MHLEPQ Submission

First Review of the Queensland Human Rights Act 2019

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ACKNOWLEDGMENT OF COUNTRY

The Mental Health Lived Experience Peak Queensland respectfully acknowledges and honours the Traditional Owners of the Lands and Waters throughout Queensland. We thank the Elders - past, present, and emerging – for their wisdom and survivorship. Due to the historical and ongoing impacts of colonisation, First Nations Peoples have a unique experience of contact with the Queensland mental health system. Their human rights should be protected, promoted, and upheld by the Australian Government which has ratified multiple international Human Rights conventions, providing the explicit duty of state governments to embed these in domestic law.

First Nations Peoples' lived and living experiences of mental ill-health, distress, and suicidality may be vastly different to non-First Nations Australians due to transgenerational social disadvantage and marginalisation by society, including housing insecurity, homelessness, and displacement from Land and Country. We respect First Nations Persons' rights and sovereignty to lead their healing through their own culture and connectedness to Country, family, and spirit.

RECOGNITION OF LIVED EXPERIENCE

The Mental Health Lived Experience Peak Queensland would like to recognise people with a lived experience of mental ill-health, distress, and suicidality who have endured harm caused by Human Rights breaches within a system that was intended to support them. We honour people who have fought for change over many years, including the right to have a collective voice that challenges existing harmful practices and who tirelessly work toward positive change within the systems that have caused harm. We draw upon the Lived Experience expertise and knowledge of our members to evidence necessary system reforms, using organisational values of Safety, Respect, Intentionality, Integrity, and Outcomes. We advocate across Queensland for a Human Rights-based approach within the mental health system and more broadly across the social sector.

WHO ARE WE?

The 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 moved to direct contracting with Queensland Health on January 1st, 2023 (formerly auspiced by the Queensland Mental Health Commission).

The 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 also part of the National Mental Health Consumer Alliance, where other state and territory consumer peak bodies meet to coordinate on shared issues, including issues relating to Commonwealth policy and government-funded services.

SUMMARY OF RECOMMENDATIONS

This submission is informed by the MHLEPQ's work with our members across several projects but especially:

- MHELPQ Submission to the Queensland Parliament Mental Health Select Committee
- Shining a Light: Eliminating Coercive Practices in Queensland Mental Health Services
- MHLEPQ Statement of Advice: Responses to Queensland Health Restrictive Practices Policy Statement Discussion Paper
- Statement of Advice to Queensland Health on Proposed Amendments to the Mental Health Act 2016
- Position Statement: Elimination of the Use of Seclusion and Restraints in the Queensland Mental Health System
- DRAFT: Human Rights in Mental Health Survey Summary Report 2024.

Other relevant projects include the MHLEPQ's advice to the Queensland Chief Psychiatrist on the review of policies under the Mental Health Act relating to: "classified patients" (people who access mental healthcare in the corrections system); and the use of seclusion, physical and mechanical restraints in the mental health system.

In addition, this submission is informed by the MHLEPQ's general interactions with our members, individuals with a lived experience of mental ill-health and suicidality in Queensland.

Recommendation 1: Expand the rights

We recommend that rights are expanded under the Human Rights Act (2019) to include:

- Legal capacity and physical and mental integrity, as detailed under Articles 12 and 17 of the United Nations Convention on the Rights of Persons with Disability (CRPD) (respectively)
- Living independently and being included in the community under Article 19 of the CRPD
- A right to health, as detailed under Article 25 of the CRPD
- An adequate standard of living under Article 11 of the International Covenant on Economic, Social and Cultural Rights, and
- A right to a clean, healthy, and sustainable environment.

Recommendation 2: Require public reporting against international human rights obligations
We recommend that the Queensland Government commit to periodic reports on its compliance with key international human rights instruments as they relate to mental health. Particularly, but not exclusively concerning economic, social and cultural rights, the elimination of restrictive practices, and the rights of First Nations people.

Recommendation 3: The Chief Psychiatrist considers human rights during their review of mandatory policies under the Mental Health Act 2016 (Qld)
We recommend that the Chief Psychiatrist be obligated to seek the Human Rights Commission's advice during periodic reviews of all Queensland mandatory policies under the Mental Health Act 2016 (Qld).

Recommendation 4: Require improvements by public authorities
We recommend that public entities involved in mental health care or policy be required, as part of section 58, to:

- Ensure that knowledge of human rights, the Human Rights Act, and competencies connected to the realisation of human rights are part of relevant position descriptions, including for leadership roles.
- Provide mandatory human rights training and onboarding processes for all staff
- Develop appropriate performance management processes and support for public service and public mental health provider staff to uphold human rights
- Make evaluations and quality assurance measures of human rights a condition of funding for new initiatives
- Utilise and publish human rights impact assessments when internally assessing compliance with section 58.

Recommendation 5: Create a positive duty to disclose "proper consideration" under Human Rights Act, section 58
We recommend that the HRA be amended to require that public entities must publicly disclose where they have properly considered and complied with human rights, as part of their duties to all relevant parties under section 58. Decisions about specific individuals should be provided to each individual directly, while decisions affecting a class of persons should be publicly available. The scope of this duty should uphold the privacy of individuals and co-designed with the community.

Recommendation 6: Require a participation duty under the Human Rights Act

As part of section 58, we recommend that the HRA be amended to require that public authorities ensure the participation of First Nations peoples, children, and people with disability (including people with lived experience of mental ill-health and suicidality) on matters that impact their human rights. We recommend that like the CRPD, this includes reference to the need to consult representative bodies of these groups.

Recommendation 7: Remove the override provision

We recommend that the HRA be amended to remove the capacity of Parliament to override human rights when passing laws.

Recommendation 8: Make 'non-derogable' rights absolute

We recommend that the HRA be amended so that rights identified by the Queensland Human Rights Commission, as well as proposed rights to legal capacity and physical and mental integrity, be absolute rights that cannot be limited under section 13 of the HRA.

Recommendation 9: An independent review of governance to protect human rights

We recommend the establishment of an independent review into state governance arrangements, including but not limited to mental health laws; oversight and safeguarding mechanisms; human rights protection and redress; as well as public administration capabilities and frameworks; to better enable the Queensland government to promote a human rights culture in the mental health system. Alternatively, the Queensland Government should request a review by the Queensland Human Rights Commission into these matters.

Recommendation 10: Enhance the Queensland Human Right Commission's powers to enforce rights

We recommend the HRA be amended to enable the Queensland Human Rights Commission to enforce compliance by public entities with the HRA, including powers to:

- Identify breaches of the HRA
- Accept enforceable undertakings to remedy breaches of the HRA
- Issue compliance notices for breaches of the HRA by a public entity.

Recommendation 11: Stand-alone cause of action

We recommend the HRA be amended to enable individuals to take proceedings directly to court without the need to "piggy-back" claims with a breach of another piece of legislation.

Recommendation 12: Full access to legal representation

We recommend that the Queensland Government commit to ensuring that all people subjected to, or at risk of compulsory mental health treatment under the MHA have access to timely, free and independent legal advice.

INTRODUCTION

The Mental Health Lived Experience Peak (MHLEPQ) is grateful for the opportunity to contribute to the First Review of the *Queensland Human Rights Act 2019* (the Review). We affirm as a representative body for people with lived experience that close consideration of people with lived experience and their views will be crucial to enhancing the *Human Rights Act 2019* (Qld) (the HRA), in line with the government's international human rights obligations.[1] Doing so will strengthen legislation that has great possibility to enhance the freedoms, equity and fairness for people who use public mental health services in Queensland.

Human rights apply to all people equally. We share Justice Bell's declaration that 'a person with mental disability has the same rights as other persons.'[2] The *United Nations Convention on the Rights of Persons with Disabilities*[3] (CRPD) clarifies the rights of people with disability, including psychosocial disability, alongside other international human rights instruments such as the *Convention Against Torture*[4] and its Optional Protocol[5], and the *United Nations Declarations on the Rights of Indigenous People*.[6] Together, these frameworks should, when implemented by Commonwealth, state and territory governments, protect civil and political, as well as economic, social and cultural rights. The HRA presents an important, if incomplete, effort to consolidate these rights.

Society and government's responses to mental distress, crisis and ill-health have, and continue to undermine people's human rights. The failure of governments to provide the material conditions for a good life – housing, education, a healthy climate, self-determination for First Nations people – creates the conditions for mental and emotional distress to arise. When we and our members find ourselves in distress, government laws and policies, and the practice of public mental health providers breach human rights and cause further harm.

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

[2] *PBU & NJE v Mental Health Tribunal* [2018] VSC 564 (1 November 2018) Per Bell J [83].

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

[4] *Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment,* opened for signature 10 December 1984, 1465, UNTS 85 (entered into force 26 June 1987).

[5] *Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment,* opened for signature 18 December 2002, UN Doc. A/RES/57/199 (entered into force 22 June 2006).

[6] *United Nations Declaration on the Rights of Indigenous Peoples*, GA Res 61/295, A/RES/47/1 (2007).

We note Australia's interpretive declaration[7] of the CRPD but find this declaration fundamentally incompatible with the convention itself. Despite our view on the Australian interpretive declaration our member's experience of compulsory mental health treatment under the Queensland Mental Health Act 2016 (Qld) (MHA) is that such treatment is often administered in breach of the CRPD even allowing for the additional scope.

Many of our members have experienced coercive treatment as the first rather than the last resort. Further, we note that threats of coercive treatment are routinely used to solicit consent to treatment. It is therefore clear that the authorisation of compulsory mental health treatment as practiced under the MHA is incompatible with the CRPD.[8] Practices of compulsory treatment, seclusion and restraint[9] that inflict severe pain and suffering have been described by the UN Special Rapporteur as amounting to torture[10].

Evidence of widespread use of forced 'treatment' across Queensland indicates that Australia is far from meeting its own interpretation of CRPD compliance. Queensland has amongst the highest rates of forced treatment per capita in Australia. Similarly, the ability to limit 'non-derogable' rights under the HRA is inconsistent with international law.[11] The MHLEPQ has frequent reports of individuals accessing public mental health services, and not being engaged in supported decision-making. This is partly due to the failure of governments and public mental health services to embed human rights in the governance, design

[7] This interpretive declaration states that compulsory mental health treatment may be consistent with Articles 12, 17 and 18 of the CRPD so long as it is 'a last resort' and that it is subject to safeguards: *Convention on the Rights of Persons with Disabilities*: *Declarations and Reservations (Australia)*, opened for signature 30 March 2007, 999 UNTS 3 (entered into force 3 May 2008).

[8] Maylea, Chris and Asher Hirsch, 'The Right to Refuse: The Victorian Mental Health Act 2014 and the Convention on the Rights of Persons with Disabilities' (2017) 42(2) *Alternative Law Journal* 149

[9] Committee on the Rights of Persons with Disabilities, General Comment No. 1, Article 12: Equal Recognition before the Law, UN Doc. CRPD/C/GC/1 (19 May 2014); Juan E Mendez, *Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, 1 February 2013, A/HRC/22/53 [63].

[10] Juan E Mendez, *Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, 1 February 2013, A/HRC/22/53 [64].

[11] We support the concerns of the Queensland Human Rights Commission that some rights, such as the right to be free from torture, can be 'limited' when they are not permitted to be limited under international law: Queensland Human Rights Commission, *Strengthening the Human Rights Act: Key Issues Paper* (Queensland Human Rights Commission, June 2024) <https://www.qhrc.qld.gov.au/__data/assets/pdf_file/0010/48961/Stengthening-the-Human-Rights-Act-key-issues-paper.pdf>.

and operation of the mental health system.[12] Collectively, these failures have been described as "gross human rights violations".[13]

The MHLEPQ has been privileged with evidence from people with lived experience of the Queensland mental health system that describes ongoing and harmful breaches of their human rights. It is the peak's responsibility to advocate for and with people, people who are often most marginalised by society, for the reform of the public mental health system.

Our foundational thinking

This submission is based on the following foundations:

- We hold knowledge of the history of the mental health system that tells a story of violent and coercive custodial strategies that were constructed by and continue to reproduce colonising agendas.
- Our understanding of one purpose of the Queensland government is to make Queensland a freer, fairer and more equitable place for all citizens based on appropriate public administration and the application of human rights frameworks and legislation.
- We know that part of the principles supporting Queensland public mental health service (MHA Section 5) provides a person with a mental illness the same human rights, presumption of capacity, maximum self-reliance and cultural rights. These principles involve obligations under the HRA, particularly section 58 relating to the conduct of public entities.
- We understand the harmful influence of erroneous mental health system objectives: biomedical dominance and associated power imbalances that centre the needs of the system[14], rather than individual human rights and the consumer's self-identified needs**.**

[12] Simon Katterl and Chris Maylea, 'Keeping Human Rights in Mind: Embedding the Victorian Charter of Human Rights into the Public Mental Health System' (2021) 27(1) *Australian Journal of Human Rights* 58; Simon Katterl, 'From Principles to Practice: Clarifying New Obligations under Victoria's Mental Health and Wellbeing Act 2022' [2024] *Australasian Psychiatry* 10398562241251595..

[13] Katterl et al, *Not before Time: Lived Experience-Led Justice and Repair (Advice to the Victorian Mental Health Minister)* (January 2023) <https://static1.squarespace.com/static/64509ef54c074f6f4dfb7138/t/648ed6db5216c12186d165f3/1687082792810/Not+Before+Time+-+State+Acknowledgement+of+Harm+2023+FINAL+ADVICE.pdf>.

[14] We note that the World Health Organization states 'An additional concern is the explicit use of a reductionist Western biomedical model in mental health law, which works to the detriment of other holistic, person-centred and human rights-based approaches and strategies for understanding and addressing distress, trauma, and unusual perceptions or beliefs (2, 86). Furthermore, applying a Western reductionist approach to different cultures including Indigenous populations who may

- There is concern that the human rights of mental health consumers are not properly considered, documented, and upheld within public mental health services, where failure to act proportionately according to human rights frameworks is commonplace, and therefore an obvious failure of their obligations.
- We hold knowledge about the relationships between international human rights legislation (that Australia is a signatory to and has ratified), domestic human rights legislation, and the failure of law and regulations to be embedded in governance, policy, and practice.[15] The discrepancies need to be addressed as a matter of urgency.
- We support our colleagues at the QMHC who called in their submission for measures to develop and strengthen the Statement of Compatibility that accompanies legislation into parliament. The MHLEPQ advises that this be extended to Section 58 of the HRA concerning the proper consideration of the impacts of decisions on specific individual human rights within public mental health services.
- We know that people who identify with communities that experience mental ill-health, distress, and suicidality are more likely to endure societal barriers to enjoying their human rights. A disabling social environment that breaches individual human rights is much more likely for people who experience intersectionality – that is, relate to identities (for example, First Nations Persons and culturally diverse people; LGBTQIA+ communities; people living with disabilities; migrants; refugees; neurodiverse people) and / or who are exposed to social determinants that contribute to inequity (for example poverty; homelessness; and adverse childhood events).

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have their own conceptions and methods of approaching mental health, well-being and healing, may be detrimental both to the individual and the collective. Mental health law often reduces persons experiencing distress to being a "problem". Scant attention is given to the underlying economic, social and cultural factors causing the distress or discrimination, which affects the capacities of individuals, families and communities to overcome them (87). This framing often leads to stigma; an overemphasis on biomedical treatment options; undue attention to changing the individual rather than the circumstances in which they live; and a general acceptance of coercive practices (33): World Health Organization, *Mental Health, Human Rights and Legislation: Guidance and Practice* (2023) 13 <https://www.who.int/publications/i/item/9789240080737>.

[15] 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.

- Our approach to responding to mental ill-health, distress and suicidality is to take a social model of disability adopted by the CRPD and the General Committee.[16]

Our aims for this review

Our aims in developing this submission for the review are that the HRA and its implementation measures can be strengthened to enable:

1. Expansion of the scope of rights protected under the HRA, including reflection of rights in the CRPD and other economic, social and cultural rights.
2. Clarification of the absolute nature of some rights, such as the right to be free from torture.
3. Greater participation, leadership and co-design with people of lived experience in the decisions that impact them.
4. Better protection, enforcement and remedies of human rights under the HRA.
5. Greater capability and prioritisation of human rights by the Queensland government and public mental health services.
6. A greater Queensland Government focus on whether the current governance arrangements of the mental health system best enable a human rights culture and protection of human rights.

[16] Committee on the Rights of Persons with Disabilities, General Comment No. 1, Article 12: Equal Recognition before the Law, UN Doc. CRPD/C/GC/1 (19 May 2014).

WHAT PEOPLE WITH LIVED EXPERIENCE TOLD US

Human rights are a priority focus for our members. While a full description of lived experience findings is outside the scope of this submission[17], there are critical human rights issues for people living with mental ill-health, distress, and suicidality in Queensland that are a major priority for reform. Themes relating to human rights and mental health include, but are not limited to:

1. **A lack of equality - systemic discrimination, stigma, and unconscious bias**

All Queenslanders should enjoy recognition and equality before the law and in areas of public life.[18] Discrimination, stigma, and bias against people with mental ill-health, distress and suicidality are pervasive in society, within organisations created to serve mental health consumers and within the professions 'trained' to care for them.

The MHA sends a Parliamentary message to consumers and the community that consumers are seen as second-class citizens, despite the principles written in Section 5. Parliament and the MHA limit the right to equality, and several other human rights in ways that would not be justifiable for other members of the community.

For some who are most marginalised by society, for example, people who receive mental healthcare in prison, the message is that criminals are lesser people, and do not deserve quality mental healthcare, dignity, or respect. Refusal to provide healthcare including mental health plans and prescribed treatment to incarcerated people is common, often resulting in a decline in their health.

People are currently let down, ignored, judged, ridiculed, abused and tortured by the system

~Direct Lived Experience as a prison mental healthcare user and classified patient~

Other laws surrounding stigma, discrimination and vilification fail mental health consumers on this right. Existing vilification laws fail to see harmful mental health stigma as a form of vilification warranting legal protection.[19] New hate crime laws

[17]For full findings see MHLEPQ reports: *Shining a Light:*: Eliminating Coercive Practices in Queensland Mental Health Services, and *Human Rights in Mental Health*. Survey Summary Report 2024.

[18] *Human Rights Act 2019* (Qld) s 15.

[19] Simon Katterl, 'Words That Hurt: Why Mental Health Stigma Is Often Vilification and Requires Legal Protection' (2023) 0(0) *Alternative Law Journal* 1.

also fail to consider disability (including mental health) as warranting protection.[20]

2. Rights breaches and systemic issues within the biomedical paradigm

Queenslanders who experience mental ill-health, distress and suicidality should be treated equally with others[21], be provided access to quality mental health supports[22] according to their choices and culture[23], and have their freedoms honoured and upheld[24]. Instead, institutionalised coercion is experienced by many people seeking support through the public mental health system.

People who seek support who are actively suicidal, for example, may be disbelieved and turned away at the emergency department or responded to with force and involuntary treatment when voluntarily seeking help. People describe that 'support' based on coercion in the context of power imbalances[25] heavily weighted to clinicians, institutions, and systems, does not feel like support at all:

> *I find it interesting the way that restrictive and coercive treatment impact on the ongoing relationship with access to and experience of care. Due to the restrictive and coercive treatment inherent in care in the public sector – it genuinely took me over 15 years before I learned that care didn't need to be combative! It wasn't until I was given dignity of risk and grace to fall within the system that I learnt to be a partner in care. The system sets us (consumers and workers) up for greater restrictive practice. It takes a lot of unlearning to have a healthy relationship with the healthcare setting*
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> *~Lived Experience as a Queensland Health mental healthcare consumer~*

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[20] 'News: Stronger Hate Crime Laws Are Now in Effect' <https://www.qhrc.qld.gov.au/about-us/news/stronger-hate-crime-laws> ('*News*').

[21] *Human Rights Act 2019* (Qld) s 15.

[22] *Human Rights Act 2019* (Qld) s 37.

[23] *Human Rights Act 2019* (Qld) ss 27-28.

[24] *Human Rights Act 2019* (Qld) ss 17, 19, 25, 29, 30.

[25] For further evidence of power imbalances in mental health care in Australia, see: Maylea, Chris et al, 'Consumers' Experiences of Rights-Based Mental Health Laws: Lessons from Victoria, Australia' (2021) 78 *International Journal of law and Psychiatry* 101737; Victoria Legal Aid, *Your Story, Your Say: Consumers' Priority Issues and Solutions for the Royal Commission into Victoria's Mental Health System* (Victoria Legal Aid, 2020) https://www.legalaid.vic.gov.au/sites/default/files/vla/vla-your-story-your-say-report.pdf

3. Inhumane and degrading treatment and a lack of justice within closed environments

Building a human rights-based culture means creating institutions, supports and services that uphold, rather than undermine, Queenslander's human rights. Detention and closed environments create the conditions for power imbalances and further human rights breaches. When liberty is restricted in these closed environments, public authorities should take extra care to ensure humane treatment,[26] and should be granted adequate legal representation so that they can experience a fair hearing.[27]

Queensland's mental health system breaches human rights, then fails to provide humane conditions when deprivations of liberty occur and fails to provide adequate legal services to safeguard rights. Our members routinely fail to get access to legal support before the Mental Health Review Tribunal. Queensland legal aid representation is only provided to persons under Forensic Treatment orders and not to persons under Treatment Authorities.

Less than 1% of cases before the Mental Health Review Tribunal lead to revocation or changes to treatment authorities or forensic treatment orders[28]. A recent visit to Cairns found five people on forensic orders in the acute psychiatric ward. They were offered no therapies as the ward was only equipped for acute symptom management. One patient was on the ward for more than 12 months with no or little prospect of receiving the therapy required to be placed on a less restrictive order.

When people are deprived of liberty, their humanity and dignity are often not respected and upheld. Experiences of human rights breaches and torture are prevalent in prison mental health units, the most common entry point for people to be shifted to psychiatric facilities, often becoming 'classified patients':

> *I looked out of my cell my first day to see a woman holding a pad in place with her hand through her gown – she had her period and was not allowed access to underwear – not even disposable underwear ~Direct Lived Experience as a Classified Patient in a Qld Woman's prison~*

[26] *Human Rights Act 2019* (Qld) s 30.

[27] *Human Rights Act 2019* (Qld) s 31.

[28] Callinan, Rory, '"As Serious as a Criminal Trial": Decisions of Sensitive Mental Health Tribunal under Scrutiny', *ABC News* (online, 1 June 2021) <https://www.abc.net.au/news/2021-06-02/study-raises-concerns-about-qld-mental-health-review-tribunal/100181556>

People told us that there were no safety mechanisms, oversight, or redress functions that were safe and accessible to them.

4. Intersectionality with trauma

Trauma is increasingly identified as a major determinant of poor mental health. People who experience adverse events and cumulative trauma in childhood and other crucial periods of development are much more likely to experience mental ill-health, distress, and suicidality later in life. Systemic human rights breaches may be more impactful for people with challenges relating to historical and transgenerational trauma, creating a vicious cause-and-effect cycle that compounds people's mental health and distress:

I had become petrified of going to hospital due to the fear of not getting the help I need

I have spent the better part of the year trying to undo a lot of the damage MH [mental health] system has done to me, while I was in distress

~MHLEPQ members, respondents to the Human Rights in Mental Health Survey~

DISCUSSION & RECOMMENDATIONS

MHLEPQ engages in systemic advocacy and reform processes across Queensland's mental health system. We engage first with our members before representing their views to Ministers, Departmental officials, statutory bodies and public mental health services. We have a unique vantage point on the status of Queensland's human rights culture, the gaps in human rights protections under the HRA, the level of influence of the HRA on the MHA, and the adequacy of existing protections and remedies on human rights.

1. *Social policy is undermining mental wellbeing and human rights*

Economic, social and cultural rights have minimal protection under the HRA. The right to education and the right to health are limited and explicitly designed to avoid a focus on the social, commercial and political determinants of mental health. We see the links between youth justice, criminal legal, climate, disability, education, health and other policies and their impact on mental health and wellbeing.

The Queensland government has committed to addressing these issues as a matter of policy. The Better Care Together framework articulates a general commitment to addressing these determinants.[29] However, in the absence of enforceable rights – including a more fulsome right to health, as well as rights to an adequate standard of living – these promises are difficult to trust. We also note that there are significant human rights issues associated with residential services[30], indicating a failure of government to uphold rights to safe independent living under article 19 of the CRPD.

We therefore support the calls to expand HRA to include these rights, as well as the rights to a clean, healthy and sustainable environment, while also calling for the review to better implement rights under the CRPD, including the right to legal capacity (article 12), the right to physical and mental integrity (article 17), the right to living independently and being included in the community (article 19) and the right to health without discrimination (article 25) of the CRPD.

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

[30] Public Advocate (Qld), *'Safe, Secure and Affordable'? The Need for an Inquiry into Supported Accomodation* (Public Advocate (Qld), 2023) <https://www.justice.qld.gov.au/__data/assets/pdf_file/0010/778888/2023-08-supported-accommodation-report-final.pdf>.

Recommendation 1: Expand the rights

We recommend that rights are expanded under the HRA to include a right to:

- Legal capacity and physical and mental integrity, as detailed under Articles 12 and 17 of the CRPD (respectively)
- Living independently and being included in the community under Article 19 of the CRPD
- Health, as detailed under Article 25 of the CRPD
- An adequate standard of living under Article 11 of the International Covenant on Economic, Social and Cultural Rights, and
- A clean, healthy and sustainable environment.

2. *An incomplete development of a human rights culture*

Ministers, the Department of Health and public mental health providers must properly consider and comply with human rights under the HRA when making decisions that will impact human rights.[31] These duties extend traditional adversarial and litigation-focused approaches to human rights, to the development of systems management, government policies, commissioning decisions, regulatory oversight frameworks and decisions by public actors that create the conditions for human rights to be complied with in public mental health services[32].

Obligations apply equally to public mental health providers, imposing duties on how boards make decisions about the strategic direction of their service, how models of service are designed, and what kinds of practitioner capabilities are selected to meet diverse community needs. Consideration of how internal quality and safety processes uphold human rights and address the organisational causes that led to adverse human rights outcomes are required.[33]

With important exceptions and some positive developments, a strong human rights culture is yet to be found in Queensland. Parliament's knowledge of the intersection between human rights and the mental health system appears limited, with the term 'human rights' only featured *twice* across the 217-page Mental Health Select Committee report, *Inquiry into the opportunities to improve*

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[31] *Human Rights Act 2019* (Qld) s 58.

[32] Katterl and Maylea (n 12).

[33] Queensland's human rights duties reflect those in effect in Victoria's *Charter of Human Rights and Responsibilities Act 2006* (Vic): Katterl, Simon, 'From Principles to Practice: Clarifying New Obligations under Victoria's Mental Health and Wellbeing Act 2022' [2024] *Australasian Psychiatry* 10398562241251595

mental health outcomes for Queenslanders.[34] Other submissions to the inquiry also told a story, with both the Health Ombudsman[35] and the Mental Health Review Tribunal failing to identify human rights issues in their submission.[36] We note that commissioning decisions don't appear to properly consider and comply with human rights, with service agreements to hospitals and health services failing to re-affirm obligations under the HRA when providing taxpayer money.[37]

Our members have expressed concern that their human rights are not upheld when they make complaints to the Health Ombudsman, who has obligations to properly consider and comply with human rights when exercising their regulatory functions.[38] We note that our Chief Psychiatrist - who has the statutory function to promote rights[39] has developed several policies, including policies relating to seclusion, physical and mechanical restraint, that do not specifically require human rights to be considered in decision-making. We also hold questions about the lack of enforcement of these mandatory policies[40], and whether rights are being properly considered and complied with during these decisions about whether to utilise enforcement powers. Collectively, these and other failures to comply with section 58 of the HRA create a permissive culture for human rights breaches within public mental health services.

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[34] Queensland Government, Inquiry into the opportunities to improve mental health outcomes for Queenslander, Report No 1, 57th Parliament Mental Health Select Committee (June 2022) <https://documents.parliament.qld.gov.au/tp/2022/5722T743-64F1.pdf>

[35] Office of the Health Ombudsman, Submission in response to the Mental Health Select Committee's Inquiry into the opportunities to improve mental health outcomes for Queenslanders (Submission to Inquiry into the opportunities to improve mental health outcomes for Queenslanders, February 2022) < https://documents.parliament.qld.gov.au/com/MHSC-1B43/IQ-5DEF/submissions/00000138.pdf>

[36] Mental Health Review Tribunal, Inquiry into the opportunities to improve mental health outcomes for Queenslanders (Submission to Inquiry into the opportunities to improve mental health outcomes for Queenslanders, February 2022) < https://documents.parliament.qld.gov.au/com/MHSC-1B43/IQ-5DEF/submissions/00000029.pdf >

[37] For example, see: Health, c=AU; o=The State of Queensland; ou=Queensland, 'Cairns and Hinterland HHS Service Agreements' (Text) <https://www.publications.qld.gov.au/dataset/cairns-and-hinterland-hhs-service-agreements>

[38] These issues reflect broader issues that we see with our interstate colleagues: Victorian Mental Illness Awareness Council, *VMIAC Policy Position Paper #7: Adherence to Mental Health Laws* (2021) <https://www.vmiac.org.au/policy-campaigns/policy-issues/>; Simon Katterl and Sharon Friel, 'Regulating Rights: Developing a Human Rights and Mental Health Regulatory Framework' in Kay Wilson, Yvette Maker and Piers Gooding (eds), *The Future of Mental Health, Disability and Criminal Law* (Routledge, 2023) 267; Simon Katterl, 'Regulatory Oversight, Mental Health and Human Rights' (2021) 46(2) *Alternative Law Journal* 149.

[39] *Mental Health Act 2016* (Qld) s 301.

[40] The Chief Psychiatrist has the power to issue mandatory notices that arise from investigations: *Mental Health Act 2016* (Qld) s 310.

We have struggled to find evidence of human rights impact assessments being performed within public mental health services when they introduce new services or develop models of care that will involve the use of forced treatment, detention, coercion, compulsory treatment, seclusion and restraint.

It is also unclear whether Aboriginal cultural rights are being considered at these stages to ensure that First Nations people don't have their cultural rights unduly limited when they enter mainstream services. Core human rights competencies around supported decision-making,[41] culturally safe and responsive mental health care, disability-inclusive, and LGBTIQ+ inclusive mental health care are absent from position descriptions. Indicating that human rights are not properly considered at this stage. It is not clear whether the training that staff access – including training on mental state examinations, risk assessments, violence risk assessments, psychological and psychiatric formulation, and more – have had a human rights impact assessment to shape both the learning outcomes and processes.

We note that there may be some deliberation of human rights consistent with section 58, but there is no public evidence. Several members subjected to forced treatment have been unable to obtain records relating to their care that demonstrate how their human rights were considered in the decision-making process. This highlights the necessity of a positive duty to publish information that indicates proper consideration and compliance with human rights. This would be an expression or realisation of the right to receive information under section 21.[42] This should of course be subject to limitations for individuals where their rights to privacy may be impacted.[43]

[41] Gooding, Piers, 'Supported Decision-Making: A Rights-Based Disability Concept and Its Implications for Mental Health Law' (2013) 20(3) *Psychiatry, Psychology and Law* 431

[42] Section 21(2) of the *Human Rights Act 2019* (Qld) provides that people have the right to 'receive' information.

[43] We note that this should not be used deletiourslyto limit the disclosure of public interest information on mental health system performance, as has been done elsewhere: Adeshola Ore, 'Victoria's Mental Health Watchdog Criticised after Fighting Release of Secret Recommendations | Victoria | The Guardian', *Guardian Australia* (online, 12 July 2023) <https://www.theguardian.com/australia-news/2023/jul/12/victorias-mental-health-watchdog-criticised-after-fighting-release-of-secret-recommendations>.

Recommendation 2: Require public reporting against international human rights obligations

We recommend that the Queensland Government commit to periodic reports on its compliance with key international human rights instruments as they relate to mental health. Particularly, but not exclusively concerning economic, social and cultural rights, the elimination of restrictive practices, and the rights of First Nations people.

Recommendation 3: Chief Psychiatrist consider Human rights during review of mandatory policies under the *Mental Health Act 2016* (Qld)

We recommend that the Chief Psychiatrist be obligated to seek the Human Rights Commission's advice during periodic reviews of all Queensland mandatory policies under the Mental Health Act 2016 (Qld).

Recommendation 4: Require improvements by public authorities

We recommend that public entities involved in mental health care or policy be required, as part of section 58, to:

- Ensure that knowledge of the human rights, the HRA, and competencies connected to the realisation of human rights are part of relevant position descriptions, including for leadership roles.
- Human rights training and onboarding processes are mandatory for all staff
- The development of appropriate performance development, support and management processes for public service and public mental health provider staff to uphold human rights
- Make evaluations and quality assurance measures as part of human rights a condition of funding for new initiatives
- Utilisation and publication of human rights impact assessments when internally assessing compliance with section 58.

3. Failure to consult and enable participation

Human rights are all interconnected and interdependent. Under the CRPD, state parties are required to consult with people with lived experience, as well as their representative bodies, in implementing the Convention. This is an expression of the mantra ‘nothing about us, without us.’ This duty, and the interdependent nature of human rights, makes clear why the participation of people with lived experience is needed for proper consideration and compliance.

Identifying, understanding, mitigating and eliminating risks to human rights is not possible without meaningful collaboration with lived experience experts. Lived experience participation supports the realisation of all human rights. However, unlike the proposed National Charter of Human Rights,[44] Queensland's HRA does not include a 'participation duty'. We support the Queensland Human Rights Commission's call for a participation duty under this Act.[45] Other measures will be needed to give life to this duty. For example, MHLEPQ continues to call for the establishment of a Chief Lived Experience Officer to enable systems reform and leadership from people with lived experience.[46]

In the absence of a participation duty, it is difficult to see how MHLEPQ, its members and the broader consumer community in Queensland will be able to assist the Queensland Government and public mental health services to develop a human rights culture. A participation duty would only address a small part of this challenge, with capability uplift on co-design, knowledge of consumer lived experience expertise, and human rights more generally needed for both Queensland Government representatives and public mental health service providers.

Recommendation 5: Create a positive duty to disclose "proper consideration" under section 58

We recommend that the HRA be amended to require that public entities must publicly disclose where they have properly considered and complied with human rights, as part of their duties to all relevant parties under section 58. Decisions about specific individuals should be provided to each individual directly, while decisions affecting a class of persons should be publicly available. The scope of this duty should uphold the privacy of individuals and co-designed with the community.

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[44] Australian Human Rights Commission, *Free and Equal: Revitalising Australia's Commitment to Human Rights: Free & Equal Final Report* (Australian Human Rights Commission, 2023) <https://humanrights.gov.au/sites/default/files/2311_freeequal_finalreport_1_1.pdf>.

[45] Queensland Human Rights Commission (n 11).

[46] Mental Health Lived Experience Peak Queensland, *Shining a Light: Eliminating Coercive Practices in Queensland Mental Health Services* (2023) <https://mhlepq.org.au/wp-content/uploads/2023/12/MHLEPQ-CP-report_Shining-a-light-FINAL.pdf>.

Recommendation 6: Require a participation duty under the HRA

As part of section 58, we recommend that the HRA be amended to require that public authorities ensure the participation of First Nations peoples, children, and people with disability (including people with lived experience of mental ill-health and suicidality) on matters that impact their human rights. We recommend that like the CRPD, this includes reference to the need to consult representative bodies of these groups.

4. ***Mental health and other discriminatory laws continue despite the Mental Health Act***

Laws are some of the biggest determinants of justice and injustice. Mental health laws are no different. We reaffirm that the use of compulsory treatment, seclusion and restraint are inconsistent with international human rights law and contrary to the views of many in our membership. The use of these practices was authorised by Parliament before the enactment of the 2019 HRA. Therefore, MHA has not been subjected to a full assessment or statement of compatibility process under the HRA.

Even if we were able to demonstrate incompatibility, the current HRA does not secure the protection of human rights. We note how the 'override' clause that has been used concerning youth justice laws significantly undermines Parliament's commitment to human rights.[47] Any future mental health laws should, at a minimum, be required to show compatibility with rights under the HRA and not be subject to override.

Before doing so, Parliament should provide more clarity on absolute rights under the HRA. Some rights deemed 'non-derogable' under international law should not be subject to limitations. The rights to freedom from torture, as well as other rights, are absolute. The current HRA has a general limitations clause that enables *all rights* to be limited, contrary to our international obligations. The ability to 'limit' rights under section 13 of the HRA should not be applied to these rights under the Act, either by public authorities, courts when they interpret other legislation, or Parliament when it passes laws.

Recommendation 7: Remove override provision

We recommend that the HRA be amended to remove the capacity of Parliament to override human rights when passing laws.

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[47] 'More than 1100 Children Charged under New Bail Laws... | NIT' <https://nit.com.au/09-04-2024/10719/more-than-1100-children-charged-under-new-bail-laws-in-queensland>.

Recommendation 8: Make 'non-derogable' rights absolute

We recommend that the HRA be amended so that rights identified by the Queensland Human Rights Commission, as well as proposed rights to legal capacity and physical and mental integrity, be absolute rights that cannot be limited under section 13 of the HRA.

5. *Failure to enforce human rights – Chief Psychiatrist, Health Ombudsman, Mental Health Review Tribunal*

Human rights require protection, enforcement and remedies. While laws and policies should eliminate the need for compulsory treatment, we acknowledge that various institutions and safeguards are in place currently to ensure that compulsory treatment is a last resort and provided in a way consistent with the MHA. The need to ensure that any limitations on rights triggered under the MHA are compliant with that law, is also required under section 29(3) of the Act.[48] Unfortunately, we are not sure that they are working.

We see regular breaches of the MHA and the HRA, with little enforcement or accountability. The mental health principles in the MHA, which are said to reflect human rights standards, have made little difference to the operation of mental health services.[49] As noted, this starts with a failure to embed these responsibilities within existing health service agreements. Again, we note that there are concerns about the operation of the Mental Health Review Tribunal, raising questions about whether human rights are being protected through ensuring the least restrictive treatment possible.

We also note that, unlike other mental health commissions, the Queensland Mental Health Commission does not have an enforcement role relating to the MHA.[50] Individuals may complain to the Health Ombudsman, but the office presents several barriers to addressing our members' needs, including a lack of visible focus on human rights knowledge and significant time delays in making adjudications. This means that should a consumer face an imminent risk of a rights breach, such as the unlawful use of seclusion, restraint, or forced injections,

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[48] *Human Rights Act 2019* (Qld) s 29(3) provides that 'a person must not be deprived of the person's liberty except on grounds, and in accordance with procedures, established by law'.

[49] 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.

[50] By comparison, Victoria has established a Mental Health and Wellbeing Commission who has a primary role, with significant statutory powers, to protect human rights under section 415 of the *Mental Health and Wellbeing Act 2022*. See further: Katterl and Friel (n 41).

they lack an oversight body with the capacity to intervene effectively to prevent this harm.

While the Chief Psychiatrist has powers to investigate and make written directions, we are unclear to what extent these have been done to enforce human rights standards with services. The failure to establish fit-for-purpose regulatory oversight mechanisms is itself a potential breach of section 29(3) of the MHA, as consumers are unable to ensure that any limitations on their rights are in accordance with policies and procedures established by law.

The deficiencies in MHA protections only heighten the need to strengthen the HRA. We acknowledge the value of the complaint's mechanism under the HRA as a valuable opportunity to enable people to seek redress for breaches of their rights. However, the Queensland Human Rights Commission lacks the power to make determinations or enforce rights under this Act, which limits the ability of the Commission to drive cultural change.

The principle of responsive regulation has been highlighted in the review of the Victoria *Charter of Human Rights and Responsibilities Act 2006*[51] and should be addressed here. We also note that the necessity to "piggy-back" breaches of this HRA to breaches of other legislation, such as the MHA presents a significant barrier to justice and undercuts the value of human rights to Queenslanders. A stand-alone course of action exists in the Australian Capital Territory and should be replicated here.[52]

Recommendation 9: An independent review into governance to protect human rights

We recommend the establishment of an independent review into state governance arrangements, including but not limited to mental health laws; oversight and safeguarding mechanisms; human rights protection and redress; as well as public administration capabilities and frameworks; to better enable the Queensland government to promote a human rights culture in the mental health system. Alternatively, the Queensland Government should request a review by the Queensland Human Rights Commission into these matters.

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[51] Michael Brett Young, 'From Commitment to Culture: The 2015 Review of the Charter of Human Rights and Responsibilities Act 2006' [2015] *Victoria*: *State of Victoria*.
[52] *Human Rights Act 2004* (ACT) s 40B.

Recommendation 10: Enhance the Queensland Human Right Commission's powers to enforce rights

We recommend the HRA be amended to enable the Queensland Human Rights Commission to enforce compliance by public entities with the HRA, including powers to:

- Identify breaches of the HRA
- Accept enforceable undertakings to remedy breaches of the HRA
- Issue compliance notices for breaches of the HRA by a public entity.

Recommendation 11: Stand-alone cause of action

We recommend the HRA be amended to enable individuals to take proceedings directly to court without the need to "piggy-back" claims with a breach of another piece of legislation.

Recommendation 12: Full access to legal representation

We recommend that the Queensland Government commit to ensuring that all people subjected to, or at risk of compulsory mental health treatment under the MHA have access to timely, free and independent legal advice.

CONCLUDING COMMENTS

Soon after the early establishment of the MHLEPQ in 2022, a lived experience advisory group tasked with submitting to the Parliamentary Select Committee Inquiry into Improving the Mental Health of Queenslanders made the following call to action:

> *We hope you will commit to far reaching change to ensure our needs and human rights are not violated. We urge you to accept us as fellow Queenslanders, entitled to the same rights and protections as others in our community*
>
> *~Lived Experience MHLEPQ member~*

They didn't listen then. Now, this submission echoes the rallying cry of the consumer movement and Queensland's peak body for consumers to seize the opportunities for meaningful reform that are offered to us. This Review provides a strong opportunity for transformational change that the MHLEPQ is highly motivated to support. The MHLEPQ is thankful for the opportunity to contribute to the discussion and welcomes the opportunity to speak directly with Professor Susan Harris Rimmer and the team if any further input would be helpful.

CONTACT

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