Submission to consultation on a new Commonwealth individual disability advocacy program

Consumers of Mental Health WA

January 2026

Consumers of
Mental Health WA

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1. Acknowledgement of Country

Consumers of Mental Health WA proudly acknowledge Aboriginal people as Australia's First Peoples and the Traditional Owners and Custodians of the Land and Water on which we live and work. We acknowledge Western Australia's First Nation's communities and culture and pay respect to Aboriginal Elders past, present and emerging.

We recognise that Sovereignty was never ceded and the significant and negative consequences of colonisation and dispossession on Aboriginal communities.

Despite the far-reaching and long-lasting impacts of colonisation on First Nations communities, Aboriginal people remain resilient and continue to retain a strong connection to culture. We acknowledge the strong connection of First Nations Peoples to Country, culture and community, and the centrality of this to positive mental health and wellbeing.

2. Preamble

2.1 About the Respondents

Consumers of Mental Health WA (CoMHWA) is Western Australia's peak body for and by mental health consumers (people with a past or present lived experience of mental health issues, psychological or emotional distress). We are a not-for-profit, systemic advocacy organisation independent from mental health services that exists to listen to, understand and act upon the voices of consumers. We work collaboratively with other user-led organisations and a diversity of stakeholders to advance our rights, equality, recovery and wellbeing.

2.1.1 Declaration of interest

CoMHWA provides an individual advocacy service for people with psychosocial disability that is funded by the WA Department of Communities, and we do not receive National Disability Advocacy Services funding.

2.2 Request for Feedback

CoMHWA works to uphold the dignity and human rights of consumers, through providing advocacy in leading change with and for consumers. We appreciate notification of the outcomes of our submission to this consultation in order to understand and communicate the difference made through our work. Please provide feedback via the contact details on this submission's cover page.

2.3 Language

CoMHWA uses the term mental health 'consumer' throughout this submission. Mental health consumers to refer to people who identify as having a past or present lived experience of psychological and emotional distress, irrespective of whether they have received a diagnosis of mental illness or accessed services. Other ways people may choose to describe themselves include "peer", "survivor", "person with a lived experience" and "expert by experience".

This definition is based on consumers' call for respect, dignity and choice in how we choose to individually identify. As individuals we choose different ways to name and describe our experiences that may confirm or trouble ideas about 'mental illness'.

CoMHWA endorses Black Dog Institute's Aboriginal and Torres Strait Islander Lived Experience Centre's universal definition of lived experience for First Nation communities:

> *A lived experience recognises the effects of ongoing negative historical impacts and or specific events on the social and emotional wellbeing of Aboriginal and Torres Strait Islander peoples. It encompasses the cultural, spiritual, physical, emotional and mental wellbeing of the individual, family or community.*
>
> *People with lived or living experience of suicide are those who have experienced suicidal thoughts, survived a suicide attempt, cared for someone through a suicidal crisis, been bereaved by suicide or having a loved one who has died by suicide, acknowledging that this experience is significantly different and takes into consideration Aboriginal and Torres Strait Islander peoples' ways of understanding social and emotional wellbeing.*

This definition recognises that there are fundamental differences to how Aboriginal and Torres Strait Islander people experience and define mental health challenges and suicide compared to mainstream definitions.

2.4 About the consultation

Reproduced from A new Commonwealth individual disability advocacy program Consultation paper:

"The Department of Health, Disability and Ageing (the department) wants your feedback on a new program to support individual disability advocacy (new program).

[…] We want to know if you agree with what we have heard and if you think our plan will help people with disability.

We want to hear from:

- people with disability, their families, carers and kin
- disability advocacy organisations and advocates
- disability service providers.

Your feedback will help us understand your views.

We also have a draft program policy framework. It explains how the government plans to fund and run a new advocacy program to support people with disability. If you work for an advocacy organisation, you may want to read it and provide feedback. Read our draft program policy framework on the Consultation Hub.

You can respond by answering the consultation questions on our Consultation Hub or by sending us a written submission.

Please send your feedback by **16 January 2026**."

3. Introduction

CoMHWA welcomes the opportunity to provide feedback to the Department of Health, Disability and Ageing on their draft plans and Program Policy Framework (hereafter, the Framework) for a new Commonwealth individual disability advocacy program. As the peak body in WA for mental health consumers, and as an organisation that is entirely Lived Experience (Peer) worker led and staffed, we focus in this submission on providing feedback informed by the individual advocacy experiences of people with psychosocial disability and/or mental health challenges, and the experiences of Peer workers who provide individual advocacy services.

CoMHWA has long heard from consumers of the need for more, and more effective, tailored and appropriate, individual advocacy services that can support consumers to exercise their rights, have their voices heard and choices respected in mental health and intersecting service systems. CoMHWA has had our own individual advocacy service[1] since 2022, and has seen the positive difference that access to flexible, responsive, specialised advocacy support makes for consumers. We have also encountered systemic barriers to building and maintaining such a service, chief among them being short-term funding cycles.

CoMHWA is pleased to see that the proposed plans for the new program to support individual disability advocacy strive to address such barriers, including promising longer funding periods to encourage the development of strong, sustainable services that are able to support the professional development and wellbeing of their staff. CoMHWA finds that many of the proposed aims, activities, and aspects of the draft program policy framework are in touch with sector needs and to provide a promising basis for effective future work. Yet, CoMHWA finds that work is needed to ensure the program is able to undertake activities necessary to support organisations offering individual advocacy services to best support their staff and develop their programs, support the services themselves to engage in the policy and systems strengthening work that they are presently often asked to do without extra resources, and to ensure that there are enough diverse advocacy organisations funded to respond to needs, including the needs of people with mental health challenges and psychosocial disability. We note the need for advocacy helpline support that is locally knowledgeable and connected. CoMHWA offers our feedback in the hope that the new program will encourage the development of well-resourced, independent, pure advocacy services that are culturally safe, inclusive and diverse.

We base our submission on:

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[1] Consumers of Mental Health WA. (2026). *Individual Advocacy*. https://comhwa.org.au/advocacy/individual-advocacy/

- Ongoing consultation with CoMHWA's consumer reference and advisory groups, including our NDIS reference group that is comprised of NDIS participants with psychosocial disability
- Ongoing data collection and input from CoMHWA's Individual Advocacy and Peer Pathways (service navigation) programs, including discussion with individual advocates about this consultation
- Ongoing consultation with consumers in Western Australia on joint priorities for an improved mental health system
- Consumer representation in relevant settings, including but not limited to: Primary Health networks (WAPHA), WA regional equivalents of the Local Health Networks (regional mental health services under the WA Health Board structure), the Mental Health Commission and the health complaints agency, Health and Disability Services Complaints Office (HaDSCO).

CoMHWA has provided our feedback in response to the questions posed in the onsultation paper and the Framework, which we have included under relevant headings in the discussion section below.

4. Response to Consultation questions

4.1 Feedback captured so far

After reading the 'What we've heard so far' section of the Consultation paper, do you think it sounds right?

CoMHWA commends the authors of the Consultation paper on capturing a great number of important points of feedback from a range of stakeholders in their summary of what consultation has heard so far. To the points already provided, we add that:

Advocacy services should be independent. This independence is important in order to enable them to work in ways that are person-centred and led, and that avoid centring systems, services or processes.

Organisations funded to provide individual advocacy services should be appropriately funded to contribute to systemic advocacy work. Many organisations are funded to provide individual advocacy but not systemic advocacy or vice versa. For organisations that lack systemic advocacy funding, they are nevertheless often asked to input on systemic advocacy projects and matters, for instance, by providing feedback on systemic issues that they identify through their work (which they are very well positioned to do) or by making submissions to consultations. This stretches the resources and time of the organisation thin, when their services are often already at capacity. While CoMHWA feels fortunate that we are funded to provide individual advocacy and systemic advocacy, we have different sources for each, and our individual advocacy service is not funded specifically to contribute to systemic advocacy. Nevertheless, our individual advocacy team contribute to our systemic work, providing timely information about emerging issues, gaps and areas of need, and their deep understanding of systemic barriers. Their connection with consumers is one of the ways we ensure that our work is strongly informed by the perspectives and experiences of consumers, who, as a peak body, we have a mandate to represent. Our perspectives align with those of the broader sector of advocacy and disability representative organisations, with the Disability Advocacy Network Australia's consultation on individual advocacy services finding strong consensus that "flexible funding contracts are needed to allow organisations to engage in systems advocacy, community education, and individual advocacy as needed in response to place-based circumstances."[2]

Advocacy services need to be flexible and adaptive to work in ways that are helpful for people with disability and that enable access, and funding models should facilitate this flexibility. Some funding models put up barriers to this, as when services are funded to operate according to time-limited episodes of support, as there are times when people's support needs fluctuate or they take breaks from engaging, and cutting off support can make it harder for them to engage in the future. CoMHWA has heard that this can particularly impact people with psychosocial disability as they may experience episodic mental health challenges, and, if they are put under involuntary treatment orders, may be unable to engage for a period of time while they are in an inpatient ward. Aboriginal and Torres Strait Islander consumers may have cultural responsibilities and needs, such as needing to take time for sorry business, and so require a break from engaging with a service for a time. Rigid service eligibility requirements and criteria are also an issue.

Individual advocacy services should be able to work across multiple areas of need where required. In some individual advocacy services, consumers are asked to identify a single issue for support, but this can be a problem because consumers experience many, intersecting and overlapping needs that can't each be addressed alone. Individual advocacy services need to be able to communicate in ways that are able to support consumers to identify areas of priority and work across different needs. Unaddressed needs can impact upon a primary advocacy issue. The capacity of consumers to engage in an ongoing way with an advocate is significantly impacted when they are experiencing other issues that they have no support with.

For instance, CoMHWA's individual advocacy team spoke of the serious impact of unaddressed housing needs. Housing is so essential, and the possibility of losing housing or experiencing homelessness is so distressing that it often becomes impossible to progress advocacy on something else until that need is met. In one case, an advocate was supporting a consumer to make a report to police when the consumer had neighbours make disruptive behaviour complaints against them that put in jeopardy their public housing. They needed advocacy support to engage with their public housing provider and ultimately with the necessary legislative processes to avoid losing housing.

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[2] Disability Advocacy Network Australia. (2025). *Final Summary Report: Consultation on a new Commonwealth Individual Disability Advocacy Program.* https://dana.org.au/wp-content/uploads/2025/11/IDAP-Consultations-Summary-Report-Final-31-Oct-2025.pdf, p. 6.

In another case, an advocate has been supporting an Aboriginal consumer to make a complaint about a hospital that was not allowing them to visit their child who was in an inpatient ward, while the consumer was, at the same time, accessing support around maintaining tenancy, and experiences of racism in services and the community. Being able to work across several areas was essential to progress advocacy because of the how racism influenced engagement with the hospital and access to other supports.

Advocates need more than training and professional development; they need support in their roles. The nature of their work means that they regularly encounter deeply difficult and sometimes negatively affecting issues, experiences, and treatment. Advocates themselves provide emotional support in the course of their roles, an aspect of the role that goes unrecognised, and they need support in order to be able to do this sustainably, appropriately, and meaningfully. Experiences of negative impacts on health and wellbeing due to work, up to and including burnout, are widespread among the advocacy workforce. This goes beyond the experiences of CoMHWA's service, as demonstrated by recent national advocacy workforce survey data, which shows that 42% of respondents felt their work affected their wellbeing daily or weekly, and 5% saying all the time.[3] Many advocates have limited access to supervision, some don't have line managers, and the work itself can be isolating. Individual advocates in designated Peer (Lived Experience) roles need to be able to access independent Peer Supervision, as CoMHWA's advocates do, and as is recommended by the *National Peer Workforce Development Guidelines*.[4] Advocates require emotional support in their roles, so that they are able to work in ways that don't compromise their wellbeing.

4.2 Plan for a new Disability Advocacy Program

4.2.1 Aims

To what extent do you agree or disagree with the aims outlined in 'Our plan for a new program' section of the Consultation paper? Why?

CoMHWA agrees with many aims described in the Consultation paper. We further note that for many groups and communities, place-based advocacy is essential. For this reason, an aim of the program could be helping people with disability get individual advocacy support not only when they need it, but *where* they need it. We also feel that organisations should be supported to provide culturally safe advocacy, and

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[3] National Centre for Disability Advocacy. (2025). *Advocacy Sector Workforce Survey: 2024 Results Report*. https://ncda.org.au/wp-content/uploads/2025/07/Advocacy-Workforce-Survey-Results-2025-final-1.0.pdf, p. 26.

[4] Byrne, L., Wang, L., Roennfeldt, H., Chapman, M., Darwin, L., Castles, C., Craze, L., Saunders, M. (2021). *National Lived Experience Workforce Guidelines.* National Mental Health Commission. https://www.mentalhealthcommission.gov.au/publications/national-lived-experience-peer-workforce-development-guidelines

this would complement the aim of promoting more culturally safe advocacy for Aboriginal and Torres Strait Islander consumers.[5]

4.2.2 Activities

To what extent do you agree or disagree with the list of activities we have identified to achieve these aims? Why?

CoMHWA broadly agrees that the activities listed in the Consultation paper are necessary and would make positive contributions towards achieving the aims of the program, but feels that they do not encompass *all* of the activities necessary to achieving those aims.

Activities not identified in the list that are needed to support the achievement of the program's aims include:

- **More funding of more, and expanded, individual advocacy services.** There are not currently enough individual advocacy services to meet the demand for this kind of support. This is evidenced by the routine nature of long or closed waitlists for individual advocacy, and by existing data on demand, which is increasing.[6] CoMHWA's Individual Advocacy service, which receives state funding, routinely maintains a waitlist several weeks long. Our Peer Pathways service, which is a statewide service navigation helpline for consumers seeking connection with options for supporting their mental health and wellbeing, notes an enduring, and increasing, demand for advocacy support. Across December 2024-December 2025, advocacy support was identified as an area of need in 16% of all Peer Pathways calls; some months, the proportion of consumers seeking advocacy support was as high as 25%.
- **Promoting broader cross-sector understanding of and respect for individual advocacy to increase capacity and willingness to work with advocates.** In WA, the Mental Health Advocacy Service (MHAS) is the one individual advocacy service that has legislative authority to do work across different settings in mental health, but this is not the case for other independent individual advocacy services. Advocates frequently experience resistance, reluctance (or even refusal) to engage, and hostility from staff in settings in which they support individuals in the course of doing their work. This is a barrier to effective individual advocacy and to the promotion of the rights of people with disability. In the words of one of

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[5] Butterworth, I., Duggan, T., Greene, R., McConnell, M., Smith, J. A., Tegan, S., Williams, C., Lalchandani, N., & Stearn, A. (2024). The importance of 'place' and its influence on rural and remote health and well-being in Australia. *The Australian journal of rural health*, *32*(4), 840–846. https://doi.org/10.1111/ajr.13158

Dudgeon, P., Agung-Igusti, R. P., Carlin, E. (2025). Interim findings from a mixed methods evaluation of a social and emotional wellbeing model of service pilot in Western Australian Aboriginal community-controlled health services. *BMJ Open,* 15(e097923), doi: 10.1136/bmjopen-2024-097923

[6] National Centre for Disability Advocacy, 2025, p. 21.

our advocates, “advocates are made to feel like they intrude into the system.” Individual advocates routinely do work that complements, facilitates or makes easier the work of service staff, for instance, by enabling clear communication, supporting emotional regulation or removing barriers to engagement with services. Messaging, training and resources to make the work that individual advocates do clear, their right to do this work respected, and the rights of people with disability to engage advocates for support recognised, would strengthen the work of the advocacy sector.

- **Support to develop the capacity of organisations to offer good individual advocacy programs** and to support individual advocates they employ is a necessary element of meeting the aim to “help organisations build their skills to provide high-quality, inclusive and responsive advocacy.” Training of individual advocates is one component of meeting this aim, but more action is needed to ensure that advocates are supported by the organisations in which they work, in order to mitigate the high rates of burnout for individual advocates.
- **Developing pathways for information sharing and collaboration.** As an example of what this can look like, in WA, the Department of Communities provides secretariat support for the WA Network of Disability Advocacy. This network facilitates regular communication and collaboration between advocates, organisations, and the Department through quarterly meetings and the development of shared priorities and activities. COMHWA understands that the National Centre for Disability Advocacy has a peer network for advocates, but we feel there should be local options that can facilitate connections and activity that responds to context, and we also feel this should be open to all advocacy services regardless of funding source. Additionally, creating enduring channels for communication of the insights of the advocacy sector to government departments and government decision-makers would improve the capacity of governments to hear and act on information in ways that are transparent, ongoing and accountable.

We comment below on the specific activities proposed in the Consultation paper.

Fund a diverse network of independent disability advocacy organisations nationwide, including access for rural and remote communities, people facing intersecting inequalities and people in segregated settings.

CoMHWA strongly agrees that it is necessary to fund a diverse network of independent disability advocacy organisations nationwide, including access for rural and remote communities, people facing intersecting inequalities and people in segregated settings. Yet, we are concerned about the trend of services merging as this can result in fewer options for consumers and other people with disability seeking advocacy support. Appropriate and effective individual advocacy for people with psychosocial disability and/or mental health challenges requires individual advocates to have specialised knowledge of mental health service systems, legislation, and statutory processes and bodies, and how these interact in ways that affect consumers’ experiences and the degree to which their decision-making, autonomy and rights are respected and upheld. Consumers' rights to make decisions about their lives, supports, treatment and wellbeing can be removed through involuntary treatment orders under WA's *Mental Health Act 2014*, or through orders made under WA's *Guardianship and Administration Act 1990*. In WA, consumers placed under involuntary treatment orders have the statutory right to advocacy through the Mental Health Advocacy Service, but consumers on guardianship and administration orders do not have the same right, despite consumers being overrepresented in figures on such orders in WA, and forming the largest proportion of all Public Advocate guardianship appointments.[7] There is significant unmet demand for individual advocacy support for consumers in psychiatric hospitals on a voluntary basis, as CoMWHA hears from consumers who have experienced coercion, issues regarding discharge arrangements, and difficulties getting their voices heard and needs met. Funding individual advocacy services for people with mental health challenges and/or psychosocial disability would enable more effective advocacy support for consumers to exercise their rights, make choices, and be heard within mental health and intersecting systems.

Furthermore, it is important to fund individual advocacy services that are able to work on NDIS-related issues. Constraints of our funding mean that CoMHWA's Individual Advocacy program is not able to provide such support, though we do observe that there is a need for specialised individual advocacy support for NDIS participants with psychosocial disability. While there are organisations in WA that are funded to provide individual advocacy in relation to the NDIS, they are in high demand and tend to have long waitlists. These services are highly valued, but do not necessarily possess specialised knowledge of the experiences of people with psychosocial disability with the NDIS, and how they are affected by the ways in which the NDIS interacts with mental health service systems, legislation and guardianship and administration legislation in WA.[8]

Support outreach to people with disability facing intersecting inequalities, such as:

- *Aboriginal and/or Torres Strait Islander people*
- *people of different ages, sexes, gender identities, sexual orientations or intersex status*
- *people from different ethnic, religious, cultural or linguistic backgrounds*
- *people with different socioeconomic status*
- *experiences of trauma and or abuse.*

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[7] Office of the Public Advocate. (2025). *Annual Report 2024/25: The Public Advocate of Western Australia.* https://www.wa.gov.au/system/files/2025-11/opa-annual-report-2024-2025.pdf, p. 5.

[8] Ibid., p. 5.

CoMHWA agrees with this activity, and adds that individual advocacy services should also be encouraged, upskilled and resourced to work appropriately and effectively with people facing intersecting inequalities and those more at risk of harm in the system, including developing their ability to prioritise working with those groups in how they structure waitlists and intake. Some services work on a first in, first out model which does not recognise that risk of increased harm within the system. CoMHWA would also like to highlight that proactive outreach is necessary to reach consumers in psychiatric hospital wards and other segregated mental health settings. In WA, the *Mental Health Act 2014* provides that whenever a consumer is placed under an involuntary treatment order, including if they are detained in a psychiatric facility under such an order, the MHAS must be notified, and the consumer must be contacted or visited by an MHAS advocate within a set period of time. However, some states and territories across Australia do not have similar legislated access to advocacy, and consumers on voluntary inpatient stays in WA may not have information about individual advocacy services.

Provide training and professional development opportunities for advocates.

We agree it is essential to increase training opportunities for individual advocates. For CoMHWA's individual advocates who work with people navigating mental health services and systems, they find that there are few tailored and relevant options for training and that what training there is can often be gatekept for clinicians. They are unable to access training offered by the NCDA as this has been locked to staff at organisations receiving National Disability Advocacy Program (NDAP) funding, as we discuss in more detail in our feedback below on the sector strengthening service stream.

Build strong relationships between the department and funded organisations.

CoMHWA agrees that it is important for strong relationships to be built within the sector, but care should be taken to avoid relationships between the department and organisations from compromising the independence of Individual Advocacy programs.

Use information from the program to guide broader action.

CoMHWA agrees that this activity is needed, but feels that the mechanisms whereby such information is gathered, provided, heard and acted on must be more overtly described. The inclusion of a further activity to resource and support organisations to undertake systemic advocacy would facilitate this, as we have already suggested in this submission.

Collect and evaluate data to track access, performance, outcomes and unmet service demand.

CoMHWA agrees with the need to collect, report on and evaluate data. In order to undertake this activity, it is necessary to understand and address barriers to collecting and reporting on data, including:

- Concerns relating to maintaining consumer privacy and confidentiality

- The challenges of collecting data on unmet demand, which include the discomfort and moral issues attendant on collecting data from those a service is turning away or not able to support, and the reluctance of individuals to provide data to a service that is not going to be assisting them
- Changes over time in reporting requirements, processes and systems, that may lead to lost or unhelpful data and compromise data integrity
- Unclear, vague or poorly conceptualised reporting requirements. These can mean that services interpret reporting requirements in different ways, which compromises systems-level data. When requirements are designed by funding body staff who do not fully understand the nature of individual advocacy work, those requirements might be challenging to meet and demoralising to report against, and can lead to the collection of data that is not reflective of the outcomes and quality of individual advocacy services. For example, requirements to report the number of cases that have resolved in the reporting period is challenging to report against because of times when advocacy support for an issue is unable to resolve it, and even when issues are resolved in the way the consumer had hoped for there are often other issues that mean that advocacy support continues. Other times, an issue and work may be ongoing, but a consumer disengages from the service
- Time pressures that render it difficult to collect all the necessary data, especially if a consumer has a time-sensitive issue.

Co-designing data collection, reporting and evaluation processes and templates with individual advocates would ensure that barriers are resolved and would result in clearer, more purposeful reporting requirements and more useful data. Developing and communicating a clear, shared understanding of the purpose for the collection of data is necessary to avoid collecting data for its own sake and clarify how it will be used and to what end.

4.2.3 Suitability and effectiveness of the new plan

After reading the 'Our plan for a new program' section of the Consultation paper, do you think our overall plan would work? Please comment (optional).

As identified in our feedback above, CoMHWA feels that some activities must be developed, and others must be added in order to achieve the aims of the program and contribute to the outcomes proposed.

4.3 Program Policy Framework

4.3.1 Principles of the Program policy framework

To what extent do you agree or disagree with the principles of this Program policy framework? Why do you agree or disagree? Please comment (optional).

CoMHWA applauds the commitment to real results for people with disability and finding ways to understand the outcomes of individual advocacy beyond reporting on numbers. The principle of stability and sustainability is also promising in its recognition of the need for organisations, services and programs to be around long term to meet ongoing needs. CoMHWA feels that the existing principles could be complemented and strengthened by:

- An explicit principle focusing on promoting and respecting the human rights of people with disability
- A promise to be led by and remain accountable to, people with disability and lived experience, and their expertise, needs, experiences and voices.

4.3.2 Grant Pathways

To what extent do you agree or disagree that the three grant pathways would together support achievement against the objectives for the new program articulated in the Consultation paper?

CoMHWA does not agree that the three grant pathways as they are currently articulated are sufficient to achieve the objectives named in the Consultation paper. CoMHWA feels some elements make promising contributions to the realisation of those aims, in particular, we think that longer grants prioritising disability-led organisations are essential. However, as we will describe below, broadening the scope of some elements and refining the details of others will create the conditions for achievement of objectives.

4.3.3 Service delivery stream

To what extent do you agree or disagree with the details of the proposed Service delivery stream?

CoMHWA agrees with some elements of this stream but feels that some changes are needed to ensure that: more people with disability have choices when seeking advocacy services, people with psychosocial disability can access tailored advocacy relevant to them, and that individual advocacy services are disability-led. We feel the increased support proposed by the stream to promote cultural safety is a positive step in improving access and outcomes for Aboriginal and Torres Strait Islander people with disability.

CoMHWA has concerns about the potential that prioritising or awarding longer grants to organisations working together in a network will encourage more organisations to merge. We understand that encouraging the development of networks can enable broader and more consistent service coverage, and that networks can enable organisations to pool funding towards larger projects. However, they can also result in fewer options for consumers and people with disability, especially if organisations choose to merge rather than remaining separate and working in a network. Smaller organisations with specialist knowledge of a certain area of advocacy or strong connections to a particular community may miss out on funding opportunities, or, if they are absorbed into a larger organisation, that specialist knowledge and community connection could be lost. CoMHWA feels that grants should be longer than 3 years for those organisations that are not in networks or consortia who have held funding and demonstrated good outcomes previously.

Competitive tender processes can pose challenges for collaboration among organisations, and can be especially challenging to navigate for smaller, grassroots organisations. Applying for grants takes considerable time, resources, and often, specific expertise and skills that larger organisations are often better resourced to dedicate. It is essential that funding is directed to the right organisations for the right populations, and support provided to smaller organisations that are well placed to reach specific populations to participate in tender processes.

CoMHWA supports the aim of promoting the proliferation of outreach activities, but is concerned about the wording around individual advocacy services being encouraged to work with other groups including service providers as a means of conducting outreach. This implies that individual advocacy services won't conduct their own outreach activities, which, combined with the idea that service providers might be conducting the outreach on behalf of advocates, potentially compromises the independence of advocacy services. CoMHWA acknowledges that it is important and necessary to work with providers and other groups and organisations to accomplish the aims of individual advocacy, to establish referral pathways, and to ensure that information about services reaches more people who need them. That said, individual advocacy services should also be appropriately supported and resourced to conduct outreach independently. CoMHWA has found that resistance from staff in some services, hospitals and other facilities can make it challenging for advocacy organisations to gain entry to certain settings as part of their outreach and engagement activities. In those circumstances, it is sometimes advantageous to collaborate with other organisations, groups or services who can facilitate outreach. Yet, it is important for barriers to direct outreach to be removed, and we suggest activities than can facilitate this, and that could build general respect for and understanding of the work individual advocates do, earlier in this submission.

CoMHWA supports many of the eligibility guidelines, particularly noting the importance of the independence of individual advocacy services, and the need for culturally appropriate and responsive advocacy that advances the rights of people with disability. CoMHWA was glad to see that capability criteria include the need for organisations to have strong representation of people with disability on their board and membership and relationships with people with disability in its community. We feel that the creation of this new program presents the opportunity to take this further, and embed such criteria at the point of deciding eligibility (with exceptions for ACCOs, for the reasons the Framework describes). Moving the category of 'disability driven' from a capability criteria to a pre-requisite, or creating a new eligibility criterion that states a minimum requirement for organisations to include people with disability in organisational staff, leadership, operations and governance would ensure people with disability are driving the future of advocacy services. CoMHWA also feels that steps must be taken to ensure individual advocacy support funded through this program is not influenced by religious beliefs on the part of service providers, and that people with disability with different religious backgrounds and beliefs can access support, and for this reason, organisations applying for Commonwealth individual advocacy funding should not be religious organisations.

4.3.4 National advocacy helpline stream

To what extent do you agree or disagree with the details of the proposed National advocacy helpline stream?

CoMHWA suggests that developing state and territory helplines, or branches of the National advocacy helpline, could be more effective than a single national helpline. Our suggestion comes from our questions about the degree to which the national-level helpline can provide specific and tailored information relevant to consumers across every state and territory. This is because state and territory-level legislation, processes and agencies determine to a significant extent the nature of systems and supports in which individuals are engaged, their experiences, and the advocacy pathways that are available.

If this helpline is to continue as stated, work must be done to build its capacity to make meaningful connections to local advocacy organisations. CoMHWA appreciates that the national helpline is able to refer to our advocacy service, and the fact that this avoids consumers having to ring around to find the right options. We note that the quality of such referrals can vary as many are outside of our funded scope, which points to the need for the helpline to develop a stronger working understanding of relevant and appropriate local supports to which to connect people they are supporting.

4.3.5 Sector strengthening stream

To what extent do you agree or disagree with the details of the proposed Sector strengthening stream?

CoMHWA feels that the activities of the NCDA could be beneficial to more advocacy services if it were funded to strengthen the sector as a whole, not just that portion of the sector that receives NDAP funding. CoMHWA’s individual advocates note that they cannot engage with some of NCDA’s activities that they feel would be helpful for them, including advocate peer networks and training webinars, because our service is funded through the WA state program. Opening up support would go some way towards reducing fragmentation in the sector and encouraging collaboration. Our individual advocates spoke highly of the resources, helpful newsletters, and training opportunities provided by the Disability Advocacy Resource

Unit (DARU).[9] DARU is funded by state-level Victorian government department funding, but despite this, they offer resources and information relevant to the broader advocacy sector. Support similar to that provided by DARU but consistently relevant to advocates across Australia would be helpful.

The list of priorities identified in this stream as focus areas for future training and development opportunities reflect many areas of training need that CoMHWA sees. CoMHWA also adds the following areas for training development targeted at advocates:

- navigating Guardianship and Administration legislation and processes, including State Administrative Tribunal processes
- training specific to navigating and working within the mental health system and legislation
- training on working with consumers with specific experiences, needs, or diagnoses, including consumers hearing voices or consumers with complex trauma experiences, as such training, where it is available, tends to be clinical in perspective (or only available to clinicians)
- providing appropriate emotional support in the course of providing advocacy.

There is a need for targeted training relevant to different aspects of advocacy, and advocacy relevant for different populations and people with disability who are encountering intersecting inequalities. To these activities CoMHWA adds the need for training and development focused on organisational capacity to support staff in individual advocacy services and better understand how to develop and sustain strong individual advocacy services, as there is a need for organisational leaders and managers of advocacy services to have access to development opportunities.

While CoMHWA agrees that the NCDA should be funded to work with government and community organisations to address systemic issues for people with disability, it is not yet clear how the NCDA would do this. They do not currently undertake systemic advocacy activities themselves, and so is it their role to be an informational conduit, or will they have other ways that they support this? More detail is needed to explain and clarify the scope of the NCDA with respect this work.

4.3.6 Overall feedback

As a whole, do you think a program designed in line with the Program policy framework would deliver good outcomes for people with disability? Please comment.

While CoMHWA thinks that this framework takes some positive steps towards delivering good outcomes for people with disability, such as more sustainably and long-term funded services, we think that there is

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[9] https://daru.org.au/

refinement needed to redesign other features if the intention is to move beyond maintaining the existing status quo when it comes to the national advocacy helpline and sector strengthening activities.

While the framework identifies that the program may connect with the NDIS appeals program, it does not yet outline a specific approach or intention for what this could look like. Advocacy relating to NDIS appeals and other NDIS-related advocacy are dominant areas of need, and services providing such supports are overtaxed. Despite people with psychosocial disability encountering specific and significant issues concerning NDIS access and supports at the moment,[10] there is a lack of options for individual advocacy support that has the depth of knowledge about psychosocial disability in the NDIS that would enable them to have support in getting those issues addressed.

Do you have any other views on the Program policy framework? Please comment (optional)

CoMHWA would like to see people with disability identified as partners in this program. We recognise that disability representative organisations are often led by or significantly staffed by people with disability, but we feel that people with disability must be engaged as partners in the co-design, planning, implementation and ongoing monitoring and evaluation of the program.

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[10] Threlfall, D., Paterson, K., Donnelly, S., Beasley, A., McKenzie, E. & Ballenden, N. (2025). *Access Denied: Psychosocial disability and the NDIS.* Australian Psychosocial Alliance (APA). https://psychosocialalliance.org.au/campaign

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