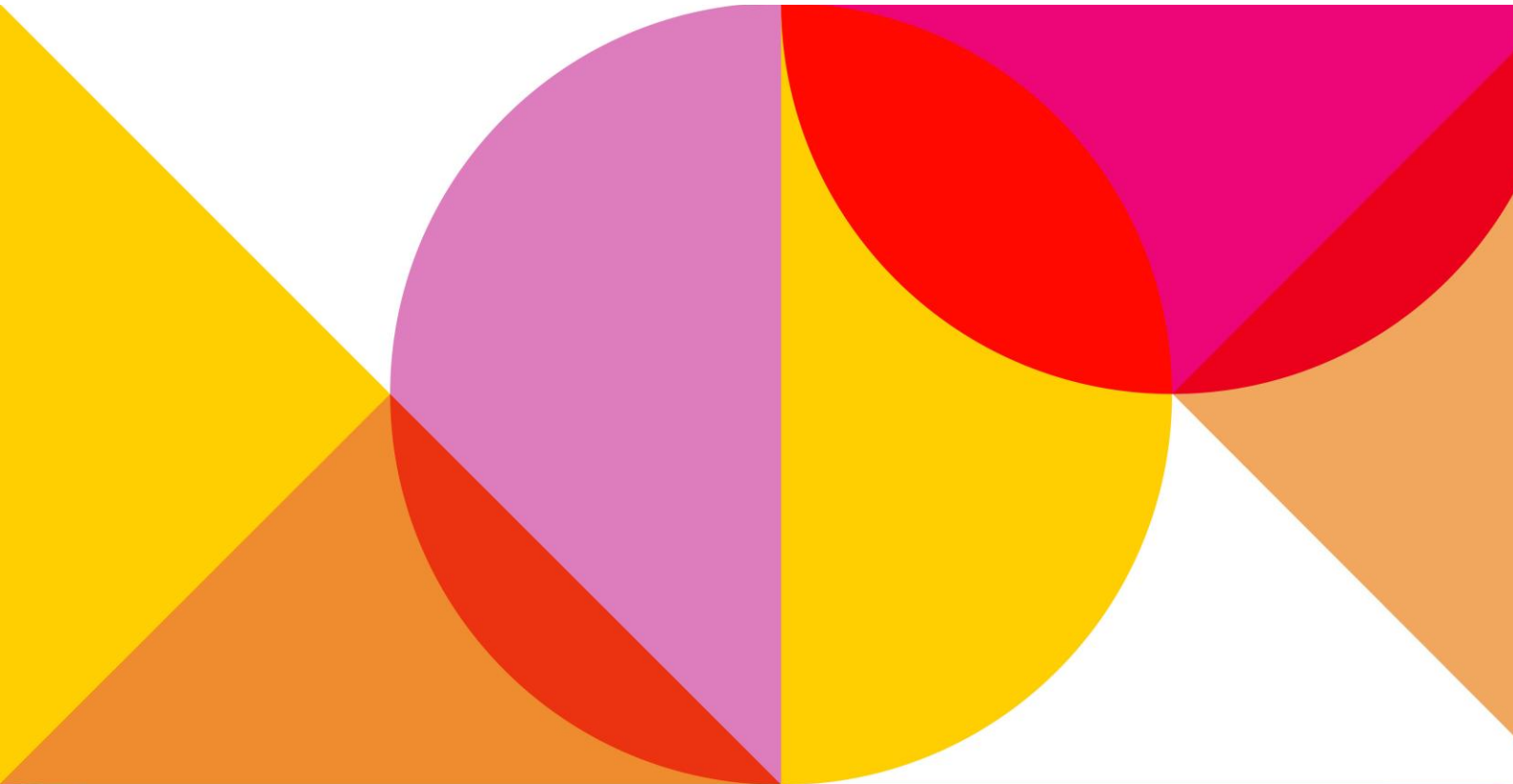
NATIONAL MENTAL HEALTH CONSUMER ALLIANCE

SUBMISSION

National Safety and Quality Health Service Standards, Version 3

01 October 2026



NATIONAL MENTAL HEALTH CONSUMER ALLIANCE

Acknowledgement of Country

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

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

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



NATIONAL MENTAL HEALTH CONSUMER ALLIANCE

About Us

The Alliance is the national peak body representing mental health consumers. We work together to represent the voice of all mental health consumers on national issues.

We are the people experiencing mental health challenges, at the table advocating with government and policy makers, and working with a robust network of grassroots communities.

More information is available on the Alliance's website:

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Terminology

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

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

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



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Executive Summary

A rights-based, person-led approach to safety and quality

Mental health consumers have a right to access safe, respectful, person-led mental health care and support focused on their individual needs, goals, strengths, and preferences. We have a right to determine who is on our care team, who should know about the care we receive and how we are addressed when receiving that care. We should be treated with dignity, have our rights protected, and be actively involved in decisions about our care, including treatment options, safety planning, and recovery goals beyond symptom reduction.

We expect clear communication, potential risks and benefits, and access to information in a way that is easy to understand. Our cultural background, identity, values, and lived experience should be acknowledged and respected at all times.

We should feel confident that concerns, incidents, and complaints will be taken seriously and used to improve service quality. We should have access to staff who are appropriately trained and accountable, and for services to regularly monitor and improve the quality and safety of care. Importantly, we should be supported to provide feedback, participate in service improvement, and be recognised as partners in achieving positive mental health and recovery outcomes.

The National Mental Health Consumer Alliance (the Alliance) welcomes the opportunity to comment on the draft Version 3 of the National Safety and Quality Health Service Standards. The proposed shift beyond minimum safety requirements towards how people experience care is important. The Alliance particularly supports stronger recognition of consumer partnership within clinical governance.

However, the draft does not yet provide sufficient protection for the rights, autonomy and safety of people experiencing mental health challenges. The removal of a standalone Partnering with Consumers Standard risks weakening accountability for consumer participation in governance, leadership, service design and delivery. The Standards should consistently promote person-led practice, supported decision-making, informed consent and the elimination of restrictive practices.

The Alliance's priority recommendations are to:

- retain mental health-specific safeguards that may otherwise be lost through integration, including access to health records, mental health promotion and prevention, personal and relational recovery, social connection, practical supports and accommodation choice;
- retain explicit and assessable requirements for partnering with consumers across governance, leadership, service design, delivery and evaluation, and establish consumer and lived experience governance as a distinct source of authority and accountability that operates alongside, rather than as a subset of, clinical governance;
- embed human rights, person-led practice and supported decision-making throughout the Standards;
- require informed consent whenever family, carers, kin or other supporters are involved;
- recognise lived experience (peer) workers as a distinct workforce and include them appropriately in multidisciplinary teams, governance, training and workforce wellbeing arrangements;
- strengthen requirements to prevent and eliminate restrictive practices, using consistent terminology and clear accountability;
- address suicidal distress, suicide attempts and follow-up care explicitly and comprehensively;
- strengthen requirements relating to rehabilitation, recovery, social connection, advance care planning, transitions of care, equity and freedom from discrimination.

Submission

This submission identifies changes required to the circulated Draft of Version 3 of the National Safety and Quality Health Standards (the draft Standards) provide clear, assessable safeguards for people with lived and living experience of mental health challenges. It focuses on rights, autonomy, participation, safety, recovery and equitable access to care.

The Alliance's recommendations are intended to strengthen the draft Standards as a national accountability framework. Where mental health-specific risks arise, the Standards should state the required outcome directly rather than rely on broad interpretation by individual services or assessors.

Mental Health Standards

The integration of the Mental Health Standards into the National Safety and Quality Health Service Standards, announced in the Mental Health and Health Ministers Meeting Communique of February 2026[1], creates a risk that important mental health-specific safeguards will not be carried forward because they do not fit readily within the revised structure. The following requirements are not currently in the draft Standards and should be expressly retained in Version 3 of the Standards:

- right of consumers to have access to their own health records in accordance with relevant Commonwealth, state / territory legislation
- promotion and prevention. For example, the health service identifies a person who is accountable for developing, implementing and

[1] Health Ministers Meeting (HMM) Communique - 13 February 2026, https://www.health.gov.au/sites/default/files/2026-02/joint-health-and-mental-health-ministers-meeting-communique-13-february-2026.pdf, accessed 28/09/2026

evaluating promotion and prevention activities and workforce is adequately trained in the principles of mental health promotion and prevention and their applicability to the specialised mental health service context with appropriate support provided to implement mental health promotion and prevention activities

- support and promote personal/relational recovery as well as clinical recovery. For example: reduction in signs and symptoms might be seen as recovery but for a lot people it is living a life of your own choosing.
- social connection, when desired, should be supported and opportunities promoted to enhance patients' positive social connections with family, children, friends and their valued community
- there is no inclusion of support that may be required by mental health consumers including:
    - access to appropriate range of agencies, programs, and / or interventions to meet the consumer's needs for leisure, relationships, recreation, education, training, work, accommodation and employment in settings appropriate to the individual consumer.
    - supports and / or provides information regarding self care programs that can enable the consumer to develop or re-develop the competence to meet their everyday living needs.
    - setting for the learning or the re-learning of self care activities is the most familiar and / or the most appropriate for the skills acquired.

- provide access to a range of accommodation and support options that meet the needs of the consumer and gives the consumer the opportunity to choose between these options.

Partnering with Consumers

While the Alliance welcomes the stronger focus on partnering with consumers within the Clinical Governance Standard, consumer and lived experience governance must not be treated as a subset of clinical governance. Clinical governance provides accountability for the safety, quality and effectiveness of clinical care, drawing primarily on professional, organisational and evidence-based frameworks. Consumer and lived experience governance provides a distinct source of authority and accountability, grounded in people's rights, first-hand knowledge, relationships, social and cultural circumstances, and experiences of care. The two functions are complementary, but they are not interchangeable: clinical governance asks whether care is clinically safe and effective, while consumer and lived experience governance also asks whether services uphold rights, share power, respond to what matters to people, and are experienced as safe, respectful and person-led.

Meaningful consumer participation is fundamental to safe, responsive and accountable health services, but participation alone is not governance. Consumer governance requires formal authority, representation, resources and accountability mechanisms that enable consumers and lived experience leaders to influence decisions at every level—from boards and executive leadership to service design, delivery, monitoring and evaluation. It must include the capacity to set priorities, question clinical and organisational assumptions, identify rights-related risks and hold services accountable for acting on consumer perspectives.

The Alliance notes that the draft Standards seek to move beyond minimum safety requirements towards a more mature focus on how people experience care. However, removing the standalone Partnering with

Consumers Standard risks making consumer partnership less visible, less assessable and subordinate to clinical governance priorities. The previous structure recognised that partnership extends beyond decisions about individual care to governance, leadership, service design, delivery and evaluation. Version 3 should therefore retain explicit and measurable requirements across each of these domains, including requirements for consumer and lived experience governance that operate alongside, and can independently scrutinise, clinical governance arrangements. This would establish consumer partnership as a core accountability mechanism rather than an optional feature of good practice.

The Alliance recommends adding the purpose, "Partnerships with consumers to help shape health care", together with an assessable requirement that boards and leadership teams establish systems to: build respectful and reciprocal partnerships with consumers; resource consumer and lived experience leadership; include consumers in governance with defined authority and clear lines of accountability; and co-design and share decision-making power across the planning, design, delivery, monitoring and evaluation of care. These arrangements should enable consumer and lived experience perspectives to influence organisational priorities and decisions, not merely provide feedback after decisions have been made.

Mental Health Standards

Throughout the draft Standards, there are key places where mental health services are not accounted for.

Standard 2.03(e), concerning assessment of decision-making capacity and the involvement of a substitute decision-maker, should be strengthened to require supported decision-making at every stage. A finding that a person lacks legal capacity should not end efforts to ascertain and give effect to their will and preferences. The Standards should require accessible information, communication assistance,

adequate time, trusted supporters chosen by the person and regular review of capacity and preferences.

In mental health settings, the Alliance recommends that supported decision-making and the person's will and preferences be the primary framework. Where substitute decision-making remains legally required, it should be a measure of last resort, be time limited, preserve the person's participation and be subject to safeguards and review.

Human Rights

Version 3 of the Standards should adopt a clear human rights framework and use the term person-led practice consistently. Person-led practice requires services to recognise each person as the primary authority on their life, uphold dignity and autonomy, and organise care around the person's will, preferences, goals and chosen supports.

Standard 2.01 should extend beyond the transmission of information. It should require services to ask about and document each person's communication and support needs, concerns, preferences and reasonable adjustments, and to record the steps agreed to meet those needs.

Clinical governance systems should explicitly identify and address risks to consumers' human rights as part of safety and quality. A general requirement for quality care is insufficient where services may regard restrictions on autonomy as necessary responses to perceived risk. Boards and leadership teams should be accountable for monitoring rights-related risks, complaints, restrictive practices and consumer-reported experience, and for taking corrective action.

To ensure human rights are embedded and considered throughout the Standards, the Alliance recommends the inclusion of a statement that reflects human rights in the Introduction – Purpose of the Standards. For

example: care is delivered in a way that upholds human rights, dignity, autonomy and freedom from discrimination.

Consent

The draft Standards include a single statement that references to patients, their families and carers should be interpreted in accordance with the patient's preferences, wishes and consent (p. 11). The Alliance is concerned that this general statement does not provide sufficient assurance that consent will be addressed in practice. The requirement should therefore be repeated wherever the Standards refer to patients, families and carers.

Peer Workers

The standards should enable, and support, consumers to participate in decisions about who is included in their care team.

The Alliance champions the incredible work that has been done in recent years to expand health services to incorporate lived experience (peer) workforces and their place in multidisciplinary teams and as a dedicated source of expertise, with a standalone skill set, values base and practical framework. Lived experience (peer) workers are a distinct workforce with a defined values base, scope of practice and body of expertise. As policy architecture expands to support high fidelity peer work, it's important that it is embedded into structures such as the Standards, to promote and safeguard the continued holistic care of consumers.

The Alliance advocates for the co-design, implementation and governance of lived experience (peer) workforce standards as a separate standard within the Standards, to reflect the authentic landscape of how people experience care and to protect the standard at which this must be delivered.

Most of the draft Standards are framed through clinical governance. That framing does not adequately reflect lived experience (peer) work

approaches, which has a distinct values base, scope of practice and relational approach. Peer workers should not be required to undertake clinical risk assessments, participate in coercive treatment or restrictive practices, or act independently of a person's own decision-making. The Standards should instead recognise the peer role's contribution to autonomy, mutuality, connection and person-led support.

In lieu of holding inappropriate guidelines for peer workers, we recommend the development of a standard that encompasses the expectations of the peer workforce in health service delivery, noting it's imperative this module is built and governed by lived experience.

For example, peer workers should be made exempt from the following Standards:

1. 2.11 (a-f), Risk of behaviours of concern are minimised and managed, as they should have no role in risk assessment and/or potential restrictive practice as this is not appropriate within their role. However, peer workers should be involved in reviewing an identified "behaviours of concern" and provide support to the relevant team to understand the potential activators in the environment and best practice ways to manage the environment to reduce harm to the consumer as a risk management measure.
2. 2.18 (a-f), Early recognition of deterioration in a patient's mental state is escalated in a timely and appropriate manner. Peer workers, walk alongside a person, helping them to make sense of their distress and make decisions about how to respond in relation to this experience, they do not assess, nor escalate action in response to a person's distress, independent of the person's own decision making. Peer workers cannot be an authority to determine a person's level of distress, risk in relation to this, nor the services that are required in response.

Definition of Lived experience (peer) workers

In Version 3, Lived experience (peer) workers are defined under 'workforce', with the current definition stated as *workforce: refers to all people working in a health service, including employed or contracted, locum, agency, student, volunteer or peer workers. The health workforce is large and diverse and includes a wide range of professionals and operational staff who are all integral to providing high- quality care. (p.)*

Although Version 3 includes lived experience peer workers within the definition of "workforce", references to the workforce appear principally in the governance provisions. Other provisions concerning care and support instead refer to clinicians and multidisciplinary teams. As a result, peer workers may be excluded from requirements relating to service delivery, capability development and coordinated care. For example:

- any support, training, development (such as 1.17 – 1.19)
- using data for better care (1.28, 1.29)
- caring for the whole person (2.04 – 2.08)
- care environment (2.09 – 2.12)
- effective communication and team work (2.13-2.15)
- recognising and responding to acute deterioration (2.16-2.18)
- coordinated and connected care (2.19-2.22)
- communicating research (2.23)

In addition, it underplays the training and professional development peer workers undertake and demotes them.

Peer workers are also left out of the standards when they refer to 'multidisciplinary care teams' which are defined as *"a group of clinicians*

from different disciplines who work together to plan, deliver and review a patient's care".

We recommend the inclusion of 'peer worker' in multidisciplinary care teams while preserving the distinct purpose and integrity of peer work. For example: A group of clinicians from different disciplines and peer workers who work together to plan, deliver and review a patient's care, with explicit mention that peer workers will not be involved in coercive treatment or restrictive practices.

Support of peer workers

The Standards should require health services to protect the wellbeing and sustainability of lived experience workforces. In addition to discipline-specific supervision, ongoing professional development, debriefing, clear role descriptions and manageable workloads, peer workers need safeguards that respond to the particular demands of designated lived experience roles. These safeguards should include protection from discrimination associated with the lived experience expertise they bring to their work.

Boards and leadership teams should ensure that peer workers are supported through role-appropriate orientation, supervision, professional development and review arrangements, and that peer workforce expertise informs organisational safety and quality systems.

Draft Standard 1.17 (p.22) states that clinicians should be supported, trained and developed to perform at their full capability and provide high-quality care. The Alliance recommends an equivalent, dedicated requirement for peer workers covering appropriate induction, role-specific orientation, professional development, peer supervision, leadership pathways and workforce wellbeing. Peer workforce expertise should also inform organisational safety and quality systems.

Restrictive practices

The draft Standards address restrictive practices only in Standard 2.11(c) and (d). These provisions concern access to appropriate care environments and evidence-informed interventions, and the monitoring, review and reduction of chemical and physical restraint.

> (c) provides access to appropriate care environments and evidence-informed practice interventions to prevent and support the safe management of behaviours of concern, including reducing environmental stimuli where possible and clinically appropriate
>
> (d) monitors, reviews and reduces the use of chemical and physical restraint, ensuring it is used only when clinically justified, that less restrictive alternatives are considered, and that use is recorded and reported to the board.

The Standards should use the broader term *restrictive practices* and establish an explicit objective of elimination. Restrictive practices include physical, chemical, mechanical and environmental restraint and seclusion. The Alliance refers to these actions as coercive practices because consumers experience them as involuntary treatment. The Standards should reflect the National Mental Health & Suicide Prevention Agreement direction to eliminate restrictive practices.

The Alliance recommends that less restrictive alternatives need to be substantially more than 'considered'. We also recommend restructuring the sentence to ensure that options of less restrictive alternatives is prioritised.

The absence of a nationally consistent definition of chemical restraint creates uncertainty about what services must record and how its use will be monitored, reviewed and reduced under the Standards.

In addition, including an ongoing development of strategy to reduce the use of coercive practices through reporting to the board is insufficient.

Standard 2.11 should require services to identify, provide and document less restrictive alternatives before any restrictive practice is used, except where an immediate response is necessary to prevent serious and imminent harm.

The Standards should include nationally consistent definitions, including for chemical restraint, and require transparent monitoring, review and reduction plans with meaningful consumer and lived experience governance, rather than relying only on reporting to the board.

Suicidality/Suicide attempt as an inpatient

The draft Standards refer to suicidal distress and self-harm but do not expressly refer to suicide attempt while in hospital. Draft Standard 2.18(d) requires services to "safely and effectively respond to patients experiencing suicidal distress or thoughts of self-harm, including those who have self-harmed while in hospital, and support appropriate follow-up care". The omission of suicide attempts creates uncertainty about the scope of the required response and follow-up arrangements and should be corrected to protect consumer safety.

The Alliance recommends that Standard 2.18(d) should require services to respond safely and effectively to suicidal distress, suicidal thoughts, suicide attempts and self-harm, including where these occur during a hospital stay, and to provide timely, person-led and coordinated follow-up care after discharge.

Rehabilitation

The Standards should recognise rehabilitation and personal recovery beyond symptom reduction as integral components of safe and high-quality care. Services should assess and respond to the practical, social

and environmental supports a person needs to live a life of their choosing, including support relating to daily living, relationships, recreation, education, employment, housing and community participation.

- access to appropriate range of agencies, programs, and / or interventions to meet the consumer's needs for leisure, relationships, recreation, education, training, work, accommodation and employment in settings appropriate to the individual consumer.
- supports and / or provides information regarding self care programs that can enable the consumer to develop or re-develop the competence to meet their everyday living needs.
- setting for the learning or the re-learning of self care activities is the most familiar and / or the most appropriate for the skills acquired.
- provide access to a range of accommodation and support options that meet the needs of the consumer and gives the consumer the opportunity to choose between these options.

Governance

There is no mention of lived experience or lived expertise in the governance process. Lived experience is required to ensure governance is shaped by real needs, outcomes and rights not just service provision. Mental health consumer governance We note also the absence of consumer voice when operating under clinical governance frameworks.

The Alliance recommends an assessable requirement for health services to develop and implement lived experience governance arrangements, particularly in relation to partnering with consumers. These arrangements should provide authority, resources and accountability for lived experience leadership and ensure that consumer perspectives can influence priorities, policy, service design, implementation and evaluation.

The Alliance recommends the following governance requirements

a. Support peer workers in leadership and governance roles

b. Embed peer mentoring and peer supervision

c. Support lived experience/lived expertise in leadership and in advocacy/committee roles as service users must be asked about their experiences in a safe way

Social Connection

Where desired by the person, services should support and promote positive social connection with family, children, friends, kin and valued communities. Care planning and discharge processes should identify risks of isolation and include practical steps to maintain or rebuild relationships and community participation.

The Standards should promote personal and relational recovery alongside clinical recovery. Improvement should not be defined only by a reduction in signs or symptoms; it should also be assessed by whether people are supported to exercise choice, sustain relationships, participate in community life and pursue goals that matter to them.

Advance Care Planning

The draft Standards, state that advance care planning is considered when appropriate (clinically appropriate, requested by a patient, a patient has repeated unplanned presentations within a 12 month period) - Standard 2.07.

The Alliance recommends that advance care planning be offered routinely on admission and revisited throughout care, rather than only when considered clinically appropriate or after repeated unplanned presentations. People should be supported to document their will, preferences, nominated supporters and preferred responses to distress before a crisis occurs. This is particularly important for people who are more likely to experience coercive treatment or treatment orders.

Deterioration of Mental Health

Standards 2.15–2.18 should make clear that recognising distress or deterioration must lead to timely, compassionate and least restrictive support, not an automatic escalation to coercive intervention. Assessment and response processes should preserve the person's rights, involve chosen supporters where consent is given, consider environmental and relational causes of distress, and document less restrictive alternatives.

Equity

The draft Standards should require equitable, culturally safe and accessible care that responds to each person's communication, identity, cultural and support needs. This includes respecting names and pronouns, providing access to interpreters and chosen supporters, and, where requested and practicable, offering a practitioner or support person of a particular gender. Compliance should be assessed through disaggregated data, consumer feedback and documented corrective action. This would preserve the Mental Health Standards requirement that consumers should, wherever possible, be able to access a staff member of their preferred gender.

Stigma/Bigotry/Discrimination

The Standards should explicitly require health services to prevent and respond to discrimination, stigma and prejudice, including discrimination associated with mental health status or psychosocial disability. Services should identify barriers in policy, practice and culture; provide accessible pathways for raising concerns; monitor consumer experience and outcomes; and take action where inequity or discriminatory treatment is identified.

The Alliance recommends that wherever the draft Standards discuss equity, then safety and racism, bias and discrimination should be included.

Transitions of Care

The list of information to be exchanged at transitions of care should also include the person's preferred treatment, gender, preferred de-escalation techniques and any advance agreement.

The Alliance recommends the following inclusions:

- the transport occurs in the safest and most respectful manner possible and complies with relevant Commonwealth and state / territory policies and guidelines, including the National Safe Transportation Principles.
- If admission to an inpatient psychiatric service is required, the health service makes every attempt to facilitate voluntary admission for the patient and continue voluntary status for the duration of their stay.

Mental state vs Mental health

Draft Standards 2.16 – 2.18 use the term "mental state" in relation to recognising and responding to acute deterioration. The term is not defined in the draft Standards and may not be meaningful to consumers. The Alliance recommends replacing "mental state" with "mental health" or adding a clear definition of "mental state" to the Standards.

Conclusion

Version 3 of the National Safety and Quality Health Standards provides an important opportunity to establish a stronger national framework for care that is safe, rights-based, person-led and accountable to the people who use health services. The Alliance urges the National Safety and Quality Commission to retain explicit consumer partnership and mental health-specific requirements; embed human rights, informed consent and supported decision-making; recognise and safeguard the lived experience workforce; pursue the elimination of restrictive practices; and strengthen

provisions concerning suicidal distress, recovery, rehabilitation, social connection, advance care planning, transitions of care, equity and discrimination. These changes would make the Standards more responsive to the realities of mental health care and better able to drive consistent improvement across health services.

Recommendations

1. Retain the mental health-specific requirements that may otherwise be lost through integration of the Mental Health Standards, including access to health records, mental health promotion and prevention, personal and relational recovery, social connection, practical supports, self-care assistance, and accommodation choice.
2. Add the purpose "Partnerships with consumers to help shape health care" and require boards and leadership teams to build respectful, reciprocal partnerships and co-design, share power and authority with consumers across planning, design, delivery and evaluation.
3. Strengthen draft Standard 2.03(e) so that supported decision-making is required at every stage, including accessible information, communication assistance, adequate time, trusted supporters chosen by the person, and regular review of capacity and preferences.
4. Make supported decision-making and the person's will and preferences the primary framework in mental health settings; where substitute decision-making remains legally required, use it only as a time-limited last resort with safeguards, review and continued participation by the person.
5. Adopt a clear human rights framework and use the term *person-led practice* consistently throughout Version 3.
6. Strengthen draft Standard 2.01 to require services to ask about and document each person's communication and support needs, concerns, preferences and reasonable adjustments, together with the agreed response.

7. Require clinical governance systems to identify, monitor and address risks to consumers' human rights, including rights-related complaints, restrictive practices and consumer-reported experience.
8. Include in the Introduction and Purpose of the Standards an express commitment that care is delivered in a way that upholds human rights, dignity, autonomy and freedom from discrimination.
9. Require the person's preferences, wishes and informed consent to be addressed wherever the Standards refer to patients, family and carers, rather than relying on a single general statement.
10. Enable and support consumers to participate in decisions about who is included in their care team.
11. Develop a separate lived experience (peer) workforce standard, co-designed, implemented and governed by people with lived experience, which recognises peer work as a distinct workforce with its own values base, scope of practice and expertise.
12. Exclude peer workers from coercive treatment, restrictive practices, clinical risk assessment and independent escalation functions that are incompatible with the peer role, while enabling them to contribute relational and environmental expertise to harm reduction.
13. Include peer workers in the definition of multidisciplinary care teams while preserving the distinct purpose and integrity of peer work.
14. Ensure that references to workforce capability, data use, whole-person care, care environments, communication, teamwork, deterioration, coordinated care and research appropriately include peer workers.
15. Require role-appropriate induction, orientation, professional development, discipline-specific peer supervision, leadership pathways, debriefing, clear role descriptions, manageable workloads, wellbeing supports and protection from discrimination for peer workers.
16. Require boards and leadership teams to ensure that peer workforce expertise informs organisational safety and quality systems.
17. Use the broader term *restrictive practices* and establish an explicit objective of eliminating restrictive practices.

18. Amend draft Standard 2.11 to require services to identify, provide and document less restrictive alternatives before any restrictive practice is used, except where an immediate response is necessary to prevent serious and imminent harm.
19. Adopt nationally consistent definitions, including a definition of chemical restraint.
20. Require transparent monitoring, review and reduction plans for restrictive practices, supported by meaningful consumer and lived experience governance rather than board reporting alone.
21. Amend draft Standard 2.18(d) to require safe and effective responses to suicidal distress, suicidal thoughts, suicide attempts and self-harm, including incidents during a hospital stay, and timely, person-led and coordinated follow-up after discharge.
22. Recognise rehabilitation and personal recovery beyond symptom reduction as integral components of safe and high-quality care.
23. Require services to assess and respond to practical, social and environmental needs, including daily living, relationships, recreation, education, training, employment, housing and community participation.
24. Provide access to appropriate agencies, programs and interventions; self-care information and support; familiar or appropriate settings for learning and relearning daily living skills; and a choice of suitable accommodation and support options.
25. Establish assessable lived experience governance arrangements with sufficient authority, resources and accountability to influence priorities, policy, service design, implementation and evaluation.
26. Support peer workers in leadership and governance roles and embed peer mentoring and peer supervision.
27. Promote personal and relational recovery alongside clinical recovery, measuring improvement by choice, relationships, community participation and progress towards goals that matter to the person as well as signs and symptoms.

28. Where desired by the person, support positive social connection with family, children, friends, kin and valued communities, and address isolation in care planning and discharge processes.
29. Offer advance care planning routinely on admission and revisit it throughout care, supporting people to document their will, preferences, nominated supporters and preferred responses to distress before a crisis occurs.
30. Clarify in draft Standards 2.15–2.18 that responses to distress or deterioration must be timely, compassionate and least restrictive, preserve rights, involve chosen supporters with consent, consider environmental and relational causes, and document less restrictive alternatives.
31. Require equitable, culturally safe and accessible care that responds to communication, identity, cultural and support needs, including names and pronouns, interpreters, chosen supporters and, where requested and practicable, a practitioner or support person of a particular gender.
32. Make equity requirements measurable through disaggregated data, consumer feedback and corrective action.
33. Explicitly require services to prevent and respond to stigma, racism, bias, prejudice and discrimination, including discrimination associated with mental health status or psychosocial disability.
34. Require accessible pathways for raising concerns and organisational action where inequity or discriminatory treatment is identified.
35. Expand information exchanged at transitions of care to include preferred treatment, gender, preferred de-escalation techniques and the existence of any advance agreement.
36. Require transport during transitions of care to occur in the safest and most respectful manner possible and in accordance with relevant Commonwealth, state and territory policies and guidelines, including the National Safe Transportation Principles.
37. Where admission to an inpatient psychiatric service is required, require health services to make every attempt to facilitate voluntary admission and maintain voluntary status for the duration of the stay.

38. Replace the term *mental state* with *mental health* in draft Standards 2.16–2.18, or include a clear definition of *mental state* in Version 3 of the Standards.

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.

