Fitzroy Legal Service
Fitzroy Town Hall Level 4
Access via 126 Moor Street Fitzroy
PO Box 297

27 January 2019

Background

This submission reflects concerns of Fitzroy Legal Service as a newly amalgamated entity with Darebin Community Legal Centre. Relevant services that have informed this submission include:

- Family violence (multiple streams)
- Family law
- Generalist advice
- Women Transforming Justice Project (addressing rapidly increasing rates of imprisonment of women)
- Criminal law
- Duty lawyers working at the Neighbourhood Justice Centre (tenancy, family violence, crime)
- Outreach services through the Drug Outreach Lawyer Program, family violence programs, mental health facilities
- Prisoner advice services

Introduction

We have had opportunity to review the submissions of the Federation of Community Legal Centres and Mental Health Legal Service. We endorse their perspectives.

We appreciate the accessibility with which interaction with the terms of reference has been framed.

We note many of the terms of reference are broad, and consider it important to place on record specific issues that we believe should be included in the inquiry.

Given time constraints, the breadth of our service delivery, and the early stages of this inquiry, we note that the issues raised herein are canvassed with a brevity that does not match the importance of deep and informed consideration, and comprehensive meaningful reform, responses, and resourcing.

Each of the themes raised are of enormous importance and interconnected, so we have not engaged in a ranking process. The matters we seek to raise potentially relate to and interact with a number of the priority areas put forward for ranking.

We believe broad interaction with the terms of reference would benefit enormously from an issues paper to allow participants to developed a deeper understanding of the existing legal and social frameworks around 'affected persons' (those diagnosed with mental illness, affected by symptoms of mental distress, those at risk of suicide) and the evidence base on which systemic responses and reforms may need to focus.

Structural and framework issues that must inform the terms of reference of the Commission

Consideration of protected human rights and current international standards/ discourse regarding provision of care to those affected by psycho-social disability, including mental illness

The framework within which legal and practical reform is to be considered must be informed in our view by globally accepted human rights norms, language, definitions, and undertakings. In particular, we believe the framework of review should be cognisant of and consistent with definitions and legal obligations incorporated into the United Nations '*Convention on the Rights of Persons with Disabilities*' (CRPD) (ratified 17 July 2008) which includes psychosocial disability within its ambit.[1] The CRPD provides an excellent lens to identify major challenges faced by users of mental health services as well generalist systems such as the criminal justice system. These include stigma and discrimination, violations of economic, social and other rights, as well as the denial of autonomy and legal capacity. It also promotes state and institutional accountability in relation to all of the above, as opposed to locating responsibility purely in the affected persons. It also provides practical measures to alter processes and enhance participation.

Additionally the United Nations '*Optional Protocol to the Convention Against Torture and other Cruel Inhumane Degrading Treatment or Punishment*' (ratified 21 December 2017)[2] also provides a crucial benchmark of state accountability, against which laws and institutional responses must be measured and remedied. It is particularly relevant to involuntary treatment of persons with psycho-social disabilities. There is a significant international discussion on this point, including opinion by Special Rapporteurs that involuntary electro-convulsive therapy for example is torture.

We note that this perspective is borne out of existing obligations Australia has committed to under the above instruments, and is consistent with the existing *Victorian Charter of Human Rights and Responsibilities Act 2006* (Vic). We specifically note the following provisions:

- recognition and equality before the law (section 8)
- right to life (section 9)
- protection from torture and cruel, inhuman or degrading treatment (section 10)
- privacy and reputation (section 13)
- protection of families and children (section 17)
- cultural rights (section 19)
- right to liberty and security of the person (section 21)
- humane treatment when deprived of liberty (section 22)
- rights in criminal proceedings (section 25).

In presenting these views, we do not seek to simplify complex questions of health and wellbeing, crisis management, and preservation of life. However, we do strongly advocate that the framework of human rights instruments and legislation should assist in framing the inquiry, including through feedback from affected persons, examination of existing law and practice, and focus areas for social investment and reform, as this is a commitment Federal and State Parliaments have made to protect the rights of affected persons.

Engagement – the centering of people with lived experience

We support the submission of the Mental Health Legal Centre in identifying the affected person as the most important participant in the inquiry process, and in identifying the importance of flexible approaches to ensure a broad range of experiences are captured, including within institutional settings (custodial and in-patient).

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[1] https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities/convention-on-the-rights-of-persons-with-disabilities-2.html

[2] https://www.humanrights.gov.au/our-work/rights-and-freedoms/projects/opcat-optional-protocol-convention-against-torture

We note that similar approaches may be adopted to those utilised in the Royal Commissions into Family Violence and Institutional Abuse in Care, and that there may be significant cross over in affected demographics.

We raise at the outset the concern that many persons with previous engagement with psychiatric services may have significant trauma around those episodes of contact, and may, based on previous experience, being the stigma of diagnosis and/or physical experience of coercive or quasi-coercive treatment, and/or a variety of associated experiences, hold the expectation that they will not be respected, heard or believed. This may result in decisions not to engage, and/or limit engagement, and/or create a heightened state of trauma or stress in which obtaining evidence is difficult.

Whilst this may seem self-evident, we are already receiving feedback of decisions not to engage in order to avoid re-traumatisation and/or because of a lack of belief that the process will be 'independent' or meaningful. For affected persons, barriers may be different and to date, common themes are:

- independence from the paradigms of treating practitioners
- dominance of self-referential institutional perspectives
- subjective experiences of consistent denial of agency and human rights
- concern regarding the role of corporate interest of pharmaceutical companies

In the most simple of terms, the concern is – who would listen to me? In this particular context, it is the recipients of primarily in patient mental health services who have provided this preliminary feedback.

The engagement of those with lived experience is vital and we expect the Commission will be aware of the importance of building trust with affected communities from the outset.

It may be that supported peer engagement and facilitated focus groups may assist, in addition to providing trauma active support and follow up.

Intersectional approaches to engagement are vital, as is a systematic approach to ensuring breath of service users, in addition to professionals and other care givers whose voices must be heard.

We recommend highly supported and responsive approaches to concerns regarding human rights implications of expanding coercive treatment, and that the experiential disempowerment of those affected by diagnoses or treatment should be explored and prioritised consistent with a human rights focussed framework.

International context – the centrality of peer networks and support groups

We note that peer networks appear to be more numerous and diverse in the international setting. It may be that the commission provides an important opportunity to invest in the same in Victoria. For many marginalised and stigmatised communities, these forums of peer to peer support have provided vital input into policy development and movement towards healing.

We further note that there is a wide array of literature written by and for peers, and online participative forums used by peers and carers which may assist the commission, or identify community leaders who may be able to provide assistance. It is beyond our expertise to comment further, but we consider it important to point out that there is a strong international peer led movement of interaction and learning that acts as resource for affected persons.

Specific sites of discrimination and associated harm

The terms of reference for the MHRC seem primarily focussed on preventative care and treatment of individuals with a psycho-social disability. It is important to recognise however, the prevalence of individuals with psychosocial disabilities within in the criminal justice system.

Dual Diagnosis – stigma discrimination exclusion & inequitable legal outcomes

We note a specific focus area identified for survey is 'integration between alcohol and other drugs and mental health services'. Dual diagnosis is a significant issue in interactions with the criminal justice system.

A range of problems derive from the prevalence of dual diagnosis, the criminalisation of substance use disorder (as defined and recognised under the DSM V), and the tension between drug (including alcohol) dependence attracting punitive legal consequences, as well as being a subset and co-existing disorder for the majority of those diagnosed with a mental health disorder.

That this structural tension results in over-representation in custodial settings, experiences of exclusion and/or stigma during episodes of care (if they are available), and highly disadvantageous legal and social outcomes is not surprising. It is easy to revert to the notion that mental health and drug and/or alcohol dependence are extricable problems, one of which is medical, the other moral/ personal choice driven.

However, the evidence of prevalence is so strong, and common sense dictates self-medication of distress must be a driving force, it seems we must examine reform urgently that reduces criminalisation of those experiencing psycho-social disabilities. For example, on current estimates: 90% of males with schizophrenia have a substance use problem; 64 % of psychiatric in patients may have a current or previous drug use problem; 75% of people with alcohol and substance use problems have a mental illness.[3] As of 31 March 2015, the findings of the Victorian Ombudsman indicated 40% of Victorian prisoners had been assessed as having a mental health condition, and that imprisoned people are 'two to three times more likely than those in the community to have a mental illness and are 10 to 15 times more likely to have a psychotic disorder.'[4]

In our experience, those affected persons with dual diagnosis have extremely limited access to treatment, and may experience excluding, stigmatising episodes of treatment from emergency triage to counselling to access to rehabilitation. The nature or severity of the mental health disorder may be determinative, as may the nature or severity of the drug/alcohol dependence disorder.

When individuals are presenting and actively seeking treatment and care, or engaged with the criminal justice system, and the evidence is incontrovertible that dual diagnosis is the expectation c.f. the exception, it is incumbent on the State and service providers to consider how to adjust practice to meet the needs of those experiencing the relevant psycho-social disability/ disabilities.

A further and related issue is the prevalence of borderline personality disorder diagnoses and exclusionary practices (from medical to legal). It may be that the in the future, complex post-traumatic stress disorder will displace borderline personal disorder as the dominant diagnosis for affected persons presenting with the relevant cluster of symptoms. The particular cluster of symptoms currently classified as 'borderline personality disorder' have a strong nexus with criminalisation and substance dependence disorder, but are excluded from consideration under

[3] Better Health Channel, 'Substance abuse and mental illness – dual diagnosis', State of Victoria, 2019, page 1
[4] 4 Victoria, 'Victorian Ombudsman Investigation into the Rehabilitation and Reintegration of Prisoners in Victoria', Parl Paper No 94 (2015) 181

established sentencing principles, access to specialist court support lists, and access to rehabilitation programs.

FLS has extensive experience in the area of dual diagnosis through the Drug Outreach Lawyer Program which has been operational for 18 years, and through the work of other members of the organisation in criminal law, therapeutic jurisprudence, family violence, family law, and harm reduction. We believe we are well placed to assist the Commission in developing a deeper understanding of the issues presenting for dual diagnosis clients in accessing services, court lists, and to assist in further elucidating barriers to equitable legal outcomes.

Further issues relating to psycho-social disability (specifically mental illness) in the criminal justice system

We draw the Commission's attention to a number of discrete legal issues (this list is not exhaustive) where legal barriers to equitable outcomes and specific harms are particularly notable:

(a) Access to bail and conditions/ treatment on remand pending forensic reports - associated delays and harm to the individual;
(b) Absence of appropriate facilities for remand and sentenced clients who require specialised care – vulnerability and inappropriateness of incarceration in general population for forensic patients;
(c) Use of isolation to manage acutely unwell prisoners where beds are unavailable in some facilities;
(d) Absence of appropriate health care (e.g. access to psychiatrist/ psychologist) for those who are not defined as acutely unwell (4 or 5 months to see a psychologist);
(e) Fitness to be tried unavailable at Magistrates Court so not accessible to a lot of people;
(f) Not guilty by way of mental impairment – requires prosecution consent & remains on disclosable criminal record permanently under the current Victoria Police Policy;
(g) Charges when clients are in an acute unit or where CAT team has been called – analysis of how the trajectory from seeking assistance to criminalisation can be stemmed;
(h) Consideration of how 'diversion' outcomes might be used more effectively to create a favourable presumption where mental illness is clearly a causative factor in offending.

Gender, family violence and childhood experiences of violence in mental health triage, service delivery & criminalisation processes

We submit that integrated scrutiny needs to be given to the prevalence of family violence and childhood experiences of violence, neglect, and sexual abuse in the psycho-social disability frame by the Commission. We note there are other areas requiring consideration than referenced above – child removal, dispossession, racism, exposure to war, immigration detention – but limit our submissions to the terms of reference to an area of intensive legal practice which engages gender and childhood experiences of harm. We note the CRPD affords specific recognition to women in Article 6:

1. States Parties recognize that women and girls with disabilities are subject to multiple discrimination, and in this regard shall take measures to ensure the full and equal enjoyment by them of all human rights and fundamental freedoms.
2. States Parties shall take all appropriate measures to ensure the full development, advancement and empowerment of women, for the purpose of guaranteeing them the exercise and enjoyment of the human rights and fundamental freedoms set out in the present Convention.

- and that the Commission is afforded a wealth of insight, research, findings and recommendations through the Royal Commission into Family Violence.

The percentage of people of people accessing mental health services that have experienced family violence is high - approximately 40 per cent of men accessing these services have experienced childhood sexual abuse[5]; and between 50 and 90 per cent of women have experienced child sexual abuse or another form of family violence.[6] Seventy-seven per cent of women who have experienced three or four types of gender-based violence had anxiety disorders[7], 56 per cent had post-traumatic stress disorder[8] and 35 per cent had made suicide attempts.[9]

The ongoing health implications are complex and risk factors for further harm are high, including through increased risk of drug/alcohol dependence, further violence, discrediting as a result of diagnosis, and engagements with legal processes, including criminalisation.

We submit that the Commission should include specific consideration of the findings of the Royal Commission, and consider how to ensure within a human rights frame that broad educative processes across institutions (including police and private/ public health service providers) engage with perpetrators and victims of family violence through a lens of consistent research driven, trauma informed practice that supports autonomy, agency, dignity and bodily integrity in those diagnosed with mental illnesses in order to further equitable outcomes directed towards health, stability and healing.

Conclusion

Consistency with ratified instruments, specifically mental illness as a subset of psycho-social disability, may permit improved opportunities to shift focus towards:

- equality
- agency
- autonomy
- dignity
- personhood
- culture
- intergenerational story
- intersectional structural positioning/ experience
- trauma informed care (that respects dignity and consciously refuses to replicate conditions and experiences that contribute and/or are causative factors in existing distress/harm)

and state/ institutional accountability in relation to all of the above, as opposed to location purely in the affected persons. We believe this is vital to all the terms of reference, and specifically, to suicide prevention.

Systemic patterns of harm that can be evidenced as attributable to discrimination on the basis of protected attributes, and systemic patterns that can be evidenced as causing harm which may ultimately result in diagnosis, treatment, suicide, drug dependence - for example

[5] Victoria, Royal Commission into Family Violence, *Report and Recommendations* (2016), Vol 4, p 18.
[6] Ibid.
[7] Victoria, Royal Commission into Family Violence, *Report and Recommendations* (2016), Vol 4, p 72.
[8] Ibid.
[9] Ibid.

- family violence
- sexual violence
- child neglect/ abuse
- trauma from institutionalisation
- removal/ separation from family
- lack of housing
- lack of secure housing
- poverty
- safe work conditions
- stigma and discrimination

– should be included in the inquiry.

Labelling and treating may not prevent the conditions in which diagnosed mental illness is more likely to arise. As such, when placed in the psycho-social disability frame, we believe 'mental illness' and the contributing conditions become a shared responsibility that requires accountability and active reorientation of service delivery, resourcing and support to reduce suffering of individuals in a human centred and socially accountable frame.

We recommend highly responsive approaches to concerns regarding human rights implications of expanding coercive treatment and the subjective or objective disempowerment of those affected by diagnoses or treatment should be explored and prioritised.

Thank you for the opportunity to participate in the process of informing terms of reference. Fitzroy Legal Service and Darebin Legal Service have a combined history of legal service provision to disenfranchised and marginalised community members of approximately 70 years.

We are available to assist in facilitating peer engagement through our various programs, and to provide further submissions once the terms of reference have been settled.

Yours faithfully

Fitzroy Legal Service

Per

Meghan Fitzgerald (Manager Social Action Team)

mfitzgerald@fitzroy-legal.org.au

FITZROY LEGAL SERVICE INC.