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**VALS' submission to the Community Consultation Panel: *Mental Health Act 1986* Review –
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INTRODUCTION

The Victorian Aboriginal Legal Service Co-operative Limited (VALS) welcomes the opportunity to comment on the Department of Justice's Mental Review of the *Mental Health Act 1986*.

Responding to linkages that have been found between cognitive impairment and the criminal justice system has been in urgent need of attention for some considerable time. The potential for disadvantage through involvement in the criminal justice system has endured through the lack of such mental health considerations. There are very significant concerns in respect of institutionalisation, consent, and involuntary treatment in light of Indigenous Australian's historical connections to negative experiences involving similar issues. VALS therefore responds in this crucial area of concern that demands urgent attention, reform, implementation and adequate funding in order to achieve systemic change in the justice system and in the daily lives of individuals and families affected by mental illness.

In considering the mental health needs of Indigenous Australian offenders in Victoria's criminal justice system specifically, we are immediately positioning ourselves at a complex and often fraught intersection of services and interests (Jones & Day 2008). Howells, Thomas-Peter and Day (2004) suggest that although the criminal justice system and the health care system have fundamentally different social functions, there are areas of common purpose and interest. Both hold a responsibility to protect *all* members of the community from harm. The criminal justice system, from initial points of contact with police through to Correctional Services and release, holds an obligation to provide adequate health and mental health services to offenders. It is therefore crucial for VALS to comment on these areas.

Indigenous Australian Perspective

People with a mental illness are overrepresented in Victorian prisons with 40% of prisoners experiencing serious mental illness and the proportion increases when other types of mental and psychiatric disabilities, such as personality disorders, are also considered (Deloitte Consulting 2003). Social disadvantage and inadequate treatment of mental health in the community inevitably equates to too many people with untreated illness ending up in prison:

Ill health and marginalisation, not criminality, are the drivers, but this goes unacknowledged by a justice system which often only serves to exacerbate illness, and may increase reoffending (Smart Justice 2009).

Social disadvantage and inadequate access to services being linked to negative contact with the justice system is an all too common theme for the Indigenous Australian community. Misunderstandings and misdealings with mental health matters acts as an additional contributor towards marginalisation for the disadvantaged and the disempowered.

Defining Mental Health

The seriousness of mental health issues can be identified through extreme negative outcomes in the Indigenous Australian community. Looking at behaviours linked to mental illness such as suicide, the prevalence in Indigenous Australian communities has been shown to be significantly higher

than that for non-Indigenous Australian populations; ‘yet Indigenous understandings and definitions of suicide and self-harming behaviours remain under-researched, undervalued and under-utilised’.¹

The unique conception of what Indigenous Australian communities consider constitutes mental health and wellbeing, as well as what is considered mental illness, must be recognised and incorporated into legislation that deals with decisions around the treatment of persons. Without this inclusion, the significantly disproportionate and tragic consequences, such as the above mentioned, will not improve for the Indigenous Australian population.

There are some common threads that run through different conceptions and definitions of what is considered “mental health”, “mentally ill” and “mentally disabled”. There is not, however strong consensus on any one definition of any of these terms. Not only are definitions of mental illness and wellbeing influenced by personal experience, but conceptions and learnings about mental health, mental illness and/or wellbeing evolve with time, place, and culture - as do their respective definitions. When conceptions of mental health evolve decisions about patients should be reviewed to ensure that the measures put in place continue to be relevant and appropriate.

This is of critical note when you consider that it is how we perceive and define mental health, illness and wellbeing that direct the way we approach better avenues to deal with such issues. An imperative tool in guiding the future of mental health matters in Australia is of course the respective legislation. VALS argues for a broader scope of what is considered under definitions of mental health or mental illness in order for the prospective legislation to attempt to be as inclusive as possible.

According to the World Health Organisation, mental illness refers to ‘the existence of a clinically recognisable set of symptoms or behaviour associated in most cases with distress and with interference with personal functions’ (1992:3). While this definition is convenient in its succinct form, VALS finds the following definitions more appropriate in relation to what should be included in local conceptions.

The National Mental Health Plan 2003-2008 defines

Mental health as:

A state of emotional and social wellbeing in which the individual can cope with the normal stresses of life and achieve his or her potential; and

Mental illness as:

A clinically diagnosable disorder that significantly interferes with an individual’s cognitive, emotional or social abilities

The above conceptualisation of mental health resonates with the notion of ‘social and emotional wellbeing’ – a term which is now widely accepted in Australia as one which significantly aids current understandings of the association between mental health, physical health, and social disadvantage (Jones & Day 2008). Further, the central role of family, culture and community in mental health is highlighted. The term ‘well-being’ has broader scope than the term ‘mental health’.

¹ Suicide Prevention Australia (SPA) position statement as at <http://suicidepreventionaust.org/PositionStatements.aspx>

Another broadening of considerations of mental health matters is included in the *Victorian Department of Justice Mental Health Strategy Project 2008* that reflects a behavioural rather than a diagnostic definition of ‘cognitive impairment’. The adoption of this broader scope of focus on mental illness than what is provided in the *Mental Health Act 1986* is important as it includes intellectual abilities, personality disorders and other impairments that influence and affect people and the aspects of the justice system they come in contact with. This definitional and conceptual broadening of mental health matters represents a positive step towards a more holistic view of the role of mental health and interaction with the justice system.

Considering intellectual disability and mental health data on Indigenous Australian people in prison

National data suggests intellectual disability it is more than three times as prevalent for Indigenous Australians (7.5%) than for non-Indigenous Australians (2%) members of the general population and when the rates of any disability or long term health condition that limits core activities were measured, Victoria data revealed an Indigenous rate of 25% - double that observed for non-Indigenous members of the population (Jones & Day 2008).

Research further indicates the overrepresentation of people with a cognitive disability in the criminal justice system, with difficulties in identifying such cognitive disability in offenders being further compounded for those who are Indigenous:

The problem of disability being masked by other factors of disadvantage is perhaps most evident when it comes to contact with the criminal justice system. If a brain injury is acquired early in life, and is never properly assessed, there is the potential that behaviours that are a consequence of that brain injury will never be properly attributed. During contact with police, behaviour is much more likely to be connected with the immediate influence of drugs and alcohol, or perhaps implicitly linked to the fact of Aboriginality rather than a brain injury. A lack of response to questions may be viewed as being the consequence of language and cultural barriers, rather than reflecting a lack of understanding” (Simpson & Sotiri, 2004: 11).

It is broadly accepted that a least a significant minority of all prisoners would meet the criteria for a diagnosis of a major mental disorder. Further, given the levels of overrepresentation of Indigenous Australians in the prison system, it is logical to assume that rates of mental disorder that are currently being reported for the general prison population will significantly *underestimate* the rates of mental illness for Indigenous prisoners (Jones & Day 2008). Therefore the levels of mental illness in the Indigenous Australian prison population are likely to exist at even higher rates than what is known of at present.

Corrections Victoria’s *Victoria Prisoner Health Study* (2003) concluded:

The overwhelming impression conveyed by the data is that the prisoner population is far less mentally healthy than the wider Victorian population. The overall pattern of findings reflects a greater prevalence of all the major mental illnesses than is found in the general population. Moreover, a very high percentage of prisoners have attempted suicide or otherwise engaged in acts of self-harm. The prevalence of addictive behaviour is also extraordinarily high. This situation is serious enough to require that careful attention be paid to the provision of broad-based mental health services to prisoners (Deloitte Consulting, 2003).

Indigenous Australian's experience of the traditional mental health system is that it does not take a holistic approach and hence is limited in its scope to assist Indigenous Australians. According to research released this year, there is a need for renewed focus on the wellbeing of Indigenous Australians, as results (based on data from the *2002 National Aboriginal and Torres Strait Islander Survey*) found that those with strong cultural attachment have significantly better self-assessed health, are more likely to be employed and are least likely to have been arrested in the past five years:

The findings also support the view that there are other means by which Indigenous disadvantage can be addressed and that restoration of Indigenous attachment to their culture may be an integral part of the solution (Dockery in ScienceAlert Australia & New Zealand 2009).

Importance of wellbeing

There is an increasing focus on mental health and wellbeing in correctional facilities and how they are addressed in and through corrections processes. The present Victorian Corrections Regulations 2009 Regulatory Impact Statement highlights the need for increased attention on a wide range of mental health issues in Corrections regulations.

VALS is concerned by claims of the following:

Our involvement with Indigenous Australian women in prison would indicate that often mental health issues are responded to punitively. Lashing out at prison officers, aggressive behaviour, verbal abuse and non-compliance with prison rules or direct orders, often result in breaches of prison rules. A 'smart' approach to prisoner behaviour is better than a 'tough' or punitive approach. Where the prisoner involved has a known mental health issue, it would be worth discovering whether this status bears on the presented behaviour. We submit that it does and so warrants a culturally specific response, the absence of which leads to the over-representation of Indigenous Australian women in the management unit (Cerveri et al 2005: 19, 33-34).

The data also revealed that mental health problems of Indigenous Australian prisoners are less likely to have been identified either in the prison itself or previously whilst in the community. From this, a clear pattern of under-diagnosis or misdiagnosis can be considered to be occurring in likely conjunction with a dearth of accessible and culturally appropriate services in existence for Indigenous Australian persons. Attention to identification and diagnosis of mental illness should be considered critical in correctional settings if the role of corrections is to be, as it claims, an avenue for rehabilitation and reintegration back into society.

VALS made the following points that relate to mental health in its recent submission in response to the Statement and other points are distributed throughout this document.

- VALS agrees with the statement: "In a correctional setting more formal measures are required to ensure the human rights of prisoners and offenders, and other members of the correctional system, are not arbitrarily interfered with, and are balanced with the safety needs of the general community." (Corrections Victoria 2009:8). Given the over-representation of Indigenous Australians in the criminal justice system, VALS is acutely aware that Corrections Regulations should reflect an awareness of trends in the prison population specific to Indigenous Australians. The prison system is predominantly

- The Charter of Human Rights and Responsibilities includes the right to a fair hearing (section 24). VALS' questions whether prisoners are receiving access to a fair hearing in light of the fact noted in the Statement that the current appeals mechanism is being used at a drastically low rate (7 judicial review proceedings in relation to Governor's Hearings since 2002, therefore averaging 1 per year) in comparison to the projected use of an improved appeals system in the form of a specialist tribunal for appeals (2,775 reviews per year).
- The practice of classifying a prisoner and then placing them at a prison for prisoners of a higher classification is questionable in light of the Charter, as is the practice of automatically placing remand prisoners in maximum security setting.
- In order to enable Indigenous Australians to have full access to "family" a spent conviction scheme should be introduced. Indigenous Australian's are disproportionately affected by the requirement that a visitor must have no criminal conviction given their over-representation of in the criminal justice system. The absence of a spent conviction scheme results in community members being prevented from volunteering at prisons and Indigenous Australian prisoners being denied the well-being associated with being visited.

Ways Forward

When looking to consider appropriate measures for mental health that focuses on Indigenous Australians, the *Ways Forward* report (1995) is remains one of the most significant. This report set the policy agenda for the development of Indigenous Australian mental health services across Australia, identifying high levels of unmet need for mental health services and promoting culturally sensitive and appropriate mental health services (Jones & Day 2008). The state of affairs at the time of *Ways Forward* writing was described as follows:

Where there was contact with or use of mainstream health services they were frequently seen as unhelpful, non-responsive, inaccessible or unavailable, and totally failing to respond to the needs of Aboriginal people with mental illness. Misdiagnosis, the inappropriateness of Western models, failure to recognise language differences, ignorance of Aboriginal culture and history, and racism complicated the picture. On occasion there were helpful individuals or models of service, but the overall picture is one of gross inadequacy and perceived need (Swann & Raphael 1995:44).

The report identified a wide range of unmet service needs for Indigenous Australian people with mental health problems, including a lack of:

- Indigenous Australian places of care/healing and access to traditional healers;
- Crisis teams;
- Culturally appropriate early intervention, inpatient mental health and rehabilitation and recovery programs;
- Direct involvement of consumers and carers in service development;
- Appropriate supportive accommodation options for the chronically mentally ill
- Alignment of mental health legislation with Indigenous Australian people's human rights and cultural needs.

Jones and Day (2008) point out the way in which the *Ways Forward* report demonstrated the criminal justice and mental health systems exacerbate mental health concerns for Indigenous

Australian people in many instances. Examples include forced separation or the imposing of treatment and management regimes that are culturally inappropriate or not discussed sufficiently with the patient or family. The report overall recommended that Indigenous Australian forensic services be added to current mainstream structures staffed by specialist teams with expertise and knowledge of Indigenous Australian culture.

The *Ways Forward* report importantly also noted the following:²

- It is important to consider mental health and substance abuse issues together rather than rather than separately. The structure of mainstream services generally separates them.
- It is of vital importance to build Indigenous-appropriate models of counselling. ‘Talking’ was repeatedly seen as being a powerful avenue for healing.
- Workforce development requires cultural competency training for non-Indigenous Australian and Indigenous Australian approaches to mental health.
- Indigenous Australian people and communities need to build capacity so that such services can be delivered more effectively.
- Consistent data collection, research and evaluation is needed to establish a reliable baseline of information on Indigenous Australian health.
- Of critical and fundamental importance is that all of the above initiatives would need to occur within a broader framework of Indigenous Australian self-determination. The report stated that herein lies a potential contradiction between the Indigenous Australian community needing capacity-building on the one hand and self-determination on the other. VALS does not see this as a contradiction and an excuse to reject the concept of Indigenous Australian self determination. In fact it makes sense that for a community that has been oppressed by colonisers, the colonisers should have a role in returning capacity of the community that has been destroyed. It is essential that Indigenous Australians are supported in terms of capacity to exercise self-determination otherwise any Government policy relating to Indigenous Australian self-determination is possibly setting an Indigenous Australian community up to fail.

While significant, it must be kept in mind that the *Ways Forward* report was written over thirteen years ago. However, subsequent policy frameworks have used some of its key elements. Examples include the *National Mental Health Plan 2003-2008*, the *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples Mental Health and Social and Emotional Wellbeing 2004-2009*, and of course the Department of Human Services’ 2008 *Because Mental Health Matters*.

² As noted in Jones and Day 2008:14.

Social Conditions

The change of social conditions is crucial to any crime prevention consideration.

We are encouraged to believe is that social factors are largely irrelevant in the genesis of criminal behaviour and that there are some people who are by nature disposed to deviance and have “a compelling propensity” to commit crime. They are intrinsically different from the rest of us and are not amenable to change. The inevitable conclusion is that the world is divided into those who are committed law abiders and those who engage in crime and that, to protect the community, the latter group need to be incarcerated since they cannot be rehabilitated. At the core of this focus on fear is the process by which the dominant social group defines into existence an inferior group, the “other”. It is no accident that the most disadvantaged and powerless minorities in our society fulfil this role (Lawrence 2007: 2).

Being “tough on crime” does not mean the same thing as being *smart* about crime and crime reduction. The fact remains that tough on crime measures don’t make people safer through the reduction of crime. We are taught from a very young age that prevention is better than cure. Surely it is conceivable that restorative justice (see below) can be part of a move towards not only dealing with criminals who have entered the criminal justice system in an appropriate way, but also can help fill the need to stop criminals from being made in the first place.

Legal Issues for People with Mental Illness.

Consultations undertaken by Karras et al (2006) through the Law and Justice Foundation of NSW indicated that people with a mental illness experience particular legal issues. Such issues often reflect their financial and social disadvantage, as well as their incapacity that may be caused by their illness. The legal issues identified, range from failings under the NSW *Mental Health Act 1990* and adult guardianship issues through to housing, employment, discrimination, domestic violence and family law and care protection issues. They argue: ‘These legal issues can have serious financial and personal consequences if not addressed, which highlights the importance of resolving them through accessing legal assistance’ (xviii).

Barriers to accessing legal assistance

The consultations for this same project also revealed that people with a mental illness face a number of barriers to accessing legal assistance, including:

- *A lack of awareness of their legal rights* – individuals do not realise that their problem has a legal element and a potential remedy.
- *Being overwhelmed*, and therefore too frightened, or lacking the motivation, to seek legal assistance.
- *Being mistrustful*, or frightened of, divulging personal information to legal service providers which may prevent the service provider from adequately assisting the client.

- *Difficult behaviour* – some individuals with mental illness may exhibit difficult behaviour that makes it challenging for service providers to assist them.
- *Lack of mental health care and treatment*, in the absence of which, can result in the exacerbation of the above barriers (Karras 2006).

In addition to these individual barriers, those that were interviewed in this research project argued that there are also systemic barriers experienced by people with mental illness accessing legal services. These include:

- *The limited availability of affordable legal services*
Given that people with a mental illness tend to have lower levels of income, they are likely to be reliant on increasingly stretched services such as Legal Aid, Community Legal Centres (CLCs), Aboriginal Legal Services and pro bono legal service provision.
- *Time constraints placed on legal service provision*
Stakeholders argued that while people with a mental illness often require longer appointment times with lawyers, the limited resourcing of CLCs, Legal Aid and Aboriginal Legal Services make this extremely difficult.
- *Remote, rural and regional issues*
Stakeholders suggested that the lack of affordable legal services is even more pronounced in rural in regional areas. The organisation and cost to travel long distances to access services can create additional barriers.
- *Difficulties in identifying mental illness*
Legal service providers may not always be able to identify that a client has a mental illness. This may result in a person not receiving the time, assistance and understanding they need to resolve a legal issue.
- *A perceived lack of credibility*
Stakeholders observed that some lawyers find people with mental illness less credible, and are less inclined to believe what they say, and more ready to dismiss their claims (Karras 2006:xix-xx).

Barriers to participating in the legal system

The Karras (2006) study also identified a number of barriers that prevent people from accessing and participating in the legal system. It was noted that while cognitive impairment is not always a symptom of mental illness, this can create barriers in understanding legal documents and their terminology and understanding legal processes within the broader justice system. In addition, features of the courtroom environment, in terms of their structure and formalities, can intimidate people with a mental illness and this has the potential to exacerbate their symptoms.

Finding also suggested certain benefits of Alternative Dispute Resolution for people with a mental illness. Concerns were raised, however, around the problem of people with a mental illness being unrepresented during the ADR process and therefore creating power imbalance between the parties involved.

Criminal Legal Issues

Research indicates instances where people with a mental illness may be charged with offences relating to behaviour arising from their illness such as offensive language and conduct, assault, resisting arrest and assaulting police:

As a general rule it's usually public disorder ...where they bring themselves under notice due to their actions.³

A lot of our clients with mental health issues or alcohol problems get pulled up on offensive language. If they are walking a bit strangely or they look like they are under the influence, a police officer will pull them up.⁴

Jails and the Mentally Ill

The prevalence of mental disorders detected in jail populations gives rise to expressions of how jails are replacing hospitals for the mentally ill in many western countries (Draine, Salzer, Culhane & Hadley 2002). One explanation for the increase in the number of people in jail with a mental illness is that these individuals are also members of other groups with a high risk of being arrested (such as substance users, unemployed, fewer years of formal education, lower income etc; Draine et al 2002). The phenomenon of persons with a mental illness being disproportionately caught up in the criminal justice system because of their greater risk of arrest has been documented in Australia in a study showing an increase in the numbers of persons with schizophrenia who were arrested after deinstitutionalisation. Interestingly this was accounted for by an increase in arrest rates in the general population and not by psychiatric status (Mullen, Burges, Wallace et al 2000 in Draine et al 2002).

This finding goes against conclusions of mental illness being criminalised or that institutionalisation has shifted from state hospitals to jail (Whitmer 1980 in Draine et al 2002). Draine et al highlight that 'few mental health interventions are conceptualised around the idea that many individuals could reasonably be treated as both criminal offenders and recipients of mental health services' (2002:567). In light of the above, it could be argued that pro-arrest and pro-incarceration and 'tough on crime' policies and practices are by their nature are inappropriately incarcerating the mentally ill over other alternatives.

Consultation Paper item 3: Involuntary Orders

The legal right of informed consent to or refusal of medical treatment is generally recognised. This exists outside the mental health context. While the current mental health legislation places limits on the circumstances in which involuntary treatment can be given, this is done via defining what constitutes mental illness in conjunction to containing grounds that must be met before a person can be treated involuntarily.

Definitions of what constitutes mental illness directly affect the grounds on which decisions are made around involuntary treatment. The provision of involuntary treatment raises a plethora of considerations and concerns in respect of the rights contained in the Victorian Charter of Human Rights and Responsibilities and in international Disabilities Conventions.

³ Consultation with NSW police inspector in Karras et al 2006:58.

⁴ Consultation with CLC workers in October 2004 in Karras et al 2006:59.

The Act contains five grounds that must be met before a person can be placed on an involuntary order:

- 1) Appears to be mentally ill – mental illness in the Act is defined as ‘a medical condition that is characterised by a significant disturbance of thought, mood, perception or memory (s 8(1A))⁵.

VALS is concerned that the above grounds of “appearing” to be mentally ill is, without the expressed requirement of thorough diagnosis is dangerous and callous. While it is recognised that the provision of involuntary treatment exists to instigate immediate treatment (see second grounds below) it should be recognised that treatment without thorough and correct diagnosis has the possibility of being counterproductive.

- 2) Requires immediate treatment
- 3) Necessary for health or safety or public protection (see later discussion)
- 4) Refusal or inability to consent – there is no definition in the Act of what constitutes capacity to consent to treatment. This is a huge gap in the mental health legislation that needs to be addressed.

In considerations of definitions of what constitutes capacity to consent, VALS recognises the contemporary handling of this issue internationally. In Scotland, for example, the *Adults with Incapacity Act 2000* moved away from an ‘all or nothing’ idea of capacity (i.e. a person either had full capacity to make a decision or none at all). The contemporary Act recognises that:

- Capacity is decision-specific and that someone may be capable of making certain types of decisions but not others and this may depend on the complexity of the decision made;
- A person’s capacity may remain stable, improve, fluctuate or deteriorate (The Scottish Government 2008).

The *Adults with Incapacity Act (Scotland) 2000* represents legislation that reflects an understanding of the nature of mental illness. It is complex, changing, and requires flexibility. This particular Act in an everyday context defines mental capacity as the ability to make decisions or take actions affecting daily life and in a legal context refers to a person’s ability to do something, including making a decision which may have legal consequences for the person themselves or for other people:

The law says an adult lacks legal capacity to make a particular decision when there is evidence that he or she is unable to:

- *Understand the information relevant to the decision; or*
- *Make a decision based on the information given; or*
- *Act on the decision; or*
- *Communicate the decision; or*
- *Retain the memory of the decision* (The Scottish Government 2008).

VALS strongly argues for revised mental health legislation for Victoria to include stipulations and definition pertaining to the nature of what is considered capacity to consent.

⁵ The definition covers psychotic disorders such as schizophrenia as well as non-psychotic disorders such as disorders of mood, severe obsessive compulsive disorder, anorexia nervosa and dementia.

5) No adequate less restrictive treatment available

3.2.2 Making Involuntary Orders

The consultation paper states that if an involuntary order is made by a medical practitioner or mental health practitioner, the authorised psychiatrist must examine the person within 24 hours to confirm whether or not the person meets the grounds for an involuntary order. VALS supports the revised *Mental Health Act* preservation of the existing legislation stipulating that if a person has capacity to consent (with definitions of what ‘capacity’ to consent constitutes to be addressed) but refuses to consent, interim psychiatric treatment cannot be provided before the authorised psychiatrist confirms whether or not the person meets the grounds for an involuntary order.

The Act does not specify the duration of an involuntary treatment order or the frequency at which a person must be clinically reviewed however a person on a community treatment order must be clinically reviewed at regular intervals to ensure they continue to meet the grounds for involuntary treatment. VALS supports periodical and frequent review of any involuntary treatment should be made mandatory. The fluctuating and every-changing nature of mental illness and its interaction with treatment needs to be closely monitored. There is additional call for accountability and transparency when treatment is being administered involuntarily.

3.3 Rethinking Involuntary Orders

3.3.1 Definition of mental illness

As touched on earlier, definitions and conceptualisations of what is considered mental illness has significant impacts on the scope of consideration; what is excluded; what is considered appropriate treatment; when consent is needed; and what elements are treated as of critical importance and therefore given attention.

While it was argued earlier that conceptions around mental health and wellbeing should be considered as broadly as possible in order to increase the likelihood of legislation that can be as positively inclusive as possible, this is not to say that this should also act to broaden the scope of individuals who should be considered to be treated involuntarily.

The Act specifies exclusions on which basis alone a person may not be considered to be mentally ill. The example given in the consultation paper is that a person with an antisocial disorder cannot be considered to be mentally ill. However, if the same person also “appears to be mentally ill” this person can be placed on an involuntary order. The lax stipulation of “appearing” to be mentally ill is a drastically insufficient decision making tool.

3.3.2 Assessment order

VALS is concerned about one of the grounds in the Act that *the person appears to be mentally ill*. The result of this is that there needs only to be the appearance of a mental illness for a person to be made an involuntary patient. This is with no actual diagnosis of mental illness made. This highly discretionary provision creates room for great inconsistencies and ineffective and potentially unethical categorisation and treatment.

VALS strongly supports the separation of the involuntary treatment process, as with some other Australian jurisdictions, where a staged process allows for an assessment order that allows for a period of assessment prior to diagnosis of mental illness. Only after this or equivalent process of assessment takes place should decisions around involuntary treatment be considered. Involuntary treatment should not be allowed to be given during an assessment stage under the vague provision of *appearance* of mental illness.

3.3.3.1 *Refusal or inability to consent (involuntary orders)*

There is great debate around whether it is ever acceptable or appropriate to treat a person involuntarily when that person has the capacity to consent and has refused treatment. Having clinicians rely on the common law test to determine whether a person has capacity is not sufficient in this complex area.

3.3.3.2 *Risk to the person or others*

To meet this ground, treatment must be necessary for only **one** of the following purposes:

- Because of the person's mental illness, involuntary treatment of the person is necessary for his or health or safety (whether to prevent a deterioration in the person's physical or mental condition or otherwise); or
- For the protection of members of the public.

VALS supports the argument that involuntary treatment to protect the person's health or safety or to protect others need to have some level of seriousness specified. 'Protection' of members of the public is very vague and does not indicate what members of the public are to be protected, and what they are to be protected from. Other jurisdictions that require a likelihood of *serious* or *immanent* risk to the person or others, or as is the case in the Australian Capital Territory, a 'serious' mental or physical deterioration, or 'immanent' harm to a person or others as is the case in the Northern Territory, exist as a more appropriate measure against which decisions of urgency and involuntary treatment should be made against.

Further, in Victoria the Act does not require that the treatment be likely to be effective. Without this requirement, VALS argues that decisions of that can be regarded as "necessary" treatment cannot be made.

3.3.4 *Consent to treatment and safeguards*

Scotland is an example of thinking inline with current understandings of the nature of mental illness and issues of treatment, consent, and protection to the individual. In all of these areas, the existing Victorian legislation remains extremely outdated and reveals itself as overdue in the revision it is now receiving. As highlighted in the consultation paper, a clinician in Scotland cannot provide involuntary treatment for a person who is unable or refusing to consent without considering the following:

- The persons reason for not consenting;
- The views of the involuntary patient and a nominated person together with any advance statement; and

- The efficacy of the treatment.

Further, the clinician must record all reasons in writing as to why the treatment is being provided and in what way it is in the patient's best interest. Without this involuntary treatment cannot be provided. The above procedure should be considered as a base standard for administration of any involuntary treatment for a person who is unable to, or is refusing to, consent. A similar procedure could have additional benefits of accountability and transparency that can act not only to protect the individual patient and practitioner, but it can also document trends in decision making and inform future decisions in this area of the mental health legislation in the future.

In Scotland there is an additional safeguard that if treatment is to continue beyond two months, an involuntary patient who is unable or refusing to consent can only receive medication after an independent psychiatrist provides a second opinion that a) the person is unable to consent or is refusing to consent, and b) the proposed treatment is in the person's best interests.⁶ This should also exist as a minimum requirement. Without such safeguards built into the legislation, the onus of making change to treatment or obtaining a second psychiatric opinion is placed on the individual who may or may not be experiencing mental illness. A barrier to an individual seeking a second opinion may be cost or accessibility.

As noted earlier, some individuals with mental illness often experience compounding sources or disadvantage and marginalisation resulting in lower levels of education, reduced likelihood of employment, and lower income. To access a second opinion when given an involuntary treatment order should not be dependent on the individuals' ability to pay for a private practitioner. Second psychiatric opinion schemes are also existent in New Zealand, Wales and England. Access to a second psychiatric opinion in Australia should be a right, especially in cases where a person's decision making ability is being striped and their liberty effectively diminished.

Capacity

The very concept of capacity and related issues is an area that requires thorough consideration. The concept of capacity is relevant in Victoria both in relation to the criteria for involuntary treatment and also in relation to the ability of a patient to consent to treatment.

While "capacity" is part of the criteria for involuntary treatment, there is no 'capacity test' or definition in the Act. As previously mentioned, Scotland takes into account the fluctuating nature of capacity for a person with mental illness and accordingly has a 'significantly impaired test'.

In relation to consent for treatment, VALS supports a move towards a 'supported' decision making model in place of a substituted decision making model. The latter represents the expert making decisions for treatment for the patient as they see fit. The former takes the patient's preferences and opinions into account. This is another area where advanced statements or advance directives could be of use (please refer to later discussion on advance statements for further comment). VALS also encourages the exploration of an independent opinion scheme in cases where a patient does not consent or is deemed incapable on consenting. In this scheme VALS would argue there would be great benefits for such a position to be filled by an Indigenous Australian person where Indigenous Australian patients are concerned. Arguments for increased co-operation and positive engagement in treatment on behalf of the patient decisions are of strong relevance in this matter.

⁶ *Mental Health Act (Care and Treatment) (Scotland) Act 2003* in consultation paper, p22.

3.3.6 Community treatment orders

Community Treatment Orders (CTO) have been active in many parts of the world in the past couple of decades following widespread occurrence of deinstitutionalisation and establishment of mental health services in the community.

As an alternative to inpatient care, CTOs is desirably structured as a long-term therapeutic relationship between the patient and the community team:

They may support the involvement of families and other agencies in care and may have a significant impact on a patient's attitude to their illness. These complex effects may lead in turn to clinical improvement and enhanced insight, reducing harm.⁷

Dawson (2004) considers a central feature of Australasian CTO legislation that is particularly relevant to their operation is the criteria for their use focuses largely on serious mental illness and its consequences, not on intellectual disability or personality disorder.

Dawson also holds that the Australasian statutes 'illustrate acceptance by our legislatures of the view that deinstitutionalisation of mental health services should be matched by deinstitutionalisation of the law' (2004:4). It is therefore the location and nature of these community treatments that should be in question. The local context for the implementation of CTOs is a vital consideration. For example, mobile community health services have rapidly developed in the last 30 years with 'a relatively non-hierarchical culture, including many experienced community nurses, and, in NZ, often including Maori mental health workers' (Dawson 2004:4).

Imprisonment is far more expensive than community mental health care. The hundreds of millions of dollars spent every year on Victorian prisons could be better spent. The Victorian Council of Social Services (VCOSS) has found that providing intensive residential support to people with mental illness is comparable in cost to prison but instead makes a 'positive contribution to people's health and wellbeing, as well as contributing to a reduction in crime and savings to the justice system' (in Smart Justice 2009:1).

Consultation Paper item 4: Patient Participation in Treatment and Care

The Act currently sets out the rights of involuntary patients including: receiving a written statement and explanation of their rights; involvement in treatment planning; obtaining a second psychiatric opinion; appealing involuntary orders; and appearing at Mental Health Review Board hearings.

VALS notes the consultation paper's mention of patient advocates arguing that many involuntary patients are not aware of their rights and find it difficult to exercise them. VALS agrees that one way to help both involuntary and voluntary patients understand their rights, and therefore effectively exercise those rights, could include an independent support person (this would be incredibly vital to individuals with no family or family member they wish to have a say in treatment and care decisions) who can assist patients in awareness and access to improved treatment plans, culturally appropriate options and advocacy.

Ways to help both involuntary and voluntary patients to understand and exercise their rights could include: a person nominated by the patient to receive information; an independent support person

⁷ Romans et al 2004 in Dawson 2004:2 from results of a national survey of New Zealand psychiatrists concerning their views on New Zealand's well established CTO regime.

who can assist patients including advocacy; improved treatment plans; and allowing people to make an advance statement.

For patients to actively participate in their treatment and care, they must have access to information about their rights and have adequate knowledge about treatments that are being offered to them. As the consultation paper highlights, when patients are involved in decisions about their own treatment, outcomes such as strengthened participation and lower rates of involuntary readmission, are found to occur.⁸

4.3.3 Patient involvement in treatment planning

The Mental Health Legal Centre communicates a strong position that each consumer knows best about the lived experience of their 'illness'. Therefore decisions made by others on their behalf will never act adequately as a substitute for the decisions people make for themselves when it concerns their own life.

This position points to considerations of self-determination. Far from being a simple catch phrase used in political circles used to give impressions of Indigenous Australian consideration, self-determination is a crucially important issue to anybody's ongoing wellbeing.

4.3.5 Advance statements

A written statement setting out a person's wishes and preferences for future treatment and care in the event that a person becomes unable to make such decisions can act as a safeguard as well as an indication of a person's preferences that can therefore remove treatment and decision dilemmas of a significant nature.

Advance statements, sometimes referred to as advance directives, also have the potential to provide legal protection for individuals and families against certain measures to be taken as treatment changes along with the patient's condition. While in some forms advance statements are not legally enforceable, they may still have value if given serious consideration by mental health workers. Of course enforceable rights through this mechanism would encourage and improvement in the recognition of the rights of people with a mental illness.

As the Act does not in its current form refer to advance statements or the like, VALS encourages the inclusion of this consideration in the review of the Mental Health Act. Advance statements are one way that patients can seek to maintain authority over their lives in a way that will in both the long and the short term keep them well (Federation of Community Legal Centres 2009).

Advance statements or directives could also be useful in an individual's expression of one treatment option over another. It could further carry out patients wishes in terms of whom mental health care workers talk to about treatment, such as particular family members that they do or do not wish to have knowledge of, or say over treatment or lifestyle decisions. An advance statement could also prove useful when a patient moves between services. This brings to mind the possibility of a state or national register of advance statements.

In Victoria common law regarding advance directives or statements suggests that when a person is deemed to be 'competent' their advance statement will be respected (Federation of Community

⁸ Rosenman 2000 in Consultation paper, 27

Legal Centres 2009).⁹ Once a person is deemed ‘incompetent’ however, the directive is in a much weaker position. Queensland is the only jurisdiction in Australia which provides for some form of advance statement in mental health legislation.

Nominated/ Allied person

Some jurisdictions provide for a patient to ‘nominate’ a person who will provide a support role. In other jurisdictions this person must be told when certain things happen (e.g. when a patient is placed on treatment order, when order altered or removed, when ECT is planned to be administered etc). Advance statements could be useful in this area should something happen to their first nominated person or this person for whatever reason is no longer able to fulfil this role.

If a mechanism such as this was established, VALS is curious as to the potential powers and roles of these nominated persons and how the nominated person’s capacity to be in this nominated role would be measured and certified at the time.

Some jurisdictions have a ‘default’ hierarchical list of who fulfils the role of nominated/allied person when patient deemed incapable of nominating/doesn’t nominate. Some jurisdictions provide for a patient to stipulate certain individuals who they do not want made their nominated/allied person in the event of incapacity.

Consultation Paper item 6: Restraint and Seclusion

VALS supports the Consultation Paper’s suggested move towards reducing the number of patients subject to restraint and seclusion, as well as the frequency and duration of these interventions, wherever possible through establishing alternative strategies.¹⁰ VALS argues that it should be emphasised in the legislation that such practises are to be used only as a last resort.

The reduction and elimination of restraint and seclusion is a priority identified in the *National Safety Priorities in Mental Health: A National Plan for Reducing Harm* (2005). The goal of this plan was to ‘identify, avoid, or reduce, actual or potential harm from mental health care delivery in all environments in which it is delivered’ (1). In this plan it is noted that restraint and seclusion are not a substitute for inadequate resources and are not to be used as a method of punishment. Further, if used in either of these ways is a serious contravention of consumer rights.

VALS strongly endorses this national plan in its argument for a non-punitive approach and culture that rewards incident reporting and is supportive of continuous quality improvement. VALS considers mental health a public health issue rather than a criminal issue and so a ‘tough’ approach is not as effective as a ‘smart’ approach which takes into account the dynamics of mental health. For further information on a smart approach see the discussion on restorative justice below.

VALS questions whether the grounds for restraint and seclusion practices should be changed. Victoria has fairly wide grounds at present. For example s81 of the Act outlines that mechanical restraint can be used ‘if the treatment is necessary for’:

- the purposes of medical treatment; or

⁹ The Federation of Community Legal Centres express that consumers are doubtful about this. They suggest that ‘perhaps it is better to suggest that this is respect-in-principle rather than respect-in-practice’ (2009).

¹⁰ Victorian Government Department of Human Services (2008) *Review of the Mental Health Act 1986 – Consultation paper – December 2008* Melbourne: Mental Health and Drugs Division, p. 41

- to prevent the person from causing injury to himself or herself or any other person; or
- to prevent the person from persistently destroying property.

VALS questions whether ‘persistently destroying property’ is appropriate grounds to justify current restraint and seclusion practices.

Under s 82, seclusion can be used if it is necessary to protect the person or any other person from an immediate or imminent risk to his or her health or safety *or* to prevent the person from absconding. VALS also questions the validity of whether ‘to prevent from absconding’ is an appropriate grounds and justification for seclusion even if there is no risk to health and safety.

For purpose of comparison, the State of Queensland provides that seclusion must not be authorised unless doctor/nurse reasonably satisfied that ‘it is necessary to protect the patient or other persons from imminent physical harm *and* there is no less restrictive way of ensuring the safety of the patient or others’ (see s 151). In relation to mechanical restraint, a doctor may authorise the use of mechanical restraint on the patient only if the doctor is satisfied it is the most clinically appropriate way of preventing injury to the patient or someone else (see s 143). This is in line with the United Nations *Principles for the protection of people with mental illness and the improvement of mental health care*:¹¹

Physical restraint or involuntary seclusion of a patient shall not be employed except in accordance with the officially approved procedures of the mental health facility and only when it is the only means available to prevent immediate or imminent harm to the patient or others. It shall not be prolonged beyond the period which is strictly necessary for this purpose. All instances of physical restraint or involuntary seclusion, the reasons for them and their nature and extent shall be recorded in the patient's medical record. A patient who is restrained or secluded shall be kept under humane conditions and be under the care and close and regular supervision of qualified members of the staff. A personal representative, if any and if relevant, shall be given prompt notice of any physical restraint or involuntary seclusion of the patient.

This UN principle is endorsed in the Australian Government Department of Health and Aging’s *National Safety Priorities in Mental Health: A National Plan for Reducing Harm* (2005).

While Victoria currently regulates mechanical restraints and seclusion only, VALS supports calls that there also be regulation for physical restraint (Tasmania and the ACT are the only jurisdictions that do so). VALS also argues in favour for regulation around chemical restraint.

6.3.4 Monitoring of restraint and seclusion

It is currently considered ‘clinically appropriate’ to the review of a secluded person’s condition by a nurse is at intervals of not more than 15 minutes. Alternatively, Queensland provides for continuous monitoring of seclusion. And, if seclusion is authorised by the senior registered nurse on duty then patient must be continuously observed while in seclusion under this authorisation (s157 of QLD MHA). If seclusion is authorised by a doctor, the senior registered nurse on duty must ensure that the patient is continuously observed, *unless* the doctor states in the authorising order that ‘it is not

¹¹ UN principles for the protection of people with a mental illness, Principle 11, paragraph 11. (available at <http://www.unhchr.ch/html/menu3/b/68.htm>)

clinically necessary to observe the patient while secluded'. The doctor must then specify the intervals (not longer than 15 minutes) at which the patient must be observed (s 154 of QLD MHA).

Consultation Paper item 7: External Review and Appeals

The presence of an external body to conduct reviews and appeals of involuntary orders is key to any modern mental health legislation in order to safeguard the rights of involuntary patients in addition to monitoring the effectiveness of methods used in relation to such patients. As stipulated in the consultation paper, the Disabilities Convention requires that involuntary orders apply for the shortest time possible and are subject to regular review by an independent and impartial authority or judicial body.¹²

7.2.1 Board hearings

The Mental Health Review Board (MHRB) hearings in Victoria presently exist as quasi-judicial body that aims to provide external review of involuntary orders and to hear appeals. Such an external review body acts not only to increase transparency and accountability, especially with reference to involuntary treatment patient care decisions, but also acts to protect the rights of people that suffer from a mental illness.

The board currently conducts reviews of involuntary orders within eight weeks of the order being made and then once twelve months following. VALS is very concerned that reviews of involuntary orders are allowed eight weeks to be undertaken. This is a very long period of time for a person to be under an involuntary order without evaluation. VALS calls for this initial review to be conducted in a timelier manner. Also, the right to a fair hearing means that patients have access to relevant information within a reasonable amount of time prior to appearing before the Board.

The board also hears appeals against involuntary orders. As hearings usually involve a legal member, a psychiatrist and a person representing the views and opinions of the community, VALS argues that the latter should be a true community representative rather than simply an objective third party. The Indigenous Australian community in Victoria is unique, and therefore a person representing opinions of the Indigenous Australian community in hearings should be, where possible, a member of the Koori community when an Indigenous patient's treatment decisions are being presided over. This could take the form of a Koori Mental Health Liaison Officer. The standing of such an Indigenous Australian may be similar to that of Elders in the Koori Court or those who appear before the Parole Board. This would be an example of Indigenous Australian self-determination.

There should also be a Koori Mental Health Liaison Officer role at the Board. The role could involve acting as a middle person who is capable of understanding the perspective of Indigenous Australians and the mental health system. The liaison officer is in a position to provide useful information to Indigenous Australians and stewards of the mental health system. The liaison officer will enable the stewards to make informed decisions and help the Indigenous Australian with a mental illness to not feel so alone whilst appearing before the Board. The predominant loyalty of the liaison officer is to the Indigenous Australian person with a mental health issue, and the benefits that they can provide to stewards of the mental health system are a positive side effect.

¹² Disabilities Convention, arts 12(4), 13(1) as at consultation paper p.49.

As these hearings are currently held at Mental Health Services throughout Victoria, VALS also suggests that in order to provide for culturally appropriate and accessible mental health care, it should be considered a possibility to have hearings made readily available at Aboriginal Health Services.

Another issue in relation to appeals is that in its current form, Victoria's *Mental Health Act 1986* places the onus for initiation of an appeal on a patient. This element does not recognise the disadvantaged position occupied by some people with mental health issues and simultaneously assumes that individuals who are in disagreement with an involuntary order:

- (a) have knowledge of the existence of, or their eligibility to use an appeals mechanism; and
- (b) have access to legal advice and/or representation in dealing with appeal processes.

The above, and earlier discussions in this submission, are underpinned by principles found under the *Mental Health Act 1986* (Vic) that states when receiving treatment and care the age-related, gender-related, religious, cultural and language other special needs of people with a mental disorder should be taken into consideration.¹³ While arguments for the needs of Indigenous Australians can be made under the 'cultural' needs mention, the importance of giving more specific reference to the need of Indigenous persons in Victoria should be considered.

For example, the Northern Territory's *Mental Health and Related Services Act* (section 8) provides that the Act should be interpreted so that any powers of functions be performed in a manner which is culturally appropriate for Aboriginal persons:

8. Interpretation of Act

This Act is to be interpreted and a power or function conferred or imposed by this Act is to be exercised or performed so that:

...

- (g) the assessment, care, treatment and protection of an Aboriginal person or a person from a non-English speaking background who has a mental illness is appropriate to, and consistent with, the person's cultural beliefs, practices and mores.

Further, section 11 provides specific principles for Indigenous persons:

- 11. When providing treatment and care to a person of Aboriginal or Torres Strait Islander background the following principles apply:
 - (a) as far as possible, the person's treatment and care is to be appropriate to and consistent with the person's cultural beliefs, practices and mores, taking into account the views of the person's family and community;
 - (b) where the person is an Aborigine, the involuntary treatment is, where possible, to be provided in collaboration with an Aboriginal health worker.

The Northern Territory is also the only jurisdiction in Australia which provides for Aboriginal health workers in the mental health legislation. Further, legislation relevant to the Northern Territories Mental Health Review Tribunal (*Mental Health and Related Services Act*, section 118) provides:

¹³ Section 6A(g)

- The Tribunal consists of persons appointed by the administrator and the persons are to be:
 - (a) Legal practitioners who have had not less than 5 years experience as a solicitor or barrister in the Territory or in a State or another Territory of the Commonwealth;
 - (b) Medical practitioners; and
 - (c) Persons who have a special interest or expertise in mental illness or mental disturbance.

- As far as is practicable, the Tribunal is to consist of persons of both sexes and from diverse backgrounds (including Aboriginal and Torres Strait Islander background).

With the above considerations, it would be useful to refer to the utilisation of Elders and Respected persons and community members in the Koori Courts. For further comment on independent monitoring please refer to the complaints section of this submission (section 9).

Consultation Paper item 8: Monitoring Patient Wellbeing

The current number of mental health workers and mental health services that are accessible to Indigenous Australians is too small. Further, more mental health workers who are Indigenous Australian, or who have cultural awareness, are required. This needs to be formally recognised.

Koori positions for Koori solutions

VALS has previously applied for funding for a Koori Healing Access Project Worker who will:

Be employed to provide support to people using the services of VALS to more effectively access the mental health system. They will also help develop mental health related community education prevention messages and use action research methodology to enhance referral effectiveness to key mental health services relevant to pre and post-court needs of clients. The Koori Healing Access Worker would also use the data collected to engage with other services, including mainstream services and professionals, to identify good practice and more culturally inclusive service provision. The Koori Healing Access Worker will organise functions of an Advisory Committee which will provide advice about how best to improve VALS' links with mental health and mental health related services and engage these organisations with the project.

This kind of placement at Aboriginal and Torres Strait Islander Legal Services (ATSILS) could serve many of the objectives of the present areas of concern under review in the *Mental Health Act* 1986. They include:

- Research and evaluation - the project is an action research model which analyses case studies and in doing so evaluates the effectiveness of the mental health system

- Access - the project is attempting to improve access to mental health services by improving the cultural appropriateness of such services (i.e. cultural inclusion tool) and educating Indigenous Australians about their options.

- Increased charter compliance - the project is an attempt to protect the human rights of Indigenous Australians with a mental illness.

VALS' funding application for such a position is yet to be successful. Continual application for this, or a similar position, will be sought in order to create a role to fulfil the following:

- **Objective:** to provide a culturally inclusive service delivery model to promote awareness around mental health issues and early intervention.
- **Related objectives:** enhance access to justice and service providers and reduce offending and recidivism.
- **Context/need:** The project recognises the context of Indigenous Australian mental health issues and responds to need. The context and consequent needs are as follows:
 - Many of VALS' clients seem unable to access mental health services due to one or more factors such as: distance, economic status, interpersonal issues, family responsibilities and cultural barriers. VALS is keen to encourage clients to look at both their legal and health problems together as they are often interconnected.
 - Access to mental health assistance is a key issue in resolving legal and other problems. There is need to prevent legal problems being compounded by mental health issues. Workers who provide assistance can reduce the onset of illness by ameliorating crisis and stress in client's lives. There is need to build bridges between the legal and health sector.
 - Lack of an adequate cultural inclusion and a cultural security framework means that many mental health workers are either not being accessed, or if they are accessed the workers are insufficiently aware of cultural factors which are necessary to engage the client in further assistance.
 - There is need to recognise and promote Aboriginal concepts of holistic healing and cultural respect. The project is needed because as according to Denis McDermott a narrow mental health approach will fail as it ignores the beliefs of Indigenous Australians as to the connectedness of physical health, culture and history to the idea of mental health.¹⁴ Application of traditional mental health practice to Koori people has resulted in misdiagnosis, an emphasis on deficit models and overlooking of resilience factors. McDermott highlights the term Indigenous Social, Spiritual and Emotional Well-Being is more inclusive and culturally appropriate than using the term mental health.
- **Actions:** The actions of the project are to:
 - Conduct action research;
 - Assist lawyers in their work with clients with mental health issues;
 - Attend appointments with clients who need support in accessing mental health

¹⁴ Denis McDermott (Koori psychologist from the Murru Marri School of Public Health and Community Medicine, University of New South Wales,) 'The political is the clinical: comfort zones, cultural safety and Indigenous mental health', 2005.

professionals;

- Create effective referral pathways to mental health services;
- Build on VALS' knowledgebase about the use of "Aboriginal English in Courts" and mental health services;
- Incorporate Aboriginal understanding of mental health (i.e. more holistic and multi-disciplinary approach) than the western concept of mental health;
- Build improved networks between the legal and mental health systems;
- Collate case studies and draw out patterns affecting service effectiveness and why clients may not access treatment services;
- Conduct systemic advocacy and training to assist mainstream agencies and their staff to become more culturally inclusive in their assessment of individuals and in program delivery;
- Promote best practice in relation to culturally inclusive practice; and
- Deliver community education messages which will highlight the need to seek help, where to go and discourage stigma.

The worker would specifically:

a) Work with VALS' Community Legal Education Officer to provide community education to Aboriginal organisations, Elders and community members about mental health and legal issues.

b) Support clients to access the highly specialised departmental and professional legal-welfare service system by being involved in the referral process and attending appointments with clients where appropriate;

c) Identify and distribute information about best practice in the areas of referral practices, culturally appropriate service provision and training strategies.

d) Advocating for systemic change to the level of cultural inclusion in mainstream organisations and professional practices. The worker will be assisted by an Advisory Group, Aboriginal organisations specialising in the area of mental health and Aboriginal workers in mental health mainstream organisations.

- **Outcomes:** The intended outcome of the project is to:
 - Help reduce Indigenous Australians' adverse contact with the justice system, such as by assisting mainstream services to meet the mental health needs of Indigenous Australians which may reduce the chances of offending.
 - Culturally appropriate program for all Indigenous Australians Lessens the need for legal aid.

- Accessible and culturally appropriate services to Indigenous Australians in the metropolitan region regardless of gender, sexual preference, family relationship, location, disability, literacy or language.
- Enhance cultural knowledge and identity by drawing on Indigenous Australian's conceptualisation of mental health/well-being and how to meet needs.

A recent review on Koori mental health identified areas for improvement (Jones & Day 2008) and included the following which this proposal addresses:

- Effective coordination of services with other agencies and planning processes;
- Ensuring staff with appropriate skills are recruited, retained and supported through ongoing training.

The Report found:

- There are dramatically higher rates of mental impairment for Indigenous offenders on a wide variety of indices, compared to non-Indigenous offenders.
- Some fundamental differences are evident between mainstream and Indigenous models of mental health and illness, from which different (although not necessarily incompatible) service responses follow
- There is an urgent need for more *culturally proficient* mental health services on a continuum from 'wellness' to 'illness', available at multiple entry points in the criminal justice system.

Consultation Paper item 9: Complaints

Currently the Act has no provisions for how a local complaint mechanism should operate and does not establish a complaint mechanism independent from mental health services that are not resolved at a local level.

However, some mental health complaints are received by the Chief Psychiatrist. Although not established for this principal purpose, the Chief Psychiatrist's office receives complaints relating to mental health service delivery. The Chief Psychiatrist responds to complaints as part of the statutory responsibility for the medical care and welfare of patients (s 105(2)(a)).

A criticism of the Office of the Chief Psychiatrist is that it is not independent enough. Described as a 'toothless tiger' for its limited powers in relation to acting on complaints, potential alternatives include a specialist independent Mental Health Commission. There has recently been a Disability Services Commissioner set up in Australia. International jurisdictions which have independent specialist mental health commissions include Scotland, UK, Northern Ireland and New Zealand.

Consultation Paper item 10: Confidentiality and Information Sharing

Deinstitutionalisation policies have increased the responsibility of families and carers to manage the care and treatment of mental health patients in the community. With this comes increased responsibility and role in the sharing of medical and treatment information. And while families and carers work in partnerships with various mental health services to improve the services they are

providing to the patients, the Act currently limits the circumstances in which information can be given to other services and agencies.

The consultation paper expresses the complex and extensive information sharing and confidentiality provisions in the Act. With confidentiality of personal and medical information presenting serious possible legal and treatment ramifications, the provisions urgently need to be streamlined and provided to health care providers, family members and carers so that all parties are aware and clear of their rights to information and their responsibilities when dealing with patient information. This streamlining process not only acts to protect individuals handling the information, but importantly ensures the patients' personal information is only used, shared and replicated when it is absolutely in the best interest of the patient and the effectiveness of their treatment.

VALS is concerned that local Aboriginal health care and/or mental health services in Victoria are not notified in any way when Indigenous Australian persons with mental illness are released from prison. This is not only a major through-care issue just for the Indigenous Australian community. As highlighted earlier, there appears to be significant numbers of mental health sufferers in the prison system. There is a substantial gap in prisoner care if no link to local mental health care agency is linked to prisoner release. The absence of this connection greatly increases the likelihood that mental illness will go unevaluated, mistreated, and mental illness symptomatic behaviours could land individuals back in contact with the justice systems.

This represents an area that urgently needs information sharing addressed. While it is recognised that an individual's privacy is of imperative importance, putting people in contact with support systems upon release from prison for mental illness is key to preventing a return to custody. The need for information sharing under this consideration is needed.

When considering cycles of contact with the justice system, VALS' concern is naturally drawn to the findings of the Royal Commission into Aboriginal Deaths in Custody (RCIADIC) and its recommendations, many of which have not been actioned. While a world of knowledge that is still very relevant today was gained from the RCIADIC, it is worth noting that the commission ended in 1991. A lot has changed at policy level since then, and with the noticeable push towards investigating mental health matters at all levels of organisation, government, and society, VALS considers the great insight that could be provided by a present day commission into not only the overrepresentation of Aboriginal people in custody, but also the effects of mental illness on, or the prevalence of mental illness issues in:

- Instances of arrest;
- Prevalence of mental illness awareness and training in the police force;
- Use of referrals (provided mental illness is identified at time of arrest);
- Contact with other justice systems;
- Prevalence of incarceration as a result;
- Mental health treatment whilst incarcerated;
- Treatment processes post-release; and
- Levels of recidivism where mental illness plays a role.

The Victorian Police Manual stipulates under ‘Care of prisoners’ (section 115-2):

6.8 Medically ill, psychologically affected and high risk prisoners

Medical advice – where there is any doubt about a prisoner’s mental fitness seek medical advice from:

- Metropolitan area – the Custodial Nursing Service or a Custodial Medical Officer.
- Country areas – the local medical officer.

Known patient of psychiatric services – where it is known that a person charged is a patient under the care of the Office of Psychiatric Services, notify the office.

Monitoring and precautions – the police member on duty must visit the prisoner at least every half-hour to check their welfare. Take additional precautions for prisoners showing suicidal tendencies.

Minimum time in custody – mentally ill prisoners are to be kept in custody for the least possible time

VALS is curious to the actual frequency with which doubt in a prisoner’s mental fitness results in the advice as stipulated, access to information if a known patient of psychiatric services, the enforcement of the monitoring frequency of prisoner’s welfare, and the measures taken to minimise the time in custody for mentally ill prisoners.

In addition, considering that the existing Victorian mental health legislation considers it appropriate to check on the welfare of secluded mental health patients at 15 minute intervals, the half-hour ‘welfare check’ outlined in the Victorian Police Manual is arguably insufficient.

There is also the question of a police officers qualification to be identifying the level of ‘mental fitness’. As noted earlier, mental illness often presents with other behaviours that lead to and affect arrest and custody. In instances where drug use and alcoholism are involved, it is arguable that questions of mental fitness can be easily attributed to these elements and not symptoms of mental illness. There is a need here for mental illness awareness training or the increased stationing of mental health workers within the police force to aid in identification and appropriate course of treatment.

Clearly information sharing about former prisoner’s mental health status and history could prove helpful in this area.

The revised Act and the corresponding publications that explain the Act should be made available to all patients.

Charter and Convention Considerations

Recent human rights developments in Victoria such as the introduction on the *Charter of Human Rights and Responsibilities* and the ratification of the *International Convention on the Rights of Persons with Disabilities* (Disabilities Convention) have created much needed momentum for review of Acts such as the *Mental Health Act 1986*.

Charter issues are:

- Recognition and equality before the law
- Protection from torture and cruel, inhuman and degrading treatment
- Be free from treatment without full and informed consent
- Freedom of movement
- Privacy and reputation of person
- Enjoy one's own culture
- Humane treatment when deprived of liberty
- A fair hearing

Convention issues are:

- Equality and non-discrimination (Article 5)
- Equal recognition as persons before the law (Article 12)
- Effective access to justice on an equal basis with others (Article 13)
- Liberty and security of person on an equal basis with others and freedom from unlawful or arbitrary deprivation of liberty (Article 14)
- Equal access to health services on the basis of free and informed consent (Article 25)

The past and present violations or neglect of human rights such as civil, political, social, cultural and economic, not only has negative impacts on the social and emotional wellbeing of the individuals whose rights are violated, but also their families and communities.¹⁵

Victoria's Equal Opportunity Act makes it unlawful to discriminate against anyone because of their disability/impairment. The Victorian Equal Opportunity and Human Rights Commission's 2008 submission to the *National Disability Strategy* argues that systemic discrimination is manifested in the overrepresentation of (young) Indigenous people with an intellectual disability in contact with the justice system.¹⁶ Also, our institutions, policies and practices can create or perpetuate a position of disadvantage. In applying a human rights framework to any disability, a strategy will need to identify different groups amongst the community to target responses explicitly.¹⁷

Tarantola (2007) highlights the insufficient understanding of the reciprocal interactions between health and human rights and mental health and human rights. In his report, *The interface of mental health and human rights in Indigenous peoples: triple jeopardy and triple opportunity*, Tarantola expresses how even definitions of health that are considered holistic in their encompassing of social wellbeing, such as that endorsed by the 192 Member States of the World Health Organisation (WHO), are qualified by some as 'reductionist' when applied to Indigenous peoples as it fails to encompass spiritual dimensions or the degree of harmony that exists between the individual and the community' (11).¹⁸ This reflects the tension between Western concepts of mental health and the holistic vision on emotional and social wellbeing expressed by some Indigenous Australian communities:

¹⁵ Smallwood G, White C and Kotiw M, 1997 'The relevance of human rights to health status in Australian Aboriginal and Torres Strait Islander communities' *Health and Human Rights* 2: 127-136.

¹⁶ Australian Human Rights Commission 2008, Preventing Crime and Promoting Rights for Indigenous Young People with Cognitive Disabilities and Mental Health Issues

¹⁷ See <http://www.humanrightscommission.vic.gov.au/pdf/submissionnationaldisabilitystrategy.doc>

¹⁸ As sighted in: Brady M 2004 *Indigenous Australia and Alcohol Policy: Meeting Difference with Indifference* Sydney: University of New South Wales Press; and Brady M, Kuniz S and Nash D 1997 'Who's Definition? Australian Aborigines, conceptualisations of health and the World Health Organisation, In L Marks, M Worboys (eds) *Migrants, Minorities and Health: Historical and Contemporary Studies* London: Routledge.

Health disparity is one of the most convincing manifestations of the lack of fulfilment of human rights. In turn, human rights principles and instrument are well suited to link health disparity to its societal roots and provide grounds and mechanisms for redress ...

...Not only does the deprivation of certain human rights directly influence mental health – for example, in situations where the right to security or health is challenged by insufficient structures and services – but the very denial of these and any other human rights, including equality, participation, employment, and housing, have a negative impact on self-perception in relation to society, and on dignity, and ultimately on health (Tarantola 2007:12-4).

It can therefore be argued that the fulfilment of all human rights is necessary for the protection of mental health outside of the mainstream Western medical response or a “normative” concept of health – concept of health shaped by State authorities and professional groups that tends to focus on health outcome and notions of risk behaviour and overlooks the holistic view of health in a way that it encompasses spiritual, cultural and emotional wellbeing (Tarantola 2007).

The passing of the Victorian Charter of Human Rights and Responsibilities creates a great opportunity to broaden the research agenda by applying a health *and* human rights framework to build the evidence of the negative impact of human rights violations on health as well as other human rights such as housing, employment, education and so on. The important task is then to translate this knowledge into policy and action.

Restorative Justice

The 2008 Mental Health Strategy expresses a goal in relation to victims and witnesses to increase and extend their involvement with the justice system and for offenders to reduce their involvement in the justice system. Restorative Justice Models have championed these goals through the recognition that outdated, increasingly irrelevant, culturally inappropriate, ineffective and adversarial processes in the Justice System fail to serve victims, offenders and the community.

Victims have traditionally been largely excluded from processes in the justice system. Restorative Justice considers the significance of the victims’ involvement and gives them a voice in processes that affect them, justice outcomes, the offender and the community. VALS therefore considers the benefits of Restorative Justice philosophy in the evolution of legislation in the area of mental health. As with victims in the justice system traditionally being removed from processes relevant to them, individuals experiencing mental illness are subject to question about their ability to make decisions and have control over their lives and treatment decisions and are therefore removed from systems that are supposed to be in place to assist them.

Restorative Justice has been shown to take various forms however all show the necessity of involving *real* stakeholders that are affected. In a nutshell, the restorative objective is a shift away from ‘punishment and the infliction of pain’ to ‘repairing the harm’ (Gabbay 2005: 357). This kind of thinking is very relevant when considering the possibility of wrongful or inappropriate incarceration of the mentally ill. Further, the lack of regulation around seclusion and restraint leaves room for the punitive treatment of mental illness. Identification and appropriate treatment in order to decrease the likelihood of, and the cycle of, incarceration of the mentally ill would be paramount in a restorative model in ‘repairing the harm’.

As Restorative Justice Models have been adapted nationwide over the years, additional advantages of the conferencing process have been reported to include:

- The use of age appropriate dynamics in line with behaviour and thinking patterns of specific groups (e.g. young persons);
- Avoids excessive long-term interventions;
- Facilitates reintegration within the community;
- Shares the responsibility for supporting the young person with members of his/her support network;
- Consults victims in a respectful and non-adversarial manner; and
- Promotes the community's trust in the system (Polak 2007).

It is not a stretch at all to see how the above advantages, while designed for a separate and specific purpose away from mental health issues, could be applied to conceptualisations of the way mental illness issues could be dealt with in the future.

CONCLUSION

A holistic Indigenous Australian perspective on mental health identifies the need for development of services at all levels of intervention whether it is primary, secondary or tertiary prevention. VALS looks forward to improvements proposed to the Mental Health Act as a result of this consultation process. To summarise, the main areas arguments and areas of concern or further investigation that the review committee should take into account are as follows.

- People with a mental illness are over-represented in Victorian prisons with 40% of prisoners experiencing serious mental illness and the proportion increases when other types of mental and psychiatric disabilities such as personality disorders are also considered. Social disadvantage and inadequate treatment of mental health in the community inevitably equates to too many people with untreated illness ending up in prison.
- Misunderstandings and misdealings with mental health matters acts as an additional contributor towards marginalisation for the disadvantaged and the disempowered.
- Research indicates instances where people with a mental illness may be charged with offences relating to behaviour arising from their illness such as offensive language and conduct, assault, resisting arrest and assaulting police:

As a general rule it's usually public disorder ...where they bring themselves under notice due to their actions.¹⁹

- There are some common threads that run through different conceptions and definitions of what is considered “mental health”, “mentally ill” and “mentally disabled”. There is not, however strong consensus on any one definition of any of these terms.
- VALS prefers conceptualisations of mental health that resonate with the notion of ‘social and emotional wellbeing’ – a term which is now widely accepted in Australia as one which significantly aids current understandings of the association between mental health, physical health, and social disadvantage (Jones & Day 2008).

¹⁹ Consultation with NSW police inspector in Karras et al 2006:58.

- Policy concerned with problems within the current mental health arena in Victoria needs to recognise research that shows people with a mental illness face a number of barriers to accessing legal assistance, including:
 - *A lack of awareness of their legal rights*
 - *Being overwhelmed*
 - *Being mistrustful*
 - *Difficult behaviour*
 - *Lack of mental health care and treatment*

In addition, systemic barriers experienced by people with mental illness accessing legal services include:

- *The limited availability of affordable legal services*
 - *Time constraints placed on legal service provision*
 - *Remote, rural and regional issues*
 - *Difficulties in identifying mental illness*
 - *A perceived lack of credibility*
- The phenomenon of persons with a mental illness being disproportionately caught up in the criminal justice system because of their greater risk of arrest has been documented.
 - VALS strongly argues for the revised mental health legislation for Victoria to include stipulations and definition pertaining to the nature of what is considered “capacity” to consent.
 - Having clinicians rely solely on the common law test to determine whether a person has capacity is not sufficient in this complex area.
 - Periodical and frequent review of any involuntary treatment should be made mandatory. The fluctuating and every-changing nature of mental illness and its interaction with treatment needs to be closely monitored. There is additional call for accountability and transparency when treatment is being administered involuntarily.
 - The lax stipulation of “appearing” to be mentally ill is a drastically insufficient decision making tool.
 - VALS is concerned about the grounds in the Act: *the person appears to be mentally ill*. The result of this is that there needs only to be the appearance of a mental illness for a person to be made an involuntary patient. This is with no actual diagnosis of mental illness made. This highly discretionary provision creates room for great inconsistencies and ineffective and potentially unethical categorisation and treatment.
 - VALS supports the argument that involuntary treatment to protect the person’s health or safety or to protect others need to have some level of seriousness to themselves or others specified.
 - VALS calls for a move towards increased accountability such as that found in the Scotland example, where involuntary treatment cannot be administered for a person who is unable or refuses to consent without considering:
 - The persons reason for not consenting;

- The views of the involuntary patient and a nominated person together with any advance statement; and
- The efficacy of the treatment.

Further, the clinician must record all reasons in writing as to why the treatment is being provided and in what way it is in the patient's best interest. Without this involuntary treatment cannot be provided. The above procedure should be considered as a base standard for administration of any involuntary treatment for a person who is unable to, or is refusing to, consent.

The additional safeguard in Scotland that if treatment is to continue beyond two months, an involuntary patient who is unable or refusing to consent can only receive medication after an independent psychiatrist provides a second opinion that a) the person is unable to consent or is refusing to consent, and b) the proposed treatment is in the person's best interests.²⁰ This should also exist as a minimum requirement.

- While "capacity" is part of the criteria for involuntary treatment, there is no 'capacity test' or definition in the Act. Scotland takes into account the fluctuating nature of capacity for a person with mental illness and accordingly has a 'significantly impaired test'. Some similar mechanism needs to be considered for Victorian mental health legislation.
- VALS argues to support CTOs where appropriate. The Victorian Council of Social Services (VCOSS) has found that providing intensive residential support to people with mental illness is comparable in cost to prison but instead makes a 'positive contribution to people's health and wellbeing, as well as contributing to a reduction in crime and savings to the justice system' (Smart Justice 2009:1).
- VALS agrees that one way to help both involuntary and voluntary patients understand their rights and therefore effectively exercise those rights could include an independent support person.
- The Act does not in its current form refer to advance statements or the like. VALS encourages the inclusion of this consideration in the review of the Mental Health Act.
- VALS supports the Consultation Paper's suggested move towards reducing the number of patients subject to restraint and seclusion, as well as the frequency and duration of these interventions, wherever possible through establishing alternative strategies.²¹ VALS argues that it should be emphasised in the legislation that such practises are to be used only as a last resort.
- As board hearings usually involve a legal member, a psychiatrist and a person representing the views and opinions of the community, VALS argues that the latter be a true community representative. The Indigenous community in Victoria is unique, and therefore a person representing opinions of the community in hearings should be, where possible, a member of the Koori community. This could take the form of a Koori Mental Health Liaison Officer and/or someone similar to an Elder in the Koori Court.

²⁰ *Mental Health Act (Care and Treatment) (Scotland) Act 2003* in consultation paper, p22.

²¹ Victorian Government Department of Human Services (2008) *Review of the Mental Health Act 1986 – Consultation paper – December 2008* Melbourne: Mental Health and Drugs Division, p. 41

As hearings are currently held at mental health services throughout Victoria, VALS suggests that in order to provide for culturally appropriate and accessible mental health care services and utilisation, it should be considered a possibility to have hearings made readily available at Koori health service centres.

- VALS argues that the onus of initiating appeals should not remain on the patient.
- VALS argues for the consideration the importance and usefulness of positions such as VALS' Healing Access Project Worker in the monitoring of patient wellbeing.
- The Act has no provisions for how local complaint mechanism should operate and does not establish a complaint mechanism independent from mental health services that are not resolved at a local level. This needs to be rectified.
- VALS is concerned that local Aboriginal health care and/or mental health services in Victoria are not notified in any way when Indigenous Australian persons with mental illness are released from prison. The absence of this connection greatly increases the likelihood that mental illness will go unevaluated, mistreated, and mental illness symptomatic behaviours could land individuals back in contact with the justice systems. This represents an area that urgently needs information sharing addressed.
- In considering the numbers of mentally ill persons in custody and the overrepresentation of Indigenous Australians remaining so many years after the RCIADIC, VALS considers a present day commission into not only the overrepresentation of Aboriginal people in custody, but also the effects of mental illness on, or the prevalence of mental illness issues in:
 - Instances of arrest
 - Prevalence of mental illness awareness and training in the police force
 - Use of referrals (provided mental illness is identified at time of arrest)
 - Contact with other justice systems
 - Prevalence of incarceration as a result
 - Mental health treatment whilst incarcerated
 - Treatment processes post-release, and
 - Levels of recidivism where mental illness plays a role.
- VALS argues the benefits of Restorative Justice philosophy in the evolution of legislation in the area of mental health. As with victims in the justice system traditionally being removed from processes relevant to them, individuals experiencing mental illness are subject to question about their ability to make decisions and have control over their lives and treatment decisions and are therefore removed from systems that are supposed to be in place to assist them.

Lack of regulation around seclusion and restraint leaves room for the punitive treatment of mental illness. Identification and appropriate treatment in order to decrease the likelihood of, and the cycle of, incarceration of the mentally ill would be paramount in a restorative model in 'repairing the harm'.

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