Making a Commonwealth Human Rights Act work for people with lived experience of mental health challenges

A practical national framework for social change, accountability and safer services

Position Paper | May 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.

All references to ‘Consumer’ and ‘lived experience’ in this position paper refer 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, but we acknowledge that different people self-identify with different terms. We do not include family, carers, kin or the bereaved in our definition of lived experience as it appears in this paper.

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 issues/distress, 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: nmhca.org.au.

National Mental Health Consumer Alliance Position

All Australians living with mental health challenges should be able to understand, rely on and claim the human rights Australia has already committed to uphold. This should not depend on postcode, legal expertise, or a person's ability to withstand a long complaint process. The Commonwealth should use its treaty-implementation power to create a national floor of protection. The immediate priority is a statutory Commonwealth Human Rights Act that preserves parliamentary sovereignty while creating enforceable duties, accessible complaints pathways, court access where appropriate, and effective remedies, including, in serious cases, court-ordered compensation for loss or harm. Public authorities would be required to act compatibly with rights and to give proper consideration to rights before decisions are made. Over time, the Commonwealth should be prepared to fully implement the Convention on the Rights of Persons with Disabilities (CRPD), including resolving inconsistencies with state and territory laws that continue to authorise coercion. The measure of success is not how many matters reach court. It is whether ministers, departments, commissions, boards and providers begin making different decisions before harm occurs.

The Problem

Across Australia, people living with mental health challenges do not have consistent access to the supports and conditions they need to live well in the community. Access to support is uneven, quality varies sharply between services, and too many people still encounter a system that is easier to enter through crisis, police or hospital than through voluntary, community-based support. These failures are not only about supports and care. They are also about housing, income, privacy, family and kinship, cultural healing, participation, education, work, safety and access to justice.

These harms are not distributed evenly. Aboriginal and Torres Strait Islander people, people in rural and remote communities, people living in poverty, refugees and asylum seekers, culturally and linguistically diverse communities, children and young people, people experiencing homelessness, and people who are incarcerated or have a criminal record, women, and LGBTIQA+ people often face overlapping discrimination, cultural unsafety, exclusion from decision-making, and barriers to care. Coercive practices remain among the clearest and most acute expressions of these broader system failures. They can be traumatic, counter-therapeutic

and discriminatory in impact. A Commonwealth Human Rights Act can reshape the laws, policies, funding and service infrastructure that determine whether people receive support early, voluntarily and on terms that respect dignity, agency and connection.

Australia does not currently have a Commonwealth Human Rights Act. Human rights are currently recognised through a patchwork of sources, including the Constitution, anti-discrimination law, privacy and administrative law, parliamentary scrutiny processes, sector-specific safeguards. The Australian Capital Territory (ACT), Victoria and Queensland do have human rights legislation. Australia has also ratified major international human rights treaties. In practice, this means protection is uneven and often indirect, especially at the Commonwealth level.

Australia has already accepted a wide range of relevant human rights obligations by signing and ratifying instruments including the International Covenant on Civil and Political Rights, the International Covenant on Economic, Social and Cultural Rights, the Convention Against Torture (and its 'Optional Protocol' known as OPCAT), the Convention on the Rights of the Child, Convention on the Elimination of All Forms of Discrimination Against Women, the Convention on the Elimination of Racial Discrimination, the Convention on the Rights of persons with Disabilities, and the United Nations Declaration on the Rights of Indigenous Peoples. But for most people living with mental health challenges, these commitments do not yet operate as a clear national framework for action.

Internationally, human rights for mental health consumers are receiving ongoing attention. World Health Organisation (WHO) and the Office of the United Nations High Commissioner for Human Rights (OHCHR) 2023 legal guidance call for rights-based reform, deinstitutionalisation, community services and elimination of coercion,[i] and WHO's 2025 policy guidance reinforces human-rights alignment, social determinants, lived-experience participation and funding shifts away from institutional models.[ii]

The Commonwealth already shapes mental health outcomes every day. It does so through Primary Health Networks (PHNs), the Commonwealth Psychosocial Support Program, Medicare Mental Health Centres, the National Disability Insurance Agency (NDIA) and National Disability Insurance Scheme (NDIS) Quality and Safeguards Commission, Better Access Initiative, social security, data systems, national agreements, and other commissioning and regulatory decisions. Without a national Human Rights Act, these systems can still be designed, contracted and evaluated without a consistent duty to think and act through a human rights lens.

Human rights are not only a legal response to individual abuse. They are a systemic framework for dealing with the drivers of discrimination and distress. Housing, adequate income, privacy, family and kinship, cultural healing, participation, education, work, safety and access to justice all shape whether a person can live well in the community. A rights-based approach therefore

improves decision-making across the whole system, not just after something has gone wrong.

There is now a real, but still uncertain, federal reform moment. The Australian Human Rights Commission's Free and Equal report expressly recommends a National Human Rights Framework and federal reform agenda,[iii] the 2024 Parliamentary Joint Committee on Human Rights report,[iv] and the committee's illustrative bill have made a Commonwealth Human Rights Act unusually concrete. But this is not yet an implementation phase. The task now is to advocate to government to commit to a model that works for mental health consumers in practice.

This paper is intended both as an advocacy position for government and as a practical explanation for Alliance members of the reform model being proposed.

A CRPD and disability lens

People living with mental health challenges are covered by all international human rights instruments. The most relevant is the Convention on the Rights of Persons with Disabilities ('CRPD'). The CRPD did not introduce new rights but sought to restate existing rights considering the historic failure of previous human rights treaties to promote and protect the rights of people with disability. It is strategically and substantively important that mental health be understood through the CRPD and disability rights lens.

Not everyone with mental health challenges will identify as a disabled person or as a person with psychosocial disability. The value of the CRPD is not that it forces a single identity label. It is that it focuses attention on the barriers that stop people participating on an equal basis with others, and on the supports needed to remove those barriers. In practice, that can include being unable to access care and/or support in a crisis, being excluded from work or study because of mental health challenges, or being denied reasonable adjustments, communication support or decision-making support. All people who are discriminated against, unsupported, excluded or abused because of their mental health challenges are protected by human rights law. The CRPD is especially useful because it speaks directly to the kinds of barriers and rights violations we commonly face.

Many people living with mental health challenges are already treated in policy and law as people with psychosocial disability, and the CRPD shifts from a narrow focus on health and illness to fundamental issues like equal recognition before the law, non-discrimination, accessibility, supported decision-making, community inclusion, and practical support. This focus shifts policy attention away from a mere need to increase funding to health services toward the need to refashion mainstream laws, policies and programming to reflect a more accurate account of human life. Mental health consumers are diverse, interdependent and move in and out of support needs. A national Human Rights Act should help refashion institutions around that reality, rather than around an ideal of the fully self-sufficient, always-rational subject.

The reform path: a long-term objective and an immediate priority

National reform should be framed in two stages. The immediate step is a statutory Commonwealth Human Rights Act. The longer-term objective is fuller Commonwealth implementation of the CRPD through the external affairs power. The immediate statutory Act should preserve parliamentary sovereignty and include the enforcement features described as a 'No Rights Without Remedy' approach: accessible complaints pathways, court access where appropriate, and effective remedies, including compensation where appropriate. Public authorities should be required to act compatibly with rights and to give proper consideration to rights before decisions are made. This is the type of statutory model reflected in the Australian Human Rights Commission's Free and Equal work and the Parliamentary Joint Committee's illustrative bill. It also keeps national reform aligned with the strongest disability-rights reading of coercion and with the direction of travel in recent WHO guidance: toward voluntary, community-based support, supported decision-making and the elimination of coercive practices.[v]

Coercion remains a central human rights issue for mental health consumers because it is where the gap between current Australian law and contemporary disability-rights standards is often most visible. State and territory mental health laws continue to authorise substitute decision-making, involuntary treatment and restrictive practices, while international disability-rights standards have moved further toward supported decision-making, freedom from coercion and community-based alternatives. A Commonwealth Human Rights Act will not resolve that conflict on its own, but it can do important work now: prevent broad carve-outs, narrow exceptions, require supported and least-restrictive responses, and shift funding and accountability toward voluntary alternatives.

What a Commonwealth Human Rights Act must do

The Act should be built for social change. Its main focus should be public education, better policy, better commissioning, and stronger public accountability. Courts remain important, but they are not the whole model.

Design feature	Why it matters in practice
Broad rights, not a narrow civil liberties list	The Act should protect civil, political, economic, social and cultural rights: equality before the law, privacy, liberty and humane treatment, health, adequate standard of living including housing, social security, education, work, family and kinship, cultural rights, civic participation, and a healthy environment. This is essential because mental health outcomes are shaped as much by income, housing, safety and exclusion as by supports

Design feature	Why it matters in practice
	and care.
First Nations self-determination and UNDRIP	The Act should recognise the particular significance of self-determination for Aboriginal and Torres Strait Islander peoples and require interpretation that is consistent with United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP) where First Nations rights are affected. Implementation must be First Nations-led, properly resourced, and connected to the Gayaa Dhuwi (Proud Spirit) Declaration and its implementation plan[vi]. This means direct leadership in compatibility processes, oversight, service design, workforce targets, data and evaluation.
An expansive public authority duty	The Act should be in force wherever the Commonwealth shapes people's lives. That means departments, agencies, regulators, tribunals and publicly funded or publicly directed services. It should extend across a range of government activities, including PHN-commissioned mental health services, Medicare Mental Health Centres, Commonwealth psychosocial support programs, Better Access Initiative, NDIA and NDIS regulatory decisions, social security administration, private hospitals and non-government organisations delivering publicly funded services, and other outsourced or contracted functions. The scope should be broad in practice without locking reform into an unnecessarily narrow definition.
Proactive, preventative duties	Public authorities should have a positive duty to act compatibly with human rights and to give proper consideration to rights before decisions are made. That duty should be backed by participation obligations for affected groups, such as people with lived experience of mental health challenges, children and First Nations communities; practical human rights impact tools; mandatory training; and annual action plans and reporting.
Strong, accessible enforcement	Enforcement should be broader than court proceedings. People should be able to complain to an independent human rights commission or comparable body and, where needed, go directly to court and obtain effective remedies. The Act should therefore include accessible complaints pathways, accessible court pathways, interpreters and communication supports, disability access measures, fully funded legal assistance, and cost protections.

Design feature	Why it matters in practice
Effective, accessible remedies	The Act should provide remedies that are practical, effective and easy to use. People should be able to seek an outcome that fits the problem, whether that means stopping the breach, getting a fresh decision, changing a policy or practice, or, in serious cases, receiving compensation. Compensation means money paid for serious harm caused by a rights breach. Rights are far more likely to shape government behaviour where breaches can lead to real accountability and meaningful repair.
A stronger national human rights regulator	The Commonwealth framework should include an independent, adequately resourced human rights commission or comparable national regulator with complaints handling and conciliation, own-motion investigations, systemic inquiries, the power to demand data and information, public reporting, compliance monitoring, recommendations to ministers and agencies, and the ability to refer serious risks or intervene in relevant proceedings. This would allow future decisions about institutional design while making clear that independent commissions and regulators are central to enforcement.
No broad mental health carve-outs	The Act should not create mental health label-based exclusions, lower rights thresholds, or general mental health exceptions. People should not lose rights protection because they are labelled to be living with mental health challenges or psychosocial disability. Where a person needs support to exercise legal capacity or participate in legal processes, those supports should be provided. Broad override mechanisms and vague 'health' exceptions would weaken the Act where mental health consumers most need it.
Rights-based agreements and commissioning	The next National Mental Health and Suicide Prevention Agreement should be renegotiated on a human rights basis, with measurable commitments on psychosocial supports, service integration, stigma and discrimination, participation, data and accountability.[vii] PHN commissioning guidelines, NDIS interfaces, social security settings, and Commonwealth psychosocial supports should all be realigned so that rights are implemented in ordinary planning and funding decisions.
State and territory	The Act should operate concurrently with existing state and territory rights frameworks and mental health laws. In the immediate statutory model, it would not automatically override state and territory mental health Acts.

Design feature	Why it matters in practice
harmonisation	Instead, it would make inconsistencies easier to identify, encourage mirror state legislation and national harmonisation, and support stronger national consistency, including in territories where Commonwealth legislation applies directly. The longer-term CRPD implementation pathway remains the route for addressing inconsistency more concretely.

What this will do for people living with mental health challenges

The main value of a Commonwealth Human Rights Act for mental health consumers is practical. It should produce different decisions in ordinary government business and make those decisions easier to challenge by creating a duty on Commonwealth public authorities to consider and act compatibly with rights, backed by complaints pathways, court access and effective remedies. In the immediate statutory model, it would work alongside state and territory mental health Acts rather than automatically overriding them. Where a State or Territory law expressly authorises coercion, that law would continue to operate unless and until further reform occurred. A Commonwealth Act would nevertheless make inconsistencies clearer, strengthen challenges to unsafe or unnecessary restrictions, and create pressure for reform, especially in Commonwealth-controlled, funded or regulated systems. It would:

- Create a consistent national baseline so that the ability to understand and claim rights does not depend on which State or Territory a person lives in.
- Improve government decision-making before harm occurs by requiring rights to be considered in policy design, service planning, commissioning, data sharing and regulation.
- Create stronger incentives to fund less restrictive, community-based, lived experience-led and culturally safe alternatives, rather than defaulting to bed-based or coercive models.
- Make systems such as PHNs, NDIS regulation, psychosocial supports, social security and publicly funded private hospitals more transparent and more accountable to the people affected by them.
- Strengthen First Nations leadership, cultural safety and self-determination across mental health policy, commissioning and evaluation.
- Build public understanding of rights and responsibilities so that accountability is political and community-facing, not only technical or court-driven.

Priority actions for government

1. Commit to a statutory Commonwealth Human Rights Act on a parliamentary-sovereignty model. The Act should include accessible complaints pathways, direct court access where needed, and effective remedies. Human rights education should be a central part of the reform agenda, not an afterthought.
2. Use the external affairs power both to enact the Act and to begin staged, fuller implementation of the CRPD, including mapping inconsistencies between treaty obligations and state and territory mental health laws.
3. Ensure the Act protects broad rights and embeds self-determination, UNDRIP and the Gayaa Dhuwi framework in national implementation.
4. Apply the framework across Commonwealth-controlled, funded and outsourced systems, including PHNs, psychosocial supports, NDIS-related functions, social security, digital systems and private hospitals delivering publicly funded mental health care.
5. Expand the powers and resourcing of Commonwealth regulators so they can conciliate complaints and conduct public inquiries, and undertake own-motion investigations and compliance reviews, compel information and data outside the existing complaint process, publish findings, monitor compliance, and support accessible pathways to justice.
6. Renegotiate the next National Mental Health and Suicide Prevention Agreement on a human rights basis and require human rights clauses in service agreements, grant agreements, commissioning guidance and public reporting.

The potential limits of a Human Rights Act

A Human Rights Act is not a complete answer. Evidence from Australia and comparable jurisdictions shows that legislation alone does not transform mental health systems; outcomes depend on implementation, resourcing, oversight, political will and continued consumer-led organising. **The value of a Commonwealth Human Rights Act is that it would create a clearer legal and institutional framework for those broader struggles, not replace them.**

Current human rights protections in Australia

Australia does not currently have a Commonwealth Human Rights Act. Instead, human rights protection comes from a mix of constitutional rules, legislation, courts, complaints bodies and international commitments.

Broad human rights laws currently exist in three Australian jurisdictions: the ACT *Human Rights Act 2004*, the *Victorian Charter of Human Rights and Responsibilities Act 2006*, and the *Queensland Human Rights Act 2019*. These laws require rights to be considered in law-making and public decision-making, but they do not create one national standard.

Current human rights protections in Australia

At the national level, the Constitution provides some important but limited protections. These include jury trial for some Commonwealth indictable offences, freedom of religion and freedom from religious tests for Commonwealth office, just terms when the Commonwealth acquires property, and protection against state discrimination based on residence. Courts have also recognised an implied freedom of political communication.

There are also many specific laws and schemes that protect particular rights or settings. These include the *Human Rights (Parliamentary Scrutiny) Act 2011*, which requires Statements of Compatibility for federal Bills and many legislative instruments; federal anti-discrimination laws; the *Australian Human Rights Commission Act 1986*; the *Privacy Act 1988*; the *Freedom of Information Act 1982*; and the *Ombudsman Act 1976*. There are also sector-specific protections, including NDIS practice standards, the Australian Charter of Healthcare Rights, and the *Statement of Rights in the Aged Care Act 2024*. All states and territories also have anti-discrimination laws and complaints bodies.

Australia has also ratified major international human rights treaties, including the International Covenant on Civil and Political Rights (ICCPR), the International Covenant on Economic, Social and Cultural Rights (ICESCR), the Convention on the Rights of the Child (CRC), the Convention on the Rights of Persons with Disabilities (CRPD) and the Convention Against Torture (CAT), and it supports the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP).[viii] These instruments shape policy, parliamentary scrutiny, advocacy and sometimes legal interpretation. But, in most cases, treaty rights are not directly enforceable in Australian courts simply because Australia has ratified the treaty. Under the current federal parliamentary scrutiny regime, Statements of Compatibility are assessed against seven core treaties; UNDRIP is not presently one of them.

Evidence on human rights protections from Australia and around the world

Australian courts have used statutory human rights frameworks to scrutinise involuntary psychiatric interventions. In *PBU & NJE v Mental Health Tribunal*,[ix] the Supreme Court of **Victoria** emphasised the vulnerability of people subject to compulsory psychiatric treatment and required careful scrutiny of decision-making capacity when authorising electroconvulsive treatment. Earlier decisions such as *PJB v Melbourne Health*[x] also show how proportionality and human rights reasoning can limit coercive treatment where the interference with liberty or bodily autonomy is not demonstrably justified.

In *Kracke v Mental Health Review Board*,[xi] the **Victorian** Civil and Administrative Tribunal found that prolonged delay in reviewing involuntary treatment orders breached the right to a fair hearing under the Victorian Charter. The case shows that rights legislation can expose systemic administrative failures affecting people subject to compulsory treatment and can force closer scrutiny of the processes by which coercion is maintained.

Evaluations of the **Victorian** Charter suggest that human rights legislation can influence administrative decision-making and reveal breaches by public authorities, including in the mental health jurisdiction,

Evidence on human rights protections from Australia and around the world

but that outcomes depend heavily on implementation. The 2015 review found variable compliance and an under-developed human rights culture, which is significant because it shows that legislation alone is not enough. It must be matched by institutional support, monitoring and accountability.[xii]

Annual reporting by the **Queensland** Human Rights Commission shows the importance of human rights legislation in framing ongoing complaints concerning health, disability and housing. In 2023–24 and 2024–25, complaints alleging human rights breaches included 17 and 16 complaints respectively in the health sector, 4 and 6 in disability services, and 10 in accommodation or housing.[xiii] The rights most frequently engaged included recognition and equality before the law, privacy and reputation, protection from cruel, inhuman or degrading treatment, humane treatment when deprived of liberty and the right to health services. The **Queensland** complaints material suggests that many of the most common rights issues affecting people with lived experience of mental health challenges arise in what might otherwise be treated as ordinary administrative settings. Equality, privacy, procedural justice, access to health services, housing and conditions of detention are all engaged. This supports the argument that a Commonwealth Human Rights Act should protect broad economic, social and cultural rights, rather than focusing only on the civil and political rights restricted by formal coercive powers.

The strongest comparative jurisprudence arises from the **European** Convention on Human Rights. In Winterwerp v Netherlands[xiv] the European Court of Human Rights established foundational safeguards for lawful psychiatric detention, including the need for objective medical evidence and procedural protections. Subsequent decisions such as *Herczegfalvy v Austria*[xv] and *HL v United Kingdom*[xvi] developed standards governing coercive treatment and deprivation of liberty in psychiatric settings. These cases show that rights instruments can create enforceable limits on detention and treatment practices in mental health systems.

Canadian Charter jurisprudence has also shaped psychiatric decision-making. In *Starson v Swayze*[xvii] the Supreme Court of Canada strengthened legal protections for treatment refusal by requiring rigorous capacity assessment. In *Winko v British Columbia (Forensic Psychiatric Institute)*[xviii] the Court clarified limits on indefinite detention for forensic patients, balancing liberty interests with public safety. These cases demonstrate that rights frameworks can sharpen legal standards for treatment override and prolonged detention.

The **New Zealand** Human Rights Commission has produced specific reviews of seclusion framed through Bill of Rights norms and related human rights instruments, showing how human rights framing can aid in government oversight and investigations.[xix]

Glossary

Better Access Initiative: A Commonwealth Medicare-funded program that supports access to certain mental health services delivered by eligible practitioners.
Coercive practices: Interventions used without a person's free and informed consent, or where consent is overridden, that restrict liberty, autonomy or bodily integrity. In mental health and related settings, this includes compulsory assessment and treatment, seclusion, physical or mechanical restraint, chemical restraint, and other forms of involuntary intervention authorised by law or policy. These practices are commonly justified on grounds of risk or treatment need but raise significant human rights concerns, particularly where less restrictive, voluntary alternatives are available.
CRPD: Convention on the Rights of Persons with Disabilities.
Dialogue model: A statutory human rights model that preserves parliamentary sovereignty. Parliament remains the final law-maker, while courts, governments and public authorities must consider rights in making laws and decisions.
Gayaa Dhuwi Framework: The Gayaa Dhuwi (Proud Spirit) Declaration Framework and Implementation Plan offers a 10-year strategic approach (2025-2035) to achieving the highest attainable standard of mental health and suicide prevention outcomes for Aboriginal and Torres Strait Islander peoples.
No Rights Without Remedy: An enforcement-oriented version of a statutory model that adds accessible complaints pathways, court access and effective remedies when rights are breached.
OPCAT: Optional Protocol to the Convention Against Torture, aimed at preventing torture and other cruel, inhuman or degrading treatment in places of detention.
PHN: Primary Health Network; a regional body that plans and commissions primary health services, including some mental health services.
Public authority: A government body, or an organisation performing public functions, that must act compatibly with human rights under a statutory framework.
UNDRIP: United Nations Declaration on the Rights of Indigenous Peoples.

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.

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See nmhca.org.au for more information about the Alliance.

For questions about this submission, please contact us at policy@nmhca.org.au.

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