Implementing Human Rights in the Queensland Mental Health System

An MHLEPQ Position Paper

November 2024

Acknowledgement of Country

The Mental Health Lived Experience Peak Queensland (MHLEPQ) respectfully acknowledges and honours the Traditional Custodians of the Lands and Waters throughout Queensland. We thank the Elders - past, present, and emerging – for their wisdom and 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 and national laws and conventions. The MHLEPQ respect First Nations Persons' rights and autonomy to lead their own healing according to their cultural beliefs and customs, including their connectedness to Country, Kin, and Spirit.

Recognition of Lived Experience

The MHLEPQ would like to recognise people with lived and living 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 knowledge and expertise 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 human experience and is related to a person's ability to participate in society and live according to their 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 their autonomy, 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.

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. Its membership guides the MHLEPQ to prioritise the human right to mental health for all Queenslanders, including understanding the legal protections and policies across the sector.

We believe that the human right to mental health includes support with the social determinants of wellbeing such as adequate housing, a clean,

healthy and sustainable environment, and health services that are affordable, effective, and culturally appropriate. We will advocate with and for 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 have contributed their knowledge, wisdom and experiences to inform this report. In doing so, they have invested in developing the Movement that the organisation was established by and inspired the ongoing inquiry into the crucial topic of the human right to mental health. We would like to extend our gratitude to Kayla Lu for her foresight and compassion in pursuing an internship at the MHLEPQ and for working so diligently to co-produce this report. We were all privileged by her presence in the office and the many gifts she left behind.

Who are the MHLEPQ?

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.

The MHLEPQ was established to provide advice and advocacy informed by people with lived experience of the Queensland mental health system, especially people most disadvantaged and marginalised by existing social structures. Our work is based on the principles of equity, access, cultural safety, recovery, and human rights.

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

Table of Contents

Key Messages 5

Recommendations 8

Introduction 11

Background 11

Issues 15

Findings 16

World Health Organization QualityRights Initiative 16

South Australia's Human Rights Analysis Tool 18

Human Rights at the Heart Model 19

Queensland Government Human Rights Guidelines and Tools 20

Discussion 21

Societal and Institutional Culture Impacts the Mental Health System 21

Lived Experience Partnership in Mental Health Services 23

Lack of Benchmarking and Evaluation Gaps 25

The Role of Community–based Mental Healthcare 26

References 28

Key Messages

1. A human rights-based culture isn't yet embedded within mental health systems in Queensland despite legislation and frameworks to support it. This position paper highlights the urgent need for comprehensive action to address the significant gaps between human rights policy and practice, an issue we call the "implementation gap".
2. This paper focuses on the evidence and recommendations for effective implementation of human rights within the strategic and operational frameworks of the mental healthcare system. While the focus is on the mental health system, we highlight the importance of human rights-based approaches across the entire social sector.
3. The current legal frameworks most applicable to the Queensland context include but are not limited to:

   a) *International conventions*:

   i. The United Nations Convention on the Rights of Persons with Disabilities (CRPD) establishes a framework for equal rights and non-discrimination for people with disabilities.

   ii. The Optional Protocol to the Convention Against Torture (OPCAT) aims to prevent torture and ill-treatment of individuals detained in closed environments, including those receiving voluntary and involuntary mental healthcare.

   iii. The United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP) protects the rights of First Nations Peoples, including their rights to culture, land, and self-determination.

   b) *State legislation*

   iv. The Queensland Human Rights Act (2019) (under review) incorporates international human rights principles into domestic law, mandating the protection of human rights within the state.

   v. The Mental Health Act 2016 requires that all persons be entitled to the same basic human rights, with respect for their human worth and dignity as individuals.

4. Some other resources and pathways support least restrictive practice and protection of consumer rights In addition to human rights legislation, including Advance Health Directives (AHDs) and Independent Patient Rights Advisors (IPRAs).
5. It is worth noting that the government is implementing two existing plans: *Better Care Together 2022-2027* and *Shifting Minds 2023-2028*. They both emphasise a human rights-based approach to mental health services in Queensland. While *Better Care Together* focuses on system reforms prioritising individual dignity and rights, *Shifting Minds* aims to create an integrated service system ensuring equitable access for all Queenslanders, especially vulnerable groups.
6. Some (relatively few) international and state human rights (HR) frameworks and implementation toolkits have been developed:

    i. The ***WHO QualityRights Initiative***, established in 2012, integrates human rights principles by promoting community-based care and patient empowerment. It provides training resources and a toolkit for assessing mental health facilities from strategic to operational levels.

    ii. ***South Australia's Human Rights Analysis Tool***, developed in 2018, aligns with human rights standards and the CRPD. The tool provides a self-assessment framework that generates collaborative recommendations for improving care models and promoting systemic reform.

    iii. The ***Human Rights at the Heart (HRatH) Model*** was developed in 2023 by Simon Katterl. It offers a framework for integrating human rights principles into leadership decision-making using three (3) steps—Forecast, Assess, and Decide. Leaders are encouraged to consider the impact of their decisions and ensure compliance with HR standards.

    iv. The ***Queensland government's Human Rights Impact Assessment*** tools support government employees to integrate HR into their daily work. The guideline outlines five steps to assess whether a decision impacts and limits human rights.

7. Four main themes emerged from our findings relating to the human rights implementation gap:

    i. ***Influence of societal and institutional culture:*** Culture change requires an analysis of power imbalances and bias in mental healthcare - factors involved in stigma, discrimination and coercion.
    ii. ***Barriers to genuine partnership with Lived Experience***: HR frameworks promote the inclusion of people with lived experience and lived expertise, but their involvement is often tokenistic. Genuine power-sharing and collaboration are required to ensure lived experience knowledge and expertise lead to authentic and sustained reform of the mental healthcare system.
    iii. ***Insufficient benchmarking and evaluation***: HR frameworks and analytical/implementation tools are important for protecting human rights, but comprehensive evaluation is lacking. Systematic benchmarking against best practices is needed to identify gaps and improve adherence to human rights standards.
    iv. ***Limited community-based mental healthcare:*** Community-based mental health systems can promote autonomy, better meet individual human rights and needs, improve cultural safety and recovery and reduce the demand for hospitalisation. Sustained investment in a community-based approach and implementation of models of care that protect human rights have been insufficient in Australia.

This position paper explores current international and national human rights frameworks and evidence of their implementation. Public entities have legal and ethical obligations to ensure that human rights are properly considered and comply with legislation. Where decisions to limit human rights occur, they must be justified and documented. We offer recommendations for bridging the implementation gaps relating to consumer human rights in the Queensland mental health system based on evidence and our findings.

Recommendations

Human rights culture change
1. That the Commonwealth and Queensland Governments implement Mental Health Anti-Stigma and Discrimination Elimination policies, targeted at elimination of structural and public stigma within health and social systems. 2. That Queensland Health supports organisational and service culture development according to Priority 4 of *Better Care Together,* including developing a more holistic mental healthcare model that is less biomedical and underpinned by human rights and supported decision-making frameworks. 3. That Queensland Health leads the quality improvement of its organisational culture relating to human rights, at all levels of strategic planning, policymaking and service delivery. Change should be monitored and reported biannually on progress against recovery-oriented, person-centred, culturally safe, trauma-informed and human rights indicators. 4. That the Mental Health Alcohol and Other Drugs Branch (MHAODB) adopt the object of eliminating all restrictive practices from Queensland mental healthcare as a public health (prevention) strategy.
Cultural safety
5. All Queensland public entities must meet their human rights obligations toward the cultural rights of Aboriginal peoples and Torres Strait Islander peoples (section 28). We recommend working in partnership with First Nations people and workforces to embed First Nations frameworks including: a. *Leading Healing Our Way*: Queensland Aboriginal and Torres Strait Islander Health Strategy 2020-2040[1]. b. *Aboriginal and Torres Strait Islander Health Workforce Strategic Framework* 2016-2026[2].

Lived experience leadership & workforce

6. MHLEPQ recommends that Queensland Health establish and resource a Chief Lived Experience Officer to lead human rights-based mental health system reform, co-designed with lived experience at all levels of organisational design, governance, policymaking, service priority-setting and delivery.
7. The Chief Lived Experience Officer should oversee the integration of the Lived Experience (peer) workforce within the Queensland Health Mental Health workforce, including achieving the target of 10% identified Lived Experience (peer) workers.
8. That Hospital and Health Services expand the roles of Lived Experience (peer) workers to include clinical documentation audits against human rights legislation, policy and guidelines in Authorised Mental Health Units. Reports to the Chief Psychiatrist should make recommendations and be publicly available. Auditors should have powers to perform functions similar to the UN Subcommittee on the Prevention of Torture.
9. That the Queensland Mental Health Commission funds MHLEPQ to facilitate a lived experience-led collaboration between their members, IPRAs and other relevant stakeholders to develop human rights advocacy tools for consumers to use in partnership with clinicians and advocates.

Change management

10. That the MHAODB continue to collaborate with the MHLEPQ to review their human rights policy suite, focusing on the inclusion of clinical guidelines for human rights decision-making and documentation.
11. That the MHAODB appoints a Human Rights Director (A08) to work with a Chief Lived Experience Officer (or a role of similar standing) to develop quality improvement programmes with human rights champions and lived experience groups at each HHS.
12. That the Chief Psychiatrist and MHAODB provide guidelines to the HHSs to provide mandatory human rights training and iterative documentation audits against an updated clinical guideline.

Benchmarking
13. That Queensland Health develops clear, measurable and reportable human rights indicators based on the clinical guidelines. 14. The MHAODB conduct a pilot documentation audit focused on human rights data across the HHSs and community services and make recommendations about the documentation of human rights in clinical decision-making.
Monitoring & Evaluation
15. All public entities involved with decision-making relating to human rights at the planning, governance, policymaking and service delivery levels should be required to evaluate and publicly report the evidence of their human rights policy and practice. 16. Data on the proper consideration and assessment of human rights by the decision maker, including the documentation of the least restrictive approach and limitation / benefit analysis should be included in the data collected in Recommendation 15 (above). 17. Ensure the *Better Care Together* evaluation framework includes qualitative and quantitative measures on consumer experiences of MHAODB services relating to whether their human rights were upheld. Consumers should be asked whether their dignity and autonomy were respected, if they felt discriminated against at any point in their care, and the level to which they were able to self-determine and actively participate in their recovery.
Advancing community-based mental healthcare
18. That all-of-Government prioritise equitable funding for culturally safe, trauma-informed, community-based mental health services and psychosocial support to marginalised and minority communities, including regional, rural and remote programmes. 19. That all-of-Government prioritises a shift to community-based care models in all mental health and social sector strategy, planning, governance and policy.

Introduction

The ongoing incidence of human rights (HR) violations in mental health care across various countries has consistently been described as a "global emergency"[3]. These violations include physical and sexual abuse, discrimination and stigma, arbitrary detention, and the inability to access healthcare. Human rights have become a central consideration in revising mental health policies and plans.

Human rights should be embedded at all levels, from governance and policymaking to service delivery and across the social sector. This position paper describes the findings from a desktop review that explored current international and national HR contexts, focusing on the implementation phase translating theory to practice. This paper focuses on the evidence for effectively integrating HR principles into the operational frameworks of various social sectors, given the established evidence base for the necessity of HR frameworks in mental health and social sectors[4].

Background

Human rights are essential for the dignity and wellbeing of all individuals and form the cornerstone of just societies. Globally, there has been much discussion and debate about how to best protect these rights, especially in the context of mental health. The 'Geneva Impasse' highlights a significant international challenge, where there is a deep divide about whether it is possible or desirable to eliminate coercion in mental health. While some within the UN human rights community argue that coercive care can be justified under certain conditions provided it is necessary, proportionate, and accompanied by appropriate legal safeguards, others insist it should be eliminated, arguing that coercion is never justified[5].

As part of the global community, Australia is a signatory to various international conventions that establish individual HR and provide frameworks for their protection. The United Nations Convention on the Rights of Persons with Disabilities (CRPD)[6] provides a framework for equal

rights and non-discrimination for persons with disabilities. The Australian Government agreed in principle that persons with disability (including psychosocial disability) enjoy the right to legal capacity on an equal basis with others in all aspects of life when they ratified the CRPD. They did, however, issue a Declaration to Article 12 of the CRPD that limits the extent of the legislation relating to supported decision-making. The Declaration allows ongoing substitute decision-making made on behalf of a person, including compulsory treatment and movement restrictions based on mental capacity assessment, a highly contested topic in the mental health field. The Australian Declaration may limit rights in certain circumstances which goes against the original intent of Article 12 of the CRPD, legislation that advocates for the non-derogability of the right to equal legal capacity based on individual will.

The Optional Protocol to the Convention Against Torture (OPCAT)[7] is also recognised as important to people who identify with mental ill-health and psychosocial disability. It aims to prevent torture and ill-treatment of detained individuals in closed environments, which may be experienced by people who are subjected to involuntary mental health treatment, as well as by people in voluntary care who have their freedom of movement restricted.

Australia is also a signatory to the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP)[8], which protects the rights of Indigenous peoples, including their rights to Culture, Land, and self-determination. After initially being rejected by Australia in 2007, UNDRIP was formally accepted in 2009, however, there have been no moves to meet its obligations to incorporate the Declaration into domestic law.

At the state level, the Queensland Human Rights Act (2019)[9] incorporates international HR principles into local law, providing the mandate to protect HR within the state. The Queensland Human Rights Commission's toolkit[10] provides a guide for public entities, helping staff understand their obligations under the Act and how to apply HR in their daily work.

Simultaneously, the Mental Health Act (2016) legislates the consideration of human rights principles, ensuring that all individuals are entitled to the same basic and inalienable human rights, with respect for their worth and dignity.

The Queensland Health Statement of Rights[12] outlines individuals' rights under the Mental Health Act 2016, complementing a suite of Queensland Health policies and guidelines that further describe these rights. They apply to involuntary and voluntary patients in mental health services and their families, carers, and support persons. Key focus areas include Treatment Authorities, Advance Health Directives (AHDs)[13], Individual Patient Rights Advisors (IPRAs)[14] and Mental Health Review Tribunal (MHRT)[15] functions.

Consumers who were assessed as having reduced mental capacity to make decisions about their treatment, have a right to be cared for in a less restrictive way. An AHD allows them to plan for future events where the capacity to make decisions may change, specifying treatment preferences and appointing someone to decide for them. This ensures treatment is based on consent, not force. If a doctor doesn't follow the AHD, they must explain why and record it.

Mental health consumers have the right to independent and impartial advice provided by IPRAs, helping them understand their rights, express treatment preferences, and access legal support. Assistance with creating Advance Health Directives or Enduring Power of Attorney may also be requested.

The MHRT (the Tribunal) is an independent body established under the Mental Health Act (2016). It is not affiliated with any health service or treating team. The MHRT functions to balance consumer rights with community safety and operates independently, without direction from any external entity. The Tribunal's main role is to review the involuntary status of individuals with mental illness and/or intellectual disability and to oversee electroconvulsive therapy and some neurosurgical procedures. The

Tribunal includes a President, Deputy President, approximately 100 members, an Executive Officer, and other staff.

Both *Better Care Together 2022-2027* and *Shifting Minds 2023-2028* are Queensland Health strategies underpinned by human rights principles, emphasising a human rights-based approach to mental health services in Queensland. *Better Care Together* guides significant system reforms by delivering state-funded mental health, alcohol, and drug services that prioritise individuals' dignity and rights. This plan promotes person-centred care and seeks to balance resources between community and hospital settings to ensure high-quality support. On the other hand, *Shifting Minds 2023-2028* serves as the State Government's overarching mental health strategy, aiming to create an integrated service system that guarantees equitable access for all Queenslanders, particularly vulnerable groups.

MHLEPQ's work with our members across several projects demonstrates our commitment to HR. In 2022, we submitted a lived experience-led report to the Queensland Parliament Mental Health Select Committee[16] addressing HR breaches, systemic power imbalances, cultural blindness and implementation failures, which called for urgent human rights-based reforms.

The MHLEPQ's report *Shining a Light: Eliminating Coercive Practices in the Queensland Mental Health System*[17] highlighted the harm caused by coercive practices, advocating for a lived experience-led, human rights-based mental health system informed by restorative justice, cultural safety and trauma-informed approaches. Earlier this year, the MHLEPQ conducted a survey of Queenslanders with lived experience of mental ill-health to ask about the impacts on their HR within the mental health system[18]. The survey findings included impacts of the biomedical model, discrimination, and trauma on people's rights, providing recommendations for positive reform of governance, policy and practice at various points in the system.

Issues

Despite international and domestic legislation and frameworks established to protect human rights, violations of these rights remain widespread. Barriers to 'real world' knowledge translation of HR theory include factors such as weak implementation strategy and enforceability, resistance from cultural and social norms (particularly biomedical dominance) and structural inequalities[19]. These issues are especially pronounced in the field of mental health where stigma and discrimination, lack of supported decision-making and risk averseness are embedded and work against the safeguarding of human rights.

Stigma and discrimination in societal attitudes make it challenging to truly protect HR in mental health services, leading to ongoing problems such as coercive practices and abuse of power. Additionally, uneven resource distribution and structural inequalities create greater barriers for socially marginalised and minority groups to access mental health services, further exacerbating HR violations[20].

The global issues are also pervasive in Australia, where gaps in legislation, governance and planning, and policy implementation undermine rights' protection. Societal stigma and discrimination against people with mental ill-health, suicidality and psychosocial disabilities compound the situation by deterring individuals from seeking help and perpetuating institutional cultures of coercive practices and power imbalances. Additionally, cultural blindness and racism remain endemic, as the mental health needs of First Nations peoples are often overlooked, and traditional cultural practices are not adequately incorporated into services[21, 22].

Community-based health care is a fundamental human right[23], essential for supporting individuals with mental health issues by offering accessible, ongoing care that meets their medical, social, and emotional needs. People who use mental health serves describe the excessive focus on short-term treatment and clinical issues rather than offering person-centred care in the communities people live in. Evidence suggests that

community mental health services in Australia are under threat of being dismantled, with many services being integrated into hospitals or provided outside community settings[24]. Our HR Survey of Queenslanders with lived experience revealed significant gaps in access to community mental health support. Many respondents were unaware of accessible community services and expressed frustration with the system's reliance on clinical and hospital-based care[18].

We have conducted a review of existing frameworks and toolkits that aim to protect and promote human rights. Queensland has the potential to become a leader in creating sustainable reform toward a strong human rights culture in our mental health system if the implementation strategies found in some 'pockets of excellence' in this review were embedded across the state.

Findings

Some international and state HR frameworks and analytic toolkits have been developed to guide the protection and promotion of human rights at various levels of the mental health sector, including strategic planning, governance, and service delivery. Among these, a few have gained significant attention for their comprehensive approach and potential to bring about meaningful change.

World Health Organization QualityRights Initiative

The World Health Organization's (WHO) *QualityRights* initiative[25] was established in 2012 to integrate HR principles into mental health services in line with the CRPD. The framework focuses on community-based care, social integration, and personal empowerment. For instance, the initiative encourages the development of community-based mental health services that provide support in less restrictive environments, reducing reliance on institutional care. The *QualityRights* framework guides policy development for transitioning to community care models, and advocating for systemic

improvements, creating more inclusive and supportive mental health services.

The initiative offers a comprehensive package of training and guidance resources including e-training modules for individuals and organisations[26]. Information is provided in a dynamic learning environment about mental health, disability, human rights, and recovery. It also includes tools for advocacy, allowing civil society organisations and advocates to promote HR in mental health.

Additionally, the WHO *QualityRights* tool kit[4] provides countries with guidance on how to assess and improve the quality and HR standards of their mental health and social sector institutions. It offers a structured framework for conducting assessments, including how to establish an assessment framework, observe facilities, review documentation, and interview service users, family members (or friends, carers and 'chosen family'), and staff. The toolkit is flexible for use by various national and international groups and organisations, either for a single assessment or as part of a broader, country-wide program to enhance facilities.

It is worth noting that the WHO recently developed the *QualityRights* questionnaire, based on the Knowledge-Attitudes-Practices (KAP) framework[27], to address the ongoing HR violations faced by people with mental ill-health and psychosocial disabilities in both the community and hospital mental health care settings. The tool measures knowledge about mental health rights, and the questionnaire demonstrates good validity and reliability for evaluating attitudes towards rights holders and explores practices related to decision-making and coercion.

In summary, the WHO *QualityRights* Initiative provides comprehensive training resources, practical applicability across diverse settings, and support for advocacy efforts to advance HR in mental health, some of which have been evaluated (mainly in resource-constrained settings). One systematic evaluation of the application of *QualityRights* in public mental health facilities in India found that the initiative significantly improved the

quality of services to consumers and the attitudes of staff, with service users feeling more empowered and satisfied, and reduced caregiving burden as perceived by support people[28].

South Australia's Human Rights Analysis Tool

The *Human Rights Analysis Tool*[29] was developed by the Office of the Chief Psychiatrist's Human Rights and Coercion Reduction Committee in South Australia in 2018. This tool stands out for its co-design methodology that involved individuals with lived experience and other stakeholders in evaluating and improving mental health services. It uses a pragmatic hands-on approach to self-assessment and is structured in two sections:

1. Assessment against the Australian Human Rights Commission's PANEL principles[1]; and
2. Assessment of eight key themes relating to the principles and articles of the CRPD.

The dual focus helps organisations align with HR standards and laws, to promote a culture that recognises individuals as rights-bearing members of society who actively participate in decisions about their care. It provides a comprehensive self-assessment tool for use with consumers and stakeholders to enhance strategic design, service model development and delivery, and guide education and workforce training.

The results of the HR analysis are then collaboratively summarised with people with lived experience and other stakeholders and formulated into a list of recommendations. The recommendations include the strategy and actions for various programmes including the care model, service model, or policy initiative.

[1] The Australian Human Rights Commission proposes the 'PANEL' model for assessing the human rights-based approach in the design and implementation of policies and services. 'P' stands for **P**articipation; 'A' stands for **A**ccountability; 'N' stands for **N**on-discrimination and equality; 'E' stands for **E**mpowerment; and 'L' stands for **L**egality.

The *SA Human Rights Toolkit's* strength lies in its applicability during major service re-design, significant revisions of existing care models, and the development of new services. This makes the *SA HR Toolkit* particularly suited for local service improvements and systemic reform.

Human Rights at the Heart Model

The *Human Rights at the Heart (HRatH) Model*[30] was developed in 2023 by Simon Katterl, introducing a structured framework for translating HR principles into actionable behaviours. This model was designed to engage leaders at all levels, including board members and executives, ensuring they uphold HR standards in their decision-making processes.

The model consists of three core steps—Forecast, Assess, and Decide. When applying these steps, key questions to consider include:

1. **Forecast:** How could our decision or policy impact the people affected? How can we draw on lived experience in this decision?
2. **Assess**: What is the human rights context and history related to this decision, policy, or area? Are any rights limited or lacking?
3. **Decide:** How do we promote, comply with, and balance human rights? How will we keep records to show that we considered human rights?

The *HRatH Model* also emphasises that the responsibility for legal compliance and associated risks goes beyond clinicians to include board members and executives who are responsible for setting working conditions for mental health employees.

The *HRatH Model* is especially useful for guiding governance and operational practices, developing new policies, and providing practical leadership training. It offers a way for leaders to effectively integrate an HR focus into their daily decision-making.

Queensland Government Human Rights Guidelines and Tools

The Queensland government's *Human Rights Impact Assessment* tools[31] provide a range of practical guides, templates and resources for applying the Human Rights Act (2019) in the workplace, with a focus on Section 58. They are designed for government employees to integrate HR into daily work, ensure decisions are made in line with HR law, and raise awareness about human rights in the workplace. The tools outline five clear steps to assess if a decision respects human rights:

1. Identify which specific human rights are affected.
2. Determine if the decision will limit any of these rights.
3. Check if the law allows for such limitations.
4. Ensure there is a valid reason for the limitation and that it is fair and reasonable.
5. Confirm that the decision aligns with human rights law.

Queensland Health also has a practical *Human Rights Decision Tool* based on the Human Rights Act (2019). It is designed using the five-step framework mentioned above to assist in considering relevant human rights when making decisions at a governance and policy level. It is an internal-only document, not intended for clinical decision-making or public use.

The Mental Health Review Tribunal (MHRT; the Tribunal) identifies the need for its operations and members to appropriately consider human rights. Each Tribunal panel is constituted by three (3) appointed members, generally including: one legal, one medical, and one community member. The MHRT reports that it provides its members with training and refers them to various resources produced by the Queensland Human Rights Commission (QHRC)[32], including guidance on acting and making decisions in line with human rights legislation[33]. The guidance involves identifying relevant rights, considering the impact, and determining whether any limitations are reasonable and justified. On the MHRT's website, de-identified statements of reasons are published, outlining how the panel assessed whether their decisions were compatible with human rights.

Evidence from MHLEPQ members who have been under the MH Act and been subject to MHRT hearings often describes human rights breaches and discrimination based on their mental health, including barriers to accessing appropriate legal and non-legal advocacy. Gaps between consumer experience and mental health legislation and policies are common and constitute systemic harm.

Discussion

We found rich resources based on both the Queensland Human Rights Act (2019) and CRPD that included HR legislation, policy frameworks, and tools, that if comprehensively implemented, would lead to a culture of human rights-based mental healthcare and improved outcomes for consumers, carers and their kin.

Qualitative and quantitative data show that in Queensland and nationally, however, too many consumers continue to experience breaches of their human rights and the negative impacts stemming from this. The current situation shows a difference between legislation, policy and practice, indicating a knowledge translation gap that impacts the quality and safety of mental healthcare for consumers. This gap necessitates a deeper exploration of several key areas to understand how to bridge the systemic discrepancies between evidence and practice.

Societal and Institutional Culture Impacts the Mental Health System

The mental health system in Queensland continues to stigmatise and discriminate against people with mental health challenges and psychosocial disability, as evidenced in the MHLEPQ HR survey and more broadly in the literature. Despite policies aimed at reducing stigma, biases persist at all levels, impacting the quality and safety of consumer care. Biases can lead to discriminatory treatment and coercive practices, further exacerbating the human rights breaches faced by individuals. Power imbalances within the healthcare system contribute to these issues, as hierarchical structures and authoritarian dynamics can marginalise the

voices of service users and their advocates, making it difficult for them to advocate for their own needs and rights effectively.

Addressing these issues requires a comprehensive approach to culture change and cannot be influenced by law and policymaking alone. Expansion of First Nations' and lived experience (peer) workforces; adoption of models of care that protect and uphold human rights; and mandatory human rights education from governance through to service delivery would support the culture shift.

In addition, redesigning professional undergraduate and graduate curricula in fields such as psychiatry, law, nursing, medicine, psychology, social work, and occupational therapy is essential to promote alternatives to coercion, where psychiatric and legal professions remain dominant stakeholders in a mainly Western paradigm. Current curricula continue to include coercive practices as necessary and need to be updated to emphasise human rights, disability awareness, and person-centred recovery in mental health care.

Recommendation 1: That the Commonwealth and Queensland Governments implement Mental Health Anti-Stigma and Discrimination Elimination policies, targeted at the elimination of structural and public stigma within health and social systems.

Recommendation 2: That Queensland Health supports organisational and service culture development according to Priority 4 of *Better Care Together,* including developing a more holistic mental healthcare model that is less biomedical and underpinned by human rights and supported decision-making frameworks.

Recommendation 3: That Queensland Health leads the quality improvement of its organisational culture relating to human rights, at all levels of strategic planning, policymaking and service delivery. Change should be monitored and reported biannually on progress against

recovery-oriented, person-centred, culturally safe, trauma-informed and human rights indicators.

Recommendation 4: That the Mental Health Alcohol and Other Drugs Branch (MHAODB) adopt the object of eliminating all restrictive practices from Queensland mental healthcare as a public health (prevention) strategy.

Recommendation 5: All Queensland public entities must meet their human rights obligations toward the cultural rights of Aboriginal peoples and Torres Strait Islander peoples (section 28). We recommend working in partnership with First Nations people and workforces to embed First Nations frameworks including:

a. *Leading Healing Our Way*: Queensland Aboriginal and Torres Strait Islander Health Strategy 2020-2040
b. *Aboriginal and Torres Strait Islander Health Workforce Strategic Framework* 2016-2026.

Lived Experience Partnership in Mental Health Services

Most HR frameworks and toolkits emphasise including people with lived experience in all design, governance, policymaking and delivery aspects of mental healthcare. There is increasing recognition that lived experience knowledge, expertise and leadership are crucial for improving outcomes for mental health consumers. Queensland Health has a mandated requirement to hold identified lived experience positions and multiple inquiries and reports make recommendations about developing lived experience workforces to support culture and practice change.

In practice, however, this participation often remains tokenistic. Lived experience knowledge and expertise are often gathered, but due to a lack of genuine power-sharing and equitable partnership, the results of consultation often don't go as far as they could[34]. Consequently, services frequently fall short of addressing consumer rights and needs, undermining the goal of providing human rights-based mental healthcare.

People with lived experience offer vital insights that can greatly improve mental health services. Their feedback helps turn HR frameworks into practical solutions by informing service design, policy development, and staff training. Actively involving people with lived experience ensures that mental health systems are more responsive, equitable, and tailored to individual needs, making their input crucial.

Recommendation 6: MHLEPQ recommends that Queensland Health establish and resource a Chief Lived Experience Officer to lead human rights-based mental health system reform, co-designed with lived experience at all levels of organisational design, governance, policymaking, service priority-setting and delivery.

Recommendation 7: The Chief Lived Experience Officer should oversee the integration of the Lived Experience (peer) workforce within the Queensland Health Mental Health workforce, including achieving the target of 10% identified Lived Experience (peer) workers.

Recommendation 8: That Hospital and Health Services expand the roles of Lived Experience (peer) workers to include clinical documentation audits against human rights legislation, policy and guidelines in Authorised Mental Health Units. Reports to the Chief Psychiatrist should make recommendations and be publicly available. Auditors should have powers to perform functions similar to the UN Subcommittee on the Prevention of Torture.

Recommendation 9: That the Queensland Mental Health Commission funds MHLEPQ to facilitate a lived experience-led collaboration between their members, IPRAs and other relevant stakeholders to develop human rights advocacy tools for consumers to use in partnership with clinicians and advocates.

Recommendation 10: That the MHAODB continue to collaborate with the MHLEPQ to review their human rights policy suite, focusing on the inclusion

of clinical guidelines for human rights decision-making and documentation.

Recommendation 11: That the MHAODB appoints a Human Rights Director (A08) to work with a Chief Lived Experience Officer (or a role of similar standing) to develop quality improvement programmes with human rights champions and lived experience groups at each HHS.

Recommendation 17: Ensure the *Better Care Together* evaluation framework includes qualitative and quantitative measures on consumer experiences of MHAODB services relating to whether their human rights were upheld. Consumers should be asked whether their dignity and autonomy were respected, if they felt discriminated against at any point in their care, and the level to which they were able to self-determine their recovery.

Lack of Benchmarking and Evaluation Gaps

The HR frameworks and toolkits described in the findings section have their own features to protect, promote and uphold human rights. They cover different application levels from strategic design to policy development and service delivery. The WHO *QualityRights* is one of the earlier frameworks, and many countries have started to adopt it. It is worth noting that there is a lack of literature describing benchmarking and evaluation of the framework by consumers, especially on reducing coercive practices.

More recent frameworks have been implemented 'piecemeal' in some Australian services, but there remains a lack of system-wide implementation and evaluation data to demonstrate their impact on service improvement. A more systematic approach to data collection and analysis is needed to fully understand the tools' contributions to long-term adherence to HR standards.

In addition to evaluating specific frameworks, we urgently need to benchmark our practices against established standards or best practices. One way to achieve this is through documentation audits against the HR

decision-making guidelines at all levels including strategic planning, law and policymaking and service delivery. By reviewing existing records and documentation, we can assess whether they align with the guideline's standards. This process helps us identify where gaps exist, understand where our current practices stand, and ultimately move towards a rights-based approach. Benchmarking will allow us to demonstrate progress over time and ensure continuous improvement.

Recommendation 12: That the Chief Psychiatrist and MHAODB provide guidelines to the HHSs to provide mandatory human rights training and iterative documentation audits against an updated clinical guideline.

Recommendation 13: That Queensland Health develops clear, measurable and reportable human rights indicators based on the clinical guidelines.

Recommendation 14: The MHAODB conduct a pilot documentation audit focused on human rights data across the HHSs and community services and make recommendations about the documentation of human rights in clinical decision-making.

Recommendation 15: All public entities involved with decision-making relating to human rights at the planning, governance, policymaking and service delivery levels should be required to evaluate and publicly report the evidence of their human rights policy and practice.

Recommendation 16: Data on the proper consideration and assessment of human rights by the decision maker, including the documentation of the least restrictive approach and limitation / benefit analysis should be included in the data collected in Recommendation 15 (above).

The Role of Community–based Mental Healthcare

Community-based mental health care is known to reduce hospitalisation rates and enhance recovery outcomes[35]. Investment in community-based mental healthcare unfortunately remains limited across the sector in Australia, including investment toward First Nations' community-controlled organisations. Multiple barriers to the development of a culture of

community-based care exist, including issues with short-term contracting, sustainable funding, lack of place-based services (particularly regional, remote, and rural), long wait times for appointments and narrow options for consumers[36] and a lack of integration with state-provided services. The result is often siloed operations that further hinder effective community-based care.

Community-based care can foster autonomy, encourage participation in care decisions, and offer holistic, non-coercive treatments aligned with human rights principles. Promoting this model reduces unnecessary hospitalisations and ensures mental health services focus on individual needs for more sustainable outcomes.

Recommendation 18: That all-of-Government prioritises equitable funding for culturally safe, trauma-informed, community-based mental health services and psychosocial support to marginalised and minority communities, including regional, rural and remote programmes.

Recommendation 19: That all-of-Government prioritise a shift to community-based care models in all mental health and social sector strategy, planning, governance and policy.

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