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Submission to the Senate Select Committee on Mental Health

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Contents

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Introduction

The Public Interest Advocacy Centre

The Public Interest Advocacy Centre ('**PIAC**') is an independent, non-profit legal and policy centre located in Sydney. Its charter is:

> To undertake strategic legal and policy interventions in public interest matters in order to foster a fair, just and democratic society and empower citizens, consumers and communities.

Established in July 1982 as an initiative of the Law Foundation of New South Wales, PIAC was the first, and remains the only, broadly based public interest legal centre in Australia. Although located in New South Wales, the work PIAC does is often of national interest or importance or has consequences beyond state boundaries.

PIAC's work extends beyond the interests and rights of individuals; it specialises in working on issues that have systemic impact. PIAC's clients and constituencies are primarily those with least access to economic, social and legal resources and opportunities. PIAC provides its services for free or at minimal cost.

PIAC's experience in the area of mental health

PIAC main experience of working for people experiencing mental illness is through the Homeless Person's Legal Service ('**HPLS**') and PIAC's litigation.

In 2003, following an extensive consultation process, PIAC and the Public Interest Law Clearing House ('**PILCH**') established the Homeless Persons' Legal Service. HPLS is currently operating with funding support from the Commonwealth Department of Family and Community Services under the National Homeless Strategy and the Public Purpose Fund administered by the New South Wales Attorney General's Department.

HPLS provides free legal advice and ongoing representation to people who are homeless or at risk of homelessness. It operates clinics, on a roster basis, at six welfare agencies in the inner city of Sydney and Parramatta. These are agencies that provide direct services, such as food and accommodation, to people in housing crisis. The clinics are co-ordinated by HPLS and staffed by lawyers from law firms that are members of PILCH. Since the launch of HPLS in May 2004 it has provided advice to over 350 clients.

The Legislative Council of NSW in its report Mental Health Services in NSW estimates that up to fifty percent of homeless people have a mental illness. HPLS's experience has borne that out. HPLS clients who have a mental illness generally have moderate to acute mental illness, although we acknowledge that individuals with the most acute mental illness probably do not access our service.

PIAC has acted in a range of matters that relate to mental illness including;

- court actions to obtain the release from migration detention of people with mental illness;
- Coronial Inquests on behalf of the families of people with mental illness who have died and of people who have died as a consequence of the actions of people with mental illness; and

- complaints of unlawful discrimination against people with mental illness.

PIAC was also a key legal participant in the Royal Commission into Deep Sleep Therapy ('**the Chelmsford Inquiry**'), The Chelmsford Inquiry focused on the use of deep sleep therapy to treat patients with mental illnesses at Chelmsford Private Hospital in Sydney. PIAC represented a number of relatives of deceased patients, a former patient, a number of former Chelmsford nursing staff, a former member of the Complaints Unit and the Citizens Commission on Human Rights.

The litigation that PIAC has undertaken has usually been in relation to people experiencing acute mental illness, as opposed to moderate or mild.

Acting for people experiencing mental illness

In PIAC's experience, providing legal services to people experiencing mental illness requires patience, clear language and, most importantly, attention to the individual needs of each client. The provision of legal services is most effective when it is provided in conjunction with health and other support services for clients.

PIAC solicitors undertake careful assessment of each client's ability to instruct and may at times resort to health professionals for assistance. Explaining complex legal issues and rights to people without mental illness can be a complex process. It is important to be aware that while this is true also in relation to some clients with mental illness, PIAC has clients with mental illness who are able to provide clear instructions and have a strong and cogent understanding of their matter and their rights. PIAC has also had clients who were suicidal, did not understand their legal rights and couldn't, at the relevant time, provide instructions. At times PIAC has sought out guardians in order to get instructions.

Legal disputes invariably take considerable time to be resolved and require at times substantial discussion with clients. Therefore, while maintaining contact with clients can be difficult, it is a necessity. PIAC appreciates the difficulties but also the importance of continuity of service provision to ensure that its provision of legal services is effective.

General comment on service provision to people experiencing mental illness

It is self evident that the provision of direct medical, counselling and other support services to people with mental illness is grossly inadequate. Many agencies providing direct services will be too overburdened to contribute to this Inquiry.

However, had those agencies the resources and time to make a submission PIAC is confident that they would have given evidence that housing stability and continuity of mental health services together provide key fundamentals for ensuring that a person is able to move toward improved mental health and away from further risk of incarceration and homelessness.

Terms of reference addressed

In this submission, PIAC addresses the issues that are most striking and arise most often from its experience working for people with mental illness in a legal context. The submission does not address all the terms of reference for the committee but is limited to the following:

b. the adequacy of various modes of care for people experiencing mental illness, in particular, prevention, early intervention, acute care, community care, after hours crisis services and respite care;

c. opportunities for improving co-ordination and delivery of funding and services at all levels of government to ensure appropriate and comprehensive care is provided throughout the episode of care;

d. the appropriate role of the private and non-government sectors;

e. the extent to which unmet need in supported accommodation, employment, family and social support services, is a barrier to better mental health outcomes;

j. the overrepresentation of people experiencing mental illness in the criminal justice system and in custody, the extent to which these environments give rise to mental illness, the adequacy of legislation and processes in protecting their human rights and the use of diversion programs for such people;

m. the proficiency and accountability of agencies, such as housing, employment, law enforcement and general health services, in dealing appropriately with people affected by mental illness;

Summary of Recommendations

Recommendation 1

That the Senate Select Committee urge the Commonwealth Government to work co-operatively with all state and territory governments to immediately increase in the funds available in the Commonwealth/State Housing to a level that adequately reflects the need to redress the appalling levels of homelessness and housing instability experienced by people with mental illnesss.

Recommendation 2

That the Senate Select Committee urge the relevant government departments in the areas of health and housing to work co-operatively and develop cross-referral and support mechanisms to ensure adequate levels of assessment and on-going to support to people with mental illnesses in public housing.

Recommendation 3

That the Senate Select Committee recommend the that, as a matter of urgency, the Commonwealth Government undertake negotiations with state and territory governments to ensure significant increases in funding for:

- specialist mental health support services to crisis accommodation and other agencies that provide services to people who are homeless or at risk of homelessness; and
- community agencies to provide training and ongoing support to their staff to enable staff to better meet the needs of clients with mental illnesses.

Recommendation 4

That the Senate Select Committee recommend the immediate provision of targetted funds in all Commonwealth/State Legal Aid Agreements for broad-focused legal services for people with mental illness. Such services should be available to address the range of legal needs that particularly face people with mental illness and should not be defined in terms of whether the matter is of a commonwealth or state nature.

Modes of care

PIAC has over the past five years been involved in a number of cases where inadequate care has lead to the death of a person with mental illness or a person associated with them. While PIAC does not argue that these situations are commonplace, the issues that are highlighted by analysing them are indicative of systemic failures. From its experience, PIAC's conclusion is that there is inadequate mental health care and that this inadequacy leads to a breakdown in continuity of care and poorer health care outcomes for people with mental illness.

A stark demonstration of this was the death of Jessica Gallacher in January 2000. Jessica was born on 25 October 1995. In January 2000, she was living with her mother and her mother's new boyfriend, William McGarrity. Mr McGarrity was known by a number of agencies to have a mental illness and was considered at times to be a danger to those around him. On 27 January 2000, after Jessica's aunt had contacted local health authorities about her concerns for Jessica's safety, a mental health team and the police attended Jessica's home with the intention of scheduling Mr McGarrity. This did not occur as Mr McGarrity managed to convince the mental health team that he was not a danger to Jessica. Three days later, police attended the home and found Jessica's body. She had been killed by Mr McGarrity.

PIAC represented Jessica's family at the Coronial Inquiry into her death. Coroner Milanovitch was highly critical of the mental health service and, to a lesser extent, of the Department of Community Services for their failures. Most tellingly, the Coroner stated that the failure of systems and inadequate services lead to Jessica's death. The Coroner found that the treating doctor did not have relevant information on the patient and did not have a clear understanding of McGarrity's history of mental illness and his medical condition. The treating doctor was required to assess Mr McGarrity's mental state and make a difficult decision—whether or not to deprive him of his liberty against his will—in a matter of minutes. As it was the doctor's first meeting with Mr McGarrity and he either did not have or did not read relevant information, he was not in a position to make an appropriate assessment and did not.

Significantly the Coroner stated:

> We all know that this was a very tragic death that could have been avoided and there is no doubt the system failed Jessica. And while the actions of William McGarrity will be seen as being abhorrent to any person it must be said that in some ways the system failed him as well, he should never have been in the community at that particular time.

This death was not an isolated occurrence. As Coroner Milanovitch stated:

> I, as Deputy State Coroner, for the last eighteen months have dealt with institution type deaths on regular basis. I know that they have been subject to many comments by my brother and sister Deputy State Coroners and many of the other coroners that serve the New South Wales community.

Jessica Gallacher's death highlighted some of the systemic inadequacies of care about which PIAC is aware through acting for people with mental illness. These inadequacies include:

- inadequate time to make client assessments and decisions;
- lack of resources to provide services to clients;
- lack of referral options (particularly housing options);
- lack of resources for co-ordination; and
- poor information systems.

These inadequacies invariably lead to failures in decisions making and service delivery highlighted by:

- a poor understanding of the client's history;
- a rushed assessment of the client's current condition;
- duplication of services on assessment of clients for services; and
- a desperate scramble for short-term accommodation options.

These are all symptomatic of a system in crisis. PIAC believes that the provision of assistance to people with mental illness is, unfortunately, driven by the turbo of crisis management. Accordingly, services are often provided in a responsive and ad hoc manner with agencies doing the best they can in extreme circumstances. PIAC believes that generally services are limited to people with mental illness in crisis because there are limited resources to provide services more widely. That crisis often arises from the potential for self harm or harm to third parties.

As funding is limited and demand high, resources are spread thinly across agencies. This means that no agency is able to provide a comprehensive and continuous service. This has two results.

The first is that agencies must prioritise client groups, offering intensive services only to clients who are most in need. These clients are often only identified when they are in an acute stage, for example, when they are threatening suicide or assault. So when the agencies provide services, they do so literally at times of crisis, often in similar situations to that confronted by Mr McGarrity's treating doctor, without access to a comprehensive history of the individual and under emergency conditions. As demonstrated by the Gallacher case, such a situation can have tragic consequences.

Secondly, many people who have either mild or moderate needs or people with acute mental illness, but not in immediate risk, will not receive services as they are not a priority client group. However, identifying and monitoring an individual's mental health can prevent them from spiralling into a severe episode of mental illness or from reaching a dangerous condition. Such an approach requires continuity of care. This is largely absent from current service provision as agencies are experiencing large demand and have inadequate resources.

PIAC notes, however, that even where people with mental illness are in danger, the level of care that can be provided to them is often inadequate. One crisis accommodation provider with which HPLS works closely stated that his staff were under constant pressure to keep moving long-term residents through crisis accommodation. He also stated that residents who had been moved sometimes ended up in psychiatric wards of hospitals, but were moved out of them as soon as their condition stabilized, even to the most limited extent. The small number of beds enables the crisis management to stumble along, but there is no capacity with which to seek long-term remedies for individuals. Clients are recycled through the system in a seemingly endless chain from crisis to stability to crisis.

In 2003, the NSW Mental Health Sentinel Events Review Committee ('**the Sentinel Committee**') reviewed the suicides of mental health patients and homicides by people in contact with mental health services. In December 2003, it published *Tracking Tragedy, The First Report of the Sentinel Committee*. It published a second report in March 2005. The Sentinel Committee noted in the executive summary to *Tracking Tragedy*:

> Admission to mental health beds is widely seen as the most effective short-term risk mitigation strategy in high-risk cases. However, anecdotal evidence strongly suggests that on occasions patients are not being admitted, or are being discharged early or without comprehensive follow up, due to an inability to access an available inpatient bed… it is now clear that the bar to

> mental health admission has been raised. In turn this had led to mental health clinicians and Area Health Services having more limited options.
>
> As a result, the risk to the general public is higher, the risk to the patient is higher, the risk to the mental health clinician is higher and the risk to Area Health management being held responsible for not supplying the responsible level of care is also higher.[1]

PIAC agrees with this analysis.

In its second report, the Sentinel Committee noted that the pressure on staff arises from 'the lack of access to a range of treatment resources including health beds'.[2] The Sentinel Committee found that the lack of health beds had a direct impact on the ability of clinicians to perform their duties adequately. It noted:

> Most acute mental health units routinely report 100% occupancy, and clinicians report that emergency access to mental health beds is a constant challenge… Concerned clinicians also report that on occasions patients are not being admitted, or are being discharged prematurely or without comprehensive follow up, due to pressures on access to available inpatient beds.[3]
>
> …
>
> These pressures frequently require clinicians to make intolerably difficult judgments regarding relative risk and relative priority for access to inpatient beds. Where the barrier to receiving inpatient care is very high the limits of clinical judgment mean that clinicians and services will inevitably make errors.'[4]

PIAC sets out below, under 'The role of private and non-government sectors', its comments in relation to non-crisis accommodation.

In summary, care is provided primarily as crisis management. As a result, there is an inability to provide continuity of care, and lack of accommodation with supporting care exacerbates the strain on agencies. Failure to provide continuity of care results in people with mental illness often becoming so unwell that they are unable to maintain their job and housing, and often results in family breakdown. A system that can only provide intervention at a crisis stage results in people with mental illness falling into poverty, social isolation and then becoming incarcerated.

[1] NSW Mental Health Sentinel Events Review Committee, Tracking Tragedy, The First Report of the Sentinel Committee, December 2003, p.vi
[2] NSW Mental Health Sentinel Events Review Committee, Tracking Tradgedy 2 March 2005, p.vii
[3] Ibid at p.vii
[4] Ibid at p.vii

Co-ordination and delivery of funding and services

While improvements could be made to co-ordination within and between agencies, failures in co-ordination and delivery of funded services are secondary issues and could, in many cases, be explained by the pressure on agencies to provide direct client services and the lack of resources to do this let alone to undertake co-ordination and interagency co-operation. The absence or inadequacy of resources remains the primary issue.

People with mental illness receive services from a range of entities. They may receive pension payments, they may live in public housing, they may use employment agencies, and they may access public or private medical services. They may also have legal problems and seek legal services. PIAC and HPLS lawyers see many people with mental illness seeking such services. It is our observation that the interface between these services is often uneven and leads to a ragged transfer of people with mental illness from one service to the next. As a result, continuity of care breaks down and the individual is then reliant on their own resources, which are usually meagre.

To illustrate the impact of poor co-ordination, we offer two examples. The first relates to inter-agency co-ordination. The second to intra-agency.

A breakdown in co-ordinated service delivery between agencies can be as simple as the discharge of a person with mental illness from a hospital with a referral to a health service without a discharge plan and a copy of the assessment of the individual's mental condition for the health service, or can be more complex, as in Brian's case.

Brian's case: housing crisis

Brian had a complex history of mental illness that had been first diagnosed in the 1970s. He became a client of HPLS after his landlord, the Department of Housing, began tenancy termination proceedings against him. The Department was seeking to evict him on the basis of an alleged confrontation at his home.

Brian told HPLS that he had been diagnosed with bi-polar disorder and a personality disorder, he said he also suffered from extreme panic attacks that often resulted in him harming himself. He had been offered his current flat on his release from jail. He had been in custody for five months after bail had been refused. However, the charges were later dismissed with no conviction recorded on the basis that he was mentally disordered at the time of the incident.

Brian said that he had been in his new home for eight months and in that time he had been unable to locate a psychiatrist in the area who would accept him on a bulk-billing basis. He was on a disability support pension. He was known to the local community mental health team, but he and his family stated that the local team had advised that he needed the specialist assistance of a psychiatrist and that they were unable to provide any assistance to him. The only medical care he received was from his general practitioner who had provided some counselling and had advocated on his behalf to the local mental health team and the Department of Housing.

Brian said his mental state had deteriorated significantly since he had moved into the flat and that he frequently felt suicidal. He had asked for a transfer from his current home to an area where he had located a bulk-billing psychiatrist. The Department of Housing denied him the transfer.

The eviction proceedings undertaken by the Department arose from an incident that resulted in the police being called and Brian being scheduled under the *Mental Health Act.* The Consumer, Trader and Tenancy Tribunal found that Brian had breached his tenancy agreement. His tenancy was terminated.

One example of a breakdown within a service is a matter in which PIAC is currently acting for the mother of a young man, Trent Lantry, who on 3 March 2000 hanged himself at Cessnock Correctional Centre. Trent had attention deficit disorder and a history of self-harm while in prison. He had been placed in the Acute Care Management Unit ('**ACMU'**) of Cessnock Correctional Centre on two occasions as he was considered at risk of self-harm. During the second period in this unit, he was reviewed by the risk intervention team, which included a psychologist, a clinical nurse and the manager of ACMU. The team decided to release Trent from ACMU and place him in a cell on his own. Shortly after his release he hanged himself using linen from the bed and a milk crate that was placed under the bed to provide it with support.

At the Coronial Inquiry into Trent's death, John Abernathy, NSW State Coroner, found that 'little was done by way of management planning on Trent Lantry leaving the ACMU'[5], and little information was given to those prison officers responsible for his care after his transfer from ACMU. The failure to design a management plan for continuity of care for Trent reflected a fatalistic and resigned attitude on behalf of the Department of Corrective Services. It seems that he was considered to be difficult and there was little that could be done.

There also seemed to be a willingness to downgrade the level of risk of people with mental illness at the sign of even minimal improvement in their condition. PIAC believes that this attitude is widespread and arises, as noted before, from an inadequacy in high-support accommodation places and, consequently, a requirement to keep individuals moving. In Trent's case though, the reliance by the risk intervention team on Trent's own words in deciding to allocate him to a one-out cell seems particularly misguided.

PIAC does not wish to criticise individual workers. Rather, it observes that, as a result of high demand and limited resources, individual workers are placed in the intolerable position of having to choose to allocate services between the person with mental illness who has the potential for self harm but perhaps not at that moment, and the person with mental illness who is currently manifesting a clear and present risk of self-harm. Once the latter is stabilised they will be moved out of the service and the other, who by that stage may be at crisis point, moved in.

When workers and agencies are faced with such pressures, there is likely to be breakdowns in record keeping, document management and co-ordination. However, these issues are often secondary, as in many cases the care provider will have nowhere to refer the client even if they have the appropriate records.

[5] Inquest into the death in custody of Trent Andrew Lantry, 11 August 2000, page 4.

The role of private and non-government sectors

The private sector is a key, but often, invisible stakeholder in the provision of services to people with mental illness. As mental illness is widespread within the community, the private sector engages with people with mental illness as employees, consumers and patients.

The private sector often provides services by default.

Housing

The unavailability of public housing has resulted in large numbers of people with mental illness obtaining housing through the private housing sector. As a result, private landlords play a key role in providing essential housing to people with mental illnesses. This is far from optimal for a number of reasons.

First, private rents in Sydney are very expensive and absorb a large percentage of even an average income. This places pressure on people with mental illness who are likely to have limited income. This pressure can trigger a health crisis, which will rapidly turn into a housing crisis; evictions often occur during a mental health episode.

Secondly, private landlords may have limited understanding of mental illness and may take action to terminate tenancies on the basis of illness-related conduct or rent arrears. This significantly increases the likelihood of homelessness, prolonged ill health and contact with the criminal justice system. Tenants facing eviction due to rent arrears usually rely on the benevolence of charities to meet rent arrears, but often face ongoing difficulties in the longer term.

Thirdly, tenancy databases, which permit private landlords through real estate agents to list former tenants deemed unsatisfactory, often operate to lock people out of entering the private housing sector in the future.

As a result of the inadequacy of public and private rental, many people with mental illnesses are housed in the unlicensed boarding house sector. It is extremely common that people currently experiencing a severe episode of mental illness to move from boarding house to boarding house and to other crisis accommodation services. However, boarding house owners run their accommodation as a business and often have minimal skills and expertise in mental illness, other than that gained through their exposure on the job. The Australian Bureau of Statistics deems accommodation provided by boarding houses to be so insecure that boarding house residents are placed in the category of homelessness. Despite the crucial role boarding houses play in housing people with chronic mental illnesses, there is almost no government support for boarding house owners or residents.

While the private sector plays a significant role in providing housing, it is increasingly inappropriate and poorly equipped for that role. The fact that it plays such a significant role only highlights the inadequacy of the government response to mental illness.

Medical services

One area in which the private sector plays a key and appropriate role is in the provision of specialist medical services to people with mental illness. Psychiatrists play a major role determining and managing mental health programs for individuals. A psychiatrist who sees a patient regularly and is able to monitor changes in behaviour is often best placed to take preventative action to avoid the

patient experiencing a decline in their mental health. A psychiatrist who is providing regular care plays a critical role in continuity of care.

However it has been the experience of PIAC and HPLS that people experiencing poverty, especially those in receipt of a pension, cannot afford to see psychiatrists and have difficulty accessing, on a bulk-billed basi,s appointments that reflect their health needs. In some cases, this has resulted in appointments once every six weeks for clients with high medical needs. In some areas of Sydney, individuals have in effect no access to a regular psychiatrist. In PIAC's view, this significantly increases the risk of deterioration of mental health, but also the likelihood of contact with the police and involuntary scheduling or imprisonment.

With such limited access to psychiatric care, people with mental illness have become increasingly reliant upon general practitioners. Again this is an unfortunate development as general practitioners are not experts in mental illness and often do not have sufficient training or experience to provide adequate services to these patients. In any event, it is well known that the numbers of general practitioners who bulk bill are decreasing alarmingly.

Unmet need as a barrier to better mental health outcomes

PIAC believes that mental health outcomes can only be improved if secure affordable housing is provided in conjunction with continuity of mental health care. Without the option of long-term, secure and high-support accommodation people with mental illness move between crisis accommodation, the police, courts, hostels, boarding houses, imprisonment and homelessness. This cycle inevitably leads to a deterioration in mental health. Accordingly, PIAC focuses its response in relation to unmet need on the impact of unmet need for supported accommodation.

Crisis accommodation

The Federal Government has failed to invest in the provision of affordable supported and unsupported accommodation and development of affordable housing strategies. As a result, one of the key elements in the provision of accommodation to people with mental illness, the Supported Accommodation and Assistance Program ('**SAAP**'), is unable to meet the needs of its clients. SAAP is currently significantly underfunded with demand on beds far outstripping supply. It is estimated that currently 700 people across Australia every night are turned away from SAAP services.

SAAP is intended to provide transitional support for homeless people to find long-term, affordable housing. A stay at a SAAP service cannot exceed three months. However, as outlined earlier in this submission, for the majority of people with mental illness who are clients of SAAP services, finding affordable housing on a Disability Support Pension or Newstart Allowance in the greater Sydney area is almost impossible, as public housing is limited and private rents unaffordable.

SAAP itself was not specifically established to deal with people with mental illness, but as a large percentage of homeless people have a mental illness, this is one of the core client groups of the SAAP services. Almost one fifth of HPLS clients live in emergency accommodation funded through SAAP. It is HPLS's experience that a consequence of the current underfunding of SAAP services is that agencies cannot afford appropriate levels of staff or access to professional development to assist in dealing with clients with a mental illness. HPLS currently operates legal clinics at five welfare agencies, and these agencies report they have, in some cases, no access to specialist mental health staff. Even those that have a clinician available to attend their service, that availability is inadequate to meet demand and provide quality individual care. The impact of this severe under-funding is that people with mental illness or dual diagnosis (mental illness with another disability, commonly an intellectual disability) are more likely to be denied accommodation in a SAAP service on a discriminatory basis.

As SAAP is transitional, clients of SAAP services must, in the longer term, move elsewhere to live. Private rental is not a long-term option. This makes public housing the only viable option for people with mental illness who are living on Centrelink or low incomes. However, public housing is not problem free.

Public Housing

The first obstacle is obtaining public housing.

Since 1996, the Commonwealth Government has cut its funding contribution to the Commonwealth State Housing Agreement by one quarter. In dollar terms, the cut was $210 million across Australia. While the NSW government has maintained and slightly increased its level of funding under the Agreement, the shortfall in funding has meant that the stock of public housing cannot be increased

sufficiently to meet the demand for it that has risen as a result of the lack of affordable private rental housing stock in Sydney. PIAC notes that increases in maintenance costs place further pressure on the Department of Housing. The end result is a public housing waiting list in excess of 70,000 applicants in NSW.

Public housing is often not appropriate for people experiencing mental illness as it is often high density, and the properties are poorly maintained. This invariably leads to disputes with other tenants and increasingly to eviction. The case study of Brian, outlined above, was an example of an individual who had deteriorating mental health and was evicted due to the manifestations of his illness.

It is PIAC's experience that people with mental illness can maintain tenancies if they are provided with adequate community and health support. While public housing has high rates of tenants who have mental illnesses and it is often the case that the tenant's illness was a key factor in their eligibility for housing, the Department of Housing does not accept that providing mental health services is an integral part of its service.

At the Consumer, Trader and Tenancy Tribunal hearing of Brain's case, the Department of Housing acknowledged that Brian had a complex mental illness and that this was the basis on which he received housing, but that it was for the local mental health team to provide this support. The local mental health team would not provide such support. The Department of Housing would not approve a transfer for Brian to an area where he would have greater access to appropriate and affordable health services. He felt like a prisoner and was extremely distressed as his mental state continued to worsen. Brian is now homeless.

Recent reforms to public housing in New South Wales, including 'acceptable behaviour agreements', have lead to the loss of security of tenure. This will impact most on people with mental illness, and will result in more of them becoming homeless. Every week in the NSW Consumer, Trader and Tenancy Tribunal, tenants are evicted due to their mental illness, whether through rent arrears or other breaches of the tenancy agreement. Once evicted from public housing it is extremely unlikely that they will ever be able to re-enter public housing and there is really no other option available.

Mental health facilities

Psychiatric facilities offer short-term accommodation for individuals suffering episodes of severe mental illness. However, as discussed earlier in this submission, bed shortages are resulting in premature discharges. It is common that people who are homeless are discharged with nowhere to go, and do not receive follow-up care.

Consequences of the failure to meet the need for supported accommodation

The grotesque result of the unmet need in supported accommodation is that prisons are currently used as a place of accommodation for people with mental illness. That said, Trent Lantry's case demonstrates that, once incarcerated, inadequate support is provided and people with mental illness will suffer a decline in their mental health. On release, people with mental illness have minimal financial resources and limited emotional support and will fall back into the cycle of homelessness and arrest. These are all factors that will increase the risk of further involvement with the criminal justice system.

People with mental illness in detention

It is widely acknowledged that people with mental illness are over-represented in the criminal justice system. In NSW, more than fifty percent of prisoners have an intellectual or psychiatric disability. As more and more individuals experiencing mental illnesses are unable to receive ongoing mental health care, it becomes more likely that there will be a deterioration in mental health, and that rather than being noted by appropriate mental health professions, those individuals will come to the notice of people in the community when their behaviour manifests in a violent, threatening or socially inappropriate manner. This is usually conflated with criminality. The Chairman of the NSW Parliamentary Committee on Mental Health Dr Brian Pezzuti has noted:

> Deinstitutionalisation, without adequate community care, has resulted in a new form of institutionalisation: homelessness and imprisonment.

PIAC's experience is that incarceration leads to a considerable decline in mental health. In PIAC's view, it is not possible to effectively treat mental illness is prisons or detention facilities, let alone cases of severe mental illness. Rather, in PIAC's experience, prison officials are focused on security and placement issues. In Trent Lantry's case, the prison authorities showed little concern for his ongoing mental health issues at the time of his discharge from ACMU. Trent's discharge sheet made no mention of management of his mental illness, which was left in his own hands. It focused instead on where he would be housed:

> Mr Lantry has been made particularly aware of inmate development services and how to make contact if needed… He can be housed one or two out as he chooses and negotiates with the wing staff.

Ultimately though, mental health will not improve in detention and so diversionary programs are of key importance. It is therefore even more disheartening when an agency refuses to embrace these options when they are available.

PIAC acted for an Iraqi asylum seeker in seeking release from migration detention as he was suffering from severe mental illness and could not be adequately cared for in detention. That finding was made by a number of eminent psychiatrists and was passed on to the Department of Immigration on numerous occasions. The Minister for Immigration was then asked to have our client assessed and if the assessment was that he could not be cared for in detention then the Minister should grant a bridging visa and release him. The Minister did not agree to having the assessment done and our client was required to file proceedings in the Federal Court before the Minister finally relented. This was not an isolated case and it demonstrates a pattern of decision-making that has kept mentally ill people in detention when it was obvious to medical experts that they could not be properly cared for in that environment.

PIAC has represented a number of other clients in immigration matters that have had severe mental illness, most often suffering from post traumatic stress disorder and depression. In some cases, these individuals have been in detention for many years, with the threat of deportation to a country—where they will have no support from family or the State—hanging over them. In each case, the provision of medical support was deficient.

Incarceration significantly increases the risk of homelessness post release from detention, with poor access to mental health services for people who are homeless and ineffective co-ordination between prison authorities and community services. Fifty percent of prisoners are homeless within nine months of their release from prison, and it is estimated that fifty percent of people living in SAAP accommodation are people in the post detention release from jail.

As crisis accommodation is inherently a temporary solution to homelessness many people experiencing mental illness move from crisis accommodation to boarding houses or to sleeping rough on the street, usually without any access to mental health services or with brief crisis mental health interventions only. It is the experience of HPLS that many ex-prisoners with mental illness are more likely to re-offend due to lack of appropriate housing and adequate mental health care.

HPLS does not provide direct legal services in criminal law matters. However, a high proportion of its clients attend for advice in criminal matters. HPLS arranges for clients to receive specialist assistance from the Legal Aid Commission of NSW. However, it is HPLS's observation that even where a person with mental illness has a solicitor, three factors remain significant barriers to obtaining a positive legal outcome.

Firstly, the high demands for the services of Legal Aid solicitors means that the time they can allocate to clients is limited. This significantly constrains the level of service available to clients with mental illness as those clients will invariably require more time.

Secondly, court referrals to diversionary schemes available to people experiencing mental illness require intensive advocacy by a solicitor, which is often not possible due to the time pressures on legal aid lawyers.

Finally, referral to diversionary schemes often have pre-conditions that are difficult to satisfy. One key diversionary scheme for people with mental illness in New South Wales requires mental health services to make undertakings to the Court that the person will receive services from the agency for six months. Many mental health agencies are unwilling to make such undertaking due to limited resources and over-stretched case managers and psychiatric staff. This results in individuals experiencing mental illnesses being denied the option of diversion by the Court into a health service.

Competence of agencies to deal with people with mental illness

People experiencing mental illness interact with housing, employment, law enforcement and health agencies on a very regular basis. Indeed, many of HPLS's clients are in dispute with such agencies. It is important to note that many of these disputes have arisen during the course of normal interactions in which the person with mental illness has a legitimate right that they are seeking to enforce. An agency's ability to deal constructively with the dispute is often the key not only to dealing with the dispute but to determining the relationship of the individual to the agency and sometimes to the individual's welfare.

This is a critical phase of early intervention. Early intervention need not necessarily be seen as solely the intervention of medical teams, but also effective dispute management by the agencies that are dealing with the person with a mental illness. The inability to properly manage potential conflict with a person with mental illness and the manifestation of the mental illness can lead to anger and the escalation of the dispute to the point of police intervention. This begins the criminalisation of mental illness. Police should be viewed as a last resort for managing mental illness.

People with mental illness may have behaviour that is particularly challenging in a mainstream service setting, dealing with which requires specific skills. Those challenges should be far from insurmountable to people who are appropriately trained and have the time to deal with the client. It is important that workers in agencies are at least able to recognise when those skills are required and if they do not possess them themselves, then they should be able to refer the client to an appropriately skilled individual.