2019 Submission - Royal Commission into Victoria's Mental Health System	
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Your contribution

Should you wish to make a formal submission, please consider the questions below, noting that you do not have to respond to all of the questions, instead you may choose to respond to only some of them.

Introduction

We welcome the opportunity to provide a submission to the Royal Commission into Victoria's Mental Health System. We would like to note the importance of the Commission and its significance as the first of its kind in Australia. The rights of people with psychosocial disability have long been marginalised around the world and it is notable that Victoria is taking the step to undertake a royal commission to address this issue and to improve the mental health system.

This submission was prepared by Dr Anna Arstein-Kerslake and Dr Yvette Maker based on the research and drafting completed by the students in the Disability Human Rights Law subject in the Melbourne Law Masters (MLM) program at Melbourne Law School (May 2019): Mariyam Maasha Ahmed, Deki Zam Dorji, Shindy Dwipangesti, Kate Fitz-Gibbon, Danika Galvin, Ling Goh Chui, Carolyn Jones, Cristian Parker, Gail Reid, Lisa Smith, Philippa Duell-Piening, and Steph Weir. The subject is focused on the human rights of people with disability, including those with psychosocial disability. The following submission is based on the articles of the United Nations Convention on the Rights of Persons with Disabilities – which has been signed and ratified by Australia and is legally binding on Australia.

1. **What are your suggestions to improve the Victorian community's understanding of mental illness and reduce stigma and discrimination?**

Whilst people with psychosocial disability experience stigma and discrimination, one pathway to combat this is through education of the wider community. Article 8 (2)(a) of the United Nations Convention on the Rights of Persons with Disabilities (CRPD) requires States Parties to initiate maintain public awareness campaigns to 'foster respect for the rights and dignity of persons with disabilities' and 'combat stereotypes, prejudices and harmful practices', among other things. This could be pursued, for instance, by funding local councils to run community education sessions.

Article 8 (2)(b) of the CRPD states that educating children from an early age on the rights of persons with disabilities is necessary. We recommend that funding be provided to teach children in primary and high schools at every level about the rights of persons with psychosocial disability and to make this age-appropriate at each level. Presentations by people who have lived experience of psychosocial disability are an important element of this. This may contribute to destigmatising and de-sensationalising psychosocial disability. It can also improve young people's awareness of the assistance and services available to them.

2. **What is already working well and what can be done better to prevent mental illness and to support people to get early treatment and support?**

What is working well

A number of initiatives currently in operation are potentially supportive of the human rights of people with psychosocial disability. In particular, we note that Victoria has a 10-year Mental Health Plan (launched in Nov 2015) which focuses on a whole-of-community approach to mental health and identified human rights as a relevant consideration in the design and delivery of services. Access to mental health care plans that provide for access to some mental health services with a

Medicare rebate contributes to the realisation of the right to health enshrined in Article 25 of the CRPD.

The State also funds a number of independent Commissioners – the Mental Health Complaints Commissioner, the Child Services Commissioner and the Disability Services Commissioner. The Mental Health Tribunal plays an important oversight role, but we note that is a reactionary body and cannot have a significant role in identifying or addressing systemic human rights violations.

What could be done better

While a mental health framework exists, it is a ‘reactionary’ model that is focused on medical solutions to mental health issues. We recommend that it be recalibrated as a holistic community and human rights approach to mental distress and psychosocial disability.

Access to information ought to be prioritised for the whole community - not just those in education or workplace settings. In addition, we note that access to actual services is often limited by immigration status, and we encourage government to ensure accessibility of information and treatment to all those in the community (international students, foreign workers, and non-English speakers), as well as those with additional disability considerations such as people who use alternative modes of communication.

We encourage government to consult in depth with persons with psychosocial disability and their representative organisations prior to making any changes. In particular, their views and experiences must inform a best practice approach, particularly from an inclusive human rights model framework.

We also encourage members of the community, and politicians and other leaders within government to share their own experiences of psychosocial disability and using mental health services, in order to assist in debunking negative stereotypes and stigma.

3. What is already working well and what can be done better to prevent suicide?

What is already working well

The Victorian Charter of Human Rights and Responsibilities (2006) is one of only two State-based human rights charters in Australia. It requires all public authorities in Victoria to consider human rights when making decisions. The charter is a catalyst for transparency and accountability in government by giving all Victorians the tools to question and challenge the law.

The development and implementation of the Victorian Suicide Prevention Framework 2016-2025 may contribute to the realisation of several human rights. It is a whole of government commitment and coordinated strategy to reduce suicide. This includes article 25 of the CRPD, which states that people with disabilities (including mental health and other issues) have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability.

Article 31 of the CRPD requires the collection of appropriate statistical and research data to enable the formulation and implementation of policies to give effect to the CRPD. In relation to suicide prevention. The collation of data in Victoria outlines who is most at risk of suicide across Victoria, and this data must be used to inform appropriate responses in consultation with those affected. This includes men Aboriginal and Torres Strait Islander people, LGBTIQ (Lesbian, Gay, Bisexual, Transgender, Intersex, Queer) people, people in rural and dairy communities, people in regional communities, emergency service workers, paramedics, police, construction workers and the elderly.

What isn't working well

Section 9 of the Victoria Charter of Human Rights and Article 10 of the CRPD guarantees the right to life. When it comes to risk of suicide or attempted suicide, service provision is not always coordinated, timely and equitable, all of which are identified as key elements of the Victorian Suicide Prevention Framework. Services are not always available, particularly to high risk communities. We recommend that the Royal Commission examine the sufficiency of funding combined with the quality of service integration and coordination in order to ensure that these fundamental rights are fully realised for all people in Victoria.

4. What makes it hard for people to experience good mental health and what can be done to improve this? This may include how people find, access and experience mental health treatment and support and how services link with each other.

The Victorian Mental Health Act 2014 ('the Act') potentially prevents people from experiencing good mental health as it is based on a model that denies their essential right to personhood and legal capacity on the basis of their disability. The impact of this wholesale denial of legal capacity results in a paternalistic substituted decision-making model with respect to treatment that is not compliant with the obligations imposed by the CRPD. A person subject to the Act has their autonomy removed and liberty curtailed impacting upon meaningful engagement with treatment and the ability to access support services.

Article 12 of the CRPD states that "State Parties shall recognise that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life"[1]

In Victoria, the practice of compulsory treatment is lawful under the Act as it explicitly removes the legal capacity of people who are subject to compulsory treatment. Legal capacity as noted by the Committee on the Rights of Persons with Disabilities ('the Committee') consists of two strands.[2] Firstly legal standing to hold rights and be recognised before the law and secondly legal agency to be able to act on those rights and be recognised before the law.[3]

Allowing a regime whereby compulsory treatment can be forced upon a consumer at the discretion of an authorised psychiatrist does not respect the notion of a person with a disability enjoying legal capacity on an equal basis with others. Once a person is diagnosed with a mental illness under the Act, their legal capacity to be recognised as a person before the law and to be able to act on those rights is undermined by the delegation of decision-making authority to an authorised psychiatrist. This is an example of substituted decision-making, which the Committee has determined is impermissible under Article 12.[4]

It may be argued that the authority bestowed upon an authorised psychiatrist is reflective of supported decision-making as section 48 mandates that an authorised psychiatrist *must* take into account the views and wishes of a patient articulated by both an Advance Statement and a Nominated Person before making a decision about treatment. However, section 48 of the Act also

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[1] See the Convention on the Rights of People with Disabilities, art 12 para 2

[2] Committee on the rights of Persons with Disabilities, 11th session (31 March -11 April 2014) General Comment No.1 (2014) para 14

[3] Ibid.

[4] Ibid. at para 27

allows an authorised psychiatrist to make a Temporary Treatment Order having had regard to a person's wishes and preferences if satisfied that treatment cannot occur in the community. For example, if a psychiatrist deems that the treatment preferred by a patient is not suitable, they are authorised to impose a different medical treatment plan.

It could also be argued that the Act does recognise legal personhood of those people who are made subject to compulsory treatment in so far as a person is considered to have the legal capacity to make an application seeking revocation of a temporary or permanent treatment order. To take this approach would mean that a person's legal capacity is arbitrarily recognised subject to what legal issue or rights are being pursued as set out in the Act. The Act essentially suggests that a person has the legal capacity to seek a revocation of an order (that removes their legal capacity with respect to treatment) but does not have the legal capacity to make decisions about treatment.

Article 14 of the CRPD notes:

"…any deprivation of liberty is in conformity with the law, and that the existence of a disability shall in no case justify a deprivation of liberty"

The Act allows for a person who has (or is diagnosed with) psychosocial disability to be deprived of their liberty while a compulsory patient. The very fact that a compulsory patient can be treated in a locked ward means that they are not free to come and go as they like. Their liberty is curtailed on the basis that they are diagnosed with a psychosocial disability and that they are deemed to require treatment. It is the disability first and foremost that justifies loss of liberty. In this way, the deprivation of liberty may be considered discriminatory and contrary to the obligations under the CRPD, which require that liberty is not deprived on the basis of disability.

Section 110 of the Act allows for a person to be kept in seclusion if deemed necessary to prevent imminent and serious harm to the person or to others.[5] This may also be considered discriminatory and contrary to the obligations under the CRPD.

Article 19 is an innovative provision in the CRPD, and it foregrounds 'the right of persons with disabilities to live in the community, with choices equal to others.' In addition to enabling persons to claim a right, it imbues a responsibility for States to 'take effective and appropriate measures to facilitate full enjoyment by persons with disabilities of this right and their full inclusion and participation in the community'. It is an important right that seeks to address human rights violations against persons with disabilities that occur through measures such as institutionalisation and other methods of exclusion.

Independent living as it is framed in the CRPD incorporates three aspects: a) persons with disabilities have the opportunity to choose one's residence and with whom they live; b) persons with disabilities have access to in-home, residential and community support services necessary to support their independent living and social inclusion in the community; and c) community services and facilities for the general population are available on an equal basis to persons with disabilities and are responsive to their needs.

However, in considering the rights of persons with psychosocial disability, it is evident that Article 19 of the CRPD is not fully operationalised in Victoria. For example, group homes are a frequently provided as a residential service for persons with psychosocial disability in Victoria. This may be taken up because there is not adequate funding to support in-home support, such as for personal assistance, not because it is the explicit preference of the person.

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[5] MHA, s110

Victoria requires significantly increased resourcing and funding of in-home, residential and community support services, if persons with psychosocial disability living in Victoria are to exercise their legal capacity (Art 12). For example, when living in institutional settings such as group homes, persons with psychosocial disability may be prevented from making decisions in their daily lives about socialising and friendships, and may be precluded from freely leaving their home to pursue their rights to education (Art 24), work and employment (Art 27), political and public life (Art 29) and community life (Art 30).

Article 25 of the CRPD states that ‘persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability.’[6] Various health care professionals provide mental health-related services and support within the Victorian health care system, including but not limited to GPs, psychiatrists, nurses, social workers, and occupational therapists.

Despite the many good intentions of health professionals in Victoria, practice decisions may not be consistent with the human rights embedded in the CRPD. The strong influence of the medical model and a risk-averse culture means that health care practices are imbued with paternalistic protections and practices that deny persons with psychosocial disability their decision-making rights. Further, persons with psychosocial disability are sometimes dealt with in an adversarial way if they are not accepting of medical decisions and norms.

The problem with the dominant paradigm of risk-aversion in health care is that professionals, not persons with psychosocial disability, have the responsibility of managing risk. The health professional decides what is in the ‘best interests’ of a person with psychosocial disability, and this is often does not take into consideration the will and preferences of persons with psychosocial disability. As a result, a person’s dignity of risk is denied and many other rights may be in jeopardy.

Article 25 (d) specifically calls for health professionals to provide care of the same quality to persons with disabilities as to others through ‘training and the promulgation of ethical standards for public and private health care’, among other things. It would appear that health professionals require increased training and education that enable them to challenge the status quo and mitigate the ethical tension and dilemmas between duty of care and enabling dignity of risk for persons with psychosocial disability.

5. What are the drivers behind some communities in Victoria experiencing poorer mental health outcomes and what needs to be done to address this?

Drivers behind poorer health in some communities

There are numerous drivers for some communities experiencing poorer mental health outcomes. There can be compounding factors, such as differences in access to services due to geographical location or funding that result in isolation and alienation from systems that could support and provide treatment to those who need it.

The rural/metropolitan divide can cause fragmentation in access to facilities. For rural areas, the concern lies in lack of services and lack of funding for services, while the primary concern in metropolitan areas relates to overwhelmed services that cannot meet demands and are overburdened with long waiting lists.

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[6] CRPD Art 25

Service provision can be very fragmented and disjointed. Referrals may involve various services that are not connected and may provide overlapping treatment, which may lead to over- or under-servicing.

There is also a lack of inclusion of mental health consumers and people with psychosocial disability in formulating legislation and policies. The absence of their voices and leadership means that laws and policy may not address the key needs of this group but rather, may represent the assumptions made by law and policymakers.

What needs to be done

We recommend greater investment of funding in rural areas to increase level of services in order to more fully realise the right to health guaranteed in article 25(c) of the CRPD. Services must be available as close as possible to people's own communities, including in rural areas.

Concurrently, there needs to be an increase in funding to metropolitan areas to help with overwhelmed services that are servicing both metro areas and those from rural locations. The quality and nature of these services must be considered before changes are made. Increasing access to services that do not respect the full suite of human rights of mental health consumers and people with psychosocial disability (such as the compulsory services outlined above) will not improve outcomes. We recommend that the Royal Commission focus on the views and needs of consumers and people with psychosocial disability and their representative organisations, including their calls for peer-run services and alternatives to mainstream or traditional mental health services. Funding should also go towards public awareness campaigns to destigmatise psychosocial disability and remove stigma associated with seeking help.

There also needs to be focus on funding on the 0-5 years age group to ensure meaningful support given to children and parents experiencing distress or psychosocial disability. This should be enhanced by increasing funding for health and well-being coordinators in all schools, so that the support continues as children grow.

6. What are the needs of family members and carers and what can be done better to support them?

Family, carers and supporters of people with psychosocial disability often have insufficient access to resources and support themselves, especially in rural and remote areas.

Community support groups play an important function in sharing knowledge and information and developing support networks.

Improving funding and access to mental health services and support in rural areas will cut down on travel times and costs associated with accessing services and thereby ease the impact on family and carers, especially in times of crises.

Increased funding for services in the metropolitan area could also benefit entire families and support networks by reducing waiting lists and enabling easier and faster access to services. An investment in cultural sensitisation programmes for public service providers would also be useful to ensure government service providers understand and are sensitive to cultural diversity.

People who provide care or support to a family member or friend may have to reduce their work hours, or leave paid employment altogether, if they cannot access flexible working conditions that provide them with adequate pay and conditions. We recommend that the Royal Commission examine the needs of carers and supporters in this regard and consider making recommendations for workplace initiatives and reforms.

The sufficiency of income support payments like Carer Payment and Newstart Allowance are an essential piece of this puzzle. People who rely on these payments are unlikely to be accruing retirement savings, entrenching their disadvantaged position throughout their lives. While this is a Federal matter, the implications of this for Victorians must be examined and addressed.

7. What can be done to attract, retain and better support the mental health workforce, including peer support workers?

Any discussion of what can and should be done to attract, retain and better support the mental health workforce in Victoria must necessarily include a consideration of the *Victorian Charter of Human Rights and Responsibilities Act 2006* (the Charter), the CRPD, and those fundamental Human Rights that the two instruments seek to promote and protect.

In order for broader reforms to be successfully implemented, Victoria's mental health system depends on the availability and accessibility of an experienced and specialised workforce. It requires the inclusion of personnel who are trained to serve the needs of the community and requires a workforce that is training and resourced to deliver the care in a manner consistent with the objectives of the CRPD, the Charter and Human Rights generally.

We know that health systems have not yet adequately responded to psychosocial disability and as a result the need for adequate treatment and provision of services is significant all over the world[7]. A key aspect of addressing barriers faced by people with psychosocial disability is through the provision of well-informed, educated and specialised mental health professionals alongside peer workers who have experience of mental health services.

The Charter and the CRPD both address the right to equal recognition before the law, and by extension, the right to legal capacity, including the right to choose what services and treatments an individual receives whilst in the mental health system[8]. No one should be subjected to treatment or experiments without their full and informed consent[9].

Emphasis and regard must be had to the individual experience. Mental health professionals must receive human rights professional development to ensure they understand the right to equal recognition and legal capacity of people with disability to make informed decisions about matters that affect their individual personhood. More education is required in terms of how mental health workers assess and treat people with psychosocial disability. Stigma still remains, for example, around the legal capacity of people with cognitive disability, and it is vital that mental health workers are educated on the importance of agency (and supported decision-making principles). The significance of mental health workers understanding and acknowledging the rights of people with disabilities to make informed decisions should not be overlooked or understated. The presence and involvement of peer workers can contribute to establishing service environments that prioritise human rights and the perspectives of consumers.

As outlined above, article 25 of the CRPD requires the recognition that people with disabilities

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[7] World Health Organisation Mental Health Action Plan 2013 - 2020

[8] see Article 12 of the Convention and Section 8 of the Charter.

[9] see Section 10 of the Charter

(including psychosocial disabilities), have the right to the highest attainable standard of health without discrimination on the basis of disability.[10] In realising this, Victoria must, inter alia, take all appropriate measures to ensure access for persons with disabilities to health services that are affordable, accessible, specialised, and free from all forms of discrimination[11].

To ensure that the highest standard of care is afforded to people with psychosocial disability, Victoria's mental health system must provide care and a service that is of the same standard provided to others[12] without psychosocial. This requires increased awareness[13] and training of mental health professionals on conscious or unconscious bias, as well as an acknowledgment of the stigma that still attaches to perceptions of people with psychosocial disability, which sees them as in need of "fixing", particularly with reference to medical models of disability.

Further, it is the right of all persons with disabilities to access health services as close to their own communities as possible, including those in remote areas[14]. Anecdotally, mental health professionals in remote or rural areas (to the extent they are available) currently experience lower rates of pay and lower standards of support than their counterparts in metropolitan areas. This, in turn, may contribute to lower levels of morale, higher rates of staff turnover and lower standards of service provided to those in the mental health system.

In order to attract and retain a quality workforce in remote or rural areas, Victoria must consider the use of financial and other incentives (such as relocation funding and/or subsidised housing) to encourage the deployment of competent and highly skilled professionals that are needed in these areas, and to retain them once they are there.

Victoria should seek to promote employment opportunities and career advancement for persons with disabilities[15] and specifically encourage the employment of persons with disabilities in the mental health system.[16] As touched on above, the system would benefit from the use of peer support workers and the upskilling of available local professionals, who have lived experience and expert knowledge of the communities in which they serve.

Where possible, there should be ongoing support and educational opportunities for peer workers to access tertiary education, vocational training, and adult education,[17] with the aim of enabling them to enter and contribute to the mental health workforce.

One particularly important consideration for the Royal Commission should be the provision of adequate levels of support to mental health professionals who experience burnout as a result of their position in the system.

There are, undoubtedly, a number of barriers in the current mental health system in Victoria. We assert that any consideration of the system by the Royal Commission in relation to the mental health workforce should pay close attention to the principles of the CRPD and the Charter, as they relate to human rights.

Specifically, the Commission should:

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[10] See Article 25.
[11] See Article 4 and Article 5.
[12] See Article 25(d).
[13] See Article 8.
[14] See Article 25
[15] See Article 27 (e)
[16] See Article 27 (g) (*to the extent the mental health system is in the public sector).*
[17] See Article 25

- Consult both mental health professionals and people with psychosocial disability and mental health consumers to better understand the limitations and restrictions faced by both groups, with the aim of determining the most significant barriers that people with psychosocial disability face to accessing help or assistance that is right for them.[18]
- Undertake analysis with the aim of determining what areas of the workforce face the greatest ‘gaps’ in resourcing and recommend the allocation of additional funding and resources as appropriate.
- Ensure that any recommendations promote a strong focus on increasing the capacity of the workforce through the provision of adequate funding and training resources.
- Provide professional development opportunities and upskilling of workers to those already working within the system and incentives for people entering the mental health workforce.
- Subsidise or allocate funding for educational costs associated with professional development in specialist programs to enable more focused, individualised and rights-based services.
- Increase the number of funded university training places, set quotas in health courses for rural background students and students with disabilities, and offer financial incentives and supports to encourage qualified health professionals to relocate to rural or remote areas.

The CRPD places a positive obligation on governments to promote the training of professionals and staff working with persons with psychosocial disability in the rights in the CRPD so as to better provide the assistance and services guaranteed by those rights. The Royal Commission, in reviewing the current mental health laws in Victoria, should do so through the lens of those human rights afforded by the CRPD. At a minimum, we assert that all health care professionals who ultimately have an impact on the lives of people with psychosocial disability should receive regular training on human rights issues in line with the CRPD and the Charter, preferably delivered by mental health consumers and people with psychosocial disability.

8. What are the opportunities in the Victorian community for people living with mental illness to improve their social and economic participation, and what needs to be done to realise these opportunities?

Social and economic participation are universal rights under the International Covenant of the Economic, Social and Cultural Rights (IESCR) and the CRPD, and are embedded in the Universal Declaration of Human Rights.

We propose further funding and support for education, to provide more opportunities for people with psychosocial disability to improve their social and economic participation. People with psychosocial disability should not be in segregated educational settings. Subsidised education, bursaries, and scholarships specifically for people with psychosocial disability may be beneficial in this regard.

Second, we propose the need for better employment support and career opportunities for people with psychosocial disability. Public sector quotas may provide a valuable precedent for expanding employment opportunities for people with psychosocial disability. Improved access to flexible work, discussed above in relation to carers and supporters, may also be important for some people with

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[18] See Article 8.

psychosocial disability. Discrimination and stigma may make it difficult for people with psychosocial disability to disclose their diagnosis or needs to their employers; awareness-raising in the community generally, and in business specifically, could improve this.

Thirdly, we propose further education and training programs for front-line staff (such as mainstream medical staff, court staff, prison staff and teachers) on disability awareness and disability rights, including mental health awareness and rights. This could greatly improve the experience of people with psychosocial disability in interacting with various systems.

While front-line staff are important points of contact for persons with disability, we believe that it is also important to educate parents, supporters and communities, on the rights of people with psychosocial disability. Raising awareness could come in the form of advertisements and education. Advertisements and education should be led and produced by people with psychosocial disability.

People with psychosocial disability and/or mental health consumers must also be part of monitoring bodies and oversight bodies like the Mental Health Tribunal. Having proper representation of people with psychosocial disability in such bodies would improve the representation of the interests of people living with psychosocial disability.

9. Thinking about what Victoria's mental health system should ideally look like, tell us what areas and reform ideas you would like the Royal Commission to prioritise for change?

Much needs to be reformed with regards to the disadvantage experienced by people with psychosocial disability.

Article 9 (1) of the CRPD holds that people with psychosocial disability should be able to access and participate fully in all areas of life. Because of serious economic disadvantage and lack of services, people with psychosocial disability often do not have ready access to government-funded services; they might not also lack choice and control over the types of services they use, especially if they are subject to compulsory treatment.

People with psychosocial disability are at higher risk of homelessness and face risks of violence and abuse associated with it. Article 16 (1)(2) of the CRPD states that the people with disability should be free from violence and abuse, while article 19 of the CRPD states that all people should live independently in the community. People with psychosocial disability should be able to choose where they live and who they live with. Forced placement reduces individuals' safety and choice.

Article 25 of the CRPD states that all persons with disability should have access to the highest standard of health care. The primary source of many people's access to further mental health help, general practitioners, are not obliged to engage in mental health care training. We recommended that such training should be a part of the program of accreditation of GPs.

As discussed in detail above, reform of legislation is necessary to ensure that forced psychiatric treatment is avoided. Article 4 (b) of the CRPD states that there is a need to modify or abolish existing laws which constitute discrimination and remove the freedom of choice. Forced psychiatric treatment (including ECT and forced seclusion) is also contrary to Article 12 (2) as it removes the legal right for informed consent to treatment that all other members of society have.

10. What can be done now to prepare for changes to Victoria's mental health system and support improvements to last?

In order to prepare for and support lasting changes to Victoria's mental health system, it firstly must be generally acknowledged that any reforms recommended by the Commission cannot be rushed. In preparing for the changes the Commission may recommend, the State must focus on the importance of creating a system that is sustainable moving forward.

At the outset, any reform to Victoria's mental health system must be based on an approach that promotes and supports human rights. The World Health Organisation notes that there is a need to '...develop mental health laws which respect human rights, promote adequate health care, and stop social exclusion'[19]. An approach for reform that is informed by the medical model of disability (that includes psychosocial disability) which views a person's mental health condition as the problem that can only be solved by improvements to medical intervention and medical treatment, without the need for attention to wider social forces and whole-of-community change, should be actively avoided.

A high-quality mental health system requires forethought and planning long before a health worker engages with a patient. For lasting change to happen, the challenges for the Royal Commission are great: providing mental health services to all who need them, in an equitable way, in the most effective manner possible and in a fashion that promotes human rights and health outcomes.

A human rights approach to reform is informed by international best practice under the CRPD. The Commission must engage with learnings from the CRPD Committee and case law on the risks and failings of mental health systems for persons with mental disability.

Under the CRPD, there are a number of articles relating to persons with psychosocial disability which could currently assist the State in preparing for change.

Article 8(1)(a) provides that a State Party must undertake effective and appropriate measures to raise awareness throughout society regarding persons with disabilities. In applying this to the State of Victoria, the State could raise awareness in the community about the challenges, rights, dignity, capabilities and contributions of persons with psychosocial disabilities. This would include raising awareness in the community within and beyond those directly involved in the mental health system in Victoria, including generalist services as well as specialist services. Raising awareness of the rights and experiences of persons with psychosocial disabilities could arguably lead to a greater understanding and acceptance by the wider community of any reforms recommended by the Commission, thus supporting reforms recommended by the Commission to last.

Other changes that the State could make now in line with a human rights approach to prepare for reform include improvements to the employment and education for persons with psychosocial disability as outlined by Articles 24 and 27 of the CRPD, as well as resources and support for families, carers and supporters. The State could prioritise funding now in these areas to strengthen these systems for persons with psychosocial disability and the people who support them.

To ensure that the improvements and changes recommended by the Commission have a lasting effect, the strategies used by the Commission to consult, collect and gather information must be robust. Article 29 of the CRPD provides that the government should guarantee persons with disabilities have equal participation in public and political life. This places an onus on the State to ensure there are meaningful and comprehensive opportunities provided for persons with psychosocial disability and their representative organisations to participate in the Royal

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[19] World Health Organisation, available online: https://www.who.int/mental_health/policy/country/en/].

Commission on an equal basis and without discrimination.

The motto ‘nothing about us, without us’[20] is a reminder that persons with disability must lead, control and actively participate in any changes to law, policy and practice relating to disability, which would include mental health reform.

Therefore, any data currently being collected in relation to the Commission’s terms of reference should be guided by the voices of people with psychosocial disability and mental health consumers. Where possible, any consultation should be led by persons with psychosocial disability or mental health consumers. Diversity and depth of inquiry are crucial because ‘...not every person with a disability [including psychosocial disability] experiences the same kind of oppression and identically resists it but rather people with disabilities are oppressed and resist this oppression individually’[21].

In addition, the drafting and finalisation of recommendations should be completed in consultation with those who will be directly impacted by the system’s reform. The representation of persons with psychosocial disability in this way will ensure that those who will be impacted by the reform have the opportunity to review and provide feedback on proposed changes.

Article 21 of the CRPD provides that information intended for the general public must be provided in accessible formats and technologies for persons with disabilities. As a result, the State must ensure appropriate resources about the Commission’s consultation process and terms of reference are available to persons with psychosocial disability in accessible formats and technologies to enable those most impacted to access the necessary information to be able to express their views on reform of the system. This also means ensuring that people currently admitted to mental health services have adequate opportunity to participate in consultations and give evidence.

There is a need to actively avoid discrimination against persons with psychosocial disability and mental health consumers. To achieve this goal, the Commission should consider incorporating Stone and Priestley’s six principles of emancipatory research[22] in its consultation process and all analysis of submissions made in response to that consultation. These principles are as follows:

- the adoption of a social model of disablement as the epistemological basis for research production;
- the surrender of claims to objectivity through overt political commitment to the struggles of disabled people for self-emancipation
- the willingness only to undertake research where it will be of practical benefit to the self-empowerment of disabled people and/or the removal of disabling barriers;
- the evolution of control over research production to ensure full accountability to disabled people and their organisations;
- giving voice to the personal as political whilst endeavoring to collectivise the political

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[20] Charlton JL, *Nothing About Us Without Us: Disability Oppression and Empowerment* (University of California Press, 1998) ch 1.

[21] Charlton JL, *Nothing About Us Without Us: Disability Oppression and Empowerment* (University of California Press, 1998) 5.

[22] Stone E and M Priestley, ‘Parasites, Pawns and Partners: Disability Research and the Role of Non-Disabled Researchers’ (1996) 47 *British Journal of Sociology*, 706.

commonality of individual experiences; - the willingness to adopt a plurality of methods for data collection and analysis in response to the changing needs of disabled people[23]. This approach is most likely to support lasting improvements as it will highlight the parts of the system that are most lacking and point to targets to promote growth, access and success in the mental health system and wider community. Recommendations can be constructed from this data and strategically aligned with the actual needs of those trying to access and use the system. Moreover, the data gathered in this way may identify any current gaps in Victoria's Mental Health Service that can be addressed now to assist services to meet needs.	
11. Is there anything else you would like to share with the Royal Commission?	
Privacy acknowledgement	I understand that the Royal Commission works with the assistance of its advisers and service providers. I agree that personal information about me and provided by me will be handled as described on the Privacy Page. ☒ Yes ☐ No

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[23] Stone E and M Priestley, 'Parasites, Pawns and Partners: Disability Research and the Role of Non-Disabled Researchers' (1996) 47 *British Journal of Sociology*, 706.