Royal Commission into
Victoria's Mental Health System

# WITNESS STATEMENT OF DR MARGARET LEGGATT

I, Dr Margaret Leggatt, make this statement on the basis of my own knowledge, save where otherwise stated. Where I make statements based on information provided by others, I believe that information to be true.

## What is your background and experience?

1 I hold a B.A. Hons. Ph.D from Monash University, and B.App.Sc (O.T.) from Latrobe University in Melbourne, Victoria, Australia. I was awarded a Churchill Fellowship in 1981 to study the rehabilitation of the seriously mentally ill in the United Kingdom, and in 1987, was awarded a Member of the Order of Australia for service to those with schizophrenia and their families.

2 From 1995 – 1997, I was a Senior Research Fellow at Deakin University where I was involved in the organization of workshops to examine the education and training needs of the professional mental health workforce, and a research project to implement and evaluate multiple family group psychoeducational interventions in the management of major mental illnesses.

3 I was the founding director of the Schizophrenia Fellowship in Victoria (now known as Wellways Australia) from 1981 - 1995, an organisation which was replicated in all States and the Australian Capital Territory.

4 I am on the Board of Tandem, the peak body of mental health carer organizations and groups across Victoria. I also sat on the Victorian Mental Health Tribunal until December 2017.

5 I am also a founder and patron of SANE Australia, an organization designed to tackle the issues of serious mental illnesses on a national scale, as well as to implement a programme designed to educate in order to change community attitudes towards mental illnesses.

6 Attached to this statement and marked "Attachment ML – 1" is a copy of my CV.

## In Australia, what role are families and carers assuming in caring for the needs of people with schizophrenia/s?

7 I have observed carers and families assuming four main roles in caring for the needs of people with schizophrenia/s:

(a) seeking and sourcing of help for the person being cared for;

(b) being the primary carer for the person;

(c) being a support network for the person; and

(d) being the landlord or household supervisor for the person.

***Role of the family in seeking and sourcing help***

8 I have observed that many a time, it may be apparent to the families and carers that a person needs professional help. In circumstances where the person denies that there is anything wrong, he or she may not be able to or want to seek professional help and it becomes the role, and responsibility, of the families and carers to find help for that person. Families and carers struggle with finding that help in the early stages or when there is a subsequent crisis. This may be the case for multiple reasons:

(a) they have no understanding of the mental health system; and often it proves too complicated for them to navigate in order to find the necessary help; or

(b) they are frightened, bewildered and terribly ashamed of the behaviour going on at home; this is an added difficulty in seeking help.

9 It used to be that GPs would tell family members seeking help that they could not do anything unless they could see the person needing help. This resulted in serious delays in receiving help. I think this is probably still the case. Nowadays there are CATTeams (Crisis assessment and treatment teams) that the GP can call upon; but they have become known as the 'Can't come today team,' or the 'Call again tomorrow team.' This is not their fault. They are overworked and under resourced. Consequently, this results in delay to the person receiving help.

10 The right of confidentiality of the person is also a barrier when families and carers are trying to obtain help. The impact of this is discussed in more detail in paragraphs 39 to 46 below.

***The family as the primary carer***

11 Families and carers in many circumstances are responsible for looking after the physical needs of the person full-time. They are also implicated in trying to make sure that the person takes their medication - a situation that is often fraught with problems. In some situations, this means that the families and carers are responsible for ensuring that the person eats, showers and as one mother reported to me recently that 'he does not stay in his room all day smoking himself to death.' The role of the carers and the family as the primary carer can also inadvertently further the tendency for the person to function less competently than may be otherwise possible. The person gets used to being 'looked after,' and makes no effort.

*The family as a support network*

12 When a person develops a mental illness, there is often an accompanying inability to relate to his or her peers, who gradually fall away. Consequently, for many people, their families and carers are their only support network. Families and carers often have no choice but to take on this role. In an emotionally fragile environment, this may be a subtle and constant reminder to the person of their position as a mentally ill and disabled person, oftentimes exacerbating feelings of inferiority and isolation.

*The family as landlord or household supervisor*

13 The families and carers are often responsible for the housing, safety and essential support of adult persons living with mental illness, whose capacity for compatible interactive family living has markedly decreased. In effect, this means that the families and carers have an unsatisfactory tenant who behaves badly, ruins property, fails to pay rent and against whom they do not wish to exert their 'rights', such as eviction – after all the person in suffering an illness and disability. In some situations, families break up under these stressful circumstances. In other situations, the family eventually gets to a position of having no choice but to evict the (adult) person. Eviction can lead to relapse and hospitalisation, or vagrancy, petty crime and jail.

**In relation to outcomes for consumers, their carers and families, what are the benefits of including family and carers in the treatment and care of people with schizophrenia?**

14 There is research evidence to support the view that both families and carers as well as the person living with schizophrenia benefit from including families and carers in the treatment and care of that person.

15 The research evidence from over 40 randomized controlled trials carried out over 30 years,[1] where families have been involved in treatment and care demonstrates:

(a) A reduction in relapse rates (up to 20%), resulting in a reduced number of hospital admissions;

(b) better adherence to medications; and

(c) reduction in psychiatric symptoms.

16 When families are involved in the treatment and care of the person, they need to learn how to communicate with the person. They need to learn how to calm down an emotional environment and establish non-emotional communication patterns. These good communication patterns help avoid escalations of tense situations and also lead to

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[1] Pharaoh F, Mari J, Rathbone J, Wong W, 2010 Family Intervention for Schizophrenia. Cochrane Database of Systematic Reviews, 12

reduction in relapse rates. A good emotional environment also helps the person be more motivated and communicative in a non-hostile way resulting in a reduction of psychiatric symptoms.

17 Research evidence[2] demonstrates other significant outcomes for the person:

(a) improved social functioning;

(b) increased employment rates;

(c) increased involvement in the community;

(d) reduction in the trauma experienced by family members;

(e) improved relationships between family members, and, between family members and the person; and

(f) cost-effectiveness.

**Are there models and strategies for the inclusion of families and friends that have demonstrated to be effective (in Australia or internationally) If so:**

***What are they and why are they effective?***

18 Internationally, the research demonstrates that there are effective care models, such as:

(a) the Multiple Family Groups developed in Maine, USA by Prof. William McFarlane; and

(b) Behavioural Family Therapy developed in Birmingham by Grainne Fadden.

19 Under the Multiple Family Groups model, the training of mental health workers takes two days, with follow-up supervision. In this model, two clinicians work together with five to six families and the person being cared for. They meet fortnightly for 18 months at the clinic where the person is receiving treatment, or, if the group prefers, at a community meeting place. The families learn a great deal from each other, as well as receiving guidance from the mental health workers. The implementation of the Multiple Family Groups model is cost-effective for hospitals. The research[3] shows that by the end of the second year of treatment, the reduction in hospitalisation costs was 34 times the expense of the groups themselves, i.e. a cost benefit ratio of $1: $34 compared to other conventional treatment approaches.

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[2] Falloon I, Optimal Treatment for psychosis in an international multisite demonstration project. Psychiatric Services, 50, 615-618 (1999); Vos et al, Assessing cost-effectiveness in mental health: helping policy makers prioritize and plan health services, Aus and NZ Jnl of Psych; 39, 701-712 (2004).

[3] William R McFarlane et al, Multiple Family Groups and psychoeducation in the treatment of schizophrenia, Arch Gen Psychiatry, Vol 52 (1995).

20 I do not know of Multiple Family Groups being implemented in Australia, except in the Waratah Community Mental Health Centre.[4]

21 Under the Behavioural Family Therapy model, training of the clinicians in Behavioural Family Therapy takes five days. Then the mental health worker works with all the members of the family over a period of time helping them to develop effective communication skills, solve problems and achieve personal goals. This model has been adapted and was being implemented in conjunction with an area mental health service in Victoria, but has since been discontinued.

22 There is also the 'open dialogue' model in Finland, which involves the person, carer and clinician talking freely to one another in an assisted environment. The aim of this model is not necessarily to reach a rapid solution or to immediately change the direction or dynamic of the family. It is intended as a model that facilitates a dialogue to understand the problems the person is facing and to enable an understanding of what has happened in his or her life. This approach, of engaging with the person in the context of their lives without strategically trying to change them, eventually arrives at solutions that are better suited for the person.

23 Additionally, there is the 'Triangle of Care' model that has been implemented in the UK. The Triangle of Care is a therapeutic alliance between the person living with mental illness, staff members and carers that promotes safety, supports recovery and sustains wellbeing. There are six key standards that are pursued under this model in order to achieve better collaboration and partnership with the person living with mental illness and their carers in their journey through mental health services. These are ensuring that:

(a) carers and the essential role they play are identified at first contact or as soon as possible thereafter;

(b) staff are 'carer aware' and trained in carer engagement strategies;

(c) policy and practice protocols re confidentiality and sharing information, are in place;

(d) defined post(s) responsible for carers are in place;

(e) a carer introduction to the service and staff is available, with a relevant range of information across the care pathway; and

(f) a range of carer support services is available.

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[4] Waratah Community Mental Health Clinic is still carrying out Multiple Family Groups, though at a reduced rate of implementation.

***Australia***

24 In Australia, the Bouverie Centre has implemented a Single Session Therapy model[5].

25 In another area mental health service, the Family Work Group[6] developed a plan to include families in treatment and care. This plan includes details on how clinicians can and should engage with families and carers from first contact, through early and ongoing stages of treatment and through to discharge planning. However, the implementation has been sporadic and nowhere near sufficient.

26 In my view, the stigma that families caring for a person with schizophrenia face is huge. It is important to implement properly, programs that have been demonstrated to be effective in including and working with families and carers. In my opinion the implementation of these programs helps families to confront the stigma that they feel. The feelings of blame, shame and guilt (such as 'the outside world will see me as having caused these problems with my son' or 'I must have been a very bad parent') are 'turned around'. Parents are reassured that they are not to blame; they are reassured that this is a genuine illness with a neurobiological basis, and that it is not their fault. Family members have their confidence restored and are more able to become pro-active. However, there is not real evidence-based research to support these claims of stigma reduction for families. These impressions that I have are based on my own interaction with many families over many years.

***Are there any important barriers to their effective implementation?***

27 In my opinion, there are significant barriers to the effective implementation of these programs.

(a) ***Research results are not widely known*** - the research results are not widely known, which means it is difficult for them to get support. These programs do not have a big corporate sponsor (like the big pharmaceutical companies that promote their medications) to lobby for their implementation, and there is a general tendency to view psychosocial research as not as important.

(b) ***Problems between the person and families*** - there is often hostility between the person and the family, particularly when families haven't been taught good communicative patterns. The legal obligation of confidentiality between doctors and patients often means that family members are excluded from the treatment. This is discussed in more detail in paragraphs 39 to 46 below.

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[5] Please refer to the submission to the Royal Commission into Victoria's Mental Health system from the Bouverie Centre for more detail on Single Session therapy.

[6] "The Family Work Group" comprises clinicians (psychiatrist, social worker), family carer and a consumer.

(c) ***Lack of training of professional staff*** - the professionals working in the mental health system are often trained to focus their treatment upon the individual, and little emphasis is given to the patient's social milieu. The staff often do not have the sufficient training or capacity to include the person's social network – their family and friends.

(d) ***Organisational context*** **-** the organisational context is oftentimes also a barrier – in many instances, the caseloads of the health worker are too large, staff are stretched to the limit and therefore are not able to involve families. Additionally, support from managers of the service is often absent.

(e) ***Social context*** - as mentioned, the stigma that families caring for a person face is a barrier to the implementation of these programs. Additionally, Australia has become more culturally diverse and there isn't sufficient understanding of the different cultural expressions of mental illness.

(f) ***Economic context*** - the economic context often is not suitable for the implementation of these programmes as:

    (1) *first,* there is no funding specifically allocated to train staff to properly involve families;

    (2) *secondly,* the system cannot afford to give staff the time off to get trained; and

    (3) *thirdly,* the emphasis is on short-stay treatment which is not conducive to the involvement of families, so the economic benefits of involving families does not happen.

(g) ***Political context*** **-** changes in government often means that initiatives started by one government are not continued by the next, and new and different initiatives are planned and introduced. Therefore, there is a lack of continuity in the planning and delivery of mental health care. In my view, mental health should not be planned and controlled by government. It should be planned by an expert body of mental health practitioners, the person and family carers.

***What is needed to effectively implement effective strategies that is not currently present in Victoria's mental health system?***

28 In my opinion, each community mental health service should have a 'Family and Friends Work Implementation or Steering Group' that meets regularly, with a designated Director of Family Work. To be effective, the requirement for such a group should be mandatory, and the work funded and subject to accreditation. Ideally the group would include psychiatrists, social workers and nurses, and would be able to develop a shared vision of family-based work, determine goals for families, choose a model of family work and plan an implementation strategy for that health service.

29 There should also be organisational changes so as to enable staff to have dedicated time to engage with families, determine and provide the necessary resources to carry out the implementation of plans, and ongoing processes that ensure that family-based work is sustainable. As discussed in paragraph 17 above, there is research evidence to show that such organisational changes are more cost-effective in the long term.[7] It has been reported[8] that the mental health workforce is more likely to find intrinsic rewards in their work when they work with families and carers who express their thanks and gratitude for their support rather than having to cope with families that are angry and frustrated. Consequently, less staff burn-out, less absenteeism and fewer resignations have also been reported.

**What do you understand to be the impact on families and carers of supporting a person with schizophrenia/s? What do families and carers report that they need in order to support their loved ones?**

30 In a research study carried out at Orygen Youth Health, it was discovered that 56% of family carers experiencing a first episode psychosis in a son or daughter, suffered a level of anxiety/depression that fitted the criteria for a psychiatric illness.[9] The stress of caring can cause families to tear apart. Siblings of the person being cared for can leave home to escape the environment. Young carers can fall behind in their schooling.

31 Due to the stigma that families and carers of the person face, they often live with unresolved blame, shame, guilt, and an unbearable sense of powerlessness. Families report that these feelings are often reinforced by the mental health services because they do not feel they are listened to, they can feel blamed – perhaps not so much these days, but they often feel that the professionals imply they may not be handling their caring role very effectively.

32 The trauma and all-consuming demands of caring can also lead families and carers to become isolated from their own social networks. There can also be severe financial constraints on families and carers that arise from caring for a person with these needs.

33 In my experience, families and carers report that they need to be listened to, to feel heard and to be believed by the mental health system. There should be an equal partnership, based on mutual respect for each other's expertise, and experiences.

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[7] See Vos et al. cited at footnote 2.

[8] Froggatt D et al, Families as partners in mental health care – A guidebook for implementing family work, World Fellowship for Schizophrenia and Related Disorders, Toronto, page 31 (2007).

[9] Gleeson et al, The Episode 11 trial of cognitive and family therapy for relapse prevention in early psychosis - Rationale and sample characteristics (2007). The data described in this article indicate distress amongst a high proportion of family members, and a high proportion of at-risk family environments amongst this cohort of remitted First Episode Psychosis patients.

34 Additionally, families and carers do not get the information, education, training and support needed to cope effectively with the situation. This is particularly problematic in the early stages of a mental illness, when families are so bewildered and confused, anxious and frightened that they do not know exactly what they want or need, and therefore do not know what to ask for or how to ask for it. Clinicians need to be trained in empathizing with the distress of families and the person being cared for in these early stages.

**In what ways is the system meeting or not meeting those needs?**

35 The system is generally not meeting the needs of families and carers, although there is greater recognition now that families and carers are an important component of effective treatment.

36 As discussed in paragraph 27(c), clinicians and other members of the mental health workforce are not sufficiently trained to involve families and carers in the treatment of the person being cared for. The training provided is focused on treating the individual, and there are no resources for training staff as to how to involve families and carers.

37 I have found out recently that many family support groups[10] are no longer functioning. I do not know all of the reasons why this has happened, as I have not been involved in mental health services for some years; but from many years previously of developing and supporting family support groups, I think this is very unfortunate as family support groups, if well-planned and effectively managed, can be hugely effective in helping families in many ways. Families share information, learn coping strategies from each other, support each other and very importantly, no longer feel isolated and alone. I have heard that because the NDIS focuses on individual treatment models, support groups are not part of their agenda and therefore not supported financially. However, this issue should be discussed with others who have more accurate knowledge of treatment models under the NDIS.

38 The employment of carer and consumer consultants in our mental health services is a very positive step. However, my experience is that these positions are perhaps 'tokenistic' at present. The Carer Support Fund, funded by the Victorian Government, is very helpful but not adequate.

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[10] I have recently been told that one family support group that was commenced in the early days of the Schizophrenia Fellowship of Victoria, will celebrate 30 years of regular meetings this year. Another support group that has been meeting since 1981, share a meal together once a month. These mothers are aged in their 80s and 90s - and they are still caring for adult children aged 60+; that amounts to 40+ years of caring

**Briefly, what is your understanding of the role of carers and families under the Mental Health Act (or any other relevant legislation)? How do the privacy rights of consumers impact the ability of families and carers to be informed about and involved in care?**

39 Under the *Mental Health Act*, 2014, the nominated person and family carers have the right to be informed about information necessary to assist in their caring role. However, in practice, I believe that many families and carers do not have this right adequately acknowledged to the extent necessary. I do not have enough knowledge here of what is happening, but I believe that it needs investigation.

40 In my experience, the privacy and confidentiality rights of the consumer take precedence over the need of families to be informed. In my experience years ago, many clinicians would not even ask the person being cared for if he or she wanted their family involved. Many people with mental illnesses may often say that they do not want the family involved. There are many reasons for this – they may have developed paranoid delusions (such as 'my mother is trying to poison me'), they are adults so they do not want to be seen as relying on their family, they blame the family for their problems or they think there is nothing wrong with them and therefore question why the family needs to be involved.

41 Prof. William McFarlane's training agenda for mental health clinicians in Multiple Family Groups starts with the clinicians explaining to the person that the family will be involved from the early stages in order for the family members to understand the best way to care for the person. In these situations, consumers typically consent to the arrangement.

42 As families and carers have to operate in a stressful and emotional environment, they may appear angry, hostile, upset etc. This at times results in their being labelled by clinicians as difficult, over-involved, over-anxious and therefore, damaging to the person being cared for. Where that occurs it can result in families and carers being ignored and excluded from the treatment and care of the person.

43 Clinicians commonly refer the families to the carer consultant for him or her to deal with, rather than involving them directly in the treatment and care from the outset.

44 In my view, taking a conservative 'legal' approach in mental health, particularly in relation to privacy rights, can hinder clinicians from drawing on the valuable information families and carers have about the person living with mental illness.

45 There is also positive research evidence of how confidentiality becomes a non-issue if appropriately handled by trained clinicians and in fact provides an opportunity for clinicians to develop quality relations with both the persons living with mental illnesses as well as their families and carers.

46 In my opinion this issue deserves close consideration by the Commission.

**Are there any other important barriers to families and carers participating effectively in the care of their loved ones?**

47 In my work, I have observed that families and carers are in a constant state of anxiety but receive no support in how to deal with the important questions that plague them. This is particularly so in relation to the issue of who will care for their family member when the carers are no longer around or able to provide the care. A significant part of the anxiety revolves around whether the person would be able to live independently without the support of their family and carers.

48 During my time at the Schizophrenia Fellowship in Victoria (now known as Wellways Australia), we developed a supported housing model, where staff were present 24*7. We observed that after a period of eighteen months[11], the 19 people living in this supported housing were not only able to exist quite independently of their families, but also that there was a huge reduction in re-hospitalisation rates.

49 I believe that ventures such as this would greatly help in assuaging the concerns of families and carers. Unfortunately, however, these kinds of ventures are few and far between.

**Has the role of families and carers evolved historically in the move from hospital-based mental health care to community care? If so, how have the major structural changes in the mental health system responded (or not responded) to the needs of families and carers?**

50 The caring role of families and friends has evolved dramatically in the move from institutional mental health care to community-based care. In the institutional mental health care system, a family member admitted to a mental institution was 'locked up and the key thrown away.' Families perhaps visited, but had no caring responsibilities [12]. However, when the mental health system moved to community-based care, the expectation shifted to the families to provide significant support. If the person had lost family contact, 'care' was often only available from appallingly inadequate supported residential facilities.

51 In the period immediately after the transition to community-based care, the mental health system did not respond at all to the needs of families and carers. However, the situation is very slowly, but 'patchily' improving, particularly with the development of

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[11] I have available a detailed evaluation of this project completed in 1991. 'Rossdale - The Story. A study and evaluation of a fully supervised apartment house for people severely disabled by psychiatric illness.'

[12] These issues are described in more detail in a book by Jeffs and Leggatt to be published later this year.

Community Care Units (CCUs) and Prevention and Recovery Care (PARC) services. However, there are not enough CCUs and PARCs.

**How well does the mental health workforce interface with families and carers?**

52 The mental health workforce by and large interacts poorly with families and carers. As discussed in paragraphs 27(c) and 36 above, the health workers who operate in this area often do not have the proper training to involve families and carers, and do not perceive families and carers as an essential part of the treatment team. Moreover, medical models of treatment and care are only concerned with the individual, and these structural limitations impede mental health workers who may desire to work with families and carers from doing so.

53 Furthermore, as discussed in paragraphs 18 to 23 above, whilst there are programs under which the mental health workers can be trained to work with families, these programs are not being implemented.

54 In my view, it must be made mandatory, by law, that mental health services have structures and programmes that involve the person's social network in their treatment and care – i.e. their families and friends. Although Section 11(1)(k) of the Mental Health Act 2014 states that carers (including children) for persons receiving mental health services should be involved in decisions about assessment, treatment and recovery, this is qualified by the term "whenever this is possible". In many instances, it will seem not to be possible because the person's confidentiality may be seen to be compromised. Therefore, this statement of principle can often be ignored. Therefore, it is crucial that mental health services have to mandatorily provide structures and programmes that involve a person's social network.

**What happens when a person living with mental illness has no family or carers, particularly given our aging population?**

55 Many people living with mental illness may not have family or carers, or may have lost contact with their family and friends. I have observed that it is more likely for persons with no family or carer to become disengaged with mental health services such as not keeping their appointments with community mental health services after having been discharged from a psychiatric ward.

56 I have observed that in these circumstances, some of these persons who have disengaged from the mental health system may end up in boarding house accommodation, which can sometimes be sub-standard. In other instances, these people become homeless, may be jailed for petty crimes or, if they have some resources of their own, become the 'oddball' living by himself/herself in their own home, isolated and ostracised by the community.

57 In my view, there is a significant role that the non-government sector can play in these situations. There are many major non-government organisations (NGOs) in Victoria which have been providing community support services for mentally ill persons with long-term psychiatric disability. In my view, these organisations do a good job of providing support to the person living with mental illness, despite having limited resources. This problem of limited resources has been further compounded by the recent de-funding of these NGOs with funding under the mental health budget being moved to NDIS.

58 There aren't enough NGOs to meet the demand for community support services. There is research evidence to show that it would be more cost-effective for the mental health system to have these NGOs in place. In my view, NGOs providing community support services, funded by the Government, is the right way forward to deal with this issue of people living with a mental illness and no family or carer support.

*sign here* ► Margaret Leggatt

*print name* Dr Margaret Leggatt

*date* 11.07.2019.

# ATTACHMENT ML-1

This is the attachment marked 'ML-1' referred to in the witness statement of Dr. Margaret Leggatt dated 11 July 2019.

# Curriculum Vitae – Dr. Margaret Leggatt

**A.M., Ph.D. B.App.Sc.(O.T)**

Dr. Margaret Leggatt holds a B.A. Hons. Ph.D from Monash University, and B.App.Sc (O.T.) from Latrobe University in Melbourne, Victoria, Australia. She was awarded a Churchill Fellowship in 1981 to study the rehabilitation of the seriously mentally ill in the United Kingdom, and in 1987, was awarded a Member of the Order of Australia for service to those with schizophrenia and their families.

Dr. Margaret Leggatt was the founding director of the Schizophrenia Fellowship in Victoria (now known as Wellways Australia) from 1981 - 1995, an organisation which was replicated in all States and the Australian Capital Territory.

From 1995 – 1997, Dr. Leggatt was a Senior Research Fellow at Deakin University where she was involved in the organization of workshops to examine the education and training needs of the professional mental health workforce, and a research project to implement and evaluate multiple family group psychoeducational interventions in the management of major mental illness.

At the conclusion of these projects, she left Deakin University in order to fulfil her commitment as President to the World Fellowship for Schizophrenia and Allied Disorders - an international organization concentrating on the development of family support organizations worldwide. This entailed extensive travelling mainly in Asia and Africa during the years from 1998 - 2004.

Dr Margaret Leggatt's last place of employment (2002 - 2007) was coordinator of the Family Participation Project at ORYGEN Youth Health, where she worked with Prof. Pat McGorry. She concentrated on developing information and support programmes for family carers of young people experiencing their first episode of mental illness.

She is on the Board of Tandem, the peak body of mental health carer organizations and groups across Victoria. Dr Margaret Leggatt also sat on the Victorian Mental Health Tribunal until immediate family concerns necessitated her resignation in December 2017.

Dr Margaret Leggatt is also a founder and patron of SANE Australia, an organization designed to tackle the issues of serious mental illness on a national scale, as well as to implement a programme designed to educate in order to change community attitudes towards mental illnesses.

Dr Margaret Leggatt's publications include articles, chapters in books, research reports and many booklets and pamphlets on issues related to mental illness. Her involvement in improving the image of schizophrenia and mental illnesses in general, has resulted in many media interviews and programmes, and a variety of talks to an extensive range of community organisations over many years.