Suicide Prevention Australia

JUNE 2023

Inquiry into Australia's Human Rights Framework

Submission

Introduction

Suicide Prevention Australia welcomes the opportunity to provide input to the Inquiry into Australia's Human Rights Framework.

Suicide Prevention Australia is the national peak body for the suicide prevention sector. We have over 370 members representing more than 140,000 employees, workers, and volunteers across Australia. We provide a collective voice for service providers, practitioners, researchers, local collaboratives, and people with lived experience.

Over 3,000 people tragically die by suicide and an estimated 65,000 people attempt suicide each year. Over 7.5 million Australians have been close to someone who has taken or attempt suicide. Our shared vision is a world without suicide and with our members, we work to inform through data and evidence; influence systemic changes that drive down suicide rates and build capability and capacity for suicide prevention.

We believe it is relevant to contribute to this Inquiry as the population groups most likely to experience violations upon their human rights are populations who are also at risk of suicide, including but not limited to: First Nations Australians, asylum seekers and refugees, and LGBTQIA+ communities.

Australia's lack of national human rights legislation fails to ensure adequate protection of human rights and freedoms at the federal level, which results in inconsistencies at the state and territory level. Currently only Victoria, Australian Capital Territory, and Queensland have human rights laws. [1]

Government decision-makers should be required to consider the impact of proposed policies on the health and welfare of communities, including whether they would unintentionally violate human rights, or increase risk of suicide among people already at risk of suicide.

Not only should the Australian Government be held accountable to considering the impact of policies on human rights, health and welfare of communities, they should be responsible for monitoring and reporting on these actions to the general public to provide transparency in their governing.

In developing our submission, we consulted with our Lived Experience Panel (LEP) members who contributed to the key issues and recommendations highlighted in this submission. Our LEP consists of people with lived experience of suicide including those who have experienced suicidal thoughts and behaviour, survived a suicide attempt, cared for someone through suicidal crisis or are bereaved by suicide.

Our submission will respond to the following Terms of Reference:

2. to consider whether the Framework should be re-established, as well as the components of the Framework, and any improvements that should be made

3. to consider developments since 2010 in Australian human rights laws (both at the Commonwealth and State and Territory levels) and relevant case law

Summary of Recommendations

Suicide Prevention Australia supports the recommendations made by the Australian Human Rights Commission in their position paper titled 'Free and Equal' to enhance human rights protections in Australia.

1. The Australian Parliament should enact a federal Human Rights Act. The Human Rights Act should include the elements proposed in the position paper 'Free and Equal' published by the Australian Human Rights Commission.
2. The parliamentary scrutiny process should be enhanced by adopting recommendations made by the Australian Human Rights Commission in their position paper 'Free and Equal'.
3. The parliamentary scrutiny process should include giving consideration to the social determinants of health that can lead to suicide in line with the United Nations Sustainable Development Goals, and potential impact on communities at-risk of suicide.
4. The parliamentary scrutiny process should be amended to include United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP) as an instrument that must be reported against in policy decision-making.
5. The UNDRIP should be declared a relevant international instrument within the Australian Human Rights Commission Act 1986 to allow for First Nations peoples access to the inquiry and complaints function of the ARHC.
6. The Yogyakarta Principles plus 10 should be included as recognised human rights similar to the human rights treaties in which Australia is a signatory in a federal Human Rights Act.

2. Australia's Human Rights Framework

According to the Australian Human Rights Commission, Australia is 'the only liberal democracy in the world that does not have a national act or charter of rights that explains what people's basic rights are and how they can be protected'. [2] Without this guidance and accountability at the federal level, human rights and freedoms are not adequately protected and protections vary across jurisdictions. [3]

Australia has continued to violate human rights since the introduction of the Human Rights Framework 2010 (to be highlighted in response to Terms of Reference 3), and the Commonwealth Human Rights (Parliamentary Scrutiny) Act 2011.

Case Study: Robodebt Scheme

This case study is used as an example of the need for community safeguards in policy decision-making.

An example of unintended consequences from Commonwealth policy was witnessed in the widely reported impact of the Robodebt Scheme. While links between unemployment, financial insecurity, homelessness and suicidality, are well established, the policy unfairly targeted people who were already living in precarious situations. [4] It has been widely argued that the result of this was that lives were lost to suicide. [5],[6],[7]

The economic cost of the Robodebt class action resulted in a record $1.8 billion settlement and a Royal Commission into the lawfulness of the Scheme. [8] The Federal Court concluded that key features of the Robodebt program were unlawful in 2019. [9] Had adequate consideration been given to the impact of the health and welfare of communities impacted by the Scheme by policy makers, the distress and harm caused by the Scheme to vulnerable Australians could have been prevented in its conception, and lives lost to suicide could have been saved.

In a transcript of proceedings to the Royal Commission into the Robodebt Scheme, former Prime Minister Scott Morrison reported that there was no advice presented that the proposal was unlawful, and that if there was legal impediment to pursuing a course of action by the government, it would have been noted in a new policy proposal checklist. [10]

It is highly concerning that while under the Commonwealth Human Rights (Parliamentary Scrutiny) Act 2011 requires a Statement of Compatibility with Australia's international human rights obligations to be provided with all Bills presented to Parliament (Sec 3.8.1) [11], that this clearly did not work to safeguard the community from suicide. This may be due to the lack of consequences outlined in the Act for failing to act in accordance with the Act.

The Commonwealth Human Rights (Parliamentary Scrutiny) Act 2011 does not include consequences for breeching human rights in policy decision-making, which may contribute to continued violations of human rights in Australia.

We support the recommendations made by the Australian Human Rights Commission in their position paper titled 'Free and Equal' to strengthen human rights protections, and enact a federal Human Rights Act. [12]

Recommendations:

1. The Australian Parliament should enact a federal Human Rights Act. The Human Rights Act should include the elements proposed in the position paper 'Free and Equal' published by the Australian Human Rights Commission.

2. The parliamentary scrutiny process should be enhanced by adopting recommendations made by the Australian Human Rights Commission in their position paper 'Free and Equal'.

3. The parliamentary scrutiny process should include giving consideration to the social determinants of health that can lead to suicide in line with the United Nations Sustainable Development Goals, and potential impact on communities at-risk of suicide.

3. Developments in Australian human rights

Suicide is a complicated human behaviour and is more than an expression of mental ill-health. Only half of those who tragically lose their life to suicide each year are accessing mental health services at the time. [13]

Recent modelling released by the Australian Institute of Health and Welfare revealed that socioeconomic factors such as being widowed, divorced or separated, being not in the labour force or being unemployed, being a lone person household and being male, are the risk factors with the strongest associations with suicide. [14]

3.1 The Human Rights of People Experiencing Suicidality

The right of everyone to the enjoyment of the highest attainable standard of physical and mental health - Article 12, ICESCR

Every person with disabilities has a right to respect for their physical and mental integrity on an equal basis with others – Article 17, CRPD

States Parties shall recognize the rights of persons with disabilities to liberty of movement, to freedom to choose their residence and to a nationality, on an equal basis with others – Article 18, CRPD

Our Lived Experience Panel identified that seclusion and restraint practices in mental health care can be a violation of human rights and are a key fear contributing to people not wanting to seek help for suicidality. They further advised that coercion exists outside of mental health care hospital units, including in crisis helplines where volunteers answering helplines may call police when it might not be appropriate.

The Australian Institute for Health and Welfare (AIHW) reported for the period 2021-22 there were 10,851 seclusion events at a rate of 7 events per 1,000 bed days in mental health acute hospital care. [16] The average duration of seclusion lasted 6 hours (excluding Forensic services which average 34 hours). [17] There were 1522 mechanical restraint events and 16,996 physical restraint events for the same period. [18] These figures reported on by the AIHW assess 135 hospitals. It's important to note that in 2020-21, there were 697 hospitals in Australia and that incidents of seclusion and restraint in Australia may be higher than the figures reported. [19]

Seclusion and restraint practices are legal in Australia. While use of these practices has declined over the last ten years [20], they are still used and the community awareness of the legality of using these practices, creates significant barriers in help seeking for people at risk of suicide.

Definitions from the Australian Institute for Health and Welfare [15]	
Seclusion	When a person is locked alone in a room and cannot leave by themselves.
Mechanical restraint	When items are used on a person's body to stop them moving freely, such as belts or straps.
Physical restraint	When staff use their hands or body to stop a person moving freely.

Case Study: The race to infringe human rights

Authored by Suicide Prevention Australia Member

I am writing this case study as an experience suicidologist with 16 years' experience. I hold a Masters Degree in Suicidology passed with the Chancellors Honours for Academic Excellence. I have managed large suicide prevention programs involving thousands of suicide interventions done annually. I am also a Master Trainer in Applied Suicide Intervention Skills Training (ASIST) a person centred, lived experience and evidence-based suicide intervention model.

Over the past 16 years I have supported countless Queenslanders finding ways to live through their suicide crisis. In by far the most cases this can be done safely in the community by identifying appropriate supports and hopes.

This is a case study of an intervention I did recently which highlights the medical model's focus on practitioner liability over patient human rights and dignity.

Over the past years I have been working with a close friend through periods of intense suicidality. In general, we have been able to find safety in the persons community and social circle. Much of the person's crisis are associated with severe childhood trauma, and a dysfunctional relationship with their biological family.

As part of our last safety planning, we agreed that the person would see their GP and ask for a referral for further assessment and diagnosis perhaps for post-traumatic stress disorder (I never diagnose). We had observed that most crisis stemmed from their past experiences and despite having attended counselling in the past we discussed options such as Cognitive Behavioural Therapy as potentially useful for them. We agreed that the person had a doctor's appointment to receive results from tests from an unrelated health concerns that they were due to receive.

On a Saturday morning I received a phone call from the person in panic and distress. They told me they had been detained in the Doctors surgery and the Doctor was insisting on calling an ambulance to take the person to ED for an assessment. They had negotiated with the doctor to wait to make the call until the person had spoken to me. I then made it down to the surgery.

The person had been threatened with compulsory treatment if they did not consent to be admitted to hospital. This is problematic in its own right as it is an abuse of power, the GP indicated that in the GPs opinion the person had the capacity to consent to go to hospital but did not have the capacity to refuse to go to hospital.

As I arrived, I engaged with the GP. The GP told me that the person had disclosed they had active thoughts of suicide, that they often thought about crashing their car into a tree but also that they really wanted things to get better and wanted to talk to someone who could discuss their post-traumatic stress. The GP was adamant that because the person had disclosed suicide ideation and an active plan the person had to go to hospital for an assessment.

It was pointed out to the GP that the very fact that the person had attended the surgery to seek support for the post-traumatic stress demonstrated future focus and willingness to live. It was further pointed out that the GP had stopped listening to the person once they disclosed suicide ideation. I did suggest to the GP that the reaction perhaps was more to do with liability risk mitigation than patient care, considering circumstances.

I pointed out to the GP that even if the person would be assessed for suicidality the only resource available in the health system would be hospitalisation and that it would be highly unlikely a bed would be available given the low risk. It was also pointed out that the GP's reaction would result in the person being reluctant to seek help in the future.

After much negotiation it was agreed that I would talk to the psychiatric nurse at the local Acute Care team and that we would discuss a course of action. In that conversation it was agreed that I would stay with the person until the Acute Care Team would call the person later in the day for a formal assessment and that the Acute Care Team, I and the Person combined would agree on further action from there.

Following this the GP then started to tell the person how much trouble this had caused as it had taken 2 hours of the GPs time at the cost of other patients. The GP also told me that I could not suggest the GP did not always act purely in the patient's interest, so I agree not to say that again. The GP then proceeded to insist that the person presented to the surgery on Monday and Wednesday for "check-ups" and that if the person would not meet up, then the surgery would call an ambulance.

As we left the surgery the person was charged an additional $250.00 for the very long consultation. The person asked for the results from their medical tests and were told that they had already taken too much time so they would have to make another appointment to get these results.

Later in the afternoon we did talk to the Acute Care Team who noted that the person was acutely suicidal and did have a suicide plan but also that there was no current intention to use the plan, in fact the person was seeking protection and support against the suicide plan. In those circumstances there was not resources available to the person they would not be admitted if they seeking admission. Unfortunately, the Acute Care Team could not provide any other resources than a link to the Head to Health Website as there were no clinics operating in our area. We looked at the website but there were no resources available to the person.

The consequence of this experience has been significant to the person. The person completely panicked about returning to the surgery as the experience had been so traumatic. I helped the person cancel the follow up opinions and we basically just had to hope the GP was bluffing in the threat to call an ambulance if the person did not turn up.

Today more than 4 months later the person still have not received their results from the unrelated health concern. The person has been unable to make another appointment or even turn up at any surgery. The person did not receive any further support for the post-traumatic stress as it would require the person to turn up at a GP for a referral.

I am happy to say the person is today through this suicide crisis. They have found yoga and exercise as a way to manage the worst distress and work arounds when the past trauma bites. However, the person has not been able to go into a medical facility since this experience as it felt so violating and disempowering.

In my professional opinion it was never needed. The GPs reaction was systems and procedures over people. The person had a strong will to stay safe that the GP could have worked with. The United Nations Convention on the Rights of Persons with Disability (which includes mental health disorders such as PTSD) provide a right to integrity and liberty of movement. The Queensland Mental Health Act also provide that restrictive practices must only be used where less restrictive options are not available. It is concerning that a person's fundamental rights are set aside purely because of stigma and misconceptions around suicide and suicide crisis.

For those that do experience seclusion and restraint practices when accessing mental health care, it is often so traumatic that it can prevent people from seeking help again in future. By limiting the accessibility of health care, Australia is violating the human right to the highest attainable standard of physical and mental health (Article 12, ICESCR) [21].

Case Study: We cannot heal when we fear for our human rights

Authored by Person with Lived Experience

I first attempted suicide when I was 12, and a second time when I was 14. I was self-harming, I had developed anorexia nervosa, and I was experiencing psychosis. The underlying factor to my first suicide attempts and mental health problems was trauma. I had tried to get help for the abuse and neglect I was experiencing from adults, but my pleas for help went unheard. I wanted to die and escape the nightmare I was living in. From that point on, I was in the public mental health system, catapulted onto adult mental health wards because the child and youth mental health services were unequipped to deal with a patient as "complex" as me.

I was already traumatized, and the treatment I experienced in the public mental health system increased and compounded my trauma, chronic mental health problems, and suicidality. It created a cycle of involuntary treatment orders, more trauma, more suffering, more suicide attempts, and more admissions. I felt like a desperate animal trying with any means to escape the agony of the world it was caught in, and the wreckage of the grief and betrayal.

During one admission when I was 18, I had just spent three weeks locked in the high dependency unit, and was taken back onto the main ward. One of the nurses who had been with me in the HDU had been kind, and these moments of compassion had helped me to come out of some of the severity of my distress, dissociation and psychotic world. Compassion was a key to feeling safer and to re-connect to myself and life.

Then some people came to visit me. Among these visitors was someone who had violently attacked me throughout my life. I froze, and lost the ability to speak. I wanted to communicate to the staff that I was in danger, and needed the visitors to leave immediately. The staff were saying that my loss of communication was a 'regression' and 'negative psychotic symptoms'. They kept interpreting my behaviour through the lens of pathology, rather than a threat and survival response to a change in my environment that they needed to understand and could also respond to in order to help me.

In desperation and panic, I picked up an object and hit it against the ground, trying to signal to the staff that this was an emergency and something was wrong. The response was immediate, but it was not help – it was violence. The very thing I was asking the hospital staff to protect me from was what they responded to me with. Staff ordered the visitors to leave, and moved them out of the door. Then three nurses slammed me to the ground, and another three joined them in restraining me against the ground as I struggled and tried to cry out. I bit my tongue as they restrained me, and it filled my mouth with blood, which I felt like I was choking on. My bones are fragile from years of suffering from anorexia nervosa, and when they slammed me to the ground, it hurt me and bruised me everywhere. The staff pulled down my clothes and forcibly injected me with sedatives.

I was already at an extremely low body weight due to my anorexia nervosa and heavily medicated with antipsychotics – because of this, I had already been struggling with my mobility and my muscles. The effects of the sedatives made this even more extreme. I couldn't control my body, and I felt like I was starting to suffocate in a cocoon of my own paralysed muscles as they crushed me against the floor.

I was carried back into the HDU, and forcibly stripped naked. I couldn't scream, I couldn't move, I couldn't fight, because the sedatives were so strong. I couldn't defend myself against the violence, and I wanted more than anything to die. The staff stripped me in front of the glass, witnessed by other patients and even more staff. Then they forced my body into a 'suicide smock' – restraint clothing. It was so heavy and thick, I felt even more immobilized than I'd been with the effects of the sedatives. I was dragged into a confinement room, and dumped onto the stinking mattress on the floor. My hair was in my mouth, mixing in with the blood where I bit my tongue. A staff member pushed me onto my side, so I could spit or vomit without choking. Then they left me in the dark.

This was one of multiple events of restraint and confinement I've experienced. It's difficult to describe the horror and impact. I still have nightmares, decades onward, of every instance. I'm still haunted by those rooms, the paralysis, the entrapment and helplessness. What if, on that day, the staff had asked themselves "What does she need? What is she trying to tell us? What just changed? How can we make her feel safe?". What if they'd asked: "What is the least harmful thing we can do right now to calm the situation down?" What if they'd just walked me to another room or quiet space, someone had sat beside me, and just talked to me, or read something out loud, or taken out some art supplies? What if I'd been treated like a human being in distress instead of something dangerous that needed to be feared and contained?

In so many cases I've risked death because I refused to call an ambulance out of fear it would happen again. When I self-harmed and was bleeding to death at 22, my partner found me, and I had told them that I would rather die on the floor at home than face the horror and dehumanization that was waiting for me in hospital. When I collapsed at work from the medical effects of my anorexia, I begged my co-workers not to call an ambulance. It was easier for me to face dying from a heart attack at 25 than more seclusion and restraint.

I've continued to avoid medical care and treatment as much as possible, and it's meant that I'm now considered 'untreatable' and 'intractable' by many professionals. I'm scared to take vitamins, I struggle to take my medication, I struggle to attend GP appointments, and the ongoing psychological care I have is now harm reduction only. This is a legacy of iatrogenic trauma – my life has been scarred by violence and abuse, and I will die to escape it. Restraints and confinement cannot exist in places that are meant to be safe. We cannot heal when we fear for our human rights, fear for our humanity and fear for our lives.

The Royal Australian & New Zealand College of Psychiatrists state 'any use of seclusion and restraint can be inherently traumatising…[and] seclusion and restraint should never be used to control behaviour, as punishment or because of inadequate resources.' [22] Our Lived Experience Panel identified that moral trauma occurs among healthcare practitioners who use seclusion and restraint practices as it violates principles of trauma-informed practice, ethics of medical practice (beneficence, dignity, respect, autonomy, and non-maleficence) and respect for human rights.

People who experience suicidality and/or are impacted or bereaved by suicide experience stigma and discrimination, this poses a threat to a free and fair community for all as outlined in the CRPD. [23], [24] Stigma can stem from a lack of understanding of the complexity of suicide, be based on negative beliefs or attitudes, and lead to a person feeling marginalised. [25]

SANE Australia's National Stigma Report Card found 95.6% of participants with complex mental health issues said they had experienced some level of stigma or discrimination in their relationships in the previous year, with 69.1% reporting that this had significantly impacted their lives. [26]

A study into suicide stigma in NSW (n=5426) found self-reported stigma of suicide to be highest among First Nations peoples, males, heterosexual people, and people living in outer regional or remote areas. [27]

Stigma can stem into social systems and services, particularly in cases involving child protection services or Family Court matters where a person's suicidality can be used as a weapon to rule a person unfit to parent or 'unstable', or intervention orders can be placed against people out of fear. These systems can have highly adverse implications for a person's recovery when they are portrayed to loved ones and the community as a risk to others.

The right to legal capacity is often denied to people with suicidality when they come into contact with the justice system due to the nature of their suicide attempt. For example, this could include traffic violations (speeding or substance affected), drug possession, firearms offences, and/or intervention order breaches.

Case Study: "I was denied my human right to legal capacity" - How discrimination from the community can stem into social systems and services

Authored by Person with Lived Experience of Suicide

I attempted suicide several years ago. I was seen by a Magistrate as a risk to my former partner and my child, and an intervention order was issued. Before the court hearing I had no money so no means to pay for a lawyer. I had been cut off financially by a partner, and I was out of state staying with a relative for support so couldn't attend the hearing. It was 3 days post my discharge from hospital.

I wrote to the court asking for the hearing to be adjourned for a week to allow me time to recover and gain funds to travel back and be represented. On the hearing day the Magistrate informed the parties they didn't want to 'waste the courts time' and without any representation on my behalf granted a full intervention order. It prevented me from returning to my own home which I shared with my partner at the time.

I had not committed any act of family violence at all, I was simply suicidal and a risk to myself, but my partner was 'scared' and this was supported by a police officer at the time (as I was reported as missing for 24 hours so the police became involved).

It really damaged me and I cannot understand to this day how a Judge can make a ruling against a person when they are not represented and are highly vulnerable.

For the fourth quarter in a row, 'cost-of-living and personal debt' has ranked as the leading cause of elevated distress and suicide risk amongst Australian adults (18+). [28] Access to adequate legal support is dependent on financial capability which limits their ability to a fair trial.

3.2 Treatment of Refugees and Asylum Seekers

No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment – Article 7, ICCPR

In January 2021, Australia had its third Universal Period Review hearing before the UN Human Rights Council. [29] Of 122 UN member states, 45 identified concerns or recommendations of refugee and detention policies raising a number of concerns with offshore processing, indefinite immigration detention, detention of children, refoulement, and compliance with international law. [30]

The Human Rights Measurement Initiative scored Australia 5.5/10 against the right to freedom from torture, and 68% of their survey respondents selected refugees and asylum seekers as a group particularly at risk of torture or ill-treatment in Australia. [31]

The human rights of Australia's asylum seekers are violated in many respects, such as their freedom of movement is restricted, the conditions in which they are detained have been equated to forms of torture and ill-treatment [32], and they are subject to arbitrary arrest and detention. [33]

A study examining suicidality among Australian asylum seeker populations for the period 1st August 2014 and 31st July 2015 reported 949 self-harm episodes. [36] Rates of self-harm were highest among asylum seekers in offshore detention in Nauru. [37] Suicidality among refugees on Papua New Guinea's Manus Island were reported to increase after the Federal election in 2019, including 10 suicide attempts. [38]

Suicidality has been evidenced in Australia's onshore immigration detention, with rates of self-harm ranging from 91 per 1000 asylum seekers in Yongah Hill IDC to 533 per 1000 asylum seekers in Perth IDC. [39] Rates of suicidality were highest among asylum seekers in immigration transit accommodation facilities, alternative places of detention, and immigration detention centres. [40]

Asylum seekers in offshore detention facilities are subject to unsafe and unsanitary living conditions, including vulnerability to physical and sexual abuse. [42] Psychological distress has been found to increase among detainees the longer they are detained and exacerbated by being detained offshore. [43]

Government policies on the treatment of refugees and asylum seekers should comply with parliamentary scrutiny processes and be subject to review in alignment with upholding human rights. This accountability to uphold human rights in Government decision-making should be legislated through a national Human Rights Act.

Case Study: Lack of access to healthcare

In 2018, a 12 year old refugee girl attempted to set herself on fire. Her father reported to The Guardian that "her desire to die is very high". [34] The Guardian reported that doctors advised prior to the incident that the child should be moved off Nauru but the decision was overruled by the Australian Border Force. [35]

Case Study: Thanush Selvarasa as reported by Human Rights Watch [41]

Thanush Selvarasa is a 31 year old Tamil asylum seeker from Sri Lanka. He spent 8 years in detention, six and a half years offshore, and one and a half years in hotel detention in Australia: "Offshore processing centers destroyed our lives. We are the victims of this cruel policy. Many of our friends lost their lives because of this cruelty. I myself tried to kill myself twice. Human beings have the right to seek safety and protection. This kind of indefinite detention really causes pain."

3.3 The Rights of First Nations Peoples

The right of everyone to the enjoyment of the highest attainable standard of physical and mental health - Article 12, ICESCR

Indigenous peoples, in exercising their right to self-determination, have the right to autonomy or self-government in matters relating to their internal and local affairs, as well as ways and means for financing their autonomous functions – Article 4, UNDRIP

Indigenous peoples have the right to the lands, territories and resources which they have traditionally owned, occupied or otherwise used or acquired – Article 27, UNDRIP

United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP) was adopted by the General Assembly in 2007. [44] While the UNDRIP received 144 member votes of support, Australia was one of the four countries who voted against it. [45] In 2009, Australia changed its position and announced support for UNDRIP. [46] Since announcing support for UNDRIP, Australia has not made significant strides to uphold the human rights of First Nations peoples, and violations of human rights continue to occur.

In 2021, 5.3% of all deaths of First Nations peoples were by suicide compared to only 1.8% of non-Indigenous Australians. [47] Similar elevated rates are witnessed in deaths by suicide among young First Nations peoples reporting 24% of deaths among those aged 0-24, compared to 17% among non-Indigenous young people. [48] When examining general health, social and emotional wellbeing among First Nations peoples, the burden of disease is 2.3 times that of non-Indigenous Australians, and rates of psychological distress and chronic diseases are higher than non-Indigenous Australians. [49]

In September 2022, the UN Human Rights Committee found Australia failed to 'adequately protect First Nations peoples against the impacts of climate change which violated their rights to enjoy their culture and be free from arbitrary interferences with their private life, family and home.' [50] Failing to address climate change resulted in the destruction of culture, livelihood, and traditional way of life of First Nations peoples. [51]

While First Nations peoples make up 3.3% of the Australian population [52], First Nations peoples account for 32% of Australia's prison population. [53] For the period 2020-21, the youth detention rate for young First Nations people (aged 0-17 years) was higher than the rate for non-Indigenous young people in all Australian jurisdictions. [54] Australian prisoners are denied access to Medicare and the Pharmaceutical Benefits Scheme which significantly limits accessibility of healthcare.

Following on from the Royal Commission into Aboriginal Deaths in Custody which examined 99 Black deaths custody in 1991, the Australian Institute of Criminology (AIC) began reporting on deaths in custody from 1992. [55] The latest AIC data recorded a total 106 deaths in custody for the period 2021-2022, which was a 23% increase in deaths from the previous year. [56] Of the 106 deaths in custody, 24 were First Nations accounting for just under a quarter of total deaths in custody (approx. 23%). [57] There has been a total 544 recorded First Nations deaths in custody since the Royal Commission in 1991. [58]

'First Nations peoples are the most incarcerated peoples on the planet…a First Nations teenage boy is more likely to go to jail than to go to university' – United Nations Association of Australia, 2021 [59]

First Nations peoples have a history of experiencing genocide, dispossession, disempowerment, and racism at the hands of the Australian Government which has resulted in intergenerational trauma, loss of land, loss of culture and language, and poor health outcomes. [60]

If we are to uphold the human rights of First Nations peoples in Australia, parliamentary scrutiny processes should be amended to include UNDRIP as an instrument that must be reported against in policy decision-making.

3.4 The Rights of Persons with Disabilities

To enable persons with disabilities to live independently and participate fully in all aspects of life, States Parties shall take appropriate measures to ensure to persons with disabilities access, on an equal basis with others, to the physical environment, to transportation, to information and communications, including information and communications technologies and systems, and to other facilities and services open or provided to the public, both in urban and in rural areas – Article 9, CRPD

In response to the violence, neglect, abuse and exploitation of people with disability, Australia established the Disability Royal Commission in April 2019. [61] The Royal Commission is still ongoing, with the final report to be released by 29 September 2023. To date they have received over 7000 submissions to the Royal Commission detailing human rights violations of people with disability. [62]

The human rights violations for people with disability can include:

- arbitrary arrest or forced detention (which can lead to violence, abuse, neglect and exploitation),
- limited or denied legal capacity,
- limited or denied access to information and communication (for example no Auslan interpreters available in service and community settings or supports not trained in Auslan),
- disability service regulations and standards are adult focused which do not include provisions for children with disability,
- restrictions on liberty of movement (for example migrants and refugees with disability can be refused entry to Australia due to disability),
- access to housing which is a human right to adequate standard of living, and
- forced treatment by medical or health professionals, education institutions, and family or support persons. [63], [64]

In 2021, 6.7% of people who died by suicide were experiencing limitation of activities due to disability. [65] People with a severe or profound disability experience significantly higher levels of anxiety-related problems than people without disability (42% compared to 12% without disability). [64]

Similar higher rates of depression are experienced by people with severe or profound disability (36%) and people with other forms of disability (32%), compared to people without disability (8.7%). [67] Adults with disability are more likely (32%) to experience high or very high levels of psychological distress than adults without disability (8.0%). This is particularly true for adults with severe or profound disability (40%). [68]

Analysis by the Human Rights Watch of coroner's inquest reports between 2010 and 2020 found 60% of people who died in prisons in Western Australia had a disability, and half of those were First Nations peoples with disabilities. [69]
The Australian Human Rights Commission proposed model for a Human Rights Act would see the Convention on the Rights of the Child and the Convention on the Rights of Persons with Disabilities incorporated domestically and embed in legislation the rights that are reflected in these instruments. [70]

3.5 The Rights of LGBTQIA+SB communities

The right of everyone to the enjoyment of the highest attainable standard of physical and mental health - Article 12, ICESCR

Everyone has the right to liberty and security of person – Article 9, ICCPR

The right of everyone to an adequate standard of living – Article 11, ICESCR

Note:
LGBTQIA+SB is defined as lesbian, gay, bisexual, transgender, queer, intersex, and sistergirls and brotherboys.
The acronym used in this section will change depending on which populations the research referenced reported on.

The current Sex Discrimination Act 1984 includes exemptions for religious organisations to discriminate against LGBTQIA+SB communities in employment and service delivery. [71] Religious charities are the largest single category of charity in Australia, and perceived discrimination due to existing legislation can serve as a barrier to LGBTQIA+SB people seeking needed support from these organisations. [72]

Equality Australia reported on several cases where exemptions have been used by religious organisations to discriminate against LGBTIQ+ people including teachers being fired from schools, and people being denied access to crisis accommodation for intimate partner violence on the basis of sexual orientation and/or gender identity. [73]

Discrimination and violence against LGBTQIA+SB communities violates human rights; however, data indicates LGBTQIA+SB communities are still subject to such in Australia. The latest data on LGBTQI people in Australia (n=6835) reported 6 in 10 participants said they had been treated unfairly to some degree because of their sexual orientation in the past 12 months, and over three quarters among trans and gender diverse participants. [74]

Participants reported experiencing social exclusion (39.5%), harassment such as being spat at or offensive gestures (23.6%), written threats of abuse (22.1%), refusal of service (10%), physical abuse (11.8%), and sexual assault (3.9%) in the past 12 months due to their sexual orientation or gender identity. [75]

LGBTQI people in Australia experience high rates of suicidality compared to the general population. Research reported over one in four (41.9%; n=2,848) LGBTQI participants had considered attempting suicide in the previous 12 months (compared to 2.3% of general population), and almost three quarters (74.8%; n=5,084) had considered attempting suicide at some point during their lives (compared to 13.3% of general population). [76]

In the past 12 months, suicidal ideation was prevalent among 39.8% of cisgender women, 31.9% of cisgender men, 58.3% of trans women, 61.2% of trans men, and 61.4% of non-binary people. [77]

Australian research informs that sexual and gender minorities are over-represented in the criminal legal system, with almost 37% of incarcerated women identify as lesbian or bisexual. [78] International research demonstrates transgender people are at higher risk of experiencing violence and sexual assault in prisons. [79]

There is a lack of data on LGBTQIA+SB communities in Australian prisons and engagement with the justice system, however we know that access to healthcare is limited in Australian prisons with Medicare and the Pharmaceutical Benefits Scheme not accessible to prisoners [80], and as such the ability to seek affirmative healthcare is unlikely.

In 2006, the Yogyakarta Principles on the human rights of people with diverse sexual orientation, gender identity, gender expression, and sex characteristics was created external to the United Nations system. [81], [82] In 2017, the Yogyakarta Principles plus 10 (YP+10) was adopted to enhance the rights of intersex people which were previously not adequately addressed. [83], [84]

Recommendations

6. The Yogyakarta Principles plus 10 should be included as recognised human rights similar to the human rights treaties in which Australia is a signatory in a federal Human Rights Act.

3.6 Suicide Risk Among Healthcare Workers

The right of everyone to the enjoyment of the highest attainable standard of physical and mental health - Article 12, ICESCR

The role of mandatory reporting for suicide risk can create barriers for healthcare workers, clinicians and first responders in disclosing their own suicidality at the risk of losing their employment, involuntary admission to hospital, and stigma associated with suicidality and mental ill-health.

The COVID-19 pandemic in Australia had a significant impact on the wellbeing of healthcare workers and first responders. Research reported 1 in 10 Australian healthcare workers reported thoughts of suicide or self-harm during the COVID-19 pandemic, with most healthcare workers not seeking professional help. [85]

Rather than reducing risk to the community, mandatory reporting creates barriers to seeking help and increase risks of impairment as health professionals who may be suffering from stress, burnout, mental health issues, or substance use concerns cannot safely access support. [86]

Currently Western Australia is the only jurisdiction that exempts a treating doctor from the mandatory reporting of a doctor-patient. [87] This practice was reviewed by the Australian Medical Association and found to not compromise the ability of the Medical Board to protect patients. [88] In 2022, a Senate Committee recommended removing the mandatory reporting of doctors seeking help for mental health to the Australian Health Practitioners Regulation Authority in line with the Western Australian model (Rec. 13). [89]

This practice should be reviewed nationally should a federal Human Rights Act be established as all healthcare workers should be able to access healthcare without risk of sacrificing their human rights to adequate living (through employment), liberty of movement, and right to the highest attainable standard of physical and mental health.

For more information contact:
Caitlin Bambridge
Policy and Government Relations Manager
Suicide Prevention Australia
caitlinb@suicidepreventionaust.org

Acknowledgements Statement

Suicide Prevention Australia acknowledges the unique and important understanding provided by people with lived and living experience. This knowledge and insight is critical in all aspects of suicide prevention policy, practice and research. Advice from individuals with lived experience helped guide the analysis and recommendations outlined in this policy position.

Members from Suicide Prevention Australia's Lived Experience Panel were consulted in the development of this submission and contributed to identifying key issues and recommendations highlighted in the submission. Suicide Prevention Australia would like to thank Rosiel Elwyn for their significant contributions from a lived experience perspective that have enhanced this this paper.

As the national peak body for suicide prevention, our members are central to all that we do. Advice from our members, including the largest and many of the smallest organisations working in suicide prevention, as well as practitioners, researchers and community leaders is key to the development of our policy positions. Suicide Prevention Australia thanks all involved in the development of this policy position.

If you or someone you know require 24/7 crisis support, please contact:

Lifeline: 13 11 14
www.lifeline.org.au

Suicide Call Back Service: 1300 659 467
www.suicidecallbackservice.org.au

For general enquiries

References

1. Victorian Equal Opportunity & Human Rights Commission. (2023). Australia's human rights framework, available online: https://www.humanrights.vic.gov.au/legal-and-policy/australias-human-rights-framework/.

2. Australian Human Rights Commission. (2022). Free & Equal, Position Paper: A Human Rights Act for Australia, available online: https://humanrights.gov.au/human-rights-act-for-australia#:~:text=Australia%20is%20the%20only%20liberal,how%20they%20can%20be%20protected.

3. Ibid.

4. Redden, J. (2018). The Harm That Data Do, Cardiff University, Journal of Scientific American, available online: https://orca.cardiff.ac.uk/id/eprint/115973/1/Redden%20The%20Harm%20That%20Data%20Do.pdf.

5. Henriques-Gomes, L. (2020). 'Not correct' that robodebt caused suicides, former head of Human Services says, The Guardian, available online: https://www.theguardian.com/australia-news/2020/jul/31/not-correct-that-robodebt-caused-suicides-former-head-of-human-services-says.

6. Community Affairs Reference Committee. (2022). Accountability and justice: Why we need a Royal Commission into Robodebt, The Senate, available online: https://parlinfo.aph.gov.au/parlInfo/download/committees/reportsen/024846/toc_pdf/AccountabilityandjusticeWhyweneedaRoyalCommissionintoRobodebt.pdf;fileType=application%2Fpdf..

7. McPherson, E. (2020). Mothers who lost sons to suicide after Centrelink debts write heartbreaking letters to Senate, Nine News, available online: https://www.9news.com.au/national/centrelink-robodebt-mothers-who-lost-sons-to-suicide-write-heartbreaking-letters-to-senate/d69bd6fc-2257-4a83-ae77-5c5c6b1384f4.

8. Whiteford, P. (2021). Debt by design: The anatomy of a social policy fiasco – Or was it something worse?, Australian Journal of Public Administration, available online: https://onlinelibrary.wiley.com/doi/full/10.1111/1467-8500.12479

9. Ibid.

10. Royal Commission into the Robodebt Scheme. (2022). Transcript of Proceedings, Wednesday 14 December 2022 at 10.01am (AEST), available online: https://robodebt.royalcommission.gov.au/system/files/2022-12/transcript-hearing-day-20-14-dec-2022.pdf.

11. Human Rights (Parliamentary Scrutiny) Act 2011. (2016). Australian Government, available online: https://www.aph.gov.au/-/media/Committees/Senate/committee/humanrights_ctte/ctte_info/HR_Act.pdf?la=en&hash=D6B6CEC22637EAFDCE44B6D30E5EF053BCCB2C66.

12. Ibid.

13. National Suicide Prevention Adviser. (2020). Compassion First: Designing our national approach from the lived experience of suicidal behaviour, Canberra, available online: https://www.health.gov.au/sites/default/files/documents/2021/05/national-suicide-prevention-adviser-final-advice-compassion-first.pdf.

14. Australian Institute of Health and Welfare. (2022). Social and economic factors and deaths by suicide: https://www.aihw.gov.au/suicide-self-harm-monitoring/data/behaviours-risk-factors/social-factors-suicide.

15. AIHW. (2023). Seclusion and restraint in mental health care, available online: https://www.aihw.gov.au/mental-health/topic-areas/seclusion-and-restraint#How%20often%20do%20seclusion%20and%20restraint%20happen.

16. Ibid.

17. Ibid.

18. Ibid.

19. AIHW. (2022). Australia's hospitals at a glance, available online: https://www.aihw.gov.au/reports/hospitals/australias-hospitals-at-a-glance/contents/summary.

20. Ibid.

21. Australian Treaty Series 1976 No 5. (1976). International Covenant on Economic, Social and Cultural Rights, available online: http://www.austlii.edu.au/au/other/dfat/treaties/1976/5.html.

22. Royal Australian & New Zealand College of Psychiatrists. (2021). Minimising and, where possible, eliminating the use of seclusion and restraint, Position Statement, available online: https://www.ranzcp.org/clinical-guidelines-publications/clinical-guidelines-publications-library/minimising-the-use-of-seclusion-and-restraint.

23. Pitman, A.L., Stevenson, F., Osborn, D.P.J. & King, M.B. (2018). The stigma associated with bereavement by suicide and other sudden deaths: A qualitative interview study, Social Science & Medicine, available online: https://pubmed.ncbi.nlm.nih.gov/29316512/.

24. Suicide Call Back Service. (2022). Stigma around suicide, available online: https://www.suicidecallbackservice.org.au/worried-about-someone/stigma-around-suicide/.

25. Ibid.

26. SANE Australia. (2021). National Stigma Report Card, available online: https://www.nationalstigmareportcard.com.au/.

27. Sharwood, L.N., Calear, A.L., Batterham, P.J., Torok, M., McGillivray, L., Rheinberger, D., Zeritis, S., Esgin, T. & Shand, F. (2023). Exploring Sociodemographic Correlates of Suicide Stigma in Australia: Baseline Cross-Sectional Survey Findings from the Life-Span Suicide Prevention Trial Studies, International Journal of Environmental Research and Public Health, 20(3), available online: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9915917/.

28. Suicide Prevention Australia. (2023). Suicide Prevention Australia Community Tracker, June Results, available online: https://www.suicidepreventionaust.org/wp-content/uploads/2023/06/Jun_SPACT_Overview.pdf.

29. Refugee Council of Australia. (2021). UN Member states challenge Australia's refugee and asylum policies, Media Release, available online: https://www.refugeecouncil.org.au/wp-content/uploads/2021/01/Australia-UPR-2101.pdf.

30. Ibid.

31. Kehoe Rowden, T. (2020). Human rights abuses of refugees and asylum seekers in Australia, Human Rights Measurement Initiative, available online: https://humanrightsmeasurement.org/human-rights-abuses-of-refugees-and-asylum-seekers/#:~:text=Asylum%20seekers%20caught%20by%20Australia's,to%20torture%20or%20ill%2Dtreatment

32. Ibid.

33. Ibid.

34. Doherty, B. (2018). 12-year-old on Nauru who tried to set herself alight not getting medical treatment, father says, The Guardian, available online: https://www.theguardian.com/australia-news/2018/sep/01/12-year-old-on-nauru-who-tried-to-set-herself-alight-not-getting-medical-treatment-father-says.

35. Ibid.

36. Hedrick, K., Armstrong, G., Coffey, G. & Borschmann, R. (2019). Self-harm in the Australian asylum seeker population: A national records-based study, Elsevier, SSM Population Health, Volume 8, available online: https://www.sciencedirect.com/science/article/pii/S2352827319300850.

37. Ibid.

38. Waldren, M. (2019). Refugee suicide attempts up on Manus after Australia election, Aljazeera, available online: https://www.aljazeera.com/news/2019/5/23/refugee-suicide-attempts-up-on-manus-after-australia-election.

39. Hedrick, K., Armstrong, G., Coffey, G. & Borschmann, R. (2020). Self-harm among asylum seekers in Australian onshore immigration detention: how incidence rates vary by held detention type, BMC Public Health, 20:592, available online: https://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-020-08717-2.

40. Ibid.

41. Human Rights Watch. (2021). Australia: 8 years of abusive offshore asylum processing, available online: https://www.hrw.org/news/2021/07/15/australia-8-years-abusive-offshore-asylum-processing.

42. Ibid.

43. Essex, R., Kalocsanyiova, E., Young, P. & McCrone, P. (2022). Psychological Distress in Australian Onshore and Offshore Immigration Detention Centres from 2014–2018, Journal of Immigrant and Minority Health, 24(4), available online: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9256570/.

44. Office of the High Commissioner for Human Rights. (2007). UN Declaration on the Rights of Indigenous Peoples, United Nations, available online: https://www.ohchr.org/en/indigenous-peoples/un-declaration-rights-indigenous-peoples#:~:text=It%20was%20adopted%20with%20144,have%20now%20endorsed%20the%20Declaration.

45. Ibid.

46. Minister for Families, Housing, Community Services and Indigenous Affairs. (2009). Statement on the United Nations Declaration on the Rights of Indigenous Peoples, Speech, Parliament House, Canberra, available online: https://parlinfo.aph.gov.au/parlInfo/download/media/pressrel/418T6/upload_binary/418t60.pdf;fileType=application%2Fpdf#search=%22media/pressrel/418T6%22.

47. AIHW. (2022). Deaths by suicide amongst Indigenous Australians, available online: https://www.aihw.gov.au/suicide-self-harm-monitoring/data/populations-age-groups/suicide-indigenous-australians.

48. Ibid.

49. Department of Health & Aged Care. (2021). Status and determinants of Aboriginal and Torres Strait Islander health, Australian Government, available online: https://www.health.gov.au/topics/aboriginal-and-torres-strait-islander-health/status-and-determinants#:~:text=Current%20status,-We%20acknowledge%20the&text=The%20burden%20of%20disease%20for,and%20Torres%20Strait%20Islander%20people.

50. United Nations Human Rights Office of the High Commissioner. (2022). Australia violated Torres Strait Islanders' rights to enjoy culture and family life, UN Committee finds, United Nations, available online: https://www.ohchr.org/en/press-releases/2022/09/australia-violated-torres-strait-islanders-rights-enjoy-culture-and-family.

51. Ibid.

52. AIHW. (2022). Profile of Indigenous Australians, available online: https://www.aihw.gov.au/reports/australias-health/profile-of-indigenous-australians.

53. Australian Bureau of Statistics. (2023). Prisoners in Australia, available online: https://www.abs.gov.au/statistics/people/crime-and-justice/prisoners-australia/latest-release#aboriginal-and-torres-strait-islander-prisoners.

54. Sentencing Advisory Council. (2022). Indigenous Young People in Detention, available online: https://www.sentencingcouncil.vic.gov.au/sentencing-statistics/indigenous-young-people-in-detention.

55. Porter, A. (2023). Quantifying an Australian Crisis: Black Deaths in Custody, University of Melbourne, available online: https://pursuit.unimelb.edu.au/articles/quantifying-an-australian-crisis-black-deaths-in-custody.

56. McAlister, M. & Bricknell, S. (2022). Deaths in custody in Australia 2021-22, Australian Institute of Criminology, Australian Government, Statistical Report 41, available online: https://www.aic.gov.au/publications/sr/sr41.

57. Ibid.

58. Australian Institute of Criminology. (2023). Deaths in Custody in Australia, Australian Government, available online: https://www.aic.gov.au/statistics/deaths-custody-australia#:~:text=There%20have%20been%20544%20Indigenous%20deaths%20in%20custody%20since%20the%20Royal%20Commission.

59. United Nations Association of Australia. (2021). Australia's First Nations Incarceration Epidemic: Origins of Overrepresentation and a Path Forward, available online: https://www.unaa.org.au/2021/03/18/australias-first-nations-incarceration-epidemic-origins-of-overrepresentation-and-a-path-forward/.

60. Ibid.

61. Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability. (2020). About the Royal Commission, Australian Government, available online: https://disability.royalcommission.gov.au/about-royal-commission.

62. Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability. (2023). Seventh Progress Report, Australian Government, available online: https://disability.royalcommission.gov.au/system/files/2023-03/Seventh%20Progress%20Report.pdf.

63. Kayess, R. & Sands, T. (2020). Convention on the Rights of Persons with Disabilities: Shining a light on Social Transformation, Research Report Commissioned by the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, Social Policy Research Centre, UNSW Sydney, available online: https://disability.royalcommission.gov.au/system/files/2020-09/Research%20Report%20-%20Convention%20on%20the%20Rights%20of%20Persons%20with%20Disabilities%20Shining%20a%20light%20on%20Social%20Transformation.pdf.

64. People with Disability Australia. (2023). Disability and human rights, available online: https://pwd.org.au/about-us/about-disability/disability-and-human-rights/.

65. ABS. (2022) Causes of death, Australia, Australian Bureau of Statistics, available online: https://www.abs.gov.au/statistics/health/causes-death/causes-death-australia/latest-release#intentional-self-harm-deaths-suicide-in-australia.

66. AIHW. (2022). Health of people with disability, available online: https://www.aihw.gov.au/reports/australias-health/health-of-people-with-disability#Mental%20health.

67. Ibid.

68. Ibid.

69. Human Rights Watch. (2020). 'He's Never Coming Back', People with Disabilities Dying in Western Australia's Prisons, available online: https://www.hrw.org/report/2020/09/15/hes-never-coming-back/people-disabilities-dying-western-australias-prisons.

70. Australian Human Rights Commission. (2022). Free & Equal, Position Paper: A Human Rights Act for Australia, available online: https://humanrights.gov.au/human-rights-act-for-australia#:~:text=Australia%20is%20the%20only%20liberal,how%20they%20can%20be%20protected.

71. Australian Human Rights Commission. (2017). Religious exemptions under the SDA – Information Sheet, available online: https://humanrights.gov.au/our-work/lgbti/publications/religious-exemptions-under-sda-information-sheet-2017.

72. Equality Australia. (2023). LGBTQI+ Experiences of Poverty, Submission to the Senate Community Affairs and References Committee Inquiry into the extent and nature of poverty in Australia, available online: https://equalityaustralia.org.au/resources/lgbtiqpoverty/.

73. Ibid.

74.O'Hill, A., Bourne, A., McNair, R., Carman, M. & Lyons, A. (2020). Private Lives 3: The health and wellbeing of LGBTIQ people in Australia, Australian Research Centre in Sex, Health and Society, La Trobe University, ARCSHS Monograph Series No. 122, available online: https://www.latrobe.edu.au/__data/assets/pdf_file/0009/1185885/Private-Lives-3.pdf.

75. Ibid.

76. Ibid.

77. Ibid.

78. Simpson, P., Hardiman, D. & Butler, T. (2019). Understanding the over-representation of lesbian or bisexual women in the Australian prisoner population, Research Gate, 31(3), available online: https://www.researchgate.net/publication/336008093_Understanding_the_over-representation_of_lesbian_or_bisexual_women_in_the_Australian_prisoner_population.

79. Donohue, G., McCann, E. & Brown, M. (2021). Views and Experiences of LGBTQ+ People in Prison Regarding Their Psychosocial Needs: A Systematic Review of the Qualitative Research Evidence, International Journal of Environmental Research and Public Health, 18(17), available online: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8430972/.

80. Linnane, D., McNamara, D. & Toohey, L. (2023). Ensuring universal access: The case for Medicare in prison, Sage Journals, 48:2, available online: https://journals.sagepub.com/doi/full/10.1177/1037969X231171160.

81. Carpenter, M. (2021). Intersex human rights, sexual orientation, gender identity, sex characteristics and the Yogyakarta Principles plus 10, Culture, Health and Sexuality, available online: https://pubmed.ncbi.nlm.nih.gov/32679003/.

82. The Yogyakarta Principles. (2017). The Yogyakarta Principles plus 10 (YP+10), available online: https://yogyakartaprinciples.org/.

83. Ibid.

84. Ibid.

85. Bismark, M., Scurrah, K., Pascoe, A., Willis, K., Jain, R. & Smallwood, N. (2022). Thoughts of suicide or self-harm among Australian healthcare workers during the COVID-19 pandemic, Australian and New Zealand Journal of Psychiatry, 56(2), available online: https://pubmed.ncbi.nlm.nih.gov/35128948/#:~:text=Results%3A%20Overall%2C%20819%20(10.5,over%20a%202%2Dweek%20period.

86. Elwyn, R. (2021). Fear of the Impaired Practitioner, Mandatory Reporting, and Clinician Suicide: Can Lived Experience Professionals Heal a Sick Mental Health Field?, Paper Presented at: Suicide Prevention Australia Symposium (Virtual Conference, April 2021), available online: https://www.researchgate.net/publication/351812833_Fear_of_the_Impaired_Practitioner_Mandatory_Reporting_and_Clinician_Suicide_Can_Lived_Experience_Professionals_Heal_a_Sick_Mental_Health_Field.

87. Ibid.

88. Ibid.

89. The Senate Community Affairs References Committee. (2022). Administration of registration and notifications by the Australian Health Practitioner Regulation Agency and related entities under the Health Practitioner Regulation National Law, Commonwealth of Australia, available online: https://parlinfo.aph.gov.au/parlInfo/download/committees/reportsen/024690/toc_pdf/AdministrationofregistrationandnotificationsbytheAustralianHealthPractitionerRegulationAgencyandrelatedentitiesundertheHealthPractitionerRegulationNationalLaw.pdf;fileType=application%2Fpdf.