Victorian Equal Opportunity & Human Rights Commission

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

July 2019

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1. Executive summary

The Victorian Equal Opportunity and Human Rights Commission (**Commission**) welcomes the Royal Commission into Victoria's Mental Health System (**Royal Commission**) and the opportunity to make a submission and inform the interim and final reports.

We thank the Royal Commission for taking into account earlier submissions, including our own,[1] on critical matters to be incorporated into the Terms of Reference. We particularly welcome its focus on prevention, supporting early recovery and improving mental health outcomes for those at greater risk of experiencing poor mental health, including Aboriginal and Torres Strait Islander people (**Aboriginal**) and other key groups. We are pleased the Terms of Reference enable flexibility to consider discrimination and stigma and note that these matters cut across all aspects of the mental health system.

In executing our statutory functions under the *Equal Opportunity Act 2010* (Vic) (**Equal Opportunity Act**) and the *Charter of Human Rights and Responsibilities Act 2006* (**the Charter**), we routinely see the harmful and complex relationship between discrimination and stigma and poor mental health outcomes. Accordingly, this submission focuses on:

- how to best prevent and alleviate mental illness by addressing discrimination against, and other violations of the rights of, people with mental illness
- the importance of human rights law in the delivery of mental health and related services.

Sections 3 and 4 of our submission consider the relationship between discrimination and mental illness and the need to strengthen the current legal framework to better protect and advance the rights of people with, or at risk, of mental illness. Section 5 then focuses on addressing the needs of particular groups at increased risk of mental illness and/or mistreatment, including Aboriginal people, women, transgender and non-binary people, and people in closed environments who are deprived of their liberty.

A summary of our key themes and recommendations is set out below.

Discrimination and stigma must be recognised as both a driver and consequence of mental illness

Through our work responding to enquiries, resolving disputes, delivering education and undertaking investigations, reviews and research, the Commission understands the interlocking relationship between discrimination and mental health. People with mental health conditions often experience discrimination and stigma across all aspects of public life (for example, in accessing goods and services, employment, accommodation and education), which can adversely impact their mental health.[2] 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 outcomes.[3]

Addressing discrimination and stigma (and their root causes) must therefore be a critical component of any primary prevention strategy and inform all aspects of mental health reform and service delivery.

Including a right to health and a dispute resolution function in the Charter would better safeguard the rights of people with mental illness

The Charter is intended to enshrine parts of the International Covenant on Civil and Political Rights[4] and focuses primarily on civil and political rights.[5] The Charter does not include a right to health. Incorporating this right, as provided in international human rights law, would provide important legal safeguards for the rights of people with mental health conditions and inform the development of legislation and policy. For example, including a right to health in the Charter would impose additional scrutiny on new legislation that may impede the rights of people with mental illness,[6] strengthen protections against discrimination within mental health service provision[7] and contribute to greater fairness and adherence to human rights in decision-making about compulsory treatment and conditions within mental health facilities.[8]

In addition, the Charter does not include an alternative dispute resolution framework to manage individual complaints. Currently there is no single body that can receive complaints about allegations of a human rights breach against all public authorities as defined in the Charter. Instead, there is a 'patchwork' of options for dealing with alleged human rights breaches. Incorporating a dispute resolution framework into the Charter, like the dispute resolution function under the Equal Opportunity Act, would strengthen accountability and enable people with mental illness to directly bring complaints about breaches of their human rights and have them resolved through a fair, timely and accessible process.

These changes would also play an important normative role in signalling to the broader community Victoria's commitment to human rights and equality and humane and dignified treatment for our most vulnerable.

Stronger regulation and enforcement powers are needed to better address systemic issues of mental health discrimination

Strengthening the Equal Opportunity Act would give the Commission greater powers to successfully address systemic issues of mental health discrimination and reduce the heavy burden on individuals to enforce the law. This includes making the positive legal duty to eliminate discrimination (and sexual harassment and victimisation) enforceable through reinstating the Commission's powers to initiate own-motion inquiries, lowering the threshold for investigations and strengthening the Commission's enforcement and compulsion tools.

There must be increased compliance with and strengthening of the Mental Health Act and its underpinning human rights principles

There is a pressing need for improved compliance by mental health professionals with the underpinning human rights principles of the *Mental Health Act 2014* (Vic), including the right:[9]

- to receive assessment and treatment in the least restrictive way possible
- to be supported to make or participate in decisions about one's care
- to have one's rights, dignity and autonomy respected and promoted
- for Aboriginal people to have culture and identity recognised and responded to
- for all people to have their unique needs (culture, language, age, disability, religion, gender or sexuality) recognised and responded to.

Funded training is needed to ensure that clinical staff, who have substantial power over the lives of people receiving mental health services, have sufficient knowledge and accreditation to appropriately comply with the Charter and the Mental Health Act

and ensure their human rights principles are appropriately implemented.[10] The Commission also supports calls for the Royal Commission to consider how the Mental Health Act, and related legislation such as the *Mental Health Treatment Planning and Decisions Act 2016* (Vic), can otherwise embed and reflect a human rights framework and focus on prioritising the least restrictive treatment.

The mental health system must be supported to build capability to comply with and advance the cultural rights and needs of Aboriginal people

Aboriginal people are almost three times more likely than non-Aboriginal Australians to experience 'high' or 'very high' levels of psychological distress.[11] Additionally, the suicide rate for Aboriginal people is more than double that of non-Aboriginal Australians.[12] Yet, the Aboriginal community has less access than other communities to mental health services.[13]

There is a vital need for better understanding of, and adherence to, Aboriginal cultural rights under the Charter and Aboriginal people's right to self-determination[14] and culturally safe services. Aboriginal Community Controlled Health Services and other Aboriginal Community Controlled Organisations (**ACCOs**) are a fundamental way in which to deliver culturally safe and relevant services for Aboriginal people experiencing, or at risk of, mental illness. Because of this, it is critical that they are well-funded and supported.

We must also disrupt the pathway for Aboriginal people from mental illness to the criminal justice system. In this regard, the Commission urges the Royal Commission to consider recommending reforms to criminal laws that disproportionately impact people with mental health issues, particularly Aboriginal people – for example, the offence of public drunkenness and the age of criminal responsibility. The Commission supports calls to increase the age of criminal responsibility from 10 to at least 14 years and invest in greater diversion and health and human rights-based supports, in place of punitive criminal justice responses for Aboriginal people.

Gender must be recognised as a social determinant of mental health

Evidence clearly shows that gender shapes differences in the way men, women and transgender and non-binary people experience mental health and the mental health system.[15] This is partly as a result of biological and genetic differences but also, to a significant extent, because of gender inequality and sex discrimination within society.[16] However, despite robust evidence, the mental health system has remained largely 'gender blind', delivering services in a way that can exacerbate poor outcomes,[17] for example by putting women's sexual safety at risk in mixed-gender mental health facilities, or disregarding or misinterpreting the mental health needs of women, transgender and non-binary people due to lack of data and understanding, or an over-reliance on medical research on men.[18]

Accordingly, it is critical to understand gender as a social determinant of mental health and apply an intersectional gender lens[19] to mental health prevention, reform and service delivery. To properly address the gendered differences and needs of people facing mental illness, the Commission recommends better collection and analysis of gender-specific mental health data and more gender-specific mental health research. These would, in turn, inform the design and delivery of gender sensitive mental health policy and services. In addition, we recommend that mental health practitioners and services are trained in, and aligned with, efforts to prevent violence against women and advance gender equality.

OPCAT presents an opportunity to better protect people with mental illness from ill-treatment in a range of settings

People with mental health conditions are exposed to a higher risk of ill-treatment as a result of involuntary treatment, restrictive practices, restraint or confinement within justice, health and mental health settings.[20]

Australia's ratification of the *Optional Protocol to the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* (**OPCAT**)[21] and the establishment of an independent system of monitoring in Victoria, if effectively implemented, will help protect people with mental illness from ill-treatment.

The Commission is concerned to ensure that OPCAT is implemented in Victoria in a way that identifies and addresses the risk of ill-treatment for people with mental illness in a range of settings, consistent with international law and best practice.

Recommendation 1.

The Royal Commission should consider the role of discrimination and stigma as drivers and consequences of mental illness, and how they can be addressed in mental health reform and service design, from primary prevention through to early intervention and response strategies.

Recommendation 2.

The Royal Commission should recommend that the Victorian Government amend the *Charter of Human Rights and Responsibilities Act 2006* (Vic) to incorporate:

a. a stand-alone right to health

b. an alternative dispute resolution function for individuals who consider that their human rights under the Charter have been breached

Recommendation 3.

The Royal Commission should recommend that the Victorian Government amend the *Equal Opportunity Act 2010* (Vic) to reinstate and strengthen the Victorian Equal Opportunity and Human Rights Commission's functions and powers to enforce the Act and address systemic issues of mental health discrimination (and other forms of discrimination, as well as sexual harassment and victimisation), including the functions and powers to:

a. undertake own-motion public inquiries

b. investigate any serious matter that indicates a possible contravention of the Act:

   i) without the need for a reasonable expectation that the matter cannot be resolved by dispute resolution or the Victorian Civil and Administrative Tribunal

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

c. compel attendance, information and documents for the purposes of an investigation or public inquiry without the need for an order from the Victorian Civil and Administrative Tribunal

d. seek enforceable undertakings

e. issue compliance notices as potential outcomes of an investigation or a public inquiry.

Recommendation 4.

1. The Royal Commission should consider how the *Mental Health Act 2014* (Vic) and related policy frameworks could be better aligned, and ensure compliance, with the *Charter of Human Rights and Responsibilities Act 2006* (Vic), the *Convention on the Rights of Persons with Disabilities* and other relevant international human rights instruments.
2. The Victorian Government should provide further funding for human rights education and training for

clinical and other mental health service staff to support increased compliance with the *Equal Opportunity Act 2010* (Vic), the *Charter of Human Rights and Responsibilities Act 2006* (Vic) and the *Mental Health Act 2014* (Vic) in the delivery of mental health services across Victoria.

Recommendation 5.

The Royal Commission should give consideration to:

a. reforming criminal laws that disproportionately impact people with mental illness, including Aboriginal people and children and young people, such as section 344 of the *Children, Youth and Families Act 2005* (Vic) and section 13 of the *Summary Offences Act 1966* (Vic)

b. the high levels of mental illness among the youth justice and prison population, particularly Aboriginal people, and how mental health services can be improved in justice settings

c. how community-based mental health services can be better used to improve health outcomes, particularly through enhancing cultural rights for Aboriginal people.

Recommendation 6.

The Royal Commission should consider making recommendations that require the mental health system and mental health service providers to:

a. comply with the cultural rights set out in section 19(2) of the *Charter of Human Rights and Responsibilities Act 2006* (Vic) and the *Balit Murrup* Aboriginal Social and Emotional Wellbeing Framework

b. enhance Aboriginal cultural competency and understanding of mental health agencies and officials

c. commit to greater self-determination, through adherence with the Victorian Aboriginal Affairs Framework, and ensure greater resourcing and involvement of Aboriginal Community Controlled Health Organisations in order to substantively enhance self-determination in the mental health system.

Recommendation 7.

1. The Royal Commission and the Victorian Government should recognise and address gender as a social determinant of health and apply an intersectional gender lens to all aspects of the mental health system, including by recognising sex discrimination and gender inequality as key drivers of mental illness for women, men and non-binary people and barriers to accessing early and effective treatment and support.

2. The Victorian Government and mental health service providers should:

    a. collect and analyse gender disaggregated data, including on the prevalence of mental illness and the effectiveness of mental health treatment and outcomes

    b. ensure that mental health-related research that they commission or conduct, including into medications and efficacy of treatments, considers gendered differences and needs

    c. design mental health policies and services in light of gendered differences and needs

    d. deliver gender sensitive and/or gender-specific services and in-patient facilities.

Recommendation 8.

The Royal Commission consider how the implementation of the *Optional Protocol to the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* and the *Convention on the Rights of Persons with Disabilities* could be implemented in Victoria to better protect people with mental illness from ill-treatment in a range of settings, through a robust and independent system of monitoring.

2. About the Commission

2.1 Our role and functions

The Commission is an independent statutory body with responsibilities under the following Victorian laws: the Equal Opportunity Act; the Charter; and the *Racial and Religious Tolerance Act 2001*.

Our role is to protect and promote human rights and eliminate discrimination (including on the basis of mental health under the protected attribute of 'disability'), sexual harassment and victimisation, to the greatest extent possible. We do this through a range of functions.

Resolve complaints	We resolve complaints of discrimination (including on the basis of disability – the definition of which comprises mental or psychological diseases and disorders[22]), sexual harassment, racial and religious vilification and victimisation by providing a free confidential dispute resolution service.
Research	We undertake research to understand and find solutions to systemic causes of discrimination and human rights breaches.
Educate	We provide information to help people understand and assert their rights, conduct voluntary reviews of programs and practices to help organisations comply with their human rights obligations and provide education and consultancy services to drive leading practice in equality, diversity and human rights, including a collaborative approach to developing equal opportunity action plans.
Advocate	We raise awareness across the community about the importance of equality and human rights, encouraging meaningful debate, leading public discussion and challenging discriminatory views/behaviours.
Monitor	We monitor the operation of the Charter to track Victoria's progress in protecting fundamental rights.
Enforce	We intervene in court proceedings to bring an expert independent perspective to cases raising equal opportunity, discrimination and human rights issues. We also conduct investigations to identify and eliminate systemic discrimination.

2.2 Our work on mental health

The Commission has considerable expertise and experience related to mental health owing to our functions under the Equal Opportunity Act and the Charter. Some of our recent work in this area is highlighted below.

- In 2019, the Commission will publish an update to the Victorian Discrimination Law Handbook, which canvasses developments in Victorian case law, including regarding mental health discrimination.
- In June 2019, we released *Fair-Minded Cover,*[23] our final report into our statutory investigation into mental health discrimination in the travel insurance industry. The report catalogued systemic discrimination across multiple insurer parties and found over 365,000 policies sold over an 8-month period contained unlawful (discriminatory) terms.[24]

- In the last three years, we answered 386 people's enquiries about mental health-related discrimination through our information service. We also responded to 227 people's complaints of mental health-related discrimination through our dispute resolution service. We also helped countless people experiencing mental illness as a result of other forms of discrimination (for example, on the basis of race, sex, gender identity and disability) or sexual harassment, to resolve their disputes, feel heard and access appropriate referrals and support.
- In 2018, we delivered 157 education sessions on the Equal Opportunity Act that covered disability discrimination and highlighted the harm to individuals, including harm to mental health, of discrimination and other unlawful behaviour under the Act. These sessions reached a total of 2,239 people across the public and private sectors.
- In 2014, we published a research report *Beyond Doubt: The experiences of people with disabilities reporting crime*[25] that documented the experiences of people with disabilities (including mental health) and examined both police practice and the upstream and downstream factors that affect reporting. Since 2014, the Commission has continued to work closely with Victoria Police to ensure the effective implementation of the recommendations stemming from the report.
- In 2013 and 2014, we intervened in *Slattery v Manningham City Council*[26] to provide guidance to the Victorian Civil and Administrative Tribunal (**VCAT**) on the definition and tests for disability-based discrimination under the Equal Opportunity Act, the application of the Charter and the obligation to provide reasonable adjustments for a person with a disability. The Commission has subsequently intervened in a number of cases[27] concerning involuntary mental health treatment, including treatment such as electro-convulsive therapy. The Commission has advocated a human rights-based approach to ensure mental health treatment aligns with the Charter.

A note on the case studies in this submission

Anonymised case studies have been included in this submission. Pseudonyms are used to protect the anonymity of the complainant. Some details of individual matters have been omitted or changed to protect the identity of complainants, where necessary.

3. Discrimination and mental health

Discrimination, bullying and exclusion on the basis of mental illness at work

'Melanie' was diagnosed with a major depressive disorder and received treatment from a psychiatrist. Melanie disclosed her mental health condition to her employer and, since that time, felt discriminated against, and excluded, isolated and bullied at work. For example, her supervisor has shouted at her, knowing this causes her serious anxiety, and referred to her as a 'nobody' and 'useless'.

This section discusses the relationship between mental health and discrimination. We firstly outline the applicable human rights legal framework, including the Equal Opportunity Act, the Charter and the Mental Health Act, insofar as it relates to human rights protections for people with mental illness. We then set out the Commission's enquiry and complaints data with respect to discrimination against people with mental illness. Finally, we explore the role of discrimination (and stigma) as both a driver and consequence of poor mental health.

3.1 The current human rights legal framework

3.1.1 Equal Opportunity Act

The Equal Opportunity Act protects people with mental illness, including people accessing mental health and related services, from discrimination, sexual harassment and victimisation.[28]

Discrimination occurs when a person is treated unfavourably because of an attribute or personal characteristic that is protected under the law.[29] There are 19 attributes protected under the Act, including disability, as well as sex, race, religious belief or activity, age, sexual orientation and gender identity.[30] Mental illness (specifically 'mental or psychological disease or disorder') is defined in the Act as a 'disability'.[31]

Discrimination is unlawful when it occurs in a public area of life covered by the Equal Opportunity Act, for example, in the provision of goods and services, employment, accommodation or education.[32]

Discrimination includes 'direct'[33] and 'indirect'[34] discrimination. Direct discrimination is defined as treating, or proposing to treat, a person unfavourably based on a protected attribute. For example, cutting a person's shifts at work after they disclose their mental illness. Unfavourable treatment can include being denied a service, being singled out for ridicule or otherwise treated unfairly.

Indirect discrimination occurs if a person imposes, or proposes to impose, a requirement, condition or practice that:

- has, or is likely to have, the effect of disadvantaging people with a protected attribute
- is not reasonable.

The protection against indirect discrimination recognises that although a condition may purport to treat everyone the same, it may operate in practice to unfairly disadvantage some people or groups of people.

The Equal Opportunity Act also prohibits 'victimisation'.[35] Victimisation occurs where a person subjects or threatens to subject another person to a detriment (or treats them unfavourably) because they have asserted their rights under equal opportunity

law or supported another person to do so.[36] For example, if a person complains to their sports club that they have been discriminated against because they have a mental illness and they are then subjected to bullying and intimidation by their team mates.

Service providers (for example, mental health services), employers and providers of education or accommodation must make reasonable adjustments for people with a disability to ensure that they can access and derive a benefit from their services.[37]

Service providers also have a positive duty under the Act to identify and take reasonable and proportionate measures to eliminate discrimination and victimisation[38] (as well as sexual harassment[39]), which means they must proactively take steps to monitor, identify and eliminate discrimination that may arise in the course of their business.[40]

However, as outlined in section 4.3 below, the positive duty is not independently enforceable. While the Commission currently uses the positive duty to influence change with amenable duty-holders, legislative reform is needed to strengthen enforcement and enable the Commission to more effectively address and eliminate systemic discrimination against people with mental illness (and other attributes).

3.1.2 The Charter

Providers of mental health services who are public authorities have obligations under the Charter. The Charter provides a robust framework that requires public authorities to act compatibly with human rights and properly consider human rights when making decisions. There are 20 fundamental human rights set out in the Charter.

A number of Charter rights apply to mental health service provision, including:

- the right to equality (section 8)
- the right to life (section 9)
- freedom from torture and cruel, inhuman or degrading treatment (section 10)
- freedom of movement (section 12)
- the right to privacy and reputation (section 13)
- freedom of thought, conscience, religion and belief (section 14)
- freedom of expression (section 15)
- the right to protection of families and children (section 17)
- cultural rights (section 19)
- the right to liberty and security of person (section 21)
- humane treatment when deprived of liberty (section 22)
- the right to a fair hearing (section 24).

The decisions and actions of public authorities that may limit human rights must be reasonable and justified, taking into consideration the factors set out in section 7(2) of the Charter, specifically:

- the nature of the right
- the importance of the purpose of the limitation
- the nature and extent of the limitation
- the relationship between the limitation and its purpose
- any less restrictive means reasonably available to achieve the purpose that the limitation seeks to achieve.

The Charter protects human rights in three key ways.

- Acting as a 'filter' for new legislation – all new laws to be considered by Parliament require a statement of Charter compatibility. This statement scrutinises how the new law compares with rights established in the Charter. If there is an inconsistency between a proposed law and a Charter right, the statement must explain why and how.[41] This includes mental health legislation.
- Placing an obligation on courts and tribunals to interpret all Victorian laws, as far as is possible, in a way that is compatible with human rights.[42]
- Making it unlawful for a public authority to act in a way that is incompatible with a human right or, in making a decision, to fail to give proper consideration to a relevant human right.[43] Public authorities must consider human rights when developing policies, proposing law reform, delivering services and making decisions.

Victorian complaint handling bodies (for example, the Mental Health Complaints Commissioner, the Health Services Commissioner, the Disability Services Commissioner, the Victorian Ombudsman and the Office of the Public Advocate) must consider the human rights issues in the complaints they are responsible for resolving.

While there is no direct cause of action arising from a breach of the Charter, the Charter does allow a person to raise a human rights argument along with existing remedies or legal proceedings.[44] The Commission[45] and the Attorney-General[46] can also intervene in legal proceedings where a question of law arises about the application of the Charter or the interpretation of another law in light of the Charter. A complaint can also be brought to the Victorian Ombudsman, who can investigate certain public authorities.

The Charter can serve to protect the rights of people with mental illness. For example, as outlined in the case study below, the Supreme Court of Victoria recently found that mental health patients have unlawfully been provided involuntary mental health treatment, such as electroconvulsive treatment.

Using the Charter to counter unlawful provision of mental health treatment

In the recent case of *PBU & NJE v Mental Health Tribunal*[47] two plaintiffs appealed against a VCAT order to impose compulsory electroconvulsive treatment on them. The Supreme Court noted that the litigation raised important legal issues about the interpretation of human rights, and the application of the capacity test and treatment assessment provisions of the Mental Health Act.

The Court found VCAT had erred by determining that the plaintiffs lacked the capacity to give informed consent and applied that Act incompatibly with the rights under the Charter as a consequence. The Court stated that the fundamental purpose of the right to equality before the law is to protect people's inherent and universal dignity. It noted that this right is particularly important for persons with a mental illness because they are especially vulnerable to interferences with their human rights, discriminatory ill-treatment, stigmatisation and personal disempowerment.[48]

The Commission uses its education function to embed a culture of human rights[49] in institutions by equipping people across government to consider how best to promote and protect human rights when making decisions and delivering services, policies and programs. The following case study illustrates how the Charter has been used to embed a culture of human rights within health settings.

Using the Charter to embed a culture of human rights in health policy, strategy and service design[50]

In 2017, the Prevention, Population Health and Place Branch in the Department of Health and Human Services (DHHS)[51] undertook a project to deepen a 'human rights in health' approach to its work. This work was prompted by a 2017 People Matters Survey that indicated low understanding of the Charter and associated obligations within the branch.

As part of the project, the branch partnered with the Commission to co-design a tailored 'human rights in health' education program. The aim of the program was to equip staff with the knowledge and skills to consider human rights and support ethical decision-making, particularly in its work with vulnerable communities across a diverse range of settings. The education sessions:

- introduced human rights principles applicable in the health sector to build human rights culture - human rights principles included participation, equality, accountability and empowerment of people accessing health services
- included practical and scenario-based content to allow staff to practice applying the Charter to realistic situations
- covered how to use the Charter and principles of a rights-based approach when formulating policies in the preventative health and wellbeing sector.

In addition, the DHHS undertook a series of other actions to embed human rights within the ongoing business of the branch. This included:

- achieving internal and external commitment to building a human rights culture
- incorporating human rights obligations into policies and procedures
- designing tailored decision-making tools and resources
- continuing to build the human rights knowledge and skills of management and staff
- seeking external research and guidance to develop an evidence base on how best to uphold human rights in the specific organisational context
- making a commitment to set minimum expectations for staff to uphold human rights.

This project highlighted that the Charter is a progressive and dynamic framework to make human rights part of the everyday business of health policy development and service design. The DHHS reflected that the Charter 'keeps the work we do focused on the people we serve'.[52]

Notwithstanding the Charter's capacity to promote and uphold human rights, it does not presently contain a right to health nor an alternative dispute resolution framework. Sections 4.1 and 4.2 below set out the Commission's recommendation for inclusion of a right to health and alternative dispute resolution process, to better protect and promote the rights of people with mental health (and other health) needs and conditions.

3.1.3 The Mental Health Act

Mental health service providers must also comply with the Mental Health Act - the key legislation governing mental health treatment in Victoria.[53] Mental health service providers and any person performing any duty or function or exercising any power under the Act must have regard to the mental health principles set out in the Act, in

the provision of services.[54] The Act contains 12 principles,[55] including a number that are designed to promote human rights, with a focus on voluntary treatment and self-determination in the receipt of mental health care:

- Principle a - Those receiving mental health services should be provided assessment and treatment in the least restrictive way possible.
- Principle c - People receiving mental health services should be involved in all decisions about their assessment, treatment and recovery and be supported to make or participate in decisions, and their views and preferences respected.
- Principle e – People receiving mental health services should have their rights, dignity and autonomy respected and promoted.
- Principles g and h - Aboriginal people receiving mental health services should have their distinct culture and identity recognised and responded to and people's other unique needs should be respected (eg needs relating to culture, language, age, disability, religion, gender or sexual orientation).[56]

Concerns have been raised, as outlined further in section 4.4 below, that mental health service providers do not always operate consistently with the Act in practice, nor do they always discharge their obligations under the Act compatibly with the Charter. This means that human rights can be overlooked when people are receiving mental health services.[57]

3.2 The Commission's enquiry and complaints data

3.2.1 Prevalence of mental health discrimination

Disability discrimination comprises the largest number of enquiries and complaints that the Commission receives each year. Mental health discrimination makes up a notable proportion of these. In 2017-18, 7 per cent of disability enquiries and 9.6 per cent of disability complaints related to mental health.

In 2017–18, 43 people made complaints to the Commission about discrimination based on their mental illness.[58] This represented 4.7 per cent of the total number (908) of complainants lodging discrimination complaints with the Commission that year.[59] Given that one in five Australians experienced a mental or behavioural condition in 2017-18,[60] there is likely significant under-reporting of discrimination against people with mental illness for a range of reasons.

Mental health discrimination is included under the legal definition of 'disability' under the Equal Opportunity Act. [61] Defining mental illness as a 'disability' allows the Equal Opportunity Act[62] to provide protection against discrimination on the basis of mental illness. However, the Commission is concerned that capturing mental illness within this definition may act as a barrier for individuals who wish to complain about mental health discrimination, as they may not consider mental illness to be a 'disability' or, otherwise, be reluctant to adopt this definition because of a perceived stigma that some community members may associate with disability. This may explain, at least in part, why the number of complaints received by the Commission are significantly lower for mental illness than other forms of disability. The Royal Commission may like to consider whether elevating mental illness to a stand-alone 'protected attribute' under the Equal Opportunity Act would increase access and protections for people with mental illness and better reflect the non-stigmatising and supportive community attitudes required to appropriately support people with mental illness.

3.2.2 The nature of mental health discrimination

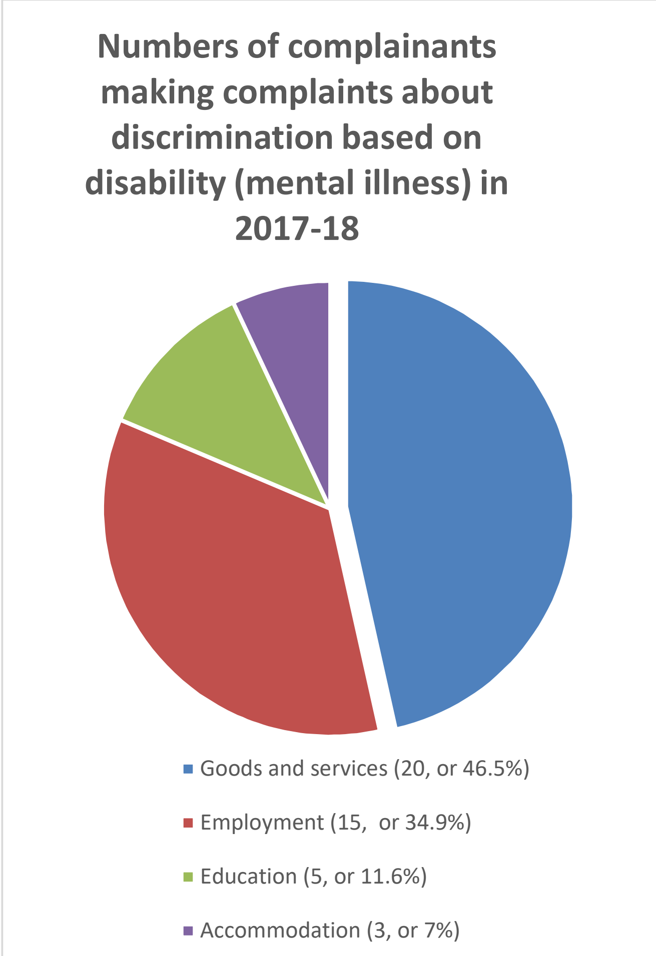
Our data shows that complainants who've experienced mental health discrimination commonly face discrimination based on at least one other personal attribute, such as sex, race, religion or disability. In 2017-18, 10 out of 43 (23 per cent) complainants alleging mental health discrimination also raised discrimination on the basis of one or more other personal attributes.

While research indicates that there are gendered differences in experiences of mental illness[63] (see section 5.2), the Commission typically receives roughly equal complaints from men and women about mental health discrimination. Further research would be needed to understand whether this accurately reflects the prevalence of discrimination between genders or may instead be due to other factors, such as confidence and access to information about making a compliant.

People complaining about mental health discrimination also report significant rates of victimisation. Victimisation occurs where a person is punished or treated unfavourably because he or she has made a complaint or supported another person to make a complaint.[64]

3.2.3 Where mental health discrimination occurs

The following table indicates that mental health discrimination is most commonly reported to the Commission in the provision of goods and services, and in employment.



In 2017-18, just under half (46.5 per cent) of all mental health discrimination complaints related to the provision of goods and services. For example, in one instance an individual was refused entry and denied service at a hairdressing salon because they were supported by an assistance dog to alleviate their mental illness. In the previous two financial years, around one quarter of mental health discrimination complaints arose in relation to the provision of goods and services and employment was the leading category.

Discrimination due to a failure to make reasonable adjustments at work

'Emma' held a management position in retail and believed her employer had not made reasonable adjustments to support her mental health. Emma struggled with an adjustment disorder after a workplace injury at her worksite. She requested a change of location, as her mental illness prevented her from returning to the same worksite where the injury occurred.

A new employee was hired into Emma's management position. Emma was happy to step down into a lower position if a manager position was not available at another work location. However, the employer advised Emma that there was no position for her at any other work location and as a result Emma resigned from her employment.

The Commission also receives reports of mental health discrimination in other aspects of our work, including through our education and engagement activities, research, reviews and investigations.

Investigation into mental health discrimination in travel insurance

In 2017, the Commission launched an investigation under the Equal Opportunity Act into potentially unlawful discrimination against people with a mental health condition in the travel insurance industry, in response to reports of unlawful discrimination against people with mental health conditions. The final report from the investigation, *Fair-Minded Cover*, was released in June 2019.[65]

The investigation was sparked by a case heard at VCAT, *Ingram v QBE Insurance (Australia) Ltd*.[66] The matter 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. Ms Ingram cancelled the trip on medical advice when she experienced an episode of depression, the only incident she had ever had. QBE denied indemnity, based on a general exclusion in the policy for any claim caused by mental illness. VCAT found that the policy and denial of indemnity amounted to unlawful discrimination.

Despite this decision, travel insurers, including QBE, continued to routinely provide policies with blanket mental health exclusions. In response to Ms Ingram's story and longstanding concerns raised by consumer advocacy groups, the Commission commenced an investigation into discriminatory policies and practices of travel insurers.

The investigation found that three major travel insurers, which made up over a third of the Australian travel insurance industry, had discriminated against people with a mental health condition by including blanket mental health exclusions in travel insurance policies and failing to indemnify people, irrespective of a condition's severity or duration. Over an eight-month period, the insurers had sold 365,000 contracts of insurance containing unlawful mental health exclusions. With one in five Australians experiencing a mental or behavioural condition in 2017–18,[67] the ripple effect of discrimination in the travel insurance industry had the potential to be far

reaching. For example, routinely failing to provide cover or indemnity for people with a mental health condition perpetuates the stigma surrounding mental health and can lead to people choosing not to seek treatment and support.

Despite these findings, the investigation revealed an industry ready to change. As a result of the Commission's investigation:

- the three insurers have already removed, or taken immediate steps to remove, blanket mental health exclusions from their travel insurance policies and agreed to take steps to address the Commission's recommendations
- the Insurance Council of Australia and the Actuaries Institute have acknowledged their role in supporting compliance with anti-discrimination law, agreeing to progress the Commission's recommendations and supporting better industry education.

For further information on the investigation please, see the full report.[68]

3.3 Discrimination and stigma as key drivers of poor mental health

Through our work, the Commission understands that discrimination has both a causal and consequential relationship with mental illness. People with mental health conditions often experience discrimination and stigma across all aspects of public life, for example in accessing goods and services, employment, accommodation or education (see section 3.2 above detailing the Commission's complaints data). It is well established that these experiences can have a compounding negative impact on mental health.[69] They can cause profound shame and alienation, deter people from seeking or maintaining treatment, jeopardise recovery and compound the severity or duration of their condition.[70]

In addition, all forms of discrimination (for example on the basis of race, sex or disability) can have profound mental health impacts, causing mental illness such as post-traumatic stress disorder, depression or anxiety, or compounding other existing mental illnesses.

Certain groups – including those already marginalised in society - are more likely than others to experience mental illness (or certain forms of mental illness), including young people,[71] lesbian, gay, bisexual, transgender, intersex and queer (**LGBTIQ**) people,[72] Aboriginal people[73] and women.[74] These groups are also vulnerable to intersectional discrimination. Intersectional discrimination occurs where an individual experiences interlocking forms of discrimination on the basis of multiple, personal attributes, such as disability and race, which interact with and compound one another.[75]

Accordingly, the Commission sees discrimination as a central issue to be examined by the Royal Commission.

3.3.1 Mental health stigma compounds discrimination

People with mental illness often face significant discrimination, stigma and high levels of physical and verbal abuse.[76] The stigma associated with having mental illness can lead to a misconception that mental illness is caused by a weakness of character, rather than an illness, or that people with mental illness are dangerous.[77] 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 mental illness may not get the help they need or adhere to treatment, jeopardising their recovery and future outcomes. Stigma leads to discrimination and marginalisation,[78] which can, in turn, affect peoples' economic, social and housing security, as well as their general health and wellbeing. As the case study below demonstrates, a lack of understanding of, and discriminatory attitudes towards, people with mental illness can affect a person's ability to access vital medical and mental health services.

Mental health discrimination deterring vulnerable people from accessing health services

'Jared' suffers from social anxiety and is autistic. He received counselling regularly at a local hospital. Jared visited the same hospital seeking treatment for a physical injury and was required to wait for an extended time in the waiting room with many other people seeking medical help. This put Jared in a situation that was potentially distressing due to his mental health issues and disability.

Jared was eventually directed to a cubicle and continued to wait to see a doctor. A person came into the cubicle and made a noise then left, which triggered his anxiety. Jared went outside the hospital to self-soothe but a security guard told him to leave the hospital and raised his voice, leaving Jared feeling degraded.

Jared took a photo of the security guard because of the way the security guard had treated him. The security guard then threatened Jared, causing Jared to leave the hospital.

Shortly afterwards, the hospital contacted Jared to cancel his counselling service, which Jared believed was due to the incident with the security guard. Jared felt he was treated unfairly because of his mental illness.

Following dispute resolution at the Commission, the hospital agreed to review the incident and provide the security guard with training in relation to his obligations to patients in the course of his work. The hospital also agreed to write to Jared welcoming him back to the hospital if he needed care.

People with mental illness also experience higher rates of poor physical health compared to others in the general community,[79] with increased rates of morbidity and mortality and lower life expectancy.[80] For example, one NSW study found people with mental illness were less likely to be screened for physical health conditions and lifestyle risk factors than other community members.[81] People have reported discriminatory attitudes when accessing medical treatment and mental health services, receiving poorer physical healthcare and experiencing higher rates of discrimination in institutional settings.[82]

It is vital that the Royal Commission contemplates how primary prevention initiatives can address discrimination and stigma as both significant drivers of mental illness and outcomes of attitudes and approaches to poor mental health. This could include:

- ensuring actions to address discrimination and stigma are appropriately incorporated and resourced within state-wide mental health promotion and primary prevention frameworks and strategies
- ensuring mental health prevention strategies are aligned with other strategies directed towards preventing discrimination such as strategies intended to increase gender equality or reduce racism

- providing more education to service providers, including health professionals, about how people with various mental health conditions may present, what their rights are and how to best accommodate their needs
- consulting with and co-designing responses with experts in mental health and primary prevention, and people with lived experience.

3.3.2 Inequality and people who face higher risks of mental illness

As noted above, people with certain attributes are more likely than others in the broader community to experience mental illness.

For example, LGBTIQ people experience higher rates of depression and anxiety than others. Discrimination (driven by homophobia and transphobia, for example) is reported to be a key contributing factor to high levels of depression and anxiety disorders affecting LGBTIQ people.[83] An Australian survey of LGBTIQ people reported that 39.5 per cent of survey respondents experienced harassment and abuse and 66 per cent of people with intersex variations faced discrimination from strangers.[84] Sixty-one per cent of same-sex attracted and gender diverse young people experienced verbal abuse, and 18 per cent suffered physical abuse as a result of their sexuality or gender identity.[85] This cohort also experiences disproportionately high rates of sexual harassment, with 92 per cent of LGBTIQ women and 77 per cent of LGBTIQ men reporting experiencing sexual harassment over their lifetime.[86] This evidence highlights the way in which vulnerable groups, such as LGBTIQ people, are subjected to discrimination and the poor mental health outcomes that result as a consequence.

Racial discrimination is a key driver of driver of poor mental health for people from culturally and linguistically diverse backgrounds. Studies of racism in public places clearly show that the cumulative impact of discrimination can have a significant negative impact on mental health and cause substantial social isolation and other individual and social harms. For example:

- VicHealth has observed that racial discrimination is associated with poorer health outcomes, particularly poor mental health and reduced quality of life, for both Aboriginal people as well as people from multicultural backgrounds[87]
- the Australian Human Rights Commission has found that racial discrimination makes victims feel like second class citizens, insecure, angry and less connected to Australia.[88]
- Internalisation of negative thoughts and stereotypes, in this way, can affect self-esteem and mental health for racial minorities.[89]

The Commission is aware of the impact of discrimination on people's existing mental health conditions and has received complaints on the basis of both racial and mental health discrimination, in which complainants describe the cumulative impact of the discrimination on their mental health, as illustrated in the case study below.

Racial and mental health discrimination at work

'Ali' suffered from depression and chronic PTSD due to trauma acquired while in immigration detention. Ali's employer was aware of his mental illnesses.

Ali stated that work colleagues taunted him about his mental illnesses, refugee status and time in immigration detention. They called him 'psycho', 'paedophile' and said people of his nationality 'are shit' and 'dirty'.

Ali made a complaint to his employer requesting to be transferred to another work site. His employer stated that the behaviour of his work colleagues would stop and

that Ali would not be relocated. The behaviour did not cease and instead escalated to include physical harm.

Ali believed he was discriminated against due to his mental illness and racial background. The discrimination exacerbated his mental illnesses.

The Commission urges the Royal Commission to carefully consider the role of discrimination and stigma (including intersectional discrimination) as both a driver and consequence of inappropriate responses to poor mental health. Addressing discrimination and stigma must be a critical component of any preventative approach to mental health and inform all aspects of mental health service design and reform. Mental health service planning and delivery should include strategies to address and prevent discrimination as a key element of the primary prevention of mental illness and an important enabler of early recovery. We suggest the thematic focus on stigma in the Royal Commission's upcoming public hearing include consideration of the way in which intersectional discrimination relates to, and impacts upon, mental health outcomes.

Recommendation 1.

The Royal Commission should consider the role of discrimination and stigma as drivers and consequences of mental illness, and how they can be addressed in mental health reform and service design, from primary prevention through to early intervention and response strategies.

4. Strengthening the human rights legal framework

This section outlines how to address a number of key gaps in the current legal framework to better protect and promote the human rights of people with mental illness in Victoria. Specifically, we outline the need for a right to health and an alternative dispute resolution function within the Charter, strengthen enforcement of the Equal Opportunity Act, and to increase compliance with the underlying human rights principles within the Mental Health Act.

4.1 Including the right to health in the Charter

As set out in section 3.1.2, the Charter predominantly protects civil and political rights, drawn from the International Covenant on Civil and Political Rights.[90] The core economic and social rights – including the right to health – are absent from the Charter, leaving people facing mental health issues without this critical avenue for recourse and protection.

Article 12 of the International Covenant on Economic, Social and Cultural Rights requires State Parties to "recognise the right of everyone to the enjoyment of the highest attainable standard of physical and mental health".[91]

The right to health at international law

The United Nations Committee on Social, Economic and Cultural Rights (the Committee) advises that the right to health includes both freedoms (sexual and reproductive freedom, freedom from interference, torture and non-consensual medical treatment) and entitlements[92] and "must be understood as a right to the [equal] enjoyment of a variety of facilities, goods, services and conditions necessary for the realisation of the highest attainable standard of health".[93]

The right is more than a right to timely and appropriate healthcare and, instead, "embraces a wide range of socio-economic factors that promote conditions in which people can lead a healthy life".[94] It is directly related to, and indeed dependent on, the realisation of other rights including the rights to non-discrimination and equality.[95]

Specifically, the right to health comprises four key elements.

- *Availability* – health facilities, goods and services, and programmes, must be available in sufficient quantity.
- *Accessibility* - health facilities, goods and services must be accessible to everyone without discrimination. This includes being physically accessible, affordable, non-discriminatory and accessible to the most marginalised or vulnerable groups in society. It also requires accessible health information.
- *Acceptability* – health facilities and goods and services must comply with medical ethics, be culturally appropriate, sensitive to gender and life-cycle requirements, respect confidentiality and, ultimately, improve the health status of those concerned.
- *Quality* – health facilities, goods and services must be scientifically and medically appropriate and of good quality. This necessitates having skilled medical personnel, approved drugs and equipment, and adequate sanitation. [96]

In line with strong community support and various Australian reviews,[97] the Commission has been calling for the inclusion in the Charter of a right to health since 2011.[98]

For Victorians, having a stand-alone right to health in the Charter would mean that any new legislation introduced into Parliament that had the potential to impede the human rights of people with mental health conditions would need to be scrutinised against the right to health (see section 3.1.2). It could support the human rights of people with mental illness, contributing to greater adherence to human rights in decision-making about compulsory treatment and access to humane and dignified conditions in voluntary and involuntary treatment and facilities.[99] It could also strengthen protections against discrimination within health provision.[100] In addition, it has great potential to influence service design and prevention, early intervention and community-based strategies – particularly with respect to the kind of long-term commitment and investment required to effectively address and prevent mental health issues.[101]

The eight-year review of the Charter, undertaken in 2015, recommended that the inclusion of the right to health and other economic, social and cultural rights be considered as part of a future review,[102] noting that many community members contributing to the review highlighted the absence of these rights as a particular concern.[103]

Relevantly, Queensland's newly enacted *Human Rights Act 2019* (Qld)[104] provides for the "right to access health services without discrimination"[105] and the right to necessary medical treatment. The right to health is also protected in human rights legislation in other countries,[106] including within Europe,[107] Africa[108] and Central America.[109] Indeed, 67.5 per cent of countries include "a provision addressing health or health care" within their national constitutions.[110]

International examples of the right to health in practice

South Africa

South Africa's Constitution includes a right to healthcare as follows:[111]

> (1) Everyone has the right to have access to:
>
> (a) health care services, including reproductive health care;
>
> …
>
> (2) The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realization of these rights.
>
> (3) No-one may be refused emergency medical treatment.

This provision is enforceable against both the State and private individuals. It requires progressive, rather than immediate, realisation, meaning South Africa must continually work towards fulfilling the right over time, taking into account its available resources. Importantly, it permits courts to inquire into whether the State has appropriately marshalled and deployed appropriate resources to address the right.[112]

While South Africa's fulfillment of this right is constrained by the challenges of socio-economic disparity, poverty and high rates of disease and trauma,[113] the inclusion of this right has been seen as an important vehicle to "redress the past" and break with a health care system which was "saturated with unfathomable disparities" and "used as one of the many political structures to shore up white

supremacy."[114] The right has also been employed by people in need, for example in the case of a man denied access to life-saving dialysis for budget reasons.[115]

Europe

The European Social Charter also contains a range of rights relevant to the health and welfare of people with mental illness, as follows:

> (11) Everyone has the right to benefit from any measures enabling him [sic] to enjoy the highest possible standard of health attainable.
>
> …
>
> (13) Anyone without adequate resources has the right to social and medical assistance.
>
> (14) Everyone has the right to benefit from social welfare services.
>
> (15) Disabled persons have the right to independence, social integration and participation in the life of the community.

Signatories are required to regularly report to the European Committee on Social Rights on their compliance with the rights contained within the European Social Charter, including the right to health and related rights outlined above. This provides a critical point for ongoing transparency, political motivation and advocacy for reform to better protect and promote the right to health throughout Europe. In addition, under the European Social Charter collective complaints can be lodged with the Committee to address violations of the right to health and promote countries' progress towards compliance.

In 2014, a successful collective complaint was brought concerning the forced sterilisation of transgender people in the Czech Republic,[116] which confirmed that "[r]espect for physical and psychological integrity is an integral part of the rights to the protection of health guaranteed by Article 11".[117] In this case, the Czech Republic had imposed a legal requirement that transgender persons must undergo medical sterilisation in order to have their gender identity recognised. The case became the first transgender discrimination case decided under the collective complaints procedure and emphasised that "[g]uaranteeing free consent is fundamental to the enjoyment of the right to health, and is integral to autonomy and human dignity and the obligation to protect the right to health."[118]

Articles 11 and 13 have also enabled successful collective complaints concerning the denial of health and other protections to unaccompanied minors seeking asylum.[119] In that case, the Committee found that the obligations under the right to health extend to foreign minors and to find otherwise would expose "the children and young persons concerned to serious threats to their lives and physical integrity".[120] The Committee further found that "health care is a prerequisite for the preservation of human dignity and that human dignity is the fundamental value and indeed the core of positive European human rights law."[121]

In addition, the European Committee has found that "a health care system which does not provide for the specific health needs of women will not be in conformity with Article 11…"[122]

The Commission encourages the Royal Commission to recommend that the Victorian Government amend the Charter to incorporate the right to the health, noting that the right could be drafted in such a way as to require courts to take a "progressive realisation" approach[123] when making decisions in relation to this human right. According to the UN Committee on Economic, Social and Cultural Rights, "[p]rogressive realization means that States parties have a specific and continuing

obligation to move as expeditiously and effectively as possible towards the full realization of article 12."[124] Notably, this approach takes into account the biological and socio-economic preconditions of the individual seeking to enforce the right, as well as the State's available resources.[125]

4.2 Incorporating a dispute resolution function in the Charter

The Charter does not include an alternative dispute resolution framework to manage individual complaints. Currently, there is no single body that can receive complaints about allegations of a human rights breach against all public authorities as defined in the Charter.

Instead, there is a 'patchwork' of options for dealing with alleged human rights breaches that rely on either internal complaints mechanisms of public authorities, the Victorian Ombudsman[126] or the Independent Broad-based Anti-Corruption Commission.[127]

Unlike the Equal Opportunity Act, which allows the Commission to take and manage complaints about discrimination, the Commission cannot take complaints under the Charter. Instead, the Commission can provide individuals with contact details of other relevant bodies to make a complaint but cannot make direct referrals due to its secrecy obligation.[128] The Commission has intervened in a number of cases where a dispute resolution function would otherwise have provided an avenue by which to resolve the issue in the first instance.

Additionally, section 39 of the Charter[129] (the remedies provision) does not allow a person to bring an independent action against a public authority for a breach of the Charter. Instead, a person can only raise the Charter by attaching the action to an existing proceeding against a public authority under a separate claim.

The absence of these mechanisms restricts the ability of vulnerable individuals, such as those in contact with the mental health system, to effectively exercise their human rights under the Charter, including existing human rights.[130]

In order to address this, at the very least, the Charter should be reformed to empower the Commission to take and manage human rights complaints. This is consistent with arrangements in other jurisdictions such as Queensland.[131] In addition, the Royal Commission may like to consider the value of reforming the Charter to insert a provision enabling judicial review on the ground of Charter unlawfulness alone and provide a direct cause of action.

This will ensure that the Charter achieves its purpose to protect and promote human rights by enhancing accessibility for those in the mental health system and creating certainty as to the legal consequences of a breach of the Charter.

Recommendation 2.

The Royal Commission should recommend that the Victorian Government amend the *Charter of Human Rights and Responsibilities Act 2006* (Vic) to incorporate:

a. a stand-alone right to health
b. an alternative dispute resolution function for individuals who consider that their human rights under the Charter have been breached.

4.3 Strengthening the enforcement of the Equal Opportunity Act

As set out in section 3.1.1 above, Victoria is unique in that its anti-discrimination legislation requires duty-bearers to take preventative action to eliminate discrimination and victimisation on the basis of mental health, alongside other protected attributes. However, this positive legal duty is not independently enforceable.

While the Commission already uses the positive duty to affect broad cultural reform, the lack of enforceability mechanisms constrains our ability to achieve greater systemic change. It is therefore critical that we have broad and flexible powers to investigate and inquire into breaches of the duty.

Effective consequences for non-compliance with the duty are also key when education and encouragement fail to bring change. In this way, the positive legal duty could – if accompanied by stronger powers and appropriate compulsion and enforcement tools – deliver systemic change and help alleviate the burden on individuals who currently bear the burden of making a complaint to enforce the law – often at great personal cost or difficulty.

Reducing the onus on individuals to enforce the law is important in a mental health context, since people with mental health issues are likely to find bringing a complaint stressful and the process may exacerbate their existing condition. Reducing the heavy burden on individuals to bring complaints in order to enforce their rights at law was an important catalyst for the Commission's decision to investigate mental health discrimination in the travel insurance industry. Despite VCAT's finding in the case of *Ingram v QBE*[132] that QBE unlawfully discriminated against Ella Ingram on the basis of a mental health condition, the longstanding efforts of consumer advocates and the existing guidance to insurers on complying with the law, the Commission identified that the practice of travel insurers offering policies with blanket mental health exclusions remained widespread. The Commission's final investigation report 'Fair-minded Cover' (discussed above in section 3.2) was undertaken with the Commission's existing powers, but it was only possible because the insurance companies chose to cooperate with the investigation. Had they declined our invitation to participate in the investigation or sought to undermine our findings by withholding information, the Commission would have been unable to undertake this investigation, leaving systemic discrimination against people with mental illness to continue unchecked.

With additional powers and functions, the Commission could take action against duty holders by undertaking an own-motion public inquiry and compelling compliance with the Equal Opportunity Act, without the need for individual complaints or litigation or the cooperation and willing engagement of the organisations under investigation.

In 2008, a review of the Equal Opportunity Act made a number of recommendations to shift the reliance on complainants to enforce the law to enable the Commission to proactively address systemic issues and resolve the underlying causes of discrimination (and sexual harassment and victimisation).[133] These included inserting a number of enforcement and compulsion powers to accompany a positive duty, as well as the ability to conduct own motion investigations into serious matters that concern a possible contravention, and own motion public inquiries into serious matters of public interest that are not appropriate to be dealt with by an individual complaint.[134]

These recommendations were partially implemented in 2010.[135] However, the Act was amended again in 2011 (before commencement of the 2010 changes) to remove or significantly limit these powers, leaving the positive duty unenforceable.[136]

Accordingly, the Commission urges the Royal Commission to recommend that the Victorian Government amend the Equal Opportunity Act to reinstate the Commission's former powers and enable greater capacity to address and eliminate systemic discrimination against people with mental illness. These changes would bring the Equal Opportunity Act in line with international best practice.[137]

Recommendation 3.

The Royal Commission should recommend that the Victorian Government amend the *Equal Opportunity Act 2010* (Vic) to reinstate and strengthen the Victorian Equal Opportunity and Human Rights Commission's functions and powers to enforce the Act and address systemic issues of mental health discrimination (and other forms of discrimination, as well as sexual harassment and victimisation), including the functions and powers to:

a. undertake own-motion public inquiries
b. investigate any serious matter that indicates a possible contravention of the Act:
    i) without the need for a reasonable expectation that the matter cannot be resolved by dispute resolution or the Victorian Civil and Administrative Tribunal
    ii) with the introduction of a 'reasonable expectation' that the matter relates to a class or group of persons
c. compel attendance, information and documents for the purposes of an investigation or public inquiry without the need for an order from the Victorian Civil and Administrative Tribunal
d. seek enforceable undertakings
e. issue compliance notices as potential outcomes of an investigation or a public inquiry.

4.4 A human rights-based approach to the Mental Health Act

Public authorities must give proper consideration to, and act compatibly with, the human rights of people experiencing mental illness, including by complying with their relevant Charter obligations and the Mental Health Act. Nevertheless, concerns have been raised that mental health service providers do not always operate consistently with the Act and Charter in practice.[138] This means that human rights can be overlooked when people are receiving mental health services.[139]

There is therefore a need to strengthen the Act to better mirror the relevant provisions and objectives of the Charter and the CRPD and, in so doing, support a cultural and practice shift towards a "least aversive treatment" model that better protects and promotes the human rights of people experiencing mental illness.[140]

The decision of *PBU & NJE v Mental Health Tribunal* (see section 3.1.2) underlines the need for greater knowledge of, and adherence to, the Charter among decision-makers – essential to the proper administration of the Mental Health Act. In that decision, Justice Bell of the Supreme Court emphasised that people with mental illness are highly vulnerable to interference with the exercise of their human rights, especially the right to self-determination, to be free from discrimination and personal inviolability- central to the right to privacy.[141] The judgment highlights the need for clarity for mental health service providers around the relationship between the Charter, the Mental Health Act and its associated principles, and the CRPD.

In this regard, the Royal Commission can play a critical role in reiterating the importance of interpreting the Mental Health Act consistently with the human rights set out in the Charter and ensuring the fundamental rights of people with mental health issues.

In addition, funded training is needed to ensure that clinical and other mental health service staff, along with Mental Health Tribunal members, have knowledge and accreditation to ensure that human rights principles in the Mental Health Act are widely implemented,[142] and done so compatibly with the Charter.

The Mental Health Act is currently being reviewed as part of its five-year review. A number of advocacy groups with mental health practice, policy or case expertise (for example, the Victorian Mental Illness Awareness Council, Law Institute of Victoria and Victoria Legal Aid) have called for the Royal Commission to review the Mental Health Act, including by investigating:

- whether mental health service providers and authorities are complying with the Mental Health Act and Charter [143]
- the compatibility of the Mental Health Act with the Charter, the CRPD and the *Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* (**CAT**), and the need for a new mental health framework that integrates the CRPD by promoting the principles of equal and full participation in society, non-discrimination, inherent dignity, individual autonomy and freedom to make one's own choices[144]
- legislative reform in areas of compulsory treatment and involuntary detention under the Mental Health Act, with specific consideration given to the least restrictive treatment available as required by the Mental Health Act[145]
- reinstatement of previous processes under the Mental Health Act and introduction of new provisions to increase accountability within the mental health system and strengthen enforcement of the rights of people with mental illness[146]
- the coordination of the Mental Health Act and mental health service system with other key service systems, particularly health and housing[147]
- how the Mental Health Act and Charter interact with the delivery of the National Disability Insurance Scheme (**NDIS**) and the NDIS Quality and Safeguarding Framework in Victoria, including how the human rights of people with mental illness will be protected in relation to mental health and related services such as housing.

The Commission shares these concerns. In particular, we support calls for the Royal Commission to consider how the Mental Health Act, and related legislation such as the *Mental Health Treatment Planning and Decisions Act 2016* (Vic) can better embed and reflect a human rights framework and focus on prioritising the least restrictive treatment. We also see a vital need for further funding of human rights education and training for mental health service providers, allied professionals and

Mental Health Tribunal members to increase understanding of and adherence to the Charter and the underlying human rights principles within the Mental Health Act. Such training should also refer to the CRPD and other relevant international human rights instruments to ensure mental health professionals have a thorough understanding of applying and respecting human rights in the provision of mental health care. We note that the LIV has also recommended specialised mental health training be provided to Victoria Police officers to ensure appropriate and respectful interactions between police and people with mental illness.[148]

Recommendation 4.

1. The Royal Commission should consider how the *Mental Health Act 2014* (Vic) and related policy frameworks could be better aligned, and ensure compliance, with the *Charter of Human Rights and Responsibilities Act 2006* (Vic), the *Convention on the Rights of Persons with Disabilities* and other relevant international human rights instruments.
2. The Victorian Government should provide further funding for human rights education and training for clinical and other mental health service staff to support increased compliance with the *Equal Opportunity Act 2010* (Vic), the *Charter of Human Rights and Responsibilities Act 2006* (Vic) and the *Mental Health Act 2014* (Vic) in the delivery of mental health services across Victoria.

5. Enhancing human rights protections for particular groups

This section considers particular groups who are at heightened risk of mental illness and/or mental health-related discrimination. We propose a number of recommendations to enhance human rights protections for particular groups within the mental system, including Aboriginal people, women, transgender and non-binary people, and people with mental illness who are deprived of their liberty.

5.1 Aboriginal people and mental health

The Commission is concerned by the high levels of mental illness within the Aboriginal community and the correlation that this has for Aboriginal overrepresentation in the justice system. This represents a systemic failure of the mental health system to prevent and address the mental health concerns of the Victorian Aboriginal community. Critically, this includes the failure to ensure the cultural rights of Aboriginal people and the right to Aboriginal self-determination in the mental health system. This section outlines how a human rights approach to addressing Aboriginal mental health can deliver more positive outcomes for Aboriginal people within Victoria's mental health system. In doing so, the Commission urges the Royal Commission and Victorian Government to recognise that Aboriginal people, communities and organisations are best placed to advance Aboriginal mental health, and access to culture and culturally appropriate care is fundamental to healing and treatment.

5.1.1 The mental health of Aboriginal people

Nationally, 30 per cent of the Aboriginal community aged 18 years and over have 'high' or 'very high' levels of psychological distress.[149] This rate is almost three times that of the non-Aboriginal population.[150] The rate of suicide within the Aboriginal community is also more than double that of non-Aboriginal Australians.[151] Despite this, the Aboriginal community experiences less access to mental health services due to economic, social and cultural barriers.[152]

This data indicates a disparity across a number of mental health outcomes and highlights the significant mental health gap that exists between the Aboriginal and non-Aboriginal population.

Within Aboriginal communities, a broad understanding of "health" exists that is fundamentally linked to culture. This includes mental health, whereby maintaining a positive spiritual, physical and emotional connection to country, culture and community is inherent in many Aboriginal beliefs about mental, social and emotional wellbeing.[153]

Because of this, connection to culture is a fundamental component of maintaining mental health. A strong cultural identity has been found to "promote resilience, enhance self-esteem, engender pro-social coping styles and has served as a protective mechanism against mental health symptoms".[154] Additionally, connection to culture, land and spirituality is foundational to build resilience and can reduce the impact of stress on Aboriginal people.[155]

On this basis, initiatives that strengthen culture are expected to be critical to protecting against mental illness. Conversely, mental health may be compromised

where cultural connection is restricted – such as in the care of the mental health system or within justice and out-of-home care settings.

This may occur in a number of ways, including where a patient is either physically denied access to culture through involuntary confinement or otherwise where the mental health or the child protection or justice systems simply fail to engage the person in a culturally informed way. In consideration of this, Aboriginal people in contact with these systems should be afforded adequate opportunities to connect to culture and access culturally safe services.

Currently, there is a legal and policy framework that is intended to ensure that the cultural rights of Aboriginal people are protected and promoted.

- At law, the Charter protects the distinct cultural rights of Aboriginal people, including the right to enjoy their identity and culture, to maintain and use their language, to maintain their kinship ties and to maintain their distinctive spiritual, material and economic relationship with the land and waters and other resources with which they have a connection under traditional laws and customs.[156] The Charter's Preamble recognises that "human rights have a special importance for the Aboriginal people of Victoria, as descendants of Australia's first people".
- Policies such as *Balit Murrup,*[157] Victoria's Aboriginal social and emotional wellbeing strategy, have been developed in recognition of the link between culture and mental health. *Balit Murrup* supports Aboriginal people, families and communities to achieve and sustain a high standard of emotional wellbeing and mental health. In doing so, it seeks to reduce the existing mental health gap between Aboriginal and non-Aboriginal people.
- Importantly, principles g and h in the Mental Health Act state that Aboriginal people receiving mental health services should have their distinct culture and identity recognised and responded to.[158]

Despite this, the Commission is concerned that, in practice, the care of Aboriginal mental health is often undertaken with little consideration of the cultural needs and rights of individuals. Poor mental health outcomes are, in-part, a result of the inability of the mental health and other related systems to engage Aboriginal people on culturally appropriate terms and promote cultural wellbeing.

As discussed further below, the mental health system must adhere to the existing legal and policy framework in order to effectively embed cultural rights into the mental health system. This will ensure positive mental health outcomes for the Aboriginal community.

5.1.2 Systemic failures of the mental health system for Aboriginal people

Aboriginal people represent around 0.9 per cent of the Victorian population,[159] yet represent nine per cent of the adult prison population.[160] Currently, there are thousands of Aboriginal people with mental and cognitive disabilities in contact with the justice system.[161]

Aboriginal people are disproportionately engaged with the justice system for minor offences, such as public drunkenness.[162] Offending such as this, is often a result of behavior and mental illness[163] that is more appropriately handled by the mental health system, rather than the justice system.

Once within the justice system, the cultural requirements of Aboriginal people are often ignored and access to culture is restricted. This effectively denies Aboriginal

people a key factor in support of their mental well-being and compromises mental health. Ultimately, this entrenches contact with the justice system. In particular, Aboriginal young people have a long history of over-representation in the criminal justice system[164] and are disproportionately represented in the youth justice system throughout Australia, where close to 70 per cent of children within the youth justice system are Aboriginal.[165] In Victoria, Aboriginal young people are around 13 times more likely to be in detention as opposed to non-Aboriginal young people.[166]

Detaining Aboriginal young people in this way undermines their mental health - there is a clear link between youth detention and poor mental health. Young people that are engaged in the youth justice system have substantially higher rates of mental illness in comparison to the general youth population[167], including higher risks of suicide and depression.[168] Within the youth justice system, young people are subjected to practices, such as solitary confinement and strip searching that may further exacerbate mental illness.

Accordingly, we support the strong calls of the Smart Justice for Young People Coalition, the Human Rights Law Centre and other organisations to amend the legal age of criminal responsibility from 10 to 14 years in Victoria, and across Australia. At present, the age of criminal culpability is in breach of international human rights law and inconsistent with international standards[169] where the median age internationally is 14 years.[170] Amending the age of criminal responsibility would align Victoria with international standards, be consistent with scientific evidence on young people's developmental progress and needs, and address a key mental health challenge. It would have a direct positive impact on the mental health of Aboriginal young people – diverting young Aboriginal people from a criminal justice response and into more restorative pathways, delivered through the health, human services and community service systems.

The Commission therefore encourages the Royal Commission to consider laws that disproportionally impact people with mental health issues, and options for diversion into the mental health system in the community.

5.1.3 Cultural rights under the Charter

The Charter recognises that "Aboriginal persons hold distinct cultural rights and must not be denied [these cultural rights]".[171] Public sector agencies and officials must therefore give proper consideration to the cultural rights of Aboriginal people when making a decision and act compatibility with those rights.[172] These obligations extend to the public sector mental health system, where the care of Aboriginal people is required to be undertaken in consideration of cultural rights under the Charter.

The Charter does not define the term "culture" and the scope of section 19 has yet to be given any detailed consideration in Victorian law. However, comparative rights are protected in national and international human rights instruments. For example, the UN Human Rights Committee has confirmed a broad and flexible interpretation of "culture", for the purposes of article 27 of the International Covenant on Civil and Political Rights.[173] It encompasses traditional beliefs and practices, as well as social and economic activities that are part of a group's tradition.[174]

Cultural rights are collective rights that may be exercised individually by a person.[175] In this manner, section 19(2) of the Charter confers a positive right on an Aboriginal person to enjoy his or her culture or identity.

Recent case law, such as *Cemino v Cannan,*[176] has confirmed the requirement of public sector agencies and officials to consider cultural rights in their decision-making and actions. While the case specifically considers the obligation on Courts to

consider Aboriginal cultural rights when making decisions in relation to an Aboriginal person's request to be heard in the Koori Court, this obligation also applies to the public mental health system in Victoria. Because of this, cultural rights are required, at law, to be considered by mental health employees and agencies that care, treat or engage with Aboriginal people.

This means the mental health system must more effectively promote and strengthen Aboriginal cultural rights in service provision. In practice, this can be achieved in a number of ways, including ensuring the mental health system is responsive to the cultural needs to Aboriginal people and ensuring that Aboriginal people receive culturally safe and trauma-informed care. This can be developed by providing mental health staff with cultural training so that they are properly equipped to understand the cultural context of Aboriginal people. Institutional cultural knowledge can be further enhanced by prioritising the recruitment and development of Aboriginal staff.

As part of improving cultural accessibility, the mental health system must acknowledge its own limitations in providing culturally appropriate care. The mainstream mental health system has a limited capacity to effectively evaluate and engage with Aboriginal cultural approaches of mental health and often traditional clinical perspectives are not appropriate.[177]

Because of this, it is critical that the mental health system recognises and adopts Aboriginal concepts of mental health, so that mental health care is culturally informed. This extends to treatment and care, where Aboriginal healing approaches, such as being on country or conducting ceremony, should be recognised by the mental health system and incorporated into treatment where appropriate.

ACCOs provide culturally safe early intervention for Aboriginal people[178] and the involvement of ACCOs is a critical means to enhance the cultural capacity of the mental health system.[179] Additionally, ACCOs offer support to Aboriginal people who are in contact with the justice system and provide access to diversion pathways, and rehabilitation in community.[180] Greater resourcing and involvement of ACCOs in both the mental health and justice systems is a substantive way in which to embed cultural rights in treatment and care.

5.1.4 The right to Aboriginal self-determination and the mental health system

The Commission supports self-determination as a guiding principle in any engagement with the Aboriginal community, including in the mental health system.

The right to self-determination is provided under international human rights law by the UN Declaration on the Rights of Indigenous Peoples,[181] which was adopted by Australia in 2009.

In Victoria, the *Victorian Aboriginal Affairs Framework*[182] provides an overarching framework that guides engagement with the Aboriginal community through a commitment to self-determination. This entrenches "self-determination enablers and principles and commits government to significant structural and systemic transformation".[183] Similarly, self-determination should be a fundamental principle guiding the work of the mental health system in relation to Aboriginal clients and communities.

The Commission acknowledges the important work of ACCOs as a mechanism of self-determination in the mental health system and echoes previous research undertaken for the Victorian DHHS that states that the:

> Aboriginal Community Controlled Health Care sector was [built] on the principle of self determination and grants local people the power to achieve their own goals in the areas of primary clinical care, community support, special needs programs and advocacy.[184]

This is supported by evidence which suggests that ACCOs reduce barriers to access and improve health outcomes.[185]

Greater focus on the role of ACCOs in the mental health system provides the most effective way to advance self-determination and improve mental health outcomes. The Commission recommends that the work of ACCOs be enhanced through greater resourcing and involvement with the mental health system.

The Commission also supports the inclusion of self-determination in the Charter as a standalone right. This would create a legal basis for self-determination in Victoria and ensure that self-determination is consistently considered by public authorities when making decisions, including within the mental health system.

Recommendation 5.

The Royal Commission should give consideration to:

a. reforming criminal laws that disproportionately impact people with mental illness, including Aboriginal people and children and young people, such as section 344 of the *Children, Youth and Families Act 2005* (Vic) and section 13 of the *Summary Offences Act 1966* (Vic)
b. the high levels of mental illness among the youth justice and prison population, particularly Aboriginal people, and how mental health services can be improved in justice settings
c. how community-based mental health services can be better used to improve health outcomes, particularly through enhancing cultural rights for Aboriginal people.

Recommendation 6.

The Royal Commission should consider making recommendations that require the mental health system and mental health service providers to:

a. comply with the cultural rights set out in section 19(2) of the *Charter of Human Rights and Responsibilities Act 2006* (Vic) and the *Balit Murrup* Aboriginal Social and Emotional Wellbeing Framework
b. enhance Aboriginal cultural competency and understanding of mental health agencies and officials
c. commit to greater self-determination, through adherence with the Victorian Aboriginal Affairs Framework, and ensure greater resourcing and involvement of Aboriginal Community Controlled Health Organisations in order to substantively enhance self-determination in the mental health system

5.2 Gender and mental health

Evidence indicates that gender shapes variances in the social determinants of mental health for men, women, transgender and non-binary people, as well as the likelihood of experiencing certain kinds of mental illness. It also effects differences in treatment received, community attitudes faced and outcomes experienced.[186] While biology has some part to play, these gendered differences in mental health experiences and outcomes are often driven by systemic sex discrimination. This includes broader gender inequality within society,[187] which interacts with other forms of discrimination and marginalisation such as racism, homophobia, transphobia and ableism.

Accordingly, it is critical to understand gender as a social determinant of mental health and apply an intersectional gender lens to mental health prevention, reform and service delivery. This is essential to address systemic sex discrimination and ensure that issues of importance to women, transgender and non-binary people are appropriately considered in mental health planning and reform, and that services are tailored, accessible and effective.

5.2.1 Evidence of gendered disparities in mental health

Gendered differences in prevalence

Globally, women are nearly twice as likely as men to suffer from mental illness.[188] The World Health Organisation notes there are “striking gender differences” in the patterns of mental health illness across gender,[189] stating:

> Globally, women are twice as likely as men to be diagnosed with unipolar depression and are also more likely to experience depression, anxiety and somatic complaints. Whereas men are more likely than women to be diagnosed with anti-social personality disorders and to develop alcohol dependence. There are no marked gender differences in the rates of severe mental disorders like schizophrenia and bipolar disorder that affect less than 2% of the population.[190]

Gender differences have also been reported through global research with respect to “age of onset of symptoms, frequency of psychotic symptoms, course of these disorders, social adjustment and long-term outcome”.[191]

In Australia, 43 per cent of women (or 3.5 million women) have experienced a mental illness during their lifetime and “[m]ental disorders represent the leading cause of disability and the highest burden of non-fatal illnesses for women in Australia”.[192] One Australian study (examining five years’ worth of national youth surveys conducted by Mission Australia) found that young women were around twice as likely as young men to meet the criteria for having a “probable serious mental illness”. Twenty-seven per cent of young women met the criteria, compared with 14 per cent of young men, and the rates were increasing more steeply over time for young women, as opposed to young men.[193]

There is also Australian evidence of gendered differences in the experience of depression and anxiety,[194] postnatal depression,[195] exposure to male violence,[196] suicide[197] and self-harm,[198] eating disorders and body image issues. Within each of these categories, women from certain backgrounds experience disproportionate rates of mental illness. For example, women with disabilities are twice as likely to experience violence throughout their lives than women without disabilities (and are

consequently more vulnerable to mental illness),[199] suicide rates among Aboriginal women are almost six times higher than for non-Aboriginal women,[200] and lesbian, bisexual and trans women and intersex people are almost four times as likely as their cis-gendered, heterosexual peers to have attempted self-harm or suicide.[201]

Gendered differences in outcomes

Gender shapes not only how likely a person is to experience mental illness, but also their outcomes. This variance in outcomes is, at least in part, due to systemic discrimination within treatment and community responses. For example, as Suicide Prevention Australia points out:

> One reason for the lack of investment in female suicidal behaviour may be that there has been a tendency to view suicidal behaviour in women as manipulative and non-serious (despite evidence of intent, lethality, and hospitalisation), to describe their attempts as 'unsuccessful', 'failed', or attention-seeking, and generally to imply that women's suicidal behaviour is inept or incompetent.[202]

Within mental health in-patient services, women's personal safety can also be at risk. One study found that "within mental health in-patient services, 45 per cent of women experienced sexual assault and more than 80 per cent lived in fear of being abused, while 67 per cent of women reported harassment during admission".[203]

In addition, the "individual pathology perspective" of mainstream mental health services is ill-equipped to deal with women experiencing reactive disorders (depression, anxiety or post-traumatic stress disorder) in response to systemic inequality. For example, "everyday traumatic experiences" of sexual harassment[204] which is a systemic rather than an individual problem.[205] Similarly a focus on "individual pathology" may be unhelpful in responding to the mental health needs of women at different life stages,[206] for example adjusting to societal attitudes and stressors associated with becoming a mother, going through menopause or reaching "the glass ceiling" at work.[207]

5.2.2 Gender as a social determinant of mental health

Gender is internationally recognised as a "critical determinant" of mental health and a cross-cutting issue with some women more vulnerable than others.[208] The World Health Organisation states:

> Gender determines the differential power and control men and women have over the socioeconomic determinants of their mental health and lives, their social position, status and treatment in society and their susceptibility and exposure to specific mental health risks.[209]

There is growing evidence that women's mental health is shaped by structural inequalities related to gender-based roles. This includes social and cultural expectations and gender power imbalances, as well as broader socio-economic inequality (including poverty, social exclusion, and geography) and negative life experiences (including violence and abuse, discrimination such as racism, homophobia, ablesism etc, and intergenerational trauma).[210] One global study published in 2018 found that "women suffer mentally more than men in societies with greater levels of gender inequality".[211]

The World Health Organisation recognises:

> Gender specific risk factors for common mental disorders that disproportionately affect women include gender based violence, socioeconomic disadvantage, low income and income inequality, low or subordinate social status and rank and unremitting responsibility for the care of others [along with] high prevalence of sexual violence to which women are exposed…[212]

Despite robust evidence of the cross-cutting role of gender as a social determinant of mental health, it is too often ignored in mental health policy and service design or seen as a subsidiary or tangential concern.[213] This not only limits the effectiveness of services, it can create barriers to access, diminish outcomes and "exacerbate inequalities between groups of women with mental distress and between women and men".[214]

5.2.3 Sex discrimination and mental health

Through our complaint, enquiry and review functions, the Commission understands the profound mental health impacts of sex discrimination and sexual harassment on women. One in five complaints the Commission seeks to resolve are from women who are discriminated against because of characteristics associated with their sex - breastfeeding, sexual harassment, being pregnant, a parent, a carer, or simply being a woman.[215] Many of these women report significant mental health impacts associated with their experiences of harassment and discrimination, including hurt, humiliation and denigration leading to depression, anxiety and post-traumatic stress disorder. We often hear from women, as well as LGBTIQ people, impacted by sexual harassment at work, that poor employer responses and workplace cultures exacerbate the mental and emotional impacts.

This relationship between sex discrimination and mental health is well documented in international research. For example, one US study found that experiencing unwanted sexual advances and "interpersonal sexual objectification" was associated with clinical trauma symptoms in women with and without a history of sexual trauma.[216] The authors concluded that "the experience of sexual objectification is a type of gender-based discrimination with sequelae that can be conceptualized as insidious trauma."[217]

5.2.4 Gender equality as a critical component of the primary prevention of mental illness

Eliminating sex discrimination and working towards gender equality must be seen as inseparable components of mental health primary prevention.

There are significant mental health benefits for men, women, transgender and non-binary people of gender equality. This includes freedom from conformity with gender stereotypes, expectations and discrimination which limit and prescribe men and women's roles in all aspects of their public and private lives, and can lead to anxiety, depression and other forms of mental and emotional harm for people who do not conform.

For women, it is critical that we recognise and address the mental health impacts of gender inequality in all aspects of women's daily lives. In the workplace, this includes pay inequality, lack of access to flexible work, anxiety around pregnancy and parental leave, sex discrimination and sexual harassment. But it is also related to, and reinforced by, gender inequality in private life, such as inequitable division of parenting and domestic duties, family violence and sexual violence, as well as other

aspects of public life, such as sexual harassment in education and the provision or receipt of goods and services.[218]

For men, evidence connects poor mental (and physical) health outcomes with rigid gender stereotypes. For example, men's high suicide rates and poor mental health outcomes have been linked to hypermasculine expectations of men that discourage or limit men from expressing vulnerability, asking for help, having emotional intimacy and equality in their relationships with partners, children and friends.[219] Conversely, increasing gender equality would enable men to more openly embrace relationships, behaviours and pursuits that support their mental and emotional wellbeing, such as spending more time caring for children, and seeking support from friends, family and professionals.

The cumulative mental health impacts of individual and systemic discrimination driven by homophobia, biphobia and transphobia on LGBTIQ people also demand attention.

Transforming gendered norms, structures and practices will create a more inclusive and positive society which embraces difference with benefits for all the community – girls and boys, women and men, trans and non-binary people. The Commission therefore calls for a mental health system that requires mental health practitioners and facilities to be trained in, and aligned with, efforts to prevent violence against women and advance gender equality. The Royal Commission may also wish to give consideration to the best way to ensure that all mental health primary prevention strategies and initiatives targeting women are sufficiently aligned with key strategies directed towards achieving gender equality and reducing violence against women including *Safe and Strong*, the Victorian Government's gender equality strategy,[220] *Change the Story*, the national framework for primary prevention of violence against women,[221] and *Free From Violence* the Victorian Government's primary prevention strategy.[222]

5.2.5 The need for an intersectional gender lens

Understanding gender as a social determinant of mental health necessitates a range of reforms to the way in which the mental health system currently addresses the mental health needs of women, as well as transgender and non-binary people. The Commission urges the Royal Commission to apply an intersectional, gender lens to its review of all areas of the mental health system and consider how gender-sensitive approaches can be embedded into prevention, research, policy, and service design and delivery. This includes taking into account the ways in which sex discrimination and gender inequality, and their intersection with other forms of discrimination, profoundly shape peoples' experience of the mental health system and the outcomes they obtain.

Specifically, there is a clear need for the Victorian Government and mental health service system to:

- recognise sex discrimination and gender inequality as key drivers of mental illness for both women, men and transgender and non-binary people, and as barriers to accessing early and effective treatment and support
- collect and analyse gender disaggregated data[223]
- commission or undertake gender disaggregated research (for example with respect to medications and efficacy of treatments)
- design mental health policy, service design and service delivery in light of gendered differences and needs, and invest in gender-sensitive approaches.

While there is unfortunately limited evidence about effective gender-sensitive interventions,[224] evidence indicates that aspects of gender-sensitive service delivery to be considered include:

- sexual safety in acute mental health inpatient units[225]
- gender-specific services and in-patient facilities, with sufficient flexibility to cater to the needs of non-binary and gender diverse people[226]
- trauma-informed care[227]
- consumer-led and peer support models[228]
- attending to mental and physical health in an integrated way that responds to the person, not the illness[229]
- recognising and responding to "a broader range of factors which impact on women's health, such as domestic violence, mental health, eating disorders, the effects of ageing and disability and women's multiple and often conflicting roles of workers, mothers and carers"[230]
- a gender-based approach to working with men and boys that recognises "the strong relationship between adherence to traditional masculinity and poorer mental health help-seeking, higher levels of mental health stigma, suicide attempts and body image concerns."[231]

Recommendation 7.

1. The Royal Commission and the Victorian Government should recognise and address gender as a social determinant of health and apply an intersectional gender lens to all aspects of the mental health system, including by recognising sex discrimination and gender inequality as key drivers of mental illness for women, men and non-binary people and barriers to accessing early and effective treatment and support.
2. The Victorian Government and mental health service providers should:
    a. collect and analyse gender disaggregated data, including on the prevalence of mental illness and the effectiveness of mental health treatment and outcomes
    b. ensure that mental health-related research that they commission or conduct, including into medications and efficacy of treatments, considers gendered differences and needs
    c. design mental health policies and services in light of gendered differences and needs
    d. deliver gender sensitive and/or gender-specific services and in-patient facilities.

5.3 People with mental health in closed environments

People with mental illness are disproportionally represented in closed environments such as psychiatric and residential mental health facilities and justice settings.[232] In those settings (often out of public view), people with mental illness are deprived of their liberty and subject to power imbalances[233] that can create opportunities for people with mental illness to be mistreated.

In recognition of the risk of torture and ill-treatment occurring in closed environments, the principles-based human rights treaty, OPCAT,[234] was developed by the United Nations in 2002. Ratified by the Australian Government in 2017, OPCAT requires signatory countries to implement a system of regular, independent, preventive visits to all places where people are deprived of their liberty to prevent the risk of torture and ill-treatment, as defined in the CAT.[235]

The *Convention on the Rights of Persons with Disabilities* (**CRPD**) specifically refers to the prevention of ill-treatment towards people with disability and the obligation to monitor all facilities and programs, extending to mental health facilities.[236] The CRPD highlights the importance of OPCAT in protecting vulnerable people within the mental health system, such as those receiving treatment in psychiatric institutions and those people subject to involuntary confinement under the Mental Health Act.[237]

The Commission is concerned to ensure that OPCAT is implemented in Victoria in a way that identifies and addresses the particular risk of ill-treatment for people with mental illness in a range of settings, consistent with international law and best practice. This includes ensuring adequate mental health expertise within the Victorian OPCAT system and taking a broad interpretation of “deprivation of liberty”[238] so that OPCAT can be flexibly applied to a range of public and private settings (including community facilities), where people with mental health issues may be deprived of their liberty.

Recommendation 8.

The Royal Commission consider how the implementation of the *Optional Protocol to the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* and the *Convention on the Rights of Persons with Disabilities* could be implemented in Victoria to better protect vulnerable people with mental illness from ill-treatment in a range of settings, through a robust and independent system of monitoring.

[1] Victorian Equal Opportunity and Human Rights Commission, Submission on Royal Commission into Mental Health Terms of Reference, *Royal Commission into Victoria's Mental Health System*, January 2019. <https://www.humanrightscommission.vic.gov.au/policy-submissions/item/1787-submission-to-the-royal-commission-into-mental-health>.

[2] See, for example, the Commission's own data outlined in section 3.1within this submission.

[3] See for example, Barbara Hocking OAM, 'A life without stigma: A SANE Report', (Research Report, SANE Australia, 2013); BeyondBlue, 'Beyondblue Information Paper: Stigma and discrimination associated with depression and anxiety', (Information Paper, BeyondBlue, 2015). <https://www.beyondblue.org.au/docs/default-source/policy-submissions/stigma-and-discrimination-associated-with-depression-and-anxiety.pdf?sfvrsn=92367eea_2>.

[4] *International Covenant on Civil and Political Rights*, opened for signature 16 December 1966, 993 UNTS 3 (entered into force 23 March 1976).

[5] Victoria, *Parliamentary Debates*, Legislative Assembly, 4 May 2006, 1291 (Rob Hulls, Attorney General).

[6] *Charter of Human Rights and Responsibilities Act 2006* (Vic), s 28.

[7] See, Committee on Economic, Social and Cultural Right, *General Comment No 14: The Right to the Highest Attainable Standard of Health*, 22nd sess, UN Doc E/C.12/2000/4 (11 August 2000); Sophia Gruskin et al, 'Do human rights have a role in public health work?' (2002) 360 *The Lancet*; P Braveman and S Gruskin, 'Defining equity in health' (2002) 57 *Journal of Epidemiology and Community Health*.

[8] Lawrence O. Gostin and Lance Gable, 'The Human Rights of Persons with Mental Disabilities: A Global Perspective on the Application of Human Rights Principles to Mental Health' (2009) 63 *Maryland Law Review* 31.

[9] *Mental Health Act 2014* (Vic), s 11(1).

[10] Victoria Legal Aid, *Productivity Commission Inquiry into the Economic Impacts of Mental Ill-Health*, (April 2019), 15; Victorian Mental Illness Awareness Council, *Royal Commission into Mental Health: Terms of Reference Submission* (Jan 2019), 22.

[11] Australian Bureau of Statistics, *Australian Aboriginal and Torres Strait Islander Health Survey: First Results, Australia, 2012-13* (27 November 2013) <https://www.abs.gov.au/ausstats/abs@.nsf/Latestproducts/9F3C9BDE98B3C5F1CA257C2F00145721?opendocument>.

[12] National Mental Health Commission, 'Report of the National Review of Mental Health Programmes and Services' (Report, National Mental Health Commission, 30 November 2014) 5.

[13] National Mental Health Commission, 'Report of the National Review of Mental Health Programmes and Services' (Report, National Mental Health Commission, 30 November 2014) 72.

[14] *United Nations Declaration on the Rights of Indigenous Peoples*, opened for signature on 13 September 2007, Article 3.

[15] See for example, World Health Organisation, 'Gender and women's mental health' *World Health Organisation* (Web page, 24 June 2019) <https://www.who.int/mental_health/prevention/genderwomen/en/>; Department of Mental Health and Substance Dependence *Gender Disparities in Mental Health* (World Health Organisation, 2019) <https://www.who.int/mental_health/media/en/242.pdf?ua=1>; Shoukai Yu, 'Uncovering the hidden aspects of inequality on mental health: a global study' (2018) 8 *Translational Psychiatry* 1-10; Women's Health Victoria, 'The social and economic benefits of improving mental health: Women's Health Victoria's Submission to the Productivity Commission Inquiry (Submission, Women's Health Victoria, April 2019) 16-17.

[16] Ibid. See also Caroline Criado Perez, *Invisible Women: Exposing data bias in a world designed for men* (Chatto & Winds, 2019).

[17] See, for example, above n 15.

[18] Caroline Criado Perez, *Invisible Women: Exposing data bias in a world designed for men* (Chatto & Winds, 2019).

[19] As discussed in further detail within this submission, applying an intersectional gender lens involves recognising and addressing the ways in which mental illness impacts differently on people because of their sex and gender, in combination with other personal attributes such as race or disability. (For example, understanding and addressing the mental health needs of Aboriginal women, women with a disability or transgender men). It also includes understanding the ways in which mental health responses indirectly discriminate against women and non-binary people, for example, due to a lack of data or an over-reliance on medical research on men.

[20] Penelope Weller, 'OPCAT Monitoring and the Convention on the Rights of Persons with Disabilities' (2019) 25 *Australian Journal of Human Rights* 131.

[21] *Optional Protocol to the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, opened for signature 18 December 2002, 2375 UNTS 237 (entered into force 22 June 2006).

[22] *Equal Opportunity Act 2010* (Vic) s 4.

[23] Victorian Equal Opportunity and Human Rights Commission, *Fair-minded cover: Investigation into mental health discrimination in travel insurance*, (June 2019), 11. <https://www.humanrightscommission.vic.gov.au/home/our-projects-a-initiatives/fair-minded-cover.>

[24] See page 15 above for further details.

[25] Victorian Equal Opportunity and Human Rights Commission, *Beyond doubt: the experiences of people with disabilities reporting crime* (Victorian Equal Opportunity and Human Rights Commission, 2014) <https://www.humanrightscommission.vic.gov.au/our-resources-and-publications/reports/item/894-beyond-doubt-the-experiences-of-people-with-disabilities-reporting-crime>.

[26] *Paul Slattery v Manningham City Council* [2014] VCAT 1442.

[27] Kracke v Mental Health Review Board & Ors (General) [2009] VCAT 646; *Taha v Broadmeadows Magistrates' Court*; *Brookes v Magistrates' Court of Victoria & Anor* [2011] VSC 642; *PJB v Melbourne Health* [2011] VSC 327; *Victorian Toll & Anor v Taha and Anor; State of Victoria v Brookes & Anor* [2012] VSCA 37.

[28] *Equal Opportunity Act 2010* (Vic) ss 7. 44. For definition of 'disability' and 'services' see *Equal Opportunity Act 2010* (Vic) s 4.

[29] *Equal Opportunity Act 2010* (Vic) s 7.

[30] *Equal Opportunity Act 2010* (Vic) s 6.

[31] *Equal Opportunity Act 2010* (Vic) ss 4, 6.
Section 4 of the *Equal Opportunity Act 2010* (Vic) says disability means: (a) total or partial loss of a bodily function; or (b) the presence in the body of organisms that may cause disease; or (c) total or partial loss of a part of the body; or (d) malfunction of a part of the body, including – (i) a mental or psychological disease or disorder; (ii) a condition or disorder that results in a person learning more slowly than people who do not have that condition or disorder; or (e) malformation or disfigurement of a

part of the body – and includes a disability that may exist in the future (including because of a genetic predisposition to that disability) and, to avoid doubt, behaviour that is a symptom or manifestation of a disability.
[32] Section 44(1) of the *Equal Opportunity Act 2010* (Vic) provides that a person must not discriminate against another person: (a) by refusing to provide goods or services to the other person; (b) in the terms on which goods or services are provided to the other person; or (c) by subjecting the other person to any other detriment in connection with the provision of goods or services to him or her.
[33] *Equal Opportunity Act 2010* (Vic) s 8.
[34] *Equal Opportunity Act 2010* (Vic) s 9.
[35] *Equal Opportunity Act 2010* (Vic) s 104.
[36] Ibid. Victimisation can also occur when a person subjects or threatens to subject another person to any detriment because they have:

- Brought a dispute to the Commission or any other proceedings
- Given evidence or information in connection with any proceedings or investigation under the Act or attended compulsory conference or mediation
- Has alleged a breach of the Equal Opportunity Act 2010 or refused to do something that would breach the EOA.

or because the person believes the other person has or intends to do any of these things.
[37] *Equal Opportunity Act 2010* (Vic) s 45.
[38] *Equal Opportunity Act 2010* (Vic) s 103.
[39] *Equal Opportunity Act 2010* (Vic) s 92(1). a person sexually harasses another person if he or she–
a. makes an unwelcome sexual advance, or an unwelcome request for sexual favours, to the other person; or
b. engages in any other unwelcome conduct of a sexual nature in relation to the other person—
in circumstances in which a reasonable person, having regard to all the circumstances, would have anticipated that the other person would be offended, humiliated or intimidated.
[40] *Equal Opportunity Act 2010* (Vic) s 15.
[41] *Charter of Human Rights and Responsibilities Act 2006* (Vic) s 28.
[42] Ibid s 32.
[43] Ibid s 38.
[44] Ibid s 39.
[45] Ibid s 40.
[46] Ibid s 34.
[47] *PBU & NJE v Mental Health Tribunal* [2018] VSC 564.
[48] Ibid, 113, 281.
[49] The Commission defines positive human rights culture as a pattern of shared attitudes, values and behaviours that influence the policy making, decisions and practices of government to uphold human rights of all people. It is a culture where the human rights of people in Victoria are thoughtfully considered and prioritised in everyday business.
[50] This case study is a summary of a more detailed case study provided by the Branch and published in the Commission's 2017 Charter report - Victorian Equal Opportunity and Human Rights Commission, '2017 report on the operation of the Charter of Human Rights and Responsibilities' (Report, Victorian Equal Opportunity and Human Rights Commission, 2018) 56-57. <https://www.humanrightscommission.vic.gov.au/home/our-resources-and-publications/charter-reports/item/1740-2017-report-on-the-operation-of-the-charter-of-human-rights-and-responsibilities>.
[51] The Department of Health and Human Services' (DHHS) Health and Wellbeing division is responsible for policy, strategy and commissioning of services in Victoria's primary prevention (prevention of ill health), secondary (ongoing treatment and care) and tertiary (specialised treatment and care) healthcare system. The division works with agencies and services to promote wellness and active participation and inclusion of all Victorians in their communities and to prevent and minimise the impact of poor health and wellbeing and disadvantage across Victoria. Victorian Equal Opportunity and Human Rights Commission, '2017 report on the operation of the Charter of Human Rights and Responsibilities' (Report, Victorian Equal Opportunity and Human Rights Commission, 2018) 56-57. <https://www.humanrightscommission.vic.gov.au/home/our-resources-and-publications/charter-reports/item/1740-2017-report-on-the-operation-of-the-charter-of-human-rights-and-responsibilities>.
[52] Victorian Equal Opportunity and Human Rights Commission, '2017 report on the operation of the Charter of Human Rights and Responsibilities' (Report, Victorian Equal Opportunity and Human Rights Commission, 2018) 57. <https://www.humanrightscommission.vic.gov.au/home/our-resources-and-publications/charter-reports/item/1740-2017-report-on-the-operation-of-the-charter-of-human-rights-and-responsibilities>.
[53] Other relevant legislation includes the *Crimes Mental Impairment and Unfitness to be Tried Act 1997* (Vic) and the *Medical Treatment Planning and Decisions Act 2016* (Vic).
[54] *Mental Health Act 2014* s 11(2).
[55] *Mental Health Act 2014* s 11(1)(a) – (l) (Mental health principles).
[56] Ibid.
[57] Victoria Legal Aid, Productivity Commission Inquiry into the Economic Impacts of Mental Ill-Health, (April 2019), 15; Law Institute of Victoria, Submission to the Royal Commission into Victoria's Mental Health System, (July 2019), 7; Victorian Mental Illness Awareness Council, Submission on the Terms of Reference to the Royal Commission into Mental Health, (Jan 2019), 21.
[58] Victorian Equal Opportunity and Human Rights Commission, *Annual Report* (2017-18), 13.
[59] Ibid.
[60] Above n 23.
[61] *Equal Opportunity Act 2010* (Vic) s 4.
[62] *Equal Opportunity Act 2010* (Vic).
[63] See for example, World Health Organisation, 'Gender and women's mental health' *World Health Organisation* (Web page, 24 June 2019) <https://www.who.int/mental_health/prevention/genderwomen/en/>; see also section 5 of this submission for discussion.
[64] *Equal Opportunity Act 2010* (Vic) s 104.
[65] Above n 23, 11.
[66] *Ingram v QBE Insurance (Australia) Ltd* [2015] VCAT 1936.
[67] Above n 23, 11.
[68] Ibid.
[69] Yin Paradies, 'A systematic review of empirical research on self-reported racism and health' (2006) 35 *International Journal of Epidemiology* 888–901; Elizabeth Pascoe, Laura Richman, 'Perceived discrimination and health: A meta-analytic review' (2009) 135 *Psychology Bulletin* 531–54. See also the discussion of the Commission's own data at section 3.2 of this submission.

[70] See for example, Barbara Hocking OAM, 'A life without stigma: A SANE Report', (Research Report, SANE Australia, 2013); BeyondBlue, 'Beyondblue Information Paper: Stigma and discrimination associated with depression and anxiety', (Information Paper, BeyondBlue, 2015). <https://www.beyondblue.org.au/docs/default-source/policy-submissions/stigma-and-discrimination-associated-with-depression-and-anxiety.pdf?sfvrsn=92367eea_2>.
[71] Australian Bureau of Statistics, National Survey of Mental Health and Wellbeing: Summary of Results (Australian Bureau of Statistics, 2007) 4326.0, viewed on 26 June 2019.
[72] G. Rosenstreich, 'LGBTI People Mental Health and Suicide' (Briefing Paper, National LGBTI Health Alliance, 2013).
[73] See section 5.1 of this submission for detail. See generally, Australian Institute of Health and Welfare, 'The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples 2015' (Report, Australian Institute of Health and Welfare, 2015) 80.
[74] See, section 5.2 of this submission for further discussion. See generally, Australian Bureau of Statistics, National Survey of Mental Health and Wellbeing: Summary of Results (Australian Bureau of Statistics, 2007) 4326.0, viewed on 26 June 2019 <www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/4326.0Main+Features32007?OpenDocument>.
[75] See, European Institute of Gender Equality, 'Homophobia and Discrimination on Grounds of Sexual Orientation and Gender Identity in the EU Member States' (Research Report, European Union Agency for Fundamental Rights, 2009); Committee on the Elimination of All Forms of Discrimination Against Women (CEDAW), *General Recommendation No 28 on the core obligations of states parties under article 2 of the Convention on the Elimination of All Forms of Discrimination against Women*, 47th sess, UN Doc CEDAW/C/GC/28 (2010) 18; Committee on the Elimination of All Forms of Discrimination Against Women, *General Recommendation 25, on article 4, paragraph 1, of the Convention on the Elimination of All Forms of Discrimination against Women, on temporary special measures*, 30th sess, UN Doc A/59/38 (2004), 12 and 28.
[76] Barbara Hocking OAM, 'A life without stigma: A SANE Report', (Research Report, SANE Australia, 2013); BeyondBlue, 'Beyondblue Information Paper: Stigma and discrimination associated with depression and anxiety', (Information Paper, BeyondBlue, 2015). < https://www.beyondblue.org.au/docs/default-source/policy-submissions/stigma-and-discrimination-associated-with-depression-and-anxiety.pdf?sfvrsn=92367eea_2>.
[77] BeyondBlue, 'Beyondblue Information Paper: Stigma and discrimination associated with depression and anxiety', (Information Paper, BeyondBlue, 2015). < https://www.beyondblue.org.au/docs/default-source/policy-submissions/stigma-and-discrimination-associated-with-depression-and-anxiety.pdf?sfvrsn=92367eea_2>.
[78] Ibid.
[79] Nicola Ballenden and Dr Maria Duggan, 'Keeping Body and Mind Together – Improving the Physical Health and Life Expectancy of People with Serious Mental Illness' (Report, Royal Australian & New Zealand College of Psychiatrists, 2015), 8. https://www.ranzcp.org/files/resources/reports/keeping-body-and-mind-together.aspx
[80] Nicola Ballenden and Dr Maria Duggan, 'Keeping Body and Mind Together – Improving the Physical Health and Life Expectancy of People with Serious Mental Illness' (Report, Royal Australian & New Zealand College of Psychiatrists, 2015), citing CW. Colton and RW. Manderscheid, 'Congruencies in increased mortality rates, years of potential life lost, and causes of death among public mental health clients in eight states' 3 *Preventing Chronic Disease: Public Health Research, Practice, and Policy* 1–14.
[81] Mental Health Commission of New South Wales, *Physical health and mental wellbeing: evidence guide*, (2016), 17, 18, 32.
[82] BeyondBlue, 'Beyondblue Information Paper: Stigma and discrimination associated with depression and anxiety', (Information Paper, BeyondBlue, 2015).
[83] National LGBTI Health Alliance, *Submission to the Religious Freedom Review*, (2018), 5, 14.
beyondblue, *Depression and anxiety in gay, lesbian, bisexual, trans and intersex populations* (May 2012), 3, 4, viewed 26 June 2019,<http://resources.beyondblue.org.au/prism/file?token=BL/1012>;
[84] BeyondBlue, 'Beyondblue Information Paper: Stigma and discrimination associated with depression and anxiety', (Information Paper, BeyondBlue, 2015).
[85] Ibid. The recent national debate on marriage equality involved vilifying, offensive, misleading and intimidating material distributed in the context of the 'No' campaign: ACON (AIDS Council of NSW), *Submission to the Religious Freedom Review* (2018) 4, 11; Victorian AIDS Council, *Submission to the Religious Freedom Review*, (2018), 10.
[86] Australian Human Rights Commission, *Everyone's business: Fourth national survey on sexual harassment in Australian workplaces* (2018), 21, 22.
[87] Victorian Health Promotion Foundation, *Mental health impacts of racial discrimination in Victorian Aboriginal Communities – Experiences of racism survey: a summary* (2012) 2; Victorian Health Promotion Foundation, *Mental health impacts of racial discrimination in Victorian culturally and linguistically diverse communities, Full report of the Localities Embracing and Accepting Diversity (LEAD) Experiences of Racism Survey* (2013), 5, 6, 39, 40.
[88] Australian Human Rights Commission, *National Anti-Racism Strategy – Consultation Report*, (2012), 3–5.
[89] VicHealth, 'Ethnic and race-based discrimination as a determinant of mental health and wellbeing' (Research Summary, VicHealth, 2009) 3, citing Williams & Williams-Morris, 'Racism and Mental Health: The African American Experience' (2000) 5 *Ethnicity & Health* 243–68.
[90] Although the rights to equality, cultural rights and the protection of families and children are also reflected in the Charter.
[91] The right to health is also recognised in numerous other International human rights instruments dating back to 1948, including: article 25.1 of the Universal Declaration of Human Rights; article 5(e)(iv) of the International Convention on the Elimination of All Forms of Racial Discrimination; articles 11.1 (f) and 12 of the Convention on the Elimination of All Forms of Discrimination against Women and in article 24 of the Convention on the Rights of the Child.
[92] Committee on Economic, Social and Cultural Right, *General Comment No 14: The Right to the Highest Attainable Standard of Health*, 22nd sess, UN Doc E/C.12/2000/4 (11 August 2000) [8].
[93] Ibid [9].
[94] Ibid [3]-[4].
[95] Above n 92. See also Office of the United Nations High Commissioner for Human Rights*, The Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care* adopted by the United Nations General Assembly in 1991, GA Res 46/119 (17 December 1991).1991, GA Res 46/119 (17 December 1991).
[96] Ibid [12].
[97] Consultation Committee for a Proposed WA Human Rights Act, A WA Human Rights Act, *Report of the Consultation Committee for a Proposed WA Human Rights Act*, (Report, Consultation Committee for Proposed WA Human Rights Act, November 2007) [4.3.3]; National Human Rights Consultation Committee, National Human Rights Consultation Report, *Report of the National Human Rights Consultation Committee* (Report, National Human Rights Consultation Committee, September 2009) 366.
[98] Victorian Equal Opportunity and Human Rights Commission, *Submission to the Scrutiny of Acts and Regulations Committee on the four-year review of the Charter* (State of Victoria, 2011) 40.

[99] Lawrence O. Gostin and Lance Gable, ‘The Human Rights of Persons with Mental Disabilities: A Global Perspective on the Application of Human Rights Principles to Mental Health’ (2009) 63 *Maryland Law Review* 8-31.
[100] Above n 42; Sophia Gruskin et al, ‘Do human rights have a role in public health work?’ (2002) 360 *The Lancet*; P Braveman and S Gruskin, ‘Defining equity in health’ (2002) 57 *Journal of Epidemiology and Community Health*.
[101] See Paul Hunt (2016) ‘Interpreting the International Right to Health in a Human Rights-Based Approach to Health’ 18 Health and Human Rights Journal 109.
[102] Michael Brett Young, *From Commitment to Culture: The 2015 Review of the Charter of Human Rights and Responsibilities Act 2006* (State of Victoria, 2015), PINPOINT.
[103] Ibid 210-225. While the final report recognised that “[t]he protection of economic, social and cultural rights [including the right to health] is an important aspect of our community values of equality and a fair go”,[103] it ultimately stopped short of recommending the Charter be amended to include them as it had already recommended a new independent cause of action be introduced which the authors felt should be embedded, before introducing the added complication of addressing new rights.[103]
[104] *Human Rights Act 2019* (Qld).
[105] Ibid s 37(2).
[106] This includes, for example, the European Convention of Human Rights, Uruguay, Latvia and Senegal. A 2013 study found that 73 United Nations member countries (38 percent) guaranteed the right to medical care services, while 27 (14 percent) aspired to protect this right in 2011. 27 countries (14 percent) guaranteed public health and 21 (11 percent) aspired to it. J. Heymann, A. Cassola, A. Raub, L. Mishra, ‘Constitutional rights to health, public health and medical care: the status of health protections in 191 countries’ 8 *Global Public Health* (2013) 639-53.
[107] *European Social Charter* opened for signature 18 October 1961, 529 UNTS 89 (entered into force 26 February 1965), art 11.
[108] *African Charter on Human and People’s Rights* opened for signature, 27 June 1981, 1520 UNTS 217 (entered into force 21 October 1986), art 16; *African Charter on the Rights and Welfare of the Child* opened for signature , 1 July 1990, OAU Doc CAB/LEG/24.9/49 (entered into force 29 November 1999), art 14.
[109] *Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights* opened for signature 17 November 1988, OAS Treaty Series No 69 28 ILM 156 (entered into force 16 November 1999), art 10.
[110] Eleanor Kinney and Brian Clark, ‘Provisions for Health and Health Care in the Constitutions of the Countries of the World’ (2004) 37 *Cornell International Law Journal* 285, 291; John Tobin, *The Right to Health in International Law* (Oxford University Press, 2012) 184.
[111] *Constitution of the Republic of South Africa Act 1996* (South Africa) s 27.
[112] Charles Ngwena, ‘The Recognition of Access to Health Care as a Human Right in South Africa: Is It Enough?’ (2000) 5(1) *Health and Human Rights* 26, 32.
[113] Ibid 36.
[114] Ibid 28-29.
[115] *Soobramoney v Minister of Health* (Kwa-Zulu Natal) [1998] 1 SA 765 (Constitutional Court). This case was ultimately unsuccessful as the claim was brought under section 27(3) of the Constitution pertaining to emergency care and the Court was not satisfied that lifelong renal dialysis following chronic renal failure constituted emergency care, but that the provision instead envisaged treatment for sudden illness or unexpected trauma. However, according to academic commentators the Court failed to sufficiently inquire into “whether priorities within the provincial and national governments' health-care budgets were in consonance with its constitutional obligations.” Ibid 33.
[116] *Transgender Europe and ILGA Europe v. Czech Republic* (European Committee of Social Rights, Complaint No. 117/2014, 15 May 2018).
[117] Council of Europe, *Digest of the case law of the European Committee of Social Rights* (2018), 128.
[118] Above n 116 [82].
[119] *Defence for Children International v Belgium* (European Committee of Social Rights, Complaint No 69/2011, 23 October 2012).
[120] Ibid [102].
[121] Ibid [101].
[122] Council of Europe, *Digest of the case law of the European Committee of Social Rights* (2018), 131. See also, *International Planned Parenthood Federation – European Network (IPPF EN) v. Italy* (European Committee of Social Rights, Complaint No 87/2012, 10 September 2013), 66; *Confederazione Generale Italiana de Lavoro (CGIL) v. Italy* (European Committee of Social Rights, Complaint No 91/2013, 12 October 2015) 162 and 190.
[123] According to the United Nations Committee on Economic, Social and Cultural Rights “[p]rogressive realization means that States parties have a specific and continuing obligation to move as expeditiously and effectively as possible towards the full realization of article 12.” Notably, the right takes into account “both the individual’s biological and socio-economic preconditions and a State’s available resources.” Committee on Economic, Social and Cultural Right, *General Comment No 14: The Right to the Highest Attainable Standard of Health*, 22nd sess, UN Doc E/C.12/2000/4 (11 August 2000) [31].
[124] Committee on Economic, Social and Cultural Right, *General Comment No 14: The Right to the Highest Attainable Standard of Health*, 22nd sess., UN Doc E/C.12/2000/4 (11 August 2000) [31], [31].
[125] Ibid.
[126] *Ombudsman Act 1973* (Vic) ss 13(2) and 13(AA). The Victorian Ombudsman also has the power under s 16I to refer complaints to a specified body (including the Commission) if the subject matter is relevant to that person or body’s duties and functions and it would be more appropriate for them to deal with the complaint.
[127] *Independent Broad-based Anti-corruption Commission Act 2011* (Vic) ss 15(3)(iii), 51-52 and 64(2).
[128] *Equal Opportunity Act 2010* (Vic) s 176.
[129] *Charter of Human Rights and Responsibilities Act 2006*, s 39.
[130] Michael Brett Young, *From Commitment to Culture: The 2015 Review of the Charter of Human Rights and Responsibilities Act 2006* (State of Victoria, 2015), 99.
[131] *Human Rights Act 2019* (Qld) Division 2 (Human rights complaints).
[132] *Ingram v QBE Insurance (Australia) Ltd* [2015] VCAT 1936.
[133] Julian Gardner, ‘An equality act for a fairer Victoria: Equal opportunity review final report’ (Final Report, Department of Justice and Regulation Victoria, 2008).
[134] Ibid; *Equal Opportunity Bill 2010* (Vic) s 133.
[135] *Equal Opportunity Bill 2010* (Vic).
[136] *Equal Opportunity Act Amendment Bill 2011* (Vic).
[137] For example, the UK equality duty enables the UK Equality and Human Rights Commission to enforce compliance through a broad range of regulatory tools, including assessments, investigations, agreements and compliance notices. It also has the

power to conduct a public inquiry into any matter relating to any of its duties, and has done so in relation to disability-related harassment.
[138] Victoria Legal Aid, Productivity Commission Inquiry into the Economic Impacts of Mental Ill-Health – April 2019, 15, 35. Law Institute of Victoria, Formal Submission to the Royal Commission into Victoria's Mental Health System (July 2019), p 7. Victorian Mental Illness Awareness Council, Royal Commission into Mental Health: Terms of Reference Submission (Jan 2019), 21.
[139] Ibid.
[140] For further discussion, see Law Institute of Victoria, Submission to the Royal Commission into Victoria's Mental Health System, (May 2019) 10-11.
[141] *PBU & NJE v Mental Health Tribunal* [2018] VSC 564 [281].
[142] Victoria Legal Aid, *Productivity Commission Inquiry into the Economic Impacts of Mental Ill-Health*, (April 2019), 15. Victorian Mental Illness Awareness Council, *Royal Commission into Mental Health: Terms of Reference Submission* (Jan 2019), 22.
[143] Victoria Legal Aid, Submission to Productivity Commission Inquiry into the Economic Impacts of Mental Ill-Health, April 2019, 15, 35; Law Institute of Victoria, Submission to the Royal Commission into Victoria's Mental Health System (July 2019), 7; Victorian Mental Illness Awareness Council, Submission on the Terms of Reference to the Royal Commission into Mental Health (Jan 2019), 21.
[144] Victoria Legal Aid, Submission to Productivity Commission Inquiry into the Economic Impacts of Mental Ill-Health, April 2019, 15, 35; Law Institute of Victoria, Submission to the Royal Commission into Victoria's Mental Health System, (July 2019), 7;Victorian Mental Illness Awareness Council, Submission on the Terms of Reference to the Royal Commission into Mental Health,, (Jan 2019), 21; *Convention on the Rights of Persons with Disabilities*, opened for signature 13 December 2006, 1577 UNTS 3 (entered into force 3 May 2008), art 3.
[145] Law Institute of Victoria, Submission to the Royal Commission into Victoria's Mental Health System, May 2019, 5.
[146] For further detail, see Law Institute of Victoria, Submission to the Royal Commission into Victoria's Mental Health System, May 2019, 5.
[147] Victoria Legal Aid, Submission to Productivity Commission Inquiry into the Economic Impacts of Mental Ill-Health, April 2019, 15, 35.
[148] Law Institute of Victoria, forthcoming submission to the Royal Commission into Victoria's Mental Health System, due for publication in July 2019.
[149]Australian Bureau of Statistics, Australian Aboriginal and Torres Strait Islander Health Survey: First Results, Australia, 2012-13, viewed 26 June 2019,
<https://www.abs.gov.au/ausstats/abs@.nsf/Latestproducts/9F3C9BDE98B3C5F1CA257C2F00145721?opendocument>
[150] Ibid.
[151] National Mental Health Commission, 'Report of the National Review of Mental Health Programmes and Services' (Report, National Mental Health Commission, 30 November 2014) 5.
[152] Ibid 72.
[153] Stephen R. Zubrick et al, 'Social Determinants of Social and Emotional Wellbeing' in Nola Purdie, Pat Dudgeon and Roz Walker (eds), Working Together: Aboriginal and Torres Strait Islander Mental Health and Well-Being Principles and Practices (Department of Health and Ageing, 2010).
[154] Stephen R. Zubrick et al, 'Social Determinants of Social and Emotional Wellbeing' in Nola Purdie, Pat Dudgeon and Roz Walker (eds), *Working Together: Aboriginal and Torres Strait Islander Mental Health and Well-Being Principles and Practices* (Information Paper, Department of Health and Ageing, 2010).
[155] Kerrie Kelly et al, 'Living on the Edge: Social and Emotional Wellbeing and Risk and Protective Factors for Serious Psychological Distress among Aboriginal and Torres Strait Islander People' (Cooperative Research Centre for Aboriginal Health, 2009) 22; Muriel Bamblett, 'Self-determination and Culture as protective Factors for Aboriginal Children' (2006) 16 Developing Practice: The Child, Youth and Family Work Journal 9, 14.
[156] *Charter of Human Rights and Responsibilities 2006* (Vic) s 19(2).
[157] Department of Health and Human Services, *Balit Murrup: Aboriginal Social and Emotional Wellbeing Framework*, (Policy Paper, Department of Health and Human Services, 2017).
[158] *Mental Health Act 2014* (Vic) s 11(1)(a) – (l).
[159] Australian Bureau of Statistics. Estimates of Aboriginal and Torres Strait Islander Australians, June 2016. cat. no. 4517.0. 2016. < https://www.abs.gov.au/ausstats/abs@.nsf/mf/3238.0.55.001 >.
[160] Australian Bureau of Statistics. Prisoners in Australia, 2018. cat. no. 4517.0. Canberra: Australian Bureau of Statistics, 2018 , viewed 26 June 2019,
<https://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/4517.0Main+Features100002018?OpenDocument>.
[161] Eileen Baldry, Ruth McCausland, Leanne Dowse & Elizabeth McEntyre, 'A Predictable and Preventable Path: Aboriginal people with mental and cognitive disabilities in the criminal justice system' (2015) *University of New South Wales Law Journal.* PAGE?
[162]Australian Law Reform Commission, *Pathways to Justice – An Inquiry into the Incarceration Rate of Aboriginal and Torres Strait Islander Peoples, Final Report,* (December 2017) 13 citing Australian Bureau of Statistics, Prisoners in Australia, 2016, Cat No 4517.0 (2016) table 25.
[163] Ibid 430 [13.8].
[164] Standing Committee on Aboriginal and Torres Strait Islander Affairs, *Doing Time – Time for Doing: Indigenous Youth in the Criminal Justice System* (Parliament of Australia, 2011) 1.
[165] Australian Institute of Health and Welfare 2017. Youth Justice in Australia 2015-16. Cat. No. AUS 211. Canberra: AIHW. Table s 78b.
[166] Australian Institute of Health and Welfare, Youth Justice in Australia 2016-2017, Cat. No. JUV 116, May 2018, 8.
[167] Chris Cuneen, 'Arguments for Raising the Minimum Age of Criminal Responsibility' (Paper presented at the Australian Social Policy Conference, Sydney, 25-27 September 2017)
[168] Australian Human Rights Commission, National Children's Commissioner, *Children's Rights Report* 2016, 187.[168] Commonwealth Government, Royal Commission into the Protection and Detention of Children in the Northern Territory, *Final Report* (2017).
[169] Committee on the Rights of the Child (CRC), *General Comment No. 10 (2007): Children's Rights in Juvenile Justice*, 25th sess, CRC/C/GC/10 (April 2007) [32]; *UN Standard Minimum Rules for the Administration of Juvenile Justice* ('The Beijing Rules'), adopted by General Assembly resolution 40/33 of 29 November 1985, Rule 4.
[170] Australian Human Rights Commission, National Children's Commissioner, Children's Rights Report 2016, 187.
[171] *Charter of Human Rights and Responsibilities Act 2006* (Vic) s 19(2)
[172] *Charter of Human Rights and Responsibilities Act 2006* (Vic) ss19(2) and 38.

[173] *International Covenant on Civil and Political Rights*, opened for signature 16 December 1966, 993 UNTS 3 (entered into force 23 March 1976); Human Rights Committee, Views: Communication No 197/1985, UN Doc CCPR/C/33/D/197/1985 (27 July 1988) [9.2]-[9.3] (‘*Kitok v Sweden*’).
[174] Ibid; Human Rights Committee, Views: Communication No. 511/1992, 52nd sess, UN Doc CCPR/C/52/D/511/1992 (8 November 1994) [9.2] (‘*Lansman v Finland*’).

[175]Human Rights Committee, *General Comment No 23: Article 27 (Rights of Minorities)*, 8th sess, UN Doc CCPR/C/21/Rev.1/Add.5 (8 April 1994) [1].
[176] *Cemino v Cannan and Ors* [2018] VSC 535.
[177] J McKendrick, R Brooks, J Hudson, M Thorpe & P Bennett, Aboriginal and Torres Strait Islander healing programs: A literature review, The Healing Foundation, Canberra, 2014, 3.
[178] Victorian Aboriginal Community Controlled Health Organisation, ‘Walk with us towards brighter future for Aboriginal Victorians – Working with Communities to enhance the health and wellbeing of Aboriginal Victorians, 8.
[179] Ibid.
[180] Ibid.
[181]*United Nations Declaration on the Rights of Indigenous Peoples*, opened for signature on 13 September 2007.
[182] Department of Premier and Cabinet, Victorian Government, *Victorian Aboriginal Affairs Framework 2018-2023* (Report, October 2018) 22.
[183] Larissa Behrendt, Miriam Jorgensen, Alison Vivian ‘Self-determination: Background Concepts – Scoping Paper 1 prepared for the Victorian Department of Health and Human Services’ University of Technology Jumbunna Indigenous House of Learning citing Michael Weightman, ‘The Role of Aboriginal Community Controlled Health Services in Indigenous Health’, (2013) 4(1) Australian Medical Student Journal 49, 49.
[184] Ibid 49.
[185] Ibid 12.
[186] See World Health Organisation, ‘Gender and women’s mental health’ *World Health Organisation* (Web page, 24 June 2019) <https://www.who.int/mental_health/prevention/genderwomen/en/>; Department of Mental Health and Substance Dependence *Gender Disparities in Mental Health* (World Health Organisation, 2019) <https://www.who.int/mental_health/media/en/242.pdf?ua=1>; Shoukai Yu, ‘Uncovering the hidden aspects of inequality on mental health: a global study’ (2018) 8 *Translational Psychiatry* 1-10; Women’s Health Victoria, ‘The social and economic benefits of improving mental health: Women’s Health Victoria’s submission to the Productivity Commission Inquiry, April 2019’ 16-17 (Women’s Health Victoria, 2019)
[187] World Health Organisation, ibid.
[188]Shoukai Yu, ‘Uncovering the hidden aspects of inequality on mental health: a global study’ (2018) 8 *Translational Psychiatry* 1-10.
[189] Department of Mental Health and Substance Dependence, *Gender Disparities in Mental Health*, (World Health Organisation) 5; Peter Bracke (2000), ‘The three year persistence of depressive symptoms in men and women’ 51 *Social Science & Medicine* 51-64.
[190] Department of Mental Health and Substance Dependence *Gender Disparities in Mental Health* (World Health Organisation, 2019) https://www.who.int/mental_health/media/en/242.pdf?ua=1.
[191] Ibid.
[192] Maria Duggan, *Investing in women’s mental health: strengthening the foundations for women, families and the Australian economy* (Policy Issues Paper, Australian Health Policy Collaboration, 2016).
[193] Mission Australia and Black Dog Institute, *Youth mental health report: Youth Survey 2012-16*. (Mission Australia, 2017) <https://www.missionaustralia.com.au/publications/research/young-people/706-five-year-mental-health-youth-report>.
[194] The 2007 (and most recent) National Survey of Mental Health and Wellbeing found that women were markedly more likely to experience anxiety and depression than men. 32 per cent of women compared to 20.4 per cent of men experienced anxiety, and 17.8 % of women compared to 12.2% of men experienced depression. A 2017 Australia-wide women’s health survey found that 40 per cent of women respondents had been diagnosed with depression or anxiety. Australian Bureau of Statistics, National Survey of Mental Health and Wellbeing: Summary of Results (Australian Bureau of Statistics, 2007) 4326.0, 27 <https://www.ausstats.abs.gov.au/ausstats/subscriber.nsf/0/6AE6DA447F985FC2CA2574EA00122BD6/$File/National%20Survey%20of%20Mental%20Health%20and%20Wellbeing%20Summary%20of%20Results.pdf>. Jean Hailes for Women’s Health, *Women’s Health Survey 2017* (Research report, Jean Hailes for Women’s Health, 2017) 7 <https://jeanhailes.org.au/survey2017/report_2017.pdf>.
[195] Australian Institute of Health and Welfare, *Perinatal depression: data from the 2010 Australian National Infant Feeding Survey* (Research Report, Australian Institute of Health and Welfare, 2012).
[196] In Australia, two in every five women (41%) have experienced violence since the age of 15 years. Approximately one in three women (34%) have experienced physical violence and almost one in five (19%) have experience sexual violence. The health impacts for women who experience violence include poor mental health, particularly anxiety and depression, alcohol and drug mis-use and suicide. VicHealth, *Violence against women in Australia: research summary* (Research Report, Victorian Health Promotion Foundation, 2017) <https://www.vichealth.vic.gov.au/mendia-and-resources/publications/violence-against-women-in-australia-research-summary>.
[197] Suicide rates are higher for men, however women have higher rates of suicidal behavior (suicidal ideation, planning and attempts). Since the late 1990s, the suicide rate for young men has steadily decreased, but the rate for young women has increased by 47 per cent in the last decade. Suicide Prevention Australia, *Suicide and suicidal behavior in women: issues and prevention* (Research Report, Suicide Prevention Australia, 2016) 6. <https://apo.org.au/node/56174>.
[198] The rate of hospitalisation for intentional self-harm is 40 per cent higher for women than men. Australian Institute of Health and Welfare, ‘Suicide and hospitalised self-harm in Australia: Trends and analysis’ (Research Report, Flinders University, 2014) 65 <www.aihw.gov.au/getmedia/b70c6e73-40dd-41ce-9aa4-b72b2a3dd152/18303.pdf.aspx?inline=true> .The number of women aged 15-24 years who require hospital treatment for self-inflicted injuries increased by more than 50 per cent from 2000 to 2016. Above n 197, 6.
[199] Women With Disabilities Victoria, *FactSheet 3: Violence Against Women With Disabilities* (Women With Disabilities Victoria, 2016) <https://www.wdv.org.au/document/Fact%20Sheet%203%20%-%20Vioelnce%20against%20women%20with%20disabilities_final%20(May%202016).pdf>.
[200] Above n 199, 24.
[201] Ibid 23.
[202] Ibid 8. Annette L. Beautrais, ‘Women and suicidal behaviour’ (2006) *Crisis* 27(4) 153.
[203] Victorian Mental Illness Awareness Council, *Zero Tolerance for Sexual Assault: A safe admission for women’* (2013) cited in Women With Disabilities Victoria, *FactSheet 3: Violence Against Women Disabilities’* (Fact sheet, 2013)

<https://www.wdv.org.au/documents/Fact%20Sheet%203%20-20Violence%20against%20women%20with%20disabilities_final%20(May%202016).pdf>.
[204] Haley Miles-McLean, Miriam Liss, Mindy J. Erchull, Caitlin M. Robertson, Charlotte Hagerman, Michelle A. Gnoleba, Leanna J. Papp, '"Stop Looking at Me!": Interpersonal Sexual Objectification as a Source of Insidious Trauma' (2015) 39(3) *Psychology of Women Quarterly* 363 <https://doi.org/10.1177/0361684314561018>.
[205] For further detail, see Victorian Equal Opportunity and Human Rights Commission, Submission to the national inquiry into sexual harassment in Australian workplaces (Victorian Equal Opportunity and Human Rights Commission, 2019) <https://humanrightscommission.vic.gov.au/policy-submissions/item/1797-submission-national-inquiry-into-sexual-harassment>.
[206] Above n 192.
[207] Ibid.
[208] See World Health Organisation, 'Gender and women's mental health' *World Health Organisation* (Web page, 24 June 2019) <https://www.who.int/mental_health/prevention/genderwomen/en/>; Department of Mental Health and Substance Dependence *Gender Disparities in Mental Health* (World Health Organisation, 2019) <https://www.who.int/mental_health/media/en/242.pdf?ua=1>; UN Committee on the Elimination of All Forms of Discrimination Against Women, *General Recommendation 24: Article 12 of the Convention (Women and Health),* 20th sess, A/54/38/Rev.1, chap. I (1999).
[209] Department of Mental Health and Substance Dependence *Gender Disparities in Mental Health* (World Health Organisation, 2019) <https://www.who.int/mental_health/media/en/242.pdf?ua=1>.
[210] Above n 192.
[211] Above n 189.
[212] Ibid.
[213] Women's Health Victoria, above n 186.
[214] Above n 192.
[215] In 2017-18, the Commission received 448 complaints from women about discrimination associated with their sex. This represents 20 per cent of the total number of complaints (2246) accepted by the Commission in 2017-18. Importantly, women also make up a significant proportion of complainants alleging discrimination related to other attributes such as race, religion, disability and, while not reported, gender may play a role in why or how these women were targeted.
[216] Above n 204.
[217] Ibid.
[218] Our Watch, Australia's National Research Organisation for Women's Safety (ANROWS) and VicHealth *Change the story* (2015) 33, 34.
[219] Steve Robertson, Anne-Marie Bagnall, Michael Walker, 'Evidence for a gender-based approach to mental health programs' (Evidence Report, Sax Institute for the Movember Foundation, 2014) <https://saxinstitute.org.au/wp-content/uploads/A-gender-based-approach-to-mental-health-programs.pdf>.
[220] State of Victoria *Safe and Strong: A Victorian gender equality strategy - Preventing Violence against women through gender equality* (State of Victoria, 2016).
[221] Above n 204.
[222] State of Victoria, *Free from violence: Victoria's strategy to prevent family violence and all forms of violence against women* (State of Victoria, 2017).
[223] See above n 42 [20].
[224] Gender-sensitive approaches exist in relation to post-natal depression and anxiety and men's suicide, but are sadly lacking in relation to other mental health conditions.
[225] See Mental Health Complaints Commissioner, 'The Right to be Safe: Summary Report' (Research Report, Mental Health Complaints Commissioner, 2018) <https://www.mhcc.vic.gov.au/news-and-events/news/ensuring-sexual-safety-in-acute-mental-health-inpatient-units>. See also Women's Health Victoria, 'The social and economic benefits of improving mental health: Women's Health Victoria's submission to the Productivity Commission Inquiry, April 2019' 16-17 (Women's Health Victoria, 2019).
[226] Ibid.
[227] Above n 192.
[228] Ibid. See also https://socialfutures.org.au/wp-content/uploads/2015/11/LivedExperienceProject_prototype.pdf.
[229] Above n 192.
[230] Women's Centre for Health Matters, *Position Paper on Gender Sensitive Health Service Delivery* (Policy Paper, Women's Centre for Health Matters, 2009) <http://www.wch.org.au/wp-content/uploads/2015/02/WCHM-position-paper-on-geder-sensitive-health-service-delivery.pdf>.
[231] Above n 219.
[232] Penelope Weller, 'OPCAT Monitoring and the Convention on the Rights of Persons with Disabilities' (2019) 25(1) *Australian Journal of Human Rights* 131.
[233] Bronwyn Naylor, Julie Debeljak and Anita Mackay, 'A strategic Framework for Implementing Human Rights in Closed Environments' (2018) 41(1) *Monash Law Review* 218.
[234] *Optional Protocol to the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, opened for signature 18 December 2002, 2375 UNTS 237 (entered into force 22 June 2006).
[235] *Convention Against Torture and other Cruel, Inhuman and Degrading Treatment or Punishment*, opened for signature 10 December 1984, 1465 UNTS 85 (entered into force 26 June 1987).
[236] *Convention on the Rights of Persons with Disabilities*, opened for signature 13 December 2006, 1577 UNTS 3 (entered into force 3 May 2008), art 16.
[237] *Mental Health Act 2014* (Vic) ss 46, 110-112 and 113-116.
[238] Above n 234, art 4.