Mental Health Act Reform Roundtable

Views and consensus report

June 2026

About this report

On 22 June 2026, MHLEPQ convened the Mental Health Act Roundtable, "Seeds of Change", at Christie Spaces in Brisbane. The day brought together people with lived experience, families and carers, clinicians, community organisations, and legal, human rights and government representatives to consider one question: do our laws reflect our values?

This report captures the views participants brought to the day and, just as importantly, the consensus that emerged across them. It draws on live Mentimeter polling, facilitated table discussions across three questions: the case for change, the role of law, and what good reform looks like, and written feedback contributed on the day. The voices throughout are participants' own words, grouped into themes, with the broad and recurring points of agreement drawn out.

Who took part

The roundtable brought together a cross-section of the Queensland mental health community. Organisations and groups represented on the day included:

- Mental Health Lived Experience Peak Queensland, convenor
- Office of the Public Advocate (Queensland)
- Queensland Health (Office of the Chief Psychiatrist and the Independent Patient Rights Advisers)
- Queensland Mental Health Commission
- Queensland Human Rights Commission
- Queensland Law Reform Commission

- Office of the Health Ombudsman
- Brisbane North PHN
- Queensland Alliance for Mental Health
- Queensland Advocacy for Inclusion
- Roses in the Ocean
- Royal Australian and New Zealand College of Psychiatry (Qld Branch)
- Queensland Lived Experience Workforce Network
- Arafmi
- Queensland University of Technology
- University of Queensland
- Mates in Construction.

Family members affected by the Act were also invited and participated. The day featured opening addresses from John Chesterman (Public Advocate, Queensland), and from MHLEPQ's CEO, and a panel discussion with representatives from psychiatry, MHLEPQ membership, Arafmi, and First Nations Queensland Health. MHLEPQ members were also brought in as expert table facilitators to support discussions.

A note on attribution

All responses captured in this report were collected anonymously, through live Mentimeter polling and written feedback. Quotes are presented in participants' own words and are not attributed to any individual or organisation. Where several quotes appear together, they reflect separate contributions making the same point. MHLEPQ has published its positions online previously[1].

Overview of the Mental Health Act

Three short discussion papers framed the day. Together they make a single argument: Queensland's stated values have moved further than its mental health law, and the gap now shows in people's lives.

The issues we can no longer ignore

[1] Mental Health Lived Experience Peak Queensland, *Elimination of the use of Seclusion and Restraints in the Queensland Mental Health System* (Position Statement, February 2024) https://mhlepq.org.au/wp-content/uploads/2024/02/MHLEPQ-Position-State-Seclusion-and-Restraint.pdf

The *Mental Health Act 2016* (Qld) mainly governs involuntary assessment, treatment and detention. In effect, it controls what happens once crisis has been reached. Against a system that says it values dignity, human rights, recovery, cultural safety and lived experience leadership, the evidence points the other way. More than half of public inpatient treatment is involuntary, and the rate has risen rather than fallen since the Act began. Aboriginal and Torres Strait Islander peoples experience involuntary treatment at more than five times the rate of others. Lived experience is not mentioned anywhere in the Act, and the system remains tilted toward hospitals and crisis.

Why we need to look at the Act more broadly

These are not isolated practice problems. Instead they are signs of how the whole system is steered. The Act is narrow. It authorises compulsory powers but says little about prevention, community care, accountability or who is responsible for reform. Too many stewardship roles, designing, funding, running, monitoring and regulating the system, sit within Queensland Health, creating conflicts of interest and weak accountability. Work health and safety law offers a useful contrast: it is broad, preventive, shares responsibility across the system, and is properly enforced. A review should therefore look beyond compulsory treatment to the system architecture around it, and embed lived experience as governance, not consultation after the fact.

Lessons from the last reform

The 2016 Act emerged from a comprehensive 2013–16 process, yet carried flaws from the outset: the “less restrictive” criteria offered little real protection, there was no supported decision-making, principles and advance directives were unenforceable, advisers sat within the services they were meant to question, and no independent

body was tasked with overseeing system performance. Involuntary treatment then rose. The lesson is that reform must start with the outcomes it seeks, embed lived experience leadership in its governance, design implementation and funding from the outset, and build monitoring, review and adaptiveness into the law itself, so it is not "set and forget".

What people care about

Before the discussions began, we asked participants what they care about, and how the Act relates to it. The answers set the tone for the day: dignity, choice, and care that does not depend on coercion.

> *"Dignity, compassion, respect, mutual care, choice and control. Any mental health act should support people's right to these and enshrine access to meet those needs. No coercion, no force."*
>
> *"People in crisis deserve care, not coercion. The Act must reflect what we know works: consent, relationships, community."*
>
> *Separate roundtable participants*

Human rights, lived experience leadership, cultural safety and trauma-informed care recurred throughout, alongside a strong concern for equity, for CALD communities, Aboriginal and Torres Strait Islander peoples, people with disability, people in prisons, and those who are invisible in the data. Others framed it as a question of basic access:

> *"I care about people, that when they are in distress they should have access to support as soon as possible without having to beg for that support. The current act does not do this."*
>
> *Roundtable participant*

This is the same starting point the discussion papers took: a system that says it

values dignity, human rights, recovery, cultural safety, lived experience leadership and accountability. The day tested those values against people's lived reality.

The case for change

Our first question was simple: what is the case for change? On this, agreement was near-universal. Participants were emphatic that the Act is not meeting its own promise, and the same verdict came back, again and again, in different words:

> *"The act is not meeting its stated purpose."*
>
> *"The current act isn't fit for purpose."*
>
> *"Involuntary treatment has risen.. clearly it isn't fit for purpose!"*
>
> *"The current act is not meeting its expectations."*
>
> *Separate roundtable participants*

Coercion is rising, not falling

The clearest evidence of misalignment, for participants as in the papers, was the trajectory of involuntary treatment and restrictive practices:

> *"Restraint and use of TAs has increased."*
>
> *"Too much compulsory treatment."*
>
> *"It hasn't decreased numbers or rates of coercive practices. There are many people traumatised under the Act."*
>
> *Separate roundtable participants*

One contribution captured the human cost with painful precision:

> *"The smallest measure of expressing emotion led to multiple types of restraint and seclusion: mechanical, physical and chemical. It was just me expressing distress."*
>
> *"If you have any kind of emotion and the system is too scared to handle it, the system will often traumatise us for change."*
>
> *Separate roundtable participants*

Trauma begets trauma, for everyone

A strong theme was that harm cycles through the whole system. Participants spoke of "moral injury" from coercion and seclusion, and of trauma that does not stop at the patient:

> *"Trauma perpetuates more trauma, which perpetuates more trauma. A cycle continues. That trauma is for families and for staff."*
>
> *Roundtable participant*

The workforce is trapped too

Notably, participants did not frame this as clinicians versus consumers. Many described a workforce that "has no faith in the Act", and staff who want to practise in a rights-based way being left exposed:

"Staff who want to take a rights-based approach have to put themselves in legal and other kinds of danger because the system doesn't support it. It's under the table, which isn't a systemic solution."

Roundtable participant

One carer recalled nurses who "worked to avoid the use of the law", and drew the obvious conclusion: "We should make the law help promote dignity."

Narrow scope, crisis focus

Participants repeatedly described an Act that is too narrow, built around crisis and compulsion, with no room for prevention:

"Too narrowly focused on crisis, no upstream wellbeing focus."

"The narrow focus of the Act which then drives behaviours that are in-line with that narrow focus."

"Should have a preventative role."

Separate roundtable participants

Accountability and equity gaps

Other recurring concerns included the disproportionate impact on culturally, racially and socially marginalised communities; deaths at the point of contact with first responders; advance health directives that are not enforceable; inconsistency with the Human Rights Act 2019; and accountability failures, including reliance on hospital data that "fabricates patient experience". Participants pointed to the Disability Royal

Commission, the Stephen Kelly inquiry and the CYMHS review as further evidence. Several put the loss of trust plainly:

> *"The experiences of betrayal that people are feeling from their current experiences."*
>
> *"The law is currently being used as a punitive measure."*
>
> *Separate roundtable participants*

Where there was agreement

There was clear and broad consensus that:

- the Act is not meeting its own objectives
- involuntary treatment and restrictive practices are rising rather than reducing and that's a problem
- that this harms people with lived experience, families and staff alike.

Participants agreed the case for change is well made and that attention should now turn to how to build a movement for reform that can influence a government of any political persuasion.

The role of law

Our second question asked what role law should play in describing the system we want, and getting us there. Participants moved the conversation from problems to purpose, and agreed law does need to do far more than regulate crisis.

Law protects rights and carries values

Many framed law as the foundation for rights and shared values:

> *"Law is the democratic infrastructure that can be used to protect human rights."*
>
> *"The law reiterates that human rights are for everyone."*
>
> *"Reflect the values that we all hold in society in terms of what our aspirations are, to live well and thrive well."*
>
> *Separate roundtable participants*

And, as one participant insisted, values cannot simply be stated. They must drive everything:

> *"It is not enough to articulate values. They must be the substrata or point of reference for everything in the Act."*
>
> *Roundtable participant*

Today the law signals crisis and control

Participants described a law that currently signals the wrong things, and steers scope and funding toward crisis:

> *"The law priority is to support and care for the citizen. The current law implementation seeks to control."*

> *"Currently, our scope is the narrow crisis level. It signals to us that this is fear, crisis, containment."*
>
> *"Legislation should be implemented from the very beginning, not just at the pointy end of the situation."*
>
> *Separate roundtable participants*

The most resonant statement of the session drew the point together:

> *"Law frames what's normal. A law centred on compulsion normalises compulsion. We need law that makes rights, community care and lived experience leadership the default… with teeth!"*
>
> *Roundtable participant*

Another person pressed this point further:

> *"If the law recognises what the system should look like, it guides earlier prevention, not just crisis response."*
>
> *Roundtable participant*

Broaden the frame: prevention, wellbeing, community

Participants wanted law that reaches upstream, early intervention, social and emotional wellbeing, the social determinants, and community care, echoing the discussion papers' work health and safety comparison:

> *"The law should reflect early intervention, social and emotional wellbeing, the broader social determinants and community care that we know are human rights."*
>
> *"If laws are only for times in crisis then it is not fit for purpose."*
>
> *Separate roundtable participants*

Accountability, oversight and teeth

A strong theme was that law must carry enforceable accountability, funding attached to legislation, data collection built in, independent oversight, reviews triggered by outcomes, OPCAT implementation, and a role for law in managing the impunity around treatment authorities. Participants also wanted the law to protect clinicians trying to practise in a rights-based way, and to enable good care rather than defensive practice:

"Assign responsibility for getting there, and hold the system accountable when it doesn't."

"The law should enable the best care possible rather than the 'cover their ass' approach. Laws shape priorities, so we can shift priorities."

Separate roundtable participants

Make it legible

Accessibility was raised as a rights issue in itself, and several noted that law need not only use words:

"The Act should be legible, people should be able to pick it up and use it. The current Act is not accessible to the people under it."

Roundtable participant

Where there was agreement

Participants agreed that:

- the law sets the system's purpose, distributes power and shapes culture, it does not merely regulate crisis.
- the law's frame should shift from compulsion and "dangerousness" toward rights, wellbeing, prevention and community care
- this must be backed by enforceable accountability, independent oversight and embedded lived experience power.

What good reform looks like

Our final question asked what a successful reform process looks like. Participants were clear that process is inseparable from outcome, and, by a wide margin, that lived experience must lead.

Lived experience led, beyond tokenism

This was the dominant theme of the session, repeated in many forms:

> *"Lived experience led."*
>
> *"Lived experience being embedded throughout the whole process."*
>
> *"Success looks like people with lived experience leading the conversation and process from start to finish. It also involves going beyond tokenism and instead welcoming genuine power sharing."*
>
> *"A successful reform process is First Nations-led, lived-experience-led, outcome-focused, transparent, and designed to reduce coercion, racism and disparity."*
>
> *"People who are impacted need to be involved from the start."*
>
> *Separate roundtable participants*

Participants wanted this alongside First Nations leadership and an explicitly anti-racist process, with "multiple perspectives and LE in leadership" rather than a single token voice.

Start with outcomes, design for implementation

Echoing the discussion papers' principles, participants called for reform that begins with outcomes and designs delivery in from the outset:

"Outcome: less restrictive treatment, more patient involvement, better health outcomes."

"Staff and carers not needing to fight with psychiatrists about more compassionate, less punitive approaches to care."

"Built to adapt and improve, not just set and forget, independent evaluation body and mechanism to inform continuous improvement."

"Attached funding to the law reform and implementation process."

Separate roundtable participants

Transparent, inclusive and accessible

People wanted a process that is open and able to be understood by everyone:

"It needs to be able to be understood by everyone. From a rights point of view, if I can't understand it how could I exercise them?"

"It is inclusive, it is broad, anyone who wants to participate can."

"People need to be heard. They want their submissions to be public and available so we know what has happened with it."

"People have been genuinely heard… and a pathway forward is clear and measurable."

Separate roundtable participants

Don't reform the Act in isolation

Participants stressed that the Act should be considered alongside system planning, not apart from it, and that reform should learn from other jurisdictions and other fields, including Disability Studies, Mad Studies and Crip Studies, with parallel work on culture change and community education "so the law sticks". This also involved ensuring law reform itself isn't done in isolation – it cuts across disciplines. Someone described good law reform as:

> *Joined up reform process by people with legal expertise, people impacted by the legislation, and people working in the system across frontline, governance and community organisations*
>
> *Roundtable participant*

Two hopes captured the spirit of the day:

> *"Won't need to fight and advocate so much!"*
>
> *Roundtable participant*

There were also reflections of simple things, like ensuring the law is better communicated through other mediums. A participant put it clearly:

> *"We need more flowcharts!"*
>
> *Roundtable participant*

Where there was agreement

There was overwhelming agreement that a successful process must:

- be lived-experience-led and involve genuine power sharing, not consultation alone.
- start with thought about the outcomes, design implementation and funding from the outset
- be transparent and accessible to all, and
- build in ongoing review, monitoring and adaptiveness.

Lived experience accounts

Among the written feedback were detailed and deeply personal accounts from participants with lived experience of the system. They are included here at some length because they draw together many of the day's themes in participants' own voices.

One contribution argued that legislation "must reflect kindness, integrity, autonomy and empowerment leading to integration instead of othering", where current legislation "leads to incarceration, coercion, sedation and discrimination". It

described how the Act can operate as a trapdoor in eating disorder care: even where a person is consenting and meeting protocol, "as soon as the patient doesn't complete a meal or demonstrates distress… they are placed under the Act". In this way, the participant wrote, clinicians "are just as trapped as the patients are in all-or-nothing approaches and unrelenting standards".

The account also spoke to the persistence of historical harm, invoking Wolston Park:

> *"No Mental Health Act has ever worked because staff don't abide by it. 'It's never the staff's fault, it's only the patient's fault.' Wolston Park staff used to say this and it still applies now."*
>
> *Written feedback, roundtable participant*

The participant referred to contemporary inpatient settings as "the new Wolston Park", described patients found heavily sedated and injured, and warned that without recognition of past harms, and accountability for those in the highest positions of power, no real change to patient safety is possible. The contribution closed with a clear standard for any future Act:

> *"Mental Health legislation must reflect the realities of practice, and practice must be grounded in the realities of patient experience and outcomes. Any Mental Health Act must be trauma informed, human rights based and grounded in lived experience."*
>
> *Written feedback, roundtable participant*

Another participant reflected on the panel discussion and the challenge of reforming the law while the system continues to operate in the same way. They cautioned that

a new Mental Health Act will not be enough if progressive change is not recognised in practice, or actually felt by people subject to the Act.

> *"The panel discussion highlighted the challenges of having a new Mental Health Act versus having a system that operates in the same way, such that progressive change may not be recognised in practice, or may not be actually felt by people."*
>
> *Written feedback, roundtable participant*

That participant described the Act as a uniquely emotive law. In their view, stigma and discrimination make the application of an already emotive law even more problematic. They also raised structural concerns: that other legislation is supported by regulations that guide its application, while the Mental Health Act relies on internal regulators and internal advocacy structures. This creates a perception of bias from the outset, and raises questions about whether data reported under the Act can be affected by the way it is collected.

The same contribution also connected the case for change to the Human Rights Act 2019. Because the Human Rights Act was introduced after the Mental Health Act, the participant argued that decisions made under mental health law must now be reviewed through a human rights lens.

> *"The voice of lived experience is the most compelling case for change. The current Act is failing a large number of people and that is not the essence of law."*
>
> *Written feedback, roundtable participant*

They urged any consultation process to ensure that lived experience voices and the system can truly talk, listen and respond to each other. As they put it, lived

experience must not be "talking at the system". It must be "speaking with the system".

The same participant offered concrete proposals, including:

- banning mechanical restraint and seclusion, with automatic independent review of every use of physical restraint;
- lived experience advocates and mental-health-specialised legal advocates on review tribunals;
- universal, independent advocacy with full access to records and an opt-out model;
- funded legal representation for every patient at tribunals;
- a specialist, independent lived-experience complaints body with ombudsman-equivalent powers;
- legally binding advance health directives;
- legislating Ryan's Rule for mental health settings, with a non-Queensland Health psychiatrist and a patient advocate present; and
- prioritising people whose basic needs, income, housing, medical care, are unmet.

A further contribution from a member came in preparation for the roundtable in the form of written notes. They noted that the Act had several issues including inconsistent application and weak enforceability:

> *"The Act's protections are not sufficiently enforceable, not consistently applied, and not aligned with contemporary best practice."*

They later reinforced:

> *"Rights must be real, not theoretical."*

These proposals and reflections are recorded in full in the source feedback and will inform MHLEPQ's continuing work. Together, the accounts show why lived experience must be central to reform: policy should reflect intent, and intent should be put into action.

Where to from here

Across the three questions, several points of agreement held firm. The Act is not meeting its own objectives, and the case for change is made. Coercion and restrictive practices are trending the wrong way. The law's frame is too narrow and must move from crisis and control toward rights, wellbeing, prevention and community.

Accountability must have teeth. And lived experience must lead, in the system and in the reform process itself, as genuine power sharing rather than consultation.

This wasn't designed to be about reaching agreement on everything. What stood out was how much agreement emerged anyway, across very different parts of the system. It was, as the opening address put it, a chance to align our laws with our values, and our system with people's lives. The contributions captured here are the seeds of change. MHLEPQ will carry them into the next phase of advocacy, including to the Queensland Government to see a review of the Act. Fundamental to this will be the central question: do our laws reflect our values?