Mental Health Council of Australia submission on Australia's Draft Initial Report under the *Convention on the Rights of Persons with Disabilities*

August 2010

Introduction
The Mental Health Council of Australia (MHCA) is the peak, national non-government organisation representing and promoting the interests of the Australian mental health sector, committed to achieving better mental health for all Australians. The membership of the MHCA includes national organisations of mental health service consumers, carers, special needs groups, clinical service providers, community and private mental health.

The MHCA supports the Australian Government's commitment to respecting the rights of persons with disabilities. The MHCA strongly supports the purpose of the *Convention on the Rights of Persons with Disabilities* (CRPD) and its ratification by the Australian Government.

Articles 5 & 8: Equality and non-discrimination, and awareness-raising
Removing stigma is a vital part of recovery for people with a mental illness. However, countries around the world are experiencing increasing rates of mental health problems, and there remains strong community stigma towards mental illness globally.

Most Australians do not have a clear understanding of mental illness. This lack of understanding perpetuates prejudice and discrimination in all levels of society. Research has shown that prejudice and discrimination can be reduced by providing equal status and common goals among groups, increasing inter-group cooperation and supporting authorities, law or custom.

Stigma is consistently identified as a major barrier to recovery by people with mental illness, their families and those working in the mental health field. Stigma acts as a social disability often causing equal, or even more, stress than the actual mental illness. A survey conducted in Australia in 2006 found that three out of four people affected by mental illness said they had experienced stigma.[1]

Stigma tends to be associated with negative experiences, which can either come from public stigma or self-stigma. Public stigma is where power groups negatively impact upon the lives of people affected by mental illness, such as landlords, employers, members of the criminal justice system, health providers, etc; and self-stigma is the impact discrimination has on an individual's own psychological wellbeing. This is often reflected in the person's health care choices and decisions about life-goals.

[1] SANE Australia (2006), *Research Bulletin 4: Stigma and Mental Illness*, SANE: Melbourne.

The MHCA would like to see a national commitment to address stigma and discrimination towards people with mental illness by implementing a range of activities to counter these issues. These activities need to be targeted in the following areas: education, the media, community level, and with health professionals.

Articles 12, 13, & 14: Equal recognition before the law, access to justice, liberty and security of the person

Disability discrimination legislation provides protection from discrimination for people with a disability, including people with mental illness, in areas of employment, education and the provision of goods and services. It does not provide any protection from vilification. This lack of protection from vilification is of concern to mental health consumers and their carers, and many claim that this situation perpetuates stigma in the community.

This lack of protection from vilification is also not covered in mental health legislation. Mental health legislation has been criticised for not incorporating human rights principles and ignoring these fundamental principles, reinforcing existing societal prejudice and stigma. One example of where this issue produces contention is in access to treatment and the inability of policy makers to try to address the conflict between involuntary treatment and social control. However, there are often difficulties balancing a consumer's human rights with health professionals' rights to health and safety. This is a difficult issue and largely missing from mental health discourse. One problem is that mental health legislation has a complex interaction with other legislation such as anti-discrimination, guardianship, child protection, criminal justice, etc.

The MHCA considers protection from vilification should be explicitly included in relevant legislation.

In Australia, people with a mental illness are over-represented in the criminal justice system and victimisation is common among people with mental illness. Victimisation of people with a mental illness can exacerbate pre-existing conditions and result in a substantially diminished quality of life. Although classifying 'victimisation' is complex and differs across studies and research methodology, it is apparent that vulnerable people are the most likely to be victimised in the community; this is often exacerbated by other issues such as substance abuse and homelessness.

Insurance is an area where mental health consumers may face discrimination, both in their attempts to access insurance and in the handling of claims. The Disability Discrimination Act 1992 (DDA) states that it is illegal to discriminate against a person on the grounds of that person's disability, including a psychiatric or psychological disability, in the provision of goods and services, including insurance. However, section 46 of the DDA states that discrimination in the provision of insurance is not unlawful, provided that the discrimination is based on actuarial or statistical data on which it is reasonable to rely, or, if this data is not available, on other relevant and reasonable factors. Mental health consumer and carer feedback outlines this discrimination occurs widely, with insurance companies interpreting the letter of the law in different ways, leading to exclusions or increased premiums applied to those mental health consumers who are able to obtain insurance.

The MHCA supports clearer guidance for interpretation of anti-discrimination legislation and how it relates specifically to mental illness and the insurance sector.

Article 15: Freedom from torture or cruel, inhuman or degrading treatment or punishment
The draft Initial Report outlines that it is contrary to the WA Mental Health Act 1996 to treat a person with a mental illness in a cruel, inhuman or degrading way, and includes reference to a number of other state-based Acts. However, interpretation of what is cruel or degrading differs depending on whether a consumer (and their carer) viewpoint is taken, or that of a health professional.

While some health professionals may consider the use of seclusion and/or restraint as a mechanism for protecting a mental health consumer from harming themselves or others, consumers and carers consider seclusion and restraint:

- are often associated with human rights abuse;
- are not evidence-based therapeutic interventions;
- can cause short and long term emotional damage to consumers and/or their family or carers; and
- can prevent trust being developed between consumers, carers and clinical staff.[2]

Article 17: Protecting the integrity of the person
There are a number of mechanisms in place to regulate involuntary treatment of people with mental illness, as outlined in the draft Initial Report. Unfortunately, consumer and carer stories about what happens 'on the ground' sometimes do not reflect the rigor intended by these oversighting mechanisms. For example, the 2009 report, *Ending Seclusion and Restraint in Australian Mental Health Services*, includes a case study of one person's experience of involuntary 'treatment' by seclusion.[3] It is clear from the person's experience that his physical and mental integrity were not respected, nor was his history of torture and trauma in another country apparently considered.

It is not enough to merely implement legislation and oversighting mechanisms that assume safeguards are actually in place or being utilised. Consumer reporting mechanisms should be an integral part of mental health service design and change should not rely on a complaints/ appeal-type process.

Articles 19, 26 & 28: Living independently and being included in the community, and adequate standard of living and social protection, habilitation and rehabilitation
Mental health and wellbeing are fundamental components of health, social cohesion, productivity and overall wellness for communities and their populations. While individuals and communities have the capacity to have good mental health, they require support in order to achieve and maintain it. A wide range of services is needed beyond those dealing with health issues to assist people with mental illness, such as social support, assisted housing, and education and training services.

A secure home is widely recognised as providing a fundamental basis for building mental wellness and it is essential mental health issues are a part of any discussion on homelessness and housing. People with a mental illness face a number of barriers in their attempts to achieve and maintain stable housing.[4] These include housing affordability, insecure tenure, poor housing conditions, financial difficulties, administrative issues, behavioural and social issues,

[2] National Mental Health Consumer & Carer Forum (2009), *Ending Seclusion and Restraint in Australian Mental Health Services*, NMHCCF: Canberra.
[3] Ibid, p9.
[4] Mental Health Council of Australia (2009), *Home Truths: Mental Health, Housing and Homelessness in Australia*, MHCA: Canberra.

stigma and discrimination, and a lack of support and treatment. Mental illness can also result from, or be exacerbated by, the experience of homelessness or unstable housing.

The links between mental illness and homelessness must be recognised with housing stock set aside specifically for people with mental illness. Zero tolerance for discharge into homelessness must be standard in health and disability services, and there must be research and evaluation of homelessness and housing programs and services to see if they meet the needs of people with mental illness.

Article 24: Education

Seventy-five per cent of mental health disorders develop by the time a person has reached the age of 25, yet 70 per cent of these young people do not seek help. More attention is needed to providing supportive environments in education systems and tackling stigma. One way to do this would be to introduce school-based interventions to overcome mental health stigma and to foster the idea of social inclusion and inclusiveness among all people in all levels of the education system.

Article 25: Health

Unlike other health issues, two-thirds of people with a mental illness do not receive any treatment in any 12 month period. However, with appropriate care, people can recover from mental illness. One of the most important things that assists recovery is compassion and understanding.

In addition, good physical health has been identified as a key component to maintaining good mental health as the relationship between physical health and mental health is closely interlinked. The relationship includes the effects that a person's mental illness might have on their physical health, meaning how mental illness might impact on the body's physiology, or whether a physical illness is either causing or exacerbating a mental illness.

The physical health of people with mental illness is largely ignored. The health system tends to focus solely on the mental illness of many mental health consumers, resulting in a lack of holistic care. There may be difficulties for people with mental illness in obtaining physical health assessments and accessing general practice. Research identifying higher death rates in all main causes of death for people with mental illness, compared with the general population, highlights this neglect.

There is an urgent need for the mental health professions to address stigma within mental health services as well as recognising the specific physical health needs of people with mental illness.

Article 27: Work and employment

Employment is critical for people with a mental illness. People with a mental illness are among the most socially and economically marginalised members of the community, experiencing high levels of unemployment and nonparticipation in the workforce.[5] Unemployment leads to a loss of purpose, structure, status and a sense of identity which employment brings. Employment supports a sense of social inclusion and meaningful participation in the wider community.

[5] Mental Health Council of Australia (2007), *Let's Get to Work: A National Mental Health Employment Strategy for Australia*, MHCA: Canberra.

Having a mental illness drastically reduces a person's ability to obtain and maintain employment, forcing them to seek financial assistance such as the youth allowance or disability support pension. Both the public and private sector have failed in terms of hiring and maintaining employment for people with mental illness.[6]

Australian workplaces need to provide a more accepting environment for people with mental illness. This includes promoting flexible workplaces, raising awareness and addressing stigma and discrimination in the workplace, providing training and education programs for people with mental illness.

Conclusion

The MHCA strongly supports Australia ratifying the UN *Convention on the Rights of Persons with Disabilities*. We are pleased that a number of articles explicitly refer to mental illness. However, there are areas that could be strengthened, particularly discrimination on the basis of disability, which occurs widely for mental health consumers attempting to access insurance. Freedom from cruel or inhuman treatment and protecting the integrity of the person are key mental health consumer issues and need greater attention within the mental health sector. Employment and housing support are essential areas of focus to ensure people with mental illness-related disability are encouraged to fully participate as members of their community.

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[6] Ibid.