"MENTAL HEALTH, HUMAN RIGHTS AND INCLUSIVE WORKPLACE IN A MULTICULTURAL AUSTRALIA"

KEYNOTE ADDRESS TO THE ANGLICARE AUSTRALIA CONFERENCE: "OPPORTUNITIES NOT VULNERABILITIES; AN AUSTRALIAN AGENDA FOR SOCIAL INCLUSION"

HELD AT

THE FOUR POINTS SHERATON HOTEL, DARLING HARBOUR, SYDNEY ON TUESDAY 2 SEPTEMBER 2008

BY DR SEV OZDOWSKI OAM

DIRECTOR, EQUITY AND DIVERSITY, UNIVERSITY OF WESTERN SYDNEY

1.0   Acknowledgements

Allow me to start in the customary way. I would like to acknowledge the traditional custodians of this land.

Thank you for inviting me to address Anglicare Australia today. It is good to be able to speak to you – the people who work at the coal face of Anglicare service provision to people with mental illness.

The timing of your conference is certainly impeccable. It is the time when the Rudd Government works towards implementation of its promising Social Inclusion Agenda. It is the time when the National Mental Health and Disability Employment strategy is being formulated.

2.0   Introduction

Today I will start my address by focusing your attention to the not often well understood relationship between culture and mental health.

I will also talk about the linkage between human rights and mental health and about my work on mental health issues during my tenure as the Australian Human Rights Commissioner.

Finally I will focus on the relationship between mental health and employment.

2.1   Mental Health and Culture

Allow me to start with a personal story.

I arrived in Australia in 1975 and, after a short stay in Sydney, we settled in Armidale, a town in the New England area with a population of twenty thousand people. My family of four moved there because I won a Ph.D. scholarship.

Two weeks after we moved to a small house we rented there, our neighbour knocked on the door and invited my wife to a party to be held in two days time at 3.00 o'clock in the afternoon.

After I returned from the University, my wife told me with some excitement about the invitation. I thought – that's fantastic – what good people these Australians are! We moved in only two weeks ago into our new home, spoke only very basic English and we are already invited to a party by our neighbour.

To be perfectly honest, I had some suspicion about the three-o'clock starting time, but I thought there must be some kind of a cultural difference. Perhaps Australians start partying earlier then we used to do it in old Europe.

Then we pressed the panic button – what should we wear? We did not have any formal clothing. We arrived with two suitcases only as refugees from Communist Poland.

So we went to the St. Vincent "boutique"; I bought myself a jacket and my wife bought herself a dress for the occasion. We have also bought a bottle of good Polish vodka, arranged for a baby-sitter and … we were ready!

On Thursday exactly three o'clock in the afternoon we knocked on our neighbour's door; the door opened and we entered in. In a sitting room there were some twenty women, but no men, so I thought we must be in the right place.

But where were the men?

I had known that Australian culture is quite sexist, so I have thought that the men must be somewhere else having a good time. So I went to the kitchen, and I only found more women there.

Then I went to the backyard thinking that perhaps men are drinking beer around the BBQ – but nobody was there. So I jumped over the fence and returned home.

I was quite confused and disappointed. After all, a bottle of expensive vodka was gone.

Two hours later my wife returned. She was confused and angry, too. She told me that first she was asked to play some games she did not understand, and then, to purchase some plastic boxes, similar to those one gets from Woollies when purchasing ice cream.

This is the way we learnt about what TUPPERWARE PARTY means. We had learnt about an important icon of Australian culture in the 1970s that was virtually unknown to us before.

Now, stop and think for a moment. This clash of understandings happened between two healthy and well meaning people from two different, but not that different, cultures.

Just think about a person with mental illness and the daily difficulties such a person may have with understanding normal life routines.

Then, add to it cultural differences of understandings and possible language difficulties and you may start imagining the enormous additional barriers and difficulties many overseas born people and Indigenous Australians with mental illness may face in their daily interactions.

Think about a workplace, visit to a doctor or trying to get access to a service. Think, for example, about undiagnosed Cornelia Rau who was kept in prison and then in Baxter Detention Centre for some 10 months because she thought she was German.

Or think about the case of mentally ill Vivian Solon-Alvarez, who despite being an Australian citizen was wrongfully deported to the Philippines - leaving her child waiting to be collected from child care. That child was ultimately placed in foster care.

The fact is that Australians of minority cultural backgrounds are particularly prone to misdiagnosis and inadequate care in case of mental illness.

There are not enough resources and training; and often cultural and linguistic sensitivity is missing. The cases of Cornelia Rau and of Vivian Alvarez are not isolated, unusual or atypical. These cases are only the tip of the iceberg of barriers faced by well over one million migrants with mental illness in accessing mental health services in Australia.

The point to remember is that we need to recognise a cultural and linguistic diversity as a key component of any social inclusion policies.

But let us now focus on the broader Australian community and mental health services that are available in Australia.

2.2 Prevalence of mental illness

Let us start with a brief look at the *Australian Bureau of Statistics* (ABS) mental health statistics and at the results of the *National Surveys of Mental Health and Wellbeing of Adults* (SMHWB).

The first conclusion that needs to be drawn is that mental health problems are impacting on a great number of Australians. In 1998 ABS estimated that 2,383,000 adults, out of some 20 million Australians, had a mental disorder.

National Survey of Mental Health of 1997, which is based on diagnostic criteria rather than self report, reported that almost one in five adults (18%) had a mental disorder at some time during the twelve months prior to the survey. Three out of every hundred (about 3 %) will be seriously affected. Depression and anxiety are the most prevalent mental disorders experienced by Australians.

Some researchers had reported even higher proportion of those with mental illness in Australian population. For example, a study by Robyn Vines[1] 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."*

---

[1] Robyn Vines et al., *the Medical Journal of Australia (MJA)*, July 2004

To sum up, mental health problems impact on at least one in five adult Australians each year.

Second, for many Australians mental health or behavioural problems are a long term condition. In fact, the proportion reporting a long-term mental or behavioural problem has increased over the last three National Health Surveys. In 1995 the proportion was 5.9%, in 2001 it was 9.6% and in 2004-05 it was 11.0%.[2]

Third, it is important to note that mental illness affects in particular young people. At least one third of young people have had an episode of mental illness by the age of 25 years.

Looking at those between 12 to 17 year olds, around 14% of them experience a mental illness in any given year. The rate of mental disorders is highest in the 18 to 24 year old age group with a staggering rate of 27%. Suicide in this age group accounts for about one-quarter of all male suicide deaths.[3]

In fact, the majority of mental illnesses begin between the ages of 15-25 years. This poses a significant threat to our nation's future workforce capacity and economic prosperity.

The Australian figures are not that different from mental health statistics recorded in the United Kingdom or in the USA.[4]

2.3   Causes of mental illness

There is a whole range of factors associated with mental illness.

Some mental illnesses could be inherited. For example, according to the Black Dog Institute, the genetic risk of developing clinical depression is about 40%.[5]

Other factors relate to an individual's own environment. For example, the prevalence of mental health disorders is highest among people who are separated or divorced and people who live alone. About 20% of women experience symptoms of depression during pregnancy or in the postnatal period.

Particular risks face people who use drugs and consume alcohol daily.
In fact drugs and alcohol are known triggers of schizophrenia and depression in young people.

Mental health problems may also result from a hyper competitive work environment with long working hours and unbearable work stress. In fact there is a growing number of common law claims in Australia for psychiatric harm suffered as a result of employment conditions.[6]

---

[2] This may reflect an increased willingness to report mental disorders.

[3]   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.

[4] A World Health Organization Study on the prevalence of mental disorders in 14 countries shows that the number of adults who experience a mental disorder during any 12 months period ranges from 26.4% (in USA) to 4.3% (PR China) depending on the country. See WHO Mental Health Survey Consortium JAMA, 2004

[5] Black Dog Institute Fact Sheet. Fact and Figures about Mental Health and Mood Disorders. Published on 1 April 2008

2.4   Mental illness results in disadvantage and poverty

But regardless of the causes, in all countries I surveyed, including Australia, 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. For example, reports indicate that up to 85% of homeless people have a mental illness.

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 stereotyping. In fact they are one of the most marginalised groups in our society.

3.0   Mental health is a human rights issue

Now let us focus on mental health as a human rights issue. And it is very appropriate for this conference to emphasise the human rights dimensions of mental health.

As you would know the Australian system of human rights protection is not the best in the developed world. Australia does not have the US style constitutional Bill of Rights; it also does not have a statutory 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). In particular our civil liberties are not well protected.

However, there are a number of mechanisms in Australia that could be effectively used to protect rights of people with mental illness, namely:
- relevant standards set up in international conventions acceded to by Australia;
- a range of domestic laws, both state and federal, including common law as well as 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).

3.1   International human rights law

As early as 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.

---

[6] See for example paper by Joellen Riley "Mental Health and Employment: Issues for Lawyers." In the 2007 University of New South Wales Faculty of Law Research Series 38

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.'**

Australia also adopted *the 1991 Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care* , 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.

Recently Australia has signed and ratified the new UN *Convention on the Rights of Persons with Disabilities* and its *Optional Protocol*. The *Convention* will provide further protection of rights of people with mental disability. It includes mental health into disability definition, aims at empowerment and inclusion (Art. 9) and specifically refers to the right to work and employment (Art. 27).

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.

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 is as a commitment to the people of Australia. Delivering on that commitment and keeping faith with the people requires accountability.

3.2   Domestic implementation of international HR treaties

To implement international human rights treaties, Australian Parliament needs to create domestic laws.

In fact, 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 in which Australia has 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 (DDA)*, which contains a broad definition of disability which includes mental disability. DDA prohibits discrimination on the basis of "*physical, intellectual, psychiatric, sensory, neurological and learning disabilities*". Australia also has quite a complex welfare system with medical and social services for people with mental illness.

Despite all of the above I and many others would argue that the rights of people with mental illness are as yet not adequately protected in Australia. To put it bluntly, the current laws, institutions and budgets are simply not sufficient to provide adequate protection.

To illustrate this point, allow me now to report briefly to you on three inquiries I conducted as a Human Rights Commissioner that dealt directly with mental illness.

I will start with the short description of the role and functions of the Human Rights and Equal Opportunity Commission.

4.0   Mental Health and the 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.

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

The Commission jurisdiction is also defined by reference to international human rights instruments appended to the HREOC Act.

Its role is to promote public debate and political accountability on human rights issues, including the rights of the mentally disabled.[7]

4.1   HREOC activities in the area of mental health

In the past HREOC had had 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 work as Human Rights Commissioner in the area of mental health.

The Burdekin Inquiry
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.

---

[7] For more see: www.humanrights.gov.au

At that time the mental health care 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 that while institutions were being closed down, community support was not being adequately built up.

The federal and state/territory governments of Australia made 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 and allocation of $200 million over 4 years for services targeted at people affected by mental illness. There were also substantial law reform initiatives.

Despite the initial positive response to the 1993 Inquiry, over the next few years however the mental health reforms stalled and mental health budgets flattened or went into decline.
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 the denial of human rights in practice.

Now allow me to say a few words about the experiences I have gained with mental health during my time as the Human Rights Commissioner.

5.0   Children in Immigration Detention Report

First, I would like to share with you my work on the Children in Detention **Report, called*: "A Last Resort?***". I have decided to mention this Inquiry because it had demonstrated a very unusual case of government policy that had resulted in mental illness of many detainees and contributed to mental health problems of many others.

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 ratified the *Convention on the Rights of the Child* (CROC)[8] in 1989 and because CROC has been incorporated into the HREOC mandate.[9]

---

[8] 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."*

[9] For more see: www.hreoc.gov.au/human_rights/children_detention_report/report/index.htm

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.[10]

The report was the result of two years of detailed research and writing.

I visited all detention centers in Australia - some of them a number of times - and spoke to staff and detainees. We also conducted many focus groups with former detainees.

The Inquiry compelled the then Department of Immigration and Multicultural and Indigenous Affairs (DIMIA) and the Australasian Correctional Management (ACM) to provide us with key documents - some 50 to 60 large boxes of them.

We carefully analyzed all those documents.

We also took oral and written evidence from DIMIA and ACM, child detainees and their parents, and a vast range of individuals and organizations.

The inquiry was extensive. It was exhaustive. It was comprehensive.

What is particularly important is that the Inquiry put the issue of children in immigration detention on a national agenda and helped the emergence of informed discussion.

So what did the report show?

It showed that children's rights had been breached by making immigration detention the **only** resort rather than the **last** resort.

Rights had been breached by ignoring the children's best interests.

Rights had been breached by the very length of immigration detention - the longest being a child who was behind the wire for five years, five months and twenty-one days. This child was eventually recognized to be a refugee and now lives in Australia.

What is of particular relevance to this conference is that rights had been breached with regard to the mental health of children and to children with disability.

During the CIDI inquiry it became painfully obvious that long-term detention was associated with the emergence of a wide range of mental health problems among children and adults. In particular, adult males who have lost their traditional roles as family provider and protector were vulnerable.

However, the most serious finding of the detention inquiry was the failure of DIMIA to implement the recommendations from mental health professionals that certain children and

---

[10] 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)).*

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."'*

The report revealed that all this had occurred despite the efforts of several watchdogs who were supposed to oversee the welfare of these children.

The report provided many graphic examples of the impact of long term detention on mental health of detainees.

Here is one such image:

A 13 year old child who has been seriously mentally ill since May 2002. The boy regularly self-harmed.

In February 2003, a psychiatrist wrote: "***When I asked if there was anything I could do to help him, he told me that I could bring a knife so that he could cut himself more effectively. He said it was more effective than the plastic knives that were 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.

As Professor Procter has said: "***What the system has done, is to add mental anguish to the trauma of flight and dislocation from their homeland***". In other words, we locked them up, we traumatized them and now as they join the Australian family, we are going to have to pay a price for that treatment.

Some time later 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 in addition I found that they experience major problems in accessing mainstream mental health services.

I started looking at what sorts of treatment are available to refugees released from the detention centres and to other people in the community. A whole new picture of human rights concerns emerged from the shadows.

It was time to take another look at the performance of mental health services in Australia.

6.0   Human Rights and Mental Health "Not for service" Report

In 2004, following my work on immigration detention and representations from NGO's about problems with mental health services I had 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 for 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 services shortages to be effective. The review needed cooperation of the whole civil society working together with HREOC for a change.

6.1   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.

6.2   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 was affecting service delivery in every State and Territory.

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 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 an 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 was 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 also received submissions from family carers which report being advised by hospital staff that they should try and organize accommodation for their sick son in a backpacker's 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 gaol cells.

The experts in the field 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 health 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 particular 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.

Double disadvantage because of minority status
An example of such disadvantage was given in opening remarks of my address.

In case of Indigenous Australians living in isolated areas this phenomenon could be easily described as triple disadvantage.

6.4   Conclusion of "Not for service" Report

The report documented beyond any doubt that 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.

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*."

7.0   National Inquiry into Employment and Disability[11]

The work on "*Human Rights and Mental Health "Not for service" Report*" made me acutely aware of the linkage between well-being of people with mental illness and their access to employment.

I decided to make a difference and on 4 March 2005 launched "*the National Inquiry into Employment and Disability*" to address the low employment rate and earning potential for people with a disability. And I am pleased to say that many organisations dealing with disability, including Anglicare, made significant contributions to the 2005 Inquiry.

---

[11] See http://www.hreoc.gov.au/disability_rights/employment_inquiry/final/index.htm

The Inquiry resulted in two reports:

- The interim report WORKability I: Barriers. People with Disability in the Open Workplace" released on 19 August 2005; and

- The final report "WORKability II: Solutions. People with Disability in the Open Workplace" released 14 February 2006.[12]

WORKability I: Barriers
The first report "*WORKability I: Barriers*" made it abundantly clear that people with disability face higher barriers to employment than many other groups in Australian society. It further identified a range of hurdles faced by people with disability in the open workplace.

The interim Report also reinforced the government's responsibility for removal of those barriers so people with disability can compete on an equal footing to those without disability. This means that government must offset any additional costs and remove any additional risks faced by people with disability and their employers.

The barriers that I have identified in this Report consisted of three sets of obstacles facing people with disability and their employers, namely:

1. **Information** – an absence of easily accessible and comprehensive information and advice that assist in decision making processes and responds to on-going needs.

2. **Cost** – concern about costs of participation for people with disability and possible costs borne by employers when employing a person with disability.

3. **Risk** – concern about any possible financial and personal impact on people with disability and their employers, especially if a job does not work out.

These obstacles were evident through all stages of the employment process:
- getting ready for the open workplace;
- recruitment and selection; and
- job retention.

Further, the absence of clear information appears to have aggravated the other two barriers by making it extremely difficult to distinguish between perceived and real costs and risks.

WORKability II: Solutions
The final Report "*WORKability II: Solutions*" was transmitted to Attorney-General Philip Ruddock two day before my statutory appointment as Human Rights Commissioner expired. Regrettably there was little follow up action either by the HREOC or the Howard government that resulted immediately after its tabling.

The Inquiry found that governments needed to do more to provide support, services and incentives to employers and to people with disability to ensure true equality of opportunity.

---

[12] See HREOC website for he "*WORKability II: Solutions. People with Disability in the Open Workplace. Final Report of the National Inquiry into Employment and Disability*".

The Report suggested a holistic response. It called on all parties in the employment process and all levels of government to act cooperatively with each other to create a level playing field for people with disability in employment.

The Report called upon governments to provide leadership to the private sector, and the community at large, by improving public sector employment practices and developing clear information strategies to address employer concerns about the costs and risks associated with people with disability as employees

It made 30 specific recommendations of different levels of generality to address the barriers identified in the "*Workability I: Barriers*", including:

- establishment of a one-stop-information-shop for employers, employment services, relevant government agencies, community groups and people with disability;
- mapping of all government programs available to employers and people with disability;
- increasing the Mobility Allowance to allow reimbursement of the cost of transport to and from the workplace and extend further Transport concessions;
- introduction of employer tax incentives; and
- development of robust government-supported work trial schemes that benefit employers and people with disability and safety net options.

Recommendation 21 dealt specifically with mental illness and called for the Commonwealth government to facilitate:

> *(a) consultation, research and development of measures that address the recruitment and employment support needs of people with mental illness; and*

> *(b) prompt implementation of those measures through a national mental health employment strategy.*

The Inquiry recommended further (*Recommendation 30*) that the Commonwealth government lead the development of a National Disability Employment Strategy, in cooperation with the multi-sector coalition, with a view to ensuring increased participation, recruitment and retention of people with disability in Australia.

Recommendation 30 has identified minimal requirements for any effective strategy, namely:

- developing a whole of government approach to ensuring appropriate financial and practical support to people with disability, including a streamlined system to provide adequate:
  - income support;
  - transport, equipment and health care subsidies and concessions;
  - workplace supports and modifications; and
  - personal care in the home and workplace.
- improving the effectiveness of government funded employment service delivery to people with disability and employers (including recruitment assistance and access to supports on an as needed basis);
- improving transition to work schemes for people with disability in secondary, tertiary and vocational education and training institutions;[13]

---

[13] The Australian Government in January 2008 funded a new program called the National Disability Coordination Officer Program across Australia. The program expands and combines the previous Regional Disability Liaison Officer and Disability Coordination Officer programs. The new program has a strong emphasis on improving the completion rate by people with disability in higher education and Vocational Education and training; and the transition of people with disability into subsequent qualified employment.

- ensuring better relationships between private sector employers and government funded information, recruitment and employment support services;
- increasing recruitment and retention of people with disability in the public sector (at the Commonwealth, State, Territory and Local government levels); and
- developing a benchmarking, monitoring and reporting system to ensure accountability and ongoing improvement to the incentives, supports and services available to people with disability and employers.

I am very pleased to acknowledge that as a part of the Social Inclusion Agenda, the Rudd Government has decided to implement Recommendation 30 of my report and is now developing a National Mental Health and Disability Employment Strategy. The Hon Brendan O'Connor MP, Minister for Employment Participation and the Hon Bill Shorten MP, Parliamentary Secretary for Disabilities and Children's Services are jointly overseeing the development of the Strategy and they released the Terms of Reference for the Strategy on 15 February 2008.[14]

8.0   Conclusion

In conclusion, let me re-state the fact that mental illness in varying degrees affects the daily lives of thousands upon thousands of people in our country.

Let us also remember that people do not choose to be mentally ill. Mental illnesses can take many forms just as physical illnesses do. Mental illness is not something shameful.

With treatment and support, the majority of people with mental illness can and do recover well.

Despite this mental illnesses are still feared and misunderstood by many people

People with mental illness are still denied their right to work and other human rights. In fact some 80% adults with mental illness are out of work. This percentage is much higher than for any other category of disability.

This needs to be changed.

With proper case management, access to medical services, flexible workplace and training most people with mental disability can work.

And their work is not only important because of the economic contribution they will make to Australia.

There are also moral and human rights imperatives to ensure the inherent dignity of all human beings. I fully agree with the Anglicare submission to current Government Inquiry that realisation of right to work by people with mental illness is an essential part played in maintaining their human dignity and citizenship.

---

[14] For more about the National Mental Health and Disability Employment Strategy see:
http://www.workplace.gov.au/workplace/Publications/PolicyReviews/EmploymentStrategy/

I opened my talk with a story of success: of a report that assisted the Australian community to act and led to the release of some children from behind the barbed wire.

I look forward to similar community action on mental health.

I look to all of you to encourage our governments to clean up the mental health mess. We need to ensure that this issue stays on the national agenda until Australia fully meets its international human rights obligations.

I also look for government leadership. In particular I look to the Commonwealth Government - largest public employer – to being a leader in employment of people with disabilities and in particular people with mental disability.

The ultimate test of our commitment to human rights as a nation is not what we aspire to, not the conventions we sign, and not even the laws that are set in place.

Rather it is how we treat our most vulnerable and powerless.

Not surprisingly, at present the treatment of the mentally ill is not in the forefront of our consciousness. Just as previously we did not focus on children in immigration detention.

And we are not focusing, because it is about the rights of the less visible and often stigmatized people in our community.

In closing, let me paraphrase a quotation: "*The statistics on sanity are that one out of every five Australians this year will experience some form of mental illness. Think of your four best friends. If they're okay, then it's you.*"

Thank you.