



MONASH
University

Because you matter survey

A survey of the social conditions and
service experiences of people accessing
psychosocial services in Australia



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To everyone who so generously shared their story with us - we're so grateful you took the time to tell us what matters and what we need more and less of.

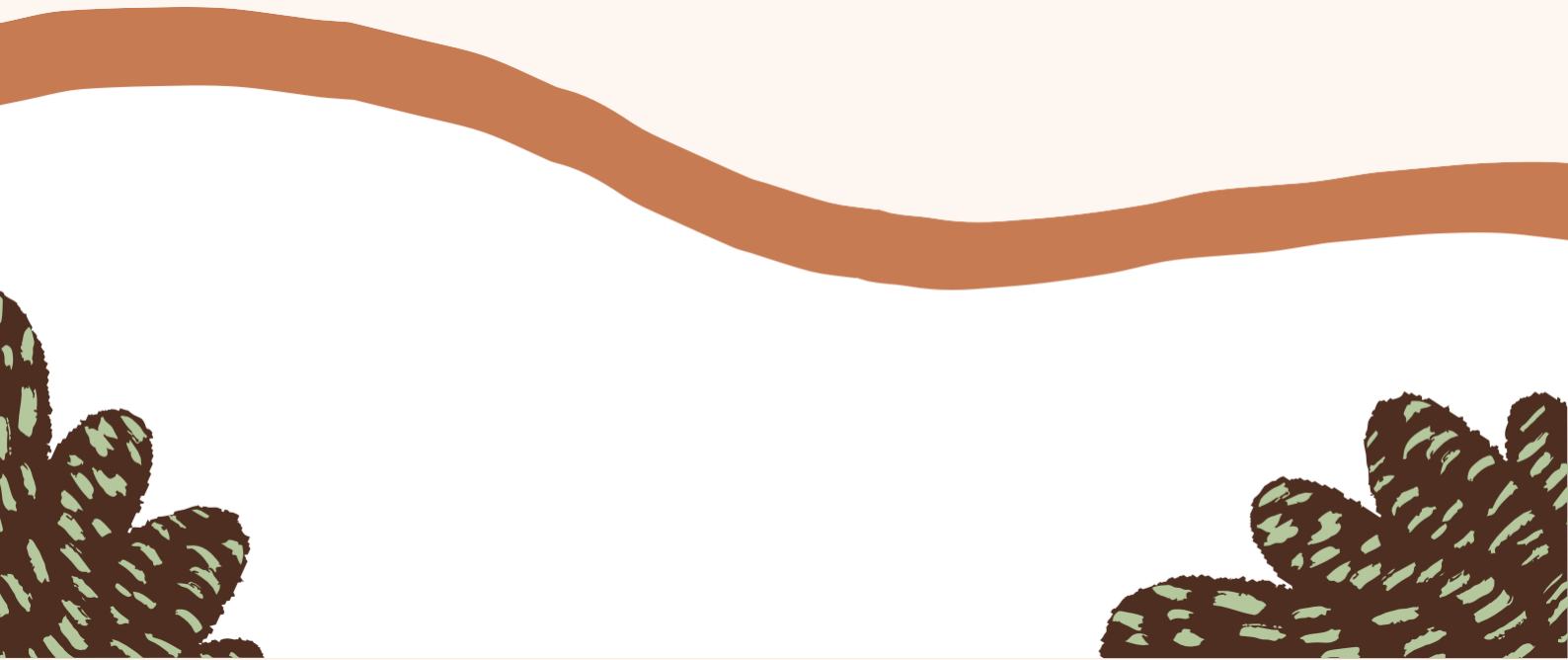
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Executive Summary



Executive summary

Recent years have seen significant change in the mental health system. New models of community based integrated care have been introduced, including Medical Mental Health Centres and the Victorian Mental Health and Wellbeing Locals. The lived experience workforce has expanded, and access to the National Disability Insurance Scheme (NDIS) for psychosocial disability continues to evolve. At the same time, communities are experiencing big social pressures such as the enduring impacts of COVID lockdowns, and housing and cost of living pressures.

This study – the first in a semi-regular series – aimed to understand how these conditions are affecting people who access services delivered by the Australian Psychosocial Alliance (APA). The APA is an affiliation of the eight largest specialist providers of community managed mental health and wellbeing services in Australia.

APA participants were invited to complete an online survey. The survey was open for 10 weeks from August – November 2025. 172 people completed the full survey, offering a snapshot of how social conditions are shaping their lives and their experiences of accessing health, mental health and community supports.

Participants who completed the full survey responded from across Australia (except the Northern Territory), with the majority living in NSW (32%), and in metropolitan regions (53.4%). There was broad age representation, led by 45–54-year-olds (30.2%). 62.2% of participants identified as female.

Four key themes were developed from the data:

Hopes for more ease and stability

- Participants shared hopes for independent lives with more peace and ease; however, cost of living and housing pressures made this hard.
- Whilst 45% of participants stated that they always or often had enough income, almost one in five participants (19%) reported that they rarely or never had enough income to meet their daily needs.
- 45% of participants selected at least 5 areas in which they went without due to living costs. Most commonly foregone were ‘fun’ or social expenses – likely impacting quality of life and social connection. Many also missed out on basic expenses such as heating/cooling, health care, and groceries.

Calling for service consistency, continuity, diversity, and accessibility

- Participants saw value in a broad and connected range of supports, yet access barriers were common, support duration was often inadequate, and budget cuts made access feel precarious.
- Almost three in four participants (72%) did not access a needed service over the past 6 months, most commonly due to cost, but also long wait times, fear of accessing the service, and not having their needs taken seriously.
- When people couldn’t access the services they required, there was an overall trend that their mental and physical health worsened.

The importance of feeling supported and listened to

- Participants wanted to feel cared for, respected, not alone, and proud of their achievements. They wanted supports that listened, and didn’t judge, assume, or try to fix things.
- They wanted the APA to advocate on what matters: systems that put people (not risk aversion or profit) at their heart.
- Almost one third of participants experienced unfair treatment or discrimination in the past 6 months, highlighting the urgency of rights-based reform.

The value of connection to people, place, and purpose

- A sense of connection – to people, places, pets, nature, housing, and activities – had the most positive impact on wellbeing for many participants
- Groups programs were valued for offering routine, friendship, and safety.
- Whilst half of participants (51%) were somewhat or extremely satisfied with their level of social connection; almost one in three participants (27%) were somewhat or extremely dissatisfied.

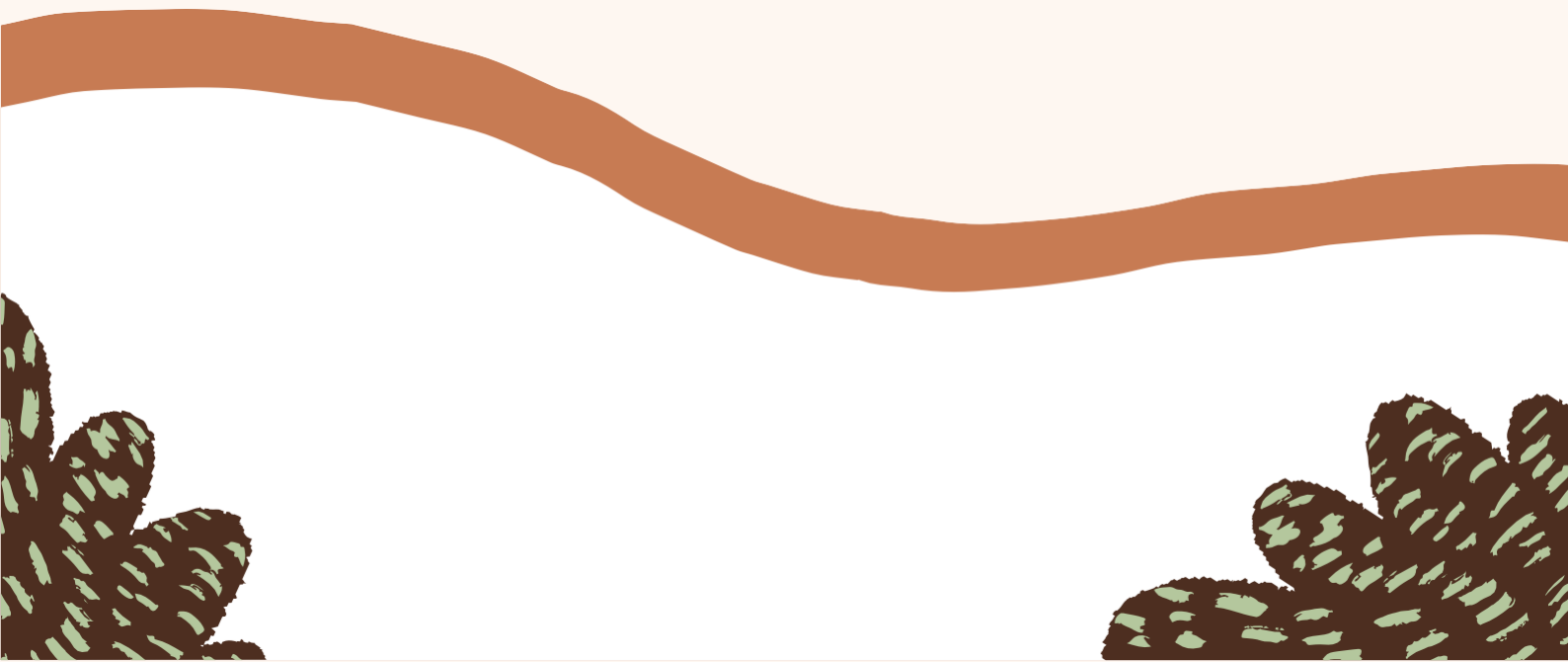
These findings highlight the need for:

- A rights-based, trauma-responsive health system that prevents further harm
- Investments in affordable health care, including dental, psychology, GP, psychiatry, and physical health services, so people can access a range of needed supports
- Income supports above the poverty line
- Adequate psychosocial alternatives to NDIS
- Continued investment in no to low-cost group programs
- Review of service timeframes to ensure they meet people's needs
- Longer-term service contracts to reduce precarity
- Robust and accessible employment supports (e.g., Individual Placement and Support)

A note on reading and sharing this report with care

Throughout this project, our Lived Experience Advisory Group (LEAG) was clear that these findings needed to be presented in a way that speaks honestly to the experiences of people accessing APA services, while maintaining the dignity of participants and never losing sight of their strength, resilience, and the possibilities ahead. We ask readers and anyone sharing this report to keep sight of the people behind the data: these are not isolated stories to be extracted or sensationalised, but shared experiences offered in trust to help improve services. We are grateful to every participant for the generosity of sharing their experience with us.

Background & Methodology



Background

This research examined the impact of social determinants and service access in shaping the experiences/wellbeing of people who access APA services. The results will inform service design and support advocacy with service users and the sector.

This report outlines the process and findings of the 2025 Australian Psychosocial Alliance (APA) “Because You Matter” consumer survey. The APA consists of eight non-governmental organisations across Australia that support people who live with experiences of mental health and psychosocial challenges. These eight organisations include: Flourish Australia, Mind Australia, Neami National, One Door Mental Health, Open Minds, Ruah Community Services, Stride, and Wellways Australia.

The survey builds on the earlier 2020 APA Consumer Survey, which explored the impacts of the COVID-19 pandemic on APA consumers’ lives (APA, 2020). Given the evolving social and economic landscape—including pressures related to housing, employment, and cost of living—the APA sought to better understand how these conditions shape the wellbeing and experiences of people accessing psychosocial support services.

The 2025 survey represents the first in a planned series of semi-regular surveys. As such, this iteration also served as a pilot to test the survey design, recruitment strategies, and data collection processes for future cycles.

Methodology

Project Team

The project pooled expertise from a range of perspectives, including:

- APA staff employed in research or service development roles (RS, RE, PE, CB, LH, EH, LG, TC. RE, CB, and LG work from a consumer lived experience perspective)
- a Lived Experience Advisory Group (LEAG) of people who had accessed an APA service (SE, BS, JH, LC, AB, JD), and
- Academics based in Monash University’s School of Occupational Therapy (EF, SL, LR)

Early development was supported by Sarah Smith and Jordan Hocking, two Social Work students completing their final placements at Neami.

The project took an iterative, collaborative approach. The LEAG contributed LE perspective across most phases of the project, from reviewing and refining survey domains, through to analysis and dissemination.

Survey Tool and Development

Survey development began with an exploration of potential domains the survey could explore. The APA’s Resilience in Isolation consumer survey (2020) exploring the impacts of COVID-19 was used as a starting point, complemented by a literature scan of domains

explored in other similar surveys, including Mission Australia's annual Youth Survey (McHale et al., 2024) and Carers Australia's Carer Wellbeing Survey (Mylek & Schirmer, 2023).

The APA Research Team and LEAG explored and refined these domains, from which survey questions were developed. This iterative approach aimed to foster rigour, accessibility, and relevance, grounded in lived expertise.

The APA subsequently partnered with the Occupational Therapy Department at Monash University to support survey design refinement, implementation, and data analysis. This collaboration strengthened methodological rigour and robust ethical oversight.

A brief pilot test was conducted with a small group of researchers from both the APA and Monash University OT teams. Feedback informed minor refinements to question wording, survey flow, and accessibility. (Refer Appendix 2)

The final mixed-methods survey contained **32 questions** in total:

- **11 demographic questions** (Questions 1-11), including APA service accessed, age, gender identity, ethnicity, employment status, and other relevant participant characteristics.
- **17 Choice-based, and Likert-scale items** (Questions 12-28), typically requiring participants to select from several options or rate experiences on a 5-point scale (e.g., rating physical health, access to income, or experiences with health services).
 - o Demographic characteristics
 - o Access to the NDIS
 - o Ratings of physical health
 - o Access to income, housing, and other material resources
 - o Access to psychological, medical, and other health services
 - o Experiences of unfair or discriminatory treatment when accessing health or mental health services
 - o Supports considered most important for wellbeing.
- **4 free-text questions** (Questions 29, 30, 30a, 31), inviting participants to describe:
 - o What has recently had the most positive impact on their wellbeing and mental health
 - o Their hopes for the future and any supporting role APA services could take
 - o Any additional comments

Ethics Approval

Ethics approval was granted by the Monash University Human Research Ethics Committee [Project ID: 45731; date approved: 17/6/2025], enabling data collection across all APA partner organisations. During the data collection phase, an amendment was made to enhance recruitment when the participant response rate was lower than had been anticipated. The main amendments related to direct emails and SMS texts to APA consumers, inclusion of a survey recruitment banner into APA staff emails, inclusion of recruitment information into relevant newsletters and promotion through APA social media posts. These amendments were approved by Monash University Ethics Committee on: 15/08/2025.

Participants provided informed consent after reading the Explanatory Statement and having the opportunity to ask questions of their APA team or contact the Monash research team.

Consent was confirmed through the online platform before participants commenced the survey. (Refer Appendix 1)

Recruitment and Data Collection

The survey was administered online using the REDCap survey platform, hosted and managed by the Occupational Therapy Department at Monash University.

The survey was distributed across all eight APA partner organisations nationally. Recruitment strategies included:

- Email and SMS text invitations
- Recruitment flyers
- APA Social media posts
- Promotion through organisational communication channels.

Consumers requiring assistance were supported by their support workers to ensure equitable participation.

The survey was open for 2.5 months (first response: 28/8/2025; final response: 8/11/2025).

No payment was offered to participants. Whilst not offering reimbursement for participants' time and expertise was a limitation of the project, it was an important means of reducing the likelihood of bot responses.

Data Analysis

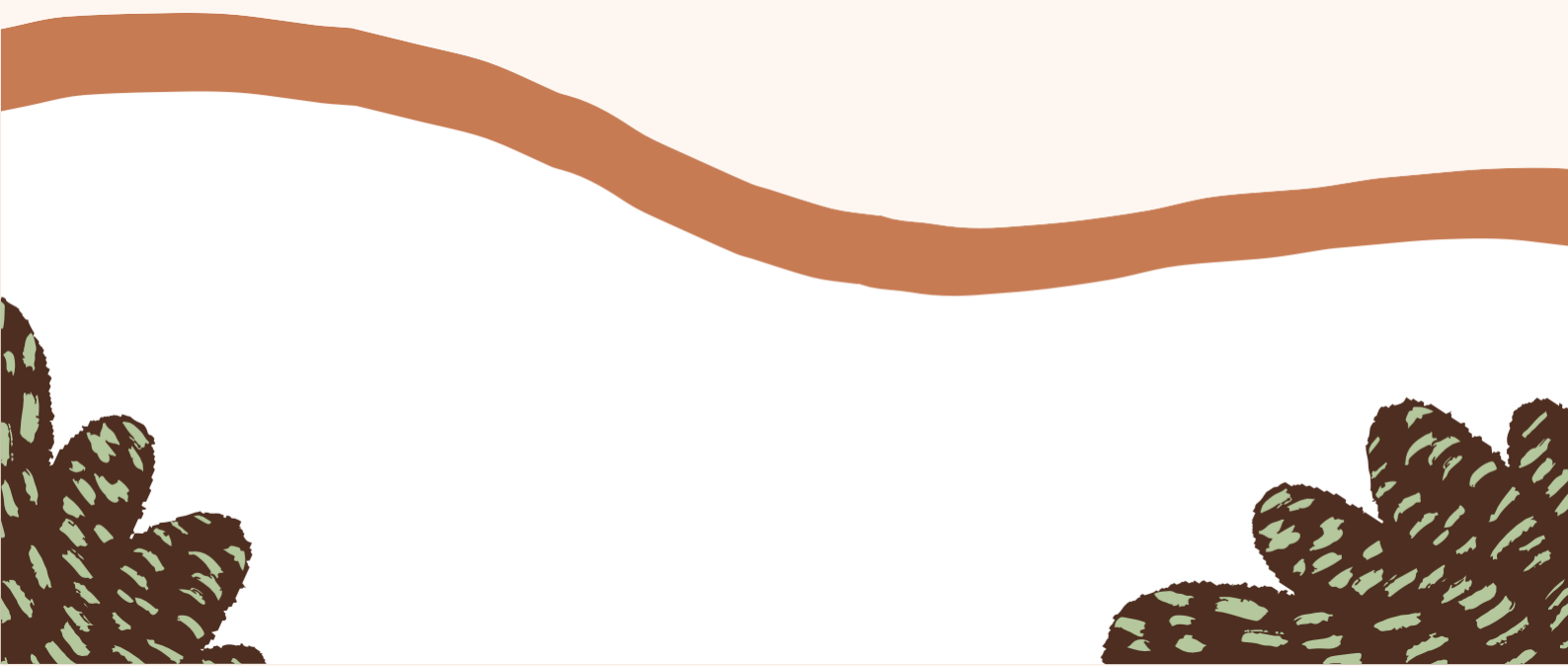
Data cleaning: A total of 281 surveys were initiated. 109 surveys (38.9%) were excluded from data analysis as the majority of survey questions were incomplete. For the 109 incomplete surveys many only had Sections 1 (Demographics) and 2 (Health Condition(s), impairment(s), and health experience(s) and NDIS-related questions) completed.

Quantitative Analysis: A total of 172 complete responses were included in the quantitative analysis. Data were cleaned in Microsoft excel and analysed using SPSS Version 29. Variables were explored with descriptive statistics. Chi-square tests (categorical) and One-Way ANOVA (continuous) were used to assess the impact of sociodemographic factors (i.e., age, gender, and location) on outcomes (e.g., physical health, connection to others, and living situation). Statistically significant relationships were detected using a p-value of .05.

In the event of a statistically significant ANOVA, a post hoc Tukey's Honestly Significant Difference (HSD) test was applied. Tukey's HSD was selected to perform all possible pairwise comparisons between the groups while strictly controlling the family-wise Type I error rate at p-value of .05.

Qualitative Analysis: Free text responses were thematically analysed. All qualitative data were fully de-identified by the Monash University OT research team (EF, LR, SL), who then conducted an initial coding analysis. The de-identified dataset and initial coding summaries were provided to the APA research team; RE and RS conducted additional coding and thematic analysis. This approach ensured academic, organisational, and lived experience perspectives informed the analysis.

Findings



Who completed the survey

Tables 1-3 provide an overview of participant demographics. Most participants identified as female (62%), with smaller proportions identifying as male (31%) or non-binary/gender diverse (3%). Ages ranged widely, though the largest group was aged 45-54 years (30%), followed by those aged 55–64 years (19%). Around one in five participants identified as LGBTIQ+ (19%). Nine per cent identified as Aboriginal (n=16). A minority reported speaking a language other than English at home (16%).

Participants were spread across Australia, with New South Wales (32%), Western Australia (26%), and Victoria (23%) representing the highest proportions. Just over half self-reported living in metropolitan areas (53%), with the remainder spread across regional and rural settings.

In terms of time use, many respondents were not in paid employment, either looking for work or not (n=98). In contrast, others reported part-time or casual employment, volunteering, unpaid caring duties, or study. Multiple responses were permitted, indicating varied combinations of work, study, and caring roles across the sample.

Table 1

Demographic Data

Variable	Category	n	%
Gender	Female	107	62.2
	Male	53	30.8
	Non-binary/gender diverse	6	3.4
	Not stated	6	3.4
Age	16–17	2	1.2
	18–25	18	10.5
	26–34	21	12.2
	35–44	24	14.0
	45–54	52	30.2
	55–64	33	19.2
	65+	13	7.6
	Not stated	9	5.2
Identify as LGBTIQ+	Yes	32	18.6
	No	126	73.3
	Prefer not to say	14	8.1

Variable	Category	n	%
Aboriginal and/or Torres Strait Islander identification	Aboriginal	16	9.3
	Torres Strait Islander	0	0.0
	No	153	88.9
	Prefer not to say	3	1.7
Language other than English spoken at home	Yes	27	15.7
	No	142	82.6
	Prefer not to say	3	1.7
Residential state in Australia	Australian Capital Territory	1	0.6
	New South Wales	55	32.0
	Queensland	14	8.1
	South Australia	10	5.8
	Tasmania	6	3.5
	Victoria	40	23.3
	Western Australia	44	25.6
	Prefer not to say	2	1.2
Self-identified living location	Metropolitan	92	53.4
	Regional	45	26.1
	Rural	20	11.6
	Not sure	10	5.8
	Prefer not to say	5	2.9

Note. $n = 172$.

Table 2

Category	n
Employed – permanent, full-time	7
Employed – permanent, part-time	19
Employed – casual, full-time	3
Employed – casual, part-time	9
Not in paid employment, looking for work	26
Not in paid employment, not looking for work	72
Unpaid caring duties	9
Volunteering	23
Studying	18
I'm not sure	5
Prefer not to say	14

Note. Participants invited to select all that apply.

Table 3

Languages Other Than English Spoken at Home

Language	n
Other, not specified	13
Prefer not to say	4
Spanish	3
Greek	2
Italian	1
Punjabi	1

Note. $n = 24$. Sorted in descending order.

Quantitative results

APA service connection and support

Participants reported receiving services from a variety of APA providers over the past 12 months. Most accessed support through Neami National (n=61) and Wellways Australia (n=41), while others utilised Flourish Australia (n=20), Ruah Community Services (n=19), Mind Australia (n=15), and Stride (n=15). Smaller numbers received services from One Door Mental Health (n=9) and Open Minds (n=1). A few were unsure about the service they received (n=1) or chose not to disclose this information (n=6).

Nearly 90% of participants accessed a single service, fourteen participants (8.1%) accessed two services in the last 12 months, and one participant accessed three (0.6%)

Table 4

Services Used in the Last 12 Months

Service	n
Flourish Australia	20
Mind Australia	15
Neami National	61
One Door Mental Health	9
Open Minds	1
Ruah Community Services	19
Stride	15
Wellways Australia	41
Not sure	1
Prefer not to say	6

Note. n = 172. Participants asked to select all that apply.

Participants reported receiving a wide range of support types from the APA services they accessed. Mental health support was by far the most common (n=140), indicating that this was the primary focus of service use. Other less frequent but important services accessed by participants included housing or accommodation support (n=28), NDIS-related services or support coordination (n=27), disability support (n=19), and carer support (n=12) or suicide-prevention/aftercare services (n=12).

Table 5*Type of Support Currently Received From Accessed Services*

Service type	n
Mental health	140
Housing/accommodation support	28
NDIS services/support coordination	27
Disability	19
Carer	12
Suicide prevention/aftercare	12
Alcohol and other drugs	10
Other	8
Homelessness/help to find housing	6
Prefer not to say	5
Not sure	1

Note. Participants asked to select all that apply. Sorted in descending order. Of the 8 participants who selected 'Other', 4 provided free text: 'art group', 'help managing life with chronic illness', 'leadership to aspire to', 'social groups at Wellways'; 2 reported they had left or no longer accessed services.

Table 6*Number of Services Accessed in the Last 12 Months*

Number of services	n	%
One	153	88.9
Two	14	8.1
Three	3	1.8
Four	1	0.6
Five	1	0.6

Note. $n = 172$. Original order retained.

Current health conditions

Participants were invited to share any health conditions they experienced. Mental health challenges / distress was by far the most common response (n=154), with psychosocial disability (n=67), attention deficit hyperactivity disorder (n=35), and autism spectrum disorder (n=23) also frequently represented.

Table 7

Health Condition, Impairment, or Challenge Currently Experienced

Health condition/impairment	n
Mental health challenges/distress	154
Psychosocial disability	67
Attention Deficit Hyperactivity Disorder (ADHD)	35
Autism spectrum disorder (ASD)	23
Other (see Table 8)	19
Prefer not to say	10
Hearing impairment	8
Visual impairment	8
Acquired Brain Injury (ABI)	7
Stroke	6
Intellectual disability	4
Spinal cord injury	4
Developmental delay	2
Down syndrome	1

Note. Participants asked to select all that apply. Sorted in descending order.

Table 8*Health Condition or Impairment Currently Experienced (Free-Text 'Other' Responses)*

Health condition/impairment	n
Physical disability	6
Chronic pain	2
Complex PTSD	2
Epilepsy	2
Chronic fatigue syndrome	2
Bipolar	1
Cancer	1
Fibromyalgia	1
Foot amputation	1
Functional neurological disorder	1
Learning disability	1
Medical issues	1
Schizoaffective disorder	1

Note. Sorted in descending order.

NDIS status

The majority of participants had never applied for an NDIS package (92, 53.5%), with a further 18 (10.5%) having their application rejected, and 14 (8.1%) with an application pending. Of the 37 participants who reported currently having NDIS approval, 30 (81.1%) indicated their package was for psychosocial support, while 4 participants (10.8%) were unsure.

Table 9

Current National Disability Insurance Scheme (NDIS) Application Status

Current NDIS status	n	%
No, never applied	92	53.5
Yes	37	21.5
No, application rejected	18	10.5
No, application pending	14	8.1
Prefer not to say	6	3.5
Not sure	5	2.9

Note. $n = 172$. Sorted in descending order. Of the 37 participants with current NDIS approval, 30 (81.1%) indicated their package was for psychosocial support; 4 (10.8%) were unsure.

Overall physical health

The majority of participants rated their overall physical health as ok (43.6%). 29% of participants rated their health as poorer than ok, with 25% of participants rating their health as better than ok. There were no significant differences in Physical Health associated with differences in age, gender, or Location (all $p > 0.05$).

Table 10

Self-Reported Overall Physical Health

Rating	n	%
Very poor	9	5.3
Poor	41	23.8
Ok	75	43.6
Good	29	16.9
Very good	14	8.1
Prefer not to say	4	2.3

Note. $n = 172$.

Social connection

Approximately half of participants (50.6%) were somewhat (38.4%) or extremely (12.2%) satisfied with their level of social connection. 16.9% were neither satisfied nor dissatisfied, with just over one quarter of participants (27.4%) reporting dissatisfaction.

There were no significant differences in sense of connection with others based on gender or Location (both $p > 0.05$). However, 26–54-year-olds felt more dissatisfied with their connection with others compared to 55+ year olds.

Table 11

Self-Reported Level of Social Connection Satisfaction

Level of satisfaction	n	%
Extremely dissatisfied	13	7.6
Somewhat dissatisfied	34	19.8
Neither satisfied nor dissatisfied	29	16.9
Somewhat satisfied	66	38.4
Extremely satisfied	21	12.2
Prefer not to say	9	5.2

Note. $n = 172$.

Living situation

Participants described a range of living situations. Participants could select as many options that applied. Most participants reported one living situation ($n=158$), with 11 participants reporting two options, and three participants selecting three.

The majority of participants lived in their own home (40), private rental (38), or living in a family home (30). Community (21) and public housing (20) were also notable options.

Age groups differed significantly on the 'House (owned or paying mortgage)' variable ($p = 0.022$). Pairwise comparisons showed that compared to people who were 34 years and under (0-11%), 35+ year olds (11-33%) were more likely to be living in their own house (most $p < 0.05$).

Table 12

Description of Living Situation(s)

Living situation	n
House (owned or paying mortgage)	40
Private rental	38
Living in a family home	30
Community housing	21
Public housing	20
Share housing/share accommodation	12
Prefer not to say	9
Supported accommodation	9
Homeless	4
Transitional housing	3
Caravan	3
Couch surfing	1
Boarding house	0
Other	0

Note. $n = 172$. Participants asked to select all that apply. Sorted in descending order.

Participants were invited to rate their satisfaction with their living situations, and any reasons for dissatisfaction. The majority of participants (63.4%) were somewhat (32.6%) or extremely satisfied (30.8%) with their living situation. Almost one quarter of participants (23.2%) expressed dissatisfaction, with 14.5% somewhat and 8.7% extremely dissatisfied. No significant differences were found based on age, gender, or location with respect to satisfaction with their living situation (all $p > 0.05$).

Table 13

Satisfaction With Living Situation

Level of satisfaction	n	%
Extremely dissatisfied	15	8.7
Somewhat dissatisfied	25	14.5
Neither satisfied nor dissatisfied	19	11.0
Somewhat satisfied	56	32.6
Extremely satisfied	53	30.8
Prefer not to say	4	2.3

Note. $n = 172$.

Participants could select all reasons for dissatisfaction applicable to them, with the majority selecting one reason, ($n=16$), up to one participant who selected 6. The most common causes of dissatisfaction were relationships with neighbours ($n=12$), isolation ($n=10$), and poor housing quality ($n=10$). Across the reasons provided for dissatisfaction with housing, no significant differences were found based on age, gender, or location (all $p > 0.05$).

Table 14

Reasons for Dissatisfaction (Rated Extremely or Somewhat Dissatisfied) With Living Situation

Reason	n
Relationship with neighbours	12
Isolation	10
Poor housing quality	10
Too expensive	9
Unsafe	8
Short-term/insecure housing	6

Reason	n
Housing doesn't meet my accessibility needs (e.g., ramp)	6
Issues with landlord/agent/housing manager	6
Family/domestic violence	6
Relationship with people I live with	6
Overcrowding (the number of people I live with)	4
Lack of public transport options	4
Lack of local amenities (e.g., shops, libraries)	2
Prefer not to say	2
Lack of parks/green spaces	1
Other	1

Note. $n = 40$. Sorted in descending order. The one participant who selected 'Other' stated 'motel' in the free-text box.

Table 15

Number of Reasons for Dissatisfaction With Living Situation

Number of reasons	n
One	16
Two	9
Three	6
Four	5
Five	3
Six	1

Note. $n = 40$.

Income for daily needs

The majority of participants sometimes had enough income to meet their needs (31.4%). Just under half of participants (44.8%) reported that they always (18.6%) or often (26.2%) have enough income to meet their daily needs. Thirty-three participants (19.2%) reported that they rarely or never had enough income to meet their daily needs.

There were no significant differences on this outcome based on gender or Location (both $p > 0.05$). However, compared to 16–34-year-olds and 55–64-year-olds, 35–44-year-olds were more likely to feel they often did not have enough income to meet their needs (all $p < .05$).

Table 16

Enough Income to Meet Daily Needs

Frequency	n	%
Never	14	8.1
Rarely	19	11.0
Sometimes	54	31.4
Often	45	26.2
Always	32	18.6
Prefer not to say	8	4.7

Note. $n = 172$.

When asked about 18 areas of potential expenditure, 45.3% selected at least 5 areas in which they went without due to living costs, with 7.6% of those going without 13–17 areas. Most commonly foregone were ‘fun’ or social expenses (having a holiday $n=84$; dining out $n=77$; going to a concert/event $n=67$; going to a movie $n=66$) – demonstrating the extent to which cost of living can impact quality of life and social connection. Many also said they missed out on quite basic items such as heating or cooling their home ($n=46$), grocery items ($n=66$), clothing ($n=75$), and health care (appointments $n=35$, prescriptions $n=35$, procedures $n=32$).

When we explored demographic differences in the *overall number of items* missed due to living costs, there was a significant difference across age groups ($p = 0.022$).

When we explored which individual items were unaffordable for people, then demographic trends emerged for seven items:

- **Maintaining Personal hygiene:** Gender groups differed with respect to affording to maintain personal hygiene in the last 6 months ($p = 0.029$). Those identifying male were more likely to go without due to their living costs compared to females ($p = 0.005$).
- **Heating/cooling home:** Age significantly impacted this outcome ($p = 0.023$). Participants aged 26–54 were more likely to go without compared to those aged 25 or

less. Further comparison showed 35–44-year-olds were more likely to go without than over 55-year-olds (all $p < 0.05$)

- **Visiting Loved Ones:** Participants aged over 35 were more restricted in affording visits to loved ones than 26–34-year-olds (all $p < 0.05$).
- **Movies:** 35–44-year-olds felt most restriction in affording movies compared to 16–25-year-olds and 55–64-year-olds (both $p < 0.05$).
- **Doctors Appointment:** Participants aged 35–54 years old were more likely to go without compared to groups younger and older (all $p < 0.05$).

Table 17

Items Participants Went Without in the Past 6 Months Due to Living Costs

Item	n
Having a holiday	84
Dining out	77
Buying clothes	75
Going to a concert or a fun event	67
Buying your usual grocery items	66
Going to a movie	66
Visiting friends/family	58
Buying furniture	53
Heating/cooling your home	46
Paying rent or a bill on time	45
Eating your regular meals	44
Petrol/public transport	37
Booking/attending a doctor's appointment	35
Filling a prescription	35
Having a required medical procedure	32
Prefer not to say	28
Maintaining personal hygiene	24
Did not go without	14

Item	n
Feeding/taking care of a pet	11
Going without/reducing the use of menstrual products	5
Other	4

Note. $n = 172$. Participants asked to select all that apply. Sorted in descending order. For the 4 participants who selected 'Other': 'Being unable to progress with home renovations, due to an unsupportive ex-partner'; 'dentist and elective surgery, mental health appointments' ($n = 2$).

Table 18

Number of Items Not Purchased Due to Living Costs

Number of items	n
One	46
Three	14
Eight	14
Not applicable	12
Four	12
Nine	11
Two	10
Six	9
Five	7
Twelve	7
Ten	6
Eleven	6
Seven	5
Thirteen	3
Fourteen	3
Fifteen	3
Seventeen	3

Number of items	n
Sixteen	1

Note. $n = 172$. Sorted in descending order.

Table 19

Stratified Number of Items Not Purchased Due to Living Costs

Number of items	n	%
1	46	26.7
2–4	36	20.9
5–8	35	20.3
9–12	30	17.4
13–17	13	7.6
Not applicable	12	7.0

Note. Sorted in descending order.

Unfair treatment and discrimination

Almost one third of participants (30.8%) stated they had experienced unfair treatment or discrimination over the past 6 months, with a further 9.3% responding they were unsure, and 5.8% preferring not to say. There were no significant differences on this outcome based on age, gender, or Location (all $p > 0.05$).

Table 20

Experienced Unfair Treatment or Discrimination

Response	n	%
No	93	54.1
Yes	53	30.8
Not sure	16	9.3
Prefer not to say	10	5.8

Note. $n = 172$. Sorted in descending order.

Mental health was the most common reason for unfair treatment or discrimination ($n=39$), followed by disability ($n=24$). When we explored demographic differences in the total number of reasons linked with discrimination, there was no significant group difference based on age, gender, and location (all $p > 0.05$).

When we looked at whether demographic groups (age, gender, location) differed significantly for each discrimination reason, significant differences emerged on these 4 reasons:

- **Finances:** Participants who felt discriminated against because of their finances differed significantly based on age ($p = 0.034$). Compared to 16–44-year-olds, 45+ year olds were more likely be discriminated against because of their age (all $p < 0.05$).
- **Finances:** Participants who felt discriminated against because of their finances differed significantly based on location ($p = 0.022$). Compared to people in regional locations, those in metro locations were more likely be discriminated against because of their location ($p = 0.005$).
- **Gender:** Participants who felt discriminated against because of their gender differed significantly based on Gender ($p = 0.046$). Compared to non-binary people and females, males were less likely to be discriminated against because of their gender (all $p < 0.05$).
- **Religion:** Participants who felt discriminated against because of their religion differed significantly based by gender ($p = 0.008$). Compared to females, males felt more discriminated against because of their religion (both $p = 0.003$).

Table 21*Perceived Reason for Unfair Treatment or Discrimination*

Reason	n
Mental health	39
Disability	24
Personal views	15
Age	13
Physical appearance	13
Financial background	11
Sexuality	10
Gender	8
Race/cultural background	8
Religion	5
Other	4
Prefer not to say	1

Note. $n = 53$. Sorted in descending order. For the 4 participants who selected 'Other': 'My paranoia can lead me to believe people are out to harm me'; 'no family support'; 'personal ideas'; 'weight, previous drug use'.

Whilst the majority of participants reported one reason for unfair treatment and discrimination ($n=17$), it was common for participants to report more than one reason, with 26 participants reporting between 2 and 4 reasons, and 9 participants reporting 5-7 reasons.

Table 21*Number of Perceived Reasons for Unfair Treatment or Discrimination*

Number of reasons	n
One	17
Two	10
Three	8
Four	8
Five	6

Number of reasons	n
Six	2
Seven	1
Nine	1

Note. $n = 53$. Sorted in descending order

Table 22

Stratified Number of Perceived Reasons for Unfair Treatment or Discrimination

Number of reasons	n
2–4	26
1	17
5–7	9
8+	1

Note. $n = 53$. Sorted in descending order.

Limitations to service access and associated impacts

72.1% of participants did not access a service they needed over the past 6 months, whilst forty-eight participants (27.9%) reported not experiencing barriers to services in the last 6 months.

When we explored demographic differences in the *total number of services* missed in the last 6 months, there was no significant group difference based on age, gender, and location (all $p > 0.05$).

When we looked at whether demographic groups (age, gender, location) differed significantly for specific services that people needed but did not access, significant differences emerged only for NDIS support, based on location ($p = 0.005$). Compared to people who were in rural locations, those in metro locations had limited access to NDIS support.

Table 23

Services Needed but Not Accessed in the Last Six Months

Service	n
Dental services	52
Psychologist/counsellor	45
GP (General Practitioner)	42
Psychiatrist	39
Physical health supports (e.g., dietitian, physiotherapist)	33
NDIS support	26
Financial support	23
Prefer not to say	16
Medical services (e.g., oncologist)	15
Centrelink/Services Australia	15
Emergency Department	14
Legal support	13
Peer worker	12
Other non-clinical mental health support workers	12
Psychiatric ward/inpatient unit	11
Support group	11

Service	n
Housing support	11
Family/domestic violence support	7
Employment support	6
Sub-acute residential services (e.g., PARC)	5
Other	1

Note. $n = 172$. Participants asked to select all that apply. Sorted in descending order. For the participant who selected 'Other': 'heart specialist'.

It was common for participants to go without multiple needed services, with approximately 43% of all survey participants reporting they did not access more than one service they needed.

When we explored demographic differences in the *total number of reasons* for not accessing any individual service type, there was no significant group difference-based age, gender, or location (all $p > 0.05$).

Table 24

Number of Services Needed but Not Accessed in the Last Six Months

Number of services	n
One	50
Two	18
Three	17
Four	8
Five	7
Six	3
Seven	6
Eight	6
Nine	2
Ten	2
Eleven	2

Number of services	n
Twelve	2
Thirteen	1

Note. $n = 124$.

Table 25

Stratified Number of Services Needed but Not Accessed in the Last Six Months

Number of services	n
1–2	68
3–5	32
6–8	15
9+	9

Note. $n = 124$.

Participants reported not accessing needed services for a range of reasons, but overwhelmingly due to cost (n=207). Long wait lists (n=88), fear of accessing the service (n=83), and not having their needs taken seriously (n=81) were also common barriers.

Table 26

Reasons for Not Accessing Needed Services

Reason	n
Cost	207
The waiting time was too long	88
Fear of accessing the service	83
My needs were not taken seriously	81
Service was not available when required	74
I was not supported to access the service	51
Dislike of the service/service model	48
Transport/distance needed to travel	46
The service was not available in my area	40
I didn't/couldn't meet the eligibility requirements	29
Other	29
I was too busy	28
I'm concerned about privacy with online / phone support	28
I did not know the service existed when I needed it	25
I did not have access to the technology needed	14
Prefer not to say	14
I had an upcoming appointment	5
Language barrier (e.g., no interpreter provided)	5

Note. n = 124. Participants asked to select all that apply. Tally combines responses across all services needed but not accessed for each reasons.

Table 27*Top Three Barriers to Access, by Service*

Service	Barrier 1	Barrier 2	Barrier 3
Dental (n = 52)	Cost (82.7%)	Fear of access (19.2%)	
Psychology/counselling (n = 45)	Cost (66.7%)	= Long wait time (24.4%)	= Inability to access when needed
GP (n = 42)	Cost (52.4%)	Long wait time (21.4%)	Needs not taken seriously (19%)
Psychiatrist (n = 39)	Cost (42.2%)	Long wait time (17.8%)	= Inability to access when needed (13.3%)/= Fear of access
Physical health care (n = 33)	Cost (78.8%)	= Fear of access (15.2%)	= Inability to access support
NDIS support (n = 26)	Needs not taken seriously (61.5%)	No support to access service (38.5%)	Dislike the service (23%)
Financial support (n = 23)	Cost (30.4%)	Long wait times (21.7%)	Not knowing the service (17.4%)
Medical services (n = 15)	Cost (86.7%)	= Long waiting times (20%)	= Inability to access when needed/= Needs not taken seriously
Centrelink (n = 15)	Long waiting times (46.7%)	= Dislike of the service (33.3%)	= Not eligible
ED (n = 14)	= Fear of accessing (11.8%)	= Long wait times	
Legal support (n = 13)	Cost (92.3%)	Long wait times (15.4%)	
Peer worker (n = 12)	Service not available in area (41.7%)	Fear of access (33.3%)	Inability to access when needed (25%)
Support worker (n = 12)	Cost (25%)	Long wait times (16.7%)	
Psychiatric ward/IPU (n = 11)	Needs not taken seriously (54.5%)	= Cost (27.3%) /= Dislike of service/=Fear of	

Service	Barrier 1	Barrier 2	Barrier 3
		service/=Inability to access when needed	
Support group (n = 11)	Fear of access (54.5%)	= Not knowing the service (45.5%)/=Service not in my area	= Dislike service (27.3%)/= Inability to access when needed
Housing support (n = 11)	Needs not taken seriously (45.5%)	= Fear of accessing the service (36.4%)/= Long wait times	
DFV support (n = 7)	= Fear of service (57.1%)/= Not being able to access when needed	= Needs not taken seriously (42.9%)/= Long waiting times	
Employment support (n = 6)	Fear of accessing the service (50%)	Cost (33.3%)	
Sub-acute residential (n = 5)	Needs not taken seriously (60%)	= Cost (40%)/= Inability to access when needed/= Transport/distance	

Note. Barriers are ranked 1–3 as reported in the source document and are not re-sorted. An equals sign (=) denotes a tie between barriers.

Not accessing required services had a range of impacts. Most commonly, participants selected that they managed on their own (n=188), noticed that their mental health symptoms increased (n=172), and their physical health got worse (n=146). Accessing alternate support from a support worker (n=88), family/friends (n=59), or another service (n=47) were less common but notable responses.

Table 28

Impact of Not Accessing a Required Service

Impact	n
I managed on my own	188
My mental health symptoms increased	172
My physical health got worse	146
I got support from my support worker	88
I got support from family/friends	59
I got support from another service	47
Attended the Emergency Department	28
Other	28
I contacted a triage/crisis service by phone or internet	23
I was admitted to hospital	22
Prefer not to say	21

Note. n = 124. Participants asked to select all that apply. Sorted in descending order.

Important and desired services

Participants were invited to select all the supports that are most important to them today, as well as select up to five options that would most support them to have the life they want. Slight differences emerge across the two options, as outlined in the tables below

Most important supports (n=172, select all that apply)

Participants selected a broad range of supports that were important to them today. The most common response was Talk therapy / Counselling (57.6%), followed by Peer support (41.3%), Making social connections (41.3%), Medication (40.1%), Physical health care (39%), and Psychiatrist (34.9%).

When we explored potential demographic differences in the essential supports endorsed by participants, there were significant group difference on several supports, however:

- **Art/Music Therapy** - endorsed significantly more by females (76.5%) compared to males (15.7%) and gender diverse people (7.8%), $p=0.003$.
- **Access to education** - endorsed significantly more by females (58.3%) compared to males (29.2%) and gender diverse people (12.5%), $p=0.042$.
- **Access to community** - endorsed significantly more by females (60.5%) compared to males (27.9%) and gender diverse people (11.6%), $p=0.010$.
- **Respite for participants** - endorsed significantly more by 45–54-year-olds (56.6%) compared to other age groups (0-13%), all $p=0.017$.
- **Drop-in Services** - endorsed significantly more by females (54.5%) compared to males (27.3%) and gender diverse people (18.2%), $p<0.001$.

Table 29

Most Important Supports Today

Support	n
Talk therapy/counselling (e.g., trauma counselling, substance use counselling, grief counselling)	99
Peer support	71
Making social connections	71
Medication	69
Physical health care	67
Psychiatrist	60
Help with practical tasks (shopping, housekeeping, etc.)	58
Group sessions	55
Skills therapy (e.g., CBT, DBT, ACT)	52

Support	n
Art- or music-based approaches	52
Community access	45
Access to nature	44
Support coordination	43
Managing my finances	39
Housing/tenancy support	36
Learning to use technology (e.g., computer, internet)	31
Access to employment/volunteering	31
Access to education	25
Animal-assisted therapy	24
Respite for me	23
Crisis support alternatives (e.g., alternatives to hospital)	23
Drop-in spaces	23
Community learning spaces (e.g., Recovery College, Neighbourhood House)	20
Spirituality-inclusive support (faith-based spiritual healthcare)	20
LGBTIQA+ specific support	14
Alcohol and other drug support	11
Support/respite for my family/chosen family/kin/carers	10
Prefer not to say	10
Culturally specific support	8
Other	3

Note. $n = 172$. Participants asked to select all that apply. Sorted in descending order.

Desired supports

From the same list of options, participants were asked to select up to five supports that would support them to have the life that they want. Talk therapy and counselling emerged as the highest-priority support, selected by just over half of the participants (52.3%). This was followed by physical health care (35.5%) and skills-based therapies such as CBT, DBT, and ACT (33.1%). Medication support (30.8%), help building social connections (30.8%), and psychiatry (30.2%) also featured prominently, indicating a strong value placed on core therapeutic, clinical, and relational supports.

Practical assistance, including help with daily tasks (29.1%) and peer support (23.3%), formed an additional group of commonly prioritised supports. Creative and community-based options, such as art or music-based activities (18.6%), group sessions (14.5%), technology assistance (14.0%), access to nature (14.0%), and housing or tenancy support (14.5%), were selected less often but still reflected meaningful preferences for a proportion of participants.

Only small numbers identified crisis alternatives, culturally specific services, LGBTIQ+ supports, respite options, or financial assistance as one of their top five priorities.

When all responses are considered, the results indicate that participants most strongly value conversational and clinical care, alongside supports to manage daily life and maintain social connections.

Table 30

Top Five Supports for the Life Participants Want

Support	n
Talk therapy/counselling	90
Physical health care	61
Skills therapy (e.g., CBT, DBT, ACT)	57
Medication	53
Making social connections	53
Psychiatry	52
Help with practical tasks	50
Peer support	40
Art- or music-based approaches	32
Group sessions	25
Housing/tenancy support	25
Learning to use technology	24

Support	n
Access to nature	24
Animal-assisted therapy	21
Community access	21
Access to employment/volunteering	20
Support coordination	17
Access to education	17
Managing my finances	16
Alcohol and other drug support	10
Respite for me	10
Crisis support alternatives	9
Drop-in spaces	7
Support/respite for my family/chosen family/kin/carer	7
Spirituality-inclusive support	7
LGBTIQA+ specific support	7
Community learning spaces	5
Culturally specific support	4
Other	4

Note. $n = 172$. Participants invited to select up to five that apply. Sorted in descending order.

Qualitative results

Things that have a positive impact

One hundred and thirty seven participants responded to the prompt “What has had the most positive impact on your wellbeing mental health over the past 6 months?”

Accessing supports

Support from APA and other services were most cited as having the most positive impact on wellbeing over the past 6 months. People mentioned the value of support workers, peer workers, counsellors, psychologists, psychiatrists, physical health supports and other allied health practitioners (although some participants mentioned they could not access supports as desired due to cost). Participants also referenced groups, peer support, PARC, supported living, housing support, AOD support, counselling, psychosocial support, stable medication, and Medicare Mental Health Centres.

“Group therapies, the friendly and encouraging faces at APA organisation, talking face to face with people again”

“Support from APA organisation as they have linked me in with Housing, Drug and Alcohol support and I enjoy making social connections through the groups”

“Connecting with APA organisation and receiving a support worker. I wouldn't have survived without their support, and I mean that very literally. I was able to access a clinical suicide prevention support program after several attempts at suicide after a long history of trauma and abuse. I cannot afford private help so this program and the service APA organisation provides helped to save my life.”

Several participants mentioned the value of a holistic support network, indicating that effective collaboration across supports is important in fostering wellbeing. Also mentioned was having regular scheduled appointments, accessibility of support, and finding the right fit.

Groups were commonly referenced, valued for the social connection they enabled. People named the value of safe and supported places to practice vulnerability and “put themselves out there”. Participants also valued the routine of groups, seeing familiar faces, and building friendships.

“I have made lots of friends [at APA group] and look forward to seeing them every week”

“APA organisation community. Meeting new people and being able to socialise in a safe space. art and gym has been therapeutic. counsellors and support workers have been helpful and kind.”

Support networks included formal supports as well as family, friends, and connection to nature, hobbies, employment, and community. Safe, reliable housing was significant for several participants.

Feeling supported and noticing change

Alongside the types of support they valued, participants also described their felt experiences, including feeling safe, supported, cared for, not alone, understood, listened to and believed. Support that was encouraging, non-judgemental, kind, accepting, authentic, hopeful, and reliable were all valued – where people felt respected and understood.

"Understands my cultural values"

"Knowing that my support workers are there regularly to help me find a way to work through situations as they pop up. And that I don't have to go through it alone"

"Having someone to talk to about difficult situations in my life, and the person following up"

"Being around people who care about me"

"Great counsellor at organisation and APA organisation doing weekly/fortnightly home visits to check on me as I have been very isolated. They have been a constant support with great positive lifestyle encouragement + support with whatever I have needed."

Participants felt pride in increasing their sense of control, independence, self-awareness, self-compassion, accomplishment, autonomy, and agency. There was also pride at creating space and clarity, routine, and improving social skills. Some people described the role of wellbeing practices and applying learnings.

"Being able to grow my independence but not fully being on my own"

"Getting stuff done"; "Feeling like I'm contributing"; "Being productive and feeling like I had a purpose"

"Being around people who care about me and ignoring things that do not matter to me. My mental health has improved naturally, and my thoughts make a lot more sense now than they used to."

"Being to do as I wish, with my time. Being accepted for who I am."

"Getting a plan and structure in my day"

Feeling connected and doing meaningful things

A sense of connection had the most positive wellbeing impact for many participants, with social connection and improved quality of relationships particularly common. People also valued connection to family, pets, nature, community, and feeling connection in employment and housing.

"Reconnecting with a friend from the past and speaking to them each week. Also making a connection with a person who does a lot of craft and crochet like myself that we can share thoughts and our projects with each other."

"Friends and family has had the greatest impact on my life."

"Friendship, ending contact with abusive people, getting out in nature, getting sun exposure, cultivating a positive mindset and practising gratitude, being able to talk with support workers"

Some specific activities were listed as having the most positive impact on wellbeing, including arts and crafts, employment, exercise, volunteering, gardening, gaming and studying.

"My friends, gaming, getting stuff done, food"

“Being with people”

“Being a volunteer”

“Connecting with my clients in my work”

“Working and using support”

There aren’t always positives

Not all participants described positive impacts over the past 6 months. They named they were unsure, that their health had deteriorated, that social conditions were adversely affecting their health, and the endurance through ambivalence when living with chronic health conditions. It’s important to hold the honesty of responses that sometimes there are no (standout) positives and recognise people’s resilience enduring sustained periods of hardship.

“loss of physical ability to seek work poor medical management poor service availability in rural areas too many restrictions on who can access services”

“Unsure. My mental health issues are chronic and wax and wane despite being generally bad. I can’t think of a singular moment that stands out as most positive. I am on a very slow plodding road to wellness, but every step is small and not without struggle or potential setbacks.”

Future hopes

One hundred and thirty seven participants responded to the prompt “What do you hope for the future?” Participants described humble hopes: stable housing and employment, health and connections so they can live independent lives. They wanted communities and services marked by kindness and where authenticity was welcomed not silenced or policed.

A life with more ease and stability

Participants described hoping to create and sustain a better life. Participants hoped for stability and independence in their lives, crucial foundations from which other hopes can be dreamed.

"Not a lot. But I hope to have adequate housing and a liveable income one day so I can have what other people have.... a life worth living. And the ability to have something stable and reliable that can help me focus on my recovery. You can't get better when you don't know where your next meal is coming from or if a doctor's visit is going to send you broke or if you lose your accommodation. This is no way for anyone to live. I want to get better but without the right circumstances, support and opportunities it's not possible. I am just in constant survival mode."

"a life"

"To live, rather than just surviving life"

"To feel happiness and joy again. To have enough money for essentials like food, medicines, rent. To finally be offered public housing. To have friends and be a real part of the community. For inclusiveness for deaf/blind people."

Participants hoped for improved/sustained health and wellbeing, more peace, ease, and ‘normalcy’ in their lives, and hopeful mindsets marked by gratitude, contentment, confidence, and positive sense of self. Others hoped for safety, security, to stay alive, and "that I'll be ok".

"That things will get easier"

"To be able to function more days than not"

"Contentment and health"

"Happiness and health for me and my children"

"Change to my mental health so I can feel good again"

Participants hoped for permanent, stable, and suitable housing, financial independence, and having a liveable income. Some participants also hoped to own a car and to have greater physical mobility.

"Being in control of my own finances"

"To save up as much money as possible"

"I hope that in the future I am in a position where I don't have to worry about finances, I have a home and I am as happy as I can be"

Participants hoped for skills, strategies and awareness to maintain their health and strengthen a sense of control, autonomy, resilience, and independence.

“To get my life together”

“To be able to help myself better”

“Better understanding of my mental health”

Having a job and doing things that matter

Many people hoped to retain, gain, or improve their employment. This was linked with a sense of financial independence, purpose, and 'normalcy'.

“I hope to get a job and live a more normal life”

“To have a good job and family”

“Employment. More money”

“Continue in my employment”

“To have a job I enjoy that is fulfilling and utilises my skills”

Other meaningful activities included pursuing personal interests and achievements, travel, study, and volunteering.

“Write a novel”

“Start my own business”

“To be well enough to volunteer”

“Excelling in art field”

“To be able to afford a holiday or even just a weekend away”

To feel connected

Participants hoped for greater connection: to other people, to family, and to pets. Some hoped for the inclusivity and belonging gained through connection to community. Others described a desire for healthier and better-quality relationships.

“To be more involved in my community”

“To feel connected to others”

“That I can continue to be socially connected and stay healthy”

“To live a peaceful life with good people around me”

Some participants hoped for a "kinder, fairer world", marked by greater acceptance and no discrimination. They hoped for the next generation - dreaming thriving lives with less hardship.

“People understand and value each other, no matter where they come from”

“For life to be better for my nieces than it was for me”

“To be able to give my kids everything they deserve”

"I hope to obtain a rental property as I have been in temporary accommodation for over a year and it is impacting my mental health and wellbeing"

Accessible and humane services

Some participants hoped for continuity of current supports, and increased availability, accessibility, affordability, and longevity of supports. Desired services included psychiatry, NDIS, psychology, respite, medication, and counselling. People wanted supports that were reliable and available when needed. Accessible supports were seen as an important strategy for stability and independence. There were calls for new models of care which enable open, honest, non-carceral conversations about suicidality, and where "people are put before profits".

"It is essential that I have continuity and their continued support. this has really helped fill a hole for me! I also really enjoy their groups and hope they are able to continue and add to their amazing group programs! and not have what is an essential service to me reduced in any way!! please!"

"To have more stable support and access to services that I need"

"Easier access and more financially viable access to supports"

"Being independent but able to access help when I need it"

How can mental health services make hope real

One hundred and thirty seven participants responded to the prompt “What role could our mental health and wellbeing services play to make that hope a reality?”

Participants described a wide range of roles APA services could provide to provide helpful supports. These included staff listening and being present, helping service users navigate complex support systems, and providing groups and connections to foster skills and connection to foster a meaningful, self-determined life. Participant responses reflected what is in place that works, while also reflecting on what could be improved.

Emotional support & being heard

Most commonly, participants expressed the need for deep listening. They wanted to be heard without judgement, and without necessarily trying to fix or problem solve. They wanted to be treated as an individual with their unique circumstances and preferences and understood. They also highlighted the importance of not dismissing their concerns or categorising their difficulties into predetermined boxes.

"Be curious - don't make assumptions and keep listening."

"Don't assume hopelessness. Don't try and fix things. Just listen and be flawed like the rest of us."

"Be more understanding with complex people and not throw them in the too hard basket."

"Time & patience."

Continuity & consistency of support

Participants continually noted that ongoing, consistent support was essential. Time-limited services and the risk of services being cut can be a source of significant distress. Participants wanted follow-up after service discharge, the knowledge that they could re-engage with the service if needed.

"Continued support and maybe follow up after discharge."

"Ensuring I have the ability to contact them again if needed in the future."

"Remove time limits on services and focus on the person rather than the desired outcome."

"As above, not have their essential groups and services cut! They are well aware of their client needs and voices need to be heard! No consultation was done with us before cutting popular groups."

Access & affordability

Several participants identified that they have experienced barriers to accessing necessary supports. This included cost, service availability in their location, age limits, and opening hours of the service. Some participants also spoke specifically to the inaccessibility to supports external to the APA, such as GPs, psychologists, and psychiatrists, particularly

when it came to cost barriers. Some participants also noted the importance of staff understanding gender identity and neurodivergence.

"Accessible to everyone who need [it], more skilled professionals, free psychiatrists and psychologists. Bulk billed specialists and GPs."

"Easier access, more affordable access, to a range of services other than just mental health."

"Group therapy, more availability/opening hours, workers having a better understanding of autism, ADHD and gender diverse presentations and experiences."

Practical help & systems navigation

Many participants would like the APA to be able to provide active support in their lives, such as assisting in finding housing and employment, referring to medical specialists, and supporting NDIS applications. The stress and burden of navigating these complex systems alone was a reoccurring concern.

"Listening to me and supporting me to get some things in motion. Navigating the systems."

"I can't apply for NDIS of my own accord. Your help would be appreciated."

"Throughout the NDIS application process I've felt like I could just fall down the crack and disappear. It would help to have someone beside me from the beginning of the process."

"Help me apply for jobs, TAFE or uni. And be supportive towards me and encourage me to do the right thing."

Housing & financial stability

Some participants requested that APA services be better equipped to support service users to access secure housing. This included practical supports such as assisting with housing applications and talking through support options, and more broadly advocating for changes to government financial assistance supports for those with mental health concerns.

"Help me to keep my house."

"Support navigating the housing system, options, taking my needs seriously. Long term or permanent housing, drop in support services."

"If there was someway to secure properties for people... something other than DCJ where we have to fight tooth and nail to get properties that are often inadequate or unsuitable and in my current case, extremely unsafe and triggering."

"Higher housing access for people who experience severe mental health issues, and higher allowances from Centrelink or more access to NDIS and DSP."

Groups, activities & social connection

Groups were among the most commonly valued supports, cited for the routine, social connection, and safe space they provided. Participants wanted APA to continue funding and expanding group programs, and to offer a broader range of community engagement activities — including for older participants.

Groups were often mentioned by participants as being valuable in creating a meaningful life, assisting social connections, and building skills. However, making groups accessible for diverse participants and for those attending through telehealth was also mentioned as a way to improve services.

"Accessible groups for programmes like the ones in hospital — CBT, DBT, Art."

"Joining groups has helped with my social skills, thus alleviating my mental distress."

"Keep community engagement activities available / more activities for older people that aren't boring."

"Encouraging us to make a wish and to help us move forward to that dream in reality - definitely peer support and group meetings."

Person-centred & strengths-based approach

Participants wanted support that focused on the whole person rather than symptoms or deficits, and that built their sense of control, independence, and confidence. They described wanting APA to help them set goals, stay accountable, and feel empowered to direct their own recovery.

"Focusing on the whole person, not just the symptoms."

"Integrating strengths-based practice into existing frameworks which are frankly, callous."

"The same, if not better support and being in charge of my life in all aspects. Feeling empowered."

"Keep me accountable to my personal development goals and seek communities and options I can try to make my goals a reality."

Diagnosis & specialist access

Several participants wanted APA's support in accessing assessments and diagnosis.

"Helping me on my journey to diagnosis of my ADHD and autism."

"Providing access to get diagnosing services and assessments."

Advocacy

Participants wanted APA to advocate on their behalf with health professionals, government, and in policy, including consumer voices in decisions about service design and funding.

"Advocacy, individual support, consumer driven and person centred. In addition input to policy and legislation."

"To advocate on our behalf with health professionals and government."

Trauma and disability informed care

Participants described the importance of trauma-informed approaches being embedded across all supports, including for people experiencing family and domestic violence. Responses described the need for staff training to support working with multiple, intersecting concerns.

"Trauma support services for DV — authority to contact and address hospitals and have priority medical care teams for DV specifically trained."

"All staff properly trained and educated to work with people with complex needs including multiple disabilities...Trauma informed and human rights approach."

Ambivalent or uncertain responses

Not all participants were able to articulate a role for services, with some expressing uncertainty, others indicating they were already receiving what they needed, and a small number expressing deep hopelessness about what services could realistically offer. Such responses, which include one participant expressing a wish for euthanasia to be legalised reflect the reality that for some people, the gap between need and available support remains very wide.

"Nothing, they have given me all I needed for the support."

"Not sure."

"APA is already helping me with what I need."

Further themes

Participants (n=96) wrote both about positive experiences with APA services alongside suggestions for improvements. They also commonly responded with broader reflections on the mental health system, including concerns about underfunding.

Gratitude & positive experiences with APA

Expressions of gratitude and positive experiences with APA services were the most common response to this question. Participants spoke of being supported, feeling accepted, and the importance of connection to feel less alone. Some participants wrote that the service was uniquely supportive in comparison to other mental health supports such as GPs, crisis hotlines, hospitals and clinical professionals.

"I do really love the service and my support worker and I will spend the rest of my days advocating this service to everybody. This service saved my life and assisted me in ways that no other service, psychologist, psychiatrist, emergency department, Lifeline, GP or case worker ever has."

"APA has really helped me grow into an independent young person. They've been there for me when I needed help but they've also let me take control of my life."

"APA is a great service to help me with my anxiety, stress and feeling alone. From my first meeting with APA I felt comfortable talking and didn't feel judged."

"I can be myself without judgement."

"[Staff member] at APA has been my biggest supporter and she's one of the reasons I've made it through the trauma myself and my family experienced."

Safety and independence.

A number of participants specifically described how access to an APA service supported their independence, sense of purpose and relational connection. For some, the service provided help that they had not previously been able to find elsewhere.

"APA organisation community services have been life changing for me and these support services are desperately needed and effective."

"I wouldn't have come as far as I have without APA — more services like this are needed."

"I was often isolated which led to an increase in my paranoid thoughts [before APA]. APA gave me the only chance I've ever been given to have a life. You cannot understand what that means to someone like me."

"Working with APA gives me a sense of purpose."

Groups & social connection

Several participants were specific in naming the groups run by APA services, and how they made a positive difference to their mental health.

"APA groups have made a real difference to my mental health. I get to meet lots of amazing people and the staff are welcoming and support me when I need."

"I really enjoy the groups I go to at APA."

Requests for advocacy – funding and continued access to services.

A recurring concern was the time-limited nature of supports, and the broader underfunding of mental health services. Participants expressed frustration at having to leave programs that were helping and called for increased government investments in expanding access to APA services, noting that freely available mental health supports are limited.

"I wish it wasn't changing to a short term service but I guess other people need help as well and hopefully they can get the same benefit."

"Grateful to be able to access these services for free. Wish there were longer periods than three months. Frustrated at current mental health system and Medicare limiting health appointments to a few a year. It isn't adequate at all."

"Please provide more and allow more access with existing services to mid to long term mental health services. There is a large gap in the mental health area for this. Get the government to stop cutting funding and much needed services please. APA would be an ideal service for this."

"Mental health services need to stop worrying about money and focus on helping participants on recovery."

Systemic gaps & service failures

Some participants described how difficult and damaging it is to fall through the cracks of a mental health system. Not being deemed suitable for services also was a barrier for some, naming age restraints, cost and location as barriers. One participant noted that their only option for adequate supports was through self-funded private care.

"Falling down the crack to the abyss is very real for people with mental health challenges. It's those times of invisibility that are dangerous for people with suicidal tendencies."

"For the most part government funded mental health services have been unhelpful and only by going through private services have I seen improvement."

"I Have had 3 strokes and two unaliving attempts in the last 2 years. The health system is screwed and people like me who have complex mental health and physical health issues honestly get pushed away. I'm either too old for the youth help that's available but also too young for the majority of other programs."

"Hope that I don't have to travel interstate again to access psychiatric care."

Neurodiversity & trauma-informed practice

Participants raised the importance of staff training in neurodiversity and gender diversity, and reflected on past experiences where they had not been recognised or supported appropriately. One participant described the traumatic impact of being forced into group participation during a psychiatric admission.

"I think training in neurodiversity and gender diversity would be a really valuable thing."

"I was very distressed but didn't present in a typical way due to my neurodivergence and trauma. I felt like I wasn't bad enough to be there."

"In my various stays in mental wards I was forced to participate [in group activities] because I was also anxious about those things. It was traumatic."

Stigma & the need for safe, non-carceral responses

One participant raised a concern about the criminalisation of suicidal thoughts and the traumatic impact of police involvement, calling for services to create safe spaces for honest conversation. Another reflected on the ongoing stigma attached to mental illness and the difficulty of disclosing their diagnosis in their community.

"Do not contact me. Everyone who knows me, already knows I feel this way. I should be able to talk about this without being arrested. Calling police on my thoughts causes me significant trauma."

"Unfortunately there is still a lot of stigma in Australian society for people suffering mental illness — I rarely disclose my personal circumstances and Bipolar I diagnosis."

Cultural inclusion

One participant mentioned the importance of bringing together people from different cultural backgrounds and creating spaces where diverse voices are heard and welcomed.

"Bring communities together. Create a space for people from different cultural backgrounds to say their piece."

Concerns & negative experiences

Some responses raised very serious concerns. One participant reported abuse by APA staff, and another described neglect from the service staff. One participant described differences between APA organisations, with one service supports feeling unhelpful, and another more personal and supportive.

"APA. ABUSE BY STAFF."

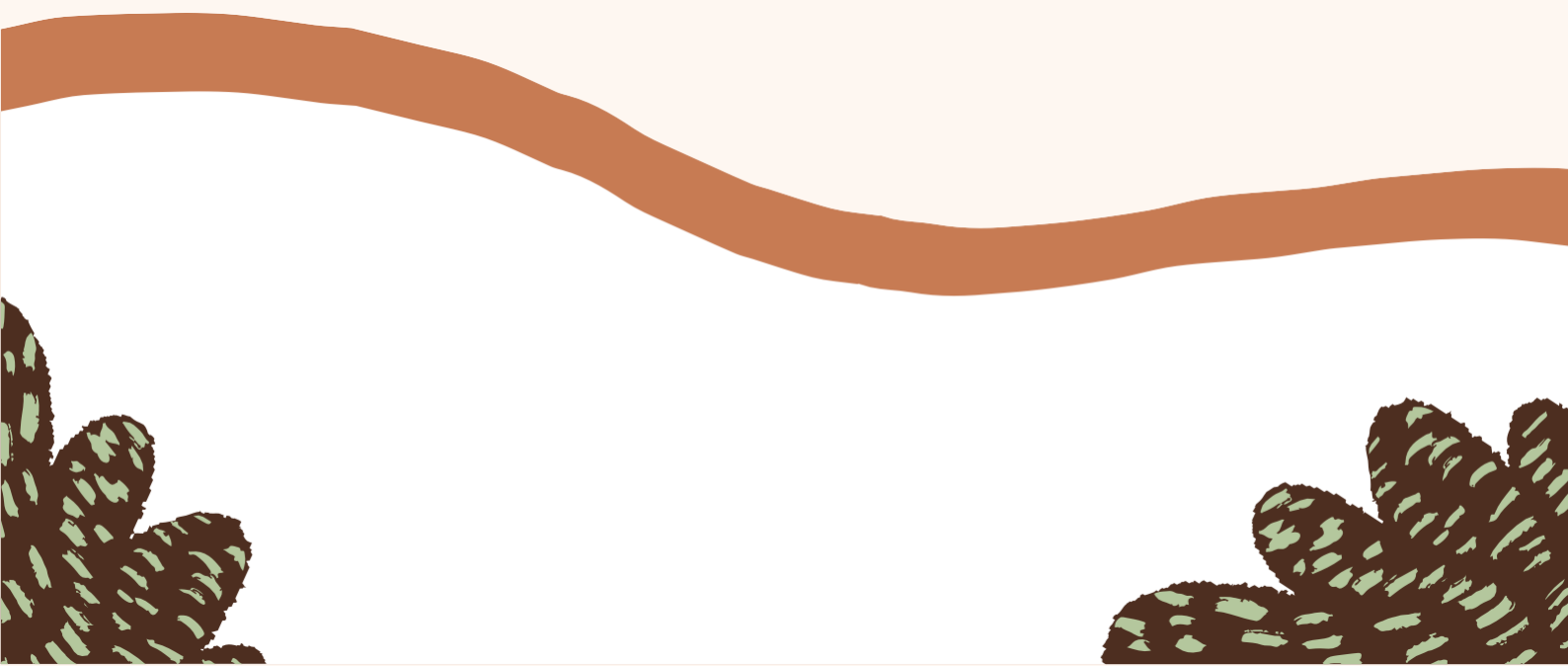
"I felt very neglected by APA — they didn't really do much at all. I can't even tell you what my three recovery coaches looked like. I never met them online even, can't even remember their names."

"Honestly, I want barbiturates and euthanasia legalised. Why does the state get to play God? It can't help me, so why not let me go? I'm a significant drain on resources and I don't contribute tax, so let me go already."

The above responses disclosed serious harm and/or acute distress, including expressions of suicidality framed in the context of feeling like a burden on the system. These responses are included as submitted, in participants own words, in recognition that omitting them would misrepresent the lived reality they are naming. As with the earlier reflection that not all participants described a standout positive over the past six months, it is important not to soften what these comments name. At the same time, these responses sit within the same dataset as participants who spoke to the value of connection, small routines, and reasons to keep going. Both lived realities reflect the range of ways people are trying to cope under the same underfunded, difficult to access system.

The recommendations that follow are offered as a response to these varied experiences, acknowledging the concrete changes (income support, service continuity, trauma-informed and non-carceral crisis responses) that participants identified as essential.

Discussion of key themes



Hopes for more ease and stability

Participants shared hopes for independent lives with more peace and ease; however, cost of living pressures and precarious housing make this hard. Whilst 45% of participants stated that they always or often had enough income, 19% reported that they rarely or never had enough income to meet their daily needs. 45% of participants selected at least 5 areas in which they went without due to living costs. Most commonly foregone were 'fun' or social expenses – demonstrating the extent to which cost of living can impact quality of life and social connection.

Many also said they missed out on quite basic items such as heating or cooling their home, health care, grocery items and clothing. The impact of this precarity is captured in these responses to the question, 'What do you hope for the future':

"Not a lot. But I hope to have adequate housing and a liveable income one day so I can have what other people have.... a life worth living. And the ability to have something stable and reliable that can help me focus on my recovery. You can't get better when you don't know where your next meal is coming from or if a doctor's visit is going to send you broke or if you lose your accommodation. This is no way for anyone to live. I want to get better but without the right circumstances, support and opportunities it's not possible. I am just in constant survival mode."

"That things will get easier"

These results echo elevated signs of financial stress in the general community (ABS, 2026; NMHC, 2025; AIHW, 2025; SPA, 2026). Approximately 1 in 8 Australian household didn't always have enough money to buy enough quality food (ABS, 2023), and basic living costs such as rent, food, and transport are often unmet for people on income support payments (Azize, 2026). Financial stress and health outcomes have reciprocal impacts (AIHW, 2025; LELAN, 2025; Andrews, 2025). Without disrupting this cycle, adverse impacts on people, wellbeing, and service access, satisfaction, and confidence will continue to be felt (CHF, 2025; Andrews, 2025).

Calling for service consistency, continuity, diversity, and accessibility

Participants saw value in a wide range of supports. Accessing diverse and connected supports was one of the most common contributors to positive wellbeing over the past 6 months.

“Support from APA organisation as they have linked me in with Housing, Drug and Alcohol support and I enjoy making social connections through the groups”

Importantly though, barriers to access were common, support duration could be inadequate, and budget cuts made access feel precarious.

“Wish there were longer periods than three months. It isn't adequate at all.”

“Get the government to stop cutting funding”

Seventy-two percent of participants did not access a service they needed over the past 6 months. Services were not accessed for a range of reasons, but overwhelmingly due to cost. Long wait lists, fear of accessing the service, and not having their needs taken seriously were also common barriers. When people couldn't access the services they required, there was an overall trend that their mental and physical health symptoms worsened.

“I cannot afford private help, so this program and the service APA organisation provide, helped to save my life.”

“It is essential that I have continuity and their continued support. this has really helped fill a hole for me! I also really enjoy their groups and hope... [to] not have what is an essential service to me reduced in any way!! please!”

Given the evolving role of the NDIS in psychosocial support, participants' experience with the Scheme is integral to consider. Just over half of participants (53.5%) had never applied for an NDIS package, and a further 18.6% had either been rejected or had an application pending. Among the 26 participants who identified needing but not accessing NDIS support in the past six months, the most common barrier was not having their needs taken seriously (61.5%), the highest rate recorded for any service type in the survey, followed by a lack of support to navigate the application process (38.5%). Access to the scheme also varied by location with participants in metropolitan areas reporting greater difficulty accessing NDIS support than those in regional and remote areas, a counterintuitive finding given assumptions that metropolitan services are typically more accessible, and one that warrants further investigation into how NDIS navigation support is distributed and resourced.

These results complement other studies which find the affordability, accessibility, and adequacy of Australian health systems lacking (Andrews, 2025; MHV, 2025; SANE, 2023; Threlfall et al., 2025). Our participants reported missing needed care more often than respondents to the 2025 National Consumer Sentiment Survey (~72% vs ~50%) (CHF, 2025), though sampling differences between the two surveys mean this gap should be interpreted with caution rather than as a precise estimate of relative unmet need. Both found cost the main barrier, especially for dentistry.

Experiencing barriers to care – whether they be about quality, affordability, or availability – can compromise trust and lead to disengagement (Andrews, 2025). Additionally, shorter-term service models that result in repeat referrals build precarity into the system as there are more points for people to experience inadequate or ineffective care and thus potentially disengage from other services (potentially to the detriment of their health). Amidst concerns

that the system is not keeping up with demand (MHV, 2025) and declining confidence in healthcare system (CHF, 2025), our findings echo calls from consumers for improved and easier service access and navigation (Andrews, 2025; LELAN, 2025).

The importance of feeling supported and listened to

Participants described how they want to feel from services, both individually and in how services stand up for people. They want to feel cared for, respected, not alone, and pride in their achievements. They wanted someone to listen, without judgment, assumptions, or trying to fix things.

"Knowing that my support workers are there regularly to help me find a way to work through situations as they pop up. And that I don't have to go through it alone"

"Don't assume hopelessness. Don't try and fix things. Just listen and be flawed like the rest of us."

These sentiments were often, but not always their experience with APA services. Some participants shared ambivalent or negative experiences of APA services and the broader health system. Some participants described feeling neglected or unsupported and one participant disclosed experiencing abuse by staff. Others described the broader mental health system as failing to catch people in crisis or leaving physical health crises unaddressed. These findings show how both access and quality matter.

"I felt very neglected by [APA service] — they didn't really do much at all"

Participants wanted the APA to use its power to advocate for better systems which see whole people not just diagnoses or symptoms, and which put people before risk management and profit. They referenced the need for safe, non-carceral responses to suicidality and more capability with supporting neurodivergent people.

This is especially important as almost one third of participants (31%) experienced unfair treatment or discrimination in the past 6 months (most commonly related to mental health or disability). This highlights the enduring need for rights-based reforms within health systems and communities more generally to foster understanding and trust and actively resist harm.

"Integrating strengths-based practice into existing frameworks which are, frankly, callous."

"I wish everyone would stop overreacting and stop criminalising my thoughts"

These findings about how people and systems show up echo consumer calls for more humane, dignifying, and compassionate approaches that uphold rights and diversify care beyond medical models (LELAN, 2025). Our sample reported rates of discrimination (31%) in line with those reported by people with a mental health condition in the 2025 General Social Survey (31%) (NMHC, 2025), which concerningly are almost twice that of the general population (18%). The devastating impacts of discrimination, including that for many people the effects of discrimination are worse than their mental health symptoms (Reavley et al., 2026), amplify the urgency of these calls for trauma-informed, rights-based health systems.

The value of connection to people, place, and purpose

A sense of connection had the most positive wellbeing impact for many participants. Participants discussed the importance of social connection and improved quality of relationships, as well as connection to family, pets, nature, community, meaningful activities, and feeling connection in employment and housing. Some specific activities were listed, including arts and crafts, employment, exercise, volunteering, gardening, gaming and studying. Groups were among the most valued supports for routine, friendship, and a safe space to show up.

"Friendship, ending contact with abusive people, getting out in nature, getting sun exposure, cultivating a positive mindset and practising gratitude, being able to talk with support workers"

"APA groups have made a real difference to my mental health. I get to meet lots of amazing people and the staff are welcoming and support me when I need."

Whilst half of participants (51%) were somewhat or extremely satisfied with their level of social connection, a sizeable 27% of participants were somewhat or extremely dissatisfied, highlighting an important area of need.

The many positive experiences of connection shared by participants are heartening, especially when considered alongside findings that interpersonal breakdowns and social isolation are increasingly contributing to suicidal distress (SPA, 2025). Amidst persistent rates of loneliness and social isolation throughout the community (ABS, 2025; AIHW, 2026), our findings highlight the importance of opportunities for connection with to people, place, and purpose, continuity of trusted supports which facilitate connection, and measures to strengthen and protect people's ability to afford connection (Andrews, 2025).

Strengths and limitations

This survey brings together 8 of Australia's largest specialist psychosocial support providers to deepen understanding of the social conditions that are shaping consumers' lives and expectations of services.

This survey builds off the Resilience in Isolation report (APA, 2020), which to our knowledge is one of the first surveys of how social conditions are affecting the lives of people accessing psychosocial support services in Australia. This specific population can be underrepresented, and we see this study as a step towards deepening understanding their needs and experiences to drive social and service change. Other surveys exploring social conditions were used as a basis to inform the development of this survey to offer points of comparison with other populations.

This study drew on a convenience sample recruited through voluntary, opt-in methods (email and SMS invitations, flyers, social media, and staff referral). As such, findings should be understood as an in-depth account of the experiences of those who chose to take part, rather than a generalisable profile of the broader population of people accessing APA services nationally.

Opt-in participation is likely to systematically favour respondents with greater digital access, literacy, capacity to complete a lengthy survey, and comfort disclosing to services, in ways that cannot be measured nor corrected for in the analysis stage.

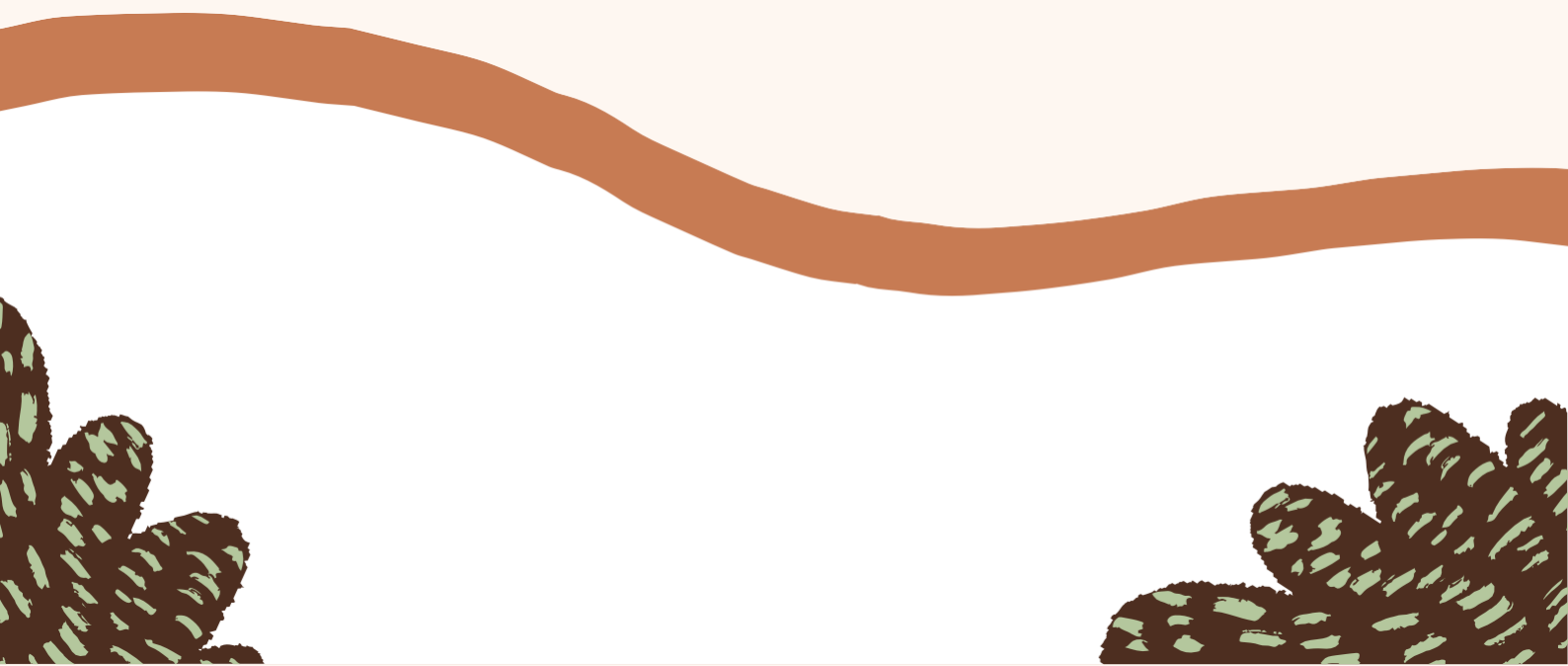
Never-the-less, our approach yielded a sample that broadly matched APA service users on gender (i.e approximately 2/3's female).

Future iterations of this survey may look to strengthen sampling diversity. This, for example, could be through targeted recruitment strategies for underrepresented regions or demographics identified through this benchmarking process, and building further connection between the research team and APA service users.

The survey used a number of questions with 'select all that apply' options. This offered choice to reflect the breadth and variety of experiences that participants but also may have complicated variable analysis. Given the diversification of services delivered by APA providers, some participants may have accessed a range of supports, including but not necessarily limited to psychosocial ones.

A substantial 9% of participants identified as Aboriginal or Torres Strait Islander. The study team will look to strengthen connections with First Nations researchers and advisors in future iterations, to introduce their community perspectives on what is asked, how responses are interpreted, and by who.

Recommendations



Recommendations

These findings provide a snapshot of how current social conditions are shaping the lives of people accessing APA supports and what they want from the health system. Overall, these findings highlight the need for:

A rights-based, trauma responsive health system that prevents further harm

Investments in affordable health care, including dental, psychology, GP, psychiatry, and physical health services, so people can access a range of needed supports

Income supports above the poverty line

Adequate psychosocial alternatives to NDIS

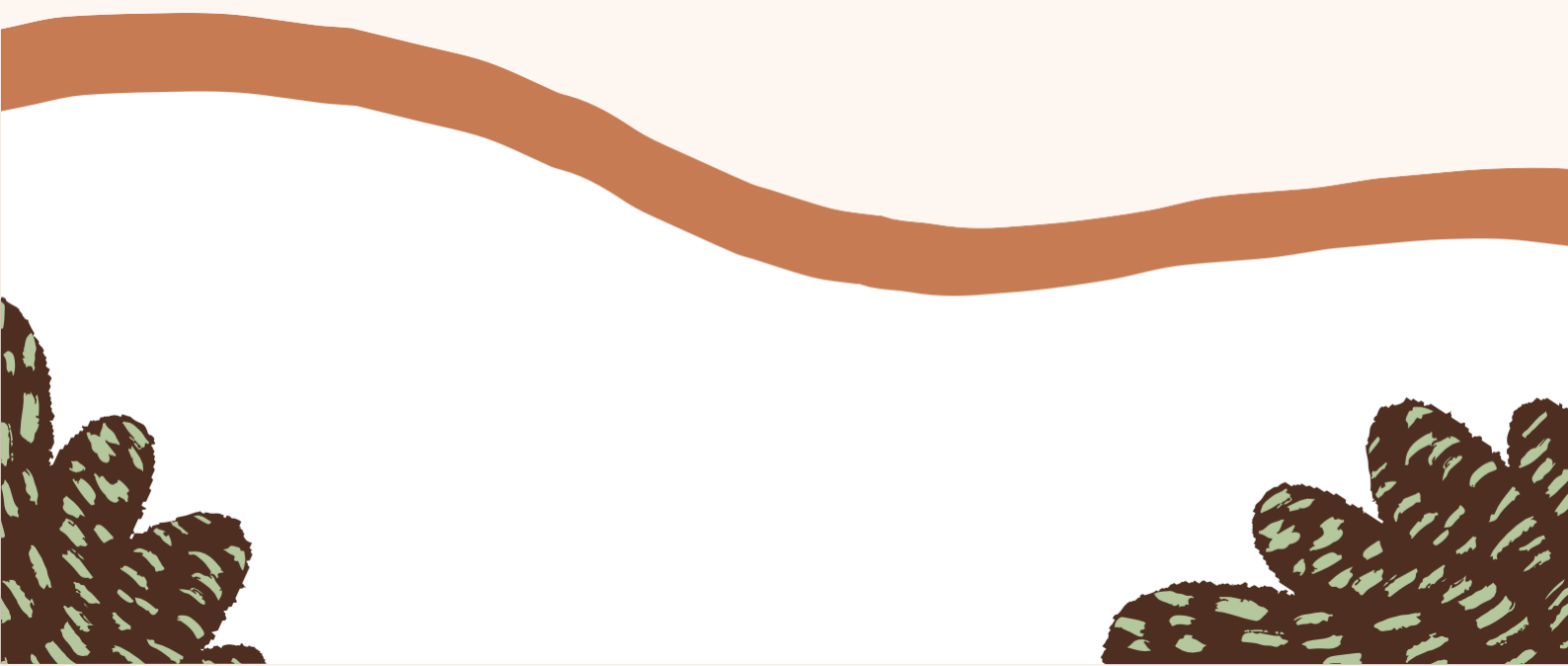
Continued investments in no to low-cost group programs

Review of service timeframes to ensure they meet people's needs

Dedicated efforts to reduce precarity in the health services system, e.g., through longer-term service contracts, continuation of proven models, etc.

Robust and accessible employment supports (e.g., Individual Placement and Support)

References & Appendix



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Appendix

Because You Matter survey

[Branching was used so questions 8, 14, 23, 25, & 26 only appeared if people selected 'yes' the previous question (or 'very unsatisfied' – 'neither satisfied/unsatisfied' in question 19).]

1. Which of the following services were you supported by during the last 12 months? (Please tick all that apply)

- ☐ Flourish Australia
- ☐ Mind Australia
- ☐ Neami National
- ☐ One Door Mental Health
- ☐ Open Minds
- ☐ Ruah Community Services
- ☐ Stride
- ☐ Wellways Australia
- ☐ I'm not sure
- ☐ Prefer not to say

2. What type of support do you currently receive from these service/s? (please select all that apply)

- ☐ Mental health
- ☐ Carer
- ☐ Disability
- ☐ Housing + accommodation support
- ☐ Homelessness / help to find housing
- ☐ Suicide prevention/aftercare
- ☐ Alcohol and other drugs
- ☐ NDIS services / support coordination
- ☐ Other (please specify)
- ☐ Not sure
- ☐ Prefer not to say

3. How old are you?

- ☐ 16-17
- ☐ 18-25
- ☐ 26-34
- ☐ 35-44
- ☐ 45-54
- ☐ 55-64
- ☐ 65 or over
- ☐ Prefer not to say

4. How do you describe your gender?

- ☐ Female
- ☐ Male
- ☐ Non-binary / gender diverse
- ☐ I prefer to describe my gender differently (please specify)
- ☐ Prefer not to say

5. Do you identify as LGBTIQA+ (lesbian, gay, bisexual, transgender, intersex, queer, asexual)?

- ☐ Yes (please specify)

- No
 - Prefer not to say
- 6. Are you Aboriginal or Torres Strait Islander? (Please tick all that apply)**
- Aboriginal
 - Torres Strait Islander
 - No
 - Prefer not to say
- 7. Do you speak a language other than English at home?**
- Yes
 - No
 - Prefer not to say
- 8. (If yes) What is the main other language you speak at home?**
- Mandarin
 - Arabic
 - Cantonese
 - Vietnamese
 - Italian
 - Greek
 - Hindi
 - Spanish
 - Punjabi
 - Other (please specify)
 - Prefer not to say
- 9. What state/territory do you live in?**
- Australian Capital Territory
 - New South Wales
 - Northern Territory
 - Queensland
 - South Australia
 - Tasmania
 - Victoria
 - Western Australia
 - Prefer not to say
- 10. What is your location?**
- Metropolitan
 - Regional
 - Rural
 - I'm not sure
 - Prefer not to say
- 11. Please tick all of the statements that describe how you spend your time**
- Employed - permanent, full-time
 - Employed - permanent, part-time
 - Employed - casual, full-time
 - Employed - casual, part-time
 - Not in paid employment, looking for work
 - Not in paid employment, not looking for work
 - Unpaid caring duties
 - Volunteering
 - Studying

- I'm not sure
- Prefer not to say

12. Do you experience any of the following? (Please tick all you feel comfortable sharing)

- Mental health challenges / distress
- Psychosocial disability
- Acquired Brain Injury (ABI)
- Attention Deficit Hyperactivity Disorder (ADHD)
- Autism spectrum disorder (ASD)
- Cerebral palsy
- Developmental delay
- Down syndrome
- Global developmental delay
- Hearing impairment
- Intellectual disability
- Multiple sclerosis
- Spinal cord injury
- Stroke
- Visual impairment
- Other
- Prefer not to say

13. Do you have an NDIS package?

- Yes
- No, my application is pending
- No, my application was rejected
- No, I have never applied
- No, my package was withdrawn
- I'm not sure
- Prefer not to say

14. If yes, is your NDIS package for a psychosocial disability?

- Yes
- No
- I'm not sure
- Prefer not to say

15. How do you rate your overall physical health? (Likert scale 1 very poor – 5 = very good)

- Very poor
- Poor
- Ok
- Good
- Very good
- Prefer not to say

16. Overall, how satisfied are you with how connected to others you feel? (Likert scale 1 Very unsatisfied - 5 = Very satisfied)

- Very unsatisfied
- Somewhat unsatisfied
- Neither satisfied nor unsatisfied
- Somewhat satisfied
- Very satisfied
- Prefer not to say

17. What is your living situation? (tick all that apply)

- ☐ Private rental
- ☐ House (owned or paying mortgage)
- ☐ Living in family home
- ☐ Share housing / share accommodation
- ☐ Transitional Housing
- ☐ Public housing
- ☐ Community housing
- ☐ Supported accommodation
- ☐ Boarding House
- ☐ Caravan
- ☐ Couch surfing
- ☐ Homeless
- ☐ Other
- ☐ Prefer not to say

18. How satisfied are you with your living situation? (Likert scale 1 Very unsatisfied – 5 = Very satisfied)

- ☐ Very unsatisfied
- ☐ Somewhat unsatisfied
- ☐ Neither satisfied nor unsatisfied
- ☐ Somewhat satisfied
- ☐ Very satisfied
- ☐ Prefer not to say

19. If you were unsatisfied with your housing, what factors contributed to this? (tick all that apply)

- ☐ Overcrowding (the number of people I live with)
- ☐ Isolation
- ☐ Unsafe
- ☐ Too expensive
- ☐ Short term / insecure housing
- ☐ Poor housing quality
- ☐ Housing doesn't meet my accessibility needs (e.g., ramp)
- ☐ Issues with landlord/agent/housing manager
- ☐ Family/domestic violence
- ☐ Relationship with people I live with
- ☐ Relationship with neighbours
- ☐ Lack of public transport options
- ☐ Lack of local amenities (e.g., shops, libraries)
- ☐ Lack of parks / green spaces
- ☐ Other (please specify)
- ☐ Prefer not to say

20. Do you have enough income to meet your daily needs? (Likert scale 1 Never - 5 = Always)

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Often
- ☐ Always
- ☐ Prefer not to say

21. Over the past 6 months, have you had to go without any of the following because of living costs? (tick all that apply)

- ☐ Buying your usual grocery items
- ☐ Eating your regular meals
- ☐ Feeding / taking care of a pet
- ☐ Maintaining personal hygiene
- ☐ Going without / reducing the use of menstrual products
- ☐ Paying rent or a bill on time
- ☐ Heating / cooling your home
- ☐ Petrol / public transport
- ☐ Visiting friends / family
- ☐ Dining out
- ☐ Going to a movie
- ☐ Going to a concert or fun event
- ☐ Booking / attending a doctor's appointment
- ☐ Filling a prescription
- ☐ Having a required medical procedure
- ☐ Buying clothes
- ☐ Buying furniture
- ☐ Having a holiday
- ☐ Other (please specify)
- ☐ Prefer not to say

22. Over the past 6 months, have you experienced unfair treatment or discrimination?

- ☐ Yes
- ☐ No
- ☐ I'm not sure
- ☐ Prefer not to say

23. If yes, and if you are comfortable sharing can you please list the reason/s for being treated unfairly and/or discriminated against? (Please tick all that apply)

- ☐ Mental health
- ☐ Disability
- ☐ Gender
- ☐ Sexuality
- ☐ Race / cultural background
- ☐ Religion
- ☐ Age
- ☐ Physical appearance
- ☐ Personal views
- ☐ Financial background
- ☐ Other (please specify)
- ☐ Prefer not to say

24. Over the past 6 months, have you needed any of the following services but NOT accessed them? (Please tick all that apply)

- ☐ Emergency Department
- ☐ Psychiatric ward / inpatient unit
- ☐ Sub-acute residential services (e.g., Prevention and Recovery Centre PARC)
- ☐ GP (General Practitioner)
- ☐ Psychologist / counsellor
- ☐ Psychiatrist
- ☐ Support group
- ☐ Peer worker

- ☐ Other non-clinical mental health support workers
- ☐ NDIS support
- ☐ Dental services
- ☐ Physical health supports (e.g., dietitian, physiotherapist)
- ☐ Medical services (e.g., oncologist)
- ☐ Housing support
- ☐ Legal support
- ☐ Financial support
- ☐ Family/domestic violence support
- ☐ Employment support
- ☐ Centrelink / Services Australia
- ☐ Other (please specify)
- ☐ No
- ☐ Prefer not to say

25. If yes, why did you not access these services? (Please tick all that apply)

- ☐ Cost
- ☐ Dislike of the service/service model
- ☐ Fear of accessing the service
- ☐ The waiting time was too long
- ☐ The service was not available in my area
- ☐ Service was not available when required
- ☐ I had an upcoming appointment
- ☐ I was too busy
- ☐ My needs were not taken seriously
- ☐ I was not supported to access the service
- ☐ Language barrier (e.g., no interpreter provided)
- ☐ Transport/distance needed to travel
- ☐ I did not have access to the technology needed (e.g., computer, internet connection, data)
- ☐ I'm concerned about privacy with online / phone support
- ☐ I didn't / couldn't meet the eligibility requirements
- ☐ I did not know the service existed when I needed it
- ☐ Other (open text)
- ☐ Prefer not to say

26. If yes, how did not accessing the services impact you? (Please tick all that apply)

- ☐ I managed on my own
- ☐ I got support from my support worker
- ☐ I got support from family/friends
- ☐ I got support from another service
- ☐ My mental health symptoms increased
- ☐ My physical health got worse
- ☐ I contacted a triage/crisis service by phone or internet
- ☐ I attended the Emergency Department
- ☐ I was admitted to hospital
- ☐ Other (please specify)
- ☐ Prefer not to say

27. What kind of supports are most important to you today? (Please tick all that apply)

- ☐ Skills therapy (e.g., CBT, DBT, ACT)
- ☐ Talk therapy / Counselling (e.g., trauma counselling, substance use counselling, grief counselling)

- Learning to use technology (e.g., computer, internet)
- Help with practical tasks (shopping, housekeeping, etc)
- Support coordination
- Physical health care
- Medication
- Psychiatrist
- Peer support
- Group sessions
- Alcohol and other drug support
- Art- or music-based approaches
- Animal assisted therapy
- Access to education
- Access to employment/volunteering
- Housing/tenancy support
- Community access
- Access to nature
- Respite for me
- Crisis support alternatives (e.g., alternatives to hospital)
- Support/respite for my family/chosen family/kin/carer
- Managing my finances
- Making social connections
- Drop-in spaces
- Community learning spaces (e.g., Recovery College, Neighbourhood House)
- Spirituality-inclusive support (faith-based spiritual healthcare)
- LGBTIQA+ specific support
- Culturally specific support
- Other (please specify)

28. If you could choose up to five supports that would support you to have the life that you want, what would they be?

- Skills therapy (e.g., CBT, DBT, ACT)
- Talk therapy / Counselling (e.g., trauma counselling, substance use counselling, grief counselling)
- Learning to use technology (e.g., computer, internet)
- Help with practical tasks (shopping, housekeeping, etc)
- Support coordination
- Physical health care
- Medication
- Psychiatry
- Peer support
- Group sessions
- Alcohol and other drug support
- Art- or music-based approaches
- Animal assisted therapy
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- Making social connections
- Drop-in spaces

- Community learning spaces (e.g., Recovery College, Neighbourhood House)
- Spirituality-inclusive support (faith-based spiritual healthcare)
- LGBTIQA+ specific support
- Culturally specific support
- Other (please specify)

29. What has had the most positive impact on your wellbeing/mental health over the past 6 months?

[free text]

30. What do you hope for the future?

- a. **What role could our mental health and wellbeing services play to make that hope a reality?**

[free text]

31. Is there anything else you'd like to share with us today?

[free text]