Australian Psychosocial Alliance

Interim report – Mental Health and Suicide Prevention Agreement

July 2025

About the Australian Psychosocial Alliance

The Australian Psychosocial Alliance (APA) includes Flourish Australia, Mind Australia, Neami National, One Door Mental Health, Ruah Community Services, 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 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. Each of our organisations have 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, Aboriginal and Torres Strait Islander people and young people. We recognise the value of lived experience and seek to co-design services and approaches wherever possible.

1. Introduction

The APA met with Commissioners Selwyn Button, Stephen King and Miriam Veisman-Apter and provided a written submission to the Review. We are pleased that our feedback regarding the operations of the current National Mental Health and Suicide Prevention Agreement (NMHSPA) have been heard and reflected in the interim report.

The APA considers that the review recommendations, and the areas for priority action, including to address psychosocial unmet need and to reinvigorate the National Mental Health Commission, are sound and if implemented would be significant in advancing system reform.

Community managed mental health (CMMH)/ psychosocial support services are significant providers of mental health support – they deliver Medicare Mental Health Centres, headspace programs, carer connect centres, step-up step-down services, residential rehabilitation, supported housing, employment, suicide prevention and postvention programs, individual mental health recovery support and support through the NDIS.

They deliver the types of programs required to meet the unmet demand for psychosocial support and the foundational and early intervention supports identified by the NDIS Review. They can be the cornerstone of the mental health service system providing support in the community, where people live their lives and in ways which match people's needs and preferences. The opportunity for new investment can rebalance the mental health service system from a reliance on high cost and high intensity clinical and NDIS services, to a suite of services with greater reach at an average lower cost.

However, CMMH/psychosocial support services are largely invisible in the current Agreement[1], including because there is no national minimum data set which captures activity, its workforce does not feature in the National Mental Health Workforce Strategy, expenditure is not counted uniformly and there is no connection to the NDIS.

It is vital that this invisibility is addressed, and that the CMMH/psychosocial support services sector is represented, and involved, in the proposed new policy architecture. This submission focuses on the elements moving forward which need to be expanded to ensure that the next Agreement actively invests in, coordinates and monitors the contribution of CMMH/psychosocial support services.

2. Comments on the draft recommendations

Draft recommendation 4.2: Building the foundations for a successful agreement.
Cross departmental coordination and commitment will be important, and we support that commitments and actions intended to improve collaboration should be in the main body of the Agreement. However, rather than establish a new mechanism through the Department of Prime Minister and Cabinet, the recommendation should support building on the expertise and capacity within the Department of Health, Disability and Ageing and the National Mental Health Commission to undertake this work, and for the commitments to be backed by appropriate funding, and mutual clauses across Agreements.

Mental health and suicide prevention is a complex area, and Departmental representatives should have a deep understanding of both how the sector works and the experience of people who use and need these services. The Department should establish (review) its working groups and their governance arrangements

[1] Expenditure by States and Territories for services delivered by non-Government Organisations in 2023/2024 was $643M or 8% of total mental health budget; Another $1.3B (49% of Commonwealth expenditure) is attributed to national programs and initiatives managed by the Department of Health Aged Care or which some would be going to CMMH via PHNs. Source: AIHW, Mental Health Online Report: Expenditure on mental health services. https://www.aihw.gov.au/mental-health/topic-areas/expenditure

to ensure that they are properly representative of service providers and service users, and to also consider internal mechanisms for ensuring that lived experience is privileged within its own processes.

The Australian Institute of Health and Welfare (AIHW) is well placed to lead the development of a nationally consistent set of outcome measures. However, reporting against the outcome measures will require new approaches to data collection and reporting if it is to capture service use and outcomes from those accessing CMMH/ psychosocial support services. (Please see further detail re draft recommendations 4.9 - 4.11).

Draft recommendation 4.3 – The next agreement should have stronger links to the broader policy environment

To ensure the necessary service integration, disability services and the NDIS need to be specifically named under this recommendation (as per Actions 2.7 and 7.6 of the NDIS Review), with clear and specific responsibilities for both Health and Disability Ministers in each jurisdiction to respond to psychosocial unmet need, for the outcomes and wellbeing for people with psychosocial disability within the NDIS, and for the sustainability of their shared service provider market.

Draft recommendation 4.4: Immediately address the unmet need for psychosocial supports outside the NDIS

The renegotiation of the Agreement provides a timely opportunity for governments to commit to providing psychosocial support outside of the NDIS which responds to people's needs and support preferences. It should also consolidate this response with agreed actions regarding the recommendations from the NDIS Review for new foundational and early intervention supports.

Our recommendation is that Governments commit to the provision of recovery focused (capacity building) community based and managed mental health and psychosocial supports across the continuum of need, with flexible access to reflect fluctuating need and with a clear pathway into the NDIS for the provision of individualised "practical" support where required.

The existing range of evidence-based and recovery focused services, such as the Commonwealth Psychosocial Support Program and similar state funded programs, provide a solid foundation to build such as response and which could be expanded immediately. The APA is well placed to work with governments and the mental health lived experience peak organisations to provide a roadmap as to what this would look like.

It is important that this action is not delayed if the negotiation of the new Agreement is put back by a year.

Draft recommendations 4.6 – 4.8: Increased transparency and effectiveness of Governance

The APA is supportive of the recommendations regarding increased transparency and effectiveness of governance arrangements.

We welcome the specific statement regarding a greater role for the broader sector in governance (draft recommendation 4.8). The mental health sector is broad and dominated by clinical (hospital) services. It is vital that the next agreement gives a stronger voice to community based and managed services and the people, their families, carers, kin and other supporters who use these services. As mentioned earlier, the Department of Health, Disability and Ageing needs to build its expertise in this area and develop a deeper understanding of the community based and managed sector, including to establish the partnerships and relationships with providers and service users for input, guidance and support.

The newly established National mental health consumer and carer peak organisations also need to be resourced to have the capacity to represent service users, families, supporters and carers across the whole mental health sector – clinical, community managed and the NDIS - and to have the capacity to contribute effectively within the governance arrangements. Currently, this is not the case as they have limited capacity

to connect across the breadth of the service system and to invest in the analysis and policy work that is required.

A more systemic approach to overcoming the barriers to genuine participation and influence in governance forums is required. This includes:

- The appropriate resourcing of the National peak organisations and appropriate inclusion in decision making forums.
- Build into funding requirements (and fund appropriately) expectations that services demonstrate integration of lived expertise within their own governance and organisational structures. This promotes best practice but also builds overall lived and living experience capacity and availability for participation in other formal structures.
- Government agencies building lived expertise into their own structures which will embed co-design and practice and provide the authority and capability to seek and represent the voices of those with lived experience.

Draft recommendations 4.9 - 4:11 – Accountability / Information request 4.3: Public Dashboard
A report on implementation of agreed actions would be a useful accountability tool. The National Mental Health Commission should be tasked (and resourced) to ensure that this happens.

The National Mental Health Commission already has part of its responsibilities to report on the state of the mental health in Australia. The AIHW has the expertise to coordinate access to data and prepare reports. The Commission should be resourced to continue its own reporting, but also to work with the AIHW around what should be being reported. The AIHW should be required to provide up to date and ongoing (to the extent that this is possible) reporting across a range of outcome areas for which data is available. This should be independent from Government.

In addition to direct measures of mental health and wellbeing, such as those collected through the National Mental Health Survey, reportable outcomes should include:

- Change in those areas which the Agreement has set clear goals (for example, around suicide, workforce growth and change).
- System and individual outcomes that indicate good mental health and wellbeing, for example the social determinants of health/psychosocial outcomes such as housing, employment and community participation.

A key issue is the significant gap in the national reporting of service users, service provision and activities regarding mental health and psychosocial support provided by CMMH organisations.

- There is no Minimum Data Set (MDS) across States/Territories and the Commonwealth to report on the activities, service user demographics or psychosocial outcomes for CMMH/psychosocial support services. The Commission will be aware that references in AIHW data to community mental health refers to hospital delivered psychiatric community based and/or outpatient services and not those delivered by CMMH organisations.
- AIHW reports on State/Territory expenditure for CMMH/psychosocial support services under the category of *non-Government organisations*. Expenditure is provided against a range of activities and in 2022/23 accounted for 8% of the State/Territory recurrent mental health budgets. Funding from the Commonwealth for similar purposes is generally via the PHNs and is reported as part of a category

identified as Department directly funded services but there is no break down by actual service type or activity. As such it is not possible to even get a clear picture of expenditure in this area[2].

In addition to a dashboard (and/or ongoing reporting from the AIHW), data regarding service use and outcomes should be widely available and easy to access for researchers, services and service users (for example, as is the case for the Specialist Homelessness Support Services MDS and the National Disability Data Asset. This enables a broad range of interests to hold Governments (and others) accountable to stated outcomes and objectives, while also promoting and assisting with research and evaluation activities.

Draft recommendation 4.12 Support Primary Health Care Networks (PHNs) to meet local needs
The APA is generally supportive of this recommendation and agree with standardising reporting, procurement methods and data collection for the PHNs, and that National models should not restrict flexibility to commission locally relevant services. However, this flexibility should extend only to how services are designed and delivered at the local level and be the result of community/service engagement.

PHNs are now a significant service arm for the Commonwealth Department, and the Agreement does need to hold PHNs accountable around their contribution to broader Government goals and/or the objectives of the Agreement. For example, developing and supporting partnerships at the local level (inclusive of service provider and lived experience engagement), funding practices which recognise (and do not hinder) outcomes regarding workforce and sector sustainability, and promoting and developing the lived experience workforce.

Draft recommendation 4.12: National Mental Health Workforce Strategy
The National Mental Health Workforce Strategy does not include CMMH/psychosocial support workers. This needs to be addressed immediately, including to ensure an agreed scope of practice for the CMMH/ psychosocial support workforce and a nationally consistent long-term commitment to workforce development.

The CMMH/psychosocial support workforce is specialised and diverse, providing evidence based, recovery focused, trauma informed and practical support for people with mental health issues living in the community. It is the workforce that is required to meet the psychosocial unmet need and deliver the foundational and early intervention supports as identified in the NDIS Review. It is also the workforce which is most likely to include people with lived experience, in both non-lived experience roles and in lived experience roles, e.g. peer workers.

We note that the Commission is seeking case studies to highlight best practice in integrating peer workers in clinical mental health and suicide prevention settings, particularly by improving clinical awareness of the peer workforce. We would welcome you to meet with us to talk about how we have incorporated lived expertise and experience across our organisations and how this provides the necessary foundation for a fully integrated workforce which values and supports peer workers[3].

[2] A useful outcome from the Psychosocial Unmet Needs Report has been to document for the first time what CMMH/psychosocial support services are provided/ funded.

[3] The Mind Australia submission to this review also provides detailed information about best practice in this area.