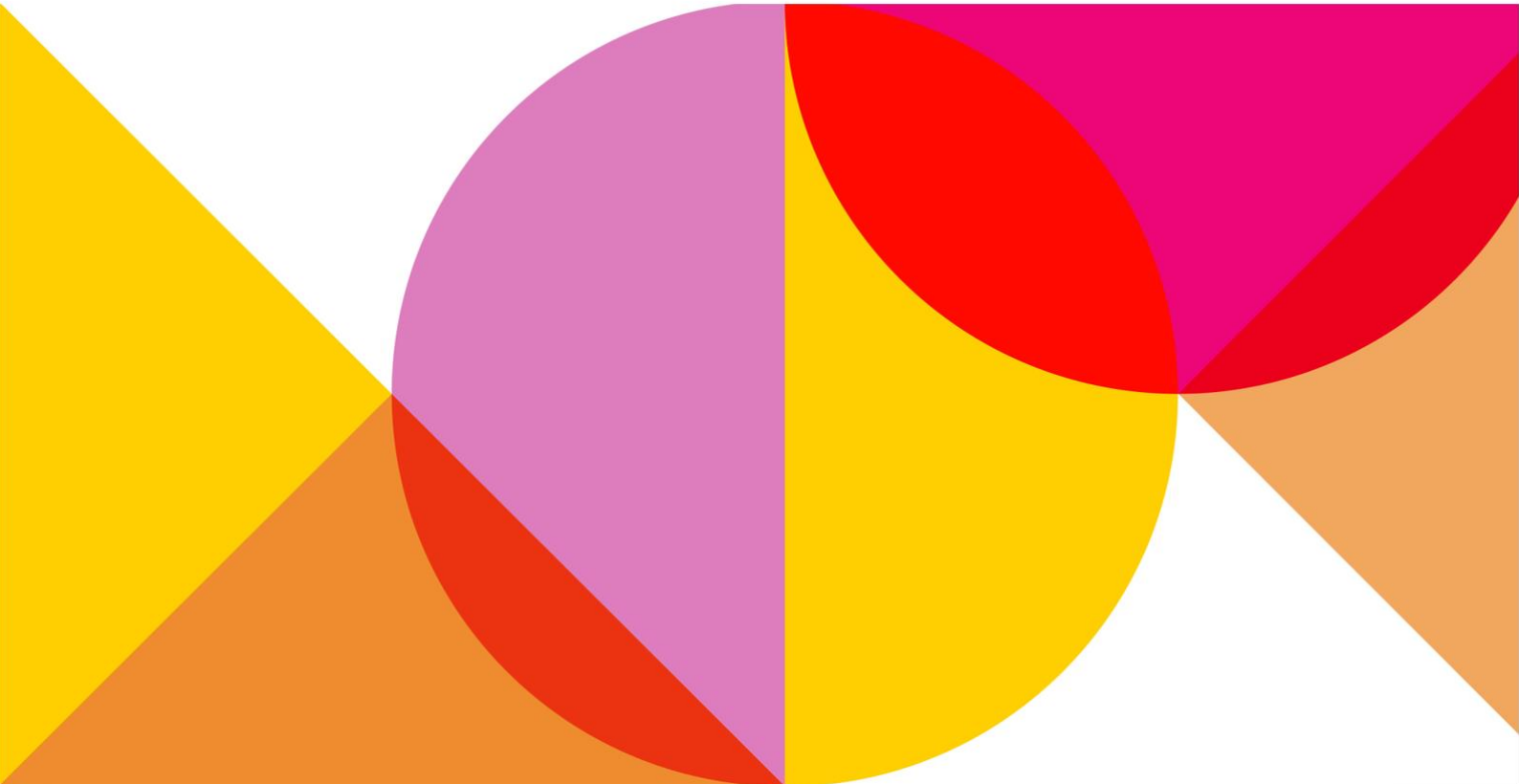
NATIONAL MENTAL HEALTH CONSUMER ALLIANCE

SUBMISSION

In Our Words

What Mental Health Consumers want from the next Mental Health & Suicide Prevention Agreement

12 August, 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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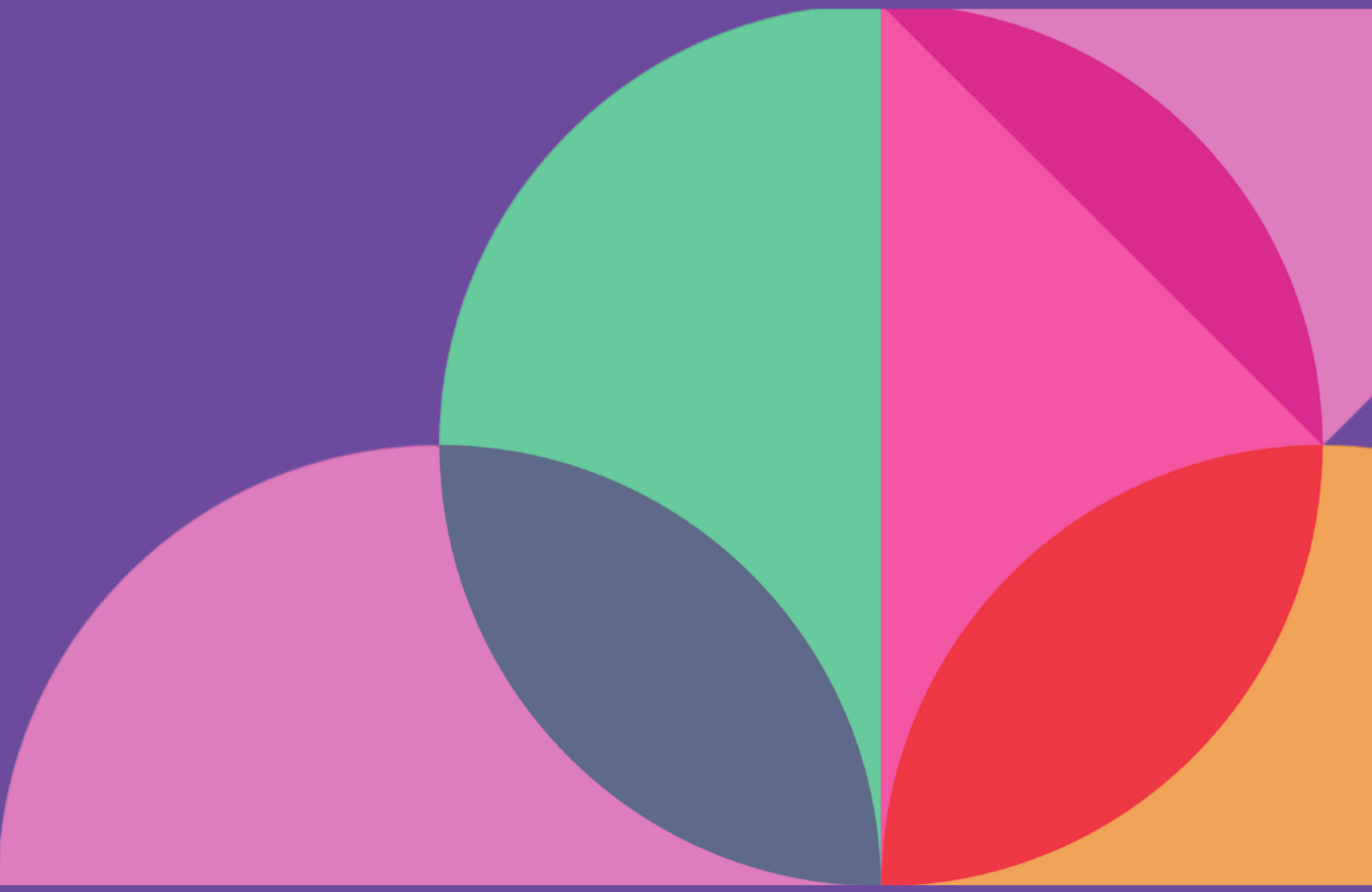
NATIONAL MENTAL HEALTH CONSUMER ALLIANCE

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.



NATIONAL MENTAL HEALTH CONSUMER ALLIANCE

Contents

Executive summary

This report presents the views of mental health consumers across Australia on whether mental health services and supports funded under the National Mental Health and Suicide Prevention Agreement (the NMHSP Agreement) deliver the key outcomes they want from mental health services. It is grounded in responses to the Alliance's 2026 national consumer survey and three online participatory sensemaking sessions with groups underrepresented among survey respondents. The sessions explored thematic areas arising from the survey in greater depth.

The strongest message from consumers is clear: we need help to be available before distress escalates, and that help must be affordable, safe, respectful and available for as long as it is needed. Access to support was the dominant consumer priority in the survey. "*When I needed help, I received it*" was ranked as the number one priority by 43% of respondents and appeared in the top five priorities of 88% of respondents.

Many consumers reported that this is not their current experience. Just under half could not access supports when needed, two thirds of those who accessed acute care could not do so in a timely way, and many were unable to access peer workers, psychosocial supports, alcohol and other drug services, family violence supports or integrated support when these were needed.

Mental health consumers also identified dignity, respect, choice and control as central to a safe and effective mental health system. Being treated with dignity and respect appeared in the top five priorities of 88% of respondents, while 56% identified real choice and control as a priority. This emphasis was also reflected in the sensemaking sessions, with

dignity and respect receiving the most votes overall across the three groups when participants considered what mattered most for the next Agreement.

Sensemaking participants deepened this finding by describing dignity and respect as relational, practical and rights-based. Across groups, participants linked dignity to being listened to, believed and understood as a whole person; having choice and control; feeling emotionally and culturally safe; and having relationships with workers and services that were continuous, collaborative and non-coercive.

The survey shows ongoing gaps in rights-respecting care and shared decision-making, particularly in acute settings. Nearly half of acute care respondents said they were not treated with dignity and respect, and a similar proportion said they were not involved in discharge planning.

The findings reinforce that mental health reform must focus on prevention and early support, not only crisis response. Consumers want timely, local, free or low-cost supports that are available before needs escalate. They also want services that respond to the whole person, including mental health, physical health, neurodevelopmental needs, housing, income, social connection, alcohol and other drug use, family violence and other social determinants of wellbeing.

Peer support is a key part of the solution. Consumers described peer workers as trusted supports who provide understanding, validation, hope, advocacy, practical assistance and help navigating fragmented systems. However, access to peer workers and peer navigators remains limited across primary, community and acute settings. Expanding and properly funding the peer workforce should be a central feature of the next Agreement.

The survey also highlights that health services that are culturally safe, identity-responsive and provide intersectional care must be embedded across the system. Respondents included many people with intersecting identities and experiences, including neurodivergent people, LGBTIQA+ people, people with other types of disability, as well as Aboriginal and Torres Strait Islander people, people of colour, migrants and refugees. Many consumers reported that mental health services did not understand or respond to their culture, identity, disability or circumstances, and some reported experiences of discrimination, bigotry or vilification when using mental health services.

Participants from culturally and racially marginalised communities emphasised that culturally safe care requires more than translated information. It includes trusted pathways into support, language access, recognition of stigma and family or carer roles, attention to migration and residency concerns, and services that understand culture as protective rather than as a barrier.

Workforce shortages and service fragmentation are undermining access, safety and continuity of care. Consumers reported difficulty getting appointments, maintaining ongoing support, moving between services, receiving coordinated discharge planning, and accessing wraparound suicide prevention and post-attempt support. Too often, consumers are left to identify, coordinate and navigate their own supports while in distress.

The sensemaking sessions also showed that access is shaped by more than service availability. Participants identified timely and sustained care, clear entry points, navigation support, flexible access across locations and circumstances, eligibility based on need rather than rigid criteria, and support that is safe and appropriate to the person's identity, culture and life circumstances as essential to meaningful access.

Digital services may have a role as part of a broader system, but they cannot replace accessible, human, trauma-informed and rights-based support. While some respondents used digital tools, many used them without support from a mental health service or peer worker, and many did not find them beneficial. Digital mental health tools should not be treated as a substitute for relational, supported care.

Finally, the current system is not sufficiently transparent or accountable to consumers. Many respondents did not know how to make complaints about services funded through the Agreement, and most did not know how to find consumer outcome data about services they might use. The next Agreement must build in consumer-facing accountability, clear complaints pathways, public reporting and genuine consumer leadership in design, governance, commissioning and evaluation.

Sensemaking participants described accountability as needing to be visible in consumers' everyday experiences of care and in broader life outcomes. They called for 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. They also emphasised lived experience leadership, transparent reporting, stronger oversight and evidence that governments are acting on issues consumers have repeatedly raised.

Overall, consumers are calling for a mental health system that is accessible before crisis, affordable for as long as needed, safe and respectful, culturally responsive, peer-supported, integrated across services and accountable to the people who use it. These findings should inform the priorities, funding, governance and accountability arrangements of the next National Mental Health and Suicide Prevention Agreement.

Key insights

1. Access is the dominant consumer priority

- The clearest headline is that consumers want help and support when they need it.
- *"When I needed help, I received it"* was the top-ranked priority and appeared in the top five for 88% of survey respondents.
- Prevention/early support is a priority for consumers. 76% (141 respondents) included *"I was able to prevent my challenges from escalating"* in their top five priorities, reinforcing that consumers want support early, not only in crisis.
- Survey results:
    - *"When I needed help, I received it"* was ranked the number one priority by 43% of respondents (p. 32)
    - Many consumer statements stressed access to early, affordable and sustained support, including support that is *"immediately and locally available"* (p. 38) and *"as and when I need it."* (p. 44)
    - Just under half of respondents (47%) could not access supports when needed, including quick access to mental health and/or suicide prevention care (p. 50)
    - 54% reported access was affected by staff shortages such as being unable to get an appointment or ongoing support. (p. 58)
    - Over half of respondents could not access acute care services in a timely manner - 66% (p. 64)
    - Peer support workers are not available when wanted or needed - 61% (p. 65)
    - Alcohol and other drug services not available when needed – 67% (p. 73)
    - Family violence services not available when needed – 65% (p. 74), integrated family violence and mental health

supports not available when needed – 84% (p. 74)

- Sensemaking results:
  - Meaningful access required more than service availability: it involved timely, affordable and sustained support; clear entry points, navigation and coordination; flexible and equitable access; access based on need rather than rigid criteria or service boundaries; and safe and appropriate support. (pp 60-62, p. 77)
  - Safe Haven-type services and accessible community-based models were forms of support that participants wanted to see more widely available. (p. 61-62)

2. Dignity, respect, choice and control are central

- Consumers consistently emphasised key outcomes of being listened to, believed, treated with dignity, and involved in decisions about their own care.
- Shared decision-making and genuine participation remain major gaps.
- Survey results:
  - 88% of respondents included *"I was treated with dignity and respect"* in their top five priorities, and 56% included *"I had real choice and control"* (p. 26)
  - 68% were not included in the design of the mental health system, showing that genuine consumer participation remains a major gap (p. 40).
  - This is especially visible in acute care, where 45% said they were not treated with dignity and respect and 48% were not involved in discharge planning (p. 64-65)
- Sensemaking results:
  - Dignity and respect received the most votes for what consumers wanted to see in the next Agreement, followed by access to help when needed. (p. 33-38)

- Dignity and respect were understood as relational and rights based.
- Choice and control also meant respecting the different forms of support and sources of wellbeing that mattered to consumers. (p. 36)

3. Cost and affordability are major barriers
    - The survey results, supported by the sensemaking findings, clearly show that free or low-cost, sustained support is a core need.
    - Financial insecurity appears as a broader determinant of mental health and access to care.
    - Cost barriers interacted with people's broader life circumstances, limiting access to appropriate and sustained support.

4. Workforce shortages cut across the whole system
    - This is one of the strongest cross-cutting findings.
    - Workforce issues affect access, continuity of care, acute care, psychosocial support, safety, and consumer confidence.
    - Survey results:
        - 49% were unable to access psychosocial supports when they needed them and indicated that the supports they received were impacted by workforce challenges (p. 62).
        - 66% said their care in acute settings was impacted by workforce challenges (p. 62)
    - Sensemaking results:
        - Workforce shortages and pressure on existing staff affected the availability and quality of care.
        - Workforce capability included the ability to recognise and address bias, understand consumers' intersecting

identities and circumstances, and connect them with a range of clinical, non-clinical, peer-led and community-based supports appropriate to their needs.

5. Peer support is highly valued but poorly available

- Consumers identify peer workers as important for trust, connection, navigation, hope and practical support
- However, access to peer workers, peer navigators and peer support in primary, acute and community settings is limited.
- Survey results:
  - 10% respondents explicitly mentioned peer support, peer workers, lived experience workers or peer-led supports as supports that felt safe (p. 50)
  - 24% reported having access to a peer worker when they wanted or needed one, 61% said they did not (p. 64)
  - 13%reported having access to a peer navigator to help them move between services and supports, 15% had access in primary care (p. 64).
  - 51% did not have access to peer support in acute care settings and 59% did not have access in community care (p. 64)

6. Safe support means more than clinical care

- Consumers describe safe support as person-centred, trauma-informed, non-judgmental, culturally safe, identity-responsive, affordable, timely and connected.
- Safety is strongly linked to relationships, trust, continuity and being treated as the expert in one's own life.
- Early support could only be effective when people felt safe enough to seek it.

7. Integrated and coordinated care is a major system gap
    - Consumers want supports that address the whole person, including mental health, physical health, neurodevelopmental needs, housing, AOD, family violence, social supports and community connection.
    - Consumers identified that they are often left to navigate fragmented systems themselves.
    - Continuity includes consistent relationships, follow-up and not having to repeatedly retell one's story.

8. Prevention and early intervention need stronger emphasis
    - Consumers want support before crisis, not only when things escalate.
    - This includes early access, walk-in options, ongoing psychological support, social connection, stable housing and financial security.

9. Suicide prevention and post-attempt support appear especially weak
    - A strong finding is that consumers are largely responsible for identifying, coordinating and accessing their own suicide prevention and post-attempt supports.
    - Wraparound support, postvention and post-attempt care are not consistently available.

10. Cultural safety, identity responsiveness and intersectionality should be prominent

- Consumers reported that mental health services did not understand or adequately respond to their culture, identity, disability or circumstances.
- The next Agreement should foreground that services must be culturally safe, neuro-inclusive, disability-accessible and responsive to gender, sexuality, age, culture and other identities.
- Services cannot be safe and respectful if they do not centre culture and identity.

11. Digital tools are not a substitute for supported care

- More than half of respondents did not find digital mental health services/tools beneficial.
- Many used these tools alone, without support from a peer worker or mental health service.

12. Transparency and accountability are weak

- Many consumers do not know how to make complaints or access service outcome data.
- This undermines accountability and makes it difficult to assess whether services are safe, effective or improving.
- Complaints processes need to be safe, transparent and timely, with clear communication about action taken in response.
- Governments need to act on systemic issues repeatedly raised by consumers.

13. Lived experience is needed at every level

- Consumers want people with lived experience to hold genuine influence in policy development, system design and positions of

power.

Priority Actions for 2027-2031 Agreement

The findings point to clear policy actions for the next National Mental Health and Suicide Prevention Agreement.

1. ### Guarantee timely, affordable access to mental health and suicide prevention supports
   The next Agreement should prioritise free or low-cost, locally available support that people can access when they need it, before distress escalates. This should include walk-in and community-based options, rapid access pathways, and sustained psychological and psychosocial support for as long as consumers need it. Complexity should not be a reason a consumer is turned away from a service.

2. ### Fund clear entry points, navigation support and community-based drop-in options
   Sensemaking participants identified confusing entry points, rigid service criteria and lack of supported navigation as key access barriers. The next Agreement should invest in visible, easy-to-access pathways, peer and independent navigation, and Safe Haven-type community spaces that people can use before crisis and without restrictive eligibility thresholds.

3. ### Embed dignity, respect, choice and control across all funded services
   Governments should require services funded under the Agreement to demonstrate rights-based, trauma-informed, person-centred and shared decision-making practice. This should include stronger safeguards against coercive practices and clear expectations that

consumers are involved in decisions about their own care, including discharge planning.

4. ### Require services to build relational safety and share power with consumers

   Sensemaking participants described dignity, respect and safety as dependent on trust, time, cultural humility, trauma-informed practice, non-coercive relationships and genuine power sharing. The next Agreement should set clear expectations that funded services demonstrate these practices in intake, assessment, care planning, discharge and ongoing support.

5. ### Expand and properly fund the peer workforce

   Peer workers and peer navigators should be available across primary care, community mental health, psychosocial supports, emergency departments and acute mental health settings. Peer roles should be funded as core system infrastructure, not optional add-ons, with clear career pathways, supervision and support.

6. ### Build integrated, whole-of-person support pathways

   The Agreement should fund models that connect mental health care with physical health, psychosocial support, housing, income support, alcohol and other drug services, family violence services, social connection and community participation. Consumers should not be left to coordinate complex systems while in distress.

7. ### Strengthen prevention and early intervention by addressing social determinants

   Prevention should include practical action on housing, income security, employment, community connection and access to local supports.

Mental health reform should not be limited to clinical services or crisis response.

8. Improve acute care, discharge planning and post-crisis follow-up

Acute services should be required to provide timely access, respectful care, coordinated discharge planning, proactive follow-up and warm referrals into community-based supports. Consumers should leave acute care with a clear plan, a point of contact and support already connected.

9. Fund coordinated suicide prevention, post-attempt and postvention supports

The Agreement should establish wraparound, person-centred support after suicidal distress, suicide attempts and suicide bereavement. Supports should include proactive follow-up, shared care planning, practical assistance and continuity for as long as consumers need it.

10. Ensure services are culturally safe, identity-responsive and intersectional

All funded services should be required to demonstrate cultural safety, disability accessibility, neuro-inclusive practice and responsiveness to gender, sexuality, age, culture, migration experience and other intersecting identities. This should include dedicated investment in Aboriginal and Torres Strait Islander-led, culturally specific and community-controlled responses.

11. Strengthen culturally trusted pathways and intersectional safeguards

The next Agreement should require services to address language access, stigma, discrimination, migration-related concerns, disability access, neurodivergence, age, gender and sexuality in practical ways. Services should be accountable for making support safe to approach, including for people who fear that help-seeking or complaints may have negative consequences.

12. Treat digital tools as supplementary, not a substitute for relational care

Digital mental health tools should only be used as part of a broader system of supported, human, trauma-informed care. Digital services should include clear privacy protections, supported navigation and access to peer or clinical support where needed.

13. Strengthen transparency, complaints pathways and consumer-facing accountability

Consumers should be able to easily find information about funded services, outcomes, complaints processes and service quality. The Agreement should require public reporting, accessible complaints pathways, consumer outcome measures and genuine consumer leadership in governance, commissioning, design and evaluation.

14. Make complaints and accountability mechanisms safe, independent and visible

Accountability should include simple and accessible complaints pathways, anonymous feedback options, independent advocacy, clear information about consumer rights, transparent reporting on what has

changed, and consequences where funded services do not meet agreed standards. Consumers should be able to raise concerns without fear of retaliation, loss of support or poorer care and Governments should act on repeatedly raised systemic issues.

Introduction

The National Mental Health Consumer Alliance (Alliance) conducted a national engagement process so the views of mental health consumers who use mental health services and supports funded by the National Mental Health and Suicide Prevention Agreement (the Agreement) would be heard and considered in the development of the next Agreement.

This involved a national consumer survey followed by three online participatory sensemaking sessions with consumers from groups underrepresented among survey respondents. The sensemaking sessions explored thematic areas arising from the survey in greater depth. Findings from both engagement activities aimed to inform the key insights and recommendations for the next Agreement.

Approach

National consumer survey

The national consumer survey ran from 1 May to 15 June 2026. It was advertised through the Alliance members, the State/Territory peak bodies for mental health consumers as well as through our Newsletter, Mental Health Australia, public social media pages (including Facebook, Instagram and LinkedIn) and other Disability peak bodies.

We sought to understand whether the services and supports provided for under the current Agreement worked for people with lived experience of mental health challenges. We asked whether the current Agreement has led to services and supports that are safe, effective, and available. This includes mental health care and supports, suicide prevention, harm

reduction, domestic violence supports, and alcohol and other drug services.

The survey was based on the five outcome domains developed by the Alliance based on the body of work that the Alliance has collectively done over the past 18 months including:

1. Consumer goals, rights and equity
2. Prevention and early support
3. Integrated supports
4. System sustainability and performance outcomes, and
5. Transparency and accountability.

The 22 outcomes under each domain are listed in Appendix One.

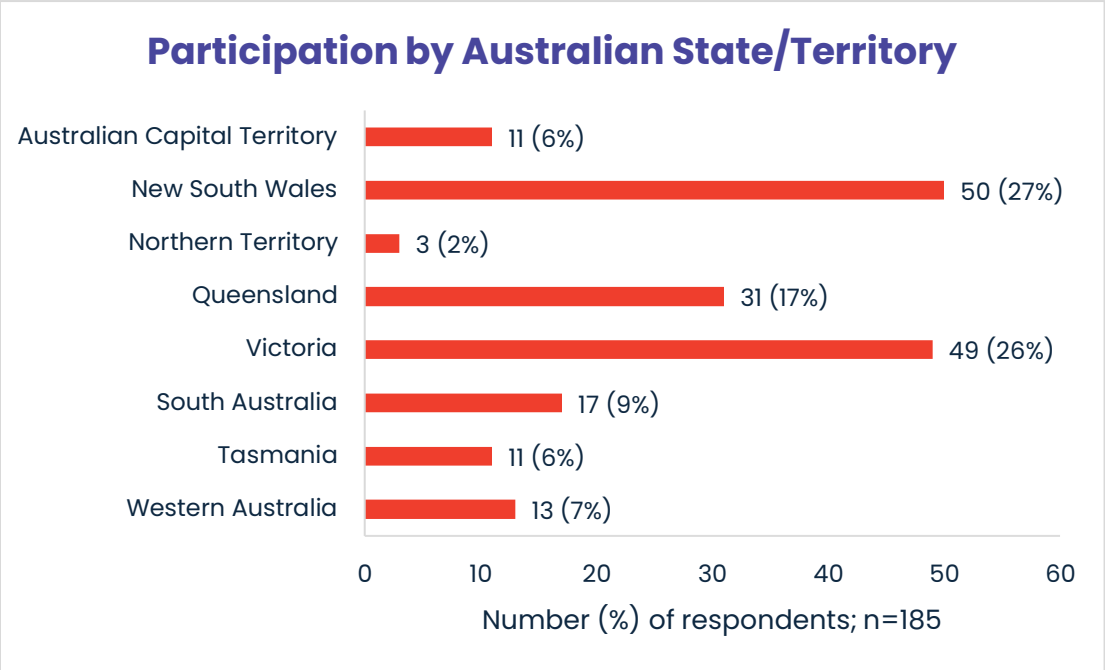
To complete the survey, respondents had to identify as having lived experience of mental health challenges and live in Australia. Respondents also provided consent for their deidentified responses to be used in reports written by the Alliance and provided to the Alliance members, the State/Territory mental health peak bodies.

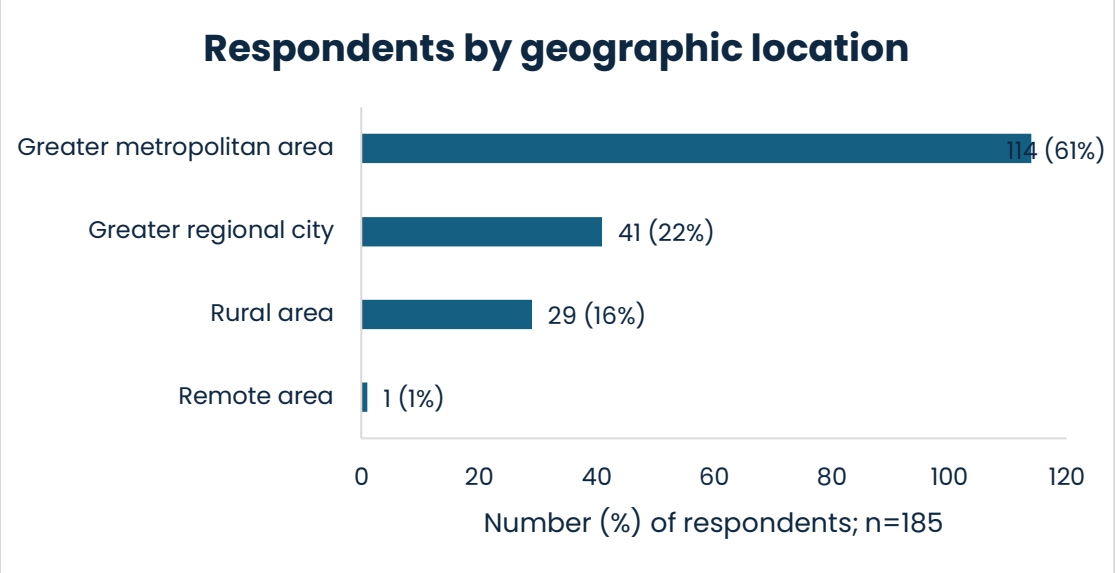
Who responded

A total of 247 people opened the survey. Of these, 185 people provided at least one substantive response beyond the demographic questions and are included in the analysis. As not all questions were compulsory, response numbers vary across questions.

Survey responses were received from each State and Territory. Over half of these were from people in New South Wales (27%, 50 respondents) and Victoria (26%, 49 respondents).

Fewer people responded from rural, regional and remote (38%, 71 respondents) as compared to city areas (61%, 114 respondents), with only one respondent living in an identified remote area.





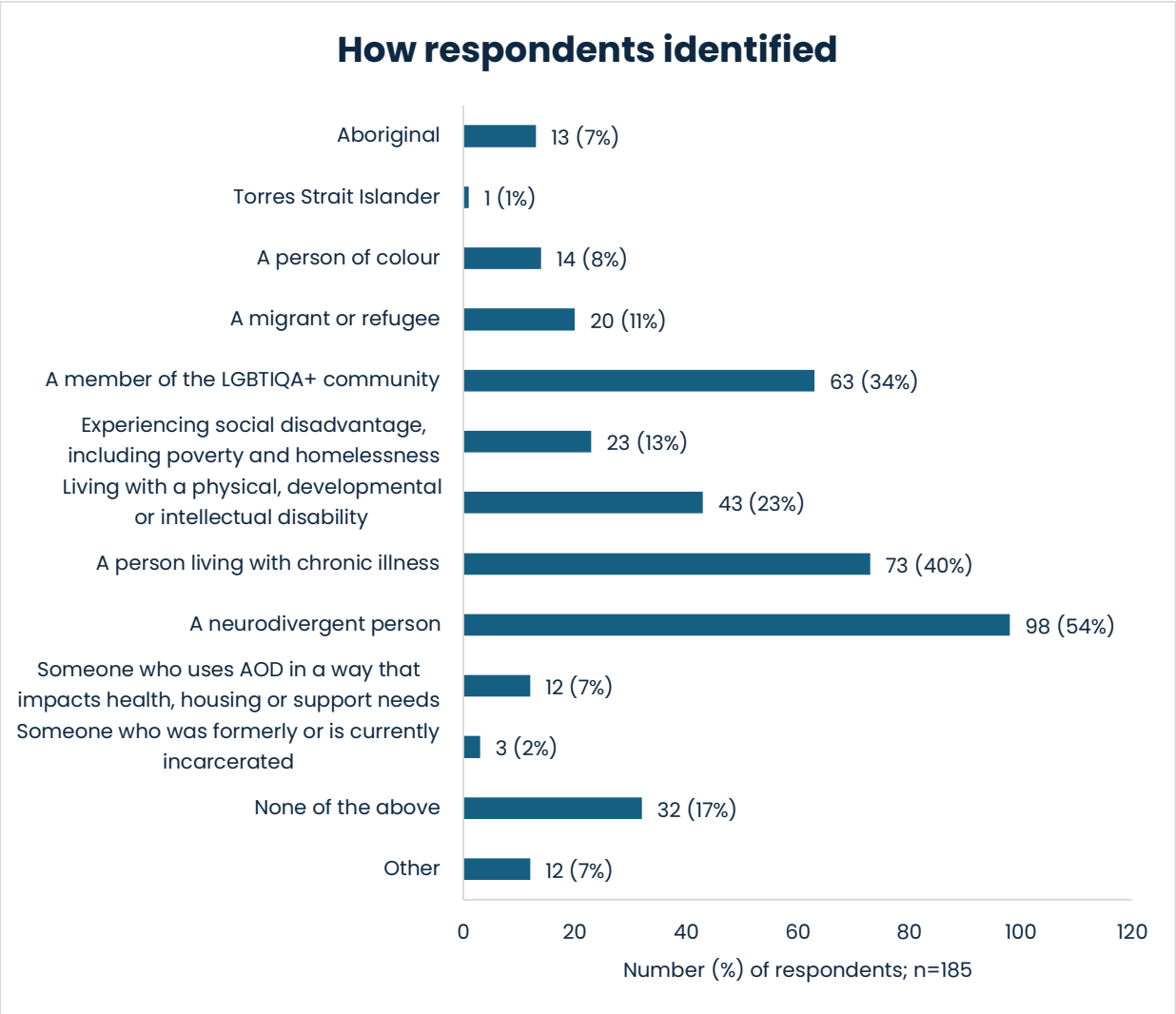
Most respondents identified as women (68%, 125 respondents) and 23% (42 respondents) as men. A smaller proportion identified as non-binary or gender diverse (8%, 15 respondents), and 2% (3 respondents) selected none or other. Fourteen (8%) of respondents identified as transgender.

All survey respondents were aged 18 or older, with 89% or 161 respondents aged between 26 years and 65 years inclusive.

Four, or 2% of respondents, indicated they were current or former members of the Australian Defence Force, while 29 or 16% were family members of current or former serving members.

Respondents identified with a range of intersecting identities and experiences including more than half that identified as neurodivergent (54%, 98 respondents) and 40% as living with chronic illness (73 respondents). One third (34%, 63 respondents) identified as LGBTIQA+. Almost a quarter (23%, 43 respondents) identified as living with a physical, developmental or intellectual disability.

Thirteen respondents identified as being Aboriginal (7%) and one as Torres Strait Islander (1%). Fourteen also identified as a person of colour (8%), and 20 as migrants or refugees (11%).



A note on survey data

As not all survey questions were compulsory, the number of respondents varies throughout the survey and in some cases between items within a question. Each graph indicates the total number of respondents who answered the relevant question or item using *n (for example, n = 156)*. Missing responses are excluded from *n* and the percentage calculations. Graph labels show the number and percentage of respondents who

selected each response option, with the percentage calculated based on the total number who answered that question or item.

Participatory sensemaking sessions

Three online participatory sensemaking sessions were held to explore key priorities and findings arising from the survey in greater depth, drawing on a broader range of consumer perspectives. The sessions were held on July 1, 6 and 8, 2026.

Sessions were held with three consumer groups that had lower representation among survey respondents: young adults aged 18 to 25, people from culturally and racially marginalised (CARM) communities, and people experiencing social disadvantage (SD). The approach enabled participants to reflect on and share their perspectives and supported collective understanding through group discussion.

Participants were invited through an online expression of interest form advertised through the same mechanisms as used to advertise the survey and screened against the inclusion criteria. Of 30 consumers invited, 28 participated: nine young adults, 11 participants from culturally and racially marginalised communities and eight people experiencing SD. Participants were from all states and territories. Participants received a consumer participation payment in recognition of their time and lived experience expertise.

The sessions explored thematic areas identified from the survey requiring more in-depth understanding: timely and affordable access; holistic, trauma-informed care and support that prevents escalation, with dignity; culture and identity and support that continues across services; and transparency and accountability.

Each session was facilitated by three Alliance staff, led by the Co-Design Manager. Participants recorded individual and small-group reflections on a digital whiteboard, while whole-group discussions were recorded and transcribed. Participants also voted for the two priorities they considered most important for the next Agreement from five which were identified as important from the survey.

The Research Manager used a framework approach to analyse the digital whiteboard reflections, transcripts and facilitator notes by participant group and theme, mapping findings against the Alliance's Outcomes Framework (see Appendix One). Cross-group synthesis identified shared themes, differences in emphasis and group-specific experiences. Generative AI assisted with comparing findings and refining themes, which were checked against the source material.

The sensemaking findings are presented alongside the survey results in this report where they add depth to the survey findings.

Consumer priorities for an ideal mental health system

Survey respondents were provided with nine consumer centric outcome statements based on the Alliance's Outcomes Framework, developed as part of our "A logical framework for the next national MH&SP agreement." The Outcomes Framework is provided in Appendix 1.

Respondents were asked to rank their top five preferred outcome statements, from these nine, that an ideal mental health system would have delivered over the past five years. The most frequently identified top

priority was "*access to help when needed*". Specifically, 43% of respondents (79 people) ranked "When I needed help, I received it" as their number one priority. It was also the most selected outcome overall, appearing in the top five priorities of 88% of respondents (165 people).The outcome statements most included in respondents' top five priorities were:

- When I needed help, I received it (88%, 165 respondents)
- I was treated with dignity and respect (88%, 164 respondents)
- I was able to prevent my challenges from escalating (76%, 141 respondents)
- I had real choice and control (56%, 103 respondents)
- Support continued when I moved between services (53%, 98 respondents)

A weighted ranking analysis was also undertaken to account for the order in which respondents ranked each outcome. This analysis showed a similar overall pattern, with access to help when needed, dignity and respect, and prevention of escalation remaining the three highest-ranked priorities, followed by having real choice and control. However, peer worker support entered the top five priorities, suggesting that while fewer respondents included this outcome overall, those who did often ranked it more highly.

Also examined was which outcome was most selected at each ranking position. This provides an indication of how priorities were distributed across the ranking scale, rather than the most common full order selected by individual respondents. Of note is that "*My culture and identity were understood*" is now included.

The most common outcomes across ranking positions were:

1. access to help when needed (ranked 1 by 43%, 79 respondents)

2. support that prevents challenges from escalating (ranked 2 by 24%, 45 respondents)
3. being treated with dignity and respect (ranked 3 by 31%, 58 of respondents)
4. my culture and identity were understood (ranked 4 by 17%, 31 of respondents)
5. support continued when I moved between services (ranked 5 by 25%, 45 of respondents).

Sensemaking findings

Reflecting the survey findings, when votes were tallied across the three groups from the sensemaking sessions, dignity and respect received the most votes for what mattered most for the next Agreement (68%, 19 votes), followed by access to help when needed, (50%, 14 votes) However, there was some variation between groups.

Dignity and respect received the most votes within the culturally and racially marginalised (CARM) participant group, followed by continuity. Continuity included consistent relationships, warm handovers and follow up.

> *"Continuity of care should mean continuity of relationships. The most therapeutic intervention is often not another assessment, but having someone who knows your story, walks alongside you over time, and ensures you are never left to navigate the system alone."*
>
> -Participant, CARM group

Their discussions also emphasised cultural safety, language access, addressing stigma, recognition of carers, and culturally trusted pathways into support. Some participants were concerned that seeking help or

making a complaint could affect their residency status, potentially discouraging them from accessing support.

In the young adults group, dignity and respect received the most votes, followed by access to help when needed as their second top priority. Other priorities were seen as interconnected with these:

"You can't have dignity and respect without centring culture and identity, and you can't have continuity if you can't access the services in the first place."

-Participant, young adults group

In their sensemaking session young adults also placed particular emphasis on autonomy, being believed and receiving identity-safe and non-coercive care. Age-based paternalism and transitions from child and adolescent to adult services were also concerns.

Among participants in the experiencing SD group, access to help when needed received the most votes, followed by dignity and respect. A key issue raised in the group discussions were compounding barriers to accessing appropriate support and the need for services to recognise how intersecting barriers significantly impacted people's ability to live a good life. Participants emphasised the harm that could occur when services failed to understand structural barriers and the person's life in context.

"People often fall through the gaps when they have complexities in their lives that the system doesn't recognise as 'contributing factors'. Instead, sectors and services are siloed and the correct care becomes inaccessible to the person."

-Participant, experiencing SD group

Overall, the sensemaking findings highlight the interconnections between the outcome statements and the importance of system reform that centres mental health consumers' lives, circumstances and rights.

Understanding what dignity and respect looks like in practice

It was evident from all the groups that dignity and respect were strongly linked to the quality of relationships between consumers, workers and services, including how power was exercised within these relationships. Dignity and respect were reflected in whether consumers could trust and feel safe in services and were active partners in decisions about their own care.

Dignity and respect included four interconnected dimensions:

1. Being listened to, seen and understood as a whole person

"Feeling seen and heard and listened to I think really means a lot. It means someone is paying attention not only to your story but to you as a person."

-Participant, CARM group

2. Choice, control and sharing power

"Creating a therapeutic relationship that is collaborative rather than coercive. Constantly taking on feedback from each other and working together towards a common goal"

-Participant, young adults group

3. Safe, trusting, trauma informed and continuous relationships

"Consistent and not rushed relationships and appointments, trauma informed care."

-Participant, experiencing SD group

4. Culturally safe, identity-affirming and accessible support

"When I request accommodations for my autism, they are facilitated without a massive fuss."

-Participant, young adults group

Understanding choice and control

The sensemaking sessions provided further insight into choice and control. Participants stressed that consumers must be active decision-makers in their care. Having care decided without their involvement was described as disempowering and dehumanising.

Participants also described how unequal power between practitioners and consumers constrained agency. They linked choice and control to dignity of risk, including the right to question, decline or resist forms of support and make informed decisions about their own lives and care.

"The hierarchy of client and practitioner created a difficult dynamic. I wish treatment was more collaborative"

- Participant, young adults group

Choice was not meaningful when only one form of support was available. Consumers also wanted a wider range of clinical and non-clinical supports, such as community groups, peer workers, Eye Movement Desensitisation and Reprocessing (EMDR) therapy, ADHD-specific support,

pet therapy, culturally specific practitioners and traditional and natural healing practices.

Choice also included the gender of practitioners. Participants emphasised that different approaches worked for different people and that choice was limited when services offered only narrow or standardised models.

"Talk therapy doesn't work for everyone yet this is what many mental health services focus on"

– Participant, young adults group

Additional key outcome statements from consumers

Survey respondents were also asked whether they had an additional key statement describing an outcome that an ideal mental health system would provide consumers. There were 76 responses.

Key themes we identified from the responses were mapped against the Alliance's outcome domains, and were reflected across three key areas, consumer goals, rights and equity; prevention and early support; and integrated supports. The results echo what consumers have consistently raised through decades of advocacy: a mental health system that is accessible, affordable, safe and connected.

Consumer statements emphasised the importance of being treated with dignity, having choice and control, receiving culturally safe care, and being able to access support early and for as long as needed. Responses also highlighted the need for holistic and integrated support, with stronger continuity across services and recognition of carers, family and kin.

Consumer goals, rights and equity

Respondents indicated that they want care that is person-centred, trauma-informed and grounded in dignity and respect. They described the importance of being able to make choices, being listened to, being seen as a whole person, receiving an accurate diagnosis and treatment, and not being pushed into inappropriate or harmful responses.

"I was believed and valued."

"I was authentically validated and supported to celebrate my strengths and capacity."

-Respondents, 2026 Survey

Respondents identified they wanted services that are safe, equitable and inclusive. This included receiving care that is responsive to their identities and circumstances and not being excluded because their needs are considered too complex.

Responses highlighted the importance of culturally safe support for Aboriginal and Torres Strait Islander People and consumers from culturally diverse backgrounds, neuro-inclusive practice, and care that is responsive to age, gender, disability and other intersecting experiences.

"*my age, gender and disabilities weren't discriminated against*."

-Respondent, 2026 Survey

Prevention and early support

Many consumer statements stressed the importance of access to early, affordable and sustained mental health support, reflecting the top key

priority of being able to access help when needed. It also included access to preventative treatment instead of just support when in crisis.

"I could access compassionate support early, consistently and close to home."

"the most appropriate help that I needed was immediately and locally available, it was free or affordable, for as long as I needed it."

-Respondents, 2026 Survey

Affordability was a clear priority, with the cost of care being a key barrier to accessing and sustaining support.

"[it would be good if] costs were not an impact and services weren't restricted."

-Respondent, 2026 Survey

Integrated supports

Responses also pointed to the need for holistic and integrated support that connects across services. Respondents described wanting care that encompasses and responds to all their needs - mental health, physical health, neurodevelopmental needs and social circumstances, rather than treating these separately.

"Holistic and integrated care with mental health services working WITH other social service providers and primary health to provide truly preventative and early intervention before crisis point."

-Respondent, 2026 Survey

Some responses emphasised the importance of universal psychosocial and non-clinical supports that help people stay connected and well outside formal treatment. This included community connection, and support for recovery, information and resources to help stay well.

Continuity across services was also important. This included the need for *"support, accountability and duty of care"* across service transitions, and for support to continue rather than people being left with *"no continual care or connection"* or *"bounced around services."* Responses also pointed to gaps in support around acute episodes, including the need for safe spaces during crisis and better follow-up after hospital discharge.

The need for support and recognition for carers, family and kin was also raised in a few responses, such as *"my unpaid carer/support person was valued and acknowledged"*.

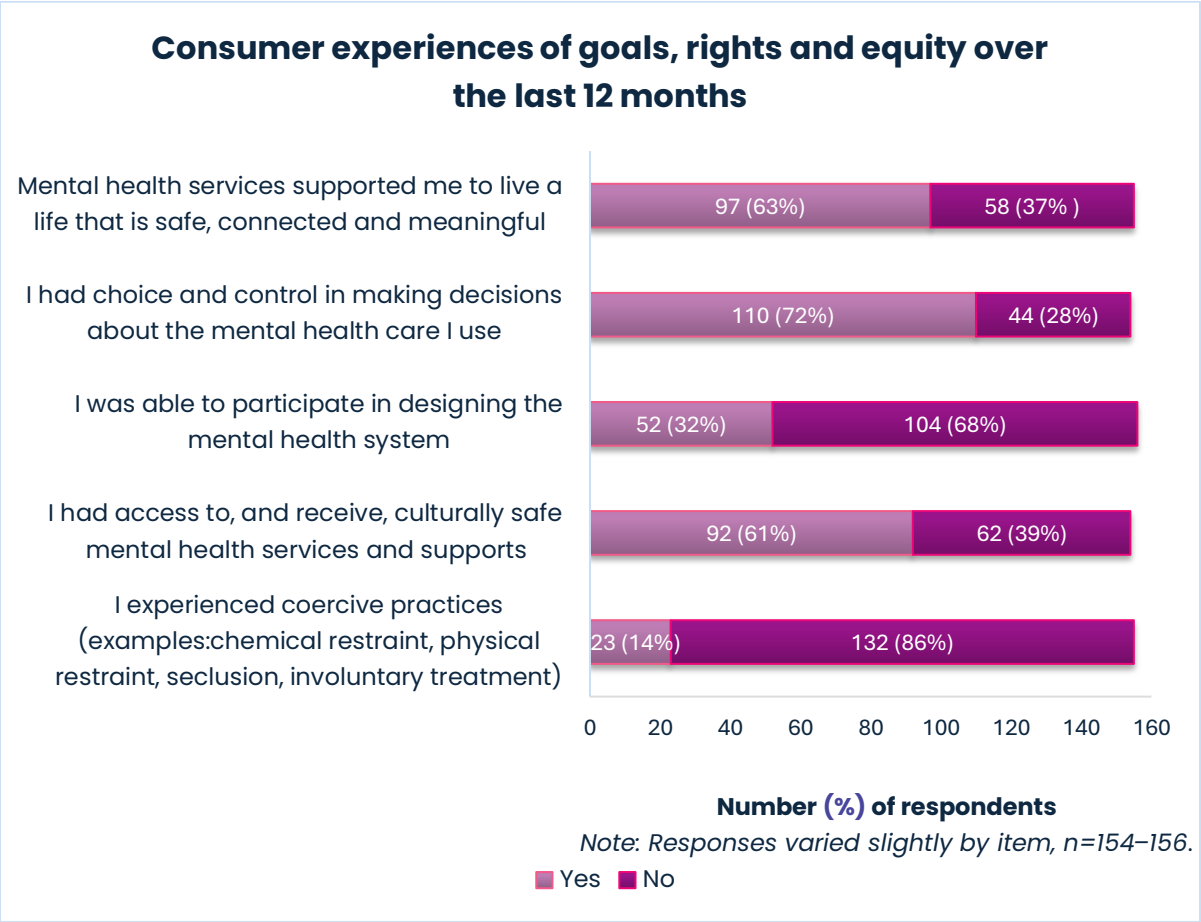
Outcome Domain 1: Consumer goals, rights and equity

Respondents were asked to consider their experiences over the past 12 months in relation to statements about consumer goals, rights and equity. There were 154 to 156 responses across each survey question. Briefly, the results indicate that:

- Many consumers reported they had choice and control in making decisions about the mental health care they used with 72% (110 respondents) answering yes in response to this statement.
- However, mental health consumers' participation in decision-making about services remains a key gap, with 68% (104 respondents) not able

to participate in designing the mental health system. This aligns with the Productivity Commission's findings that the current Agreement has not sufficiently involved people with lived experience in its design and governance, and that policy reform must embed the voices of consumers across the system through genuine co-design and co-creation.

- A concerning proportion of consumers, 39% (62 respondents), did not have access to culturally safe mental health services and supports over the last 12 months.
- The use of coercive practices remains a concern, with 14% (23 respondents), reporting that they had experienced coercive practices in the last 12 months.
- Nearly two thirds (63% or 97 respondents) indicated that mental health services supported them to live a life that is safe, connected and meaningful.



Supports for living a safe, connected and meaningful life

We asked respondents to describe supports they currently receive, or would like to receive, to help them live a safe, connected and meaningful life. There were 127 responses to the question.

Overall, responses suggest that consumers need affordable and ongoing mental health support, peer workers and peer groups, practical psychosocial support, community connection, culturally safe and identity-responsive services, skilled and trauma-informed providers, and help navigating across fragmented systems to live a safe, connected and meaningful life.

Peer support was particularly prominent, suggesting it should be recognised as a key element of connection, trust and early support.

Responses aligned with consumer goals, rights and equity; prevention and early support; integrated supports; and workforce and service provider capability.

Consumer goals, rights and equity

Responses highlighted the importance of flexible, person-centred support. Consumers described wanting to be seen as a whole person, involved in decisions about their care, and supported in way that reflect their own goals and understanding of what helps.

"I would like care to be flexible, person-centred and based on shared decision-making, so that I feel heard and involved in decisions about my own wellbeing"

"I want a health team that see me for a person and not for my diagnosis."

-Respondents, 2026 Survey

Consumers also wanted culturally safe and identity-responsive support.

"It is important to feel listened to without judgement and to receive support that recognises the impact of culture, faith, family expectations and lived experience."

-Respondent, 2026 Survey

Responses also showed how income and financial disadvantage shape access to care, particularly where consumers felt the public system did not provide the same level of support as private care. One respondent

receiving the Disability Support Pension described relying on private health insurance to access appropriate care, despite the cost placing pressure on basic needs:

"I would like to be able to get the same level of care and support through the public system rather than being required to pay for top hospital private health insurance to ensure that I have access to the care I need. This is very expensive and I have to sacrifice other needs including food to afford to maintain my cover."

-Respondent, 2026 Survey

Prevention and early support

Access to early and sustained support that is free or low cost was also a common theme. Several respondents suggested extending the number of sessions available through a mental health care plan (the Better Access Initiative). Their comments included:

"affordable/free consistent psychology session throughout the year (not just 10 times a year)"

"access to ongoing, quality, no cost/low-cost mental health support/treatment."

-Respondents, 2026 Survey

Respondents also described the need for support to be available when needed, before needs escalate, and without waiting.

"more access to walk in clinics where mental health support is freely given when a person feels they are struggling."

"access to mental health support as and when I need it."

-Respondents, 2026 Survey

Some responses linked a safe, connected and meaningful life to the broader conditions that support wellbeing.

"stable housing, community connection, peer support and practical help with navigating systems and services."

"better system navigation support, respite, financial stability, and access to healthcare [would strengthen my wellbeing]".

-Respondent, 2026 Survey

Respondents also wanted local options for connection and participation.

"support to access the community and participate in community groups."

-Respondent, 2026 Survey

Integrated supports

The role of the peer workforce was a strong theme in responses about living a safe, connected and meaningful life. Respondents valued support from peers as it was grounded in lived experience distinct from a clinical approach, and they called for greater access to peer workers, peer-led services and lived experience-led spaces.

"I'd love to see more peer workers in the community, I truly believe they bridge the gap."

"I want a drop-in centre close to my home which is staffed primarily by lived experience workers (peer recovery support specialists)."

-Respondents, 2026 Survey

A lack of access to peer workers in rural and regional areas was also raised.

"There is only 2 in the entire region, and they are for carers and disability services."

-Rural-based respondent, 2026 Survey

There were calls for coordinated support around the whole person. Consumers described wanting mental health support to connect with physical health care, Alcohol and Other Drugs (AOD) services, primary care, social supports and practical assistance.

Addressing barriers to navigating services was also stressed:

"I need help navigating the system. Understand that my needs fluctuate."

"access to clinicians firstly, then ability to see same person for continuity, where possible."

-Respondent, 2026 Survey

Responses also noted the role of families, carers, and kin in supporting people to stay safe and connected, including the need for services to listen to and involve them where this is what the consumer wanted.

Workforce and service provider capability

Responses underscored the importance of ensuring consumers have access to a skilled and capable mental health workforce that delivers

responsive care. Consumers described wanting providers who understand complex and co-occurring needs, including autism, ADHD, trauma, chronic mental health challenges, physical health conditions and suicide distress.

"[we need teams that are] skilled at working with people with ASD and ADHD who also have co-occurring other mental health diagnosis."

-Respondent, 2026 Survey

Responses also demonstrated the importance of provider knowledge, and referral capability:

"GPs offer me a MH plan but have no idea who to refer me to".

-Respondent, 2026 Survey

One respondent stated that paying for psychology appointments with practitioners who had *"no idea about trauma informed care"* had caused harm and financial stress.

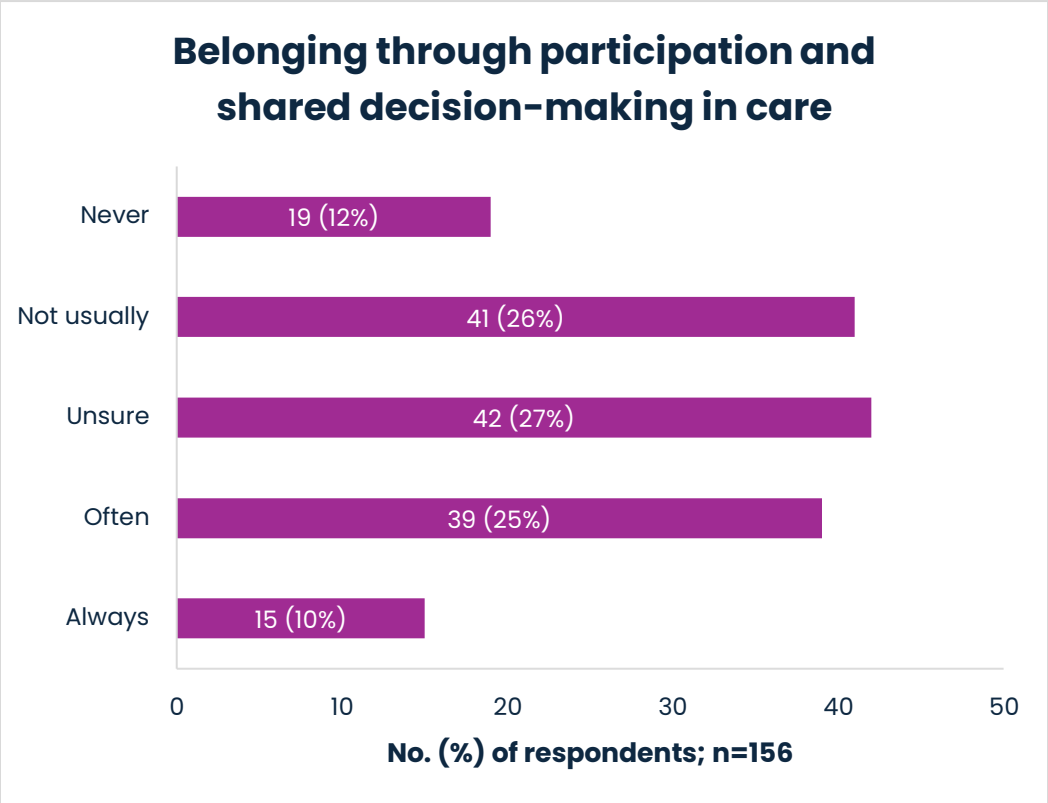
Belonging and participation in mental health services

Respondents were asked whether over the past 12 months, their engagement with mental health services helped them feel a sense of belonging through real participation and shared decision-making in the design and delivery of the care they needed.

The results showed that meaningful participation in care is inconsistent for many consumers.

Over one third, 38% said they never felt or didn't usually feel a sense of belonging through participation and shared decision-making in the design, and delivery of care that they needed, while 27% were unsure.

Around one-third of respondents (35%) reported that mental health services often or always helped them feel they belonged through participation and shared decision-making.



Access to safe supports for consumers

Consumers have the right to receive care in an environment that feels safe for them.

We asked respondents to identify what supports feel safe for them.

Across the common supports listed, safety was often linked to person-centred and consistent support, participation and shared decision-making, respect, dignity, cultural safety and trust.

- **Psychologists and psychological supports**: Of 130 responses, just over a quarter (28%, 37 respondents), identified psychologists or psychology as current supports that appeared to feel safe. Respondents described safety in relation to trusted therapeutic relationships, consistency, and support that was non-judgemental, trauma-informed or responsive to neurodivergence, gender diversity and other aspects of identity.

> *"[I am]able to work with a neurodivergent, gender diverse psychotherapist who understands multiple layers of my identity."*
>
> *-Respondent, 2026 Survey*

- **GPs**: just under a quarter (22%, 29 respondents) of the responses mentioned GPs or local doctors, with some describing these as safe because they provided consistency, trust and knowledge. However, some responses also showed the limits of relying on GPs, with respondents describing them as the only support available while other specialist or broader mental health supports were delayed or inaccessible.

> *"with the exception of my GP whom I trust and have confidence in, whose practice bulk bills for me, but who clearly has limited training in and understanding of complex mental health issues, I receive no mental health support."*
>
> *-Respondent, 2026 Survey*

- **Psychiatrists/psychiatry**: 15% of responses (20 respondents) identified psychiatry that appeared to be safe, including support that enabled shared decision-making and was respectful and empathetic.

> *"my psychiatrist involves me in decision making, giving me choices with pros and cons and explains what he is thinking."*

-Respondent, 2026 Survey

Long term access to a psychiatrist through the public mental health system was described as important:

"the long-term therapy that a public mental health system psychiatrist has offered me feels safe because of the stability, any possibility of that support eases my anxiety."

-Respondent, 2026 Survey

- **Peer support**: One in ten respondents (10%, 13 respondents) explicitly mentioned peer support, peer workers, lived experience workers or peer-led supports as supports that felt safe. Some respondents described these as important because they helped reduce feelings of isolation, create connection and help people feel understood. As one respondent wrote, peer support was valuable because it was provided by *"people who have walked similar paths."*

- **Culturally safe and First Nations-specific supports:** A small number of responses referred to Aboriginal specific services, a local Aboriginal medical service or cultural connection as supports that felt safe.

"I am now seeing a psychologist at my local Aboriginal medical service. The mainstream mental health system failed me terribly."

-Respondent, 2026 Survey

Another described being unable to find *"a culturally supportive counselling service"* and said mainstream services did not understand their needs, were judgemental, and did not make them feel valued or heard. The responses demonstrate the need for culturally safe services and the harm caused when mainstream services are unsafe.

- **Other supports**: these included social workers, mental health nurses, occupational therapists, support workers, counselling, cultural connection, online groups, family and friends.

- **No safe support:** Of 130 responses, around 14%, or 18 respondents, indicated that they do not currently receive any mental health supports that feel safe. This included respondents who explicitly said "none", as well as others whose responses indicated they had no formal support, or an inability to access support. Some linked this to services which were not culturally safe, previous experiences of harm, cost barriers or available supports not being able to meet their needs.

What makes support feel safe

A further open-ended question was asked about what a safe support looks like for consumers. There were 129 responses. Consumers described safe support as person-centred, respectful, non-judgemental, accessible, culturally safe, trauma-informed and connected around the whole person.

Key themes included being heard and believed, having choice and control, access to timely and affordable support, capable and responsive workers, culturally safe care, and services that communicate and work together.

- **Consumer-centred purpose**: over half of all responses described safe supports as those which put consumers at the centre. Many responses described safe support as respectful, non-judgemental, empathetic and trusting relationships. Person-centred support was also described as recognising the whole person, including people's needs, relationships, culture, identity and community.

"[Safe support is a system where people feel] *heard, believed, respected and supported to stay connected to their own recovery, relationships, culture, identity and community."*

-Respondent, 2026 Survey

- **Participation and shared decision-making**: choice, control and participation were central to safety, reflected across many responses. Respondents described the importance of being involved in decisions, being able to make informed choices, and being seen as the expert in one's own life.

"[A safe support is] *where I am an equal and am working in collaboration with my supports, rather than the support working 'on' me."*

-Respondent, 2026 Survey

A small number of respondents emphasised that choice and control also extended to power sharing in the design of services and policy, including people who are structurally marginalised, for example "*the multicultural voice being a decision maker at the head tables*."

- **Immediate, affordable and equitable access:** Safe support is accessible, affordable, timely, locally available, physically accessible and available for as long as needed. Equity was also described in intersectional terms, with safe support needing to respond to people's identities, circumstances and access needs.

[safe support is] *"queer and trans inclusive, disability friendly, and is free to access."*

-Respondent, 2026 Survey

- **Workforce and service provider capability:** almost one in five responses (24 respondents) related to workforce skills, knowledge and practice needed for support to feel safe. This included trauma-informed practice, as well as neuro-inclusive care, understanding physical health and co-occurring needs and responsiveness to intersecting identities. Examples of responses included support that is

"delivered by professionals who use a neuro-inclusive, intersectional lens that puts ME at the centre"

and the need for providers who "*keep up to date in their area of expertise.*"

-Respondents, 2026 Survey

- Some respondents identified trauma-informed practice as a particular area where workforce capability needs to be strengthened. As one respondent stated,

"we talk about trauma-informed care, but we are not getting this, and that does not ensure that anybody actually understands what trauma does to you or what you might be struggling with."

-Respondent, 2026 Survey

- **Culturally safe:** respondents described that services and supports must be culturally safe and responsive with adequate funding to ensure this.

"a system that recognises culture is protective, not a barrier."

-Respondent, 2026 Survey

- **Collaborative and integrated support:** many responses highlighted the need for supports to work together around the person. This included multidisciplinary care, communication between providers, and support that can step up or down as people's needs change. Respondents described wanting:

  "holistic, inclusive and collaborative support from multiple people and services in a multidisciplinary way"

  "collaboration and communication between my supports and me being at the centre of that."

  -Respondents, 2026 Survey

  This also included reducing the burden on consumers to repeatedly retell their story when moving between workers, services or parts of the system. As one respondent stated, safe support means referrals that stop people from *"constantly needing to retell their story to get help."*

Sensemaking findings

Participants in the sensemaking sessions also emphasised that safety enabled consumers to seek help, participate genuinely in decisions about their care, exercise choice and control, and remain engaged with services.

"Early support is only effective if people feel emotionally safe enough to ask for it before they reach crisis"

-Participant, CARM group

Some participants described experiences where services were unsafe because their choices were limited and decisions about their care were made without them. The fear of consequences including the possibility of

coercion could remain present within care relationships and undermined trust.

"Threat of being put on an order always in the room so no trust in the relationship."

-Participant, young adults group

Relational safety also depended on workers having cultural humility, awareness of bias, shifting their power to support shared decision-making, and there being sufficient time to build trust and tailor support.

"Workers entering conversation without an agenda, acknowledging the power dynamic, bringing the person into that with them collaboratively."

- Participant, experiencing SD group

Safety was also connected to the service premises being welcoming, accessible and inclusive including sensitive and respectful communication from administrative staff, who were often a person's first point of contact with a service and to whom they were required to disclose personal information. Some participants identified improvements to these early administrative and intake interactions as important to establishing safety and trust.

"Receptionists can demand information from you on the phone to triage when I don't know who they are."

-Participant, experiencing SD group.

Outcome Domain 2: Prevention and Early Intervention

Addressing social determinants

Results highlight that prevention must address the determinants of health including employment, income security, housing and community belonging. Of 145 respondents:

- just under half of respondents (48%, 70 respondents) did not have stable and secure employment over the last 12 months; while 43% (63 respondents) reported their income was not stable or adequate;
- over half of respondents (52%, 76 respondents) did not feel connected to their community; and
- one quarter of respondents (24%, 35 respondents) did not have safe, stable and affordable housing.

Sensemaking findings

Building on the survey findings, participants emphasised the importance of situating mental health within the broader conditions of people's lives, highlighting the need for support that responded to a person's life as a whole. Housing was particularly stressed as a foundation for wellbeing and stability.

"Consider practical issues such as housing, employment, physical health, financial stress and social connection, because mental health does not exist in isolation."

– Participant, CARM group

"Housing is a MAIN FOUNDATION to be able to take your mental health/life back!"

– Participant, experiencing SD group

Pets were also highlighted in the group discussions as an important source of companionship and support for wellbeing, which participants wanted practitioners to recognise and respect.

"Being told off for having pets and spending money on them and not your health."

-Participant, experiencing SD group

Participants also described how addressing social determinants was an important form of prevention. This required a broader understanding of what comprises mental health support and investment in the conditions that promote mental health and wellbeing.

"Expanding the idea of what actually constitutes mental health support on a systemic level such as access to green spaces, access to fresh fruits and vegetables, affordable and safe housing"

-Participant, young adults group

"Adequate support in early education, securing house and job security for people, access to free psychoeducation and peer led support groups, community care programs, affordable food and clothing, medical / health systems that don't treat people like numbers, I could go on forever"

Participant, experiencing SD group

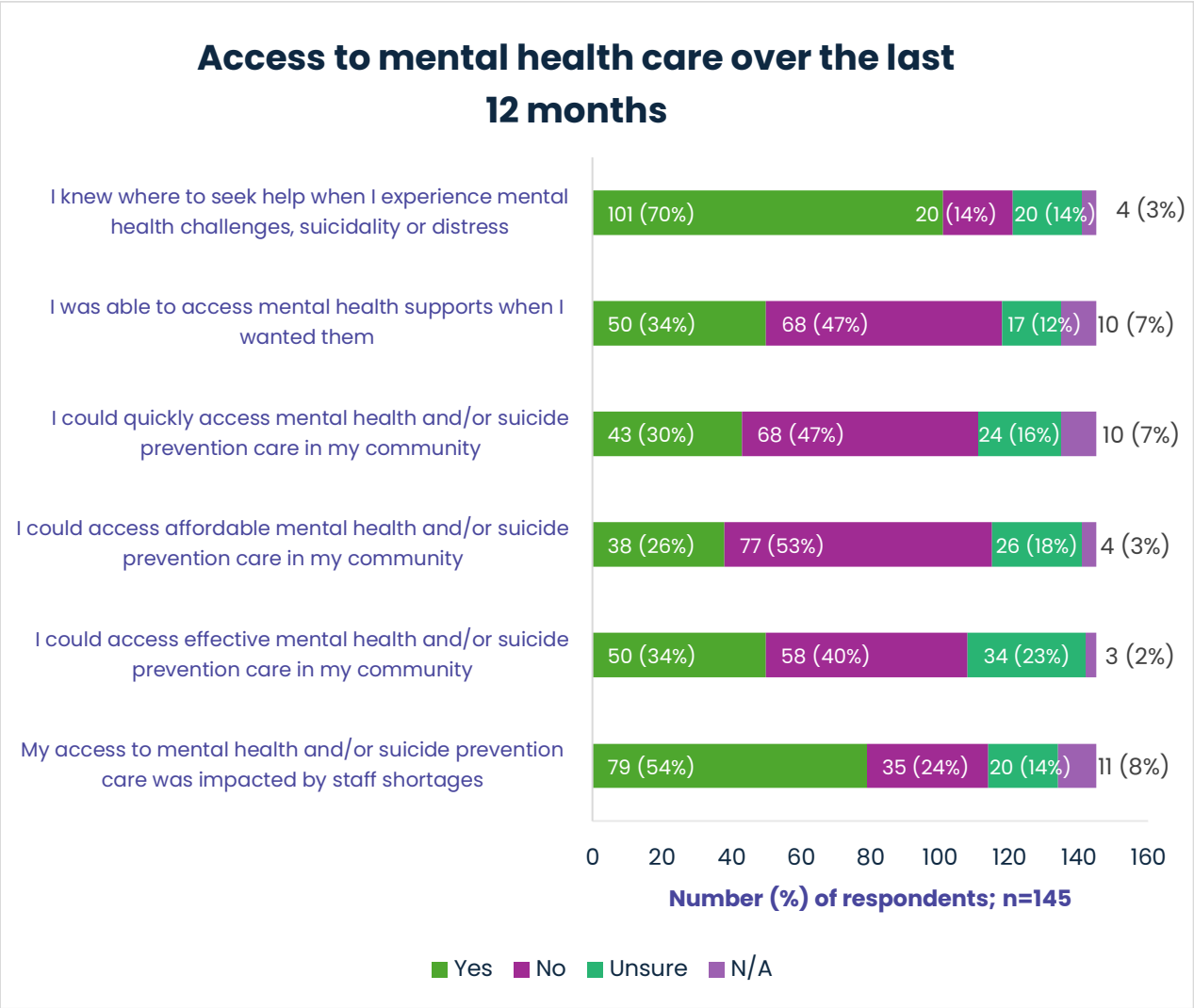
Access to care

Consumers have the right to care that meets their needs. Governments have a responsibility to ensure mental health care is available, affordable, timely and appropriate.

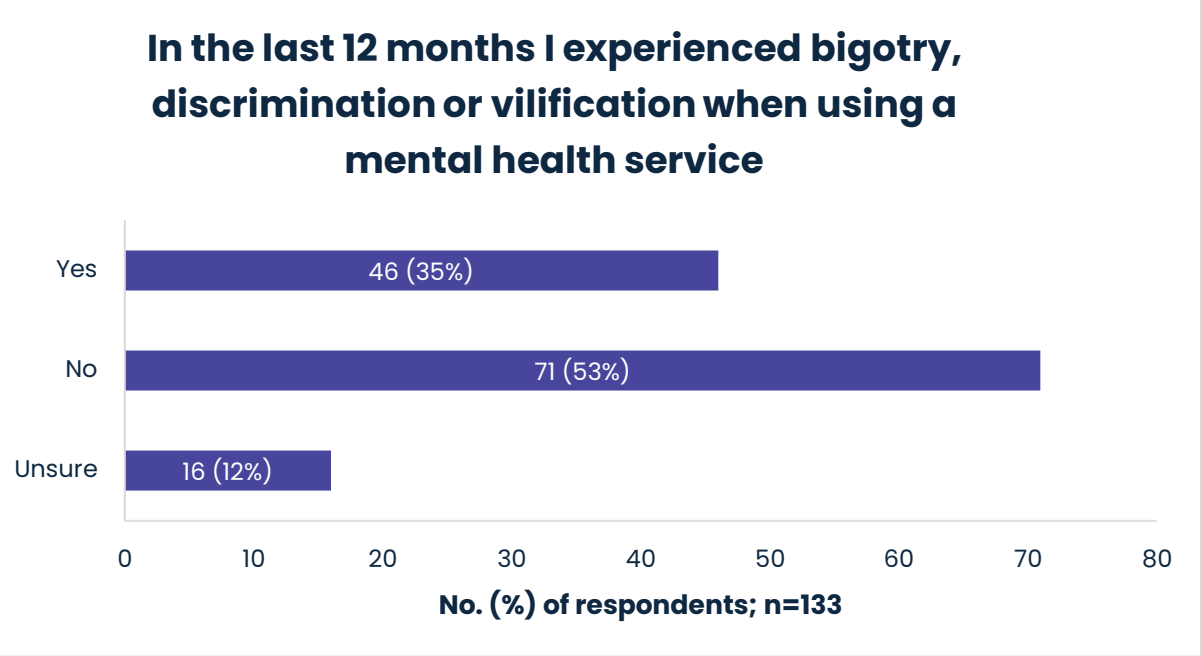
While many respondents knew where to seek help (70%, 101 respondents), they reported that access to care was not timely, affordable or effective.

Just under half (47%, 68 respondents) could not access supports when needed; this included quick access to mental health and/or suicide prevention care.

Further, over half (54%, 79 respondents) reported that access to mental health and/or suicide prevention care was impacted by staff shortages, such as being unable to make an appointment or get ongoing support.



Experiences of bigotry, discrimination and vilification are also reported as a barrier to safe and equitable care. Around one-third of respondents to this question (35%, 46 respondents) said they had experienced bigotry, discrimination or vilification when using a mental health service.



Sensemaking findings

The sensemaking findings helped to deepen understanding of what factors supported meaningful access to help when it was needed. Participants described access as being shaped not only by whether services were available, but also by how they were organised and responded to their needs and circumstances. Analysis of the discussions identified five interconnected dimensions:

1. Timely, affordable and sustained access

"I know my GP is backed up with bookings, usually up to five weeks. Psych appointments are usually around six weeks. People usually reach support after their mental health has significantly deteriorated. This is a huge issue for prevention."

Participant, experiencing SD group

2. Clear entry points, navigation and coordination

"Not knowing where to start. Navigating services can be confusing, especially in crisis states."

-Participant, young adults group

3. Flexible and equitable access across locations and circumstances

"Even with subsidies, regional consumers can be trapped by limited therapist choices. Psychologists can charge what they want in a small market."

-Participant, experiencing SD group

4. Access based on need and not rigid criteria or service boundaries

"Rigid criteria for services means I was unable to access a lot of support. You are either "too sick" or "not sick enough". Some services are only available in some areas. I was one street away from being in the catchment for specialist treatment."

-Participant, young adults group.

5. Access to safe and appropriate support that matches a person's needs

For some conditions like schizophrenia and bipolar, not many supports are available, especially culturally aware ones."

-Participant, CARM group

A cross-cutting finding was the value placed on Safe Haven-type services and other community-based support models. These models were consistently identified across all three groups as forms of support that

participants wanted to see more widely available, providing immediate access without restrictive eligibility criteria.

"We need more community drop in spaces (like Safe Havens) to support the wellbeing of people who are on a wait list so they're not left to fall between the cracks while waiting to access support."

-Participant, experiencing SD group.

"Easy-to-access community hubs or drop-in centres where people can seek support without needing to meet strict eligibility criteria."

-Participant, CARM group

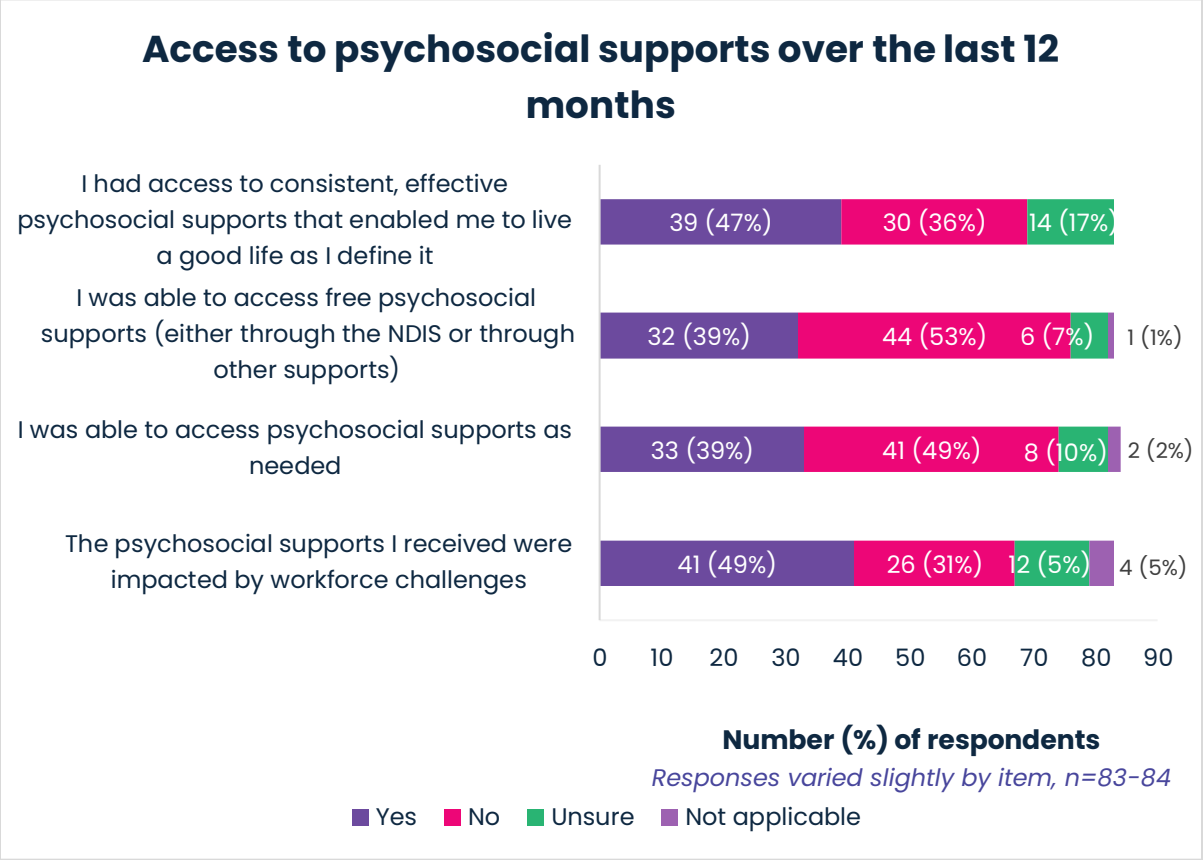
Outcome Domain 3: Integrated supports

Universal psychosocial supports

The survey results suggest that consumers are often unable to access the psychosocial supports they need for a safe, connected and meaningful life. Responses identified workforce shortages as a key barrier, including limited staff availability and a lack of consistent support.

Across the psychosocial support questions, 83 to 84 respondents answered each question. Just over half of respondents were unable to access free supports (53%, 44 respondents). Around half (49%, 41 respondents), were unable to access supports when they needed them

and indicated that the supports they received were impacted by workforce challenges.



Access to acute care services

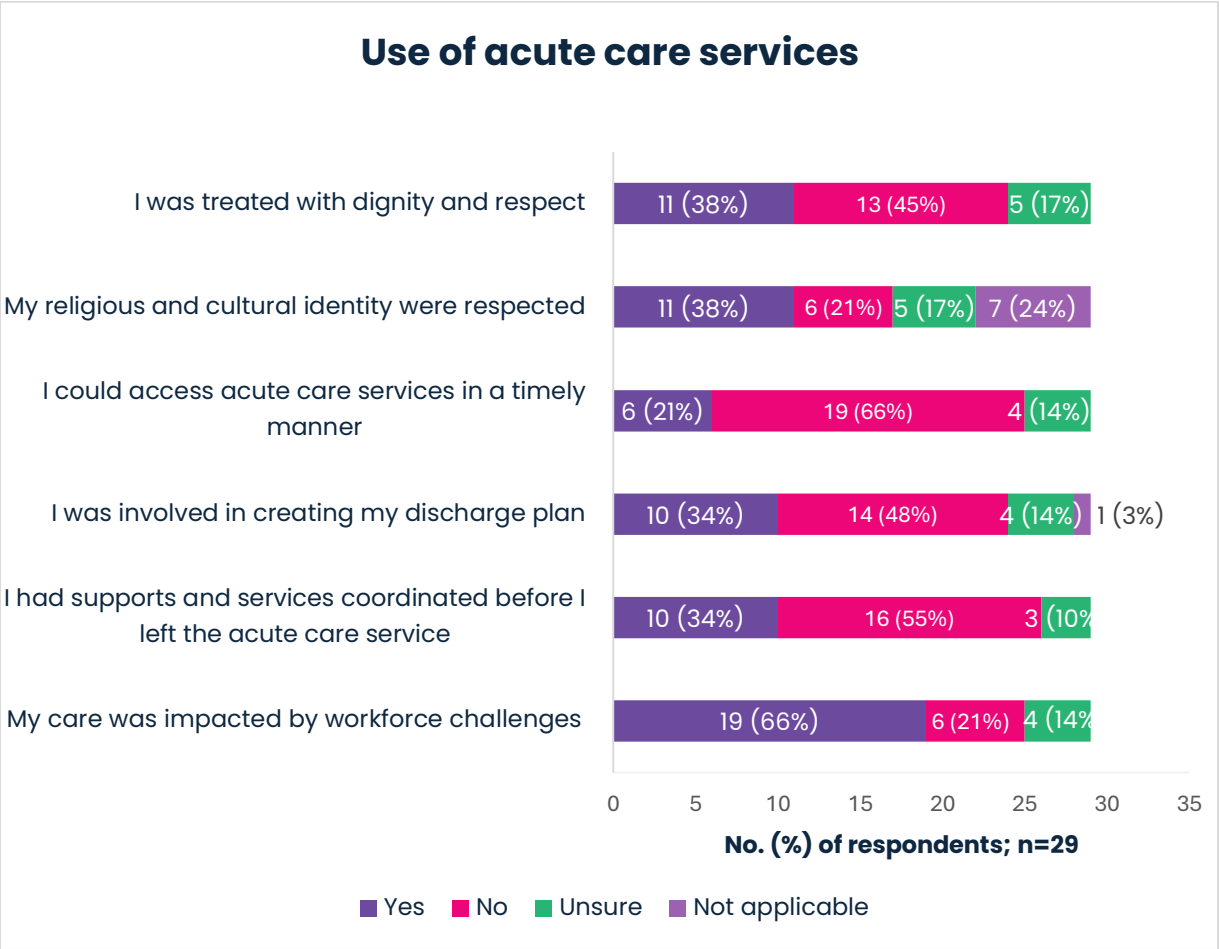
Twenty-nine respondents indicated they had accessed acute care over the last 12 months. Their responses point to gaps in timely access, workforce capacity, discharge planning, coordination and rights-respecting care.

Two-thirds (66%, 19 respondents), said they could not access acute care services in a timely manner. The same proportion, (66%, 19 respondents), said their care was impacted by workforce challenges.

Discharge planning and follow up were also key concerns. Nearly half (48%, 14 respondents), said they were not involved in creating their discharge plan, and more than half (55%, 16 respondents), said supports and services were not coordinated before they left the acute care service.

Responses were mixed in relation to dignity, respect and cultural safety. Nearly half, (45%, 13 respondents) said they were not treated with dignity and respect.

For religious and cultural identity, where just over a third (38%, 11 respondents) said their identity was respected, 21% (6 respondents) said it was not. The question was not applicable for 24% (7 respondents).



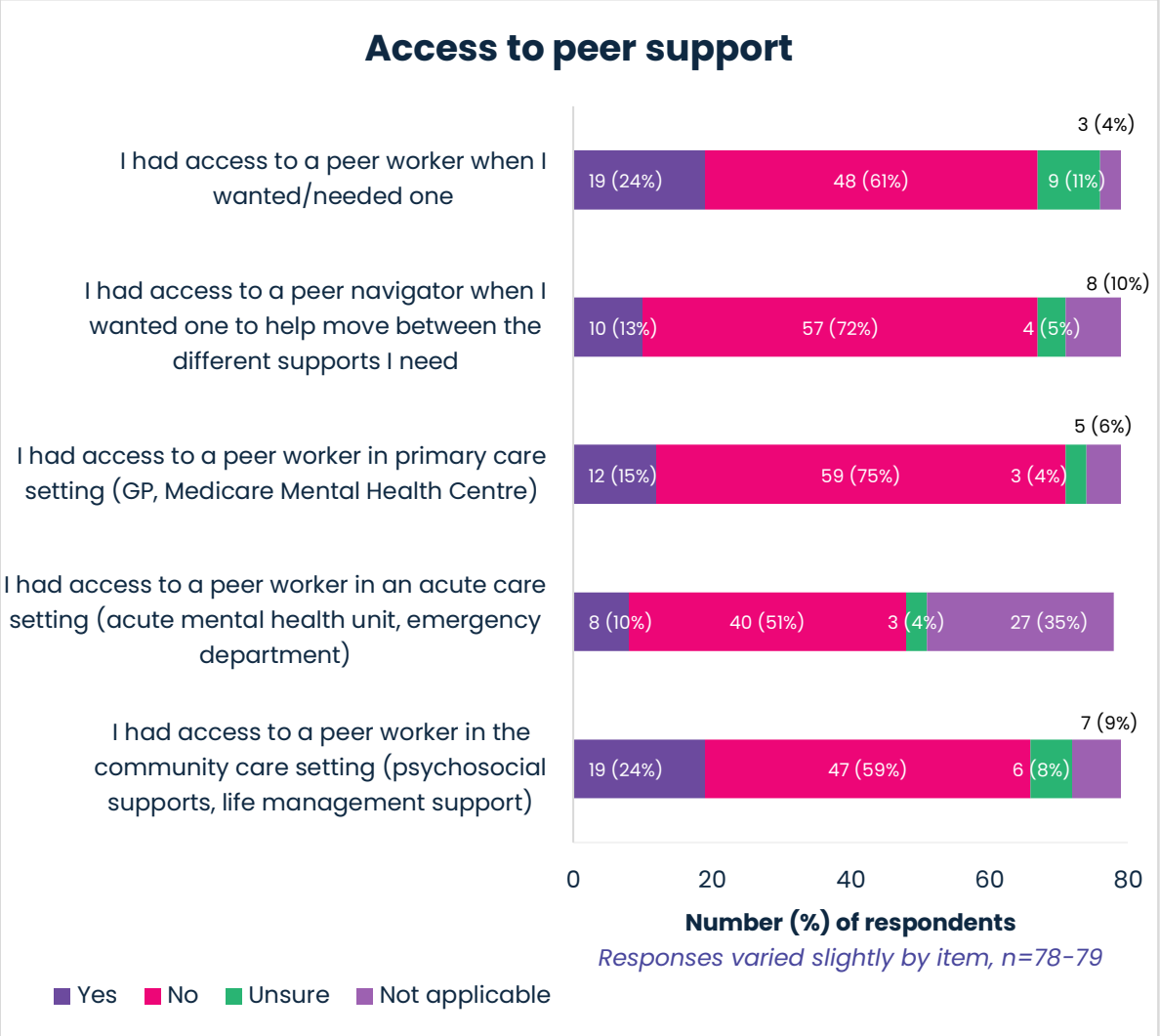
Peer worker access and support

The survey results show respondents had limited access to peer support across mental health services over the last 12 months. Importantly, respondents advised that they could not access a peer worker, did not know how to access one, or were not told about peer work.

Across the peer support questions, 78 to 79 respondents answered each question. Around a quarter, (24%,19 respondents), reported having access to a peer worker when they wanted or needed one, while nearly two thirds (61%, 48 respondents) said they did not.

A small number (13%, 10 respondents) reported having access to a peer navigator to help them move between services and supports. Access to peer support in primary care settings was also limited, with less than one fifth (15%, 12 respondents) reporting access.

Over half of respondents, (51%, 40 respondents) reported they did not have access to peer support in acute care settings. Access in community care was higher than other settings but still limited, with again over half (59%, 47 respondents) reporting no access.



The survey also asked people what supports they received from a peer worker. There were 46 responses. Consumers described them as providing emotional support, validation, hope, advocacy, practical assistance and navigation.

"I was able to access a conversation without judgement, knowing that, in any way, they would understand my perspective"

"Supporting me visiting the housing office / fighting housing for what I needed."

-Respondents, 2026 Survey

Movement between services/supports

Fifty respondents described how a peer worker would support their movement between primary, community and acute settings. Responses showed that consumers see peer workers as playing an important role in helping people move through a fragmented system. Peer workers were described as trusted supports who could explain what services are available, provide continuity, offer reassurance, and help people feel safer during transitions.

"Peer workers seem to be able to be like glue that can flow and either link everything together for you and then place it before you like [a] jigsaw all done so you can see the picture, instead of it all being jumbled... Really helpful and so needed when trying to manage the maze of health system"

"Having someone who understands the system from lived experience can make these transitions feel safer, less disempowering, and more aligned with my needs and goals."

-Respondents, 2026 Survey

However, access gaps were also described. Some respondents said they had not been able to access a peer worker, and that peer support would have been beneficial during previous experiences of moving between services. One respondent directly noted that peer work also depends on there being appropriate and accessible services to move between.

"This question assumes that there are appropriate and acceptable services to transition from and to, but such services do not exist in my community or anywhere that is accessible to me."

-Respondent, 2026 Survey

Key benefits of a peer worker

Of 64 responses, consumers most identified the key benefit of peer workers as being understood by someone with lived experience, rather than only professional knowledge. Respondents described this as creating a different kind of support which was grounded in shared understanding, trust, respect and non-judgement.

"It is not just about "having been through something similar." It is about using that experience with purpose, so the person feels less alone, less judged, and more able to see that recovery, change and connection are possible. A peer worker can often sit beside someone in distress differently, because the relationship is built less on authority and more on mutuality, respect and shared humanity."

-Respondent, 2026 Survey

Peer workers were also described as having a rights-enabling role in everyday care. Respondents saw peer workers as helping people to be heard, understood and supported to access care that responds to their needs.

"A peer worker can identify my needs and understand what kind of help with benefit my wellbeing. Without a peer worker I'm just a number and I won't receive the care that meets my needs."

"They advocate for my needs and bridge gaps in the system—for example, helping communicate my preferences or needs (ability or sensory) between services so I don't have to repeat my story or lose control over my care."

-Respondents, 2026 Survey

Sensemaking findings

The sensemaking sessions offered deeper discussion on the value of peer workers. Peer workers supported access and navigation, while also helping to build trust. Participants valued access to peer workers across settings, including in person and online, and saw them as important to getting help early.

"The option to see a peer worker helps people feel safer. I've always appreciated when I can talk to a peer first before opening up to a clinical worker because I trust the peer to treat me like a human, not a problem to be solved."

-Participant, experiencing SD group

"I think that having access to a peer worker whether it be in person or online would be helpful and potentially reduce the steep decline into needing crisis support. Having help earlier can aid in keeping things steadier."

-Participant, CARM group.

Suicide prevention and post attempt support

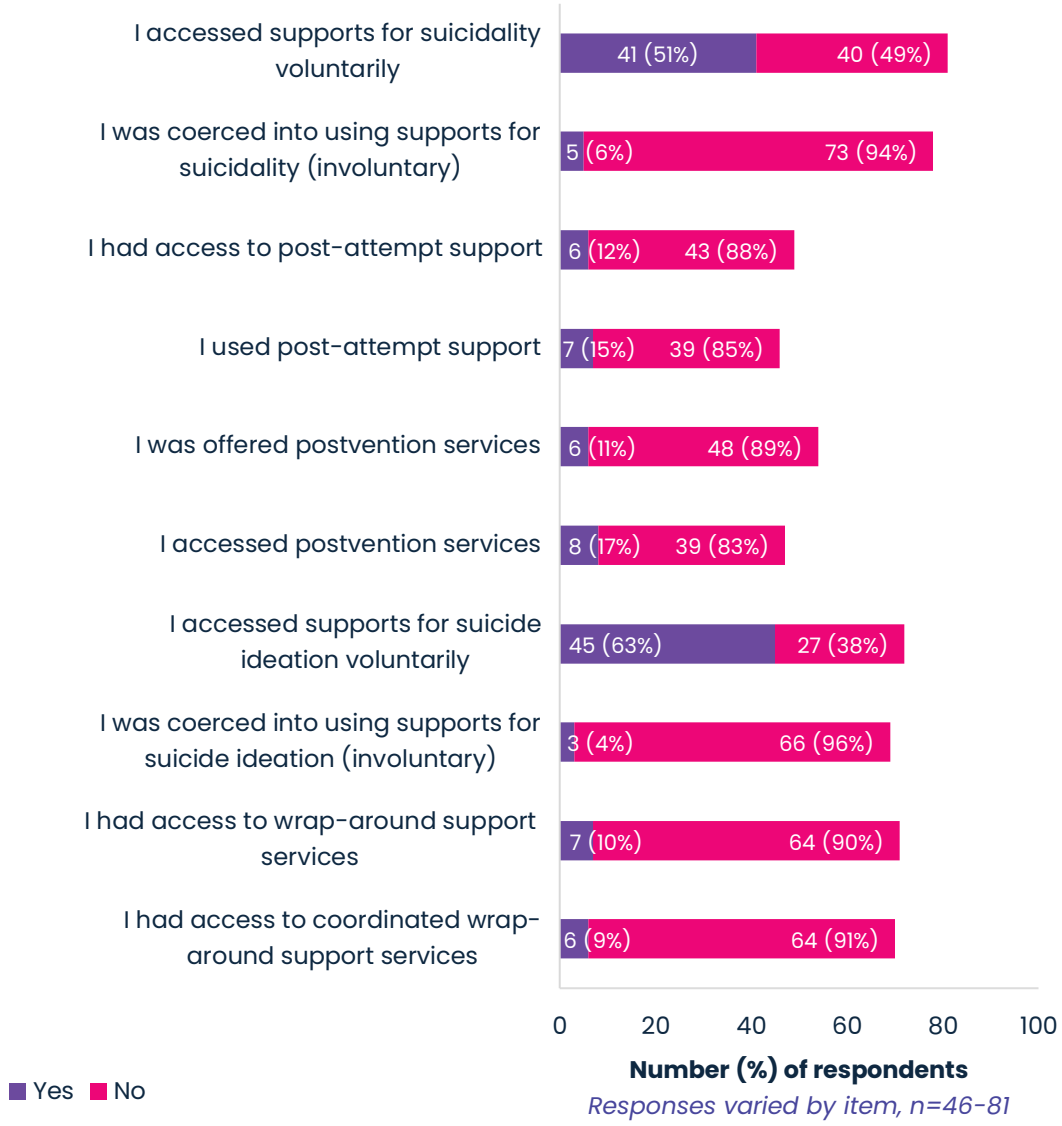
The survey shows that in the last 12 months, mental health consumers were largely responsible for identifying, coordinating, and accessing their own suicide prevention and post attempt supports.

Response numbers varied across the yes/no survey questions, with between 46 and 81 responses per question. Most respondents reported not having access to coordinated wrap around support services (91%, 64 respondents) including clear referral and coordination pathways and where services have joint accountability for shared outcomes or general wrap around supports. The result was similar for having access to wrap around support services designed to surround the mental health consumer with a team of supports that address multiple aspects of life, including mental health, education, housing, and social services. Again, most respondents (90%, 64 respondents) reported not having access.

Postvention services were not available to most people (89%, 48 respondents).

Most respondents reported they did not have access to post-attempt support (88%, 43 respondents) and fewer used post-attempt supports (85%, 39 respondents) even when available.

Experience of using suicide prevention, post attempt support



Responses varied by item, n=46-81

Coordinated supports postvention

Coordinated post-attempt and postvention support was commonly described as needing to be proactive, person-centred, and available for as long as people need it.

"There should be no caps on services, which need to be indefinitely and fully available to everybody for however long THEY feel that they need them not how long some government thinks they should have them."

"ensuring support is continuous, person-centred, and responsive to individual needs."

-Respondents, 2026 Survey

Clear pathways, proactive follow-up and shared accountability across services were also central to coordinated support. Respondents described poor practice among services which were harmful, leaving them more vulnerable.

"I do not trust organisations to work together to support me after my experiences because no one communicates and that left me in danger."

"Coordinated supports would mean no gaps in care following a suicide attempt, with proactive follow-up and a consistent point of contact so I am not left to navigate services alone during a time of heightened vulnerability. Services would share information with my informed consent and work from a shared care plan, reducing the need to repeat my story and avoiding disjointed responses."

-Respondents, 2026 Survey

Respondents also described coordinated support as needing to address the needs and conditions around a person's life, not just clinical needs.

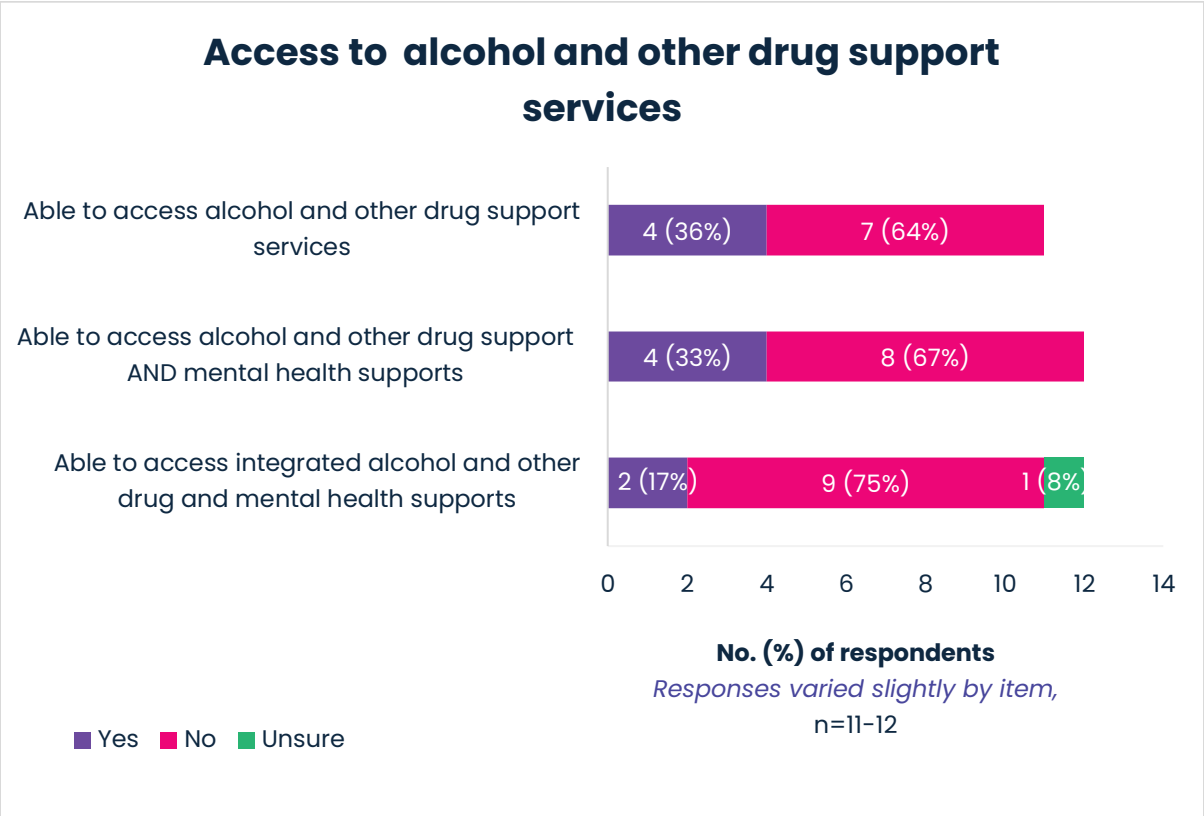
"A holistic approach that not only includes counselling, but helps in practical terms: housing, finances, employment and in general getting back on track with life in all areas. Counselling is not enough."

-Respondents, 2026 Survey

Alcohol and Other Drug support services

While only a small number of respondents indicated they had sought out Alcohol and Other Drug (AOD) services in the past 12 months, access was limited for most of those who did seek support.

Three-quarters of respondents, (75%, 9 respondents), said they could not access integrated AOD and mental health supports. A smaller number (67%, 8 respondents) said they were unable to access AOD and mental health supports when needed, and (64%, 7) said they could not access AOD services.



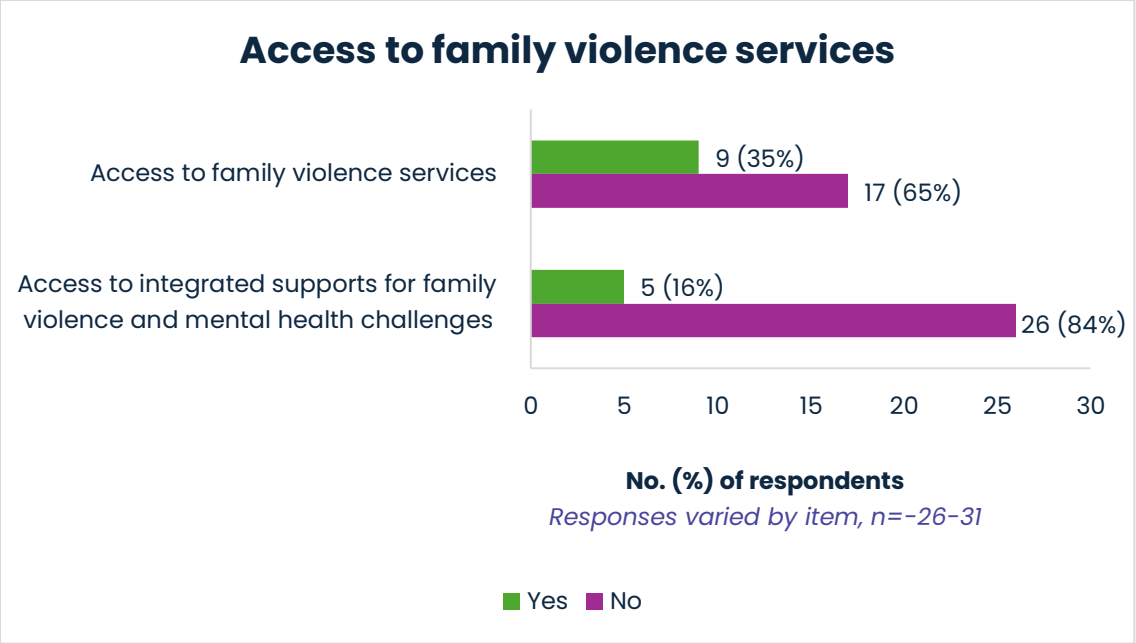
Access to family violence services

Access to family violence services was limited for respondents who answered these questions, suggesting that respondents faced barriers to access, particularly where family violence and mental health support needed to be provided in an integrated way.

Of the 26 respondents who answered the question about access to family violence services when needed, 65% (17 respondents) said they could not access support, while 35% (9 respondents) said they were able to access support.

Access to integrated family violence and mental health support was even more limited. Of the 31 respondents who answered this question, most respondents (84%, 26 respondents) responded that they were unable to

access integrated supports when needed, with less than one fifth or respondents (16%, 5 respondents) stating they were able to access them.



Outcome Domain 4: System sustainability and performance

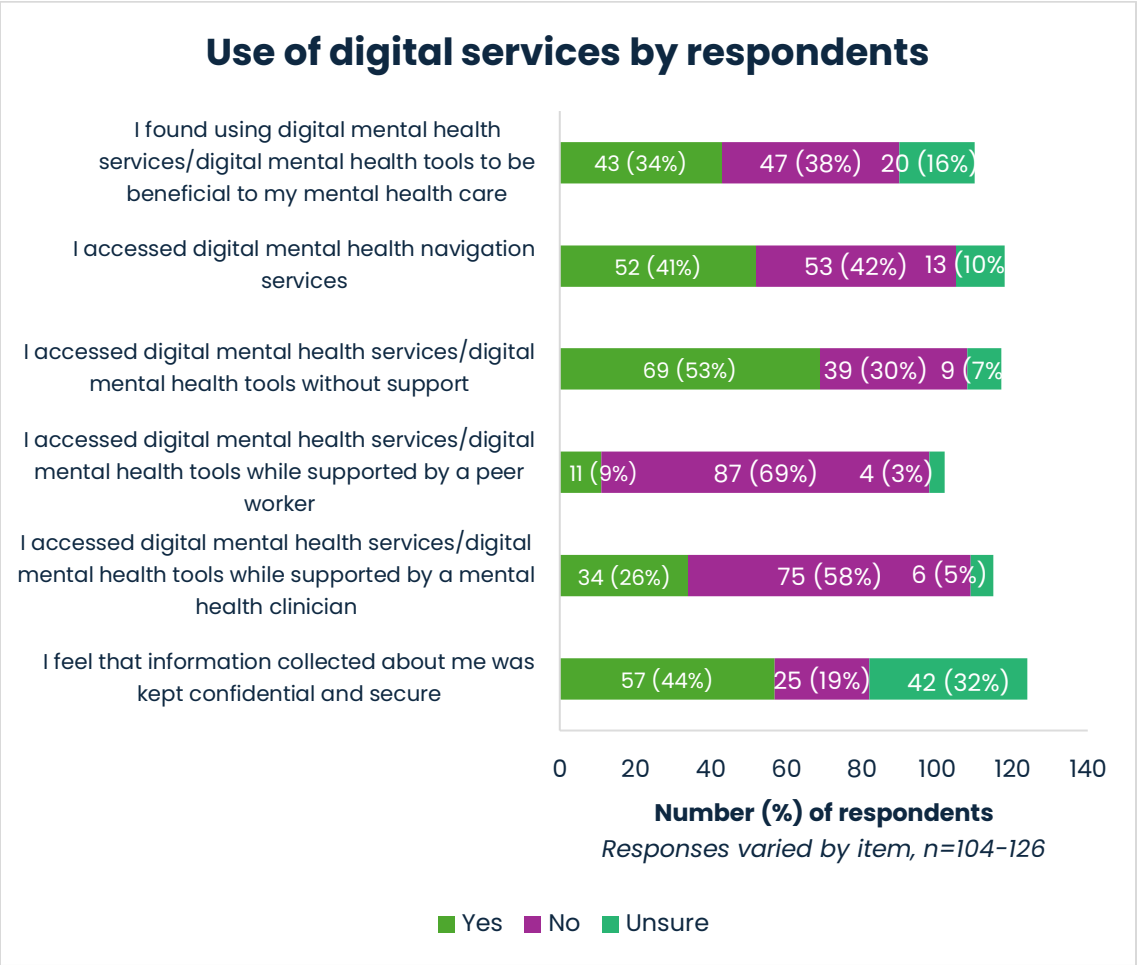
Use of digital mental health services and tools

Just over half (53%, 69 respondents), reported accessing digital mental health services or tools without support. For those who did have support, a quarter (26%; 34 respondents) were supported by a mental health professional, and 9% (11 respondents) accessed them while supported by a peer worker.

Many respondents did not find digital tools beneficial. Around one-third, (34%, 43 respondents), said they found digital mental health services or tools beneficial, while 38% (47 respondents) said they did not and 16% (20 respondents) were unsure.

Access to digital mental health navigation services was also mixed, with 41% (52 respondents) reporting access and 42% (53 respondents) reporting no access.

Privacy and security were also areas of uncertainty. More than half of respondents, 54% (67 respondents), either did not feel that information collected about them was kept confidential and secure or were unsure whether it was. By comparison, 44% (57 respondents) felt that their information was kept confidential and secure.



Sensemaking findings

Within the domain of system sustainability and performance workforce and service provider capability was an issue raised across all groups. This reflects the findings in other sections of the survey where respondents described workforce issues. Meaningful access depended on the availability of practitioners with the relevant knowledge and skills to provide culturally responsive, trauma-informed and appropriate support. Workforce shortages and pressure on existing staff affected the availability and quality of care.

"Systemic gaps, staffing shortages, overworked and under supported staff"

-Participant, experiencing SD group.

"Every person needs individual time, which often can't be measured. We need more flexible time and [smaller] caseloads so that clinicians can actually do their job."

-Participant, CARM group

Workforce capability included the ability to recognise and address bias, understand consumers' intersecting identities and circumstances, and connect them with a range of clinical, non-clinical, peer-led and community-based supports appropriate to their needs.

"It depends on what someone is presenting with, their gender, their disability status and their race. Knowingly or unknowingly these biases affect how quickly people are seen and how seriously they are taken."

-Participant, young adults group

Outcome Domain 5: Transparency & Accountability

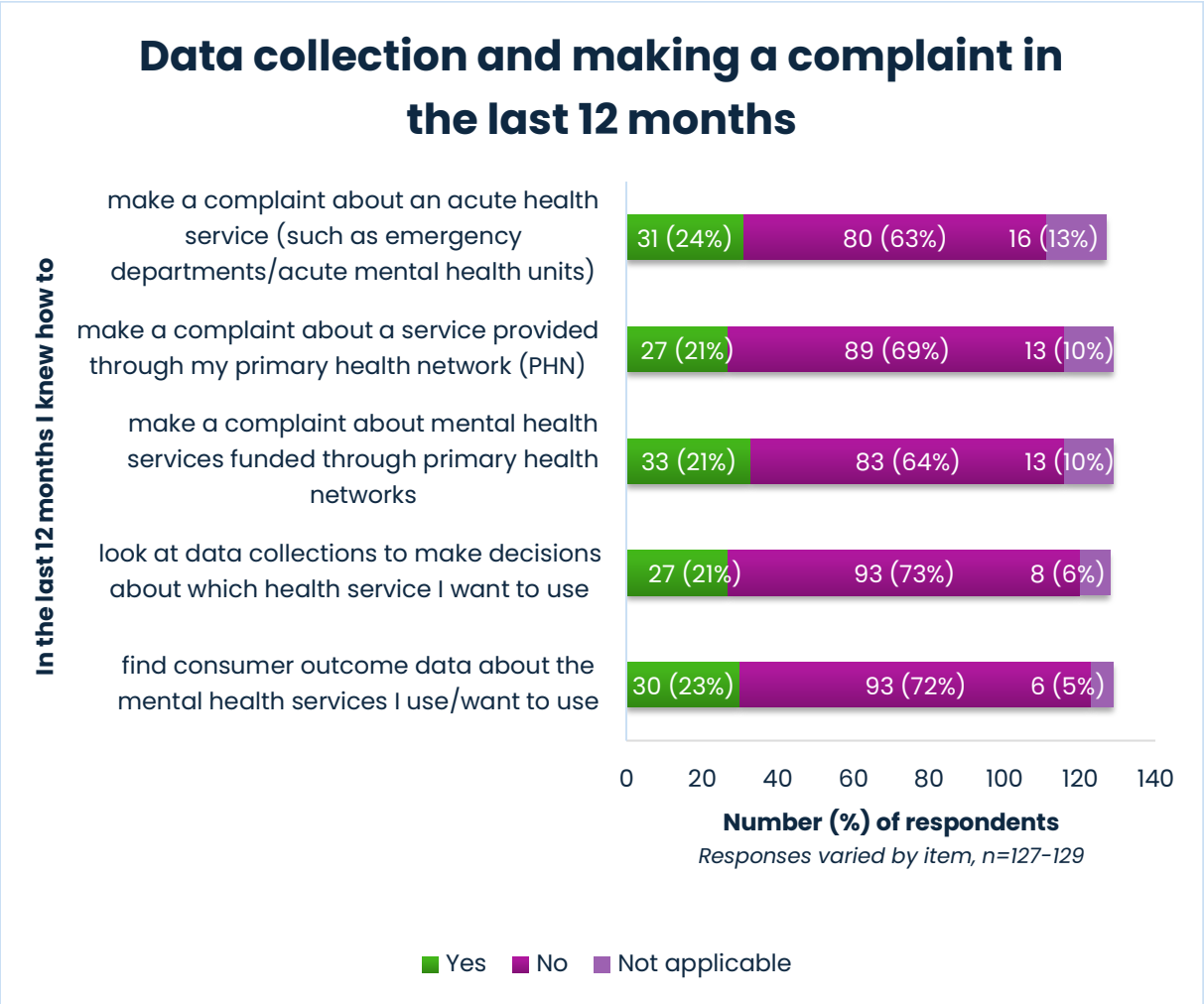
Data transparency and accountability

The survey asked respondents to identify whether they knew how to make a complaint about a service funded by the Agreement and whether they knew about, and used, data collections about health services they wanted to use. Responses ranged slightly from 127 to 129 across survey

questions. The responses show that the current system is neither transparent nor accountable to mental health consumers.

Around two thirds of respondents did not know how to make a complaint about acute health services (63%, 80 respondents), a service provided by their primary health network (69%, 89 respondents) or a mental health service commissioned by a primary health network (64%, 83 respondents).

Data about mental health services is not readily available to mental health consumers. Over two thirds did not know how to find consumer outcome data about mental health services they may want to use (72%, 93 respondents) OR what data collections to look at about these mental health services (73%, 93 respondents).



Sensemaking findings

While the survey measured whether respondents knew how to make a complaint and access service outcome data, the sensemaking discussions explored what would make complaints processes easier and safer to use. Participants across all three groups identified concerns that raising an issue could affect their care or future access to support. The survey and sensemaking findings demonstrate that complaints processes must not only be clearly communicated but also safe.

Participants also identified transparent reporting, lived experience leadership and demonstrable improvements in consumers' experiences and lives as essential to accountability.

1. ***Consumers must be able to raise concerns safely and without fear of consequences***

Fear of consequences was strongly emphasised in relation to giving feedback, making complaints or raising concerns, with participants highlighting that the conditions need to be created where people can exercise their rights and participate in their care without fear of punishment, retaliation or loss of support.

"It's difficult to know how to make a complaint. I felt like I wasn't believed. I was afraid that making a complaint would result in losing services."

-Participant, young adults group.

"People are generally afraid to make a complaint for fear that they will be treated unfairly in retaliation. It occurs so frequently in services so we stay silent and end up receiving support that is irrelevant."

-Participant, experiencing SD group.

"If feedback could be provided safely, without fear that it would affect future access to care."

-Participant, CARM group.

Participants proposed making complaints and feedback safer through anonymous options, access to advocates and multiple ways to raise an issue. They also wanted services to provide accessible information about consumers' rights and ensure that complaints processes were

transparent and timely, with safeguards to ensure that a complaint could never adversely affect a person's care.

"Complaints processes were simple, transparent and timely, with clear communication about what action has been taken."

-Participant, CARM group.

Participants also wanted greater access to independent advocacy services that could support consumers across the service system.

"Independent advocacy service that can actually help you like in whatever the situation, whether it's like the community or whether you're in a hospital, but can help advocate for your needs independently."

–Participant, young adults group

2. Lived experience expertise must influence system decisions

Participants wanted lived experience expertise embedded in policy development and system design, with people with lived experience holding positions of power and genuine influence over decisions.

"Getting people with lived expertise into positions of power."

-Participant, young adults group

"The importance of having lived experience feedback when it comes to policies and designing systems and improving them, I think is paramount." – participant, experiencing SD group

3. Accountability must lead to visible and meaningful change

Participants wanted accountability to be demonstrated through visible improvements in everyday care and broader life outcomes, including

timely and affordable access, clearer care pathways, culturally safe and person-centred care, greater choice and control, improved continuity, and support that did not cause harm or retraumatise consumers.

"Ultimately, success should be measured by people's lived experience of the system. If people can say, "I got the help I needed when I needed it, I was treated with dignity, and I didn't have to fight the system to get support," then the reforms are working."

-Participant, CARM group

Participants also wanted governments to demonstrate how commitments under the next National Agreement contributed to measurable improvements in the wider conditions which influenced mental health.

"Improved outcomes people care about such as better wellbeing, stability, connection, housing, employment, relationships and quality of life."

–Participant, young adults group

Proposed measures and mechanisms for system-level accountability which were put forward included national benchmarks, transparent reporting when standards were and were not met, audits and reviews, workforce metrics, stronger independent oversight, lived experience leadership and genuine co-design.

"Transparency and reporting. Governments share clear data showing what has changed, who is benefiting and where gaps remain."

–Participant, young adults group.

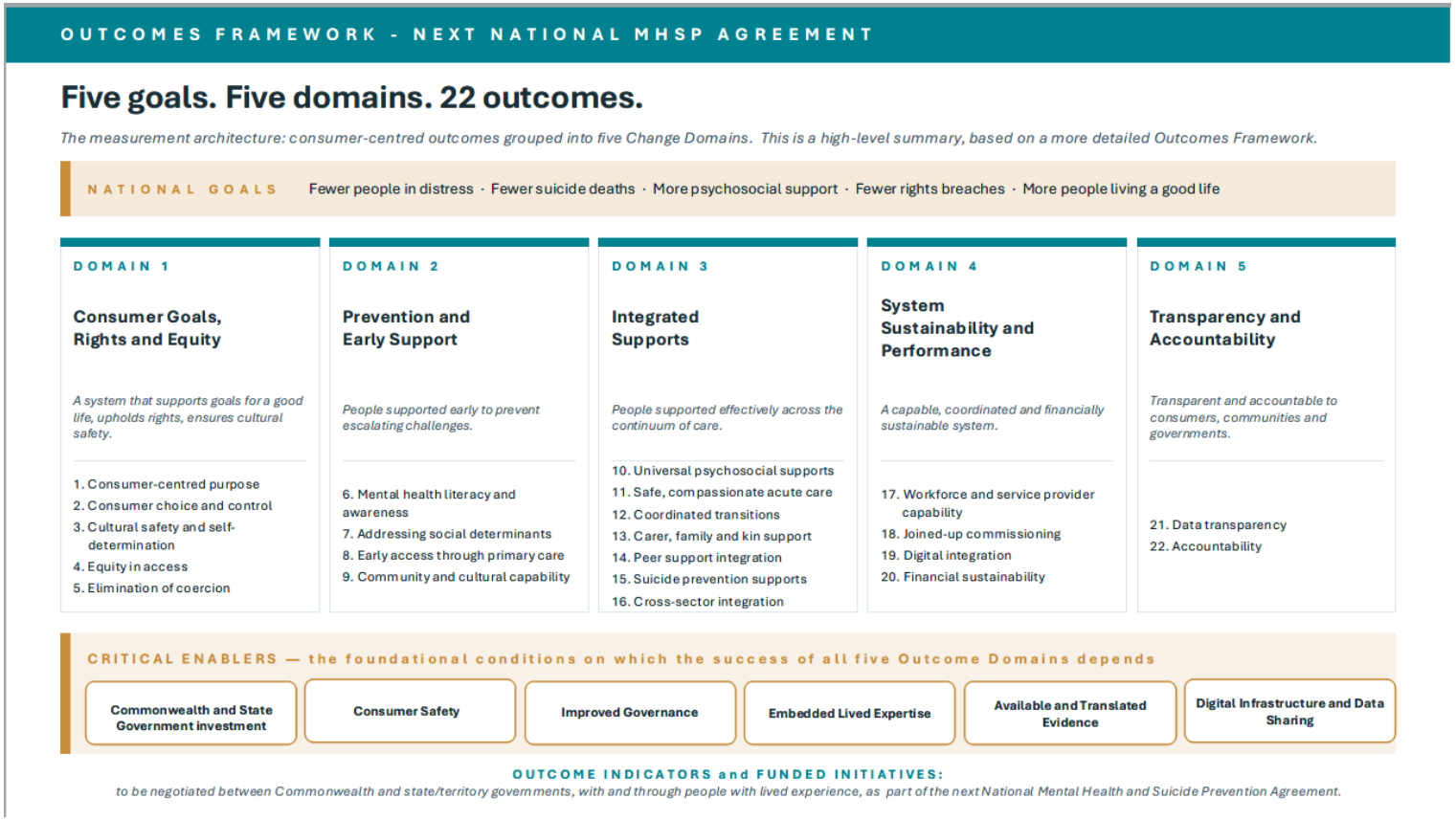
Accountability required governments to act on problems that had already been repeatedly raised through systemic advocacy. One participant suggested that change would be evident when consumers no longer had to raise the same systemic issues without an effective response.

"I think accountability would be reached by not hearing the same stories continuously over and over again."

-Participant, young adults group

NATIONAL MENTAL HEALTH CONSUMER ALLIANCE

Appendix 1



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.