Submission No 51

INQUIRY INTO EQUITY, ACCESSIBILITY AND APPROPRIATE DELIVERY OF OUTPATIENT AND COMMUNITY MENTAL HEALTH CARE IN NEW SOUTH WALES

Organisation: Justice Action

Date Received: 6 September 2023

Submission to Inquiry into the equity, accessibility and appropriate delivery of outpatient and community mental health care in New South Wales

6 September 2023

TABLE OF CONTENTS

(Note: Structure follows that of the inquiry's terms of reference)

To the Portfolio Committee No. 2:

We present the following submission in response to the Terms of Reference of the Committee's "Inquiry into the equity, accessibility and appropriate delivery of outpatient and community mental health care in New South Wales"

Justice Action (JA) is a not for profit, self-funded organization based in Australia that champions the interests and rights of marginalized members of the society. We have been involved in service provision, peer mentoring and accommodation as well as supervising Community Service Orders for twenty three years.

JA advocates for the improvement of the social and mental health of people locked in prisons and hospitals ensuring their voices and those connected to them are heard and respected. In pursuance of those goals, JA engages in policy development, initiates campaigns and liaises with stakeholders including victims of offences.

We have decades of experience working with mental health consumers, including four cases before the NSW Supreme Court, being Primary Carer to seven people and representing them before the Mental Health Review Tribunal for many years.

More information about us is here. Our Strategic Plan is here. Some of our achievements are here.

Justice Action has prepared five papers for this Mental Health Inquiry. They demonstrate the necessity for structural reform in NSW mental health. Some current practices are not only dangerous and damaging to vulnerable people, but are also illegal. In this Submission we call for the withdrawal of the Chief Psychiatrist's Communiqué 2014 on coercive practices, and redrafting the guidelines on Community Treatment Orders, Forced Medication, Chemical Restraint, and Crisis Intervention. Those issues are examined in reference to terms (a) to (j). The Executive Summaries of those papers are in the Submission text below with links to the full documents.

We present specific material about the Corrective Services system and the recent NSW initiative to give every prisoner an in-cell computer device with managed access to communication and services. Telehealth information and counselling services are now becoming available.

We ask to give evidence to the Committee regarding these matters.

We tender the papers prepared to the Inquiry.

1. Withdrawal of the Chief Psychiatrists Communiqué:
https://justiceaction.org.au/wp-content/uploads/2023/08/Proposal-for-Withdrawal-of-the-Chief-Psychiatrists-Communique%CC%81-2.pdf

2. Forced Medication:
https://justiceaction.org.au/wp-content/uploads/2023/09/Legal-Analysis_-Forced-Medication.pdf

3. Crisis Intervention and Support:
https://justiceaction.org.au/wp-content/uploads/2023/09/CrisisInterventionSupport.pdf

4. Community Treatment Orders:
https://justiceaction.org.au/wp-content/uploads/2023/09/Copy-of-CTO-Report-2.pdf

5. Chemical Restraint:
https://justiceaction.org.au/chemical-restraint/

MATTERS FOR CONSIDERATION OF THE COMMITTEE

IN RELATION TO THE TERMS OF REFERENCE

Please find below JA's responses to the Terms of Reference.

(a) equity of access to outpatient mental health services

In prisons

Prisoners' health needs are ill-served by prison authorities—and more so for mental health than for physical health. Access to psychiatrists is provided by the Justice Health and Forensic Mental Health Network (**Justice Health**). Visits by psychiatrists are infrequent and nowhere near sufficient for prisoners' needs. Corrective Services does employ psychologists, but they are not engaged in counselling prisoners, but rather assessment and recommendations for management of prisoners. Prisoners may assume that anything they tell a Corrective Services psychologist may be passed on to prison management. They cannot expect confidentiality.

As with services for physical health (but more so), services for mental health provided to prisoners are further constrained by State budgetary limitations. Medicare rebates and Pharmaceutical Scheme (**PBS**) benefits are not available for services provided by prisons.[1]

> Among the services that the exclusion prevents prisoners from accessing are the MBS (Better Access) Initiative,[2] which provides MBS-funded mental health services for properly referred patients with a mental disorder;[3] and the Medicare Health Assessment for Aboriginal and Torres Strait Islander People (Indigenous Health

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[1] Under s19(2) of the *Health Insurance Act* 1973. See also Medicare Access for Prisoners (Community Justice Coalition, 2022); Cumming, Kinner et al "In Sickness and in Prison: The Case for Removing the Medicare Exclusion for Australian Prisoners" (2018) 26 JLM 140.

[2] Department of Health, *Better Access to Psychiatrists, Psychologists and General Practitioners through the MBS (Better Access) Initiative* (16 December 2015) http://www.health.gov.au/internet/main/publishing.nsf/content/mental-ba.

[3] Department of Health and Ageing, Better Access to Mental Health Care: Fact Sheet for Patients http://www.health.gov.au/internet/main/publishing.nsf/Content/betteraccess_factsheet_for_patients.

Check), an initiative to improve detection and treatment of illness in Indigenous people.[4]

The exclusion of prisoners from Medicare and PBS distorts Australian health administration in a number of ways.

- It undermines the fundamental function of Medicare, which is to provide universal health coverage.
- It distorts health statistics, because they are mostly collected through Medicare records.[5] Prisoners have higher health needs than the rest of the community. That particularly applies to mental health needs. Their omission from health statistics therefore distorts the statistics, making them unreliable inputs into decision making about health.[6]
- Many programs—including those for vulnerable communities such as First Nations people, culturally and linguistically diverse (CALD), LGBTQIA+ people, young people, and people with disability—are administered through Medicare. Those groups are over-represented in prisons and have needs that could be addressed by those programs. But they are excluded from targeted programs that could help them. The results can be lethal.[7]

In NSW, in theory prisoners are permitted to go outside the services provided by the prison, and to engage medical services privately, at their own expense. In practice it is difficult to arrange with prison authorities, and it is generally uneconomic for doctors to visit prisons for single appointments.

That picture can be transformed by 2 major reforms:

1. Almost all NSW prisoners now have access to computers or tablet devices in their cells, with some facility to access the Internet. Prisoners should be enabled to use those devices for telehealth, with practitioners of their choosing, independent of Corrective Services. Those sessions should be confidential, just as they are for non-prisoners.

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[4] Department of Health, Medicare Health Assessment for Aboriginal and Torres Strait Islander People (MBS ITEM 715) (15 February 2016) http://www.health.gov.au/internet/main/publishing.nsf/Content/mbsprimarycare_ATSI_MBSitem715 .

[5] Cumming, Kinner et al "In Sickness and in Prison: The Case for Removing the Medicare Exclusion for Australian Prisoners" (2018) 26 JLM 140.

[6] *Ibid.*

[7] As in the case of Mootijah Douglas Andrew Shillingsworth, who died of an untreated ear disease (coroner's inquest report at https://coroners.nsw.gov.au/content/dam/dcj/ctsd/coronerscourt/documents/findings/2022/Inquest_into_the_death_of_Mootijah_Douglas_Andrew_Shillingsworth.pdf).

2. All prisoner health services, including mental health services, should be eligible for Medicare and PBS rebates and refunds on the same basis as for non-prisoners.

People in prison are currently unable to access information and healthcare, including mental health services and independent psychologists, as they are not yet allowed to access telehealth services through their computers and/or tablets.

Computers in cells are safely used by the 18 hours prisoners spend in isolation. They can provide online counselling through trusted external providers, proven to be even more effective than in-person counselling in many cases. They allow for the stability of providers through the sentence (including moves from one facility to another) and after release, as well as encouraging self-management.

Medical services and prescriptions provided to prisoners should be covered by Medicare and the Pharmaceutical Benefits Scheme. Health services and prescriptions provided to prisoners by prison authorities are excluded from benefits under the *Health Insurance Act* 1973 (Cth). They are ineligible for Medicare rebates and Pharmaceutical Benefits. As a result:

- Mental health services in prisons run up against State budgetary constraints, and do not meet their stated objective of being equivalent to the services available in the rest of the community. Access to doctors—general practitioners and specialists—and to medicines is restricted.
- There is no continuity of health care (including mental health care) between times when a person is in prison and when they are not.
- People in prison are excluded from certain health programs (including mental health programs) that are provided through Medicare.
- People in prison (whose health needs, including mental health needs, are higher than in the general population) are not included in standard medical statistics, which are usually collected through Medicare. Those statistics are thereby distorted.

In the community: crisis intervention

Untrained responders are often not equipped to de-escalate and understand a situation that may prevent consumers from receiving proper mental health care

- For more, please see the Executive Summary of JA's Crisis Intervention Support Paper as seen in **Section (i)** below.

(b) navigation of outpatient and community mental health services from the perspectives of patients and carers

Community-based approaches to mental health crises are limited and hard to access, and in many cases police, not paramedics or crisis workers who have the relevant training, are the first responders to intervening with the situation.

Currently, state interventions (eg: police, public healthcare services) are preferred, as informed by the medical model that takes a top-down approach to providing mental health treatment, therefore leaving less room and funding to develop community-based approaches to mental health crisis intervention.

- We must increase accessibility and support for independent organisations with links to mental health legal teams.
- Support should be given to establish community-based interventions to mental health crises/issues to divert people away from the health system, and thereby the harm associated with police intervention, and compulsory inpatient treatment and treatments as ordered by the CTO.
- For more, please see Crisis Intervention Support Paper as shown in **Section (i)** below

(c) capacity of State and other community mental health services, including in rural, regional and remote New South Wales.

The biomedical model using drugs to solve personal and social problems is adopted when there are no respectful ways to manage personal disturbances. In the Nathan Chetty case the Canterbury Community Mental Health Team said they had no psychological service to offer and asked us to lobby for that to be funded. Instead they forcibly injected him until we won his case.

As discussed at length in our paper here, decisions about Community Treatment Orders (**CTOs**) in NSW are made using, as guidelines, a communique issued by the Chief Psychiatrist for NSW in 2014. The **Executive Summary** of JA's paper titled the 'Proposal for Withdrawal of the Chief Psychiatrist's Communique' is shown below.

Paper 1: Withdrawal of the Chief Psychiatrist's Communiqué regarding Community Treatment Orders

The withdrawal of the Chief Psychiatrist's 2014 Communique is necessary for effective change due to several critical reasons. Firstly, the role of Chief Psychiatrist in NSW, currently held by Dr. Murray Wright since October 2014, lacks any legislative force or legal foundation. It is vague or silent about the meaning of important safeguards designed to limit the use of CTOs; and (which is worse) to the extent it is clear it goes against the clear intent of the legislation and

the case law that has interpreted it. While Dr. Wright's position is described as a leadership and advisory role that shapes NSW policy and advises the Executive Director of Mental Health Branch, Sally Lee, the absence of official government sources outlining the role hinders clarity.

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

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

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

The NSW Chief Psychiatrist's communique (2014)[8] that was written in response to the Waterlow inquest, was never justified. It set out misleading definitions of 'serious harm' with the result being that it was followed by practitioners in the field. While the broad consideration of 'serious harm' provided more nuances to the implications of harm, the implementations of a communique in the form of a fact sheet rather than legislative amendments misled clinicians to make decisions of involuntary treatment.[9]

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[8] NSW Government Department of Health, 'Amendments to the NSW Mental Health Act (2007)', *NSW Government* (Web Page) <https://www.health.nsw.gov.au/mentalhealth/resources/Factsheets/community-medical-practitioners.pdf>.

[9] Ibid; Christopher James Ryan, Sascha Callaghan and Matthew Large, 'Better laws for coercive psychiatric treatment: Lessons from the Waterlow case' (2012), 20(4) *Australasian Psychiatry* 283-6.

Mental health is a key matter of concern in Australia with 1 in 5 Australians living with a mental health condition.[10] Despite the prevalence of this issue, mental health care systems across Australia continue to remain dysfunctional and negligent towards consumers. NSW has not responded to the changes that have been adopted by other states such as the recent Victorian Royal Commission into Mental Health. Critical issues include the disrespect and disempowerment of mental health consumers, forced medication, the lack of peer workers in the mental health workforce, and poor funding for mental health services. These issues have been further exacerbated by the COVID-19 pandemic.

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

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

The picture that emerges is disturbing, but sadly not surprising. These issues have been highlighted in the Federal Royal Commission into Disability (2019), the Victorian Royal Commission into Mental Health (2019) (VRC) and the National Suicide Strategy which have all exposed the failure of the mental health system to recognise and uphold the basic human rights of those suffering distress. Urgent reform and cultural change is required to reduce rates of coercive treatment and medication as consumers continue to be marginalised throughout their mental health battles.[11]

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[10] Australian Bureau of Statistics, *Mental Health, 2017-18* (Catalogue No 4364.005.001, 12 December 2018).

[11] Martin Zinkler and Sebastian von Peter, 'End Coercion in Mental Health Services - Towards a System Based on Support Only' (2019) 8(3) *Laws* 19.

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

The application of the *Mental Health Act 2007* (NSW) is a critical legal issue that supports the involuntary detaining of persons who, by reason of mental illness, are likely to cause serious harm to themselves or others. “Serious harm”, according to the decisions of the courts, amounts to threats to life or to bodily or mental integrity. The NSW Chief Psychiatrist’s Communique (2014), that was written in response to the Waterlow inquest, resulted in setting out a broader scope of what constitutes ‘serious harm,’ with this being misleading to clinicians. The consequence of this has been that in practice the provisions have been loosely applied and done so on the basis of lesser risks, such as harm to reputation, fraught personal relationships, and the potential of not being able to take care of oneself.[12] Under this legislation, mentally ill people are subject to forced treatment in accordance with Community Treatment Orders (CTO). The use of forced medication raises serious concerns regarding ethical, legal and human rights violations.

Far more effective and humane alternative methods exist to these coercive practices.[13] They include cognitive behavioural therapy, the transferral from prisons into appropriate mental health care, peer mentoring programs and social support services. These more holistic practices can help to create an environment where human rights, including disability rights, are respected, in which the path to recovery is far easier for these Australian citizens.

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

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

The NSW government needs to follow the expert guidance provided by the World Health Organisation,[14] its own 'Living Well Strategy',[15] and the Victorian Royal Commission. NSW must legislate to eliminate abusive and inhumane practices, coercive treatments and unnecessary involuntary admissions which violate individuals' power, dignity, and autonomy. In response to the current model, consumers are deterred from seeking treatment or support and are driven further into alienation, isolation, despair and hopelessness, subsequently impacting not only their own lives but the wider community as well.

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

Aims:

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

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

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

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

- There is a large discrepancy in the funding given to mental health services in the city compared to rural, regional and remote NSW, thereby limiting access and quality of mental health services and non-police interventions in these areas (as with the case of Clare Nowland).

- We must establish and increase funding for community level mental health services, including NDIS services, in order to expand accessibility and competency, whilst reducing overreliance on police intervention. For more, please see the Crisis Intervention Support Paper Executive Summary in Section **(i)**

- The introduction of CTOs as instruments for deinstitutionalisation is highly problematic as community services are often inadequately funded and the overarching policy lacks transparency and a comprehensive system of accountability. For more, please see Community Treatment Order Executive Summary as shown in **Section (f)**

- Sufficient funding should be allocated to telehealth services across NSW to ensure prisoners, regardless of where they are incarcerated in, are provided adequate mental health support.

  Full paper is here.

(d) integration of physical and mental health services, and mental health services and providers

- Greater attention and care should be taken in integrating legal definitions and policy into mental health services, so as to avoid a lack of transparency, inaccurate interpretations of terminology such as “serious harm” (as seen in the Chief Psychiatrists Communiqué) and other negative consequences for consumers.
    - For more, please see JA’s Executive Summary on Withdrawal of the Chief Psychiatrist's Communiqué in **section (c)**
- Stronger links must be made between legal services and mental health services with specific reference to appealing CTOs and ensuring easier consumer and carer navigation of health systems.
    - JA prepared a paper that delves on the legality of the imposition of Forced Medication on citizens. Instead of improving the health of the citizens, this process has left a huge scar on the lives of the people subjected to it. While parliament has tried to put limits to this through its passage of the *Mental Health Act 2007,* the

provisions of the said law are rendered useless by the ineffectual implementation and insufficient resources. For more, please see the Executive Summary below:

Paper 2: Limits to Forced Medication

Forced medication is one of the most invasive, insulting, violating, and ultimately degrading, exercises of government power against its citizens. By its compulsory nature it will almost always occur in the absence of any therapeutic relationship. Usually the relationship will be one of frank opposition. The process itself does enormous, lasting and often irreversible harm to those subjected to it. That is in addition to the direct pharmacological effects of the drugs (of which much the same can often be said).

Parliament has tried to put safeguards around the exercise of that power—limits on the power to forcibly medicate. The language of the *Mental Health Act* is sometimes broad, but it has been given some definition by the few cases that have found their way to court. Although those limits could no doubt be improved, at least they are there: they are not illusory—at least in theory.

In practice those limits are not being observed. They are being diluted, avoided, flouted, ignored—case by case, and also at a systemic level. There are a range of reasons for this, including unhelpful and inequitable procedures, lack of resources, and even misstatements of the law from within the government itself.

This paper:

- carefully examines and establishes the existing legal limits on forced medication;
- shows how and why they are being broken in practice;
- outlines a path to ensuring that the practice of ordering CTOs is conducted consistent with the law and and with the basic human rights of those considered to be mentally ill; and
- proposes a foundation for dialogue with Health authorities aimed at better incorporating empathetic care and scientifically supported treatments into their protocols.

- Paramedics, nurses, crisis workers and peer workers must further collaborate in order to access and divert people experiencing a mental health crisis away from the ER and directly to mental health services.
    - This requires more community based mental health services and the development of a shared understanding regarding intervention processes between all levels of physical and mental health providers.

- Effective integration of mental and physical health services could improve emergency response treatments and response times, and allow faster and more successful treatment.
- This integration must also be supported through more effective resource allocation in accordance with term **(e)**, and will improve the capacity of mental health services in terms of communication and treatment in rural areas with specific regard to term **©.**
- For more, please see Crisis Intervention Support Paper Executive Summary in **Section (i).**

- There must be greater communication and collaboration between services to facilitate dialogue between consumers and physicians, for example in Advance Care Directives and consumer worker interactions.

For more, please see Community Treatment Order Executive Summary in **Section (f).**

Full paper is here.

(e) appropriate and efficient allocation of mental health care workers, including psychiatrists, nurses, psychologists, GPs, counsellors, social workers, allied health professionals and peer workers

- A lack of time and resources allocated to less-invasive and restrictive approaches to consumer treatment has led to the unjust use of forced medications and overuse of CTOs.
  - Through adequate funding, appropriate resources may be directed towards reducing forced practices and increasing non-invasive support.
  - For more on context and alternatives, please see the Forced Medication Executive Summary in **Section (d).**
- A lack of training and resources accounts for many avoidable incidents and inappropriate responses, and with effective medical and social support measures, individuals in crisis can receive quicker and better treatment.
  - Alternatives to police as crisis intervention may involve consumer workers i.e. people with lived experience (in Terms of Reference: ‘peer workers’) and crisis workers (people of are trained in handling and de-escalating mental health crisis).
  - These solutions would require better funding and more extensive training programs, as well as more efficient allocation and support of emergency response services.
  - For more, please see the Executive Summary of the Crisis Intervention Support Paper in **Section (i).**

- Community Treatment Orders should be imposed as a last resort *only* upon the advice of a professional, who has extensively studied the case and has the necessary background, training, and resources to adequately support the best interests of the individual.
    - This may be supported via the employment of consumer workers, or people with lived experiences in patient treatment programs. The consumer workers' intimate understanding of what the mentally ill individuals are going through enables them to empathize and effectively support them with their needs.
    - For more, please see Community Treatment Order Executive Summary in **Section (f).**

- Psychologists and various mental health professionals should be made available in both telehealth and in-person services for prisoners to choose from and ensure self-determination, as in accordance with term **(a)** equity of access.

(f) the use of Community Treatment Orders under the Mental Health Act 2007

- Whilst the Parliament has tried to put safeguards around the exercise of the power via CTOs to forcibly medicate they are not being observed, largely due to unhelpful and inequitable procedures, lack of resources, and even misstatements of the law from within the government itself.
    - In issuing Community Treatment Orders (CTO), mental health consumers are often forced to take medications against their expressed desires and without taking into consideration other less restrictive alternatives. This a violation of section 53 of the *Mental Health Act 2007,* and actively worsens the current problem.
    - CTOs should be imposed as a last resort and only upon the advice of a professional, in accordance with term **(e).**
    - For more, please see Forced Medication Executive Summary in **Section (d).**
- The broad applicability and criteria of CTOs have allowed them to be used as a tool for control rather than a method for rehabilitative recovery that focuses on individual needs and the best interests of mental health consumers.
    - CTOs are only to be used strictly life-threatening situations.
    - JA wrote a paper detailing how the excessive use of Community Treatment Orders (CTOs) in affecting arrests, hospital stays, and forced medication has led to the ineffective, counterproductive, discriminatory and an obstruction to the recovery of mentally ill individuals. The full Executive Summary is shown below:

Paper 3: Community Treatment Orders

Community Treatment Orders ('CTOs') are legal orders for a person to receive compulsory mental health treatment, as authorised by legislation, without a person's consent. These orders have been continually rising over the years despite this form of 'treatment' generally being limited to use during arrests, hospital stays, and forced medication. This paper will argue that CTOs are ineffective, counterproductive, discriminatory and a hindrance to recovery.

Although the imposition of CTOs operates as the NSW health and criminal justice system's current response to persons seen as a threat to themselves or others, particularly in cases concerning an individual with a history of refusing treatment, their wide scope and intrusive nature enables significant opportunity for misuse and abuse. The broad applicability and criteria of CTOs have allowed them to be made into a tool for control rather than a method for rehabilitative recovery focusing on individual needs and the best interests of mental health consumers.

The introduction of CTOs as instruments for deinstitutionalisation is highly problematic as community services are often inadequately funded and the overarching policy lacks transparency and a comprehensive system of accountability. Further, CTOs are coercive and anti-therapeutic as they remove all elements of personal autonomy for individuals with mental illness. The real potential for discrimination and counterproductive outcomes for affected individuals is incredibly detrimental to their wellbeing. Studies have proven the ineffectiveness of CTOs; 85 orders are required in order to prevent 1 readmission, 27 orders to prevent 1 case of homelessness, and 238 orders to prevent 1 arrest. CTOs only further the misconception that mentally ill incarcerated persons are dangerous people who are behaviourally unpredictable and incapable of making decisions for themselves.

The use of CTOs in prisons, also known as Forensic CTOs ('FCTOs'), is unjustified and oppressive. Introduced into NSW in 2011, the primary purpose of legislating FCTOs is for convenience, resulting in an average annual increase of 4% since the 2017/18 period. This further demonstrates the ongoing failure of NSW public policy and practices, given that there is an obligation in NSW for affected incarcerated persons to be transferred to a hospital and receive proper care, which is not occurring due to replacement with CTOs. Prisons now have overwhelming authority to forcibly medicate incarcerated persons under the guise of a CTO, functioning as an extended form of 'prisoner punishment'. This extrajudicial punishment of incarcerated persons, aside from being highly unethical and unjust, has resulted in distrust

between prison/medical personnel and incarcerated individuals. This form of coercive control should not be tolerated as it directly conflicts with fundamental human rights afforded to all persons.

Recent case studies, as discussed in this report, highlight the coercive effects of CTOs. These case studies, in the context of legal frameworks and research conducted in this area, evidence the criticisms of CTOs. The examination of CTOs in this report makes these orders' stringent and invasive nature abundantly clear. Most notably, CTOs infringe on an individual's autonomy, freedom and self-determination. Although CTOs serve as an alternative to incarceration in NSW and other Australian states, their restrictive form of compulsory treatment can be seen as a form of detention due to their ability to significantly impede upon a person's life. In addition, there is no conclusive evidence that CTOs are greatly beneficial or effective, yet it can be shown that CTOs instead encourage the stigmatisation of people with mental illness.

Alternatives to CTOs, such as access to consumer workers and the option of establishing a directive, should be considered in place of CTOs to not only work towards reducing the continued stigma that comes with mental illness but also provide the individual with an opportunity to possess some control over their impending treatment when they are of sound mind. Research derived from other countries that have successfully instituted these alternatives to CTOs evidences their effectiveness and the importance of allowing individuals a sense of autonomy as opposed to implementing means of forced medication. Therefore, CTOs in Australia are not fit for purpose and must be reevaluated in order to be used as a valuable tool in rehabilitating individuals with mental illness.

Recommendations

This paper calls for significant and urgent change to the use of Community Treatment Orders at State and Federal levels. The recommendations of this report are as follows:

- ☐ To safeguard of Community Treatment Orders to strictly life-threatening situations;
- ☐ To abolish the use of Forensic Community Treatment Orders;
- ☐ To promote alternatives to Community Treatment Orders; and
- ☐ To increase transparency and data collection.

Full paper is here.

(g) benefits and risks of online and telehealth services

- Responses to mental health crises are likely to be administered more quickly through online or telehealth services as opposed to physical services, thus lessening the duration of distress.
- The privacy and anonymity of online and telehealth services incentivises their utilization as the stigma of being seen attending a mental health, is removed.
- Online and telehealth services lack face-to-face communication and support which some may find more effective in managing a crisis.
    - For more, please see Crisis Intervention Support Paper Executive Summary in **Section (i)**
- Telehealth services provide multiple benefits to prisoners, which is especially important considering the prevalence of mental health issues within the population.
- Telehealth services allow prisoners access to mental health services as any other individual while incarcerated.
- Quality of care to prisoners can be improved by allowing access to relevant mental health services through telehealth services, in turn reducing the demand for in-person mental health care within the prison.
- The incorporation of telepsychology and telepsychiatry services in prisons significantly lowers the costs of providing physical mental health care within the facility, thereby providing more funding for other services and facilities in prisons.

(h) accessibility and cultural safety of mental health services for First Nations people, culturally and linguistically diverse (CALD), LGBTQIA+ people, young people, and people with disability

- For CALD people, ensuring the provision of appropriate telehealth services and workers will result in better accessibility of crisis intervention and support.
- Enhance the support provided to Indigenous patrols in Indigenous communities as to ensure culturally competent intervention, whilst negating the likelihood of trauma and conflict from police intervention.
- Address and improve specialized community level support for groups such as LGBTQIA+, young people, disabled people, and the incarcerated

- For more, please see the Crisis Intervention Support Paper Executive Summary in **Section (i).**

- The communities referred to in this paragraph of the terms of reference are overrepresented in prisons, and are denied access to programs designed for them that are administered through Medicare. NSW should work to achieve Medicare equality for prisoners.

(i) alternatives to police for emergency responses to people experiencing acute mental distress, psychosis, delirium, dementia or intoxication in the community, including but not limited to Police, Ambulance, Clinical, Early, Response (PACER)

- Alternatives to CTOs, such as access to consumer workers and the option of establishing a directive, should be considered in place of CTOs to not only work towards reducing the continued stigma that comes with mental illness but also provide the individual with an opportunity to possess some control over their impending treatment when they are of sound mind.
  - For more, please see the Community Treatment Order Executive Summary in **Section (f).**
- Urgent responses to mental health crises should come from trained carers, health professionals, consumer responders, or support networks who can expertly assist them out of their panic states and regain a sense of stability. People with lived experience should also be involved in handling crisis services and de-escalation as they could act as peer support workers and consumer workers. Alternatives can be modeled with reference to existing measures outside Australia.
- Funding should be diverted from police to further develop human rights informed, community-based, and consumer worker approaches to mental health crisis.

  - JA's work on the Crisis Intervention Support Paper outlines the policy and procedural failures that led to unnecessary deaths in situations of mental health crisis, and calls for greater emphasis on non-violent and informed responses to consumers under stress in reference to Term of Reference (i). The Executive summary is presented below:

Paper 4: Crisis Intervention and Support

The untimely death of 95 year old dementia patient, Clare Nowlands, killed New South Wales police, was a shocking tragedy. The high profile killings of Ron Levi in 1997—who was shot after a mental health episode—and Jack Kokaua in 2018—a runaway mental hospital patient who was pepper sprayed, tasered and assaulted by officers—are two other cases amongst many, corroborating the constant failure of the police in managing people with mental illness (PWMI). It is evident that the mobilisation of police as first responders to mental health crises poses a lethal threat to Australia's most vulnerable.

Background to Crisis Interventions

A mental health crisis refers to 'a situation where an individual's current distress exceeds their ability to cope.' Often in such instances these individuals exhibit behaviours that place themselves or others in danger.

The police force's role in the community revolves around enforcing the law and handling dangerous and violent situations. However, during situations which they deem 'threatening', police officers are neither advised nor expected to negotiate or appease anyone. The retitling of the police 'service' to the police 'force', is reflective of the aggressive culture that validates excessive force. By force of training, police officers resort to violence and in some cases, fatal 'de-escalation' methods as evident in the **case of Clare Nowland**.

Urgent responses to mental health crises should come from trained carers, health professionals, consumer responders, or support networks who can expertly assist them out of their panic states and regain a sense of stability. People with lived experience should also be involved in handling crisis services and de-escalation as they could act as peer support workers and consumer workers.

Overseas Community Based Solutions

In the United States, they were able to successfully implement several crisis intervention programs that did not require the involvement of the police. One of which is the 'Crisis Assistance Helping Out On The Streets' (CAHOOTS) program that has been operating in Eugene, Oregon since 1989 and has been highly commended for its reduction of the social stigma surrounding police and crisis intervention. Aside from this, they were lauded for its cost effectiveness in dispatching its vans instead of police units. It was further noted that of the 24,000 calls that CAHOOTS received in 2019, only 150 of them required police reinforcement. Due to its exemplary performance, a bill was passed in Congress (2020) advocating for its replication. However, this legislation was held back for financial reasons. At present, CAHOOTS is partially funded by the City of Eugene and the Eugene Police

department. Implementing this kind of program in other states would require further state and federal funding, which unfortunately, are diverted in favour of police units.

Another program is the ‘Support Team Assisted Response’ (STAR) program, established in Denver in 2020. A year after its creation, STAR program effectively initiated responses to 1,323 calls and prevented any injuries, arrests and police interference. Regardless, STAR was widely criticised for its racial inclusivity as most of its social workers are unable to relate to people who are undergoing a mental health crisis.

Nevertheless, CAHOOTS and STAR programs were both laudable programs as they are able to prevent or minimize police intervention or interactions with the criminal justice system. They are able to do this mainly by subjecting individuals undergoing low, non-violent, or non-imminent risk crises to welfare checks, appropriate transport, referrals, and conflict mediation.

Australian Crisis Solutions

There are several community based mental health programs that are currently running in Australia. The most notable is the ‘Mental Health Acute Assessment Teams’ (MHAAT). Despite its limited funding and accessibility, MHAAT has been assisting people in the Western Sydney Local Health District (WSLHD) since 2013. Another program is the ‘Police and Clinical Early Response Model’ (PACER) in Victoria, which for limited periods in 2007, 2014 and 2018, had medical practitioners accompany police officers during crisis responses.

There are also the Indigenous Patrols in Aboriginal communities, which are popular within indigenous circles but also suffer from limited funding and a lack of state support. Crisis assessment and treatment teams (CATTs) is another program whose federally funded mental health support units operate under major local hospitals and respond to various mental health emergencies. Anyone in Australia can ask CATTs anytime for support or intervention during a mental health crisis. Additionally, there is Lifeline, which is the leading suicide prevention program in the country. Just like CATT, anyone undergoing a mental health crisis in Australia can seek assistance from Lifeline volunteers, who are very knowledgeable and have had extensive training. Unfortunately, they can only be reached by phone or text as they are not trained to be in-person first-responders.

Despite the limitations of community based mental health programs, the existing programs that focus on police presence in crisis intervention often have a reverse effect of escalating crisis situations. The New South Wales Police is running the ‘Mental Health Intervention Teams’ (MHITs) but these teams are ineffective due to their police culture, distrust, limited impact, and insufficient funding. This is also the case with police-affiliated, ‘Acute Care Teams’ (ACT). ACT is often criticised for its lack of regard for the cases, which they deemed

to be insignificant. Neither do they have a connection to long-term support for disturbed people.

Consumer Worker Approach

A successful Australian mental health crisis intervention scheme calls for the implementation of a consumer worker approach. While the importance of de-escalation has been recognised by many, individuals who have gone through a similar experience are the ones who can best understand PWMI. Hence, under the consumer worker approach, individuals who have gone through and survived a mental health crisis should accompany first responders for crisis intervention. Including people with lived experiences in responding to mental health crises helps alleviate the escalating demand for crisis intervention programs. This also ensures that PWMI will receive more understanding and compassionate support when they are at their lowest point in their lives.

Recommendations

- Police should not intervene in a mental health crisis.
- Trained teams composed of a crisis worker and medic should be used to de-escalate the crisis and support the distressed person.
- People with lived experience, including peer support workers and consumer workers, should be engaged in crisis support.
- Funding should be diverted from police to stronger widespread mental health and crisis intervention programs.

Full paper is here.

(j) any other related matter

The 2014 Communique also failed to clearly define the powers of the Chief Psychiatrist of NSW. The lack of transparency, accessibility, and meaningful contact with the Chief Psychiatrist, free from Ministerial intervention, places a burden on individuals and organisations seeking direct changes related to the Chief Psychiatrist.

Instead, JA is proposing for the complete withdrawal of the Chief Psychiatrist's 2014 Communique as it lacks clarity in providing guidance to clinicians regarding the quantification of

‘serious harm’. The communique fails to address the impact it imposes on individuals, thereby rendering it both harmful and unjust.

Instead, JA is advocating for the Chief Psychiatrist to issue a clearer and more comprehensive set of guidelines that would be consistent with the laws and regulations on mental health. The new guideline should provide a more precise definition of ‘serious harm’ to help reduce the number of individuals placed under involuntary treatment and provide them autonomy to make decisions regarding their own healthcare.

Reforms in the NSW mental health system must address both cultural and systemic policies in order to develop a recovery-focused, trauma-informed model that is led by culturally diverse and informed practitioners.

Mental health laws must also be aligned with consumer-centered decision-making principles. This must include increased access to peer workers, social workers and independent legal representation within the mental health system. Mechanisms for accountability will drive this reform, including a regular collection of data from consumers as to their choice of medication and/or psychological counseling

JA is also propounding for the adoption of more holistic practices that can help create an environment where human rights, including disability rights, are respected, in which the path to recovery is far easier for these Australian citizens. These would include cognitive behavioural therapy, the transferral from prisons into appropriate mental health care, peer mentoring programs and social support services.

For more, please see the Executive Summary of the Withdrawal of the Chief Psychiatrist's Communiqué paper in **Section (c).**

Accordingly, based on the arguments set forth above, we request that this Submission be considered by the Committee in the conduct of its inquiry.

Kind regards,

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