

2025



Position Statement

Mental Health and Human Rights

September 2025



ACKNOWLEDGEMENT OF COUNTRY

BEING acknowledges the traditional custodians of various countries across New South Wales. We pay our respects to Elders past, present and emerging. We acknowledge land was never ceded, and was, is, and always will be Aboriginal land. We value your holistic management of country over the millennia and realise that Indigenous knowledge systems have much to teach us about how we can thrive as a society.



RECOGNITION OF LIVED EXPERIENCE

BEING values all people with lived experience of mental health challenges, especially those from intersectional backgrounds whose experiences remind us that we need a mental health system for all. We stand alongside you all, in your strength and courage, as driving forces in the work we do. Your voice will always matter.

BEING – Mental Health Consumers is the independent, NSW peak organisation speaking with and for people with lived/living experience of mental health issues and emotional distress. Our primary focus is to ensure the voices of people with mental health issues are heard by decision makers, service providers, and the community, to lead and influence systemic change in services and systems.

BEING – Mental Health Consumers is committed to human rights principles of diversity, inclusion and equity, and believes that recovery is possible for all people who live with mental health issues and emotional distress.

Contents

Introduction.....	4
Service survivors and service users	4
Emancipation of survivors	4
Distress or disability	4
Rejection of psychosocial disability	5
The social model of disability	5
Inclusion of survivors and users under the CRPD	5
The Convention on the Rights of Persons with Disabilities	5
Allows for both reform of services and refusal of care	6
Alliances with other disability advocates.....	6
The social model of disability – a different response	6
BEING’s position	7
Compliance with Australia's human rights commitments.....	7
Psychosocial disability as a basis for advocacy	7
The Convention on the Rights of Persons with Disabilities and key areas for mental health advocacy.....	7
Introduction	8
Article 10 – Right to life	8
Article 12 – Equality before the law.....	8
Supported and substitute decision-making.....	8
Control of financial affairs	9
Australia’s Interpretive Declarations	9
Article 4(3) - Close consultation and active involvement.....	9
Inclusion of lived experience	9
Article 14 – Liberty and security of the person	10
Existence of disability is no grounds for detention.....	10
Article 19 - Living independently and being included in the community.....	10
Education, Healthcare and Employment.....	11
Adequate standard of living and social protection	11

Convention Against Torture and Other Cruel, Inhumane, or Degrading Treatment or Punishment 11

 Involuntary detention and torture 11

 National Preventative Mechanism 11

 NSW’s failure to comply with the OPCAT 12

Mental Health and Human Rights

Introduction

This position paper has two sections. The first addresses the relationship between those who identify as survivors of the mental health system, and those who identify as consumers of the mental health system.

We recognise there is divide in the mental health advocacy community between those who identify as consumers and those who identify as survivors, and those who believe that the language of psychosocial disability is helpful and those who don't.

This position paper clarifies where BEING situates itself in these debates and how key human rights instruments, primarily the *Convention on the Rights of Persons with Disabilities* (CRPD) can be understood as including the views of both consumers and survivors. It also articulates what we believe some of the limits of the CRPD are when it comes to mental health advocacy.

Service survivors and service users

Emancipation of survivors

Distress or disability

Ann Plumb argued in her seminal discussion *Distress or Disability?* that people who have contact with the psychiatric service system are survivors of that system, and that the psychiatric service system itself is a system of oppression.¹

Survivors view themselves as survivors of our social structures and institutions, and of our cultural practices and values. Aligned with this is a critique of the medicalisation of psychological distress. According to Plumb there is not a qualitative distinction between mentally pathological states and normative psychological states as the medical model suggests, but rather a continuum of states of distress and dissent which society uses the language of mental illness to describe.²

¹Anne Plumb, 2011, '.....Distress or Disability?' in Centre for Disability Research Manchester University, 2011, 'Distress or Disability? Proceedings of a symposium held at Manchester University 15-16 November, Available at:https://eprints.lancs.ac.uk/id/eprint/69391/1/Distress_or_Disability.pdf, pp.6-10.

² (Plumb 1994, pg. 5)

Rejection of psychosocial disability

This sociological model leads Plumb to reject the idea of psychosocial disability, viewing the idea as a product of the medical model of mental health, because it distinguishes between the impaired and the non-impaired. ³ Further, Plumb argues that the oppressive psychiatric institution punishes people who experience mental health challenges for their perceived social deviance, rather than a method for curing people of their mental pathologies. ⁴

The social model of disability

These views also lead Plumb to critique the effectiveness of the social model of disability for the human rights of system survivors. From Plumb's perspective, the social model of disability presupposes an organic source of disability, an impairment, while her own position explicitly argues against that in relation to mental distress. Plumb advocates for emancipation from psychiatry, rather than reform of psychiatry and mental health service provision.

While Plumb believes that system survivors share certain experiences with people with disability including being discriminated against, being segregated and excluded and being objects of pity,⁵ Plumb asserts that not all people with mental health challenges understand themselves as disabled and by implication, those who do may be wrong.

Inclusion of survivors and users under the CRPD

The Convention on the Rights of Persons with Disabilities

By contrast, in *Advancing the Rights of Users and Consumers*,⁶ Tina Minkowitz ⁷argues that the concept of psychosocial disability as articulated in the United Nations *Convention on the Rights of Persons with Disabilities* (CRPD) ⁸ allows space for both people who identify as users and people who identify as survivors of the psychiatric system, to prosecute their own distinct advocacy positions and politics⁹

³ See Plumb's brief discussion of Vic Finkelstein's articulation of the social model. (Plumb 2011, Pg 4)

⁴ Plumb quotes Kate Millet in relation to psychiatry as a system of oppression. See (Plumb 2011, pg. 6)

⁵ (Plumb 2011, Pg 12)

⁶ Tina Minkowitz, 'Advancing the rights of Survivors and Consumers' in, Ed. Helen Spandler, Jill Anderson and Bob Sapey, 2015, 'Madness, Distress and the Politics of Disablement', Policy Press.

⁷ Tina Minkowitz represented the World Network of Users and Survivors of psychiatry during the development of the Convention on the Rights of Persons with Disabilities (CRPD) as a person who identified as a survivor of psychiatry and has a long history of involvement in the mental health rights space (Minkowitz 2015, Pg. xxxxx).

⁸ CRPD - <https://social.desa.un.org/issues/disability/crpd/convention-on-the-rights-of-persons-with-disabilities-crpd> United Nations, Convention on the Rights of Persons with disabilities, 2006, A/RES/61/106, Available at: <https://www.ohchr.org/en/instruments-mechanisms/instruments/convention-rights-persons-disabilities> .

⁹ (Minkowitz 2015, pg. 173)

Allows for both reform of services and refusal of care

The consumer perspective

The CRPD's core commitment to equality between people with psychosocial disability and all other human beings¹⁰ and to the right to the exercise of autonomy by people with psychosocial disability¹¹ allows those who identify as users to advocate for system change and reform.

The survivor perspective

On the other hand, the support provided by the CRPD for the elimination of involuntary treatment¹² allows those who identify as survivors to advocate for the elimination of involuntary treatment by the mental health service system and to choose not to receive medical treatment if they wish.

Alliances with other disability advocates

While Plumb argues that there is a significant risk in the distinctive story of mental health advocacy being hidden by the different history of advocacy for the rights of people with physical disabilities, Minkowitz argues that an inclusive concept of disability is a heterogeneous concept, and that people with different disability may not recognise all of their experiences in people with other kinds of disability.¹³

However, Minkowitz believes there to be sufficient commonality between different disability groups to allow for common rights being expressed in the CRPD. This view also ultimately provides support for a politics of alliances, but at the same time, it allows space for the differences and disagreements identified by Plumb as well. For Minkowitz there are different types of disability, including psychosocial.¹⁴

The social model of disability – a different response

Minkowitz does not accept the version of the social model of disability critiqued by Plumb. Minkowitz argues that one of the central features of the social model in relation to psychosocial disability, is the notion that society should adapt to the varying needs of those who are disabled, whether that be because of psychosocial disability or not. It is a

¹⁰ CRPD Article 12

¹¹ CRPD Article 3

¹² Respect for the will and preferences of another person under article 12 of the CRPD, implies respecting their right to choose not to be treated. Further support for this view is provided in General Comment No 1 2014 on article 12 of the CRPD which explicitly asserts that all signatory states have an obligation to replace regimes of substitute decision making with supported decision making.

<https://docs.un.org/en/CRPD/C/GC/1>

¹³ (Minkowitz 2015, pg. 177)

¹⁴ (Minkowitz 2015, pg. 175)

self-consciously political model that demands society changes to adapt to people with disability and not the other way around.¹⁵

Minkowitz also argues that the social model and the associated concept of reasonable accommodation have allowed people with psychosocial disability to reclaim a more positive view of themselves that does emphasises difference from others, rather than pathology.¹⁶

BEING's position

Compliance with Australia's human rights commitments

BEING grounds its advocacy on Australia's human rights commitments under the CRPD, since Australia is a signatory to the CRPD and both Australian and state and territory governments have an obligation to implement it.¹⁷ However, the CRPD has not been adequately integrated into law and policy in NSW, so as a result, advocating for better implementation of the CRPD is core to BEING's work and advocacy.

Psychosocial disability as a basis for advocacy

While we understand that not everyone feels included in the term "psychosocial disability", we believe that it provides a minimal set of obligations for mental health service providers.

At the same time, BEING also recognises that this minimal set of obligations are not the end, but the beginning for advocacy and that there is a wide and complex range of different experiences when it comes to accessing the mental health service system and to understanding one's own experience in the system. Therefore, BEING is committed to building on the inclusive model of disability already embedded in the CRPD.

The Convention on the Rights of Persons with Disabilities and key areas for mental health advocacy

In the below second section of this position statement, BEING articulate some of the key advocacy areas grounded in the CRPD, and how they relate to mental health advocacy in NSW.

¹⁵ (Minkowitz 2015, pg. 176)

¹⁶ (Minkowitz 2015, Pg 176)

¹⁷ United Nations Treaty Collection, '15 Convention on the Rights of Persons with Disabilities', Available at: https://treaties.un.org/pages/viewdetails.aspx?src=treaty&mtdsg_no=iv-15&chapter=4&clang=_en. Note that Australia became a signatory to the treaty in 2007 and this was ratified in 2008.

Introduction

The CRPD provides support for advocacy in several important areas. This includes the right to supported decision-making, the right to refuse treatment, the right to life, the right to control your own financial affairs, the right to have a say about how mental health services and systems function, and the right to live in the community with access to rights that ensure a person's economic and social participation (the right to education, the right to health, the right to work and employment, the right to an adequate standard of living and social protection).

Article 10 – Right to life

The most fundamental right of all in the CRPD is the right to life of people with disability. While it is thankful that this is not a right we have fight for in modern Australia, we believe that it is vital for us to remember that during the 20th century, it was not always a given that those with psychosocial and other disability had a right to life and that one of the motivations for developing the current international human rights framework was pushing back against political systems that did not respect the right to life, and therefore eugenic practices.

Article 12 – Equality before the law

Article 12 asserts that all people with disability have the right to equal recognition as persons before the law. It also asserts that people with disability have equal legal capacity to those who are not disabled. In mental health settings, this pushes back specifically against the longstanding paternalism of the biomedical model of mental health, which regularly utilises substitute decision-making, and involuntarily and coercively treats people with mental health challenges.

Supported and substitute decision-making

Article 12(3) commits governments to ensuring that the will and preferences of people with disability are respected, as part of any decision-making process involving a person with disability. While people with disability have equal legal capacity, additional efforts is needed by duty holders, such as service providers, to have measures and cultures in place that respects the will and preferences of people with disability. This further

implies an obligation to make available supported decision-making supports¹⁸ so people with psychosocial disability can exercise their legal capacity.¹⁹

However, the mental health system is still heavily dominated by substitute decision-making models, such as involuntary treatment and Community Treatment Orders. Shifting away from substitute decision-making toward supported decision-making needs to be much more embedded.

Control of financial affairs

Article 12(5) also protects the right of those with psychosocial disability to own property and manage their own financial affairs. Autonomy and freedom to decide are protected in several different ways for people with psychosocial disability. While progress has been made integrating supported decision making into guardianship laws and policies there is still further work to be done in NSW.²⁰

Australia's Interpretive Declarations

When Australia signed the CRPD it made three interpretative declarations. One of those relates to Article 12, and the Australian Government expressed the view that the CRPD allows for fully supported and substitute decision making. BEING believes that this interpretive declaration should be withdrawn by Australia and the full scope of the Article adopted. Doing so would mean withdrawing the power psychiatrists currently have in all Australian states, to treat those with psychosocial disability involuntarily in certain cases.²¹

Article 4(3) - Close consultation and active involvement

Inclusion of lived experience

One of the other important ways in which the CRPD recognises the decision-making capacity and rights of people with psychosocial disability is by asserting that

¹⁸ For a recent review carried out as part of the Disability Royal Commission see , Bigby, C., Carney, T., Then, S-N., Wiesel, I., Sinclair, C., Douglas, J., & Duffy, J., (2023). Diversity, dignity, equity and best practice: a framework for supported decision-making. Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, available at <https://disability.royalcommission.gov.au/news-and-media/media-releases/report-outlines-framework-supported-decision-making-people-cognitive-disability>

¹⁹ Note that this view has also been supported by the Disability Royal Commission (Recommendations 6.4 to 6.10), although we note that the royal commission slips back into paternalism in some of the language it uses.

²⁰ Supported decision making - NSW Public Guardian - <https://www.nsw.gov.au/departments-and-agencies/trustee-guardian/news-stories/supported-decision-making-and-my-rights-matter-project> , but see also the office of the Queensland public guardian - <https://www.publicguardian.qld.gov.au/guardianship/restrictive-practices-decision-making/supported-decision-making>

²¹ https://treaties.un.org/pages/viewdetails.aspx?src=treaty&mtdsg_no=iv-15&chapter=4&clang=en

consumers and survivors have a right to be included in the development of services and systems.

In NSW this is aligned with the ongoing implementation of the peer workforce and with the regular adoption of co-design methods in service and policy development.

However, although progress has been made, there is still further work to be done to ensure that there is adequate consumer representation in the development of services and policies.

BEING's vision is for all mental health decision in NSW to be decided in active partnership with those with lived experience of mental health challenges, and we prioritise building lived experience leadership and governance in all mental health services and systems.

Article 14 – Liberty and security of the person

Existence of disability is no grounds for detention

Article 14 explicitly targets the justification of involuntary detention because of disability, or perceived disability. When survivors and consumers are subject to involuntary treatment under the mental health acts that currently exist in all Australian states, they are being detained on the grounds that they have a psychosocial disability. However, having a psychosocial disability should not be grounds for detention, but rather the beginning of a process that leads to a clearer understanding of the will and preference of the consumer, which may result the consumer's decision not to receive treatment.

Article 19 - Living independently and being included in the community

Article 19 articulates a general obligation to ensure community inclusion for people with psychosocial disability. Stigmatisation of disabled people and the discrimination that can follow from it can lead to the exclusion of disabled people in the community.

Key to challenging attitudes that exclude people with disability is ensuring that people with disability, including those with psychosocial disability live independently and are included in all aspects of the community. A clear limitation that exists in realising this, is the limited range of housing options, with those with psychosocial disability disproportionately overrepresented among those who are homeless and rough sleepers

As a result, many with psychosocial disability are routinely not exercising their right to choose who and where they live [Article 19(a)] without having to access needed supports in non-institutional housing settings [Article 19(b)]. Without secure housing, accessing other rights that are fundamental to being included in the community is compromised.

Education, Healthcare and Employment

Article 19(c) further commits signatories to ensuring that community facilities that are available to the non-disabled community are also accessible for people with disability. The protection of access to community facilities is made more explicit in several of the following articles: The right to adequate access to education (Article 24), the right to adequate standards of healthcare (Article 25), and the right to work and employment (Article 27).

For these reasons, a core feature of BEING's advocacy focuses on improving the various determinants and drivers of mental health challenges, as an integral part of meeting the needs of mental health consumers.

Adequate standard of living and social protection

While Articles 24, 25 and 27 can be understood as further articulating the key elements of community inclusion and assuring that people with disability have access to services within the community in the same way as those without disability, Article 28 commits signatories to providing assistance and support to people with disability, because of their disability

This includes dedicated assistance to manage disability-related expenses for people with disability living in poverty [Article 28(c)], access to public housing for people with disability (Article 28 (d)) and access to retirement benefits [Article 28(e)]. While Articles 19, 24, 25 and 27 can best be understood as ensuring equality with those who are not disabled, Article 28 identifies rights that are specific to people with disability and result from their differences from non-disabled people.

Convention Against Torture and Other Cruel, Inhumane, or Degrading Treatment or Punishment

Involuntary detention and torture

There is also an important intersection between the CRPD and the *Convention Against Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment* (UNCAT). Article 15 of the CRPD asserts a right to freedom from torture and from medical experimentation for all people with disability. This aligns with the central concerns of the UNCAT in its positing of a right to freedom from torture in Articles 1 and 2 of the UNCAT.

National Preventative Mechanism

To support the implementation of the UNCAT, Article 4 of the Optional Protocol to the UNCAT (OPCAT), asserts that all signatories must implement a national compliance mechanism for the UNCAT. The OPCAT recognises that there is a risk of torture and

mistreatment in all settings where people are held involuntarily. This includes settings where mental treatment is involuntary, such as locked inpatient mental health units.

The OPCAT requires all signatories to allow visits to all places of detention including locked inpatient mental health units. While the NSW mental health act already includes some oversight mechanisms including the Official Visitors program²² and the Mental Health Review Tribunal,²³ it is evident that there are still significant shortfalls in especially with the use of seclusion, restraints and other restrictive practices such as the use of psychotropic medication and sedation.

NSW's failure to comply with the OPCAT

Further to that when the UN Subcommittee on the Prevention of Torture last visited Australia to review places of detention for compliance, they were not provided access by relevant agencies in NSW. In the NSW Parliament's Annual Review of Reports of Oversighted Agencies, it was recommended that a National Preventative Mechanism (NPM) for NSW be implemented as soon as possible given that the due date for implementation was January 2023.²⁴ The then NSW Attorney-General, Micheal Daley, responded with advice that there are disagreements between NSW and the Commonwealth governments regarding resourcing and that no action would be taken until these issues were resolved.²⁵

To date, no NPM has been nominated by the NSW Government. The Government has the option to nominate different NPMs for different settings, as some other Australian jurisdictions have.

²² Official visitors program - <https://officialvisitorsmh.nsw.gov.au/Pages/OVP.aspx> , Mental Health Act 2007 No 8, Chapter 5

²³ Mental Health Review Tribunal - <https://mhrt.nsw.gov.au/the-tribunal/> . Note that the MHRT is Mental Health Act 2007 No 8, Chapter 6.

²⁴ Recommendation that NSW implement a national preventative mechanism asap - <https://www.parliament.nsw.gov.au/ladocs/inquiries/2995/Report%20-%202023%20review%20of%20annual%20and%20other%20reports%20of%20oversighted%20agencies.PDF>

²⁵ NSW Attorney General reply to recommendation to implement a national preventative mechanism in NSW - <https://www.parliament.nsw.gov.au/tp/files/190098/Government%20Response%20-%20Letter%20-%20Attorney%20General%20to%20Clerk%20-%202023%20review%20of%20annual%20and%20other%20reports%20of%20oversighted%20agencies.pdf>



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