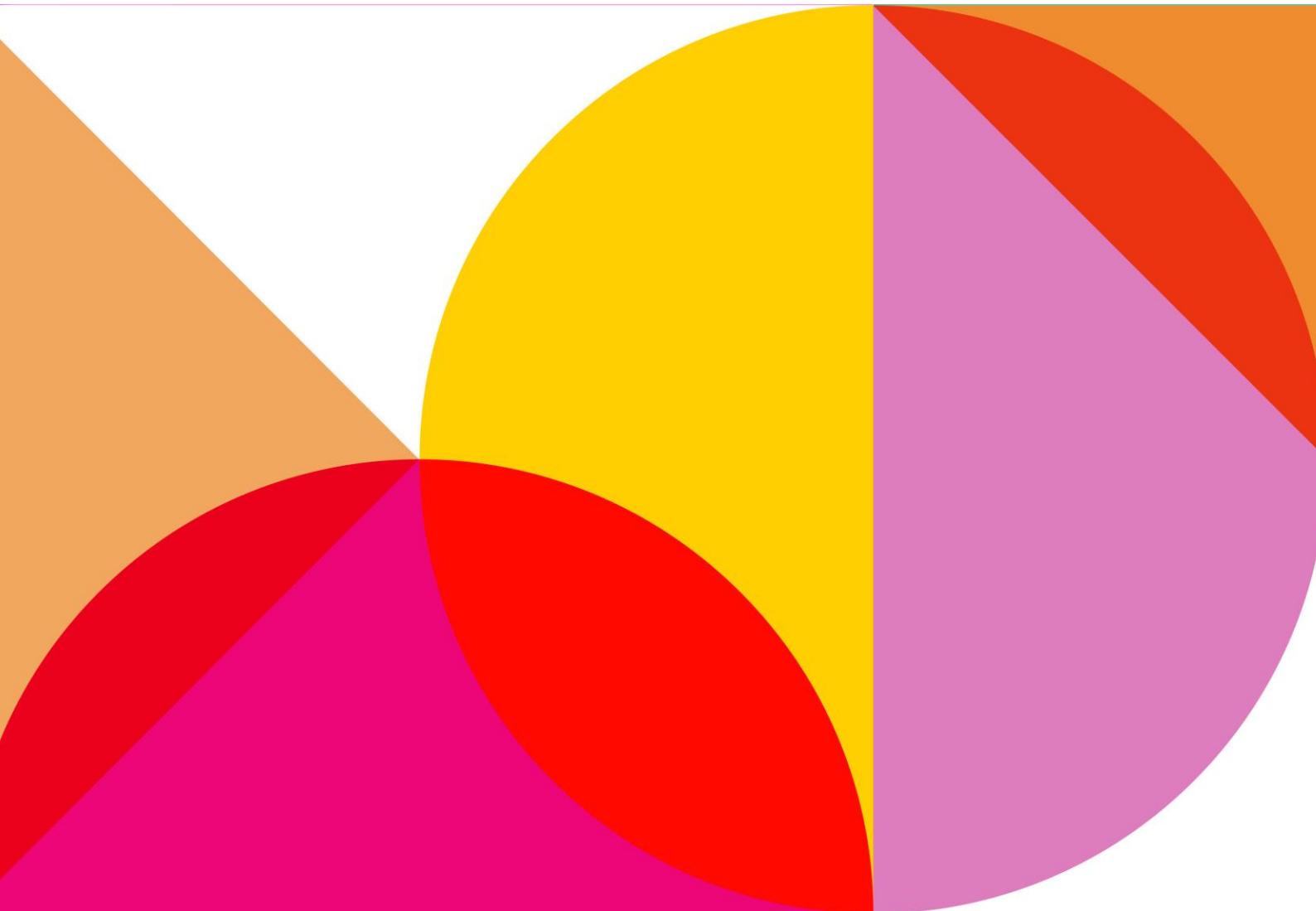
NATIONAL MENTAL HEALTH CONSUMER ALLIANCE

POSITION PAPER

Mental Health Commissions

A national policy position on independence, accountability and consumer rights

26 October 2026



NATIONAL MENTAL HEALTH CONSUMER ALLIANCE

Acknowledgement of Country

The National Mental Health Consumer Alliance acknowledges the Traditional Custodians of the lands and waters across Australia where we live, work, and advocate.

We pay our deepest respects to Aboriginal and Torres Strait Islander peoples, and to their Elders past and present. We acknowledge that First Nations lived experience is inseparable from the impacts of colonisation, dispossession, racism, and structural inequity. These ongoing injustices must be named, understood, and addressed.

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



NATIONAL MENTAL HEALTH CONSUMER ALLIANCE

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 submission 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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Alliance Position

The National Mental Health Consumer Alliance (the Alliance) wants a mental health system where people with lived and living experience of mental health challenges get support on their own terms, wherever they live[i], with their human rights upheld[ii], and where consumers and survivors lead the decisions that shape their lives[iii]. We see national, state and territory mental health commissions as critical tools to ensure these expectations are met.

The Alliance calls for the following:

- **An independent National Mental Health Commission:** The Australian Government to urgently legislate the National Mental Health Commission (NMHC) as an independent, primary statutory body, situated outside any government department.
- **Commissions in every jurisdiction:** Every Australian state and territory to establish and maintain an independent, statutory mental health commission.
- **Accountability and core functions:** Each commission should be accountable to people with lived experience of mental health challenges and have, at a minimum, clear functions for systemic advocacy, independent monitoring and oversight, promotion and protection of human rights, and public reporting on government and service-system performance.
- **Lived-experience leadership:** Mental health consumer lived-experience leadership must be embedded in the governance, executive decision-making, workforce design and evaluation.
- **Authority, resources and independence:** Commissions must have sufficient authority, resources and independence to identify systemic failures and drive corrective action.
- **Independent consumer peak oversight:** Australian governments to recognise and fund independent consumer peaks to monitor the effectiveness of mental health commissions and guard against capture or politicisation.

NATIONAL MENTAL HEALTH CONSUMER ALLIANCE

Policy context and problem definition

The Alliance has already outlined problems and opportunities relating to human rights, bigotry, discrimination and vilification[iv], under-resourced psychosocial support schemes, digital mental health and the impact of AI,, regional and remote mental health, lived experience governance and more.

Mental health governance arrangements are connected to these challenges, with that governance varying significantly across Australia. Mental health commissions exist in several jurisdictions, but their mandates range from advisory and reform functions to service commissioning and regulatory oversight[v,vi]. Other jurisdictions rely on departments, chief psychiatrists, commissioners or sector bodies to perform parts of these functions. This fragmented landscape means that independence, public accountability, consumer participation and avenues for rights protection depend heavily on where a person lives.

A National Mental Health Commission

The National Mental Health Commission (NMHC) has a role that no state or territory commission can perform. Australia's mental health system is federated. The Commonwealth funds Medicare-subsidised care, primary health networks and psychosocial supports, and shares responsibility for the National Disability Insurance Scheme. States and territories run public mental health services and the laws that authorise involuntary treatment. National agreements tie these responsibilities together, and people with lived experience move across them every day. When the system fails someone, the failure often sits in the gaps between governments. Only a national body can see those gaps whole and hold every government to account for closing them. The additional value that a national body can provide is to hold state and territory governments accountable for their performance, without being funded by those governments – a dimension that no other mental health commission can enjoy.

We value the work the Commission has done since 2012, including its national reporting and its efforts to place lived experience at the centre of reform. That work has always been constrained by the Commission's status. It has never had its own legislation, and since October 2024 it has operated as a non-statutory office inside the Commonwealth health department, as an interim step in reforms the Government announced in the 2024–25 Budget. This places the body charged with scrutinising the system inside the department that runs much of it. In our 2024 submission[vii], we told the Government that this conflict of interest made none of its proposed structural options acceptable.

The Productivity Commission's 2025 review of the National Mental Health and Suicide Prevention Agreement[viii] recommended that governments formalise the Commission's independence and responsibilities, and the Commission itself has welcomed that call. The direction is clear. What remains is the will to act.

Drawing on our submission we call on the Australian Government to legislate a NMHC that:

- is an independent, primary statutory body, located outside the Department of Health or any other department;
- is politically neutral, gives frank and fearless advice, and holds all governments to account for system performance through transparent public reporting;
- monitors and reports publicly on performance against agreements between the Commonwealth and other jurisdictions, and promotes coherence across national, state and territory roles without duplicating the work of state and territory commissions;
- has the power to require access to performance data;
- embeds human rights across its work, including negotiating timelines to phase out seclusion, restraint and involuntary treatment in favour of consumer-led, community-based alternatives;
- has at least one empowered consumer lived experience Commissioner, lived experience advisory bodies and lived experience staff in senior decision-making roles, with a budget that properly covers that expertise;

- respects Aboriginal and Torres Strait Islander self-determination in its structure and work; and
- is itself subject to independent oversight, for example through the Auditor-General or direct reporting to Parliament.

Timing matters. In its final report[ix], the Productivity Commission recommended governments co-design a new national architecture. We have urged the Government to introduce legislation before the next National Mental Health and Suicide Prevention Agreement is finalised to ensure the NMHC is external to a Government department allowing it to credibly monitor the next Agreement, something it cannot do while it operates within the department that helps negotiate the Agreement. We continue to recommend, as we did in 2024, the co-design of the NMHC's structure with consumers and survivors. We stand ready to do that work together.

Policy models and institutional functions

Australian mental health commissions broadly reflect four models:

- advisory and reform bodies;
- commissioning bodies that plan, purchase or fund services; and
- regulatory or complaints bodies that handle complaints and enforce standards about quality, safety, rights; and
- system performance and monitoring, that monitor these issues from a systems perspective[x],[xi].

Some jurisdictions combine elements of these models. The choice of model determines a commission's independence, leverage, potential conflicts of interest and capacity to secure action.

Appendix 1, Table 1, summarises the four models, with the main strengths and weaknesses of each. Table 2 summarises the current Commission model and arrangements for each Australian jurisdiction.

Why reform is needed

Reform of commissions cannot be separated from the broader issues and hopes that mental health consumers have for the system. For example[xii]:

- Consumers want access to public mental health supports and timely and sustained care when they want and need it, in order to prevent escalation, yet the system is forcing people to use crisis systems as services which are either unavailable or unaffordable and often unsafe.
- Consumers are seeking health services that are culturally safe, identity-responsive and provide intersectional care. Instead they are faced with services that do not understand, or ignore, their culture, identity, disability or circumstances. Consumers experience discrimination, bigotry and/or vilification when using mental health services.
- Consumers want accountability, complaints processes that are simple, safe, timely and supported by independent advocacy, with safeguards so feedback or complaints do not affect future access to care. Further, complaints systems are often unknown, hard to navigate or do not result in systemic reform, while questions still arise about why governments do not act on complaints.
- Consumers speak of human rights, while progress nationally and in key states often stalls or backslides.

Mental health commissions have a key role in addressing these issues. Against many of the original measures and hopes that underpinned mental health commissions, they have not succeeded. Across many jurisdictions we see the same issues:

- inconsistent independence
- uneven rights protection
- insufficient authority
- fragmented accountability
- limited lived experience leadership
- potential conflicts of interest and
- jurisdictional gaps

Clarifying how their role should be articulated to meet these ends should be a matter for state and territory mental health consumer peaks, driven by their members' views.

Independent consumer peaks as a safeguard

Every model in this paper can fail. Advisory commissions see their strategies shelved. Commissioning bodies struggle to use the lever they hold. Complaints and monitoring bodies can drift towards the services and departments they oversee, or step back from their accountability functions when that work becomes politically uncomfortable. Recent experience in Victoria shows how quickly a well-designed watchdog can lose its force[xiii]. When that happens, people with lived experience carry the cost.

Statutory independence and internal lived experience leadership is necessary, but it is not sufficient. Commissions also need someone outside the system watching them. Independent consumer peaks perform that role and need to be further authorised to do so. We are led, directed and governed by consumers and survivors. We answer to our members. And we are often the first to hear when a mental health commission stops working for the people it exists to serve.

This role has a legal foundation. People with lived experience of mental distress are persons with psychosocial disability under the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD). Article 4(3) requires governments to closely consult with and actively involve people with disability through their representative organisations, and article 33(3) requires those organisations to participate fully in monitoring. The UNCRPD Committee's General Comment No 7 confirms that representative organisations must be independent of public authorities, and that governments should give priority to their views over organisations that provide services.

In 2019 the Committee found that Australia had no permanent or effective mechanisms for this participation in implementation and monitoring, and recommended that Australia establish them with adequate resources. The broader literature on regulation and governance supports "third parties" existing to prevent capture and co-option[xiv,xv].

For mental health commissions, this means independent consumer peaks should:

- Be resourced and authorised to monitor and report publicly on each commission's effectiveness and performance, including whether it uses its powers and acts on what consumers tell it;
- Have formal oversight roles of commissions, including on governance, appointments, priority-setting and statutory reviews, without becoming part of the commission itself;
- Receive commission data and reports in time to scrutinise them, and receive formal responses when we raise concerns; and
- Receive secure, direct core funding that preserves our freedom to criticise governments and commissions alike.

These safeguards protect commissions as much as consumers. A commission that knows an independent consumer movement is watching has a reason to resist pressure from departments and ministers, and a public ally when it does. We have played this role for decades, often without funding. We ask governments to recognise it, resource it and build it into the design of every commission, national, state and territory.

Actions

The Alliance calls for the following actions:

1. The Australian Government should urgently legislate the NMHC as an independent, primary statutory body, with the functions, powers, lived experience leadership and oversight set out in this paper, before the next National Mental Health and Suicide Prevention Agreement is finalised.

2. Each Australian state and territory should establish and maintain a mental health commission in legislation, with:
    a. statutory independence, including transparent appointment processes, security of tenure and freedom to publish without ministerial approval;
    b. system-wide monitoring and oversight of quality, safety, equity, human rights and reform implementation;

c. effective powers to obtain information, initiate inquiries, investigate systemic issues and make findings and recommendations;
d. accountability mechanisms requiring governments and relevant agencies to provide timely, public responses to recommendations;
e. lived-experience leadership embedded in governance, executive decision-making, workforce design and evaluation;
f. adequate and secure resourcing proportionate to the commission's statutory responsibilities.

3. Every jurisdiction should provide accessible, trauma-informed and culturally safe processes for consumers, families and supporters to raise complaints and systemic concerns. Complaints must be independently assessed, investigated within clear timeframes, resolved where possible, and used to identify and remedy recurring system failures. These mechanisms should be able to prevent imminent harms rather than simply redress harm after the fact. These may be inside or outside a mental health commission.

4. Where a commission also plans, purchases or funds services, legislation and governance arrangements should clearly separate commissioning decisions from independent monitoring, complaints and investigation functions.

5. Australian governments should agree a nationally consistent minimum standard for mental health commissions while allowing additional functions to reflect local circumstances.

6. Each commission should publish an annual report on system performance, rights, complaints trends, implementation of recommendations and progress against mental health reform commitments. Ideally these reports would be consistent across commissions nationwide to enable data to be compared by consumers.

7. Australian governments should recognise independent consumer peaks as representative organisations under the UNCRPD and fund them directly to monitor and report publicly on the effectiveness of mental health commissions, with formal roles in commission governance and statutory reviews.

Implementation priorities

Implementation should proceed in three stages.

First, each jurisdiction should independently assess its current institutional arrangements against the proposed national minimum standard, including statutory independence, powers, lived-experience governance, complaints pathways and resourcing.

Second, governments should publish funded reform plans with clear responsibilities and timeframes, prioritising jurisdictions without a dedicated commission and strengthening existing bodies where gaps are identified.

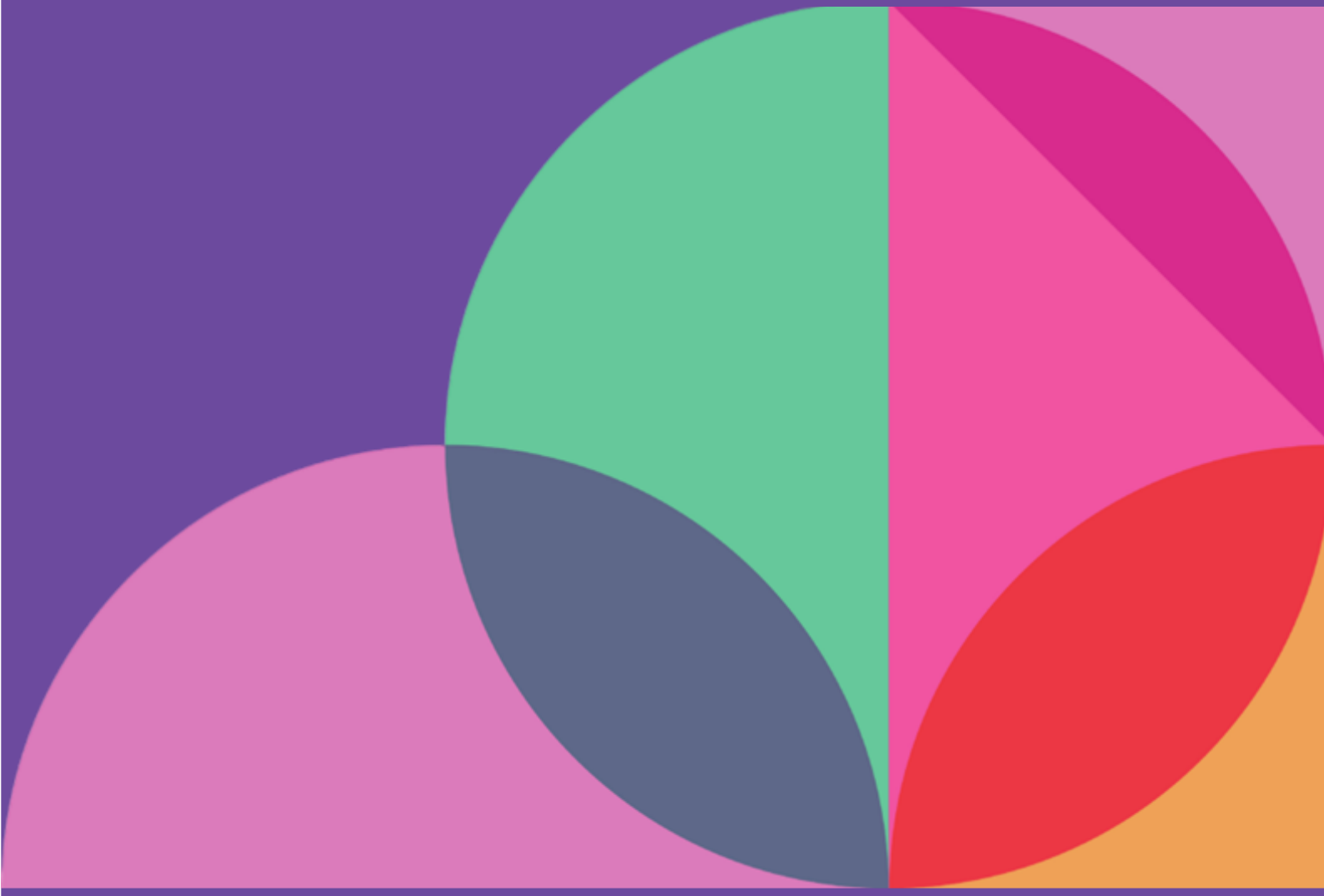
Third, progress should be reviewed publicly at regular intervals in partnership with consumer-led organisations, with findings reported to parliaments and used to refine the national standard

NATIONAL MENTAL HEALTH CONSUMER ALLIANCE

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.



Appendix 1

Table 1: Commission models at a glance

Model	What it does	Strengths	Weaknesses	Implementation Challenges
Advisory and reform	• Gives governments independent advice on policy, strategy and reform • Monitors reform progress, though often without power to compel relevant information or conduct public inquiries • Advocates publicly for change • Cannot direct agencies, regulate providers or control funding • Influence rests on evidence, relationships and public reporting • Examples: New South Wales, Queensland and South Australia	Independent voice Whole-of-government view Strong focus on lived experience and reform	Weakened system and service accountability No control over services or funding	Advisory commissions have struggled to deliver more resources to mental health and many of their reform strategies don't get implemented.[xvi,xvii ,xviii ,xix ,xx]

Model	What it does	Strengths	Weaknesses	Implementation Challenges
Commissioning and system stewardship	• Plans, purchases and funds services • Manages the contracts that deliver them • Turns policy priorities directly into services • Has real leverage over how money is spent • Example: Western Australia (mental health, alcohol and other drug services)	Turns policy directly into services Strong leverage over funding and performance Can reshape service delivery	Funding role can conflict with independent oversight May be seen as part of the system it should scrutinise	Commissions that have this function have typically failed to effectively use the commissioning lever to drive change.[xxi,xxii,xxiii]
Regulatory and complaints	• Receives and resolves complaints • Investigates concerns • Enforces standards of quality, safety and rights • Gives people an avenue for redress when its powers are clear, accessible and properly resourced • Example: Victoria's former Mental Health Complaints Commission and now Mental Health and Wellbeing Commission	Strong accountability Focus on rights, safety and quality Independent of service delivery	Little influence over funding decisions Reform still depends on government action Typically not given powers to *prevent* harm	Commissions with these powers have not utilised them in ways expected by consumers, with concerns of regulatory capture.[xxiv,xxv,xxvi,xxvii,xxviii,xxix]

Model	What it does	Strengths	Weaknesses	Implementation Challenges
System performance and monitoring	• Tracks how the whole system performs on quality, safety, rights and outcomes • Publishes findings • Can require formal responses from governments and providers through powers and public inquiries • Shows where the system fails people and whether governments deliver promised reforms • Example: Victoria's Mental Health and Wellbeing Commission	System-wide view of performance Public reporting builds transparency Tracks reform commitments over time	Cannot resolve individual complaints Relies on governments to act on findings	Commissions with these powers have been accused of politicisation as they withdraw from their accountability functions.[xxx,xxxi,xxxii,xxxiii]

Table 2: Jurisdictional policy landscape

Jurisdiction	Model	Current arrangements
Mental Health Commission of New South Wales	Advisory and reform	The Mental Health Commission of New South Wales is an established statutory body with responsibility for leading, supporting and monitoring reform across mental health, wellbeing and suicide prevention. Its model emphasises strategic advice, cross-government coordination and public reporting on outcomes rather than direct service delivery or regulation.[xxxiv]
Queensland Mental Health Commission	Advisory and reform	The Queensland Mental Health Commission, established under the Queensland Mental Health Commission Act 2013, supports reform across mental health, alcohol and other drugs, and suicide prevention.[xxxv] Its broad mandate supports a whole-of-government approach.
Mental Health Commission (WA)	Commissioning and system stewardship	Western Australia's Mental Health Commission combines policy leadership and reform responsibilities with planning, commissioning and funding of mental health, alcohol and other drug services.[xxxvi]
Mental Health and Wellbeing Commission - Victoria	Regulatory and accountability	Victoria's Mental Health and Wellbeing Commission was established following the Royal Commission into Victoria's Mental Health System. As an independent statutory authority, it has functions spanning system monitoring, complaints, investigations, quality, safety and public reporting.[xxxvii]

Jurisdiction	Model	Current arrangements
South Australian Mental Health Commissioner	Advisory and reform (commissioner)	South Australia uses a commissioner model focused on independent advocacy, human rights, lived-experience leadership and systemic reform.[xxxviii]
Tasmania	No dedicated commission	Tasmania does not have a dedicated statutory mental health commission comparable to those operating in several other jurisdictions. Leadership and accountability functions are distributed across government, statutory offices and sector organisations.[xxxix]
Australian Capital Territory	No dedicated commission	The Australian Capital Territory does not have a dedicated mental health commission. Relevant leadership, oversight and advocacy functions are distributed across the Office for Mental Health and Wellbeing, the Office of the Chief Psychiatrist and other statutory and community-sector bodies.[xl]
Northern Territory	No dedicated commission	The Northern Territory does not operate a separate mental health commission. Governance, service-system leadership and oversight are undertaken through departmental and statutory arrangements.[xli]

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