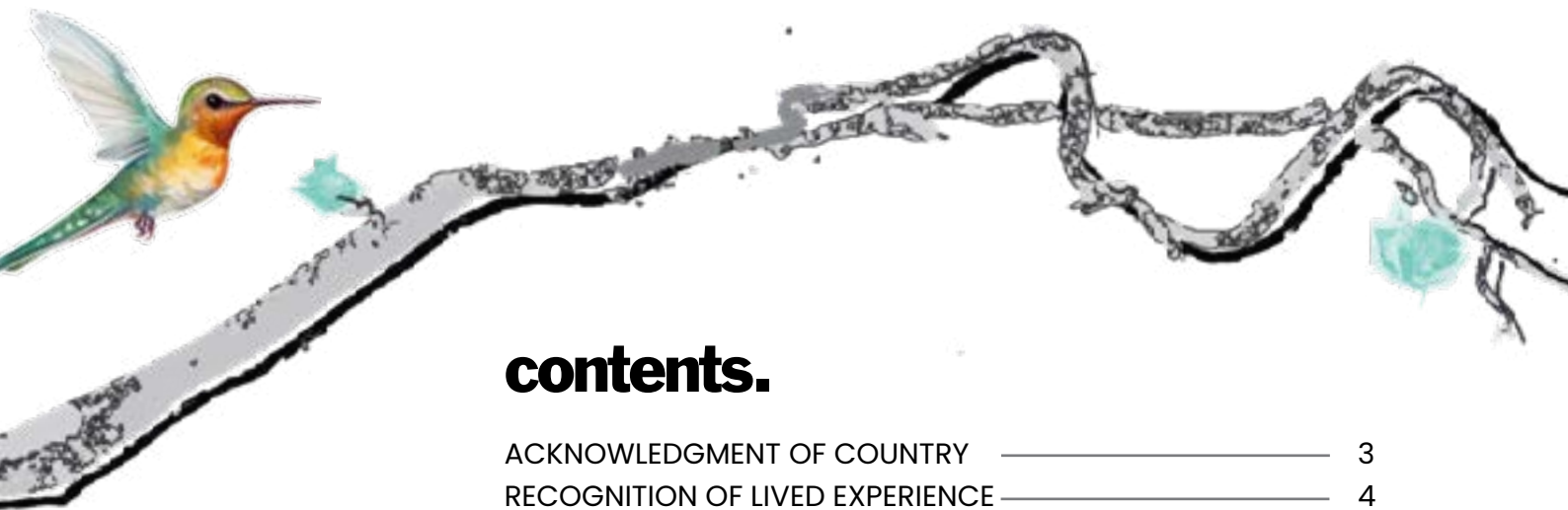




HUMAN RIGHTS **in mental health**

SURVEY REPORT 2024

MHLEP 



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acknowledgement of country.

The Mental Health Lived Experience Peak Queensland (MHLEPQ) 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. We acknowledge that First Nations Peoples have a unique experience of contact with the Queensland mental health system and have human rights that should be protected, promoted, and upheld by multiple international human rights Conventions.¹ We respect First Nations Persons' rights and autonomy to lead their own healing, through their own culture and connectedness to Country, family, and spirit.

¹ Notably, but not exclusively: the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP), endorsed by Australia in 2009; the United Nations Convention on the Rights of Persons with Disabilities (CRPD), ratified by Australia in 2008; and the Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT), ratified by Australia in 2017.



You
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recognition of lived experience.

The MHLEPQ would like to recognise people with a lived experience of mental ill-health 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 reforms, using organisational values of Safety, Respect, Intentionality, Integrity, and Outcomes, while advocating across Queensland for a human rights-based approach within the mental health system.

human rights statement.

Mental health is vital to overall human experience and is related to a person's ability to participate in society and live according to their own sociocultural and political values. The Mental Health Lived Experience Peak Queensland advocates that the right to mental health is a fundamental human right and it is a whole-of-society obligation to promote, protect, and uphold that right. People have the right to be treated with dignity, be protected from torture and cruel, inhuman, or degrading treatment, and live free from discrimination and stigma according to their own cultural determination.

We believe that this right should include support with the social determinants of mental health such as adequate housing, a clean, healthy and sustainable environment, and health services that are affordable, effective, and culturally appropriate. By acknowledging mental health as a fundamental human right, we affirm our commitment to a just and equitable society where everyone can thrive.

Human rights in mental health are both a constitutional and working principle of the peak and one of the main objectives of its advocacy work. The MHLEPQ is guided by its membership to prioritise the human right to mental health for all Queenslanders, including understanding the legal protections and policies in place across the sector. We will advocate for and with Queenslanders to ensure the proper consideration and compliance with human rights regulations, ensuring that individuals with mental ill-health, distress and suicidality are not excluded or marginalised.



with appreciation.

The MHLEPQ staff would like to pay our deepest respects to the people who contributed their knowledge and insights through responding to our survey and the report. In doing so, they have built upon the work that was previously invested in the Queensland Select Committee Mental Health Inquiry and have inspired the next wave of advocacy on the crucial topic of human rights in mental health. We would like to extend our gratitude to Hannah Wilson, for her commitment, dedication, and enthusiasm in co-producing this report.

glossary.

Autonomy is a person's capacity for being able to make decisions about their own life – including the right to choose one's own mental health care and live a meaningful life of their own making.ⁱ

Biomedical model of health is a model of health that focuses on purely biological factors and excludes psychological, environmental, and social influences.ⁱⁱ This is the dominant paradigm in healthcare in most Western countries, where knowledge and expertise are controlled by medical professionals.²

Coercion is forceful action, involuntary treatment, and/or threats³ undertaken while providing treatment or addressing perceived harm that a person poses to his/her own self or others due to a mental health condition.ⁱⁱⁱ

Coercive practices include formal detention, treatment without consent ("compulsory treatment"), seclusion and restraint, including the use of mechanical devices, person-to-person restraint, or psychotropic drugs for the primary

purpose of controlling movement ("chemical restraint") and / or the use of electroconvulsive treatment.^{iv}

Developmental trauma is a diagnostic term that refers to chronic traumatic experiences that occur during childhood and adolescence. It describes the psychological and biological effects of ongoing exposure to stress and adversity due to physical or sexual abuse, neglect, witnessing or being the object of violence, death or loss of a caregiver, attachment disruption, war, chronic stress in the family and their environment, serious cognitive and physical problems, and any events that overwhelm a child's or adolescent's coping strategies and impacts the developmental process itself.^v

Dignity⁴ refers to "the inherent and inalienable worth of all human beings irrespective of social status such as race, gender, physical or mental state".^{vi}

Discrimination is the unfair or prejudicial treatment of people and groups based on characteristics such as race, gender, age, or sexual orientation.^{vii}

Discrimination Specific to mental health relates to prejudice, negative community attitudes, social exclusion and marginalisation, and abuse directed at people living with mental health problems, mental illness, problematic alcohol and other drug use, and people affected by suicide.^{viii}

Electroconvulsive therapy (ECT) is treatment used in the psychiatric field worldwide. It involves delivering an electrically induced seizure to anaesthetised patients to alleviate symptoms of mental illnesses particularly those associated with serious disturbances of mood.^{ix}

Holistic approach is support that looks at the whole person, not just their mental health needs. The support may consider their physical, emotional, social and spiritual wellbeing.^x

Human rights are rights that are inherent to all human beings, regardless of race, sex, nationality, ethnicity, language, religion, or any other status. Everyone is entitled to these rights, without discrimination.^{xi}

2 The biomedical model in the mental healthcare context argues that mental disorders are brain diseases and uses predominantly pharmacological treatments to target presumed biological abnormalities (Deacon, 2013). The biomedical model of mental disorder: a critical analysis of its validity, utility, and effects on psychotherapy research. *Clin Psychol Rev.* Nov; 33(7):846-61. doi 10.1016/j.cpr.2012.09.007.

3 MHLEPQ members report that 'threat' may be both implicit and/or explicit

4 Dignity is embedded in Article 3 of the United Nations Convention on the Rights of Persons with Disabilities (CRPD), as the first guiding principle of the Convention: "Respect for inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of persons". United Nations Department of Economic and Social Affairs. Convention on the Rights of persons with disabilities. Article 3-General Principles. <https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities/article-3-general-principles.html>

Human rights-based approach is an approach that converts human rights principles and laws into effective practice, increasing knowledge and understanding of human rights and empowering individuals to exercise their own rights.

Relating to legality, this approach requires that the law recognises human rights and freedoms as legally enforceable entitlements.

Relating to accountability, effective monitoring of human rights standards and human rights goals are required, and effective remedies for human rights breaches are enforced.^{xii}

Informal care is care provided to those who need it within the context of an existing relationship, such as a family member, a friend, or a neighbour.^{xiii}

Intersectionality describes how different forms of oppression overlap and interact to create complex experiences of discrimination. Aspects of an individual's identity may include a person's gender, race, ability, sexual orientation, age, class, or immigration status.^{xiv}

Involuntary treatment is the compulsory assessment and/or

treatment of people in mental health services without the person's consent being given. This is described as a form of restrictive practice and is mandated under respective state and territory legal and regulatory frameworks and approved under certain conditions.^{xv}

Lived experience is the experience of life-changing mental health challenges, service use, and periods of healing that have profoundly impacted a person's world-view, direction, and life. This can be a direct personal (consumer) experience or an experience as a family member/carer supporting a loved one facing mental health challenges.

Lived expertise is the capacity to use lived experiences in ways that are useful to other people and the structures and systems that were experienced, drawing on knowledge and evidence bases that are recognised as equal value to clinical and academic ones.^{xvi}

Medicalisation means 'to make medical' or more specifically the process by which previously non medical problems become defined and treated as medical

problems, usually as diseases or disorders.^{xvii}

Self-determination 'is concerned with the fundamental right of people to shape their own lives'^{5, xviii}

Shared decision-making is a set of skills and practices that clinicians can learn in order to engage in a collaborative decision-making process for healthcare decisions.⁶

Substitute decision-making is appointing someone who is permitted by law to make decisions on behalf of another person who does not have capacity.^{xix}

Supported decision-making is the process of assisting a person to make their own decisions, particularly ones that are legally recognised, so they can develop and pursue their own goals, make choices about their life and exercise some control over the things that are important to them.^{xx}

Systems trauma is "exposure to traumatic systems," or "situations in which organized systems create trauma, including those designed to mitigate trauma".^{xxi xxii} (Stewart, 2021; Lucero and West, 2017).

5 Self-determination is embedded in Article 19 of the CRPD: Living independently and being included in the community. In the context of disability, it means exercising freedom of choice and control over decisions affecting one's life with the maximum level of self-determination and interdependence within society. Committee on the Rights of Persons with Disabilities. (2017). General comment on article 19: Living independently and being included in the community. CRPD/C/GC/5. https://www.ohchr.org/Documents/HRBodies/CRPD/GC/CRPD_C_18_R_1_docx#:~:text=Personal%20autonomy%20and%20self%2Ddetermination,health%20care%2C%20religious%2C%20cultural%20and

6 Hoffman et al (2014). Shared decision making: what do clinicians need to know and why should they bother? The Medical Journal of Australia 201, 35-39.

key messages.

A systemic lack of respect, protection and promotion for their human rights was described by many respondents.

Breaches of many individual human rights were described by lived experience people, including, but not limited to:

- The right to protection from torture and cruel, inhuman, or degrading treatment.
- The right to humane treatment when deprived of liberty.
- The right to liberty and security of person.
- The right to freedom of movement.
- The right to take part in public life.
- The right to health services.
- The right to recognition and equality before the law.
- The right to privacy and reputation.

Australia is a signatory to several international human rights conventions meaning that domestic legislation is required to provide the regulatory mechanisms to enact international human rights law. The international human rights conventions of primary interest to the peak and its members are the CRPD, OPCAT and UNDRiP. In Queensland, the primary domestic legislation is the Human Rights Act 2019 (HRA) (currently under review).

The Queensland Human Rights Act 2019 functions to protect human rights and oblige public entities to properly consider and comply with legislation:

S 14: Nothing in this Act gives any person or other entity a right to limit to a greater extent than is provided for under this Act, or destroy, a human right of any person.

S 58(1) requires public entities to:

- act and make decisions in a way that is compatible with human rights; and
- properly consider human rights when making a decision.⁷

⁷ Which means a decision-maker must document their thinking to prove that proper consideration was given, where a person's rights were limited. https://www.forgov.qld.gov.au/_data/assets/pdf_file/0025/442906/Obligations-under-section-58-of-the-Human-Rights-Act.PDF



All decision-makers in public entities

whose choices impact an individual's human rights, including the people the decision-makers devolve authority to, are obliged to ensure that those decisions are compatible with the HRA. The proper consideration of specific human rights must be documented, as well as consideration and compliance with the law of any human rights that are considered necessary to limit, according to S 58.

The Queensland Mental Health Act 2016

deals with the involuntary assessment and treatment of "mentally ill"⁸ people if they are deemed "incapable" of consenting or refuse to consent.⁹ It also deals with "mentally ill" people who have been charged with a criminal offence. The MH Act is underpinned by the principle that people under the Act have the same human rights as all people.

The Queensland mental health system

currently delivers institutionalised coercive responses to consumers and people seeking support for their mental health. A paradigm shift is required to provide an alternative system where a human rights-based approach to recovery is person-led, based on partnership, culturally safe, trauma-informed and available in community-centric models.

An analysis of cultural, commercial and social determinants of mental ill-health, distress and suicidality must be included in a whole-of-society approach to system reform, including factors such as people's socioeconomic conditions, minority and marginalised identities, adverse childhood events, intergenerational trauma, and system-based exclusions.

Providing a human rights-based society and mental health system requires an acknowledgment of the complexity of reforming that system's foundations. National and state governments and all public entities that serve consumers are obliged to respect, protect and promote the human rights of people with mental ill-health and they have multiple legislative levers to do so. In Queensland, these include but are not limited to the HR Act 2019, MH Act 2016, CRPD, OPCAT and UNDRiP.

Human rights frameworks within legislation

provide a mechanism for monitoring, evaluating, and accountability for the impacts of public entity activities and inactions on citizens, including people who require mental health services. Public reporting on the application of both human rights principles and specific human rights will begin to shift the paradigm away from a culture of coercion to one based on respect for the dignity, autonomy and human rights of all people, equally.

8 MHLEPQ acknowledge that the terminology associated with people who identify as experiencing mental ill-health, distress or suicidality is highly contested. "Mental illness" is a biomedical concept that many people distance themselves from, but is commonly used in literature, policy and legislation, such as in the *Queensland Mental Health Act (2016)*.

9 We note that the concepts of being "incapable" or "refusing" consent are not CRPD-compliant, and that the model of "mental capacity" is not consistent with the CRPD.

recommendations.

These recommendations build on lived expertise and knowledge of human rights-based approaches toward mental health system reform. We've included human rights recommendations from various sources, including, but not limited to:

1. [The MHLEPQ Submission to the Queensland Parliament Mental Health Select Committee](#) (the MH Inquiry).
2. The MHLEPQ discussion paper, [Shining a Light. Eliminating Coercive Practices in Queensland Mental Health Services](#).
3. [The MHLEPQ Position Statement on the Elimination of the Use of Seclusion and Restraint in the Queensland Mental Health System](#).
4. The Human Rights in Mental Health Survey findings.
5. Lessons learned from other jurisdictions.

If implemented, and overseen by authorities with appropriate responsibility and accountability, these recommendations would lead to a paradigm shift away from coercion and towards partnership-based care. We would see the institutionalisation of a human rights-based approach to person-centred, culturally safe and trauma-informed care, delivered in people's local contexts and according to their autonomous or supported decisions.

The MHLEPQ asserts that a whole-of-society approach to mental health system reform should be adopted, considering the importance of the cultural, commercial and social determinants of mental health and environmental factors such as organisational and professional culture change. In addition, system re-design and decision-making power must sit with people of lived experience in a way that it previously never has – based on partnership and equity, rather than hierarchies and power imbalances.

COMMONWEALTH GOVERNMENT

1. That the Commonwealth Government accept all recommendations made by the *Parliamentary Joint Commission on Human Rights*¹⁰ including, but not limited to:
 - The establishment of a National Human Rights Act.
 - Review of Australia's legislation, policies and practices for compliance with human rights.
 - Enhancements to the role of the Australian Human Rights Commission.
 - Consultation with First Nations Peoples, people with disability, children's groups, civil society and other experts on how the proposed participation duty and equal access to justice duty should operate; and
 - The government provide ongoing resources for public authorities to embed human rights frameworks, in consultation with the Australian Human Rights Commission.
2. That the Australian Human Rights Commission is expanded to include an eighth Commissioner with specific responsibility for mental health, mental ill-health, and suicidality.




¹⁰ See Recommendations 1-17, pp. 21-28, [Parliamentary Joint Committee on Human Rights \(2024\) Inquiry into Australia's Human Rights Framework](#)

QUEENSLAND GOVERNMENT

1. That the Minister requests a report from the Queensland Human Rights Commission on the human rights implications of the use of coercive practices as all public entities currently apply them¹¹ and provides recommendations where necessary.
2. That the Minister introduce a bill that enhances the oversight functions and powers of the Queensland Mental Health Commission. This could include, but not be limited to accepting complaints about designated services from people under the Mental Health Act (2016); undertaking investigations; making recommendations to services, public entities, the Secretary and / or the Minister; issuing warnings for breaches of the MH Act and HR Act; and issuing compliance notices to services. The design of this oversight mechanism must have lived experience leadership across all its parts.
3. That Queensland Health prioritises organisational and service culture development according to Priority 4 of *Better Care Together* and monitor and reports biannually on progress against recovery-oriented, person-led, culturally safe, trauma-informed and human rights-based indicators.
4. That Queensland Government establishes and resources the office of Chief Lived Experience Officer. The Office of the Chief Lived Experience Officer will be the Queensland Government's principal advisor on all matters relating to peer-work, collaboration and co-design with people of lived experience (Rec. 7, MHLEPQ submission to the MH Inquiry).^{xxiii}
5. That evidence of all decisions under the *Queensland Mental Health Act 2016* properly considers human rights made by the decision-maker according to S58 of the Queensland Human Rights Act 2019, including those made at the Mental Health Review Tribunal. That there is mandatory reporting of this evidence to the Chief Psychiatrist.
6. That the Chief Psychiatrist develops a direct reporting template following the *Human Rights Guide. Obligations under section 58 of the Human Rights Act 2019*^{xxiv} issued by the Department of Justice and Attorney-General and that the report be available to any consumer impacted by a decision to limit their human rights, including those made by the Mental Health Review Tribunal.
7. That the Chief Psychiatrist issues an annual human rights overview specifying all relevant statistical information relating to limits to specific human rights, categories of justification for such limitations, and less restrictive options considered when limiting human rights. Data from the Mental Health Review Tribunal should be included.
8. That the Chief Psychiatrist publicly reports to the Queensland Human Rights Commission against an elimination plan for seclusion and restraints in Authorised Mental Health Services, including an analysis of cultural, social and commercial determinants of exposure to them.

¹¹ Investigation should include any social sector where coercion, seclusion and restraint policies and practices exist, for example, Health, Education, Justice, Aged Care, Child Protection etc.

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9. An independent review of the practical application of the *Mental Health Act* according to Australia's existing obligations under the Human Rights Act 2019 should be undertaken by a Minister-appointed Commissioner, such as the Human Rights Commissioner or the Mental Health Commissioner. The review should also consider international human rights legislation including CRPD, OPCAT, and UNDRiP.
 10. That Queensland Health ensures that all mental health facilities that have a locked ward also have an open ward to ensure facilities are available to provide care in a person-led manner, and according to [s18(2)] that there is no less restrictive way for the person to receive treatment and care for the person's mental illness.
 11. That a whole-of-government campaign is launched to strengthen informed consent and supported decision-making policy and practice across the social sector. Queensland Health and the Mental Health Review Tribunal should tailor their policies to include direct reference to coercive practices, including consent by advance health directives and by an authorised guardian or advocate.
 12. That Queensland Health changes its policy objective from working towards a "reduction and elimination" of seclusion and restraint to the target of "elimination".

introduction.

Mental Health Lived Experience Peak Queensland (MHLEPQ) is the peak body in Queensland for people with Lived Experience of mental ill-health, distress, and suicidality. On International Human Rights Day, December 10th, 2023, a survey was distributed to MHLEPQ members asking questions about the links between their lived experience and their human rights.

Human rights are fundamental to all human beings. However, for people living with mental ill-health, distress, or experiences of suicidality, evidence shows their rights are often not protected, promoted, or upheld in public services in Queensland or across Australia. We believe that a more equitable, just, and humane mental health system (MH system) is one that holds human rights at its forefront. This is a Human rights-based approach.

Previous work by a Lived Experience Advisory Group to MHLEPQ submitted the following sombre conclusion to the Parliamentary Inquiry into the Mental Health Outcomes for Queenslanders (the Mental Health Inquiry) in 2022:

More money will neither address the power imbalances nor the failures of implementation and the continuing neglect of human rights so clearly evident from the hundreds of inquiries and thousands of recommendations made over the past three decades.^{xxv}

Multiple international, national, and state legislative frameworks provide levers for creating a mental health system that is focused on human rights, which the MHLEPQ has written extensively about in our report, [*Shining a Light. Eliminating Coercive Practices in Queensland Mental Health Services \(Shining a Light\)*](#).

The HR Act is currently under review and was enshrined in legislation to protect the human rights of all Queenslanders by requiring Government and public entities to consider impacts on human rights in legislation and decision-making. The HR Act includes rights that relate to mental health; however, our survey suggests that these rights are not always properly considered or upheld by Government entities in their interactions with mental health consumers.

The United Nations Convention of Rights for Persons with Disabilities (CRPD), ratified by Australia in 2008, was created to promote, protect, and uphold the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities (including people with psychosocial disabilities). The potential of this Convention lies largely untapped in Queensland, as is not currently embedded in domestic legislation such as the *Queensland Human Rights Act 2019* (the HR Act) or the *Mental Health Act 2016* (the MH Act), and there are no oversight mechanisms for human rights monitoring against the CRPD or other international human rights legislation such as OPCAT or UNDRIP.

This paper reports the experiences of Queenslanders with a Lived Experience of mental ill-health, distress, and suicidality. It provides information about how their human rights have and have not been upheld when in contact with the Queensland mental health system and beyond. It describes some of the complex relationships between human rights and mental health and gives Lived Experience-led recommendations toward a mental health system in Queensland embedded with human rights.

what we did.

Our members have a strong focus on human rights, particularly relating to compulsory treatment, forensic treatment orders, and restrictive practices (including physical, mechanical, chemical restraint and involuntary or coerced psychiatric medication). Advocacy for a human rights-based approach has emerged from various pieces of work including:

- A lived experience advisory group's MHLEPQ submission to the Qld Parliamentary Select Committee inquiry into Mental Health.
- A lived experience advisory group's MHLEPQ Statement of Advice to the (draft) Queensland Health Restrictive Practices Policy Discussion Paper.
- Lived Experience Advisory Group and member consultation, Shining a Light.
- Member survey of priority advocacy topics (2023).

A 47-question qualitative survey was distributed to members and the public, seeking in-depth responses to questions about their mental health and human rights. Descriptive statistics were gathered to understand more about the people who replied, the context of their lives and the experiences they've had. Eighteen (18) responses were received.

This report describes findings from the respondents under the four domains that we identified: the biomedical model of care, discrimination, human rights and personal power, and the origin and impacts of trauma. Multiple themes were identified under each of the four domains, and we delved into each of these. Verbatim quotes taken directly from the survey are written in green.

We highlight that a survey of lived experiences of consumers' human rights in mental healthcare was more likely to draw negative experiences than positive experiences because these are the ones that remain unresolved for people and that need addressing. We bring these perspectives forward because they are actual experiences of individual's human rights limitations. We acknowledge that many consumers have positive experiences and feel supported, and we are aware that other consumers may have had their rights protected and upheld, the examples of which will be represented in other reports.

The draft report was sent to the MHLEPQ membership for their review and further insights were included in the final report, published and will be incorporated into a position statement for the peak in future.

the people who responded.

Eighteen (18) people responded to the survey, 95% (n=17) of whom spoke from a first-person, consumer perspective. In other words, they were commenting with Lived Experience knowledge and expertise. One participant was unsure of what lens they were answering from, but nobody answered “no” to the question of whether they were answering from a consumer perspective. More than half (n=10) of the people identified as MHLEPQ members.

Most people were from Brisbane and Southeast Queensland, although other areas were represented including Cairns, Bundaberg, Nanango, and Hervey Bay. Two-thirds of the participants were women, and the remainder were an even mix of men, transgender, and nonconforming people. One person preferred not to say. There was a broad and even distribution of ages between 18 and 60.

Two-thirds of people identified as living with a physical, developmental, or intellectual disability / neurodivergence, and more than half were part of the LGBTQIA+ community. There was significant intersectionality for people, with many relating to two or more groups, particularly concerning social disadvantage and disability. Half of all participants had experiences of social disadvantage including poverty and homelessness.

Representation across cultures and ethnicities was lower than desirable, with only one First Nations Persons’ response, and two culturally and linguistically diverse people. No migrants or refugees responded.

People described issues that were important to them relating to their identity, diversity, and experiences including:

- Vulnerability to disclose their MH status has resulted in discrimination in professional settings.
- Developmental trauma was an important social determinant not captured by many people or organisations dealing with MH distress or illness.
- Racism as a determinant of distress, harm, and hardship was noted.
- Homelessness as both a contributor and result of mental health challenges.





what they told us.

We asked participants about the location, settings, and types of MH systems they had experienced. Responses are outlined below:

People experienced support in various locations including cities, towns, local communities, rural and remote (Figure 1).

A range of support was provided in community-based, public, or private settings, noting whether the care was voluntary or involuntary (Figure 2).

Half of the respondents hadn't had an experience of being under the MH Act. Seven (7) out of eighteen (18), almost 39% experienced either a treatment support order or treatment authority, or both. Nobody who had been under a forensic order responded to the survey. One-third of respondents were either "unsure" or wrote "other" to the question, "Do you have experience of the Mental Health Act?" (Figure 3).

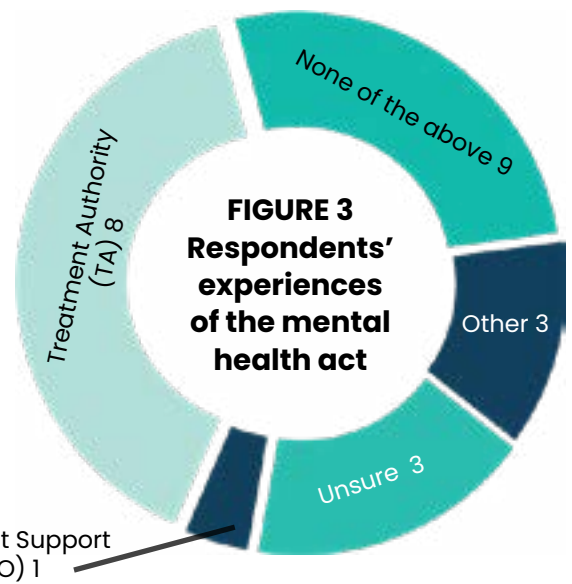
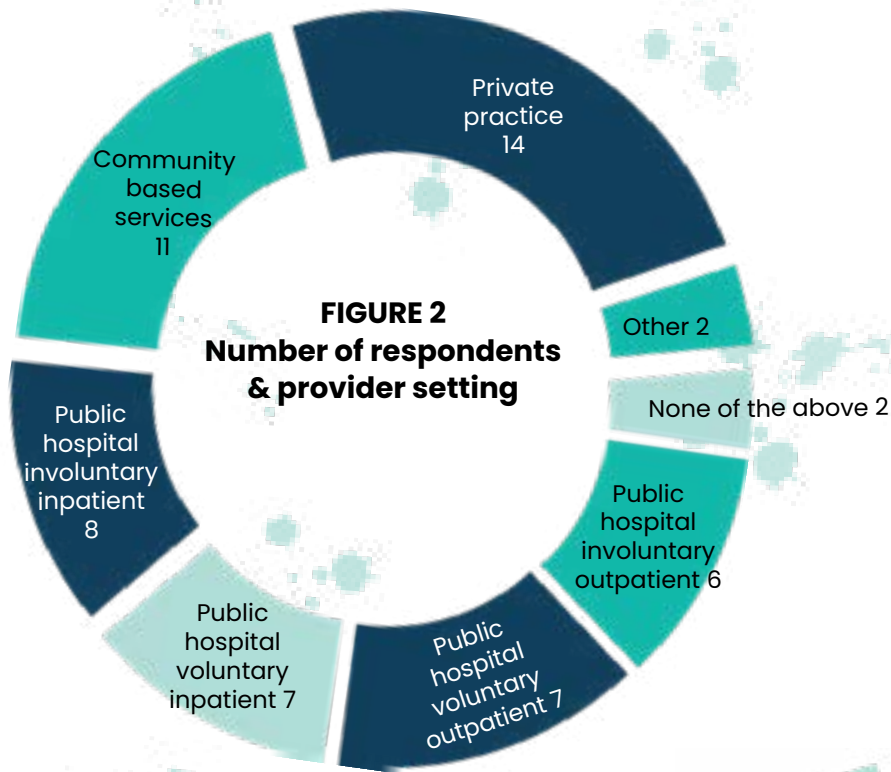
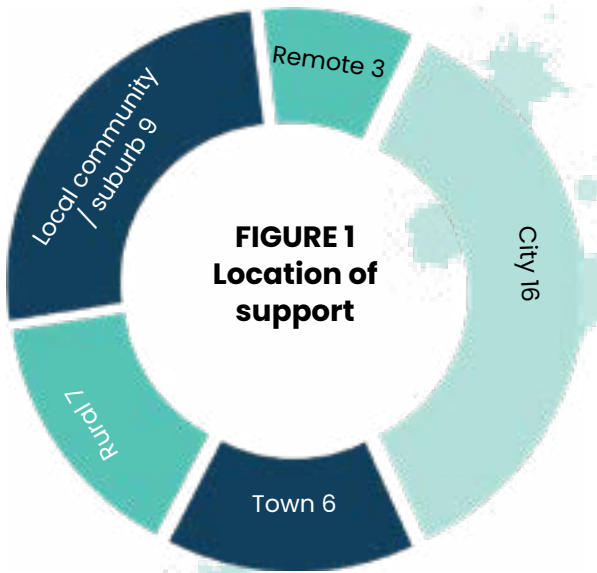
People described a range of restrictive or coercive practices when receiving mental healthcare, with more than half of all people describing some of the following:

- Threats of compulsory treatment when not consenting to treatment.
- Medication without fully informed consent.
- Decisions about me, without me.

At least a third of respondents described:

- Threats of cancelling or denying leave if not consenting to treatment.
- Feeling psychological threat or coercion by treating staff.
- Abuse or violence from staff.
- Physical restraint by staff or security.

Most people had experienced counselling / therapy and pharmaceutical treatments ($n = 17/18$ for both modes); two (2) had electroconvulsive therapy (ECT), and twelve (12) related to "non-clinical treatment" but didn't specify what form that took.



findings.

Four domains emerged from respondents' perspectives about the relationships between their human rights and mental health, described as the biomedical model of care; discrimination; human rights and personal power; and origins and impacts of trauma. Each domain had two or more major themes that are described below under each heading.

1. BIOMEDICAL MODEL OF CARE

1.1 Impacts of treatment type and setting

Survey respondents discussed a variety of different experiences in both voluntary and involuntary treatment. Involuntary treatment was used in many cases to ensure people received treatment deemed necessary for their mental health. This included inpatient admission, medication, and ECT.

Experiences were largely described as negatively impactful, although one participant recognised the need for involuntary treatment and had experienced it safely. The same person described multiple situations when they were disrespected and discriminated against. A person said that they agreed that hospital care was what they wanted and needed when unwell, however treatment with antipsychotic medication and ECT was against their wishes.

Medication was given both voluntarily and involuntarily and was a mainstay of the biomedical model, playing a major role in many people's mental healthcare. One person discussed the use of antipsychotic medication given as part of involuntary outpatient treatment, saying it caused significant harm to their brain and body, diminishing their quality of life and ability to function:

I am constantly poisoned by harmful antipsychotics which disable me and force me to stay in bed all day.

People often felt that the involuntary administration of medication violated their dignity. In particular, the use of intramuscular injections given forcibly (otherwise known as chemical restraint), often while being physically restrained.

One woman discussed her positive experience in a private hospital on a mother and baby unit that helped her to recover to the point that she didn't think she'd have another baby without



a private hospital option. She believed that the treatment she received would not have been possible in a public hospital, and she described the importance of keeping the mother and baby together (if it was safe to do so) and facilitating breastfeeding or expressing breastmilk.

Informal care was described as playing a key role within the biomedical model of care. A person reported that they benefitted from informal care through their partner helping them make decisions when they struggled to make them. They believed that the decisions their partner made for them aligned with what they would have wanted. However, some stated that when others made decisions for them, they were not justified in doing so. A person said that the only time they felt it was okay to make decisions on their behalf was when they were in acute psychosis, but even then, they did not want to be forced to take antipsychotics.

1.2 Alternative use of community supports

Some respondents reported that they were uninformed of the community support available to them. People described that more holistic care was as important as medical options, for example, the need for advocacy as part of the support system. Lack of advocacy had resulted in people being hospitalised for their mental health and in a worse mental state than if they'd received support earlier:

No one ever suggested a support or advocate for me, and I was unaware that this was an option.

People stated that their GP and other health professionals mainly focussed on medication as a “quick fix” to increase their “functioning”, instead of looking at the deeper reasons that they were struggling. This often led to their recovery being in a self-directed and self-taught manner.

1.3 Lacking medical care

Many of the negative experiences described were attributed to issues with the medical care being provided. A person described the “current overloaded and failing system” as a reason they were not able to access the best available mental health care.

Lacking a clear treatment plan was an issue described by consumers of the mental health system. Due to disagreements between different

treating professionals, a patient's mental health consequently suffered as they were unable to seek clear, consistent treatment from their mental health team. Misdiagnosis also occurred for multiple people leading to inadequate care.

Some people found the MH system inadequate when they tried to seek help. Despite the fact they were presenting to mental health services actively suicidal or after attempting to take their life, they were still not taken seriously:

One time, I was in ED [Emergency Department] at [hospital name] for 5 minutes before a mental health clinician told me to leave and was escorted out by security.

Some people said that their physical health treatment was insufficient due to their mental health, including not being taken seriously for complaints about pain. One person described being in a lot of pain as an inpatient in a mental health unit resulting in them not being able to participate in any therapeutic intervention but not being given adequate support for it. In another circumstance, a person was not taken seriously for their physical health issues, leaving them in an unsafe situation:

The clinician thought I was just sleepy and being rude. Consequently, I was cleared for discharge. [...] I was unable to walk, and my vision was very blurry.

1.4 Interactions with health professionals

Just over a third (38%) agreed or strongly agreed that their dignity was upheld in care, with people reporting positive experiences such as being treated with dignity, respect, and choice by their caregivers and treatment team:

My caregivers and treating team at all times treated [me] with dignity, respect, and choice.

While others described their experiences with mental health professionals as rushed or transactional. Just under two thirds (62%) of people disagreed strongly, disagreed, or felt neutral that their dignity was upheld in periods of mental unwellness or distress, with someone describing their human right to bodily autonomy being violated:

Giving injections into backside instead of other area disrespects dignity. Nurses shutting themselves away from patients behind glass shows contempt for us, and disrespect when they ignore our requests. Doctors disrespect us by refusing to follow our reasonable wishes/requests, overriding our treatment decisions and AHD's, dismissing our experiences of antipsychotic side effects, claiming we don't have capacity when we do, being arrogant, using medication as a punishment, telling us to be "compliant" and acknowledge their "authority", turning away from us.

It was common for people to experience a strong power imbalance in mental health settings, describing situations where psychiatrists used their position to override people's human rights. People described breaches of human rights by staff concerning ownership of their records, as well as with their treatment, for example, psychiatrists using medication as punishment in an inpatient setting.



2. DISCRIMINATION

2.1 Discrimination in the workplace

Discrimination in the workplace was described by people as both contributing to their mental health challenges, as well as being because of their mental health.

One person described the link between their mental health status and being discriminated against at work:

I have been vilified, victimised, taken advantage of due to my mental health, and willingness to disclose my struggles in an aim to help others, [...] but feel I'm then made a joke of or manipulated for disclosing it - by my previous employer.

One participant reported how their workplace employer in the disability support industry was unable to provide them with attainable work adjustments for their mental health, subsequently coercing the person to quit their role.

Someone else found that until their current role as a lived experience peer support worker, they had never been able to disclose their mental health issues in the workplace as they never felt safe or supported to do so.

One person described that their mental health status was used as justification for an employer trying to absolve themselves of harm-doing and breaches of their Human rights and employment rights.

Many people experienced discrimination due to their mental health while applying for jobs, as well as in the workplace:

I have also missed out on opportunities for promotion due to the stigma and discrimination surrounding my Bipolar Disorder.

2.2 Discrimination in medical settings

Discrimination in medical settings was a strong theme that emerged from the survey. Discriminatory and disrespectful treatment by mental health professionals was common, such as doctors refusing to follow reasonable requests, dismissing experiences of medication side effects, and unfair claims that patients couldn't decide, when they could. More than two-thirds (69%) of people felt they had been discriminated against while using mental health services:

Because of my BPD diagnosis I was refused care

An individual who had experienced frequent and reoccurring psychosis described ways in which they were discriminated against including assumptions about their lack of capacity to make treatment decisions, including refusing hospital treatment. The same person was discriminated against for reacting poorly to antipsychotics.

When I want to go to hospital they refuse to admit me despite the severity of my psychosis.

Another person felt that they were not listened to or taken seriously by mental health professionals when feeling actively suicidal due to their "good presentation" with good speech, eye contact, and understanding, not presenting as a "typical" person in crisis.

A person stated that their views and preferences were ignored due to the fact they were mentally unwell. Another person described a psychiatrist's claim that conflicted with their own understanding of their mental illness:



Psychiatrist claims I lack capacity, but I have more insight into my illness than she does.

People with Borderline Personality Disorder (BPD) often faced discrimination when trying to access care, particularly in hospital settings – sometimes being denied any care at all. This also occurred at times when people’s lives were at risk.

When I was assessed by [...], she told me that people with BPD do not get admitted here, which I later found out to be false.

When trying to access medical treatment for physical health issues, people stated that they were not believed or had assumptions made about them due to their mental health issues. Another participant reported significant prejudice and discrimination for self-medicating with drugs to help with their mental health.

2.3 Societal discrimination

There were some reports of racism and gender-based discrimination towards participants that intersected with their mental health challenges to cause further harm and distress. A transgender respondent recalled the medicalisation of their gender identity preventing the identification and treatment of their “actual problems”.

A participant described racism in the court systems and services resulting in personal hardship such as being abused in the court setting with no one speaking up to say it was wrong. Harm was also caused to a vulnerable child in this person’s family, which then became a cause of mental health issues.

People also felt discriminated against due to their mental health even when it was not deemed relevant to their activity:

My personal information is private, I do not need to disclose my diagnosis or how long I have been treated simply to get help with a University form – that’s ridiculous.

Multiple people stated difficulty or being unable to obtain health insurance, life insurance, and income protection due to their mental illness. They described barriers to access including limited choice and very expensive premiums:

When asked “Are there ways that your mental health status has impacted on your human rights” one respondent replied, “In every way possible”.

3. HUMAN RIGHTS & PERSONAL POWER

3.1 Impacts on personal power

A person described that they found a way to empower themselves while living with mental illness but have had that used against them:

I have championed vulnerability and openness to disclosing my experiences, but sadly have had these used against me in professional settings.

People discussed the power differential between doctors and consumers around not being believed or listened to, and not having partnership in their care.

"I was not believed; they knew what was best for me."

Another person described their experience of feeling coerced, rather than consulted about their treatment in partnership. They were presented with closed statements such as "this is what you should do", with an expectation that they would simply agree or disagree, rather than being provided a proper explanation to make informed decisions together.

Due to their mental health status, some people have had others speaking on their behalf who were not chosen advocates, leaving the consumer feeling disempowered and harmed:

My line manager at the service where I was employed talked to my psychiatrist in my appointment for half an hour, I could not hear her side of the conversation and I was forcibly hospitalised.

Some people found that when they were unable to make decisions, the decisions made for them were "absolutely not" what they would have wanted. For example, a person said that their domestically violent partner was given power over their treatment.

Another person had a positive experience of their family and treatment team working together to help them make decisions when they could not for themselves, but as they recovered, they were able to take that power back and carefully make decisions with their doctor.

Coercive treatment was also reported by many respondents, including not allowing leave from wards despite being a voluntary patient.

One person described a strong frustration with the Human Rights Act not being properly implemented.

Human Rights Act is a waste of time when govt, courts, police, child safety seem exempt from following it and the average person is left wearing the dire consequences.

3.2 Dignity

One person drew a link between their mental health condition and the human right to housing, "I have been homeless due to psychosis". Adequate housing is essential for human survival with dignity.^{xxvi}

People's dignity was not protected at times in hospital settings when receiving treatment. People reported that their rights were not respected and ignored in the name of treatment.

I was made to sleep in the common area on a mattress on the floor, in seclusion attire and bedding.

People reported being placed in handcuffs and treated like a criminal while experiencing mental health crises, instead of responders using de-escalation techniques:

Instead of talking to me, I was placed in handcuffs and was wheeled into ED like a criminal.

Another person reported being stripped naked and put on a 24-hour watch by male nurses. One respondent stated that their human rights could be respected by allowing consumers to dress into patient gowns themselves, instead of being forced to strip in front of security and then forced into isolation.

3.3 Autonomy

Over one-third (37.5%) of people agreed that they were the key decision-maker in their recovery journey as far as their circumstances allowed for it. Under two-thirds (62.5%) of people either strongly disagreeing, disagreeing, or neutral about whether they were autonomous in their decision-making about their treatment:

My husband had too much say [...] I was seen as not knowing what was best for me

People's autonomy was violated in various circumstances, with one person describing the restrictions on their human rights, freedom, and autonomy because of a treatment authority:

I've been on a Treatment Authority for the last 3 years and the more I object to getting depot injections the more they insist on forcing them on me.

They would get arrested if they didn't receive their depot injection and they were prevented from travelling interstate or overseas. They felt their bodily autonomy was violated by the forced medication that gave them significant side effects and reduced their quality of life.

3.4 Self-determination

Increased self-determination was described as something that would

improve people's quality of life. Full self-determination in decision-making wasn't possible in many cases because the biomedical model of care didn't recognise a person's right to autonomy. Addressing power imbalances between the treating professionals and the patient would lead in many cases to increased self-determination.

Substitute decision-making was often talked about. For example, a person under an involuntary treatment authority discussed how they were being forcibly given medication that significantly harmed their quality of life and how they had alternative medications that they would be more willing to take. However, when they wanted treatment in a hospital they were refused and sent home unwell.

Another person under a treatment authority was told to take medication that made them more unwell or else have it injected. They described the lack of choice and powerlessness that came with that.

There was a range of responses to the four questions related to support for decision-making (whether formal or informal) and advocacy when the person was unable or prevented from deciding autonomously. It was an interesting finding that almost 75% of people either agreed (26.7%) or were neutral (46.7%) that when substitute decision-making was used, it was what they would have wanted:

Although never formally without capacity, there were times that decision[s] were too hard, and I deferred to my partner. Looking back, he did make all the same decisions I would have wanted.

Of the people who strongly disagreed or disagreed with the decisions made on their behalf (26.7%), the consequences of those decisions were often dire:

The ex of 14 years was found guilty of videoing my daughter in our bathroom which he renovated fit for purpose and for upskirting 18 other women. He was instrumental in my being forcibly treated and hospitalised.

Over half (56.3%) either agreed or were neutral when asked if their preferences were considered when others made decisions on their behalf, but again, for those who disagreed or strongly disagreed about their views considered (43.8%), the negative impacts were large and unsafe:

I knew that I was close to completing suicide and wanted more intensive support, but because I didn't present as typically in crisis, I don't feel I was listened to or taken seriously.

Approximately 60% of people strongly agreed, agreed, or were neutral about how justified the decisions made on their behalf were. Interestingly, a third (33.3%) of people strongly disagreed in hindsight that there was any justification.

A two-thirds majority agreed in some capacity or were neutral that their liberty should only be limited by way of safety to "self or other". Over one quarter (26.7%) of respondents strongly disagreed, describing experiences that stripped them of their liberty and ability to decide for themselves.

3.5 The acceptability of breaching Human Rights

Approximately two-thirds (66.7%) of people stated that in most circumstances they believed it was not okay to breach or restrict a person's human rights to provide them with mental health care, tending towards moderate or qualified answers rather than a binary or black and white response (figure 4):

It depends - my default answer is no but if there are other dependents it becomes a more complex conversation that should be explored collaboratively.

People stated that the only circumstance they believe it is okay is when the person is a danger to themselves or others (especially children) or if they can't make decisions about their treatment. Someone also stated that if a person is in psychosis and there is a treatment available that will minimise their overall suffering and improve their quality of life then it is okay to breach or restrict a person's human rights.



FIGURE 4

Is it ok to breach human rights?

No 66.7%

Yes

Other

4. ORIGINS & IMPACTS OF TRAUMA

4.1 Impacts of personal trauma

People described how their personal experiences of trauma related to both their human rights and their mental health.

People described how impactful adverse experiences in childhood (such as sexual abuse and domestic violence) were on their mental health. A participant reported experiencing developmental trauma that had a long-lasting impact on reaching life goals including education and working. Another respondent experienced homelessness due to their experience in psychosis and had multiple serious crimes committed against them while in that state including sexual exploitation, despite having never harmed anyone themselves.

Mental health service responses to distress and diagnosis were also described as traumatic experiences. One person described that in response to their trauma within the hospital, they were punched in the stomach by a paramedic while staff tried to “catch” them trying to leave the setting.

The right to participate fully in public life by way of employment was also discussed by people, two-thirds (68.8%) of those believing that their mental health had prevented them from getting work that they were qualified and capable of doing. Only 18.8% agreed thought that their mental health hadn't stood in the way of work opportunities:

I have since coming out as a consumer been cancelled and my BPsych is not given credence anymore. I cannot get work in my region excepting entry level consumer work

4.2 System-produced trauma

There were people with experiences of systems trauma causing harm in court and other government departments. An example of systems trauma was this person's experience in Mental Health Review Tribunal (MHRT) hearings:

The MHRT hearings are completely biased in favour of the "treating psychiatrist" and are a farce. My reputation has been horribly tarnished due to false information written by my psychiatrist, and even when I can prove her claims false, I'm still not allowed to correct the misinformation.

Another kind of systems trauma that had a significant effect on participants was medical trauma due to misinformation, misdiagnosis, coercive treatment, and not getting their care needs met:

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.

When asked about the impacts their mental health had on obtaining health insurance, almost half of the people (46.7%) had experienced barriers due to disclosure about their mental health. Forty percent had a neutral response, possibly meaning they hadn't tried, while 13.6% had not experienced barriers to getting insurance despite their mental health status:

I could not afford health insurance it was 12 times the rate my daughter and 10 times the rate my brother pays.

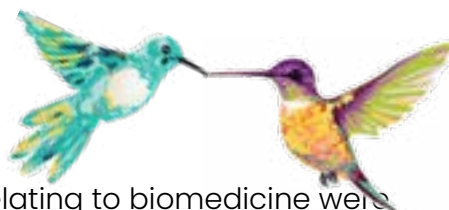
Not health insurance per se, as I have always held health insurance and they can't take that off me. It has certainly impacted me obtaining life insurance and income protection though.

REFLECTIONS ON THE SURVEY

Future human rights surveys will focus on increasing diverse representation across cultures and ethnicities, which was lower than desirable in this consultation. We acknowledge that First Nations Peoples, culturally and linguistically diverse groups, and communities living with disabilities are more likely to experience breaches of their human rights when seeking support for their mental health challenges. We are committed to understanding more about the issues of these people.

All but one participant agreed or strongly agreed that the survey was relevant to them and that it was easy to complete. One person strongly disagreed that we asked the right questions, and gave the following recommendations:

1. Add “not applicable” as a response;
2. Warn people that completing the survey “may bring up difficult memories”; and
3. Include questions about the following topics:
 - Abuses of power;
 - Psychiatrist misconduct;
 - MHRT hearings; and
 - Treatment dissatisfaction.



There was a disagreement with how the findings relating to biomedicine were presented, describing them as too negatively positioned and possibly not representative enough of the lived experience collective. The view suggests that the critical ‘voice’ of the report risked turning people away from the topic of human rights, and had this to say about the discussion point on “institutionalised coercive responses”:

[...] this blanket statement risks readers reactions (especially those that could change system reform) to be defensive and dismissive as it is demonizing all that work in the system [...] inclusive of the peer workforce who are working within to bring about change [...] I fear much of this report will be dismissed as more demands from the noisy consumer movement [...] the angry insistence of the need to change is understandable, but please consider writing from a more central tone.

A counter-position to this was another participant's view about the necessity of expressing anger toward the injustice of the current system:

Where is the redress? Where is the recourse?? Missing ... as ever [...] I like what has been produced but what is missing is the white hot anger at lives destroyed needlessly by an abusive and corrupt system of victim blaming, forced drugging and neurotoxins without the ability to seek and obtain damages ... if you are “lucky” enough to have survived thus far.

The MHLEPQ staff greatly appreciate the time and energy people give to our various projects and acknowledge that for some, their contribution may feel uncomfortable, draining, and at times, exploitative. The staff is open to hearing your feedback on our processes and we encourage ‘courageous conversations’ about hard things.



discussion.

The worldwide movement to embed international human rights frameworks into local mental health and social systems is gaining momentum. Queenslanders with Lived Experience of our public mental health system are an important group to lead this change, and our members have provided their insights through the first MHLEPQ Human Rights in Mental Health Survey.

The Queensland Government is obliged to uphold its commitments to international Human Rights treaties and conventions¹² through embedding and overseeing Queensland-specific legislation into public policy and services.

MHLEPQ members and LEAGs have brought human rights recommendations into much of their work over the last two years. This section will bring together the principles of those discussions.

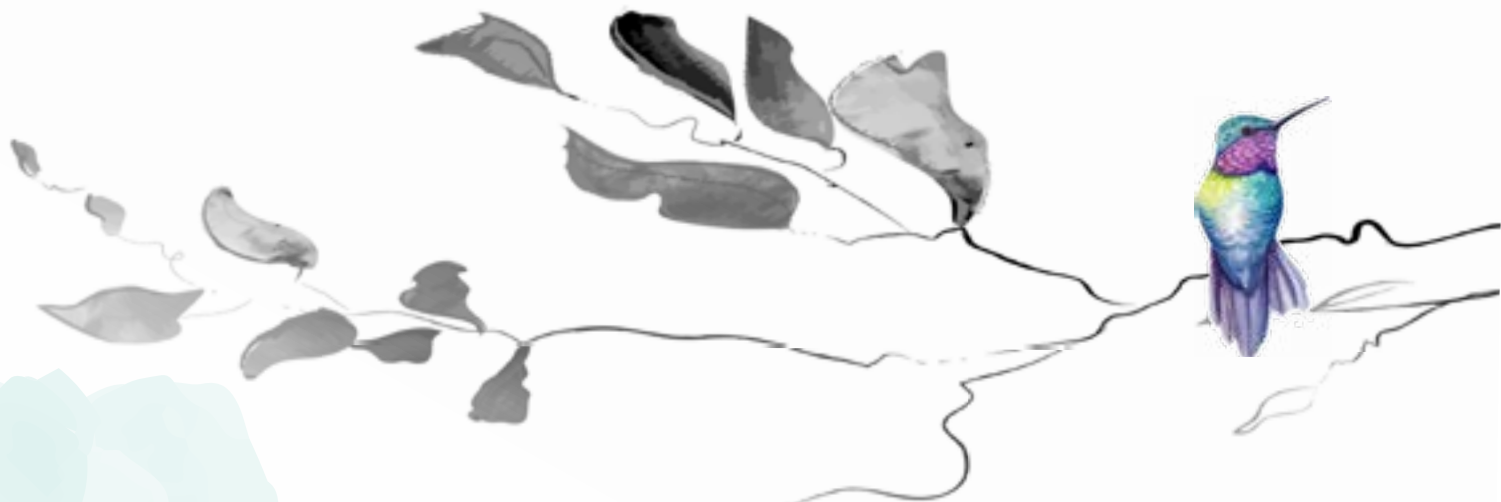
HUMAN RIGHTS LEVERS

1. The Queensland HR Act (2019) is currently under review and is the main domestic legislation, naming twenty-three (23) human rights applicable to all Queenslanders (drawn from international human rights law)^{xvii}. While all human rights are relevant to all people, we have listed eleven (11) legislated rights from the HR Act that are perhaps the most relevant to people with lived experience:

- i. Cultural rights of Aboriginal peoples and Torres Strait Islanders peoples:** Aboriginal and Torres Strait Islander peoples with Lived Experience of mental ill-health have unique cultural rights in Queensland. These include but are not limited to the right to practice the beliefs and teachings of their culture; use their languages; protect and develop their kinship ties; and maintain their relationship with the lands, seas, and waterways.

- ii. Protection from torture and cruel, inhuman, or degrading treatment:** people experiencing mental health difficulties have the right not to be treated in a way that badly hurts their body or mind or given medical treatment unless the consumer understands and agrees. Currently, there is an exception where consent is not required if the treatment is given to save your life or protect you from harm (including reputational harm).
- iii. Humane treatment when deprived of liberty:** when freedom is taken away from people due to reasons of their mental health, they still have the right to be treated with respect and dignity.
- iv. Right to liberty and security of person:** people with Lived Experience have the right to be free and safe. If someone struggling with their mental health is legally detained in a mental health unit, they are still entitled to certain minimum rights.
- v. Freedom of movement:** people with Lived Experience of mental ill-health, illness and distress have the right to move freely within Queensland and leave and come back to Queensland.
- vi. Right to life:** people struggling with their mental health have the right to have their lives protected by laws about things like violence and health and safety.
- vii. Taking part in public life:** those with Lived Experience have the right to take part in public life including the right to vote, apply for work in government, and stand for election in government.
- viii. Right to health services:** people with Lived Experience of mental ill-health have the right to access health services, and to be able to access these services without discrimination.

¹² Including, but not limited to the United Nations Conventions on the Rights of Persons with Disabilities; Universal Declaration of Human Rights; International Covenant on Civil and Political Rights; and International Covenant on Economic, Social and Cultural Rights.



This includes the right to receive emergency medical treatment to save their life or to stop serious damage to their health.

ix. Recognition and equality before the law:

people with Lived Experience have the same rights as everyone else including the right to the same protection; and the right to use and receive mental health services and other government services without discrimination.

x. Right to education: people with Lived Experience have the right to access schooling, training, and vocational education that meets their needs and suits their abilities without discrimination.

xi. Privacy and reputation: the government cannot share information about the mental health of people with Lived Experience unless the person gives the government authority to do so. The government can also not say things about those with mental health issues that are false or may damage their reputation.

It is the importance of **section 58** under the HR Act that we would like to raise awareness, visibility, and accountability to, as a lever for promoting and protecting the human rights of people receiving care within the public health system. All government departments and employees have a responsibility for upholding human

rights, in both actions and decisions, written as:^{xxviii}

Under section 58, the Act requires public entities to act and make decisions in a way that is compatible with human rights, and to properly consider human rights when making decisions.

An act or decision is compatible with human rights if it does not limit a human right or only limits a human right if it is justified and in proportion with the circumstances.

2. The Mental Health Act (2016) provides Queensland's legislative and regulatory framework for most of the involuntary treatment, seclusion, restraint, care, and protection of people who are deemed not to have the capacity to consent to be treated, administered by the Chief Psychiatrist. Section 5 of the MH Act specifies the principles that apply to how the Act is administered concerning a person who has or may have a mental illness.¹³

i. Same human rights: All persons are to have the same basic human rights as all people recognised and taken into account. Further, a person's right to respect their human worth and dignity as an individual must be recognised and taken into account.

ii. Decision-making matters: A person is presumed to have capacity to make decisions about their treatment and

¹³ See Mental Health Act (2016) s (5) Principles for persons with mental illness <https://www.legislation.qld.gov.au/view/html/inforce/current/act-2016-005#sec.5>

care under the Act. To the greatest extent possible the person should be part of decision-making and their view, wishes and preferences considered when decisions are made.

- iii. **Support persons** must be involved in decision-making (subject to privacy) where a person's decision-making capacity is impaired.
- iv. **Provision of support and information:** A person must be provided with support and information to allow them to exercise their rights under the Act.
- v. **Achievement of maximum potential and self-reliance**, to the greatest extent practicable a person must be supported to achieve physical, social, psychological and emotional potential, quality of life and self-reliance.
- vi. **Acknowledgement of needs** relating to age, gender, religion, communication and other special needs, including hearing, visual or speech impairments.
- vii. **Unique cultural needs** of Aboriginal people and Torres Strait Islanders, including care and communication that is culturally appropriate and consistent with Aboriginal tradition or Island custom and social and emotional wellbeing.

viii. **Unique cultural, communication and other needs** of persons from culturally and linguistically diverse backgrounds.

- ix. **Recognition and promotion** of the best interests and needs of minors, separately from adults if practicable.
- x. **Maintenance of supportive relationships** and community participation, providing treatment in the community in which the person lives.
- xi. **Importance of recovery-oriented services** and mental illness stigma reduction.
- xii. **Provision of treatment** and care only if it is appropriate for promoting and maintaining the person's health and wellbeing; and
- xiii. **Recognition of a person's right to privacy** and confidentiality must be taken into account.

While the 2016 Act was intended to improve the human rights of patients, including by minimising compulsory treatment, some unintended opposite impacts have occurred. The reasons for this are complex, however, barriers to full implementation of the MH Act reforms have been cited as paternalistic and restrictive organisational culture; lack of systemised alternatives to compulsory treatment; lack of relevant training; risk aversion in clinicians and society, and lack of safeguards in the legislation.^{xxix xxx}

Our survey findings clearly show that there are common failures of public mental health facilities to effectively apply s 5 of the MH Act and these represent breaches of the Human Rights Act. It is also important to remember that all domestic legislation must be seen and understood in light of international human rights obligations, notably obligations to the CRPD, OPCAT and UNDRiP.



3. The United Nations Convention on the Rights of Persons with Disabilities

(CRPD) is a civil rights act that has multiple articles and eight (8) foundational guiding principles on the rights of people with disability, including psychosocial disability.^{xxx}

- Respect for inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of persons
- Non-discrimination
- Full and effective participation and inclusion in society
- Respect for difference and acceptance of persons with disabilities as part of human diversity and humanity
- Equality of opportunity
- Accessibility
- Equality between men and women
- Respect for the evolving capacities of children with disabilities and respect for the right of children with disabilities to preserve their identities

Several CRPD articles are crucially important to the lives of people living with mental ill-health, distress, and suicidality, including, but not limited to:

- i. Article 12: the right to equal recognition before the law
- ii. Article 14: the right to liberty and security of person on an equal basis with others
- iii. Article 15: freedom from torture or cruel, inhuman or degrading treatment or punishment
- iv. Article 16: freedom from exploitation, violence and abuse
- v. Article 19: the right to live independently and be included in the community
- vi. Article 28: the right to an adequate standard of living

4. The Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment

(OPCAT) is a highly relevant convention that Australia became a signatory to in 2009 and ratified in 2017, to prevent the mistreatment of people in all places of detention, including locked mental health wards.

5. United Nations Declaration on the Rights of Indigenous Peoples (UNDRiP)

was adopted by the General Assembly in 2007 and endorsed by Australia in 2009. The Declaration promotes the rights of Indigenous People to be enjoyed equally with all people. The Commonwealth Closing the Gap strategy recommends a national programme to implement UNDRiP,^{xxxii} and the Declaration will be an important consideration for Queenslanders as they embark on the Truth-telling and Healing Inquiry which began on July 1, 2024.^{xxxiii}

Australia is a signatory to the CRPD, OPCAT and UNDRiP, denoting an obligation to embed both frameworks into domestic legislation and "develop frameworks sufficient for its implementation and maintenance,"^{xxxiv} which to date has largely been unrealised.





REMEDIES FOR HUMAN RIGHTS BREACHES

When looking through a human rights-based lens at the findings from the survey respondents, we can see that both international and domestic human rights laws could guide assessments of the impacts on consumers' treatment in care, including whether human rights are breached, or not.

There are overt breaches where people describe, for example, that they were discriminated against due to their diagnosis within the mental health system, meaning that they were not afforded recognition and equality before the law. Or where they were not offered the physical healthcare that they needed due to their mental health condition, breaching their human right to health services.

At times more subtle are where people have their human rights breached due to a diminishment of their personal power when not listened to, believed, or judged about their mental health, resulting in a breach of their right to take full part in public life.

Based on the findings of this survey and previous work, the MHLEPQ believes that an appropriate collective Lived Experience response to breaches of human rights relating to mental health status is to advocate for a human rights-based approach to mental health system design. In addition, society must think even more broadly than the mental health system, to create communities that consider the cultural, social and commercial determinants of poor mental health and how to prevent them and intervene earlier in the life course, where challenges most often start.

A human rights-based approach that meets people's mental health needs requires a paradigm shift from the current culture of institutionalised coercive structures, policies, and practices. These are the 'long tail' of the previous 40 years of biomedical psychiatry and medicine, and we believe the 'alternative' must become the norm. The new norm must be a person-centred, human rights-based approach that is strengths-based, trauma-informed, located in the community, and focused on the cultural, social and commercial determinants of mental health.^{xxxv}

Our recommendations for the proposed reform centre on the obligations (both decisions and actions) of the Government and its people and services to protect, promote and uphold the human rights of people who seek their support, the outcomes of which we believe they are required to oversee.^{xxxvi}

Our recommendations build on the Lived Experience knowledge from previous work by MHLEPQ members and from Lived Expertise across the sector, as we continue to build on the Consumer movement's task of realising human rights for all who seek support in the mental health system.

concluding comments.

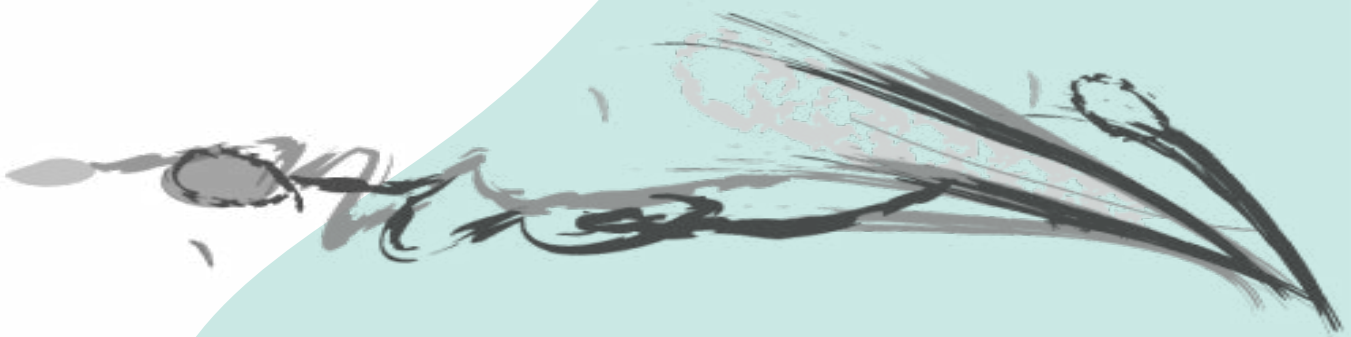
The MHLEPQ invited insights from people with lived experience of mental ill-health, distress and suicidality in Queensland through a human rights lens to build on previous work and the growing national and international knowledge base. In-depth qualitative information was combined with descriptive statistics to provide a picture of lived experience-led solutions to the complex issues that exist in mental health systems today.

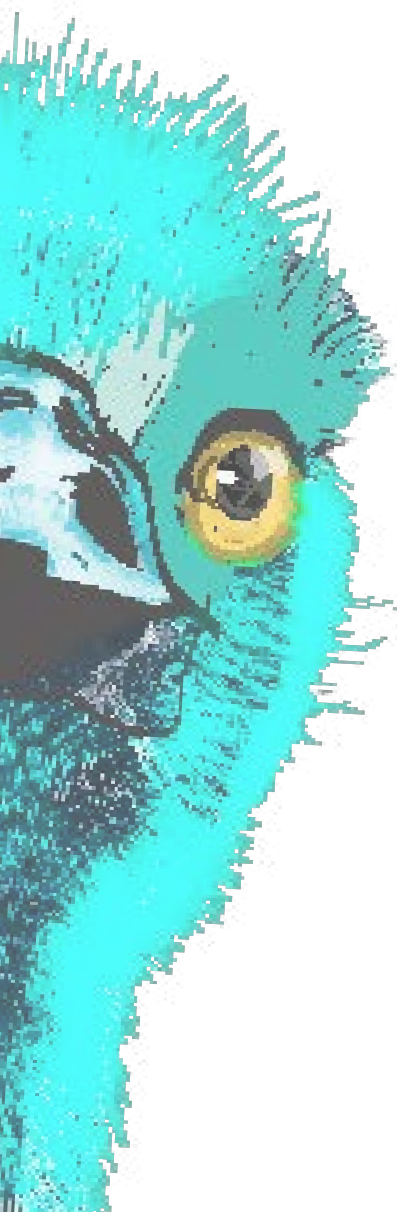
This report continues our exploration that began with members for the Mental Health Inquiry when lived experience people asserted:

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.

The draft report went through a member, public and stakeholder consultation and the feedback has now been integrated into the final draft. The final report will form the basis for ongoing human rights advocacy including a MHLEPQ position statement to reflect a broad range of member views, building on the collective knowledge of previous lived experience work.

The MHLEPQ intends to build on the findings from this survey and other related work by incorporating them into future systems-reform advocacy. By continuing to survey the experiences and expertise of people seeking mental health support through a human rights-based lens, we believe the evidence will begin to impact governance, policy, and practices as our recommendations are taken forward to implementation, evaluation, and enhanced monitoring and oversight of the system.





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Artwork by *Natasha Hobson Design*
natashahobsondesign@gmail.com