LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

STANDING COMMITTEE ON EDUCATION AND COMMUNITY INCLUSION
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Submission Cover Sheet

Inquiry into Disability Inclusion Bill 2024

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Mental Health
Community Coalition ACT

Inquiry into Disability Inclusion Bill 2024

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Acknowledgements

Acknowledgement of country

Mental Health Community Coalition ACT is located on Ngunnawal Country. We acknowledge the Traditional Custodians of the land. We pay our respects to their Elders, past and present. We further acknowledge all Aboriginal and Torres Strait Islander Traditional Custodians and Country and recognise their continuing connection to land, sea, culture and community.

Acknowledgement of mental health lived experience

We also acknowledge the individual and collective expertise of those with a living or lived experience of mental health. We recognise their vital contribution at all levels and value the courage of those who share this unique perspective for the purpose of learning and growing together to achieve better outcomes for all.

Introduction

Thank you for the opportunity to give feedback on the Disability Inclusion Bill 2024. This Bill marks a tremendous effort towards upholding the human rights and participation of people with disability, including people experiencing mental ill-health.

MHCC and its members would be delighted to further participate in the Inquiry into Disability Inclusion Bill 2024 through involvement at public hearings. In addition, we would be delighted to respond to any questions of the Standing Committee on Education and Community Inclusion. For further information, you can contact Dr Erin Stewart, MHCC Advocacy, Policy, & Media Manager via erin.stewart@mhccact.org.au.

About MHCC ACT

The Mental Health Community Coalition of the ACT (MHCC ACT) is a membership-based organisation which was established in 2004 as a peak agency. It provides vital advocacy, representational and capacity building roles for the Not for Profit (NFP) community-managed mental health sector in the ACT. This sector covers the range of non-government organisations (NGO) that offer mental health recovery, early intervention, prevention, health promotion and community support services.

Our members make up two-thirds of Canberra's mental health system and comprise Canberra's soup kitchens, childcare centres, domestic violence shelters, health services for marginalised groups, and more.

We advocate for a mental health system that offers people support and belonging within their community, speaking directly to the inclusion that this Bill intends to uphold and protect.

The Social Model of Disability

For a long time, disability has been widely defined through a 'deficit' lens – a 'problem' to fix. While in our and our members' work, we see that the symptoms of mental health conditions cause significant distress for those with lived experience, their carers, and kin, there is far more to the picture. The symptoms of mental health conditions are exacerbated by exclusion. Stigmatising attitudes around mental ill-health may lead to feelings of shame, which has the effect of deepening distress. Experiences of discrimination are further destabilising and may cut people off from the means to find necessary support.

A strength of this Bill is that, as with much contemporary work around disability advocacy, it frames disability using the 'social model'. Its items are provoked by the implicit understanding that social circumstances can be just as – if not more so – disabling that the symptoms of conditions themselves. The textbook example of this social model is when a wheelchair user needs to get into a building that does not have an access ramp. It is not the person's disability that prohibits their access to the building, it is a lack of accessible entry points.

The same logic applies to mental health conditions, although by nature of the invisibility of these conditions, lack of access can manifest themselves subtly. Some people with anxiety conditions, for example, find it difficult to participate in spaces where their back is to the door. An individual may decide not to attend an event, or feel discomfort throughout, because they cannot see an exit point in the room or keep an eye on who is coming and going. An straightforward means of including those who have this experience is simply to ensure there is a seat available in a part of the room they feel safe. The person is not the problem, a lack of accessibility is.

MHCC ACT believes that all Canberrans play a role in building a mentally healthy, safe, connected community. Those 80,000 Canberrans with disability will benefit from the framework presented in the Bill to ensure a social approach to inclusion. All Canberrans will further benefit from the contributions those with disability will be empowered to make through their improved inclusion.

Summary of Recommendations

This submission makes three recommendations to the Standing Committee on Education and Community Inclusion, detailed over this submission. The recommendations are as follows:

1. Redefine ableism in the Bill to also encapsulate its intersections with historical and contemporary eugenics and systemic human rights violations.
2. Explicitly extend inclusion rights and processes to people with disability without requiring diagnosis or disclosure wherever possible.
3. Include universal design within the principles for disability inclusion in the ACT community.

Ableism

The Bill defines “ableism” as “a belief that people with disability are, as a result of disability, less worthy of respect and consideration, less able to contribute to or participate in society or of less inherent value than people without disability.” Although MHCC ACT largely agrees with this definition, and the Bill prioritising addressing ableism, we also feel it is worth teasing out ableism both as an individual and social force.

An individual may hold ableist beliefs stemming from ignorance, ingrained biases, and stereotypes. However, ableism extends beyond personal beliefs, permeating societal structures and systems, reinforcing disparities and marginalisation. Ableism deeply intersects with the ideology of eugenics, casting disability as an object of eradication, bolstered by practices in Australia such as forced sterilisation and strict barriers faced by people with disability looking to migrate to Australia. These, and other policies that challenge the right of people with disability to exist are still issues this community faces in 2024, as is borne out by the injustices tabled at the National Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability. Addressing ableism requires challenging both individual mindsets and systemic inequalities.

Thus, it is our belief that addressing ableism goes beyond revising individual ableist attitudes – although this is important too. The ACT community and its policy instruments must reckon at large with day-to-day, systemic injustices fuelled by ableism.

Coercive practices

One of these injustices in the mental health space is the ongoing acceptance of coercive practices under the guise of mental health “treatment”. Coercive practices refer to both regulated and unregulated forms of dehumanising treatment encountered by mental health service users. These practices include formal detention, treatment without consent (compulsory treatment), seclusion and restraint, including the use of mechanical devices, person-to-person restraint, or psychotropic drugs for the primary purpose of controlling movement (chemical restraint) and/or the involuntary use of electroconvulsive treatment. Environmental constraint is another practice that restricts a person’s free access to all parts of their environment, including their possessions.

The Queensland Mental Health Lived Experience peak, with significant consultation with a range of stakeholders, have also identified other forms of restraint, such as emotional restraint. Emotional restraint occurs where an individual loses confidence in their ability to express themselves without facing punitive retaliation. Emotional restraint includes threatening and manipulation, harassment, verbal abuse, bullying and provocation. An example is where a person is voluntarily admitted to care and objects to an aspect of that care, they can be threatened that they will be involuntarily re-admitted if they choose to leave.

Legally, in the ACT, restrictive practices such as seclusion and physical restraint should only be used as a last resort. Involuntary admissions, likewise, can only occur when an individual poses a danger to themselves or other people. Other coercive practices such as chemical and emotional restraint are not regulated at all. However, we are getting anecdotal reports of quite a different situation. Changing this situation amounts to redressing ableism required for a truly inclusive community. Further, for the situation to be changed, we need to take heed of the voices of lived experience on this issue.

Stereotypes about mental illness (especially severe and/or complex illness) often cast those with lived experience as dangerous, violent, out-of-control, or even sub-human. These attitudes infiltrate the public, as well as some service providers, which causes a situation where those with lived experience may be viewed with suspicion, the threat they pose may be overestimated, and their reports of abuse may not be believed. Stigma increases the likelihood that coercive practices are seen as justified. Further, stigma makes it difficult to ascertain exactly why coercive practises have been used, and makes it difficult for those with lived experience to complain about their treatment or receive compensation for abuse.

The desirability of reducing, even eliminating seclusion and restraint practices from Australian mental health care has been acknowledged for some time. Serious concerns about the use of seclusion and restraint in mental health care have been raised at least since 1993 by the Australian Human Rights and Equal Opportunities Commission. In 2005, Australian health ministers collectively agreed to reduce coercive practices. In 2009, the Beacon project introduced strategies to reduce coercive seclusion and restraint in the public mental health system. It is a central part of the current work of the National Mental Health Commission. This work has developed from previous efforts led by the College of Mental Health Nurses and others.

In other words, while the challenge of addressing the ongoing danger posed by unsafe seclusion and restraint practices in ACT mental health services remain considerable, the issue is less about what to do than it is about ensuring the support and resources to enable known, effective changes to be implemented and sustained.

A further discussion of coercive practices in the ACT and what we can do to improve this situation to create a more inclusive, rights-based community for those with disability is beyond the scope of this Inquiry. We wish to put to the Committee though that there are major reporting problems rendering the situation in the ACT opaque. Further, the process for understanding and learning from seclusion and restraint episodes is unclear. At seclusion and restraint reviews, only the perspectives of service providers are shared, and it is not clear if they truly formed a “last resort” option. We must include the voices of those who have experienced coercive practices to understand this problem as it exists in the ACT. These issues are affronts to disability inclusion, and contribute to community concern about the quality and safety of ACT mental health services.

Moreover, wider policy efforts to reduce and eliminate coercive practices such as prevention, early intervention, and hospital diversion have not been sufficiently undertaken to prevent episodes of seclusion and restraint. Those who experience mental ill-health often find themselves unable to get the support they need in the community, which drives distress, escalation, and potential coercive treatment. We reiterate the lesson of the social model of disability: the person is not the problem, the inaccessibility of the mental health system is.

We believe that the Bill’s admirable commitment to redressing ableism would be bolstered by closely considering routine human rights violations – such as coercive practices – to establish a deeper means of embedding the value of the humanity and testimony of those with disability.

Recommendation: Redefine ableism in the Bill to also encapsulate its intersections with historical and contemporary eugenics and systemic human rights violations.

Diagnosis and Disclosure

A fundamental component of much legislation around disability rights and inclusion involves:

a) A person having a diagnosed disability; and
b) A person disclosing their disability with or without providing evidence of their disability.

In some scenarios, these contingencies make practical sense, particularly if they are to confer resources or opportunities that would not be feasible to confer to all people.

However, diagnosis and disclosure – particularly as it pertains to inclusion – can also be problematic. We believe that the Bill should explicitly consider inclusion of those with disabilities who have not received a diagnosis, who are unable to safely disclose their disability, and/or who are unable to provide evidence of disability.

Diagnosis for disability can be inaccessible or take many years. Relating to mental health, those with bipolar disorder, as an example, typically experience a delay of 10-20 years between their first illness episode and receiving a diagnosis. While GPs can diagnose some mental health conditions, some diagnostic processes involve multiple appointments with a psychiatrist, which can be expensive depending on what services are available. In Canberra in particular, we see a general shortage of specialists and long wait times.

Diagnosis is not a prerequisite to experiencing barriers to inclusion. In fact, lack of diagnosis is demonstrative of many of the barriers people with lived experience face.

Further, even where diagnosis is attained, the administrative burdens associated with filling in paperwork and otherwise providing "proof" of diagnosis can be expensive, requiring specialist appointments, as well as procedurally cumbersome and inaccessible.

Even when these practical barriers are overcome, people with disability may not always feel safe to disclose their disabilities as a result of the ableism this Bill is rightly looking to redress.

In exploring these issues, MHCC ACT wishes to highlight that the Bill should be broad in its encapsulation of who is included within disability inclusion efforts. We believe the Bill should reflect the fact that inclusion involves including people without a diagnosis, and people who are not in a safe position to make a disclosure.

For our own sector, ideally community-based mental health services would be funded in such a way that we would be able to promote universal access to services so that people can access support as soon as they need it, regardless of diagnostic status.

Recommendation: Explicitly extend inclusion rights and processes to people with disability without requiring diagnosis or disclosure wherever possible.

Universal Design

Universal design is an approach that assumes a diversity of users and needs. Ideally, in a society that incorporates universal design, nobody needs to disclose their disability, as their needs are already accounted for. Universal design takes the burden off people with disability in advocating for adjustments, as they navigate through spaces in which the adjustments are already in place. Universal design is radically inclusive as diversity of needs is conceived as the norm, rather than "special treatment".

Such design is clearly beneficial for people with disability, but it can also be beneficial for everyone. An example of universal design in action is curb cuts, areas of footpath that gradually descend towards the road at an intersection. These curb cuts allow wheelchair users to navigate footpaths with greater ease. They also are beneficial to people riding bikes, on skateboards, people pushing prams, people making deliveries, and people wheeling suitcases. Universal design extends the ways we can interact with our environment, allowing for greater possibilities and flexibilities throughout our neighbourhoods.

In the case of psychosocial disabilities, crowded and low frequency public transport have been identified as barriers to accessing public life. A solution from a universal design framework to uphold inclusion would be to increase frequency of public transport services and coverage of public transport networks. This would constitute disability inclusion while also enhancing the experience of public transport for all users.

The community-managed mental health sector, if adequately resourced, is another means of universal design. Many mental health services around the ACT offer universal supports to anyone who needs them. For some services, however, high demand levels make triage an unfortunate necessity. Ideally anyone experiencing challenges would be eligible to access relevant services, with or without clinical-level symptoms, with or without diagnosis. The benefit of the universal design of this sector is that access to early help may prevent an exacerbation of distress, affording our entire community a supportive safety net.

MHCC believes that universal design approaches would create wonderful opportunities for disability inclusion in the ACT.

Recommendation: Include universal design within the principles for disability inclusion in the ACT community.

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