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homeless persons' legal clinic

Submission to the Review of the *Mental Health Act 1986*

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1. Executive Summary and Recommendations

1.1 Summary

The Homeless Person's Legal Clinic (***HPLC***) makes these submissions in response to the Victorian Government's Consultation Paper on the Review of the Mental Health Act 1986 (Vic) (***MHA***).

Specifically, this submission addresses:

- the role of the HPLC;
- the relationship between homeless persons and the *MHA*;
- the *MHA*'s existing framework for treating people with special needs;
- Involuntary Treatment Orders (part 3 of the Review);
- patient participation (part 4 of the Review);
- external review and access to justice (part 7 of the Review); and
- confidentiality and information sharing (part 10 of the Review).

1.2 Recommendations

Recommendation 1

The HPLC recommends the new Act:

(a) prohibit discrimination in the provision of treatment and care for mental illness;

(b) specifically refer to and prohibit discrimination on the basis of homelessness.

Recommendation 2

The HPLC recommends the new Act contain additional reform objectives which recognise that human rights obligations require an specific and comprehensive consideration of the problems facing homeless persons with a mental illness. The HPLC recommends that consideration be given to the ways in which a commitment to co-ordinated policy and funding based responses is also required to achieve improved outcomes for homeless people.

Recommendation 3

The HPLC recommends the new Act:

(a) recognise that specific measures need to be taken to overcome barriers to access faced by homeless people;

(b) encourage service delivery and treatment approaches in a manner adapted to homeless people;

Recommendation 4

The HPLC recommends the new Act contain provisions for the practical realisation of the objectives in the current *MHA.*

Recommendation 5

The HPLC recommends the new Act contain provisions encouraging comprehensive discharge planning, continued support and monitoring of patients on release in a way which addresses barriers to service access for homeless people;

The HPLC recommends that the Victorian Government address the considerable lack of appropriate housing for homeless people with a mental disorder.

Recommendation 6

The HPLC recommends the new Act contain:

(a) adequate provisions for continued support and monitoring of patients so that patients are not placed on involuntary treatment orders as a consequence of their social and housing circumstances;

(b) the new Act specifically acknowledge the links between homelessness and mental health;

(c) a statutory guarantee that no homeless involuntary patient will be discharged into homelessness;

(d) a statutory guarantee that appropriate housing must be made available to homeless patients upon discharge as an involuntary patient.

Recommendation 7

The HPLC recommends the new Act provide:

(a) for the use of advance statements;

(b) the development of criteria or guidelines to assist hospital staff, carers, advocates, patients and the Board evaluate the currency of the advance statement;

(c) flexibility to update and amend advance statements;

(b) that homeless people with a mental health disorder be given every assistance to create and update their statement in a manner appropriate to their needs.

Recommendation 8

The HPLC recommends the new Act provide:

(a) all involuntary patients be provided with an independent support person as soon as possible following being made involuntary;

(b) the independent support person is to be a patient advocate and act as an independent, patient-centred, partial and trusted confidante who explains rights, expresses views of, and advocates for patients in respect of external (involuntary status) and internal (individual and systemic complaints) rights;

(c) in cases of need (involving homelessness or co-morbidity issues), a support worker to provide non-rights support.

Recommendation 9

The HPLC recommends that:

(a) the authorised psychiatrist not be responsible for the provision of rights advice;

(b) the *MHA* remain unaltered in respect of the way in which advice is to be given but attention be given to effectively realising legislative provisions in relation to provision of advice;

(c) rights advice be provided by an independent support worker or other independent person;

(d) rights advice be given at defined intervals following involuntary treatment.

Recommendation 10

The HPLC recommends the provision of advocacy be facilitated either by amendments to the *Legal Aid Act 1978* or through increased funding of a mental health advocacy service.

Recommendation 11

The HPLC recommends that participation in external review could be achieved by provision of an independent support person to involuntary patients.

The HPLC reiterates recommendations above that the new Act provide:

(a) all involuntary patients be provided with an independent support person as soon as possible following admission as an inpatient

(b) the independent support person is to be a patient advocate and act as an independent, patient-centred, partial and trusted confidante who explains rights, expresses views of, and advocates for patients in respect of external (involuntary status) and internal (individual and systemic complaints) rights.

Recommendation 12

As a minimum, the HPLC recommends that the new Act:

(a) provide involuntary patients have the right to a second independent psychiatric opinion free of charge;

(b) the provision of the second psychiatric opinion is to be made in a timely fashion and any report be made available to the patient for use in treatment negotiations and MHRB hearings.

Recommendation 13

The HPLC recommends that the new Act:

(a) provide for a central complaints body for complaints in respect of treatment under the *MHA;*

(b) give consideration to the ways in which homeless people can be assisted to make and resolve complaints under the Act;

(c) assist in the provision of data collection to identify and address systemic issues.

Recommendation 14

The HPLC recommends that the new Act:

(a) create a Commissioner for Mental Health;

(b) provide the Commissioner for Mental Health with such powers and funding as to enable significant recommendations, investigations and inquiries in relation matters relating to mental health;

(c) the Commissioner for Mental Health have specific obligations in relation to vulnerable consumers such as homeless people in order to investigate and address the causes of systemic disadvantage.

Recommendation 15

The HPLC recommends that the provisions of the new Act should not facilitate the provision of confidential information to family members or others who are estranged from the patient or are not involved in the patient's ongoing treatment and care.

Recommendation 16

The HPLC recommends that even in circumstances where a carer or family member is providing ongoing care, wherever possible disclosure should be made with the patient's consent and the Act should place positive obligations on practitioners to obtain this consent.

Recommendation 17

The HPLC recommends that even in circumstances where a carer or family member is providing ongoing care, wherever possible disclosure should be made with the patient's consent and the Act should place positive obligations on practitioners to obtain this consent.

1.3 Acknowledgments

The HPLC gratefully acknowledges the significant contributions to this submission of Allens Arthur Robinson and individual lawyers: Annette Hughes, Rachel Nicolson, Jessica D'Souza, Lisa Mortimer and Helen Beatty

2. About the PILCH Homeless Persons' Legal Clinic

The PILCH Homeless Persons' Legal Clinic (***HPLC***) is a project of the Public Interest Law Clearing House (***PILCH)*** and was established in 2001 in response to the great unmet need for targeted legal services for people experiencing homelessness. The HPLC has the following aims and objectives:

- to provide free legal services to people who are homeless or at risk of homelessness, in a professional, timely, respectful and accessible manner, that has regard to their human rights and human dignity;

- to use the law to promote, protect and realise the human rights of people experiencing homelessness;

- to use the law to redress unfair and unjust treatment of people experiencing homelessness;

- to reduce the degree and extent to which homeless people are disadvantaged or marginalised by the law; and

- to use the law to construct viable and sustainable pathways out of homelessness.

Free legal services are offered by the HPLC on a weekly basis at 13 outreach locations that are already accessed by homeless people for basic needs (such as soup kitchens and crisis accommodation facilities) and social and family services.[1] Since its establishment in 2001, the HPLC has assisted over 3500 people at risk of, or experiencing, homelessness in Victoria.

3. Homeless people and the Mental Health Act

It is vital that the review of the *MHA* address the situation of homeless people experiencing mental illness. In particular, the review should acknowledge and consider:

- the strong relationship between homelessness and mental illness;
- the intersection between homelessness and poverty;
- the vulnerability of homeless consumers of mental health services;
- the particular challenges that homeless people experiencing mental illness face in seeking and receiving effective treatment and care; and
- the relevance of human rights in this context.

This submission explores these themes. It identifies issues raised in the Review document and parts of the *MHA* that could be better applied to respond to the needs of homeless people experiencing mental illness. It also identifies possibilities for reform of the *MHA*.

3.1 Definition and experiences of homelessness

In dealing with problems and issues associated with homelessness, the definition and concept of homelessness should not be restricted to the narrow traditional idea of living on the street. The Mental Illness Fellowship highlights the importance of a broad approach to homelessness and the significant social and psychological dimensions that affect and contribute to homelessness.[2] In Australia, there is an emerging consensus around the definition of homelessness developed by Chamberlain and MacKenzie and adopted by the Australian Bureau of Statistics. Specifically, homelessness includes primary homelessness, which is 'sleeping rough', secondary homelessness, which involves moving around amongst transitional and emergency housing options, and tertiary homelessness, which is living in boarding houses without private facilities or security of tenure.[3] When considering homelessness, 'marginal housing' which includes those living in housing

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[1]Host agencies include Melbourne Citymission, The Big Issue, the Salvation Army, Anglicare, St Peters Eastern Hill, Ozanam House, Flagstaff Crisis Accommodation, Salvation Army Life Centre, Hanover, Vacro, Koonung Mental Health Centre, Homeground Housing Service, St Luke's Bendigo and Loddon Mallee Housing Service. Legal services are provided at our host agencies by volunteer lawyers from law firms: Allens Arthur Robinson, Arnold Dallas & Mcpherson, Baker & McKenzie, Blake Dawson, Clayton Utz, Mallesons Stephen Jaques, Minter Ellison, DLA Phillips Fox, Corrs Chambers Westgarth, Stella Stuthridge and Associates and the legal department of Goldman Sachs JBWere.

[2] See Mental Illness Fellowship Victoria, *Mental Illness and Housing*, Preliminary Discussion Paper, Schizophrenia Awareness Week, 19-26 May 2008 at 7.

[3] Ibid. See, eg: Chris Chamberlain, *Counting the Homeless: Implications for Policy Development (*ABS*).*

situations which are close to minimum standards should also be considered.[4] Importantly, hidden or housed homelessness must also be taken into account – this includes those who may lack economic and social support for independent living and therefore reside in sub-optimal conditions, such as with aging parents.[5]

3.2 The Relationship between Homelessness and Mental Illness

A significant proportion of homeless people experience mental illness. Notably:

- The Victorian Government recently acknowledged 'high levels of homelessness experienced by people with severe mental health problems – an estimated 30 per cent of Australia's homeless population have a mental health problem'.[6]
- The Senate Select Committee on Mental Health's first report, *A national approach to mental health – from crisis to community* (the ***Senate Committee Report***), observed that there are 'clear causal and consequential associations' between homelessness and mental illness.[7] The Senate Committee Report cited studies indicating that '…between 30 and 80 per cent of people experiencing homelessness also experience mental disorders.'[8]
- A 2005 literature review found 'that between one quarter and one half of adult homeless persons across western cities are experiencing severe and perhaps chronic mental illness'.[9]
- In 2004-05, around 12% of Supported Accommodation Assistance Program (***SAAP***) clients reported a mental health problem.[10]
- A 2007 report on homelessness in Melbourne (***Homelessness in Melbourne Report***) stated that '[w]e know there is a correlation between mental disorders and homelessness, with some people claiming that as many as eight in ten homeless people suffer from mental health problems… Such a claim sits at the extreme end of the spectrum and the general consensus is that somewhere between 20 and 30 per cent of the homeless suffer from mental health problems…'[11]

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[4] Ibid.

[5] Ibid, 8.

[6] Victorian Government Department of Human Services, *Because mental health matters: A new focus for mental health and wellbeing in Victoria – Consultation Paper* (May 2008), 93.

[7] Senate Select Committee on Mental Health, *First report: A national approach to mental health – from crisis to community* (March 2006), 241.

[8] Ibid, footnote omitted.

[9] Australian Institute of Health and Welfare, *Bulletin 51: Homeless SAAP clients with mental health and substance use problems 2004-05 – A report from the SAAP National Data Collection* (March 2007), 1, quoting St Vincent's Mental Health Service and Craze Lateral Solutions.

[10] Ibid, 2.

[11] Chris Chamberlain, Guy Johnson and Jacqui Theobald, *Homelessness in Melbourne: Confronting the Challenge* (February 2007), 28.

Mental illness can be a cause of homelessness,[12] and can also arise (or be exacerbated) as a result of the experience of homelessness.

3.3 The Intersection between Homelessness and Poverty

3.4 Carla[13]

Carla is approximately 45 years of age. She has experienced homelessness for years and suffers from chronic mental illness. Carla has been diagnosed at various times with bipolar affective disorder, schizoaffective disorder and psycho affective disorder. She is unable to work because of her condition and therefore relies upon a disability support pension. HPLC has assisted Carla in relation to a range of issues since approximately 2004. During this period she has moved repeatedly through a cycle of hospitalisation, release, relative stability, descent back into crisis, breakdown and rehospitalisation.

Because of her condition, which is characterised by severe mood swings and delusions, Carla has regularly been subject to Community Treatment Orders to ensure that she receives continued psychiatric treatment. She has been admitted as an inpatient to psychiatric care on numerous occasions since 1994, in most instances on an involuntary basis. These episodes of inpatient care have generally lasted from weeks to months.

When she is released from care Carla has little or no family support and has over the years relied upon a range of outreach and housing support services including Homeground Services, Hannover Inner North Outreach Support and most recently, North West Mental Health Services. Because of her condition, Carla's relationships with these services has often been volatile. Over these years she has lived in a range of rooming houses and other temporary accommodation.

More recently she has been provided with her own apartment in the northern suburbs. However, because of her condition it is difficult for her to live independently and she requires ongoing outreach support.

Poverty has been described as 'the common denominator' of homeless people.[14] As Carla's story demonstrates, the debilitating effects of mental disorders can have severe impacts on a person's ability to maintain employment or a minimum level of financial comfort. According to the Homelessness in Melbourne Report, '[i]t is common for homeless people to miss out on food and to have insufficient money to cover basic medical expenses'.[15]

There are also strong links between poverty and poor mental health. Socio-economic status is a critical determinant of health status, with lower socio-economic status generally

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[12] 'People with moderate to severe mental health problems – particularly those with enduring psychiatric disability, co-occurring substance misuse and/or other complex problems – face ever-increasing difficulties in accessing and often maintaining, stable housing.' Victorian Government Department of Human Services, above n 5, 92.

[13] Not her real name

[14] Chris Chamberlain, Guy Johnson and Jacqui Theobald, op cit, page 24.

[15] Ibid, 28.

associated with poorer overall health. Poor mental health plays a central role in creating, exacerbating and perpetuating poverty.[16]

3.5 The Particular Vulnerability of Homeless Consumers of Mental Health Services

Carla's story also demonstrates the specific vulnerability of homeless consumers within mental health processes. As this case demonstrates, the cycle of hospitalisation, stabilisation, release to inappropriate housing, descent to crisis, breakdown and return to involuntary treatment without any *stability* or *continuity* of care is a reality for homeless people.

Homeless people experiencing mental illness are particularly vulnerable consumers of mental health services. They experience numerous barriers to access including financial barriers and hardship, lack of transportation, competing needs, lack of documentation including proof of identity and medical records, lack of a Medicare Card, lack of contact details, reluctance to engage with services due to previous negative experiences, inability to access services and navigate the service system, difficulty maintaining appointments, disconnection from supportive social networks, stigma and prejudice arising from homelessness and co-morbidity between mental illness and addiction[17]. Homeless people may face discrimination from providers of mental health care and treatment because of their homelessness, and are less likely to have access to resources and support systems to assist them in asserting their rights.

The National Coalition for the Homeless (an American organisation) has observed that '[h]omeless people with mental disorders remain homeless for longer periods of time and have less contact with family and friends.'[18] That body has further observed that '[t]he mentally ill homeless population encounters more barriers to employment, tend to be in poorer physical health, and have more contact with the legal system than homeless people who do not suffer from mental disorder.'[19]

3.6 Challenges in Seeking and Receiving Treatment

As noted above, the experience of homelessness may cause or exacerbate mental illness, undermining treatment and care.

In particular, homelessness can place people experiencing it at greater risk of being exposed to violent and stressful situations. The Homelessness in Melbourne Report found that '[b]oarding houses are often in poor condition and the culture of boarding houses can impact on people's well being and mental health.'[20]

Paradoxically, homeless people experiencing mental illness may be more likely to be in environments that are especially detrimental to their mental health. A 2004-05 study found

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[16] PILCH Homeless Persons' Legal Clinic submission to the Senate Select Committee on Mental Health, *Homelessness, Mental Health and Human Rights*, April 2005, at 17.

[17] Ibid, at 6

[18] National Coalition for the Homeless, *Mental Illness and Homelessness: NCH Fact Sheet #5* (June 2008).

[19] Ibid.

[20] Chris Chamberlain, Guy Johnson and Jacqui Theobald, op cit, page 27.

that SAAP '[c]lients with a substance use or mental health problem were more likely than clients without these problems to be living in a car, tent, park, street or squat both before and after support.'[21]

In a practical sense, being homeless makes it harder to maintain contact with service providers, to keep appointments (including medical appointments) and to provide necessary documentation.[22]

In short, homelessness is an obstacle to receiving effecting treatment and care for mental illness.

4. The relevance of human rights

Carla's story also demonstrates the complex intersections between poverty, homelessness and health. The HPLC considers the experiences of Carla and other homeless people with a mental disorder support a rights-based response. A rights based approach should emphasise that homeless persons with a mental illness possess rights which they are entitled to exercise, rather than being beneficiaries of charity.[23] It is important and empowering that the people experiencing homelessness and mental illness feel that it is their right rather than any privilege to obtain the services they need.[24]

Relevant rights include, but are not limited to the rights to:

- housing;[25]
- equality before the law;[26]
- reasonably attainable standard of health;[27]
- protection from torture, cruel, inhuman and degrading treatment;[28] and
- a fair hearing.[29]

Some of these rights can be found in the *Charter of Human Rights and Responsibilities Act 2006* (Vic) (***Charter***), for example the right to equality before the law, to protection from torture, cruel, inhuman and degrading treatment and the right to a fair hearing. In relation to

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[21] Australian Institute of Health and Welfare, above n 8, 4.

[22] See Senate Select Committee on Mental Health, *First report: A national approach to mental health – from crisis to community* (March 2006), 242.

[23] See *Office of the United Nations High Commissioner for Human Rights,* http://www2.ohchr.org/english/issues/disability/intro.htm#human.

[24] See: *Housing as a human right,* National Conference on Homelessness, Council to Homeless Persons, Address by Chris Sidoti, Human Rights Commissioner, 4 September 1996 available at http://www.hreoc.gov.au/pdf/human_rights/housing.pdf.

[25] *International Covenant on Economic, Social and Cultural Rights, article 11* ; *Convention on the Rights of Persons with Disabilities*, article 28.

[26] Section 8 of the *Charter of Human Rights and Responsibilities Act 2006 (Vic).*

[27] *International Covenant on Economic, Social and Cultural Rights, article 12.*

[28] *Charter,* Section 10

[29] *Charter,* Section 4

these rights the Consultation Paper expressly states that 'the Act should be compatible with the Charter'.[30]

The right to housing and to a reasonable standard of health are found in international treaties that Australia has ratified, most importantly the *International Covenant on Economic, Social and Cultural Rights* (***ICESCR***) and the *Convention on the Rights of Persons with Disabilities* (***CRPD***). When Australia becomes party to an international human rights treaty, it does not automatically become part of Australian law. Rather, the rights have to be specifically incorporated into domestic legislation. This means that the rights that have not been specifically incorporated into domestic legislation do not have direct enforceability in Australia. Nevertheless, international human rights documents are a legitimate and important source for the development of legislation in Australia and must be taken into account by the Victorian government in any new incarnation of the MHA.

The HPLC notes that s 32(2) of the Charter provides that international law may be relevant to the interpretation of a statutory provision. This means that interpretation of any new MHA will be affected by the content of the right to health and the right to housing at international law. Further, section 14 provides that the Charter must be reviewed in 2011. This review must examine, amongst other things, the possible incorporation of economic, social and cultural rights. There is, therefore, a prospect that the right to health and the right to housing will be incorporated into domestic law.

Given that the provisions of any new MHA may be interpreted with regard to the rights to health and to housing, and that these rights may be incorporated in the Charter at the 4 year review, the government should ensure that the new MHA protects these fundamental human rights. The content of these rights is discussed below.

4.1 The Principle of Non-Discrimination

Further to the rights set out above, the HPLC considers that the principle of non-discrimination should underpin Victoria's legislative, policy and funding approach to treating and caring for homeless people experiencing mental illness. As discussed in this submission, discrimination against homeless people may manifest itself either directly or indirectly as a result of the numerous barriers to access and treatment experienced by homeless people.

Article 26 of the *International Covenant on Civil and Political Rights* (***ICCPR***)[27] provides that '[a]ll persons are equal before the law and are entitled without any discrimination to the equal protection of the law.' It further provides that the law should prohibit discrimination and should guarantee equal and effective protection against discrimination, including discrimination on the grounds of property or other status.

The *MHA* should expressly prohibit discrimination in the provision of treatment and care for mental illness, including discrimination on the basis of homelessness. In addition, in order to facilitate meaningful enjoyment of homeless persons' rights under the Act, the *MHA*

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[30] Consultation Paper 11.

[27] Opened for signature 19 December 1966, 999 UNTS 171 (entered into force 23 March, except for Article 41, which entered into force on 28 March 1979).

should continue to provide for the consideration of 'special needs' (see the discussion in section 4, below). A level of positive discrimination is necessary in responding to the acute vulnerability and challenges that homeless people face in seeking and receiving care and treatment for mental illness.

> **Recommendation**
>
> The HPLC recommends the new Act:
>
> (a) prohibit discrimination in the provision of treatment and care for mental illness;
>
> (b) specifically refer to and prohibit discrimination on the basis of homelessness.

4.2 Rights to health and housing

Article 12 of the *ISCESCR* provides that States recognise the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. In relation to the right to the highest attainable standard of mental health, General Comment 14 notes that essential elements of this right include services that are (a) available, (b) accessible, (c) accessible and (d) of appropriate and good quality.[31]

Housing is a key issue for people experiencing homelessness and mental illness. Adequate housing is a basic human right. Parties to the *ISCECR* recognise the right to an adequate standard of living, including adequate housing.[32] States are obliged to take steps to protect this right. The right is also recognised by parties to the *CRPD*, which provides specifically that persons with disabilities, including those with a mental illness, should have access to public housing programmes.[33] Appropriate accommodation is a precondition to meaningful enjoyment of many rights relevant to people receiving treatment and care for mental illness.

The World Health Organisation has noted the possibility of giving people experiencing mental illness priority access to public housing:

> Legislation could incorporate provisions for giving persons with mental disorders priority in State housing schemes and subsidized housing schemes. For example, the Finland Mental Health Act states, 'In addition to adequate treatment and services, a person suffering from a

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[31] CESCR, *General Comment 14*.

[32] *International Covenant on Economic, Social and Cultural Rights*, Opened for signature 16 December 1966, 993 UNTS 3 (entered into force 3 January 1976), Article 11(1).

[33] *Convention on the Rights of Persons with Disabilities*, Opened for signature 30 March 2007, General Assembly Resolution A/RES/61/106, (entered into force 3 May 2008), Article 28(1).

The parties to the Convention on the Rights of Persons with Disabilities also highlight 'the fact that the majority of persons with disabilities live in conditions of poverty…' and recognise '…the critical need to address the negative impact of poverty on persons with disabilities' (*Convention on the Rights of Persons with Disabilities*, Opened for signature 30 March 2007, General Assembly Resolution A/RES/61/106, (entered into force 3 May 2008), Preamble, (t)).

The parties to the Convention agree to take appropriate steps to safeguard and promote the right to social protection, '…including measures…[t]o ensure access by persons with disabilities to public housing programmes' (*Convention on the Rights of Persons with Disabilities*, Opened for signature 30 March 2007, General Assembly Resolution A/RES/61/106, (entered into force 3 May 2008), Article 28(2)(d)).

> mental illness or some other mental disorder must be provided with a service flat and subsidized accommodation appropriate to the necessary medical or social rehabilitation as separately decreed' (Mental Health Act, No. 1116, 1990, Finland).[34]

Acknowledging that this may not be feasible in all States, the WHO indicates that '…at the very least, people with mental disorders should not be discriminated against in the allocation of housing.'[35]

4.3 The interconnectedness of rights

The *CRPD* expressly acknowledges in its preamble 'the universality, indivisibility, interdependence and interrelatedness of all human rights and fundamental freedoms'.[36] Similar recognition can be found in other international instruments. The interdependence of rights is profoundly relevant to the situation of homeless persons experiencing mental illness, in particular the link between the right to housing and the right to health.

This connection between housing and mental health issues has been recognised by the Victorian Government who have acknowledged that '[a]ccess to appropriate, affordable, stable housing and maintaining tenancy are the most crucial issues affecting people with mental health problems and their families.'[37]

The link between the right to housing and the right to health has also been discussed by the UN Committee on Economic Social and Cultural Rights who note in General Comment 14, that the right to health has an inclusive definition which extends 'to the underlying determinants of health… such as an adequate supply of safe food, nutrition and housing'.[38] General Comment 14 further states the right to health is closely related to and dependent upon the realisation of other human rights including the right to housing[39].

Reform of the *MHA* is necessary and desirable. However, the situation of homeless persons experiencing mental illness cannot be adequately addressed through reform of mental health legislation alone. Homelessness and mental illness present complicated and interrelated challenges for government. The HPLC considers that an effective response requires a multi-faceted and co-ordinated response, premised on the interdependence and indivisibility of human rights.

The HPLC also endorses the rights-based approached detailed in the submission on the Review of the *MHA* made by the Human Rights Law Resource Centre.

1. What, if any, additional reform objectives should be reflected in the new Act?

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[34] World Heath Organisation, *WHO Resource Book on Mental Health, Human Rights and Legislation: Stop Exclusion, Dare to Care* (2005), 81.

[35] Ibid.

[36] *Convention on the Rights of Persons with Disabilities*, Opened for signature 30 March 2007, General Assembly Resolution A/RES/61/106, (entered into force 3 May 2008), Preamble, (c).

[37] Victorian Government Department of Human Services, op cit, 92.

[38] CESCR, *General Comment 14*, at 11.

[39] CESCR, *General Comment 14*, at 3

The HPLC recommends the new Act contain additional reform objectives which recognise that human rights obligations require specific and comprehensive consideration of the problems facing homeless persons with a mental illness. The HPLC recommends that consideration be given to the ways in which a commitment to co-ordinated policy and funding based responses is also required to achieve improved outcomes for homeless people.

5. The MHA's existing framework for consideration of 'special needs'

Part 2 of the *MHA* sets out:

- the objects of the Act;
- the objectives of the Department of Human Services (***DHS***);
- the functions of the Secretary to the DHS; and
- the principles of treatment and care.

Some of the provisions in Part 2 offer an existing framework for the consideration of the particular needs of homeless persons who receive treatment and care under the *MHA*. In particular:

- it is Parliament's intention that the *MHA* is interpreted (and powers under the *MHA* are exercised) so that 'people with a mental disorder are given the best possible care and treatment *appropriate to their needs*…' (section 4(2)(a), emphasis added);
- it is an objective of the DHS to create mental health services that 'take into account the…special needs of people with a mental disorder' (section 5(a)(ii));
- the functions of the Secretary to the DHS include helping to identify '…special needs groups and to encourage the development of mental health services which are responsive to the varying needs of those groups' (section 6(l)); and
- one of the principles of treatment and care is that the '…special needs of people with a mental disorder should be taken into consideration' (section 6A(g)).

4.1 Tom[40]

Tom is approximately 41 years old. He suffers from chronic mental illness and has been diagnosed with schizophrenia. Tom has been in and out of mental health facilities since he was approximately 15 years old. He notes that when he was first diagnosed, there was no ongoing counselling or support and that he was incredibly isolated. Apart from his mother, who passed away approximately 11 years ago, Tom explains his family have not understood his illness and he believes that they considered him 'not safe to be around'.

Tom explains that, at the time of his diagnosis he soon ended up living on the streets and using heroin to self medicate his mental disorder. Although he notes there is more support available now, Tom believes his transition to homelessness occurred as a direct result of the lack of support he experienced in relation to his diagnosis. Since first becoming homeless at 15, Tom has experienced homelessness for over 20 years.

[40] Not his real name

On two occasions, Tom's sister-in-law involuntarily admitted him as she thought he might become aggressive. He believes that his sister-in-law did not understand his mental illness. Tom explains he had a very limited relationship with his sister-in-law and that she was in no way involved in his care. On several occasions, Tom admitted himself for treatment as he thought it would be safer for him and his partner if he were placed under voluntary care.

Tom has lived in a variety of accommodation all over Australia, in both cities and regional areas. He has moved from men's shelters to government housing, transitional rooming houses and with his family. He notes that in some of these cases he has experienced issues with violence and bullying.

Tom noted he was generally unaware of his rights as a voluntary patient. He believed the mental health facility regularly took advantage of the confusion as to his rights and did not make it clear whether he was entitled to leave or whether he was to be made involuntary.

Tom further noted experiencing extremes of treatment where *'they [mental health teams] don't want anything to do with you unless you are having an episode*'. While on several occasions he was able to admit himself and get the treatment he needed as an inpatient, he suggested that this extreme response may have been avoided if he had had more support such as counselling, or had just been able to '*reach out to the right service*'.

At one point Tom was living in South Australia and a South Australian health worker came and visited him to '*check in on him and have a cuppa*' approximately once a week. He was quite positive about that continual support. Tom currently has weekly counselling sessions but advises he was only able to access this service after considerable effort on his behalf.

Tom has lived in many parts of Australia and has noticed provision of mental health services has improved in recent years. Nonetheless, his experiences show that coordination between agencies and service delivery to homeless consumers could still be improved.

As discussed above, homeless persons experiencing mental illness are especially vulnerable and face particular challenges when attempting to access services. Specific measures need to be taken to overcome these obstacles because '[s]ervices most likely to be used by homeless people with mental illness are those that have adapted service delivery and treatment approaches to reflect the experiences and reports of their homeless clients'[41]. Under the provisions of the *MHA* set out above, these special needs should be considered when homeless people are provided with treatment and care. Such an approach is consistent with recognition of 'the diversity of persons with disabilities'.[42]

The HPLC questions whether the 'special needs' framework of the *MHA* is realised in the day-to-day operation of the *Act*. If not, steps should be taken to ensure that the promise of the above provisions is fulfilled for homeless persons. The HPLC acknowledges that this may be best achieved by a shift in policy, additional resources and / or increased awareness of issues facing

[41] Australian Department of Health and Ageing, Homelessness and Mental Health Linkages, May 2005 page 5

[42] *Convention on the Rights of Persons with Disabilities*, Preamble, (i).

homeless people experiencing mental illness; however the HPLC is of the view that legislative reform to bolster the special needs regime would also assist in improving the system.

Recommendation

The HPLC recommends the new Act:

(a) recognise that specific measures need to be taken to overcome barriers to access faced by homeless people;

(b) encourage service delivery and treatment approaches in a manner adapted to homeless people.

6. Involuntary Treatment Orders (*ITO*)

6.1 Unique experience of homeless people and involuntary treatment orders

Subjecting a person to medical treatment without their consent is a severe encroachment on that person's human rights and is only justifiable in the most limited circumstances. The experience of homeless people with a mental disorder differs from other patients by virtue of the risk of being released from involuntary treatment into homelessness. This risk includes release in circumstances where patients are subject to a community treatment order while being homeless, which significantly limits the effectiveness of treatment received.

The mental health system should ensure that people experiencing homelessness are not discharged on to the street or into accommodation which is likely to damage or detrimentally impact their health or welfare. Failure to do so means that the already disempowering experience of being treated against one's will is magnified by the ultimate failure of the treatment upon discharge. The case study relating to Tom is a clear example of the way in which treatment fails where not underpinned by broader supports such as housing assistance.

Nonetheless, it should also be noted that issues surrounding 'discharge into homelessness,' any human rights analysis also suggests that patients may not be held where the criteria for involuntary treatment is not satisfied.

6.2 ITOs and appropriate housing

The experiences of Carla, Tom and Sam (see below at 6.1) highlight circumstances in which patients were compelled to admit themselves to mental health facilities and subsequently were put on an ITO. It is possible that in these circumstances, an ITO was not the least restrictive treatment available[43], but due to Carla, Sam and Tom's social and housing circumstances it was the most appropriate option available. Indeed, while acknowledging the high use of Community Treatment Orders in Victoria, it is also possible

[43] In this regard, research into the percentage of homeless people who voluntarily admit themselves to inpatient mental health facilities (as opposed to housed patients) would be instructive.

that their admission as inpatients may have been, in part, resulted from the absence of alternatives.[44]

As both Tom and Carla's cases identify, people experiencing homelessness and a mental disorder cycle between the streets and inpatient facilities. This situation was considered in a 1995 study in which a group of 100 homeless men with a diagnosis of schizophrenia were compared to a group of 100 housed men who shared the same diagnosis. The study found that 'homeless men were more likely to have been discharged against medical advice and had less adequate discharge arrangements for housing and financial support. The most inadequate discharge plans were made for people with schizophrenia, personality disorder and a history of substance abuse.'[45] Consistent with this study, clients of the HPLC who have experienced release into homelessness have observed that the experience is one of extremes, where the patient swings from intensive care when in hospital to very little care upon returning to the community.

These extremes in treatment and non-treatment should be addressed by adequate provision in the mental health regime for comprehensive discharge planning, continued support and monitoring of patients on release, particularly in a way which addresses barriers to service access for homeless people. In the HPLC's view, this would avoid treatment extremes and reduce the amount of time people spend on ITOs.

Without access to affordable and appropriate supported housing, evidence indicates that people experiencing homelessness before entry into hospital will continue to be released from hospital into conditions which are likely to damage their mental health rather than improve it. It is incontrovertible that to address and improve health outcomes, people experiencing homelessness and a mental disorder must be housed. While provision of appropriate housing to these individuals is both a significant policy and funding challenge, it should not be forgotten that both Australian and international human rights require such action.

As noted in the Victorian Government's Consultation Paper *Because Mental Health Matters,* there is a clear lack of affordable accommodation options in Victoria.[46] There is an even greater shortage of appropriate housing for vulnerable persons who have a mental illness. As a consequence, housing workers often refer homeless people to unsuitable accommodation such as boarding houses.

In light of the obstacles to both care and participation faced by homeless people, the significance of adequate discharge planning is obvious. It is clear, however, that in these circumstances no amount support or discharge planning will resolve structural issues such as the shortage of appropriate housing.

Recommendation

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[44] Dr Michelle Funk, The Role of International Human Rights in National Mental Health Legislation, page 33

[45] Australian Department of Health and Ageing, Homelessness and Mental Health Linkages, May 2005, page 17

[46] *Because Mental Health Matters: A new focus for mental health and wellbeing in Victoria*, Consultation Paper, May 2008

The HPLC recommends the new Act contain provisions encouraging comprehensive discharge planning, continued support and monitoring of patients on release in a way which addresses barriers to service access for homeless people;

The HPLC recommends that the Victorian Government address the considerable lack of appropriate housing for homeless people with a mental disorder.

Q 12 How should the new Act address the issue of the 'least restrictive manner' in the grounds for an involuntary order?

The HPLC recommends the new Act contain:

(a) adequate provisions for continued support and monitoring of patients so that patients are not placed on involuntary treatment orders as a consequence of their social and housing circumstances;

(b) the new Act specifically acknowledge the links between homelessness and mental health;

(c) a statutory guarantee that no homeless involuntary patient will be discharged into homelessness;

(d) a statutory guarantee that appropriate housing must be made available to homeless patients upon discharge as an involuntary patient.

7. Patient Participation

The *MHA* already contains provisions concerning patient participation. These include the following:

- One of the objectives of the DHS is to create mental health services that 'encourage patients and other people with a mental disorder to participate as far as possible in the development and operation of those services'.[47]
- It is a principle of treatment and care that 'every effort that is reasonably practicable should be made to involve a person with a mental disorder in the development of an ongoing treatment plan.'[48]
- When an authorised psychiatrist prepares, reviews or revises a patient's treatment plan, they must take into account 'the wishes of the patient, as far as they can be ascertained'.[49]

7.1 Case study - Sam[50]

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[47] *MHA*, s 5(a)(ix).

[48] *MHA*, 6A(j).

[49] *MHA*, 19A(2)(a).

[50] Not his real name

Sam is 26 years of age and has a history of homelessness. In the past he had been involuntarily hospitalised as a result of manic episodes with associated psychotic features. Sam recently returned from interstate and voluntarily admitted himself to a mental health facility so that he could have a roof over his head, something to eat, a shower and so he could make phone calls. He claimed that he was not 'unwell'.

After arriving in hospital, Sam was assessed and placed on an involuntary order. Soon after being made involuntary he sought legal advice in order to resist medical treatment but discovered there would be no Mental Health Review Board hearing for another 2 weeks. Sam further discovered that he would not receive Legal Aid assistance until shortly prior to the hearing.

Sam was extremely concerned about the effects of the medication he was about to receive. He explained that one psychiatrist at the mental health facility had agreed to discuss with him the possibility of further counselling over his medication. Unfortunately this psychiatrist only worked one day a week and it was likely that he would have received the medication by the time this doctor returned to the facility.

Sam notes that although the medication had been successful in the past, he had also suffered adverse effects. He wanted his treatment team to take these effects into consideration. His numerous attempts to obtain a second opinion to support these claims were unsuccessful. Ultimately Sam discovered that obtaining a second opinion was not a realistic option as (a) he was unable to pay for the consultation (b) even on the slight chance he did find a psychiatrist prepared to provide an opinion at no cost, this opinion would take days, *if not weeks*, to obtain.

Despite Sam's objections to the medication he did not want to be discharged from hospital and into homelessness. He said that e was prepared to remain in hospital and obtain counselling, rather than medication.

As Sam and Tom's case studies indicate, homeless people experience significant barriers to expressing their wishes and being involved in development of their treatment plans. Key barriers experienced by homeless people are their isolation from family and carers, the absence of collected medical information and detailed medical history, the lack of contact details, the absence of continuity of care, the lack of premises to store documentation including reports and prescriptions, the lack of contact details and the inability to access transport.

Participation is fundamental to the realisation of a person's human rights. Given the high correlation between homelessness and mental health disorders, it is clear that participation of people experiencing homelessness in relation to decisions about treatment and care are critical.

One of the principles of the *CRPD* is '[r]espect for inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of persons'.[51] Accordingly, people experiencing a mental illness (including homeless people) should be given the maximum possible opportunity to make choices about their own treatment and care.

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[51] *Convention on the Rights of Persons with Disabilities*, Opened for signature 30 March 2007, General Assembly Resolution A/RES/61/106, (entered into force 3 May 2008), Article 3(a).

The new Act should consider mechanisms for improving patient participation and realising the worthy objectives set out in the current iteration of the *MHA*. In particular, the HPLC advocates the use of advance statements and effective use of independent support workers.

> **Recommendation**
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> The HPLC recommends the new Act contain provisions for the practical realisation of the objectives in the current *MHA.*

7.2 Advance Statements

Through advance statements, people experiencing a mental illness can record preferences about their future treatment (and related matters) and care. For example, a person might indicate that they favour a certain kind of medication, object to a particular kind of therapy or nominate a carer (or perhaps someone who should *not* be contacted in relation to decision making). Advance statements would have assisted Sam to justify his desire to refuse medication. An advance statement would have also assisted 'Tom' to exclude his sister-in-law from involvement in his treatment planning. Advance statements are recorded in writing at a time when a person is capable of making decisions about their treatment and care. The statements can then inform treatment decisions at times when the person is not capable of making such decisions.

The HPLC supports the amendment of the *MHA* to provide for the use of advance statements. However, it notes that, for homeless people experiencing mental illness, advance statements may present particular issues. In particular:

- It may be more difficult for a homeless person to retain a hard copy of an advance statement, and to produce it at relevant times. In this respect the case study of Tom is instructive. Not only did Tom's transient homelessness create problems when he sought to have his wishes considered, it also posed issues in relation to the provision of ongoing, consistent treatment. For this reason, it may be helpful to create an online database of advance statements;
- A lack of access to resources may make it more difficult for a homeless person to create or maintain an advance statement. As a result, people experiencing homelessness may update advance statements infrequently. Because preferences about care and treatment can change over time, the currency of any advance statement would need to be taken into account. The HPLC is concerned that rigid application of outdated advance statements would have the undesirable effect of undermining the wishes of people receiving treatment and care; and
- People experiencing homelessness and a mental health disorder should be given every assistance to both create and update their advance statement in a manner appropriate to their needs, consistent with the objectives of the *MHA*.

In the design of any system providing for the use of advance statements, the particular situation of homeless people should be borne in mind.

> **Q 30 If an advance statement scheme is considered necessary: (a) What requirements should the new Act contain to ensure their effectiveness? (b) In what**

circumstances, if any, should the new Act allow an advance statement to be overridden?

The HPLC recommends the new Act provide:

(a) for the use of advance statements;

(b) the development of criteria or guidelines to assist hospital staff, carers, advocates, patients and the Board evaluate the currency of the advance statement;

(c) flexibility to update and amend advance statements;

(b) that homeless people with a mental health disorder be given every assistance to create and update their statement in a manner appropriate to their needs.

7.3 Independent support person & support workers

In order to effectively exercise the right to make choices about treatment and care, people experiencing mental illness may require support. Independent support is especially critical for people who are also experiencing homelessness, because of their particular vulnerability.

The role of an independent support person should be considered in terms of both rights (referred to here as an *independent support person*) and non-rights support (referred to here as a *support worker*). In relation to rights support, rights advice is currently the responsibility of the authorised psychiatrist (see discussion below). Further, although telephone advice is available from the Mental Health Legal Centre and Victoria Legal Aid (***VLA***), legal representation and advocacy for involuntary inpatients is only available shortly prior to hearing.

Mental health legislation in many jurisdictions overseas provides for an independent rights advocate and support service for involuntary patients. Research performed by Mr John Lessor, Mental Health Review Board President, refers to comparative international legislative frameworks[52] and notes 'in all jurisdictions, patients' advocates act as an independent, patient-centred, partial and trusted confidante, who explains rights to, expresses the views of, and advocates on behalf of, patients in respect of both external (involuntary status) and internal (individual and systemic complaints) rights.'[53]

In relation to non-rights support, a support worker involved at an early stage of involuntary treatment could greatly assist homeless people with developing detailed discharge plans including developing housing and treatment plans.

Q 26 What requirements should the new Act contain to assist patients to understand and exercise their rights throughout the involuntary treatment process?

Q 27 What requirements, if any, should the new Act contain to assist voluntary patients to understand and exercise their rights?

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[52] England, Scotland, Netherlands, Denmark, Ontario Canada

[53] Report by John Lesser 2006 Churchill Fellow on a study project, *Review and Decision Making for Persons with a Serious Mental Illness: Achieving Best Practice: A Cross-Jurisdictional Evaluation of Involuntary Mental Health Review and Decision-Making Systems*, 2006, at 39.

The HPLC recommends the new Act provide:

(a) all involuntary patients be provided with an independent support person as soon as possible following being made involuntary;

(b) the independent support person is to be a patient advocate and act as an independent, patient-centred, partial and trusted confidante who explains rights, expresses views of, and advocates for patients in respect of external (involuntary status) and internal (individual and systemic complaints) rights; and

(c) in cases of need (involving homelessness or co-morbidity issues), a support worker to provide non-rights support.

8. External reviews and access to justice

8.1 Access issues

Sam's case indicates the practical barriers faced by homeless persons in the external review process. Sam sought advice soon after he was made involuntary. He did not want to leave hospital but he *did* want to refuse medication. He was unable to access VLA advocacy as the MHRB was not due to hold hearings for another fortnight. In relation to a second psychiatric opinion, Sam was overwhelmed by resources, timing and logistical issues required to obtain the opinion.

Practically speaking, prior to being forced to receive medication there was very little scope for Sam to (a) access advocacy, (b) access an independent psychiatrist in order to support his treatment wishes, (c) negotiate with his treatment team in relation to the decision whether to administer medication and (d) ultimately, to obtain an evidence-based decision in relation to whether he could legitimately refuse treatment.

While rights such as the right to be represented before the MHRB and the right to obtain a second opinion are contained in the *MHA*, HPLC submits that homeless persons are often unaware of these rights and lack the resources and social infrastructure to enforce these rights. This is inconsistent with the principle of non-discrimination, and, specifically, the right to the equal protection of the law.

Studies have found that the disruption caused by homelessness (or the risk of homelessness) influences decision making ability and capacity to undertake or complete activities.[54] Additional support is required to ensure that being homeless is not a barrier to accessing services or enforcing rights under the *MHA*.

Access to justice issues experienced by homeless persons (and other disadvantaged groups), as a subset of the mentally ill, should be considered in any reforms of or policy implementation regarding the *MHA*. The HPLC appreciates that these reforms will also have funding implications, but considers that access to justice is crucial for individuals subject to the *MHA*.

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[54] Chris Chamberlain, Guy Johnson, Jacqui Theobald, above n 10, 18.

8.2 Awareness of rights

The *MHA* provides that, on becoming a patient, every person must be given the appropriate prescribed printed statement advising the patient as to the legal rights and entitlements under the *MHA*. In addition to the statement, the patient must be given an oral explanation of the information contained in the statement in a mode of communication or terms which the patient is most likely to understand.[55] The provision requiring advice to be given in a manner which is most likely to be understood derives from principle 12 of the UNHCR principles for the protection of persons with mental illness. It is the duty of the authorised psychiatrist to ensure that this obligation is complied with by the approved mental health service.

It is the HPLC's experience that an information pamphlet is given to involuntary patients but the explanation of rights is not performed in a manner likely to be understood by the patient. There is no consequence for failure to properly advise patients of their rights and there is no reference to the frequency with which rights advice should be given. Furthermore, HPLC clients perceive a lack of independence or conflict of interest where rights advice is given by the same person who is administering treatment involuntarily. The HPLC considers the explanation of rights to be a critical factor in exercise of those rights.

For any rights contained in the *MHA* to be effective and meaningful, people experiencing homelessness and mental illness need to be aware of their rights and be supported to act on them. As discussed above, the HPLC supports the concept of independent support person and support workers**.** In order to avoid the problems referred to above the HPLC considers that an independent support worker (or equivalent independent person) should be available to provide advice in relation to patient rights. Advice in relation to rights should be linked with advocacy and assistance where the client seeks to rely on this advice. Further, the advice provisions of the *MHA* should be amended to take into consideration the fact that a mental disorder may pose an obstacle to understanding or recalling any explanation of rights. The HPLC therefore believes any rights advice should be given at defined intervals following involuntary admission.

Q 26 What requirements should the new Act contain to assist patients to understand and exercise their rights throughout the involuntary treatment process?

The HPLC recommends that:

(a) the authorised psychiatrist not be responsible for the provision of rights advice;

(b) the *MHA* remain unaltered in respect of the way in which advice is to be given but attention be given to effectively realising legislative provisions in relation to provision of advice;

(c) rights advice be provided by an independent support worker or other independent person; annd

(d) rights advice be given at defined intervals following involuntary treatment.

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[55] *MHA*, s18

8.3 Representation

A recent report by the Mental Health Legal Centre states that advocacy is highly valued by most consumers and that,

> '[c]onsumers are adamant that advocacy is a vital way of ensuring that rights are upheld and the voice of the consumer is heard by Board members. Advocacy is viewed as an important way of empowering the consumer and ensuring the Board is held to account.'[56]

The *MHA* currently provides that a patient may be represented by a legal practitioner or any other person the patient authorises to represent them.[57] Where a patient is not represented, the MHRB may appoint a person to represent the patient.[58] The *MHA* requires that every person, on becoming an involuntary patient, must be given information about their legal rights, including the right to obtain legal representation.[59] Further, contact details for VLA must be kept at a place readily accessible to patients.

Despite these provisions of the *MHA*, in its 2007/2008 Annual Report, the MHRB reported that only 5.6% of hearings involved legal representation.[60] A further breakdown as to what percentage of this figure were homeless is not available. The HPLC addresses the need for centralised data collection below. The HPLC understands that VLA representation on a legally aided basis only where VLA forms the view that the matter has merit (i.e. the involuntary treatment order may be discharged) although this situation is ameliorated somewhat by the availability of representation by a duty lawyer. Another issue is that generally VLA assistance is only provided a short time before the MHRB hearing.

The case study relating to 'Sam' demonstrates that patients may require advocacy soon after being made involuntary. The delay before both advocacy and a hearing before the MHRB meant Sam had very limited ways of meaningfully resisting involuntary treatment.

The provision of legal representation is supported by international law and (as noted in the Consultation Paper) it has also been included in legislative provisions in the Northern Territory and South Australia. The procedural safeguards set out in principle 18 of the *United Nations Principles for the Protection of Persons with Mental Illness* (***UN MI Principles***) require the provision of a legal representative for those that cannot afford a lawyer. The right to a fair hearing in Article 14 of the *ICCPR* and sections 24 and 25 of the *Charter of Human Rights and Responsibilities Act 2006 (Vic) (the* **Charter***)* are also relevant to reviews and appeals before the MHRB. Given the consequences of a decision of the MHRB for the liberty of a person, we submit that representation in front of the MHRB should be considered akin to representation in criminal proceedings. The HPLC recommends the provision of advocacy be facilitated either by amendments to the *Legal Aid Act 1978* or through increased funding of a mental health advocacy service.

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[56] Topp, Thomas, Ingvarson, *Lacking Insight*, October 2008, page 57

[57] *MHA*, s26(3)

[58] *MHA*, s26(5)

[59] *MHA*, s18(1)

[60] Mental Health Review Board Annual Report 2007 – 2008, page 31.

HPLC refers to the discussion of independent support person, above. The HPLC considers any right to representation and advocacy should commence immediately following involuntary admission and continue up to representation before the Board. As provided above, the independent support person should provide rights advice, advocacy and assist with both internal and external complaints.

Recommendation

The HPLC recommends the provision of advocacy be facilitated either by amendments to the *Legal Aid Act 1978* or through increased funding of a mental health advocacy service.

Q 47 How should the new Act address issues of patient participation in external review?

The HPLC recommends that participation in external review could be achieved by provision of an independent support person to involuntary patients.

The HPLC reiterates recommendations above that the new Act provide:

(a) all involuntary patients be provided with an independent support person as soon as possible following admission as an inpatient

(b) the independent support person is to be a patient advocate and act as an independent, patient-centred, partial and trusted confidante who explains rights, expresses views of, and advocates for patients in respect of external (involuntary status) and internal (individual and systemic complaints) rights.

8.4 Second psychiatric opinions

The *MHA* requires that on becoming an involuntary patient, every person must be given information about their legal rights, including the right to obtain a second medical opinion.[61] Practically speaking, however, there are numerous obstacles facing inpatients who would like a second opinion. Those barriers include:

- Availability & cost: While it is possible to contact the Victorian Mental Illness Awareness Council for the names of psychiatrists who bulk bill, many psychiatrists do not bulk bill. This is particularly problematic for people experiencing homelessness, given the nexus between poverty and homelessness[62].
- Logistics: Given that inpatients are only allowed to leave psychiatric facilities in limited circumstances (generally in the company of nurses), there are significant logistical barriers to obtaining a second psychiatric opinion in a timely fashion.
- Timing: Further to logistical problems, it is difficult for inpatients to obtain a second psychiatric opinion within a reasonable period for use either in negotiations with the psychiatric facility or before the Board.

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[61] MHA, s18(1).

[62] Note that Although, the cost of preparing a report can sometimes be avoided if the psychiatrist is prepare to right a simple note or letter for the Board.

The HPLC is not aware of any circumstances in which a homeless involuntary patient has been able to either obtain an independent psychiatric opinion or to rely on this opinion in dealings with the hospital or Board. Sam's story is a good example of the barriers facing homeless inpatients. Despite making numerous telephone calls, he was unable to locate a psychiatrist prepared to examine him. He was unable to make it past even the first barrier, let alone confront the logistical or timing issues.

Given the seriousness of the consequences of a decision of the MHRB in relation to a person's liberty, the HPLC submits that as a component of the right to a fair hearing in Article 14 of the *ICCPR* and section 24 of the *Charter*, anyone appearing before the MHRB should be afforded a statutory right to an independent second opinion free of charge. Principle 18 of the *UN MI Principles* also supports this position and further provides for a patient's right to present an independent opinion.

In addition, as noted in the Consultation Paper, the *MHA* does not currently require the MHRB to take into account a second psychiatric opinion. To give full effect to the right to present a second opinion, consideration of the second opinion should be included in addition to the s8(1) the criteria that the MHRB must consider in reviews and appeals.

Q 14 If a second psychiatric opinion scheme is considered necessary, in what circumstances should the new Act require a second opinion?

As a minimum, the HPLC recommends that the new Act

(a) provide involuntary patients have the right to a second independent psychiatric opinion free of charge

(b) the provision of the second psychiatric opinion is to be made in a timely fashion and any report be made available to the patient for use in treatment negotiations and MHRB hearings

7.6 Complaints

As outlined in the Consultation Paper, there is no central comprehensive complaints body established by the *MHA*. The HPLC understands that complaints are most often directed to the Chief Psychiatrist's office. Under the *MHA*, community visitors may also look into any complaint made to them by a person receiving treatment or care for a mental disorder[47.] The Chief Psychiatrist and community visitors also have the power to make enquires about the treatment and care of people with a mental disorder.[48] The Chief Psychiatrist also has powers to make written directions to a psychiatric service[49]. The Consultation Paper also notes the variety of other bodies to whom complaints can be made, such as the Health Services Commission, the Public Advocate, the Victorian Equal Opportunity and Human Rights Commission and the Ombudsman. The HPLC considers that this variety of bodies would cause confusion for anyone, let alone a person challenged

[47] MHA, s109(g).

[48] *MHA,* s106(5), 112(1)(c).

[49] *MHA*, s106AA.

by mental health issues and homelessness. A central complaints system would be far more manageable, accessible and effective, not to mention cost-effective to administer.

The HPLC supports the establishment of a central complaints body to deal with complaints made in relation to treatment under the *MHA*. For such a complaints body to be effective it would need to have a wide jurisdiction and be adequately funded. For example, as discussed above, a homeless person may have a complaint relating to accommodation issues while on a CTO. To be effective, a complaints body would need to be able to address and attempt to resolve these wider issues, perhaps in conjunction with other government departments.

A clear set of complaints procedures should also be established[50] and presented in a readily accessible and easy to understand form for mental health patients. Support workers could also help guide mental health patients through this process. Further, ideally complaints should be resolved at a local level, but the HPLC recognises that this is not always possible.

We note that one of the advantages in establishing a centralised complaints body would be to facilitate the collection of data. Such data, properly collected and categorised, would allow for ongoing systemic issues to be identified and addressed. Due to the link between homelessness and mental health outlined above, appropriately targeted data collection and analysis on particular subsets of mentally ill persons, such as homeless persons, would be helpful in identifying and addressing systemic issues.

Q 57 (A) What complaints functions and powers should the new Act contain?

The HPLC recommends that the new Act

(a) provide for a central complaints body for complaints in respect of treatment under the *MHA*

(b) give consideration to the ways in which homeless people can be assisted to make and resolve complaints under the Act

(c) assist in the provision of data collection to identify and address systemic issues.

7.7 Commissioner for Mental Health

As discussed and seen in the cases of Carla, Tom and Sam, many of the issues faced by homeless people relate not only to the provisions of *MHA* but also to broader housing and welfare funding arrangements and policies. A pure mental health complaints body may be restricted in its resources and powers to deal with broader systemic issues. While acknowledging the level of additional resources required, the HPLC supports the establishment of a Commissioner for Mental Health or perhaps extension of the powers of the Health Services Commission to examine and deal with the wider systemic issues.

[50] See World Heath Organisation, above n 25, 71

A Commissioner for Mental health could have similar powers and functions to those exercised by the New South Wales Ombudsman who receives and addresses complaints and conducts investigations in relation to treatment of persons with mental illness.[~~46~~51]

A Commissioner for Mental Health could have the power and appropriate funding to:

- make determinations regarding complaints about homelessness and mental health;
- make and enforce such orders as are necessary to improve or enhance positive housing and mental health issues;
- receive and consider complaints regarding matters of homelessness and mental health, including in relation to the extent to which the rights to adequate housing and the highest attainable standard of health are protected, respected and fulfilled;
- undertake as well as initiate investigations and inquiries regarding matters of homelessness and mental health and the extent to which the rights to adequate housing and the highest attainable standard of health are protected, respected and fulfilled;
- produce an annual report on the work undertaken by the body and make recommendations for systemic changes to improve social and economic determinants of mental health and address issues of homelessness, poverty and discrimination; and
- consider, investigate, monitor, analyse and report on programs directed towards improvement of the social and economic determinates of mental health, including programs directed to addressing poverty, homelessness and discrimination.[~~47~~52]

Q59 What requirements, if any, should the new Act contain to ensure that information learned from complaints is used to promote service improvement?

The HPLC recommends that the new Act

(a) create a Commissioner for Mental Health

(b) provide the Commissioner for Mental Health with such powers and funding as to enable significant recommendations, investigations and inquiries in relation matters relating to mental health

(c) the Commissioner for Mental Health have specific obligations in relation to vulnerable consumers such as homeless people in order to investigate and address the causes of systemic disadvantage.

[~~46~~51] See NSW Ombudsman Annual Report 2007 – 2008. In Particular see the summary of an investigation relating to helping people with a mental illness access and sustain social housing on page 31 and case study 35 on page 92.

[~~47~~52] See also our submission to the Senate Select Committee on Mental Health, above n 14, 38-39 and our submission to the Department of Human Services Review of the *Health Act 1958*, November 2004.

9. Confidentiality and information sharing

Section 13 of the *Charter* establishes a person's right not to have his or her privacy unlawfully or arbitrarily interfered with and not to have his or her reputation unlawfully attacked. Similar provisions are found in article 17(1) of the *ICCPR* and article 22 of the *Convention on the Rights of Persons with a Disability*. *UN MI Principles* 6 and 13(b) also recognise that the right to confidentiality of information of mentally ill patients should be respected and that every patient shall have the right to full respect for his or her privacy.

Balancing a patient's right to privacy with the needs of families and carers to access information to enable them to undertake their caring role is a matter of great importance in any piece of mental health legislation. In the Consultation Paper it is noted that de-institutionalisation policies have meant that families and carers now play a vital role in supporting people with a mental illness.[63] While this may be the case generally, the observation does not necessarily reflect the experience of homeless persons with a mental illness specifically. One of the many factors that may lead to a person becoming or remaining homeless is the fact that, for various reasons, they do not have the ongoing support of family members or other carers. In these circumstances, many HPLC clients express concern that their right to privacy should be upheld and that information should not be provided to family members or others who are not involved in their day-to-day care. Disclosure of a patient's confidential information to guardians, carers or family members, where relationships are strained can have counter-productive results. For example, it may undermine trust between patients and health professionals and may result in further disengagement of patients from the mental health system.

The *MHA* currently permits the non-consensual disclosure of information only to people who are involved in providing 'ongoing care'. The HPLC submits that any change to this requirement should not facilitate the provision of confidential information to family members or others who are estranged from the patient or are not involved in the patient's treatment and care. It is also recommended that even in circumstances where the carer or family member is providing ongoing care, wherever possible disclosure should be made with the patient's consent and positive obligations should be placed on practitioners to obtain this consent. Any provisions would have to strike the right balance between the need to give cerers proper information on patient discharge and the privacy of patients.

As well as ensuring that appropriate legislative provisions are enacted, it is important that the government implement measures to require compliance with such provisions. In the HPLC's experience, a number of clients have expressed concern that confidential information had been given by practitioners to non-care-giving family members. Measures to facilitate compliance include appropriate schemes for educating both carers and mental health staff of their rights and obligations with respect to confidential information. Other useful measures may include providing sanctions and penalties for non-compliance and ensuring that there are effective procedures in place to monitor compliance. Ideally, remedies other than legal prosecution, such as education of the person and proper

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[63] Review of the *MHA* Consultation Paper, p 73.

administrative procedures, should be used where a patient's confidentiality has been breached.

Q 60 In what circumstances should the new Act *permit* disclosure of information to families and carers without patient consent?

The HPLC recommends that the provisions of the new Act should not facilitate the provision of confidential information to family members or others who are estranged from the patient or are not involved in the patient's ongoing treatment and care.

The HPLC recommends that even in circumstances where a carer or family member is providing ongoing care, wherever possible disclosure should be made with the patient's consent and the Act should place positive obligations on practitioners to obtain this consent.

A final point to note in relation to confidential information is that in many cases a homeless person will fall through the gaps of the mental health system in part because of the prevalence of co-morbidity and their interaction with various government services. As illustrated in the case of Carla, the complete nature of homeless persons' needs often means they interact with a broad variety of government services such as housing, Centrelink, primary health care providers and mental health services. There is a clear need for a whole of government response and for co-operation between the various services with which a homeless person may interact. While the HPLC recommends that initiatives be developed to increase integration between such services, confidential medical information should not be shared between services without a patient's consent except in the most limited circumstances, for example where there is a significant risk of serious danger to the patient or to others.

Q 64 a) What service providers, if any, should receive identified information without a patient's consent? (b) If so, in what circumstances should they receive identified information without a patient's consent?

While acknowledging the need for increased integration between various service providers, the HPLC recommends that confidential medical information should not be shared between services without a patient's consent except in the most limited circumstances, for example where there is a significant risk of serious danger to the patient or to others.

10. Conclusion

In its submission to the review of the *MHA*, the HPLC has sought to highlight the complex and powerful connections between homelessness and mental illness. Accordingly, one of our core recommendations is that the *MHA* must be amended to expressly acknowledge these links. The HPLC seeks reform of specific aspects of the *MHA*, to reflect the situation of homeless persons experiencing mental illness and better protect their rights. In particular, the HPLC's recommendations seek to address the options available to people experiencing homelessness after they are discharged from care, as well as the financial and logistical challenges

they face, the importance of independent support, advice and advocacy, and the potential for strained relationships with family members and others. Through its submission, the HPLC has sought to emphasise that the complex and interrelated challenges posed by homelessness and mental illness demand coordinated policy and funding based responses, in addition to legislative reform.

APPENDIX 1 - CASE STUDIES

Carla

Carla is approximately 45 years of age. She has experienced homelessness for years and suffers from chronic mental illness. Carla has been diagnosed at various times with bipolar affective disorder, schizoaffective disorder and psychoaffective disorder. She is unable to work because of her condition and therefore relies upon a disability support pension. HPLC has assisted Carla in relation to a range of issues since approximately 2004. During this period she has moved repeatedly through a cycle of hospitalisation, release, relative stability, descent back into crisis, breakdown and rehospitalisation.

Because of her condition, which is characterised by severe mood swings and delusions, Carla has regularly been subject to Community Treatment Orders to ensure that she receives continued psychiatric treatment. She has been admitted as an inpatient to psychiatric care on numerous occasions since 1994, in most instances on an involuntary basis. These episodes of inpatient care have generally lasted from weeks to months.

When she is released from care Carla has little or no family support and has over the years relied upon a range of outreach and housing support services including Homeground Services, Hannover Inner North Outreach Support and most recently, North West Mental Health Services. Because of her condition, Carla's relationships with these services has often been volatile. Over these years she has lived in a range of rooming houses and other temporary accommodation.

More recently she has been provided with her own apartment in the northern suburbs. However, because of her condition it is difficult for her to live independently and she requires ongoing outreach support.

Tom[64]

Tom is approximately 41 years old. He suffers from chronic mental illness and has been diagnosed with schizophrenia. Tom has been in and out of mental health facilities since he was approximately 15 years old. He notes that when he was first diagnosed, there was no ongoing counselling or support and that he was incredibly isolated. Apart from his mother, who passed away approximately 11 years ago, Tom explains his family have not understood his illness and he believes that they considered him 'not safe to be around'.

At the time of his diagnosis, Tom explains that he soon ended up living on the streets and using heroin to self medicate his mental disorder. Although he notes there is more support available now, Tom believes his transition to homelessness occurred as a direct result of the lack of support he experienced in relation to his diagnosis. Since becoming homeless at 15, Tom has experienced homelessness for over 20 years.

On two occasions, Tom’s sister-in-law involuntarily admitted him as she thought he might become aggressive. He believes that his sister in law did not understand his mental illness. Tom explains he had a very limited relationship with his sister in law and that she was in no way involved in his care. Also on several occasions he admitted himself for treatment as he thought it would be safer

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[64] Not his real name

for him and his partner, if he were placed under voluntary care. Tom has lived in a variety of accommodation all over Australia, in both cities and regional areas. He has moved from men's shelters to government housing, transitional rooming houses and with his family. He notes that in some of these cases there have been issues with violence and bullying.

Tom noted he was generally unaware of his rights as a voluntary patient. He believed the mental health facility regularly took advantage of the confusion as to his rights and did not make it clear whether he was entitled to leave or whether he was to be made involuntary.

Tom further noted experiencing extremes of treatment where *'they [mental health teams] don't want anything to do with you unless you are having an episode*'. While on several occasions he was able to admit himself and get the treatment he needed as an inpatient, he suggested that this extreme may have been avoided if he had had more support such as counselling, or had just been able to '*reach out to the right service*'.

At one point Tom was living in South Australia and a South Australian health worker came and visited him to '*check in on him and have a cuppa*' approximately once a week. He was quite positive about that continual support. Tom currently has weekly counselling sessions but advises he was able to access this service after considerable effort on his behalf.

10.1 Case study - Sam[65]

Sam is 26 years of age and has a history homelessness. In the past he had been involuntarily hospitalised as a result of manic episodes with associated psychotic features. Sam recently returned from interstate and voluntarily admitted himself to a mental health facility so that he could have a roof over his head, something to eat, have a shower and make phone calls. He claimed that he was not 'unwell'.

After arriving in hospital, Sam was assessed and placed on an involuntary order. Soon after being made involuntary he sought legal advice in order to resist medical treatment but discovered there would be no Mental Health Review Board hearing for another 2 weeks. Sam further discovered that he would not receive Legal Aid assistance until shortly prior to the hearing.

Sam was extremely concerned at the effects of medication. He explained that one psychiatrist at the mental health facility had agreed to discuss with him the possibility of further counselling over medication. Unfortunately this psychiatrist only worked one day a week and it was likely that he would have received the medication by the time this doctor returned to the facility.

Sam noted that although the medication had been successful in the past, he had also endured adverse effects. He wanted his treatment team to take these effects into consideration. His numerous attempts to obtain a second opinion to support these claims were unsuccessful. Ultimately Sam discovered that obtaining a second opinion was not a realistic option as (a) he was unable to pay for the consultation (b) even on the slight chance he did find a psychiatrist prepared to provide an opinion at no cost, this opinion would take days, *if not weeks*, to obtain.

[65] Not his real name

Despite Sam’s objections to the medication he did not want to be discharged from hospital and into homelessness. Indeed he was prepared to remain in hospital and obtain counselling, rather than medication.

APPENDIX 2 – RECOMMENDATIONS

Recommendation 1

The HPLC recommends the new Act:

(a) prohibit discrimination in the provision of treatment and care for mental illness;

(b) specifically refer to and prohibit discrimination on the basis of homelessness.

Recommendation 2

The HPLC recommends the new Act contain additional reform objectives which recognise that human rights obligations require an specific and comprehensive consideration of the problems facing homeless persons with a mental illness. The HPLC recommends that consideration be given to the ways in which a commitment to co-ordinated policy and funding based responses is also required to achieve improved outcomes for homeless people.

Recommendation 3

The HPLC recommends the new Act:

(a) recognise that specific measures need to be taken to overcome barriers to access faced by homeless people;

(b) encourage service delivery and treatment approaches in a manner adapted to homeless people;

Recommendation 4

The HPLC recommends the new Act contain provisions for the practical realisation of the objectives in the current *MHA.*

Recommendation 5

The HPLC recommends the new Act contain provisions encouraging comprehensive discharge planning, continued support and monitoring of patients on release in a way which addresses barriers to service access for homeless people;

The HPLC recommends that the Victorian Government address the considerable lack of appropriate housing for homeless people with a mental disorder.

Recommendation 6

The HPLC recommends the new Act contain:

(a) adequate provisions for continued support and monitoring of patients so that patients are not placed on involuntary treatment orders as a consequence of their social and housing circumstances;

(b) the new Act specifically acknowledge the links between homelessness and mental health;

(c) a statutory guarantee that no homeless involuntary patient will be discharged into homelessness;

(d) a statutory guarantee that appropriate housing must be made available to homeless patients upon discharge as an involuntary patient.

Recommendation 7

The HPLC recommends the new Act provide:

(a) for the use of advance statements;

(b) the development of criteria or guidelines to assist hospital staff, carers, advocates, patients and the Board evaluate the currency of the advance statement;

(c) flexibility to update and amend advance statements;

(b) that homeless people with a mental health disorder be given every assistance to create and update their statement in a manner appropriate to their needs.

Recommendation 8

The HPLC recommends the new Act provide:

(a) all involuntary patients be provided with an independent support person as soon as possible following being made involuntary;

(b) the independent support person is to be a patient advocate and act as an independent, patient-centred, partial and trusted confidante who explains rights, expresses views of, and advocates for patients in respect of external (involuntary status) and internal (individual and systemic complaints) rights;

(c) in cases of need (involving homelessness or co-morbidity issues), a support worker to provide non-rights support.

Recommendation 9

The HPLC recommends that:

(a) the authorised psychiatrist not be responsible for the provision of rights advice;

(b) the *MHA* remain unaltered in respect of the way in which advice is to be given but attention be given to effectively realising legislative provisions in relation to provision of advice;

(c) rights advice be provided by an independent support worker or other independent person;

(d) rights advice be given at defined intervals following involuntary treatment.

Recommendation 10

The HPLC recommends the provision of advocacy be facilitated either by amendments to the *Legal Aid Act 1978* or through increased funding of a mental health advocacy service.

Recommendation 11

The HPLC recommends that participation in external review could be achieved by provision of an independent support person to involuntary patients.

The HPLC reiterates recommendations above that the new Act provide:

(a) all involuntary patients be provided with an independent support person as soon as possible following admission as an inpatient

(b) the independent support person is to be a patient advocate and act as an independent, patient-centred, partial and trusted confidante who explains rights, expresses views of, and advocates for patients in respect of external (involuntary status) and internal (individual and systemic complaints) rights.

Recommendation 12

As a minimum, the HPLC recommends that the new Act:

(a) provide involuntary patients have the right to a second independent psychiatric opinion free of charge;

(b) the provision of the second psychiatric opinion is to be made in a timely fashion and any report be made available to the patient for use in treatment negotiations and MHRB hearings.

Recommendation 13

The HPLC recommends that the new Act:

(a) provide for a central complaints body for complaints in respect of treatment under the *MHA;*

(b) give consideration to the ways in which homeless people can be assisted to make and resolve complaints under the Act;

(c) assist in the provision of data collection to identify and address systemic issues.

Recommendation 14

The HPLC recommends that the new Act:

(a) create a Commissioner for Mental Health;

(b) provide the Commissioner for Mental Health with such powers and funding as to enable significant recommendations, investigations and inquiries in relation matters relating to mental health;

(c) the Commissioner for Mental Health have specific obligations in relation to vulnerable consumers such as homeless people in order to investigate and address the causes of systemic disadvantage.

Recommendation 15

The HPLC recommends that the provisions of the new Act should not facilitate the provision of confidential information to family members or others who are estranged from the patient or are not involved in the patient's ongoing treatment and care.

Recommendation 16

The HPLC recommends that even in circumstances where a carer or family member is providing ongoing care, wherever possible disclosure should be made with the patient's consent and the Act should place positive obligations on practitioners to obtain this consent.

Recommendation 17

The HPLC recommends that even in circumstances where a carer or family member is providing ongoing care, wherever possible disclosure should be made with the patient's consent and the Act should place positive obligations on practitioners to obtain this consent.