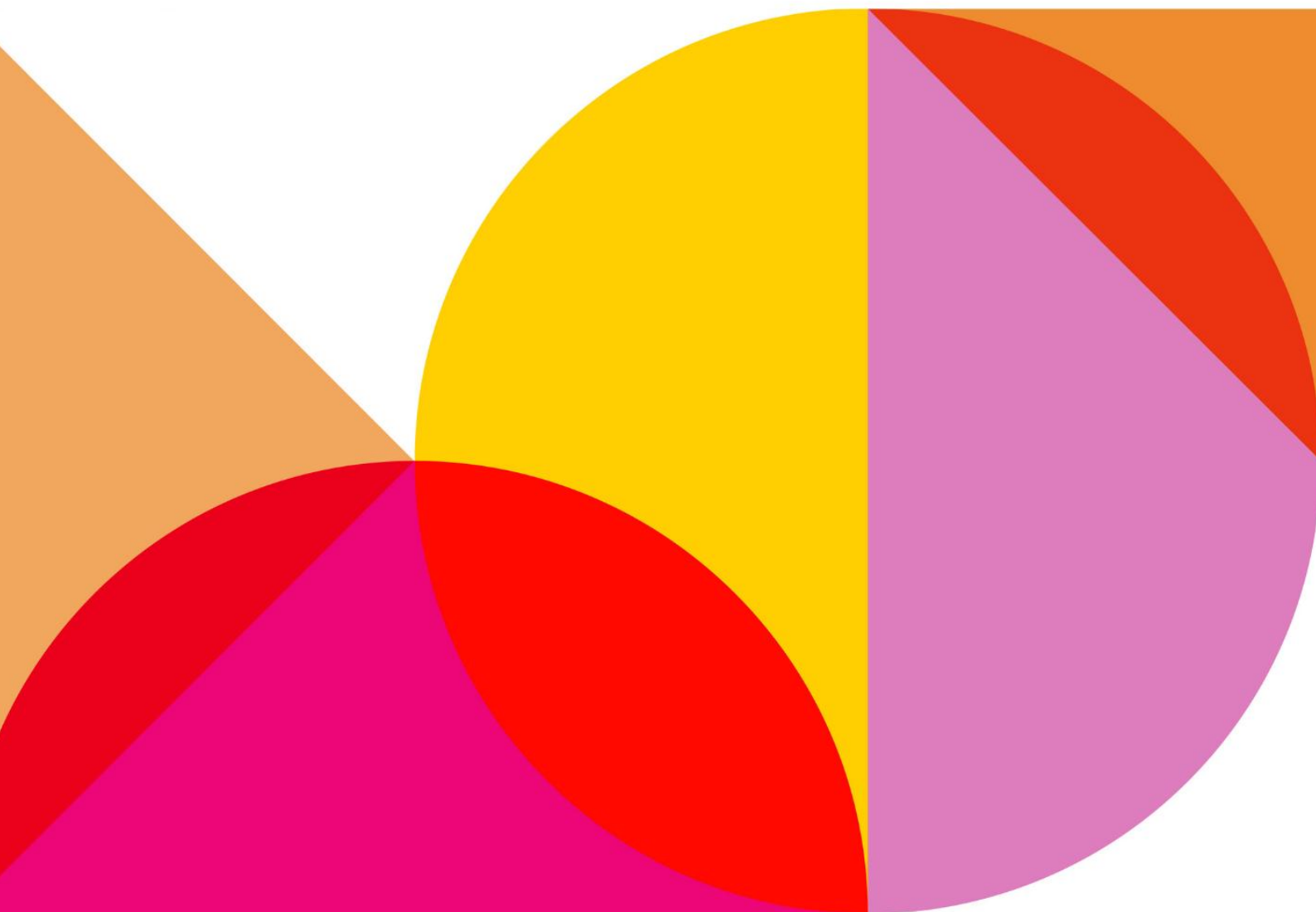


2025 National Human Rights Report

Human rights of people living
with mental health challenges in
Australia

October 2026



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.





About Us

The Alliance is the national peak body representing mental health consumers. We work together to represent the voice of all mental health consumers on national issues.

We are the people experiencing mental health challenges, at the table advocating with government and policy makers, and working with a robust network of grassroots communities.

More information is available on the Alliance's website:

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Terminology

All references to 'Consumer' and 'lived experience' in this report refers to mental health consumers with lived experience of mental health challenges and / or suicidality.

We use the term "mental health consumers" as a catchall term due to its connection with our movement's history. We also respectfully 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 submission.



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Acknowledgement of Contributors

The National Mental Health Consumer Alliance extends its heartfelt thanks to the hundreds of mental health consumers who participated in the 2025 National Human Rights Survey. The honesty and expertise reflected in these responses make this report possible.

The Alliance also acknowledges ACACIA: The ACT Consumer and Carer Mental Health Research Unit at the Australian National University for its data analysis and advice, and the state and territory consumer peak bodies and community partners that supported the survey's national reach.

Ethics and data governance. Participation in the survey was voluntary, and respondents could choose which questions to answer. This report presents aggregate findings and anonymous quotations and does not identify individual respondents.

Accessible formats. To discuss accessible formats, contact the Alliance at admin@nmhca.org.au or 1300 001 581.

A note about consumer voice. Selected anonymous quotations come from the 2025 survey responses. Spelling has been corrected where needed. Grammar, punctuation and wording have otherwise been retained. Quotes illustrate individual experiences and do not measure how common a view was.

Foreword

Human rights can sound abstract. For mental health consumers, they are experiences in seemingly ordinary moments: being believed, receiving voluntary and safe care, getting to an appointment, being told about rights and advocacy, and having a complaint taken seriously.

The Alliance created the National Human Rights Survey to record those experiences each year. The 2024 report provided the baseline for these experiences. This report asks what has changed since then.

The answer is mixed and, overall, worrying. More respondents felt more connected to their local communities than in 2024, but access to the services that make inclusion possible declined. Discrimination remains entrenched. Many inpatients were not told about their rights or independent advocacy unless they proactively asked. Complaints were rarely handled or resolved satisfactorily, and some consumers could not vote because practical support was absent.

Governments are making some efforts to change the legal and service systems on which consumers rely. While public consultation on the Disability Discrimination Act 1992 review has ended, the law has not yet changed. Australia still has no Commonwealth Human Rights Act, and implementation of the recommendations of the Disability Royal Commission remains slow, with progress varying across recommendations and jurisdictions.

The findings in this Report point to a clear course of action. Rights must be enforceable, supports must be available in practice, and accountability systems must be accessible and fit-for-purpose for the people they are meant to protect. Consumers must be equal partners in deciding what reform looks like and how progress is measured.

Executive Summary

"I am sure human rights exist in theory. I do not feel that anybody with power is interested in applying them to me, or protecting me when they are not applied"

The Alliance's second National Human Rights Survey shows that rights continue to be uncertain and inconsistently realised for mental health consumers in Australia. In 2025, 54% of respondents said their human rights were not respected, compared with 50% in 2024. More than half are telling us that their rights were not being respected in everyday life. ^{2,3,4}

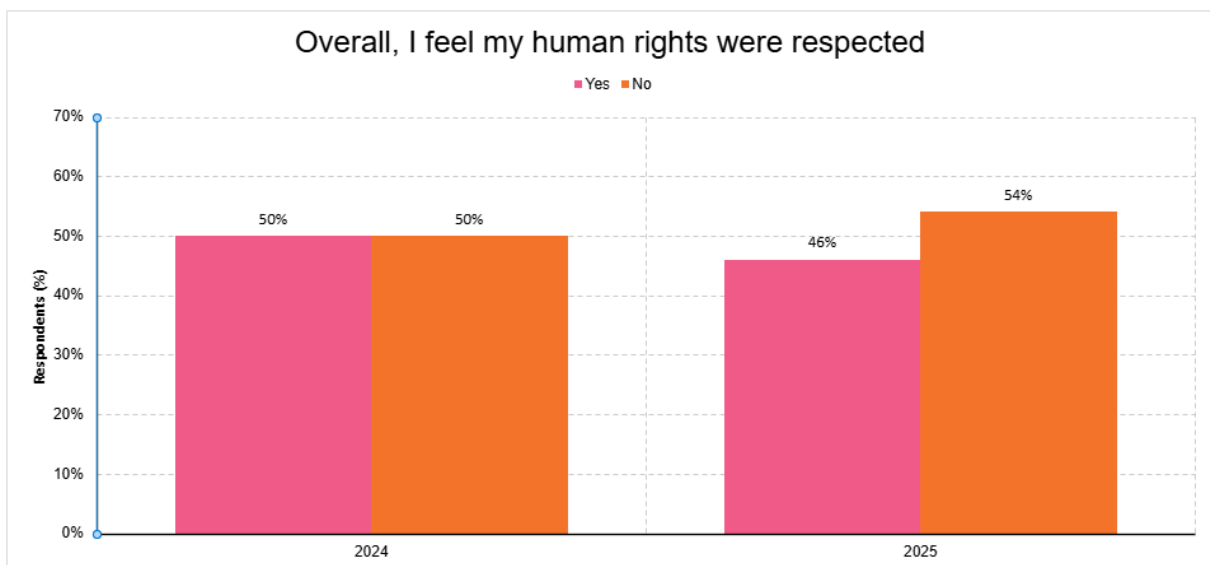


Figure 1. Overall, I feel my human rights were respected

Source: Alliance 2024 and 2025 National Human Rights Survey data.

One result stands out: connection improved while access worsened. The proportion of respondents who felt included in their local community outside mental health supports rose from 36% to 47%. At the same time, access to the transport, housing, employment, healthcare and other services needed for inclusion fell from 52% to 48%. This suggests that

people may be building connection through their own relationships and communities while formal systems continue to fall short.^{2,3,4}

Public discrimination barely shifted. In 2025, 88% said the news media did not treat people with psychosocial disability or experience of mental health challenges fairly. A further 91% had heard people with lived experience spoken about in a discriminatory way in public, consistent with results gathered in 2024. Nationally representative data released by the National Mental Health Commission in July 2026 similarly found that around 70% of people with mental health challenges had experienced discrimination in at least one area of life.^{2,3,22}

Basic safeguards were also inconsistent in inpatient settings. Of the 85 respondents who had been patients in acute care settings, only 32% received a statement of rights without asking, while another 32% did not know such a statement existed. 48% of respondents were unaware of non-legal advocacy services, and 19% asked for advocacy but did not receive it. These gaps leave people without the information and independent support needed to exercise their rights.^{2,3}

Complaints data showed a similar accountability gap. 32% of respondents made a complaint about mental health treatment. Among those who answered, 82% said their complaint was not handled satisfactorily and 87% said it was not resolved satisfactorily.^{2,3} Separate Alliance research found that around two in three respondents did not know how to complain about several categories of services funded under the National Mental Health and Suicide Prevention Agreement.²⁸

The survey also showed that state elections in Tasmania and Western Australia were not accessible for many mental health consumers. Of the 103 relevant respondents, 15 (14.6%) said they were unable to vote in their state election because of lived experience. At the federal election, 28 of 364 relevant respondents (7.7%) were unable to vote. The reasons were failures of institutions and support systems, with the survey indicating that voting assistance was not provided in inpatient units and that people could not obtain the community support needed to reach a polling place.³

What consumers prioritised

Affordable and consistent healthcare ranked first, followed by a national Human Rights Act, support informed by trauma, and the elimination of restrictive practices. These priorities closely match the areas where laws, safeguards and services remain unfinished.^{2,3}

Some policy processes have started or progressed since the 2024 report, but very little has been implemented. The Disability Discrimination Act 1992 (DDA) review completed its initial public consultation in November 2025, yet proposed changes such as a positive duty to prevent disability discrimination have not been enacted. In May 2024, the Parliamentary Joint Committee on Human Rights recommended legislation to establish a Commonwealth Human Rights Act. At the time of writing, the Australian Government had not formally responded. A Commonwealth private member's bill also shows growing support for stronger protections.^{9,10,11,12}

Progress on the Disability Royal Commission recommendations is also mixed. The Australian Government's 2025 report recorded only eight of 172 Commonwealth or shared recommendations as complete. Work remains unfinished on helping people make their own decisions, changing Australia's declaration on Article 12 of the Convention on the Rights of Persons with Disabilities (UNCPRD), and ending restrictive practices. Article 12 says people with disability have the same right as everyone else to make decisions about their own lives, with support if needed, yet laws across states and territories still authorise the use of non-consensual

restrictive practices and substitute decision making through guardianship arrangements.^{13,14,15,16,18}

Australia is not yet moving clearly towards a mental health system grounded in human rights. Community connection, service access, autonomy, political participation and accountability are closely linked. The real test of reform is whether consumers experience greater dignity, choice, safety and inclusion, not how many consultations, strategies or implementation categories exist.

Key Findings at a Glance

Table 1: Key Findings of 2025 Survey at a Glance

Finding	2025 result	What it means
Overall respect for rights	54% said no	More than half did not feel their rights were respected, up from 50% in 2024.
Services for community inclusion	48% lacked access	Access fell from 52% in 2024 to 48% in 2025. Needed services include transport, housing, employment and healthcare.
Belonging outside mental health services	47% felt included	Belonging rose from 36% in 2024, but 53% still felt excluded. Improved connection did not mean better service access.
Public discrimination	91% heard it	Nine in ten heard discriminatory public speech, unchanged from 2024.
News media	88% said treatment was unfair	Unfair media treatment rose from 86% in 2024 to 88% in 2025.
Inpatient rights information	32% did not know a statement of rights existed	Of 85 acute inpatients, 32% received rights information without asking and 5% asked but did not receive it.

Finding	2025 result	What it means
Advocacy in acute mental health units	48% did not know advocacy was available	Of 85 acute inpatients, 48% were unaware of advocacy and 19% asked but did not receive it. Only 14% were offered advocacy and accepted.
Complaints	82% said their complaint was not handled satisfactorily	32% made a complaint. Of 116 follow-up respondents, 82% were dissatisfied with handling and 87% with resolution.
Voting: Tasmania and Western Australia	15 of 103 (15%) were unable to vote	15 of 103 valid respondents could not vote because of lived experience.
Voting: federal election	28 of 364 (8%) were unable to vote	28 of 364 valid respondents could not vote. Eight lacked inpatient voting support and 20 lacked community support.

Source: Alliance 2025 National Human Rights Survey. Denominators vary by question. See Introduction and Method for the respondent profile and Appendix II for limitations.

Recommendations

The recommendations below respond to the specific findings of the 2025 survey and build on the direction established in the 2024 Report. They should be read alongside the full set of 2024 recommendations, including those concerning the monitoring partnership, intersectional reform, Mental Health Commissions, adequate income and restrictive practices data, whose implementation is tracked in Appendix I. All recommendations should be implemented by governments in genuine partnership with the Alliance and state and territory mental health consumer peak bodies.

Each recommendation identifies the governments or public bodies responsible where this is clear from the evidence. In their formal responses to this report, governments should name a lead agency, publish an implementation timeframe and milestones for every recommendation, and report publicly on progress each year.

1. Enact a Commonwealth Human Rights Act.

The Australian Government should work with consumers and other affected communities to pass a comprehensive Commonwealth Human Rights Act. Public authorities should be required to respect human rights when they make decisions and provide services. People should have a simple and accessible way to challenge decisions and seek a remedy when their rights are breached.^{9,10,11}

2. Complete and legislate the Disability Discrimination Act (DDA) reforms.

The Attorney-General should publish the outcomes of the 2025 consultation and introduce co-designed amendments to the DDA without unnecessary delay. The reforms should include a positive duty to prevent discrimination. This means employers, services and public bodies must take reasonable steps to prevent disability discrimination before it happens, rather than waiting for a person to make a complaint. The law should also make reasonable adjustments clearer, give regulators stronger powers and make it easier for people to seek justice.^{12,18}

3. Implement a national plan to end coercive practices, in line with the recommendations of the Disability Royal Commission.

Coercive practices include physical, chemical, mechanical and environmental restraint and seclusion. The Alliance refers to these actions as coercive practices because consumers experience them as involuntary treatment. Australian governments should set binding targets, public reporting requirements and deadlines to end these practices in every setting. National, state and territory mental health consumer peak bodies must share decision-making power in governance, monitoring and evaluation.^{4,5,8,16,18}

4. Protect community inclusion.

Governments should guarantee access to the psychosocial support, transport, housing, healthcare, employment support and information needed to take part in community life. These supports should be funded, locally available, accessible in practice and designed with mental health consumers. Governments should report whether people can obtain the support they need. ^{2,3,5,19,20,26}

5. Create enforceable standards for media representation and stronger protection from vilification.

The Australian Government should work with the Alliance, the Australian Human Rights Commission, the National Mental Health Commission and media bodies to create national standards for responsible reporting on psychosocial disability. It should also introduce a civil prohibition on disability-based offensive behaviour, modelled on sections 18B to 18D of the Racial Discrimination Act 1975 (Cth), for non-private conduct reasonably likely, in all the circumstances, to offend, insult, humiliate or intimidate a person or group because of disability, with appropriate good-faith exemptions. More serious conduct, including conduct that threatens or incites hatred or violence, should be addressed through a distinct vilification provision. ^{4,5,22,27}

6. Guarantee voting access for all eligible voters, including in hospitals, closed settings and the community.

State and Federal electoral commissions and health departments should establish consistent and identifiable procedures nationally for enrolment, accessible information, mobile polling, postal voting, support with decisions, transport and practical assistance. Acute mental health units should be legally required to provide reasonable assistance so eligible consumers can enrol and vote. National Preventive Mechanisms (NPMs) should review whether acute mental health units and other closed mental health settings enable people to enrol and vote, and should publish findings and recommendations. ^{5,6,8,24}

7. Make rights information automatic, accessible and repeated.

Every consumer receiving care and support in an acute mental health unit or service should receive an accessible statement of rights without having to ask. Staff should provide the information in the person's preferred communication format and repeat it at useful points during the admission. ^{1,2,5}

8. Proactively offer independent, non-legal advocacy before people have to ask.

Every consumer admitted to a mental health unit or service should be proactively offered access to an independent, non-legal advocate. The advocate should be independent of the treating service and able to explain rights and options, support the person to communicate their preferences, raise complaints, participate in reviews and plan for discharge. Lived experience (peer) workers should also be available, but are not a substitute for independent advocacy. Advocacy and lived experience (peer) workers must be properly funded, culturally safe and accessible to people with all disabilities and communication needs. ^{2,5,17}

9. Ensure complaints processes exist and make them safe, consistent and accountable.

Every jurisdiction should have an independent mental health complaints process that is easy to find and use. Australian governments should agree on consistent national minimum standards and common data definitions so results can be compared across jurisdictions. Processes should be trauma informed, supported by independent advocacy and include protections against victimisation. Complaints bodies and services should publish accessible, comparable data about common issues, response times, outcomes and changes made. Consumers should receive clear reasons for decisions and information about review options.²⁵

10. Australia should withdraw its interpretative declarations to UNCRPD Articles 12 and 17.

Australia's declaration on **Article 12 (equal recognition before the law)** allows substitute decision-making in some circumstances. Its declaration on **Article 17 (protecting the integrity of the person)** states that compulsory treatment of people with disability may be permitted as a last resort and subject to safeguards. These declarations should be withdrawn and Australian laws reformed so that disability is not used as a basis for denying a person decision-making autonomy or imposing compulsory treatment.^{5,15,18,25}

11. Fully implement the Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT) in mental health settings.

OPCAT requires independent preventive inspections of places where people may be detained, including psychiatric hospitals. Every Australian government should designate and fully fund its NPM with ongoing resources, clear legal powers, independence and unrestricted access to all relevant settings. Monitoring should include consumer expertise, examine access to rights including voting, and lead to timely public recommendations and government responses. The Australian NPM has warned that inadequate resourcing limits effective preventive monitoring.^{8,18,24}

12. Make healthcare affordable, consistent and peer led.

Governments should continue to expand access to bulk billed General Practitioners (GPs), and expand access to bulk billed psychologists, psychiatrists and mental health social workers. Better Access should be reformed so people with ongoing and complex needs can receive consistent care. Governments should also invest in lived experience (peer) workers and care that is trauma informed and culturally safe, so people have real alternatives to clinical crisis services.^{2,19,23}

13. Fund a nationally consistent psychosocial support scheme and ensure mental health consumer peak bodies have real decision-making power.

Our National Psychosocial Supports Scheme position paper outlines what consumers want and need. As outlined in this paper, national, state and territory mental health consumer peak bodies should be equal and properly funded partners in planning, funding, monitoring and governing services.^{19,20,21,26}

Introduction and Method

The second annual report

During November and December of 2024, the Alliance ran its first National Human Rights Survey to establish a baseline understanding of the experiences faced by consumers of mental health services. The 2024 report documented discrimination, coercive practices and economic insecurity, and made 15 recommendations to governments. This second annual report, based on the 2025 National Human Rights Survey conducted between 1 November and 31 December, shifts the focus from describing the problem to asking what has changed and who is accountable.⁴

The 2024 Report explains Australia's main human rights agreements and obligations in detail. This 2025 Report uses the same framework. The key agreement is the United Nations Convention on the Rights of Persons with Disabilities, known as the UNCRPD. It sets out the rights of people with disability and what governments must do to protect them. Other international human rights instruments include the International Covenant on Civil and Political Rights (ICCPR), which protects rights such as voting; the International Covenant on Economic, Social and Cultural Rights (ICESCR), which protects rights such as health and housing; Optional Protocol to the Convention Against Torture (OPCAT), which requires independent oversight of places where people may be detained; and United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP), which recognises the rights of Indigenous peoples.^{4,5,6,7,8}

Survey purpose and reach

The 2025 survey asked mental health consumers and people with lived experience of psychosocial disability about whether their rights were respected across health services, emergency services, inpatient units, employment, education, housing, community participation, media, voting,

advocacy and complaints. It also asked respondents to rank reforms that would improve life for people with lived experience.¹

A total of 438 people were included in the data set. The number of people answering individual questions varied because some questions were conditional, some included not applicable options, and some respondents did not complete all questions. The respondent profile is reported below.^{2,3}

Respondent profile

The survey included 438 quantitative records. Demographic questions were completed by 344 respondents. Because demographic questions occurred near the end of the survey, the profile below describes those who completed that section rather than the full sample.³

Table 2: Respondent Profile

Characteristic	Largest groups	Valid demographic base
State or territory	NSW 29.4%; WA 19.8%; Victoria 18.6%; Queensland 12.8%	n=344
Geography	Metropolitan 60.8%; regional city 23.3%; rural 14.8%; remote 1.2%	n=344
Gender	Female 67.7%; male 22.1%; non-binary/gender diverse 7.0%; other 3.2%	n=344
Transgender	5.2% answered yes	n=344
Age	Largest group 50–59 years (28.8%), followed by 30–39 (21.8%) and 40–49 (20.9%)	n=344

This report does not include demographic figures for First Nations status or culturally and racially marginalised (CARM) background due to low response rates. The available profile therefore does not allow the Alliance to determine whether these communities are adequately represented.

A plain language guide to the International Human Rights treaties referenced in this report

Several articles of the UNCRPD are referenced in this report:

- Article 5 means equal treatment and protection from discrimination.
- Article 12 means the right to make your own decisions, with support if needed. Article 13 means access to justice.
- Article 16 means protection from violence and abuse.
- Article 19 means choosing where and with whom you live and getting support to be part of the community.
- Article 29 means the right to vote and take part in public life.

OPCAT is a separate United Nations agreement requiring independent inspections of places where people may be detained, including some mental health units.

A negative survey response does not by itself prove that a law was broken in an individual case. Repeated patterns can, however, show where systems are failing to protect people's rights.

What Changed After the 2024 Report?

“We can’t fix any of this until we fix all of it. We need to stop tinkering around the edges and we need to make human rights a reality now.”

The 2024 Report made 15 recommendations covering discrimination, coercive practices and economic security. Since then, there have been reviews, parliamentary bills, funding announcements and implementation processes. For this report, consultation, a working group or an 'in progress' label is recorded as activity, not implementation.⁴

National Human Rights Act: growing support, but still no law

In May 2024, the Australian Parliamentary Joint Committee on Human Rights recommended that the Australian Government introduce legislation to establish a federal Human Rights Act. At the time of writing, the Australian Government had not formally responded to the Committee’s report.^{9,10}

Andrew Wilkie MP introduced a private member’s Human Rights Bill 2026 in the House of Representatives on 25 May 2026. At the time of writing, the Bill had not been enacted. This is political and parliamentary activity, rather than completed reform.¹¹

Disability Discrimination Act 1992: consultation is complete, but the law has not changed

As recommended by the Disability Royal Commission, a recent review of the DDA considered the implementation of a positive duty, which would require organisations to take steps to prevent discrimination before it happens. It also considered clearer tests for discrimination, stronger duties to make reasonable adjustments and easier access to justice.^{12,18}

Public consultation took place in late 2025 and the Attorney-General's Department is considering the feedback. No amendments, including a positive duty to prevent disability discrimination, have been enacted at the time of writing.¹²

Disability Royal Commission: most relevant reforms remain unfinished

The Australian Government's 2025 progress report reported against the recommendations for which the Commonwealth is solely or jointly responsible. It listed 71 as in progress, 51 as requiring further work, 36 as subject to further consideration, eight as complete and six as noted. These labels describe the government's process. They do not show whether people with disability have experienced a measurable improvement.¹³

Several recommendations central to this Report remain incomplete. Governments have started work on national principles for supported decision making, but they do not yet agree on one approach. Australia is also still considering whether to withdraw its declaration on Article 12 of the UNCRPD. Article 12 says people with disability have the same right as everyone else to make their own decisions, with support where needed. Targets for reducing coercive practices are listed as in progress, but consumers are still waiting for a national plan and changes to laws.^{14,15,16}

There was one funding announcement for disability advocacy: the Commonwealth committed \$39.7 million over four years to a new individual advocacy program. However, this funding **does not** ensure that every mental health consumer in a mental health acute unit is offered independent, non-legal advocacy when they need it.¹⁷

National Mental Health Agreement: an opportunity to rebuild accountability

The Productivity Commission's final review of the National Mental Health and Suicide Prevention Agreement found that the Agreement was not fit for purpose. Services remain fragmented, unaffordable and difficult to navigate, and a new policy structure was needed. The review recommended working with people with lived experience, stronger accountability and completion of outstanding commitments, including psychosocial supports.¹⁹

The Australian government, including the Assistant Minister for Mental Health, has recognised unmet need for psychosocial support as a central national priority. Future National Mental Health and Suicide Prevention Agreements should maintain continuity of support while strengthening accountability. The next Agreement must embed lived experience of mental health challenges in all aspects of the Agreement and turn policy work and consultation into funded and measurable access.^{20,21,26}

See Appendix I for the combined progress table covering the 2024 recommendations.

Overall assessment

Most recommendations from the Alliance's 2024 National Human Rights Report have led to reviews, meetings or policy work, but few changes are complete. Reviews and consultations matter only when they lead to laws people can enforce, properly funded support, and clear improvement in consumers' lives.

Belonging Requires More Than Mental Health Services

"It's overwhelming and complicated to navigate the system of accessing appropriate community-based supports – it took me being admitted into hospital to receive any of the right support/care."

Article 19 of the UNCRPD says people with disability have the same right as everyone else to choose where and with whom they live and to be part of community life. It also says governments must make sure people can get support at home and in the community, so they are not isolated or forced into segregated settings. Community inclusion is therefore about more than using a mental health service. It depends on transport, housing, work, healthcare, information, relationships and access to public life.⁵

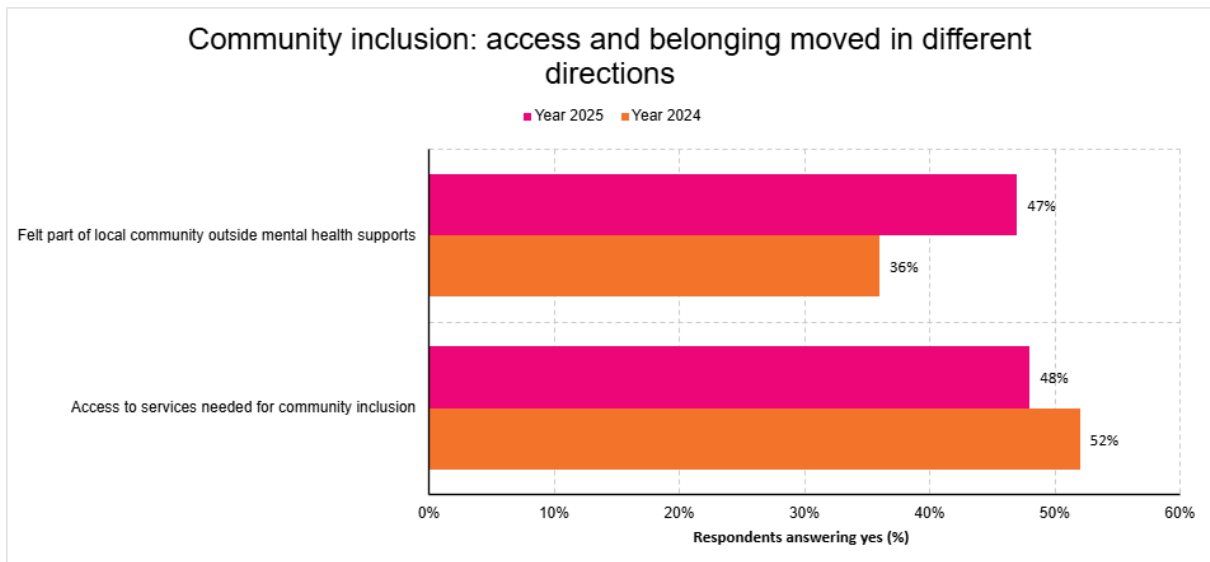


Figure 2. Community inclusion: access and belonging moved in different directions

Source: Alliance 2024 and 2025 National Human Rights Survey data.

In 2025, 48% of respondents said they had access to the services needed to feel included in their community, a decline from 52% in 2024. At the same time, 47% felt part of their local community outside mental health supports, up from 36% in 2024. While the improvement in belonging matters, 53% still did not feel part of their local community.^{2,3,4}

These results need to be understood together. Consumers may be finding connection through relationships, local groups, peer networks and informal support even while access to essential services remains poor. Improved belonging should not be used as evidence that formal supports or the service system is working. The right to inclusion requires both connection and practical access.

Other results tell a similar story. 58% had access to the information needed to live in the community. The proportion who felt able to talk about their lived experience fell from 63% in 2024 to 59% in 2025. Only 34% felt that other people understood what lived experience meant to them. Being present in the community is not enough when people still expect misunderstanding or discrimination.^{2,3}

Discrimination narrows community life

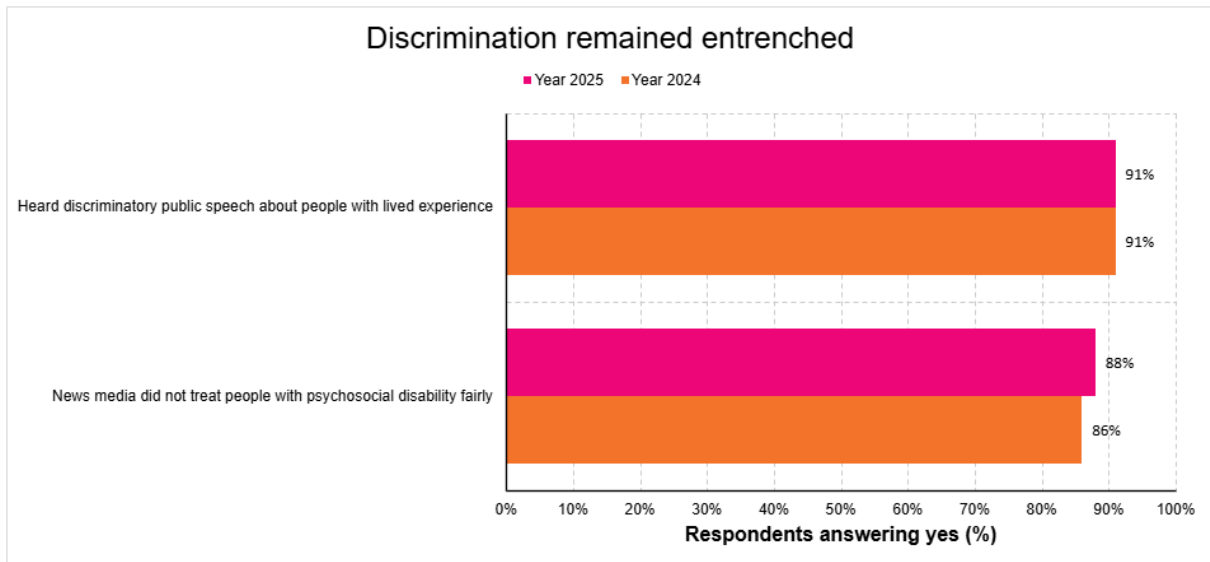


Figure 3. Discrimination remained entrenched

Source: Alliance 2024 and 2025 National Human Rights Survey data.

In 2025, nearly nine in ten respondents (88%) said the news media did not treat people with psychosocial disability fairly, compared with 86% in 2024. Nine in ten (91%) heard people with lived experience of mental health challenges spoken about discriminatorily in public, unchanged from 2024. Stigma shapes whether people feel safe to disclose, seek support, work, study, form relationships and participate in local life.^{2,3,4}

"I definitely felt like we as a society have taken a step backwards in how we talk about those with mental health issues. The reporting on the stabbing in NSW was incredibly discriminatory and that has opened up the door for people to openly say that those with mental health issues should be locked away and use other terms."

The National Mental Health Commission's 2026 Stigma and Discrimination Report Card supports these findings. Using nationally representative data, it found that around 70% of people with mental health challenges had experienced discrimination in at least one area of life. The consistency across both data sets points to the need for action by governments, media organisations, workplaces, health services and communities.²²

Article 5 of the UNCRPD says people with disability must be treated equally and protected from discrimination. Article 8 says governments must challenge stereotypes and prejudice and promote respect for people with disability.⁵ The survey results show these duties are not being met in everyday life.^{2,3}

Human rights finding

The increase in local belonging is welcome. However, it sits alongside declining access to services and persistent discrimination. Inclusion is not secure when consumers must fill the gaps left by underfunded systems, inaccessible services and public stigma.

Survey responses show how individual support can help prevent hospitalisation and why choice and control matter in people's daily lives.

"I had regular and relevant therapeutic support with an Occupational therapist, Dietitian, Nurse Practitioner and Psychologist through my NDIS plan. All were helpful supports that kept me out of public hospital where previously I have experienced repeated and frequent breaches of my human rights in the public hospital setting."

Voting Is a Right, Including When We Are Unwell

Article 29 of the UNCRPD says people with disability have the right to vote and take part in public life on an equal basis with others. Article 25 of the ICCPR protects the same right for everyone. Voting procedures, places, information and support must be accessible. Being in hospital, experiencing distress or needing practical help does not remove the right to vote.^{5,6}

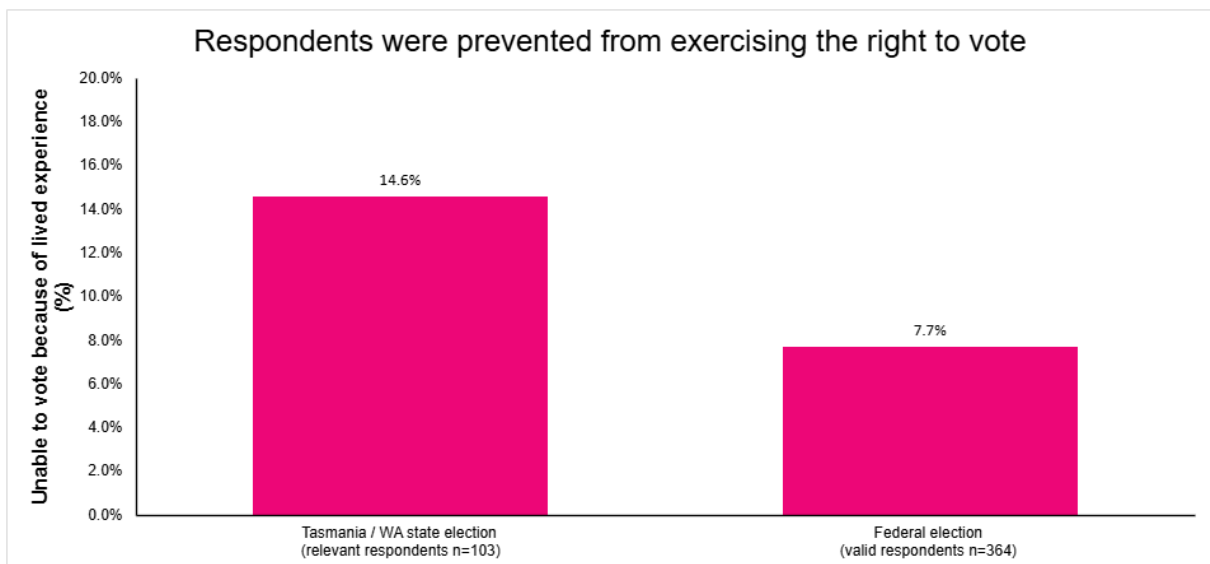


Figure 4. Respondents were prevented from exercising the right to vote

Source: Alliance 2025 National Human Rights Survey and ACACIA voting denominator advice.

Tasmania and Western Australia state elections

About one in seven respondents who said they are based in Tasmania and Western Australia (15 of 103, or 14.6%) said they were unable to vote in their 2025 state election in Tasmania or Western Australia because of their lived experience of mental health challenges.³

Federal election

About 8% of respondents (28 of 364 valid responses) said they were unable to vote in the 2025 federal election because of their lived experience of mental health challenges.³

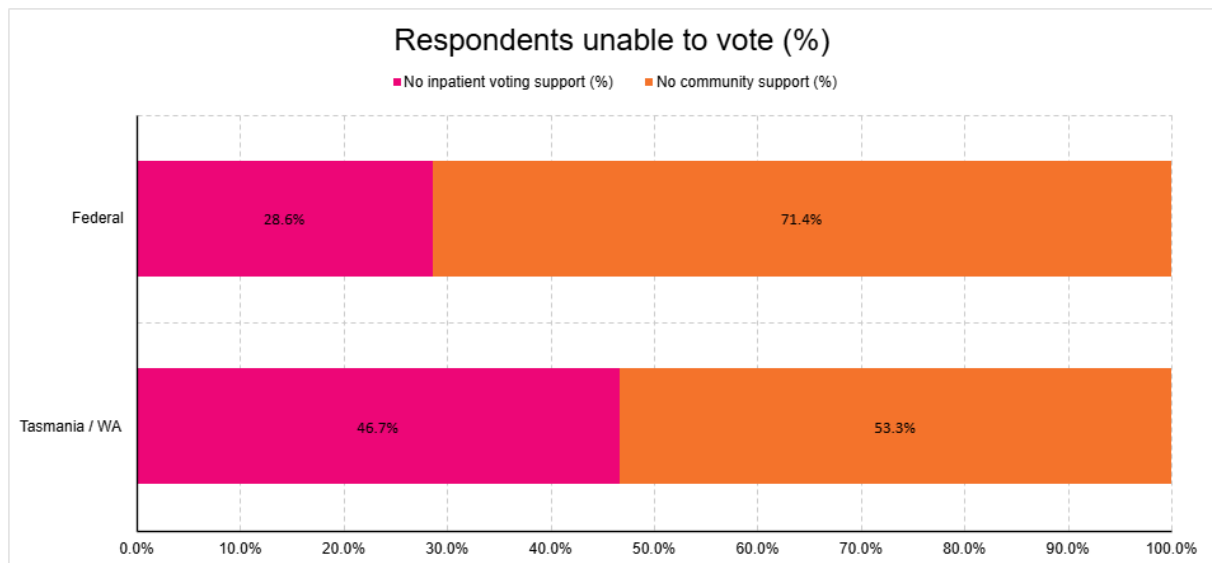


Figure 5. Respondents unable to vote

Source: Alliance 2025 National Human Rights Survey. State n=15; federal n=28.

The reasons point to failures in hospitals and community support rather than a lack of interest in voting. In Tasmania and Western Australia, 7 of the 15 respondents (46.7%) said an inpatient unit did not provide voting support, while 8 (53.3%) could not obtain community support to reach a polling station. Federally, 8 of 28 respondents (28.6%) reported inpatient support failure and 20 (71.4%) could not obtain the community support needed to reach a polling station.³

"Complete overwhelm with everything and being too unwell. Needing a witness to sight postal vote – I didn't see anyone or leave the house that month."

These barriers were foreseeable. Elections are scheduled well in advance, giving hospitals, electoral authorities and community support systems time to arrange accessible information, enrolment, postal voting, mobile polling, transport, communication assistance and decision support. Equal access is not achieved when an unwell person is left to identify and coordinate all of this alone.

Human rights finding

These results show that hospitals and community support systems failed to provide the help some people needed to exercise the right to vote.^{3,5,6}

What must change

- Each inpatient mental health service should have a written election access protocol activated for every federal, state, territory and local council election.
- Rights information should include accessible voting options and deadlines.
- Electoral commissions should work with their relevant national, state and territory mental health consumer peaks to audit the accessibility of mobile polling, postal voting and hospital voting arrangements.
- Community psychosocial and disability supports should explicitly include assistance to enrol, understand options, travel to a polling place and communicate voting preferences.
- Governments should publish data on voting access for people in mental health services and closed settings and respond to identified failures.
- NPMs should review whether mental health inpatient units and other places where people may be detained enable people to enrol and vote, including access to information, mobile or postal voting and practical support, and should publish their findings.^{5,6,8,24}

Rights That Are Not Known Cannot Be Exercised

“Still waiting for a response from the hospital”

Rights statements, independent advocacy and complaints are often managed as separate processes. For consumers, they are parts of the same pathway. People need to know what their rights are, understand how those rights apply, get independent support to use them and be able to raise concerns without fear of retaliation. When one part fails, it becomes harder to use the others.

Statements of rights were not routinely provided

85 respondents had been inpatients in an acute mental health unit during 2025. Only 32% received a statement of rights without asking. 32% were not given one unless they asked, 5% asked and did not receive it, and 32% did not know a statement existed.

The 2025 survey question used separate response options for receiving a statement without asking, receiving one only after asking, asking but not receiving one, and not knowing that a statement existed. Because the response structure differed from 2024, the overall results should not be directly compared.^{2,3}

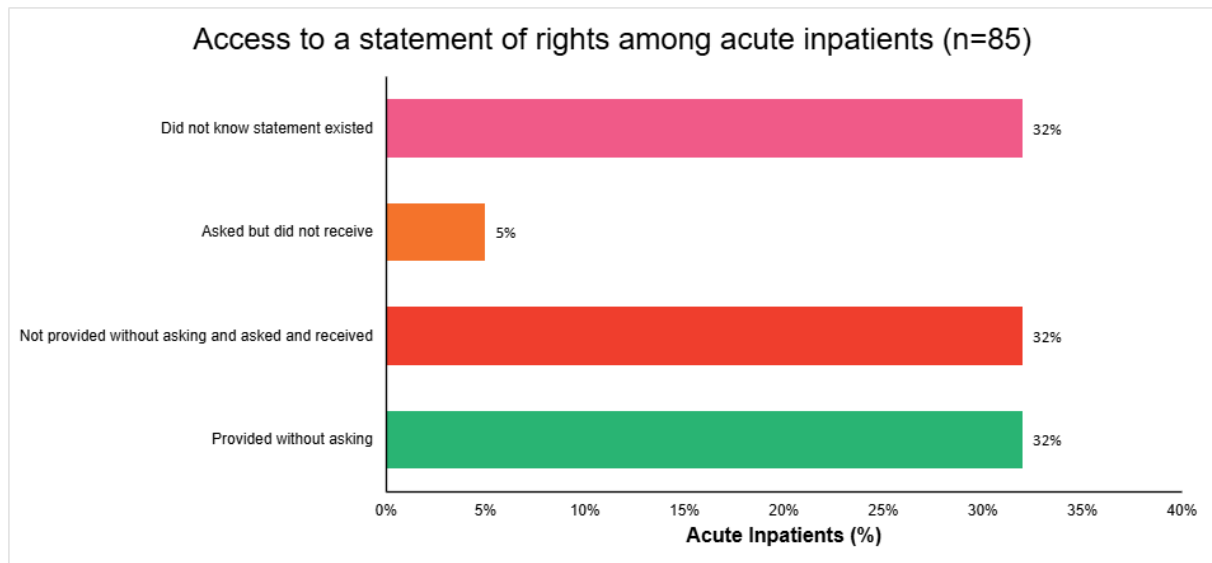


Figure 6. Access to a statement of rights among acute inpatients (n=85)

Source: Alliance 2025 National Human Rights Survey.

It is especially concerning that one in three respondents did not know a statement of rights existed. A person should not have to know the name of a document before a service provides it. During an admission, distress, medication, fear, communication disability, language, trauma and unfamiliarity with the system can all make it harder to seek information. Services should provide and explain rights proactively.

Independent advocacy was frequently invisible or unavailable

Among the same 85 inpatients, 14% were offered non-legal advocacy and accepted it, 6% were offered it and declined, and 13% asked for it and received it. However, 19% asked and were not provided advocacy, while 48% did not know that the service was available.^{2,3}

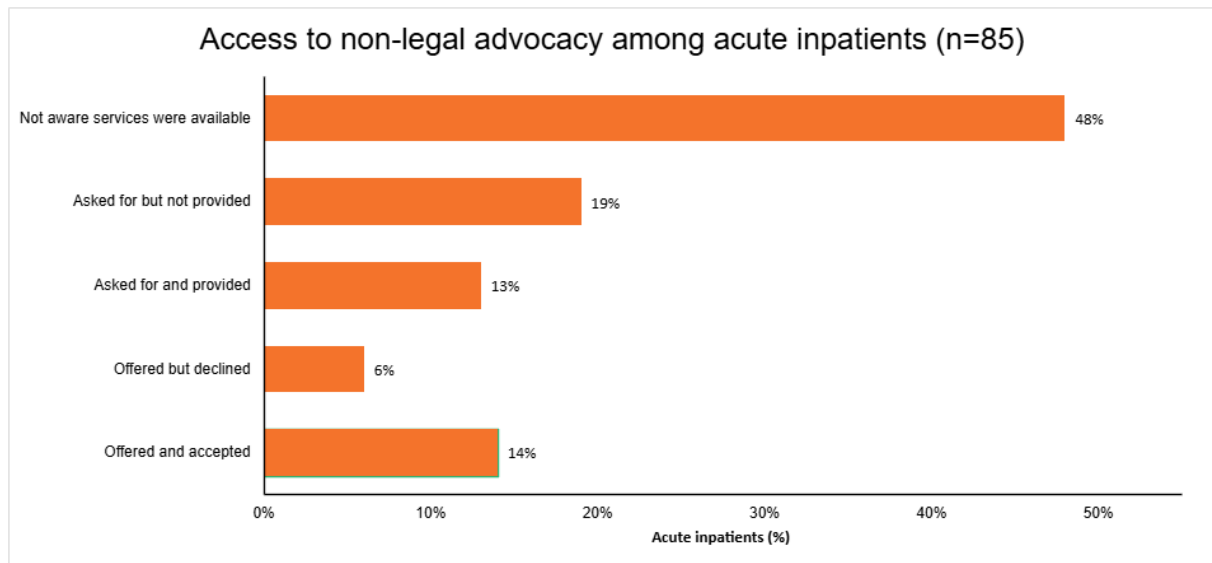


Figure 7. Access to non-legal advocacy among acute inpatients (n=85)

Source: Alliance 2025 National Human Rights Survey.

An independent advocate can help a person understand information, say what they want, take part in reviews, raise concerns and plan for discharge. This is especially important when a service can detain or medicate a person without consent, or use physical, chemical or mechanical restraint. The Disability Royal Commission advocacy funding announcement is welcome, but it must lead to reliable access in mental health inpatient settings, offered before people have to ask. ^{5,8,17}

Complaints rarely produced satisfactory outcomes

32% of respondents made a complaint about their mental health treatment in 2025, unchanged from 2024. Among the 116 people who answered the follow-up questions, 82% said their complaint was not handled satisfactorily and 87% said it was not resolved satisfactorily. Only 18% were satisfied with the handling and 13% with the resolution.^{2,3}

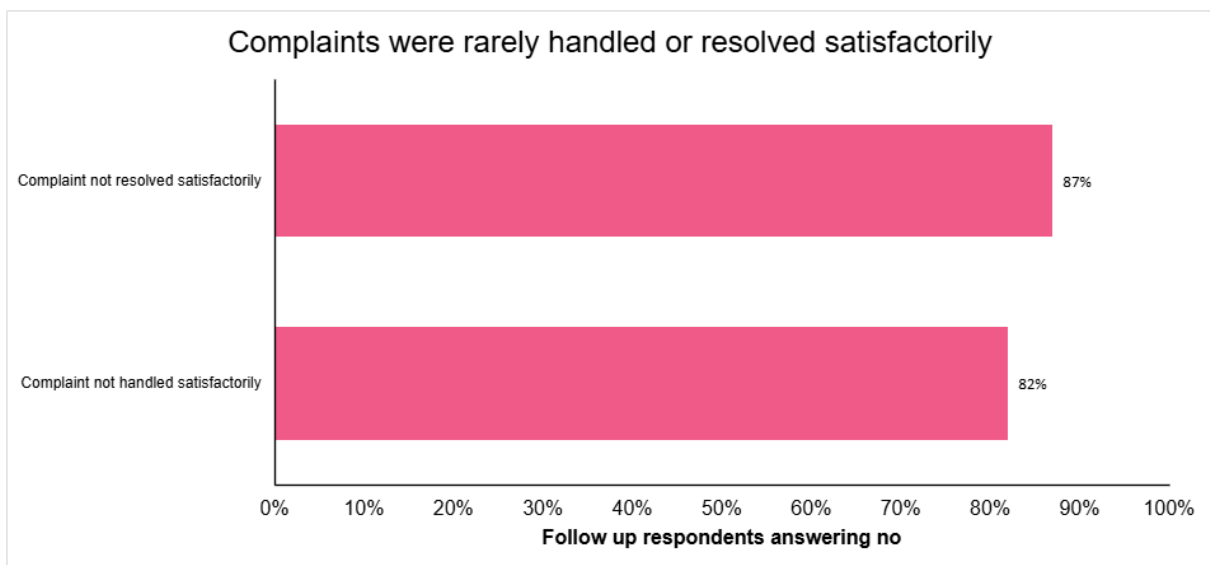


Figure 8. Complaints were rarely handled or resolved satisfactorily

Source: Alliance 2025 National Human Rights Survey. Follow-up questions n=116.

The 68% who did not complain should not be assumed to have been satisfied. Separate Alliance research on services funded under the National Mental Health and Suicide Prevention Agreement found that:

- 63% did not know how to complain about an acute health service,
- 69% did not know how to complain about a service provided through a Primary Health Network
- 64% did not know how to complain about a mental health service commissioned by a Primary Health Network,
- 72% did not know how to find consumer outcome data, and
- 73% did not know which service data collections to use.²⁸

These results help explain why a low complaint rate cannot be read as satisfaction. People may stay silent because the complaints process is unclear or inaccessible, advocacy is unavailable or they fear consequences. When a complaint is made, poor handling and resolution further erode trust. A credible accountability system must address each of these barriers.

“The hospital completely ignored my complaints or I was told it would be escalated and no one would ever come talk to me. I ended up taking it to the mental health commission”

Articles 12 and 13 of the UNCRPD say people with disability have the same right as everyone else to make decisions, be recognised by the law and seek justice. Article 16 requires protection from violence and abuse, independent monitoring and support to recover when harm occurs. OPCAT requires independent preventive inspections of places where people may be detained, including some mental health units. NPMs are the bodies that carry out this work. Their 2024-25 annual report says national coverage remains incomplete and inadequate resourcing limits effective monitoring. Rights information, advocacy, complaints and external monitoring should work together.^{5,8,24}

Consumers Have Already Told Governments What to Prioritise

"There's no use having rights if you can't afford adequate medical care or a home."

Respondents ranked their top three ideas from the 2024 survey for improving life for people with lived experience. The weighted result combines first, second and third choices. It is different from the percentage of respondents who placed an issue first.^{1,2,3} The top four responses are in pink and discussed below.

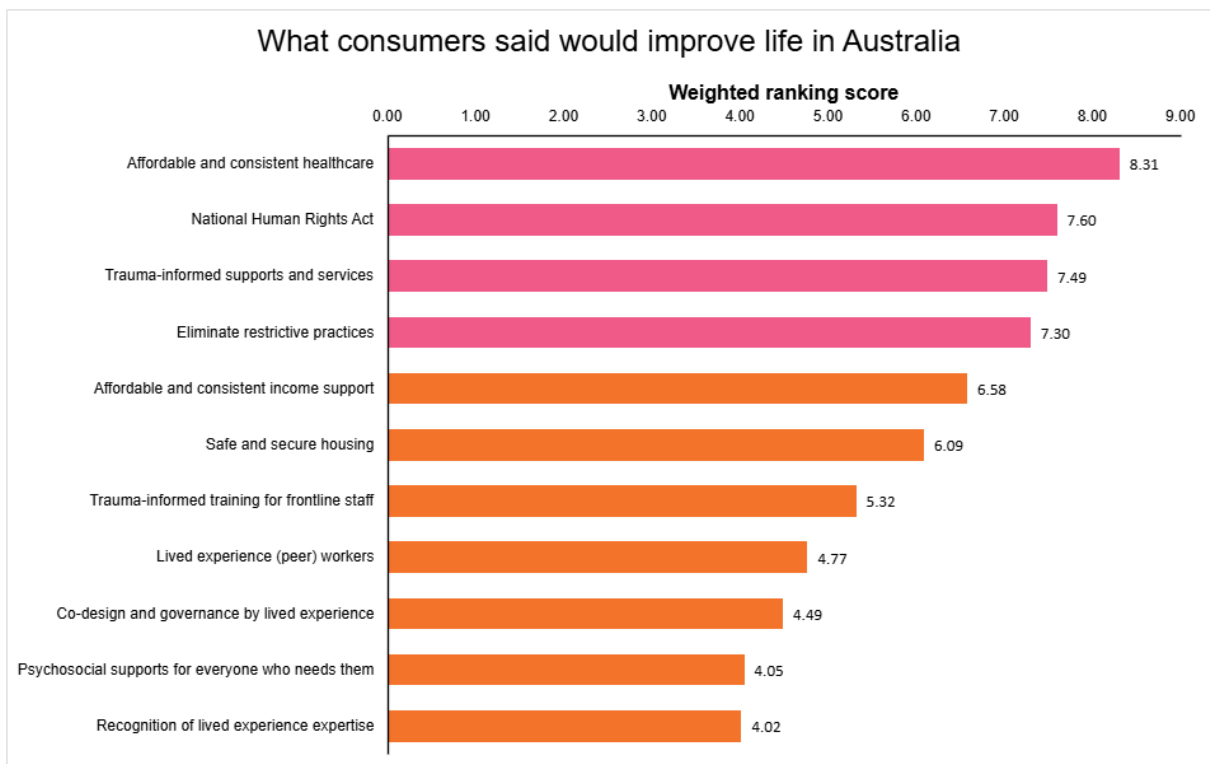


Figure 9. What consumers said would improve life in Australia

Source: Alliance 2025 National Human Rights Survey weighted ranking.

1. Affordable and consistent healthcare

Free, affordable and consistently available healthcare ranked first with a weighted score of 8.31 and was the first choice of 23% of respondents. The result reflects the barriers shown elsewhere in the survey. 42% said none of the listed bulk billing options were easily available. Only 53% reported easy access to a bulk billed GP, 15% to a private psychologist and 7% to a private psychiatrist. Only 34% said their physical and mental health needs were attended to.^{2,3}

Better Access provides Medicare benefits for up to 10 individual and 10 group therapy services each calendar year for eligible people. It does not guarantee bulk billing, affordable specialist care or continuity for people with complex and ongoing needs. The survey shows that being eligible for a rebate is not the same as being able to access care.²³

"I have been unable to access positively life-altering medication only accessible through a psychiatrist that has previously helped me significantly this year due to psychiatrist unaffordability and ridiculous wait times"

2. A national Human Rights Act

A national Human Rights Act ranked second with a weighted score of 7.60 and was the first choice of 20% of respondents.^{2,3} This reflects the gaps in Australia's current protections. Australia has signed international human rights agreements, but most of those rights cannot be directly enforced under Australian law. Disability discrimination law still puts the burden on the person harmed to make a complaint and prove discrimination after the event. The implementation of a national Human Rights Act as well as the proposed positive duty on the DDA would require public authorities to consider rights before making decisions and would give people a clearer way to challenge decisions that breach their rights.^{5,6,7,9,10}

The survey gives this reform a clear consumer endorsement. Consumers reported failures in hospitals, community support, voting and complaints. These are areas where preventive duties and enforceable accountability matter.

3. Trauma informed supports and services

Trauma informed supports ranked third with a weighted score of 7.49. A service informed by trauma recognises how common trauma is, avoids recreating powerlessness and gives priority to safety, trust, choice, collaboration and cultural responsiveness. A single staff training session cannot achieve this while coercive laws, inaccessible environments and punitive complaints cultures remain in place.

“Trauma Informed practice needs to be implemented MUCH MORE EFFECTIVELY. Everything needs more time so people are not rushed through without time to apply care and TI principles and time to learn, understand and integrate training in experiences people themselves have not lived through. There needs to be more Part Time peer roles available so that people can find work that aligns with the self care models that are being taught to peers.”

The importance of trauma informed practice is visible throughout the data. 38% agreed to care because they feared involuntary treatment, 38% avoided seeking support because they feared coercion, 13% experienced physical restraint and 16% experienced chemical restraint. Care informed by trauma and the elimination of coercion must be pursued together.^{2,3}

4. Elimination of coercive practices

Eliminating coercive practices ranked fourth by weighted score at 7.30, but 16% of respondents placed it first. That was higher than the 11% who placed trauma informed support first. This shows the intensity of concern about seclusion, restraint, chemical restraint and involuntary treatment.^{2,3}

Other priorities included adequate income, safe housing, frontline services informed by trauma, lived experience (peer) workers, shared design and governance, universal psychosocial support and recognition of lived expertise.^{2,3} These are not secondary concerns. Together, they describe the conditions needed to prevent crisis and realise the rights to health, work, an adequate standard of living and community inclusion.^{5,7}

Coercion, Choice and Access to Care

The 2025 survey highlighted new community priorities, but the concerns identified in the 2024 report have not disappeared. Coercion, restraint, limited choice and unaffordable care still shape whether consumers seek support and whether treatment feels safe.

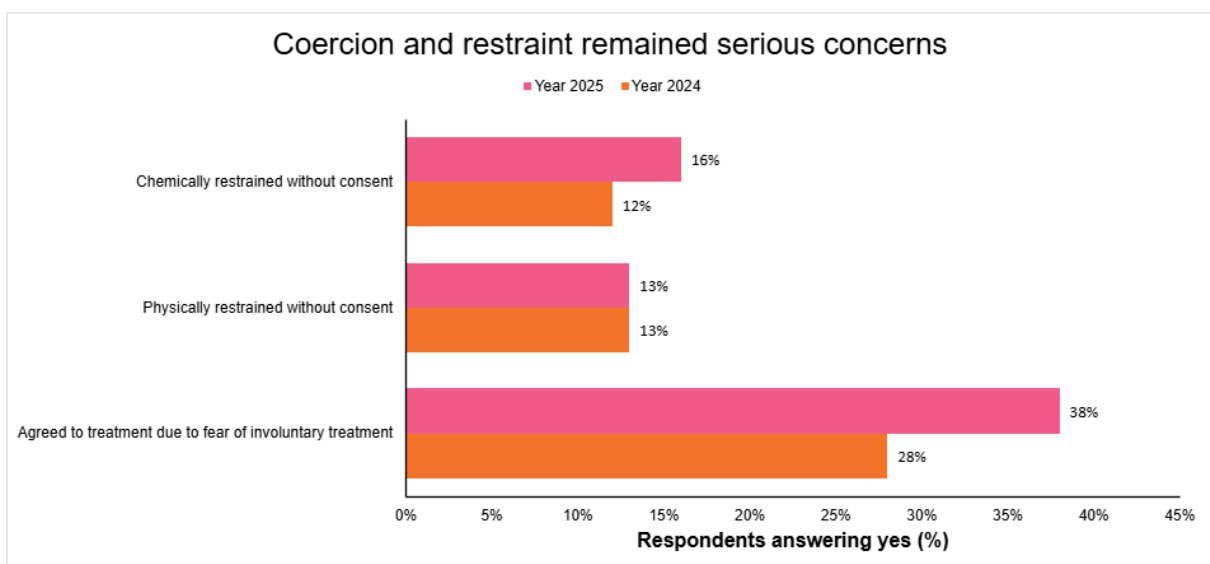


Figure 10. Coercion and restraint remained serious concerns

Source: Alliance 2024 and 2025 National Human Rights Survey data.

Fear changed consent and service use

38% of respondents agreed to care, treatment or another action because they feared that refusing would lead to involuntary treatment, up from 28% in 2024. The same proportion said fear of coercion caused them not to seek mental health support. Although the 2024 comparison for the avoidance question is unreliable because only a few people answered it, the 2025 result is serious in its own right.^{2,3,4}

Consent is not freely given when a person reasonably fears detention, forced medication or another involuntary response if they say no. Fear can also cause people to delay seeking help until their distress becomes more severe. A service cannot describe treatment as a real choice while the threat of coercion remains in the background.

“Doctors kept pushing coercion to take medication even though I was having adverse side effects”

Restraint did not reduce

Physical restraint without consent was reported by 13% (n=438), unchanged from 2024 and chemical restraint was reported by 16% (n=438), compared with 12% in 2024. Both forms of restraint occurred in inpatient units, emergency departments, homes and other settings.^{2,3}

These practices affect several rights under the UNCRPD. People have the right to make their own decisions, to liberty and safety, to be free from torture and other cruel or degrading treatment, to be protected from violence and to have their physical and mental integrity respected. OPCAT also applies because psychiatric hospitals and some other mental health settings can be places where a person is detained. It requires independent oversight to prevent ill-treatment. Australia’s NPM network has reported that national coverage is incomplete and that inadequate resources limit effective preventive monitoring.^{5,8,24}

The Disability Royal Commission called for one national approach to reducing and ending restrictive practices. Work has started on data, targets and a joint action plan, but the Commission’s deadline for targets and performance measures has passed. Australia still has no national plan backed by law that covers mental health, disability, health, education and justice settings.^{16,18}

Choice remained limited and healthcare remained unequal

Only 42% said they had access to a good choice of mental health supports, while 58% did not. Half said health professionals did not treat them as respectfully as they treat people without mental health challenges. Among respondents for whom the question applied, 54% said emergency service personnel did not treat them as respectfully as other people. Only 34% said their physical and mental health needs were attended to equally.^{2,3}

Choice is limited when the available options are inaccessible, unaffordable or coercive. Community care is also not a genuine alternative to hospital when psychosocial support is missing. Reform must expand voluntary support, including lived experience (peer) workers and care that is culturally safe, informed by disability and trauma, and available before, during and after crisis.

“Support from peer workers with relevant experience was imperative to being able to trust accessing necessary help for my mental-health recovery.”

Australia has started work on supported decision making and advocacy, but its declaration on Article 12 of the UNCRPD remains in place. Article 12 says people with disability have the right to make their own decisions, with support if they need it. Australia’s declaration still allows decisions to be made for a person as a last resort. National reform should instead require decisions to follow the person’s will and preferences and should remove disability as a reason for compulsory treatment.^{14,15}

Human rights finding

Poor access to services and coercion are connected. When affordable, voluntary support is not available in the community, people are more likely to reach services in crisis and have less choice. Prevention requires real community alternatives and an end to coercive practices.

Conclusion

The Alliance's second National Human Rights Survey asked whether Australia is moving closer to a mental health system grounded in human rights. The 2025 results do not show the improvement consumers should expect.

There were signs of stronger local connection, with more respondents feeling part of their community outside mental health supports. That improvement sat beside reduced access to the services needed for inclusion, persistent public and media discrimination, limited choice and major affordability barriers. Belonging should not be presented as a policy success while the practical foundations of community life remain missing.

Accountability systems were also unreliable. Rights statements were not routinely provided, independent advocacy was often invisible or unavailable, and most complaints were handled and resolved poorly. Some people were unable to vote because hospitals and community services did not provide support. These failures affect people's ability to make their own decisions, take part in democracy, stay safe and be treated with dignity.

Policy activity since the 2024 report has not produced a comparable improvement in consumers' lives. The Disability Discrimination Act 1992 review has completed consultation, but the law has not changed. Support for a Commonwealth Human Rights Act has grown, but Australia still has no enforceable national law. Disability Royal Commission implementation remains slow and incomplete. ^{9,10,11,12,13,18}

Consumers have already set out the direction of reform: embedding lived experience in design, development, implementation and governance of mental health policy, affordable healthcare, enforceable human rights, culturally safe support informed by trauma and led by lived experience (peer) workers, economic security, community inclusion, support to make decisions and the elimination of coercive practices. These priorities reinforce one another.

"Human rights isn't just about access to MH services, they affect every aspect of our lives, and they should ensure that nobody is disadvantaged or impoverished or discriminated against or treated in any undignified manner WHATSOEVER, and least of all by governments!"

Appendix I

Progress at a Glance on the 2024 Recommendations

This combined tracker distinguishes consultation and administrative activity from completed implementation and measurable outcomes. It includes the related advocacy priority.⁴

Table 3: Progress at a Glance on the 2024 Recommendations

2024 priority	Development since publication	Assessment	Action needed
1 Human Rights Act	Parliamentary recommendation remains unanswered; a Commonwealth private member's bill has been introduced.	Limited progress	Enact a comprehensive Commonwealth law with accessible remedies and consumer involvement.
2 Human rights monitoring partnership	New stigma reporting and proposals for stronger independent monitoring; no formal Alliance partnership identified.	Partial progress	Fund a formal Alliance–National Mental Health Commission partnership and annual human rights reporting.
3 DDA duty to prevent discrimination	Initial consultation completed in November 2025; the law has not changed.	Consultation completed	Publish findings and legislate a positive duty, clearer adjustments and accessible remedies.
4 Responsible media standards	National stigma reporting strengthens the evidence; no enforceable national standards identified.	Limited progress	Develop enforceable standards with mental health consumer peaks, human rights and media bodies.
5 Protection from public abuse and hatred	No nationally consistent legal protection identified.	No implementation identified	Introduce consistent protection from disability-based offensive behaviour and accessible enforcement.

2024 priority	Development since publication	Assessment	Action needed
6 Intersectional mental health reform	National reports recognise overlapping discrimination; implementation and data remain inconsistent.	Mixed	Assess effects on mental health consumers across race, disability, sexuality, poverty, location and other characteristics; involve affected communities.
7 Withdraw UNCRPD declarations	Article 12 declaration remains under consideration; neither declaration has been withdrawn.	No implementation	Withdraw the Article 12 and 17 declarations and protect decision-making autonomy and personal integrity.
8 End coercive practices	Targets and joint action planning are in progress; no binding national roadmap across settings.	Incomplete	Set legal limits, deadlines, targets and public outcome reporting across all relevant settings.
9 Supported decision making	Commonwealth work to identify laws has begun; jurisdictions do not yet agree on one approach.	Early work	Reform guardianship and mental health laws so decisions follow the person's will and preferences.
10 Independent inspections under OPCAT	National coverage remains incomplete; the NPM reports inadequate resources for preventive monitoring.	Incomplete	Fully fund independent NPMs, ensure unrestricted access and consumer expertise, and monitor voting and other rights.
11 Mental Health Commissions with human rights duties	Stronger National Mental Health Commission independence and reporting recommended; no consistent legal model.	Limited progress	Protect independence and establish clear human rights duties through national principles.
12 Coercive practices data	Royal Commission data recommendations are in progress; gaps remain across settings and jurisdictions.	Partial progress	Publish comparable data by relevant groups and report progress towards ending coercive practices.

2024 priority	Development since publication	Assessment	Action needed
13 Adequate income support	No change identified that guarantees payments meet living costs; income stress continues.	No implementation identified	Raise and index payments to living costs and allow flexible access during crisis and recovery.
14 Psychosocial support and shared decisions	Agreement review, extension and Psychosocial Project Group provide a path for reform; unmet need remains.	Policy work continuing	Fund a nationally consistent scheme and give mental health consumer peak bodies decision-making power.
15 Affordable and consistent healthcare	Better Access and some free service initiatives continue; specialist affordability remains poor.	Partial progress	Expand bulk billing and ongoing care, with lived experience (peer) workers and culturally safe, trauma-informed services.
Related priority Independent advocacy	\$39.7 million over four years announced for individual disability advocacy; this does not guarantee inpatient access.	Positive but partial	Offer independent, non-legal advocacy automatically in mental health settings.

Sources: 2024 Alliance report; official government and parliamentary sources listed in the References.

Status is the Alliance's assessment of implementation, not the government's administrative label.

Appendix II

Limitations

- The survey was distributed through consumer networks, service providers, and online channels. It is not a random or nationally representative sample.
- People with internet access, links to consumer organisations, and enough time and capacity to complete a long survey may be more likely to be represented.
- People in closed settings, people without reliable internet, children and young people, people with high communication support needs, Aboriginal and Torres Strait Islander people, and people from culturally and racially marginalised (CARM) communities may not be adequately represented.
- Question wording and response options changed for some measures between 2024 and 2025. Direct comparison is avoided where this would be misleading.
- Questions allowing more than one response can total more than 100%.
- Qualitative responses were reviewed by theme. Spelling in selected quotations has been corrected where needed, while grammar, punctuation and wording have otherwise been retained. Leading and trailing spaces have been removed. Quotations illustrate individual experiences and do not represent every respondent.

These limitations matter when interpreting the findings. The survey documents consumers' experiences, tracks repeated measures and identifies issues for further inquiry and public accountability

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Recognition of Lived Experience

As a consumer lived experience-led organisation, the National Mental Health Consumer Alliance values the skill and expertise of consumers with lived experience. We pay tribute to those we have lost for the work that they have done to advocate for our rights. We acknowledge that we stand on the shoulders of giants who have paved the way for the rights we have today, and we will continue their work today and every day until the mental health system recognises and upholds our human rights.

Nothing about us without us.

