Submission to the Royal Commission into Victoria's Mental Health System

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1. The Royal Commission must ensure that the experience and expertise of people with a lived experience of mental illness are central to all of its deliberations.

2. The Department of Health and Human Services should fully fund the MHLC to deliver advance statements clinics to support consumers to write effective advance statements.

3. The Mental Health Act should be amended to give advance statements more weight and to place a greater responsibility on treating teams to follow them.

4. Any override of a person's treatment preferences under an advance statement should be required to be reported to the Chief Psychiatrist who should review and monitor the rate of overrides.

5. There should be a central repository for advance statements. The MHT could fulfil this role or perhaps a Mental Health Commission if we had one.

6. Care should be taken to ensure that any changes to access to health information or involvement in treatment decisions respects consumer rights to privacy and self-determination.

7. A system wide commitment is needed to significantly reduce the reliance on compulsory treatment in Victoria. Regular monitoring of the use of compulsory treatment should take place at both a service level and a system wide level.

8. A non-police based first response should be the default approach to people experiencing a mental health episode.

9. Consideration should be given to incorporating the use of advance statements into a first response to mental health crises.

10. An independent review should be conducted any time that a welfare check or section 351 apprehension results in criminal charges.

11. The availability of community based psychological services should be increased significantly.

12. Ongoing training should be provided to the mental health workforce to identify and appropriately respond to family violence situations. All people who disclose family violence should be referred to appropriate support services.

13. A government funded health justice partnership should be developed by the MHLC to deliver specialist outreach legal clinics in all aged mental health services.

14. Alternatives to inpatient admissions including crisis houses and home based services should be identified and considered for implementation in Victoria.

15. Priority should be given to the resourcing of holistic, integrated service delivery models for people with serious mental illness with a focus on skilled and knowledgeable case coordination.

16. Legal services should be considered an essential component of any integrated model of service delivery.

17. The MHLC and Bolton Clarke Homeless Persons Program should receive full, ongoing government funding to continue to support the health and legal needs of vulnerable Victorians experiencing homelessness.

18. There should be an urgent and sustained increase in investment for public and community housing.

19. A review of the effectiveness of rooming house laws should be conducted to consider their effectiveness in preventing unscrupulous operators from continuing to own and run rooming houses.

20. The Victorian government should advocate at a Commonwealth level for an increase in the rate of Newstart and changes to make DSP more accessible for people with serious, ongoing mental illness.

21. An overarching independent commission with responsibility for monitoring, reviewing and driving improvements in mental health service delivery should be introduced in Victoria.

22. Consumers should have a single entrance point to the HCC and MHCC if there care falls between both.

23. The MHCC should be empowered to conduct own motion investigations into any public mental health service.

24. The MHCC should be given greater powers to compel mental health services to participate in the complaints resolution process.

25. There should be an automatic right to legal representation for MHT hearings and the MHT should have a co-ordinating function in arranging legal representation in Victoria.

26. The MHLC should be funded to provide representation for patients at community treatment order hearings and at inpatient treatment order hearings where VLA is unavailable or unable to act.

27. The MHT should conduct a research project into the reasons why patients do not attend their hearings and set a goal to improve attendance rates.

28. The MHT should sit under the Department of Justice and Community Safety rather than the Department of Health and Human Services to support a perception of independence.

29. The use of chemical restraints should be regulated and episodes of chemical restraint should be monitored and reported on.

30. The Department of Health and Human Services should provide annual public reports regarding the use of restrictive interventions at each mental health service in Victoria.

31. The documentation for restrictive interventions should be reviewed to ensure clinician obligations are clear and include a requirement that the necessity for the use of the restrictive intervention (and why no less restrictive option can be used) is documented.

32. There should be a binding mechanism for consumers to refuse consent to future ECT.

33. The alternative ECT consent pathway for adults who lack decision making capacity should be reviewed.

34. Patients should be able to seek a review of an ECT order after their ECT treatment has commenced.

35. Public reporting of mental health data should be comprehensively reviewed with input from mental health consumers and carers to identify data to be reported and ensure it is presented in a way that is meaningful for consumers.

Overview

The Mental Health Legal Centre is a community legal centre based in Melbourne that has been providing legal services for more than 30 years to people who have experienced mental illness. We provide a range of innovative services in the community, in treatment facilities and in prisons. We work in partnership with other agencies to provide integrated services that address the needs of the most complex and vulnerable members of our community.

This submission covers a broad range of topics and is drawn from our experience of working alongside consumers navigating the mental health system and dealing with the other parts of their lives that significantly impact their wellbeing including their housing, income, family relationships and community connections.

We have used the framework of recovery oriented practice to explore the experience of our clients. Recovery-oriented practice provides a useful lens for considering the effectiveness of Victoria's mental health system and for guiding reform and improvements going forward.

We have focussed on three aspects of recovery oriented practice:

- individual choice and control;
- person centred, individualised care; and
- holistic, integrated approaches that recognise a person's individual, non-clinical needs.

We have also addressed oversight of the mental health system including:

- external oversight bodies;
- legislation safeguards; and
- use of data.

The only way in which fundamental system reform can occur is to put consumers at the centre of the system and genuinely partner with them to drive lasting change. This submission identifies a number of ways in which the system is falling short and identifies positive approaches to support people's recovery journeys.

There should be a strong focus on avoiding inpatient treatment (particularly compulsory treatment) through providing appropriate community-based treatment at an early stage of illness and an early stage of episode. Inpatient treatment is expensive to deliver and extremely disruptive for the individual patient. The enormous demand for inpatient beds and lack of capacity within the system is widely recognised. There is certainly a need for further investment in inpatient beds but system-wide improvement will be driven most efficiently by adequately resourcing community mental health services and the whole of life services that support individual wellbeing.

The experience of consumers must be central to the work of the Royal Commission. As Janet Meagher told the Royal Commission on its second day of hearings, they have "the expertise borne from experience" that is needed to genuinely reform our mental health system.

Recommendation 1: The Royal Commission must ensure that the experience and expertise of people with a lived experience of mental illness are central to all of its deliberations.

About the Mental Health Legal Centre

Established in 1989, the MHLC has worked on behalf of consumers of mental health services since inception and that focus remains. MHLC provides critical services to vulnerable Victorians in times of crisis. Through a network of interconnected services the MHLC is able to support diverse groups of clients navigating legal and social problems. The services of the MHLC are broken down into a number of specific areas and these are all separate access points for consumers. MHLC consumers often move between the services and many of the lawyers are able to provide services across a number of areas enabling continuity of service. Our different programs are set out below.

Day Service

Our telephone lines are open from Tuesday to Friday 9am-5pm. Our highly experienced and well trained administrators answer our calls and provide support and information to anyone who calls. As we are a generalist service we are often the last port of call for people who have been endlessly referred on throughout the system. We take the time to speak to people and identify their needs and endeavour to provide warm referrals and realistic information. Our administrators refer clients to our night service or individual MHLC programs where appropriate and can also utilise our social worker. We currently receive over 5000 calls per year. We receive no direct government funding to support our phone service.

Many of the calls we receive relate to requests to provide representation at upcoming Mental Health Tribunal (MHT) hearings. In the past year we have represented 169 clients at the MHT and we unfortunately unable to assist a further 159 people. Representation is provided through our lawyers and a network of over 50 pro bono lawyers who work with us. We train and support all of our pro bono lawyers. Again this service receives no direct government funding.

Night Service

People who call during the day seeking legal advice are referred to our telephone night service (unless the matter is urgent). The night service is staffed by an administrator, an experienced community lawyer and up to 12 pro bono lawyers and law students. The service runs every Tuesday and Thursday evening. We receive calls from people who are inpatients across the state. We operate a 1800 number for people outside the metro area. Again we receive no government funding for this service. From these calls we are also able to provide ongoing case work for a limited number of clients across a number of different

areas of law. One of the areas we seek to assist is minor criminal matters where a person will struggle to represent themselves but will not be eligible for legal aid.

Advance Statements Project

The MHLC has spent over 12 years campaigning for and promoting advance statements which were introduced in the Mental Health Act 2014. We were concerned that the Department of Health and Human Services were not funding practical supports for people to prepare advance statements and sought philanthropic backing to support this critical service. The MHLC ensured that the outputs and outcomes were fully evaluated and continue to provide evidence of the importance of advance statements.

Bolton Clarke Homeless Persons Project

The MHLC has worked with the team of dedicated nurses at Bolton Clarke for the past four years building an outstanding Health Justice Partnership. This fully evaluated project with exceptionally high satisfaction ratings from clients and our partner nurses is an excellent model of integrated service design. With clinics in Frankston and Glenroy working alongside nursing teams funded through the Rough Sleepers Initiative we are able to provide meaningful legal support for people with complex mental health needs and insecure housing. The funding for this project ceases this year and we are respectfully requesting that the government review the data provided and provide ongoing funding for this work. We also suggest that the model could be replicated across the system. This service is an invaluable workforce tool enabling health care providers to focus on their role in providing healthcare knowing that other members of the team are working on non-health issues.

This service also combines an embedded education component which enables clinical staff to easily identify legal issues and make effective referrals.

Inside Access Project

The MHLC provides a unique service to women prisoners at the Dame Phyllis Frost Centre (DPFC). The project continues to evolve to meet the needs of a changing prison population and we have developed educations sessions and clinic-based legal and social work services provide holistic services to women in prison. The team consists of a general lawyer and co-ordinator, a child protection lawyer, a family violence and victims of crime lawyer, a specialist fines lawyer and a social worker. This unique suite of services is possible due to funding from the Department of Corrections, the Attorney General and philanthropic organisations.

At Ravenhall Correctional Centre we also provide a generalist lawyer providing one to one clinics along with education services and a fines services. This work is funded by GEO. This service has been online just over 18 months and has expanded to meet the growing demands within at service.

Over the past 6 years through the leadership of the Board, the MHLC has evolved to provide tailored bespoke services which address the complex needs of our clients. We also support and train our colleagues in the regions enabling access across the state. The MHLC has worked tirelessly to ensure that the needs of vulnerable Victorians are placed at the front of

the services provided. The MHLC also seeks to work in partnerships and in integrated service models to ensure the best outcomes. We have been able to demonstrate outcomes across our projects through our embedded evaluation framework. We have done so with minimal government funding.

We call on this Royal Commission to recognise the work of the MHLC as the only specialist mental health legal centre in the state of Victoria and make recommendations to support the ongoing funding of our fully evaluated and evidence-based programs which are now embedded in integrated service delivery models.

Delivering on recovery-oriented practice

Embedding recovery-oriented practice is a key goal of the *Mental Health Act 2014*.

In the second reading speech for the new Mental Health Act, the Minister for Mental Health set out a number of very worthy intentions for the new legislation. These included the intention to:

- Embed supported decision making in the law;
- Promote recovery oriented practice;
- Minimise the use and duration of compulsory treatment;
- Require compulsory treatment to be provided in the least restrictive and least intrusive manner possible;
- Better facilitate carer and family involvement in treatment and care;
- Increase safeguards to protect patients' rights and dignity; and
- Encourage public sector clinicians and service providers to engage in continuous service improvement and reforms to the mental health service system.

A Framework for Recovery-oriented Practice was developed in 2011 (Department of Health 2011). It states that recovery-oriented practice:

- encourages self-determination and self-management of mental health and wellbeing
- involves tailored, personalised and strengths-based care that is responsive to people's unique strengths, circumstances, needs and preferences
- supports people to define their goals, wishes and aspirations
- involves a holistic approach that addresses a range of factors that impact on people's wellbeing, such as housing, education and employment, and family and social relationships
- supports people's social inclusion, community participation and citizenship.

Three of the key elements of this approach are:

- individual choice and control
- person centred, individualised care
- holistic, integrated approaches that recognise a person's individual, non-clinical needs.

Individual choice and control

Supports that empower individuals to actively participate in their care facilitate better clinical outcomes and give people more choice and control over other aspects of their lives. Supported decision making is recognised by the international community through the Convention for the Rights of Persons with Disabilities as a means for people to exercise their fundamental rights of autonomy and self-determination. Although some advances have been made in this area, people with a lived experience of mental illness still find themselves treated in a paternalistic manner with their views and preferences given less weight than those of the professionals they interact with. Too little recognition is given to the sense of powerlessness felt by consumers on compulsory treatment orders and the way in which this can undermine therapeutic relationships and an individual's recovery.

Skilled and responsive workforce

Delivering a mental health system that maximises individual choice and control requires a skilled and willing workforce. Promoting individual choice is a fundamentally different way of delivering care for a system that has traditionally operated under a clinician led "best interests" model. It is also a challenge to maximise individual choice and control in the only area of health care where people with capacity can be treated without their consent. The mental health workforce needs to have a clear understanding of the power they hold and the role that coercion plays in the system.

The workforce can act as a block to system change. This is sometimes due to unwillingness to change but is also due to the sheer demand of working in an under-resourced system that doesn't allow the time or scope to identify and implement best practice.

The Royal Commission has had a particular focus on stigma in their initial hearings. For many of our clients the area of their lives where they feel the most stigmatised is in their mental health treatment. They feel that their diagnostic labels crowd out any other view of them as people. Normal human emotions to distressing life events or daily frustrations are pathologised and behaviour from years ago is regularly raised again and again in their medical records and MHT reports.

At the MHLC we constantly receive calls from people frustrated that their treating team has not listened to them and believed what they have to say. This is incredibly disempowering and undermines the therapeutic relationship. Our lawyers regularly come across situations where our clients are not believed even though they are correct.

Case study

> The MHLC represented John in a rooming house matter at VCAT. John was awarded $10,000 compensation by the Tribunal. The company that owned the rooming house never paid the compensation despite multiple attempts to get them to do so. This was understandably very frustrating and disappointing for John.

The MHLC also assisted John with an infringements matter. We requested a letter from his mental health service detailing his mental health issues and treatment. The report from his caseworker stated that John had a persistent delusion that he was owed money from a court case despite there being no evidence to support this. Our lawyer responded that this was not a delusion.

Consumer leadership

Strong consumer leadership and partnering with consumers is vital to facilitating workforce cultural change. A well trained peer support workforce that has a central role in the organisational structure of mental health services and is recognised as bringing valuable insights to service delivery can play a key role in changing workforce culture.

Advance statements

Advance statements are the key legislative tool available in Victoria to formally facilitate supported decision making. These were introduced under the Mental Health Act 2014 as an important component of its recovery-oriented framework. They were intended to "improve communication, give patients greater control over their treatment when they are subject to compulsory treatment and promote an improved patient experience and recovery." (Victoria, Legislative Assembly 2014, p 472).

Advance statements can be made at any time and allow for people experiencing mental illness to express and communicate their treatment preferences.

The MHLC's Advance Statement Project

The Mental Health Legal Centre advocated for the inclusion of advance statements in the 2014 legislation. With the commencement of the legislation we developed our Advance Statement Project to increase awareness of the existence and benefits of advance statements among both consumers and clinicians and to increase their uptake by providing practical assistance to people to draft their advance statements. We have found this practical support to be key. Although advance statements are a fairly simple document, consumers can find the prospect of preparing one to be a daunting task and are keen to have support to do so.

The project was delivered in partnership with Saltwater Clinic (Mercy Mental Health), Thomas Embling Hospital and Orygen. Outreach clinics were offered at each service providing direct support to consumers to develop their advance statements. In addition training and information sessions were run for staff at each service to inform them about advance statements and encourage referrals to the project. Our experience was that mental health workers were supportive of advance statements and keen to see their expansion, but they simply lacked the time to be able to work with clients to develop advance statements.

Consumers co-designed the evaluation framework for the project and contributed to continuous improvement processes during implementation. Consumers reported that the project delivers significant benefits and their feedback was very positive. A survey of project participants found that 73% of respondents felt that the project had a positive impact on their well-being, including feeling safer, more secure and happier. 93% of consumers agreed

that the advance statement service provided by the MHLC was an important one. Staff at partner mental health services also recognised the importance of the project with 95% agreeing that it was an important service.

The MHLC continues to support the uptake of advance statements. We now assist people to complete advance statements through outreach sessions, phone appointments (for people living outside of Melbourne), a weekly clinic at our office and the development of a new app. Our app is in the final stages of development and will allow a person to develop a basic advance statement online with the opportunity to further refine it and sign it with one of our team. We also continue to provide training to the mental health workforce.

Treatment and other preferences

The primary purpose of advance statements under the Act is to communicate treatment preferences. People include detailed information about their medication preferences and side effects, their wishes for non-medication based therapies and their views on ECT.

In addition to expressing treatment preferences, advance statements allow for consumers to express non-treatment preferences and to give their treating team or the MHT a picture of who they are as a person. Consumers value this aspect of their advance statements and it aids clinicians as well. It is arguably the communication of these non-treatment preferences that offers the most opportunity for improving person centred care and recovery-oriented practice. Advance statements can contain practical directions to a treating team that help minimise the impact for people of suddenly being pulled out of their day to day life. Arrangements for the care of children or the feeding of pets might seem like side issues to treatment but actually cause significant stress. We repeatedly have clients who lose their housing, possessions and their beloved pets during admissions because steps are not taken by services to draw in additional support.

Some of the many non-treatment preferences our clients have expressed in their advance statements include:

- I have a small elephant that helps to calm me down. Please contact my girlfriend to bring it in for me.
- It is very important that my cat, Simba, be looked after. Please contact my neighbours to arrange this.
- I find loud unexpected noises on the TV unsettling. If I become distressed allow me to go for a walk away from the noise to calm down.
- When I am unwell I start to text a lot of people. This can be detrimental to both personal and professional relationships which negatively impacts my recovery. To stop this happening please take my phone away and give it to my friend X. She will know when it is safe for me to have it back.
- I like going to church and reading the bible. Please help me to access this.

Case study – advance statements

For most of his adult life Steven had dealt with childhood trauma by drinking. He instructed the MHLC that the abuse he had experienced as a child, coupled with years of alcoholism had left him with symptoms of depression and anxiety.

After his wife of 40 years passed away Steven became unwell and drank heavily on several occasions. On one occasion the CATT team was called and Steven was diagnosed with schizophrenia. Steven did not agree with this diagnosis. He was placed on a Community Treatment Order shortly after. Steven felt pathologised and powerless when dealing with psychiatrists who claimed to know more about how he felt than he did. The shaking and tremors caused by the medication were so severe that Steve became embarrassed and too self-conscious to leave the house. Steven ranked his quality of life as a zero out of ten

The MHLC assisted Steven by helping him to draft an advance statement that told his story in his own words. He wrote:

> *My wife died in January this year. The psychiatric reports imply my brain is deteriorating as a result. My grief is not a symptom of mental illness but a natural reaction to my loss. I don't agree that strong medication is the best way to manage traumatic life events especially when the side effects are so severe and create their own problems that have to be managed with more medication.*

Steven's advance statement detailed the severe side effects of the medication that he was receiving under the treatment order as well as setting out his preferred treatment for anxiety and depression.

Unfortunately the MHLC was unable to provide legal representation on the day of Steven's MHT hearing. However, armed with his advance statement to read from, Steven attended his own hearing and the Tribunal decided to revoke the order. Steven was "over the moon" with the result.

Benefits of advance statements

There are a number of benefits of advance statements. These include:

- the process of reflecting on previous experiences with the mental health system and treatment preferences is valuable. Many of our clients report that the process of completing an advance statement is validating and helps them to understand the trajectory of their treatment and recovery.
- advance statements offer an opportunity to give the treating team a snapshot of who a person is, what matters to them and what works best for them. When an advance statement is followed by the treating team, it builds trust and engenders confidence in treatment.
- advance statements have been found elsewhere to reduce the duration of compulsory treatment and inpatient stays.
- advance statements assist clinicians and the MHT to make decisions that respect individual choice and control – they can demonstrate a less restrictive option for

treatment, set out views on ECT and communicate medication preferences and known side effects.

Barriers to the effectiveness of advance statements

Despite the potential benefits of advance statements, there are a number of barriers to their effectiveness and the take up of them throughout the system. These include:

- Very weak provisions in the legislation to encourage clinicians to follow a person's advance statement. As a result many consumers feel that they are not "enforceable".
- A scepticism on the part of clinicians that advance statements will be used to refuse all treatment or request unrealistic treatments (in our experience this is very rare).
- The fact that advance statements are still rare and clinicians are still unsure how to support people to make them or to take them into account when making treatment decisions.
- Advance Statements can be difficult to locate. Although the existence of an advance statement is noted on a person's statewide record there is no centralised place where they are held. Consumers have to be proactive in sharing their advance statements with their treating teams.
- The lack of practical supports to assist people to prepare advance statements.

Recommendation 2: The Department of Health and Human Services should fully fund the MHLC to deliver advance statements clinics to support consumers to write effective advance statements.

Recommendation 3: The Mental Health Act should be amended to give advance statements more weight and to place a greater responsibility on treating teams to follow them.

Recommendation 4: Any override of a person's treatment preferences under an advance statement should be required to be reported to the Chief Psychiatrist who should review and monitor the rate of overrides.

Recommendation 5: There should be a central repository for advance statements. The MHT could fulfil this role or perhaps a Mental Health Commission if we had one. Upon admission this independent body would automatically be notified and the advance statement could be obtained. Access could also be given to first responders if the consumer had given consent to this.

Involvement of carers and family members

It is clear that more can be done to support the vital role of carers and family members in mental health services. There must however be recognition that consumers and carers can have very different perspectives on a range of matters.

Patient privacy is not simply a legal nicety or an inconvenience. It is an essential part of supporting individual choice and control and a fundamental human right. The Mental Health Act 2014 already contains multiple provisions supporting carer involvement in treatment. While it is important to facilitate family members and carers being able to access information from health services, consumer consent must remain the threshold for this

access. Where an individual has clearly expressed a desire not to have a particular family member involved in their treatment that must be respected.

Recommendation 6: Care should be taken to ensure that any changes to access to health information or involvement in treatment decisions respects consumer rights to privacy and self-determination.

Role of coercion and compulsory treatment

One of the goals of the Mental Health Act 2014 was to reduce the incidence and duration of compulsory treatment. Although there has been some reductions in the rate of people subjects to community treatment orders (CTOS) in Victoria, we still have one of the highest rates in Australia (Light 2009).

There is a lack of evidence to demonstrate that community treatment orders provide a benefit to consumers or the community. Some studies suggest that involuntary treatment can cause trauma and that mental health treatment without force and coercion and with the consent and involvement of the individual results in more positive responses to treatment and better long term outcomes.

Compulsory treatment sits at odds with the focus in recovery oriented practice on empowering consumers to make their own decisions (Edan et al., 2019). It is our experience that there is limited recognition from clinicians that voluntary treatment really matters to people. As one of our clients expressed in his advance statement:

> *I have a strong preference to be treated on a voluntary basis. I want to be trusted. I want to voluntarily engage with my treatment and not to be forced to do so under a treatment order. I recognise that I need to take medication and will have to do so for the rest of my life.*

The Mental Health Commission of New South Wales includes reducing the rate of involuntary treatment orders as one of its ten indicators of how mental health reform is tracking:

> *The Commission believes that a high rate of ITOs, whether in hospital or in the community, is a marker of a system which is not intervening early or effectively in the course of a person's mental distress or increasing illness. Treatment in hospital should be a last resort for people and their families. Involuntary treatment can be a very traumatising or re-traumatising experience for the person involved.*

Even when people are not receiving compulsory treatment, coercion plays a role. We hear of many cases where the threat of being placed on an order is used to encourage cooperation with treatment that a voluntary patient might not want. We regularly have to give a disclaimer to clients, alongside advice about their legal rights as a voluntary patient, that they will potentially be placed on a compulsory order if they exercise the right to refuse treatment or leave hospital. Most people with a history of involvement with the mental health system are aware of this and it frequently influences their decision making. The situation relayed by one of our clients is not uncommon:

I am not currently on any treatment orders under the Mental Health Act 2014 and am considered a voluntary patient. I would like to be treated at home however I have been told that if I try and leave or do not comply with my treatment, the treatment team will take action under the Mental Health Act 2014.

Recommendation 7: A system wide commitment is needed to significantly reduce the reliance on compulsory treatment in Victoria. Regular monitoring of the use of compulsory treatment should take place at both a service level and a system wide level.

Person-centred, individualised care

First response

The first response provided to a person in a mental health crisis is crucial and has a lasting impact on their experience of, and willingness to engage with, treatment. Police should only be used as a last resort where there is a clear risk of serious harm to others. Police should not be routinely used for welfare checks or to transport a person to a mental health service or emergency department for assessment or admission.

The MHLC hears from many clients who have found their interaction with the police at a time of being acutely unwell to be terrifying and traumatising. Clients have reported having armed police burst through their door, having guns pointed at them, being handcuffed and in the worst cases being assaulted and/ or arrested. The capture on CCTV of six police officers assaulting 'John', a mentally ill disability support pensioner outside of his home in Preston in August 2018 validated an experience that a number of clients have reported through our telephone advice service. As an example, a client recently contacted us who had been visited by police to conduct a welfare check. Family members present said he was not violent towards the police but he ended up handcuffed and placed in the police van. He was later charged on summons for assaulting police. This is an unacceptable outcome of a process seeking to ensure someone's welfare. As a result his mental health has deteriorated and his family will be hesitant to seek support in future.

While it is possible to make a complaint through the Police Conduct Unit, our clients know it will be their word against the police present and that their account will be discounted because of their mental illness.

Although initiatives such as PACER (Police, Ambulance and Clinical Early Response) provide a better response, the MHLC supports the development of a system of first response for people experiencing a mental health episode (or suspected to be) that is entirely separate from a law enforcement response.

The MHLC welcomes the introduction of the PROMPT trial in Geelong (Prehospital Response of Mental Health and Paramedic Teams) and recommends that this model be carefully evaluated to consider rolling it out across Victoria.

The MHLC also recommends that additional supports and avenues be developed to avoid the need for people to be transported to emergency departments. Community based drop-

in centres that incorporate mental health workers and other services could be a more effective way of supporting people through difficult periods and dealing holistically with their issues. Long periods of time in an emergency departments can be very distressing for people experiencing acute mental health episodes. State-wide data shows that more than 40% of mental health presentations to emergency departments are not transferred to a mental health bed within the statement target of 8 hours (Victorian Agency for Health Information 2018). Chemical and physical restraint is regularly used as a means of dealing with agitated patients in these settings.

The MHLC also recommends that consideration be given to integrating advance statements into a refined first response system. This could allow for non-police first responders to obtain a copy of a person's advance statement (if person had given consent for it to be used in this way). The advance statement could contain important information that would assist with de-escalation and identifying appropriate supports for the person.

If advance statements were held by a centralised body such at the MHT they would also be able to identify whether a response led to compulsory treatment orders.

Any time that criminal charges arise from a welfare check or section 351 apprehension, the incident should be independently reviewed to identify how the matter escalated, what training might be necessary and whether charges were appropriate. Such a function could sit within a Mental Health Commission.

Recommendation 8: A non-police based first response should be the default approach to people experiencing a mental health episode.

Recommendation 9: Consideration should be given to incorporating the use of advance statements into a first response to mental health crises.

Recommendation 10: An independent review should be conducted any time that a welfare check or section 351 apprehension results in criminal charges.

Trauma informed care

Many of our clients report a history of trauma that has a significant impact on their mental health and their experience of mental health treatment. The mental health system's focus on diagnosis and treatment through medication can often leave trauma unaddressed or see people being re-traumatised through their interaction with the system particularly if they are subject to coercive treatment or restraint or seclusion.

Case study – trauma informed practice

Our client Lisa had a history of severe trauma that was compounded when she was unlawfully restrained during an inpatient admission. The incident significantly undermined the therapeutic relationship between Lisa and her treating team and she found it very difficult to trust them. Some months later Lisa was allocated a case worker who she strongly associated with the traumatic inpatient admission. The psychiatrist disregarded her concerns about the

caseworker stating that it would be “an opportunity to work through that traumatic experience”.

There are limited options within the system for people to access psychological services to address underlying trauma. While access to psychological treatment has expanded through the Better Access to Mental Health Care initiative there are still significant limitations. The first is of course that it is limited to a maximum of 10 sessions a year. There is also the problem that most psychologists charge significantly more than the Medicare rebate leaving a considerable gap payment. For many of our clients this gap payment is unaffordable. There remains a need for a substantial increase in the provision of community based psychological services to service people needing more intensive treatment and those on low incomes.

Recommendation 11: The availability of community based psychological services should be increased significantly.

Family violence

There is a strong intersection between family violence and mental illness and the mental health system frequently fails to respond appropriately to incidents or allegations of family violence. The mental health system can be used as a means of power and control by perpetrators of family violence and this is particularly concerning when the treating team give credence to their account of events. Women often find their reports of family violence to be dismissed by mental health services as delusions.

Case study

Jill was admitted as an inpatient on the basis that she was suffering from a delusional disorder. Her delusions were said that be that she believed that she had been subjected to family violence for a number of years. The treating team prevented Jill from accessing family violence supports because they did not want to validate her delusions.

Case study

June went to her local hospital in a state of extreme distress seeking help in relation to family violence. She was admitted to a locked mental health ward. Although she was a voluntary patient, she was not told that she was and did not realise she was free to go. She contacted our service and it took a senior lawyer an hour on the phone with the treating team to convince the treating team to realise her. She then left the hospital with no referral to any family violence services.

Recommendation 12: Ongoing training should be provided to the mental health workforce to identify and appropriately respond to family violence situations. All people who disclose family violence should be referred to appropriate support services.

Aged mental health care

Patients in aged mental health services are some of the most vulnerable in the system. The lines between capacity, consent and compulsory treatment are blurred. There is confusion among clinicians and family members about how to navigate the complex and intersecting paths of compulsory treatment under the Mental Health Act, medical treatment decision laws and guardianship laws.

The MHLC is of the view that specialist outreach legal support is required at aged mental health care units to provide support in relation to MHT hearings (including for ECT which appears to be increasing for this cohort), guardianship and administration, elder abuse and other issues. While undertaking hearings at aged care units we have taken the opportunity to seek the opinion of a number of doctors who all welcomed the presence of lawyers regarding the presence of lawyers and more options for legal advice. This would free up clinicians and social workers to from getting embroiled in these issues.

Recommendation 13: A government funded health justice partnership should be developed by the MHLC to deliver specialist outreach legal clinics in all aged mental health services.

Case study

The MHLC represented an elderly client, Sue, on New Year's Eve who was being held on a temporary inpatient treatment order. When asked how long she said been in hospital, Sue responded that it had been since before Christmas. Sue had an active social life and was very active in her local church. Being hospitalised over Christmas had been very distressing for her. When asked what treatment she was receiving Sue said none. A check of her drug chart confirmed this. At the hearing the MHLC argued that, as there was no immediate treatment being provided, there was no basis for an order. During the course of the hearing it was revealed that the purpose of the treatment order had been to keep Sue in hospital until a guardianship hearing that was scheduled 5 days later could take place. This was a clear misuse of the Mental Health Act. No order was made and Sue was released from hospital immediately. Sue should never have had to spend Christmas in hospital.

Case Study

72 year old Emma contacted the MHLC for representation at an ECT hearing. Emma who had under mental health system since she was 17. Emma did not want ECT as she she had recollections of receiving it years before when she was an inpatient at Larundel. Emma had been very unwell when admitted but was clearly responding to her treatment. Emma did not like the treating team and would not have attended her hearing without the support of the MHLC . The application for ECT was refused. Emma was very relieved and returned home some weeks later. We continue to work with Emma.

Alternatives to inpatient admission

Inpatient admissions are very disruptive to an individual's live are mental health units are usually not ideal environments for recovery. Due to demand on the system inpatient mental health units are only able to provide care for the most acutely unwell individuals. There are limited options available for people who might recognise that they are at an early of an episode and want some intensive support.

Adult prevention and recovery units (PARCs) offer an alternative to inpatient treatment but can be difficult to access. Another option that could be further considered is the crisis house model that operate in the United Kingdom. Crisis houses in the UK have strong support from consumer groups. Intensive home based services are another model that could be considered to provide additional support early in episode to avoid an inpatient admission.

Recommendation 14: Alternatives to inpatient admissions including crisis houses and home based services should be identified and considered for implementation in Victoria.

Integrated approach to whole of life services

The lack of integration between health care and various social supports has a significant impact on the overall wellbeing of individuals. An integrated system would ensure that individuals receive timely treatment and appropriate psycho-social supports, while also being able to access and maintain stable housing, obtain appropriate income support and participate as fully as possible in society.

At present the mental health system has a limited ability to build connections with the broader health and social service delivery system.

Some of the consequences of this lack of integration that we see at the Mental Health Legal Centre are:

- people discharged from inpatient treatment to street homelessness or precarious housing situations
- people losing their housing during inpatient stays and in many cases losing their possessions and even pets because there are minimal supports to address these issues
- clinically unnecessary inpatient stays because appropriate arrangements are not in place that would allow timely discharge with non-clinical supports
- non-government funded services filling the service delivery gaps

The social service delivery system is itself highly fragmented and very difficult for individuals to navigate without support. For some of our clients the NDIS has provided an effective way of both navigating their support needs (through funded care coordination) and obtaining them (through funding for individual services). For those unable to access the NDIS or those

who do not have adequate packages the system is becoming increasingly more difficult to navigate.

At the MHLC we are seeing an ever-increasing number of clients who have fallen through the gaps. They are in desperate need of co-ordinated support but do not fit within the criteria for particular programs. As a service that is generalist in nature and one that receives limited government funding we are often a last port of call for people who have been on the referral roundabout. We endeavour to always have our phones answered by one of our highly skilled administration team who can provide a listening ear and a meaningful response. Our social worker (who is funded by RMIT and whose primary role is supervising social work students) regularly finds herself taking on a case coordination role for individuals who have no other options and for whom there are no appropriate referral pathways.

While co-location can be very effective in delivering integrated service delivery, the most important aspect of it is services working together with shared goals and a commitment to supporting clients in a holistic manner. Co-location without appropriate cars coordination will not improve outcomes for individuals.

Recommendation 15: Priority should be given to the resourcing of holistic, integrated service delivery models for people with serious mental illness with a focus on skilled and knowledgeable case coordination.

Role of legal services in integrated service delivery

Although it is often overlooked and misunderstood, legal services can play a vitally important role in integrated service delivery. People experiencing poor mental health will often have a variety of legal issues. These issues can arise as a result of someone's mental illness or exacerbate a person's condition due to the enormous stress caused.

Integrated legal service delivery models have been established to address these issues. Our health justice partnership with the Bolton Clarke Homeless Persons Program (HPP) is an established and proven example of this.

Recommendation 16: Legal services should be considered an essential component of any integrated model of service delivery.

MHLC and Bolton Clarke Homeless Persons Program Health Justice Partnership

The health justice partnership focusses on people experiencing, or at risk of, homelessness. The MHLC worked in partnership with the Bolton Clarke HPP nurses to develop a project to address the legal needs of patients. The nurses recognised that legal issues were having a significant impact on the mental and physical health of their patients.

The lawyers in the team partner with the nurses to provide assertive outreach services to some of the most vulnerable members of our community. These include people who are street homeless, living in crisis accommodation or in rooming houses and caravan parks. It also includes people at risk of homelessness and those who are newly placed in housing. An important aspect of the program is that the lawyers meet the clients where they are rather

than expecting them to access formal appointments and centre-based services. The clients already have a relationship of trust with their nurses and MHLC can build on that relationship to quickly establish rapport and identify how to most effectively assist clients. The nurses facilitate contact with the client, in many cases attend client interviews, prepare support letters and help the lawyer to link into other service providers if needed.

The lawyers assist with a broad range of legal issues and endeavour to address multiple issues for a client rather than having strict guidelines for assistance. The main areas of law are fines, debt, housing, access to health services, minor criminal matters not covered by legal aid, social security, MHT, family violence and crimes compensation.

The lawyers provide regular education sessions to the nursing team. The education topics are selected in consultation with the nurses. The sessions are practical in nature and highly interactive. The sessions help the nurses to recognise when a client has a legal issue so that prompt referrals can be made and the nurses can focus on providing clinical care and other supports.

An independent evaluator was appointed at the commencement of the project and has been key to ensuring that the project is effective, responsive and constantly improving. The independent evaluation also allows us to clearly see the evidence of impact.

Since the project began in 2016 it has assisted more than 246 clients with 365 legal matters. A large number of clients (30%) completed evaluation forms giving a clear insight into their experience of the service. Client satisfaction ratings are high (90%) and 95% of clients said that they would use the service again. 85.7% of clients reported that using the legal team had an impact on their wellbeing including less worry, sleeping better and improved mental health. The nurses also rate the program highly and 75% of them had referred clients to the lawyers. Nurses referring to the project had a 94% satisfaction score.

The project has been funded for 4 years by the Legal Services Board and Commission but the funding ceases at the end of this year. Without sustainable government funding this service will be unable to continue and our clients, who simply do not access other legal services, will return to a situation where their legal needs are not met.

The project also demonstrates the need for Innovative, outreach based, integrated service delivery models in order to effectively deliver services to the most complex individuals within our community. The expansion of models such as this will improve people's mental health and have genuine social and economic benefits.

Recommendation 17: The MHLC and Bolton Clarke Homeless Persons Program should receive full, ongoing government funding to continue to support the health and legal needs of vulnerable Victorians experiencing homelessness.

Integrated legal service delivery case studies

We include a number of case studies here to demonstrate the importance of dealing with a person's legal problems alongside their health and social needs.

Case study – lawyer assisting client to have more control over finances

Liam had been under an administration order for nearly 20 years and was finding that it was very restrictive and stopping him from living life as he wanted to particularly in relation to travelling to different parts of Australia. He had a part-time gig that gave him a small income which he managed independently. After speaking to his nurse about this she referred him to our outreach lawyer. We worked with Liam and his nurse to obtain the reports he needed to challenge the administration order and represented him at the Victorian Civil and Administrative Tribunal. The Tribunal found that Liam could manage all of his own money for the first time in two decades. The decision made an enormous difference to Liam's sense of dignity and self-worth.

Case study – lawyer assisting client to resolve conflict with her family

Samantha was a young women living in crisis accommodation whose relationship with her family had broken down. Her parents and siblings had applied for intervention orders and she had made cross-applications. The situation had been going on for years.

The situation was causing enormous distress to Samantha who felt isolated from her family and unsupported in a time of poor mental health. Her nurse contacted our service and our lawyer was able to visit the client with her nurse at her temporary housing. Our lawyer was able to contact Samantha's family and worked hard to negotiate between the parties for consent orders that provided everyone with a sense of safety but also allowed for the possibility of reconciliation. Our lawyer provided representation at two hearings before the matter was resolved by consent orders. The legal process which threatened to further harm the relationship between the parties instead paved the way for resumed contact. This supported Samantha's ongoing recovery. Samantha's sibling contacted our lawyer after the matter finished to thank her for her role in de-escalating the conflict between everyone.

Case study – lawyer assisting client to deal with debt collectors and large debt

Kim was referred to the MHLC by her nurse. Kim had lived an itinerant lifestyle, travelling between states. She had experienced intermittent homelessness and had spent time in and out of jail as a result of her drug addiction. Kim also had significant mental health issues. On referral Kim was reasonably settled in a boarding house in Melbourne and engaging with treatment. She was however being pursued by a debt collection company for nearly $20,000.00 in court fines and infringements that she had incurred while living interstate.

After seeking advice from interstate community legal centre colleagues and the state's debt recovery body we put in an application to have the fines written off. The application was made on the basis of Kim's financial hardship, her mental health issues (all of which were being exacerbated by the anxiety of the debt and the debt collectors), her substance dependence and homelessness. We also

showed how Kim was progressing with her rehabilitation and the stability she had achieved in her life.

Ten days after we had submitted the application (lightning speed compared to Victoria!) we received a response that write-off had been approved. Kim was very happy with the outcome which bolstered her

With the positive relationship Kim has built with her treaters and the resulting stability in treatment and, without the added anxiety of this debt, she continues to achieve encouraging outcomes in all areas of her life.

Housing

The MHLC sees the impact of housing issues throughout our work and in particular through our health justice partnership with the Bolton Clark Homeless Persons program and our work in prisons.

Stable, affordable housing is a fundamental pre-condition for people to achieve optimal mental health and fully participate in society. Without stable housing it is nearly impossible for people to manage their mental illness. However having a serious mental illness impacts heavily on an individual's ability to secure and maintain housing.

Many individuals experiencing mental illness find themselves in private rooming house accommodation – this is often expensive, unsafe and run by unaccountable, private operators. In Victoria, a handful of operators working through constantly shifting shelf companies, control a large share of the rooming house market. Their activities distort the market and they receive significant public funds through crisis housing services and residents paying rent directly from their Centrelink payments through Centrepay. Due to a major shortage of short-term or crisis housing, housing services feel forced to continue to use these providers even though many of our clients would actually be safer on the streets. While some services have indicated they will stop using these providers, at present there is such enormous demand for housing that they continue to operate.

Recommendation 18: There should be an urgent and sustained increase in investment for public and community housing.

Recommendation 19: A review of the effectiveness of rooming house laws should be conducted to consider their effectiveness in preventing unscrupulous operators from continuing to own and run rooming houses.

Case study – private rooming houses

Jim was living on the streets when he was placed in a private rooming house by a crisis accommodation service who paid his rent for 2 weeks. The door to his room did not close or lock properly. The rooming house operator said this would be fixed but it never was. At the end of two weeks Jim was admitted to hospital. He needed to have surgery. While in hospital he received a text message from the rooming house operator telling him that all his possessions had been put in

storage and he would have to pay the fees for this. When Jim was out of hospital he tried to get in touch with rooming house operator. They never called him back. All of his possessions were gone including personal papers and a new television.

Jim was referred to us by his nurse. We helped him to apply for compensation for the illegal disposal of his goods. The rooming house operator did not attend but Jim was awarded compensation. Despite numerous attempts to recover the amount ordered, Jim never received his money. The company dissolved and the director continued operations under a new entity.

The individuals behind the company continue to operate numerous rooming houses throughout Melbourne. One of the steps we have taken in response to this case it to meet with Centrepay to address the systemic issue of companies like this receiving direct debit payments from people's social security payments.

While better regulation of the private rooming house market is needed, more funding for community-based services is essential. Community based services (while sometimes struggling with residents with serious mental illnesses) tend to provide higher quality housing with better protections for residents and tenants. They also offer an opportunity for integrated service provision that can support people to maintain housing over the long term.

Hospitalisation can have a detrimental impact on many aspects of a person's life, in particular their housing. People already living in insecure housing on admission may find that they have been evicted (legally or otherwise) while they have been in hospital. It is not uncommon for mental health patients to be discharged to homelessness with this situation continuing until their condition deteriorates to the point of crisis again and they are re-admitted. This cycle has an enormous cost to the individual, the community and the health system.

Housing providers sometimes find it challenging to deal with people who experience mental illness. The MHLC regularly acts for people facing eviction for being dangerous or disruptive or who have been targeted by neighbours through intervention orders or body corporate processes. In many cases we are able to work with housing providers and housing support services to maintain people's housing. This work is vitally important because our clients struggle to find alternative housing and are at serious risk of homelessness.

Due to sustained funding cuts to specialist tenancy services, most people facing eviction in these situations are unable to access legal representation and are forced to navigate the process on their own.

Case study – lawyer helping to maintain housing

Liam suffered from several serious health conditions that had an impact on his cognitive function. He also had a long history of depression. He lived in a

community housing property that contained a mix of community housing tenants and private renters. Liam's housing had been stable for 4 years and he received a range of supports there including home care and nursing visits. Liam started to have some issues with bureaucracy that were causing him a lot of frustration. On two occasions he came home from dealing with these issues in an angry state and damaged a neighbour's property. The community housing organisation issued him with an immediate notice to vacate for danger.

Liam was referred to the MHLC by his outreach nurse at Bolton Clarke who had been working with him for many years. Liam was difficult to get a hold of by phone and our lawyer left many messages for him. While more traditional services may have been forced to give up, we were able to work with his nursing team to contact him when they were conducting a home visit. Our lawyer liaised with Liam's nurse, his GP and his support worker to prepare for the eviction hearing and opened discussions with the housing provider. We represented Liam at his tribunal hearing and his nurse and support worker attended with him.

The Tribunal accepted that Liam's actions were out of character and that he did not present an ongoing danger to other tenants. As a result of a multi-disciplinary team working together, he avoided the devastating consequences of immediate homelessness and the attendant loss of services.

Liam was also charged by the police in relation to the incidents. He had no criminal record and our lawyer was also able to represent him at court where he was granted diversion.

Case study – lawyer assisting client with housing conditions

Tim was referred by his RDNS nurse because he was having a great deal of difficulty getting his community housing provider to address cockroach infestation in his apartment. The infestation was having a serious impact on Tim's mental health. We assisted Tim to prepare a breach of duty notice to his landlord which finally resulted in him being transferred to temporary accommodation while the infestation issue was being dealt with.

Following this we visited Tim and his nurse at the infested property where we took photos and collected information about the impact of the infestation and the delay in dealing with it. Tim had waited 10 months for the matter to be taken seriously, he was out of his home for nearly 3 months while treatment was taking place and all of his worldly goods were affected by the infestation.

We wrote a very comprehensive letter to the housing provider who agreed to a meeting. At the meeting three senior staff from the organisation apologised to our client and set out how they would address his matter and ensure it didn't happen again. This process was very validating for our client who responded with enormous grace and good humour. We were also able to negotiate a

substantial payment to compensate Tim for his loss of amenity and the damage to his goods. Tim was thrilled with this outcome and was able to move back into his cockroach-free property with new furniture and appliances.

Adequate income

Although social security is a Commonwealth responsibility, it is vital to consider the impact that poverty has on a person's mental health. Increasing numbers of people with serious mental health issues are struggling on Newstart allowance. There has been no real increase to the rate of Newstart in 25 years and it is very difficult for anyone to live on. The mental system as a whole has to recognise the impact that living on such an inadequate income has for people in terms of housing stress, inability to afford costs of transport to appointments, inability to pay for medication or to pay out of pocket medical expenses. Mental health services also have a role in supporting people to apply for the disability support pension and assisting to provide supporting materials where needed. When a person is supported to make a DSP application and comprehensive supporting information is provided to Centrelink at the outset, applications can be processed more quickly and have a higher chance of success. DSP applications should be included as a core part of workforce training, to ensure that applications are timely, have the required medical supporting material and a knowledge of review and appeal pathways and supports available. This is a key way to prevent vulnerable mental health patients slipping further into poverty.

The current system of obtaining income support for people with significant mental illness is difficult to navigate and often inconsistent in application. The requirement for a condition to be stabilised and fully treated for an individual to be eligible for the disability support pension is a serious impediment for many seriously unwell individuals. Changes made to the eligibility criteria have meant that many of our clients, though very unwell, find themselves unable to access the disability support pension. Although they have limited prospects of returning to work in the short term, they remain on Newstart. This has two key impacts. The Newstart payment is significantly less than the disability support pension. The second is that many of our clients find Newstart's reporting and other requirements impossible to meet and therefore risk having their payments cut off.

Centrelink processes are opaque, slow and enormously difficult to navigate. There are limited services available to support people applying for payments or appealing against payment rejections or alleged debts. Our service is able to provide some ongoing case work for clients of our programs to seek reviews of DSP rejections.

Recommendation 20: The Victorian government should advocate at a Commonwealth level for an increase in the rate of Newstart and changes to make DSP more accessible for people with serious, ongoing mental illness.

Case study – lawyer helping to access income support payments

Our client, Jane, who had received disability support pension some years before, moved to regional Victoria for work. After a couple of months her mental health deteriorated and she was admitted to hospital for treatment for her anorexia.

She lost her job and was unable to work or even to leave the house. Jane started to receive Newstart payments and applied for the disability support pension. She had limited assistance to do so and was navigating the application on her own while seriously unwell.

She approached her treating team for a letter to support the application. The psychiatrist that she was meeting for the first time wrote a letter stating that Jane was very unwell but was refusing treatment which she was not. Jane's application for DSP was knocked back 42 weeks after she made her application. Jane came to our service for assistance at a time of crisis. We prepared an application for an internal review by Centrelink. This was unsuccessful on the grounds that Jane's condition could not be considered stabilised because her psychiatrist had said she was refusing some aspects of her treatment. This review process took another 6 months.

We appealed on Jane's behalf to the Administrative Appeals Tribunal. The AAT found in Jane's favour almost 2 years to the day after she first applied for the DSP. The difference between Newstart and DSP was so significant that Jane received over $18,000 in backpay.

On Newstart Jane struggled to afford her basic expenses. Her private rental payments took up much of her income. On top of that she spent large sums on petrol to travel to the nearest large town to access community mental health care. There were no bulk billing GPs in her town and the gap payment was difficult for her to afford. She was unable to access any private psychology or psychiatric services. Once she was receiving DSP, she was able to move back to Melbourne to be closer to specialist eating disorder services and a bulk billing private psychiatrist. She was able to move out of being in crisis mode and take some control over her life.

Oversight

Appropriate oversight of mental health is essential to ensure person centred care, avoid preventable harm, appropriately respond to individual episodes of poor care, drive system improvement and inform long term planning.

At present the mental health system operates under a disconnected web of oversight that does not allow for systemic issues to be identified and escalated or for state-wide planning to take place.

The MHLC submits that fundamental changes to system level governance are needed and supports the introduction of an overarching, independent commission with responsibility for monitoring, reviewing and driving improvements to mental health service delivery. In Victoria's model of devolved health service governance the role of an independent agency is

of particular importance in identifying best practice and creating the momentum for system and cultural change.

Recommendation 21: An overarching independent commission with responsibility for monitoring, reviewing and driving improvements in mental health service delivery should be introduced in Victoria.

External oversight bodies

Mental Health Complaints Commission/ Health Complaints Commission/ AHPRA

An effective, accessible and fair external complaints handling body is essential to maintaining consumer confidence in the mental health system and ensuring concerns are addressed. The establishment of a mental health specific complaints commission in Victoria has had some positive impacts. The staff that work at the MHCC handling complaints are skilled at working with people with a lived experience of mental illness and provide an empathetic and respectful response.

Unfortunately, many of our clients find the experience of making a complaint to be invalidating and disempowering despite being positive about the individuals they have dealt with at the MHCC. Consumers proceed with complaints primarily because they want services to be held accountable and they want to prevent other people from experiencing what they have. Many of our clients who have initiated complaints have found the process to be unsatisfying and, in some cases, quite traumatic. The focus on conciliation and an inability to compel a service to act or respond is challenging for clients who perceive that their voice is dismissed.

The MHCC only deals with mental health care provided in public mental health services. This means that it doesn't deal with mental health care provided by general practitioners or private psychiatrists and psychologists or care provided in private hospitals. It also doesn't deal with care provided to a person under the Mental Health Act in a medical ward or people receiving treatment in emergency departments. An individual who perceives themselves to be receiving a singular episode of care may find themselves having to make multiple complaints to different complaints bodies.

Complaints about the conduct of a particular practitioner must be made to AHPRA. If a consumer has a complaint about a practitioner and about their treatment more broadly part will be dealt with by AHPRA and part by the MHCC or HCC. The practitioner conduct aspect of the complaint will be carved out and not considered by the complaints commission which means that any systemic issues can't be considered or addressed. AHPRA takes a very different approach to handling notifications from patients, there is minimal involvement beyond the initial notification and clients often express frustration that they are not invited to provide additional information to AHPRA or asked further questions. It can take a number of years to resolve a complaint through AHPRA causing considerable distress for complainants.

The division of complaints between the Health Complaints Commission and the MHCC prevents either body from having a clear overview of all aspects of mental health care.

Recommendation 22: Consumers should have a single entrance point to the HCC and MHCC if there care falls between both.

Recommendation 23: The MHCC should be empowered to conduct own motion investigations into any public mental health service.

Recommendation 24: The MHCC should be given greater powers to compel mental health services to participate in the complaints resolution process.

Case study

Our client Beth had a difficult inpatient admission under the Mental Health Act 2014. She had anorexia and was initially admitted to a mental health service co-located at her local regional hospital. During the course of her inpatient stay she was transferred to the medical ward (which was part of a different health service) to receive feeds through a nasogastric tube. While on this ward she would receive visits from psychiatrists and other clinicians from the mental health service and she remained in an inpatient treatment order. While on the medical ward she had a particularly traumatic incident of care where she was choking on a misplaced NGT for a lengthy period of time and then shackled to stop her from trying to remove the misplaced tube. The incident was not appropriately documented and although the hospital later acknowledged to AHPRA that the tube had been misplaced, this was not recorded in her medical records. When she was discharged from hospital she was referred to community mental health. The incident caused her significant ongoing trauma but because it was not recorded in her notes she was treated as though she had invented the incident.

Beth wanted to make a complaint about her experiences. She had to do so through three different complaints bodies. She had to go through AHPRA to make a complaint about the conduct of the nurses who restrained her while she was choking and failed to document the incident. She had to go through the Health Complaints Commission to deal with her general experiences as an inpatient in the medical ward (although they would not consider the incident itself because AHPRA was investigating). Finally she complained to the MHCC in relation to her treatment for the periods in which she was an inpatient in the mental health service and her care from the community mental health service following discharge. As each entity had only some of information about her concerns, it was difficult for them to consider the interconnected issues that arose from what was in Beth's mind a singular episode of care. The AHPRA investigation has been on foot for nearly 3 years without a final outcome. The complaints to the MHCC have now been closed with the health service refusing to respond to aspects of the complaint (which set out clear inconsistencies between their responses to the MHCC and our client's medical record obtained through FOI). The MHCC was powerless to compel a response and although they

made a number of recommendations to the mental health service, our client felt the process was futile.

Chief Psychiatrist

There is significant confusion about the purpose of the Office of the Chief Psychiatrist and its role in quality and safety improvement within the system. The *Mental Health Act 2014* sets out a broad role and a number of functions for the chief psychiatrist in providing clinical leadership, promoting continuous improvements in quality and safety and promoting the rights of people receiving mental health services. The fifth anniversary of the 2014 Act provides an opportunity to consider how well the Office of the Chief Psychiatrist is fulfilling its role and functions.

One of the functions of the chief psychiatrist is to develop and publish standards, guidelines and practice directions for the provision of mental health services. The MHLC notes that there are thirteen guidelines on the OCP's website that have not been updated to reflect the 2014 Act.

An important task that the OCP has undertaken in the past is to audit inpatient deaths. The last audit of inpatient deaths dealt with deaths up until 30 June 2014 and was published in 2017. There should be more timely audits of inpatient deaths to address vital quality and safety issues and engender community confidence in the system.

The Chief Psychiatrist should be a part of Safer Care Victoria (alongside the Chief Nurse and Midwife, Chief Medical Officer and Chief Paramedic).

Legislative safeguards

We note that the *Mental Health Act 2014* is due for a review and as such are commenting primarily on practical aspects of the legislative safeguard. The comprehensive review of the legislation should not be delayed.

Mental Health Tribunal

Victoria has low rates of legal representation for people appearing before the Mental Health Tribunal and there is no commitment to taking steps to address this.

In 2017/18 patients were legally represented at only 15 % of hearings. Patient attendance rates at the Tribunal are also low with patients being in attendance at only 57% of hearings in 2017/18. These figures compare unfavourably with some other states. In NSW in 2017/18 the attendance rate for civil hearings was 85.7%. In 80% of these cases the patient was legally represented. In the Northern Territory, the Mental Health and Review Tribunal ensured arrangements were in place for consumers to have legal representation in 100% of cases. In NSW there is an automatic right to legal representation in a range of situations. There would seem to be a correlation between attendance rates and the prevalence of legal representation in a jurisdiction.

The decisions made by the MHT impact on some of the most fundamental rights of individuals – to make their one decisions and not to be forced to have medical treatment. In such a setting the legal representation should be an automatic right.

In Victoria there is no automatic right to legal representation for MHT hearings and it is the responsibility of individual patients to access legal assistance. This is a particularly onerous burden to place on someone who is unwell enough to be subject to a treatment order or in a confined environment where access to any kind of communication device is fraught. In Victoria hearing notifications are provided to patients by the mental health service not the MHT. Patients often do not receive hearing notifications in a timely manner and as such struggle even more to obtain legal representation.

At present there is limited capacity for legal service providers (Victoria Legal Aid and ourselves) to provide a higher level of legal representation and demand exceeds supply across both organisations. Victoria Legal Aid operates a duty lawyer style scheme at some inpatient facilities but are often unable to assist people on inpatient orders and rarely assist in relation to community treatment orders. The MHLC used to be funded to provide representation for community treatment orders but this funding is now directed to Victoria Legal Aid. Despite receiving no government funding to support our MHT representation, we represented 169 clients in the year to 30 June 2019. We were able to do this only with the support of an extensive network of pro bono lawyers. We were unable to represent a further 159 people at their hearings although we always endeavoured to provide phone advice prior to their hearings.

The MHT does not view the low levels of legal representation as a problem. In its 2017/18 Annual report it stated that it was vital to avoid "creating a misconception that having a lawyer is necessary to ensure a fair hearing or that it determines outcomes" (Mental Health Tribunal 2018). The solution focussed approach that the MHT takes to hearings is said to take place whether or not an individual is legally represented.

The emphasis on solution focussed hearings, while worthy, does not adequately recognise the system that the MHT is operating within. If recovery oriented practice was embedded throughout the system, solution focussed hearings would be an ideal mechanism for supporting individuals in their hearings. We currently however have a system were less than 60% of patients attend their hearings – a significant minority of patients do not appear to be convinced that their attendance will make a difference.

It is important to understand that attending an MHT hearing is overwhelming and many consumers feel that there is a significant power imbalance. Although the MHT is of course independent, hearings take place at mental health services and consumers perceive themselves as the outsider in a room with clinicians from their service, another psychiatrist or doctor, a lawyer and a community member. This is unquestionably intimidating particularly at a time of acute mental illness. Being asked questions by a panel of three members and having to articulate your views and address the legal criteria that decisions are based on is difficult. The presence of a lawyer is very comforting for people, they feel that there is someone specifically there for them.

There is incredible expertise on the MHT but members are limited to deciding whether or not to make a treatment order and the length of such an order. The limited options available to them constrains their ability to take a truly solution focussed approach. They

have no ability to alter treatment plans. The MHT should be able to directly refer people to the Second Psychiatric Opinion Service if the psychiatrist or another member is of the view that it is warranted.

Once an order has been made by the MHT a patient is largely at the mercy of their treatment team. The *Mental Health Act 2014* recognises supported decision making, the need to obtain informed consent and other measures but there is no mechanism under Act to ensure this happens. Many of our calls are from people frustrated at not having their preferences and concerns addressed. They are not refusing treatment but are unhappy with aspects of it such as medication they react badly to or being forced to have depot injections. It would be useful for the MHT to have more ability to engage with treatment plans.

Recommendation 25: There should be an automatic right to legal representation for MHT hearings and the MHT should have a co-ordinating function in arranging legal representation in Victoria.

Recommendation 26: The MHLC should be funded to provide representation for patients at community treatment order hearings and at inpatient treatment order hearings where VLA is unavailable or unable to act.

Recommendation 27: The MHT should conduct a research project into the reasons why patients do not attend their hearings and set a goal to improve attendance rates.

Recommendation 28: The MHT should sit under the Department of Justice and Community Safety rather than the Department of Health and Human Services to support a perception of independence.

Restraint and seclusion

Restraint and seclusion no longer have a place in mental health care and their continued use highlights a mental health system operating in a bygone era. The experience of our clients demonstrates that much more needs to be done to change the culture within services and to ensure that the safeguards we have are adequate and actually followed by those on the front line.

The forms for authorising the use of restrictive interventions lack clarity and are open to be misunderstood or incorrectly completed by clinical staff. The forms should also require an explanation of why less restrictive strategies were not appropriate in the circumstances. There is a lack of clarity around the use of restrictive interventions on people with mental illness outside of mental health services. This includes in medical wards and in emergency departments.

The regulation of chemical regulation is unclear and it is open to misuse. Episodes of chemical restraint should be properly authorised and clearly documented. They should also be reported in the same way that physical restraint is.

Case study

Beth, our client whose case study was included in the section on the Mental Health Complaints Commission, was physically restrained when she tried to pull

out a nasogastric tube that was incorrectly inserted and choking her. In itself this use of restraint was horrific. There were also however a number of failings in the care of Beth while she was restrained and the documentation of the restraint episode. The authorisation for use of a restrictive intervention had been signed by the psychiatrist 2 days prior to the episode of restraint and the psychiatrist signed the section that said the person was still subject to the restrictive intervention when she came to examine them, that she had examined them and that continued restraint was necessary. At the time Beth had not been restrained. One the day she was restrained no additional authorisation was given or obtained and the restraints were applied by nurses who did not complete any additional documentation. There was no record that the psychiatrist was ever notified of the use of restraints. Shortly after the restraints were applied the client was administered Olanzapine and sometime later diazepam. She was not otherwise taking these medications and while they are recorded in her drug chart there was no justification for them included in her progress notes. They had the effect of sedating Beth. There is no record in the progress notes of the time at which restraints were applied or removed and no indication that Beth was clinically reviewed at least every 15 minutes as required under s116(3) of the *Mental Health Act.* This episode happened in a medical ward that was co-located with a mental health service participating in Safewards.

The episode of restraint (both physical and chemical) had a devastating impact on Beth. It led to a significant deterioration in her mental health including the development of severe food phobias, agoraphobia, regular dissociative episodes and a worsening of her PTSD.

Case study

Phil ended up in hospital after he was hit by a car while crossing the road. His arm and legal were both broken. Phil was diabetic but was not given appropriate medication nor was he listened to about his physical health needs. The decision was taken to put Phil on a treatment order to force him to take psychiatric medication. He became increasingly agitated and staff shackled him to the bed. He was restrained in this manner for 3 days and transported to another hospital in restraints.

Recommendation 29: The use of chemical restraints should be regulated and episodes of chemical restraint should be monitored and reported on.

Recommendation 30: The Department of Health and Human Services should provide annual public reports regarding the use of restrictive interventions at each mental health service in Victoria.

Recommendation 31: The documentation for restrictive interventions should be reviewed to ensure clinician obligations are clear and include a requirement that the necessity for the use of the restrictive intervention (and why no less restrictive option can be used) is documented.

Electroconvulsive Therapy

Electroconvulsive therapy remains a treatment that consumers have very polarised views on. Some consumers see it as an effective treatment that they are happy to receive. Many others find the prospect of it deeply distressing and are adamant that they do not want it. The Mental Health Act 2014 recognises that ECT is in a different category of treatment. Many of our advance statement clients address their concern about ECT in their advance statements – some expressly state that they do not consent to future ECT treatment. While this is not legally binding, the preferences expressed in an advance statement are required to be considered by the MHT in determining whether there is no less restrictive way for a patient to be treated. The MHLC submits that there should be a binding mechanism, possibly through an advance statement, for a consumer to refuse consent to future ECT.

There is significant confusion among consumers and clinicians about the use of the alternative ECT consent pathway for adults who lack decision making capacity. The MHLC submits that this pathway should be reviewed with broad input from consumers, clinicians, the MHT and legal services.

Recommendation 32: There should be a binding mechanism for consumers to refuse consent to future ECT.

Recommendation 33: The alternative ECT consent pathway for adults who lack decision making capacity should be reviewed.

Recommendation 34: Patients should be able to seek a review of an ECT order after their ECT treatment has commenced.

Data

Appropriate data collection is vital for monitoring the effectiveness and safety and quality of our mental health system. Public reporting of data is essential to providing accountability and helps to drive service improvement through transparent benchmarking of services.

Public reporting of mental health service level data is very limited and what is available is not consumer friendly. The data is only presented in quarterly reports making it very difficult to identify pockets of poor practice or trends over time. There is no narrative introduction or explanation of reports just tables of figures with minimal explanations about what they mean. VMIAC recently collated the data available in multiple reports on the DHHS website to create a meaningful report on the use of seclusion in mental health services. This type of report should be readily available. A mental health commission could play a key role in monitoring and reporting on service and system level data.

Recommendation 35: Public reporting of mental health data should be comprehensively reviewed with input from mental health consumers and carers to identify data to be reported and ensure it is presented in a way that is meaningful for consumers.