provide them autonomy to make decisions regarding their own healthcare. Mental health is a major concern for many Australians, with an increased demand for mental health support following the COVID-19 pandemic. The current system is inadequate and requires a major reorientation towards human rights and recovery pathways. Reforms of the NSW mental health system, informed by the insights from the VRC final report and the WHO, will lead to similar benefits for individuals and their

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[5] 'Chapter 4 Section C: Admission to hospital under the Mental Health Act 2007 (NSW)' Mental Health Rights Manual (Web Page) <https://mhrm.mhcc.org.au/chapters/4-nsw-mental-health-law-and-processes/4c-admission-to-hospital/#4|C|1>.

[6] 'A new approach to mental health in NSW', *Mental Health Australia* (Web Page, 16 December 2014) <https://mhaustralia.org/general/new-approach-mental-health-nsw>.

[7] World Health Organisation, *World mental health report: Transforming mental health for all* (Final Report, 16 June 2022) 193.

[8] Mental health commission of NSW, *Living Well: A Strategic Plan for Mental Health in NSW 2014-2024* (Report, 2014).

communities in NSW. This will help to provide empowerment of consumers to take control and responsibility for their own lives and happiness.

## Aims:

The aims of this proposal are as follows:

1. We request the complete withdrawal of the Chief Psychiatrist's 2014 Communique as it lacks clarity in providing guidance to clinicians regarding the quantification of 'serious harm'. The communique fails to address the impact it imposes on individuals, thereby rendering it both harmful and unjust.

2. We request the replacement of the communique with a more clear and comprehensive set of guidelines issued by the Chief Psychiatrist. These guidelines must be in strict accordance with the relevant laws and regulations pertaining to mental health. The intended outcome of this replacement is to restore agency to individuals, empowering them to regain control over their own lives.

# 1. ILLUSTRATIVE CASE STUDIES

This section will look at four cases that illustrate the current problems within mental health services in New South Wales. They show negative—even devastating—results for individuals, and highlight the need for reform. Miriam Merton's case, which occurred in 2015, shocked the public and the industry, yet did not result in any substantial changes to the mental health system in NSW. Nathan Chetty's case has only recently been resolved, and reflects the current state of the mental health system in highlighting some of the unaddressed failures.

## 1.1 Nathan Chetty

Nathan Chetty is a 41-year old man of Fijian-Indian descent. He is partially blind and lives with his mother. His story highlights the negligence, unprofessionalism, and mistreatment that the NSW Health Department shows to those who require its care the most. See here for a more in-depth account of Nathan's story and the hardships he endured as a result of NSW's Mental Health System.

In 2015 Nathan was a single man living with his parents. Nathan had been traumatised following threats from a family member and was accused of pulling overhead electrical wires while standing on the car in the garage. On this basis Canterbury Community Mental Health Center (CCMHC) sought and was granted a Community Treatment Order (CTO). Under that order Nathan was forcibly injected monthly with antipsychotic medication and involuntarily hospitalised.

Nathan and those 'treating' him never developed a trusting therapeutic relationship. He suffered severe side effects from the medication, increased stress, and declining mood. Despite no evidence that Nathan posed any significant risk to himself or others, he was still subjected to this draconian regime which did nothing to aid his recovery. His parents, who were also negatively impacted by the CTO and its effects, requested Justice Action's intervention.

Under the CTO Nathan underwent intrusive surveillance-type restrictive reviews, constant monitoring, and unexpected home visits. Nathan was prescribed a 400mg injection of Abilify/Aripiprazole monthly, for nearly seven years. This followed two years on Paliperidone monthly injections. Nathan suffered severe side effects including weight gain, feelings of losing consciousness, insomnia, declining overall health (such as kidney function), and pain in the right side of his body. Nathan experienced distress in his loss of dignity and felt degraded, describing his

experience as *"psychologically scarring"*. This approach served to further pathologize Nathan's paranoia, as decision-making regarding his own life seemed out of his control. Nathan's expressed distress and dissatisfaction were written off by health centre staff as oppositional, thus using this as further evidence for continued enforcement.

In February 2021 Nathan and his mother asked for support from Justice Action who represented Nathan in a series of Mental Health Review Tribunal hearings and in the negotiation of a NDIS package. This package included an NDIS coach, a clinical psychologist, support workers, in addition to his general practitioner. Justice Action argued Nathan now had enough support working with him, rather than against him, to justify the elimination for the need of the CTO. In October 2022, the Tribunal enforced a further 6 months of the CTO, however, it determined that if there was to be a further application for a CTO the CCMHC personnel needed to provide evidence of having formed a 'therapeutic relationship' with Nathan.

In December 2022, the CCMHC insisted that Nathan attend Canterbury Centre to receive his injection. This was a sudden change from the home visits he had been receiving previously. This demand by the CCMHC to attend the centre did not take into account Nathan's partial blindness and his difficulty walking. Justice Action was still in negotiation with the CCMHC and asked for discretion from the police to prevent Nathan's arrest. The police said they had no discretion and the CCHMC ignored the negotiation and called the police. Nathan was arrested, strapped into an ambulance and taken to the Concord Hospital Locked Ward. He was held there for six days despite them accepting that he was not disordered. His elderly father, for whom Nathan was a carer, was left alone at home and his mother was not notified of his arrest.

On the 17th of April 2023, CCMHC contacted Nathan and insisted he attend the centre by midday that day under threat of police arrest. Nathan and his support team had difficulty making the appointment. In a continuation of a pattern of contradictory behaviour, after a 8-year battle, the CCMHC agreed to discontinue the CTO. Nathan is now able to pursue his own personal management plan of recovery.

## 1.2 Miriam Merten

Miriam was a mother of two and a mental health inpatient at Lismore Base Hospital. She died on the 3rd of June 2014 from injuries sustained during her time in seclusion. Disturbing CCTV footage of her final hours showed Miriam, splattered in blood and faeces, wandering the corridors of the Lismore facility on the night of her death. This exposed the gross negligence of the NSW

Health Staff at Lismore Base Hospital, along with their abject failure to intervene to prevent her untimely death.[9] Her full story detailing all of the hardships she faced can be found here.

Miriam passed away from a brain injury after she fell more than 20 times whilst a nurse mopped the floor around her. The hospital lied to the family about what had happened. The coronial inquest into her death found that she died from a "traumatic brain injury caused by numerous falls and the self-beating of her head on various surfaces, the latter not done with the intention of taking her life".[10] Two Inquiries followed.

A review led by the Chief Psychiatrist Dr Murray Wright on seclusion, restraint and observation of consumers with a mental illness in NSW Health facilities, along with a panel of five mental health experts, made very serious criticisms of the NSW mental health system.[11] The review denounced the NSW mental health culture, stating it lacked compassion, humanity, and any real interest in the individuals beyond risk management.[12] The review held that the system used coercive compliance, had no internal oversight (even after Miriam's death),[13] lacked guidelines, had little evidence of engagement with consumers or carers and involvement in care plans,[14] and had no examples of the necessary leadership required to give high quality compassionate care.[15] Additionally, the review held that peer worker support was very limited despite being a vital resource to lessen seclusion and restraint.[16] These findings demanded urgent action from NSW Health.

A further independent analysis conducted by Justice Action explored the implementation of reforms following Miriam's death.[17] It revealed that little had changed, concluding that the limited response of Local Health Districts further highlighted ongoing issues in the NSW health system. None of the leading organisations nor the Health Department addressed Miriam's death or the prevention of such deaths in their presentations. In the inquiries that followed none of the recommendations would have made any difference to changing the damaging culture of NSW

[9] "Miriam Merten Mental Hospital Death Inquiry Media Release 22nd December 2017." *Justice Action* (Web Page, 22 December 2017) <https://justiceaction.org.au/miriam-merten-mental-hospital-death-inquiry-media-release-22nd-december-2017/>; Death of Miriam Merten." *Justice Action*, <https://justiceaction.org.au/death-of-miriam-merten/>.
[10] 'Lismore Hospital death: Inquiry launched into Miriam Merten's death', *9NEWS* (Web Page, 12 May 2017) <https://www.9news.com.au/national/nsw-patient-left-to-wander-naked-through-hospital-hours-before-death/f7c829e6-15ff-404d-b5ce-02cefd54f4c9>.
[11] Murray Wright, *Review of seclusion, restraint and observation of consumers with a mental illness in NSW Health facilities* (Final Report, December 2017).
[12] Murray Wright, *Review of seclusion, restraint and observation of consumers with a mental illness in NSW Health facilities* (Final Report, December 2017) 7, 22.
[13] Ibid 29.
[14] Ibid 25 and 35.
[15] Ibid 24.
[16] Ibid 33.
[17] Justice Action, *Report of LHDs Implementation of Miriam Merten Reforms* (Report, 2014).

Health, as they failed to empower or dignify consumers like Miriam. The recommendations made focused on more resources from provisioning authorities. Although more resources should be devoted to mental healthcare, this alone will not address the deeply rooted cultural problems within the health system exposed by Miriam's degrading and unnecessary death.

Justice Action identified six issues which would make a difference:

1. mobile phone access;
2. forced medication/peer worker intervention;
3. access to education;
4. consumer representation;
5. CCTV monitoring, and;
6. media access.[18]

CEOs of each Local Health District in NSW were contacted by Justice Action regarding these issues. Justice Action encountered surprising resistance towards such crucial reforms - such as the mandatory presence of CCTV in hospital units. It was the presence of CCTV cameras and the footage derived from them that contradicted the lies the hospital told Miriam's family about how she died. CCTV cameras are essential to ensure staff accountability and protect patients from mistreatment. Ultimately, NSW health must dismantle the culture of negligence which led to the unjust death of Meriam, and which has also led to so many other similar deaths in custody.[19]

## 1.3 Antony Waterlow

In 2009, Antony Waterlow stabbed and killed his father, Nick, and his sister, Chloë, at Chloë's house in Clovelly. He also seriously injured Chloë's daughter. More information regarding Antony's story and the challenges he experienced can be found here.

Antony Waterlow had suffered from paranoid schizophrenia for a decade. His paranoid delusions as a result of his condition had made him believe that his own family were persecuting him. Between 2004 and 2007 he saw numerous doctors including several psychiatrists, with his friends and family expressing concern about his aggression towards some of them. However, at no time did Mr Waterlow see himself as unwell. Mr Waterlow refused to take antipsychotic medication and even

[18] Ibid 4.
[19] "Deaths in Custody." *Justice Action*, <https://justiceaction.org.au/death-in-custody/>.

though an involuntary detention was considered, it was never undertaken. What is clear from the Waterlow case is that he had threatened family members, friends and neighbours with death and rape repeatedly over a number of years. He was known to use drugs and alcohol and his psychiatrists agreed he was dangerous and unstable. He could and should have been compulsorily detained and engaged under the existing law. He was tried for murder, and found not guilty by reason of mental illness.

The findings and recommendations of the inquest into the deaths of Nicholas Waterlow and Chloe Heuston[20] highlight the need for an increase in support for people in mental distress. The coronial inquest recognised the need to remove ambiguity from tests and definitions in relation to what actually constitutes 'serious harm'.[21] In the case of Waterlow, it has been held that the:[22]

> reason for Mr Waterlow's not receiving effective psychiatric treatment prior to the killings was that the doctors who examined him did not think they had reasonable grounds for believing that detention was necessary for the protection of others from serious harm.

The Waterlow case represents a key issue in the mental health system. Psychiatrists did not recognise the serious danger that Mr Waterlow presented not only to himself but especially to the people around him. Had this misstep not occurred and a proper application of a CTO been utilised, innocent people's lives may not have been lost.

The NSW Chief Psychiatrist's communique (2014)[23] that was written in response to the Waterlow inquest was never justified. It set out misleading definitions of 'serious harm' being followed by practitioners in the field. While the broad consideration of 'serious harm' enabled more nuances regarding the implications of harm, the implementation of a communique in the form of a fact sheet rather than legislative amendments results in clinicians being misled into making decisions for involuntary treatment.[24] Rigorous examination of what constitutes serious harm and what it takes to intervene is highlighted in Justice Action's report on forced medication.

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[20] Magistrate P. A. MacMahon, *Inquest into the deaths of Nicholas WATERLOW and Chloe HEUSTON - Reasons for Findings* (Report, 10 January 2014).
[21] Ibid; Justice Action, 'Analysis of the Coronial Recommendations of ANTONY WATERLOW CASE' (Web page, 14 April 2021) 8-9; *The Mental Health Act 2007* (NSW) s 14.
[22] Christopher Ryan et al, 'Better laws for coercive psychiatric treatment: Lessons from the Waterlow case' (2012) 20(4) Australasian Psychiatry 283-6.
[23] NSW Government Department of Health, 'Amendments to the NSW Mental Health Act (2007)', *NSW Government* (Web Page) <https://www.health.nsw.gov.au/mentalhealth/resources/Factsheets/community-medical-practitioners.pdf>.
[24] Ibid; Christopher James Ryan, Sascha Callaghan and Matthew Large, 'Better laws for coercive psychiatric treatment: Lessons from the Waterlow case' (2012), 20(4) *Australasian Psychiatry* 283-6.

## 1.4 Kerry O'Malley

The case of Kerry O'Malley provides another case study of the failure of the NSW mental health system.[25] Over the last 47 years Kerry has been arrested, abandoned in a locked hospital, and stripped of individual autonomy. Kerry was subjected to CTOs many times and forcibly medicated with severe physical, mental and social side effects.[26] Psychiatrist Dr Yola Lucire defended Kerry against forced medication despite the weight of the industry norms. Her story and a deeper understanding of her case can be found here.

Kerry approached the Mental Health Review Tribunal (MHRT) to reject the CTO against her.[27] During the MHRT she complained to the hospital regarding the medication they provided her, claiming it made her feel sick, depressed, anxious, tired, mentally foggy and unable to concentrate. The hospital completely disregarded her concerns. Kerry felt degraded by the CTO and preferred to choose her own doctor.[28] She had a strong support network that she trusted and explained that the intervention of the MHRT made her feel fearful. The Tribunal agreed with her complaints.

Kerry approached Justice Action to assist her to fight against the CTO after her application for Legal Aid was refused. Kerry's case demonstrates not only the failure of the NSW mental health system to recognise the individual autonomy of those with mental health issues, but also the need for adequate legal representation to allow advocacy for those individuals impacted by mental illness. Justice Action assisted Kerry to appeal to the Supreme Court of NSW, where eventually lawyers for the Department of Health conceded that the CTO was invalidly made and should be quashed. Despite this they indicated they would seek another order.

In this case, the court dropped the CTO against Kerry and ruled costs against NSW Health. The Minister for Mental Health, Bronnie Taylor, responded in Parliament to a question regarding the Supreme Court decision in Kerry O'Malley's case.[29] The Minister's response was disappointing in that it justified the Health Department's stance.

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[25] Justice action, 'Kerry O'Malley – Forced Medication and Community Treatment Orders', *Justice Action* (Web Page) <https://justiceaction.org.au/kerry-omalley-forced-medication-and-community-treatment-orders/>.
[26] QwN - Involuntary treatment protocol -asked 18 March 2021 [1]
[27] Ibid.
[28] Ibid.
[29] Justice Action, 'QUESTION ON NOTICE LEGISLATIVE COUNCIL', *Justice Action* (Web Page) <https://docs.google.com/document/d/181dmfar8CPRHEqY6nF63zuz1YhYjO6lTWIPddmqUgvc/edit>.

# 2. FORCED MEDICATION, COMPULSORY TREATMENT ORDERS AND THEIR ALTERNATIVES

CTOs involve the authorisation of compulsory treatment imposed on a person without their consent through mental health legislation.[30] In Australia, mental health laws, policies, and practices authorise the forced treatment of those living with psychosocial disability. This limits the liberty, security and equality before the law of affected individuals. Laws have failed to prevent and in some cases have actively condoned unacceptable practices. These include irreversible approved treatments, such as the authorisation of psychosurgery, electroconvulsive therapy, as well as forced sterilisation, chemical, mechanical and physical restraint, and seclusion.[31]

The VRC's report on the excessive use of CTOs in accordance with the *Mental Health Act 2014* (VIC), outlined that the imposed treatment is generally reduced to nothing more than arrest and forced medication—the cheapest and most inactive option in mental health care. Similar practices are sanctioned by the *Mental Health Act 2007* (NSW) s 51. This Act gives Magistrates and the MHRT the power to grant a CTO. The vast majority of CTOs are made by the MHRT. The MHRT is required to operate as an independent body. It reviews requests for CTOs and is obligated to approve and review CTO applications presented to informal hearings. The Tribunal detailed that between 2020-21 there has been a 1% decrease in CTO hearings but a 7% increase in people in relation to whom a CTO is made.[32] There has also been a 2% increase in CTOs made by MHRT since 2020.[33] A total of 5857 CTO applications in relation to 4227 mental health consumers were considered by MHRT in the financial year of 2021.[34]

## NSW

In NSW, compulsory treatment orders may be made for the treatment of a *mentally ill person*. A mentally ill person is defined as follows:

> **14 Mentally ill persons**

[30] *Mental Health Act 2007* (NSW) s 51.
[31] Disabled People's Organisations Australia 'Factsheet: Forced Treatment and Restrictive Practices' *Disabled People's Organisations Australia* (Web Page, 9 March 2018) <https://dpoa.org.au/factsheet-forced-treatment/>.
[32] Mental Health Report Tribunal, Annual Report 2021 (Final Report, 29 October 2021) 24.
[33] Ibid.
[34] Ibid, 14.

(1) A person is a mentally ill person if the person is suffering from *mental illness* and, owing to that illness, there are reasonable grounds for believing that *care, treatment or control of the person is necessary*—

(a) for the person's *own protection from serious harm*, or

(b) for the *protection of others from serious harm*.

(2) In considering whether a person is a mentally ill person, the continuing condition of the person, including any likely deterioration in the person's condition and the likely effects of any such deterioration, are to be taken into account.

So, a *mentally ill person* is not simply a person suffering from *a mental illness*. There must be reasonable grounds to believe that care or treatment is *necessary* (not just convenient or desirable) to prevent *serious harm*. The Act spells out a number of matters which are *not* sufficient, by themselves, to indicate that a person is a mentally ill person[35] — which underscores the gravity of what must be proved.

NSW has authorised compulsory treatment such as forced medication for mental illness in prisons,[36] through a practice unique to NSW known as 'Forensic Community Treatment Orders' (FCTOs).[37] These orders apply to incarcerated persons diagnosed with a mental illness while in prison, and to forensic patients detained in a prison. FCTOs and CTOs are highly contentious, raising a number of ethical issues including:

- Breach of the entitlement to equal treatment as available in the community;
- Denial of the right to autonomy and bodily integrity, and;
- Failure of proper administration of care for vulnerable individuals within highly restrictive environments such as prisons.

In the 2021-2022 Annual Report by the Mental Health Review Tribunal, they stated that there were a total of 6,767 CTOs made, which is an increase of 6% from the previous year.[38] Moreover, the Tribunal dealt with 6,556 hearings concerning CTOs for 4,985 individuals, depicting a 12% increase in hearings.[39] The report highlighted that a notable majority of these hearings discussed changing the conditions of existing CTOs.[40]

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[35] *Mental Health Act* 2007 (NSW) s 16(1).
[36] Justice Action, *Forced Medication of People with Disabilities: Breach of OPCAT* (Report, 3 December 2021).
[37] Mental Health Report Tribunal, Annual Report 2021 (Final Report, 29 October 2021) 10.
[38] Mental Health Report Tribunal, Annual Report 2022 (29 October 2022) 16.
[39] Ibid 24.
[40] Ibid 34.

A revision of CTOs regarding practical and ethical implications will allow for the health and safety of individuals to be the main priority. Fifty non-randomised studies addressing effectiveness of CTOs, produced a lack of substantial evidence regarding the patient benefits.[41] This demonstrates the need for reform that provides further support of individuals and their health, alongside a dire need for current outcome studies to form the foundation of changes to be made.

## 2.1 Ineffectiveness of Compulsory Treatments

CTOs and FCTOs are coercive measures that should not be tolerated. They breach basic human rights including liberty and security of the person, especially when no personal crisis exists. Studies indicate that compulsory treatment of serious mental illness is generally ineffective in improving mental health outcomes.[42] Consumers who are restrained within enclosed mental health facilities for CTOs are also removed from fundamental support and connections in their community.[43] This is an inappropriate environment for the care and treatment of mentally ill persons.

This 'treatment' is not only convenient, easy and cheap, but it can also be used as a form of 'prisoner punishment' by authorities in the prison.[44] It is clear that the complexities of mental health issues are not being appropriately addressed when involuntary treatments are enforced. CTOs inflict further psychological stress on individuals through the traumatising process of involuntary medicating.[45]

Justice Action has conducted independent research into the subject of compulsory treatments and produced a number of papers including:

- 'Community Treatment Orders';[46]
- 'Unethical Treatment of Mental Health in Prisons: Forensic Community Treatment Orders'[47]
- 'Limits to Forced Medication'.[48]

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[41] Jorun Rugkåsa, 'Effectiveness of Community Treatment Orders: The International Evidence' (Research Report, January 2016) 15–24.
[42] Justice Action, *Community Treatment Orders* (Report) 7-8.
[43] Ibid.
[44] Ibid 2.
[45] Ibid 8.
[46] Justice Action, *Community Treatment Orders* (Report).
[47] Justice Action, *Unethical Treatment of Mental Health in Prisons: Forensic Community Treatment Orders* (Report) https://justiceaction.org.au/wp-content/uploads/2021/06/Stop-FM-in-Prisons-JA-June-2021.pdf
[48] Justice Action, *Limits of the Power to Forcibly Medicate* (Report). https://justiceaction.org.au/wp-content/uploads/2021/05/LimitsForced-Medication.pdf

With the interest of offering a more effective and autonomous treatment in mind, we enlist Recommendation 55 of the VRC's final report. The Royal Commission details that the Victorian Government has 'set targets to reduce the use and duration of compulsory treatment on a year-by-year basis', and 'when commissioning mental health and wellbeing services, set expectations that they will provide non-coercive options'. Although there is an urgent need for similar goals to be set in NSW, it is our understanding that the NSW government currently does not have any plans to enact these corresponding changes. Additionally, the VRC has recommended the use of CTOs as a last resort as well as aiming to decrease the usage and duration of forced treatment, but the NSW government shows reluctance to accept this idea despite internationally recognised lack of robust evidence supporting their effectiveness.[49] Added to this, Recommendation 55.3 called for the commissioning of offering non-coercive services to mental health consumers at high risk of being imposed compulsory treatment, illuminating the intentions of VRC in 'reducing coercive practices'.

As part of a recommendation, we suggest for Section 99(1)(c)-(d) of the *Mental Health And Cognitive Impairment Forensic Provisions Act 2020* (NSW) be withdrawn, and for any CTOs and FCTOs administration in NSW to be ceased. Mentally ill persons within prisons should be transferred to the health departments and alternative measures should be considered. For incarcerated persons remaining in prison, formal alternatives like counselling are recommended as a more effective support model, alongside informal alternatives including:

- Open dialogue;
- Quality time with friends and families, and;
- Peer-mentoring with trained incarcerated persons.

An independent review into compulsory treatment criteria and the alignment of mental health laws, led by Hon Justice Shane Marshall AM, began in October 2022 and is expected to be completed by late 2023. Upon consultation of the legislation, different views about the criteria for compulsory treatment were illuminated which is being investigated further. Alignment of mental health laws with other laws should occur sooner than recommended by the Royal Commission with a further review of the new *Mental Health and Wellbeing Act 2022* (VIC) after the first five years of operation. The Act will seek to accomplish the following:

- promote good mental health and wellbeing for all Victorians
- reset the legislative foundations for the mental health and wellbeing system

[49] https://www.researchgate.net/publication/278788674_Forensic_community_treatment_orders_Waste_of_time_or_exciting_new_provision

- support the delivery of services that are responsive to the needs and preferences of Victorians
- establish new roles and entities recommended by the Royal Commission
- put the views, preferences and values of people living with mental illness or psychological distress, families, carers and supporters at the forefront of service design and delivery. [50]

Additionally, greater consideration should be given to understanding the organisational and environmental factors that contribute to poor mental health in prisons. Long periods of isolation without mental stimulation, staff shortages caused by a strenuous working environment and a hostile prison culture results in feelings of anger and frustration that further contributes to the issue. As a result, an investigation into these problems is paramount in addressing the mental health crisis in prisons by addressing it at its root cause.[51]

## 2.2 Youth and Mental Health

The diagnosis of mental health in incarcerated youth is a significant issue that needs to be accounted for in order to effectively consider the ramifications of the usage of FCTOs and more specifically, forced medication. Social disadvantage, intergenerational trauma and racial bias all adversely impact the children who end up in Youth Justice. Defining them as mentally ill, and having them accept that label, can be a self-fulfilling and damaging structure, which should be avoided at all cost. The diagnosis of mental health disorders is significantly higher in incarcerated youth when compared to both the adult and youth population of non-incarcerated individuals, and this statistic is skewed even more heavily when accounting for Indigenous populations.

Surveys of incarcerated young people in NSW shows 83-88% have a mental health disorder and 14-18% have an intellectual disability. The data also noted higher rates in Indigenous youth with 92% having a mental health disorder and 24% having an intellectual disability. Furthermore, incarcerated juvenile populations also have significantly higher rates of other cognitive disabilities such as fetal alcohol spectrum disorder, traumatic brain injury, and language impairments.[52] An American meta analysis of 2 million incarcerated youth revealed that 50-75% of individuals meet

[50] https://www.health.vic.gov.au/mental-health-reform/a-new-mental-health-and-wellbeing-act-for-victoria
[51] Nurse, J., Woodcock, P., & Ormsby, J. (2003). Influence of environmental factors on mental health within prisons: focus group study. *Bmj*, *327*(7413), 480. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC188426/>
[52] Cunneen, C., Goldson, B., & Russell, S. (2016). Juvenile justice, young people and human rights in Australia. *Current Issues in Criminal Justice*, *28*(2), 173-189. <http://classic.austlii.edu.au/au/journals/CICrimJust/2016/23.html>

the criteria for a mental health disorder, with 40-80% of incarcerated youth having at least one diagnosis, showing an international concern for the issue.[53]

The imprisonment of young people with mental health disorders is an issue that links itself to poorer outcomes later in life, mainly a significantly higher risk of recidivism.[54] The prevalence of mental health disorders among incarcerated youth raises concerns about whether the current age of criminal responsibility is too low. At present, the age of criminal responsibility in NSW is 10 years old.[55] Taking into account the prevalence of developmental and mental health disorders among children, this may indeed be too low. For example, children with complex mental health needs may not be able to wholly comprehend and appreciate the nature of their actions.

### 2.2.1 ADHD

Attention Deficit Hyperactivity Disorder (ADHD) is a diagnosis often applied to young people, but adults may also be diagnosed later in life. Typical symptoms of ADHD include struggling to pay attention, an inability to control impulsive behaviours, and overactivity such as fidgeting and restlessness. ADHD is caused by a wide array of different causes including genetics and environmental factors such as substance use during pregnancy, harmful chemical exposure, brain anatomy, premature birth and low birth weight.[56] The differences found in brain anatomy, neuron networks and neurotransmitters disrupt a person's ability to manage their own emotions, thoughts and actions.[57] Furthermore, the brains of people with ADHD do not fully mature until later than most.[58]

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[53] Underwood, L. A., & Washington, A. (2016). Mental illness and juvenile offenders. *International journal of environmental research and public health*, *13*(2), 228. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4772248/>

[54] Heretick, D. M., & Russell, J. A. (2013). The impact of juvenile mental health court on recidivism among youth. *Journal of Juvenile Justice*, *3*(1), 1. <http://bscchomepageofh6i2avqeocm.usgovarizona.cloudapp.usgovcloudapi.net/wp-content/uploads/JOJJ0301.pdf#page=7>

[55] Talina Drabsch, *Age of Criminal Responsibility - Parliament of NSW* (January 2022) <https://www.parliament.nsw.gov.au/researchpapers/Documents/Age%20of%20criminal%20responsibility%20-%20Final.pdf>.

[56] https://www.nhs.uk/conditions/attention-deficit-hyperactivity-disorder-adhd/causes/#:~:text=Genetics,likely%20to%20have%20ADHD%20themselves.

[57] https://my.clevelandclinic.org/health/diseases/4784-attention-deficithyperactivity-disorder-adhd#:~:text=Scientists%20have%20discovered%20there%20are,own%20emotions%2C%20thoughts%20and%20actions.

[58] Ibid

It is estimated that 1 in 20 children in Australia have ADHD.[59] It is more prevalent in males compared to females. More than 3 out of 4 children with ADHD continue to experience symptoms into adulthood.[60] Typically, children usually have to be five years old in order to get assessed for ADHD but they may be assessed at a younger age if they have a strong family history. It is most often the case that those who receive a diagnosis as a kid will have it last into adulthood as well.[61]

With regards to the treatment of ADHD, a common route for suppressing symptoms is the usage of one or a variety of different medications. Types of medication that are typically used include *stimulants,* which are the most commonly utilised; *non stimulants,* which do not work as fast but can last for 24 hours; and *antidepressants*, which are just sometimes prescribed due to adverse effects.[62] Despite their apparent effectiveness in relieving symptoms of ADHD, medication usage has a host of adverse side effects including a loss of appetite, trouble sleeping, irritability, jitteriness, headaches, stomachaches and high blood pressure.[63] These side effects may cause more harm overall, especially to children, consequently resulting in a possible need for other solutions.

Alternatively to or in conjunction with medication, ADHD can be treated using behavioural therapy including parent-delivered behavioural therapy and teacher-delivered behavioural therapy.[64] Whilst using medication can be a common resort to treat the condition, treating ADHD through peer mentoring may ultimately provide individuals suffering from ADHD the opportunity to learn how to cope and deal with the condition themselves. In turn, this may help individuals understand their complex needs and better address the condition. Resorting to using medications raises scepticism on whether medical intervention can effectively assist individuals suffering from ADHD learn to deal with their impulsive tendencies themselves. For example, peer mentoring sessions help individuals learn new strategies to help cope with their specific complex ADHD challenges, which medication alone cannot offer. Therefore, there are many apparent benefits of treating the condition through peer mentoring and expert support offers that medical intervention alone cannot provide.

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[59] https://www.rch.org.au/kidsinfo/fact_sheets/Attention_deficit_hyperactivity_disorder_ADHD/#:~:text=Attention%20deficit%20hyperactivity%20disorder%20(ADHD)%20is%20a%20long%2Dterm,children%20in%20Australia%20have%20ADHD.

[60] https://www.healthdirect.gov.au/attention-deficit-disorder-add-or-adhd

[61] Ibid

[62] Ibid.

[63] https://kidshealth.org/en/teens/ritalin.html#:~:text=The%20most%20common%20side%20effects,or%20taking%20a%20higher%20dose.

[64] Centres for Disease Control and Prevention,, *What Types of Treatment Do Children with ADHD Receive?* (2022) <https://www.cdc.gov/ncbddd/adhd/features/kf-national-treatment-profile-adhd-nsdata.html#:~:text=Based%20on%20the%20best%20available,and%20teacher%2Ddelivered%20behavior%20therapy>

Estimated ADHD rates are higher in incarcerated people compared to the general population with it being 5 times more common in young prisoners and 10 times more common in adult prisoners.[65] The rates in Indigenous prisoners isn't known exactly but is likely to be higher as well. Many of these affected prisoners were never previously diagnosed prior to entering the criminal justice system, and the diagnosis of ADHD is typically complicated by comorbidity with other mental health disorders and substance abuse. Limited surveys on the topic indicate that between 33-41% of young prisoners have ADHD globally,[66] whilst 25% of adult prisoners have ADHD. The 2015 Young People in Custody Health Survey measured the prevalence of ADHD in several groups: 22.3% for males, 27.3% for females, 24% for people identifying as Aboriginal or Torres Strait Islander and 20.7% who did not identify with these groups.

## 2.3 Alternatives: Cognitive Behavioural Therapy

Cognitive Behavioural Therapy (CBT) is a form of psychological therapy. There is ample evidence to support the effectiveness of CBT, which has trumped other treatments (e.g. medication) for depression, anxiety, substance abuse, and severe mental illness.[67] CBT is based on the conclusion that psychological problems are in part based on unhelpful ways of thinking and learned patterns of unhelpful behaviour. These problems can be treated by learning to understand these patterns, using problem solving skills to address these patterns, and developing a patient's confidence in their abilities. To stimulate behavioural change, patients are encouraged to face their fears, to utilise role-play in imagining challenging situations, and learn techniques to relax the mind and body.

CBT also emphasises that patients are given the tools to become their own therapist of sorts. For example, patients are given 'homework' and are supported to learn coping skills they can implement outside of therapy. Thus, a patient's self-motivation and self-efficacy is an important part of CBT.  CBT is also more focused on the present situation, as opposed to what took place in the client's history to lead to their psychological problems. As an alternative to CTOs, CBT programs should:

- Be accessible by choice to offenders at all stages, from arrest to re-integration into society;
- Be facilitated in safe, private and individualised environments, which allow family and friends to assist in the rehabilitation process;
- Have a transparent funding system with accountable decision making processes;
- Be available online and;

[65] https://adhdguideline.aadpa.com.au/subgroups/correctional-system/
[66] http://classic.austlii.edu.au/au/journals/JCULawRw/2019/9.pdf
[67] American Psychological Association, 'What is Cognitive Behavioural Therapy' (Web Page, 21 July 2022) <https://www.apa.org/ptsd-guideline/patients-and-families/cognitive-behavioral>.

- Ensure governments are responsible for improving external factors which influence crime rates, such as social and economic disadvantages.

## 2.4 Alternatives: Prisons and Community Care

### 2.4.1 Queensland Model

The jurisdiction of Queensland currently appears to be operating what is deemed as the 'best practice' model of mental health services within prisons. NSW should aim to replace the use of involuntary treatment in prisons by what is currently provided by the Queensland PMHS.

Queensland's PMHS provides services using a multidisciplinary approach involving nurses, social workers, psychiatrists and psychologists. NSW is the only jurisdiction in Australia, and one of the few in the world, that allows involuntary treatment in prisons. In contrast, Queensland is the only jurisdiction in Australia, and one of the few in the world, where prisoners are routinely transferred to authorised community mental health services for the provision of involuntary treatment by authorised doctors and senior practitioners.

In 2018–19, 250 prisoners were transferred from prison to community mental health units in Queensland, most of whom were either already subject to community treatment authorities or required to be made subject to treatment authorities to facilitate involuntary treatment of their mental illness. In contrast it has been extensively documented that prisoners in NSW, in practice, are rarely transferred to hospital units for involuntary treatment of mental illness, despite the legislation allowing for this. This directly counters the Royal Australian and New Zealand College of Psychiatrists' 2017 paper, which asserted that involuntary treatment of mentally ill persons in custodial environments was inappropriate and had many negative outcomes, including breaching human rights.[68]

An additional practice of Queensland's system allows the Director of Forensic Mental Health Services to monitor how long it takes to implement recommendations for the transfer of a prisoner to an authorised mental health service. If the delay becomes excessive, the Director can escalate the

[68] The Royal Australian and New Zealand College of Psychiatrists [RANZCPS], 'Involuntary Mental Health Treatment in Custody <https://www.ranzcp.org/news-policy/policy-and-advocacy/position-statements/involuntary-mental-health-treatment-in-custody>.

matter to the Office of the Chief Psychiatrist, who must remain dedicated to the principle of equivalence between the treatment available to prisoners and in the community.

The PMHS provides daily clinic sessions and on-call psychiatrist services after hours and on weekends. This is noteworthy because the lack of adequate community mental health services outside prisons has been identified as a contributor to the over-representation of mentally ill people in prisons. Furthermore, difficulties in accessing these have led to disproportionate effects on marginalised individuals such as those struggling with substance abuse, which can lead to recidivism.

Additionally, of the nineteen correctional centres in Queensland, thirteen have in-reach (one stop hub) specialist prison mental health services and the remaining six have access to specialist mental health services. While in-reach specialist responsibilities differ based on the context of treatment, this role involves daily clinic sessions as well as on-call psychiatrists for prisons, which allows direct access to a mental health clinician after hours and on weekends. A UK study found, having specialist in-reach mental health services that were only available on weekdays from 9-5 caused anxiety because "mental illness does not confine itself to office hours."

Moreover, Queensland provides Indigenous mental health workers to support Indigenous peoples in prison. Queensland has also implemented the group program *Self-Management and Recovery Training*, which is delivered by facilitators of the PMHS to address problematic behaviours and promote self-directed behaviour changes. This is a positive change towards recognising and safeguarding the autonomy and self-responsibility of mentally ill prisoners.

NSW should therefore, aim to replace the use of involuntary treatment in prisons with psychological interventions like what is currently provided by the Queensland PMHS. This includes the interventions of illness education, insight therapy and motivational interviewing-based abstinence counselling, and a specialised dual-diagnosis referral service which also features an opioid -replacement therapy service in selected prisons, a referral pathway to drug and alcohol services, and residential rehabilitation services in the community.

### 2.4.2 Victoria's Approach

To facilitate de-institutionalisation in relation to hospital care, 'International and Australian research consistently shows that community-based treatment is superior to hospital centred care for

the vast majority of people with acute and long term mental illness'.[69] This practice has a history in Australia; between 1993-1998, when Victoria's mental health service system underwent a major transformation.

Taking into account the problems arising from institutionalised services, the Victorian government implemented a range of community care services before shutting down its psychiatric institutions. As a result, Victoria was able to fund new, locally accessible services with institutional savings quarantined for its purpose as well as improving the wellbeing of its patients. However, following the 1996 federal election, which brought a conservative government to power, mental health reform lost priority, (Gerrand 2005) with its reform process remaining undeveloped and incomplete.

According to Alan Rosen, Liz Newton, and Karen Barfoot, models of deinstitutionalisation can contain the following:[16]

- Recovery-oriented services: services to develop a culture to "stimulate, enhance, and support individual recovery by promoting health, healing, empowerment and connection in the lives of each individual served."
- GP's have a pivotal role: they know the person and family, and are in a position to organise all aspects of clinical care. Stabilised persons can be transferred to a GP for coordination of care focussed on counselling and support.
- Crisis intervention: "evidence now clearly indicates that 24hr home visiting crisis response services should be integrated into local services for people seriously affected by mental illness and their families."
    - People affected by psych illness are more likely to co-operate when interventions are tailored to their needs and when family is given choice, receive sufficient information, and low dose interventions are offered.
    - Reduces the trauma of hospitalisation.
- Family interventions: have been shown to prevent relapses. Techniques include problem solving skills to minimise conflict and hostility.
- Assertive community treatment: "an intensive, mobile community case management system for people with severe and prolonged mental illness". Research shows it is efficient and cost effective and works best for heavy users of mental health services.
- Day and evening programs: including 'drop in' and 'club house model' where users participate and manage the centre.

[69] Alan Rosen, Liz Newton. Karen Barfoot, "Clinical Perspectives: Evidence based Community Alternatives to Institutional Psychiatric Care" *Medicine Today*, vol 4, no. 9 (September 2003), p. 90.

- Vocational rehabilitation: focused on living skills and leisure activities. This is a pathway for other opportunities, such as work opportunities.
- Open employment: traineeships and apprenticeships specially funded should be pursued.
- Individual placement and support schemes: helps users find a job within their interests and provides support for both the employee and employer.
- Supported employment: mainstream jobs with on-job training for people with a mental illness. Partnerships include cafes, nurseries.
- Transitional and sheltered employment: enables members to have short-term jobs in local businesses with support. Provides work experience, confidence and skills.
- Service users as paid service providers: create paid work from within the mental health service budget within the mental health industry. Studies show positive outcomes.

## 2.5 Alternatives: Peer Support Workers or Mentors

In a report by the Royal Commission, Dr Christoper Maylea, Senior Lecturer in Social Work at RMIT University and previous Chair of the Committee of Management of the Victorian Mental Illness Awareness Council, argues that there is 'no overall benefit to compulsory treatment' and that:

> 'obvious alternatives to compulsory treatment required, which would involve investment into Victoria's mental health services (particularly in community mental health services) and a re-focus on general themes of recovery-based treatment, early intervention and support, choice and the increased availability of peer work services and workers.'[70]

Justice Action has engaged in numerous mentoring projects relating to correctional services, including the Justice Action Mentoring Project, which provided advice and support to prisoners and opportunities to collaborate on Community Service Orders. We have set up and run half-way houses and created long term jobs for some people who have been able to use their experience and knowledge of life after prison to help others. Another example of the efficacy of this system is the Women in Prison Advocacy Network (WIPAN) with 93% of mentees staying out of prison after release, compared to 53-57% of the general prison population outside of the program.[71]

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[70] Royal Commission into Victoria's Mental Health System, *Final report*, Volume 4 [The fundamentals for enduring reform] (2021) 375.
[71] Women in Prison Advocacy Network, *Mentoring Program: Frequently Asked Questions* (n.d.) 3 <https://www.womensjusticenetwork.org.au/wp-content/uploads/2015/11/Mentoring-FAQ_Sheet.pdf>.

We have found that while some educational and rehabilitative programs offered in jail and on release can be useful, many suffer from being delivered by people who have little understanding of the effect of life in prison. These programs are also delivered in a context where the client has little to no control or choice other than be forced to take them or "risk" dissent against the system.

Mentoring, on the other hand, is about building a relationship of mutual trust, friendship and support. Help, advice and assistance can be offered as part of the process of re-building a life after being labelled a criminal and where many barriers actively prevent return to normal life. As the mentor and the mentee relationship is voluntary, this initial willingness and motivation heightens the chances of creating a beneficial relationship, with successful outcomes. With the assistance of a mentoring program, a mentor assists the mentee to gain the necessary skills, confidence and direction to overcome life's obstacles, empowering a mentee to find and implement their own solutions whilst building a strong, adaptive support network.

# 3. SPECIFIC ISSUES IN THE MENTAL HEALTH SPACE

Numerous mental health issues can be readily observed, however many of these problems are explained by further underlying issues. This section identifies some components that engender the broader issues of mental health and thus supports that the complexity and prevalence of these problems necessitates an inquiry. Significantly, there is a clear relationship between experiences of trauma and subsequent poor mental health.

## 3.1 Mental Health in Marginalised Communities

### 3.1.1 Prisoners

People in prison experience adverse and complex mental health issues. Comorbid mental health and other issues are prevalent, whereas support and help services are lacking.[72] Contemporary society sees and utilises prison as a facility for people with mental health needs, whereas such requirements previously were handled by mental health institutions. According to the *Mental Health Act 2007* (NSW) involuntary detention of a person is permitted if the person is determined to be mentally ill and if there are reasonable grounds to believe detention is necessary to prevent

[72] Australian Institute of Health and Welfare, 'Medication use by Australia's prisoners 2015: how is it different from the general community?', *Bulletin 135* (June 2016).

serious harm either to the person themselves or others, less restrictive methods of quality care are unavailable.[73]

NSW psychiatrists interpretations of what defines serious harm have produced a view that such harm must be beyond the symptoms of mental illness.[74] Most St Vincent's hospital staff would not admit Mr. Waterlow despite concerns from his friends and family regarding his aggression.[75] However, if prison is to be an option for punishment of mentally ill people or even people who experience mental health issues, correctional services should be prepared to accommodate such needs.

### 3.1.2 Aboriginal and Torres Strait Islander Peoples

Trauma plays a significant role for Aboriginal and Torres Strait Islander people's mental health issues. Within the community many self-report depression, anxiety, behavioural or emotional problems, harmful use or dependance on drugs or alcohol, and are described as having mental health issues.[76] This presents the complex and extensive reach of the problem.

Effectively managing mental health within Indigenous communities requires individualised, grassroots consultation with local communities. The Aboriginal Mental Health and Wellbeing Strategy is one such initiative that aims to provide improved mental health services to Indigenous people in NSW by encouraging each district to develop a localised implementation plan with Indigenous services, staff, people and communities.[77] To improve mental health within Indigenous communities, accessible support and culturally appropriate care is crucial.

### 3.1.3 Women

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[73] *Mental Health Act 2007* (NSW) ss 12(1), 14-15.
[74] Christopher Ryan, Sascha Callaghan and Matthew Large, 'Better laws for coercive psychiatric treatment: lessons from the Waterlow case' (2012) 20(4) *Australiasian Psychology* 283, 284.
[75] Christopher Ryan, Sascha Callaghan and Matthew Large, 'Better laws for coercive psychiatric treatment: lessons from the Waterlow case' (2012) 20(4) *Australiasian Psychology* 283, 283.
[76] Australian Bureau of Statistics, *Aboriginal and torres strait islander people with a mental health condition* (28 April 2016) <https://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/4714.0~2014-15~Feature%20Article~Aboriginal%20and%20Torres%20Strait%20Islander%20people%20with%20a%20mental%20health%20condition%20(Feature%20Article)~10>.
[77] NSW Ministry of Health, *NSW Aboriginal Mental Health and Wellbeing Strategy 2020-2025,* <https://www.health.nsw.gov.au/mentalhealth/resources/Publications/aborig-mh-wellbeing-2020-2025.pdf>.

Mental health issues continue to affect women at an alarming rate. Mental health disorders are the leading disability amongst women for non-fatal illnesses in Australia. Of Australian women, 43% or 3.5 million have experienced mental illness,[78] which can be attributed to several causes.

Experiences of domestic violence and sexual assault are prevalent within NSW, and disproportionately target women, whereby 1 in 6 women experience physical or sexual violence by a partner from the age of 15.[79] There is a need for, not only the promotion of psychiatric services for women experiencing domestic violence and sexual assault, but an emphasis on continued supply of specialist services that aim to resolve the mental health issues that arise for women who undergo traumatic events.

Additionally, women are often primary caregivers, especially women in prison. The strain experienced from being incarcerated or institutionalised continues to suppress women's ability to properly care for their family. This greatly affects women and their future well-being, together with the well-being and quality of life of their families. Children who are not properly cared for experience significant attachment issues and are more likely to experience mental health issues themselves. Consequently, this leads not only to individual complications, but also societal consequences such as criminality and increased government expenditure.[80]

### 3.1.4 Youth

Mental health issues heavily impact the youth of Australia. The Victorian Government revealed that 75% "of severe mental health problems emerge before the age of 25",[81] indicating the importance of intervening and supporting young people living with mental health problems to avoid future or further developing issues.

Moreover, in 2020, 381 young Australians between 15 to 24 committed suicide.[82] Depression and anxiety is common both for young people and adults, as well as psychosis, serious mood and/or

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[78] Victoria University, *Investigating in Women's Mental Health* (1 April 2016) <https://www.vu.edu.au/mitchell-institute/policy-solutions/investing-in-women-s-mental-health>.
[79] Australian Institute of Health and Welfare, *Family, domestic and sexual violence* (7 July 2022) <https://www.aihw.gov.au/reports/australias-welfare/family-domestic-and-sexual-violence>.
[80] Australian Government Department of Health and Ageing, *Child Abuse, Neglect and Mental Health* (2010) <https://ihcsupportagency.org.au/wp-content/uploads/2019/05/Child-Abuse-and-Mental-Health.pdf>.
[81] Department of Health (Vic), *Mental illness in children, adolescents and young people* (29 May 2015) <https://www.health.vic.gov.au/mental-health-services/mental-illness-in-children-adolescents-and-young-people>.
[82] Australian Institute of Health and Welfare, *Suicide & self-harm monitoring* (7 July 2022) <https://www.aihw.gov.au/suicide-self-harm-monitoring/data/populations-age-groups/intentional-self-harm-hospitalisations-among-young>.

eating disorders.[83] Access to treatment for mental health issues in Australia is not a simple path to navigate and this issue must urgently be addressed. Easily accessible services in terms of localising, cost and transport are essential to address the mental health among youth. Other barriers to services should also be addressed, such as potential stigmatisation and language barriers.

New forms of technological engagement represent opportunities to address mental health issues, particularly for young people. Concepts like *Project Synergy* speculate that within 5 years every Australian teenager considering suicide may be able to access high quality, personalised care, facilitated by personal devices.[84] These initiatives connect to youth through social media platforms to promote mental wellness, body image and help with mental illness support.

### 3.1.5 People with disabilities

Adults with disabilities experience five times as much mental distress as adults not living with disabilities.[85] This shows how vulnerable some people of our population are, highlighting the intersectional and complex needs of the population in terms of support services. During the COVID-19 pandemic especially, isolation, disconnect, disrupted routines, and diminished health services have greatly impacted the lives and mental well-being of people with and without disabilities.[86] Additionally, mental distress is associated with "poor health behaviors, increased use of health services, mental disorders, chronic disease, and limitations in daily life",[87] all of which would require further state or territory assistance.

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[83] Department of Health (Vic), *Mental illness in children, adolescents and young people* (29 May 2015) <https://www.health.vic.gov.au/mental-health-services/mental-illness-in-children-adolescents-and-young-people>.
[84] TED x Sydney, *A new tech Platform shines a light in dark moments for Australia's youth* (n.d.) <https://tedxsydney.com/idea/a-new-tech-platform-shines-a-light-in-dark-moments-for-australias-youth/>.
[85] Centres for Disease Control and Prevention, *The Mental Health of People with Disabilities* (30 November 2020) <https://www.cdc.gov/ncbddd/disabilityandhealth/features/mental-health-for-all.html#:~:text=A%20recent%20study%20found%20that,distress%20than%20those%20without%20disabilities.&text=In%202018%2C%20an%20estimated%2017.4,in%20the%20past%2030%20days>.
[86] Centres for Disease Control and Prevention, *The Mental Health of People with Disabilities* (30 November 2020) <https://www.cdc.gov/ncbddd/disabilityandhealth/features/mental-health-for-all.html#:~:text=A%20recent%20study%20found%20that,distress%20than%20those%20without%20disabilities.&text=In%202018%2C%20an%20estimated%2017.4,in%20the%20past%2030%20days>.
[87] Centres for Disease Control and Prevention, *The Mental Health of People with Disabilities* (30 November 2020) <https://www.cdc.gov/ncbddd/disabilityandhealth/features/mental-health-for-all.html#:~:text=A%20recent%20study%20found%20that,distress%20than%20those%20without%20disabilities.&text=In%202018%2C%20an%20estimated%2017.4,in%20the%20past%2030%20days>.

## 3.2 Impacts of COVID-19 on Mental Health

According to Hewson. Shepherd, Hard and Shaw (2020):

> ‘‘Prisoners are a vulnerable group, with multiple complex health needs and worse health outcomes relative to the general population worldwide.1 To date, little focus has been given to the effects of the COVID-19 pandemic on the mental health of prisoners; an area of concern given their high rates of pre-existing mental disorders, suicide, and self-harm, and the links between poor mental health, suicide, and self-harm, and reoffending behaviour.”[88]

The financial, psychological and associated physical health impacts of lockdowns and COVID-19 have exacerbated existing rates of mental illness in the population, making it a particularly pertinent issue. There has been a lack of detailed and publicly available information on the Covid-19 measures implemented in prisons and the associated mental health outcomes. Prisons and detention centres are managed by State and Territory Governments, resulting in varied measures being implemented. [89] The pandemic and following lockdowns have been stressful for everyone, and continues to impact people’s mental health and well-being. Issues relating to poor mental health include sleeping problems, alcohol and substance use, worsening of chronic conditions and reduced capacity to perform well professionally.[90] People with mental health issues, substance use disorders, or who are part of racial minorities face disparities in social and structural determinants of health, with these groups also more likely to be incarcerated.[91]

During the Covid-19 pandemic and the lockdowns implemented in prisons, isolation due to increased solitary confinement, lack of prison visits and reduced access to mental health services likely contributed to negative impacts on the mental health of prisoners.[92] While the worst of the COVID-19 outbreak has passed, people continue to experience mental health problems and are now facing distress relating to the economic recession. Increased sharing of information and

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[88] https://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366(20)30241-8/fulltext

[89] https://pursuit.unimelb.edu.au/articles/people-in-prison-still-in-covid-19-lockdown

[90] Nirmita Panchal, Rabah Kamal, Cynthia Cox and Rachel Garfield, ‘The Implications of COVID-19 for Mental Health and Substance Use’ (2021) *KFF.*

[91] Lemasters, K., McCauley, E., Nowotny, K. *et al.* COVID-19 cases and testing in 53 prison systems. *Health Justice* 8, 24 (2020). https://doi.org/10.1186/s40352-020-00125-3

[92] https://bmjopen.bmj.com/content/11/5/e046547

collaboration between justice, health and research sectors would allow for more effective policy development and decision making.[93]

## 3.3 Staff Shortages

The shortage and unavailability of mental health staff indicate the lack of appropriate support available for people with mental health issues. Community based mental health services are stating that they need more skilled staff to meet growing demand with the estimate of more than 150,000 people in Australia missing out on support. It is said that Australia needs to double the number of psychiatrists, psychologists and mental health nurses to meet the increased pressure from the pandemic on the already stressed mental health system. Additionally, Australia is calling on other countries' workforces to fill the gaps.[94] Staff shortage significantly impacts the care available to people who require it. However, unemployment in Australia is on the rise again and increased to 3.5% in August 2022.[95] As of March 2021, 1.17 million people over 16 years of age received JobSeeker payments. The demand for mental health workers is high. With many people in Australia desperately trying to find work to afford a living, this area could be significantly improved.

## 3.4 Suicide and its Impacts

Approximately 65,000 Australians attempt suicide every year.[96] It is devastating for families, friends and communities. Suicide is particularly prevalent among people aged 15 to 44, among Aboriginal Australians and Torres Strait Islander peoples, in the LGBTIQ+ community and rural populations.[97]

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[93] https://pursuit.unimelb.edu.au/articles/people-in-prison-still-in-covid-19-lockdown

[94] Rachel Clun, 'Australia must import mental health workers to double workforce to fix crisis', *The Sydney Morning Herald* (online, 21 October 2021) <https://www.smh.com.au/politics/federal/australia-must-import-mental-health-workers-to-double-workforce-to-fix-crisis-20211020-p5911l9.html>.

[95] Australian Bureau of Statistics, *Labour Force, Australia* (15 September 2022) <https://www.abs.gov.au/statistics/labour/employment-and-unemployment/labour-force-australia/latest-release>.

[96] Black Dog Institute, *Facts about Suicide in Australia* (2022) <https://www.blackdoginstitute.org.au/resources-support/suicide-self-harm/facts-about-suicide-in-australia/>

[97] Lifeline, *Data and statistics* (2022) <https://www.lifeline.org.au/resources/data-and-statistics/>.

In 2020, over 3000 Australians lost their lives to suicide, making suicide the fifteenth leading cause of death.[98] In NSW 2020, 897 people died by suicide, making it the state with the highest number that year. More than three quarters were male and over half were between the ages of 25 to 54, mirroring similar risk factors of people in prison.[99] This highlights the importance of providing mental health support and services to detainees. Furthermore, the economic impact to the Australian community is conservatively estimated to be $17.5 billion per year.[100] Risk factors of suicide include stressful life events, trauma, mental illness, physical illness and substance abuse. Suicide does not only affect the person who goes through with it or attempts it, but also the family and friends who often have to live with grief, guilt, confusion and distress.[101]

Groups particularly at risk include Aboriginal and Torres Strait Islander people, with suicide rates in 2020 at 27.9 deaths per 100,000.[102] The Stolen Generation and other oppressive colonial experiences towards Indigenous people in Australia has had an enduring effect on the mental health of Aboriginal and Torres Strait Islander people to this day.

Transgender people in Australia also experience significant rates of mental health issues and suicide. A study of 928 participants showed a lifetime diagnosis of depression was warranted for 73% with 63% having participated in self harm and 43% having previously attempted suicide.[103] Providing explicit training regarding specialised care and maintaining a register of 'trans-friendly' doctors may help individuals to feel safer when accessing psychological care.

Reducing avoidable readmissions supports better health outcomes, improves safety, and leads to greater efficacy in the Australian healthcare system.[104] *Towards Zero Suicides* is a $143.4 million

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[98] Australian Bureau of Statistics, *Causes of Death, Australia* (29 September 2021) <https://www.abs.gov.au/statistics/health/causes-death/causes-death-australia/latest-release#intentional-self-harm-deaths-suicide-in-australia>.
[99] NSW Ministry of Health, *NSW Suicide Monitoring System,* Report No 6 (February 2021) <https://www.health.nsw.gov.au/mentalhealth/resources/Publications/sums-report-feb-2021.pdf>.
[100] Parliament of Australia, *Chapter 2 Costs of Suicide* (24 June 2010) <https://www.aph.gov.au/parliamentary_business/committees/senate/community_affairs/completed_inquiries/2008-10/suicide/report/c02>.
[101] Healthy Place, Effects of Suicide on Family Members, Loved Ones (16 January 2022) <https://www.healthyplace.com/suicide/effects-of-suicide-on-family-members-loved-ones>.
[102] Australian Bureau of Statistics, *Aboriginal and torres strait islander people with a mental health condition* (28 April 2016) <https://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/4714.0~2014-15~Feature%20Article~Aboriginal%20and%20Torres%20Strait%20Islander%20people%20with%20a%20mental%20health%20condition%20(Feature%20Article)~10>.
[103] University of Melbourne, 'Why have nearly half of transgender Australians attempted suicide?', *Pursuit* (online, 23 March 2021) <https://pursuit.unimelb.edu.au/articles/why-have-nearly-half-of-transgender-australians-attempted-suicide>.
[104] Australian Commission of Safety and Quality in Health Care, *Avoidable hospital readmissions* (July 2022) <https://www.safetyandquality.gov.au/our-work/indicators/avoidable-hospital-readmissions>.

initiative to address priorities of the Strategic Framework for Suicide Prevention and reduce readmission rates.[105] The aim is to reduce the suicide rate by 20% by 2023, investing $87 million in new suicide prevention over 3 years. Importantly, the National Mental Health and Suicide Prevention agreement sets out the Australian Government's commitment to support mental health and suicide prevention for all Australians.[106] Justice Action sees value in these initiatives, but recognises that issues may arise regarding the efficacy of implementing such strategies.

## 3.5 Current Mental Health Funding Model

In Australia, the majority of mental health funding derives from state or territory governments. Of the $9 billion of mental health spendings in 2015-16, $5.4 billion came from state or territory governments, $3.1 billion came from the Australian Government and $466 million from private health insurance funds.[107] This equates to approximately $373 per person. Veterans' mental health is funded through the Department of Veterans Affairs.[108] However, costs have presumably risen since these numbers were announced. Australia uses the Government funded Medicare system for physical and mental health services.

The NSW budget for mental health services in 2022-2023 is $2.9 billion. Of that, $73.3 million will be put towards building more and better mental health facilities.[109] The NSW Government has allocated $130 million to help people whose mental health is affected by the Covid-19 pandemic, this includes the provision for more appointments for psychology, psychiatry and other allied health services. It also goes to Headspace, suicide prevention training and community groups. In addition, it will commit $35 million over two years to expand the mental health clinical workforce.[110]

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[105] NSW Health, *About Towards Zero Suicides* (25 October 2021) <https://www.health.nsw.gov.au/towardszerosuicides/Pages/about.aspx>.
[106] Federal Financial Relations, *National Mental Health and Suicide Prevention Agreement* (May 2022) <https://federalfinancialrelations.gov.au/sites/federalfinancialrelations.gov.au/files/2022-05/nmh_suicide_prevention_agreement.pdf>.
[107] Parliament of Australia, *Mental health in Australia: a quick guide* (14 February 2019) <https://www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library/pubs/rp/rp1819/Quick_Guides/MentalHealth#:~:text=Spending%20on%20mental%20health%20services&text=Of%20the%20%249.0%20billion%2C%20%245.4,by%20private%20health%20insurance%20funds>.
[108] Parliament of Australia, *Mental health in Australia: a quick guide* (14 February 2019) <https://www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library/pubs/rp/rp1819/Quick_Guides/MentalHealth#:~:text=Spending%20on%20mental%20health%20services&text=Of%20the%20%249.0%20billion%2C%20%245.4,by%20private%20health%20insurance%20funds>.
[109] https://www.health.nsw.gov.au/mentalhealth/Pages/budget.aspx

[110] https://www.health.nsw.gov.au/mentalhealth/Pages/funding.aspx#:~:text=The%20NSW%20Government%20is%20putting,disorders%20and%20self%2Dharm%20presentations

### 3.5.1 Australian Government Budget and Projects

The Australian Government is investing $391.7 million to help facilitate accessible and effective mental health treatment programs as part of their 'Mental Health and Suicide Prevention Plan - Stage 2' scheme.[111] The Australian Government is also said to commit $15.9 million to ensure Australian youth can access critical mental health services. A range of funding to help young Australians is also underway. [112]

The 2022-23 Budget includes a $13.5 million initiative which will extend to operate over the next 4 years to expand State-wide Community and Court Liaison service to an additional 36 local courts.[113] In essence, this initiative will provide people with serious mental health issues, necessary treatment and care from the Local Health District Mental Health Services as an alternative to custody.[114]

The Australian Government is also investing $8 million into seven collaborative research projects. The Hon Emma McBride has stated that these projects are designed to "deliver research and improve health and wellbeing outcomes in our communities".[115] In essence, these projects have developed a new model of care for individuals living in remote locations, and allow for individuals to be connected with the best mental health care that is both suitable and caters to their distinctive and varying mental health needs.[116] Other projects are also under way to respond to, and address, youth health concerns. For instance, to address the rising rates of youth suicide, aftercare services have been evaluated.[117]

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[111] Australian Government Department of Health, *Prioritising Mental Health and Suicide Prevention - Treatment (Pillar 3) Budget 2022-23* <https://www.health.gov.au/sites/default/files/documents/2022/03/budget-2022-23-mental-health-treatment-pillar-3.pdf>.

[112] Australian Government Department of Health, *Prioritising Mental Health and Suicide Prevention - Treatment (Pillar 3) Budget 2022-23* <https://www.health.gov.au/sites/default/files/documents/2022/03/budget-2022-23-mental-health-treatment-pillar-3.pdf>.

[113] NSW Council of Social Service, *NSW Budget 2022-23 Analysis: Mental Health* <https://www.ncoss.org.au/nsw-budget-2022-2023-analysis-mental-health/>.

[114]NSW Council of Social Service, *NSW Budget 2022-23 Analysis: Mental Health* <https://www.ncoss.org.au/nsw-budget-2022-2023-analysis-mental-health/>.

[115] Ministers of Department of Health and Aged Care, *$8 million for health and wellbeing research partnerships* (December, 2022) <https://www.health.gov.au/ministers/the-hon-emma-mcbride-mp/media/8-million-for-health-and-wellbeing-research-partnerships>.

[116] Ministers of Department of Health and Aged Care, *$8 million for health and wellbeing research partnerships* (December, 2022) <https://www.health.gov.au/ministers/the-hon-emma-mcbride-mp/media/8-million-for-health-and-wellbeing-research-partnerships>.

[117] Ministers of Department of Health and Aged Care, *$8 million for health and wellbeing research partnerships* (December, 2022) <https://www.health.gov.au/ministers/the-hon-emma-mcbride-mp/media/8-million-for-health-and-wellbeing-research-partnerships>.

### 3.5.2 Medicare-Subsidised Sessions

Medicare is originally intended to be a public health scheme to allow access to health care for all Australians. Unfortunately, a large proportion of the population is excluded from this benefit. For example, prisoners, who instead access health care through state or territory health services, which oftentimes is not appropriate and can lead to significant complications, including death. Justice Action are currently writing a paper about this which will be released later this year. *Medicare access for prisoners* explains the current issue of prisoners being excluded from Medicare, what this means and what can be done.[118] For the community, Medicare allows eligible patients free of charge or low-cost physical health services through the Medicare Benefits Schedule. Mental health care is provided through the *Better Access initiative.*[119]

Under the *Better Access initiative*, Australians can access up to 20 individual mental health sessions and ten group sessions. The patient is required to obtain a mental health care plan to claim $84 (registered psychologists) or $124 (clinical psychologists) per appointment.[120] However, the Australian Psychologist Society's Schedule of Recommended Fees suggests $267 for a 46–60-minute consultation.[121] Rates charged are often even higher in inner metropolitan areas.

This equates to a gap fee of $143-183 per hourly session, placing psychological intervention financially out of reach for many Australians. This is particularly true of vulnerable Indigenous Australians, youth, low-socioeconomic and linguistically diverse groups who are most likely to require assistance. Additionally, bulk billing psychologists are incredibly rare and where they exist, they are often overbooked and closed to new clients. Medicare funded mental health services should be extended and advanced to expand accessibility for the whole population.

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[118] Justice Action, *Medicare access for prisoners* (2022) Draft paper

[119] Australian Government Services Australia, *Better Access Initiative - supporting mental health care* (7 Jul 2022) <https://www.servicesaustralia.gov.au/better-access-initiative-supporting-mental-health-care?context=20#a1>.

[120] Australian Government Services Australia, *Better Access Initiative - supporting mental health care* (7 Jul 2022) <https://www.servicesaustralia.gov.au/better-access-initiative-supporting-mental-health-care?context=20#a1>.

[121] Australian Psychological Society, 'Psychologists' fees in 2021-22' (2021) 43(3) *InPsych* <https://psychology.org.au/for-members/publications/inpsych/2021/august-special-issue-3/psychologists-fees-in-2021-22>.

# 4. THE VICTORIAN ROYAL COMMISSION

The Royal Commission into Victoria's Mental Health System delivered its final report in February 2021.[122] The Commission included 65 recommendations in addition to the nine recommendations of the Interim Report. The final report set a 10-year vision for a balanced, flexible, responsive mental health and wellbeing system. The subsequent *Mental Health Act,* oriented toward wellbeing and recovery as directed by the Commission, stipulated that the Commission and its subsidiary boards include leadership of relevant professionals such as nurses, peer workers, social workers and particularly those with lived experience of the mental health care system. Critically, the hierarchy of treatment plan decision-making should not be dominated by the current establishment but rather embrace a multidisciplinary and consumer-led approach.

The release of the final report represents an opportunity to build a strong foundation for mental health care reform nationwide. There is a critical need for reform in states such as New South Wales where Forensic Community Treatment Orders (FCTOs) make up just one of the many failures of mental health care in the community and our prison systems. FCTOs:

> "...authorise the forcible medication of individuals with mental illness within prison. These orders can apply to both prisoners who develop a mental illness while in prison and to forensic patients who are detained in a prison. FCTOs raise a number of ethical issues, namely the breach of one's entitlement to equivalent treatment, the denial of the right to autonomy and bodily integrity, and the failure to properly administer care for vulnerable individuals within highly restrictive prison environments. Despite this knowledge, FTCOs continue to be used in New South Wales ('NSW') and is the only jurisdiction in Australia to do so."[123]

The FCTO also authorises compulsory care for a person not in a mental health facility. Most people subject to this are detained in a correctional centre and are provided treatment under the FCTO and will continue to operate after the patient/inmate has been released. The Commission presents a significant opportunity for ensuring future protection of mental health consumers' fundamental rights and dignity. In response to the severe systemic failings, the 2020-21 budget provided $868.8 million in mental health funding and $578 million for implementing their recommendations to provide the people of Victoria access to effective and humane mental healthcare.[124] FCTOs raise

[122] Royal Commission into Victoria's Mental Health System, *Final report*, Volume 4 [The fundamentals for enduring reform] (2021) 375.
[123] Justice Action, *Unethical Treatment of Mental Health in Prisons: Forensic Community Treatment Orders* (2021).
[124] Justice Action, *Unethical Treatment of Mental Health in Prisons: Forensic Community Treatment Orders* (2021).

broad social and legal issues, which has been explored by the Royal Commission previously. Suitable alternatives to improve the health and well-being of citizens are fundamental.

## 4.1 Victorian Royal Commission Analysis

The Royal Commission into Victoria's Mental Health System identified a 'broken' system.[125] The Volumes and Final Report from the Commission found that the over reliance on seclusion, restraint and involuntary treatment is no longer fit for purpose. There is a need for a paradigm shift to re-align practices with a recovery orientated and cooperative model of mental health treatment.

The Final Report's recommendations 53-56 focus on mental health consumers rights and the elimination of restrictive practices such as compulsory treatment orders, seclusion, and restraint.[126] These recommendations are essential to a contemporary and more compassionate mental health system that should be responsive to consumers rights and needs. These Recommendations respect, empower and centre around consumers. It recognises the individuality of each consumer case and the consumer's right to dignified treatment and autonomy of self.

Designed to uphold mental health consumer's human rights and participation, a prime function of these reforms will be the steady reduction and eventual elimination of all restrictive interventions or practices.[127] There is a move towards more collaborative and real person-centred approaches oriented to personal recovery that will promote alternative interventions to better suit consumer needs and choices. The Report claims that real changes will be put in place to shift practices and culture to ensure consumers' human rights are upheld. The biomedical model, which is oriented to what practitioners can do to consumers, over consumers often stated needs, also is limited to deficits focus, and what can be fixed by medication. Based on this limited and flawed base, it lacks multidisciplinary breadth that exists in a psycho-social-medical model. The consequence is that the health system becomes only focussed on restraining any short-term risk (for which it saps most public funding) rather than being responsible for providing long-term care with an emphasis on consumer rights and recovery.

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[125] Justice Action, *Royal Commission Into Victoria's Mental Health System 2021 - Analysis: A Blueprint For Consumer Control* (2021) 4.
[126] Royal Commission into Victoria's Mental Health System, *Final report*, Volume 4 [The fundamentals for enduring reform] (2021).
[127] Justice Action, *Royal Commission Into Victoria's Mental Health System 2021 - Analysis: A Blueprint For Consumer Control* (2021) 6.

Contemporary mental health care requires the concept of personal recovery to be embedded in every level of our mental health system. Consumers are integral to this reform, engaged in its rebirth and forging new pathways of support, acting as stakeholders at every level. Australians have seen previous reforms fail to live up to expectations, and efforts have been stymied by lack of funding and political engagement. Australians want both sides to commit to funding and implementation.[128]

### 4.1.1 Recommendation 53: Quality and safety of mental health services

This section focuses on the quality and safety of mental health and wellbeing services. The VRC reports on the failings of the current mental health system with the preference and excessive use of the most risk-averse treatment options such as seclusion, restraints and forced medication. The VRC highlights the importance of a governing body accountable for overseeing, monitoring, inquiring, and reporting on system-wide quality and safety standards.[129] It is recommended that facilitation and oversight of mental health services using the Mental Health and Wellbeing Tribunal's resources to monitor and report on system-wide quality and safety.[130] However, the Department of Health (VIC) fails to establish a strong shift toward cultural change and address the gaps in clinical mental healthcare practices by reinforcing the hierarchy ideology present in the current failing system.

### 4.1.2 Recommendation 54: Elimination of practices using seclusion and restraint

The VRC advocates for the elimination of practices using seclusion and restraint to treat mental health consumers.[131] The VRC emphasises the profound, dehumanising and often long-term effects from the trauma and re-traumatisation of consumers subject to restrictive practices in the mental health system. The VRC urges that healthcare providers consider the harm caused to their patient before engaging in abusive practices of seclusion and restraint. The Department of Health (VIC) has not acknowledged the need for legislative change for the immediate reduction in the use of seclusion and restraint practices. A cultural shift away from violent and inappropriate administering of restrictive practices must ensure healthcare providers are held accountable to the management of any resulting harm or trauma imposed on mental health consumers.

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[128] Rachel Green, 'Sane's response to the Royal Commission into Victoria's Mental Health System', *SANE* (11 March 2021) <https://www.sane.org/latest-news/sane-response-victorian-mental-health-royal-commission>.
[129] Royal Commission into Victoria's Mental Health System, *Final Report*, Volume 1 (2021) 89.
[130] Royal Commission into Victoria's Mental Health System, *Final Report*, Summary Plain Languages (2021) 34.
[131] Royal Commission into Victoria's Mental Health System, *Final Report*, Volume 1 (2021) 315.

### 4.1.3 Recommendation 55: Excessive use of compulsory treatment orders

The VRC reports on the excessive use of compulsory treatment orders (CTOs). Compulsory treatment is where a person with mental illness is subject to forced treatment in accordance with a CTO,[132] under the *Mental Health Act 2014* (VIC). It is recommended by the Commission that 'when commissioning mental health and wellbeing services, set expectations they will provide non-coercive options'[133] and the Victorian Government 'set targets to reduce the use and duration of compulsory treatment on a year-by-year basis.'[134]

Another paper published by the Victorian Government highlights the lack of a well-structured and systematic approach in the Department of Health's (VIC) proposed pathway to meet the Royal Commission's vision of a more balanced mental health and wellbeing system.[135] While the Victorian Government has agreed to a 10-year timeframe to eliminate restrictive practices,[136] there is no presentation of a formal framework, strict guideline or information on services and interventions to support this proposal. The impact of this lack of critical detail can be seen explicitly in the inadequacies of the Department of Health's (VIC) proposed response to the VRCs concerns of the administration of CTOs. Mechanisms for proper accountability will drive reform including the regular and uniform collection of CTO data for public recording.

### 4.1.4 Recommendation 56: Least restrictive options and access to legal representation

The VRC recommendation ensures the promotion and protection of consumer rights through opting for the least restrictive options and increased access to legal representation, contained within the mental health system reformation. The VRC proposes a legislative provision for the new *Mental Health and Wellbeing Act* enabling an opt-out model of access to non-legal advocacy services for consumers subject to, or at risk of compulsory treatment. Mental health laws must be aligned with decision-making principles and practices, and to be consumer centred rather than focusing on the clinical paradigm.

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[132] Justice Action, *Community Treatment Orders*, (2014) <https://justiceaction.org.au/community-treatment-orders/>.
[133] Royal Commission into Victoria's Mental Health System, *Final report*, Volume 5 (2021) 91.
[134] Royal Commission into Victoria's Mental Health System, *Final report*, Volume 4 [The fundamentals for enduring reform] (2021) 91.
[135] Department of Health (Vic), *Mental Health and Wellbeing Act,* Update and engagement paper (June 2021) 24-27 <https://s3.ap-southeast-2.amazonaws.com/hdp.au.prod.app.vic-engage.files/7716/2371/1631/Update_and_Engagement_paper.pdf>.
[136] Royal Commission into Victoria's Mental Health System, *Final Report*, Volume 1 (2021) 90.

The paper by the Department of Health (VIC) further demonstrates major failures in the Department's proposed uptake of the VRC's recommendations.[137] While there are laudable efforts to ensure the increased autonomy and greater involvement of mental health consumers in decision making regarding medical treatment, the proposal is forsaken by a critical lack of detail and undermined by the absence of appropriate funding for independent advisory organisations such as Independent Mental Health Advocacy.

# 5. REFORMING THE MENTAL HEALTH SYSTEM: CONSUMER RIGHTS

The Victorian Royal Commission Report found that focusing on consumer rights is pivotal in reforming the Victorian mental health system. Recommendation 56 S*upporting consumers to exercise their rights* ensures the promotion and protection of consumer rights through opting for the least restrictive options and increased access to legal representation, contained within the mental health system reformation.

To ensure consumer rights are respected within a non-coercive, person-centred and recovery-oriented approach, the Commission recommended that an independent statutory authority be set up 'hold the government to account for the overall performance and quality and safety of the mental health and wellbeing system, including public health and prevention'.[138] Within a newly legislated *Mental Health and Wellbeing Act,* a Mental Health and Wellbeing Commission is the recommended body to fulfil this purpose and function. The Commission will have a range of duties in promoting good mental health and wellbeing, including ensuring consumer involvement in the development and evaluation of such services. Consumer representation on the Safer Care Victoria Council is one of the ways that consumers have the opportunity to be integral to the regeneration of contemporary mental health systems of health and wellbeing.

Within these new and legislated structures, consumer representatives will shape the new procedures of support, and servicing will be commissioned in sustainable ways to respond to the diverse preferences and expectations of people living with mental illness or psychological distress. With

[137] Department of Health (Vic), *Mental Health and Wellbeing Act,* Update and engagement paper (June 2021) 13-22 <https://s3.ap-southeast-2.amazonaws.com/hdp.au.prod.app.vic-engage.files/7716/2371/1631/Update_and_Engagement_paper.pdf>.
[138] Royal Commission into Victoria's Mental Health System, *Final report,* Volume 4 [The fundamentals for enduring reform] (2021) 78.

consumers engaged to co-create a novel architecture of reforms by participating at all levels, including the commissioning of contemporary, adaptable services and enabling consumer leadership through representation in Safer Care Victoria, the oversight and management of reforms is to be phased out over years. Designed to uphold mental health consumer human rights and participation, a prime function of these reforms will be the steady reduction and eventual elimination of all restrictive interventions or practices, including seclusion, physical and chemical restraint, and CTOs.

The rights of the individual consumer is being emphasised in relation to promoting consumer advocacy. The obligation and presumption for service providers is to support consumer's empowerment in making their own decisions regarding mental health and wellbeing management via respecting consumer choice and through non-coercive practices. This includes more collaborative and real person centred approaches oriented to personal recovery that will promote alternative interventions and support to better suit consumer needs and choices. New legislative basis is expected to have consumer input that will replace the current *Mental Health Act,* and be in line with mental health and wellbeing rather than a focus on illness.

The expectation is that by moving towards mental health and wellbeing, and reorienting services to support consumer empowerment and adopting non-restrictive practices that emphasise trauma-informed practices and de-escalation methods, an individual's 'dignity of risk' will be better respected. In doing so, it is intended that including consumer representation in the oversight of current and new ways of servicing, plus embedding consumer report responses in service provider evaluations, will likely substantially reduce compulsory treatment. This will gradually eliminate restrictive practices such as seclusion and physical restraint over Victoria's next 10 year time frame.

## 5.1 NSW: Protected Consumer Rights

In NSW, the *Mental Health Act 2007* (NSW) seeks to protect people with mental illnesses or disorders and ensure they have access to appropriate care while also defending their legal rights.[139] The legislation provided entitlements to all individuals brought involuntarily into mental health facilities, regardless of their background or language barriers. Entitlements to mental health encompasses the right to be protected against possible displacements, abuse, as well as the right to information in regards to magistrate inquiries, medication and discharge planning. Attempts to

[139] NSW Health, *Mental Health Act 2007 Information Sheet for Consumers and Carers* (2007) <https://www.slhd.nsw.gov.au/mentalhealth/pdf/MHA_NSW_Health_Mental_Health_Act_2007_Factsheet.pdf>.

improve mental health issues can consider this document as a legal platform for the development of future initiatives and their targets.

The Federal Government's *Mental Health Statement of Rights and Responsibilities* also details the rights of mental health patients and the government's subsequent responsibilities: Australian governments have a key duty to maintain and develop high quality mental health systems.[140] Mental health consumers have the right to access assessment, support, treatment and other services to assist in their care. Mental health consumers are entitled to participate in all decisions that affect them and need to benefit from special safeguards if involuntary destination is imposed. The right to privacy and confidentiality must also be respected.

## 5.2 International Consumer Rights

Across the world, there has been a critical recognition of alternative methods to coercive methods. Driven by human rights, several organisations and bodies are calling for significant mental health reforms to minimise non-coercive practices, including:

- Victorian Royal Commission
- WHO Global Guidance[141]
- National Disability Royal Commission[142]
- Griffith Review 72: States of Mind[143]

Current and recent initiatives relating to mental health represent avenues for future progress. These programs provide platforms to make inroads into mental health issues, whilst they potentially represent shortcomings from which future improvements can be made.

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[140] Standing council on Health and National Mental Health Startegy, *Mental Health Statement of Rights and Responsibilities* (2012) <https://www.aihw.gov.au/getmedia/83e6a041-d020-4182-8eab-fadcc676d0a1/Mental-health-statement-of-rights-and-responsibilities-2012.Standing council on Health and National Mental Health Startegy>.
[141] Mental Health and Substance Use, *Guidance on community mental health services: Promoting person-centred and rights-based approaches*, WHO (2021).
[142] Christopher Ryan, Sascha Callaghan and Matthew Large, 'Better laws for coercive psychiatric treatment: Lessons from the Waterlow case', (2012) 20(4) *Australasian Psychiatry* 283-286 <https://doi.org/10.1177/103985621244966>.
[143] Griffith Review, *States of Mind*, (2021) Edition 72 <https://www.griffithreview.com/editions/states-of-mind/>.

### 5.2.1 WHO Global Guidance

The World Health Organisation (WHO) presents specific recommendations and action steps towards developing human rights-centred practices in the mental health sector. The WHO recognises coercive practices as denying an individual's right to legal capacity through practices such as involuntary treatment and the administering of antipsychotic medication, electroconvulsive therapy and psychosurgery without informed consent. The heavy toll on the mental health of people subjected to coercive practices often leads to disempowerment, distress, low self-worth and trauma.[144]

Without the creation of strict legislative requirements, it is possible for human rights abuses to occur when coercive practices are arbitrarily exercised on the basis of risk or dangerousness.[145] In Australia, many people with psychosocial disabilities and mental health conditions are vulnerable to human rights violations through the coercive practice of forced medication. Alongside necessary legislative and policy changes, the WHO has provided several recommendations directed at promoting non-coercive practices in mental health care, including:

- Education of service staff about power imbalances;
- Education of staff about coercive practices and their consequences;
- Systematic training for staff on non-coercive responses in crisis situations;
- Individualised planning with people using the service;
- Modifying the physical and social environment to create a welcoming atmosphere;
- Developing effective means of hearing and responding to complaints;
- Reflection on the role of all stakeholders within the mental health system.[146]

General public understanding and value for societal wellbeing are rapidly changing. So too are public and professional opinions and expectations for reforms in mental health. We see this evidence exemplified in the recent global release of WHO, where the Assistant Director General stated:

> "Around the world, mental health services are striving to provide quality care and support for people with mental health conditions or psychosocial disabilities. But in many countries, people still lack

[144] Mental Health and Substance Use, *Guidance on community mental health services: Promoting person-centred and rights-based approaches*, WHO (2021) 8.
[145] Mental Health and Substance Use, *Guidance on community mental health services: Promoting person-centred and rights-based approaches*, WHO (2021) 8.
[146] Mental Health and Substance Use, *Guidance on community mental health services: Promoting person-centred and rights-based approaches*, WHO (2021) 8.

> access to quality services that respond to their needs and respect their rights and dignity. Even today, people are subject to wide-ranging violations and discrimination in mental health care settings, including the use of coercive practices…
>
> Everyone has a role to play in bringing mental health services in line with international human rights standards – policy makers, service providers, civil society, and people with lived experience of mental health conditions and psychosocial disabilities."[147]

Now, it is our turn to do what we can to focus on evidence-based reforms including the difficulty of balancing practice and legal issues of coercive treatment. Rather than being driven by public figures, we need to look at the statistics and do what we can in driving reform.

# 6. CAMPAIGN ADMINISTRATION

## 6.1 Allies

a. NSW Mental Health Consumer Peer Workforce Committee (CPWC)
    i. Provides support, leadership, advocacy, professional development
b. BEING: Mental Health Consumers
    i. Client advocacy, consultation, trainings, research, organisational development
c. National Mental Health Consumer and Carer Forum
    i. Represents mental health consumers, a platform to speak for individuals suffering from mental health issues

Organisations representing consumers, carers & general health support should be included in a list of people assisting the creation of an inquiry.

New South Wales politicians including the Shadow Minister, the Greens spokesperson and the special committee prepared to examine Mental Health should all be lobbied in pursuit of this inquiry.

NSW Mental Health Consumer Peer Workforce Committee (CPWC) provides support, leadership, advocacy and professional development.

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[147] Mental Health and Substance Use, *Guidance on community mental health services: Promoting person-centred and rights-based approaches*, WHO (2021) VIII.

BEING: Mental Health Consumers are for client advocacy, consultation, training, research and organisational development.

National Mental Health Consumer and Carer Forum represents mental health consumers and provides a platform to speak for individuals suffering from mental health issues.

The South Eastern Sydney Local Health District - Mental Health Service has a variety of committees and councils: Clinical Council, Towards Zero Suicides Governance Committee, Family Focused Recovery Steering Committee, Service Development and Innovation Committee, St. George Clinical Governance Committee, Sutherland Clinical Governance Committee, Eastern Suburbs Clinical Governance Committee.

## 6.2 Politicians

### 6.2.1 NSW Minister for Mental Health

Hon. Rose Jackson is a current Member of the NSW Legislative Council and is Minister for Mental Health, Homelessness, Housing, Water, Youth and the North Coast. According to the ALP website profile: identifies as a feminist, unionist and community activist with a "life-long commitment to social justice, equality and democracy".[148]

### 6.2.2 NSW Shadow Minister for Mental Health

Robyn Preston MP is the Shadow Minister for Mental Health and Medical Research, since May 2023.

Melissa McIntosh is the Shadow Assistant Minister for Mental Health and Suicide Prevention, since June 2022.

### 6.2.3 NSW Greens Spokesperson for Mental Health

Dr Amanda Cohn MLC is the Greens NSW Spokesperson for Health, including Mental Health and Youth. She has previously led initiatives for inclusion and accessibility for people with a disability.

[148] https://www.nswlabor.org.au/rose_jackson.

Cate Faehrmann MLC portfolios include Drug Law Reform & Harm Reduction, with areas of policy interest including mental health.

### 6.2.4 Committee Considering Mental Health

The NSW Legislative Council established Portfolio no. 2- Health (including Mental Health) on 10 May 2023.[149] Contact email is: portfoliocommittee2@parliament.nsw.gov.au

[149] https://www.parliament.nsw.gov.au/committees/listofcommittees/Pages/committee-details.aspx?pk=188#tab-contactus