

Joint Submission to the Royal Commission into Victoria's Mental Health System

Authorised and written by: the Australian Federation of Disability Organisations, Disability Resources Centre, Women with Disabilities Victoria, Women's Mental Health Network Victoria and Disability Justice Australia.



**Australian Federation of
Disability Organisations**



**WOMEN'S
MENTAL HEALTH
NETWORK VICTORIA**



**Disability
Justice
Australia Inc.**

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Acknowledgments

We acknowledge the traditional owners of the land on which this submission was produced, the lands of the Kulin Nations, the home of the Wurundjeri, Boonwurrung, Wathaurong, Taungurong and Djadjawurung peoples. We acknowledge Aboriginal and Torres Strait Islander people's connection to this land and acknowledge that sovereignty was never ceded. We pay our respects to community members and Elders past, present and emerging.

A note about language

Many people with disabilities have come to refer to themselves as 'targeted' and 'at risk' rather than 'vulnerable.' This change of language shifts the focus away from a blaming tone towards the victim/survivor of violence – and on to the people who choose to abuse people with disabilities and the social conditions that make this common. We also encourage employing empowering language that recognises the credibility of people with disabilities by using the words 'targeted' and 'at risk', rather than 'vulnerable' and using the word 'disclosures', rather than 'allegations' of violence; and naming violence against women.

Endorsements

Women's Health Victoria has endorsed this submission.



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Australian Federation of Disability Organisations

Since 2003, the Australian Federation of Disability Organisations (AFDO) has been the recognised national peak organisation in the disability sector, along with its disability specific members, representing and run by people with disability or lived experience of disability.

AFDO's mission is to champion the rights of people with disability in Australia and support them to participate fully in Australian life. AFDO has strong relationships, not just with its member organisations, but across the disability sector including peaks representing service providers as well as those representing families and carers.

As one of the three founding members of the National Disability and Carer Alliance, AFDO played a key role in the campaign for the introduction of the National Disability Insurance Scheme (NDIS) through its 'Every Australian Counts' campaign. As the NDIS has moved through the trial phase and begun the transition to full scheme, AFDO and its members have continued to work constructively with the National Disability Insurance Agency (NDIA) as well as Commonwealth, State and Territory governments to provide critical feedback and address implementation issues as they arise.

Our members represent disability specific communities nationally with a total reach of over 1, 700, 000.00 million Australians. AFDO continues to provide a strong, trusted, independent voice for the disability sector on national policy, inquiries, submissions, systemic advocacy and advisory on government initiatives with the Federal and State/Territory governments. AFDO's members include: Blind Citizens Australia, Brain Injury Australia, Deaf Australia, Deafblind Australia, Autism Aspergers Advocacy Australia, Down Syndrome Australia, Physical Disability Australia, Disability Advocacy Network Australia, Disability Justice Australia, People with Disability WA, Disability Resources Centre, Inclusion Australia (NCID), People with Disabilities ACT, Women with Disabilities Victoria, Enhanced Lifestyles, Deafness Forum of Australia, and Women with Disabilities ACT.



Disability Resources Centre

The Disability Resources Centre Inc. (DRC) is a statewide Disabled Peoples' Organisation, which was formed in 1981. DRC is a membership-driven organisation managed and staffed by people with disabilities. Membership of the DRC is free and people with disabilities are encouraged to join. In addition to its metropolitan individual advocacy program, DRC also prioritises system advocacy. DRC's systemic advocacy is focused on ensuring that people with disabilities have a voice that is heard, and advocates for change to achieve equity.

Disability Justice Australia

Disability Justice Australia Inc. (DJA) was formed in 1990 to provide advocacy support to people with disabilities. DJA was formerly known as the Action Resource Network. DJA receives funding through the Department of Social Services (DSS) to provide individual, legal and systemic advocacy across Melbourne. DSS also funds DJA to provide NDIS appeals support in the North-Eastern suburbs for Melbourne. DJA is a membership based DPFO with over 100 members and is governed by a board of people with disabilities. We provide services to people with intellectual, psychosocial, sensory or physical disability or combination of these and their families.

Our mission is to enrich the lives of people with disabilities through innovative and person-centred solutions. Our purpose is to provide a range of services that are responsive to the needs of people with disabilities and their families. We provide a mobile individually tailored person-centred outreach service to promote, empower, enhance and protect human rights, support full and effective participation and inclusion in society, respect intrinsic dignity, recognise the right to equal opportunity, show respect for individual differences, respect the right to make own choices; and to ensure freedom from discrimination, exploitation, abuse, harm, neglect and violence. These are enshrined in our new constitution and underpin all our policies, procedures and tools at the governance and operational levels.

On the 08 September 2018, our members voted for DJA to become a national entity and to change our name from Disability Justice Advocacy to Disability Justice Australia, to reflect our new business model. Our new strategic vision is to be the leading provider of services for people with disabilities, as per our 2018-2022 Strategic Plan. DJA is now a Not-for-Profit charity registered with the ACNC and recently registered with the NDIS.

Women with Disabilities Victoria

Women with Disabilities Victoria (WDV) is the peak body of women with disabilities in Victoria. Women with Disabilities Victoria is a membership-based organisation run by women with disabilities, for women with disabilities. Our members, board and staff live across the state and have a range of disabilities, lifestyles and ages. We are united in working towards our vision of a world where all women are respected and can fully experience life.

To advance real social and economic inclusion for women with disabilities in Victoria, we act as a voice for women with disabilities, create opportunities to be visible and to be heard, build partnerships and engage the community to challenge attitudes and myths about women with disabilities. Our gender perspective allows us to focus on areas of particular inequity to women with: access to women's health services, gendered National Disability Insurance Scheme (NDIS) services and safety from gender-based violence. We undertake research and consultation; provide professional education, representation, information and leadership programs for women with disabilities.

Women's Mental Health Network Victoria

The Women's Mental Health Network Victoria Inc. (the Network), is an advocacy organisation with more than 180 members consisting of women consumers, carers, health professionals and women who are interested in women's mental health. The focus of our work is to promote awareness of issues that impact on women's mental health and support women in the mental health system by highlighting gender sensitive practice that takes into account the lived experiences of women as they interact with the system at any stage.

Central to the Network is the recognition of consumers' lived experience and their expertise and ability to partner in their own recovery. We aim to bring together women who have the passion, expertise, innovation, hope and determination - to make a powerful voice for change. The Network is a charitable association registered and run largely by volunteers - we have been influential in the mental health sector over many decades. We have worked tirelessly for positive change in the experience of female psychiatric patients when accessing mental health services.

We aim to embed a culture of safer gender-sensitive care in staff practice, promoting a healing environment for women consumers. The Network has been a front-runner in the co-design and co-production of policy, training and programs involving consumers, carers and service providers from its establishment in 1988. We have co-produced the *Women Speak Out Program*, consumer advocacy training that helps build confidence and skills to enable women to actively participate

in their communities, public forums or committees and services. Its rural and regional counterpart program *Breaking the Silence* - a pilot program - supports women by enabling networking at the local level to provide sustainability for connecting and engaging consumers in regional settings.

Glossary of terms

Disability: there is no single definition or model of disability. Although the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) acknowledges 'disability' as a continually evolving concept, it specifically enshrines a social model of disability through its definition. The UNCRPD defines 'disability' as long-term physical, mental, intellectual or sensory impairments, *which in interaction with various barriers*, hinders an individual's full and effective participation in society on an equal basis with others. This definition of disability directly informs this submission.

People with disability: in this submission, when we speak about 'people with disabilities', we are speaking about all people with disabilities, including those with psychosocial disabilities, co-occurring illnesses or dual disabilities. When using the terms 'persons with mental health conditions', 'consumers' or 'psychosocial disabilities', we do so to talk about this as a specific cohort or group and to acknowledge, for various reasons, not all people identify with the term 'psychosocial disability'.

Psychosocial disability: the term 'psychosocial' refers to the interaction between psychological and social-cultural components of disability. The socio-cultural component refers to societal and cultural stigma and limits. We see the term 'psychosocial' as best aligned with a socially focused, human rights model for understanding mental health impairments.

The social model of disability: a social model of disability sees 'disability' as the result of the interaction between people living with impairment(s) and an environment filled with physical, attitudinal, communicative and social barriers that do not accommodate the person. It argues that the physical, attitudinal and social environment(s) are what must change to enable people living with impairment(s) to participate in society on an equal basis with others.

The social model of health: a social model of health focuses on addressing the social and economic determinants of health, including social inequalities (i.e. income, education, social status, housing, employment etc.) and empowering individuals and communities. The social model of health recognises that the social conditions people live under are the most important determinants of either good or poor health.

The medical model of disability: under the medical model of disability, impairments or differences are to be 'fixed' or changed by medical intervention and treatment. In the context of mental health, a medical or 'bio-medical model' sees mental illnesses as 'brain diseases' and emphasises the pharmacological treatment of such presumed biological and mental differences.

Lived experience: 'lived experience' is the knowledge and understanding you get when you have lived through something. For the purposes of this submission, lived experience refers to the experiences of consumers of the mental health system and people with disabilities, but may also refer to the experience of carers and family, where specified.

Introduction and executive summary

We welcome this opportunity to contribute to the Royal Commission into the Mental Health System in Victoria (the 'Royal Commission'). This joint submission between our organisations is based on research, practice experience, systemic advocacy work and consultation with people with lived experience of disability, including people with mental health conditions or psychosocial disabilities. We view this as a critical opportunity to ensure that the mental health system in Victoria is equitable and accessible for people with disabilities.

We advocate in our submission that reform to Victoria's mental health system must be embedded in both an intersectional and human rights framework that recognises and upholds rights under the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) and responds to the multiple layers of disadvantage experienced by people with disabilities. Australian and international evidence shows that the health of people with disabilities is worse than that of non-disabled people across a range of health outcomes, including mental health.¹ Although there are a range of barriers to accessing services for people with disabilities, people with disabilities are rarely identified as a priority population group in mental health policy and practice.² This is why the Royal Commission must recognise people with disabilities as a group at greater risk, with much higher rates of mental illness.

During May 2019, the Women's Mental Health Network Victoria (WMHNV) developed a survey focused around key issues relating to women's mental health. This has allowed for input from women in the community to inform our submission. The survey was sent to all the members of the Network, across the Network's website and social media platforms and for anyone in the broader public to access. 56 people completed the survey, with eighty-nine per cent 89% identifying as women, seven per cent 7% as men, and three per cent 3% preferring not to state gender, or who did not identify as 'male' or 'female'. We have chosen to highlight five key aspects from this piece of research in this submission. Quotes in this submission are directly from the Network's survey responses, unless otherwise specified.

Human rights, intersectionality and public health approaches

Underlying social disadvantages contribute to poor mental health outcomes and a lack of access to support and services. In order to support Victoria's mental health system in becoming one that is more responsive, and accessible to, people with disabilities, we argue that evidence demonstrates a need to apply an intersectional, gender-sensitive and a public health approach,

¹ World Health Organisation and World Bank Group 2011, 'World report on disability', (WHO: Geneva).

² VicHealth, (2012), 'Disability and Health Inequalities in Australia: Research summary', p. 1.

across all aspects of the mental health system. We also discuss the need for a strengths-based approach to disability and a holistic view of the individual, through the social model of health.

A social model of health focuses on addressing the social and economic determinants of health, including reducing social inequities and empowering individuals and communities. For people with disabilities, these social determinants of health are often at issue, as people with disabilities are more likely to:

- live in poverty;
- live in poor-quality or insecure housing;
- have low levels of workforce participation and/or education;
- be marginalised or social isolated;
- face violence and discrimination related to their disability; and
- have difficulty accessing appropriate health care.³

These deep social and economic inequalities are a major contributor to poor mental health for people with disabilities.

Violence, abuse, neglect and exploitation of people with disabilities

People with disabilities report high rates of experiencing violence, abuse and neglect. Because of this, people with disabilities stand to benefit from recovery-oriented and trauma-informed support and service delivery, which respects self-determination and choice. 'Trauma-informed' care is based on the premise that many behaviours and responses expressed by people with mental illness have a direct relationship to a previous or current experience of trauma. Research has shown that at many as ninety per cent 90% of those accessing public mental health services have experienced an incident, or multiple incidents, of trauma.⁴

As many people with disabilities have experienced mental health issues as a direct result of the impact of trauma through violence, including family and sexual violence, abuse or neglect, these approaches are vital to understanding the harm caused through coercion in the mental health system. This harm can be experienced in mental health settings, such as in hospital wards, and through the use of seclusion and restrictive practices. This is often traumatising and distressing, as well as being a violation of a person's recognised human rights. While people with disabilities are often victims of violence, women with disabilities are particularly at high risk of experiencing violence. The high prevalence of violence against women with disabilities in Australia has been extensively documented through multiple United Nations (UN) and civil society reports into

³ VicHealth (2012), VicHealth Indicators Survey, Melbourne, Australia.

⁴ Victorian Government, Department of Health and Human Services, (2015), 'Trauma and Mental Health: 10-year mental health plan technical paper.'

human rights violations.⁵ At the Victorian level, Women with Disabilities Victoria has documented this high prevalence of violence experienced by women with disabilities through systemic advocacy and research, such as through the Voices against Violence research project.⁶

Centering lived experience

We also stress the primary importance of centering the perspectives of those with lived experience in the Royal Commission's work and findings. Respect for the experiences of consumers and their feelings about, and interactions with the mental health system, as varied as these may be, must be as a central part of the Royal Commission's work. The first-hand, lived experience of the mental health system is extremely valuable, whether from consumers, carers and workers and this knowledge should be respected. We believe that those with lived experience must be involved at every step, so that there can be meaningful input into system design.

While the role of carers and their lived experience is vital, consumers require a different, elevated level of recognition and self-determination. The importance of consumer lived experience is evident when looking at the benefits of initiatives that actively engage consumers in their own recovery, building support networks with others with lived experience and in being active members of their communities. As peer support focuses on groups of people with similar experiences, there is also a need to resource peer support initiatives that aim to provide a safe environment for women with lived experience of the mental health system, particularly around gendered experiences of trauma, such as family and sexual violence (including violence experienced during hospital admissions). Some good practice examples of consumer input are found in user-led initiatives, such as peer-run crisis centres and self-help groups. A few examples include:

- The Leeds Survivor-Led Crisis Service;
- *Piri Pono*, a New Zealand, peer-run service which is an alternative to hospitalisation;
- Safe Haven Support cafes in the United Kingdom and
- Intentional peer support, to name a few.⁷

⁵ See: Australian Human Rights Commission, (2012), Visit of the UN Special Rapporteur on Violence Against Women: Australian study tour report, Australian Human Rights Commission, Sydney; Human Rights Law Centre, (2014), Torture and Cruel Treatment in Australia: Joint NGO Report to the United Nations Committee Against Torture, Human Rights Law Centre, Melbourne; S. Browne, (2012), How have global services addressing violence against women with disabilities understood their needs and what are the lessons for the next generation of practice?, The United Nations Women, Global Virtual Knowledge Centre to End Violence against Women and Girls; Disability Rights Now: Civil Society Report to the United Nations Committee on the Rights of Persons with Disabilities, (2012), Compiled by Disability Representative, Advocacy, Legal and Human Rights Organisations, Australia.

⁶ You can access the 'Voices against Violence' papers on the Women with Disabilities Victoria website, at <<https://www.wdv.org.au/our-work/building-the-knowledge/voices-against-violence/>>.

⁷ For a further examination of international evidence of user-led initiatives, see: Gooding, P; McSherry, B; Roper, C; Grey, F., (2018), Alternatives to Coercion in Mental Health Settings: A Literature Review, Melbourne: Melbourne Social Equity Institute, University of Melbourne, pp. 40 - 43. This report provides a comprehensive overview of non-coercive

In a consultation run by Women with Disabilities Victoria, women with disabilities spoke about the need for consumer and lived experience perspectives and voices:

"I want to speak in a small group of my peers, not in public or one on one with a Commissioner or professional."

"There's a lack of opportunity to talk to our peers before making submissions to [the Victorian Royal Commission into Mental Health], the questions for an upcoming consultation are too broad to have a real discussion. These are big experiences. People need space and time to start thinking them through. We also need to develop peoples' confidence and momentum to take control."

"Consultation spaces should be gendered – and safe for women with disability."

Tensions between medical and social models of disability and mental health

A range of socioeconomic, biological and environmental factors determines mental health. Multiple social, psychological, and biological factors all play a part in the level of mental health of an individual person at any point of time. For example, violence and persistent socio-economic pressures are recognised risks to mental health. Some of the clearest evidence is associated with sexual violence. Poor mental health is also associated with rapid social change, stressful work conditions, gender discrimination, social exclusion, unhealthy lifestyle, physical ill health and human rights violations.⁸

A social model of disability sees 'disability' as the result of the interaction between people living with impairment(s) and an environment filled with physical, attitudinal, communicative and social barriers that do not accommodate the person. It therefore argues that the physical, attitudinal, communication and social environment(s) are what must change to enable people living with impairment(s) to participate in society on an equal basis with others.⁹ In contrast, a medical or 'bio-medical model' of disability, posits that mental disorders are "brain diseases" and emphasises the pharmacological treatment of presumed biological and mental differences. There is a tension between these two models, partly because the medical model predominates the mental health world; and the social model of disability remains more widely understood in the disability sector.

alternatives to mental health settings, include those which are peer and service-user led initiatives. See also: Victorian Mental Illness Awareness Council (VMIAC)'s submission to the Terms of Reference consultation, (2019).

⁸ World Health Organisation (WHO) (2019), Factsheets, Mental Health: Strengthening our Response.

⁹ See: People with Disability Australia (PWDA)'s website on the 'social model of disability', at <<https://pwd.org.au/resources/disability-faqs/social-model-of-disability/>>.

We know that untreated mental health conditions can lead to negative consequences for individuals with mental health conditions. Psychosocial disabilities, mental health conditions and illnesses can impair a person's ability to engage with their wider world, family and loved ones. The social model of disability, as it focuses on the aspects of an external social environment that needs to change, does not as easily address some of the complex barriers people with mental health conditions or psychosocial disabilities experience. The fact that the mind is, in a sense, 'impaired' and is not an easily visible aspect of 'the body', can set up a different set of parameters, needs and understandings.

The tensions between these models is reflected in the way that some people may understand their conditions and the range of self-identifications. Some consumers are not comfortable with the term 'disability' and do not identify with it, and thus, are less engaged with a social model of disability. As a result, some consumers are less likely to engage in the disability community and disability supports, such as the National Disability Insurance Scheme (NDIS). Some mental illnesses are very episodic in nature, while others may experience more persistent, chronic and ongoing mental illness. The recovery model, which is influential in the mental health sector, provides that consumer's 'recovery' from mental illness is possible, with the right supports. Disability is often not approached in the same way, or is more likely to be understood as a condition or impairment, which is 'permanent' and non-episodic. The complexities of mental illness and its relationship to understandings of 'disability' require an understanding of the nuances around the social model of disability, medical models and notions of recovery. However, at all times, despite the contentious nature of some of these debates, a person's choice to identify in any particular way should be respected and should not be a barrier to receiving the support they need.

The variety and complexity of settings

Victoria's mental health system contains within it a variety of settings, services and types of support. We stress that while all experiences matter, they are not always the same and differences are important to acknowledge. There is a need for the Royal Commission to recognise this diversity and hear from people all across the service settings within the mental health system, including both the private to public health systems, General Practitioners (GPs), community mental health services, peer-support services, hospital and inpatient experiences, non-clinical community services and forensic services. This Royal Commission should also pay attention to the breadth of experiences within the mental health system, both voluntary and compulsory.

Structure of this submission

This submission is organised around the following themes, which are also tied to expected outcomes and Terms of Reference for the Royal Commission.

1. Intersectional disadvantage – the impacts of both gender and disability.
2. The need for trauma-informed care and practice.
3. Violence, abuse and neglect of people with disability.
4. Accessibility of Victorian mental health services.
5. The role of social inclusion, peer support and community participation.
6. The role of carers.
7. Issues with regional and rural mental health services for people with disability.

1. Intersectional disadvantage: gender, disability and mental health

1.1 Gender, disability and intersectionality

Women with disabilities experience intersecting barriers to good health and wellbeing throughout their lives, including access to mental health services. Women with Disabilities Victoria (WDV) repeatedly hears reports from women with disabilities who have experienced inaccessible services. They speak about not being respected, not been involved in the decisions that affect their care and treatment, a lack of physical access and a recurrent focus being on their disability, rather than their health concerns. However, there is a lack of research on the health requirements of women with disabilities. This in itself is an indicator of the level of discrimination and the invisibility of women with disabilities within research, policy and decision-making.¹⁰

However, the World Health Organisation (WHO) has recently recognised the importance of sex and gender as critical determinants of health.¹¹ Gender roles, norms and gendered behavior have an influence on how people access services and how systems respond to their needs. The different and often unequal abilities of women to protect and promote their health, including mental health, requires recognition so that appropriate and sensitive health interventions can be planned.¹²

The right of women with disabilities' to access safe and sensitive mental health services is also infringed regularly in the current system. Women with disabilities in institutional settings specifically experience added difficulties and barriers to accessing appropriate support and treatment.¹³ Lesbian, gay, bisexual, transgender and intersex (LGBTI) people with disability also experience discrimination from within both the LGBTI and disability communities, increasing feelings of social isolation and contributing to an increased risk of mental health issues.¹⁴ Even when services or support is accessed, the needs of LGBTI people with disabilities can be ignored if services are not inclusive and supportive.

¹⁰ Sylvia Petrony, Dr. Philomena Horsley and Professor Anne Kavanagh, 2010. 'Access to Health Services for Women with Disabilities: A review of the literature.' Women with Disabilities Victoria and The Centre for Women's Health, Gender and Society at The University of Melbourne. Unpublished.

¹¹ United Nations, (2010), World Health Organisation, 'Sex and gender are increasingly recognised as important determinants of health for women and men'.

¹² Ministry of Women's Affairs, (2008), A Fair Share for Women: Cambodia Gender Assessment. Phnom Penh: MoWA; Walston, N., 2005. Challenges and Opportunities for Male Involvement in Reproductive Health in Cambodia. Phnom Penh: USAID and Policy Project; World Health Organisation, (2010), Gender, Women and Primary Health Care Renewal. Discussion Paper, (Geneva: WHO), cited in Men, C. H., Frieson, K., Socheat, C., Nirmita, H., Mony, C., World Conference on Social Determinants of Health, (2011), Gender as a Social Determinant on Health: Gender Analysis of the Health Sector in Cambodia: Background Paper.

¹³ Women with Disabilities Australia, Tasmania, (2009), Submission to the National Human Rights Consultation.

¹⁴ Leonard, W. and Mann, R. (2018) The everyday experience of lesbian, gay, bisexual, transgender and intersex (LGBTI) people living with disability, No.111 GLHV@ARCSHS, La Trobe University: Melbourne, p. 6.

Evidence also suggests that while gender is an important social determinant of mental health, the needs and experiences of women have often not been considered in mental health policy or service design, or that they have been considered of secondary importance. While men are admitted to mental health inpatient units in greater numbers and have high rates of suicide, more women experience suicidality and women's needs are less likely to be factored into reviews by government. Similarly, a 2018 report by the Mental Health Complaints Commissioner found that 80% of concerns about sexual safety in acute mental health inpatient units were about women's experiences.¹⁵ There is a strong need for gender-sensitive approaches and approaches that acknowledge intersectionality and multiple disadvantage and discrimination, so that these underlying issues can be addressed. Other determinants impact on mental health for women, such as access to sexual and reproductive health information, services and choices, access to support for primary carers (for example child care, disability respite, home and community care and aged care supports), access to safe and accessible transport and access to healthy, affordable food.

Intersectionality articulates the ways that gender intersects with other forms of inequality to negatively affect mental health outcomes. Addressing the impact of intersectionality is needed to make rectify the multilayered levels of discrimination that people with disability experience. It is essential to the idea of intersectionality to recognition that inequalities are never the result of any single or distinct factor such as race, class or gender, but are 'the outcome of different social locations, power relations and experiences'.¹⁶ Article 6 on the UNCRPD outlines that states must recognise that women and girls with disabilities are subject to 'multiple discrimination'. Disability discrimination, combined with gender-based discrimination, raises the level of risk for women with disabilities in experiencing violence, harassment and abuse. When women with disabilities experience two kinds of discrimination, it can be said that they experience intersectional discrimination, new and discrete forms of discrimination.

Recommendation 1: embed an understanding of intersectionality and the human rights of people with disability in workforce development efforts and training. This should include a strong emphasis on user-led training, which imparts direct lived experience perspectives.

Recommendation 2: recognise gender and disability as determinant factors on mental health outcomes through intersectionality, by involving women with disabilities – especially women with psychosocial disabilities or mental health conditions - as a key population group in policy and decision-making. Consult with women with disabilities to generate a gender-sensitive approach to mental health policy and service delivery for women.

Recommendation 3: prioritise user-led prevention and health programs that are gender sensitive and accessible to people with disabilities.

¹⁵ Women's Health Victoria (2019), Submission informing the Terms of reference for the Victorian Royal Commission into Mental Health. Women's Health Victoria. Melbourne.

¹⁶ O, Hankivsky, (2014), Intersectionality 101. Cal, 64(1), 238, cited in Multicultural Women's org. Intersectionality Matters.

Recommendation 4: ensure data collected is gender disaggregated and reported as such. Data collected (and reported) should also represent the experience of LGBTI people.

Recommendation 5: ensure staff across the whole service system (GPs, psychologists, hospital staff) are adequately trained in sensitive, LGBTI-friendly service provision.

1.2 Women's inpatient unit safety

Women consumers continue to experience intimidation, sexual harassment and assault whilst receiving inpatient care. Far too many women still experience fear in what should be safe and healing environments. The Women's Mental Health Network Victoria's public consultation for this Royal Commission identified that attitudes of staff contribute to unsafe care in private and public hospitals. Survey responses demonstrated that women reported that they are often re-traumatised from becoming an inpatient, with trauma history being a dominant factor for 80% of those surveyed. A responsive mental health system is one that is gender sensitive and supports patients who have trauma history, optimising a patient's recovery.

"I'm a survivor of child abuse ... the presence of male patients while I was so vulnerable ... still gives me nightmares."¹⁷

Embedding a culture of safe, gender-sensitive practice within Victoria's mental health system will better enable an adequate response to women's needs without further disadvantage. When women are admitted involuntarily (as most inpatients are), the majority of them have a history of trauma or victimisation, as a result of past physical or sexual abuse and assault.¹⁸ A literature review indicated that between 49% and ninety per cent 90% percent of women admitted to psychiatric inpatient units have experienced childhood sexual abuse, intimate partner abuse or family violence.¹⁹ These experiences can increase women's vulnerability, especially when their safety and privacy is compromised in mixed-sex environments.

The 'Right to be Safe Report' further reinforces that safety issues are not being resolved in the current environment and that women-only corridors are not currently enforced.²⁰ This lack of compliancy for the basic human right to privacy in inpatient services nationally (such as, a right to

¹⁷ Women's Mental Health Network Victoria (WMHNV), (2019), Victorian Royal Commission into the Mental Health System, survey respondent.

¹⁸ Department of Human Services, (1997), Tailoring Services to Meet the Needs of Women, p. 23.

¹⁹ Department of Health, (2011), Literature Review for Service Guideline on Gender Sensitivity and Safety, p. 14.

²⁰ State of Victoria, Mental Health Complaints Commissioner, The Right to be Safe Report: Ensuring Sexual Safety in Acute Mental Health Inpatient Units – Sexual Safety Project report'.

privacy when sleeping, bathing and accessing spaces for family and children visiting)²¹ is concerning, as it further undermines the quality and safety of women when they are most at risk. Female consumers are at a disadvantage in the acute psychiatric system, constituting lower numbers and exposed to violence, aggression and sexual advances or attacks, due to their need to access services for mental health and wellbeing. We need urgent and continuous interventions throughout the psychiatric system to allow female consumers to feel safe and experience a healing environment when unwell.

The Network's research clearly illustrates the need for the provision of separate treatment spaces for women in hospitals. Since mixed treatment spaces became the norm in the 1960s, many women have resisted hospital admissions for fear of abuse by male consumers.²² Whilst mixed-gender units have too often been identified as not meeting women consumer's safety needs, the Network's Hospital Experience Survey called the efficacy of women-only corridors into question in 2017.²³ A decade after the Network's last hospital survey, these issues are not dissimilar to those in the Burdekin Report 1993, which highlighted women-only spaces as a way to create safe and sensitive environments for healing.

- 65% of women were not given the option of care in a female only corridor.
- 57% said that male patients could access female only corridors and other female only spaces.
- 32% found working locks were installed on their bedroom/bathroom doors.
- 67% were not given the right to lock their bedroom/bathroom doors when occupying them.
- Women say they find it destructive when staff do not act on their reports of feeling unsafe.
- Women feel vulnerable when staffing levels are inadequate.
- Women feel a lack of dignity and insecurity when they have to share bedrooms or have shared bathrooms.
- Women feel that there is ambiguity about how staff need to respond to support their care.

From the Network's Hospital Experience Survey report, 2017.

²¹ World Health Organisation, (2012), QualityRights Tool Kit: Assessing and Improving Quality and Human Rights in Mental Health and Social Care Facilities.'

²² Victorian Mental Illness Awareness Council, (2013), Zero Tolerance for Sexual Assault: A Safe Admission for Women.

²³ Women's Mental Health Network Victoria, (2017), Building in Safer and More Productive Outcomes for Consumers and Mental Health Workers: Key Findings of the Network's 2016 Hospital Experience Survey.

The majority of inpatient units today provide some gender separation, but too often this is a stop-gap measure, rather than a real solution. Previously, a great deal of funding has been directed towards changing hospital infrastructure to create women-only spaces, gendered areas, safety tools (such as swipe wristbands for gendered spaces, and locks on bedroom doors). The Network's consultation and research suggests that there is currently a lack of consistency in adherence to using these processes and quality improvements for the purpose they were designed. Gender-sensitive care for women may also include an understanding of living within a patriarchal environment, the impact of social and ethnic mores, access to financial resources, educational opportunities and encouragement to pursue meaningful work. All of these elements help shape the way a woman presents for care in a psychiatric unit and how she responds to treatment. When these elements are integrated into the physical environment with care offered on a unit, women will be seen as individuals rather than as a homogeneous whole.

The Women's Mental Health Network Victoria's survey consultation also reported 52% of respondents who indicated that they felt the training of mental health workers is inadequate. 95% indicated that gender-sensitive and safe practice education needs to be core training for all mental health workers. 50% of respondents to the Women's Mental Health Network Victoria's recent survey²⁴ indicated that hospital management do not actively promote and respond to gender-sensitivity and safety issues. 48% indicated that women-only corridors and spaces are not used effectively for the safety and wellbeing of women in Victorian mental health facilities.

Some respondents indicated that they find mental health worker training too clinical and label-focused, and not sufficiently holistic or person-centered. Gender is one of the key social determinants of mental health and yet it receives little specific focus in the mandatory training of mental health professionals. The same is true of training that informs staff of the differential issues and experiences of women in the context of mental health and underlying factors that drive and sustain inequality. We call for training to be incorporated in a trauma-informed lens, gender and disability-informed lens. Such training is needed to enable staff to understand the factors that influence experiences of mental ill health and the best practice strategies and processes that can support women's recovery and safety.

"I find the clinical system more intent on labelling and pushing the person out. Their skills in understanding the experience and what might help recovery [is] limited and not trauma informed. When you mix skills like in a PARC [Prevention and Recovery Care services] I find the training and knowledge is better."

²⁴ Women's Mental Health Network Victoria (WMHNV), (2019) Victorian Royal Commission into the Mental Health System survey report.

"I was admitted to a hospital that had a women's only corridor but no-one ensured the rule was followed and as a result it wasn't really a women's corridor, since the men were able to walk in whenever they wanted and not get in trouble".²⁵

The Network promotes safe and effective mental health services for women by working with services and empowering women to tell their story about their experiences. We want to see safe and healing environments for all women who access mental health care and women-sensitive mental health policy and practice.

Recommendation 6: that women-only corridor and facilities are used for their intended purpose in mental health facilities, with support, flexibility and options provided for gender diverse, intersex, non-binary and gender non-conforming people.

Recommendation 7: that policy direction and funding of hospitals, including all new capital works, be linked to the safety of female inpatients – this includes dedicated women-only corridors in wards, therapeutic areas; or women-only wards.

Recommendation 8: consider policies for moving to 'women-only wards' and ensure local policies and staff training provide clear and practical guidance to implement safe bed allocations.

1.3 The impact of family violence on the mental health of women with disabilities

For women with disabilities, rates of family violence and abuse are extremely high and this has an impact on mental, as well as physical health. The literature on violence against women with disabilities shows that women with disabilities experience higher levels of interpersonal violence and are more marginalised than men with disabilities and other women.²⁶ For example, women with disabilities represent 40.9% of all female victims of male intimate partner violence²⁷ and research shows that women with disabilities experience higher rates of violence over their lifetime and at the hands of a greater number of perpetrators.²⁸ Gender-based violence and/or disability-

²⁵ Women's Mental Health Network Victoria (WMHNV), (2019), Victorian Royal Commission into the Mental Health System, survey respondent.

²⁶ C., Frohmader, (2007), *Forgotten Sisters – A global review of violence against women with disabilities*. Women with Disabilities Australia (WWDA) resource manual on violence against women with disabilities, WWDA, Tasmania.

²⁷ Mitra-Kahn, T., Newbiggin, C., & Hardefeldt, S. (2016). Invisible women, invisible violence: Understanding and improving data on the experiences of domestic and family violence and sexual assault for diverse groups of women: State of knowledge paper (ANROWS Landscapes, DD01/2016). Sydney: ANROWS.

²⁸ K. Hughes, M.A. Bellis et al, 2012, 'Prevalence and risk of violence against adults with disabilities: a systematic review and meta-analysis of observational studies,' *Lancet*; R. B. Hughes, E. M. Lund et al, 2011, 'Prevalence of Interpersonal Violence Against Community-living Adults with Disabilities: A Literature Review', *Rehabilitation Psychology*, 56, 4: 302-319; H. Khalifeh, L. Howard et al, 2013, 'Violence Against People With Disability in England and Wales: findings from a

based violence can be experienced in disability and health settings, including institutional settings, as well as the home. Violence against women with disabilities is a result of systemic gender-based discrimination against women, but also of disability-based discrimination against people with disabilities.

There is a crucial link between family violence and mental health problems. The Victorian Family Violence Royal Commission in 2016 played an important role in shining a light on the interactions and overlap between the mental health and family violence sectors. Victorians have a great deal to benefit from a mental health system that is linked to, and consistent with, the findings from the Victorian Royal Commission into Family Violence, including advice on:

- undertaking family violence risk assessments;
- secondary consultation and referrals with family violence, sexual assault and other violence response services such as police and legal services; and
- service coordination with violence response services.

The negative impacts of family violence on women's health include poor mental health, in particular anxiety and depression, as well as problems during pregnancy and birth, alcohol and drug use, suicide, injuries and homicide.²⁹ However, women with disabilities are often invisible and have fewer support options. Family violence is a form of violence against women and Victoria's understanding of this is underpinned by the VicHealth Preventing Violence Against Women Framework. This framework is clear about the gendered nature of violence and later work has built on this understanding.

There are already existing frameworks and strategies that seek to address the underlying drivers of family violence, including gender inequality, for example, Change the Story, a national approach to preventing violence against women, the Victorian primary prevention strategy, *Free from Violence*, and the Victorian gender equality strategy, *Safe and Strong*. Accessing information and support, and finding safety from risk of further violence and trauma, can all assist greatly in a person's recovery. Victoria currently has an opportunity to create a gender-sensitive mental health system, which is in keeping with contemporary understandings of trauma, family violence and health promotion.

National Cross-Sectional Survey', PLOS ONE, 8,2; S-B. Plummer and P. Findley, 2012, 'Women with Disabilities' Experience with Physical and Sexual Abuse: Review of the Literature and Implications for the Field, Trauma, Violence and Abuse, 13, 1: 15-29; D. A. Brownridge, 2009, Violence Against Women: Vulnerable Populations, Routledge, New York.

²⁹ Women's Health Victoria, (2017), Series Issues Paper: Growing Up Unequal: How Sex and Gender Impact Young Women's Health and Wellbeing'.

Case study: 'Woman was trapped by violent husband because he was her carer, Royal Commission into Family Violence hears'

"A woman in a wheelchair whose husband raped and assaulted her over many years felt trapped in the relationship because he was also her carer ... Ms. Brown said her husband often told her that her mental health problems were the reason for his behaviour."

"I just thought I was hopeless. Yes, I do have a mental health problem; I am responsible for everything that's going on." Since her relationship ended her mental health has improved dramatically, and she no longer try to self-harm, Ms. Brown told the hearing."³⁰

Recommendation 9: that the Victoria Government commit to ensuring mental health services are safe places for women by implementing a clear strategy in line with existing gender and violence prevention frameworks, developed in consultation with women with psychosocial disabilities or mental health conditions.

Recommendation 10: incorporate mental health workforce development on gender-safe practice and identifying family violence.

Recommendation 11: invest in evidence-based primary prevention strategies that address the social determinates of poor mental health for women, including violence prevention strategies.

Recommendation 12: encourage cross-sectoral partnerships within the mental health sector to facilitate collaboration with sexual assault and family violence response and prevention services. Partnership potentials include skill-sharing placements, training, secondary consultation and referral.

1.4 Trauma informed care and practice is central to recovery

Trauma history is an important determinant for mental ill health. Whilst awareness of the prevalence and impact of trauma has increased greatly in society and within health care over the recent years, there is still more work required to integrate a trauma-informed care model with the lived experience of recovery. Trauma-informed care is a framework that needs to be applied to all policy and mental health care.³¹

Trauma has been defined as a form of overwhelming stress. Interpersonal trauma includes experiences of sexual abuse, physical and emotional abuse, community and family violence, as well as neglect. Trauma can affect many areas of a person's life, and can often arise during

³⁰ The Age, '[Woman was trapped by violent husband because he was her carer, Royal Commission into Family Violence hears](#)', July 22, 2015.

³¹ State of Victoria, Department of Health and Human Services, (2018), Chief Psychiatrist Guideline and Practice Resource: Family Violence.

childhood. Experience of family violence, including childhood sexual abuse, can cause, or exacerbate, mental health problems and mental illness.³² Abuse and trauma across the life course can have a cumulative, deleterious effect on health and wellbeing.³³ Traumatic life events are a driver of service need. Policies and service providers must address and respond to trauma appropriately to ensure the best outcomes for individuals and families using these services.³⁴

On an organisational level, trauma-informed means adopting cultures and practices that empower consumers in their recovery by emphasising autonomy, collaboration and strength-based approaches, ensuring all staff (clinicians and others) are well supported to provide trauma-sensitive care and create safer environments for consumers and family members to talk about all forms of abuse, including family violence. Many people who have experienced trauma can be triggered through a range of circumstances and behaviours. Inpatient units and bed-based services in particular can be spaces that are particularly re-traumatising for people. A trauma-informed care practice approach includes understanding a person's potential triggers and providing sensitive support when this occurs.

For women, as previously discussed, family and sexual violence are common traumatic experiences. For Victorian women aged between 15 - 44 years, intimate partner violence is the leading cause of preventable death, disability and illness. At least one in five women experiences sexual assault in their lifetime. Sexual harassment and stalking are highly gendered experiences; women are overwhelmingly the victims, and men the perpetrators. The high prevalence of sexual violence to which women are exposed and the correspondingly high rates of Post-Traumatic Stress Disorder (PTSD) in women, following such violence, renders women the largest single group of people affected by this disorder.³⁵

Trauma-informed care and practice involves a shift to understanding the impact of trauma on a person's life, their health and mental health. Specific groups of women are particularly at risk of violence, due to the interplay of a number of intersecting forms of marginality and discrimination, including Aboriginal and Torres Strait Islander women, women with disabilities and culturally and linguistically diverse women. For Aboriginal and Torres Strait Islander women, the impacts of intergenerational trauma, systemic racism and a lack of cultural safety, remain significant barriers to health system access.³⁶ Further, culturally and linguistically diverse women can be doubly

³² State of Victoria, Department of Health and Human Services, (2018), Chief Psychiatrist Guideline and Practice Resource: Family Violence.

³³ Australian Government, Department of Health, (2018), National Women's Health Strategy 2020-2030.

³⁴ Australian Government, Institute of Family Studies, Wall, L., Higgins, D., and Hunter, C., (2016), 'Trauma-informed care in child/family welfare services, Child Family Community Australia (CFCA) Paper, No. 37.

³⁵ World Health Organisation, Department of Mental Health and Substance Dependence, (2000), Women's Mental Health: An Evidence Based Review, (WHO: Geneva).

³⁶ Australian Government, Department of Health, (2017), My Life, My Lead – Opportunities for Strengthening Approaches to the Social Determinants and Cultural Determinants of Indigenous Health: Report on the National Consultations.

disadvantaged in a system that does not address to the specific cultural needs of different ethnic or religious groups. For example, some Muslim women may be confronted with challenging circumstances when sharing public facilities with other male consumers, such as in inpatient units of hospitals.³⁷

"I'm a survivor of child abuse—and that was the cause of my mental health problems."

"Being locked up, stripped, forced to have powerful drugs all triggered abuse memories and made me more suicidal. The presence of male patients while I was so vulnerable, with nothing but hospital pajamas, that left me feeling exposed, was also terrifying."

"Admissions and drugs never helped me—they made me worse."³⁸

Having the confidence, knowledge and ability to seek support and access appropriate services is also difficult for many women.³⁹ Currently there are no targeted services to identify mental health issues emerging from trauma history or family violence, even when associated with childhood abuse and trauma. Mental health workers would benefit from targeted training in trauma history and care models, in responses to family violence and history of child abuse. This includes emphasising education about caring for those who have Stolen Generations history and experiences, either as a child of a parent identifying as member of the Stolen Generation, or an adult with this lived experience. Mental health workers should also be aware of any recent history of admissions. This recommendation is reinforced by a consultation conducted by the Network, which explored traumatisation after hospital admissions.⁴⁰ Of the fifty per cent (50%) of respondents for whom the question was relevant, thirty-six per cent (36%) indicated they felt traumatised, with 29% of these feeling strongly traumatised, after their hospital admission.

The need for trauma-informed service delivery and staff trained and competent in trauma-informed care is highlighted by these responses, which is consistently reflected in the other research findings of the Network. The majority of women who have admissions into acute mental health facilities have trauma histories. Many of these have experienced family violence and/or sexual abuse, the trauma of which has led to mental health difficulties. Their experience of mental ill health can often make them more at risk of experiencing further abuse and traumatisation.

³⁷ Women's Mental Health Network Victoria, (2015), Submission to the Victorian Royal Commission into Family Violence.

³⁸ Women's Mental Health Network Victoria, (2019) Victorian Royal Commission into the Mental Health System survey report.

³⁹ Australian Government, Department of Health, (2018), National Women's Health Strategy 2020-2030.

⁴⁰ Women's Mental Health Network Victoria (WMHNV), (2019) Victorian Royal Commission into the Mental Health System survey report.

Safety, respect, and a sense of choice and control, are integral to women's ability to heal from trauma. Mental health service delivery must facilitate each of these core recovery needs in every way possible.

Case study: good practice example of workforce planning, development and training

The Women's Mental Health Network Victoria (WMHNV) has developed an effective training program for staff working in mental health and drug and alcohol services. The 'Building Gender-Sensitive and Safe Practice Training Program' is based on the 'Service Guideline on Gender Sensitivity and Safety'. The 'Building Gender Sensitive and Safe Practice Training Program' is an interactive training program and resource that is designed to support mental health services and practitioners to consider the needs, wishes and experiences of people in relation to their gender and sexual identity and to ensure access to high-quality care based on dignity and respect. The training program aims to support staff and management to:

- Ensure a gender sensitive and safe approach to work;
- Build organisational, capacity for gender sensitive and safe practice;
- Embed the service guideline on gender sensitivity and safety - promoting a holistic approach to wellbeing into everyday practice;
- Discuss and review what gender sensitive and safe practice looks like.

In addition to this training license, the Women's Mental Health Network Victoria has been active in curriculum development, delivering gender-sensitive practice education sessions for undergraduate programs and interested academics and building capacity in the mental health sector for multiple entry points. For further information regarding this example, please refer to the Victorian Women and Mental Health Network's website: www.wmhmv.org.au

Recommendation 13: that the Victorian Government fund the Women's Mental Health Network Victoria to promote gender-sensitive safe practice training for the mental health sector in the context of the service guidelines.

Recommendation 14: that the Victorian Government fund the Women's Mental Health Network Victoria to promote gender-sensitive and safe practice training development to build capability to respond with respect and care (for of all health workers, allied health workers and sector partners such as Ambulance, Victoria Police and others).

Recommendation 15: ensure that all mental health service staff receive regular training and reflective practice sessions in the application of trauma-informed care, within the context of gender-sensitive practice.

Recommendation 16: establish regular gender-sensitivity and safety audits as a requirement for all mental health services, to ensure that best practice is being implemented (e.g. physical spaces and safety tools are utilised and are effective and functional).

Recommendation 17: ensure that hospital management are trained in gender-sensitive and safe practice, understand best practice and actively promote and role model these approaches.

Recommendation 18: increase access to, and support for, peer support and trauma-informed care in emergency departments and front-line health services.

Recommendation 19: that all levels of mental health workforce curriculum be reviewed to ensure quality of care training includes trauma-informed care.

Recommendation 20: that trauma informed care and practice education is an integral and continual part of tertiary health professionals' training and workforce development.

Recommendation 21: that specialised mental health workers are employed in all family violence related services.

Recommendation 22: ensure that systems support trauma-informed aged care services.

Recommendation 23: ensure that all mental health staff are trained to respond to the lived experience of Aboriginal and Torres Strait Islander peoples' with Stolen Generations experiences and related trauma.

Recommendation 24: that a mental health framework is developed on trauma-informed care, inclusive of a Stolen Generational context.

Recommendation 25: establish clear referral pathways and information for clients with trauma histories to locate Medicare-accredited psychologists and social workers with specialist skills in working with trauma, family violence and sexual abuse.

2. Centering lived experience

2.1 Violence, abuse and neglect of people with disability

Poor mental health outcomes for people with disabilities are known to be associated with experiences of marginalisation, discrimination, trauma, stigma, violence and abuse. Particularly, the issue of the high rates of violence, abuse and neglect of people with disabilities in Australia has led to many groups, community organisations, advocates and activists to call for a specific Royal Commission into violence and abuse against people with disability. The violence people with disability experience, both structural and institutional, occurs in a range settings, including in education, the justice system, housing, group homes, aged care and employment. 18% of people with disability report being victims of physical or threatened violence compared to 10% people without disability.⁴¹

Forms of violence can include impairment related violence, denigration and unethical practices in care service settings. People with disability who live in institutional and residential settings are highly susceptible to violence (particularly sexual violence) from numerous perpetrators and frequently experience sustained and multiple episodes of violence.⁴² The violence and abuse of people with disabilities occurs within the context of power inequalities between staff and residents and in settings where, in the absence of appropriate safeguarding practices and resourcing, it is easy to isolate and denigrate residents with impunity. This issue was the subject of a 2015 Senate Inquiry, and will again be a focus in the upcoming Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disabilities. Already in these early stages, we note that people with disabilities are contacting Disabled Peoples Organisations (DPOs) for increased assistance and support, in relation to this Royal Commission. The impacts of violence, abuse, neglect and exploitation experienced by people with disabilities across various settings has a relationship to the prevalence of ill health and mental health impacts and inequalities.

Within the disability sector, there is relatively little awareness of the gendered nature of violence against women, and in fact, family is resoundingly perceived as a positive support or 'natural safeguard' for women with disabilities. WDV has called for an increased understanding of violence against women and the need for gendered policies and practices, which are equipped to prevent and respond to violence. It is important to recognise that girls, boys, women and men with disabilities are understood to experience disability-based violence differently, because of the different interplay of sources of power and inequalities between perpetrator and victim-survivor. Relations of power and control are not only gendered, but intersect with other forms of

⁴¹ Commonwealth of Australia, Council of Australian Governments, (2011), National Disability Strategy 2010-2020.

⁴² Attard, M., & Price-Kelly, S. (2010) Accommodating Violence: The experience of domestic violence of people with disability living in licensed boarding houses, PWDA, NSW. See also: World Health Organisation, Violence against adults and children with disabilities, see <http://www.who.int/disabilities/violence/en/>. See also: Coulson Barr, L. (2012) 'Safeguarding People's Right to be Free from Abuse: Key considerations for preventing and responding to alleged staff to client abuse in disability services' (Occasional Paper No.1, Disability Services Commissioner, 2012).

discrimination, including Aboriginal and Torres Strait Islander identity, ethnicity, sexuality, age, class and spatial location.

WDV's own research *Voices Against Violence*, involved a review of the files of one hundred women with disabilities at the Office of the Public Advocate (OPA). The findings of this review were that:

- 45 of the 100 women reported experiencing violence at the hands of a total of 89 perpetrators;
- The most common forms of violence reported were psychological, physical, controlling behaviour and economic abuse;
- Impairment-related abuse included withholding medication and disability aids – (such as for example, a woman experiencing family violence who has the wheel from her wheelchair removed); and
- Many women experienced social isolation as both a risk factor for, and a consequence of, violence. Some perpetrators used social isolation as a form of violent behaviour in itself.⁴³

Gendered-violence prevention strategies are needed that engage with the social realities of violence, abuse and neglect for people with disabilities. There must be appropriate recognition and response strategies to the violence and related trauma and ill mental health experienced by people with disabilities, especially women with disabilities.

Recommendation 26: address the high rates of mental illness and trauma arising from discrimination and violence experienced by people with disabilities by ensuring that the mental health workforce understands, and has the tools to respond to, the specific kinds of violence enacted against people with disability, including women with disabilities.

Recommendation 27: ensure that both disability and mental health advocates are well resourced through training and funding to help clients navigate multiple systems of support (such as the mental health system, sexual assault services and the National Disability Insurance Scheme).

Recommendation 28: integrate trauma-informed care and gender-sensitive and safe practice, into core mandatory training schedules of tertiary curriculum (for nurses, doctors, allied health professionals etc.), and within ongoing staff professional development in mental health services.

⁴³ See: Woodlock, D., Healey, L., Howe, K., McGuire, M., Geddes, V. and Granek, S., *Voices Against Violence Paper One: Summary Report and Recommendations* (Women with Disabilities Victoria, Office of the Public Advocate and Domestic Violence Resource Centre Victoria, 2014).

2.2 People with intellectual disabilities and mental health

Although people with intellectual disability represent 1.8% of the overall Australian population, people with intellectual disability experience mental illness at two, to three times higher compared to the general population.⁴⁴ The New South Wales Council for Intellectual Disability cited a Western Australian study that identified 31.7% of people with an intellectual disability had a psychiatric condition. This included 3.7 – 5.2% of people with intellectual disability with schizophrenia, whereas the prevalence in the general population is about 1.26%⁴⁵

Many people with an intellectual disability also experience a high degree of complexity and an atypical profile and presentation of mental illness, thus requiring a higher level of mental health expertise and coordinated approaches between support services. The mental health outcomes for people with intellectual disability, and commitments to address these issues have previously been articulated in the current National Disability Strategy 2010-2020 and the Fifth National Mental Health and Suicide Prevention Plan.⁴⁶

Despite this, there is limited evidence and research in relation to the risk factors that predispose a person with intellectual disability to a mental health condition. However, we do know that issues of social exclusion, trauma, poverty and isolation, and create situations of multiple marginalisation and discrimination for people with intellectual disability. It is generally accepted that Australian mental health policy, as it applies to people with an intellectual disability, is not aligned with international standards and falls short of meeting Australia's international human rights obligations under the UNCRPD.

Recommendation 29: that Victoria mental health policy and reform specifically recognise, address and accommodate the needs of people with intellectual disability.

Recommendation 30: that Victorian mental health services provide equitable access and appropriately skilled treatment to people with intellectual disability.

Recommendation 31: that Victorian mental health services collect and report data to the Victorian Government, so that the mental health needs, access to services and outcomes for people with intellectual disabilities can be made publicly available and monitored.

2.3 The role of carers

In Australia, more than two thirds of primary carers are women.⁴⁷ Carers may also have direct lived experience of disability, or have mental health conditions themselves. 70% of the respondents to

⁴⁴ Australian Institute of Health and Welfare. Disability Prevalence and Trends; AIHW 2003

⁴⁵ New South Wales Council for Intellectual Disability. National Roundtable on the Mental Health of People with an Intellectual Disability Background Paper; NSW CID 2018

⁴⁶ University of New South Wales. 2018 National Roundtable on the Mental Health of People with an Intellectual Disability Background Paper; UNSW 2018

⁴⁷ Australian Bureau of Statistics (2015) Survey of Disability, Ageing and Carers.

the Women's Mental Health Network Victoria survey indicated that the Victorian mental health system does not meet the needs of women who are carers of people with psychosocial disabilities or mental health conditions, as they seek to navigate and advocate for those they care for.

Women indicated that they feel mental health professionals often do not seek or value their wisdom or input about the care of their family member or loved one and that the importance of their knowledge and understanding of their family member is not respected and sometimes overlooked. Respondents also highlighted the inadequacy of the NDIS in meeting the needs of those experiencing mental health problems and their carers.

"Even though I am health literate I am disregarded and labelled. The stigma is incredible and despite being witness to the scariest events and suicide attempts as the first person - no one has ever asked if I am ok."

"Also, the impact on work and huge costs associated with trying to help and pay for accommodation, food, travelling to see if they are ok, it is not something you can talk about to people at work. I am crying as I write this, as the utter loneliness and stigma applies more to women and mothers."⁴⁸

Recommendation 32: ensure there is application of a family and carer perspective in mental health services, across all aspects of service delivery, which is appropriately balanced with respect for the autonomy, self-determination and authority of the consumer.

Recommendation 33: ensure carers are also included, where appropriate, and that their wisdom is integrated in a collaborative and useful way, to enhance the admission and recovery experience.

Recommendation 34: ensure carer inclusion is supported through staff training, and through prompting questions in admission, planning and discharge documents and case conferencing.

Recommendation 35: address the inconsistencies in eligibility and other processes for utilising NDIS funding in a mental health context.

⁴⁸ Women's Mental Health Network Victoria (WMHNV), (2019), Victorian Royal Commission into the Mental Health System, survey respondent.

3. Accessibility

3.1 Access to support services for people with disability

In terms of receiving a range of support services, people with disabilities, including people with psychosocial disabilities and mental health conditions, can have an increased need for:

- Outreach services, such as home visits;
- More flexibility in receiving services, flexibility for appointments, due to the effects of medication, pain, memory issues, etc.;
- A choice in their preferred modes of communication;
- A choice of medical practitioners – such as a preference for specialists with experience in working with consumers with their diagnostic-type of disability, choices around gender preference of practitioner and understanding of lived experience; and
- Understandings of the way people transition through services as they age, for example, young people leaving youth services, but who do not fit into mainstream, adult services, etc.

When it comes to people with disabilities accessing other types of services, there is a considerable lack of tailored supports for older people with disabilities who are experiencing mental health issues. Organisations are also observing increased complexities for their clients, people with disabilities, in accessing state-funded services, which co-exist alongside nation-wide services, such as the National Disability Insurance Scheme (NDIS) and Centrelink. There is an observable lack of communication and integration between Victorian, federal and Commonwealth bodies and programs. Critically, there needs to be better protections for people with complex mental health issues, so that they do not fall into the justice system, due to lack of supports received in other systems.

In recent years, particularly after the introduction and rolling out of the NDIS, there has been increased recognition of people with mental health conditions or psychosocial disabilities as users of services within the disability sector. This has led to an increased demand for disability advocacy services, which are under additional pressure through the increasing complexity of caseloads, increased demand due to issues associated with the implementation of the NDIS and minimal funding and resourcing for advocacy organisations. In light of the upcoming Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, there needs to be additional resourcing and support for disability advocacy organisations to conduct their work while supporting many of their members and clients who will be engaged in this Royal Commission.

A commitment to accessibility means more than adhering to the obligations under the *Disability Discrimination Act 1992* (Cth), it also means adopting a strengths-based view of people with disabilities. Simplicity and ease of use of the system is essential for an accessible system for people

with disabilities. To be accessible for people with disabilities, all health services, including mental health services must offer:

- accessible health information utilising multiple formats, such as in Auslan, Easy and Plain English;
- Provision of physical access, clear signage and accessible facilities;
- Adequate time and resources, such as longer and multiple appointments, to meet the health needs of all, particularly those with intellectual and communication disabilities.
- A holistic approach to health care, specific for women with disabilities, recognising women's total health needs and right to live full sexual and reproductive lives.

Recommendation 36: increase funding for accessible support and counselling services, including creating specialist disability counselling services, and resource and equip mainstream organisations to better meet the needs of people with disability

Recommendation 37: ensure that mental health services are encouraged to develop Disability Action Plans (DAP) to assess and improve their information, buildings, services and policies, bringing them up to *Disability Discrimination Act 1992* (DDA) standards.

Recommendation 38: develop clear targets or measures to monitor progress in improving accessibility of all mental health services in Victoria.

Recommendation 39: provide access to information about mental health, rights and support services in a much broader range of accessible formats – provide gender specific, disability accessible health and service information.

Recommendation 40: invest in all Victorian mental health services to conduct audits and complete access upgrade plans to ensure services are accessible to all people with disabilities.

Recommendation 41: that the Victorian Government recognise that an already under-resourced disability advocacy sector is experiencing an increase in the volume and complexity of advocacy cases, including more clients with psychosocial disabilities.

Recommendation 42: that the Victorian Government commit to increased, secure funding for all advocacy organisations who provide individual advocacy to people with psychosocial disabilities in Victoria, including those who are not currently receiving state funding.

3.2 Access to justice

Research collected by the Australian Bureau of Statistics (ABS) demonstrates that people with disability, specifically psychosocial disabilities and mental illnesses, are overrepresented in the criminal justice system. Aboriginal and Torres Strait Islander people with psychosocial disabilities and women with psychosocial disabilities are amongst the fastest growing groups of people being

detained.⁴⁹ Prisoners with disabilities, including Aboriginal and Torres Strait Islander prisoners, are at serious risk of bullying, harassment, violence and abuse from fellow prisoners and staff.⁵⁰

Academics have recently conducted research on Aboriginal and Torres Strait Islander people with mental health disorders and cognitive disability in the criminal justice system. The research findings showed that:

- Those with complex needs, such as multiple diagnoses and disability, particularly women – were some of the most disadvantaged.
- Aboriginal and Torres people from highly disadvantaged areas, especially regional and remote areas, fared the worst.
- Aboriginal and Torres Strait Islander people were 2.6 times more likely to have been in out-of-home care as children and their age of first contact with police was 3.4 years younger than non-Aboriginal and Torres Strait Islander people.
- Aboriginal and Torres Strait Islander people were 2.4 times more likely to be in juvenile justice custody than non-Aboriginal and Torres Strait Islander people.
- Aboriginal and Torres Strait Islander people had higher numbers and rates of convictions and more episodes of remand in prison.⁵¹

In Victoria, and across all other Australian jurisdictions, people with cognitive or psychosocial disabilities can also find themselves in periods of indefinite detention. This typically happens in two ways: a forensic or criminal mental health order, or via a scheduled order under mental health, disability or guardianship frameworks. When a person with a cognitive disability or psychiatric condition is alleged to have committed a crime, legislation provides that, in specific circumstances, such a person can be declared unfit to stand trial. Those who deemed unfit to stand trial may become subject to a forensic or criminal order. The court, or mental health review tribunal, will assess a person's risk to themselves or others and the need for ongoing treatment, and will impose forensic orders, which typically detain the person in a prison, hospital, mental health care facility or prison hospital for mental health treatment, for an indefinite period. It is difficult to know how many people with mental health issues and/or cognitive disabilities are detained indefinitely in Australia, and Victoria more specifically. In some cases, no statistics are publicly available at all, as State and Territory corrections departments do not maintain a public register of the numbers of people held on a forensic or criminal mental health order.⁵²

⁴⁹ Victorian Ombudsman, (2015), Investigation into the Rehabilitation and Reintegration of Prisoners in Victoria.

⁵⁰ Human Rights Watch, (2018), "I Needed Help, Instead I Was Punished": Abuse and Neglect of Prisoners with Disabilities in Australia.

⁵¹ Baldry, E., McCausland, R., Dowse, L. and McEntyre, E. 2015 A predictable and preventable path: Aboriginal people with mental and cognitive disabilities in the criminal justice system. UNSW, Sydney.

⁵² Commonwealth of Australia, The Senate Community Affairs References Committee, (2016), Indefinite detention of people with cognitive and psychiatric impairment in Australia.

There is also an intimate connection between violence against women, trauma, disability and incarceration. The number of female prisoners, while smaller than men, is growing fastest.⁵³ We also know that almost half of all women in prison have psychosocial disabilities or a serious mental health condition. Women who have been incarcerated are also more likely than men to be diagnosed with a mental illness during their lifetime.⁵⁴ Aboriginal and Torres Strait Islander women are a spiking prison population and that over ninety per cent (90%) of Aboriginal and Torres Strait women in prison are diagnosed with a mental illness.⁵⁵ Women offenders also demonstrate higher levels of previous victimisation, poor mental health, substance misuse and social disadvantage compared to other women in the community.⁵⁶

Women with disabilities, including Aboriginal and Torres Strait Islander women with disabilities, are encountering the prison system as a directed result of poverty, homelessness and experiences of family violence. Almost all have experienced significant trauma, including family violence or sexual violence. We strongly recommend that the Royal Commission have a targeted focus on people with disability entering Victoria's prison system; with specific attention to women who have complex mental health needs in prisons and forensic (secure hospital) services. Programs that treat and support women with disabilities before they fall into the prison system and housing options that support women upon release are drastically needed. As part of this Royal Commission, we also call on the Victorian Government put an end to the indefinite detention of people with cognitive or psychosocial disabilities in Victoria.

Recommendation 42: provide specific programs for women with disabilities that address the sources of trauma and mental health issues, before individuals encounter the correctional system.

Recommendation 43: that the Victorian Government fund different levels of care for women in forensic services, as there currently are for men in Victoria (e.g. separate subacute, continuing care wards).

Recommendation 44: that the Victorian Government fund transitional support and secure housing for women to assist and prevent them being re-incarcerated.

Recommendation 45: that the Victorian Government work with other States and Territory Governments to establish consistent legislative approaches across all Australian jurisdictions to provide a range of options for the placement of forensic patients beyond unconditional release and prison.

⁵³ Victorian Ombudsman, (2015), Investigation into the Rehabilitation and Reintegration of Prisoners in Victoria.

⁵⁴ Australian Institute of Health and Welfare, (2015), The health of Australia's prisoners.

⁵⁵ Victoria Department of Justice, (2013), Koori Prisoner Mental Health and Cognitive Function Study—Final Report, 13.

⁵⁶ Australian Institute of Family Studies, (2012), Addressing women's victimisation histories in custodial settings, ACCA Issues, 13.

Recommendation 46: that the Victorian Government work with the Commonwealth and other State and Territory Governments in developing consistent legislative approaches with respect to limiting terms for forensic patients in all Australian jurisdictions.

3.3 Access to the NDIS

The introduction of the NDIS has led to many changes in the way that people with disabilities interact with the Victorian mental health system. The NDIS is eligible to people with disabilities, including those with psychosocial disabilities, an internationally recognised term under the UNCRPD, describing the experience of people with impairments and participation restrictions related to mental health conditions. These impairments can include a loss of ability to function, to think clearly, experience full physical health and manage the social and emotional aspects of their lives. The term "*psychosocial*" describes the 'social consequences of disability': the effects on someone's ability to participate fully in life, as result of mental ill health. Although the NDIS is available to those with psychosocial disabilities, issues can often arise through the tensions between the concept of recovery, which is influential in the mental health system, and the wording in the *National Disability Insurance Scheme Act 2013*, which states that an impairment, should be, or is likely to be, permanent.⁵⁷ The recovery model conflicts with the ways in which applications for the NDIS requires one to demonstrate the permanence and severity of a condition, in order to gain access to support and services. In many ways, this runs counter to the ethos of recovery.

Our organisations are noticing a reduction in support and access to services for people who do not meet NDIS access criteria, but still require ongoing mental health support. Many services that were previously available to *anyone* with mental illness or a mental health condition are now exclusively available to NDIS participants only. Since the introduction of the NDIS, Victorian mental health services appear to be increasingly siloed, with limited overlap between services; there is a fear that the NDIS will not act as a bridging service for various organisations or consumer groups. We also observe that the Victorian mental health system is refusing services to individuals who *are* NDIS participants, but who do not have specific funding in their plan for mental health supports. NDIS participants who have a disability which is listed by the National Disability Insurance Agency (NDIA) as their 'primary disability'; with a mental health or psychosocial disability listed as a 'secondary disability', can also experience less importance being placed on their needs for mental health support.

Currently, there is a limited number of mental health professionals familiar with the NDIS, its language and eligibility criteria, which would allow them to write reports that enable entry to the NDIS. Mental health professionals unfamiliar with the NDIS may write their reports using inconsistent terminology, frameworks and understandings, for example, writing under influence

⁵⁷ Women's Mental Health Network Victoria, (2017), Internal Paper on Strategic Direction and Mental Health Policy Environments.

of recovery model(s). The application of this framework in seeking access to the NDIS can be problematic, as the NDIS eligibility guidelines require that participants have a "*permanent and significant*" disability. Occupational Therapists (OTs) are currently experiencing a substantial increase in the demand for report writing to assist as part of a person's NDIS application. However, many OTs lack adequate training in mental health and cannot accurately assess functionality where psychosocial disability or a mental health condition is the primary, or sole, disability type. The limited availability of practitioners and the inhibitory costs also widens inequalities and hinders access to support. NDIS eligibility requirements often privilege those with well-defined and recognised diagnostic conditions. Some people with disabilities may not be able to access a neat diagnosis of their condition(s) by professionals, due to a complex presentation or due to the rareness of their condition(s).

In applying for access to the NDIS, many people with disabilities are feeling overexposed, as they are often required to obtain multiple detailed reports, containing highly sensitive and private information. Some people with psychosocial disabilities report feeling that their private information is not well protected, and that the request for multiple reports in order to satisfy NDIS access criteria is too burdensome without support to assist with the process.

One of the biggest areas of concern is that people with mental health conditions who are multiply marginalised, socially isolated, receive no outreach services and are not connected to their communities will be much less likely to have an awareness of the NDIS and may not access it all. People with psychosocial disabilities who are not linked in with key contact services need to have clearer pathways to accessing the NDIS.

For those who have been able to access the NDIS, the type of NDIS plan a person receives is contingent on how a person identifies and articulates their support needs and goals, how they frame their conditions, through evidence and reports provided, and the negotiating skills of whoever may be advocating for them (if they have someone advocating for them). We need services for those who do not meet NDIS eligibility criteria and who will not be NDIS participants, but still have unmet needs in everyday life functioning and require regular mental health support, such as community mental health services.

We also recommend that more work is done to address the tensions between demonstrating a 'permanent' disability in order to access the NDIS, the often-uneven trajectory of mental illness and the goals of recovery. Without this, many people with psychosocial disabilities will continue falling through the gaps. The Women's Mental Health Network Victoria also recommends further consultation on NDIS frameworks. This should take place through collaborative consultation with academics, community groups and consumer groups.

Case study – Sarah's* experience of trying to access the NDIS

Sarah is a middle-aged woman who lives in a rooming house. Prior to living in the rooming house, Sarah was homeless. She has experienced significant trauma, has spent a lot of time in psychiatric facilities and has a serious mental health condition. She is unemployed and is supported by the Disability Support Pension (DSP). She has no contact with her family.*

Before the NDIS, Sarah was on the waitlist for supported housing with a mental health service provider and was receiving services through her local council's Home and Community Care (HACC) services. When the NDIS started rolling out, Sarah was told she would receive help from the NDIS. Sarah received a letter from the NDIA stating that the Victorian Government had passed on her details. After receiving the letter, she phoned the NDIA many times, but was consistently reassured each time that she should wait for the NDIA to contact her and that she would receive the NDIS.

Sarah was then asked to submit paperwork to the NDIA in order to prove her disability, but received no information about how to get support with this. She submitted reports with the assistance of a former mental health case manager, who had very little knowledge about the NDIS application process. Sarah was unsuccessful in her application. She asked for an internal review of the decision, but it was also unsuccessful.

Sarah was then upset and shocked to find out that she was removed from the housing waiting list. She was told this is now only available to NDIS participants. Without anyone to support her, Sarah lodged another application to challenge the NDIA's rejection of her application. Sarah then contacted a disability advocacy service in order to receive some advocacy support. The advocacy service was able to organise a government-funded neuropsychologist assessment for Sarah, which confirmed that she also has difficulties in intellectual functioning and recommended that she be eligible for the NDIS. Her difficulties with intellectual functioning were not diagnosed during her time in the mental health system.

Sarah has struggled to organise a current psychiatric assessment through her local mental health service because she is deemed not "unwell enough". After being referred by her local mental health service to a private psychiatrist, Sarah was forced to cancel her appointment at the last minute, because she could not afford the cost of the assessments.

Sarah's inability to obtain a current psychiatric assessment is a major impediment to her being able to challenge the NDIA's decision to deny her access to the NDIS.

** Sarah's name has been changed. Case study used with permission.*

Recommendation 47: that the Victorian Government commit to a 'Co-coordinating Hub' with regard to the implementation of NDIS.

Recommendation 48: that all NDIS staff, including Local Area Co-coordinators and NDIA planners, be trained in mental health awareness and how to support those people with a lived experience accessing the system.

Recommendation 49: that all state plans linked to the Victorian 10 Year Mental Health Plan be better connected in ways that incorporate recovery goals without prejudice.

Recommendation 50: fund the gap in community mental health services for people ineligible for the National Disability Insurance Scheme (NDIS).

Recommendation 51: improve communication between the NDIA and Victorian mental health services.

3.4 Social inclusion, peer support and community participation

Many people with severe mental health conditions and psychosocial disabilities can face stigma, isolation and attitudinal barriers in the community. Negative community attitudes, stereotypes and a lack of opportunities affect wellbeing, recovery and levels of participation in community. Stigma, a lack of inclusion, opportunities and attitudinal barriers, means that people can become isolated and do not receive the support needed to participate in their communities. This is why access to peer support groups, programs and advocacy services are vital.

Alongside adequately funded prevention-focused mental health interventions, there should also sit opportunities and interventions that aim to increase social inclusion and connection for people with mental illness or psychosocial disability. It should be noted that social inclusion, as well as economic participation, such as through employment, are critical areas of inequality experienced by all people with disabilities, particularly women with disabilities.

Peer support groups can also develop natural safeguards and supports. Women in a WDV focus group in preparation for this submission reiterated how important peer connections and support are for reducing their social isolation and building confidence. Peer support is also an important mechanism for sharing information on services, rights and corrective measures. These views were also shared by many of the women interviewed for Women with Disabilities Victoria, DVRCV and OPA's *Voices against Violence* research, who found that more informal support could be incredibly helpful.⁵⁸ Community participation and preventing social exclusion and isolation are critical means of ensuring people are informed and empowered. Current initiatives to involve people with disabilities in local community life should continue to be resourced by the Victorian Government as it has many positive effects on the mental health and social connectedness of people with disabilities.

⁵⁸ D. Woodlock. (2014), pp cit, 'Paper 6.'

Case study: the value of community participation – MetroAccess, RuralAccess and deafaccess Officers

Metro Access, Rural Access and Deaf Access Officers work locally across Victoria to support and create social inclusion. These local government-based positions are successful in engaging people with disabilities in many aspects of community life. They also play an important role in building locally based programs, such as Women with Disabilities Victoria's Enabling Women Leadership Program. Enabling Women is a program that plays a key role in teaching women with disabilities to speak up and be more connected.

Australia's history of disability rights has shown that funded advocacy and self-advocacy supports to be essential safeguards that build capacity amongst people with disabilities. Victoria's Self-Advocacy Resource Unit (SARU) have demonstrated the importance of supporting self-advocacy. SARU supports a range of groups such as those run by, for example, people with Acquired Brain Injury (ABI), people with intellectual disabilities and people with intellectual disabilities who have lost their children through child protection. Members of these groups work together, set goals, run forums, share information and meet with government representatives in order to make change.

Recommendation 52: create opportunities through funding peer support, self-advocacy, community participation programs and other peer-led initiatives in local communities.

Recommendation 53: expand the paid 'lived-experience' and peer workforce to provide people with more choice in the types of services they receive, including peer-support and advocacy.

Recommendation 54: maintain the MetroAccess, RuralAccess and deafaccess programs, as they ensure the social connectedness of people with disabilities.

3.5 Accessing regional and rural mental health services

Ninety-one per cent (91%) of respondents to the Women's Mental Health Network Victoria's survey indicated they would like to see more funding for regional and rural mental health services.⁵⁹ When asked about where responses should be improved in regional and rural services, seventy per cent (70%) of respondents highlighted family violence and trauma history as important areas. This again emphasises the need for trauma-informed care in both staff training and in service delivery practice. We also note that rurality is a risk for family violence and the prevalence of family violence is higher in regional and rural areas. The 'Strengthening Hospital Responses to Family Violence' (SHRFV) project is a great initiative that arose out of the 2016

⁵⁹ Women's Mental Health Network Victoria, (2019) Victorian Royal Commission into the Mental Health System survey report.

Victorian Royal Commission into Family Violence and ought to be extended and sustained within mental health services at hospitals.

Access to specialist mental health services is a constant challenge for people living in rural areas. There is a critical lack of psychiatrists and visiting outreach mental health services. Women also highlight the lack of therapeutic treatment programs, group programs and support groups in regional and rural areas, in contrast to what is available in metropolitan areas (for example, outpatient eating disorder, perinatal depression, or dual-diagnosis programs).

"...there is no early-intervention or post-intervention support if you live in smaller regional towns. I would like to see PARCs [Prevention and Recovery Care services] there for all regional hospitals that don't offer mental health - being dragged off two hours away to be discharged with no help to get home puts women and their children at risk."⁶⁰

Recommendation 55: significantly increase funding to mental health services in regional and rural areas in order to reduce the impact of obstacles to accessing services.

Recommendation 56: establish ongoing affordable group treatment and psychosocial programs, such as specialist trauma recovery treatments programs, in regional and rural areas to enhance people's recovery. Provide specialist trauma professional development training for public and private mental health professionals who may be accessed by clients with trauma histories.

Recommendation 57: provide incentives to attract mental health professionals to relocate to regional and rural areas.

Recommendation 58: increase transport options, including expansion of the Royal Flying Doctor Wellbeing Service and community bus programs in regional and rural areas.

Recommendation 59: provide increased funding for Telehealth capabilities and expand access to this for health service providers and their patients in regional and rural areas.

⁶⁰ Women's Mental Health Network Victoria, (2019) Victorian Royal Commission into the Mental Health System survey respondent.

Conclusion

This submission is based on the combined research, evidence and practice experience over the many years of working to provide support and provide advocacy on behalf of people with disabilities and mental health conditions. Most importantly, we want to see a system that works for the people it is intended to support, that is safe and upholds and respects peoples' human rights and enables their recovery. Mental health services should be a place people can get the support they need in a trauma-informed and gender-sensitive way, with a commitment to principles of human rights, collaboration, access and choice.

We would like to thank the Victorian Government for the opportunity to contribute to this consultation and we would welcome further consultation on any of the matters raised in this submission. This Royal Commission is an invaluable opportunity to improve the system that should protect and promote the rights of Victorians, including people with disabilities and we welcome further opportunities for consultation. We also wish to thank those people we consulted with and shared their stories with us, as part of this submission.

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