Queensland's
Mental Health
Lived Experience Peak

Position Statement

Human Rights in the Queensland Mental Health System

Rise Position

People who seek support in the mental healthcare system will experience improved outcomes when a culture of respecting and protecting consumer human rights (HR) is widespread. Governments and institutions can contribute to this shift by:

1. Implementing Human Rights legislative and policy frameworks
2. Monitoring compliance with relevant Acts, the Queensland Human Rights Act 2019 (HRA) and Mental Health Act 2016 (MHA)
3. Focusing on whole-system reform
4. Prioritising Cultural Safety
5. Advocating for Human Rights-based approaches to mental healthcare.

Purpose

This position statement represents the position of Rise: Queensland's Mental Health Lived Experience Peak (Rise, formerly Mental Health Lived Experience Peak Queensland) on respect for the human rights of mental health consumers. It is based on work with Rise members since 2022. We describe five (5) key themes based on dozens of human rights recommendations made across multiple reports towards systemic change.[1] Rise advocates for transformative reform of mental health and suicide prevention systems underpinned by a human rights-based approach.

[1] Mental Health Lived Experience Peak Queensland, *Shining a Light: Eliminating Coercive Practices in Queensland Mental Health Services* (Report, 2023) <https://mhlepq.org.au/wp-content/uploads/2023/12/MHLEPQ-CP-report_Shining-a-light-FINAL.pdf>; Mental Health Lived Experience Peak Queensland, Submission to the First Independent Review of the Human Rights Act 2019 (Qld) (June 2024) <https://mhlepq.org.au/wp-content/uploads/2024/07/MHLEPQ-Submission-to-the-Qld-Human-Rights-Act-Review-FINAL.pdf>; Mental Health Lived Experience Peak Queensland, *Human Rights in Mental Health: Survey Report* (Report, 2024) <https://mhlepq.org.au/wp-content/uploads/2024/09/MHLEPQ-HR-Survey-Report_FINAL.pbp_.pdf>; Mental Health Lived Experience Peak Queensland, *Implementing Human Rights in the Queensland Mental Health System* (Position Paper, November 2024) <https://mhlepq.org.au/wp-content/uploads/2024/11/HR-Implementation-position-paper_-FINAL.pdf>; Mental Health Lived Experience Peak Queensland, Submission to Mental Health Select Committee, Parliament of Queensland, Inquiry into the Opportunities to Improve Mental Health Outcomes for Queenslanders (February 2022) <https://mhlepq.org.au/wp-content/uploads/2022/02/MHLEPQ-Submission-to-Improve-Mental-Health-Outcomes-for-Queenslands-Final.pdf>.

Background

Human rights breaches of people accessing mental healthcare are often significantly challenged due to an institutionalised culture of coercion that reinforces stigma and discrimination, coercive practices, and power imbalances.[2]

The lack of human rights protection, autonomy and dignity continues despite the existence of human rights and mental health laws, policies and frameworks aimed at protecting and upholding individual human rights in mental healthcare. These issues are compounded for some groups, including First Nations and people in marginalised and minority groups, by significant gaps in the translation of human rights legislation to strategic design, governance, and policy implementation. Rise has established dozens of human rights recommendations across multiple reports[3] and established categories of recommendations described below: legislative and policy frameworks; Act compliance; systemic reform; cultural safety and human rights-based approaches to care.

Key Themes

Legislative and policy frameworks

There is a growing call for a National Human Rights Act to better safeguard the rights of individuals with disabilities and ensure consistent legal protections aligned with international standards.

Australia is a signatory to multiple international human rights conventions such as the United Nations Convention on the Rights of Persons with Disabilities (CRPD), which promotes equal rights and non-discrimination for people with disabilities;[4] and the Optional Protocol to the Convention Against Torture (OPCAT), to protect individuals with mental ill-health or psychosocial disabilities from torture and ill-treatment, especially in settings where their movement is restricted, such as involuntary mental health care.[5] Additionally, the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP) highlights the right of Indigenous peoples to maintain their social and emotional wellbeing rooted in their cultural, spiritual, and traditional practices.[6]

At the state level, the HRA incorporates international human rights principles into local law, mandating their protection.[7] The MHA states that all Queenslanders are entitled to basic human

[2] Mental Health Lived Experience Peak Queensland, *Shining a Light* (n 1).

[3] Mental Health Lived Experience Peak Queensland (n 1).

[4] *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007, 2515 UNTS 3 (entered into force 3 May 2008).

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

[6] *United Nations Declaration on the Rights of Indigenous Peoples*, GA Res 61/295, UN Doc A/RES/61/295 (2 October 2007, adopted 13 September 2007).

[7] *Human Rights Act 2019* (Qld).

rights, which includes receiving health care that respects their autonomy and dignity without discrimination.[8]

Act compliance

Rise has observed that poor compliance and low literacy of consumer human rights according to international and state legislation continue to impact the experience of people seeking support. Rise notes the movement towards a National Human Rights Act that would strengthen compliance with conventions such as the CRPD and OPCAT, with improved reporting overseen by the Australian Human Rights Commission.

The HRA and MHA are examples of local legislation that public entities are obliged to comply with. We have made multiple recommendations in line with international, national and state human rights advocacy bodies towards embedding a culture of human rights and enhanced implementation and evaluation.[9] We lack regular public reporting on compliance with the HRA and MHA, and decision-making processes under these laws often fail to demonstrate proper consideration of human rights. Public entities often lack human rights training, and compliance is not transparently disclosed.

An equity lens is not applied with consistency to understand the human rights impacts on marginalised and minority groups, including First Nations peoples, children, and people with disabilities. Compliance with these laws is crucial for transparency, accountability, and genuine human rights protection. The Chief Psychiatrist (CP) must ensure all decisions under the MHA provide mental health consumers with the same human rights as other Queenslanders. The CP should require mandatory reporting and resources for human rights assessments. Like all public entities, Queensland Health (QH) must integrate human rights knowledge into all relevant staff roles and training.

Whole-system reform

Human rights violations continue across the Queensland social sector despite the existence of international and domestic legislation and policy frameworks. Challenges in applying human rights frameworks to practice stem from factors like weak implementation, weak enforceability, and resistance due to the cultural and structural status quo. Stigma and discrimination deter help-seeking and reinforce coercive practices in mental healthcare. Mental healthcare is still shaped by a historical reliance on coercion. Transforming mental healthcare requires leadership to address culture, care models, and workforce attitudes more broadly than in healthcare alone.

Cultural Safety

Low levels of cultural safety in mental healthcare are evident in cultural blindness, systemic racism, and the neglect of social determinants of mental health. This includes the failure to uphold the cultural rights of Aboriginal peoples and Torres Strait Islander peoples and the lack of genuine collaboration with First Nations communities. Studies show that First Nations

[8] *Mental Health Act 2016* (Qld).

[9] Mental Health Lived Experience Peak Queensland (n 1).

peoples experience disproportionate rates of coercion, hospital seclusion, and restraint, with their traditional practices often excluded from mental health services.[10] Increased commitment by Governments and institutions to existing human rights levers such as UNDRIP and national agreements such as Closing the Gap will improve cultural safety by working in partnership with Aboriginal and Torres Strait Islander people, addressing institutional racism and transforming government institutions.[11] In Queensland, the HealthQ32 First Nations First Strategy 2032 prioritises eliminating racism as one of the key determinants of improving cultural safety and protecting cultural rights in health care.

Human rights-based approaches to care

Queensland's strategy for mental health, alcohol and other drug services, Better Care Together, describes the necessary approach to improving healthcare and outcomes for people experiencing mental ill-health, problematic alcohol and other drug use, and suicidality:[12]

> **"Under Better Care Together, this means person-centred and recovery-oriented, rights-based treatment, care and support. It means balancing treatment, care and support so it is provided in the community as well as in hospitals and ensuring the right mix of services and treatment, care and support, the right type of beds at the right time. It means contemporary and comprehensive responses that respond holistically to people's needs, supported by integrated and multi-agency approaches."**

A consumer-led, person-centred system that upholds human rights is widely advocated, emphasising dignity, autonomy, and equitable access to support. Community-based care is an important public health strategy to prevent and intervene early in deteriorating wellbeing. By providing accessible and continuous support, it addresses the medical, social, and emotional needs of individuals with mental health challenges, fulfilling a fundamental human right.[13] New models of human rights-based care must be developed, evaluated, monitored and resourced for the Queensland context.

Call to Action

Rise calls for the following changes:

1. The CP is given the specific obligation under the MHA to monitor and publicly report on all limitations on human rights under the MHA.

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[10] Piers Gooding et al, *Alternatives to Coercion in Mental Health Settings: A Literature Review* (Report, Melbourne Social Equity Institute, University of Melbourne, 2018) <https://figshare.unimelb.edu.au/articles/report/Alternatives_to_Coercion_in_Mental_Health_Settings_A_Literature_Review/21128083>.

[11] Coalition of Aboriginal and Torres Strait Islander Peak Organisations and Australian Governments, *National Agreement on Closing the Gap* (July 2020) <https://www.closingthegap.gov.au/national-agreement>.

[12] Queensland Health, *Better Care Together: A Plan for Queensland's State-Funded Mental Health, Alcohol and Other Drug Services to 2027* (2022) 4 <https://www.health.qld.gov.au/__data/assets/pdf_file/0032/1178744/BetterCareTogether_HR.pdf>.

[13] Renee O'Donnell et al, 'Effect of Community Mental Health Care Programs in Australia: A Systematic Review' (2020) 26(6) *Australian Journal of Primary Health* 443.

2. That a specific HR assessment tool be developed and applied, and that every HR assessment in connection with care under the MHA be provided to the CP and they publicly report this information annually.
3. That all persons in the QH system authorised under the MHA to administer care to patients under the Act undergo specific human rights training.
4. That every instance of HR limitations be considered under s 58 of the HRA and that a full HR assessment be made freely available to any person whose human rights could be or were affected by the decision.
5. That a person whose HR has been restricted must be afforded full legal or non-legal representation, acceptable to the person, to challenge the decision and when appearing before the Mental Health Review Tribunal (MHRT).
6. That a person who has had personal freedom and movement restricted is afforded a rapid review option in the MHRT to challenge any assessment under s 58.
7. That the MHRT be given a specific obligation (and appropriate training) to analyse HR assessments during ordinary hearings and any rapid reviews of decisions under s 58.
8. That a consumer be given the right and support to request review of any decision of an HR assessment determined by the MHRT to a suitable court.
9. That QH adds performance indicators on the specific cultural rights of Aboriginal peoples and Torres Strait Islander peoples according to HRA s 28, UNDRIP Article 24, and the First Nations First Strategy 2032, and monitors, reviews and evaluates progress on cultural rights.
10. Innovation of person-centred models of care must be designed to eliminate human rights limitations in health care to the greatest possible extent, and implemented, evaluated and overseen by governments and institutions.
11. That QH considers all HR limitations as failures of care and fully investigates each event utilising restorative justice principles (see: Rise position statement: Elimination of the Use of Seclusion and Restraints in the Qld MH System).
12. The position of Chief Lived Experience Officer is created and responsible for monitoring and reporting on the state of HR in the mental health system in partnership with the Qld Human Rights Commission, QH and the CP.

Policy Governance	
Policy Approved By	Board
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