MHLEPQ
MENTAL HEALTH LIVED EXPERIENCE PEAK QUEENSLAND

Queensland Health

Submission on the Queensland Health Legislation Amendment Bill 2026 – Consultation Paper

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Acknowledgement of Country

Mental Health Lived Experience Peak Queensland (**MHLEPQ**) respectfully acknowledges and honours the Traditional Custodians of the Lands and Waters throughout Queensland. We thank the Elders—past, present, and emerging—for their wisdom and enduring strength.

We recognise that the legacy of colonisation has profoundly impacted First Nations peoples, contributing to unique and significant experiences of trauma within the mental health system. Colonisation has enforced systems of racism, stigma, and discrimination, leading to intergenerational social disadvantage and marginalisation.

These historical and ongoing injustices have compounded the challenges faced by First Nations (Aboriginal and/ or Torres Strait Islander) peoples, affecting their social and emotional wellbeing.

We acknowledge the enduring resilience and resistance of First Nations peoples in the face of these adversities. We respect their rights and autonomy to lead their own healing journeys, guided by their beliefs and traditional practices and connectedness to Country, family, and spirit. In honouring their wisdom and experiences, we commit to supporting their self-determination and promoting equitable and culturally responsive approaches to mental health care.

Who are MHLEPQ?

Mental Health Lived Experience Peak Queensland (**MHLEPQ**) is an initiative funded by the Mental Health, Alcohol and Other Drugs Branch, Department of Health. Our organisation was created in July 2021 and is funded by Queensland Health as the peak body for people with lived experience of mental health issues in Queensland.

MHLEPQ was established to provide advice and advocacy informed by people with lived experience of the Queensland mental health system with a specific focus on those who are socially disadvantaged and marginalised. Our work is based on the principles of equity, access, cultural safety, recovery, and human rights.

MHLEPQ is a member of the National Mental Health Consumer Alliance (**NMHCA**) and engages with other state and territory consumer peak bodies to coordinate on shared issues. These issues include those relating to Commonwealth policy and government-funded services.

Whilst this participation supports collaboration and information sharing at a national level, this submission reflects the independent views of MHLEPQ only and does not represent the views or positions of the NMHCA.

Introduction

MHLEPQ welcomes the opportunity to respond to the *Health Legislation Amendment Bill 2026 – Consultation Paper* (**Consultation Paper**), in support of the *Health Legislation Amendment Bill 2026* (Qld) (**Bill**). The Bill proposes amendments to six Acts,[1] including the *Mental Health Act 2016* (Qld) (**MHA**).

This submission focuses on the proposed amendments to the MHA and is grounded in key human rights principles.[2] It draws on MHLEPQ's expertise in protecting the rights of people subject to involuntary treatment, emphasising strong legal safeguards, least-restrictive practices, and alignment with domestic and international human rights standards.[3]

MHLEPQ supports a review of the MHA, nearly nine years after its commencement. Several national and Queensland based changes and circumstances prompt the need for reform, including abnormally high rates of involuntary treatment in Queensland[4], the need for greater lived experience and regional engagement in system design and decision-making, as well as forthcoming changes prompted by negotiation of the National Mental Health and Suicide Prevention Agreement. Without proper scrutiny, including evaluation of past, current and future workings and failures, the touchpoint for ensuring the well-being of those that engage with the system is limited. Queensland has had the second highest increase in Australia in mental health presentations to emergency department settings[5], highlighting that we are increasingly falling into a

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[1] *Hospital and Health Board Act* 2011 (Qld), *Pharmacy Business Ownership Act* 2024 (Qld), *Tobacco and Other Smoking Products Act* 1998 (Qld), *Public Health Regulation Act* 2018 (Qld), *Public Health Act* 2025 (Qld).

[2] *Universal Declaration of Human Rights,* UN General Assembly, 1948, Article 3, the right to liberty, Article 1, the right to dignity, Article 5, freedom from cruel, inhuman or degrading treatment, Article 9, freedom from arbitrary detention and persecution.

[3] *Human Rights Act 2019* (Qld); *Universal Declaration of Human Rights,* UN General Assembly, 1948.

[4] Neeraj S Gill et al, 'Measuring the Impact of Revised Mental Health Legislation on Human Rights in Queensland, Australia' (2020) 73 *International Journal of Law and Psychiatry* 101634; Neeraj S Gill et al, 'Human Rights Implications of Introducing a New Mental Health Act–Principles, Challenges and Opportunities' (2020) 28(2) *Australasian Psychiatry* 167.

[5] 'State and Territory Emergency Departments Data - Mental Health', *Australian Institute of Health and Welfare* (19 August 2025) <https://www.aihw.gov.au/mental-health/topic-areas/hospital-based-services/emergency-departments/state-and-territory-data>.

crisis-based system. Narrow reforms such as this will only delay the important legislative reform needed to deliver better outcomes for Queenslanders with lived experience.

Nevertheless, the Bill focuses on involuntary treatment procedures rather than on the broader transformation of a system in need of reform. This approach is inconsistent with a human rights-based approach to mental health, which seeks to reduce reliance on coercive practices rather than entrench them. As such, the Bill runs counter to what people with lived experience are calling for.

Our submission focuses on specific elements of this Bill while calling for broader review and reform of the MHA. This is most evident from the outset of the Consultation Paper. It clearly stipulates the authority for involuntary treatment. However, it fails to adequately address how these significant statutory powers are to be exercised, omitting the safeguards and principles that guides their use. [6] This omission is significant, given the profound impact involuntary treatment has on the rights, dignity, liberty and autonomy of individuals subject to the MHA.

Our submission brings a mental health lived experience lens on the following four topics identified in the Consultation Paper:

1. Strengthening protections for healthcare workers treating high-risk patients.
2. Transferring the responsibility for review of forensic orders (Criminal Code)
3. Allowing disclosure of personal information to respond to serious risk
4. Supporting safe transport for patients removed, deported or extradited from Queensland.

We provide the Committee with opportunities to address specific issues that arise from these amendments. We reiterate the importance of broader review and reform of the MHA.

[6] See s 3(2) *The Mental Health Act 2016* (Qld).

Part 1 - Strengthening protections for healthcare workers treating high-risk patients

The Bill proposes to grant power to the Chief Psychiatrist to make a policy in relation to safety and security considerations for high-risk patients when being transferred from a custodial setting and treated in an authorised mental health service. This is due to stated risks regarding safety and protection for health care workers.

For some healthcare workers, admitting patients is a regular occurrence that can significantly compromise their safety, wellbeing or ability to function in the workplace. For these healthcare workers, there is a need to provide a system that protects them, especially in regard to admitting "higher risk patients" to authorised mental health services.

In this context, higher risk patients refers to patients that pose "a higher risk of harm towards others or to property."[7] Higher risk patients includes both involuntary (classified patients and patients on forensic orders) and voluntary patients. For the purpose of this Consultation Paper, involuntary patients are the focus.

MHLEPQ affirms that all people in the mental health system – people with lived experience and people working in the system – should be safe. Our view and those accessing the system is that our safety is best found together[8], and the evidence supports this too. Evidence supports the fact that safety is not held by one group but rather produced in relationship.

[7] Queensland Health, *Health Legislation Amendment Bill 2026* (Qld), p10.

[8] Helena Roennfeldt et al, 'We Can Do Better: Recommendations for Mental Health Crisis Care from People with Lived Experience' (2025) 37(1) *Emergency Medicine Australasia* e14528 ('We Can Do Better'); Catherine Brasier et al, 'Peer Support Work for People Experiencing Mental Distress Attending the Emergency Department: Exploring the Potential' [2021] *Emergency Medicine Australasia*.

Importantly, the same findings that support staff safety are those that support elimination of restrictive practices[9]. The Queensland Government and Chief Psychiatrist's work will be hampered by an approach that defines safety as competitive resources rather than as collaborative processes.

Therefore, we acknowledge the importance of safety being further refined but seek to ensure that the Chief Psychiatrist and broader Queensland Government's response follows the evidence that supports safety for all. Additional guidance on scope, the inclusion of lived experience, and the necessity of safety-together framings will be critical. Such guidance should appropriately apply human rights standards and be aimed at enhancing safety for all. Without intent, it is possible that a high-risk patient's human rights could be further infringed with the addition, for example, of a policy inclusive of restraint or seclusion.

Recommendation 1 – Guidelines for making of policy
The Chief Psychiatrist must ensure that MHLEPQ is specifically sought for stand-alone advice on this policy before commencing the substantive work on it.

[9] Lisa A Marshall, Emma A Adams and Melanie I Stuckey, 'Relationships, Experience, and Support: Staff Perception of Safety in a Forensic Mental Health Facility' (2019) 30(5) *The Journal of Forensic Psychiatry & Psychology* 824 ('Relationships, Experience, and Support').

Part 2 - Transferring the responsibility for review of forensic orders (Criminal Code)

Queensland Health in this Consultation Paper calls for continuity between the Mental Health Court (**MHC**) and the Supreme and District Courts regarding forensic orders. At present, only the MHC can make forensic orders with a non-revocation period. In effect, this results in a person being detained without review of their forensic order for a period not exceeding 10 years.

Continuity is sought by amending the MHA to allow for Supreme Court and District Court powers for forensic orders to be transferred directly to the MHC. This in effect would mean that the non-revocation period would apply across the board.

Explaining: Forensic Order Process by Mental Health Court, Supreme Court and District Courts.

If a person is deemed of "unsound mind" at the time the alleged offence was committed or is unfit for trial, the MHC can make a forensic order for a person charged with a serious offence.

In addition to this power of involuntary treatment, the Supreme Court and District Courts can make forensic orders "following a finding that the person is not fit for trial, not sound of mind, or acquitted on the grounds of insanity".[10]

When a forensic order is made by the Supreme Court or District Court, notice must be given to the MHRT of that decision. The MHRT will then make a new forensic order. Importantly, the powers of the MHRT and the MHC differ remarkedly.

The MHC can order that the forensic order stays in place without review for a period up to 10 years (non-revocation order). This is not the case

[10] Queensland Health, *Health Legislation Amendment Bill 2026* (Qld), page13.

with Supreme Court or District Court forensic orders as no such power exists.

MHLEPQ expresses grave concerns with this approach. We consider a period of detainment up to 10 years to be draconian and punitive. This in effect sentences the person to detainment equivalent to the criminal setting when a person is sentenced to imprisonment without the right of parole.

The stated purpose of the forensic mental health system is to enable broader community safety where a person is deemed not to be legally responsible for their conduct. The principal considerations therefore, should be what is the least restrictive way on a person's liberties to maintain safety for all. This is a decision best made on the evidence and not a decision made as part of punishment.

The current approach outlined in the Bill and Consultation Paper outlines that a desired effect of non-revocation periods is that they provide "victims and the broader community with certainty about the period a person charged with a serious offence will continue to receive treatment as a forensic patient".[11]

Detaining a person without regular, meaningful review, and in the absence of current evidence of ongoing mental ill-health, amounts to arbitrary deprivation of liberty.[12] It is also actively avoiding evidence about someone's risk and community safety, which is better assessed by clinicians rather than politicians.

[11] Queensland Health, *Health Legislation Amendment Bill 2026* (Qld), p.14.
[12] *Human Rights Act 2019* (Qld), s 30; *Universal Declaration on Human Rights*, UN General Assembly, 1948 Article 3.

It must also be noted that forensic orders, by their very nature, involuntarily detain individuals for potentially indefinite periods. These orders do not have fixed expiration dates instead; they are subject to periodic review. By contrast, a person convicted of a serious criminal offence is provided with a clearly defined commencement and end date to their sentence. It is unacceptable for a person to be detained against their will without being given clear and definite information as to how long that detention will last.

Recommendation 2 – Forensic orders to remain with Supreme Court and District Courts
The Supreme Court and District Courts should continue to have the power to make forensic orders. Power to make such orders should not be transferred to the MHC.

Recommendation 3 - Non-revocation decision-making power should be rescinded
The MHC should cease having powers to make non-revocation orders as they are punitive, not evidence-based restrictions on a person's liberty.

Recommendation 4 – Forensic orders should be given clear expiration dates
Forensic orders made by the MHC and the Supreme and District Courts should have commencement and end dates for when such orders can lawfully be in place.

Part 3 - Allowing disclosure of personal information to respond to serious risk

The Bill proposes to legalise the disclosure by the MHRT – Tribunal members and staff – of a patient's personal information in circumstances involving serious risk to an individual or the public.

At present, the MHRT cannot disclose personal information protected by the MHA even in situations where it would "mitigate a serious threat to life, health or safety of a person, or to public safety."[13]

Only a nominated person with the sign off in writing by the Chief Executive, can disclose if there are reasonable grounds that it is necessary "to lessen or prevent serious risk to life, health or safety of a person or public safety."[14] Designated health practitioners of the Department or a hospital and health service and the Chief Psychiatrist in certain circumstances my also disclose such information.

The current piecemeal approach to disclosure is sought to be amended to create consistency in Queensland and reflect other Australian jurisdictions. This is to be done by granting disclosure of personal information powers to the President of the MHRT to authorise disclosure of personal information by Tribunal members and staff where necessary to address serious risk.

The proposed change contains several wide-reaching, undefined powers of granting authority and includes statements such as "holds a reasonable belief", "where necessary", "will lessen or prevent a serious risk". Definitions as to what these references mean are missing.

Although the Consultation Paper speculates as to what could be possible examples of intended serious risk, it is not contained in the Bill. Whilst this is useful, it needs to be placed into the Bill and final changes to the MHA.

[13] Queensland Health, *Health Legislation Amendment Bill 2026* (Qld), p.16.
[14] Queensland Health, *Health Legislation Amendment Bill 2026* (Qld), p.16.

As set out in Part 1, an unregulated and broad approach to document creation and the administration of powers must be avoided, particularly where the release of information may impact on a person's rights.

Recommendation 5 – provide definitions of what is a "reasonable belief ""where necessary" and a "serious risk" into the Amendment Bill.
Community consultation to be undertaken to decide what definitions are considered reasonable and appropriate in the circumstances.

Part 4 - Supporting safe transport for patients removed, deported or extradited from Queensland

The Queensland Government seeks to clarify who can disclose personal information to authorised Commonwealth officers and other federal law enforcement officers. At present, it is legally unclear as to the extent that staff members of an authorised mental health service can engage in disclosure.

Commonwealth law allows, in certain circumstances, for people receiving treatment under the MHA to be apprehended, detained, and either deported, removed, or extradited from Australia. This is only to occur by authorised Commonwealth officers and other federal law enforcement officials.[15]

It is therefore, proposed that this position be changed to expressly include staff and identify the role of the Chief Psychiatrist. The stated purpose is to allow for appropriate planning or execution of the person's removal. This would allow for timely access to accurate information, including personal information such as their mental health status.

While MHLEPQ acknowledges the need to share information with Commonwealth officers, it is concerned that broad discretion in determining what constitutes "relevant" personal information creates unacceptable risks to privacy and accountability.

As discussed in Part 1 and Part 3, leaving open ended powers as to meanings involving the stripping away of human rights, is to be avoided. What is "relevant" could be interpreted widely and include for example, self-incriminating information gained out of context with significant consequences.

[15] Queensland Health, *Health Legislation Amendment Bill 2026* (Qld), p20.

Recommendation 6 – A definition be written into the MHA as to what is considered relevant personal information.
Community Consultation to be undertaken to consider what information should be disclosed and in what circumstances.

Conclusion

The proposed amendments in the Bill represent a missed opportunity to meaningfully reform the MHA in line with lived experience perspectives and contemporary human rights principles, such as:

- freedom from arbitrary detention[16]
- right to liberty and security of person[17]
- freedom from torture and cruel, inhuman or degrading treatment.[18]

While MHLEPQ welcomes review of the MHA in principle, the narrow scope and technical nature of the proposed changes largely reinforce existing involuntary treatment frameworks rather than addressing their fundamental shortcomings.

Across several proposals, there is a clear trend toward strengthening detention and information-sharing powers without equivalent safeguards, clarity, or limits. In several instances, broad discretions are proposed without clear definitions, oversight mechanisms, or assurances that the principles of least-restrictive care and recovery-oriented practice will be upheld.

Of particular concern are proposals that would entrench prolonged detention through non-revocation periods, expand detention powers initiated by the Chief Psychiatrist, and limit review or notification processes. These measures message a favouring of community protection over individual rights, while risking to adequately support either.

MHLEPQ urges that any reform of the MHA must be grounded in genuine co-design with people who have lived and living experience, a robust human rights analysis, and a clear commitment to reducing, rather than entrenching, involuntary treatment. Without this shift, the proposed amendments risk deepening existing harms and further distancing the MHA from its stated recovery-focused and rights-based intent.

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[16] *Human Rights Act 2019* (Qld), s 29.2; *Universal Declaration of Human Rights,* UN General Assembly, 1948, Article 9.
[17] *Human Rights Act 2019* (Qld), s 29(1); *Universal Declaration of Human Rights,* UN General Assembly, 1948, Article 3.
[18] *Human Rights Act 2019* (Qld), s 17; *Universal Declaration of Human Rights,* UN General Assembly, 1948, Article 5.

Communication

Future communication about this submission or associated matters can be made with: Danie Williams-Brennan Policy Director

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Sincerely

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