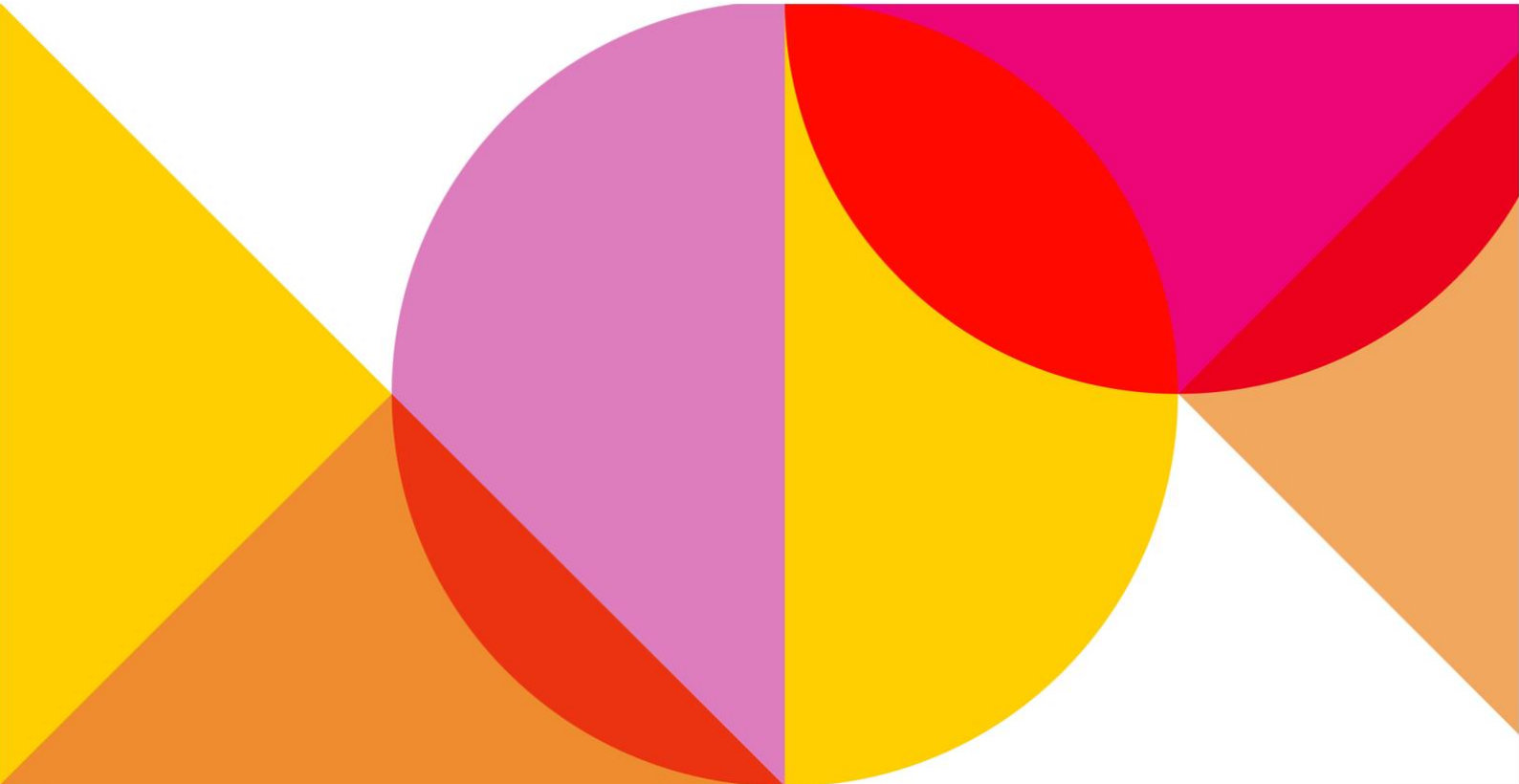
NATIONAL MENTAL HEALTH CONSUMER ALLIANCE

SUBMISSION

In Our Words

What Mental Health Consumers want from the Next Mental Health and Suicide Prevention Agreement

11 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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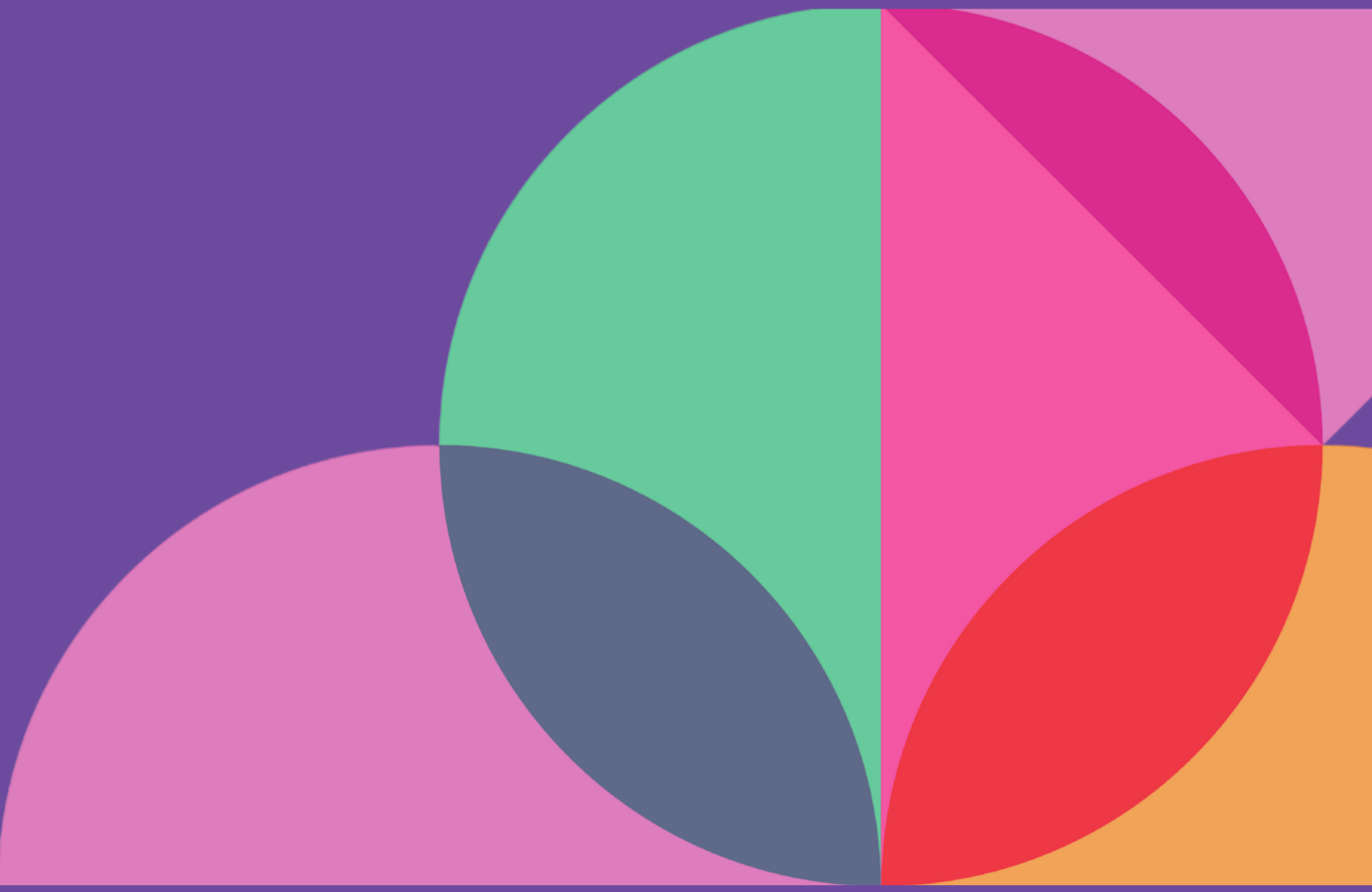
Terminology

All references to 'Consumer' and 'lived experience' in this submission refers to mental health consumers with lived experience of mental health challenges and / or suicidality.

We use the term "mental health consumers" as a catchall term due to its connection with our movement's history. We also respectfully acknowledge that different people self-identify with different terms.

We do not include family, carers, kin or the bereaved in our definition of lived experience as it appears in this submission.



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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
        - Many consumer statements stressed access to early, affordable and sustained support, including support that is *"immediately and locally available"* and *"as and when I need it."*
        - Just under half of respondents (47%) could not access supports when needed, including quick access to mental health and/or suicide prevention care.
        - 54% reported access was affected by staff shortages such as being unable to get an appointment or ongoing support.
        - Over half of respondents could not access acute care services in a timely manner - 66%.
        - Peer support workers are not available when wanted or needed - 61%.
        - Alcohol and other drug services not available when needed – 67%.
        - Family violence services not available when needed – 65%, integrated family violence and mental health supports not

available when needed – 84%.

- 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.
  - Safe Haven-type services and accessible community-based models were forms of support that participants wanted to see more widely available.

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".*
  - 68% were not included in the design of the mental health system, showing that genuine consumer participation remains a major gap.
  - 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.
- 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.

- 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.

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.
        - 66% said their care in acute settings was impacted by workforce challenges.
    - 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.
  - 24%,reported having access to a peer worker when they wanted or needed one, 61% said they did not.
  - 13%reported having access to a peer navigator to help them move between services and supports, 15% had access in primary care.
  - 51% did not have access to peer support in acute care settings and 59% did not have access in community care.

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

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.