2019 Submission - Royal Commission into Victoria's Mental Health System

Organisation Name
N/A

Name
Mr Guy Coffey

What are your suggestions to improve the Victorian communitys understanding of mental illness and reduce stigma and discrimination?
"I have not addressed this question in my submission and it is not something I have particular expertise in. However I believe the following needs to be considered. - information provision and increased understanding within the community is a necessary but not sufficient condition to reduce stigma. Some very well informed people (including MH professionals) still possess stigmatising attitudes. - Attempting to bring attitudes into alignment with views on physical health is useful up to a point however there are also important differences in the nature and experience of physical and mental illness that need to be acknowledged. Often to a greater extent, mental illnesses can affect how we see ourselves and who we are to others. - it is a reality that some people with severe mental illnesses have a vastly reduced quality of life as a result. This needs to be acknowledged in educational campaigns but also needs to be a cause for compassion and grounds for significant societal support, not a reason to marginalise and stigmatise. - the experiences of mentally ill people need to be part of any public education campaign. Bringing the community to understand the immense struggle and courage required to live with a severe mental illness is an important part of encouraging empathy and compassion. - a human rights perspective not just more information is needed. The goal is too increase empathy, compassion and a sense of community commitment and duty to promote the rights of mentally unwell people. - as with many pressing and complex human problems, we are not the first to try to find a solution. A thorough review of what has and hasn't worked internationally should be undertaken "

What is already working well and what can be done better to prevent mental illness and to support people to get early treatment and support?
N/A

What is already working well and what can be done better to prevent suicide?
N/A

What makes it hard for people to experience good mental health and what can be done to improve this? This may include how people find, access and experience mental health treatment and support and how services link with each other.
N/A

What are the drivers behind some communities in Victoria experiencing poorer mental health outcomes and what needs to be done to address this?
addressed in the submission

What are the needs of family members and carers and what can be done better to support them?

N/A

What can be done to attract, retain and better support the mental health workforce, including peer support workers?
N/A

What are the opportunities in the Victorian community for people living with mental illness to improve their social and economic participation, and what needs to be done to realise these opportunities?
N/A

Thinking about what Victorias mental health system should ideally look like, tell us what areas and reform ideas you would like the Royal Commission to prioritise for change?
addressed in the submission

What can be done now to prepare for changes to Victorias mental health system and support improvements to last?
N/A

Is there anything else you would like to share with the Royal Commission?
please see the submission

Submission to the Royal Commission into Victoria's Mental Health System

Submission Date: 5 July 2019

Guy Coffey[1]

Introduction

Thank you for the opportunity to make a submission to the Royal Commission. In accordance with my area of experience a focus of this submission is mental health service delivery to refugees. However, I also address a range of matters falling within the Royal Commission's terms of reference which relate to mental health service provision to the Victorian community generally. I will comment on the following subject areas:

1. mental health service delivery to asylum seekers and refugees;
2. the mental health care of young asylum seekers and refugees in the correctional system;
3. the mental health care of people with post-traumatic conditions;
4. access to private sector psychological treatment by people of non-English speaking background;
5. the capacity of public mental health services to deliver evidenced based psychological treatments; and
6. the quality of rehabilitation services for people with chronic mental illnesses.

This submission makes a number of propositions.

1. The policy environment governing the lives of asylum seekers is fundamentally inimical to their mental health and mental health services are unable to adequately meet their needs.
2. Commonwealth migration law interacts with the justice system in ways that deprive young asylum seeker and refugee offenders of mental health treatment and opportunities for rehabilitation.

[1] Foundation House, 4 Gardiner Street Brunswick VIC 3056. Mob. 0419322468 email: [redacted]

3. Post-traumatic conditions are not adequately treated within the public mental health system. Access to specialist posttraumatic mental health services is limited.
4. Migrants and refugees who are not fluent in English have far less access than English speakers to publicly funded private psychological services owing to the limited provision of interpreters for these services. This is an objectively discriminatory practice in mental health service delivery.
5. Public mental health services do not deliver the range of evidence based psychological treatments recommended by all major best practice treatment guidelines. Psychological treatments are inadequately integrated into treatment plans and services have insufficient staff possessing the requisite psychotherapeutic skills.
6. There are significant gaps in the delivery of rehabilitation services. Two examples are provided: there is a lack of focus on ameliorating cognitive impairments which have persisted beyond the remission of acute symptoms and vocational training and placement appears to be ineffective in many instances.

This submission draws on my experience of working in mental health services. I have worked as a clinical psychologist for 30 years in public mental health and specialist psychological trauma services including 21 years within Veterans' Psychiatry and the Psychological Trauma Recovery Service at the Austin and Repatriation Medical Centre. I am currently the practice development advisor at the Victorian Foundation for Survivors of Torture, a psychological treatment and support service for refugees, where I have worked part time for 20 years. I act as a consultant to organisations on psychological and legal issues in relation to refugees including the UNHCR and the Department of Home Affairs. I conduct research and publish in the field of refugee mental health. I provide forensic psychological reports for the courts in Victoria and psychological assessments of applicants for refugee status. With respect to my comments on refugee migration law and Commonwealth policy relating to asylum seekers, these are based on my experience working as a lawyer at Victoria Legal Aid providing assistance to asylum seekers and refugees.

The views expressed herein are my own and are not necessarily those of the organisations at which I am employed.

This submission has been written within a tight timeframe and is not a fully referenced scholarly paper but a set of propositions based on either direct observation derived

from clinical practice, research or both. More detailed and referenced explanations of aspects of the submission can be provided on request.

1. Mental health service delivery to asylum seekers and refugees

In order to deliver a mental health service that meets the needs of refugees, the determinants of their needs must be understood. For the purpose of this discussion, I will provide a very brief summary of what is known about the variables affecting refugee psychological well-being.

Influences on psychological well-being

People who entered Australia as refugees or have sought asylum in Australia are a large and heterogeneous community group ranging from the now very elderly post WW2 refugees to recently arrived asylum seekers and humanitarian entrants. While the mental well-being of refugees is as diverse as that which exists in the general community, decades of study of the mental health of refugees have demonstrated that at a population level a number of generalisations can be made:

- among many cohorts of asylum seekers and refugees rates of mental illness are many times higher than in the overall Australian population[2];
- the most common mental health problems experienced are Posttraumatic Stress Disorder, depression and anxiety disorders[3];
- there is evidence from international studies that rates of severe mental disorders such as schizophrenia are elevated among refugees[4];
- rates of mental disorder are predicted by the extent of pre-arrival trauma and loss, *and* by post-arrival stressors[5];

[2] There is a large number of studies of prevalence of mental disorder among refugees; for example, Fazel, M et al. (2005) Prevalence of serious mental disorder in 7000 refugees resettled in western countries: a systematic review. *Lancet* 365:1309-14. Steel Z et al. Association of Torture and Other Potentially Traumatic Events With Mental Health Outcomes Among Populations Exposed to Mass Conflict and Displacement. *Journal of the American Medical Association*, August 2009. Turrini G et al. Common mental disorders in asylum seekers and refugees: umbrella review of prevalence and intervention studies *Int J Ment Health Syst* (2017) 11:51.

[3] For example, Turrini G et al. Common mental disorders in asylum seekers and refugees: umbrella review of prevalence and intervention studies Int J Ment Health Syst (2017) 11:51.

[4] Hollander, Anna-Clara et al. (2016) Refugee migration and risk of schizophrenia and other non-affective psychoses: cohort study of 1.3 million people in Sweden. *BMJ* (2016) 352.

[5] Porter, M., & Haslam, N. (2005). Predisplacement and postdisplacement factors associated with mental health of refugees and internally displaced persons: A meta-analysis. *Journal of the American Medical*

- while there is a dearth of epidemiological studies of the mental health of asylum seekers, the available evidence is that rates of PTSD and depression[6] and rates of self harm[7] are many times higher than in the general community.
- the post-arrival stressors most commonly associated with poor mental health include insecure residency status; destitution; experience of discrimination; concerns about family overseas; and prolonged immigration detention[8].

A number of the 'post arrival stressors' which have been found both in Australia and internationally to adversely affect asylum seeker and refugee mental health are directly produced by Australian government law and policy. These include:

- providing for mandatory and indefinite immigration detention for all people arriving in Australia without visas – the adverse mental health consequences of immigration detention for asylum seekers is established unequivocally[9];
- causing asylum seekers who arrived by boat to be eligible for temporary protection visas only, ensuring ongoing insecure residency;
- preventing temporary protection visa holders (the residency status of many thousands of successful asylum seekers who arrived by boat) from bringing family to Australia;
- inadequate material support for asylum seekers including removal of work rights and any source of income support for some bridging visa holders (there are currently about 6,800 asylum seekers in Victoria who arrived by boat who hold bridging visas[10]);

Association, 294, 602−612. Fredrick Lindencrona et al. 2008, Mental Health of recently resettled refugees from the middle east in Sweden. *Soc Psychiatry and Psychiatric Epidemiology.* 43:121-131

[6] An unpublished current study of a representative sample of asylum seekers in NSW found that nearly half of the cohort had probable depression and over a quarter suffered probable PTSD: The Sydney ReAssure Study, Steel Z et al. (UNSW). Turrini G et al. Common mental disorders in asylum seekers and refugees: umbrella review of prevalence and intervention studies *Int J Ment Health Syst* (2017) 11:51.

[7] See Hedrick, K et al (2019, under review) *SSM – Population Health.* This research, based on self-harm incidents reported to the Department of Immigration and Border Protection in the 12-months to 31st July 2015, found that self-harm episode rates among asylum seekers in community-based arrangements were four times the Australian community rates for hospital-treated self-harm and self harm rates for asylum seekers living in the community under community detention arrangements were 22 times the Australian community rates. Rates of self-harm for people in immigration detention facilities were many times higher again.

[8] Edith Montgomery, (2008) Long term effects of organized violence on young Middle Eastern refugees' mental health *Social Science and Medicine* 67 1596-1603; Steel J et al. The Psychological Consequences of Pre-Emigration Trauma and Post-Migration Stress in Refugees and Immigrants from Africa *J Immigrant Minority Health* (2017) 19:523–532.

[9] For a recent review: von Werthern M et al. The impact of immigration detention on mental health: a systematic review *BMC Psychiatry* (2018) 18:382 https://doi.org/10.1186/s12888-018-1945-y.

[10] Department of Home Affairs, Illegal Maritime Arrivals on Bridging E Visa, 31 March 2019.

- the creation over two decades of a divisive public debate over asylum seeker policy which has created antagonism toward people seeking asylum in some sections of the community.

The effect of poor mental health among asylum seekers has immediate and long term consequences. When an asylum seeker is mentally unwell, the demands of the protection visa application process are made even more daunting and the likelihood of an unfair outcome is increased because the applicant's ability to articulate their claims is compromised[11]. In the longer term the capacity of the successful applicant to adapt and integrate into the Australian community is made considerably more challenging by a lack of psychological well-being. Mental health clinicians who work with refugees are familiar with people who arrived in Australia to seek asylum, who were detained for extended periods, endured a protracted visa application process, lived in poverty in the community, were separated from family for many years or lost contact entirely, and who now suffer severe and chronic posttraumatic or other mental health conditions that rob them of a decent quality of life.

Shortcomings in mental health service delivery to asylum seekers and refugees

Some asylum seekers and refugees receive expert and compassionate care in the mental health system. However in my experience the standard of care is very uneven. The reasons for this fall into three categories: lack of knowledge among treating staff; difficulty altering the circumstances adversely affecting mental health; and lack of access to services.

Most mental health clinicians do not have a good understanding of the circumstances of asylum seekers and refugees. Many are unaware of the stressors they are enduring. While asylum seekers and refugees suffer from the same range of mental disorders as the general population, their presentations are often shaped by posttraumatic symptoms and reactions to current stressors; few public mental health clinicians have specific training in treating these presentations.

[11] The UNHCR has been concerned about the affect of asylum seekers' mental health on the fairness of the protection visa application process in the context of current Australian practice. As a consequence they produced guidelines to assist refugee status decision makers: See https://www.unhcr.org/publications/legal/5a127e907/guidance-note-on-the-psychologically-vulnerable-applicant-in-the-protection.html

Clinicians can often, understandably, feel helpless in the face of refugees' psychological difficulties because they are unable to alter what has precipitated and maintains them. Sometimes this results in minimising and under-diagnosing the difficulties – the patient might be seen as primarily presenting with a vulnerable personality or suffering from an 'Adjustment Disorder' - a condition which is situationally driven and which might be considered not amenable to treatment. However clinicians who are experienced in assisting refugees know that valuable mental health assistance can be rendered to asylum seekers and refugees even when their circumstances are dire.

It can be daunting and demoralising nonetheless for mental health clinicians to work with clients whose mental health is being devastated by their circumstances. Their ability to provide effective treatment is increased if they work together with services advocating for improvements in the client's situation, whether that involves material aid, resolution of residency status, assisting contact with family or ameliorating one of the myriad other possible sources of asylum seekers' distress. Currently the coordination between public mental health providers and refugee legal, advocacy and support groups is not strong.

Asylum seekers and refugees can lack access to mental health services for a range of reasons. Posttraumatic conditions, even when causing the same level of debilitation and distress as other severe mental disorders, may not be seen as primarily the responsibility of the public mental health system. When severe trauma has been experienced developmentally, it may manifest as a personality disorder, including Borderline Personality Disorder. Few public mental health facilities have specialist programs and clinicians trained in the treatment of this condition.

Adding to the difficulty in gaining access to treatment is a view that psychologically based treatments are either not culturally appropriate for people of non-western background or not effective if delivered with the assistance of an interpreter. It is difficult to ascertain how widespread such beliefs are, but the research evidence and clinical experience strongly contradicts them[12].

With respect to the provision of psychological treatment to asylum seekers and refugees through Medicare ('Better Access') or Primary Health Network funded services, there

[12] There is a large literature; for example, Turrini G et al (2019). Efficacy and acceptability of psychosocial interventions in asylum seekers and refugees: systematic review and meta-analysis. *Epidemiology and Psychiatric Sciences* 1–13. https://doi.org/10.1017/S2045796019000027

are two barriers to access. A subgroup of asylum seekers in the community are ineligible for Medicare services and rely on public hospitals and some community health centres for medical services. Secondly, under these funding arrangements for psychological services there are limited or no interpreting services available (this is discussed further below in relation to non-English speakers generally). Another issue of access in the private sector involves the coordination of the services needed for people with complex and multiple needs. Asylum seekers and refugees, not dissimilar to other populations with raised prevalence of posttraumatic conditions (for example veterans) often have other concurrent mental disorders, medical conditions affecting mental state, family and social problems, and vocational training needs. A treatment plan involving an individual psychologist in private practice will often not provide the coverage of treatment and the set of medical, psychological and psychosocial interventions required for optimum outcomes. Furthermore, ten or twelve individual sessions will usually not be anywhere near adequate to provide psychological treatment to a refugee with a chronic post-traumatic condition.

2. The mental health care of young asylum seekers, refugees and non-citizens in the correctional system

The observations made in this section are derived from my experience in conducting forensic psychological assessments of asylum seekers and refugees for the courts and providing legal representation for asylum seekers and refugees whose visas have been cancelled due to their offending.

Children from CALD backgrounds, including some refugee communities, are substantially overrepresented in the youth justice centre population[13]. For those who are non-citizens, their passage through the criminal justice system may diverge markedly from that of children who are citizens even though the same sentencing principles apply to them. The overarching principle in sentencing children and young people is rehabilitation; the approach is enshrined in legislation[14] and has been unequivocally endorsed by the judiciary:

[T]he primacy of rehabilitation in the sentencing of young offenders is well established, both at common law and by the principles of the *CYFA*…

…

[13] A recent survey found that 39% of the Victorian youth justice centre (custodial) population comprised children and young people of CALD background: Sentencing Advisory Council, June 2019, 'Cross Over Kids, Vulnerable Children in the Youth Justice System', report 1, p 44.

[14] Section 362(1) of the *Children, Youth and Families Act (2005).*

> [t]he statutory framework for juvenile justice compels the court sentencing a young offender (almost always the Children's Court) to adopt the offender-centred (or 'welfare') approach, rather than the 'justice' or 'punishment' approach... just as importantly, this strong legislative policy is well supported by the extensive research into adolescent development conducted over the past 30 years[15]

The sentencing of child offenders is consequently governed by considerations including preservation of family relationships, furtherance of education and minimisation of the stigma associated with a criminal sentence[16].

The fate of an asylum seeker or refugee child or young adult or indeed any non-citizen who is charged with a criminal offence is determined, however, by the interaction of Victorian criminal law and the *Migration Act 1958* (the 'Migration Act'). The provisions of the Migration Act that come into play are those providing for the cancellation of bridging visas[17] on the basis of criminal charges (s 116) and cancellation of substantive visas (including temporary and permanent protection visas) upon conviction for a criminal offence (s 501). The interaction of state criminal and Commonwealth migration law leads to a range of trajectories for young offenders who are non-citizens. There are many permutations but the following examples are illustrative – all are drawn from cases I have worked on directly or of which I am aware[18].

Scenario 1 – an asylum seeker's bridging visa cancellation upon charges being laid, immigration detention, charges dropped and release into the community
A mentally unwell young adult asylum seeker is charged with an offence. His bridging visa is cancelled and he is therefore by operation of law placed in immigration detention. After some months the charges are withdrawn on the application of the police informant owing to deficiencies in the evidence. The asylum seeker remains in immigration detention for more months until the Minister for Immigration grants a bridging visa[19] and after nearly a year of detention he again lives in the community. While held in immigration detention his mental health deteriorates. He is exposed to violence and witnesses suicide attempts. While detained he is not able to obtain treatment from the public mental health facility he normally attends. He suffers from a

[15] *Bradley Webster (a pseudonym) v The Queen* [2016] VSCA 66 (Maxwell P and Redlich JA) at [9] and [28].
[16] Section 362(1) of the *Children, Youth and Families Act (2005)*
[17] Bridging visas are held by people who are waiting for the outcome of a visa application for a substantive visa (that is, a visa allowing the person to remain for a fixed period or permanently in Australia) and allow them to live lawfully in the community while this occurs.
[18] Identifying details have been removed; some facts have been changed in order to anonymise the scenario.
[19] The Minister for Immigration has a discretionary power under s195A of the Migration Act to grant a visa. There is no timeframe as to when the visa grant may occur. If the asylum seeker arrived in Australia without a visa he or she will be unable to apply for a bridging visa while in immigration detention.

complex posttraumatic condition and depression and there are no specialised treatment services available for these conditions while he is in immigration detention. When released his mental health has deteriorated to the point where his ability to engage with his lawyer and participate in the protection visa application process are significantly compromised.

Scenario 2 – a child asylum seeker is charged, bridging visa cancelled, remanded, Children's Court custodial sentence, upon completion of sentence indefinite immigration detention, refusal of protection visa on character grounds

A child asylum seeker arrives in Australia with his family. He had lived for years in the midst of a civil war and was profoundly traumatised. He suffers from complex PTSD that includes severe dissociative symptoms, unstable mood, intense labile emotion in response to stressors and periodic self-harm and suicidality. When 16 years old he is charged with a serious offence. His bridging visa is cancelled and he is remanded in a youth justice centre. An application for bail is not a viable option because if successful it would lead to him being detained in immigration detention – without a bridging visa his detention is mandatory. While remanded he receives psychological counselling, pharmacotherapy and psychiatric review but no specialist services for his complex needs are available. During remand he is physically and sexually assaulted. The Children's Court sentences him to a term of detention in a youth justice centre. The Court finds that the offending occurred in the context of severe mental health problems and that a rehabilitative disposition including extended specialised psychological treatment is appropriate. He serves a term in a youth justice centre during which he receives further counselling, support and pharmacotherapy which he finds helpful but which are not specialised interventions tailored to his specific needs. Upon the expiration of his sentence he is placed in immigration detention. He is found to be a refugee but a protection visa is refused on character grounds. His emotional lability, severe dissociative symptoms and periodic self-harm are difficult for the immigration centres to manage. He is also vulnerable to mistreatment by older detainees. He is moved between detention centres, including for an extended period in another state and away from his family. On a number of occasions he is held in seclusion rooms as an attempt to contain his agitated and disruptive behaviour. He is held in protection units to remove him from other detainees who pose a risk to him. He receives psychiatric reviews and some intermittent counselling while in immigration detention but no treatment specific to his needs. On a number of occasions he alleges that he has been physically and sexually assaulted. His protection visa application remains on foot.

He is now a young adult held in indefinite immigration detention. Of the nearly five and a half years since arriving in Australia as a traumatised child asylum seeker he has spent four and a half years in immigration detention or youth justice centre detention (the majority in immigration detention) and one year in the community.

Scenario 3 – child refugee resettled in Australia with a permanent visa. Youth offending resulting in cancellation of visa, youth detention and then adult prison

A late primary school aged child refugee resettles in Australia with his family. He and his family were displaced due to civil war and then spent a number of years in a refugee camp. He had received no formal education prior to arriving in Australia. He acquires English slowly and seems distractible in class. In mid secondary school he becomes disruptive in class; his literacy and numeracy are two to three years beneath his year level. He receives psychological assessment regarding his learning ability but although post-traumatic symptoms and family conflict are noted to be contributing to his learning difficulties he receives no formal interventions. He begins using substances at 14 years old. From the age of 15 years he begins committing multiple gang related crimes involving theft, armed robbery and home invasion.
He is sentenced to his first term of youth detention when 16 years old. When remanded a psychological assessment notes that he suffers problems with unstable mood, intense labile affect, identity confusion, attention deficits, and stimulant related substance abuse. He receives counselling while remanded and some mood stabilising medication, the first treatment he has received. He is refused bail. While in youth detention he is assaulted, on one occasion causing him to lose consciousness, and he assaults others. Disruptive behaviour while in detention leads to him being confined to his cell for 23 hours a day for three weeks. Further charges are laid and, having turned 18, he is transferred to an adult prison. In adult prison he is confined to his room for 23 hours a day for a number of weeks, although he says he prefers not to leave his cell at all because he doesn't feel safe. He describes a deterioration in his mental state while secluded including more intense memories of traumatic events from his childhood. While serving his sentence in adult prison he is not receiving any mental health care. Owing to the gravity of the offending he will face mandatory visa cancellation and indefinite immigration detention upon the completion of his sentence. The instability in his country of origin is likely to make repatriation impossible and therefore a very extended period in immigration detention is likely.

Scenario 4 A young adult non-citizen – a child migrant, he arrived in Australia as an infant. Early childhood neglect and abuse. Parents separated when an infant and left in care of severely mentally unwell mother. Placed in foster care where abused. Offending from mid adolescence. Mentally unwell from late adolescence. Visa cancellation in early adulthood.

The young adult has never applied for citizenship. He is diagnosed with schizophrenia and borderline personality disorder when 19 years old but has only received intermittent treatment for his condition at the time he is remanded when 21 years old. He receives a mandatory visa cancellation after he is given a 14 month custodial sentence – he had previously received many non-custodial sentences. He is not granted parole because he cannot re-enter the community without a visa. Upon completion of his sentence he faces many months or years of immigration detention while legal appeals are finalised. He requires treatment for his complex set of mental disorders. In prison he has received medication for his psychotic illness but no psychological treatment. In immigration detention his treatment is likely to be less comprehensive still. Forensic psychological reports tendered during his sentencing indicated a need for thorough ongoing treatment involving pharmacotherapy for his psychosis and mood instability; psychotherapy for complex developmental trauma and to assist the management of recurrent psychotic symptoms; treatment for substance addiction; case management; and vocational training.

These scenarios are in my opinion illustrative of the pathways through the corrections and migration systems of non-citizen and mentally unwell young offenders. The consequence of the interaction of Commonwealth migration law and policy and State criminal law is that rehabilitative objectives in the sentencing of children and young adults are defeated. Instead of receiving bail, parole and the benefits of community corrections orders, all of which are likely to be accompanied by mental health treatment and rehabilitation, the young non-citizen is held in remand, custody without parole and immigration detention. For all young people, but particularly asylum seekers, refugees and people with traumatic histories, treatment within custody is inferior to what can be achieved in the community due to the narrower range of services available and the adverse psychological effects of the custodial environment. Service providers working with young asylum seekers and refugees are aware that custody often causes mental health deterioration rather than rehabilitation. Experiencing physical assault and witnessing violence to others, exposure to anti-social attitudes and the use of extended seclusion as a management measure are conditions which preclude a traumatised young

person's recovery. When, following a custodial sentence, a young person is held in immigration detention rather than the community under parole or a community corrections order, they are placed in a second environment which is antithetical to recovery. An environment which we know is unequivocally associated with mental health deterioration over time, takes the place of what a court would normally envisage for a young offender - a community setting in which the young person can start to regain their mental equilibrium through comprehensive mental health care, education, vocational training and the support of family and friends.

In summary, the modern humane societal approach to young offenders, as enshrined in the *Children, Youth and Families Act (2005)*, is frustrated by Commonwealth migration law and policy. The range of non-custodial and pre and post custodial rehabilitative community dispositions available to the Courts are in practice often unable to be accessed by the non-citizen offender. The sentencing objectives for young offenders directed to, to the extent possible[20], preserving family relations, avoiding criminalisation, minimising disruption to education, improving the offender's well-being and addressing the causes of the offending are thwarted when migration law pursues its own grounds for imposing detention. For the mentally unwell non-citizen charged with or serving a criminal sentence, one of many consequences is that they are less like to receive adequate treatment and care and their condition is likely to be exacerbated.

3. The mental health care of people with post-traumatic conditions

Post-traumatic conditions are elevated in populations that have increased levels of exposure to potentially traumatising events – for instance refugees, veterans and victims of crime. Violence and sexual abuse in childhood and extended trauma during adulthood can give rise to complex post-traumatic presentations which the new diagnostic category of 'Complex Posttraumatic Stress Disorder' in the yet to be finalised ICD 11 (World Health Organisation) taxonomy of mental disorders aims to capture. In addition to the PTSD symptom clusters, the diagnosis describes so-called 'disorders of self organisation' – negative self-concept, disturbances in relationships and affective dysregulation.

[20] The rehabilitative dimension to sentencing, particularly in relation to more serious offences, is balanced with the need for community protection: s 362, *Children, Youth and Families Act (2005).*

The majority of people experiencing PTSD experience concurrent disorders and conditions – one or more of depression, other anxiety disorders [21], substance use[22]and increased rates of suicidality[23]. Rates of PTSD have been found to be elevated in people suffering bipolar disorder[24] and psychoses[25]. These comorbid conditions cannot be separated from the post-traumatic symptoms and need simultaneous treatment. The sequencing of interventions and how each condition may pose challenges for the treatment of the other, is a subject which is currently given much research attention.

PTSD had been found to be a common disorder experienced by patients in primary care settings; for example a US study found almost one-quarter of patients met the criteria for current PTSD and one-third met the criteria for lifetime PTSD, although only 11% were diagnosed in medical records[26]. As described, rates of PTSD are markedly elevated in many cohorts of refugees and somewhat elevated among people with major mental illnesses. There is reason to believe that post-traumatic conditions are under-identified and undertreated in public mental health facilities[27]. There are a number of reasons for this. Psychoses and major affective disorders tend to be the diagnoses receiving the most clinical attention. Secondly, these facilities are oriented toward pharmacotherapy and case management as the first line of treatment and care whereas the evidence based first line treatments for PTSD are various forms of trauma focused psychological treatments[28]. Few mental health clinicians are specifically trained in these treatments.

---

[21] Nickerson et al. Comorbidity of Posttraumatic Stress Disorder and Depression in Tortured, Treatment-Seeking Refugees *Journal of Traumatic Stress* August 2017, *30,* 409–415. Haagen, J. F et al. (2016) Predicting post-traumatic stress disorder treatment response in refugees: Multilevel analysis. *British Journal of Clinical Psychology*, *56*, 69–83. https://doi.org/10.1111/bjc.12121.

[22] Berenz, E at al. Posttraumatic stress disorder and alcohol dependence: Epidemiology and order of onset. *Psychological Trauma: Theory, Research, Practice, and Policy. Vol.9(4), 2017, pp. 485-492*

[23] Afzali, M et al. Trauma characteristics, post-traumatic symptoms, psychiatric disorders and suicidal behaviours: Results from the 2007 Australian National Survey of Mental Health and Wellbeing. *Australian and New Zealand Journal of Psychiatry*. Vol.51(11), 2017, pp. 1142-1151.

[24] Madhavi, R et al. Bipolar I disorder with comorbid PTSD: Demographic and clinical correlates in a sample of hospitalized patients. *Comprehensive Psychiatry*. Vol.72 2017, pp. 13-17.

[25] Grubaugh A et al. Trauma exposure and posttraumatic stress disorder in adults with severe mental illness: A critical review. *Clinical Psychology Review* 31 (2011) 883–899.

[26] Liebschutz J el al . PTSD in urban primary care: high prevalence and low physician recognition. *J Gen Intern Med*. 2007 Jun;22(6):719-26. Epub 2007 Mar 10.

[27] This has been identified as an issue in public mental health services internationally: see Grubaugh A et al. Trauma exposure and posttraumatic stress disorder in adults with severe mental illness: A critical review. *Clinical Psychology Review* 31 (2011) 883–899.

[28] For example: The Australian Guidelines for the Treatment of Acute Stress Disorder and Posttraumatic Stress Disorder. Phoenix Australia –Centre for Posttraumatic Mental Health 2013.

With regard to complex post-traumatic presentations, where the disorder manifests as Borderline Personality Disorder, there is a specialist state wide public facility[29] but the area mental health services have little, or are only just now beginning to acquire, the capacity to deliver systematic evidence based treatments for this condition.

Currently there is an inequitable distribution of specialist services for the treatment of post-traumatic mental health disorders in Victoria. There is one public hospital that treats veterans, police, emergency service personnel and people whose conditions are compensable (due to having been precipitated by an event, such as a workplace injury or road accident for which there is statutory coverage of medical costs)[30]. There are, to my knowledge, a small number of private clinics which provide programs for sufferers of PTSD which can assist people with private medical insurance[31]. When the condition is particularly complex, when the person presents periodic significant risk to themselves, or where there is a comorbid major mental illness a private practitioner is unlikely to be able to provide the range of services that the client needs. In my view public mental health facilities should be able to provide expert mental health care for this group. This may be achieved through more thorough screening for post-traumatic conditions, ensuring a subgroup of staff within each area mental health service has specialist training in the treatment of PTSD, and establishing formal programs in the network of mental health services within which sufferers of PTSD who do not have private insurance or eligibility for compensable treatment can receive comprehensive care.

Part of the suite of care available should be an inpatient facility specifically designed to treat post-traumatic conditions. A subgroup of people with severe PTSD requires a safe, therapeutic inpatient environment at certain phases of their treatment; such an environment is not provided by acute psychiatric inpatient units and is not currently available in any other setting[32].

[29] Spectrum Personality Disorder Service.
[30] The Psychological Trauma Recovery Service, The Austin Hospital.
[31] For example, The Albert Road Clinic.
[32] The Psychological Trauma Recovery Service, The Austin Hospital, provides inpatient services for eligible people but not to the general community.

4. Access to private sector psychological treatment by people of non-English speaking background

Private providers delivering Medicare (better access) and Primary Health Network funded psychological treatment have limited or no access to interpreters. These services are unavailable for people - primarily migrants and refugees but also some indigenous people - who are not fluent in English. The only way the service might be delivered to these groups is if there is a provider who speaks the language of the client; access to a provider with the linguistic and therapeutic skills matched to the client's needs is in most cases unavailable.

This arrangement, involving a very large allocation of public funds for community healthcare, should be regarded as discriminatory and unconscionable.

I have described the need for more strongly coordinated multidisciplinary plans of care involving a range of practitioners each of whom takes responsibility for a specific area of care. However access to onsite interpreters is a precondition for assisting people who are not fluent in English (or who prefer to speak in their mother tongue when engaging in psychological treatment).

Beyond basic equitable principles, there are a number of considerations that should inform policy with regard to access to interpreters by private practitioners. In psychotherapy of any depth an interpreter becomes integral to the therapeutic relationship and the success of the treatment. It is often very important to engage the same interpreter or a limited number of interpreters when working with trauma survivors or indeed when any exploratory psychological work is being undertaken. Employing a phone interpreter is an arrangement which is usually entirely inadequate to the task. Even for those who have acquired reasonable fluency in English, I have found that many clients prefer to speak in their mother tongue because they are able to express themselves with greater ease and nuance and feel that they are fully in contact with their emotions rather than, when speaking in English, observing their emotions 'from the outside'. They feel, in other words, even when bilingual, that their mother tongue remains the language of their emotional life and of their own self.

It may be that the current situation could be slightly ameliorated by encouraging more bilingual practitioners with the requisite community languages to become part of primary health networks and for geographical barriers to be overcome by increased use of teleconferencing facilities. However these arrangements, while worthwhile, will not

address the larger issue of equitable access. In this regard I should also note that in my experience there is not an insignificant number of migrants and refugees, especially from smaller or emerging communities, who, for reasons of perceived confidentiality, wish to receive treatment from a clinician from outside their own community.

5. The capacity of public mental health services to deliver evidenced based psychological treatments

National guidelines require that '[t]reatment and support provided by the MHS [mental health service] reflects best available evidence and emphasises early intervention and positive outcomes for consumers and their carer(s)'[33]. The National Mental Health Strategy and codes of professional conduct require practice to be evidence based. Clinicians now have available to them an extensive set of treatment guidelines produced both in Australia and internationally. The evidence for the effectiveness of particular treatments and interventions is typically organised according to a hierarchy ranging from high grade evidence offered by a systematic review of randomised control trials to low grade evidence provided by a case series with pretest/posttest outcomes. High level evidence for the effectiveness of a treatment provides the clinician with some assurance that on a population level the intervention will assist clients with a particular mental disorder. However good clinical practice never involves the unreflective application of the treatment to the disorder; the client's specific preferences, cultural beliefs, psychological characteristics and capacities, and social circumstances lead the competent clinician to make choices between different effective treatments and to tailor the chosen treatment to the specific needs of the client.

Like all treatments for complex mental health conditions, the provision of effective psychological treatments requires considerable training and experience. It is also labour intensive and time consuming. In relation to psychological treatments, in my experience public mental health services have never had staff profiles or funding to provide what evidence based treatment guidelines indicate should be provided. There is in fact a chasm between treatment guidelines' recommendations and clinical practice with respect to psychological treatment.

This point can best be made by example. The treatment guidelines for treating depressive disorders produced by the Australian Psychological Society and the Royal

[33] National standards for mental health services 2010; Standard 10, Delivery of Care.

Australian and New Zealand College of Psychiatrists recommend psychological treatments for this disorder. The APS guidelines indicate there is level 1 evidence for a number of treatments including Cognitive Behavioural Therapy and Interpersonal Therapy. Both guidelines indicate that for moderate to severe depression combined psychological and pharmacotherapy is more effective than either treatment alone. The RANZCP guidelines state that '[f]or most patients with depression, a combined treatment approach is more effective than either psychological or antidepressant treatment alone. This applies particularly to depression of moderate or greater severity … and chronic depression'[34]. The recommendations guiding treatment of depression in the UK are similar: the NICE guideline indicates that high intensity psychological interventions[35] combined with pharmacotherapy is the treatment of choice for persistent subthreshold depressive symptoms, mild to moderate depression with inadequate response to initial interventions, and moderate and severe depression[36].

It is unlikely in my experience that even a sizeable minority of people suffering a major depressive disorder who attend a public mental health service are receiving a recommended psychotherapy.

Treatment guidelines allocate a role for psychological treatments for all mental disorders suffered by people attending public mental health services. The role will vary according to the mental disorder and the person's specific needs. Treatment guidelines indicate psychological interventions as first line treatments for PTSD, some anxiety disorders, mild to moderate depressive disorders and borderline and other personality disorders; as first line treatment in combination with pharmacotherapy for moderate and severe depressive disorders; as useful in relapse prevention for bipolar disorders and as an adjunctive treatment during the acute depressive phase of the illness; and as an important element in the treatment of schizophrenic disorders in relation to treatment resistant positive symptoms and in rehabilitation and relapse prevention.

I believe a survey of past and current practice would find that the delivery of psychological treatments in public mental health facilities is not aligned with best practice treatment approaches and in fact falls far short of them. Psychological treatments should be an integral and ubiquitous feature of public mental health treatment plans and the treatments should be delivered by suitably qualified and

[34] Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines for mood disorders, Australian and New Zealand Journal of Psychiatry 2015, Vol. 49(12) 1-185, 41

[35] The NICE guideline describes high intensity psychological interventions as involving 16 to 20 sessions over 3 or 4 months with follow-up sessions.

[36] National Institute for Clinical and Care Excellence, Depression in adults: recognition and management. Clinical guideline published 28 October 2009.

experienced clinicians.

6. The quality of rehabilitation services for people with chronic mental illnesses

I do not have particular expertise in this area but I wish to make a few comments based on an all too frequent observation: that people recover from the acute phase of severe mental illness but are then unable to recover purposeful and satisfying lives. There are many reasons for this, I will focus on just two – the persistence of inadequately treated cognitive impairments and the inadequacy of vocational training and placement.

All major mental illnesses cause cognitive impairment. In my experience people suffering from a range of disorders, mood and anxiety disorders, PTSD and psychotic disorders will often indicate that attention problems, and impairment in recollection of daily events and retrieval of autobiographical memories are among the most debilitating experiences associated with their mental illness. Even when the disorder is in remission, in disorders such as schizophrenia, major depressive disorder and PTSD, there is evidence that cognitive impairment persists[37]. In my experience cognitive impairment is rarely a focus of clinical attention. Most mental health clinicians have limited skills in the remediation of cognitive impairment. Neuropsychologists who are experts in cognitive disorders, are usually not employed in public mental health services nor at non government psychiatric rehabilitation and support services and are generally difficult to access. Their skills are not confined to explaining neuropsychological consequences of brain disorders; they can also provide expert assistance in the management and rehabilitation of the cognitive effects of functional disorders. Recovery goals for people with chronic mental illness should include specific interventions to improve cognitive functioning; neuropsychologists and other clinicians with relevant skills such as occupational therapists should make substantial contributions to the implementation and delivery of this phase of treatment. Mental health services should employ or have direct access to clinicians with specialist knowledge of the remediation of cognitive abilities in people with major mental illnesses.

An indispensable element in rehabilitation is the person's ideas about how they would like to improve the quality of their daily lives and what set of activities would have value

[37] For example depression in remission: Bora E, Harrison BJ, Yucel M, et al. (2013) Cognitive impairment in euthymic major depressive disorder: A meta-analysis. *Psychological Medicine* 43: 2017–2026.

and meaning to them. Assisting the person define what this life looks like and what the barriers are to realizing it should be integral to rehabilitation. When the person's goals are to find paid employment or a voluntary activity that is meaningful to them, employment services or non-government rehabilitation services are often involved in assisting the client. Often the knowledge about the person held by the mental health service and the vocational assistance provided by the employment service or NGO is not well integrated. It is my experience that many mentally ill people who have spent extended periods out of the workforce find the attempt to regain employment a frustrating and demoralizing experience. They have told me that they would benefit from pre-vocational training but this has not been available. They have also said they would be assisted by a graduated re-entry into employment, commencing with part-time work and ongoing assistance from a person whose role it is to provide practical support in the transition back to work, but this does not happen.

Many people who have suffered from a mental illness in my experience feel abandoned at the point when they attempt to move back into a fuller life involving work or study. How people with severe mental illnesses are assisted back into the workforce and to engage in the broader life of their community needs to be rethought.

7. Concluding remarks

Mental health services can be viewed from many perspectives. It is true to say that within the current system good practices co-exist with those that are neglectful and inattentive to the mentally ill person's needs. I have attempted to describe some of the latter practises.

If the Commission would be assisted by further comment on any of the areas outlined in this submission, I would welcome the opportunity to do so by means of oral or additional written evidence.

Guy Coffey

5 July 2019