**National Mental Health Commission submission to the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability**

**Introduction**

The National Mental Health Commission (NMHC) welcomes the opportunity to make a submission to the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability.

Almost a third (32%) of adults with disability experience high/very high psychological distress, compared with 8% of adults without disability.[[1]](#endnote-1)

People with disability who have a mental health condition are likely to face additional challenges. Compared with other people with disability, those aged 10 and over who have a mental health issue are more likely to have experienced domestic and family violence (35% compared with 23%). [[2]](#endnote-2) People with disability experience a higher level of violence after the age of 15 (47%) compared to people without disability (36%). [[3]](#endnote-3)

**About the NMHC**

The NMHC was established in 2012 and is an independent executive agency in the Australian Government Health Portfolio. The NMHC is a listed entity under the *Public Governance, Performance and Accountability Act 2013* with the NMHC’s purpose set out in clause 15 of Schedule 1 of the *Public Governance, Performance and Accountability Act 2014.*

The NMHC’s purpose is to:

* monitor and report on investment in mental health and suicide prevention initiatives;
* provide evidence-based policy advice to Government;
* disseminate information on ways to continuously improve Australia’s mental health and suicide prevention systems; and
* act as a catalyst for change to achieve those improvements. This includes increasing accountability and transparency in mental health through the provision of independent reports and advice to the Australian Government and the community.

**Section 1: Responding to the terms of reference**

This submission will respond specifically to the below listed terms of reference.

(a) What governments, institutions and the community should do to prevent, and better protect, people with disability from experiencing violence, abuse, neglect and exploitation, having regard to the extent of violence, abuse, neglect and exploitation experienced by people with disability in all settings and contexts.

(b) What governments, institutions and the community should do to achieve best practice to encourage reporting of, and effective investigations of and responses to, violence against, and abuse, neglect and exploitation of, people with disability, including addressing failures in, and impediments to, reporting, investigating and responding to such conduct.

(c) What should be done to promote a more inclusive society that supports the independence of people with disability and their right to live free from violence, abuse, neglect and exploitation.

(d) Any matter reasonably incidental to a matter referred to in paragraphs (a) to (c) or that you believe is reasonably relevant to your inquiry.

**(a) What governments, institutions and the community should do to prevent, and better protect, people with disability from experiencing violence, abuse, neglect and exploitation, having regard to the extent of violence, abuse, neglect and exploitation experienced by people with disability in all settings and contexts.**

The NMHC supports working towards the elimination of seclusion and restraint of people experiencing mental health difficulties in mental health services.

The NMHC acknowledges that this is a multifaceted issue. We recognise that people have a right to safe and effective care, and to work in an environment that is safe and supportive. We appreciate that considerable work is underway around Australia to understand and address the factors that lead towards seclusion and restraint, and to monitor its use.

States and territories have made significant advances in relation to seclusion and should be congratulated for what they have achieved. In 2014, Disability Ministers from the Australian, state and territory governments agreed to the National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Service Sector.[[4]](#endnote-4) In 2016 the National Principles to Support the Goal of Eliminating Mechanical and Physical Restraint in Mental Health Services[[5]](#endnote-5) were endorsed by the advisory council to Australian Health Ministers. These national agreements provide guidance to governments on restrictive practices.

Restrictive practices are also monitored through the NDIS Commission for NDIS participants. Registered providers who develop behaviour support plans or use restrictive practices are required to comply with the NDIS Quality and Safeguarding Framework[[6]](#endnote-6), which is underpinned by the same high-level guiding principles as the National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Service Sector.

In 2017, the NMHC partnered with the Australian College of Mental Health Nurses to better understand the decision making processes of mental health nurses around using seclusion and restraint. The final report from this project outlined that a number of factors influence the use of restraint.

In 2018 the NMHC continued to promote best practice in the reduction of restrictive practices. To support cultural change by nurses, the NMHC engaged the Australian College of Mental Health Nurses (ACMHN) to progress the ‘Safe in care, safe at work’ project which builds on the 2017 Supporting Mental Health Nurses towards cultural and clinical change: Facilitating ongoing reduction in seclusion and restraint in inpatient mental health settings in Australia project. The project responds to discussions between the ACMHN, the NMHC and key stakeholders invested in the ongoing reduction of seclusion and restraint in Australia. The project reflects a recognition of the importance of safety in care and at work and is a response to an ongoing dialogue with key stakeholders, including mental health nurses, consumers, carers and industry.

The final package is comprised of an audit toolkit for services, the Australian adaption of the Six Core Strategies checklist and a list of guiding documents to reduce seclusion and restraint. An abridged version for mental health staff and managers was developed that emphasises the use of the checklist to guide the reduction of seclusion and restraint.

**Incarceration**

Although there are significant data gaps around the mental health of the youth detention population, we know that higher rates of mental illness and cognitive disability exist than in the general population.[[7]](#endnote-7)   
  
The intersection between mental health, disadvantage and the justice system is complex and concerning, as is the high prevalence of mental illness amongst those in incarceration.[[8]](#endnote-8) Not only are young people with a mental illness overrepresented in youth incarceration, just being incarcerated as a young person is associated with experiencing worse physical and mental health later in life.[[9]](#endnote-9)   
  
Often people with mental illness, cognitive disability and drug and alcohol issues end up in incarceration because there are no other alternatives available (particularly in rural and remote areas).[[10]](#endnote-10) In the absence of a nationally consistent reporting system or framework we are limited in our understanding of how supports are provided to these groups once in incarceration, including how well these adhere to evidence-based practices.[[11]](#endnote-11) Regardless of the support provided, incarceration is neither an appropriate nor effective response to address mental health and cognitive disability.

Concerns have been highlighted regarding the justice systems’ ability to adequately respond to the mental health needs of incarcerated youth. The Royal Commission into the Detention and Protection of Children in the Northern Territory in 2017 pointed out a number of issues:

* inadequate health assessment processes on admission to youth detention;
* inadequate healthcare for young people experiencing mental health issues;
* lack of consistency in managing behaviours initiated by a history of trauma, symptoms of foetal alcohol syndrome, ADHD, and other mental health issues in detainees; and
* youth justice officers being required to identify at-risk behaviours in detainees with minimal or no mental health training.

In light of these findings, and in line with our 2013 National Report Card, the NMHC continues to be conscious of ongoing issues regarding equity of rights and access to services. While substantial investment is required to address these issues and create alternate pathways away from incarceration, the existing economic and social costs of youth incarceration dwarf the investment required to prevent it.[[12]](#endnote-12) Available data indicates that on average, it costs $600 per day per prisoner to incarcerate a young person. In addition, there are indirect economic costs from loss of employment and deterioration of employable skills, which in turn create a cycle of re-offending. Social impacts can include separation of families, loss of engagement with community as well as poorer health outcomes.[[13]](#endnote-13)

**(b) What governments, institutions and the community should do to achieve best practice to encourage reporting of, and effective investigations of and responses to, violence against, and abuse, neglect and exploitation of, people with disability, including addressing failures in, and impediments to, reporting, investigating and responding to such conduct.**

The mental health system has a way to go in appropriately responding to the impact of violence and trauma, with interim findings from the Victorian Royal Commission into Mental Health citing the need for a common understanding of trauma and violence informed care. This speaks to the current models of health care that neglect to take into consideration the family and social context surrounding an individual and any co-existing issues. For example, treating mental health and substance use issues in isolation of the impact of domestic, family and sexual violence (despite the crossover of service users), is treating only the symptoms not the underlying cause of mental health and substance use issues i.e. violence.[[14]](#endnote-14)

In a statement endorsed by the NMHC, and the Mental Health Commissions of NSW, Queensland, South Australia and Western Australia following the closure of the Royal Commission into Institutional Responses to Child Sexual Abuse, the commissions outlined nine actions for the Australian and state and territory governments to implement. Many of these are just as relevant to the violence and abuse experienced by people with disability and have been adapted below.[[15]](#endnote-15)

* Recognise that violence and abuse is broader than institutional settings.
* Recognise the strength and resilience of survivors and use this, rather than an illness-based approach, to build positive outcomes.
* Build trauma capability across the full spectrum of services that recognises and responds to the specific needs of people managing the devastating impacts of abuse.
* Develop co-ordinated responses to the varied needs of consumers, including extended access to Medicare-funded counselling.
* Prepare for increased demand.
* Increase community-based support workers.
* Develop culturally appropriate services for Aboriginal people.

Although limited in their evaluation, there are promising frameworks that have the potential to address the issues of inadequacy to respond appropriately to domestic, family and sexual violence (DFSV) in the health and mental health systems and form a common understanding of trauma and violence informed care.

The Health Systems Implementation Trauma and Violence-Informed Model was developed by the

Australia’s National Research Organisation for Women’s Safety.[[16]](#endnote-16) Input for the model was sought from women with lived experience of DFSV, staff working in hospitals, sexual assault centres and a clinical mental health service as well as conducting a literature review of similar or related existing evidence-based models. This framework underpins both a female centred care approach and a practitioner or staff-centred service approach, where women are empowered and receive a holistic response and practitioners and staff are supported and provided with the necessary education and resources to provide appropriate care.

Insights can also be garnered from the Women with Co-occurring Disorders and Violence Study that generated a wealth of knowledge regarding the effectiveness of comprehensive, integrated and trauma-informed service models for women with co-occurring histories of violence and mental health issues.[[17]](#endnote-17) For a detailed understanding of the neurobiological impact of trauma on the body

‘The Body Keeps the Score: Brain, Mind, and Body in the Healing of Trauma’ by Bessel van der Kolk is

a valuable resource.

**(c) What should be done to promote a more inclusive society that supports the independence of people with disability and their right to live free from violence, abuse, neglect and exploitation.**

People with mental illness continue to experience stigma, not only in the general community, but most importantly in the services from which they require support.

Stigma restricts access to social and community resources relevant to good health and exposes individuals to more toxic environments, which acts to erode the health of people who are stigmatised.

People with psychosocial disability continue to require mainstream services such as healthcare, education, transport and housing. The NMHC supports continued efforts to ensure mainstream services are not only accessible for people with psychosocial disability, but are also inclusive, person-centred and free from stigma.

Full and meaningful participation by people with disability and their carers can support more effective and efficient services, delivering benefits for clinicians, policy makers and funders, as well as for consumers and carers. Engaging with people who are most directly affected by mental health services, policies and programs is essential to understanding whether these different components of the system are achieving their aims and opportunities for continuous improvement.

Engagement and participation is also vital to ensuring the safety and dignity of people with disability and carers and achieving a person-centred approach to care. It supports consumers and carers to exercise choice and control, and influence the decisions that affect their lives. Engagement and participation can also foster emotional wellbeing and self-confidence, and can be a powerful way to break down stigma and prevent discrimination.

**(d) Any matter reasonably incidental to a matter referred to in paragraphs (a) to (c) or that you believe is reasonably relevant to your inquiry.**

**Impact of COVID-19 and bushfires**

Many people with disability are at higher risk of infection during COVID-19 due to their existing mental and physical health issues. They also rely on carers, formal and informal supports that may have been restricted as a result of pandemic response measures. Barriers that may exist in accessing health information, including a lack of information available in plain or accessible language, can also increase the risk of infection[[18]](#endnote-18) and highlights existing inequities faced by people with disability. In turn these factors can create a greater risk of a decline in mental and physical health.[[19]](#endnote-19),[[20]](#endnote-20)

In addition, concerns have been raised regarding decision making in the context of prioritisation of medical care and treatment. There are fears that these decisions are being made with a degree of underlying ableism that devalues and discriminates against people with disability.[[21]](#endnote-21) This may raise significant distress for people with disability.

The following concerns have also been expressed by the disability sector regarding the National Disability Insurance Agency (NDIS):

* Difficulties faced by people regarding access to IT to participate in online services. Such as the cost of purchasing the technology, cost of purchasing data/internet, fear of using or no knowledge of how to use technology.[[22]](#endnote-22)
* Confusion around use of flexible funding within plans
* Advice required as to when personal protective equipment (PPE) is warranted, how it can be sourced and information for the workforce on its correct use.
* Impacts for families and carers, including consideration of how the National Disability Insurance Agency can support them as an informal workforce and provide respite. Issues include some carers who have quit jobs to care for family members, family members returning home to families to isolate and the consequent change to family dynamics placing greater pressure on households and fears about wellbeing and safety.
* The need for data, both quantitative and qualitative, to drive some of the lessons we might learn from this situation.
* The current lack of a clear picture of how people are linking into the mental health system, e.g. are people using telehealth services, are people taking medication, particularly for those with severe and complex needs.

**Conclusion**

People with a disability should expect the same rights, opportunities and health as those without a disability. Simply put, this is about having a good home, meaningful activity, valued friendships, proper health care and opportunities for education and training, all without experiencing discrimination.

The mental health impact of violence, abuse and neglect on people with disability can influence their outcomes across the lifespan and result in ongoing trauma and physical health issues. The engagement of people with lived experience in developing processes and practices to develop safeguards for vulnerable cohorts is essential to minimising violence, abuse and neglect of people with disability.

Reducing violence and abuse is a whole of system responsibility and requires connected supports that provide holistic appropriate services to the individual and their families and carers, provided by qualified staff. Greater understanding and clear guidelines for identifying and responding to incidents of violence and abuse across all areas of health, mental health, education, employment and the justice system will provide a safer environment for a broad range of vulnerable cohorts.

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