Productivity Commission
Inquiry into the Disability Discrimination Act

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INTRODUCTION

The Mental Health Council of Australia

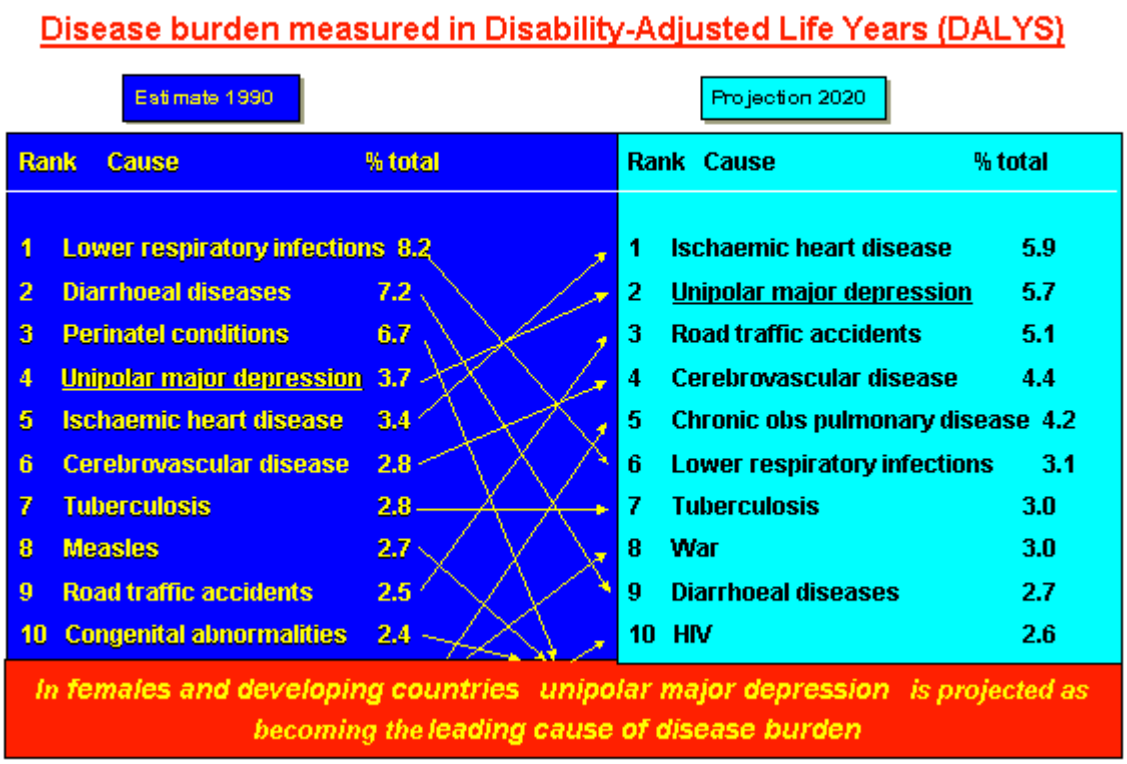
The Mental Health Council of Australia (MHCA) is the peak, national non-Government organisation established to represent and promote the interests of the Australian mental health sector. The MHCA constituency includes consumers, carers, special needs groups, clinical service providers, private mental health service providers, non-Government organisations, Aboriginal and Torres Strait Islander groups, and State/Territory based peak mental health bodies[1]. The activities of the MHCA primarily consist of management and coordination of national projects, representation on national committees, and development, analysis and evaluation of policies, including drafting of policy position papers and submissions to various inquiries.

The Global Burden of Disease

The Global Burden of Disease study was conducted by the World Health Organization, the World Bank, and Harvard University. The study developed a single measure to allow comparison of the burden of disease across many different disease conditions by including both death and disability. This measure, called Disability Adjusted Life Years (DALYs), measures lost years of healthy life regardless of whether the years were lost to premature death or disability. The disability component of the measure is weighted for severity of the disability. For example, disability caused by major depression was found to be equivalent to blindness or paraplegia, whereas active psychosis seen in schizophrenia produces disability equal to quadriplegia.

> *The next two decades will see dramatic changes in the health needs of the world's populations. In the developing regions where four-fifths of the planet's people live, noncommunicable diseases such as depression and heart disease are fast replacing the traditional enemies, such as infectious diseases and malnutrition, as the leading causes of disability and premature death. By the year 2020, noncommunicable diseases are expected to account for seven out of every ten deaths in the developing regions, compared with less than half today. Injuries, both unintentional and intentional, are also growing in importance, and by 2020 could rival infectious diseases worldwide as a source of ill health.* (The Global Burden of Disease – A comprehensive assessment of mortality and disability from diseases, injuries, and risk factors on 1990 and projected to 2020)

[1] Member organisations of the MHCA are listed at Attachment A.



The study illustrated the significant underestimation of the burden of psychiatric conditions. For instance, as highlighted in the table below, of the ten leading causes of disability worldwide in 1990, (measured in years lived with a disability), five were psychiatric conditions including: unipolar depression, alcohol use, bipolar affective disorder (manic depression), schizophrenia, and obsessive-compulsive disorder. In both developing and developed regions, depression is women's leading cause of disease burden. In developing regions, suicide is the fourth.

The leading causes of years lived with disability, worldwide, 1990

	Total (millions)	Per cent of total
All causes	472.7	
1. Unipolar major depression	50.8	10.7
2. Iron deficiency anaemia	22.0	4.7
3. Falls	22.0	4.6
4. Alcohol use	15.8	3.3
5.Chronic obstructive pulmonary disease	14.7	3.1
6. Bipolar disorder	14.1	3.0
7. Congenital anomalies	13.5	2.9
8. Osteoarthritis	13.3	2.8
9. Schizophrenia	12.1	2.6
10. Obsessive compulsive disorders	10.2	2.2

... while the severity and duration of different forms of mental illness vary substantially, the resulting disability may effect the individual for long periods of time… 'The manifestations of mental illness are diverse, range in severity and are inextricably linked with quality of life issues, employment opportunities, social and family relationships, general health, economic factors and community participation'. (Burdekin, 1993, p14)

Disease Burden by Selected Illness Categories in Established Market Economies, 1990, (measured in DALYs*)

	Percent of Total
All cardiovascular conditions	18.6
All mental illness including suicide	15.4
All malignant disease (cancer)	15.0
All respiratory conditions	4.8
All alcohol use	4.7
All infectious and parasitic disease	2.8
All drug use	1.5

Mental Illness as a Source of Disease Burden in Established Market Economies, 1990, (measured in DALYs*)

	Total (millions)	Percent of Total
All Causes	98.7	No Value
Unipolar major depression	6.7	6.8
Schizophrenia	2.3	2.3
Bipolar disorder	1.7	1.7
Obsessive-compulsive disorder	1.5	1.5
Panic disorder	0.7	0.7
Post-traumatic stress disorder	0.3	0.3
Self-inflicted injuries (suicide)	2.2	2.2
All mental disorders	15.3	15.4

Unipolar depression alone was responsible for more than one in every ten years of life lived with a disability worldwide. Altogether, psychiatric and neurological conditions accounted for 28 per cent of all Years Lived with a Disability (YLDs), compared with 1.4 per cent of all deaths and 1.1 per cent of years of life lost. The predominance of these conditions is by no means restricted to the rich countries, although their burden is highest in the Established Market Economies. They were the most important contributor to YLDs in all regions except Sub-Saharan Africa, where they accounted for a relatively modes 16 per cent of the total (The Global Burden of Disease – A comprehensive assessment of mortality and disability from diseases, injuries, and risk factors on 1990 and projected to 2020).

As with the 1990 assessments, psychiatric diseases emerge as a highly significant component of global disease burden when disability, as well as death, is taken into account. The projections show that psychiatric and neurological conditions could increase their share of the total global burden by almost half, from 10.5 per cent of the total burden to almost 15 per cent in 2020. This is a bigger proportionate increase than that for cardiovascular diseases (The Global Burden of Disease – A comprehensive assessment of mortality and disability from diseases, injuries, and risk factors on 1990 and projected to 2020).

Prevalence of Mental Illness in Australia

The MHCA recognises the growing burden of mental illness in Australian society. It has been estimated that currently, over one million Australians experience a mental illness, and at any particular point in time 3-4% of Australians experience severe mental disorders which will significantly interfere with their mental well being and reduce their capacity to participate fully in community life.

The *National Survey of Mental Health and Well Being* (1997) conducted by the Australian Bureau of Statistics found that almost one in five Australians aged 18 years or over met a criteria for a mental disorder at some time during the 12 months prior to the survey. Alarmingly, only 38% of those surveyed with a mental disorder had accessed health services. This suggests a large unmet need for mental health services. Indeed, this indicates that 62% of people with a mental illness are either receiving no assistance, or are depending on informal sources of support usually from unpaid carers and families. In addition, children and adolescents less than 18 years make up 25% of the Australian population and in any six month period 15-20% of this group may have a mental health problem.

Mental health is influenced by risk and protective factors that occur in the many different domains of everyday life. Risk factors increase the likelihood that a mental illness or mental health problem will develop and can increase the burden of an existing illness or problem. Protective factors give people resilience in the face of adversity and moderate the impact stress and transient symptoms have on social and emotional wellbeing, thereby reducing the likelihood of mental illness or mental health problems *(Promotion, Prevention and Early Intervention for Mental Health – A Monograph 2000)*.

The determinants of an individual's mental health include a range of psychosocial and environmental factors such as income, employment, poverty, education, access to community resources, physical health, and demographic factors such as gender, age and ethnicity *(Promotion, Prevention and Early Intervention for Mental Health – A Monograph 2000)*. Effective action to promote mental health, prevent the development of mental health problems, and intervene early in mental illness is crucial. The growing burden of mental illness in Australia has an enormous economic cost to the Australian population. More importantly, there is a direct and increasing burden to the individuals with mental health problems and those who provide care for them, often family and friends (*National Action Plan for Promotion, Prevention and Early Intervention,* 2000*).*

Stigma and discrimination is a common experience of those who suffer from mental illness. The destructive effects of stigma and discrimination are well documented. Groom, Hickie & Davenport (2003) identified how the profound barriers to community understanding of mental illness further perpetuate the experiences of stigma and discrimination. For example, hospital transportation via police van rather than an ambulance reinforces the stereotype that people with mental illness are violent; media reporting on mental illness and suicide and the focus on mental illness rather than mental health stories may convey inaccurate messages about mental illness to the community.

"There is no such thing as a 'schizophrenic' and I urge researchers and the community to stop referring to people as an illness" (Quote from Consumer - Groom, Hickie & Davenport, 2003, p27)

"If the general public are given the choice between supporting a fundraiser for cancer or diabetes…or the choice of supporting a fundraiser for the mentally ill, we all know where the money and support will go" (Quote from Consumer - Groom, Hickie & Davenport, 2003, p27).

DISABILITY DISCRIMINATION

The 1993 Report of the National Inquiry into the Human Rights of People with Mental Illness recognised the Disability Discrimination Act (hereafter DDA) as an important piece of legislation potentially impacting on the lives of people with psychiatric disability.

> *In October 1992 legislation was passed by Federal Parliament prohibiting direct and indirect discrimination on the grounds of disability, including physical, sensory, intellectual and psychiatric impairment. Harassment on the ground of disability is made unlawful. The Disability Discrimination Act complements legislation already existing in some States, in that it prohibits discrimination throughout Australia in employment, provision of goods and services (including transport and education services), accommodation, membership of clubs and the administration of Commonwealth programs. The legislation includes a requirement to make 'reasonable accommodation' for an individual with disabilities – balanced by the proviso that such accommodation is not required if it would cause 'unjustifiable hardship'. The recently appointed Disability Discrimination Commissioner, operating as a member of the Human Rights and Equal Opportunity Commission, administers this legislation*. (Burdekin, 1993, p 60)

Definitions

In response to the following questions:
What have been the effects of the DDA's broad definition of disability?
Are any elements of the DDA's definition of disability too narrow or too broad?
Would an alternative definition of disability be more appropriate?
Are the definitions of disability used for different purposes appropriate?
Have there been any unintended effects of using different definitions of disability for different purposes? If so, how should they be addressed?

The comprehensiveness of the **definition of disability**[2] used by the DDA attempts to ensure all potential sources of discrimination based on disability are covered. In regards to psychiatric disability, distinction is often made between a mental illness and mental health problem based on severity and duration of the condition. The National Mental Health Strategy provides the following definitions:

> *Mental health* – The capacity of individuals and groups to interact with one another and the environment in ways that promote subjective well-being, optimal development and use of cognition, affective and relational abilities, and the achievement of individual and collective goals consistent with justice.

[2] - Physical, intellectual, psychiatric, sensory, neurological or learning disabilities, physical disfigurement and the presence in the body of a disease-causing organism;
- Disabilities people have now, have had in the past, might have in the future or are believed to have;
- 'associates' of people with disabilities (partners, relatives, carers and people in business, sporting or recreational relationships)

> *Mental health problem* – A disruption in the interactions between the individual, the group and the environment, producing a diminished state of mental health.
>
> *Mental illness* – describes the full range of recognised, medically diagnosable illnesses that result in significant impairment of an individual's cognitive, affective or relational abilities. Using the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders – fourth edition* (DSM IV) terminology, it encompasses all disorders on Axis I and II of that classification system.
>
> *Second National Mental Health Plan*, 1998, p.26 - 27

It is unclear under the DDA, who determines the definition of a psychiatric disability. It is also unclear if the DDA limits psychiatric disability to mental illnesses only, or whether it is inclusive of mental health problems also. It is also unclear under the DDA, that when making a complaint that discrimination has occurred, does the complaints body require proof of psychiatric disability, and if so, what kind of proof - given that 'seeing' a psychiatric disability is generally more difficult than 'seeing' a physical disability.

The DDA's definition of disability in relation to a person includes a disability that (a) presently exists; or (b) previously existed but no longer exists; or (c) may exist in the future; or (d) is imputed to a person. These provisions do not specifically include episodic disabilities, such as a psychiatric disability where a person may be mentally well for a period of time, and then mentally unwell for a period of time. This fluctuation in mental state influences the person's capacity to participate in the community and live a quality and meaningful life. For a psychiatric disability, the definition of disability provided by the DDA may encompass each of the above criteria due to the episodic nature of mental illness. Indeed, with prevalence rates of mental illness increasing and the research suggesting that one in five Australians will experience a mental health problem during their lifetime, the DDA's definitional criteria in (c) above may apply to all Australians.

Whilst the MHCA acknowledges that different definitions of disability may be required for different purposes, there is a danger that such definitions may be inclusionary for some while exclusionary for others in different circumstances, and a lack of understanding and clarity around the different areas and definitions of disability by those who are involved in the many different components of the disability sector, including consumers and carers.

Reasonable Adjustment and Unjustifiable Hardship

In response to the following questions:
How has the concept of 'unjustifiable hardship' enhanced or reduced the effectiveness of the DDA?
Does the DDA provide sufficient guidance on the meaning of unjustifiable hardship? If not, what additional guidance would help?
Should 'reasonable hardship' be defined in the DDA? If so, how?
What are the costs of reasonable adjustments? Who currently bears these costs? What is their impact, if any, on competition? Who should bear them, and why? What is their impact, if any, on competition?
Why shouldn't unjustifiable hardship apply in the areas of sport and administration of Commonwealth laws and programs?
How has the prohibition of harassment worked in practice? How could it be improved?

A **reasonable adjustment** for people with psychiatric disability and their carers may be much more than making physical adjustments such as building a ramp in front of a building to allow for physical access, which would be considered for people with a physical disability. The types of 'reasonable adjustments' people with psychiatric disability and carers may require often relates to more non-material adjustments such as attitudinal adjustment by others, and provision for flexibility in their daily schedules. For example, understanding by employers towards people with a

psychiatric disability and carers such as offering flexible work arrangements[3], having access to open and lower ground spaces (to accommodate for those who have difficulties coping with heights and confined spaces), having scheduled time for breaks and time-out stress-free periods or time for treatment appointments, can significantly assist in promoting mental health, preventing illness relapse, and encouraging active participation in community life. The unique needs of people with mental illness and the episodic nature of mental illnesses must be taken into account when determining 'reasonable adjustment' to accommodation for the needs of people with psychiatric disabilities and carers.

In determining whether **unjustifiable hardship** has been experienced when, for example, a service is asked to make a reasonable adjustment to accommodate for the needs of people with psychiatric disability, is complex and should take into account the impact such adjustments will have on the abilities of a person with a psychiatric disability. Should, for example, providing time for an employee to attend a weekly doctor appointment, impact on the productivity of the employee to complete his/her workload, support mechanisms and delegation of tasks should be examined, as would occur should a person with a physical disability requiring regular physiotherapy treatment for example. In this instance, employers should also realise that periods of un-wellness will not necessarily be ongoing, and that seeking treatment and care early in an episode of illness will promote earlier onset of periods of wellness. As such, disruption and 'hardships' will not necessarily be ongoing.

Also, organisations must recognise the numerous 'hardships' people with psychiatric disability experience on a daily basis as a result of making adjustments for their disability - such as physical, emotional, attitudinal, and financial hardships. For instance: people with psychiatric disability experience the ongoing stigma and negative attitudes held by the community and often by health professionals; they experience financial hardship in terms of the level of income support / welfare payments they may receive and the high costs of ongoing treatment, particularly pharmacological treatments. Such financial hardship may often prevent participation in activities or interests of enjoyment due to the allocation of the small level of income being subsumed by basic living costs on top of ongoing, often unsubsidised, treatment costs.

Another issue relates to the criteria used to determine what is reasonable and what is unjustifiable, and whether these are considered on a case–by–case basis, taking into account both the needs of the discriminator and the needs of the aggrieved person.

Harassment is an issue with much potential for occurrence for people with psychiatric disability, particularly when the occurrence of such a disability is known. The negative nature of comments made about people who experience mental illness is not only evident in media reporting and sensationalization of tragic stories, but is also evident within the community and within the practices of health professionals working in mental health services (see *Enhancing Relationships between Health Professionals and Consumers and Carers Report*, MHCA, 2000; *Out of Hospital, Out of Mind,* Groom, Hickie & Davenport, 2003).

Bullying and harassment, particularly in the workplace is a recognised problem, and people with a psychiatric disability may be particularly vulnerable to it, and perhaps less likely to be believed when it does occur. Of particular concern is how the occurrence of harassment particularly in mental health facilities is monitored. Often people with a psychiatric disability who have been admitted to in-patient hospital care may be so disempowered and may not have the mental functioning capacity to recognise examples of harassment and may not have the capability to report such occurrences. If a health professional or other person is harassing a person with a psychiatric disability during their admittance to hospital, what mechanisms are in place to ensure such practice is rectified? The employment of consumer advocates within mental health services

[3] The Australian Bureau of Statistics report on Managing Caring Responsibilities and Paid Employment (Queensland) highlighted examples of the type of flexibility employers could offer to accommodate for the needs of carers when caring for a person with a psychiatric disability. Such working arrangements could include provision for: paid leave, flex-time, rostered day off, time in lieu, temporarily reducing working hours, working from home, unpaid leave, or other informal arrangements with an employer. (http://www.abs.gov.au/ausstats/abs@.nsf/0/55313B32628BB7EACA256D1500833DBA?Open&Highlight=0,4903.3)

seeks to ensure the rights of clients are upheld and are not exploited. However, as illustrated by Groom, Hickie & Davenport (2003), human rights abuses are still occurring.

Direct Discrimination: A Case Example

In response to the following questions:

Do you have any comments on the definitions of direct and indirect discrimination? How could they be improved?

What evidence can you provide of progress in eliminating discrimination in different areas and for different types of disability?

What evidence can you provide of performance in ensuring equality before the law?

What evidence can you provide of progress of the DDA in promoting recognition and acceptance of the rights of people with disabilities?

Should the DDA be amended to allow HREOC and/or other appropriate bodies to initiate complaints?

How has HREOC been as an educator? How could its effectiveness be improved?

- **Investigation of Insurance Company Discrimination**

Most insurance policies have exclusions for pre-existing ailments/conditions. Psychiatric disability is a difficult issue due to the episodic nature of mental illness. People with mental illness may be well for a certain amount of time and able to participate in community life, but may then become unwell for a period of time and may not be able to actively participate within the community and lead a satisfying lifestyle. As a result of the nature of the illness, people with mental illness may often be discriminated against in accessing insurance products and benefits.

The stipulation of minimum waiting periods for claims associated with pre-existing ailments can cause disputes between insurance companies and consumers. Due to the episodic nature of mental illness, often resulting in longer-term treatment plans and possibly more admissions to hospital, insurance companies need to recognise consumers are often not able to seek professional help due to financial constraints and the lengthy waiting period to receive benefits. Such discrimination, resulting in lack of treatment could potentially result in damaging effects in progressing an individual's mental illness.

If the DDA covers 'disabilities people have now, have had in the past, might have in the future or are believed to have', then under the DDA insurance companies cannot exclude insurance coverage for people who currently have, have had, or who may have in the future, a psychiatric disability, unless they have the statistical and actuarial evidence to support their actions.

The Productivity Commission's Issues Paper notes on page 12 that 'discrimination is lawful in the provision of superannuation and insurance only on actuarial or other 'reasonable' grounds. A significant issue the MHCA together with 'beyondblue: the national depression initiative' has been investigating over the past two years relates to alleged insurance discrimination.

Increasing evidence has been provided to the MHCA and beyondblue since 2001 by individuals who are currently experiencing a mental illness or who had previously experienced a mental illness, that insurance companies were allegedly engaging in discriminatory practices. These allegations were provided to the MHCA and beyondblue by members of the community and could be clustered into three main groups.

First, some individuals reported alleged discrimination because they currently experience mental illness or are still continuing to receive active treatment for their condition. Frequently, as with other medical disorders, the person is no longer suffering symptoms of the condition but has been advised of the necessity to continue treatment to prevent illness relapse. As a consequence of receiving active treatment for a mental illness, individuals allege they have been denied insurance protection, including for all other medical disorders. Individuals allege that some companies have

been willing to offer insurance if they discontinue with advised medical treatment and then remain well for a prolonged period (eg. after two years).

The second group of individuals reported alleged discriminatory practices as a result of experiencing a mental illness previously. Most of these reports relate to a single episode of mental illness, which has not recurred. These allegations had been received from persons who were no longer continuing to receive treatment and often the episode of depression or anxiety involved had not been severe.

The third group involves persons who alleged that when making claims against insurance companies, they have been denied payments on the basis of an 'undeclared' mental illness. Claimants alleged illnesses were often based on a review of previous medical records, undertaken by insurance companies, and often resulted in insurance companies disputing claimants had "fully disclosed" their medical history at the initial application stage.

The allegations made against insurance companies were broad ranging, suggesting many types of insurance coverage was denied to people with either current mental illness or a history of mental illness. Types of insurance products being denied included: income protection, life insurance, mortgage, house and contents, travel, and health insurance.

In most instances, people felt they had been denied insurance policies without adequate explanation of the basis for refusal to provide cover. When challenged, many insurance companies were not willing to provide either an explanation of why applications had been denied or failed to provide the statistical or actuarial evidence to support their position.

The MHCA and beyondblue are aware there are several national and international laws established in order to protect people from discriminatory practices and for the protection of people who experience mental illness. In addition to these laws, there are other well identified principles Australia has agreed to abide by both at a national and international level.

Australia is internationally recognised by the principles relating to the protection of persons with a mental illness and for the improvement of mental health care which was adopted by the United Nations General Assembly in 1991. It is important to note that while these principles have not been formally incorporated into Australian legislation, they have been endorsed by all Australian Health Ministers and provide the platform for the National Mental Health Policy (1992).

The United Nations principles specify they are to be applied without discrimination of any kind such as on grounds of disability, race, colour, sex, language, religion, political or other opinion, national ethnic or social origin, legal or social status, age, property, or birth. Importantly these principles also stipulate that every person with a mental illness has the same basic rights as every other person. More specifically included in the rights set out in the International Convention on Civil and Political Rights and the rights recognised in the Declaration on the Rights of Disabled Persons is that:

> *'discrimination on the basis of mental illness is not permitted, that every person with a mental illness has a right to live and work as far as possible in the community, that people being treated for a mental illness must be accorded the right to recognition as a person before the law, that principles also re-affirm that individuals who have a mental illness or who have experienced mental illness have the right to protection from exploitation whether economic, sexual or in other forms'.*

The MHCA, in partnership with beyondblue, submitted a request to the Human Rights and Equal Opportunity Commissioner's Office to undertake an investigation into the complaints received. The submitting organisations called on the Commissioner to investigate alleged discriminatory practices towards those individuals who either currently experience, or had at some stage experienced the most common forms of mental illness in Australia, namely major depression and anxiety disorders.

These disorders are likely to affect one in five people in their lifetime and are commonly treated with available medical and psychological treatments. When people are appropriately treated they are typically able to resume their full range of personal and social responsibilities. When untreated, or when treatment is stopped inappropriately, persons are at risk of ongoing ill health, recurrence of illness, and social dysfunction. The MHCA and beyondblue argued the Commissioner should recognise that allegations of discriminatory practices by insurance companies had been made to both the MHCA and beyondblue, by members of the Australian public who either have or had experienced a wide range of mental illnesses. The MHCA and beyondblue also requested the Commissioner recognise these alleged discriminatory practices by insurance companies had been in relation to a broad range of insurance products.

Given that discrimination in relation to insurance is unlawful under the DDA except where discrimination is reasonable having regard to available statistical or actuarial data, the submitting organisations suggested areas for a HREOC inquiry and/or comments include the following:

- What statistical or actuarial data is available to support refusal of cover or higher premiums on the basis of depression and anxiety disorders?

- How far does this data distinguish between different types of severity of illness or treatment practices for depressive illness and anxiety disorders?

- Are people who have experienced depression or an anxiety disorder being refused insurance coverage or offered insurance cover only on less favourable terms than those who have not been diagnosed with depression or an anxiety disorder at any stage in their life?

- How far does the practice of insurers distinguish between different types and severity of illness, or treatment practices for depressive illness and anxiety disorders?

- What distinctions in insurance on the basis of depression ought to be regarded as reasonable for the purposes of discrimination legislation?

- Is coverage being refused, or offered only at substantially higher premiums, in situations which might instead be managed by use of appropriate exclusion clauses?

- Should HREOC make any revisions to its guidelines on insurance and disability discrimination?

- Is the Sex Discrimination Act also relevant to any HREOC inquiry given that childbirth is a natural life-cycle event and discrimination is alleged to have taken place towards those who have encountered post-natal depression?

The proposed inquiry was deferred when the major industry body, the Investment and Financial Services Association (IFSA) advised it was prepared to auspice a cooperative process to work on the issues in this area. IFSA's willingness to cooperate was influenced by the threat of the review of the situation under the DDA by HREOC. This threat was deemed effective enough to spark action through a formalised commitment to address the issues in partnership and has resulted in the signing of a cooperative Memorandum of Understanding between the mental health sector stakeholders and IFSA member organisations. This is an example of evidence in progressing the elimination of discrimination for people with psychiatric disability.

- **Discrimination in Legislation**

A recent incident the MHCA believes discriminates against people with psychiatric disability relates to the Victorian *Wrongs & Limitation of Actions Act (Insurance Reform) Bill* 2003 which has been passed by the Victorian Lower and Upper House in the August Session 2003.

This legislation appears to be directly discriminating against people with psychiatric impairment. Key points relating to this discrimination include:

1. Physical injury must obtain more than 5% impairment;
2. Depression due to injury is excluded altogether;
3. To claim any psychiatric injury you must have nearly double the impairment in percentage points;
4. This law clearly devalues and discriminates against psychiatric illness, seeing physical injury as of greater importance and significance;
5. Physical and psychiatric injuries cannot be combined to obtain entry to the scheme.

The Global Burden of Disease Study and other major studies clearly indicate the level of disability caused by major depression is equal to blindness or paraplegia – how then can the Victorian Government put forward legislation that flies in the face of such compelling evidence?

The MHCA was advised the DDA does not apply to the drafting of proposed legislation. What legislation does exist in ensuring discrimination does not occur in legislation (including workers compensation insurance problems)?

As previously highlighted, the MHCA and beyondblue have put in an enormous amount of work over the past two years to gain cooperation of the insurance industry in Australia through the signing of a Memorandum of Understanding that would work towards ensuring equity of access for people with mental health problems to insurance products and yet, here we have a State Government passing legislation that clearly does the opposite – blatant discrimination towards people with mental illness. A copy of the new legislation is available at http://www.dms.dpc.vic.gov.au/pdocs/bills/B01531/B01531I.html

The *Americans with Disability Act* explicitly bans the use of 'mental disorders' as a justification for workplace discrimination. However, in Australia psychiatric diagnoses of 'mental disorders' are a requirement in Australian workers compensation legislation, and are treated as essential in some judicial interpretations of such legislation.

Another example of discrimination occurring in legislation relates to the incorporation of associations in each State and Territory of Australia. The legislation is different in each State/Territory but generally there is a set model of rules which could be adopted for incorporation purposes. In some cases the model rules contained a provision for vacancies to occur in respect of office holders or membership of committees if a person suffered from a mental illness, however there was no similar provision for physical illness. For example in Tasmania the office of an officer of an association or of an ordinary committee member became vacant if the individual became of unsound mind. In NSW the model rules provided for a casual vacancy to occur if the holder of an office became mentally incapacitated, however there was no similar provision for physical incapacity. In the ACT[4] the model rules provide for this to occur if the person suffers from mental or physical incapacity so there is no discrimination between mental and physical, but why is it necessary. These examples which distinguish between physical and psychiatric disability raise the question as to why a person should be penalised for any incapacity if they are able to fulfil their duties, or able to fulfil the inherent requirements of a job.

- **Other Examples**

Don't judge what I can do by what you think I can't: Ten years of achievements using Australia's Disability Discrimination Act (HREOC, 2003) provides specific case examples where the DDA has been used in the case of people with psychiatric disability. These examples are provided below.

[4] Associations Incorporations Act 1991 (ACT) http://www.legislation.act.gov.au/a/1991-46/current/pdf/1991-46.pdf

A chef complained that when he experienced a severe anxiety attack and required seven days sick leave during which he was admitted to a psychiatric hospital, he was dismissed. The complaint was settled with payment of $55,000 compensation and provision of a reference. (p.42)

A woman with Post Traumatic Stress Disorder following an accident complained that her employer had changed her hours of work which meant she now could not get a lift to work and would need to use public transport. This made her extremely fearful. The complaint was settled when the employer agreed that her previous working hours could be maintained and that there would be consultation before any changes. (p.43)

A man with a mental illness complained when his appointment was terminated after difficulties relating to colleagues and clients. The employer had been informed the man had a medical condition but not informed of its specific nature. The President held that the complainant had been discriminated against because of manifestations of a disability. He had not been given a fair chance to show he could carry out the inherent requirements of the job after he returned from sick leave. (p. 46)

The parents of a boy with a psychiatric condition complained that he had been discriminated against when he was refused admission to a secondary college after the principal formed the view that he was unsuitable for mainstream schooling. After a conciliation conference the college apologised and paid $5,000 compensation. (p. 49)

A woman who had experienced post-natal depression (PND) complained that she had been discriminated against by being refused insurance. The insurer responded that it assessed PND based on underwriting manuals which do not make distinctions as to cause of depression. After a conciliation conference the insurer agreed to provide insurance coverage at standard rates as she was able to provide medical evidence that she had recovered from PND. The insurer also agreed to pay compensation, and to write to the international underwriting companies it deals with to highlight the fact that PND had different effects and duration to other forms of depression. (p. 58)

A woman with a psychiatric disability complained that she had been refused death or disablement cover because of her disability which she had disclosed to the insurer. In conciliation the insurer advised it was prepared to insure the complainant provided she submitted a medical report regarding risks arising from her disability. The respondent subsequently provided her with insurance cover with no restriction on death but with a restriction for permanent disablement arising from her current disability. This resolved the complaint. (p.58)

A carpenter complained that he had been refused accident / sickness insurance because of a single psychotic episode eighteen months earlier. The complaint was settled when the insurer offered cover with an exclusion clause covering psychotic illness. (p.58)

A woman with bi-polar disorder complained of discrimination after her application for mortgage protection insurance was refused. At a conciliation conference it was agreed that she should have been provided with better information on the reasons for declining her application and on alternative products for which she could have been eligible. The insurer apologised and paid $5000 compensation. (p.59)

A man complained that he had been discriminated against when his insurer refused to pay a claim on a family travel insurance policy after his son had a panic attack in flight and the family had to return home. The claim was refused on the basis that the claim arose from a mental or nervous disorder which was excluded by a clause in the policy. The matter was settled by payment of medical, travel and accommodation expenses. (p.59)

The wife of a man with a manic condition complained that the real estate agency which managed the property where he lived had taken steps to have him evicted. Evidence indicated he had behaved very disruptively and made threats against other tenants. The complaint was settled on the basis that the agent would make reasonable efforts to assist the man to find alternative accommodation (p.62).

Indirect Discrimination[5]: A Case Example

In response to the following questions:

Do you have any comments on the definitions of direct and indirect discrimination? How could they be improved?

What evidence can you provide of progress in eliminating discrimination in different areas and for different types of disability?

What evidence can you provide of performance in ensuring equality before the law?

What evidence can you provide of progress of the DDA in promoting recognition and acceptance of the rights of people with disabilities?

Can the relationship between the DDA and other Commonwealth legislation be improved? How?

Have the accessibility of public transport / public premises / provision of goods, services and facilities / accommodation improved since the DDA was introduced? What remains to be done?

How has the term 'unjustifiable hardship' been interpreted in the provision of public transport / public premises / provision of goods, services and facilities / accommodation?

What are the costs of 'reasonable adjustments' in public transport / public premises / provision of goods, services and facilities / accommodation? Who currently bears these costs? Who should bear them, and why?

People with a psychiatric disability are often considered one of the most vulnerable and chronically disadvantaged groups in the community. Numerous reports and national reviews clearly highlight the failings of current community-based systems to provide adequate support and treatment services (see Groom, Hickie & Davenport, 2003). Specifically, services are failing in terms of restricted access, variable quality, poor continuity of care, and lack of support for recovery from illness or protection against human rights abuses. This does not represent a failure of policy, but rather a failure of implementation through poor administration, lack of accountability, lack of ongoing government commitment to genuine reform, and failure to support the degree of community development required to achieve high quality mental health care outside institutional-based settings (Groom, Hickie & Davenport, 2003).

[5] Indirect discrimination refers to 'situations where the same rule or condition applies to everybody but has a disproportionate effect on a person with a disability, and the rule is not 'reasonable' in the circumstances' (Productivity Commission's Issues Paper, p13).

- **The Medicare System**

A prime example of indirect discrimination relates to access to health care under the Medicare system. Despite Australia having a universal health insurance system under Medicare, variations in access to health care services are stark. Changes to the Medicare system, specifically the current decline in the availability of bulk-billing systems of payment and the personal out-of-pocket expenses and requirement for 'up-front' payment for service, is a significant barrier to people with psychiatric disability accessing care.

Research indicates a high percentage of people with a psychiatric disability receive some type of income support payment, such as a disability support pension. In fact, people with psychiatric disability comprise the second largest recipient group of the disability support pension. In the absence of appropriate payment systems, people on low income (such as the majority of people with psychiatric disability) are restricted in access to health care, such as general practitioners, as they may not have the capacity to pay upfront for the consultation. Moreover, they may not have the capacity to pay the gap between the Medicare rebate and the health professional's fee. This is in effect, indirect discrimination against people who are less able to manage on their incomes and who have a greater need for services (e.g. people with a psychiatric disability who are overly represented in this group). The 'one size fits all' generic rule seemingly based on capacity to pay rather than basis of need, unreasonably excludes people with psychiatric disability from accessing the service, constituting 'unjustifiable hardship' on the part of the consumer.

This issue is particularly relevant given that the first point of contact for people with mental illness is usually their general practitioner, and there is no legislation in Australia restricting how much a GP can charge for a consultation (Young & Dobson, 2003). Indeed, research on GP consultation usage by Australian women indicates that when higher out-of-pocket costs per GP consultation exist, there is lower use of GP consultations (Young & Dobson, 2001). If people with a psychiatric disability are already experiencing barriers to access their GP, additional barriers such as increased consultation fees may indeed prevent access altogether. In recognition of current severe restrictions in access to specialist mental health services, eliminating access to GPs for people with mental illness will cut of all common forms of effective assistance.

- *The experience of current consumer of mental health care is that they have severely limited access to primary care (exacerbated by current declines in bulk-billing rates), emergency care, specialist care, or rehabilitation services.*

- *Current care systems are perceived to be chaotic, under-resourced and overly focused on providing brief periods of medicalised care within acute care settings.*

- *Private psychiatric services are grossly maldistributed and involve large out-of-pocket costs, while access to specialist psychologists and other allied health services has been restricted by lack of government or private insurance support.*

- *The demands on the carers and families of people with mental illness are increasing.*

(Groom, Hickie & Davenport, 2003, p7 – 8)

This is contrary to the universal understanding that prevention and intervening early in mental health problems leads to better mental health outcomes. Indeed, with current and predicted increasing prevalence rates of mental illness and the psychological impact of recent world events, new pressures on Australia's health system will undoubtedly emerge. Action is required to not only combat the current crisis, but also to invest in ensuring the long-term sustainability of a mentally healthy community through fostering promotion, prevention, and early intervention strategies.

- **Interaction of Disability with other Portfolios**

Disability is an issue which falls across several Governmental portfolios. Such interaction requires consideration of the impact various policies and systems developed in one portfolio may have on another portfolio. An example highlighting the interaction between disability support services and the DDA is illustrated in anecdotal reports collected during the national review of Australian mental health care (see Groom, Hickie & Davenport, 2003). Such reports highlight the difficulties experienced by people with a psychiatric disability who require access to various support services, such as home care assistance (e.g. cooking lessons). Reports suggest that when a person with psychiatric disability is unable to pay for such assistance, due to inadequate rate of payment under a pension, such support services ceased.

A key theme of the *Out of Hospital, Out of Mind* report was that while structural institutionalisation may have ceased by closing down the large psychiatric institutions and transferring care into the community, institutionalisation still exists in the community.

> *'My son sits alone in a unit with nothing to do, no motivation, no energy and doped up on a tranquiliser. I see other people like my son around where I live, who appear lost and lifeless, who roam aimlessly all day'* (Quote from a carer – Groom, Hickie & Davenport, 2003 p.18).

An example of the occurrence of institutionalisation in the community is in the location of public housing for people mental illness. In the event that housing is actually available, often it is provided in regional centres or on the fringe of cities where there is limited access or ability to 'connect' with others and actively participate in community living. Availability of public transport to these areas is restricted, resulting in people not having access to ongoing health care services which are important in the management and treatment of mental illness, but also limits access to important community structures such as shopping centres, theatres, movies, sporting events, and public facilities such as libraries, restaurants and clubs. Utilisation of these important structures promotes a feeling of community connectedness and can act as mental health protective factors. Isolation of public housing for people with mental illness is a significant barrier to promoting a sense of connectedness to the community and community involvement, and may further perpetuate the likelihood of mental illness relapse.

Lack of such support services may prevent people from participating in community life / independent living, effectively discriminating against them due to their disability (both psychiatric disability and financial disability).

Discrimination and Employment

In response to the following questions:

Do you have any comments on the definitions of direct and indirect discrimination? How could they be improved?

What evidence can you provide of progress in eliminating discrimination in different areas and for different types of disability?

What evidence can you provide of performance in ensuring equality before the law?

What evidence can you provide of progress of the DDA in promoting recognition and acceptance of the rights of people with disabilities?

Can the relationship between the DDA and other Commonwealth legislation be improved? How?

What Australian and international evidence is available on the extent of employer discrimination towards persons with disabilities?

How should the effectiveness of the DDA in eliminating employment discrimination be measured?

Is there evidence of any counter-productive effects of the DDA on employment of persons with a disability, at the firm, sectoral, or economy-wide level?

How have the eligibility criteria for the Disability Support Pension and employment support services affected incentives for people with disabilities to participate in the labour force?

What influence is better access to public transport likely to have on people with disabilities entering the workforce?

How have the terms 'inherent requirements', 'unjustifiable hardship' and 'reasonable adjustment' been interpreted in employment?

What are the costs of 'reasonable adjustments' in employment? Who currently beards these costs? Who should bear them, and why?

What impact, if any, do they have on competition?

What are the advantages and disadvantages of developing disability standards for employment?

- **Employment**

Discrimination in the workplace is a major issue for people with psychiatric disability. Indeed, the World Health Organisation and the World Federation for Mental Health recognised the severity of the issue and dedicated the theme for World Mental Health Day (10 October) to focus on this issue in 2000 – 2001.

> *Many respondents from all parts of the mental health system felt that stigma remains a significant issue for people with mental illness. There is still a lack of understanding of mental illness in the community and even a fear of those with mental illness. In addition, respondents felt that stigma discourages help-seeking behaviour and has an adverse effect on access to paid and even voluntary employment opportunities. In the study, there were several reports of consumers losing their jobs and not being able to apply for courses for education and training. It was stated that people do not disclose a history of mental illness when seeking employment for fear of stigma.*
>
> *…A respondent said that if an employee has depression they must be very circumspect as the possible financial and emotional cost is too high given the expected bad reaction from colleagues and employers. Several respondents argued the practice and policies of insurance industries may even be a broader problem than stigma. Insurance companies attach mental health item numbers to consumers that can limit access to both mental and physical health services; consumers may not be able to then claim both services on Medicare.* (Groom, Hickie & Davenport, 2003, p28)

Due to stigma of mental illness and reluctance to disclose such illness, many employees may experience mental health problems in the workplace without receiving adequate support services from their employer. At the same time, some employers are unclear about their obligations to employees with psychiatric disabilities. Some employers, particularly Government departments, may have available Employee Assistance Programs. However, lack of availability of such programs or support services may prevent employees from seeking assistance and may negatively impact on their current employment status or future prospects, effectively discriminating against them due to their psychiatric disability. In an article entitled '*The disability that dares not speak its*

name' featured in the Anti-Discrimination Board of New South Wales *Equal Time* newsletter (February 2003), reference is made to the experience of discrimination in the workforce:

> *Ideally, arrangements relating to accommodation will be arrived at by agreement between the employer, the employee and the employee's doctor, psychiatrists and/or case worker, or brokered by a workplace mental heath consultant. An employment support service for people with mental illnesses might also be able to help, particularly if the person's continued employment is at risk. In fact, failing to obtain help from an available support service may constitute less favourable treatment. In Randall v Consolidated Bearing Co ([2002] FMCA 44), the magistrate found that Mr Randall was treated less favourably in the same situation because CBC had called in assistance for other trainees who were having difficulties. If he had received the available assistance and was still making mistakes at the end of his period of probation, CBC could have argued that he could not fulfil the inherent requirements of the job. A management plan should set reasonable standards of behaviour and performance, outline the rights and responsibilities of both parties and include guidelines for dealing with any problems that might arise.* (page 5)

- **Australia's Welfare System**

Another area of concern under the DDA relating to the employment needs of people with a psychiatric disability is Australia's welfare system. The current reform of Australia's social support system is desperately warranted given the numerous issues it poses for people with a psychiatric disability and their ability to actively participate socially and economically in the community, including gaining and maintaining meaningful employment.

The MHCA has highlighted in various submissions throughout the welfare reform process that the current level and requirements of social support payments to people with a psychiatric disability are inadequate and unrealistic when consideration is given to the unique needs of mental illness. The MHCA advocates that adequate financial support must be provided to people in need, and as highlighted previously, people with a psychiatric disability are considered one of the most vulnerable and chronically disadvantaged groups in the community, often with high levels of support needs due to the restrictions having a mental illness places on their ability to participate socially and economically in the community. Research on homelessness and mental illness suggests that for young adults, the combination of low/no income and mental illness is a major contributor of homelessness. This is further complicated as many young adults do not have access to clinical services, and often their mental illness is undiagnosed.

When imposing penalties for failing to comply to social support system requirements, it is important to consider that given some people with a mental illness who access income support may not disclose their mental illness (often due to the prevailing stigma attached to such disclosure), can it be adequately assessed that people with a mental illness are not being unduly penalised for a breach in meeting their requirements. Consideration must be given to the nature of mental illness which often allows people to be more able to participate when they are well (i.e. managing the symptoms of mental illness). However, when people are unwell (i.e. experiencing an episode of mental illness) they may be less able to participate in community life and less able to meet their obligations for social / income support services. The presumption that failure to perform the activity or administrative requirements of income assistance is the result of fraud, is extremely problematic and does not take into account reasons why a failure to meet obligations may have occurred.

The MHCA recognises the need for measures of accountability and responsibility of recipients of income support. In some cases, this may include sanctions for those people who deliberately fail to comply with their obligations. The MHCA is concerned over the dramatic rise in breaching of requirements and questions whether this may be due to the system (e.g. are the requirements unrealistic to achieve), whether there is an issue with recipients (e.g. are some recipients

deliberately failing to comply with their obligations), or is the system inappropriately structured for vulnerable groups such people with a mental illness.

An effective welfare system should protect and provide for vulnerable groups in society, and promote active social and economic participation. Only a minimum occurrence of breaching should occur. The current high breach rate may be indicative of failures in the system. Non-compliance should not be assumed as being deliberate and greater emphasis needs to be placed on promoting compliance rather than preventing breaching.

Research indicates that 24% of recipients of the Disability Support Pension (DSP) are people with a psychiatric or psychological illness. This figure is reflective of the prevalence of mental illness in the general population. However, this figure also reflects the amount of people who have disclosed their mental illness, which is not necessarily indicative of the amount of people who are accessing income support and have a mental illness. Further research must be undertaken regarding whether recipients who have breached their obligations may not have disclosed their mental illness because of the prevalent stigma and discrimination they experience as a direct result of the illness.

In the MHCA's submission to the Senate Community Affairs References Committee *Inquiry into Participation Requirements and Penalties* (2002), the following recommendations were made:

1. Improved research and data collection on who is being penalised for a breach. The levels of breaching on people who have a mental illness is high, yet because of the stigma and discrimination of mental illness, many recipients may not disclose their illness to Centrelink. The nature of mental illness will impact on the ability of recipients to fulfil the stringent activity test requirements and may result in people with a mental illness being disproportionately penalised.

2. Centrelink staff must receive adequate training to ensure referrals are made to appropriate organisations. Staff of Centrelink must be cognisant of the occurrence and episodic nature of mental illness to ensure that breaching is avoided. Interviewing, communication, referral and investigation must be paramount before the imposition of a penalty.

3. A greater level of research is required to assess the extensive anecdotal evidence that the breaching regime effects the emotional and social wellbeing of social security recipients.

In relation to the DDA, when a person with a psychiatric disability receiving, for example a disability support pension, fails to meet their participation requirements due to becoming mentally unwell, and is consequently penalised for such non-compliance, this could in effect be an example of discrimination as the effect of the breaching rule has a disproportionate effect on a person with a psychiatric disability, and the breaching rule is not considered reasonable in the circumstances due to the episodic nature of mental illness and the restrictions having a psychiatric disability places on the individual's capacity and ability to meet participation requirements. The individual has not intentionally failed to comply with the requirements, but rather, their illness has prevented such compliance, and they should not be penalised for being unwell.

Others Issues

- **Promotion / Publicity of the DDA**

A significant issue impeding on the potential use of the DDA in issues of discrimination against people with psychiatric disability is the lack of awareness not only of the DDA itself, but of the process on how to make a complaint when discrimination may have occurred. Often people may be aware that discrimination should generally not occur. However, they may not know what to do and what legislation to utilise when discrimination does occur.

Following the 10 year anniversary of the DDA and the outcomes of the Productivity Commission's inquiry into the DDA, perhaps it is timely to conduct another community information and education campaign. It is important the community understands their rights and responsibilities in relation to disability discrimination, and particularly for people with a psychiatric disability and intellectual disability, carers and advocates can play an important role in ensuring consumer rights are upheld and a person's diminished state of mental functioning is not taken advantage of and does not give reason to overlooking occurrences of discrimination.

The complaints process for reporting occurrences of discrimination is no doubt a stressful process. But particularly for people with a psychiatric disability, the necessary self-disclosure and stigma they may experience during the process may act as a deterrent and the process may indeed be a risk factor in illness relapse.

In general, the DDA and its objectives[6] have had variable impact on people with psychiatric disability. In some instances, the threat of the DDA has been sufficient to spark appropriate action, illustrating the power of enacting such legislation and the ability it has to influence change. Despite these achievements however, there are numerous instances where discrimination is still occurring, and while the DDA is one tool to combat discrimination, only when there is community understanding, acceptance, and de-stigmatisation of mental illness, will the need for protective legislation such as the DDA become obsolete as basic principles of human rights for all will be accepted and honoured by the community.

[6] The objects of the DDA are:

a to eliminate, as far as possible, discrimination against persons on the ground of disability in the areas of:
  i. work, accommodation, education, access to premises, clubs and sport; and
  ii. the provision of goods, facilities, services and land; and
  iii. existing laws; and
  iv. the administration of Commonwealth laws and programs; and

b to ensure, as far as practicable, that people with disabilities have the same rights to equity before the law as the rest of the community; and

c to promote recognition and acceptance within the community of the principle that people with disabilities have the same fundamental rights as the rest of the community.

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ATTACHMENT A: MHCA MEMBER ORGANISATIONS

Association of Relatives and Friends of the Mentally Ill (ARAFMI)
Australasian Society for Psychiatric Research
Australian & New Zealand College of Mental Health Nurses
Australian Association of Occupational Therapists
Australian Association of Social Workers
Australian Board of Certified Counsellors
Australian College of Psychological Medicine
Australian Counselling Association
Australian Infant, Child, Adolescent and Family Mental Health Association
Australian Medical Association
Australian Mental Health Consumer Network
Australian Neuroscience Society
Australian Psychological Society
Australian Rotary Health Research Fund
Australian Transcultural Mental Health Network
Carers Australia
Catholic Health Australia
GROW
Healthscope Limited
Institute of Australasian Psychiatrists
Lifeline Australia
Mental Health Coordinating Council
Mental Health Foundation of Australia
Mental Illness Education Australia
Mental Illness Fellowship Council of Australia
National Aboriginal Community Controlled Health Organisation
National Network of Private Psychiatric Sector Consumers and Carers
National Rural Health Alliance
Network of Australian Community Advisory Groups
OSTARA Australia
Queensland Alliance of Mental Illness and Psychiatric Disability Groups
Ramsay Health Care
Royal Australian & New Zealand College of Psychiatrists
Royal Australian College of General Practitioners
Royal Flying Doctors Service of Australia
SANE Australia
VICSERV (Psychiatric Disability Services of Victoria)
Western Australian Association for Mental Health

National Consumer and Carer Forum[7]

[7] The National Consumer and Carer Forum was established in 2002 by the Commonwealth of Australia, and is operated under the auspice of the Mental Health Council of Australia. The aim of the NCCF is to progress consumer and carer partnerships at a national level.