

‘Human Rights and Mental Health in Australia’
by
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1.0 Acknowledgments

Firstly let me thank the British Council for the invitation to speak today and in particular to professor Amita Dhanda for her introduction.

My best congratulations to the organisers: Christine Wilson, Farah Kabir and Alison St. Clair-Ford - it takes plenty of effort and good planning to organise such an important international seminar.

Allow me to also acknowledge:

- the Seminar chair
- my fellow speakers
- all other distinguished guests who have worked to champion the rights of people affected by mental illness and in particular, representatives of civil society.

2.0 Introductory Comments

I have been asked to speak briefly about the Australian experience in the area of human rights and mental health. To do so, I would like to give you a *tour de horizon* of Australian developments in this area over the last 10 years or so. I hope to do so not in parochial way, but rather in a way that focuses on issues of general applicability.

I understand that this seminar has a very practical focus as it aims to:

- raise awareness amongst policy makers regarding policies and legislation, and
- initiate dialogue for both practitioners and advocates.

Let us start with few introductory comments.

Prevalence of mental illness

Allow me first to call to mind the human scale of the issues we are talking about.

In 1998 the Australian Bureau of Statistics (ABS) estimated 2,383,000 adults, out of some 20 million Australians, had a mental disorder. This included 1,300,000 people with anxiety disorders; 778,000 with depression or other affective disorders; and 1,041,000 with substance use disorders. (Adding these numbers gives more than the total number of individuals affected because some people had more than one mental disorder.)

The rate of mental disorders was highest in the 18 to 24 year old age group with a staggering rate of 27%. The ABS did not have as clear a set of figures for mental health problems in children and adolescents as for adults. But it did indicate 20% of adolescents had significant mental health problems.

A study by Robyn Vines *et al.* published in the Medical Journal of Australia (MJA) in July 2004 asserts that *'About 25% of Australians report at least one mental disorder in any 12-month period, and between 19% and 40% presenting to general practitioners have mental health difficulties.'*

The Australian figures are not that different from mental health statistics recorded here in the United Kingdom or in any other parts of the world. So if one could paraphrase a quotation: *'The statistics on sanity are that one out of every five people this year will experience some form of mental illness. Think of your four best friends. If they're okay, then it's you.'*

Mental illness associated with disadvantage and poverty

In all countries I surveyed, including Australia and the United Kingdom, mental disability is associated with disadvantage and poverty.

People with mental illness and their families have much smaller incomes, participate less often in the workforce and are more often unemployed. They face difficulties with accessing education, housing, transport, communication, health and social services and so on. Many people with mental or psychiatric disability suffer daily violence, intimidation and denial of their basic civil rights in addition to economic disadvantage. Further more many of them suffer stigma and type-casting. In fact they are one of the most marginalised groups in our society.

Government responsibility

In modern society a significant part of the cost of medical care and the social services required by people with mental health problems is a government responsibility. The government is also responsible to ensure that people with mental illness are not discriminated against and can meaningfully and equitably participate in community life when they are well.

But when one looks at these statistics it is remarkable that for so long people with mental disabilities were pushed to the margins, or not taken into consideration at all in major social decisions. They were pushed to the margins because their special needs were overlooked or given lower priority in budgetary allocations for mental health services and infrastructure.

People with mental illness also were failed because often no adequate regulatory regimes or effective implementation mechanisms were put in place. Lack of proper regulation and laws deny people with mental disability their human rights and equal standing in society.

To sum up, mental illness is now the biggest social issue that is confronting contemporary society. This clearly constitutes a significant challenge to contemporary policy makers and to those who advocate for people with mental disability.

Mental health and positive rights

The role of government in relation to human rights is not limited, however, to refraining from arbitrary or illegal actions which infringe upon human rights - actions such as wrongful detention or illegal deportation, to pick a couple of examples out of the air.

People also look to governments to take positive actions to secure human rights. Those actions can require the application of very substantial resources. One cannot have the basic rights to a fair trial and equal protection of the law without investing in independent judges, impartial and uncorrupted prosecutors and police as well as other features of a justice system. Equally, you cannot have the right to the highest attainable standard of mental health without investing in the medical and community facilities to ensure that people who need it have access to treatment and support.

3.0 Mental health is a human rights issue

Introduction

It is very appropriate to be having a conference that highlights mental health as a human rights issue. And today I am addressing you not as an expert on mental health, but as a human rights expert. Thus, I will emphasise the human rights dimensions of mental health issues.

Australia does not have the US style Bill of Rights; it also does not have a document similar to the *British Human Rights Act* (1998); neither is it a party to the *European Convention for the Prevention of Human Rights and Fundamental Freedoms* (1950). Furthermore, when talking about Australia it is important to remember that Australia is a Federal state and that the 'health' issues are mainly the responsibility of State and Territory governments.

Protection of rights of people with mental illness in Australia depends on:

- relevant standards set up in international conventions acceded to by Australia;
- Australia's, both state and federal, domestic laws, including common law, elected legislatures, independent courts, free media and the broader civil society including mental health advocacy NGOs; and
- a range of official watchdogs, including the Human Rights and Equal Opportunity Commission (HREOC or the Commission).

International human rights law

As early as in 1948 Australia signed and then ratified the *Universal Declaration on Human Rights*. Article 25 of that Declaration refers to '*the right to medical care and other necessary social services as part of a right to an adequate standard of living.*' The Universal Declaration is not a binding treaty. But it is accepted around the world as a common standard for governments to strive towards and, in the case at least of more prosperous countries like Australia, a standard that people should feel entitled to expect.

Then, Australia signed and ratified a range of important human rights treaties, which explicitly recognise the right of everyone to the highest possible mental health care. For example:

- the *International Covenant on Economic Social and Cultural Rights*, Article 12, states: '*The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.*'

- ***The Convention on the Rights of the Child***, Article 24, states: ‘*States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.*

It also adopted ***the Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care*** (United Nations General Assembly, 1991) which reinforce the rights enshrined in the International Covenants and provide valuable guidance as to how those rights ought to apply to people with mental illness, namely:

- Principle 8(1) makes clear that people with mental illness have the right to the same standard of health care as other ill persons.
- Principle 14 states that mental health facilities should have the same level of resources as any other health facility.
- Additionally, Principle 7 emphasises the right to be treated and cared for as far as possible in the community.

Currently Australia is actively working with UN on a new convention dealing with human rights of people living with disability. The convention will cover human rights of people with mental disability as well.

Domestic implementation of international HR treaties

Although the Australian Government was closely involved in the negotiation of the human rights treaties and then ratified them, the fact is that the treaties and international declarations of principles do not implement themselves as they are not self-executing in Australia. To implement them, Australian Parliament needs to create domestic laws.

Supporters and opponents alike of the role of the United Nations in human rights often speak as if the main point of international human rights law is as a commitment to the international community. But really the point of the Australian government subscribing to human rights treaties and supporting international declarations on human rights issues is as a commitment to the people of Australia. Delivering on that commitment and keeping faith with the people requires accountability.

In Australia there is a whole range of laws, both state and federal, budgetary and other measures and programs for people with mental illness.

One way which Australia and other countries have tried to promote accountability on human rights issues is by establishing domestic anti-discrimination legislation and human rights commissions.

In 1992 Australia enacted the ***Disability Discrimination Act*** 1992, which contains a broad definition of disability which includes mental disability. It prohibits discrimination on the basis of ‘*physical, intellectual, psychiatric, sensory, neurological and learning disabilities*’. Australia also has a relatively generous welfare system with medical and social services for people with mental illness.

However, it is important to stress that protection of human rights is not only the task of relevant legislation or even a human rights commission. Protection of human rights is everybody’s business. All parts of the political and legal system and indeed organisations

beyond that in the private and community sector, also have to play their part if human rights of the mentally ill are to be realities.

The Australian Human Rights and Equal Opportunity Commission

The Australian Human Rights and Equal Opportunity Commission (HREOC) is a national independent statutory authority established by the *Human Rights and Equal Opportunity Commission Act* (HREOCA) in 1986. The Federal Attorney General is the Minister responsible in Parliament for the Commission.

The Commission is administered by the President, who is the Chief Executive Officer. He is assisted by the Human Rights, Race, Sex, Disability and Aboriginal and Torres Strait Islander Social Justice Commissioners. Under the legislation administered by the Commission, HREOC has responsibilities for inquiring into alleged infringements under five anti-discrimination laws – including the Disability Discrimination Act 1992 as well as inquiring into alleged infringements of human rights under HREOCA.

Furthermore, the Commission jurisdiction is defined by reference to international human rights instruments appended to the HREOC Act. Its role is not to be the mental health expert but to promote public debate and political accountability on how well Australian governments deliver on these commitments made to Australian people through ratification of international human rights treaties. For more see: www.humanrights.gov.au

4.0 HREOC activities in the area of mental health

HREOC has a proud record of long standing involvement with mental health issues. One of the things HREOC has done successfully over the years is to provide forums for the voices of people who are disadvantaged and have difficulty being included and heard.

This brings me to the subject of the Burdekin Inquiry of 1993 and to my current work in the area of mental health.

4.1 Burdekin Inquiry

Background

Back in 1993 the Commission released the report of its National Inquiry into the Human Rights of People with a Mental Illness. It is widely known as the Burdekin report, in honour of the massive contribution by my predecessor Commissioner Brian Burdekin. This report was based on a national inquiry carried out over several years, including hearings conducted around Australia, hundreds of submissions and on extensive research.

At that time the mental health system had begun to move away from institutionalisation to care predominantly occurring in the community. In fact, Australia was the world leader in de-institutionalising mental health services. This approach remains supported by all the experts and by all major organisations in the mental health sector.

In summary form, the Inquiry found that the care and support provided by the Australian health care system at that time contravened the basic human rights of our mentally ill and that while institutions were being closed down, community support was not being adequately built up.

Findings

In particular the 1993 Inquiry has found that:

- although the movement towards community care and mainstreaming of mental health services had reduced the stigma associated with psychiatric care, in general the money saved by deinstitutionalization had not been redirected into mental health and related services in the community.
- Health services and other services which would enable people with a mental illness to live effectively in the community were found to be seriously under funded or in some areas just not available at all. Thus, people affected by mental illness were suffering from widespread systemic discrimination and were consistently denied their human rights and services to which they were entitled.
- Governments were found to be relying increasingly on NGOs to provide services but were treating NGOs as peripheral in the allocation of funds.
- Accommodation for people with a mental illness was found to be particularly inadequate, with government housing support programs either excluding people with mental illnesses or failing to address their specific needs. The absence of suitable supported accommodation was the single biggest obstacle to recovery and effective rehabilitation.
- In the employment area, people affected by a mental illness were found to be disadvantaged by negative attitudes, a lack of awareness of means of accommodating employees with a psychiatric disability, and by inadequate vocational and rehabilitation services.
- Families and carers were found to be badly overstretched and insufficiently supported.
- Mental health services for children and young people were found to be seriously under developed. There were also recommendations for improvements in services for women. As well as recommendations on culturally appropriate services for Aboriginal and Torres Strait Islander people and people from non-English speaking backgrounds.
- Mental health professionals and allied staff working both in institutions and the community were found to require education and training in the delivery of community based services. And needs for improved education and training were identified throughout the sector.
- Mentally ill people detained by the criminal justice system were frequently denied effective health care and human rights protection. Procedures for detecting and treating mental illness and disorder in the Australian criminal justice system were found inadequate in all jurisdictions.
- Laws regulating mental health services were found to be badly in need of reform. On one hand, laws failed to recognise sufficiently the principle of applying the “least restrictive alternative” and gave wide discretionary powers of detention without sufficient provision for review of decisions for detention or compulsory treatment. Yet on the other hand, there was inadequate provision for treatment as a voluntary patient, much less a recognised legal right to access treatment. Furthermore laws providing safeguards regarding hospital treatment generally failed to extend to community treatment.

To summarise, Australia provided world-wide leadership in de-institutionalising mental health services however failed it with provision of necessary resources to build up required community support systems for people with mental illness.

Implementation of the Burdekin report

The federal and state/territory governments of Australia did make major responses to the Burdekin Inquiry. In particular, the Inquiry clearly contributed to the development of the first National Mental Health Strategy which reflects a human rights approach to mental health.

The Strategy was a welcome and overdue acknowledgement of the role of the federal government in mental health. In fact, the federal government allocated funds for the first time specifically for mental health services, and became involved in providing some leadership in the area through a collaborative National Mental Health Strategy, rather than just leaving it all to the states. Federal initiatives in response to the Inquiry Report included \$200 million over 4 years for services either directly targeted at, or providing substantial benefit to, people affected by mental illness.

The states and territories also temporarily increased their funding in response to the 1993 HREOC report.

There were also substantial law reform initiatives. A particular issue in the criminal justice area highlighted by HREOC's inquiry was the position of people found unfit to plead because of their mental condition. A person who could not be tried would generally be subject to indeterminate detention "at the governor's pleasure." The inquiry described this as a clear breach of human rights. It meant that a person with a mental illness might well serve a longer period of imprisonment than if he or she had been convicted, and without any opportunity to have the charge tested.

Furthermore, it can be said confidently that the 1993 Inquiry had contributed to changing perceptions of mental illness. It did highlight issues affecting people with a mental illness as human rights issues rather than being purely medical issues. Its views and recommendations have been widely adopted by governments at least at the level of principle.

An evaluation of Australian mental health legislation was conducted then for the Australian Health Ministers Advisory Council, by reference to a "rights analysis instrument" based on international standards. This evaluation had shown that there had been significant progress. Every state and territory had amended or was amending its mental health legislation to move away from an emphasis on detention to a model based on human rights.

However, the same evaluation showed that no Australian jurisdiction had achieved full compliance with the United Nations Principles for Protection of Persons with Mental Illness and for the Improvement of Mental Health Care.

Post Burdekin years

Despite the initial positive response to the 1993 Inquiry, there was clear understanding among the mental health advocates that there is a great distance still to travel before we could be satisfied that we are responding adequately to the human rights of people who have or have had mental illness.

Over the next few years however the mental health reforms stalled and mental health budgets flattened, or even went into decline in some places and the situation of people with mental illness became even more difficult. In fact, small scale post-Burdekin monitoring

by HREOC has indicated continuing concerns. These relate both to the level of resources and to implementation of HREOC recommendations about co-ordination of services and program design and eligibility.

The most substantial follow ups to the 1993 mental health report were HREOC's 1998 consultations in response to concerns regarding community treatment orders. These consultations only dealt with a small sample of the issues covered by the national inquiry report, but they indicated that implementation of the report remains far from complete. In fact, they provided disturbing evidence about how little has changed in practice.

Consultations suggested that the right of people with mental illness to live, work and participate in the community to the full extent of their capabilities is still being compromised by the lack of available community based services and care options.

Particular criticism was made of community treatment orders. HREOC was told that:

- community treatment orders often amount to nothing more than a fortnightly injection at a local medical clinic or a community mental health service.
- mental health consumers are often subject to a community treatment order without receiving adequate case management, review or follow-up.
- mental health consumers subject to community treatment orders do not have access to, or support in accessing, an appropriate range of services that meet their needs for leisure, recreation, education, training, work, accommodation or employment.
- community based services are often non-existent or fragmented.

More recently non-government organisations have been expressing particular concern regarding income support arrangements – on the basis that people who fail to attend job interviews or meet other requirements because of mental health issues are being “breached.” Failing to meet these requirements meant being cut off from income support for weeks or left to survive on drastically reduced benefits.

By the year 2000 it appeared that despite the advances in legislation and in policy at the level of rhetoric, the reality for people with a mental illness and their carers continued to be denial of human rights in practice. It appeared clear that most of the Burdekin recommendations about the support needed by people with a mental illness still needed attention. To put it simply, the resources allocated for community based support required by people with mental illness proved to be inadequate.

4.2 CIDI inquiry

In December 2000, when I was appointed as the Human Rights Commissioner, the Australian mandatory immigration system had become one of the most important human rights concerns. In November 2001 I announced that the Commission would hold a National Inquiry into Children in Immigration Detention (CIDI).

And here it is important to stress again the role of the international human rights law in this enterprise. The conduct of CIDI inquiry by HREOC was only possible because Australia adopted the *Convention on the Rights of the Child* (CROC) in 1989 and because CROC has been incorporated into the HREOC mandate. The Convention indeed provided a very powerful tool and formed the backbone to the CIDI report to Parliament on children in immigration detention, titled: “*A last resort?*” (for more see: www.hreoc.gov.au/human_rights/children_detention_report/report/index.htm).

In fact, CROC's standard setting influence is almost universal. At this time, CROC is the most widely adopted Convention in the history of the United Nations and it formally establishes in international law a range of clearly defined children's right to special protection and care. One of the basic principles of the convention is that "*the best interest of the child*" should be a primary consideration in all decisions that affect them. In the case of unauthorised immigration, CROC allows detention of children only in exceptional circumstances "*as a matter of last resort*" and "*for the shortest appropriate period of time.*"

Although CROC covers almost everything from education to health, both physical and mental, to the right to play and the right to family unity, Article 24(1) of CROC requires ensuring that all children in Australia enjoy: "*the highest attainable standard*" of physical and mental health that Australia can offer. Or as it is stated in the formal treaty language: "*States Parties recognise the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.*" (Art. 24 (1)).

During the CIDI inquiry it became painfully obvious that long-term detention is associated in some cases with serious deterioration of mental health. However, the most serious finding of the detention inquiry was the failure of the Department of Immigration and Multicultural and Indigenous Affairs (DIMIA) to implement the recommendations from mental health professionals that certain children and families with mental health problems cannot be treated in detention and that they should be released for appropriate treatment. The recommendation read as follows: the Government's '*failure to implement repeated recommendations by mental health professionals to remove children with their parents from detention amounted to "cruel, inhumane and degrading treatment."*'

Although the CIDI report was criticised by the Minister of Immigration as backward looking and harsh on DIMIA when it was released, soon after its release the government started removing all children and parents from detention and before the end of my term as the Human Rights Commissioner all children were out of the detention centres. The fact that children with their parents were allowed out of immigration detention centres is a testimony both to the strength of international law concerning human rights standards and to the strength of Australian civil society.

In fact, by now the findings of the CIDI report looks rather prophetic in the light of the revelations of the treatment of two mentally ill women, namely Cornelia Rau and Vivian Solon-Alvares, by DIMIA and other areas of government. Cornelia Rau, permanent resident of Australia since her childhood, was kept in prison and then in Baxter detention centre by a DIMIA mistake for some 10 months and Vivian Solon-Alvares, an Australian citizen, was wrongfully deported to her mother country the Philippines.

But let me briefly give you one "inhumane treatment" case study from the report to add a little flesh to the dry bones of that 'finding' and I refer now to the case of a 13 year old child who had been seriously mentally ill since May 2002.

This boy had regularly self-harmed. In February 2003 a psychiatrist examining the boy wrote the following: '*When I asked if there was anything I could do to help him, he told me*

that I could bring a razor or knife so that he could cut himself more effectively than with the plastic knives that are available.'

The most disturbing fact is that there had been approximately 20 recommendations from mental health professionals saying that he should be released from detention with his family. Some said that removal from detention was a matter of urgency.

When finally released, (after 3 years detention, and 2 years after mental illness diagnosis) as refugees, following a Refugee Review Tribunal finding, into the Adelaide community, all members of the family were severely mentally traumatized; prescribed heavy, daily medication, too ill to work and requiring extensive community support and assistance.

Some time after the CIDI report was tabled in Parliament, I visited the family of the 13 year old boy in Adelaide and I found that the boy and his father still suffer from mental health problems and do have major problems in accessing mainstream mental health services. I followed this up with some other refugees and their advocates to see what assistance they were able to get in the broader community and found that again the mental health system was failing them. Being very concerned about what I had seen and heard, I subsequently spoke with our top mental health bureaucrats and asked for an explanation of the current shortages.

There was no satisfactory explanation received. It became clear, that the mental health system of Australia was not delivering on the promise of the Burdekin reforms, at least as far as refugees were concerned. It was time to take another look at the performance of mental health services in Australia.

5.0 Human Rights and Mental Health “Not for service” Report

Background

From the time I commenced as Human Rights Commissioner in 2000, I was receiving report after report indicating a situation of ongoing crisis in access to effective mental health services. Ever increasing concerns were also being communicated to me by community members and NGOs.

I was reluctant to commence yet another inquiry in this area and add to the pile of reports and impose on the limited resources of HREOC (HREOC lost some 40% of its budget in 1996). For some time people working in the mental health sector were saying that they actually did not want another inquiry because it would just put pressure on the people and organisations struggling to provide services and supports with inadequate resources.

As time went by I became more and more concerned about the obvious failures of mental health services and formed a view that HREOC need again to undertake major work in this area to:

- refocus debate on mental health as a human right; and
- draw public and political attention to the failures of the mental health system as a means of promoting accountability and remedies where abuses or neglect of human rights were found.

Or in other words, the purpose of this national review of human rights and mental health issues was not to produce another report, but to put the issue of the lack of mental services on the national agenda. To achieve this, the involvement of the Australian civil society

was needed. In particular the review needed public opinion makers, media, church leaders and many others to publicise the issues associated with mental health shortages to be effective. The review needed cooperation of the whole civil society working together with HREOC for a change.

So, when in 2004 I, as the Human Rights Commissioner joined forces with the Mental Health Council of Australia (MHCA) and the Brain and Mind Research Institute to conduct a national review of human rights and mental health, our common purpose was, rather than to talk about inadequate services and outcomes, to put the focus where it belongs, on governments and bureaucracies which were still not giving enough priority to mental health issues - and on a community and political culture which allows them not to.

Methodology

The primary mechanisms used to collect data for this review included:

- written submissions
- consultations
- open community forums, and
- two community surveys

In addition, the Human Rights Commissioner wrote to all state and territory governments seeking information about the levels of community need and the effectiveness of mental health services. A draft report was provided to all governments for their comment.

Consultations and community forums

To start with, MHCA and HREOC issued an invitation to all those interested in mental health issues to provide written submissions. In response, some 360 submissions covering a wide range of issues were received by the review.

The consultations were conducted all over Australia: Perth, Brisbane, Sydney, Canberra, Bunbury in WA, Rockhampton and Broken Hill – to name but some of our destinations - and invited mental health experts to share their mental health experiences with the review. And it will come as no surprise to most of you here, that the review team was overwhelmed by the number of experts participating and the quality of their submissions.

Then between July and October 2004 the review conducted 20 open community forums in each State and Territory. Approximately 1,200 people came to participate in the forums including consumers, carers, general members of the community, clinicians, advocates, service providers (e.g. mental health, general health, accommodation providers), emergency personnel (e.g. police), academics and administrators.

We also conducted individual meetings with specific community, professional and non-government groups as well as meetings with various members of State and Federal governments.

The volume of input we received to the review from all these sources was overwhelming, as shown by the fact that the “*Not for service*” report is nearly as large as the original Burdekin report.

The findings - key points

The story that unfolded is not a pretty one. It is true to say that there is a long way to go before Australia's mentally ill can truly enjoy the highest attainable standard of mental health as the human rights treaties require.

The people consulted make two general points.

First, that there is increasing evidence that widespread use of common drugs such as cannabis, amphetamines, alcohol and ecstasy had been contributing to an increased rate of mental illness among young people. In addition, that they were making those young people even more disturbed when they finally present for care.

And second, that in the treatment of mental illness the state government services were failing in the delivery of proper care. Not only was there a general lack of services, but there was also a huge shortage of services that cater specifically to young people who need help. It was often a tragic tale of medical neglect and community indifference. Those with a mental illness were still being blamed for being sick. And this kind of thinking affects those who care after the ill in every State and Territory. And, tragically, it affects the young more than we would like to admit.

Below there is a list of specific findings made by the review:

- **Inadequate resources**

Resources provided were simply inadequate to match the level of needs and ensure access to treatment and services when they were needed. Australia currently spends only about 7% of its health budget on mental health. By comparison, other first world economies are spending between 10-14% of their health budgets on mental health. New Zealand now spends twice as much per capita compared with this country.

This call from the grassroots for more resources is backed up by the governments' own assessments. The evaluation of the Second National Mental Health Plan published by the Department of Health and Ageing in March 2003, stated that: *"While the aims of the Second Plan have been an appropriate guide to change, what has been lacking is effective implementation. The failures have not been due to lack of clear and appropriate directions, but rather to failures in investment and commitment."* A shorter and plainer way of saying that is to say that governments have not sufficiently matched their words with dollars.

The review was also told of a pattern of underspending and lack of investment in mental health.

Furthermore, accountability for money allocated to mental health services was seriously lacking. And even when resources were provided in name, there was no serious accountability for how that money was spent. For example, the West Australian Government withdrew \$4 million dollars provided under the National Mental Health Plan from mental health services and reallocated the money into general health. The reason? Different priorities.

- **Absence of early intervention**

The most frequently mentioned gap in mental health services was the absence of early intervention and other specialist services for young people. We know that approximately 75 percent of mental illness first occurs in people aged between 15 and 24 years old. One

in four people in that age group will suffer a mental illness in any 12 month period. Yet when the illness emerges many of these young people are denied basic treatment and care – they are simply told to go home and sort themselves out and only to come back when they are really ill.

This is despite the fact that Australia leads the way in development of early intervention programs for the mentally ill. A group of Australian clinicians led by Professor Pat McGorry in Melbourne has developed world-leading programs for young people in the early phases of psychotic and other severe mental illnesses. These programs are now being rolled out nationally in the United Kingdom and underpin major initiatives in Scandinavia, Europe and the USA. However, these same programs are still not being delivered routinely in Australia.

Lack of prevention and early intervention will mean the high cost of the treatment, in the future. As somebody said to us during one of the Melbourne consultations: “It is better to put a fence at the top of a cliff, instead of the ambulance at the bottom.”

- **Lack of services for dual diagnosis**

Many people with mental health problems have a range of other health and care needs.

As I have mentioned earlier, in Australia, there is increasing evidence that widespread use of common drugs such as cannabis, amphetamines, alcohol and ecstasy is contributing both to an increased rate of mental illness among young people as well as making those young people more severely disturbed when they finally do present for care. This also increases the likelihood that police or corrective services will become involved as well as increases the likelihood that involuntary hospitalization will eventually be required. In such cases, the chances of medical neglect or other obvious human rights abuses increase.

International evidence now clearly shows the link between cannabis abuse and onset of psychotic illnesses such as schizophrenia. It appears that the earlier the adolescent is exposed to such drugs the higher the chance of developing a mental illness.

Furthermore current research suggests that up to half of the cases of alcohol and drug abuse that we now see in our young people are secondary to earlier mental health problems that have gone undetected or untreated.

Despite the increasing evidence of links between drug use and mental illness Australia still lacks adequate mental health facilities to cope where a person has both drug addiction and mental illness at the same time – or other forms of dual diagnosis. This is especially the case for those youth who are dependent on alcohol or drugs. Medical policy dictates that drug addiction be treated first, before the mental illness is tackled. But the reality is that they are often interconnected. So they are left in limbo, with the likely result being anything from preventable suicide, permanent brain disease, destroyed families to huge economic and social costs for society as a whole. And the failure to treat a dual diagnosis may lead to at least 20 years of life expectancy being lost.

- **Children in adult facilities**

In all states I received reports of children and young people being admitted to inappropriate adult facilities.

- **Poor emergency services**

Emergency services are overburdened and often inaccessible. To illustrate I will give you two examples:

First, in Western Australia I was told about a twenty year old man who reported to hospital suffering from an episode. The hospital's clinical response was to chemically induce sleep for 20 hours, because there was no psychiatrist available.

Second, a Sydney hospital clearly took the "lock 'em up and throw away the key" mentality a step too far recently. It locked a mental patient and his two accompanying young police officers together in a room, and refused to let them go until a doctor arrived several hours later. The constables remained 'locked up' with the patient, even after their police sergeant made a direct request to hospital officials for their immediate release.

- **Poor acute care services**

Acute care services are too often simply missing, especially in regional Australia. To put it simply, these acute beds simply disappeared after the deinstitutionalisation reform. While this was never the intention of deinstitutionalisation, evidence exists that in a number of cases the lack of acute care services resulted in preventable death.

In fact, suicide rates in teenagers and young adults remain historically high. We were told a great many stories of preventable suicides of young people. Let me tell you two of them:

A Central Coast teenager was admitted to a psychiatric unit because of attempted suicide. He was prescribed Valium and released the next day with no follow up. He died hours later after throwing himself in front of a moving train. The coroner found that he was inadequately assessed and discharged too early, because an on-going shortage of beds in the unit.

In Canberra we were told about a young man with a history of depression, and openly suicidal, who jumped from a sixth floor balcony only two days after being refused admission to the psychiatric unit following a second suicide attempt.

- **Inadequate accommodation**

Going back to the original objectives of the National Mental Health Strategy in 1992, all governments committed to:

- Reducing the size or closing existing psychiatric hospitals and at the same time providing sufficient alternative acute hospital, accommodation and community-based services; and
- Increasing the number and range of community-based supported accommodation services and ensuring a range that provides a level of support appropriate to the needs of the consumer.

It is obvious that governments really got on with the closure of the psychiatric institutions. However, one of the biggest problems, it seems, is that they have not followed through with their commitment to build a strong system of community based care. One which includes adequate supported accommodation as the lack of appropriate supported accommodation for people with a mental illness has been a very strong theme coming through our community forums. The problem of course becomes much more acute in rural areas.

As an example of how bad the situation is, in the submission from St Bartholomew's House in Western Australia, which has been providing accommodation and support for people experiencing homelessness for 40 years, it was stated that even though staff try to provide a quality service, the lack of resources, a staff ratio of 1:54, poor education of staff and the number of people requiring care limits the capacity to deliver safe quality care.

We have also received submissions from family carers that report being advised by hospital staff that they should try and organize accommodation for their sick son in a backpackers hostel or if that failed then living in his car should be considered as an option. In the absence of appropriate supported accommodation, many people end up sleeping on the street or worse, in jail cells.

The experts in the field have advised the review that safe and stable accommodation is a vital element in someone's recovery. Without it, people have little hope of getting well or staying out of hospital.

- **Use of prisons to provide mental care**

Not only are Australia's mentally ill being turned away from the health services that they need, they often end up in gaols instead. When in prisons they may face especial difficulties getting access to help. The earlier mentioned case of wrongfully detained Cornelia Rau provides a good illustration – her acute mental illness went undiagnosed during her imprisonment.

One can further claim that on the basis of the data collected through community forums and submissions there did appear to be a broader trend towards a "law and order" type response toward mental illness. We received many reports of the high percentage of people in our prisons with a mental illness. We were told that even in the community, it is the police who are often left to respond when someone is in the midst of a mental health crisis. This approach is so different to the approach taken to people suffering from physical illness. People having a heart attack, for example, are not left to be dealt with by the police.

- **Physical health care**

The review staff was told on numerous occasions that the physical health of people with mental illness is considerably worse than the average. This was explained by the fact that a GP would tend to focus on mental health issues and neglect undertaking physical health check-ups. Communication problems were also blamed for the situation.

- **Community services unable to cope**

The evidence suggested that community supports were seriously overburdened and unable to cope with the existing demand. Further, the carers of people with mental health problems were frequently ignored by services.

The issue of community resources, or lack of them, also had particular application for young people still within the family environment. And I refer here to the issue of the young person's "carer or carers" being removed from the home due to their own mental illness. In these cases, that young person, and typically in these scenarios we are talking about more than one child, may be left in the home with insufficient community support mechanisms to ensure they are properly attended to, while their carer is receiving treatment for their mental illness.

- **Stigma and discrimination**

There is still fear and intolerance of people with mental health problems. Those with a mental illness were still being blamed for being sick. Also carers of people with mental illness can experience much of the same stigma as the people they support.

This stigma is reflected in discrimination against people with mental illness in their daily life. People with mental illness are denied job opportunities, access to accommodation and health services and so on.

- **Rural and remote areas – double disadvantage**

While people living in capital cities had many difficulties in accessing the mental health care and support that they needed, those problems were exacerbated in rural and remote areas. Let me give two examples of the additional problems facing people in rural areas.

First, distances between available services and the people who need them have meant there is an over-reliance on treatment by phone - which is completely inadequate for many people with a mental illness.

Second, we heard that there were sometimes extremely long journeys for people needing acute care under conditions which were entirely inappropriate. For example GP's may be required to over-sedate someone so that they can be transported by air. Or people who need medical assistance, not punishment, may be required to travel long distances under police escort – which is demeaning for the patient, distressing for families, and an unwelcome diversion of police from the jobs they are trained to do.

Having read some UK literature, for example policy papers produced by the Sainsbury Centre for Mental Health, one could form an opinion that Australian problems are not unique in the world. In fact many governments around the world are desperately searching for ways of promoting mental wellbeing among all the people they serve.

- **Limited accessibility for Indigenous and ethnic Australians**

There were also significant and unacceptable inequities in access to mental health services and in the reported outcome of services for Indigenous and non-English speaking background Australians. The Indigenous disadvantage in access was often aggravated by residence in remote locations. Both groups were denied access because of their cultural and linguistic characteristics and lack of culturally and linguistically sensitive services.

For more see: www.hreoc.gov.au/human_rights/mental_illness/index.html

The situation described in Australia in fact, does not differ that much from actual situation in many other countries. People with mental illness are those whose human rights are most often the most neglected world wide.

6.0 Conclusion

People with mental illness are still denied their rights

Although it is acknowledged that some initial improvements were made post Burdekin inquiry, it needs to be said that what we found while conducting the review in 2004-05 was all too disturbingly close to the findings of the 1993 report. In fact the review has documented a mass of suffering and a mass lack of services and treatments which takes opportunities away from people with mental illness and imposes a severe burden on the economy.

In fact, to be perfectly honest, the review brought no surprises. The neglect of mental health services was going on for some time. All the concerns that were reported in evidence to the review had been in fact well known for a considerable period of time. The failure of adequate funding for mental health services, the failure by governments to address the issue and the resulting human right breaches and the suffering of people with mental health problems and their carers were all well known for a number of years.

As one submission to the ‘*Not for Service*’ review put it in simple terms: ‘*The dream of closing psychiatric institutions and moving towards community-based care has turned into a nightmare. Community care is under-resourced and integrated services are lacking. Too many people are denied treatment and slip through the gaps.*’

Furthermore, when one adds the stigma and stereotypes that surround the mentally ill to this already explosive cocktail the extent of this bleak picture can be seen. Truly, all this gives flesh to the pattern of neglect which has been described by the phrase: “Out of hospital, out of mind.”

The fact that young people with mental health issues were missing out on access to mental health and other services was of particular concern because it was taking future opportunities away from them. As somebody told us in Victoria: “*It is better to build a fence at the top of the cliff, than to provide an ambulance at the bottom.*”

There is a light at the end of the tunnel

The extent of the problem is clear and so is the solution. Governments need to provide leadership; they need to work together instead of apportioning blame; they need to provide more resources for mental health services and supports, and more accountability for how the money is spent.

And since the review was initiated and its evidence started to gain media attention things have started to change. The good news is that we are starting to get statements from political leaders who are placing mental health reform high on their agenda. First it was the Western Australian government which has returned to the mental health budget the \$4 million transferred to the general health budget. The newest State Premier, Mr. Iemma in New South Wales said in his inaugural speech that mental health would be one of his top priorities and followed it with money. Money for mental health was also found in other states and territories.

The Federal government, first in the election context, committed an additional \$110m to mental health. After the “*Not for service*” report was launched by the Minister for Health the hon. Tony Abbott, the Federal government took Australia wide leadership and put the mental health issue on the agenda of the February meeting of the Council of Australian Governments (COAG) and there is a talk of multi billion dollar joint Federal/State package being developed to improve mental health services. In fact, all COAG leaders committed publicly to development of a new national mental health plan and committed significant resources to address the problems identified by the report “*Not for service.*” Only time will show whether the current initiatives will bring permanent improvements or if they are temporary in their nature as the post Burdekin improvements were.

Human rights laws and watchdogs can make a difference

The final point that needs to be made is that people with mental health problems do not constitute a powerful political lobby able to look after their own interest. In fact they are quite low in the pecking order when it comes to determining budget priorities or having their voices heard. They need the help of others to secure a decent life. And here is where human rights are of significance.

First, the international human rights instruments set world wide mental health standards of appropriate care. These standards provide a very useful implementation guide to the

national governments. The current draft disability convention, when adopted by the UN, will expend these standards enormously.

Then, in many countries there are national human rights institutions like the Australian HREOC charged with monitoring of the international human rights standards by national governments. These institutions can make a big difference for the mentally ill. It is not because I expect governments to take instructions from a Human Rights Commissioner or to regard the Commission as the experts on everything, but because I think that on issues of access to mental health services around Australia, HREOC has helped to make the voices of people affected by mental illness heard - directly, or as family members providing care and support. The HREOC review has put the issue of mental health back on the national agenda.

Finally, there is a role for the international human rights treaties monitoring bodies to assist national governments with human rights issues. And one could hope that the new UN Human Rights Council will have enhanced interest in mental health issues.

Just as the example of the UN role allows me to finish with an opinion expressed recently by the UN Committee on the Rights of the Child reviewing a Member State's (not Australia) report on its compliance with CRC: *"The Committee joins the State Party in expressing concern at the long waiting list and delayed access to mental health services and professionals for children which are due to an insufficient number of psychologists and psychiatrists. The Committee encourages the State Party to explore ways of providing children with more timely access to mental health services and to address in particular the shortage of psychiatrists and psychologists."*

I am suggesting today that the comment I have just quoted, which was incidentally addressed to Norway, would certainly resonate strongly in many states with regard to timely access for young people to mental health services.

The people with mental health issues need their human rights protected more than any other group of people in the world.

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