Australian Psychosocial Alliance

Productivity Commission Final Review of the National Mental Health and Suicide Prevention Agreement

March 2025

About the Australian Psychosocial Alliance

The Australian Psychosocial Alliance (APA) includes Flourish Australia, Mind Australia, Neami National, One Door Mental Health, Ruah, Stride Mental Health, Open Minds and Wellways Australia. We are specialist providers of community managed mental health and wellbeing services in Australia, with most registered as NDIS providers with a particular focus on psychosocial disability.

Members of the APA have extensive experience providing recovery-oriented care and support which focuses on personal goals, participation and living a meaningful life. We have evidence of what works, and combine this with service delivery wisdom, to provide recovery-oriented services that support people to manage their symptoms and build their capacity to participate in society and manage their lives. This includes support to sustain a tenancy, build the skills to live independently, find fulfilling work, and build social connections.

The people who access our supports come from diverse communities across Australia, with each of our organisations having a clear commitment to promoting community inclusion and participation. We have experience providing services to at risk groups, such as LGBTIQ+ individuals, culturally and linguistically diverse communities, and Aboriginal and Torres Strait Islander people, as well as young people. We recognise the value of lived experience and seek to co-design services and approaches wherever possible.

APA Submission to the Productivity Commission Final Review of the National Mental Health and Suicide Prevention Agreement

1. Overview

APA organisations provide a significant proportion of Australia's specialist mental health and wellbeing and psychosocial services. Together, we estimate we support around 95,000 people with mental health issues and/or psychosocial disability each year and employ a workforce of around 7,500 of allied health practitioners, and community mental health and psychosocial disability support workers, including a substantial lived experience/lived expertise and peer workforce. We provide Commonwealth funded Headspaces, Medicare Mental Health Centres, the Commonwealth Psychosocial Support Program, a range of programs under the "stepped care" model and suicide prevention, aftercare and postvention support. We deliver similar State funded community mental health and psychosocial support programs, including sub and post-acute mental health services and most of us are registered NDIS service providers offering specialist psychosocial disability support.

This submission has a focus on the experience of the Community Managed Mental Health (CMMH)/specialist psychosocial disability support sector and the people who use our services. This submission should be read in conjunction with the submission made by Mental Health Australia which provides a broader perspective.

The National Mental Health and Suicide Prevention Agreement (NMHSPA; the National Agreement) has overseen much needed investment in new community mental health infrastructure which is contributing to better pathways to mental health care. However, the investment is arguably piecemeal, with it being inconsistent across Australia and within each jurisdiction. While the National Agreement's principles, objectives and outcomes are sound, they exist in isolation of a framework which describes what a coordinated, integrated or responsive mental health and suicide prevention service system should look like, how it should operate and an accompanying program logic which links actions through to outcomes.

The National Agreement also relies on the Primary Health Networks (PHNs) as a key mechanism for the planning, coordination and commissioning of mental health and suicide prevention services. As outlined in our submission to the recent review into the PHN Business and Mental Health Flexible Funding Models, the APA notes that the PHNs are struggling to do this well and that this is impacting on service delivery and access[1].

Critically, the National Agreement has (perhaps inadvertently) stalled action in addressing the growing gap in the provision of psychosocial support ("unmet need"). In part this is because it prioritised the re-visiting of the Productivity Commission analysis of need in this area over action, while simultaneously failing to provide a pathway or framework for addressing the gap or addressing the interface issues between the NDIS and the mental health service system. Psychosocial and CMMH support has also remained relatively invisible in the context of the National Agreement. There is no national minimum data set for these services, the workforce is not included in the National Mental Health Workforce Strategy and Commonwealth funded services are largely commissioned through the PHNs with a lack of clear accountability and visibility into the Department of Health.

2. Priorities for the next National Agreement

- **To be based on a new National Mental Health Plan**. The development of the National Mental Health Plan must be prioritised. This Plan and the next National Agreement should engage and involve people with lived experience of mental health issues and psychosocial disability, family, carers and supporters, service providers, health professionals, peak bodies and researchers and other key stakeholders.

[1] Please contact kate.paterson@mindaustralia.org.au for a copy of this submission or download at https://psychosocialalliance.org.au/submissions

- **To take a whole of Government approach.** The National Agreement must encompass the NDIS and its role in supporting 64,000 people with severe mental health issues and psychosocial disability, and commit to the health and disability systems working together to deliver a comprehensive response across the spectrum of need and lifespan.

- **To articulate a nationally consistent approach to service design and delivery**. While this needs to respond to local environments and communities, there needs to be agreement on the core components of a well-functioning and responsive mental health service system and a plan for filling the gaps. It must include a lived experience core component in the design phase.

- **To leverage community based services** (to the full scope of their practice) to support more people earlier in their communities and to support people to access a broader range of supports and services (responding to the social determinants of health and mental health).

- **To champion a future where suicide prevention is not merely reactive but transformative**, building the capacity to have a whole-of-community response to suicide prevention. The NMHSPA must become an enabler of this holistic approach and realign itself to the National Suicide Prevention strategy.

- **To take responsibility for ecosystem stewardship** with a focus on ensuring a thriving, accessible and available CMMH sector. This stewardship needs to occur at a national level and across portfolios and jurisdictions, with consideration to workforce implications, price and contracting practices.

- **To support the National Mental Health Commission as a statutory body** with resources to effectively guide, monitor and report on the National Agreement and National Mental Health Plan.

- **To support the introduction of an appropriate national minimum data** set for the CMMH/psychosocial support sector which includes measurement of psychosocial outcomes.

2. Statements against Terms of Reference

a) Impact of programs delivered under the National Agreement on wellbeing and productivity.

The National Agreement has supported the growth and delivery of a range of programs which we know are benefitting those who have been able to access them. We particularly note the importance of programs such as Headspace and the Medicare Mental Health Centres in contributing to universal access for mental health care.

- The **Medicare Mental Health Centres** (and in Victoria the mental health Locals) are showing early signs that they can provide good access to support, and positively impact on the integration and coordination of care and support for those that use (and have access to) these services.
    - In a recent consultation undertaken by Wellways, service users and their carers, families and other supporters identified that such offerings are providing an important “foundation/base” for accessing services and navigating to other supports.
    - Neami’s co-evaluation of four first wave Medicare Mental Health Centres and an urgent mental health care centre is showing that they are highly valued and accessible. People are feeling heard, listened to, understood and able to tell their stories; they are valuing the “mixed team” from peer workers to clinical staff, and identify that they are being offered choices about who provides care and support and how this is provided (See Box 1).

[2] *"I've had a lot of support growing up, but I really liked Head to Health [now Medicare Mental Health Centres] in the way they do things. So I think it's honestly the best support I've had in my mental health over the years." (Guest Conversation)*[3]

- The **Headspace** program continues to provide an important platform and entry point for young people to mental health care and support. However, it has been designed for people with low-moderate needs. Our services are responding to those with moderate to severe needs (IAR 4 -5), and only a small proportion have staff and resources to respond (for example, through an early psychosis team) and for the most part state based Child and Adolescent Mental Health Services (CAMHS) are also unable to respond. We also note a lack of flexibility in the Headspace programs to renegotiate aspects of the service model and targets to better respond to local challenges, such as strengthening community mental health support where it is difficult to attract psychologists.

Box 1: Medicare Mental Health Centre (MMHC)/ Urgent Mental Health Care (UMHCC) Effectiveness [2]

Evidence of accessibility:
- About 1/3 of guests indicated they were seeking mental health support for the first time.
- 50% of guests at the MMHC were unsure where they would have sought support (23%) or would have gone nowhere (27%) to seek support.
- 44% of Guests at UMHCC would not have sought support elsewhere.

Evidence the services are diverting people away from Emergency Departments (ED):
- 11% of survey respondents indicated they would have attended ED/hospital for support
- 42% of guests at UMHCC would otherwise have attended ED for support

Evidence a substantial proportion of visitors were seeking support for suicidal risk:
- 34% of survey respondents (to the alive survey) indicated attending for suicidal distress

Evidence the services are supporting people with moderate to severe distress:
- MMHC: Mean K10 scores indicated very high levels of distress (m=34); 62-70% IAR scores = 3 (indicating moderate intensity services); 94% and 99% IARs 2 – 4
- UMHCC: 38% Triage level 4 (different to IAR; "Semi urgent, see within 60mins"); 70% were triaged at Levels 2-4.

The most common principal diagnoses at the MMHC are mixed anxiety/depression symptoms.

b) Effectiveness of reforms across different communities and populations.

The National Agreement outlines good objectives for reforms across different communities and populations. However, the high unmet demand for psychosocial support and access barriers to the NDIS for people with mental health issues[4], means that finding accessible mental health and psychosocial support remains difficult, and therefore even more difficult for those who face disadvantage or whose needs are complex. We note that there is minimal transparency or effective reporting against the reform areas (see discussion at g).

[2] ALIVE National Centre for Mental Health Research Translation (2024). Neami National Head to Health and Urgent Mental Health Care Centre Implementation Co-Evaluation. Final Report & Implementation Learnings (unpublished). Melbourne: ALIVE National Centre for Mental Health Research Translation.
[3] livenetwork.com.au/our-projects/head-to-health-implementation-co-evaluation/#:~:text=With%20the%20ongoing%20implementation%20of%20Head%20to%20Health%20and
[4] See note 15.

As CMMH organisations we pride ourselves on delivering welcoming, safe and responsive services to everybody, supported through co-design processes, ongoing evaluation and quality improvement processes. To this end, the universal access platform of the Medicare Mental Health and Headspace programs is an important feature and is supporting access for a diverse range of people.

However, aftercare in the National Agreement has been too narrowly defined, resulting in the main pathway being through the Emergency Department—thus excluding many people who would benefit from these services and should have access. We are aware that not only are the EDs not referring all people who present for suicide attempts into Aftercare programs, but there is great variability on the part of States and Territories to create alternative pathways. Universal access to such care is therefore a long way off (see also discussion at c).

A particular challenge for our services is to maintain commitment to and a presence in regional and rural areas, with commissioning and funding processes making it unsustainable to remain and/or establish new services in some areas. (see discussion at d). Additionally, where there are workforce or other geographical challenges, a lack of willingness from funders to alter models or consider alternative service delivery models reduces overall service capacity (for example, in the Headspace program as previously mentioned).

Access to affordable and safe supported housing is one of the single most effective interventions to improve health and wellbeing for people with mental health issues and psychosocial disability[5]. It is also integral as part of any reform to address many of the different communities and populations listed in the National Agreement – particularly for those who are also socio-economically disadvantaged and/or who experience any type of abuse, neglect or violence. The National Agreement makes no mention of housing and support models, and the lack of focus on housing and support points to a failure of Governments to ensure a more joined up approach and the use of such Agreements to affect change[6].

c) Opportunities to adopt best practice approaches – where productivity improvements could be achieved.

The NMHSPA has not itself affected significant reform, and while initiatives such as the Medicare Mental Health Centres are largely positive and have the potential to reform how mental health care is accessed, the lack of oversight and vision for a joined up service system means that even where there may be pockets of best practice, they are not being driven by a shared understanding of what this is[7]. For example, we note that in the case of Medicare Mental Health services there are some that provide predominantly clinical therapeutic care while others are providing a holistic approach which incorporates psychosocial support, including peer led support.

Lack of investment in evidence based psychosocial and community based mental health supports is inefficient.

We know that people prefer community based mental health care[8]. The evidence base for the effectiveness of community mental health and psychosocial support, including to intervene early and to reduce the need for higher cost services, is not contested. Likewise, support to link to community, to build connections, to

[5] Mental Health Australia and KPMG, Investing to Save (2018), 43, https://mhaustralia.org/publication/investing-save-kpmg-and-mental-health-australia-report-may-2018.; Hayes L, Gibson L, Botchway Commey E and Ballenden N 2023, Long Term Housing and Psychosocial Support Reduce Hospitalisation for People with Long Term Mental Health Challenges — a Preliminary Report.

[6] It is also worth noting that the National Agreement is also quiet on the need for mental health/psychosocial support programs across employment, education, physical health and legal support.

[7] In part, this is because there is no comprehensive national mental health plan.

[8] MHA and NMHCCF (2024) Advice to Governments: Evidence informed and good practice psychosocial services

improve physical health and wellbeing, have safe housing and be employed – amongst other life and psychosocial outcomes – is critical to the recovery journey[9].

CMMH organisations have a broad scope of practice providing comprehensive community based support, with capacity to integrate allied health/clinical, community mental health and psychosocial support. CMMHs also have a track record for:

- Responsiveness across the priority groups identified in the Agreement
- Working in and with communities
- Service integration
- Embedding of lived expertise across management, service design and delivery
- Reducing consumers' use of inpatient treatment and other high cost or avoidable interventions, including by directing consumers into the right support at the right time.

The lack of commitment to growth in the delivery of psychosocial supports has contributed to market contraction in, and increasing sustainability issues for, the CMMH sector, over the life of the NMHSPA[10]. It has simultaneously reduced access to effective interventions for a growing number of people.

The 2024 Mental Health Australia and National Mental Health Consumer and Carer Forum document *Advice to Governments: evidence informed and good practice psychosocial services* draws on the evidence base to identify the types of supports that work. Some recent evidence of effectiveness from within the APA organisations include:

- Across 15 sites, a 2024 report of the Mind Australia step up step down (SUSD)/prevention and recovery care (PARC) services showed significant reduction in psychological distress, significant improvement across a range of "recovery" areas and high satisfaction ratings[11].

- Reduced hospital stays for residents of Havens. The average number of days hospitalised per client before moving in was 53.1 days (SD = 111.8). After moving in, the average days hospitalised per client was reduced to 7.4 days (SD = 19.5).

- The Resolve Program delivered a 40% reduction in Emergency Department visits, a 67% reduction in bed days, and a 52% reduction in hospital admissions compared to the year prior to enrolment in the program[12].

- In the NSW HASI/CLS program, hospital admissions decreased 74% following program entry, and average length of stay decreased 74.8% over two years; and programs are generating more in cost offsets than the cost in programs.[13]

The lack of growth, recognition and commitment to CMMH and psychosocial support has been a lost opportunity to adopt best practice approaches that would support earlier intervention, improve outcomes across psychosocial domains and reduce use of more expensive clinical support.

Suicide Prevention programs need to be community based and better coordinated.

[9] The Mental Health Australia advice to Government on effective evidence based services pulls together this evidence base, and includes reference to both Australian and international experience.
[10] Other factors include inconsistent pricing across sectors (eg: aged care), and NDIS pricing which suits small/sole providers with no overheads. The broader picture includes PHN Commissioning processes and a real decrease in funding. (see discussion at c).
[11] https://www.mindaustralia.org.au/sites/default/files/2024-07/Snapshot_PARC_SUSD_Outcome_Measures_Report.pdf
[12] SVA (2024) *Resolve Social Benefit Bond Annual Investor Report 2024*, https://www.socialventures.org.au/wp-content/uploads/2024/08/Resolve-SBB-Annual-Investor-Report-2024-Final.pdf
[13] https://www.health.nsw.gov.au/mentalhealth/resources/Pages/cls-hasi-eval-rpt.aspx

The NMHSPA must become an enabler of a whole-of-community approach to suicide prevention, emphasising the need for community based, peer-led, collaborative strategies. This approach prioritises empowerment, agency, and hope— and requires a whole-of-community response, acknowledging the various roles for individual and community prevention, after-care and postvention support.

Since the introduction of the NMHSPA there has been a trend towards clinically focused hospital-based programs such as the Hospital Outreach Post-Suicidal Engagement (HOPE) in Victoria. Such clinical models are misaligned with the National Suicide Prevention Strategy[14] and have led to a lack of community based support. As noted earlier, some of these programs have also limited access to those presenting at the Emergency Department (and even then not all people are referred to aftercare or postvention care), rather than focussing on those who are most at risk of self harm.

There is a consistent overall architecture for evidence-based suicide prevention and aftercare models which allows for innovation. Local and global community-based initiatives have demonstrated how collaboration between services, lived experience and community can drive compassionate and effective responses to suicide prevention and postvention support. Under the NMHSPA we have seen local examples of best practice, but it is ad-hoc and funded in pockets under narrow PHN or bilateral agreements. Examples of peer led suicide prevention programs that are working well include the Safe Haven/Safe Space models in New South Wales/Australian Capital Territory and Queensland and in Western Australia, a pilot called Luminos is an example of an innovative approach to supporting young people (See Box 2).

Box 2: What is The Luminos Project?

The Luminos Project is a peaceful recovery space for young people, supported by trained staff including a Clinical Psychologist, Youth Suicide Counsellors, Peer Support workers, and support counsellors– all with lived experience. It focuses on helping young people build hope, resilience, and practical strategies for their future.

Developed by Ruah in partnership with **Samaritans WA** and **The Kids Research Institute Australia** this innovative service supports up to 300 young people and their families every year. Located in Subiaco, The Luminos Project's Sanctuary provides therapeutic support for young people aged 16-24 experiencing suicidal thoughts. It offers early intervention with up to four nights' stay for five individuals at a time, helping them before reaching a crisis point.

Inspired by the international **Maytree UK's** 20-year model, The Luminos Project has been co-designed with global experts in youth suicide support, mental health services, and research, alongside input from young people with lived experience, ensuring it meets their needs effectively.

Early evaluation data is showing that six months after the intervention, participants are reporting significantly reduced suicidal thoughts.

d) The extent to which the National Agreement enables the preparedness and effectiveness of mental health and suicide prevention services to respond to current and emerging priorities.

Over the last three years, the mental health and suicide prevention service system has become increasing fragmented and at the same time Australia's mental health has worsened[15]. There is a high[16] and growing

[14] chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.mentalhealthcommission.gov.au/sites/default/files/2025-02/the-national-suicide-prevention-strategy.pdf?form=MG0AV3
[15] National Mental Health Commission Report Card 2023, https://www.mentalhealthcommission.gov.au/publications/national-report-card-2023
[16] Health Policy Analysis (2024) Analysis of unmet need for supports outside of the NDIS Final Report.

unmet need for psychosocial support[17]. The lack of change in the service system to respond to these known issues, and the slow pace of implementation of the NMHSPA in any case, indicates poor preparedness and effectiveness of the mental health and suicide prevention system to respond to current or emerging priorities.

There is no defined "ecosystem" of mental health care or guiding framework

Underpinning this poor state of affairs is the fact that the National Agreement fails to deliver a comprehensive or coordinated overarching narrative or framework for the delivery of mental health and suicide prevention services. This leaves too much variation across jurisdictions and creates siloing (or a lack of joined up responses) across different portfolios, most notably health and disability, and in the case of suicide prevention with other relevant portfolio areas, for example around natural disasters, financial stress and cost of living. Additionally, the narrow and ad hoc approach to what is included in the NMHSPA also means that there is no overview of how services are working together to provide comprehensive and coordinated care. For example, while aftercare, postvention and Distress Brief Support (DBS) are important parts of the suicide prevention strategy, and can be highly effective, any monitoring is done without reference to other critical aspects of suicide prevention, such as the crisis support lines which are not part of the National Agreement.

The APA notes that there is also no National Mental Health Plan or Strategy, a feature which has guided Agreements in the past – for example, the first National Mental Health Strategy paved the way for the transition away from institutional care. A new National Mental Health Plan is needed.

The NMHSPA has also been a missed opportunity to start the conversation about how the NDIS and the mental health service system can and will work together, including to ensure appropriate pathways into and out of the NDIS and ensure a holistic and integrated response for people with mental health issues and psychosocial disability. This was highlighted in the 2023 NDIS review, which—across multiple recommendations and actions—identified lack of connection and coordination across service systems, and the importance of Government agreements taking responsibility for determining how the NDIS and mental health services should interface. It also highlighted the need for prioritisation of support for people with a psychosocial disability outside of the NDIS and as part of foundational supports. Action 7.6 specifically identifies that Governments should update the NMHSPAs to set out an overarching approach to psychosocial disability supports to improve the integration and coordination of the NDIS and mental health systems.

Community Managed Mental Health/Psychosocial Support Services are largely absent and not supported

The effectiveness and preparedness of the CMMH and psychosocial support services sector has been further hampered by a lack of agreement around its growth and development, and acknowledgement of the value it can deliver. Over the life of the NMHSPA, the specialist CMMH sector has continued to shrink, with providers exiting regional areas and/or merging to be of sufficient size to remain viable. The effects of short and unpredictable funding cycles, lack of indexation, managing multiple and different funding mechanisms, reporting and data requirements, and changing registration/regulatory environments are affecting the sustainability of the sector, with flow on effects to workforce and ultimately affecting the choice and availability of services for people and communities[18].

We also note that:

[17] Access rates to the NDIS for people is now less than 30% and is declining (NDIS Quarterly Report, Q1 2024-2025, Supplement E, https://dataresearch.ndis.gov.au/media/4109/download?attachment); and with funding not keeping up with indexation, there has been a decline in capacity in other programs (notably the Commonwealth Psychosocial Support Program) which is contributing to more people needing but unable to access psychosocial support.

[18] As noted earlier, the impact of inconsistent pricing across sectors (eg: aged care), and NDIS pricing which suits small/sole providers with minimal overheads also contributes/adds to this complexity.

- While there has been a lack of investment in workforce measures generally, there have been none targeting the psychosocial/CMMH sector. The National Mental Health Workforce Strategy workforce neither recognises the CMMH workforce nor that CMMHOs are significant employers of people with Lived Experience, in roles requiring lived expertise across management and program structures, and as peer workers. As a sector we continue to advocate for appropriate funding and commissioning structures which represent the full costs of creating inclusive and supportive work environments for people with LE.
- There is no national minimum data set for CMMH (see discussion later at g).
- The main planning tool, the National Mental Health Services Planning Framework, dates from 2011. The taxonomy used does not reflect the current service offering and the workforce categories do not include community mental health/psychosocial support workers. The peer worker role also assumes that this is a homogenous category rather than reflecting the diversity of those working in this role.

Finally, there has been insufficient focus on the suicide prevention workforce issues, which continues to limit the preparedness and effectiveness of these services. The sector experiences significant burn out and high turn over, and within the peer workforce there is yet to be a sustainable approach to expansion including better models for career progression. The NSPO workforce strategy needs to be expanded to an initiative with funded actions.

The Primary Health Networks have not provided an effective or efficient mechanism for the planning and delivery of mental health services.

The NMHSPA identifies that the Commonwealth is responsible for system management, funding and policy direction for primary mental healthcare, as well as physical and mental health services subsidised by the Medicare Benefits Scheme (MBS) and commissioned through the Primary Health Networks (PHNs).

However, there are significant issues with the PHN business model and the PHN commissioning practices which has impacted on effective and efficient service delivery[19]. Key concerns which impact on productivity include:

- Significant variation between PHNs in their approaches to commissioning like services. PHNs individually "reinvent" the wheel, which is inefficient for them and inefficient for service providers—who need to make changes, not in response to local needs which would be appropriate, but to different pricing and administrative requirements.
- Inappropriate pricing and funding structures including arbitrary caps on administration or non-salary costs—which limit flexibility, do not recognise different cost structures for different service types and prohibit the full cost of service delivery being funded; not funding indirect costs associated with employing a Lived Experience (LE) workforce or other specialist workforce, such as those associated with compliance, risk and quality improvement; and not passing on indexation to meet award increases.
- Commissioning appears to operate in a vacuum, without consideration of broader market structures or requirements, or how this impacts broader government policy and objectives such as supporting and growing the health workforce or building a healthy and competent psychosocial support services market. Frequent commissioning creates unnecessary competition and is contributing to the thinning of the market (for example, through agencies moving out of service provision in a particular geographical area;

[19] The APA provided detail around these concerns in its submission to the Review of the PHN Business and Mental Health Flexible Funding Models. Please contact kate.paterson@mindaustralia.org.au for a copy or download at https://psychosocialalliance.org.au/submissions

and workforce moving sectors). As noted earlier, this has serious implications for rural and regional service access.

The PHN arrangements also mean that there are even different data collections for the same program. Not only is this hugely inefficient for organisations, it means it is not possible to monitor for activity and outcomes at a national or state level, or to ensure that there is a systemic approach to service planning and development.

Many PHNs have also moved away from service coordination and integration and are not investing in the partnership work which is necessary for good local planning and service system development.

The APA identify that the Commonwealth Department of Health and Aged Care (DOHAC) has not seemed to provide sufficient support, guidance and funding certainty to the PHNs so that they can competently and confidently purchase mental health supports that respond to their local communities while also delivering a nationwide systemic mental health response.

e) Unintended consequences such as cost shifting, inefficiencies and adverse consumer outcomes

The re-prosecution of the Productivity Commission's work which identified high levels of unmet need for psychosocial support has resulted in the stalling of any response in this area. It has allowed for:

- The gap for psychosocial support for people with mental health issues and psychosocial needs to continue to increase. This has happened because of decreasing access to NDIS, changes to the NDIS which is reducing support and declining capacity (and therefore service activity) due to erosion of funding through increased costs (see note 14).
- Shrinking and consolidation of the CMMH sector (as previously mentioned).

The NMHSPA has manifested a siloing of responsibilities across health and disability, with neither the States nor the Commonwealth taking leadership to solve the issue. The consequence of which is a lack of commitment and effort to ensure that people with mental health issues and psychosocial disability have access to the necessary support, and a lack of coordination between parts of the system.

For example, many of the psychosocial support programs outside of the NDIS (such as the Commonwealth Psychosocial Support Program) limit the support period– often to one year. However, these time frames are neither sufficient for a person to determine if their psychosocial disability is permanent and enduring such that they would meet the eligibility criteria for the NDIS nor long enough to receive the support to make sufficient recovery so that they do not need supports on an ongoing basis. It leaves people in limbo and increases pressure on the NDIS and hospital services because there are no other support options available.

Additionally, when the NDIS is struggling to provide appropriate support for, or respond to, people with psychosocial (including those raised in the NDIS review) there is no joined up mechanism to ensure that people's needs are being met and that this marginalised group of people are not further disadvantaged. For example, Health Ministers/ Departments are not actively participating in NDIS policy and program decisions and/or assisting the NDIA to ensure that it appropriately responds to people with mental health issues and psychosocial disability, nor holding the NDIA accountable to ensure access as agreed as part of the Disability bilateral agreements. These mechanisms are particularly important because self-advocacy is often harder for this group because of the very nature of psychosocial disability and the impairments related to it. The current situation facing the Haven Foundation and its residents is a case in point (see Box 3).

In suicide prevention, we see pressure on the "aftercare" services to also provide "before care" because of the absence of crisis services and because they are often the only staffed services available.

Across the system, as services (including funders) create tighter pathways or eligibility criteria, the more inequitable the service system becomes. Those with the most resources and capability to understand how to the make the system work, or afford assessments or to see health professionals who can navigate a pathway to care for them, are those that get the access. The flip side is those with the highest needs are increasingly missing out. We see this in relation to the NDIS (with those who can afford expensive assessments and support to access the scheme more likely to get access), but also to psychological support which (if you can afford it) the requirement to visit a GP for a mental health plan is a barrier in itself due to the cost, and having to "tell your story" and/or "convince" the GP of one's needs.

Box 3: The Haven Foundation – Impact of the lack of coordination between Mental Health Programs and the NDIS.

Across Australia, State Governments have invested in building new social housing for people with mental health issues and psychosocial disability through the Haven Foundation. Each Haven comprises 12 – 16 individual living units and provides 24 hour support, and individualised and group support programs. Access to a Haven leads to improved mental health, increased community participation and reduced use of hospital based care (including emergency departments). They provide an important pathway for people out of extended care.

As a social housing program, Haven was designed to interface with the NDIS, with potential residents to meet the criteria of enduring mental illness and psychosocial disability (ie: participants who the States previously supported but under the agreement with the NDIA were to transfer into/be eligible for the NDIS). Until recently, residents have received NDIS packages which they have been able to use to purchase the support they need at the Haven.

However, changes to the NDIS are now challenging the viability of the service model. There are people who need and want a Haven service but cannot access it, or whose residency is at risk, due to insufficient funding in their NDIS package or because changes to the way their package is configured does not allow for the efficient purchase of shared supports, such as those that are required overnight or as a backup during the day.

The Haven model is effective and cost efficient, but there is no clear mechanism within the (individualised) NDIS pricing structure through which to access funding in a way which can deliver these cost efficiencies. The lack of an alternative psychosocial response means that there is full dependence on the NDIS, but the NDIS is not demonstrating flexibility to address the need of psychosocial participants, and there is no accountability or clear roles and responsibility within the system (or systems) to ensure that this needed, effective and efficient service model remains viable for the people who choose and need it.

The APA also notes that despite the acknowledgement of the need for more psychosocial supports outside of the NDIS, there is no commitment to these either being funded through "foundational supports" or through health budgets. The NMHSPA provides no pathway for resolving this and creates an environment for all parties to refer and defer to another.

f) Effectiveness of the administration of the National Agreement, including the integration and implementation of Schedule A and the bilateral schedules that support its broader goals.

The APA does not have any direct experience with the effectiveness of the administration of the Agreement. The heavy reliance on the bilateral agreements to provide most of the new funding activity has led to

substantial differences across States in terms of both activities and funding commitments. Some bilateral agreements contained no mention of postvention and one did not include aftercare.

We question the accountability for implementation of the Agreement and whether some clauses are meaningful. For example, the Victorian bilateral allows for up to 60 Adult and Older Adult Mental Health Locals but stipulates no minimum number; it identifies a shared objective of working towards no service gaps as Adult and Older Adult Local Mental Health and Wellbeing Services are established by 2026 and expectations of the transition of all Mental Health and Wellbeing Hubs to Locals by 2026. However, the Victorian Government has stalled the roll out of its mental health Locals and these goals will not be met.

g) Effectiveness of reporting and governance arrangements

Reporting Arrangements

To date there has only been one public report on the Agreement by the National Mental Health Commission.

The APA supports an ongoing role for the National Mental Health Commission in reporting on the state of mental health service delivery in Australia and it should have independence and ability to report objectively on mental health system funding, performance, and service delivery and be resourced appropriately to report effectively and frequently[20].

The National Mental Health Commission should also be enabled to collect information and, if necessary, require the production of information about the mental health system from all Australian jurisdictions. This may require enactment through legislation and/or formal agreement as part of the National Agreement or associated bilateral agreements with each jurisdiction.

The NMHSPA facilitates collection and reporting of data across a range of Medicare funded and clinical programs, which provides important information about trends of service usage. It does not include social determinants of health to allow for an understanding of how the environment impacts on wellbeing, including the interface with suicide; nor report on psychosocial outcomes which would provide for a more holistic understanding of mental health and wellbeing.

We also note that the last national survey on *People living with psychotic illness* was in 2010, and this remains the most up to date information describing the lives of people using publicly funded specialist mental health services. The Government (in its various forms) often invests in consultation, but these often fail to target those who are not resourced to or interested in participating. This type of survey work needs to be replicated and expanded to understand what is working, what the service gaps are and the needs of people who most need mental health support.

As noted earlier, there is no national or coordinated approach to data collection and outcome measurement for the CMMH/psychosocial support sector. It is timely to consider a more national approach to data collection and implementation of a common data set across the range of CMMH programs, including those funded through the PHNs. This should be managed and overseen by the AIHW and data should be publicly available to aid research and monitoring across community and academia.

We also note that actual spending under the National Agreement is not transparent; and particularly to identify what is happening in each State.

[20] Please see the APA response to the Discussion Paper: Strengthening the National Mental Health Commission and National Suicide Prevention Office (2024). Contact kate.paterson@mindaustralia.org.au or download at https://psychosocialalliance.org.au/submissions

Governance Arrangements

The Governance arrangements have improved over the life of the National Agreement, including better representation of, and participation by, people with lived experience. While the APA welcomes the involvement and contribution of peak bodies such as Mental Health Australia (MHA) we are concerned that there is insufficient direct representation from the specialist CMMH sector, and particularly regarding matters which impact significantly on service provision. For example, this is the case for the Psychosocial Unmet Needs Project Group where actual CMMH/psychosocial support service providers with direct experience in working within the system (not representative bodies) would assist in understanding the interface issues, challenges and quality implications.

h) Applicability of the roles and responsibilities established in the National Agreement.

There is not enough clarity around the roles and responsibilities, and too many shared responsibilities without consideration of how these roles will be shared. This has particularly been the case in relation to the provision of psychosocial support.

As previously mentioned, the APA is concerned about the:

- Significant reliance on PHNs for the commissioning/oversight of mental health services with Commonwealth funding. The PHN business model is not fit for purpose and there has been limited guidance, governance or resources from DoHAC to incentivise innovation or cross-PHN collaboration and connection.
- Lack of a national mental health services framework that articulates the "ecosystem" of care and support for the delivery of mental health and psychosocial support services across Australia, including that provided through the NDIS.
- Lack of clarity and responsibility for the funding of psychosocial support.

i) Without limiting the matters on which the PC may report, in making recommendations the PC should consider the complexity of integrating services across jurisdictions and ensuring that the voices of First Nations people and those with lived and/or living experience of mental ill-health and suicide, including families, carers and kin are heard and acted upon.

As previously mentioned, many of the suicide prevention and postvention programs funded through the NMHSPA do not represent best practice as identified by people with lived and living experience of mental ill-health and suicide.

Commissioning arrangements for mental health and suicide prevention programs often do not include appropriate timeframes for co-design – for example, it is often two weeks and tokenistic. Similarly, program funding rarely covers the true costs of employing, developing and supporting a lived experience workforce.

Finally, we also note that funders often prescribe the K10 as an outcome measurement tool across platforms. It is a deficit-based tool which is particularly unsuitable for measuring recovery or well-being, including in First Nations communities. We also regularly receive feedback from our service users that they do not like the tool and they do not like being asked the same questions multiple times. A different approach is required[21].

[21] The APA advocates that instead of prescribing individual outcomes tools, funders should expect services to invest in a suite of tools for individual and service outcome measurement. It is reasonable to expect that providers should choose these tools, and change and adapt measures to suit different service types and information needs. It is unclear that it is necessary that this information be compiled at an aggregated level and/or whether it can or could provide useful information in any case. However, providers should and could share this information for insights about what is working (or not). Government and funders should focus on data collection which allows system reporting. Regardless, all evaluation and monitoring should also measure what is important to the service user.