



2024 Human Rights Report

December 2025

**NATIONAL MENTAL HEALTH
CONSUMER ALLIANCE**



Acknowledgement of Country

The National Mental Health Consumer Alliance acknowledges the Traditional Custodians of the lands and waters across Australia where we live, work, and advocate. We pay our deepest respects to Aboriginal and Torres Strait Islander peoples, and to their Elders past and present. We acknowledge that First Nations lived experience is inseparable from the impacts of colonisation, dispossession, racism, and structural inequity. These ongoing injustices must be named, understood, and addressed.

The National Mental Health Consumer Alliance works in solidarity with the Indigenous Australian Lived Experience Centre, recognising the critical leadership of First Nations peoples in truth-telling, healing, and social and emotional wellbeing.





Acknowledgement of Contributors

The National Mental Health Consumer Alliance extends its heartfelt thanks to the hundreds of mental health consumers who took part in the 2024 National Human Rights Survey. The honesty, insight, and courage of our movement in sharing lived experiences has made this report possible.

We also wish to express our gratitude to ACACIA: The ACT Consumer and Carer Mental Health Research Unit at the Australian National University for its advice and contributions throughout the life of the project. ACACIA receives funding from the ACT Government for lived experience research.

A note on language

All references to 'Consumer' and 'lived experience' in this submission refer to mental health consumers with lived experience of mental health challenges and/or suicidality. We use the term "mental health consumers" and "people with psychosocial disability" as catchall terms in this report due to their connection with our movement's history, but we acknowledge that different people self-identify with different terms. We do not include family, carers, kin or the bereaved in our definition of lived experience as it appears in this report.



About the Alliance

The National Mental Health Consumer Alliance (the Alliance) is Australia's new national peak body led by and for mental health consumers. Established in November 2019 and formally recognised in July 2024, the Alliance unites state and territory mental health consumer peak bodies into a federated structure. Together, Alliance members (State and Territory mental health consumer peak bodies) bring a rich history of more than 135 years of collective lived experience leadership to drive national outcomes for mental health consumers.ⁱ

Who we represent

- The Alliance's members are state and territory consumer peaks: independent, lived-experience-led organisations that advocate in their jurisdictions.
- Collectively, we represent over 8,000 active members and a broad network of grassroots communities across Australia.
- Our member organisations are the backbone of the Alliance, ensuring that national advocacy is always grounded in the lived expertise of consumers on the ground.ⁱⁱ

What we do

The Alliance exists to ensure that mental health consumers are not just consulted, but at the centre of national decision-making. We:

- Advocate on national policy and legislative issues, including human rights, discrimination, restrictive practices, and psychosocial supports.
- Elevate consumer voices through coordinated research, submissions, and campaigns.
- Work with governments, researchers, services and communities to reimagine mental health systems so they are rights-based, inclusive, and person-led.

Our unique role

As the national peak, the Alliance's authority comes from both policy evidence and the lived reality of thousands of people navigating mental health systems. This dual perspective positions the Alliance as a thought leader and trusted advocate for reform.





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Foreword

This inaugural Human Rights Report marks a turning point for mental health reform in Australia. It brings something long missing from national debates — lived experience as evidence of people’s human rights experiences. Evidence that is rigorous, honest, and grounded in the realities mental health consumers face every day.

For too long, discussions about mental health have centred on services, symptoms, and costs. What has been missing is the most fundamental question: Are people’s human rights being upheld? The findings of this report make the answer painfully clear.

Despite decades of inquiries and reforms, discrimination, vilification, bigotry, coercion, poverty, and exclusion remain routine experiences for people with mental health challenges.

- **Nine in ten** respondents heard discriminatory or demeaning comments made about people with mental health challenges in 2024.
- **Half** avoided seeking care while admitted in inpatient mental health units because they feared coercion.
- **One in four** agreed to treatment not because they wanted it, but because they feared what would happen if they refused.
- **Mental health care is unaffordable.**
 - **Less than half could access a bulk-billing general practitioner**
 - Only one in five could access a bulk-billed psychologist and
 - Only 1 in 10 could access a bulk-billed psychiatrist.
- Nearly **one in thirteen** (8%) respondents experienced unstable housing (including temporary arrangements or homelessness) in 2024.

Behind every statistic is a person entitled to dignity, safety, and choice — yet we are encountering systems that too often deliver the opposite.

These are not isolated incidents. They reflect structural failures long identified by the Burdekin Report, reiterated through the Disability Royal Commission, and now once again confirmed by consumers themselves. The continuity of these findings across three decades is a stark reminder that human rights cannot be upheld by goodwill alone. They require legal protections, accountability, and meaningful consumer leadership.



As Australia renegotiates the National Mental Health and Suicide Prevention Agreement and considers major reforms to disability and anti-discrimination laws, this report offers a clear path:

We need a human rights approach — and a national Human Rights Act.

A Human Rights Act would enshrine the rights that people with psychosocial disability have been denied for too long: equality before the law, free and informed consent, safety, housing, economic security, and the right to live independently and be included in community. It would require governments to act, not only respond, when rights are breached.

We also need a broader human rights approach to health care, particularly for people with psychosocial disability. Strengthening and modernising Australia's Disability Discrimination Act would be a good starting point, as would removing Australia's interpretive declarations to the United Nations Convention on the Rights of Persons with Disability which currently enable coercive control.

This report also represents something powerful about our movement. It shows the strength of lived expertise. It shows the value of consumers gathering our own data, telling our own truth, defining our own priorities, and shaping the reform agenda with authority.

We extend our deepest thanks to every person who completed the survey, and to our state and territory consumer peaks whose leadership and community connection made this report possible. We also thank ACACIA at the Australian National University for its guidance and partnership.

This is the baseline from which we will measure progress — every year. It is also a call to action: to governments, to services, to communities, and to all who hold power.

We imagine a future where our human rights are not aspirational statements but lived realities. A future where mental health systems are built on safety, dignity, and trust. A future where lived expertise is not an afterthought, but a foundation.

With solidarity and determination,

Priscilla Brice, CEO

National Mental Health Consumer Alliance



Executive Summary

The Alliance imagines a future where consumers are genuinely heard and seen as a whole person, not just as a 'diagnosis'. We aspire to a society that prioritises proactive well-being and holistic support:

- Where the system provides tools and support to help people stay well and feel a genuine sense of human connection.
- Where supports are affirmative, transparent, and dignity-based; and empathy, respect and trauma-informed behaviour are measurable and non-negotiable for all staff.
- Where funding and KPIs are shifted from crisis containment to community-led, self-directed wellness programs, affirming the right to define one's own health trajectory and offering supported decision-making for all treatment choices.
- Where your legal right to make your own decisions is recognised and respected.
- Where application processes and institutional interactions are clear, transparent, and simple.
- Where you do not have to fight the system just to get the supports you need when you need them.
- Where people with mental health challenges HAVE the capacity to direct their own lives.
- Where policies and practices are co-created with mental health consumers that support choice and control, and empower a person to live with full agency.
- Where all support policies (financial, housing, treatment) are reviewed and purged of all paternalistic elements that restrict or punish a person's life choices and promote dependency.

“We all recognise that the system is broken yet nothing changes. We need more funding and funding that allows us to collaborate and share resources rather than compete”

Anonymous, 2024 Human Rights Survey

This is the future mental health consumers have been asking for. It is also a future grounded in human rights.



To get there, we need to know where we are and where we've come from. Too often, discussions about human rights lack the detail to say what is working and what isn't. The lack of clarity undermines progress on compliance and culture change.

This report presents the findings of the Alliance's inaugural Human Rights Survey, drawing on the results of the 2024 National Human Rights Survey of people living with mental health challenges. Conducted between November and December 2024, the survey represents one of Australia's largest consumer-led examinations of human rights in mental health to date.

A total of 311 people participated in the survey, with 234 completing it in full. Respondents represented every state and territory, and their responses captured both quantitative and qualitative data. The survey was designed to be repeated annually to monitor progress, identify areas where governments and systems continue to fall short of their human rights obligations, and inform the Alliance's advocacy.

The findings of this inaugural report come at a critical moment for Australia's mental health and disability systems. Major reforms, including the implementation of government responses to the recommendations from the Royal Commission into Violence, Abuse, Exploitation and Neglect of People with Disability (Disability Royal Commission (DRC)),ⁱⁱⁱ the review of *Australia's Disability Discrimination Act 1992 (DDA)*,^{iv} major changes to the National Disability Insurance Scheme (NDIS),^v the rollout of three new Targeted Action Plans (TAPs) under Australia's Disability Strategy 2021–2031 (ADS)^{vi} and the review and re-negotiation of the National Mental Health and Suicide Prevention Agreement^{vii} will shape how people with psychosocial disability experience our rights, access supports, and participate in our communities over the coming decade.

The 2024 survey revealed three core themes:

- Widespread **discrimination** across healthcare, employment and media.
- The continued use of **restrictive practices** that breach human rights obligations.
- Severe **economic insecurity**, with many consumers experiencing poverty, unemployment, unaffordable healthcare, and unstable housing.



Across all three areas, the survey data revealed persistent and systemic breaches of consumers' rights, highlighting an urgent need for coordinated structural reform across jurisdictions. Consistent with the results, the Alliance strongly supports the implementation of the DRC's recommendations calling for the elimination of restrictive practices, the strengthening of anti-discrimination protections, fully resourced implementation of National Preventative Mechanisms (NPMs) across Australia, and the embedding of lived experience leadership in all levels of policy and service design.

The results from the survey reflect the themes coming from our ongoing project, Making Rights Real,^{viii} which reveals that the current support ecosystem, encompassing clinical, bureaucratic and community settings, is built on paternalism and actively undermines our human rights. The challenges are not merely deficiencies in service delivery; they are clear indicators of systemic human rights violations, specifically concerning the United Nations Convention on the Rights of Persons with Disabilities (CRPD) Articles 12 (Equal recognition before the law), 17 (Protecting the integrity of the person) and 19 (Living independently and being included in the community), which concern legal capacity, dignity and non-harm.

The core finding is that the system's reliance on a deficit-based, reactive model transforms the essential act of seeking support into a source of re-traumatisation and the denial of self-determination. Overall, the mental health system is a dehumanising, professional-centric system. This system often fails to prioritise the human element of care, leading to a lack of trust and making people feel like just another file to be passed on. Reform must begin by dismantling these rights-violating mechanisms.

Above all, this report is both a baseline and a call to action. It establishes a foundation for measuring change over time while demanding immediate, rights-based reform. To uphold the CRPD,^{ix} governments must act now to ensure equality, dignity, and inclusion for all.



Recommendations

The following recommendations are drawn from the voices of people who completed the Alliance's 2024 National Human Rights Survey and the participants of the Making Rights Real project which is a collaboration between the Alliance and Community Mental Health Australia. They identify what must change across three key areas:

1. Discrimination/Vilification, 2. Restrictive Practices, and 3. Economic Security, to ensure the rights of people with psychosocial disability are fully upheld. Each set of recommendations draws on recommendations from previous enquiries, including the DRC, and outlines specific actions for governments.

Creating a more equal future (addressing discrimination)

We deserve a society where people with mental health lived experience are valued and equal. Successive governments' poor laws and lack of new policy actively sustain systemic discrimination. Our recommendations urge redesigned policy with lived experience leaders to create a more equal and fair future. To achieve this, the Australian Government should:

1. In partnership with relevant peak bodies and other relevant stakeholders, co-develop a plan to introduce a national *Human Rights Act*, consistent with the intent of DRC Recommendations 4.1-4.21^x and advocacy from national DRCOs.^{xi} This must include development and implementation of a structure for the Human Rights Act to operate within and with other legislation and regulations and a timeframe for implementation.^{xii}
2. Through the National Mental Health Commission (NMHC), partner with the Alliance to monitor and measure the human rights of mental health consumers in Australia.
3. Through the review of the DDA, introduce a positive duty requiring employers, businesses, governments, organisations, service providers and systems to take proactive steps to prevent discrimination before it occurs. Amendments to the DDA should be consistent with DRC Recommendation 4.12^{xiii}
4. Partner with the Australian Human Rights Commission (AHRC), and mental health consumer peaks to establish national standards for responsible media representation, in line with CRPD Article 8 on awareness-raising.^{xiv}



5. Introduce nationally-consistent anti-vilification laws to protect people with psychosocial disability from mental health vilification.
6. Ensure mental health reforms take an intersectional approach, addressing the compounding discrimination faced by First Nations peoples, women, Lesbian Gay Bisexual Transgender, Intersex Queer and Asexual (LGBTIQ+) communities, people of colour, people from Culturally and Linguistically Diverse communities, criminalised people, people living in poverty, and people living in rural, regional and remote areas.

Restoring dignity through non-coercive care (eliminating coercive practices)

Survey respondents reported high levels of coercion, involuntary treatment and restraint; experiences that directly breach Australia's obligations under the CRPD and United Nations Convention against Torture (CAT).^{xv} Respondents called for elimination of these practices and a transition toward voluntary, rights-based care. To achieve this, the Australian Government should:

7. Immediately withdraw its interpretative declarations to Articles 12 and 17 of the CRPD, in line with advocacy from the Alliance^{xvi} and advice from the Committee on the Rights of Persons with Disabilities.^{xvii}
8. Partner with the Alliance to develop and implement a National Roadmap to eliminate coercive practices in all settings, including mental health service and support settings, with clear timelines and public reporting, consistent with DRC recommendations 6.37-6.41. This must include all forms of coercive practices, including: chemical restraint, physical restraint, mechanical restraint, environmental restraint, and seclusion.
9. Consistent with Disability Royal Commission Recommendations 6.4–6.14,^{xviii} work collaboratively with state and territory governments to implement a nationally consistent *Supported Decision-Making* framework that upholds the right to legal capacity under Article 12 of the CRPD and ensures people with psychosocial disability can make and communicate decisions on an equal basis with others, in all settings and contexts.



10. Ensure the full implementation of the Optional Protocol to the Convention Against Torture (OPCAT),^{xxix} including through adequately resourcing national and state and territory based NPMs,^{xxx} with independent reporting powers on conditions and practices in forensic disability services, psychiatric hospitals, and inpatient mental health units.
11. Legislate nationally consistent approaches to Mental Health Commissions that drive compliance with human rights and support the elimination of forced treatment.
12. In line with DRC 6.37–6.39, ensure nationally consistent data collection and public reporting on restrictive practices to track progress toward elimination. Ensure State/Territory mental health consumer peaks are central to:
 - the review of the current system measure of rates of restraint of people with psychosocial disability in acute mental health hospital services during the first major evaluation of ADS,^{xxxi} and
 - the design of any future system measures relating to people with psychosocial disability under *Australia's Disability Strategy 2021-2031 (ADS) Outcomes Framework*.^{xxxii}

Improving living standards (economic security)

Consumers identified poverty, insecure housing, unemployment, and the high cost of healthcare as major barriers to wellbeing and participation. Addressing economic insecurity is essential to upholding CRPD Articles 25 (right to healthcare), 27 (Work and Employment) and 28 (right to an adequate standard of living)^{xxxiii}. To do this, the Australian Government should:

13. Raise income support payments^{xxxiv} (including the Disability Support Pension and JobSeeker payment) to meet the cost of living,^{xxxv} and allow flexible access during periods of mental health crisis or recovery.
14. In partnership with State/Territory Governments and mental health consumers, address unmet need for psychosocial supports for at least half a million Australians^{xxxvi}. This should be done via a model jointly commissioned, monitored and evaluated/validated by people with lived experience.



15. Expand bulk-billing for general practitioners, psychologists, psychiatrists, and Accredited Mental Health Social Workers, and reform Better Access^{xxvii} to include peer-led, trauma-informed, and culturally safe supports.



Introduction and Background

This report represents the key findings of the Alliance's first National Human Rights Survey for people living with mental health challenges run during November and December 2024. The survey was designed to measure the human rights experiences of consumers during the calendar year of 2024. This information is essential in ensuring that the work of the Alliance can amplify the issues that people with psychosocial disability experience in Australia. The survey was designed with the intention of being repeated each year, using the 2024 results as a benchmark to identify both progress and gaps.

Promotion and Reach of the Survey

The survey was hosted online via Survey Monkey and circulated through state and territory consumer peak bodies, the Alliance contact list, Primary Health Networks, and LinkedIn.

A total of 311 people responded to the survey and 234 completed the survey in its entirety. To our knowledge, these results make the survey the largest human rights survey in Australia led by and for mental health consumers.

The survey captured both quantitative data (tick-box questions) and qualitative data (open-text responses). This combination provides a broad picture of systemic issues while also amplifying the lived voices of consumers.

This Report

This report marks the first of what will become the Alliance's annual Human Rights Report. Its purpose is to track, year by year, the lived experiences of mental health consumers across Australia, shining a light on where rights are being upheld and where they continue to be breached.

The findings in this inaugural report are especially significant because they come at a time of major reform and heightened scrutiny in Australia's mental health and disability systems:

- Governments are beginning to implement some of the recommendations of the **Disability Royal Commission (DRC)**,^{xxviii} which handed down its Final Report in 2023.^{xxix} The DRC was clear: systemic failures have left people with disability exposed to abuse and neglect, and reform must be anchored in a human rights approach.



- The **Disability Discrimination Act 1992 (DDA)** is currently under review.^{xxx} A key proposed part of the reform, which arose from the DRC,^{xxxi} is the introduction of a positive duty requiring governments, businesses, employers, organisations and service providers to take proactive steps to prevent discrimination before it occurs.^{xxxii}
- Australia's **National Disability Insurance Scheme (NDIS)** is undergoing significant and rapid change^{xxxiii} following the 2023 Independent Review into the National Disability Insurance Scheme (NDIS Review) and the subsequent passing of the *NDIS Amendment Bill 2024*.^{xxxiv} For people with psychosocial disability, these reforms will reshape how supports are delivered. This makes it crucial that consumer voices guide reforms, to ensure rights and access are not lost in the process.
- Three new **Targeted Action Plans (TAPs)** under **Australia's Disability Strategy (ADS) 2021–2031** are being implemented across jurisdictions.^{xxxv} Together, these TAPs establish practical frameworks for achieving systemic change and accountability in key areas affecting the daily lives of people with disability, including those with psychosocial disability.
- The **National Mental Health and Suicide Prevention Agreement (Agreement)** has recently been under review by the Productivity Commission. The Productivity Commission's report into the current National Agreement identified that the current mental health system was fragmented and failing people with lived experience of mental health challenges.^{xxxvi}

The Productivity Commission's report represents a pivotal moment for mental health consumers because:

- it listened to consumer experiences, and validated long-standing consumer-led findings of a fragmented, top-down, system not producing sustained and equitable outcomes,
- it provides a mandate for embedding lived experience leadership in the architecture of reform, and
- it establishes the groundwork for a genuinely co-produced, rights-based, and peer-led mental health system, the central aim of the Alliance.



This report from the Alliance's first survey focuses on three key themes identified in consumers' responses:

- **Discrimination:** including negative treatment in health care, workplaces, and the media.
- **Coercive Practices:** such as involuntary treatment, seclusion, and the use of restraints.
- **Economic Security:** covering income, employment, housing and access to services as critical social determinants of mental health.

Each theme is explored through the lens of survey findings, framed within Australia's human rights obligations.

Above all, this report is both a baseline and a call to action. It establishes a benchmark against which future reports can measure progress, while also demanding immediate reforms so that the rights of consumers are fully respected, protected, and fulfilled.



Australia's Human Rights Obligations

Vision: Human Rights as the Foundation for Mental Health Reform

A human rights framework envisions a society where people with psychosocial disability can live with autonomy, dignity, equality and safety. This vision is grounded in international treaties such as the *Convention on the Rights of Persons with Disabilities (CRPD)*,^{xxxvii} the *United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP)*,^{xxxviii} and the *International Covenant on Economic, Social and Cultural Rights (ICESCR)*.^{xxxix} These collectively require governments to remove discriminatory laws, uphold free and informed consent, and ensure inclusion in all areas of life.

“The wait times in the psychiatric wards have been so long ...(I) have had no access to showers, food, sunlight/outside, freedom, having to wait over 24 hours to see a doctor to be allowed any freedom is a violating of human rights”.

Anonymous, 2024 Human Rights Survey

What is International Law?

International law is made through agreements between different countries (known as state parties) and put into treaties such as the CRPD and CAT. Because Australia has a *dualist* legal system, these treaties do not automatically become enforceable in domestic law. However, they create expectations that government policy and legislation will comply with these international standards. This means our advocacy must focus on “domesticating” these obligations through laws and practice reforms.

Australia's Obligations

Australia is a signatory to several international treaties that protect the rights of people with psychosocial disability. The most significant is the CRPD, which Australia ratified in 2008.^{xl} The CRPD requires governments to ensure and promote the full enjoyment of all human rights by people with disability, free from discrimination. Key Articles of the CRPD relevant to this report include Article 5 (Equality and non-discrimination), Article 8 (Awareness-raising), Article 12 (Equal recognition before the law), Article 13 (Access to justice), Article 14 (Liberty and security of the person), Article 15 (Freedom from torture or cruel, inhuman or degrading treatment or punishment), Article 16 (Freedom from exploitation, violence and abuse), Article 17 (Protecting the integrity of the person), Article



19 (Living independently and being included in the community), Article 25 (Health), Article 27 (Work and employment), Article 28 (Adequate standard of living and social protection) and Article 33 (National implementation and monitoring).^{xli}

Australia's human rights obligations also extend to its First Nations peoples through the *United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP)*. UNDRIP affirms the right of Indigenous peoples to self-determination (Article 3), to maintain their mental and physical integrity (Article 7), and to live free from forced assimilation or interference with their cultures (Article 8). It further recognises the right to traditional medicines and health practices (Article 24), and requires free, prior and informed consent in decisions that affect Indigenous lands, resources, and communities (Article 10).^{xliii} Upholding UNDRIP within mental health systems means recognising that for Aboriginal and Torres Strait Islander peoples, health and wellbeing are inseparable from culture, community and sovereignty. Embedding these principles is essential to achieving genuine equality under the CRPD for all Australians.

In 2017, Australia also ratified the Optional Protocol to the Convention against Torture (OPCAT).^{xliii} As a signatory to the OPCAT, Australia is required to establish systems of preventive monitoring of places of detention to protect people against torture and ill-treatment.^{xliv} For mental health consumers, this obligation means that there is a requirement for independent oversight over psychiatric hospitals and inpatient mental health units, where restrictive practices such as seclusion and restraint are still routinely used.^{xlv}

Despite these commitments, Australia has weakened its obligations through interpretative declarations, particularly regarding CRPD Articles 12 and 17.^{xlvi} Article 12 recognises the equal right of people with disability to make decisions about our own lives.^{xlvii} However, Australia has declared its view that the Convention allows for supported or substituted decision-making, including decisions made on a person's behalf, provided these are "necessary, as a last resort, and subject to safeguards."^{xlviii} In relation to Article 17, which protects the integrity of the person,^{xlix} Australia has stated that compulsory treatment of people with "mental disability" can still be permitted "as a last resort and subject to safeguards."¹ However, Australian Institute of Health and Welfare (AIHW) data regularly demonstrates that compulsory treatment is a frequent occurrence.



Interpretative declarations are statements governments make at the time of ratification to explain how they intend to apply a treaty.^{li} While not the same as formal reservations, their effect is similar: they allow governments to justify non-compliance with international obligations.

This approach has been strongly criticised by the United Nations Committee on the Rights of Persons with Disabilities, which oversees the implementation of the CRPD.^{lii} Through reporting processes, the Committee has repeatedly found that forced treatment and detention based on disability are forms of discrimination, incompatible with the CRPD's principles of autonomy, dignity, and non-discrimination. The United Nations Special Rapporteur on Torture has also stated that forced psychiatric interventions, including involuntary medication and Electroconvulsive Therapy (ECT), may constitute torture or ill-treatment, particularly when administered without free and informed consent.^{liii} The Committee has called on Australia to withdraw its interpretative declarations and to legislate for the elimination of coercive practices.^{liv} Successive Australian governments have not acted on these recommendations,^{lv} leaving mental health consumers vulnerable to ongoing rights violations.

“If government agencies finally adhered to the CRPD, especially re abolishing substitute decision making regimes and forced/coerced interventions without exception, and now, not at some indeterminate point in the future.”

Anonymous, 2024 Human Rights Survey

The reality is that people with psychosocial disability continue to be subjected to coercive practices, in community settings, residential care, and acute and non-acute inpatient mental health units.^{lvi} This is reinforced by the government's interpretative stance on Article 12, which continues to legitimise involuntary treatment.

The Alliance also notes that the government itself acknowledges that involuntary treatment should be avoided or minimised. One of the Key Performance Indicators for Public Mental Health Services is to reduce the use of involuntary hospital admissions.^{lvii} This is further reinforced under *Australia's Disability Strategy Outcomes Framework*,^{lviii} which identifies the “number of involuntary hospital admissions” as a key system measure for tracking progress in mental health outcomes. Yet despite this recognition, such practices remain widespread,^{lix} highlighting the gap between international obligations, government commitments, and the lived reality of consumers.



Solutions: Domestic Implementation and System Reform

To make rights real, Australia must align domestic mental health and disability laws with its international obligations. This includes:

- Implementing a Human Rights Act;
- Withdrawing interpretative declarations;
- Embedding supported decision-making and peer-led models of care; and
- Fully implementing its international obligations as a signatory to Conventions such as the CRPD, the ICESCR, the UNDRIP and the OPCAT.



Key Theme – Discrimination

Overview

Discrimination emerged as one of the strongest themes in the survey, with 92% of respondents indicating they had heard people with lived experience spoken about in a discriminatory way during 2024.

Consumers reported being treated unfairly in multiple areas of life, including healthcare, employment, and housing. Many also described the harm of negative portrayals in the media, which reinforce discrimination and shape the way people are treated by services and society.

Discrimination against mental health consumers is a clear breach of Article 5 of the CRPD, which affirms the right to equality and non-discrimination,^{lx} and Article 8, which requires governments to take measures to raise awareness, challenge stereotypes, and promote respect for people with disability.^{lxi} The survey results confirm that these obligations are not being met in Australia.

Systemic exclusion and ableism is evident in all parts of life. The environments, from communities to workplaces and government institutions, are not designed with everyone in mind. This forces people to either conform to a narrow standard or feel ostracised.

The system operates on a baseline assumption of incapacity concerning a person's mental health challenges, leading to acts of dehumanisation and a lack of informed consent. This manifests when professionals (i.e. psychiatrists) dismiss concerns, provide medication without adequate explanation of purpose or side effects, or when service/hospital staff dehumanise people through disrespectful comments, jokes or mistreatment.

“Go beyond mental health and address intersectionality” - identity and intersectionality

Discrimination rarely occurs in isolation. Many survey participants described the compounding impact of gender, sexuality, race, or other identities alongside psychosocial disability:



- 73% of respondents were women;
- more than one-third (34%) identified as LGBTIQ+; and
- over 60% reported living with another disability, chronic illness, or neurodivergence.

“...considerations to go beyond the mental health space and to address intersectionality”

Anonymous, 2024 Human Rights Survey

These findings show that addressing discrimination requires an intersectional lens. A one-size-fits-all approach will not capture the different ways consumers experience discrimination. For example, an Aboriginal woman with psychosocial disability may face simultaneous racism, sexism, and mental health discrimination.^{lxii} The Alliance stresses that reforms must explicitly recognise these intersecting forms of discrimination, in line with the intersectional obligations in the CRPD preamble and under Articles 6 and 7,^{lxiii} which affirm that women and girls with disabilities and children with disabilities, respectively, are subject to multiple forms of discrimination.

“LE [lived experience] considerations to go beyond the mental health space and to address intersectionality and social determinants.”

Anonymous, 2024 Human Rights Survey

“Confront discrimination” - discrimination in health services

Many respondents described being treated differently because of their mental health challenges. This was most pronounced in health care settings. Consumers reported that emergency services and health professionals frequently failed to take their concerns seriously, particularly when reporting physical health symptoms.

“Mental health care reform that focuses on re-educating clinicians to confront and work through their biases towards and discrimination against mentally atypical people”

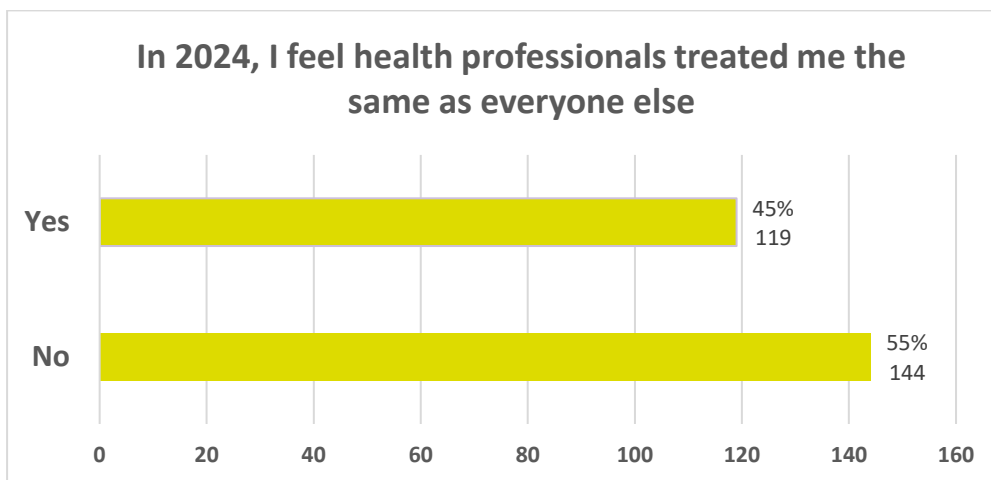
Anonymous, 2024 Human Rights Survey



Survey data illustrates how widespread this experience is:

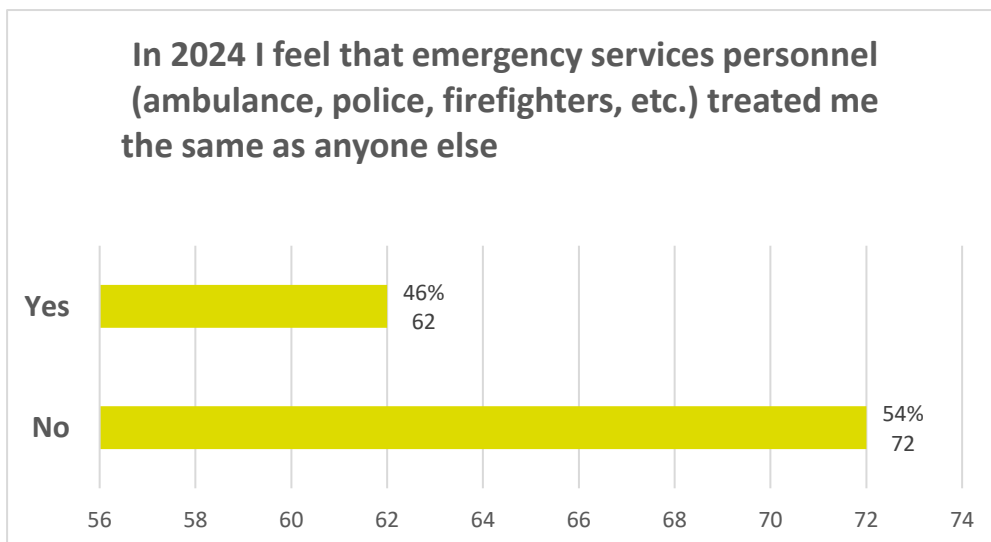
- More than half (55%) of respondents said they were treated differently by health professionals because of their mental health challenges.

Figure 5. Treatment by health professionals



- 54% also reported differential treatment by emergency services personnel.

Figure 6. Treatment by emergency services personnel





For many mental health consumers, being treated differently in healthcare means not being believed, or having our physical health concerns dismissed or overshadowed by a mental health diagnosis.^{lxiv}

“Access to medical care without being accused of drug seeking purely because my psychiatrist who prescribed them was away would improve life for people with lived experience in Australia in the future”

Anonymous, 2024 Human Rights Survey

This results in poorer health outcomes and reinforces the perception that the lives of people with mental health challenges are valued less. Under the CRPD, such treatment constitutes a breach of rights protected under Article 25 (Health) and Article 5 (Equality and non-discrimination),^{lxv} highlighting the urgent need for governments to do more to prevent discrimination in healthcare and across other service systems.

[We need] *“Mental health care reform that focuses on re-educating clinicians to confront and work through their biases towards and discrimination against mentally atypical people.”*

Anonymous, 2024 Human Rights Survey

“Reinforcing mistruths – violence, criminal, NDIS fraudsters” - media representation

Survey participants also drew attention to the role of media in shaping perception of people with psychosocial disability and increasing discrimination and vilification:

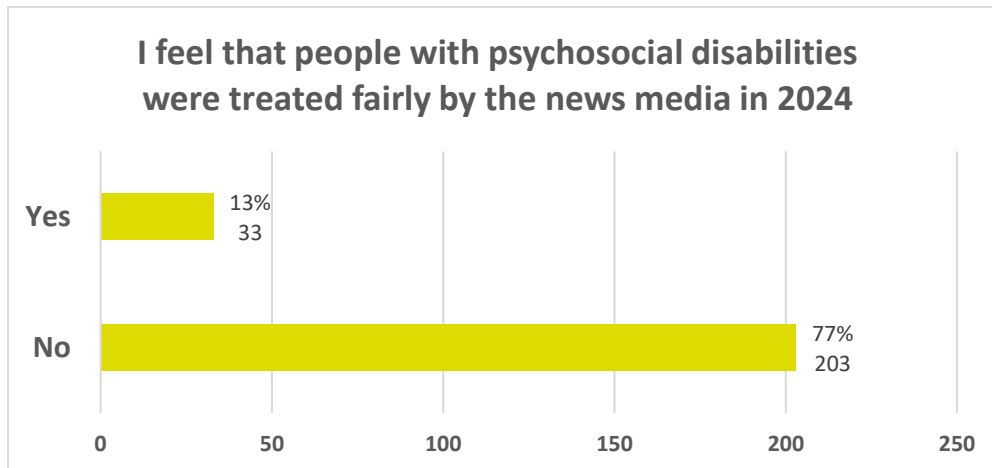
- only 14% of respondents felt people with psychosocial disability were treated fairly by the news media; and
- a striking 86% reported that portrayals were unfair or negative.

“Life for people with lived experience would improve by seeing people on mainstream media who do have lived experience (in employment).”

Anonymous, 2024 Human Rights Survey



Figure 7. Fairness of news media portrayals of people with psychosocial disability



“Media constantly portrays mental health poorly. Criminals, fraudsters of NDIS etc. It’s really disheartening.”

Anonymous, 2024 Human Rights Survey

These numbers confirm what we have long known: the media is a powerful driver of discrimination.^{lxvi} Negative portrayals not only affect how the public perceives mental health consumers, but also reinforce discriminatory treatment in services, workplaces, and communities.

[Stopping] “people with lived experience being used for political fear mongering e.g., political news articles about psychosocial participants on the NDIS ... set taxpayers against people with lived experience for political gain would improve the life of people with lived experience.”

Anonymous, 2024 Human Rights Survey

Under CRPD Article 8 (Awareness-raising), Australia is obligated to raise awareness, challenge stereotypes, and promote respect.^{lxvii} Instead, the media continues to reinforce narratives that people with psychosocial disability are dangerous, incompetent, or burdensome.^{lxviii} Consumers expressed a need for more accurate and positive portrayals - showcasing people living full, meaningful lives with psychosocial disability, rather than focusing solely on crisis and tragedy.



“Media ... laws to stamp out incorrect reporting that reinforces mistruths about mental illness and generalisations!! E.g., the perpetrator had a mental illness as if the mental illness caused (instead of just happened to be associated with) the violence and all people with mental illness are violent.”

Anonymous, 2024 Human Rights Survey

“You are tardy, You are slack” - systemic employment discrimination

Workplaces were another major place of discrimination, with the survey showing:

- 39% of respondents said they were unable to find work because of their lived experience;
- 27% of those employed reported being bullied, harassed, or discriminated against, rising to 35% among those who disclosed their mental health challenges;
- only 36% of employed respondents were provided with reasonable accommodations, though this improved slightly to 47% among those who disclosed; and
- 13% reported being paid a lower hourly rate because of their lived experience.

Figure 8. Employment barriers – consumers unable to find work due to lived experience

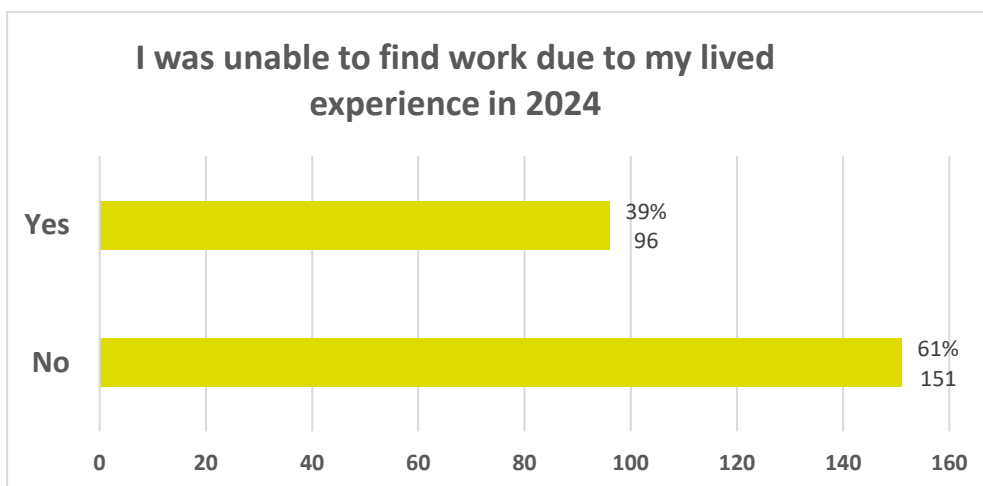
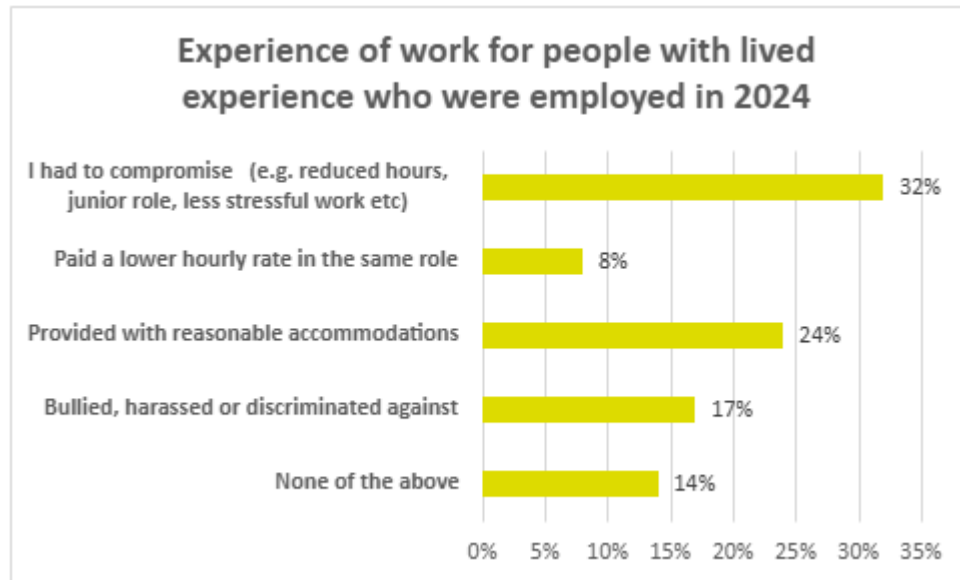




Figure 9. Employment barriers – experience of work for consumers who worked in 2024



[They] “... reduced my hours and advertised for the same position - hire more staff when I desperately need the hours and they give me one shift a monthit was implied by my direct boss I had to do nights.”

Anonymous, Making Rights Real Project

*I was actually condemned... I lost my job. My boss didn't give a rats a**. He just said to me that I didn't have a mental health issue... 'You're tardy, you're just slack' and sacked me due to the fact that I was taking time off to go see my psychologist.”*

Anonymous, Making Rights Real Project

These figures paint a stark picture of exclusion from the workforce. Not only are people with psychosocial disability less likely to find work due to discriminatory attitudes,^{lxi} but those of us who do are often subjected to hostility and denied the adjustments that would allow us to thrive.^{lxx} This violates CRPD Article 27 (Work and employment), which guarantees the right to work on an equal basis with others.^{lxxi} The results also reflect the results from the national *Our turn to speak* survey, which, in 2020, found that over three quarters (78%) of consumers reported experiencing some level of discrimination in relation to employment.^{lxxii}



The whole thing of being disbelieved and marginalised... I got a telephone call for a meeting in the office. He goes, 'I'm really sorry but we're letting you go due to budget cuts.' I asked, 'Is this due to my work performance because I've been unwell? I have all the medical evidence.' It was probably one of the most damaging things."

Anonymous, Making Rights Real Project

These survey results are consistent with national trends. The Australian Human Rights Commission (AHRC) has repeatedly identified employment as one of the leading areas of disability discrimination complaints under the DDA.^{lxxiii}

The DRC recommended significant reforms to address systemic workplace discrimination.^{lxxiv} One example is the introduction of a positive duty on employers, which would shift the burden away from individuals making complaints and instead require workplaces to take proactive steps to eliminate discrimination.^{lxxv}

"He goes 'You don't have bipolar disorder.'... He goes 'There's a lot of crazy people in this office and you're not one of them.' It was probably the worst moment of my life."

Anonymous, Making Rights Real Project

"Better legislation that protects our rights" - legislative and legal policy context

The survey results must be understood against the current backdrop of legislative reforms, such as the current review of the DDA, Australia's primary anti-discrimination law for people with disability.^{lxxvi} The DRC called for a number of amendments to the DDA to make it more accessible for people with disability to file and access justice through discrimination cases.^{lxxvii} This is a direct response to the reality that many people experiencing discrimination lack the resources, support, or energy to pursue individual complaints.

"In Victoria, there is a reluctance within the mental health system to accept the outcomes of the Royal Commission into Mental Health and the Mental Health and Wellbeing Act 2022 is being consistently misinterpreted by clinicians"

Anonymous, 2024 Human Rights Survey



Key Theme – Restrictive Practices

Overview

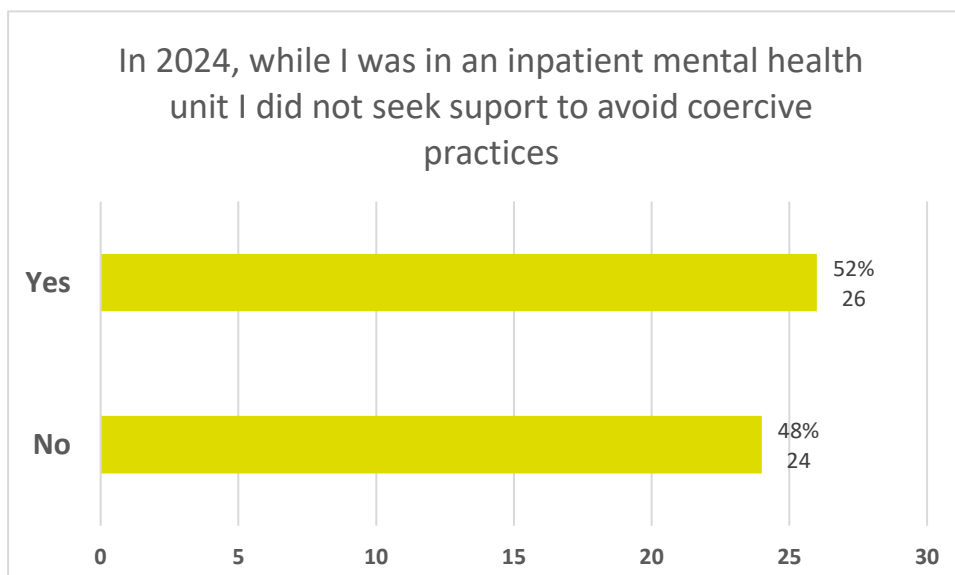
The survey revealed widespread use of involuntary and coercive treatment against people with psychosocial disability. Respondents described being detained, medicated, or restrained against their will. Such practices deny people choice and control, perpetuate fear and mistrust of the mental health system and create vicarious trauma for those who are witness to the experience.

Under the CRPD, particularly Article 12 (Equal recognition before the law), Article 14 (Liberty and security of the person), Article 15 (Freedom from torture or cruel, inhuman or degrading treatment or punishment), Article 16 (Freedom from exploitation, violence and abuse) and Article 17 (Protecting the integrity of the person),^{lxxviii} these practices are clear breaches of international human rights standards. They are also inconsistent with Australia’s obligations under the CAT.^{lxxix}

“I avoid supports due to ongoing threat” - involuntary and coercive treatment

The survey showed that half (52%) of all respondents reported avoiding seeking support altogether to escape coercive practices such as forced medication or threats of detention while in a mental health inpatient unit.

Figure 9. Chose to not seek support to avoid coercive practice in mental health inpatient units



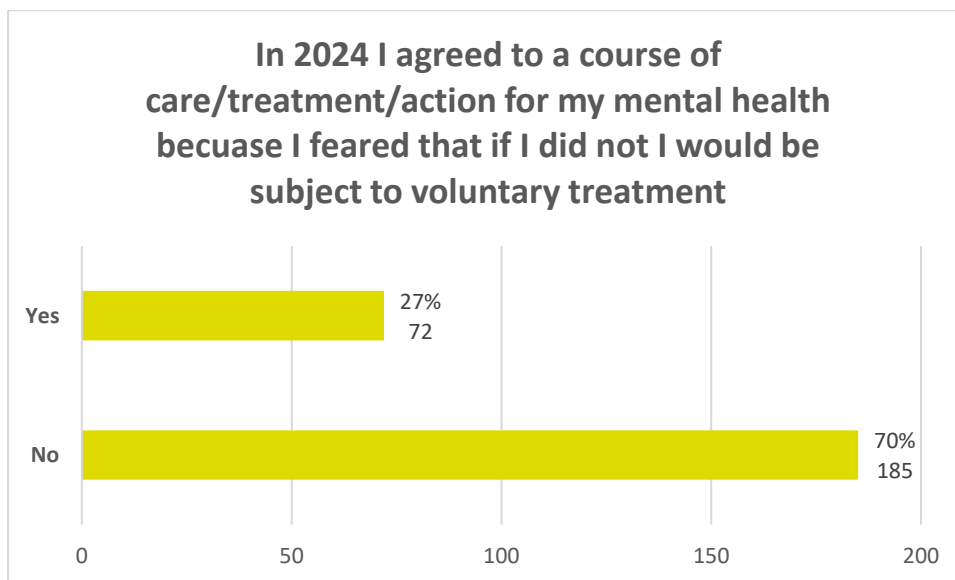


Survey results also show that coercive practices remain a daily reality for many consumers. 27% of respondents agreed to treatment out of fear of being subjected to involuntary treatment, also known as informal coercion.

“I avoided accessing support because of the ongoing threat of involuntary treatment and trauma related to previous violence and experiences of restraint in psychiatric services”

Anonymous, 2024 Human Rights Survey

Figure 10. Agreement to care/treatment/action in 2024 due to fear of coercion



National data from the Australian Institute of Health and Welfare (AIHW) echoes these findings: in 2022–23, nearly half (43%) of all acute mental health hospitalisations were involuntary, along with 27% of non-acute hospitalisations, such as rehabilitation or extended care.^{lxxx} These figures have barely shifted in recent years,^{lxxxi} signalling a lack of meaningful reform. Australia has some of the highest rates of involuntary psychiatric treatment in the world, with admission and detention rates significantly exceeding those of comparable countries.^{lxxxii}

“...nuances between being forced and feeling forced need to be explored further”

Anonymous, 2024 Human Rights Survey



For many respondents, coercion was most common in mental health inpatient units. 20% of survey respondents spent time in an acute mental health unit in 2024, and of these, the majority, 55%, said they did not receive a statement of their rights and 67% did not have access to non legal advocacy service such as an Official Visitor, which left consumers without independent support.

“supports for people in distress that doesn't involve clinicians or coercion”

Anonymous, 2024 Human Rights Survey

Figure 11. Provision of a statement of rights in mental health inpatient units

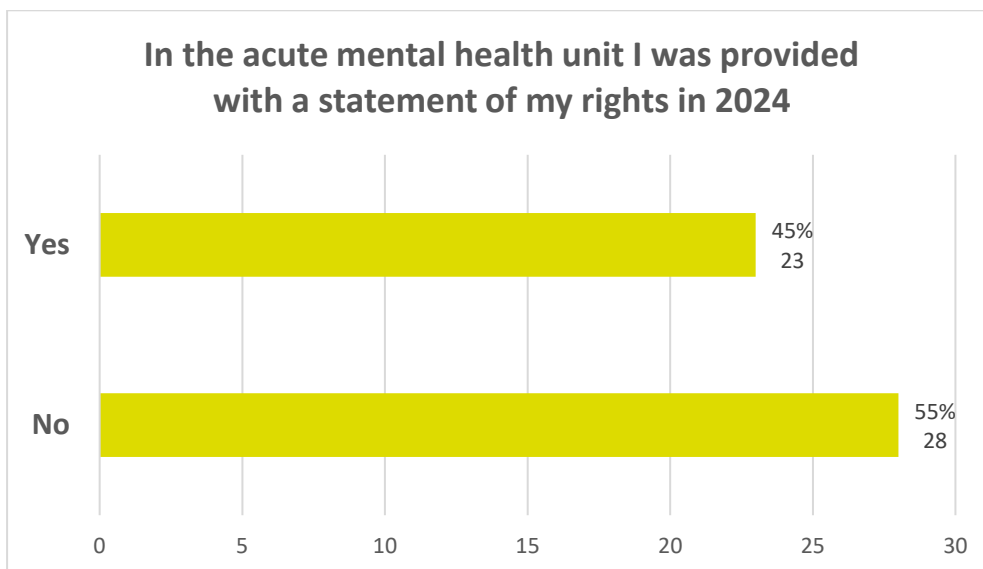
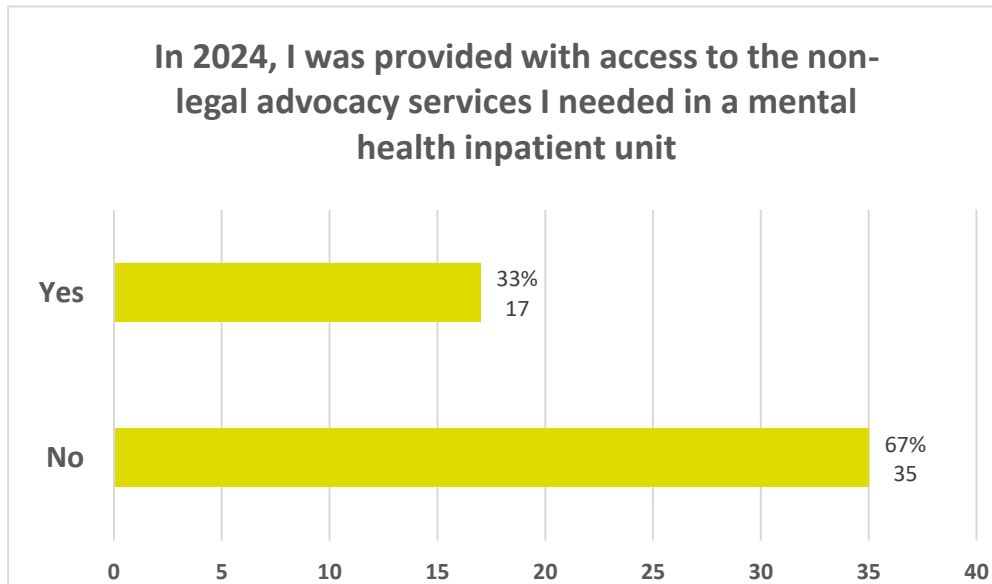




Figure 12. Access to non-legal advocacy services in mental health inpatient units



These low response rates are likely the result of each State and Territory not having a clearly identified, statutory non-legal inpatient mental health advocate program. Of those that do:

- Australian Capital Territory has an Official Visitors scheme, and 100% of respondents reported they had no access to an Official Visitor and were not provided with a statement of rights.
- Victoria has Independent Mental Health Advocacy recognised under the *Mental Health and Wellbeing Act 2022 (Vic)*, and 80% of respondents reported they had no access to an Official Visitor and 86% of respondents reported that they were not provided with a statement of rights.
- Western Australia has a Mental Health Advocacy Service recognised under the *Mental Health Act 2014 (WA)*, and 100% of respondents reported they had access to an Official Visitor and 40% of respondents reported that they were not provided with a statement of rights.

For the States/Territories that do not have a clearly defined program where responses were received, Northern Territory, Queensland, South Australia, Tasmania and Victoria, only 22% of respondents identified that they had access to an Official Visitor yet 55% of respondents advised that they were provided with a statement of rights.



This is a violation of international human rights laws, and indicative of the need for a national Human Rights Act that would require States and Territories that do not have mental health laws imposing a duty to provide this information to do so. For the ACT, Vic and WA, it could be a breach of the state mental health laws themselves, which impose a duty to provide this information.^{lxxxiii}

These experiences highlight how inpatient mental health units violate consumers' rights to equality before the law (CRPD Article 12) and to the protection of physical and mental integrity (CRPD Article 17).^{lxxxiv} They also raise clear concerns under the OPCAT^{lxxxv}, which requires Australia to prevent ill-treatment in places of detention — including inpatient mental health units.

The DRC found that coercion, including involuntary admissions, remains widespread and contributes to trauma, disengagement, and mistrust of services.^{lxxxvi} It called for a fundamental shift toward voluntary, rights-based care models, supported by trauma informed practice, peer support, and access to advocacy. These are similar findings to the Royal Commission into Victoria's Mental Health System, which recommended the elimination of seclusion and restraint from the mental health system within ten years.^{lxxxvii}

The Alliance's survey results confirm that urgent action is needed to phase out coercion and ensure all treatment is grounded in consent, dignity, and human rights.

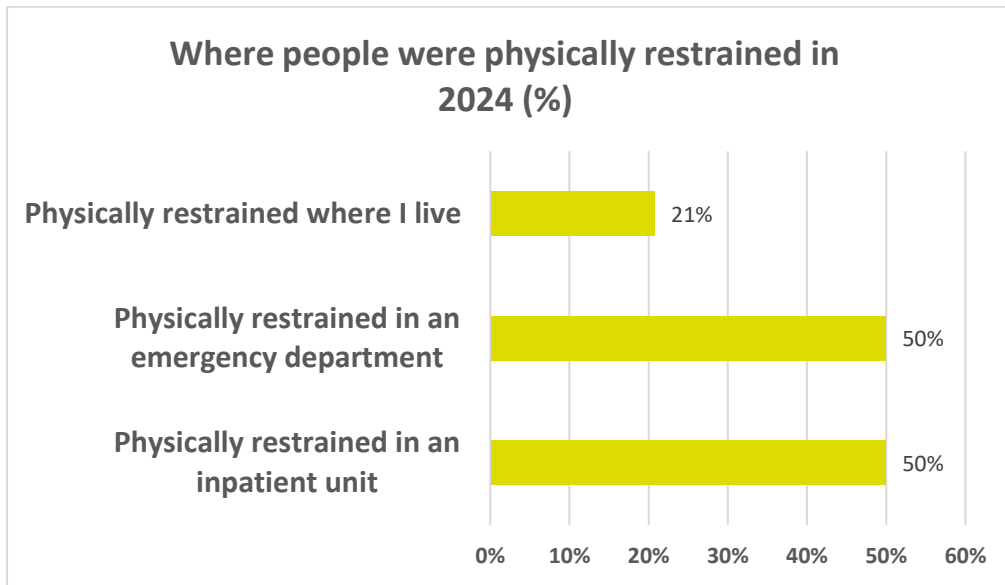
“No options, restraints chemically, physically and threats” - physical and chemical restraints

The survey results also revealed the ongoing use of both physical and chemical restraints. Respondents reported being physically restrained by staff, forcibly medicated, or subjected to increased medication dosages against their will.

Of the 29 respondents who reported physical restraint, 12 reported that it occurred in an inpatient mental health unit, another 12 in an outpatient or rehabilitation setting and five in their place of residence.



Figure 13. Location of where people had been physically restrained. People could select more than one option.



Similarly, of the 16 respondents who reported chemical restraint, 10 said it occurred in an inpatient mental health unit, six in an emergency department, four in their place of residence, and one in a community setting. One respondent reported restraint via medication.

“...by having more medications added to my regime (as an inpatient and where I live) even though I told them that they affected me adversely...”

Anonymous, 2024 Human Rights Survey

The DRC concluded that seclusion and other forms of restraint are breaches of human rights and should be phased out and eliminated.^{lxxxviii} Research from the University of New South Wales, the University of Melbourne and the University of Technology Sydney, commissioned by the Royal Commission, showed that alternatives such as trauma-informed care, peer-led de-escalation, and environmental modifications are effective at reducing crises without resorting to coercion.^{lxxxix}



“Improving mental health care through utilising lived experience peer workers in all aspects, including mental health hospital wards and as first responders to mental health crisis as well as having mandated mental health trained nurses in mental health wards.”

Anonymous, 2024 Human Rights Survey



Key Theme – Economic Security

The survey revealed widespread financial stress among people with psychosocial disability. Many respondents reported relying on government payments that were insufficient to cover the rising costs of living, leaving people in ongoing poverty. Consumers described being forced to make difficult choices between essentials such as food, medication, transport, and housing.

Low incomes were often compounded by limited access to employment, with many respondents unable to secure work or were excluded from the labour market because of discrimination.

*[We need] “adequate support to meet basic living needs (housing, food, etc)”
Anonymous, 2024 Human Rights Survey*

This reflects broader national data showing that people with psychosocial disability are among the most likely to live below the poverty line. Data from the 2022 Survey of Disability, Ageing and Carers (SDAC) showed that:

- among people with psychosocial disability of working age (15-64 years), the median gross income was \$450 per week, just over half the \$803 per week income of people with other disability;
- over half (51.5%) lived in households in the lowest two quintiles for equivalised gross household income, compared with 32.3% of those with other disability; and
- 7.3% lived in households with equivalised gross household income in the highest quintile compared to 15.0% of those with disability other than psychosocial.^{xc}

We know from research that this is related to systemic disadvantage. Inadequate income support entrenches exclusion and undermines recovery, making it harder for people to access safe housing, employment, and healthcare.^{xc} Under CRPD Article 28, Australia has a clear obligation to ensure people with disability enjoy an adequate standard of living and access to social protection.

“I cannot get Centrelink or DSP because my partner earns too much, so I'm forced to work and burn myself out all over again because of the cost of living. People with disability should be able to access financial recourse without having to rely on their partner. Anonymous, 2024 Human Rights Survey



“Only the wealthy can afford consistent support” - access to mental health services

Economic security directly shapes whether consumers can access the services we need. The survey highlighted affordability as one of the biggest barriers to healthcare. While 45% of respondents reported having access to a bulk-billing general practitioner, access to specialist services was far more limited: only 18% could see a bulk-billed psychologist, and just 11% could see a bulk-billed psychiatrist. The financial barriers to accessing psychiatry is also exacerbated by the fact that there is currently no fee regulation for psychiatrists or other private specialists, meaning they can charge unlimited fees at their own discretion.^{xcii}

[We need] “Free psychiatric and psychological support with short waiting. At the moment there is piecemeal help via help lines, but only wealthy can afford consistent psychiatric or psychological support. And it needs to be consistent for complex needs.”

Anonymous, 2024 Human Rights Survey

“I had greater access to support due to my financial situation. I fear many of my responses would have been very different if I did not have financial security”

Anonymous, 2024 Human Rights Survey

For many, the cost of private mental health care was prohibitive. Respondents explained that a lack of bulk-billing availability contributed to delays in seeking help or resulted in reliance on public hospital emergency departments.

It is extremely difficult to get immediate affordable treatment. I had to pay \$700.00 to be able to access a psychiatrist urgently which I had to pay on my credit card.

Anonymous, 2024 Human Rights Survey

“Mental health is health care and it is absolutely outrageous to expect people to be able to afford \$200+ per hour to access help”

Anonymous, 2024 Human Rights Survey



From a rights perspective, this is a breach of CRPD Article 25 (Health), which requires governments to ensure people with disability have equal access to healthcare, without discrimination, and at an affordable cost.^{xciii} The Alliance’s findings demonstrate that economic security and access to services cannot be separated; without adequate income and affordable options, people are locked out of the very supports intended to uphold their rights and wellbeing.

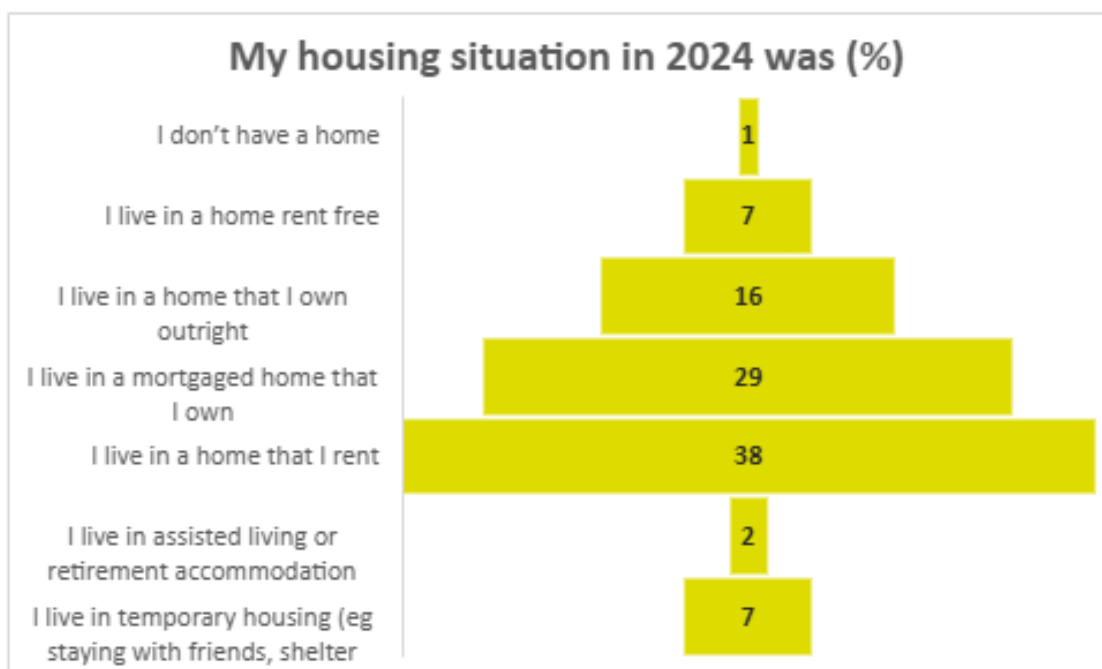
"Housing that is independent and affordable" - housing

The survey found that people with psychosocial disability experience significant housing insecurity compared to the general population. Respondents were far more likely to be renters or living in unstable housing and under-represented among homeowners.^{xciv}

Survey data showed the following housing situations for respondents:

- 38% were renting;
- 8% reported living in unstable housing (including temporary arrangements or homelessness); and
- 45% either owned their home outright (16%) or had a mortgage (29%).

Figure 14. Housing situation of respondents





These results highlight the over-representation of consumers in insecure housing and our under-representation in home ownership. Experiences of homelessness were also higher than the national average,^{xv} with almost one in eight respondents reporting being without stable housing during 2024.

The survey demonstrates that secure housing remains out of reach for many people with psychosocial disability. Without stable homes, consumers face greater barriers to recovery, increased exposure to poverty, and exclusion from community life.

“Being able to afford housing, food, medical bills, etc. If I could take care of my basic human needs, I might not be so affected by my mental illness”

Anonymous, 2024 Human Rights Survey



Conclusion

The findings of the Alliance's inaugural Human Rights Report make one thing clear: despite decades of advocacy and reform, people with psychosocial disability in Australia continue to experience systemic human rights breaches.

We are calling for change that goes beyond rhetoric. We want action that embeds lived experience at every level of decision-making, from national policy and legislation to local service design and delivery. We want governments to meet their international obligations under the CRPD and OPCAT.

This report sets the baseline for accountability. It is the first of what will become annual reports tracking whether Australia is moving closer to a rights-based mental health system or continuing to fall short.

The message from consumers is clear:

- Take steps to prevent and enforce accountability for discrimination in all its forms.
- End restrictive practices and coercion.
- Guarantee economic security, affordable health care, and safe housing.
- Embed lived experience leadership at every level.

Only when these steps are taken will Australia truly meet its human rights obligations, not just on paper, but in our lives, the people most affected.



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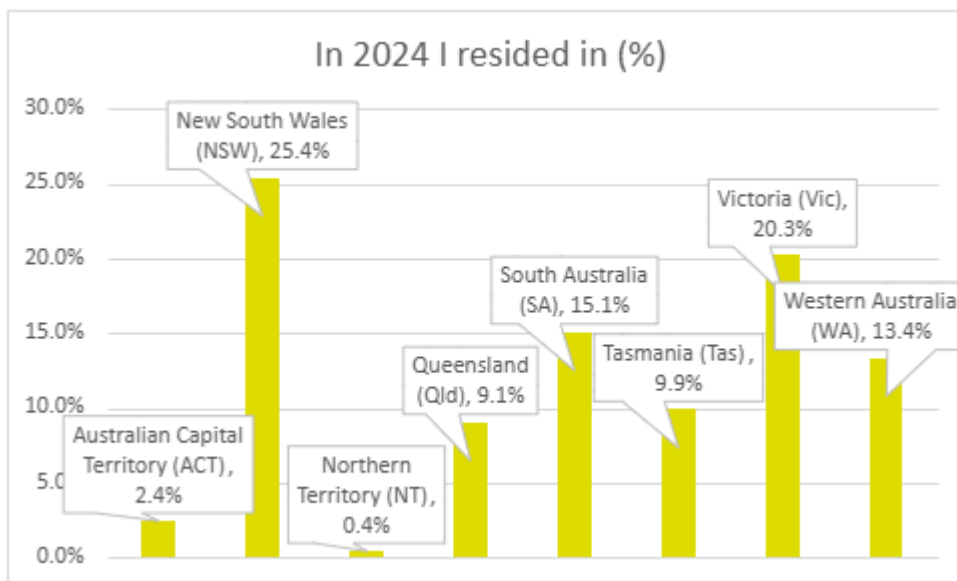


APPENDIX I

Demographics of Survey Respondents and Limitations of this Report

A total of 234 people completed the survey. Respondents came from across Australia, with participation broadly reflecting population size in each state and territory. The largest groups were from New South Wales (25%, n=59), Victoria (20%, n=47) and South Australia (15%, n=36), followed by Western Australia (13%, n=32), Tasmania (10%, n=23) and Queensland (9%, n=21). Smaller numbers of respondents came from the Australian Capital Territory (6%, n=15) and the Northern Territory (<1%, n=1).

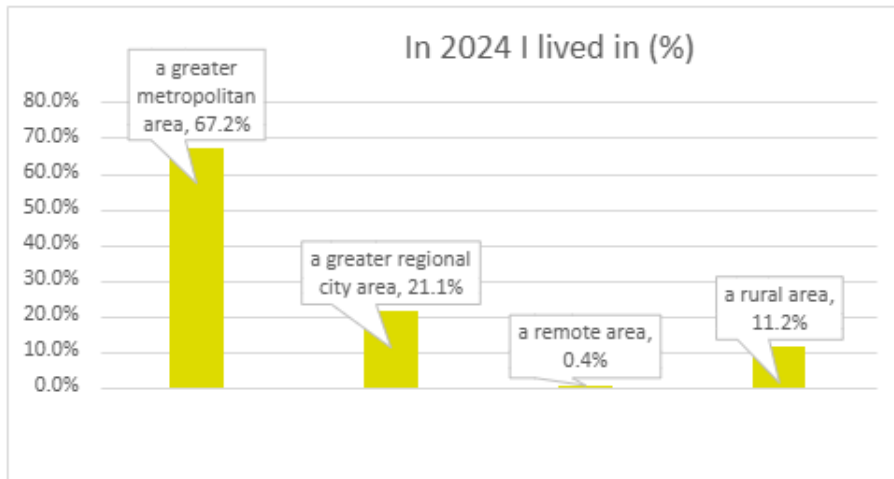
Figure 1. Geographic distribution of survey respondents by state and territory



Most respondents lived in metropolitan areas. More than two-thirds (>67%) were based in greater metropolitan centres, while 21% lived in regional cities, 11% in rural areas, and less than 1% in remote communities.

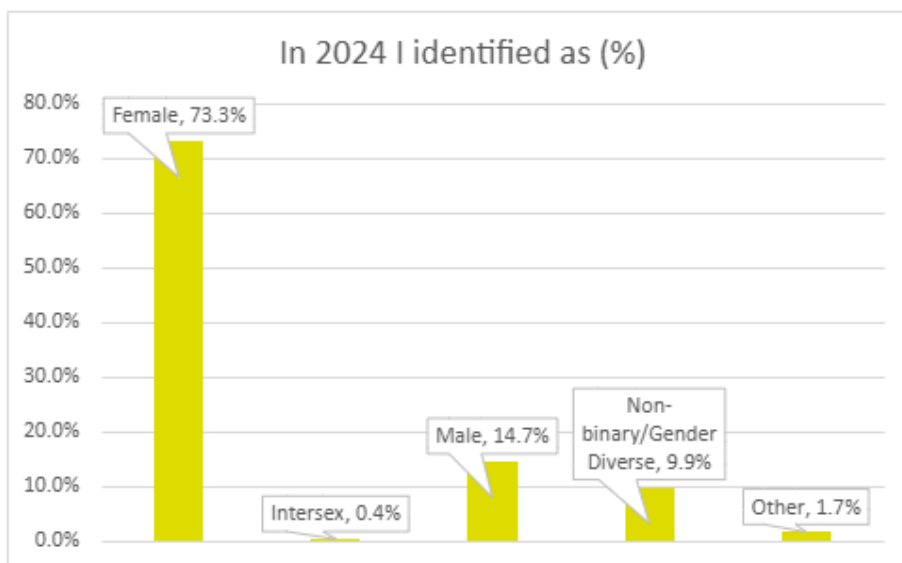


Figure 2. Residential location of survey respondents



The majority of respondents identified as female (73%, n=171). Male respondents made up 15% (n=34), while 10% (n=23) identified as non-binary or gender diverse, and a small number identified as agender, plural, or gender non-conforming. We note that we have more work to do in terms of gender parity for future surveys.

Figure 3. Gender of survey respondents





The survey also captured a broad range of intersectional identities. Respondents included:

- 6 people (2.5%) who identified as Aboriginal and/or Torres Strait Islander;
- 80 people (34%) who identified as members of the LGBTIQ+ community;
- 143 people (61%) who identified as living with another disability, chronic illness, or neurodivergence in addition to psychosocial disability;
- 13 people (5.5%) who identified as migrants or refugees;
- 25 people (11%) who identified as people of colour; and
- 57 people (24%) who reported experiencing social disadvantage, including poverty and homelessness.

These demographics demonstrate the diversity of the consumer movement, but also highlight gaps. Relatively few responses were received from First Nations people or from consumers in remote communities, and as such we commit to working with the Indigenous Australian Lived Experience Centre (IALEC) in future surveys. Future surveys will need to strengthen outreach and partnership with under-represented groups to ensure that the full breadth of experiences is captured.