LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

STANDING COMMITTEE ON EDUCATION, EMPLOYMENT AND YOUTH AFFAIRS
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Submission Cover Sheet

Inquiry into Youth Mental Health in the ACT

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Canberra Mental Health Forum is a community group advocating for improved mental health services. We are an active group of carers, consumers, people with work experience in mental health services or policy development. For more information we refer you to our website: **canberramentalhealthforum.org.au ,** or contact through [redacted].

ACT Youth Mental Health Inquiry – June 2020

The Canberra Mental Health Forum notes the broad consultation that occurred in 2019 regarding child and youth mental health, which members participated in, and refer the Committee to the Office of Mental Health and Wellbeing Report. In addition to these recommendations we advocate for stronger support for young people up to age 25 with mental illness and/or comorbid drug and alcohol issues. Some of our members have lost their family members to suicide when services could have been provided.

For some young people there has been or there is potential to be involved with the justice system. Experiences include confusion between the responsibilities Canberra Health Services and the requirements of the *Mental Health Act* and the criminal code. Lack of information sharing between Corrective Services and Health resulted in further harm to young people. Research reports far better outcomes, including lower recidivism for those caught up with the justice system, when treated at mental health facilities rather than through prisons. Thereby, also reducing the likelihood of suicide, self-harm and harm to others.

Recommendations

For all services:

- access to services at any time is essential as most crises occur on Thursday, Friday and Saturday nights. These crisis services need to be staffed appropriately and activated so they actually arrive in a timely manner when called.
- continuity of care processes in-place as a person needing ongoing care can be lost in the system when no one takes ownership for managing ongoing care needs of an individual
    - all services provided need to be co-ordinated and communicated thus avoiding a silo approach
    - discharge planning and communication with carers needs immediate attention
- greater involvement of consumers/carers in providing feedback on mental health services
    - carers need to be included with all aspects of care planning, especially as they are present 24/7 whereas clinicians provide sessional involvement and there is significant staffing turnover
- intervention programs need to be evidence-based practice as often new therapies demonstrate positive outcomes, however, are not implemented despite their value
    - rigorous evaluation is required and if there are shortcomings, changes to the model of care implemented

    - address co-morbid drug and alcohol dependency, as well as mental health issues
    - address physical health – diet and exercise, as part of whole person wellbeing
- enhance staffing recruitment and retention including psychiatrists, psychologists, social workers, nurses, allied health and peer workers to support a connected community involving the family where possible. Ensure indigenous Australians are part of the mental health workforce.
    - A larger core group of staff need to be highly trained in this area of speciality
- increase dedicated provision to the 18-25 year age group in health infrastructure to provide integrated services covering all aspects of physical and mental health including health promotion, prevention and early intervention.
    - use of computer driven self-treatment programs should be encouraged, when appropriate and accessible
    - broaden high school and university messaging about mental health, include reference to psychosis, eg noticing changing behaviour
    - programs should include a focus on vocational activities as employment is a significant issue for younger Australian, especially for those with a disability
    - services need to be culturally friendly and inviting for all Australians, supporting multicultural and multifaith communities
- clearer communication of the breadth of services, how to access, how they interact and an overarching complaint service (one stop shop) to address systemic issues.

Justice System:

The ACT Government reports a focus on Justice Re-investment. This needs to:

- improve understanding and address complex mental illness in justice services
- better integrate police and mental health services,
- accelerate work on the Disability Justice Strategy
- resource dedicated mental health units, especially for those under 25 involved with the justice system to divert young people from custodial harm

Coronial reform:

- The suicide rate in Australia is increasing and we are losing too many young people to suicide. It is recognised that the coronial process is often ineffective and opportunities for our community to analyse, understand and implement change are lost. CMHF supports a restorative process of investigating deaths by suicide. We attach a document outlining the current issues and possible solutions, prepared by the Coronial Reform Group.

DOES THE CORONIAL PROCESS MEET THE NEEDS OF GRIEVING FAMILIES?

Rosslyn Williams, Eunice Jolliffe, Ann Finlay ACT

ABSTRACT

The Coronial Reform Group (CRG) was established 5 years ago by several families in the ACT who had participated in coronial processes after the death of a close family member. The families found the process ineffective, disempowering and retraumatising and, as a result, established the group to advocate for improved processes across Australia to ensure that the families/carers of those who have lost their lives can have an equal voice in the coronial process. The group sees reform as essential to ensure systemic failings can be identified and acted on in a timely manner so lives can be saved.

The paper will look at the role of the coroner and the significance of coronial processes to suicide prevention measures and mental health service provision generally. It will also ask the question Is the coronial process therapeutic for grieving families?

The key areas for reform that the group has highlighted will be outlined, including the need for better support for families, an end to the adversarial approach and more effective government and institutional responses to coronial recommendations. CRG is calling for national oversight of the learnings that come from coronial processes and sees this as essential when planning suicide prevention measures.

This paper will briefly explore the options for coronial reform though restorative practice and outline the group's efforts to initiate a trial that will give families and other stakeholders an equal voice based on the principles of participation, voice, validation, vindication, accountability and prevention.

INTRODUCTION

With suicide rates rising in Australia, there is considerable discussion about the support and assistance that needs to be provided to families/carers who have been impacted by the death of a close relative, however, the needs of families/carers who must go through the coronial inquest that takes place after someone dies prematurely or unexpectedly, barely get a mention. Members of the Coronial Reform Group (CRG) were all impacted negatively by the coronial process finding it disempowering, retraumatising, unfair, exhausting and expensive. Over the past few years the group has met with and assisted other families going through similar processes.

Not many people in our community are conversant with the role and function of a coroner and why a coronial inquest differs from what happens in a regular court. Coroners are tasked with finding out who died, where the death occurred, when the death occurred, what the manner and cause of death was, whether a matter of public safety is found to arise from that death and if so, to comment on that matter. An inquest is intended to be more like an inquiry than a regular court case. It is held when there is a sudden, unexpected, accidental or violent death or when a doctor will not issue a medical certificate.

There are different types of inquests. Some are brief and held *in chambers* whilst others take days, months or even years. Some inquests are mandatory, for example when there is a suspected homicide or a death in custody. If a matter of public safety arises the coroner may make recommendations, but what happens next in regards to those recommendations, varies from jurisdiction to jurisdiction across Australia.

For those working in mental health services, it is important to understand why having robust coronial processes are essential to high quality service provision. Firstly, we are aware that the suicide rate in Australia is increasing. Suicide is the leading cause of death for Australians between 15 and 44 with over 3,000 Australians dying in 2017[1]. Secondly, the number of deaths from drug and alcohol related issues is increasing. Information from the National Drug and Alcohol Research Centre (UNSW) tells us that in 2017, there were 1,795 deaths, with opioids the main drug cited and most of these deaths attributed to pharmaceutical opioids.[2] Thirdly the number of people with a mental illness is on the increase and half of all Australians (16-85 years) will experience mental illness in their lifetime, that is 20% of us in any particular year.[1] Whilst it is important to note that not all suicides are deaths of people with a mental illness, the proportion is high. These deaths will mostly result in a coronial inquest and learnings from those inquests should impact future mental health service provision.

We referred earlier to a mandatory inquest taking place after a death in custody. Whilst this term refers to those who die in prisons and other correctional facilities, it also refers to those who die *whilst being taken into or detained …under the Mental Health ACT. Whilst being restrained, or otherwise being provided with care under the order or arrangement.* [3]

Coronial processes should be an important mechanism for the community, governments, service providers and families/carers to understand what has gone wrong and to act to prevent similar deaths occurring. They should also provide opportunities for families to find answers and come to terms with their loss. Members of the CRG know that in many cases these opportunities are lost.

THE CURRENT SYSTEM'S IMPACT ON FAMILIES AND CARERS

It is only fair to say that experiences for families/carers going through a coronial inquest vary. Some families talk about the process as being cathartic and therapeutic, giving them the answers they need and helping them move to some sort of resolution. However, in our experience, many families find the process overwhelming, retraumatising, confusing, exhausting and challenging. Families/carers talk about the process being *for only them and not for us* and feel that their voices were not adequately heard. Some reflect later that they were made to feel that they had done something wrong. The process can exacerbate the feelings of distress and guilt that are a common response when there is an unexpected death in a family. Families find themselves writing submissions, reading through often up to 3,000 pages of medical notes, reliving in detail the day by day experience preceding the death, often with little legal support or guidance.

In the ACT and in many other jurisdictions in Australia there are unacceptable delays. Coronial inquests are given a low priority by governments and magistrates and families/carers have been kept in limbo from 3 to even 7 years. Being forced to revisit the trauma and grief of the death after that duration is inexcusable.

Families/carers are also conflicted by what they perceive is an invasion of privacy. Whilst CRG understands the importance of thorough coronial investigations, we believe the extent

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[1] Black Dog Institute, *Facts about Suicide*, 17 September 2019<https://www.blackdoginstitute.org.au/clinical-resources/suicide-self-harm/facts-about-suicide-in-australia>

[2] Chrzanowska, A., Dobbins, T., Degenhardt, L., Peacock A., (2019), *Trends in drug-induced deaths in Australia 1997-2017*. Drug Trends. Sydney.

[3] Coroners ACT 1997 s3C ss3

of the exposure of the person who has died and that of the family during the inquest and, in particular, in the findings, is often unnecessary.

CRG is not alone in calling for reform. For example, Michael King, a magistrate and honorary Fellow at the Faculty of Law at the University of WA stated:

> *The coroner's work is intimately connected with wellbeing….The coronial process can cause further trauma to family members. A protracted delay between the death and the coronial finding…., a lack of information concerning the process and reasons for delay, the confronting nature of evidence….can cause the family much distress.* [4]

An issues paper from the Federation of Community Legal Centres (Vic) tells us.

> *…many families who have lost loved ones experience the coronial process and its aftermath as traumatic, mystifying, frustrating and disempowering*.[5]

The process can be extremely expensive for families. In the ACT, if families want independent legal representation (often necessary given that the circumstances relating to the death of someone with a mental illness can be complicated) the costs range from $20,000 to more than $35,000. Legal aid is very limited and many restrictions apply. Families are justifiably concerned about relying solely on the services of Counsel Assisting the Coroner who, as the title suggests, is there to primarily assist the coroner, not the family. It is common for the taxpayer to fund the provision of top quality legal counsel to represent institutional bodies whilst families are largely left to fend for themselves. The issue of funding for independent legal representation is central to fair and just process. CRG believes the current situation may breach Australia's human rights obligations.

> *As a fundamental component of Australia's international human rights obligations under the right to life, funding and availability of legal assistance providers must be sufficient to enable all families to obtain, without financial hardship effective legal advice and representation for investigations and inquests,* ***at a level that is consistent with the level of legal representation accorded to government and other institutional parties in the inquest****.* [5]

A CALL FOR CHANGE

So why doesn't the current process work? Firstly, in some cases, instead of the process being inquisitorial it becomes adversarial. The imbalance of power permeates the system and the adversarial approach obscures truth and increases anger. There are long delays and generally inadequate resourcing. Recommendations made by coroners can be poorly thought through and any implementation can be slow and ineffective. Victoria is the only state or territory in Australia that has a body to oversight recommendations, tasked with ascertaining if there are patterns and themes of deaths and as a result ensure changes are made. In the ACT and other jurisdictions it is not mandatory for the government to act on recommendations or even to explain to families/carers or the community, why recommendations, deliberated on for many days by experts, are 'not accepted'.

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[4] King, M.S., 2008, *Non-adversarial justice and the coroner's court: A proposed therapeutic, restorative, problem-solving model*, Journal of Law and Medicine, 442.

[5] Issues paper, 2013 *Saving lives by joining up justice,* Federation of Community Legal Centres (Vic) Inc.

CRG is calling for change both in the ACT and Australia wide. Our aim is to empower bereaved people, who are often excluded from exercising their legal rights and to ensure that their voices are heard by policy makers, parliamentarians and the wider public. The key issues we are advocating for include:

- The appointment of Coronial Family Liaison Officers to support and provide advice to families throughout the inquest process, from the time a death occurs till after the implementation of recommendations.

- The appointment of a dedicated coroner in the ACT and a reduction in lengthy delays across the country generally.

- Equal opportunity for family members/carers to comment on adverse findings before they are handed down.

- The right to appeal findings without going to the Supreme Court (an option not available in the ACT).

- More 'robust' recommendations, follow up and implementation.

- A mandatory requirement for governments/other parties to adequately respond to recommendations.

- Thorough analysis and oversight of recommendations both locally and nationally to highlight patterns and themes of deaths.

- A process whereby the voices of lived experience are fairly heard and responded to ie a process that is both fair and healing.

AN INNOVATIVE SOLUTION

CRG has been active in promoting the urgent need for coronial reform in the ACT. One of the positive developments for our group in recent months has been to secure a commitment from the ACT Attorney General to explore and progress opportunities for restorative coronial reform. We are aware that the current process is not restorative and feel that it is time to stop thinking that a solution based on tinkering at the edges will fix things. We believe our community needs to consider a different and innovative solution. A restorative approach is a way of working with conflict that puts the focus on repairing the harm that has been done. It asks all parties to share what their involvement was, how the incident of conflict has affected them and to agree what needs to be done for things to be put right.

Researchers in restorative justice have established a framework for identifying the justice needs relevant to victims of crime.[6] Whilst we understand that families/carers involved in coronial processes are not usually 'victims of crime' we concur with others in saying that the framework could provide a good model to explore in the coronial setting. The identified needs mentioned above include participation, voice, validation, vindication,

[6] K Daly, *Reconceptualizing Sexual Victimization and Justice*, in I Van Fraechem, A Pemberton and F Ndahinda (eds), Justice for Victims: Perspectives on Rights, Transition and Reconciliation (Routledge, 2014).

accountability/prevention.[6] Researchers have worked through each of these needs and identified how they might be relevant and resolved through a well-conducted restorative process. Whilst it may be unlikely that restorative processes will be effective for all coronial cases, we feel that the process should be trialled to discover if it can provide opportunities for more open discussion about what has happened and if lengthy, expensive legal processes can be avoided. The ACT now has a group of committed, knowledgeable families with lived experience who would support this trial and the territory should now take a lead in this reform.[7]

The focus for most families/carers is to find out what happened and to ensure that the same sequence of events does not happen to someone else. Families/carers want to see that when there have been systemic failings that those failings are acknowledged and that change is implemented in a timely manner.

Ann Finlay, founding member of CRG, speaks with courage and in considerable detail about her retraumatising coronial experience in the podcast, *Losing Paul.*

> *Gruelling, adversarial coronial hearings are pointless unless lessons are learnt and taken seriously. There is something rotten in a system that continuously defends and denies the hard reality of mistakes made. Instead of denial, failings such as those that happened in Paul's case should be seen as opportunities to improve our health services.*[8]

CRG is fully aware that a balance is needed between the needs of families, the needs of other parties and the overall integrity of the coroner. For too long, however, proceedings have minimised the voices of families/carers leaving them often disenfranchised and, at times, retraumatised. A more balanced and therapeutic approach is urgently required. Meeting the justice needs of any, begins to meet the justice needs of all. We are all served by improving the coronial system and ensuring that we have effective processes to uncover what happened in ways that are humane, incisive and truly just.

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[7] CRG would like to acknowledge the pro bono work of Dispute Management Consultant Rhiân Williams in providing ongoing support to our group in considering what a restorative coronial process could look like.

[8] Burdon D., Back A., *(*2018) *Losing Paul,* Canberra Times podcasts, <https://www.canberratimes.com.au/story/6024224/losing-paul-a-canberra-times-podcast-about-the-death-of-paul-fennessy/>