Royal Commission into
Victoria's Mental Health System

WITNESS STATEMENT OF KRISTEN HILTON

I, Kristen Hilton, Commissioner of the Victorian Equal Opportunity and Human Rights Commission (VEOHRC), of Level 3, 204 Lygon Street, Carlton, Victoria say as follows:

Background

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

2. I am providing evidence to the Royal Commission into Victoria's Mental Health System in my capacity as Commissioner of VEOHRC.

Overview of my experience

3. In 2016 I was appointed to a five-year term as Commissioner of VEOHRC to progress the legislative mandate under the *Equal Opportunity Act 2010* (Vic) (Equal Opportunity Act), the *Charter of Rights and Responsibilities Act 2006* (Vic) (Charter) and the *Racial and Religious Tolerance Act 2001* (Vic) (Racial and Religious Tolerance Act).

4. Prior to my term as Commissioner I served as Executive Director of Civil Justice, Access and Equity at Victoria Legal Aid from 2009 to 2015 and then as Executive Director of Legal Practice from 2015 to 2016. Prior to joining Victoria Legal Aid I served as the Chief Executive Officer at Justice Connect (then the Public Interest Law Clearing House) and as the Manager and Principal Solicitor at the Homeless Persons Legal Clinic. In 2006 I was awarded a Churchill Fellowship to conduct international research on homelessness and human rights.

5. Prior to commencing my career I graduated from my Bachelor of Arts and Laws with honours. I am also a graduate of the Australian Institute of Company Directors.

6. Attached to this statement and marked 'KH-1 is a copy of my curriculum vitae.

My role as Commissioner of VEOHRC

7. As Commissioner, my role is to promote and protect human rights and equality across the state and lead the Commission's work in creating a rights respecting culture within organisations, governments and communities with specific responsibilities under the Equal Opportunity Act, the Charter and the Racial and Religious Tolerance Act.

Please note that the information presented in this witness statement responds to matters requested by the Royal Commission.

8. I am responsible for the strategic direction and operational priorities of the Commission, leading and supervising the day-to-day operations and staffing of a range of regulatory functions including: reporting to the Attorney General and Parliament on systemic issues and trends, providing dispute resolution and education to the community, undertaking policy and research, systemic reviews and investigations, developing guidelines and resources and community engagement. I report directly to the Board and Audit and Risk Committee and manage the Commission's budget and corporate governance requirements. I represent the Commission on significant committees and at key events along with speaking at conferences and forums addressing equality and human rights issues.

About VEOHRC

Key information and statistics pertaining to discrimination against people living with mental illness

9. The following statistics and information relate to the number of complaints and enquiries VEOHRC has received since 2013.[1]

10. We receive far more enquiries than we do complaints. In the past seven years, we have received 9,254 disability discrimination enquiries and 1,612 of those (17.5%) relate to mental health. Mental health is a category of disability, and disability is a protected attribute under the Equal Opportunity Act.

11. In relation to complaints, year-on-year disability discrimination is the most complained about attribute. In the past seven years, we have received 2,350 complaints of disability discrimination. Within that number, almost 500 of these complaints pertained to mental health (21%). This equates to approximately 70 complaints per year.

12. We also receive enquiries and complaints about discrimination on the basis of mental health alongside discrimination on the basis of other protected attributes such as sex and race. These complaints are not always designated as complaints about mental health discrimination by VEOHRC because they fall under the broader category of disability.

13. The most common types of mental health issues we see are people are making complaints or enquiries about stress, anxiety and depression.

[1] We count an 'enquiry' to have been made when a person contacts VEOHRC asking for information or asking how to make a complaint. We deem a complaint to have been made where VEOHRC's formal dispute resolution process is commenced.

14. The financial settlements that people receive for complaints relating to mental health discrimination are generally lower than those received for other types of complaints. I think this primarily occurs because employers don't treat discrimination on the basis of mental health as seriously as other types of discrimination.

15. 35% of the complaints about mental health discrimination occur in the area of employment, 18% relate to education, 16% relate to the provision of goods and services, 11% relate to accommodation (mainly in the private rental market) and 5% relate to sporting clubs.

16. We find that employment related complaints tend to involve complaints by an employee that they have not been provided with reasonable adjustments by their employer for their mental health condition. For example, this will include where an employee discloses that they have a mental health issue and their employer denies their request to work flexibly or have additional time to prepare for meetings.

17. Education complaints will generally be made in the context of tertiary education and relate to students who are having difficulty with completing course requirements but are refused extensions or additional time to complete examinations. There are also some circumstances where prospective students have been denied access to a course or degree because of a pre-existing mental health issue.

18. We also receive a large number of complaints on the basis of disability discrimination from parents and carers of students with a disability. Typically, the subject of these complaints will be discrimination on the basis of physical disability, autism or ADHD. Often, both carers and the person with a disability will be experiencing stress and anxiety as a result of discrimination.

19. For complaints made about the provision of goods and services, the most common complaints relate to income protection insurance.[2] Complaints are also commonly made about being refused entry into public venues because of a perceived mental health issue, often when the person seeking entry is in a state of distress.

20. Accommodation complaints typically relate to being denied a rental property where an applicant has volunteered information about their disability or receipt of the disability support pension. They also encompass complaints about eviction where a person is unable to pay rent because of their mental health issue.

[2] In this setting, VEOHRC has also completed a major investigation into mental health discrimination in travel insurance policies. This is discussed below at paragraphs 72 to 76.

21. About 60% of the complaints relating to mental health discrimination are resolved at conciliation. A number are withdrawn but those figures aren't any higher than any other types of complaint that we receive.

22. We have observed that complaints about mental health discrimination have remained steady over the past seven years. This strikes me as unusual because in this period, there has been significant growth in public awareness about mental health. It suggests to me that there remains a need for more education about the rights of mental health consumers under the Equal Opportunity Act, particularly for other mental health service delivery or regulatory organisations which might be the first port of call for a consumer who has experienced discrimination. I think it is important that people in these organisations, whether it be the Mental Health Complaints Commissioner or Beyond Blue, understand that the distress a consumer feels and reports to them could also be an instance of unlawful discrimination.

23. VEOHRC works with public sector and disability advocates to educate them on workplace equality, human rights and equal opportunity law to increase understanding of the law. In May this year, as a part of Law Week, VEOHRC ran two online seminars on understanding reasonable adjustments at work for people with disabilities and making requests for reasonable adjustments. VEOHRC has also commenced a 3-part skills development program for disability advocates.

Amendments to the Charter to include a right to health

24. The Charter required the Attorney General to conduct a review of the Charter after four years of its operation. Section 44 of the Charter required that this review consider whether additional human rights should be included as human rights under the Charter, including but not limited to, rights under the International Covenant on Economic, Social and Cultural Rights (ICESCR). The right to health is one of these human rights.[3]

25. VEOHRC has strongly advocated for the inclusion of the right to health and other economic, social, cultural rights in the Charter for some time. The present COVID-19 context provides an opportunity to revisit the importance of this right. We have seen that access to health and a functioning and quality health system is one of the top three most important issues for Australians when it comes to their expectations of government.[4]

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[3] Article 12 of the ICESCR provides for the right to the enjoyment of the highest attainable standard of physical and mental health.

[4] See this summary of the 2019 Vote Compass results: https://www.abc.net.au/news/2019-04-17/vote-compass-election-most-important-issues/11003192 [accessed 10 July 2020].

26. Our experience is that governments are hesitant to enshrine economic, social and cultural rights into law.[5] This hesitance is often motivated by a perception that legislating for these rights will not provide a benefit and may require courts to comment on the appropriateness of government resource allocation. It is important to understand, however, that some of the obligations on the government are immediate and some are subject to progressive realisation. Progressive realisation is an obligation to take appropriate measures toward the full realisation of the rights to the maximum of available resources. A government must show that they are allocating available resources at their disposal to ensure continual improvement, not regressing or stalling. It does not require the delivery of an 'A+' standard of healthcare in all cases.

27. We think that a right to health in the Charter should be formulated similarly to the rights to health contained in the ICESCR and the Convention on the Rights of Persons with Disabilities (CRPD).[6] In these two instruments, the right to health is formulated broadly, and it contains both freedoms (e.g. the right to be free from invasive or non-consensual medical treatment and the right to elect the type of medical treatment you receive) and entitlements (which concern the availability, affordability, acceptability and quality of health care). In accordance with the ICESCR and the CRPD, a right to health in the Charter should encompass physical and mental health.

Improving experiences and outcomes for mental health consumers, their families and carers through an enshrined right to health

28. Enshrining a right to health in the Charter will assist efforts to change and improve Victoria's mental health system for the following reasons:

    (a) A right to health in the Charter would provide a unifying standard, or benchmark for the analogous rights contained in other acts and instruments. There are already a number of legislative and regulatory schemes operating in Victoria and Australia that adopt a human rights framework inclusive of the right to health, such as the *Mental Health Act 2014* (Vic) (Mental Health Act) and the Australian Charter of Healthcare Rights. In 2019, Queensland passed the *Human Rights Act* 2019 (Qld) that gives legislative protection to the right to access health services without discrimination.

    (b) A right to health in the Charter would help set the priorities for cultural and service change by government. Human rights guide public authorities on the

[5] See for example the Victorian Government Response to the Review of *Charter of Human Rights and Responsibilities Act 2006* (Vic), 14 March 2012, para 2.10 available here: https://www.parliament.vic.gov.au/images/stories/committees/sarc/charter_review/report_response/20120314_sarc.govtresp.charterreview.pdf [accessed 10 July 2020].
[6] See Article 25 of the Convention on the Rights of Persons with Disabilities.

standards of protection to which rights holders are entitled and therefore the content of the duty owed by the public authority. The right to health offers a framework through which to improve existing services, identify gaps and deliver more comprehensive health care.

(c) A right to health also provides a framework for public authorities to navigate difficult ethical and moral decisions, both when designing policy and delivering services, by requiring public authorities to balance and weigh up competing rights and interests. It offers a clear framework for lawfully limiting human rights when reasonably necessary and justified. This assists front line workers treating and caring for people with mental illness to uphold standards.

29. If an enshrined right to health were to be coupled with a Charter dispute resolution function, a person denied timely access to mental health services could make a complaint to VEOHRC. For example, a person living in Gippsland made to wait to access mental health treatment longer than they would have to wait in the city might complain that the State is not taking sufficient action to progressively realise the right to health by making health services more available in the region. The result of this complaint would not necessarily be that the State is obliged to inject more money into mental health services in Gippsland. It would consider any retrogressive action, such as a wind back of services, any stagnation in service availability or a lack of future planning to progressively realise the right. At present, this type of complaint cannot be made to VEOHRC – which is limited to receiving discrimination complaints under the Equal Opportunity Act and the Racial and Religious Tolerance Act. A dispute resolution function would provide an opportunity for rights holders to pinpoint gaps in our health system and then the state would have the responsibility to show that every effort has been made to use all available resources at its disposal in order to satisfy its obligations.

30. A Charter complaints mechanism would also work at a systemic level to highlight gaps in the State's mental health system. Aggregate complaints data might reveal parts of the mental health system that are failing to deliver timely, high-quality and culturally appropriate care. This information could then be used by government to redirect funds and improve services. Because a human rights framework employs principles of non-discrimination, the right to health would also ensure fairer allocation of resources. Irrespective of whether you live in Kyabram or Toorak, ideally you should be able to access the same quality mental health services.

31. A rights-based framework for health emphasises principles of accessibility, availability, acceptability and quality of care. This provides an agenda for the whole of the mental health service delivery system that can be progressively realised by government. Conversely, an enshrined right to health might be breached where a government cuts

mental health services despite there being a great amount of demand for them. This does not mean that programs can't be improved or changed, but it makes the government accountable for taking any retrogressive measures.

Embedding a right to health in Victoria's future mental health system

32. VEOHRC has experience working with public authorities and service providers to build a human rights culture across government. We have partnered with the Health and Wellbeing Division of the Department of Health and Human Services (DHHS) to deliver an education program to deepen a human rights approach to its health work. Following the program, the division saw a willingness to explicitly frame a human rights approach when undertaking consultations with communities on key policy priorities such as women's health, HIV, mental health and vulnerable children. The rights-based approach to health helped connect the division with its values, focus the work on the people they service and strengthen relationship with community.

33. VEOHRC delivered an education program to the staff of the State Trustees to build confidence and skills in applying the Charter in its work. We provided foundational skills in preparation for the new *Guardian and Administration Act 2019* (Vic) that has the protection of the human rights and dignity of persons with disability as its primary objective. The State Trustees used the Charter to guide complex decisions, in particular when limiting human rights.

34. We have been working with Barwon Prison to build its capability to protect prisoner rights by applying the Charter in decision making. Using realistic scenarios, the program allowed officers to practice applying the Charter to day to day situations. Following the education program, prison management observed that acknowledging prisoner rights improved relationships between prisoners and officers, and using the Charter to guide decisions led to better decision making.

35. Based on our experience in delivering Charter education to embed human rights approaches in government, we understand the transformational nature of using a human rights-based approach.

36. If the right to health were to be protected in the Charter, it would provide a legal framework to support cultural change in mental health service delivery and design. It could lead to better decision-making by health professionals and frontline staff, guiding complex and difficult ethical decisions. Unlike the civil and political rights currently contained in the Charter and to a limited extent in the Mental Health Act, a right to health would provide a decision-making framework that speaks directly to health professionals' work and their values of dignity and care, it would focus the work and

service design on the people they serve and strengthen relationships with patients and impacted communities.

Quality and safety

The Optional Protocol to the Convention Against Torture and Other Cruel, Inhumane or Degrading Treatment or Punishment (OPCAT)

37. OPCAT is an international human rights treaty that supplements the UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT). It is the mechanism for countries to implement their obligations under CAT. OPCAT requires signatory countries to:

    (a) establish independent body or bodies – a National Preventative Mechanism (NPM) – to access and inspect all places of detention in all states and territories; and

    (b) permit inspections of places of detention by the United Nations Subcommittee on the Prevention of Torture (SPT).

38. OPCAT aims to prevent cruel, inhuman and degrading treatment or punishment within 'closed environments', which can include prisons, immigration detention centres, police detention facilities, psychiatric wards and care facilities. The first stage of OPCAT implementation, however, only provides for the independent inspection of 'primary places of detention' which are limited to prisons, police detention facilities, remand facilities and forensic mental health services. It is not clear if or when Australia will implement its wider OPCAT obligations with respect to all closed environments.

39. Upon completing an inspection of a closed environment, an NPM body will provide a report containing its recommendations to the government, as well reporting annually to the SPT.

40. The SPT is the UN body of independent experts responsible for conducting visits to places of detention in jurisdictions that have ratified OPCAT and also for providing guidance to NPMs to assist in the performance of their duties. Following a visit, the SPT communicates its recommendations to the State and, if necessary, to the NPM in a confidential report. It also reports annually reflecting on State visits. While a signatory country does not have to act on any recommendations made through the reporting process, the process promotes transparency and ensures the publication of expert opinion about what takes place within closed environments.

41. OPCAT and the establishment of an independent system of monitoring in Victoria will be a valuable mechanism to protect people with mental illness from ill-treatment,

particularly in relation to the use of restrictive practices and seclusion, involuntary treatment and indefinite detention. A comprehensive inspection framework will also help to facilitate Australia's compliance with international human rights obligations in those challenging contexts.

42. People with mental illness are disproportionately represented in closed environments such as psychiatric and residential mental health facilities and justice settings. In those settings (often out of public view), people with mental illness are deprived of their liberty and subject to power imbalances that can create opportunities for people with mental illness to be mistreated. Independent oversight of places where people with mental health issues are deprived of their liberty is particularly important at this time when we know institutions are managing COVID risks by using seclusion practices and reducing access to facilities.[7] In Australia, where robust legal and criminal justice frameworks exist, the general risk of torture is low. However, OPCAT also prohibits other cruel, inhuman and degrading treatment or punishment that falls short of the legal definition of torture. This could encompass ill-treatment as a result of involuntary treatment, restrictive practices, restraint or confinement within justice, health and mental health settings.

43. The negative effect of restrictive practices and seclusion on well-being and quality of life, particularly for people who have disabilities, is well established and has been a focus of NPM bodies and inspections in other jurisdictions. In New Zealand, for example, the NPM bodies have focused on the use of seclusion and restraint in mental health facilities.[8] The NPM and the UN Sub-committee on the Prevention of Torture (during a country visit) found that the reporting and documentation of seclusion and restraint were not consistent across detention environments, with some powers being used on a more routine basis than provided for in legislation. As a result, the New Zealand NPM undertook a comprehensive study of seclusion and restraint policies and practices within detention facilities in order to identify a preferred practice.[9]

44. The Australian government ratified OPCAT on 21 December 2017 and has until January 2022 to implement its obligations under the protocol. NPMs are being set up at state and commonwealth levels of Australian government, and it has been decided that the Commonwealth Ombudsman will be the NPM in respect of federal places of detention.

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[7] See these news stories for example https://www.sbs.com.au/news/youth-mental-health-worker-among-30-new-cases-of-coronavirus-in-victoria and https://www.abc.net.au/news/2020-04-24/coronavirus-outbreak-at-psychiatric-facility-in-victoria-covid19/12180212. All in-person visits to prisons were also suspended https://www.corrections.vic.gov.au/covid19#visits [accessed 10 July 2020].

[8] See for example https://www.hrc.co.nz/files/9314/7251/4226/He_Ara_Tika_Report_2016.pdf [accessed 10 July 2020].

[9] See https://www.seclusionandrestraint.co.nz/ [accessed 10 July 2020].

In Victoria, there has not been a final decision about the model to be implemented – work is underway to determine the most appropriate body (or bodies) to carry out independent inspections of places of detention.

45. We hope that the implementation of OPCAT will improve practices within forensic mental health institutions. OPCAT is also designed to provide greater assurance and transparency about the treatment of people within correctional settings. Those found not guilty but indefinitely detained pursuant to a custodial supervision order under the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) may also raise issues of compatibility with Australia's international human rights obligations, and fairness and equality before the law. Legislation affecting people with mental illness or cognitive impairment should enshrine the concepts of "least restrictive care". Where possible, alternative community and family-based rehabilitation should always be the first option. Prison settings are particularly inappropriate for such groups, and place them at heightened risk of abuse and discrimination.

46. We think that it is very important that any model chosen by Victoria to conduct inspections of places of detention is informed by people with lived experience of mental health issues as well as mental health advocates and human rights experts to ensure their expertise guides the NPM. A human rights based approach acknowledges the agency, autonomy and dignity of people with mental illness, their capacity to contribute, with support if necessary, to designing best practice and the solutions to issues that affect them. This reflects the paradigm shift from the old medical model of understanding disability to a social one. Under that model people with disabilities were seen as passive subjects of medical intervention. A social model understands that society must adapt and support people with disabilities to exercise their capacity. Inspection teams should include mental health professionals with experience in recognising mental illness, cognitive disabilities, and other conditions which may be underlying causes of challenging behaviours within institutional settings. Such professionals would be more likely to be able to interview detainees and staff in a manner that is unlikely to traumatise the people concerned. It is also important that the mechanism set up by Victoria is alive to the different sorts of vulnerabilities that Aboriginal and Torres Strait Islander people, as well as people from other cultural backgrounds, experience in closed environments. The NPM should understand that these groups often experience intersecting forms of discrimination on the basis of multiple attributes, such as disability and race. This intersectional discrimination may make these groups more vulnerable to ill-treatment when in detention. It is clear that a cookie-cutter approach will not suffice.

Human rights culture

Embedding a human rights culture into government departments and public authorities

47. As I discuss above, VEOHRC has worked in conjunction with a number of government departments and public authorities to embed a human rights culture into these organisations.

48. We have also developed a Human Rights Culture Indicator Framework which is designed to allow organisations to measure the strength of their internal human rights culture. The framework considers six areas of influence: leadership, attitudes and values of employees, transparency and accountability, community engagement and participation, operational capability, knowledge and resourcing and systems and processes.

49. VEOHRC is disseminating the Human Rights Culture Indicator Framework with executive and management teams of public authorities to support organisations build a culture of human rights. In 2019, cohealth revised its Human Rights Framework in an effort to ensure that human rights are central to the design and delivery of all its services. cohealth adapted the VEOHRC Human Rights Indicator Framework to set out human rights culture performance indicators and corresponding metrics for the implementation of a human rights-based approach.

Human rights education and training for clinical and other mental health service staff to support increased compliance with the Equal Opportunity Act, the Charter, and the Mental Health Act

50. Our experience has shown that when delivering human rights and anti-discrimination education and training, it is important to begin with the managers or leaders within an organisation. Failing to do so means that the right authorising environment is not established.

51. It is then important to ensure that people who have an advisory role within the organisation, such as its legal and policy advisers, are provided with human rights knowledge and skills. People in these roles can assist the organisation to embed principles of human rights, equality and non-discrimination.

52. It is also necessary to train and educate front-line service delivery workers. People in these roles can sit anywhere in the organisation's hierarchy, but they interface daily with people with mental illness and make the day-to-day decisions that significantly impact people's lives and human rights. This is particularly the case with the provision of

mental health services. It is important that their organisation and its leaders stand behind them as they work to embed human rights in their work. Because front-line workers are often overburdened, clever solutions for formal and informal education are required to connect them with the key expectations of their organisation.

The enablers of successful education and training programs

53. We consider that there are five key enablers of successful education and training programs. They are:

    (a) Committed leadership that role-models good human rights practice.

    (b) Making education part of a broader plan and strategy to build capability of a workforce. Organisations need to have a roadmap for how they want to change their workforce, what they want to change and how.

    (c) A partnership approach to designing education programs between educators, service providers and front line workers.

    (d) Long term investment in building staff capability so that formal education is backed up by informal education opportunities to embed practice.

    (e) Using systems and processes already in place.

54. We consider the following to be the key elements and features of human rights education and training programs:

    (a) Build knowledge: human rights programs should strengthen the knowledge of human rights specifically protected in Victoria, as well as the duties of public authorities to act in a manner that is compatible with and gives proper consideration to human rights when making a decision.

    (b) Develop skills: education programs should provide an opportunity for staff to develop and practice skills in identifying relevant rights in their work and how to use the Charter as a tool to lawfully limit rights when necessary.

    (c) Tailored to the workplace: Charter education is most effective when tailored to the workplace so that staff practice applying the Charter to realistic workplace scenarios.

    (d) Formal and informal education: A broad view of education incorporates formal and informal education opportunities to reinforce learning and embed practice.

(e) Design of tools: equality and human rights education should be supported by the design of bespoke tools that guide the organisation to apply the Charter in its decision making processes, record decisions and manage risk of non-compliance.

Stigma and discrimination

55. The harmful and complex relationship between discrimination, stigma and poor mental health outcomes can be understood in two main ways.

56. First, people with mental health conditions often experience discrimination and stigma because of their mental health condition. This can occur in a variety of areas of public life, such as when accessing goods and services, employment, accommodation and education. This discrimination, in turn, adversely impacts their mental health and so their mental health condition worsens. In this way, there is an interlocking relationship between discrimination and mental health.

57. There is strong stigma associated with having mental health condition. This stigma can lead to a misconception that mental health conditions are caused by a weakness of character, rather than an illness, or that people with mental health conditions are dangerous. This can cause shame, a reluctance to disclose a diagnosis and the perception that a person should be able to manage their condition on their own. It means that people with a mental health condition may not get the help they need or adhere to treatment, jeopardising their recovery and future outcomes. Stigma leads to discrimination and marginalisation, which can, in turn, affect peoples' economic, social and housing security, as well as their general health and wellbeing

58. Second, certain groups – including those already marginalised in society - are more likely than others to experience a mental health condition (or certain forms of mental illness), including young people, lesbian, gay, bisexual, transgender, intersex and queer (LGBTIQ) people, Aboriginal and Torres Strait Islander people and women. People from these groups are more likely to experience discrimination and stigma because of a mental health condition. On top of the discrimination they experience on the basis of their mental health condition, people from these groups are also subjected to intersectional discrimination. Intersectional discrimination occurs where a person experiences interlocking forms of discrimination on the basis of multiple, personal attributes, such as sex, disability and race, which interact with and compound one another. At VEOHRC we routinely receive complaints of disability discrimination accompanied by other attributes such as sexuality or race. All forms of discrimination can have profound mental health consequences, creating or exacerbating mental health conditions, posing barriers to accessing treatment and recovery, and limiting the potential for positive life outcomes.

Reasons for under-reporting of discrimination against people living with mental illness

59. There are a range of reasons why discrimination on the basis of mental illness is underreported.

Mental health is not a protected attribute

60. Mental health is not its own protected attribute under the Equal Opportunity Act, it is a subset of the protected attribute of disability. This might lead to underreporting as it is not intuitive that mental health falls within the category of disability, and many people may not know that mental health discrimination is unlawful. Further, people who have experienced mental health discrimination might not necessarily consider themselves to have a disability.

61. VEOHRC has recommended that the Equal Opportunity Act be amended so that mental health is its own protected attribute. We think that this would encourage duty holders (such as employers and service providers) to better understand that they have obligations in relation to mental health and that discrimination on the basis of mental health is unlawful. It would also improve public awareness and understanding of individual rights such that there would be increased reporting and complaint-making.

The burden of complaint making rests with the individual

62. Presently, the burden of complaint making rests with the individual who has suffered discrimination. As a result, the system relies on people who have had traumatic experiences knowing that their rights have been infringed, and then finding the correct place to make their complaint. They are then required to go through a complaints process which can be re-traumatising despite VEOHRC's best efforts. This can deter a person from making a complaint. Of those who do make a complaint, one in six of all the people who disclosed to us that they are living with a mental health condition withdrew their complaint before attempting dispute resolution.

63. Given that a sizeable proportion of mental health discrimination complaints relate to the area of employment, fear of victimisation by an employer for making a complaint can also be a deterrent to complaint-making. While representative complaints are possible under the Equal Opportunity Act, they are not used as often as they could be because of the requirement to have a named individual complainant who consents to the dispute being brought on their behalf. In VEOHRC's experience, the fear of victimisation can prevent people from making a complaint who would otherwise feel safe to be represented by a representative body, such as a religious body, community organisation or union. The law should allow representative complaints on behalf of an anonymous

complainant by removing the requirement to name an individual complainant or for individual consent. This would encourage reporting and reduce the fear of victimisation.

64. Sadly even when complaints are made and resolved they rarely address the cause of the discrimination and rarely ensure that discrimination will not occur again in the future. The outcomes of dispute resolution are predominantly financial compensation (for lost income or pain and suffering), and in an employment context a statement of service and references. It is rare that respondents agree to outcomes such as training or changes to policies and practices to help prevent future discrimination.

Strengthening VEOHRC's functions and powers to enforce the Equal Opportunity Act

65. We think that there is a need to move the burden of enforcement away from the investigation of individual complaints towards achievement of systemic change. However, as the State's anti-discrimination regulator, VEOHRC does not presently have the full suite of regulatory powers that an effective regulator requires to achieve systemic change.

66. This could be achieved by granting VEOHRC greater powers of investigation, enforcement and inquiry. These are powers that we previously and briefly possessed in the original Equal Opportunity Act. Following extensive consultation and review of the operation of the *Equal Opportunity Act 1995* (Vic), Julian Gardner recommended that VEOHRC be granted the power to investigate matters of a serious nature and enter into enforceable undertakings or issue compliance notices following an investigation.[10] In 2010, the Equal Opportunity Act passed with these powers included, however they were removed following a change of Government by the *Equal Opportunity Amendment Act 2011* (Vic).

67. Currently, it is difficult for VEOHRC to effectively enforce the Equal Opportunity Act because we are not equipped with sufficient powers to address systemic issues of discrimination. For example:

    (a) There is a restrictive set of criteria which must be met in order for VEOHRC to investigate systemic discrimination, sexual harassment and victimisation. We can only investigate a serious matter that indicates a possible contravention of the Equal Opportunity Act if there is a reasonable expectation that the matter cannot be resolved by dispute resolution or VCAT and the matter relates to a class or group of persons.

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[10] Julian Gardener, *An Equality Act for a Fairer Victoria: Equal Opportunity Review Final Report* (2008) page 134.

(b) When VEOHRC investigates a matter, it cannot compel attendance, information and documents for an investigation without an order from VCAT. This means that we must rely on those being investigated voluntarily cooperating with an investigation in good faith.

(c) Where VEOHRC finds discrimination, it lacks the enforcement powers to remedy it and stop discrimination from occurring in the future. While we can refer the matter to VCAT we cannot seek enforceable undertakings or issue compliance notices as potential outcomes of an investigation.

68. Presently, VEOHRC can only investigate an issue (in respect of mental health discrimination, but also more broadly) where it is a matter that cannot reasonably be expected to be resolved by an individual making a complaint. If we were to learn of an employer that is consistently discriminating against employees with mental health conditions, we would be powerless to take action without first considering whether a complaint can be made by one of those employees instead.

69. Ideally, VEOHRC would commence an investigation to determine whether unlawful discrimination by that employer has occurred. If we determined it had, we could then make recommendations to that employer, which might be around training, information to staff, changing recruitment procedures and the retention of personal information. With enhanced enforcement powers, we could also return to that workplace to ensure that our recommendations had been complied with.

70. This would require amending the VEOHRC's powers to enable it:

(a) To undertake own-motion public inquiries.

(b) To investigate any serious matter that indicates a possible contravention of the Equal Opportunity Act:

i. without the need for a reasonable expectation that the matter cannot be resolved by dispute resolution or VCAT, so the burden of enforcement is shifted away from the individual, and

ii. with the introduction of a 'reasonable expectation' that the matter relates to a class or group of persons.

(c) To compel attendance, information and documents for any purposes of an investigation or public inquiry without the need for an order from VCAT so that we do not need to rely on those being investigated voluntarily cooperating with an investigation in good faith.

(d) To seek enforceable undertakings and issue compliance notices as potential outcomes of an investigation or a public inquiry so that when we find discrimination has occurred, we can take steps to remedy it.

71. Increased investigatory and enforcement powers would enhance VEOHRC's existing functions, including the functions of education and training which take up most of its time. Without compulsive powers, we are unable to change the behaviour of organisations that do not want to do the right thing. This is not about handing VEOHRC the ability to issue large fines, but instead, granting it the ability to follow up and ensure compliance with recommendations designed to effect systemic change.

Fair Minded Cover Investigation

72. In October 2017, VEOHRC launched a statutory investigation into mental health discrimination in the travel insurance industry.[11] While this investigation was successful, its effectiveness was reliant on the voluntary participation of insurers and industry bodies that provided information to assist the investigation.

73. There were several reasons why the insurers in this investigation participated voluntarily. These reasons may not always be present in other contexts.

74. First, the investigation was pre-empted by a case heard at VCAT, *Ingram v QBE Insurance (Australia) Ltd (Human Rights)* [2015] VCAT 1936. We understand that this 2015 decision had already prompted insurers to take steps to understand the servicing, product, pricing and commercial impacts of providing coverage to people with a mental health condition. The Ingram case involved a 16-year old student, Ella Ingram, who had paid for a school trip to New York and a travel insurance policy issued by QBE. Ella cancelled the trip on medical advice after experiencing their first and only episode of depression. QBE refused to cover their costs, based on a general exclusion in the policy for any claim caused by mental illness. VCAT held that QBE had directly discriminated against Ella and was in breach of section 44(1)(b) of the Equal Opportunity Act when it had issued a policy that included the blanket mental health exclusion, and was also in breach of section 44(1)(a) when it refused to indemnify Ella when they lodged a claim. It is rare for discrimination claims to successfully reach final hearing and prompt industry change in the way this case did. Importantly, although the case produced an outcome for Ella, VCAT was not able to make an order remedying the systemic problem of similar discriminatory contractual terms used across the industry.

75. Secondly the context in which this investigation took place facilitated voluntary compliance. This context was as follows:

[11] Victorian Equal Opportunity and Human Rights Commission, *Fair-minded cover: investigation into discrimination in the travel insurance industry,* 12 June 2019.

(a) Advocates for consumers of mental health services have long advocated for the insurance industry to keep pace with changes in community attitudes by improving practices related to people with mental health conditions. Building on these concerns, between 2017-19 the spotlight turned to the difficulties that people with mental health conditions face in accessing and claiming insurance.

(b) The Royal Commission into Misconduct in the Banking, Superannuation and Financial Services Industry examined practices in the insurance industry that impact on people with a disability (including mental health conditions).

(c) The federal Parliamentary Joint Committee on Corporations and Financial Services into the Life Insurance Industry made recommendations about mental health claims related to life and income protection insurance.

(d) Between 2017-2019, insurance industry bodies such as the Insurance Council of Australia and the Actuaries Institute took active steps to support insurers to understand and comply with the law, and to facilitate best practice. The Actuaries Institute's 2017 Green Paper on Mental Health and Insurance explored the complex balance between insurers maintaining affordable and sustainable insurance products while meeting community expectations. The 2017 Review of the Insurance Council of Australia's General Insurance Code of Practice recommended introducing best practice guidance on mental health (including a statement that insurers must, as a minimum standard, comply with anti-discrimination laws).

76. The above factors revealed an industry that was ready to change. However, it is rare to encounter a systemic issue with such a broad range of key stakeholders and processes pushing for change. VEOHRC considers that to effectively regulate the Equal Opportunity Act, it requires strengthened powers and functions under the Act. If the insurers that were the subject of the *Fair-minded cover* investigation had been unwilling to cooperate and engage with our investigation, we could not have obliged them to do so, without applying for an order from VCAT for their attendance to answer questions. If the insurers had been unwilling to provide us with relevant information, we could not have accessed the documents without an order from VCAT, which can be an expensive and lengthy process. Also, if the insurers had been unwilling to remedy the discrimination we identified, we could not have required them to do so.

Comparative powers in other jurisdictions to address systemic discrimination

77. Other comparable jurisdictions overseas such as the United States, Canada, the United Kingdom and Sweden have granted their human rights commissions powers to investigate and address systemic discrimination.

78. For example, the Equal Employment Opportunity Commission (EEOC) in the United States has the power to investigate compliance with the law of its own motion, to compel production of the documents and information needed, to make agreements following an investigation or to prosecute the breach in a Court.

79. The EEOC issues press releases every week announcing the outcomes of its investigations into discrimination. In 2018, the EEOC investigated a large fashion retailer for systemic discrimination against workers with a disability and pregnant workers.[12] The EEOC found that the company denied reasonable adjustments, forced workers to take unpaid periods of leave, and terminated employees because of their disabilities. As part of the outcome of the investigation the EEOC entered into an agreement with the company to revise its employment policies, conduct companywide training for over 10,000 of its employees, and report to the EEOC periodically for three years on its responses to requests for reasonable accommodation by employees with disabilities.

80. We know that if a similar claim were to be brought by an individual in Victoria the matter would likely settle confidentially, with no systemic change, and with no positive impact for other employees of the company.

Employment

Strengthening the Equal Opportunity Act to respond to the negative experiences that people living with mental illness can have at work

81. As I mention above, complaints about mental health discrimination in employment settings are common. VEOHRC is keen to expand the education provided to employers about their obligations to make reasonable adjustments for employees with mental health issues.

82. We also consider that there is a need to amend the Equality Opportunity Act to reduce the instances of people being denied employment due to pre-employment medical testing. Section 107 of the Act provides that '*a person must not request or require another person to supply information that could be used by the first person to form the basis of discrimination against the other person*.' However, section 108 of the Act contains a broad exclusion that permits employers to obtain medical information from a prospective employee for almost any reason.

83. We see the barrier this poses to people with mental health conditions obtaining ongoing employment in our dispute resolution service. For example:

[12] See https://www.eeoc.gov/newsroom/cato-corporation-pays-35-million-settle-eeoc-systemic-investigation [accessed 10 July 2020].

(a) One complainant was offered a retail position at a truck parts company pending a medical examination. After the examination he was told that he failed the medical test and would not be hired. The complainant asked why and was told that the reason could not be disclosed. He was diagnosed with bi-polar disorder. His treating doctor provided supporting documentation during his pre-employment medical examination. The complainant's condition did not affect his capabilities to perform the duties of the advertised position. He believes his mental health was the reason why he was not selected for employment. The parties participated in a conciliation conference at VEOHRC and the respondent agreed to pay the complainant $2,000 compensation to settle the complaint.

(b) Another complainant alleged disability discrimination in employment against a Government emergency responder. She applied for a position with the agency and progressed through a lengthy selection process. The complainant was not selected for employment due to suffering a period of mental illness many years ago, and despite her treating medical practitioner certifying that she had no current mental health issues and was in excellent mental health.

The respondent stated that the complainant was found unsuitable for employment by the interview panel and deemed permanently unsuitable as a result of a medical assessment. The respondent considered the complainant's previous history of being unwell presented a significant future risk. The respondent's position was based on the historical medical information available which informed the assessment that the complainant could not safely perform the inherent requirements of the role.

At a conciliation conference the complainant put forward a proposal for settlement that further medical opinions to be sought by the respondent to enable her selection for employment to proceed. The respondent did not agree to this proposal and the complaint was closed as not resolved.

84. This wide exclusion permits discrimination on the basis of mental health. We think the exclusion should be reduced in scope, so that medical testing and information can only be requested by an employer to ensure that a prospective employee can undertake the genuine and reasonable requirements of the job they are applying for.

sign here ►

print name Kristen Hilton

date 15.07.2020

Royal Commission into
Victoria's Mental Health System

ATTACHMENT KRISTEN HILTON-1

This is the attachment marked 'KH-1' referred to in the witness statement of Kristen Hilton dated 15 July 2020.

Curriculum Vitae of Kristen Hilton

PROFESSIONAL EXPERIENCE

June 2016 - Present **Victorian Equal Opportunity and Human Rights Commissioner**

- Appointed for 5-year term to progress legislative mandate under the *Equal Opportunity Act* (Vic), the *Charter of Rights and Responsibilities* (Vic) and the *Racial and Religious Tolerance Act*
- Responsible for strategic direction and operational priorities of the Commission
- Leading and supervising the day-to-day operations and staffing of a range of regulatory functions including: reporting to the Attorney General and Parliament on systemic issues and trends, dispute resolution, education, policy and research, systemic review and investigations, developing guideline and resources and community engagement
- Mananging the Commission's budget and corporate governance requirements
- Direct reporting to the Board and Audit and Risk Committee
- Representing the Commission on significant committees and at key events
- Speaking at conferences and forums and addressing equality and human rights issues and regular engagement with media

June 2015 - June 2016 **Victoria Legal Aid**

Executive Director, Legal Practice

Director, Western, Barwon and South East Regions

- Responsible for $80 million budget and eligibility decisions for state funded legal assistance services
- Member of Senior Executive Team reporting directly to the VLA Board and instrumental in the development and implementation of organisational strategy
- Leadership of over 150 legal and non-legal staff working across criminal, family and civil jurisdictions
- Responsible for leading and evaluating organisational strategic advocacy initiatives with a focus on gender equality, the protection and promotion of rights for children and young people and best practice administrative decision making
- Management of key stakeholder relationships including courts and tribunals, private practitioners, community organisations and state and federal government
- Oversight of VLA Audit and Risk functions, legal compliance and the VLA Complaints function

Nov 2009 - June 2015 **Victoria Legal Aid**

Executive Director, Civil Justice and Access and Equity

Director, Barwon and South Coast Regions

- Responsible for all state civil and administrative legal services with expertise in equality

and discrimination law, charter litigation, refugee law, social security and mental health and disability law

- Established Victoria's first specialist Equality Law Service now providing legal representation, education and advocacy to over 3000 Victorians each year
- Procured new funding from the Departments of Justice and Health to establish a state-wide 'centre of excellence' for Mental Health and Disability Advocacy including the employment of 12 social workers to work alongside lawyers.
- Led organisational responses to key policy and legislation including amendments to the *Equal Opportunity Act* (Vic), *Charter of Human Rights and Responsibilities* (Vic) and the *Fair Work Act* (Cth)
- Implemented significant organisational change including transformation of VLA's Legal Help Call centre (120,000 calls annually) resulting in significant increase of people able to access legal advice by phone in 21 different languages
- Instituted new funding principles for 41 community legal centres to promote greater accountability, collaboration and innovation across the justice sector

June 2007 - **Public Interest Law Clearing House (now JusticeConnect)**

Nov 2009 **Chief Executive Officer**

- Responsible for high level strategic direction and governance of Australia's largest pro bono law organisation reporting to a 12 member Board from mostly corporate sector roles
- Grew operating revenue from $800,00 to $2.2 million by attracting additional corporate, government and philanthropic investment
- Implemented a range of new services aimed at protecting human rights and access to justice including: Senior Rights Victoria, a service focused on the rights of older Victorians and PILCHConnect, a legal service for not-for-profit organizations
- Instrumental in the establishment of Victoria's first specialist human rights legal centre – Human Rights Law Centre – providing funding, strategic advice and governance as a member of the HRLC Board
- Responsible for ensuring excellent stakeholder engagement with state and federal government departments and corporate and community stakeholders

Mar 2004 - **Homeless Persons Legal Clinic (HPLC)**

June 2007 **Manager and Principal Solicitor**

- Coordinated and supervised specialist legal services with over 300 volunteer corporate lawyers to provide free legal assistance to people experiencing homelessness
- Established the HPLC Consumer Advisory Group – a group comprised of people experiencing homelessness to provide strategic guidance to the HPLC
- Directed law reform work, public policy analysis and advocacy in relation to homelessness, poverty and human rights
- Led a state-wide coalition of NGOs in advocating for a state Charter of Human Rights
- Provided direct advocacy to the UN General Assembly in Geneva on housing and human rights

Feb 2001 - Dec 2003 **Blake Dawson Waldron**

Solicitor – Industrial Relations

- Represented employers and employees in relation to discrimination claims at relevant courts and tribunals
- Provided legal advice under the Equal Opportunity Act (Vic), the Disability Discrimination Act (Cth) and the Sex Discrimination Act (Cth)
- Provided advice and training in relation to bullying, discipline, OHS and ASIC compliance
- Seconded to Youthlaw as a lawyer for young people experiencing homelessness

BOARDS and COMMITTEES

Current	Chair, Male Champions of Change for Fire and Emergency Services
	Member of Ministerial Council for Women
	Chair of Expert Panel for the Victoria Police Review into sexual harassment and predatory behaviour
2014 - 2017	Sir Zelman Cowen Centre – Victoria University
2014 - 2016	Melbourne University Law School Advisory Board
2012 - 2017	National Pro Bono Resource Centre Advisory Board
2010 - 2011	Member of State Attorney - General's Human Rights Leadership Group
2009 - 2011	Member of Federal Government Joint Taskforce on Compact for Not-for-Profit Organisations
2006 - 2009	Director, Women's Housing Limited (Vic)
2007 - 2008	Advisory Group Member, Street Smart Australia
2006 - 2010	Advisory Group Member, Human Rights Law Resource Centre
2006 - 2010	Management Committee Member, Liberty Victoria
2006 - 2008	Steering Group Member, Neighbourhood Justice Centre
2006 - 2008	Convener, Infringements Working Group, Federation of Community Legal Services
2006 - 2009	Convener, National Network of Homelessness Legal Services
2005 - 2007	Committee Member, LIV Access to Justice Committee

ACCOLADES

2008 - Attended 2020 Summit on invitation of the Australian Government

2007 - Won Law Institute of Victoria Community Lawyer of the Year

2006 - Won Churchill Fellowship to conduct international research on homelessness and human rights

2006 - Shortlisted for Law Institute of Victoria Access to Justice Award

2006 - Won National Australia Bank/PILCH Access to Justice Scholarship

1996 - Scholarship to Goethe Institute, Berlin

1996-1998 - University of Melbourne – Dean's List for Academic Excellence

EDUCATION

The University of Melbourne

Master of Laws and Development

Bachelor of Laws (Honours)

Bachelor of Arts

Diploma of Modern Languages – French, German, Swedish

Other

Graduate of Australian Institute of Company Directors

IKD Executive Leadership Course

Fluent in Danish, Swedish and German