

Victorian Mental Health Strategy

Submission by Women with Disabilities Victoria

15th June 2015

**Women with Disabilities Victoria**

Level 9, 255 Bourke Street

Melbourne 3001

Phone 9286 7800

[www.wdv.org.au](http://www.wdv.org.au)

**Contacts**

Keran Howe

Executive Director

[Keran.howe@wdv.org.au](mailto:Keran.howe@wdv.org.au)

Jen Hargrave

Policy Officer – violence against women with disabilities

[Jen.hargrave@wdv.org.au](mailto:Jen.hargrave@wdv.org.au)

03 9286 7800

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# Women with Disabilities Victoria

Women with Disabilities Victoria is an organisation run by women with disabilities for women with disabilities. Our members, board and staff live across the state and have a range of disabilities, lifestyles and ages. We are united in working towards our vision of a world where all women are respected and can fully experience life.

We undertake research, consultation and systemic advocacy. We provide professional education, representation, information, and leadership programs for women with disabilities. Our gender perspective allows us to focus on areas of particular inequity to women with disabilities; access to women’s health services, gendered NDIS services, and safety from gender-based violence.

Inter-sectoral partnerships are integral to our work. As such we have worked to improve women’s access to health services and information through a 2014-15 workforce development training program at the Royal Women’s Hospital.

Under Victoria’s Plan to Address Violence Against Women and Children we were funded to pilot a ground breaking workforce development, prevention program in disability services. The Gender and Disability Workforce Development Program commenced in 2013 and the program evaluation was completed in Augusts 2015.

In 2014 we published the [Voices Against Violence](http://www.wdv.org.au/voicesagainstviolence.html) research project with partners Office of the Public Advocate Victoria (OPA) and Domestic Violence Resource Centre Victoria. The seven papers of the project examined the intersecting forms of gendered and disability based violence experienced by women with disabilities. They include studies of literature, OPA files, legislation, and interviews with OPA staff and women with disabilities.

This submission draws on findings and recommendations from these projects, alongside our previous projects, work with other organisations and consultations with women with disabilities.



Women with Disabilities Victoria members, associate members, board, staff and supporters

# List of recommendations

Recommendation 1: That the mental health strategy is gender sensitive; that it articulate the gendered nature of men’s violence against women, that it incorporate workforce development on gender safe practice and identifying family violence, and that it take every opportunity to gender disaggregate through data and evaluation designs.

Recommendation 2: That Victoria commit to ensuring mental health services are safe places for women.

Recommendation 3: That the mental health strategy identify the higher rates of trauma arising from discrimination and violence that are experienced by people with disabilities. That the strategy have appropriate recognition and response strategies to the violence related trauma experienced by people, especially women, with disabilities.

Recommendation 4: That the strategy direct development in screening consumers for experiences of trauma (including family violence and sexual assault) in ways which are resourced adequately (with time and training), gender sensitive, disability accessible, and family-violence-informed.

Recommendation 5: That consultations, governance and future work related to this strategy include specialists from women’s violence response services, disability services and women who experience/d mental illness, including women with intellectual disabilities.

Recommendation 6: That the mental health strategy use a strengths based approach to disability.

Recommendation 7: That the mental health strategy recognise and incorporate the concepts inherent in the social model of disability.

Recommendation 8: That the mental health strategy recognise and respond to the inequities between people who are disabled and abled, and between women with disabilities and men with disabilities.

Recommendation 9: That the mental health strategy establish frameworks for collecting data on disability and providing disability access supports and referrals.

Recommendation 10: That a disability access plan is made for all information related to this strategy’s development, content and dissemination.

Recommendation 11: That the mental health strategy highlight the need for gender specific, disability accessible health and service information.

Recommendation 12: That mental health services are encouraged to develop disability action plans to assess and improve their information, buildings, services and policies, bringing them up to Commonwealth Disability Discrimination Act standards.

Recommendation 13: That focus is put into studying good practice examples of accessible and tailored services for people with disabilities.

Recommendation 14: That the mental health strategy connect with the NDIS safeguarding and quality framework to uphold rights to safety, justice and autonomy.

Recommendation 15: That the mental health strategy take a whole of government approach and connect with other highly relevant inquiries on gender, disability and violence.

# Trauma Informed Care

Following are responses to some of the questions raised in the Trauma and Mental Health Technical Paper.

**Q1.** How else could we describe this subject (of Trauma Informed Care)? Are important details or way of understanding this subject missing?

We wish to raise several topics which we recommend the Strategy incorporate.

**Violence against women**

The technical paper draws the crucial link between family violence and mental health problems, The paper also links to the Family Violence Royal Commission. Victorians have a great deal to benefit from a Mental Health Strategy that is linked to findings from the Royal Commission, including advice on:

* undertaking family violence risk assessments
* secondary consultation and referrals with family violence, sexual assault and other violence response services such as police and legal services.
* service coordination with violence response services.

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| CASE EXAMPLE: “A woman in a wheelchair whose husband raped and assaulted her over many years felt trapped in the relationship because he was also her carer… Ms Brown said her husband often told her that her mental health problems were the reason for his behaviour. *"I just thought I was hopeless. Yes, I do have a mental health problem, I am responsible for everything that's going on."* Since her relationship ended her mental health has improved dramatically, and she no longer try to self harm, Ms Brown told the hearing.”[[1]](#footnote-1) |

Family Violence is a form of Violence Against Women, and Victoria’s understanding of this is underpinned by the VicHealth Preventing Violence Against Women Framework. This framework is clear about the gendered nature of violence, and latter work has built on this understanding. Victoria has an opportunity to create a gender-sensitive Mental Health Strategy which is in-keeping with contemporary understandings of trauma, violence and health promotion.

The technical paper recognises some gender disaggregated data. It is important that we do gender disaggregate data so that we are prepared to respond to the higher rates of sexual and family violence experienced by women. Family Violence, in it’s nature, lasts for longer periods of time than violence from a stranger. VicHealth and the World Health Organisation are clear about the negative impacts of this on women’s mental health.

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| Good practice example:The WDV Gender and Disability Workforce Development Program is designed to change culture across whole organisations, working with clients, staff, managers and executives. This aim is to improve gender equitable service delivery as a strategy for increasing women’s well-being and reducing gender based violence. The package is co-delivered by women with disabilities and professionals from relevant sectors. Ongoing communities of practice within the pilot organisations support and sustain the project. WDV piloted all Program packages throughout 2014/2015 alongside an evaluation process to be completed in August 2015. See ‘Appendix 2 G and D’ for more information. |

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| Recommendation 1: That the mental health strategy is gender sensitive; that it articulate the gendered nature of men’s violence against women, that it incorporate workforce development on gender safe practice and identifying family violence, and that it take every opportunity to gender disaggregate through data and evaluation designs. |

**Gender sensitive, safe practice**

With the seriously high rates of violence against women within Victoria’s mental health services documented by the Victorian Mental Illness Awareness Council (VMIAC) and the Women’s Mental Health Network Victoria (WMHNV) among others (See VMIAC’s Zero Tolerance report), this strategy has no choice but to be leading improvements to women’s rights to safety and justice.

In addition to women’s disclosures of violence and harassment during admission, it is important that we acknowledge women’s reports that staff did not know how to respond. There is an urgent need to embed policies such as the Department’s 2011 [guideline for gender sensitive service delivery](https://www2.health.vic.gov.au/getfile/?sc_itemid=%7b84F93199-D99F-487A-9546-431E5CE42EE5%7d&title=Service%20Guideline%20for%20Gender%20Sensitivity%20and%20Safety) and practices such as the training developed by WMHNV. Clearly, secure women’s only wards are also essential. It is not acceptable to re-traumatise women during treatment, as this can only serve to deter women from services.

Gender sensitive, safe practice is discussed further below under the heading, NDIS Quality and Safeguarding Framework.

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| Recommendation 2: That Victoria commit to ensuring mental health services are safe places for women. |

**Disability and trauma**

Research shows that women with disabilities experience higher rates of violence over their lifetime, and for longer periods of time in comparison to their male counterparts and women in the general population, and at the hands of a greater number of perpetrators.[[2]](#footnote-2) This is particularly so for women with communication disabilities and cognitive disabilities. Some studies say that women with intellectual disabilities are up to twice as likely to experience violence compared to other women.

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| EAMPLE: In a random audit of 100 women’s files at the Office of the Public Advocate, nearly 50% of women had disclosed experiencing violence to their Advocate/Guardian. This is particularly stark when we consider that violence is under reported and at that time, OPA staff had no training or screening processes to detect it.[[3]](#footnote-3) |

This violence stems from a culture of inequality between women and men, adherence to rigid gender stereotypes and notions of male dominance, superiority and entitlement over women. Violence against women with disabilities is a result not only of this systemic gender-based discrimination against women but also of disability-based discrimination against people with disabilities. These intersect with other sources of power inequalities such as colonisation, ethnicity, citizenship status, sexuality, age and class. Combined forms of discrimination and power inequalities increase the risk of experiencing violence exponentially.

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| Recommendation 3: That the mental health strategy identify the higher rates of trauma arising from discrimination and violence that are experienced by people with disabilities. That the strategy have appropriate recognition and response strategies to the violence related trauma experienced by people, especially women, with disabilities.  Recommendation 4: That the strategy direct development in screening consumers for experiences of trauma (including family violence and sexual assault) in ways which are resourced adequately (with time and training), gender sensitive, disability accessible, and family-violence-informed. |

**Q4.** Who else could be involved in thinking through this subject and strategic responses?

We heard at the Royal Commission into Family Violence from specialists such as Dr Sabin Fernbacher ([transcript](http://www.rcfv.com.au/MediaLibraries/RCFamilyViolence/Transcripts/Transcript-RCFV_Day-008_22-Jul-2015_Public.pdf)) about the tremendous outcomes achieved through cross sectoral partnerships. The mental health sector should be working collaboratively to its full potential with sexual assault and family violence response and prevention services. Partnership potentials include skill sharing placements, training, secondary consolation and referral. Likewise, partnerships with disability specialists such as Office of the Public Advocate and Office for Disability in DHHS is beneficial for building disability expertise.

The Mental Health sector is familiar with consumer participation. It is important that women are given safe, genuine and resourced opportunities to provide feedback on services and develop policy. Well established networks such as WMHNV and WDV can be further capitalised on.

WDV support the ideas in the Discussion Paper about cross sectoral collaboration, workforce development and hearing the voices of clients.

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| Recommendation 5: That consultations, governance and future work related to this strategy include specialists from women’s violence response services, disability services and women who experience/d mental illness, including women with intellectual disabilities. |

**Disability access to services**

Following are responses to the questions raised in the Intellectual Disability (ID) technical paper.

**Q1.** Are the key barriers to good mental health – and disadvantage associated with poor mental health – for people with intellectual disability (dual disability) adequately described? How else can this be understood?

To understand dual disabilities it is helpful to understand the following additional points.

**Understanding a strengths based approach**

This paper presents intellectual disability as a deficiency, something less than normal. For example:

* “Lack of awareness of mental illness symptoms by the person” could be better described as lack of accessible, available information about mental illness.
* “Symptoms of mental illness often present differently in people with an ID making it hard to recognise and diagnose” could be better described as ‘meaning we need to learn more about how to recognise signs of mental illness.’ This very point is actually put brilliantly in the paper later, “Mental Health professionals often lack the confidence training or experience to assess and effectively engage and treat people with dual disability.”
* “This occurs because their strange accounts or interpretations of life and ‘odd’ behavioiur or speech pattern are seen as a sign of mental illness.”
* “…intellectual disability … result(s) in serious and life long impairments.” This is not the case for all people with intellectual disabilities.
* “The complex needs of the client group” certainly problemitises and ‘others’ people with ID. This is unhelpful when we acknowledge, as this paper does, that a significant proportion of people with ID require mental health support.

This Strategy can take a more sophisticated approach to ID, it can address discrimination and bias against people with disabilities in our community and improve services by taking a strengths based view of people with disabilities. A strengths based approach is a key to breaking down barriers.

For example, let’s recognise the strength, resilience, credibility and experiences of people with disabilities by; using the words ‘targeted’ and ‘at risk’ rather than ‘vulnerable’, using the word ‘disclosures’ rather than ‘allegations’, and naming violence against women.

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| Recommendation 6: That the mental health strategy use a strengths based approach to disability. |

**Understanding the disability service sector context, legislative frameworks and the Social Model of Disability**

To create disability accessible services, in keeping with the Disability Discrimination Act, it is helpful to understand what disability is. While disability is strongly written into Human Rights, there is no universally agreed definition of disability. This has major implications for how services are funded and who is eligible for them.

The UN Convention on the Rights of Persons with a Disability recognises ‘disability’ as “the interaction between persons with impairments and attitudinal and environmental barriers that hinders their full and effective participation in society on an equal basis with others”.

We also have static and various definitions of disability and impairment set out in the Commonwealth Disability Discrimination Act, the National Disability Insurance Scheme Act, Social Security Act, the Victorian Disability Act, and The Victorian Mental Health Act, among others. We note that these various definitions can include and exclude a broad range of disabilities such as mental ill health, communication disabilities, cognitive disabilities, chronic illness, physical and sensory impairments. Having a disability may bring people into contact with multiple service systems including the NDIS, state disability services, local government, aged care, health, mental health, the TAC and WorkCover. Note also that, the different legislation and policy governing these services creates service gaps.

Women with Disabilities Victoria adopt the definition of the Convention on the Rights of Persons with a disability which is also in keeping with what is known as the Social Model of Disability. Rather than seeing someone with a disability as abnormal and focusing on their impairment or their ‘deficiency’, this model recognises the systemic barriers we face, these may be in architecture, information formats or attitudes. For example, Jen’s home and workplace are adapted to suit her impairment. When she leaves the house and goes onto the street or to a friend’s house, she encounter difficulties. When she meets people with negative attitudes about disability she encounter difficulties. These difficulties are not created by her impairment, but by social norms and systems.

Women with disabilities are a large and diverse population. We represent all walks of life. Although, it is important to note that we are more likely to experience poverty, unemployment, violence and less education compared men with disabilities and compared to other women.

The Australian Bureau of Statistics report that, according to their definition of disability, nearly 1 in five women and girls have a disability. This number is slightly higher in rural and regional areas and for women from other cultural backgrounds. Nationally, 51% of Aboriginal women have a disability. Consequently, mental health policy and programs must account for the impact of compounding disadvantage in women’s lives.

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| Example: Evidence provided by lay witness, Melissa Brown, at the Family Violence Royal Commission, highlighted the mental health sector’s lack of awareness of the high risks of violence against women with disabilities or appropriate responses and supports. Melissa received disability support from her husband. While this evidence is protected, we can say that it was stark in Melissa’s evidence that mental health professionals had asked her if she would like to leave the relationship, but that none had asked her what she would need to be safe. With no picture of what services may be available, Melissa saw no possibility of caring for herself and her children without disability support. Published details include that fact that after police excluded her husband from the home it was over 2 months before she was referred for disability supports (through the DHHS Disability Family Violence Crisis Response Initiative). |

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| Recommendation 7: That the mental health strategy recognise and incorporate the concepts inherent in the social model of disability.  Recommendation 8: That the mental health strategy recognise and respond to the inequities between people who are disabled and abled, and between women with disabilities and men with disabilities. |

**Q2.** Are there particular outcomes we should focus on for people with intellectual disability (dual disability) and communities?

It is impossible to measure engagement rates and outcomes for priority communities if priority community participation rates are not measured. We recommend that this strategy count disability in across the board, and encourage new directions in developing disability access approaches.

**Accessible mental health information**

Through a health literature review with The University of Melbourne and the Voices Against Violence Research we found many women with disabilities do not have access to information about their rights and support services.[[4]](#footnote-4) To provide women with access to these resources on an ongoing basis is one important strategy to improve their mental health.

There are a multitude of reasons women with disabilities have reduced access to information. Our ‘Your say, our rights’ research (2012) found that women with disabilities have reduced access to information technology communications. Many women with disabilities experience isolation from services and support information, either living on their own or in supported living such as group homes. Further, the majority of information about health and services is not in Plain or Easy English or other alternative accessible formats.

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| Recommendation 9: That the mental health strategy establish frameworks for collecting data on disability and providing disability access supports and referrals.  Recommendation 10: That a disability access plan is made for all information related to this strategy’s development, content and dissemination.  Recommendation 11: That the mental health strategy highlight the need for gender specific, disability accessible health and service information.  Recommendation 12: That mental health services are encouraged to develop disability action plans to assess and improve their information, buildings, services and policies, bringing them up to Commonwealth Disability Discrimination Act standards. |

**Q3.** How can we improve these outcomes for individuals with intellectual disability (dual disability), given what we know about the barriers and harms experienced by individuals with intellectual disability (dual disability)? What do we know works?

This paper identifies some well informed strategies to address these access barriers, for example:

* Strengthen workforce capacity
* Explore opportunities to develop a capacity framework
* Strengthen evidence base
* Increase services.

WDV support these strategies. We recommend they have a gendered approach, given the high levels of sexual assault experienced by women with disabilities, particularly those with intellectual disabilities.

Noting that community supports have not proven to service people with ID, the new tailored community support initiative will be important to watch and learn from, and expand statewide. We have seen tailored programs work excellently in other areas. For example, the Making Rights Reality program.

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| Good practice example: Making Rights Reality enhances existing services for people who have been sexually assaulted and have a cognitive impairment and/or communication difficulties. South East Centre Against Sexual Assault and Springvale Monash Community Legal Centre enhance existing services to maximise disability access. The [project website](http://www.secasa.com.au/services/making-rights-reality-for-sexual-assault-victims-with-a-disability/) shares Easy English materials for victims. It was positively evaluated in 2014.[[5]](#footnote-5) |

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| Recommendation 13: That focus is put into studying good practice examples of accessible and tailored services for people with disabilities. |

**Q4.** How do we integrate mental health programs generally or programs focused on individuals with intellectual disability (dual disability) in particular into a system of care?

This strategy comes at an ideal time to consider how Victorian mental health work will coordinate with the National Disability Insurance scheme.

**National Disability Insurance Scheme eligibility**

It is evolutionary that we can now see people experiencing psychiatric disabilities and co-occurring other disabilities receive support through one service, the NDIS. The Intellectual Disability technical paper says that the NDIS “will ensure people with a psychiatric disability and a co-occurring intellectual disability receive support to live in the community.” This is not a certainty, and in fact we can see from NDIS reports that people with intellectual disability are under represented in their client statistics.

While the NDIS will be a central service in the lives of people many with disabilities, we must recognise that many thousands of people with disabilities will not receive services, either because they are deemed ineligible or because they are not in a position to self refer (for example, they do not have access to information about who can apply and how to do so).

**NDIS quality and safeguarding frameworks**

The Department of Social Services has this year been consulting on the NDIS Quality and Safeguarding Framework. **Please see WDV’s submission in the attached appendix.** As the mental health system will now be so acutely linked with the NDIS, it is important to consider how they will share safeguarding frameworks.

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| Recommendation 14: That the mental health strategy connect with the NDIS safeguarding and quality framework to uphold rights to safety, justice and autonomy. |

**Coordinating knowledge and a whole of government approach**

As discussed, the Family Violence Royal Commission has shone a light on the interactions between mental health and family violence. During 2015 we have also seen a State parliamentary and a Senate committee inquiry into abuse in disability services. In addition, the Victorian Ombudsman is running an investigation, and COAG have commissioned a consultation on an NDIS Safeguarding and Quality Framework. Yet within the disability sector there is very little awareness of the gendered nature of violence against women, and in fact, family is resoundingly perceived as a positive support or ‘natural safeguard’ for women with disabilities. WDV has contributed to these consultations, calling for an increased understanding of violence against women, and gendered policies and practices which are equipped to prevent and respond to violence. **For more information see attached, WDV Violence Position Statement.’**

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| Recommendation 15: That the mental health strategy take a whole of government approach and connect with other highly relevant inquiries on gender, disability and violence. |

1. The Age <http://www.theage.com.au/victoria/woman-was-trapped-by-violent-husband-because-he-was-her-carer-royal-commission-into-family-violence-hears-20150722-gihvu8.html#ixzz3l7rb97vV> [↑](#footnote-ref-1)
2. K. Hughes, M.A. Bellis et al, 2012, ‘[Prevalence and risk of violence against adults with disabilities: a systematic review and meta-analysis of observational studies](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(11)61851-5/abstract),’ Lancet; R. B. Hughes, E. M. Lund et al, 2011, ‘Prevalence of Interpersonal Violence Against Community-living Adults with Disabilities: A Literature Review’, *Rehabilitation Psychology*, 56, 4: 302-319; H. Khalifeh, L. Howard et al, 2013, ‘Violence Against People With Disability in England and Wales: findings from a National Cross-Sectional Survey’, *PLOS ONE*, 8,2; S-B. Plummer and P. Findley, 2012, ‘Women with Disabilities’ Experience with Physical and Sexual Abuse: Review of the Literature and Implications for the Field, *Trauma, Violence and Abuse*, 13, 1: 15-29; D. A. Brownridge, 2009, *Violence Against Women: Vulnerable Populations*, Routledge, New York. [↑](#footnote-ref-2)
3. WDV, OPA, DVRCV, 2014, Voices Against Violence. [↑](#footnote-ref-3)
4. D. Woodlock, et al, ‘Voices Against Violence: Paper 6: Raising Our Voices - Hearing from with Women with Disabilities.’ Women with Disabilities Victoria, Office of the Public Advocate and Domestic Violence Resource Centre Victoria, 2014. [↑](#footnote-ref-4)
5. P. Frawley, ‘Making Rights Reality: Final Evaluation Report.’ La Trobe University, 2014. [↑](#footnote-ref-5)