Review of Queensland's Anti-Discrimination Act

Submission to the Queensland Human Rights Commission

March 2022

The Queensland Mental Health Commission

The Queensland Mental Health Commission (the Commission) is an independent statutory agency established under the *Queensland Mental Health Commission Act 2013* (the Act) to drive ongoing reform towards a more integrated, evidence-based, recovery-oriented mental health and substance misuse system.

Under the Act, the Commission focuses on systemic mental health and problematic issues. In addition, the Commission takes account of the issues affecting people who are vulnerable to or at significant risk of developing mental health problems; and recognises the importance of custom and culture when providing treatment, care, and support to Aboriginal and Torres Strait Islander peoples.

The Commission's main function are to:

1. develop a whole-of-government strategic plan to guide innovation, integration, and coordination; and monitor and report on implementation to the Minister for Health
2. monitor, review, and report on issues affecting the mental health and alcohol and other drugs system, the broader community, and consumers, their families, and carers
3. facilitate and promote mental health awareness, prevention, and early intervention
4. foster and support collaborative, participative, representative, and accountable partnerships, and state-wide mechanisms.

The Commission promotes policies and practices aligned to the vision of the *Shifting minds: Queensland Mental Health, Alcohol and Other Drugs Strategic Plan 2018-2023* (Shifting minds) and its sub-plan, *Every life: The Queensland Suicide Prevention Plan 2019-2029* (Every life), for "a fair and inclusive Queensland, where all people can achieve positive mental health and wellbeing and live their lives with meaning and purpose".

- *Shifting minds* sets the strategic direction for a whole-of-government, whole-of-community, and whole-of person approach to improving the mental health and wellbeing of all Queenslanders. It is a five-year plan that represents a longer-term outlook. Shifting minds establishes three areas for strategic focus:
  - ***Better lives*** *through person-centred and integrated services*
  - ***Invest to save*** *through improved population mental health and wellbeing as well as intervening early, in life, in vulnerability and in illness and episode, and*
  - ***Whole-of-system improvement*** *through a balanced approach and collective action*.
- *Every life* is a whole-of-government plan that provides a renewed approach for suicide prevention in Queensland, with renewed drive and urgency to reduce suicide.
  Every life recognises suicide is preventable and emphasises the vital importance of working together to reduce suicide. It acknowledges that effective suicide prevention requires responses beyond health services and must incorporate the voices of people with lived experience, their families and carers. Aligned with national and international best practices, evidence, and innovation, *Every life* identifies four action areas:
  - ***Building resilience*** *by improving mental health and wellbeing in our people and communities*
  - ***Reducing vulnerability*** *by strengthening support to vulnerable populations and people*
  - ***Enhancing responsiveness*** *to suicidality, including enhanced options for care, and*
  - ***Working together*** *to achieve more through coordinated approaches and improved use of data and evidence.*

The Commission has led a renewed approach to alcohol and other drugs in Queensland, which is currently pending Queensland Government consideration. It is based on extensive cross sectoral consultation and contemporary evidence. This approach seeks to prevent and reduce the impact of alcohol and other drugs on the health and wellbeing of Queenslanders. It supports the Queensland Government strategic direction outlined in Shifting minds and is aligned with the National Drug Strategy and sub-strategies. Priority actions under Shifting minds which seek to support the wellbeing of Queenslanders include:

a. system-wide integration
b. multi-agency responses to meet the needs of individuals and groups with complex needs
c. drug policy reform
d. alcohol harm minimisation
e. increasing alcohol and other drugs prevention and early intervention
f. growth and development across the continuum of service responses for problematic alcohol and other drugs drug use
g. workforce development, and
h. addressing stigma and alcohol and other drugs literacy.

The work of the Commission is supported by the independent Queensland Mental Health and Drug Advisory Council (the Advisory Council), which acts as a champion for people living with mental health issues, problems related to alcohol and other drugs use, or affected by suicide.

Overview

The Commission welcomes the opportunity to make a submission to the Review of Queensland's Anti-Discrimination Act.

Our focus is to advocate for:

- The use of the term 'impairment of functioning' rather than disability and to make the definition inclusive of the spectrum of mental ill-health. Definitions of terminology should be inclusive and allow for consideration of the specific circumstances of individual cases.

- Discrimination on combined grounds due to the likelihood of mental ill-health co-occurring with other social and cultural disadvantages and to clarify the legislation so that the burden of proof does not require differentiation between types of attributes that can be discriminated against.

- Removal of the evidentiary burden on complainants regarding proving indirect discrimination as this is difficult and complex for people with a mental illness. Mental illness occurs on a spectrum from mild to severe and can be episodic in nature. Mental ill-health affects individuals in different ways in different circumstances.

- The duty to make reasonable accommodations for people with a mental illness. But this also needs to be bolstered by whole-of-community approaches to reduce the stigma associated with mental illness. There is substantial evidence to suggest that when reasonable accommodations are made for people with a mental illness that significant financial, social and health benefits can be obtained. There is strong support to include a positive duty in the Anti-Discrimination Act to ensure institutions and businesses adopt approaches based on inclusivity in its broadest sense.

- Greater powers of the Queensland Human Rights Commission to explore, monitor, review and address systemic discrimination in a proactive way. This includes making guidelines and issuing compliance notices to institutions and organisations to prevent discrimination when it is identified. The Queensland Human Rights Commission needs to be enabled to establish mechanisms to monitor and evaluate systemic discrimination and to proactively enforce protections for people.

Issues considered by the Commission in relation to the review

Experiences of discrimination

People with a mental illness experience discrimination on several levels. Discrimination occurs at a societal and structural level as well as on personal levels. Experiences of discrimination has been reported by people with a mental illness across a variety of areas including in personal relationships, employment, access to treatment, and access to services including insurance and housing.

Examples of experiences of people with a mental illness dealt with under the current Act are provided in Attachment 1.

It is difficult for people with a mental illness to report their experiences due to many reasons including, stigma associated with mental illness, definitions of mental illness and disability, systemic barriers experienced by people who are socially disadvantaged – this includes the burden of proof, and additional intersectional disadvantages including cultural and language barriers. The impact of institutional racism, particularly on Aboriginal and Torres Strait Islander communities presents a significant barrier to raising complaints about discrimination.

Mental illness itself presents a barrier for people to assert their rights, given that mental illness will involve some degree of impact on a person's functioning, including (though not necessarily altogether) an impact on cognitive, emotional, behavioural and social function. Thus, a person with a mental illness may find it challenging to assert their rights at the very time when those rights are being breached.

It has been found that discrimination based on mental illness is common. In one international survey, 79 per cent of people attending a specialist mental health service reported that they had experienced discrimination because of their mental illness[1]. Furthermore, between 20 to 37 per cent of survey respondents reported stopping themselves from doing something important because they anticipated they would experience discrimination, leading them to give up on important life goals. This study also found that common sources of discrimination were from family members and in employment settings. This finding was replicated in a community survey of 2,000 Australians by *beyondblue*.

The Information Paper[2] developed by *beyondblue* in 2015 summarised the impact of stigma and discrimination on people with depression and anxiety. These impacts included:

- Feelings of shame and discomfort to talk about mental health issues within families.
- Feeling questioned about work competence and fears that mental illness would be construed negatively. People with depression and anxiety reported discrimination during

[1] Lasalvia, et al. *Global pattern of experienced and anticipated discrimination reported by people with major depressive disorder: a cross-sectional survey.* The Lancet, 381 (9860), 55-62; 2013.
[2] Beyondblue. *Information Paper: Stigma and discrimination associated with depression and anxiety*; 2015.

recruitment, returning to work, promotional opportunities and during workplace-related mental health problems. People with a mental illness or substance misuse may also avoid seeking the treatment or support they need due to concerns about their mental health/substance misuse history adversely impacting employment opportunities. Employees can be reluctant to use counselling services through employee assistance programs due to concerns about confidentiality and career impacts.

- Feeling patronised or punished in dealing with health professionals as well as a reluctance to access treatment or services due to concerns about reactions from others in the community.
- Obtaining and claiming insurance. Substantial difficulties have been reported by people with mental illness when seeking various insurance products (whether life insurance, income protection, travel and health insurance). Exclusion of people based on broad assumptions about their ability to maintain employment and manage their life appear to be made based on diagnosis (and at times an incorrect understanding of the nature of mental illness) rather than on individual circumstance.

In additional to the personal impacts, structural discrimination defined by societal-level conditions, cultural norms or institutional policies that act to constrain the opportunities for people with a mental illness have been documented, including[3]:

- Health systems. Structural discrimination is reflected in the poor resourcing of mental health services, power differentials between a person with a mental illness and their treating practitioner, lower quality of care, reduced life expectancy, and inequitable allocation of research funding. Structural discrimination also exists in relation to access to mental health care under the Medicare system, particularly the lack of bulk-billing providers and the need to make gap payments resulting in people with a mental illness being unable to access primary healthcare.
- Employment. People with mental illness have been found to have lower rates of employment compared to the general community. Discrimination also manifests in workplaces failing to make reasonable adjustments to allow people with a mental illness to work effectively.
- Justice and legal systems. People with a mental illness are over-represented in the criminal justice system as evidenced by limited access to legal representation, lack of access to timely and culturally appropriate mental health care in correctional facilities, and lack of supported decision-making processes.
- Education outcomes. Students with a mental illness have been found to score lower than students without a mental illness in all NAPLAN tests domains and across year levels. They have also been found to have more school absences and lower levels of connectedness to school work. Poor academic outcomes were compounded by additional social disadvantages[4].
- Housing. People with particularly complex mental illness have higher rates of homelessness compared with the general community. Reports have found that discrimination occurs at

[3] Reavley, N., & Morgan, A. *Structural stigma and discrimination: Evidence review*. Centre for Mental Health Melbourne School of Population and Global Health; 2021

[4] Goodsell, B., Lawrence, D., Ainley, J., Sawyer, M., Zubrick, S. R., & Maratos, J. C*hild and Adolescent Mental health and educational outcomes. An analysis of educational outcomes from Young Minds Matter: the second Australian Child and Adolescent Survey of Mental Health and Wellbeing*. Perth: Graduate School of Education, The University of Western Australia; 2017

multiple stages within the private rental system making it harder for people with a mental illness to obtain and sustain rental accommodation[5].

Alcohol and other drugs

Stigma and discrimination cause significant adverse impacts on people experiencing problematic alcohol and other drug use. Not necessarily everyone who has problematic substance use will experience mental ill-health, however the co-occurrence of mental and substance use disorders is common with 25-50 per cent of people experiencing this co-morbidity[6]. For this reason, it is appropriate to consider the inclusion of provisions within the Anti-Discrimination Act for people experiencing problematic alcohol and other drug use. Problematic alcohol and other drug use, particularly illicit drug dependence is recognised as one of the most stigmatised conditions in the world according to the *World Health Organisation*. This stigmatisation can inhibit people from seeking help and further isolate people and groups.

In 2018 the Commission provide funding to research the impacts of stigma and discrimination on people who have problematic substance use. The report, *Changing attitudes, changing lives* outlines 18 options for reform regarding systemic issues to address stigma and discrimination for people experiencing problematic alcohol and other drug use, and their families. The report is intended to encourage policy discussion and enhance understanding of the prevalence and impacts of stigma and discrimination. It also seeks to inform services, and the community about ways to address the attitudes, policies and practices that may directly or indirectly manifest stigma and discrimination against people experiencing problematic substance use.

A qualitative research report, *Don't Judge, and Listen* describes the impact of stigma and discrimination related to problematic substance use on Aboriginal and Torres Strait Islander individuals, families and communities. The report describes the general and pervasive nature of racism experienced by Aboriginal and Torres Strait Islander communities throughout their lifetime and within diverse personal, family and community settings. Elders considered that experiencing racism 'since they were born' had complicated the ability of Aboriginal and Torres Strait Islander people to understand how racist behaviours impact their lives and wellbeing. People found that racist behaviour was linked to stereotypes of Aboriginal and Torres Strait Islander people, including in relation to alcohol and other drug use, which conflated and reinforced the overall experience of racism.

Meaning of impairment

The meaning of "impairment" in the current Act is wide but does not include mental illness and problematic alcohol and other drug use. However, discrimination against people with a lived experience of mental illness and/or problematic alcohol and drug use is a reality. Such discrimination and the associated stigma are barriers for people seeking help and obstacles in their recovery journey.

[5] Maalsen, S., Wolifson, P., Rogers, D., Nelson, J. and Buckle, C. *Understanding discrimination effects in private rental housing*, AHURI Final Report No. 363, Australian Housing and Urban Research Institute Limited, Melbourne; 2021.

[6] Teeson, M., Baker, Al., Deady, M. et al. *Mental health and substance use: opportunities for innovative prevention and treatment.* Sydney: New South Wales Mental Health Commission; 2014.

People with a lived experience need better protections from discrimination. This can only be achieved if the terminology of the new Act includes mental illness as well as problematic alcohol and other drug use.

The Commission recommends drafting the terminology similar to the definition of Part 1, Division 3, Section 11 of the *Disability Services Act 2006* in a way that focuses on a person's reduced capacity and functions; however, it should not be defined as a disability. Importantly, the definition needs to state that the condition can be temporary as recovery is possible for the majority of people with a mental illness or problematic alcohol and other drug use.

Mental ill-health is not always able to be visually observed (unlike some physical disabilities) and although symptoms can be consistently identified and classified to form a diagnosis, not everyone experiences mental health symptoms in the same way. People can also experience mental health 'problems' which may diminish their functioning but may not meet diagnostic criteria. Mental ill-health can also be episodic as well as persistent in duration.

Psychiatric disability is the consequence and impact of a mental illness on the affected person's ability to function and is a term used in the Australian *Disability Discrimination Act 1992*. Psychiatric disability may be intermittent and associated with symptoms of schizophrenia, affective disorders, anxiety disorders, addictive behaviours, personality disorders, stress, psychosis, depression and adjustment disorders. Increasingly the disability sector is moving towards the term psychosocial disability to describe the type of disability as it affects the daily functioning of a person and to recognise the broader social disadvantage and effects of mental illness on people.

Definitions of terminology should be inclusive and allow for consideration of the specific circumstances of individual cases. It must also be recognised that definitions of mental illness may be required for different purposes. Given the complex nature of mental illness, making a complaint about discrimination should not require proof of mental illness.

Discrimination on combined grounds

Some population groups such as First Nations and culturally and linguistically diverse peoples, experience other forms of discrimination such as racial discrimination. The impact of discrimination on combined grounds has been found to be associated with increased psychological distress[7]. Some studies have found that people who are from a culturally and linguistically diverse background have been found to have a comparatively higher risk of mental ill-health and are disproportionately impacted by the social determinants that are associated with mental illness[8]. Social inequalities particularly pertinent to migrants or people from a culturally and linguistically diverse background such as a drop in socioeconomic status, language barriers, challenges navigating systems, difficulties finding employment and housing, and experiences of racism and discrimination have been found to increase the risk of mental illness[9]. For this reason, it is relevant to allow people to bring forward complaints based on the confluence of personal characteristics and not have the burden of proof for each attribute separately.

[7] Kelaher, M., Ferdinand, A., & Paradies, Y. *Experiencing racism in health care: the mental health impacts for Victorian Aboriginal communities*. Medical Journal of Australia, 201 (1): 44-47; 2014.
[8] Bignall, T., Jeraj, S., Helsby, E., & Butt, J, *Racial disparities in mental health: Literature and evidence review*. 2019.
[9] Ferdinand, A., Paradies, Y., Kelaher, M. *Mental health impacts of racial discrimination in Australian culturally and linguistically diverse communities: A cross-sectional survey*. BMC Public Health, 15, 201; 2015

Some population groups like First Nations peoples have faced discrimination through legislation and polices such as Aboriginals Protection and Restriction of the Sale of Opium Act 1897 (Qld) which led to the involuntary movement of people onto missions and reserves and stolen wages, and assimilation policies that led to the forcible removal of Aboriginal and Torres Strait Islander children. These examples are important to demonstrate that discrimination in enacted through policy and legislation (which also reinforces negative attitudes in society), rather than there being anything inherent to groups that are discriminated against, it also demonstrates that policy and legislation can protect against future discrimination.

The Commission produced a brief summary of the historical events that have had an impact on the human rights of First Nations people in Queensland. *Don't Judge, and Listen* provides insight of the impact of stigma and discrimination on First Nations peoples, including on their mental health and wellbeing. The experiences detailed in this report demonstrate the significant influence of institutional racism that continues to pervade our systems, communities and organisations.

People with intellectual and developmental disability experience mental health conditions at an earlier age and at higher rates than the general population[10]. Mental health conditions are two to three times more prevalent for people with intellectual disability compared to the general population. Barriers to accessing and engaging with mental health services are increased for people with intellectual and developmental disability who may also experience social disadvantage. Individuals living in rural locations, similar to those without an intellectual disability, encounter greater barriers to accessing mental health services. People with intellectual and developmental disability from Aboriginal or Torres Strait Islander backgrounds experience elevated rates of mental health issues and are over-represented in the mental health sector. Barriers to accessing mental health services are further compounded for non-Australian citizens who are also ineligible for the National Disability Insurance Scheme (NDIS).

For lesbian, gay, bisexual, transgender, intersex and queer (LGBTIQ+) people, experiences of direct and indirect discrimination is prevalent and often compounded by mental ill-health. In a national survey of the health and wellbeing of LGBTIQ+ people, more than half (57.2 per cent; n = 3,818) of participants reported high or very high levels of psychological distress during the past four weeks. Almost half (44.4%; n = 2,781) of participants reported using one or more drugs for non-medical purposes in the past 6 months. One seventh (14.0%; n = 388) reported experiencing a time within the past 6 months when they had struggled to manage their drug use or where it negatively impacted their everyday life[11]. Experiences of discrimination by LGBTIQ+ people can result in increased social isolation and prevents people from accessing and using support services.

Making reasonable accommodations

People with a mental illness and/or problematic alcohol and other drug use are facing discrimination at their workplaces, potentially negatively impacting their recovery, their career development, and economic prospects. The Commission supports businesses and employers to make reasonable accommodations for people with a lived experience at their workplace.

In accessing employment and workplace environments, people who a criminal record for minor illicit drug possession charges are discriminated against via the Queensland criminal history check

[10] Cooper SA, Smiley E, Morrison J, Williamson A, Allan L. *Mental ill-health in adults with intellectual disabilities: prevalence and associated factors*. Br J Psychiatry.;190:27-35.2007

[11] Private Lives 3. The Health and Wellbeing of LGBTIQ people in Australia. Hill, A.O., Bourne, P.R., Mcnair, M., & Carman, A.L. 2020.

process. A police criminal history check in Queensland lists all court findings even when no conviction was recorded regardless of how minor the charge, such as small qualities of cannabis, and the historical context of the charge. Having a criminal record for a minor drug possession charge also prevents people with a lived experience from gaining employment in youth and family alcohol and other drug services where a Blue Card for working with children is required. People with a criminal record for minor drug possession can also be discriminated against in family law matters and overseas travel. Drug law reforms that divert people (who come into contact with police in possession of a small quantity of illicit substances) into early intervention and health responses that is not listed on an individual's criminal record would reduce these discriminatory practices. Other jurisdictions have also introduced a 'clean slate' or 'amnesty' process whereby historical and current minor drug possession offences are removed from criminal records.

The types of reasonable adjustments people with a mental illness may require often relate to more non-material adjustments such as attitudinal change by others and provision for flexibility in their daily schedules. Approaches that promote wellbeing and prevent illness relapse are key strategies that can make a significant difference to people experiencing mental illness in workplaces and educational institutions. Recognition that periods of mental health challenges may not necessarily be ongoing and that facilitating early recognition and treatment is essential to improved productivity over the longer term. Criteria used to determine what is reasonable should be considered on a case-by-case basis considering the needs of all stakeholders rather than blanket approaches.

Amendments to the legislation should also clarify the legality of identified lived experience positions. There are still doubts whether employers are able to create and fill identified positions for people with a lived experience of mental illness and problematic alcohol and other drug use under the current Anti-Discrimination Act. Legal advice has confirmed that identified positions are supported by the current Anti-Discrimination Act, but it would be beneficial if amendments could make this clearer to remove doubts and support the ongoing development of the lived experience workforce.

A new approach

There is a general lack of awareness of the Anti-Discrimination Act and of the process to make a complaint when discrimination occurs. An additional barrier relates to individuals not wanting to self-disclose due to the stigma of mental illness. Given the systemic drivers of discrimination encountered by people with a mental illness who also frequently experience a range of other intersectional disadvantages – an individual complaints process that is reliant on the onus of proof upon the individual is problematic.

For example, the barriers to making a complaint is compounded for people from culturally and linguistically diverse backgrounds who may experience discrimination on multiple grounds. Limited capacity to navigate systems, culture-based differences in communication styles and concepts of self-advocacy can make it difficult to make complaints; as can a mistrust in government services due to past experiences and traumas.

Whilst legislative change is required to make the process of making a complaint about discrimination easier for people with a mental illness, shifts in whole-of-community understanding and de-stigmatisation of mental illness is required. Unless this is supported through integrated systemic approaches to address stigma about mental illness, the benefits of the anti-discrimination legislation cannot be fully realised.

There is strong support for an approach that includes a positive duty on organisations, institutions and industries to consider organisation-wide policies, procedures and practices to ensure social, economic, and cultural inclusivity. This would be in alignment with existing approaches advocating for shared accountability for the prevention of mental illness. Given that the adjustments often required in relation to mental illness are relatively minor in cost and can be practicably implemented in most settings these should be adopted in a proactive way rather than only when someone raises a complaint. There is strong evidence to suggest that when workplaces and other institutions adopt positive messaging about mental health and wellbeing and implement strategies to prevent mental illness, there can be substantial financial, social and individual benefits achieved.

What the Human Rights Commission can do

The current Act provides limited mechanisms to deal with systemic discrimination against people with a mental illness and/or problematic alcohol and other drug use.

As outlined in the discussion paper the current system is reactive and deals with complaints at an individual basis but struggles to address discrimination on a wider scale. This in combination with the limitations of the existing complaints process which puts the burden of proof on individuals who may already be experiencing difficulties functioning, will require reform with strengthened functions for the Queensland Human Rights Commission.

The Commission therefore supports greater powers of the Queensland Human Rights Commission to manage systemic discrimination and proactively enforce protections for people. There also needs to be commitment to identify data gaps including areas for further research. The Queensland Human Rights Commission could also function to identify the social, cultural, and economic conditions and contexts that are associated with increased discrimination in order to prevent it in the first place.

Conclusion

Discrimination is harmful. It impacts Queenslanders living with a mental illness and/or problematic alcohol and other drug use in many ways. It is a barrier to seeking help, leads to social isolation and hinders people to reach their full social and economic potential. The review of the Queensland's Anti-Discrimination Act is important and essential to drive reform to improve the lives of many vulnerable Queenslanders. It is an opportunity to finding new ways to address systemic discrimination and inequality that should not be missed. The limitations of the current complaints system which relies on individuals to come forward is problematic and a possible barrier for some individuals.

A more forward-looking approach and greater powers of the Queensland Human Rights Commission to explore, monitor, review and address systemic discrimination in a proactive way is required. This includes the ability of making guidelines and issuing compliance notices to institutions and organisations to prevent discrimination when it is identified. There needs to be mechanisms to monitor and evaluate systemic discrimination and ensure appropriate protections for everyone, particularly vulnerable individuals.

Attachment 1:

Complaints resolved under the current *Anti-Discrimination Act 1991* (some alignment with *Human Rights Act 2019*):

1. Depressed worker forced to do suicide prevention training

Type of outcome	Queensland Civil and Administrative Tribunal decision
Contravention	Discrimination
Attribute	Impairment
Area	Work
Outcome	Complaint upheld
Compensation	$10,000
Year	2012

Summary

A temporary administrative worker at a prison was required to undertake Suicide Prevention Awareness training, despite having earlier been excused from a scheduled session of the training because of her medical condition of depression with a history of attempted suicides. The worker experienced difficulty undertaking the training on-line on her own and had to take breaks during which she sought assistance from the employer's equity officer.

The employer disputed the circumstances of training and the effect on the worker; however, the tribunal preferred the evidence of the worker to that of the manager.

The tribunal found a term had been imposed, and even though the worker did the training, she did it under duress fearing for her job security and suffered extreme emotional distress. The tribunal found the term was not reasonable and awarded $10,000 damages for emotional pain and suffering.

Rushton v Muller & Anor [2012] QCAT 505

2. School and parents work together to support a child with a disability

Type of outcome	Conciliation
Contravention	Discrimination plus *Human Rights Act* (alignment)
Attribute	Impairment
Area	Education

Relevant human rights	Right to education (HRA section 36)
Outcome	Develop an Individual Behaviour Support Plan for student Regular meetings
Year	2020–2021

Summary

A mother lodged a complaint on behalf of her 7-year-old son who attends a state school and has a disability which manifests as anxiety, sensory and behavioural problems. The school became concerned about his escalating behaviour and that some of his behaviours could increase the risk of transmission during the COVID-19 pandemic and issued a notice of suspension as a result. The child's mother communicated that her son felt confused, upset, anxious, and unwanted. Many of the details were in dispute, and communication between the family and the school had broken down.

Following a conciliation conference, the mother agreed to share information from the child's treating occupational therapist, and the school agreed to take this report into consideration in the development of an Individual Behaviour Support Plan. To improve future communication, the mother and the school agreed to use a communication book and meet at the beginning of each term to discuss the plan.

3. Unreasonable restrictions in insurance policy

Type of outcome	Conciliation
Contravention	Discrimination
Attribute	Impairment
Area	Insurance
Outcome	Mutual non-disparagement and confidentiality agreement Provision of insurance at standard rates, with less restrictive exclusion clauses
Year	2019–2020

Summary

In 2018, the complainant applied for life, total and permanent disability (TPD) and income protection insurance through the trustee for her superannuation fund. She disclosed in her application that she had a history of depression and anxiety but was not currently on any medication and was self-managing with occasional psychologist visits. She further disclosed an abnormal blood test result as a result of a bleeding episode post-surgery in 2012.

The trustee of the superannuation fund asked the complainant to undergo a blood test and the results were normal. After that, the trustee offered the complainant insurance but with a broad exclusion clause for TPD and income protection, excluding liability to pay any benefit under the policy arising from specific psychological type illnesses, or disorders relating to substance abuse or dependence including alcohol and drugs. The offer also stipulated a 100% loading on the premium payable due to a history of mild urge incontinence and history of mild bleeding disorder.

The complainant requested a review of the decision and asked the insurer to provide evidence to justify why she was considered to be at higher risk.

The company issued an amended offer which reduced the loading to 50% but retained the mental health exclusion. The complainant argued there was a lack of evidence to justify such a broad exclusion or the loading.

Both the trustee of the superannuation and the insurer were named as respondents.

The respondents argued that the exclusion and loading placed on the offer of insurance were not discriminatory. They provided a significant amount of published information about the psychiatric conditions, and how that applied to make the decision about what terms to place on the offer of insurance to the complainant.

Separate agreements were reached with each of the respondents including mutual non-disparagement and confidentiality with one of the respondents. An agreement was reached with the other respondent to provide insurance at standard rates with a much less restrictive exclusion clause relating to anxiety, depression and stress, and subject to completion and assessment of a current underwriting health declaration. The respondent also reserved the right to obtain further supporting medical verification and information on any future increases or alteration in cover in the event of an increase in risk.

And there are some case studies that are resolved with further training and education. It shows further education in discrimination could assist in resource reduction related to dispute resolution:

Oppressive accommodation clauses for tenant with a disability

Type of outcome	Conciliation
Contravention	Discrimination
Attribute	Impairment
Area	Accommodation
Outcome	Financial compensation Apology Training in discrimination
Compensation	$8,000
Year	2019–2020

Summary
The complainant suffered from post-traumatic stress disorder (PTSD). She applied for rental accommodation with the respondent at a unit complex. The respondent required clauses in her lease that she must provide all relevant medical information in relation to her current medical condition, that she consent and agree to be examined and assessed by their medical practitioner,

that she follows any certificate provided by the practitioner, and that the manager could enter her unit at any time without warning.

The organisational respondent representatives were new to the organisation. They agreed that matters had been handled poorly and there were serious issues in relation to the management of the unit complex. Prior to the conference all tenant leases were remade to omit the additional clauses and the complex manager was disciplined.

The complaint was resolved on the basis of $4000 general damages and $4,000 economic loss (for a home-based business the complainant could not continue due to lack of privacy), an apology, and training in discrimination for the complex manager.

4. Medical examination to assess fitness for job

Type of outcome	Conciliation
Contravention	Discrimination
Attribute	Impairment
Area	Work
Outcome	Apology Policy change / change in practice Other
Year	2000–2001

Summary

The complainant applied for an emergency service communication room position. He had served previously in a similar position for many years and was offered the position pending a medical examination. He disclosed on his application form that he suffered from posttraumatic stress disorder.

The respondent denied him employment on the basis of his impairment stating that the position was extremely stressful and there was potential risk to clients and fellow workers.

At conciliation it was agreed that procedures were not followed, his physician should have been consulted and the notification form letter was cursory. The matter settled with an agreement to reassess the application after examination by a specialist, an apology and a commitment to change the wording of the rejection letter.

5. Appropriate accommodation found for family's quarantine stay

Complaint type	*Anti-Discrimination Act* plus human rights (alignement)
Anti-Discrimination Act contravention	Impairment – State laws and programs
Relevant human rights	Recognition and equality before the law (section 15) Freedom of movement (section 19)

Outcome	Allocated more appropriate hotel quarantine accommodation
Year	2020–2021

Summary

A family was moving back to Queensland after living overseas and requested to quarantine at home because their 8-year-old daughter has ASD, ADHD, anxiety, and obsessive behaviours. Because of her disability she is prone to meltdowns and has food aversions. The request for exemption from hotel quarantine was rejected.

The complaint was resolved on the basis that the family was allocated more appropriate hotel quarantine accommodation of a 2-bedroom apartment with a kitchen and balcony.

There are national campaigns rolling out recently such as the National Stigma Report Card (https://www.sane.org/adrc/current-adrc-projects/national-stigma-report-card) development by SANE Australia and the national stigma and discrimination strategy (https://www.mentalhealthcommission.gov.au/Mental-health-Reform/National-Stigma-Strategy) established by the National Mental Health Commission as one of the stigma reduction recommendations outlined in the Productivity Commission Inquiry Report for Mental Health.

Beyond Blue is also funded by the federal government to develop tools and educational material to assist organisations to create a healthier environment to prevent mental ill-health and to sustain health and wellbeing of individuals. The Beyond Blue website provides an example on the difference between a healthy workplace and an environment of being bullied and harassed:

https://www.headsup.org.au/training-and-resources/stories/details/stories/personal-stories/sonia's-story