ABORIGINAL LEGAL SERVICE OF WESTERN AUSTRALIA (INC).

Submission to the Western Australian Parliament

Draft Mental Health Bill (WA) 2011

March 2012

Contents

1 Executive Summary

The draft Mental Health Bill 2011 (the Bill) proposes to replace the *Mental Health Act 1996* (WA) (current Act).

The Aboriginal Legal Service of WA (ALSWA) endorses many of the changes proposed by the Bill, particularly:

- the introduction of the Charter of Mental Health Care Principles (Schedule 1 of the Bill);
- reduced maximum timeframes & referrals for examination and detentions; and
- the obligation to collaborate with Aboriginal health workers and traditional healers when treating Aboriginal or Torres Strait Islander involuntary patients or mentally impaired accused.

ALSWA notes that Aboriginal and Torres Strait Islanders are a particularly vulnerable sector of users of mental health services. Aboriginal and Torres Strait Islanders often face multiple barriers that diminish their capacity to meaningfully participate in and gain equal access to mental health services.

This submission suggests a number of measures which the Western Australian Parliament (**Parliament**) could adopt when finalising the Bill, to address some of the barriers typically encountered by Aboriginal and Torres Strait Islander users of the mental health system.

These recommendations will also facilitate compliance with Australia's international obligations including those under the United Nations Convention on the Rights of Persons with Disabilities (**DisCo)**.

2 Introduction and Structure of Submission

ALSWA prepared this submission in response to the request for public comment on the Draft Mental Health Bill 2011.

This submission analyses certain key changes proposed by the Bill, in each case, commenting briefly on how the provision will affect Aboriginal and Torres Strait Islander mental health patients.

A detailed analysis of the proposal to replace the Mental Health Review Board with the Mental Health Tribunal is provided in Part 7.

Finally, Part 8 considers whether the Bill is compatible with Australia's international obligations under DisCo and CROC.

3 About ALSWA

ALSWA is a community based organisation that was established in 1973. ALSWA aims to empower Aboriginal peoples and advance their interests and aspirations through a comprehensive range of legal and support services throughout WA.

ALSWA aims to:

- deliver a comprehensive range of culturally-matched and quality legal services to Aboriginal peoples throughout WA;
- provide leadership which contributes to participation, empowerment and recognition of Aboriginal peoples as the Indigenous people of Australia;
- ensure that Government and Aboriginal peoples address the underlying issues that contribute to disadvantage on all social indicators, and implement the relevant recommendations arising from the Royal Commission into Aboriginal Deaths in Custody;2 and
- create a positive and culturally-matched work environment by implementing efficient and effective practices and administration throughout ALSWA.

ALSWA uses the law and legal system to bring about social justice for Aboriginal peoples as a whole. ALSWA develops and uses strategies in areas of legal advice, legal representation, legal education, legal research, policy development and law reform.

ALSWA is a representative body with 16 executive officers elected by Aboriginal peoples from their local regions to speak for them on law and justice issues. ALSWA provides legal advice and representation to Aboriginal peoples in a wide range of practice areas including criminal law, civil law, family law, and human rights law. ALSWA also provides support services to prisoners and incarcerated juveniles. Our services are available throughout WA via 14 regional and remote offices and one head office in Perth.

In drafting this submission ALSWA has relied upon various sources which are referenced. ALSWA also references the submission by the North Australian Aboriginal Justice Agency (NAAJA) to the Community Affairs References Committee Inquiry into Commonwealth Funding and Administration of Mental Health Services, which was reviewed and formed the basis of some of the comments contained within this submission.

4 Particular issues affecting Aboriginal and Torres Strait Islanders

4.1 High incidence of mental health issues

Aboriginals and Torres Strait Islanders are over-represented in mental health systems across Australia[1].

Mental health is affected by a broad range of socio-economic factors and the exposure to stressors including incidents of domestic violence, substance misuse, physical health problems, imprisonment, family breakdown, level of education and social disadvantage. In addition, for many Aboriginal and Torres Strait Islander people, individual mental wellbeing is dependent on the social and emotional wellbeing of the community, which is in turn influenced by cultural

[1] Darren Garvey, 'Review of the social and emotional wellbeing of Aboriginal and Torres Strait Islander peoples-considerations, challenges and opportunities' (2008), <http: //www.healthinfonet.ecu.edu.au/ sewb_review> at 29 February 2012.

and historic issues such as dispossession, separation of families and discrimination.[2]

The presence of psychological stressors or risk factors makes it more likely that an individual will develop a mental illness, whilst protective factors decrease that risk. By measuring exposure to stressors, people may be categorised according to whether they experience low to moderate psychological distress, or high to very high distress, the latter category often requiring professional intervention to treat the distress. [3]

The most recent statistics collected by the Council of Australian Governments (COAG) in 2008, indicated Aboriginal and Torres Strait Islander adults reported experiencing high/very high levels of psychological distress at 2.6 times the rate of non-Aboriginal and Torres Strait Islander adults. Alarmingly, between the surveys done in 2004-05 and those done in 2008, the proportion of Aboriginal and Torres Strait Islander adults experiencing very high psychological distress increased significantly from 26.6 per cent to 31.7 per cent (in comparison with the corresponding proportions of non-Aboriginal and Torres Strait Islander adults which dropped from 13.1 per cent in 2004-05 to 12.2 per cent in 2008). [4]

As one academic noted, it is clear that:

> "Indigenous people continue to face many factors that serve to promote and diminish their SEWB [social and emotional wellbeing] and at times limit the available choices. In general terms, such factors are common for the maintenance of good mental health for all people, but, in policy and practice, Indigenous people have had to adapt to very specific impacts on their lifestyles and localities. Current understandings of SEWB reveal Indigenous people as having to confront a broad range of social, economic, educational and legal stressors seen as exacting an ongoing influence on their mental health"[5]

4.2 Cultural, linguistic and geographic barriers must be overcome in the provision of mental health services

The experience of many Aboriginal and Torres Strait Islanders with the mental health system to date has not been overly positive. There is a lingering stigma associated with 'mental illness' within Aboriginal and Torres Strait Islander communities. In light of this, recent health initiatives have sought to move away from the negative connotations associated with the terms mental health and mental illness by referring instead to the social, emotional, spiritual and cultural wellbeing (**SEWB**) of individuals and whole communities.[6] The concept of SEWB aligns much more closely with the holistic view that many Aboriginal and Torres Strait Islander people take towards health and gives recognition to the deep connections between people and their environments.[7]

It is not suggested in this submission that the Act should necessarily adopt the rhetoric of SEWB in preference to 'mental illness' or 'mental health'. This rhetorical difference is however an example of the importance of establishing a mental health system which can address the barriers that prevent equal access and

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[2] Steering Committee for the Review of Government Service Provision (**SCRGSP**) , Productivity Commission, *Overcoming Indigenous Disadvantage: Key Indicators 2011 - Overview*, (2011), Canberra, p 41.

[3] Steering Committee for the Review of Government Service Provision (**SCRGSP**) , Productivity Commission, *Overcoming Indigenous Disadvantage: Key Indicators 2011*, (2011), Canberra, [7.53].

[4] Ibid, [7.55].

[5] Garvey, above n 1.

[6] Garvey, above n 1; A Wilczynski, K Reed-Gilbert, K Milward et al, '*Evaluation of the Bringing Them Home and Indigenous Mental Health Programs'*, Report prepared by Urbis Keys Young for the Office for Aboriginal and Torres Islander Health, Department of Health and Ageing, (2007), Canberra, p 3.

[7] Garvey, above n 1.

participation by providing culturally appropriate services to Aboriginal and Torres Strait Islanders.

SCRGSP identified that where an individual experiences a particular social disadvantage they are more likely to experience other types of social disadvantage as well.[8] For example, individuals who have only obtained a low level of education are more likely to be low income earners, experience homelessness or housing issues, have poor general health and suffer from substance misuse. A high percentage of Aboriginal and Torres Strait Islanders experience multiple disadvantages in this way, which necessarily inhibits their ability to access and meaningfully participate in mental health treatment, unless the system is capable of overcoming barriers such as limited financial means and lower literacy rates. Moreover, this contributes to disadvantage in terms of their ability to access and understand the justice system.

ALSWA notes that approximately 29% of the Australian population, including 64% of the Aboriginal population, live in rural and remote areas.[9] This is especially true of Western Australia, where ALSWA has 14 regional offices to cater for the needs of Aboriginal persons living regionally and remotely.

In their article, 'Disadvantage and Discontent', the Centre for Rural and Remote Health conclude that Aboriginal peoples living in rural or remote communities experience higher levels of mental illness than Aboriginal people living in metropolitan areas.[10] Widespread socio-economic disadvantage and disproportionate access to vital social and healthcare services are some of the factors that exacerbate this problem.[11]

There is a real danger that unless adequate primary health care and specialist services are provided in remote communities, those who should be accessing assistance for their mental health disorder, intellectual disability or cognitive impairment will not be able to do so.

Best practice suggests that Aboriginal people living in remote communities should be provided with access to mental health services of the same 'quality, predictability, sustainability and practitioner continuity'[12] as those living in metropolitan areas. Such a recommendation is consistent with objective 1.2 of the National Indigenous Law and Justice Framework. This provides that Aboriginal peoples in all social settings should be given greater access to "effective, inclusive, responsive, equitable and efficient" services that are adequately funded and reviewed, so that they ensure just outcomes for Aboriginal peoples.[13]

There also needs to be recognition of transportation and accommodation difficulties facing those from remote communities. Where it is not possible to

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[8] SCRGSP, above n 3, [13.1].

[9] National Health and Medical Research Council, *When it's Right in Front of You: Assisting Health Care Workers to Manage the Effects of Violence in Rural and Remote Australia* (2002) 5 <http://www.nhmrc.gov.au/_files_nhmrc/file/publications/ synopses/hp16.pdf>.

[10] Centre for Rural and Remote Mental Health, 'Disadvantage and Discontent: A Review of Issues Relevant to the Mental Health of Rural and Remote Aboriginal and Torres Strait Islanders' (2007) 15 *Australian Journal of Rural Health* 88, 89.

[11] Ibid.

[12] Ibid.

[13] Standing Committee of Attorneys-General Working Group on Indigenous Justice, *National Indigenous Law and Justice Framework 2009-2015* (2009) <http://www.ag.gov.au/www/agd/rwpattach.nsf/VAP/(8AB0BDE05570AAD0EF9C283AA8F533E3)~IPS+-+National+Indigenous+Law+and+Justice+Framework+-+FINAL+-+PDF+version.PDF/$file/IPS+-+National +Indigenous+Law+and+Justice+Framework+-+FINAL+-+PDF+version.PDF>.

provide mental health services to remote communities, it needs to be recognised that clients need assistance and support to access metropolitan services located in Perth. For example, ALSWA encounters instances where regional and remote clients are expected to make their own way to Perth to attend a psychological or psychiatric appointment and are simply ill-equipped to do this without support.

The 2009 Senate Inquiry into Access to Justice noted the discrepancies in service provision that exist in regional and remote parts of Australia.

Statistics reveal that '30-50% of residents of discrete Aboriginal and Torres Strait Islander communities have no access to allied health or mental health care workers'.[14] In addition there is a general lack of crisis intervention services. In 2011, a shockingly high number of youth suicides were revealed in Roebourne and Wiluna, some of whom were ALSWA's juvenile clients, in a remote community. It came to light that some of the deceased youth had previously attempted self harm by slashing their wrists or other means. The police would detain the individuals and then take them to the local health care clinic. The clinic tended to their injuries but offered no mental health assistance or follow up.

Moreover, where mental health services do exist, their effectiveness is often limited by factors such as under-resourcing, misdiagnosis, adherence to Western models of treatment, language barriers and failure of medical clinics to refer clients to mental health services for assessment.[15]

ALSWA has had extensive experience of this in the criminal jurisdiction. In one client's case, their medical notes from the local health clinic revealed that a referral to a mental health service was required. An ALSWA solicitor called the clinic on three separate occasions to request that the client be referred to the local mental health service for assessment and treatment. However, the clinic failed to do so. As a result, the Solicitor had to make arrangements for the referral herself and eventually for the client to attend Perth to access the services required, which were funded by ALSWA. ALSWA has had multiple clients request that referrals to mental health services be made on their behalf, often for those who have never accessed such services previously. ALSWA often bears (and does not recover) the costs of for psychological or psychiatric evaluation services.

4.3 Aboriginal and Torres Strait Islander children and mental health

The mental wellbeing of Aboriginal and Torres Strait Islander children is necessarily intimately connected to the mental wellbeing of their parents and communities. The SCRGSP observed that risk factors for vulnerability to mental and physical illness are often transmitted through generations unless there is an intervention to break the cycle.[16]

The Western Australian Aboriginal Child Health Survey (**WAACHS**) from 2005 found that:

- 24% of Indigenous children were identified by their parents as being at high risk of clinically significant emotional or behavioural difficulties, in comparison to 15% of children in the general population;

[14] Centre for Rural and Remote Mental Health, 'Disadvantage and Discontent: A Review of Issues Relevant to the Mental Health of Rural and Remote Aboriginal and Torres Strait Islanders' (2007) 15 *Australian Journal of Rural Health* 88, 91.

[15] Human Rights and Equal Opportunity Commission, Bringing Them Home: Report of the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from Their Families (April 1997) Pt 5, Ch 18.

[16] SCRGSP, above n 3, [7.61].

- 70% of surveyed Indigenous children had experienced 3 or more major life stress events (such as death in the family, serious illness, family breakdown, financial problems or arrest) in the 12 months prior to the survey. 22% had experienced 7 or more such events in that same period; and

- Children whose parents had been forcibly separated from their families were 2.3 times more likely to be at high risk of clinically significant emotional and behavioural difficulties and they had twice the rate of alcohol and other drug use. [17]

Aboriginal and Torres Strait Islanders, and in particular their children, are a vulnerable sector of users of mental health services. Wherever practical, measures should be implemented to compensate for and break-down the barriers affecting full understanding of, participation in, and access to mental health treatment for Aboriginal and Torres Strait Islanders.

4.4 Other issues that ought to be considered

ALSWA also recommends that Parliament and those reviewing the Draft Bill further consider and take into account the following issues affecting Aboriginal and Torres Strait Islander people with a mental impairment. It is with these issues in mind that the recommendations in this submission are made.

A stronger focus on effective engagement with and treatment of Aboriginal and Torres Strait Islanders suffering from mental health problems would likely contribute to a reduction in the representation of those persons within the justice system.

A continued failure to properly engage with Aboriginal and Torres Strait Islander users of the mental health system is likely to widen the gap between the mental wellbeing of Aboriginal and Torres Strait Islander and non-Aboriginal and Torres Strait Islanders.

a) Heightened Need in Remote Areas

The provision of mental health services in rural towns and remote communities should be increased to ensure that Aboriginal people residing in such areas have the same 'quality, predictability, sustainability and practitioner continuity' as those living in metropolitan areas.

b) The Provision of Culturally Appropriate and Holistic Mental Health Services

Mental health referral processes, service provision and therapeutic intervention, should be administered in a way that meets and respects the holistic and culturally distinct needs of the Aboriginal community.

All mental healthcare workers in Aboriginal communities ought to be given appropriate cross-cultural training and education in Aboriginal conceptions of mental health.

c) Language and Interpreters

[17] Garvey, above n 1.

Aboriginal and Torres Strait Islander people receiving mental health care, particularly in remote communities, should have access to interpreters, to ensure that they understand the mental health concepts being explained to them.

d) Community Controlled Services

Where possible, mental health services should be administered by organisations that are run by Aboriginal people for Aboriginal people.

There ought to be increased funding, support and training should be provided for Aboriginal mental health workers.

Mental health strategies should facilitate effective partnerships between the local health clinic, the mental health service and the client and their family.

e) Community Education and Mental Health Promotion

Mental health strategies should include education about the causes of mental health problems, the benefit of prevention and early intervention and treatment options.

f) ALSWA Clients detained Under the *Mental Health Act*

Remote and metropolitan health clinics, police stations and other relevant places of detention should be adequately funded and resourced to ensure that someone who has been sectioned under the *Mental Health Act* is appropriately supervised and kept safe.

5 List of recommendations

1 *Information, advice and assistance under section 15 of the Bill should be provided to Aboriginal and Torres Strait Islander voluntary patients in collaboration with Aboriginal health workers where practical and appropriate.*

2 *Parliament provide guidance on when it may be reasonable to refuse treatment under the criteria for involuntary treatment orders in sections 25(1)(c)(ii) and 25(2)(c)(ii) of the Bill. Reasonable grounds for refusing treatment should include cultural beliefs or practices.*

3 *Wherever possible, where the patient is an Aboriginal or Torres Strait Islander, police powers under the Bill should be undertaken in consultation with Aboriginal police liaison officers.*

4 *Aboriginal and Torres Strait Islander patients should be visited within a reasonable period of time by a Mental Health Advocate who has qualifications, training or experience in dealing with Aboriginal and Torres Strait Islander people.*

5 *That the Tribunal be required to develop an action plan to appropriately reach out to Aboriginal and Torres Strait Islander patients and their*

communities, including through the adoption of culturally-sensitive hearing practices and outreach efforts to Aboriginal and Torres Strait Islander communities.

6 *Parliament provide guidance on the qualifications required of Mental Health Advocates and persons who can represent patients at Tribunal hearings.*

7 *Parliament provide details of how the Tribunal will facilitate representation where a patient requests representation under section 353 of the Bill, including where the Tribunal will source representatives from.*

8 *Principle 7 of the Charter be redrafted to contain a requirement that information about legal rights be communicated in a form that is most likely to be understood by the patient so to heighten an individual's ability to make informed decisions.*

9 *Parliament address the mental health services both in prisons and following release of prisoners in the proposed Act to ensure the availability of mental health services, advice and assistance to meet the needs of incumbent, incarcerated and released prisoners.*

6 Analysis of key changes

6.1 Provision of information and advice to voluntary patients

Section 15 of the Bill prescribes the information, advice and assistance that must be given to voluntary patients before they can give informed consent to treatment. Section 15 is more proscriptive than the current Act and requires, among other things, clear explanations of the nature and purpose of the treatment, the expected benefits and risks, and the reasonably available alternatives.

ALSWA endorses this requirement as an important protective measure for all patients but notes that in order to ensure that information is presented in a meaningful way to Aboriginal and Torres Strait Islander patients, collaboration should be sought from Aboriginal health workers where it is practical and appropriate to do so (as is contemplated in respect to involuntary patients and mentally impaired accused under section 143 of the Bill). The involvement of Aboriginal health workers in this way will help to ensure that voluntary patients receive culturally appropriate explanations, enabling them to give informed consent as the Bill intends.

In particular it is submitted that it would be appropriate and beneficial for Aboriginal health workers to regularly visit detention facilities where Aboriginal and Torres Strait Islander patients are serving sentences or are otherwise detained by law to assess, advise and assist them as to their rights.

In addition to the role of Aboriginal Health Workers, interpreters in Aboriginal languages will also have an important role to play in assisting voluntary patients who do not speak English as a first language. To this end, the Bill highlights the need for a properly resourced and accredited interpreter service in Aboriginal languages to be introduced across Western Australia and we commend the introduction of such a service to the Parliament.

Recommendation 1 - Information, advice and assistance and appropriate interpretation services under section 15 of the Bill

should be provided to Aboriginal and Torres Strait Islander voluntary patients in collaboration with Aboriginal health workers where practical and appropriate.

6.2 Involuntary treatment criteria

Section 25 of the Bill sets out the criteria that must be satisfied before an involuntary treatment order can be made. The Bill introduces the concept of 'unreasonable' refusal of treatment, so that an order can only be made where the person either does not have capacity to give informed consent or has unreasonably refused treatment.

Whilst ALSWA endorses the introduction of this safeguard, this provision would be strengthened by Parliament providing guidance on when it may be reasonable to refuse treatment. Circumstances should include where information and explanations have been provided as contemplated under section 15 and treatment is refused on the grounds of cultural belief or practice.

Recommendation 2 - Parliament provide guidance on when it may be reasonable to refuse treatment under the criteria for involuntary treatment orders in sections 25(1)(c)(ii) and 25(2)(c)(ii) of the Bill. Reasonable grounds for refusing treatment should include cultural beliefs or practices.

6.3 Decreased timeframes for referral for examination, transport orders and detention periods

Part 5 of the Bill decreases the time frames within which practitioners may make referrals for examination by a psychiatrist, in respect to patients whom they suspect require an involuntary treatment order. Referral orders under the Bill expire within 72 hours (the patient must be taken to an authorised hospital or other place for an examination within this time) in comparison to the 7 days allowed under the current Act. Once at the authorised hospital, patients must be examined by a psychiatrist within a further 24 hours.

ALSWA welcomes the reduced timeframes but is concerned about the possibility to extend timeframes in respect to patients in 'declared areas' and the potential for this to particularly affect Aboriginal and Torres Strait Islanders. The Minister's power under section 53 to make certain areas 'declared areas' is intended to make exceptions for regional and remote areas, where services are fewer and further apart. The validity of referral orders for patients in declared areas can effectively be extended for a further 72 hours (by virtue of section 128(3) of the Bill which concerns transport orders) and the time for examinations by a psychiatrist can be extended to 72 hours.

Many Aboriginal and Torres Strait Islanders live in regional or remote areas and accordingly, Aboriginal and Torres Strait Islanders requiring mental health services are likely to be particularly affected by extended timeframes in practice. ALSWA is concerned that the extended timeframe will become the default timeframe for patients in declared areas.

The requirement in section 53(5) of the Bill that the referring practitioner must ensure that the patient has the opportunity and means to contact their nominated person, their carer and the Chief Mental Health Advocate as soon as practical after an extension order is made and at all reasonable times during the detention, is an important safeguard that may assist Aboriginal and Torres Strait Islander

patients living in remote areas and ALSWA strongly endorses the inclusion of this provision.

ALSWA considers that this provision should also require the referring practitioner to provide opportunity for the patient to access to an interpreter soon as practical after an extension order is made and at all reasonable times during the detention. Again, interpreters in Aboriginal languages will play a critical role in ensuring that patients understand and are able to enforce their rights under the proposed Act.

Further, a practitioner exercising discretion to extend a referral order must do so in accordance with the objects of the Bill, including that patients receive *'treatment and care with the least possible restriction of their freedom'* (section 6).

6.4 Consideration of patient's wishes

ALSWA supports the requirement that clinicians have regard to the patient's wishes when deciding what treatment will be provided under section 142 of the Bill and encourage the use of interpreters to ascertain a patient's wishes where not readily apparent or communicable.

This requirement may facilitate the provision of a more culturally appropriate form of treatment, in circumstances where there are treatment alternatives.

6.5 Involvement of Aboriginal Police Liaison Officers

ALSWA endorses the authorisation of Aboriginal police liaison officers to perform the powers of police officers under the Bill (section 137).

ALSWA recommends that this provision be strengthened to require that, wherever possible, police powers such as those relating to transport orders are in fact carried out in consultation with Aboriginal police liaison officers where an Aboriginal or Torres Strait Islander patient is concerned. ALSWA appreciates that due to lack of experience or training it may not be appropriate for an APLO to exercise the police powers on all occasions, however, if an APLO in a particular region does have the requisite experience and training, the police powers under the Bill ought to be carried out by that APLO in that region. In all other circumstances the local APLO ought to be consulted as to the most culturally appropriate manner in which to carry out police powers, including liaison with a patient.

Recommendation 3 – Wherever possible, where the patient is an Aboriginal or Torres Strait Islander, police powers under the Bill should be carried out in consultation with Aboriginal police liaison officers.

6.6 Involvement of Aboriginal health care workers

ALSWA supports the requirement that treatment must be provided to Aboriginal and Torres Strait Islander involuntary patients and mentally impaired accused in collaboration with Aboriginal health workers and traditional healers from the patient's community, unless it is not practicable or appropriate to do so (section 143).

Aboriginal health workers have the potential to bridge the gap in understanding between western mental health practitioners and Aboriginal and Torres Strait Islander patients. Research shows that the best outcomes for mental health patients are achieved when Western systems operate alongside and collaboration

with traditional local resources.[18] In reviewing relevant literature on the issue, Garvey explains:

> …high levels of ignorance and misunderstanding pertaining to Indigenous culture and the intergenerational impacts of past policies on the social and emotional wellbeing of Indigenous people still exist among many non-Indigenous practitioners. In a review of 'traditional' Indigenous health beliefs, Maher argues that Western health professionals often experience difficulties in providing health care to Indigenous people because of the distance between mainstream and Indigenous cultures. The differences in health belief systems exacerbate difficulties experienced in cross-cultural health delivery settings because there is poor compatibility between the underlying values of the Western medical system and traditional Indigenous health beliefs.
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> […]
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> Westerman recommends that professional development programs in this area target the development of culturally competent practitioners. Such programs should incorporate knowledge, skills and attitudes that facilitate their improved involvement with Indigenous people. Cultural competence concerns the ability of practitioners to identify, intervene and treat mental health complaints in ways that recognise the central role that culture plays in mental illness.[19]

The involvement of Aboriginal health workers may facilitate the provision of culturally appropriate mental health services in this way. Where requested by a party or deemed necessary, in legal proceedings against or involving an Aboriginal person with mental health or suspected mental health issues, the proceedings ought to be stayed until such time as the person is able to seek and received culturally appropriate treatment. In the case of mentally impaired accused, the accused ought not to be detained except in the most serious of cases while they seek to access such services.

ALSWA recommends that this principle be extended beyond treatment, to also involve Aboriginal health workers and traditional healers in the provision of advice and information to voluntary Aboriginal and Torres Strait Islander patients, as part of the informed consent requirements (see **Recommendation 1**).

6.7 Mental Health Advocates

ALSWA regards the establishment of mental health advocacy services under section 271 of the Bill as a very important safeguard in terms of patients' rights.

Section 265(4) contemplates the appointment of one or more Mental Health Advocates that have qualifications, training or experience in dealing with particular community groups.

Given the proportion of Aboriginals and Torres Strait Islanders who access or require mental health services, and the barriers typically faced by Aboriginal and Torres Strait Islander mental health patients, it should be a requirement that any Mental Health Advocate visiting an Aboriginal and Torres Strait Islander patient have qualifications, training or experience in dealing with Aboriginal and Torres Strait Islander persons.

ALSWA notes that periods of delay can be particularly difficult or distressing for persons suffering from mental impairment and can potentially affect their recall of and response to circumstances more pronouncedly than for non-affected

[18] Garvey, above n 1.

[19] Garvey, above n 1.

individuals. Therefore, in circumstances where a Mental Health Advocate is required, ALSWA suggests that there be time constraints imposed legislatively to ensure prompt access to justice and to avoid of unnecessary periods of delay, detention or distress.

Again ALSWA reinforces the need for the assistance and availability of Aboriginal language interpreters to assist Mental Health Advocates obtain instructions and act for Aboriginal and Torres Strait Islander patients, particularly in regional areas**.**

Recommendation 4 - Aboriginal and Torres Strait Islander patients should be visited within a reasonable period of time by a Mental Health Advocate who has qualifications, training or experience in dealing with Aboriginal and Torres Strait Islander people.

6.8 Aboriginal and Torres Strait Islander children

ALSWA supports the inclusion of Part 15 of the Bill, which deals specifically with the rights of children who have a mental illness. In addition, ALSWA supports the introduction of a distinction between adult and children patients in Parts 17 and 18 of the Bill.

The connection between youth offending, mental illness and intellectual disability is an under-explored area in WA. A NSW study found that intellectual disability was particularly high amongst Aboriginal young offenders, and that over 88% of young people in custody reported symptoms consistent with mental illness.[20]

It is ALSWA's experience that many Aboriginal young offenders have never had their mental health properly assessed, despite the presence of obvious symptoms. These young people move through the juvenile justice system without receiving the specialist interventions which could identify and begin to address the underlying causes of offending.

Alcohol consumption is a major, well known social issue in WA. Despite this, foetal alcohol disorders are markedly undiagnosed and unaddressed. The prevalence of such disorders amongst Aboriginal young offenders is unknown. We note the comprehensive discussion of Foetal Alcohol Spectrum Disorder contained in the *'Doing Time – Time for Doing'* report.

ALSWA notes, in particular, that provisions relating to the detention (for up to indeterminate periods) of mentally impaired persons may more significantly impact upon children than on adults. Moreover, the Convention on the Rights of the Child (CROC) rejects the detention of children save for in the most exceptional of circumstances.

Noting the high incidence of mental health problems in Aboriginal youth in WA, ALSWA submits that clear distinctions must be drawn in any legislation that may have the consequence of youth being detained for an indeterminate period. To detain or punish youth suffering from mental health problems, albeit undiagnosed, may have a pronounced long-term effect on their incidence of offending, psychological well-being and mental health. There necessarily must be different provisions relating to children with a high focus on intervention and providing access to mental health services from as early an age as possible.

[20] Kelly Richards, *Trends in Juvenile Detention in Australia* (May 2011) Australian Institute of Criminology <http://www.aic.gov.au/documents/D/6/D/{D6D891BB-1D5B-45E2-A5BA-A80322537752}tandi416.pdf>.

Both NSW and Victoria have incorporated mental health responses into the administration of the juvenile justice system. The Victorian Children's Court has a 'Children's Court Clinic', staffed by specialist psychologists and psychiatrists. Clinic practitioners provide assessment and reports recommending specific treatment needs, and also act as a referral service.[21]

In NSW mental health nurses are available at youth courts. They provide assessment and referral services, ensuring the court is fully informed of a young person's mental health status at the time of sentencing. This means that court processes and sentences can be tailored to a young person's developmental and cognitive needs.

It is important to again emphasise the importance of mental health responses being culturally relevant. In WA, where up to 70% of the young people in juvenile detention are Aboriginal, mental health responses must be suited to the specific cultural and physical needs of Aboriginal young people.

WA desperately requires more accessible mental health services for young people involved in the youth justice system. If the court's priority is a young person's rehabilitation, and ultimately to prevent recidivism, young people must have ready access to mental health services and court must be able to structure their responses to offending to reflect the limitations, needs and capacities of the young person before it.

ALSWA has recently acted for a 17 year old Aboriginal male who pleaded guilty to a number of serious offences of violence involving the use of a weapon. The youth was diagnosed as suffering from schizophrenia, diabetes, heart disease and had serious alcohol and cannabis abuse problems. His compliance with his medication regime for both diabetes and schizophrenia was very poor. He lived in a remote Aboriginal community on the Ngaanyatjarra lands in the desert near the Northern Territory border. There is no regular psychiatric presence in or service to the Ngaanyatjarra lands, such that the youth's condition and medication regime remained largely unmonitored. This in turn meant the youth was at serious risk of reoffending in a violent fashion on his release from custody thereby placing other members of his community at serious risk and remaining untreated himself.

7 Replacing the Review Board with a Mental Health Tribunal

7.1 Tribunal to replace Mental Health Review Board

The Bill proposes to replace the existing Mental Health Review Board (**the Board**) with a new Mental Health Tribunal (**the Tribunal**). The Tribunal is intended to discharge many of the same functions as the Board, but has also been given new powers and responsibilities, such as the power to issue compliance notices (see section 327). The Tribunal will also be able to review a user's individual treatment plans and make recommendations should those plans prove deficient.[22]

[21] See: Children's Court of Victoria, *Children's Court Clinic* (2009) <http://www.childrenscourt.vic.gov.au/CA256CA800017845/page/Family+Division-Clinic?OpenDocument&1=20-Family+Division~&2=90-Clinic~&3=~>.

[22] Mental Health Commission, Government of Western Australia, *Summary Overview of the draft Mental Health Bill 2011* (2011), p 6.

The rationale for converting from the Board to the Tribunal is to modernise the system for review of mental health treatment. According to the Henderson Report, the establishment of the Tribunal marks "an increase in priority for upholding rights and responsibilities" and "increased considerations [for] individualised care and support plans that have real community links."[23] The Tribunal, in line with international best practice, should conduct itself in accordance with principles of reciprocity, described by the Henderson Report as being where:

> …any restrictions on people's freedoms are met with a statutory duty to provide for an individualised care, support and treatment plan for all users of services under involuntary status.[24]

ALSWA considers these to be important and worthwhile principles, particularly the recognition of community and cultural links in developing individual treatment plans. Generally speaking, ALSWA supports the introduction of a Tribunal that exists for clients to challenge an involuntary admission and seek an independent review.

However, ALSWA also recommends that additional measures should be put in place to ensure that the Tribunal is capable of delivering outcomes consistent with the principles and in light of the concerns highlighted in this submission, particularly, access for regional/remote persons and culturally appropriate services and representation. As a general comment, ALSWA considers that more could be done in the proposed legislation to acknowledge and overcome the additional barriers and impediments that Aboriginal and Torres Strait Islander patients are likely to face in dealing with the Tribunal.

7.2 Implications for Aboriginal and Torres Strait Islanders

Other Australian jurisdictions currently utilise tribunal systems for mental health review. Studies in relation to the tribunals in other jurisdictions shed some light on the issues faced by Aboriginal and Torres Strait Islander patients during review processes.

Representation

One issue that emerges on a jurisdictional comparison is that a lack of representation can often limit Aboriginal and Torres Strait Islander users' meaningful participation in hearings before the Tribunal.

Australian mental health tribunals have been noted to have relatively low rates of representation for users by international standards.[25] For example, in New Zealand, nearly 70% of patients are represented when they go before a mental health tribunal, and representation is mandatory in Ireland. By contrast, less than 10% of Victorian users had legal representation when appearing before a mental health tribunal in 2002.[26]

In the Northern Territory, where 53% of patients going before the Northern Territory Mental Health Review Tribunal (**NTMHRT**) were of Aboriginal or Torres Strait Islander descent, 98% of such patients had legal representation

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[23] Gregor Henderson Ltd, *Developing a Quality Assurance Framework for Mental Health in Western Australia: Final Report* (2011), p 11.

[24] Henderson, above n 14.

[25] Carney, above n 18, p 16.

[26] Ibid.

according to the most recent review.[27] Most legal representatives were experienced practitioners whose fees were paid by the Northern Territory government.[28] To this end, ALSWA notes that in the NT, it was previously the case that ALSWA's equivalent organisation, NAAJA, provided a culturally relevant legal service to the Mental Health Review Tribunal. The service included an Aboriginal Client Service Officer as well as a solicitor. Importantly, the service was also able to provide advice to clients not only on the day of their Tribunal hearing, but also in advance. However, due to funding limitations, NAAJA became unable to provide the service and its funding proposals to resume this service were declined by the government. Instead, the NT Government opted to fund private solicitors at greatly increased cost to provide a duty lawyer service to Aboriginal and non-Aboriginal clients. While ALSWA submits that these solicitors do not necessarily provide a culturally relevant approach and do not assist clients other than on the morning of their Tribunal hearing, it is nevertheless beneficial for there to be at least some representation afforded for Applicants before the Tribunal.

The Bill in its present form does allow for patients to be represented (sections 350- 353).

Section 268(3) of the Bill appears to allow Mental Health Advocates to represent patients at tribunal hearings. However, no guidance or requirements are provided regarding the qualifications of Mental Health Advocates or the qualifications of any other persons who can represent patients. It is not clear whether either of these positions requires legal training, for instance. ALSWA submits that some form of legal training ought to be a mandatory requirement for any such persons or Advocates.

Section 353 of the Bill provides that the Tribunal can make arrangements for representation if a party to the Tribunal proceedings wants such arrangements to be made. The Bill does not give any indication as to how representatives will be sourced and consequently, whether there is likely to be a shortfall of representatives. ALSWA submits that as a culturally appropriate legal service it is best placed to provide advice and representation to patients appearing before the tribunal and submits that parliamentary consideration ought to be given at a State level to allocate funding to ALSWA to provide these services. Given the high incidence of mental health issues, particularly among clients in the Criminal and Family law jurisdictions in WA, it may be presumed that there would be a high volume of representation required.

Not only is representation before a court or tribunal an important human right, it is also likely to be beneficial by resulting in higher discharge rates for involuntary patients. The Victorian Auditor General found that:

> [d]uring 2002, patient outcomes varied considerably for patients with and without legal representation. Overall, patients with legal representation were discharged from their involuntary status 15.1 per cent of the time, while patients without representation were discharged on 4.5 per cent of occasions.[29]

There appears to be some division amongst experts as to whether legal representation, as opposed to some kind of lay representation, is in the best interests of patients. Some authors have suggested that legal practitioners may bring a mindset that is too adversarial to mental health review proceedings.[30]

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[27] Mental Health Review Tribunal (NT), *Annual Report 2010-2011* (2011) p 18.

[28] Ibid, pp 5-6.

[29] Auditor General Victoria, *Mental Health Services for People in Crisis* (2002),p 7.

[30] Carney, above n 18, pp 16-17.

The experience of the Northern Territory however, where there is almost universal representation by experienced barristers and solicitors, has been extremely positive.[31]

The experiences in Tasmania and the Northern Territory suggest that experienced legal practitioners, or suitably qualified and trained legal volunteers, would significantly assist both the Tribunal and individual patients, by facilitating meaningful participation in the mental health review process.

Further, the potential exists that Aboriginal and Torres Strait Islander patients appearing before the Tribunal will face a greater risk of being unrepresented due to under-resourcing in the community legal sector as exemplified by a 2005 Commonwealth report which found that Aboriginal and Torres Strait Islander Legal Services (**ATSILS**) faced significant impediments in receiving funding to deal with civil or family law issues.[32]

While, in Tasmania, anyone appearing before that State's mental health tribunal has the option of free representation through the Tasmanian Mental Health Representation Scheme (**MHTRS**), there is no indication that the services of a WA Mental Health Advocate will be free. The MHTRS uses volunteers (predominantly law students) to represent patients at hearings after providing mental health-related training to the volunteers.[33] The MHTRS has been cited by the tribunal itself as contributing to users being willing to take a more active role in their hearing.[34] ALSWA endorses this approach and says further that efforts should be made to source and train Aboriginal and Torres Strait Islander law students, court officers or lawyers to be made available for any Aboriginal or Torres Strait Islander applicants who seek culturally or linguistically appropriate representation.

To ensure that the proposed Mental Health Review Tribunal sufficiently safeguards the rights of Aboriginal and Torres Strait Islander clients, it is essential that there is access available to culturally appropriate legal representation.

It is also unclear whether the Tribunal as proposed will have the financial capacity to sit in remote locations. ALSWA would be opposed to a Tribunal that could not do so.

Regional and remote sittings would enable family and the person concerned to attend and ensure that the decision makers are aware of the realities of life for that person, such as the medical and housing facilities that exist in a given community, while acknowledging their ties to land and culture which may prevent them from leaving a community for prolonged periods to seek treatment.

The geographic isolation and remoteness of many Aboriginal and Torres Strait Islander communities may limit individual's ability to access tribunal services and processes. A visit by a Mental Health Advocate may assist to overcome this barrier.

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[31] Mental Health Review Tribunal (NT), above n 29, p 6.

[32] Joint Committee of Public Accounts and Audit, Parliament of Australia, *Access of Aboriginal and Torres Strait Islanders to Law and Justice Services* (2005), [2.40].

[33] Valerie Williams, 'The Challenge for Australian Jurisdictions to Guarantee Free Qualified Representation before Mental Health Tribunals and Boards of Review: Learning from the Tasmanian Experience' (2009) 16 *Psychiatry, Psychology and Law* 108, pp 118-119.

[34] Mental Health Review Tribunal (TAS), *Annual Report 2004-2005* (2005), p 11.

Finally, particularly in remote and regional settings, the assistance of and access to interpreters skilled in Aboriginal language are required.

Applicant Anxiety

It has been noted that many people appearing before mental health tribunals experience anxiety at the prospect of attending a hearing.[35] A review of the Queensland Mental Health Tribunal (**QMHRT**) found that users receiving involuntary treatment would avoid hearings because:

(a) they were unclear about their rights and the role of the QMHRT;

(b) they did not view attending the hearing as a high priority;

(c) they believed that the QMHRT would 'side' with their doctor; and

(d) they wanted the QMHRT to deliver services it was not equipped for, such as hearing complaints about the mental health system.[36]

Similar findings were made by Professor Terry Carney, who found that people who went before mental health tribunals frequently felt distressed and powerless. The structures and processes of tribunals are often poorly explained to users of the mental health system, and consequently, are poorly understood. As Professor Carney noted:

> Consumers, as well as their carers…find the mental health system, including [tribunals], an amorphous system to navigate. It can be difficult for consumers to understand what kinds of services are available, where assistance can be sources, as well as what role, rights and responsibilities a person may have within this system.[37]

A review of the QMHRT found that Aboriginal and Torres Strait Islander users encountered the same issues as non-Aboriginal and Torres Strait Islander users when dealing with tribunal systems.[38] However, the review also found that Aboriginal and Torres Strait Islander users faced some additional barriers to participating in tribunal processes related to their treatment, including:

(a) perceiving an association or equivalency between the QMHRT and the court system;

(b) avoiding hospital-based hearings due to an association between hospitals and death;

(c) feeling uncomfortable or intimidated by the QMHRT; and

(d) accessibility issues due to hearings being held far away from places where Aboriginal and Torres Strait Islander patients live.[39]

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[35] Sally Fisher, Deborah Kilcullen, Gwen Schrieber and Brian Hughes, 'Widening the Circle: Making Mental Health Review Tribunal hearings accessible in Indigenous, rural and remote settings' (2009) 17 *Australasian Psychology* S83, S84.

[36] Fisher et al, above n 16.

[37] Terry Carney, 'Mental Health Tribunals – Rights, Protection or Treatment? Lessons from the ARC Linkage Grant Study?' (Paper presented Rights Responsibilities Rhetoric conference, Adelaide, 8-9 October 2009),p 21.

[38] Fisher et al, above n 16.

[39] Ibid.

There are a variety of measures that could be put in place to limit some of the apprehensions felt by Aboriginal and Torres Strait Islander patients. The QMHRT, for example, has highlighted engagement with Aboriginal and Torres Strait Islander patients and their communities as a strategic priority,[40] and has adopted the following measures in response:

(a) increasing the number of Aboriginal and Torres Strait Islander members of the QMHRT;

(b) developing culturally appropriate hearing practices;

(c) respecting Aboriginal and Torres Strait Islander values; and

(d) developing the role of Indigenous Mental Health Workers (**IMHWs**) as a source of information for the QMHRT.[41]

Culturally appropriate hearing practices might include:

(a) holding hearings in venues acceptable to local Aboriginal and Torres Strait Islander communities based on consultation with local community groups, leaders and service providers;

(b) having an Aboriginal or Torres Strait Islander tribunal member sitting to hear cases involving Aboriginal and Torres Strait Islander users, so that the member can perform their normal role and provide relevant cultural information to the rest of the panel (in the same way that the Tribunal will include a member with experience in dealing with children where the involuntary patient is a child in sections 302, 309, 315, 322 and 333 of the Bill);

(c) providing cultural awareness training to all tribunal members; and

(d) allowing Aboriginal and Torres Strait Islander users to bring a cultural support person to the hearing, such as a family member, health worker or a member of the user's community.[42]

The QMHRT has also created specific resources for Aboriginal and Torres Strait Islander patients, IMHWs and Aboriginal and Torres Strait Islander communities, including a dedicated section of the QMHRT website and DVDs explaining QMHRT processes to Indigenous people.[43]

ALSWA notes that the Bill as currently drafted does provide for patients to be visited or contacted by a Mental Health Advocate. If the Mental Health Advocate has qualifications, training or experience in dealing with Aboriginal and Torres Strait Islander persons (as ALSWA suggests should be a requirement when visiting Aboriginal and Torres Strait Islander patients - see Recommendation 4), this provision may go some way towards ensuring Aboriginal and Torres Strait Islander users have an appropriate level of understanding of tribunal processes and the ability to raise concerns and complaints regarding treatment and care.

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[40] Mental Health Review Tribunal, Queensland Government, *Strategic Plan 2010 – 2015* (2010),p 8.

[41] Fisher et al, above n 16, S85.

[42] Ibid, S85-S86.

[43] Mental Health Review Tribunal (QLD), *Aboriginal and Torres Strait Islander People*, (2010), <http://www.mhrt.qld.gov.au/?page_id=68> at 1 March 2012.

It has been suggested that turning mental health tribunals into an informal space in which mental health users can freely contribute would have positive effects for a wide range of people, including users and their families.[44] The provision in the Bill at section 342(1) that hearings occur with as little formality as possible is a welcome inclusion.

RECOMMENDATION 5: That the Tribunal be required to develop an action plan to appropriately engage with Aboriginal and Torres Strait Islander mental health patients and their communities, including through the adoption of culturally-sensitive hearing practices and a consideration of how services can be delivered to remote areas.

RECOMMENDATION 6 – Parliament provide guidance on the qualifications required of Mental Health Advocates and persons who can represent patients at Tribunal hearings.

RECOMMENDATION 7 – Parliament provide details of how the Tribunal will facilitate representation where a patient requests representation under section 353 of the Bill, including where the Tribunal will source representatives from.

8 Compatibility with international obligations

8.1 Compliance with United Nations *Convention on the Rights of Persons with Disabilities*

Australia ratified the United Nations Convention on the Rights of Persons with Disabilities (the **DisCo)** on 17/07/2008 and the Optional Protocol on 2/09/2008.

The provisions of DisCo are enlivened by the Bill as a result of Article 1 which states that the purpose of DisCo is to promote, protect and ensure the full and equal enjoyment of all human rights by all persons with disabilities, where relevant disabilities include long-term physical, mental, intellectual or sensory impairments.

ALSWA endorses the inclusion of the Charter of Mental Health Care Principles (the **Charter**) set out at Schedule 1 of the draft Bill. The inclusion of the Charter in the Bill is likely to facilitate compliance with Australia's obligations under DisCo. ALSWA notes the Charter's recognition of the need to provide services that are both sensitive and responsive to an individual's culture, community, spiritual beliefs, mores and practices (Charter Principles 2 and 5). These principles accord with the text and the underlying intent of DisCo (specifically Article 12).

The following sections outline how relevant principles in the Charter accord with the requirements under DisCo:

(a) Charter Principle 4: Accessibility

ALSWA is particularly concerned with the ability of Aboriginal and Torres Strait Islander peoples to access mental health services and be heard by the Tribunal, in light of the barriers typically faced by Aboriginal and Torres Strait Islander mental health patients, including the geographical isolation of many Aboriginal and Torres Strait Islander

[44] Carney, above n 18, pp 23-24.

communities. Article 13 of DisCo requires States to ensure effective access to justice for persons with a disability, on an equal basis with others.

Art 25 (c) of DisCo also requires health services for persons with disabilities to be provided as close as possible to people's own communities, including in rural areas.

The difficulties associated with access to justice and services for individuals in remote Aboriginal and Torres Strait Islander communities are canvassed above at Part 7. Recommendations 5 and 7 relate to accessibility.

(b) Charter Principles 6 and 7: Communication

ALSWA endorses Principles 6 and 7 that require information about diagnosis and treatment (Principle 6) and legal rights (Principle 7) to be clearly explained to patients. This will help individuals to make informed decisions and will facilitate compliance with DisCo Article 3 that requires States to respect an individual's inherent dignity, individual autonomy and freedom to make their own choices.

ALSWA endorses the requirement in Principle 6 that information be communicated in a 'language, form of communication and terms that are likely to be understood […] to facilitate informed consent.' This will enable communication to be culturally sensitive.

Recommendation 8 - Principle 7 of the Charter be redrafted to contain a requirement that information about legal rights be communicated in a form that is most likely to be understood by the patient so to heighten an individual's ability to make informed decisions.

(c) Articles 12 and 13 of DisCo:

The location of the Tribunal may particularly affect the right of Aboriginal and Torres Strait Islanders to receive equal recognition under the law and access to justice as required by Articles 12 and 13 of DisCo.

Full compliance with the requirements in DisCo may be achieved by ensuring that those living in remote areas have access to tribunal processes through a circuit tribunal or allowing for attendance at hearings via a video link (where this is appropriate).

9 Prisoners Mental Health

ALSWA submits that the Draft Bill does not adequately address the mental health of Prisoners or detainees. In light of the tragic case of Mr Marlon Noble, it is submitted that it is essential to do so in any legislation regulating mental health.

Prisoners with mental health issues are some of the communities most vulnerable and high needs people. This is because they often present with comorbid issues such as intellectual impairments, hearing impairments, and substance misuse issues. Properly treating prisoners with mental health issues involves addressing their holistic, broader social needs.

It is ALSWA's experience that prisoners with mental health issues do not have many of their broader needs met. This includes lack of access to programs, lack of access to interpreters or hearing aids, restricted opportunities to transfer to lower security areas of the prison, and poor repatriation and post-release support practices.

9.1 Lack of access to programs

It is ALSWA's experience that people with mental health issues are often precluded from participating in rehabilitation programs. This is because their behavioral needs are assessed as being too risky, or too high.

ALSWA has appeared for an Aboriginal male from a remote community who was sentenced for violent crimes against women and had a history of prior convictions for violent crimes against women. His prison management plan mandated that he participate in substance abuse, cognitive behavioural thinking and anger management programs, all with a view to modifying his behavior and attitudes towards women. The man was serving his sentence in a Perth metropolitan jail. None of the mandated courses were made available to him. He was then refused parole on the basis that he had not completed such programs. He then served the full terms of his sentences of imprisonment. On release, he was not subject to any supervisory or program requirements conducted by the Department of Corrective Services. The risk of him reoffending, especially in a violent manner towards women is palpable.

Prisoners with mental health issues confronted with the same lack of access to mental health programs are similarly at high risk of reoffending when returned to their communities. This is counterproductive not only to the interests of the prisoners themselves but also to the interests of the wider community which remains unprotected from the risk of violent offending.

The long-term implications of denying prisoners with mental health issues access to programs is that because this category of offender are not provided with any rehabilitation treatment and then released unsupported, their risk of recidivism remains high.

ALSWA submits that prisoners with mental health issues should have opportunities to access rehabilitation treatment whilst incarcerated. If it is not appropriate for them to participate in a group context, they should be provided with individual treatment. Moreover, programs and treatment should be readily provided at all prisons in Western Australia, including and in particular, regional prisons which the Director General of Custodial Services regards as 'Aboriginal Prisons' by virtue of the overrepresentation of prisoners from the Aboriginal and Torres Strait Islander population in residence.

9.2 Lack of access to low security classification

Prisoners with mental health issues are treated from the medical clinic, which is located in the medium security section of the prison. Prisoners who require regular treatment (such as medication monitoring, or fortnightly depot injections) are not permitted to transfer to the low-security section of the prison, as they are required to reside in close proximity to the clinic.

The conditions in the medium security section of the prison are characterized by regular lock-downs (usually for a minimum of 12 hours per day), restricted work opportunities, and restricted reintegration opportunities.

Conversely, the low security section of the prison has few lock down restrictions, opportunities to work both within and outside of the prison, education opportunities, opportunities to progress to open-security classification and reside in cottages as opposed to cells, and more general reintegration support.

Having the opportunity to transfer to the low security section of the prison, and participate in the opportunities provided, is also looked upon favorably by the Parole Board. It is difficult for prisoner's in the medium security section of the prison to achieve parole.

Because prisoners with mental health issues are denied access to both programs and the low security section of the prison, they are subsequently also denied parole. Again, this results in prisoners with mental health issues being released unsupported and unsupervised when they reach their full term date.

ALSWA submits that it is important that prisoners with mental health issues have the same classification opportunities as prisoners without mental health issues. The prison should accommodate for medication requirements in the low security section of the prison. This will ensure prisoners with mental health issues have rehabilitation and reintegration opportunities.

9.3 Lack of post-release support and repatriation assistance

There is a marked lack of post-release support and repatriation assistance for prisoners with mental health issues.

This is a significant area of need, especially in regional and remote Western Australia. It is ALSWA's experience that many prisoners are returned to their communities having had no access to rehabilitation or treatment programs which are typically located in regional towns or metropolitan centres. There is a dire need for expansion of these programs into remote Aboriginal. As discussed above, prisoners with mental health issues are less likely to achieve parole, having been denied rehabilitation and low security classification opportunities.

Additionally, because many prisoners with mental health issues are likely to have previously breached suspended sentences, or other supervisory orders, they are more likely to be sentenced to an actual, rather than suspended, term of imprisonment. They are therefore often in a situation of also being released without court ordered supervision.

Accordingly, without supervision from parole, or a court order, it is essential that prisoners with mental health issues be provided with sufficient post release support and proper repatriation assistance.

ALSWA has had a number of clients released without their medication. We have also had instances where clients who have been formally found mentally impaired, are released without post release planning. Lack of post release clinical and broader social support exposes prisoners with mental health issues to a high level of risk.

ALSWA recommends that all prisoners with mental health issues be provided with comprehensive post release support. This would ensure they are not exposed to high levels of unacceptable risk. It would also assist in their reintegration, and reduce the likelihood of reoffending.

9.4 Summary

ALSWA considers it a high priority that the broader needs of prisoners with mental health issues be met. This will ensure prisoners with mental health issues do not continue to cycle through the criminal justice system.

ALSWA is concerned that current prison practices mean that prisoners with mental health issues have fewer opportunities to rehabilitate through undertaking rehabilitation programs, or through a supported release. The consequence of this is that prisoner's with mental health issues are often warehoused, and subsequently released into vulnerable situations, with a high risk of recidivism.

ALSWA recommends that the WA Government commit to meeting the broader needs of incarcerated people with mental health issues. This will likely result in better continuity of care, reduced risk, and a reduction in recidivism.

Recommendation 9 - Parliament address the mental health services both in prisons and following release of prisoners in the proposed Act to ensure the availability of mental health services, advice and assistance to meet the needs of incumbent, incarcerated and released prisoners.

10 Conclusion

This submission has considered how the provisions of the draft Mental Health Bill currently before Parliament are likely to impact Aboriginal and Torres Strait Islanders accessing mental health services. ALSWA supports many of the changes proposed by the Bill and in particular, the measures designed to overcome Aboriginal and Torres Strait Islander disadvantage and provide cultural appropriate mental health services to Aboriginal and Torres Strait Islanders.

This submission makes numerous recommendations that ALSWA believe are necessary to facilitate equal access to and meaningful participation in mental health services for Aboriginal and Torres Strait Islanders and to truly fulfil the purposes for which the legislation is intended.