Australian Government
Productivity Commission

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Mental Health and Suicide Prevention Agreement Review

Interim report

What we've heard so far

This document is an extract from the interim report.
Page numbers have been retained to aide in referencing.

Key points

* Understanding the experiences of people when they need mental health and suicide prevention services is a key part of reviewing the National Mental Health and Suicide Prevention Agreement. The reflections of consumers, carers and service provides underpin the PC's assessment of progress under the Agreement and the recommendations for future policy directions.

* To gather people's perspectives, the PC undertook meetings and site visits, received submissions and conducted an online survey. The PC spoke to people with lived and living experience, their families and carers, peer workers, service providers, practitioners and researchers, peak bodies and associations, primary health networks, hospitals, mental health commissions and government departments in all states and territories.

* In meetings and submissions, people reflected on the limited progress achieved under the Agreement and the need to develop stronger accountability mechanisms in future. Many spoke about the limited involvement of people with lived and living experience in the development of the Agreement and the urgent need to embed consumers' and carers' perspectives in policy and service delivery.

* In the online survey, consumers reflected on four key themes, including:
  * costs and waiting times
  * gaps and shortages in services
  * inadequate crisis support
  * experiences of discrimination when accessing services.

* Carers reflected on experiences of exclusion and not being able to access information and support. Practitioners spoke about the need for change in the way services are staffed and funded.

* Consumers, carers and practitioners also spoke about positive experiences of compassionate, person-centred services and the difference these made to their lives.

At the core of the mental health and suicide prevention system are the experiences of the people who need it. For some, these experiences are positive and contribute to healing and recovery. But for many, finding the right services at the right time and receiving the support they need for themselves or their loved ones is a very difficult task.

The National Mental Health and Suicide Prevention Agreement aims to create a person-centred system, improving the experiences of people who use mental health and suicide prevention services as well as their supporters, family, carers and kin. To assess progress under the Agreement, the PC undertook extensive engagement with a wide range of people and organisations. This chapter summarises what we've heard so far.

Throughout this review, we used the principles of the Review of the National Agreement on Closing the Gap (PC 2022b), to ensure engagement was:

* fair and inclusive
* transparent and open
* ongoing
* reciprocal.

To inform this review, the PC has spoken to people with lived and living experience, their supporters, families and carers, peer workers, service providers, practitioners and researchers, peak bodies and associations, primary health networks, hospitals, mental health commissions and government departments in all states and territories.

The PC thanks all review participants and acknowledges in particular the contributions of the people with lived and living experience of mental ill health and suicide and the organisations that represent them. Working towards embedding the voices of people with lived and living experience throughout all aspects of the mental health and suicide prevention system – including this review – ensures that reforms contribute to the delivery of comprehensive, compassionate and person-centred services.

The perspectives of people and organisations were gathered through meetings, submissions and an online survey. Following the receipt of the review's terms of reference in January 2025, the PC released a call for submissions. In response to this paper, the PC received 94 public submissions.[1] We also held 72 meetings and visited services and organisations in Hobart, Launceston, Brisbane and Ipswich. Between 11 February and 21 March 2025 the PC invited people to share their views and experiences of mental health and suicide prevention services via an online survey. We hosted a webinar on early messages from consultations on 11 April 2025, as part of our commitment to ongoing and reciprocal engagement.

This interim report is the next stage in the engagement process. The PC invite all interested people and organisations to share their feedback on this report through submissions and public hearings (chapter 1).
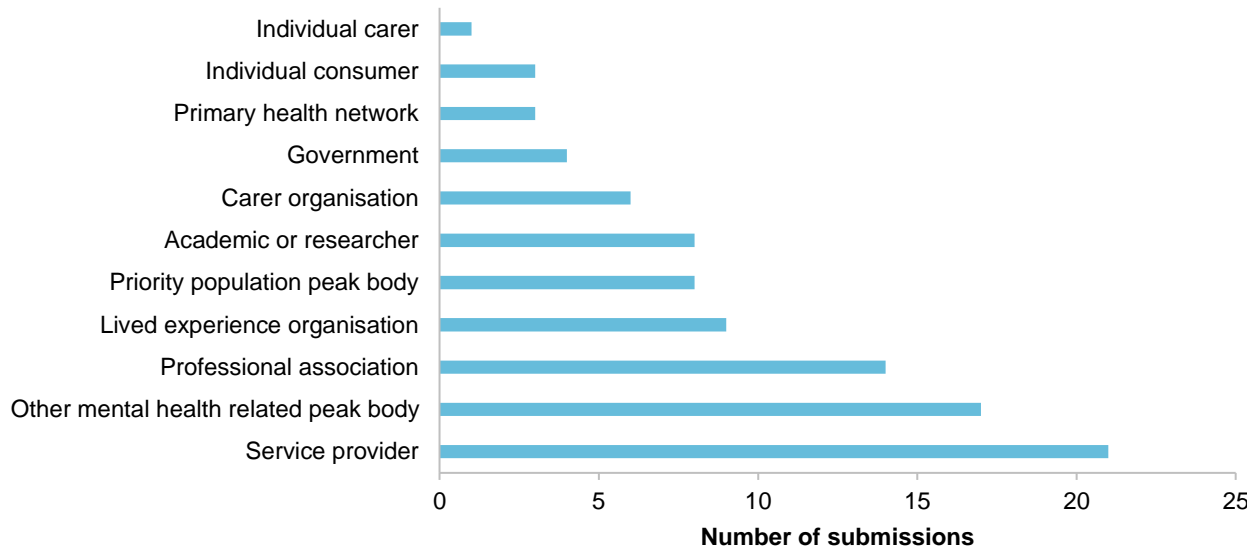
Reflections from submissions

A wide range of organisations made a total of 94 submissions, including representative bodies for consumers, carers and service providers as well as individual service providers, government agencies and a small number of consumers, carers and researchers (figure 5). We received two submissions from Aboriginal and Torres Strait Islander organisations (counted in one of the other categories related to what the organisation does). Public submissions were published on the PC website and are listed in appendix A.

Table 1 lists key themes raised across submissions. These themes have been common to multiple or many submissions. However, some submissions included information and recommendations about specific mental health conditions, specific groups of people disproportionately impacted by mental ill health or suicide, specific types of services or specific groups within the workforce. While these specific themes are not listed in the table, they have all informed our analysis. Other chapters in the report draw on specific suggestions and information in submissions and include many direct quotes and citations. Readers are encouraged to read individual submissions on the PC website to understand the range of ideas contributed by participants.

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[1] The PC received 95 submissions for publication but one was later withdrawn. The numbering of submissions on website and quoted in the interim report includes a number assigned to the submission that was provided but later withdrawn.

Figure 5 – Public submissions by type of organisation or person[a]

a. 'Priority populations' are those listed in the National Mental Health and Suicide Prevention Agreement (clause 111).

Table 1 – Key themes from submissions

The overall value of the National Agreement	Strong support for having a National Agreement on mental health and suicide prevention and for the principles within it. Concern the Agreement had failed to achieve many of its objectives and it was not designed in a way to transform the mental health and suicide prevention system. The creation of new Medicare Mental Health Centres was seen as a success of the Agreement. Delays and slower progress than planned in developing and implementing services agreed under the bilateral schedules.
The need for a national strategy on mental health	Some highlighted the absence of an overall national strategy on mental health and suggested a national strategy (linking to the National Suicide Prevention Strategy) should be developed as a foundation for the next and future national agreements.
People with lived and living experience should inform the Agreement and its governance	Many submissions highlighted the lack of input from people with lived and living experience into the development and ongoing governance of the Agreement. There was strong support for co-design of the next agreement with people of lived and living experience; and ensuring people with lived and living experience would be part of ongoing decision making in the implementation and measurement of progress for the Agreement.
Cooperation between the Australian, state and territory governments	Views were mixed about the extent to which the Agreement had improved cooperation between the Australian, state and territory governments. Some examples were provided of improved cooperation and planning in developing and implementing services. Other submissions highlighted examples of duplication, lack of consistency, poor communication and coordination and competition for qualified staff and resources between the Australian Government and state-funded services.

Contracting and commissioning of services	Many submissions called for improvements in contracting and commissioning of mental health and suicide prevention services. There have been inconsistent contracting, commissioning and reporting processes between different primary health networks (PHNs) and variations in PHN capabilities. Inconsistencies between PHNs increases costs and creates challenges for service providers working across multiple PHN regions. There is variation in the degree of communication, cooperation and coordination between PHNs (funded by the Australian Government) and state and territory government local health networks in regional planning, contracting and commissioning.

Gaps and priorities in mental health services	Submissions highlighted numerous gaps in mental health services, including:
	• insufficient availability of community-based care. There is a lack of coordination and communication between different services for people with mental ill health – including limited information sharing causing consumers to frequently retell their story
	• the importance of prevention and engaging early in distress (early intervention services) and how these can reduce the number of people needing acute care
	• the lack of, or limitations in digital health services as a supplement to face-to-face services and for consumers in locations where face-to-face services are unavailable
	• a need for greater investment in psychosocial support services for people not receiving support from the National Disability Insurance Scheme
	• the difficulties people in rural and remote areas have in accessing mental health services
	• the high cost of private mental health services and suggestions for increasing Medicare rebates for services provided by psychiatrists, general practitioners, psychologists and other mental health professionals
	• insufficient funding to improve access to mental health and suicide prevention services for all who need them
	• specific recommendations for improving the accessibility and appropriateness of mental health services for groups disproportionately impacted (priority populations) including:
	  – children
	  – young people
	  – people from culturally and linguistically diverse, migrant and refugee backgrounds
	  – LGBTQIASB+ people
	  – veterans
	  – older people
	  – people in occupations with higher rates of mental ill health and suicide.

Aboriginal and Torres Strait Islander people	Aboriginal and Torres Strait Islander people should be involved in the co-design and governance of the Agreement. Cultural capability in service provision is essential. The National Mental Health and Suicide Prevention Agreement should deliver on priorities identified in the National Agreement on Closing the Gap. Strong support for the Gayaa Dhuwi (Proud Spirit) Declaration Framework and Implementation Plan and the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy.
Carers	The role of carers is vital to improving outcomes for people with mental ill health but there is little support for carers under the Agreement. Carers need greater information, support and resources.

	Clinicians should ensure carers are informed about the treatment needed by those they are caring for as they are the people providing care every day and need to know about treatments and medications.
Addressing social determinants – a whole-of-government approach	Social determinants such as housing and homelessness, education, employment and interactions with the justice system have significant implications for mental health and suicide prevention. Action from agencies across governments is required to improve outcomes for people with mental ill health.
Mental health and suicide prevention workforce	There are workforce shortages across most professions working in mental health and suicide prevention. Peer and lived experience workers were identified as particularly important for improving outcomes. Improved training is needed across the mental health and suicide prevention workforce
Accountability and evaluation	There has been little accountability for delays or lack of progress against outputs under the Agreement. There is strong support for regular, timely public reporting of progress against key indicators of outcomes, with reporting overseen by an independent body Programs and activities funded under the Agreement should be evaluated to inform policy and practice.
Data	Many submissions called for a national data framework, consistent data standards and a national minimum data set to provide a foundation for measuring performance against the Agreement.
Evidence-based practice	Research and evidence of good practice and what works in services and treatments are readily available but do not always inform mental health and suicide prevention services.
Suicide prevention	There was widespread support for the National Suicide Prevention Strategy. Many submissions called for a greater focus on suicide prevention in the Agreement.

Reflections from meetings and visits

The PC held 72 meetings with organisations and individual people between February and May 2025. Of these, 18 were in person meetings in Canberra, Brisbane, Ipswich, Hobart and Launceston, and the remaining 54 meetings were virtual online meetings. People and organisations the PC met with are listed in appendix A.

Of the 72 meetings and visits:

• nine were with organisations representing people with lived and living experience of mental ill health and suicide
• four were with organisations representing carers of people with mental ill health and suicidality
• 25 were with government agencies (six mental health commissions and 19 other government agencies)
• nine were with organisations providing services to people with mental ill health and suicidality
• five were with primary health networks (PHNs) and PHN representative bodies
• five were with other advocacy and peak bodies in the mental health and suicide prevention sector
• three were with organisations representing professions working in mental health and suicide prevention
• seven were with Aboriginal and Torres Strait Islander people and organisations

- four were with individual people with lived and living experience of suicide or mental ill health
- one was with academics/researchers.

As might be expected, there is overlap in the themes identified from meetings and visits with the themes found in submissions. However, each type of engagement highlighted different aspects of these themes.

Table 2 – Key themes from meetings and visits

The overall value of the Agreement	General support for having an Agreement in principle, but concern the current Agreement has failed to achieve many of its objectives and commitments
	The Agreement has resulted in some increase in coordination between Australian, state and territory governments' commissioning of services but with scope for much more improvement.
	Expansion of Medicare Mental Health Centres has been valuable
	There is not a clear connection between the Agreement and the bilateral schedules between the Australian, state and territory governments.
	A desire from some participants for greater consistency across jurisdictions and bilateral schedules and some funding for national services (such as telephone or digital services). However, some providers, state and territory governments and primary health networks favoured more regional and local flexibility.
The need for a national strategy on mental health	Support for a longer term national mental health strategy to provide a foundation for any future national agreements.
	A strategy could provide a program logic or theory of change that is lacking in the current Agreement.
People with lived and living experience should inform the agreement and its governance	The Agreement was developed with very limited input from people with lived and living experience and there is limited lived and living experience input into the ongoing governance and implementation of the Agreement.
	The next agreement should be co-designed with people with lived and living experience who should also be part of decision-making in the ongoing governance and implementation of the next agreement.
	Input from people with lived and living experience is gradually becoming a more common feature in mental health and suicide prevention services and the creation of new peak bodies for consumer and carer lived experience is valuable.
Cooperation between the Australian, state and territory governments	Inconsistency in how the Agreement has been implemented between states and territories.
	Cooperation and coordination between Australian, state and territory government agencies varies, some going well and others problematic.
Contracting and commissioning of services	Inconsistent contracting and commissioning processes across the 31 primary health networks (PHNs) increases administrative burdens and costs for service providers.
	Some PHNs and state and territory government local health networks have good relationships and are working well together to provide co-commissioned, collocated and coordinated services, planning and avoiding duplication, whereas in other regions they are not working well together.
	PHNs do not always have autonomy to commission services that best meet local needs as they are required to adhere to national policies and guidelines about locations, the nature of the services and who is eligible for them. This makes it difficult for service providers to meet local community needs.
	Commissioning processes are sometimes rushed.

	Short term contracts impose uncertainty and create insecurity for service providers, staff and consumers.
	The Agreement does not provide an opportunity for funding of services that might be better commissioned nationally such as digital or telephone services.
Gaps and priorities in mental health services	Medicare Mental Health Centres are providing services for people who do not require hospitalisation but whose needs are greater than can be met by some other services in the community.
	The rebranding of Head to Health services to Medicare Mental Health Centres dissuades some people from using them.
	Restrictions on eligibility to receive services is preventing access for some people but some providers and PHNs are working to make services as accessible as possible.
	Some Medicare Mental Health Centres have attracted large numbers of consumers and have waiting lists.
	People in rural and remote areas have significantly less access to services than those in urban areas.
	Some people need acute care and there is need for additional beds in hospitals but greater focus on prevention and engaging early in distress (early intervention) can reduce the need for hospitalisation.
Aboriginal and Torres Strait Islander people	Separate funding streams for social and emotional wellbeing and mental health services from the National Indigenous Australians Agency and the Australian Government Department of Health, Disability and Ageing create additional administrative burdens for service providers.
	The transition of funding of services for Aboriginal and Torres Strait Islander people from mainstream to Aboriginal and Torres Strait Islander community-controlled organisations as required under the National Agreement on Closing the Gap is slow or yet to happen.
	The Aboriginal and Torres Strait Islander peer workforce should be expanded.
	The Social and Emotional Wellbeing Policy Partnership and Aboriginal and Torres Strait Islander people should have a much greater role in shaping and overseeing the next agreement.
	Governments, PHNs and mainstream service providers talk about the importance of Aboriginal and Torres Strait Islander people but do not genuinely partner with or hand over control to Aboriginal and Torres Strait Islander people and organisations.
Carers	Clinicians do not always recognise carers and include them in conversations about the care of the person with mental ill health. Some clinicians make an effort to include carers, but consumer privacy and confidentiality can preclude this, as can restrictions on Medicare and other funding for clinicians to spend time with carers.
	Carers do not always identify themselves as carers, which creates a barrier to obtaining support and information as well as care for their own physical and mental health.
	Caring for someone with mental ill health can be very isolating and difficult and increased availability of respite care is important.
Addressing social determinants – a whole-of-government approach	Housing and homelessness, education and interactions with the justice system are important social determinants that affect the outcomes of mental health and suicide prevention services.
	The Agreement has relatively little effect on agencies across governments that provide services and oversee policies related to these social determinants, despite the inclusion

	of Schedule A (chapter 1) and the existence of cross agency groups and committees in each jurisdiction.
	Many participants called for a greater focus on social determinants, particularly housing and homelessness.
Mental health workforce	Shortages were identified across a range of professions in the mental health and suicide prevention workforce.
	Addressing workforce needs is an important part of the Agreement and the National Mental Health Workforce Strategy was welcomed but there was concern that it was yet to be implemented.
	Australian, state and territory government funded services in local areas were often competing for workers. State and territory health services were also competing against each other for the same workforce.
	A range of participants suggested extending Medicare funding – increasing the total number of sessions covered, increasing payments to reduce gap fees for clients and extending eligibility to a wider range of clinicians and workers.
	The peer workforce was identified as important to improved consumer outcomes but required more training and support.
Accountability and evaluation	Many participants noted a lack of accountability mechanisms under the Agreement and that this contributed to a lack of progress.
	There should be financial consequences if jurisdictions fail to achieve outcomes or to provide data, financial reports or information for reporting.
	There was strong support for restoring the independence of the National Mental Health Commission and its ability to monitor and report on outcomes and progress against the Agreement.
	Evaluation is important but the data for evaluation is not always available.
Data	There is a lack of data on suicide and suicide attempts.
	A dashboard publishing data on outcomes from the Agreement would improve accountability and transparency.
	There is very little transfer of data and information between hospitals and community providers with negative impacts on continuity of care for consumers.
	Developing new data sets can be slow because of the need to ensure confidentiality, negotiate data linkage with different jurisdictions and data custodians and ethics approval processes.
	Developing consistent national data sets is difficult, not all jurisdictions have resources to implement new data specifications, and data specifications may not be consistent with clinical practice.
	Service providers can have contracts with multiple funding sources each with different data requirements.
	A lot of data collection is focused on outputs and not outcomes.
	Good data is a foundation for sound evidence upon which to base services.
Suicide prevention	Aftercare following a suicide attempt is sometimes only available to those who have presented to a hospital emergency department. People should be able to seek aftercare directly and not via a hospital.
	Many people attending emergency departments following suicide attempts do not receive any ongoing support.
	There is insufficient suicide prevention support for people in a suicide crisis.

Reflections from the online survey

The online survey was designed to explore three broad research questions that map onto the Terms of Reference for the review of the Agreement:

- what gaps and shortcomings in mental health and suicide prevention services have people experienced?
- what changes in service provision have people seen in the past three years?
- what are some examples of good service provision and system improvement that people have experienced or would recommend?

Appendix A provides details of the methods used and sample characteristics. A total of 293 people participated in the survey (table A.3). 10 of these were excluded from analysis because they left the main questions unanswered, and a further nine were excluded from analysis because they did not provide consent.

Respondents could identify as a consumer, carer or worker/volunteer in service provision. We categorised respondents as consumers if they selected 'I have used mental health or suicide prevention services'. This is intended to be inclusive of people who identify as having lived (past) and/or living (current) experience of mental ill health, irrespective of whether they have a formal diagnosis, who have accessed mental health services and/or received treatment, and inclusive of people who have accessed suicide prevention services and people who have experienced distress, attempted suicide, cared for a person experiencing distress or have been bereaved by suicide.

Of the 283 respondents who answered the main survey questions, nearly 75% identified as consumers. About one third identified as carers and about one quarter as workers/volunteers in service provision. Many respondents identified as belonging to more than one of the three main respondent categories. For example, 39 respondents identified as both a consumer and worker/volunteer in service provision, 38 identified as both a consumer and carer and 17 identified as a consumer, carer and worker/volunteer in service provision. The location that respondents reported as their primary residence broadly reflected the distribution of the Australian population. About 2% (n=5) of respondents identified as Aboriginal or Torres Strait Islander.

Care should be taken interpreting the findings of this qualitative study. The study is based on a non-probability sample (convenience sample) and therefore the findings are not generalisable to the population level. The recruitment methods used have meant some potential respondents have been systematically excluded (for example, people who are too unwell to participate and people who cannot access the survey online). The open-ended questions we asked meant some individual respondents could share views and experiences from multiple perspectives (consumer, carer and/or volunteer/worker) and raise issues outside the scope of the Agreement or the Terms of Reference for the review. The subjective interpretation of the data, which may reflect the researchers' positions and perspectives on the issues raised, will have influenced the findings of the thematic analysis.

A description of the main themes in responses from consumers, carers and service providers is presented below, including some illustrative extracts (verbatim quotes). Minimal edits have been made to the verbatim quotes and only where necessary to improve clarity, remove any obvious typographical errors contained in the original and to preserve anonymity and confidentiality. Labels in brackets after each extract refer to the identification number we assigned to each survey respondent (sr.).

Main themes in the survey responses from consumers

The survey showed many consumers feel unable to access sufficient and appropriate care and support for their mental ill health. Many point to similar obstacles, such as inadequate availability and accessibility of some essential services (e.g. shortages of psychiatrists, psychologists, crisis support), long waiting times and high costs for using services as well as experiences of discrimination when using services (figure 6).

Positive experiences and feelings towards the mental health and suicide prevention service system were reported by some consumers, but these were less common. Sentiment analysis found 64% of consumer responses to the survey questions were very negative/moderately negative and 36% were very positive/moderately positive.

Figure 6 – Main themes identified in consumer responses

Theme 1 **Waiting times and costs**	Waiting times and costs of services act as a major barrier and deterrent to accessing the mental health care that people are seeking	Theme 2 **Gaps and shortages in services**	Inadequate acute care (hospitals) and shortages of primary and specialist providers (GPs, psychiatrists, psychologists) prevent many people from receiving quality treatment and support
Theme 3 **Inadequate crisis support**	When people are experiencing a mental health crisis or suicidal distress, the available care and preventive supports are not always responsive or appropriate	Theme 4 **Discrimination when using services**	People often experience discrimination and re-traumatisation when using services

Consumer theme 1: Waiting times and costs

A major theme in what we've heard from consumers is that there are significant barriers to accessing services because of the long waiting times and high costs. Many respondents told us about their experiences of long waiting times for accessing treatment and support, in acute settings as well as in primary, specialist and allied care settings. In acute settings such as hospital emergency departments (EDs), the long waiting times before receiving treatment often added to the distress people were experiencing at the time.

> The ED department would have been fine, except i sat there alone for 12 hours only to have a psychiatrist at the end of sitting there for 12 hours telling me i can go home. If anything it made me more distressed. (sr. 226)

> Hospital made me wait 6 hours to be seen for 5 minutes sent me back out to the waiting room so I left without being properly assessed. (sr. 237)

The waiting times for accessing mental health services in community settings can also be substantial.

It's now almost 12 months since hospital and I still have not been able to access any support for my mental health or my living conditions exacerbating the issues. I am on a 16 week wait list to see a general mental health worker at the local health centre. (sr. 140)

I was on waiting lists for close to a year. (sr. 246)

Because of the long waiting times experienced, some people felt their mental health and wellbeing was put at risk or declined further.

The services that are accessible with a mental health care plan are difficult to get into (with long wait times and long times in between appointments) which does not facilitate mental health. (sr. 63)

I have the highest level of health insurance & have been on a waiting list to be admitted for almost 6 months with no time frame at all … While my condition is getting worse (sr. 227)

The experience of long waiting times also appears to discourage some people from seeking the help they need.

Inadequate services, wait times too long, couldn't stay on hold any longer. (sr. 142)

The waiting lists are getting longer, bulk billing is disappearing, and people are avoiding doctor visits due to financial issues. (sr. 149)

The services simply ask for consumers to show respect, but it seems that respect isn't always reciprocated. Just take a look at those long waiting times! (sr. 149)

We also heard that combined with the long waiting times, the financial costs individuals face for obtaining mental health care and support can put services out of reach for many people.

Mental health and suicide prevention services are incredibly expensive or time consuming. If you request a mental health plan from non-bulk billing GPS (as bulk billing GPS are incredibly difficult to get appointments), you are already out of pocket. This means these life saving services are inaccessible. (sr. 63)

I stopped seeing my psychologist because I couldn't afford it. (sr. 37)

People on a fixed and/or low income told us that high costs of services represent a major barrier to them accessing treatment and support.

when I have needed to most, it's been completely cost prohibitive and I could not access the care I needed. There is almost no support available for the unemployed or underemployed. (sr. 89)

outpatient services are overbooked and have lengthy delays or are massively expensive. And as someone who is currently unable to work due to the exacerbation of my mental illness during and after covid, it is very difficult to access the appropriate level of support. (sr. 135)

I am forced to rely on welfare meaning even with a mental health plan, appropriate care is entirely unaffordable. (sr. 137)

Some consumers also said they did not have any support navigating through the service system to overcome barriers such as long waiting times and out-of-pocket costs.

> They tell you to see a gp and get a mental health care plan. That's not immediate help and there's a large out of pocket cost also. (sr. 211)

> I took a day off work (unpaid) to see GP for a mental health plan, he did not know who to refer me to and told me to go and find a service myself. when I did the research I found zero services available in Dubbo, only one service had open books with a six month waitlist. (sr. 213)

Regarding the private system, we heard that the high costs of such services are also prohibitive for many people.

> I cannot afford private mental health admissions so I suffer alone at home. (sr. 122)

> I was referred to residential treatment programs but these were all in the private sector. I had to drop my private insurance due to financial constraints which means I could not access them. (sr. 89)

When asked about any changes in services they've noticed over the past three years, many respondents said they felt waiting times had become longer and costs had also increased, making services less accessible and less affordable for them.

> In regional areas the availability, access and affordability has dramatically reduced (and it was poor to begin with). (sr. 126)

> Getting worse, less services available, longer wait times or all have closed books. (sr. 213)

> When we had COVID was allowed 20 sessions covered. This was great. Now back down to 10 that may cover 10 months going once a month. Does not help the long term patients at all. (sr. 248)

Consumers gave a range of suggestions for reducing the barriers to services and improving accessibility (figure 7).

Figure 7 – Suggestions for reducing barriers and improving access to services

Increase information for consumers and support with system navigation

"You need to advertise services and to everyone not just certain age groups. Parents need to know where to take their child and friends need help in helping others. (sr. 048)"

"Public awareness campaigns need to continue with open mental health discussions to 'normalise' diagnosis and treatment options. Mental health needs to become a recognised part of health as a whole. (sr. 209)"

"You need some sort of advocacy support out here. Like a support coordinator for folks who are really struggling just to eat or whatever let alone figure out which hoops to jump through and actually do it. I needed my hand held. (sr. 252)"

Provide better resourcing for the mental health service system

"More funding, resources and options in the public system to stop people falling through the cracks. (sr. 019)"

"People need greater access to affordable and timely ongoing care and management of mental ill health. This would ultimately lead to less times of reaching "crisis" point. (sr. 043)"

"Please provide better fast responses and people focused services in rural and remote places. (sr. 056)"

"There needs to be more funding for services outside of the system that has alternative ways of doing things. That don't involve calling police or CATT or sectioning or risk assessments. Fund peer support outside of the system. (sr. 270)"

Reduce pressure on the mental health service system by increasing the range and flexibility of services on offer

"I think the service system continues to be far too fragmented and way too reliant on clinical services. The only way I see this changing is by communities being given more say over how supports are delivered locally. (sr. 189)"

"There needs to be more help within the community to support families with respite, continuity of care, and options other than going to the ER for 20 hours. (sr. 206)"

Increase the supply, quality and capacity of workers to provide mental health and suicide prevention services

"GPs should receive greater training in medication and have the right tools and funding to follow up with patients in an emergency. (sr. 089)"

"We need nurse practitioners that make home visits to mentally ill people (public and privately funded) to support outpatient care. (sr. 231)"

"Increase the number of psychiatrist trainees annually to reduce the wait times for private psychiatry. (sr. 262)"

Consumer theme 2: Gaps and shortages in services

Many consumers have experienced gaps in services. The context of many such experiences is hospital-based services. Consumers told us about experiences of not receiving adequate treatment for their mental health care needs when presenting to hospital emergency departments or when admitted to inpatient facilities.

> I have been taken to hospital numerous times and every time they have said the mental health team isn't here, theres no beds, go home and someone from the mental health team will call you. (sr. 30)

> When I first went to hospital people kept saying "you will be okay with supports in the community" but no one told me what they were or how to access them. (sr. 148)

Many also said they did not feel their needs were recognised or respected while in hospital.

> Services at hospital are judgemental, rude, disrespectful and make everything worse. Hospital is not a safe place for someone suicidal due to staff ignorance and restrictive practices. (sr. 256)

> The treatment from the mental health team was not good for the most part in the acute care space. They made me feel like I was not worthy of help. (sr. 265)

However, some respondents also described positive experiences when they've used hospital-based services.

> Psychiatric treatment involving medication and Hospitalisation have saved my life on a number of occasions. (sr. 245)

> The hospital staff were really compassionate and listened to me when I was voluntarily admitted. (sr. 135)

Beyond hospitals, many respondents told us about experiencing difficulties getting access to key mental health services across the primary, specialist and allied care system in the community. For example, many told us about difficulties accessing psychiatrists.

> I have been unable to find a psychiatrist and psychologist (both public and private) who are accepting new patients in the past 4 years after my old ones retired. (sr. 30)

> During a period of severe mental illness, the only way I was able to get on a psychiatrist's books in under 6 months was to check into hospital privately, at significant expense too (top tier insurance premiums). (sr. 34)

Similarly, many respondents told us about difficulties accessing psychologists, with several highlighting the limited access to publicly subsidised consultations.

> I can only get 12 visits to a psychologist - how is that going to fix years of trauma and clinical major depressive disorder and PTSD? (sr. 25)

> 10 psychologist sessions a year is not enough. (sr. 116)

> There are no bulk-billing psychologists available within reach. (sr. 137)

> No psychologist will treat me as i can only get 10 govt funded mental health sessions per 12 months, I have been told again and again that unless I can afford 40 sessions over a year they cannot help. (sr. 173)

Difficulties accessing general practitioners (GPs) for primary mental health care were also reported by many respondents.

> Can't get a gp that's less than a months wait. (sr. 109)

> Can't get and afford a Gp or psychologist. (sr. 188)

> GPS have closed books in our region also, at least a three week wait for appt it you can get one. (sr. 213)

Experiences of local gaps and shortages in service provision, particularly in rural and remote areas, were also reported by many consumers

> There is a single sub-acute mental health service in the NT that is based in Darwin, and is only available for people who can physically get to the office. (sr. 76)

> Live in regional NSW and people need to travel over 200kms (minimum) for inpatient support where the is rarely adequate support provided and they are released to find their own way home whilst still unwell. (sr. 111)

In addition to concerns about limited availability and accessibility, many people raised concerns about the quality of mental health services.

> Have no confidence in the local services, poorly staffed (attitude, skills, training or experience), too quick to apply medications, no holistic approach. (sr. 126)

> This system is alienating, inadequate, ill-informed, and under-resourced to the point where it is literally costing lives. (sr. 137)

We also heard how the poor quality of some services had sometimes adversely impacted people.

> The reason I haven't used any mental health or suicide prevention services in the past 3 years is because of the large number of very negative experiences I have had in the past when I've tried to reach out for help. (sr. 36)

> Trying so hard to find help for myself drove me even further into suicide because of the trainees in these services. They couldn't care less. (sr. 68)

> Intake processes are not trauma informed and have often left myself and my loved ones re-traumatised. (sr. 98)

> Feeling invisible when left to wait for hours to be seen. Nurses ignoring my distress. Psychs not respecting identity and questioning my experiences. (sr. 230)

Based on consumer responses, it appears gaps and shortages in service availability and the inconsistent quality of services are sometimes exacerbated by fragmentation in the service system and by a lack of coordination and continuity in care.

> I've not once had a clinician interact with another, apart from when I was hospitalised for an extended period of time. (sr. 05)

> In-patient programs only take us so far. No reintegration and community care/support once discharged. No offer of outpatient programs. (sr. 54)

> Emergency services called. Taken to ED - spoke with MH Nurse/Social workers then discharged with no plan, no referral to other services, no safety plan. (sr. 91)

In terms of changes over recent years, some consumers said they had seen some slight improvements, such as a wider range of services becoming available. To some extent, these have addressed gaps in services.

The existence of more alternatives to ED is a positive change. (sr. 18)

There have been lots of positive introductions into the system over the past few years, like safe spaces and head to health centres. (sr. 22)
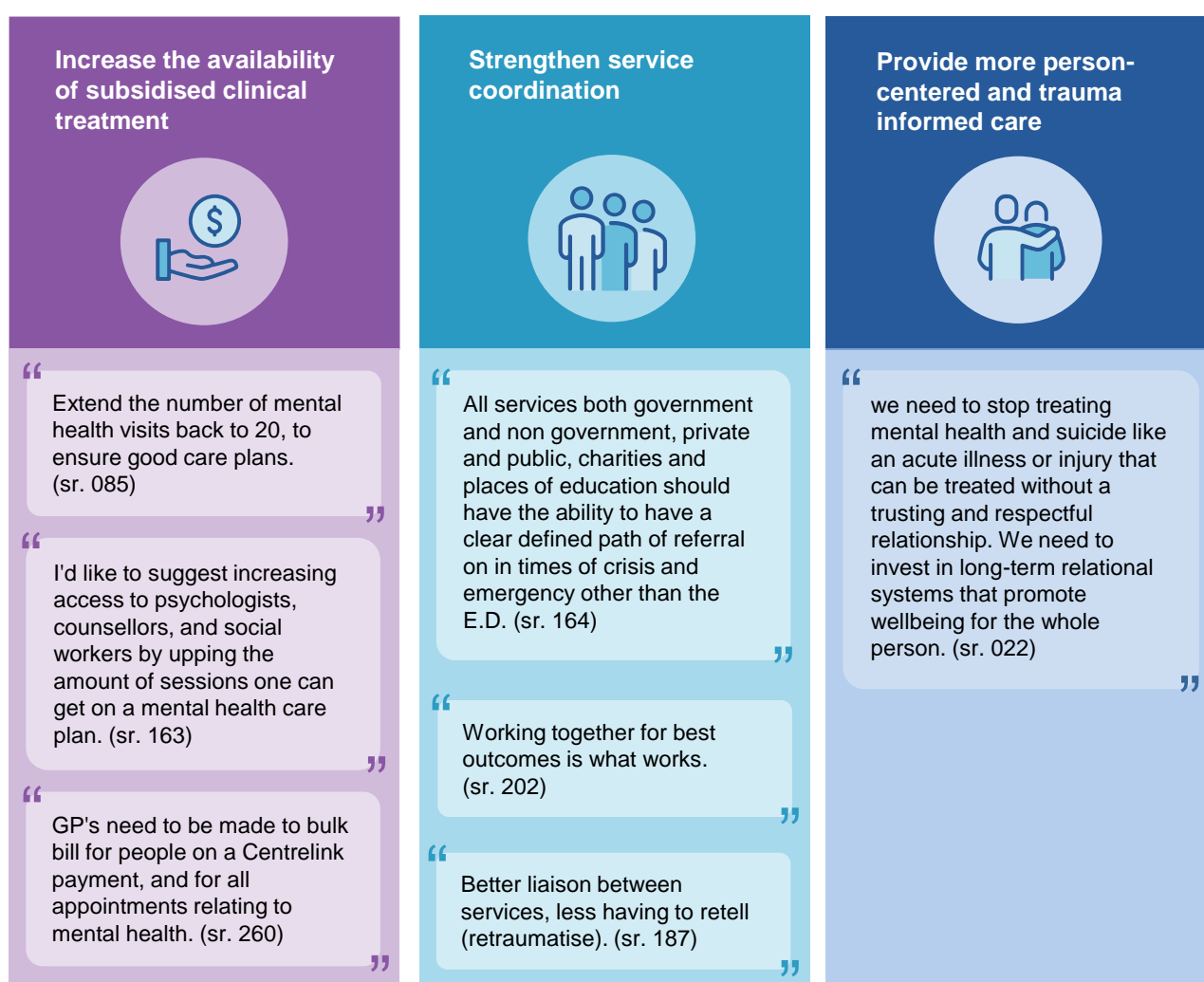
as some services are starting to focus on including lived experience people in the workforce, services are becoming kinder. (sr. 76)

There seems to be a few bulk billed organisations that offer services now. (sr. 183)

There seems to be more support available, but the waitlists are longer, prices are higher, and accessibility doesn't seemed to have effectively changed. (sr. 196)

Consumers gave a range of suggestions for improving service accessibility, system integration and service quality (figure 8).

Figure 8 – Suggestions for reducing gaps and shortages in services

Increase the availability of subsidised clinical treatment	Strengthen service coordination	Provide more person-centered and trauma informed care
"Extend the number of mental health visits back to 20, to ensure good care plans. (sr. 085)"	"All services both government and non government, private and public, charities and places of education should have the ability to have a clear defined path of referral on in times of crisis and emergency other than the E.D. (sr. 164)"	"we need to stop treating mental health and suicide like an acute illness or injury that can be treated without a trusting and respectful relationship. We need to invest in long-term relational systems that promote wellbeing for the whole person. (sr. 022)"
"I'd like to suggest increasing access to psychologists, counsellors, and social workers by upping the amount of sessions one can get on a mental health care plan. (sr. 163)"	"Working together for best outcomes is what works. (sr. 202)"	
"GP's need to be made to bulk bill for people on a Centrelink payment, and for all appointments relating to mental health. (sr. 260)"	"Better liaison between services, less having to retell (retraumatise). (sr. 187)"	

Consumer theme 3: Inadequate crisis support

The inadequate availability of appropriate care and preventive supports for people who are experiencing a mental health crisis or suicidal distress is another major theme in consumers' survey responses. Many consumers felt these services are not always as accessible, responsive or appropriate as they need to be.

emergency departments not equipped for mental health crises. (sr. 06)

It has been hard to navigate available services. There is a lot of information available online, but sometimes it's not exactly what you need in the moment. (sr. 56)

at times in the last 3 years I have been suicidal but there are not many services which could have helped me. (sr. 202)

A lot of times you are unable to get support if you don't fit into a certain box. This creates hesitancy to reach out as it becomes to much to try and work through. (sr. 254)

There are no services to help in a crisis. (sr. 256)

We heard many examples of poor continuity of care following treatment for a crisis and a lack of ongoing suicide prevention support.

There are mental health lines … however these are strictly crisis management, do not provide multiple sessions and are not tailored to early intervention (sr. 38)

Whenever I have a crisis or suicide attempt, they have kept me overnight in ED then send me home the next morning with no follow up usually! (sr. 122)

There's no continuity of care in the public mental health system, and therefore trauma-informed care is not possible. (sr. 132)

Only crisis care and then you're thrown to the community with no follow up at all and just hopes that you'll figure it out yourself. (sr. 123)

Services are still only geared for people in crisis … There is no on-going suicide prevention support for people not in crisis, this hasn't changed and I don't see it even on the radar. (sr. 212)

Safe spaces are seen by many respondents as valuable and important during a crisis. Safe spaces are drop-in services for people experiencing suicidal crisis that provide welcoming and supportive environments aimed at reducing distress. These recognise that clinical services such as hospitals emergency departments are often not ideally suitable or safe for people in distress. However, many told us these are difficult to access.

The only public service I've interacted with was the local Safe Haven while suicidal. When I could access it, it was incredibly helpful and high quality … but such limited hours. (sr. 34)

I would like more availability of non-clinical drop in services so they can be accessed 24/7. (sr. 83)

I desperately needed help, my family were trying everything, but there is nowhere safe to go. (sr. 134)

When I needed suicide prevention services, alternatives to hospital were not available. It is great to see that now there are more services you can access when feeling suicidal. I think if these

services were available when I needed them it would have been a better experience than hospital. (sr. 194)

There are no services for urgent situations besides going to the ER, which is a terrible place to go when you are in crisis and results in exhaustion and no actual help. (sr. 206)

Many respondents also told us about experiencing poor quality care or negative experiences when they had used services during a crisis.

Clinicians who didn't listen to me, misdiagnosed me or left me in dangerous situations. (sr. 41)

Let me just remind you that, if you want to seek medical help while your feeling suicidal your going to be forced to pay over 1000$ for an ambulance to come and lock you in a mental ward. (sr. 58)

In many instances they have been incredibly harmful and damaging, and this has left me with trauma that has had and continues to have a significant negative impact on my life. (sr. 65)

I have yet to find any public hospital settings to help with a crisis which wouldn't make me more suicidal and depressed. (sr. 89)

The impatient psychiatric ward was extremely unhelpful. Even though it kept me safe, I experienced a lot of traumatic events there. (sr. 112)

Presenting to emergency suicidal and being sat in the waiting room 8 plus hours, then spending the night in a hard chair with little to no support. (sr. 184)

Though not common, involuntary services (restrictive practices/interventions) were highlighted by some respondents as a source of distress they have experienced when receiving treatment during a time of crisis.

The involuntary service made me lose my job, has left me physically worse off and discredited me further. (sr. 57)

Public mental health services and community treatment order made me suicidal. (sr. 118)

When I present to hospital suicidal, they treat me like a prisoner and give me no support. (sr. 122)

Experiences of using phone services during a period of suicidal distress or in a crisis were reported by many respondents. Overall, there are mixed feelings and experiences about these services. Some people told us about negative experiences when they have used crisis phone services.

Both services actually increased my suicide risk. Neither informed me at the start they had a 20 minute limit, so conversation was wound up unexpectedly when I was unprepared. I felt vulnerable, foolish, even more worthless than at the start of the call, and more suicidal. (sr. 31)

At times where I've used crisis lines, the hold music has made me more suicidal, and the lack of instant grounding techniques used have been a struggle. (sr. 93)

all called triple 0 when all i needed was someone to talk to in person. Doing this, forced me to go into hospital where i was stuck in the ED for over 12 hours. (sr. 226)

However, some also told us about positive experiences of using phone services.

> The phone lines help you connect to a human who is empathetic to your situation … The human connection is vital for isolated individuals. (sr. 42)

> The person on the phone helped. I hear they use volunteers a lot, that's why they are so busy. But very helpful. (sr. 181)

> an amazing service, I can tell the responders are better trained. (sr. 231)

And some people told us about having inconsistent experiences.

> I have had a good experience where the person and I talked for an hour, taking me out of a crisis state and calming me down. However, I have had other times where they either do not answer or provide extremely unhelpful comments/advice that further escalated the state I was in. (sr. 112)

> it was relief to talk to someone and to make a plan for how I am going to get support/manage the immediate crisis. However, this experience isn't consistent as i have had some people from [service provider] be less helpful (eg. I'm telling them I have thoughts of suicide and she tells me to have a cup of tea) (sr. 162)
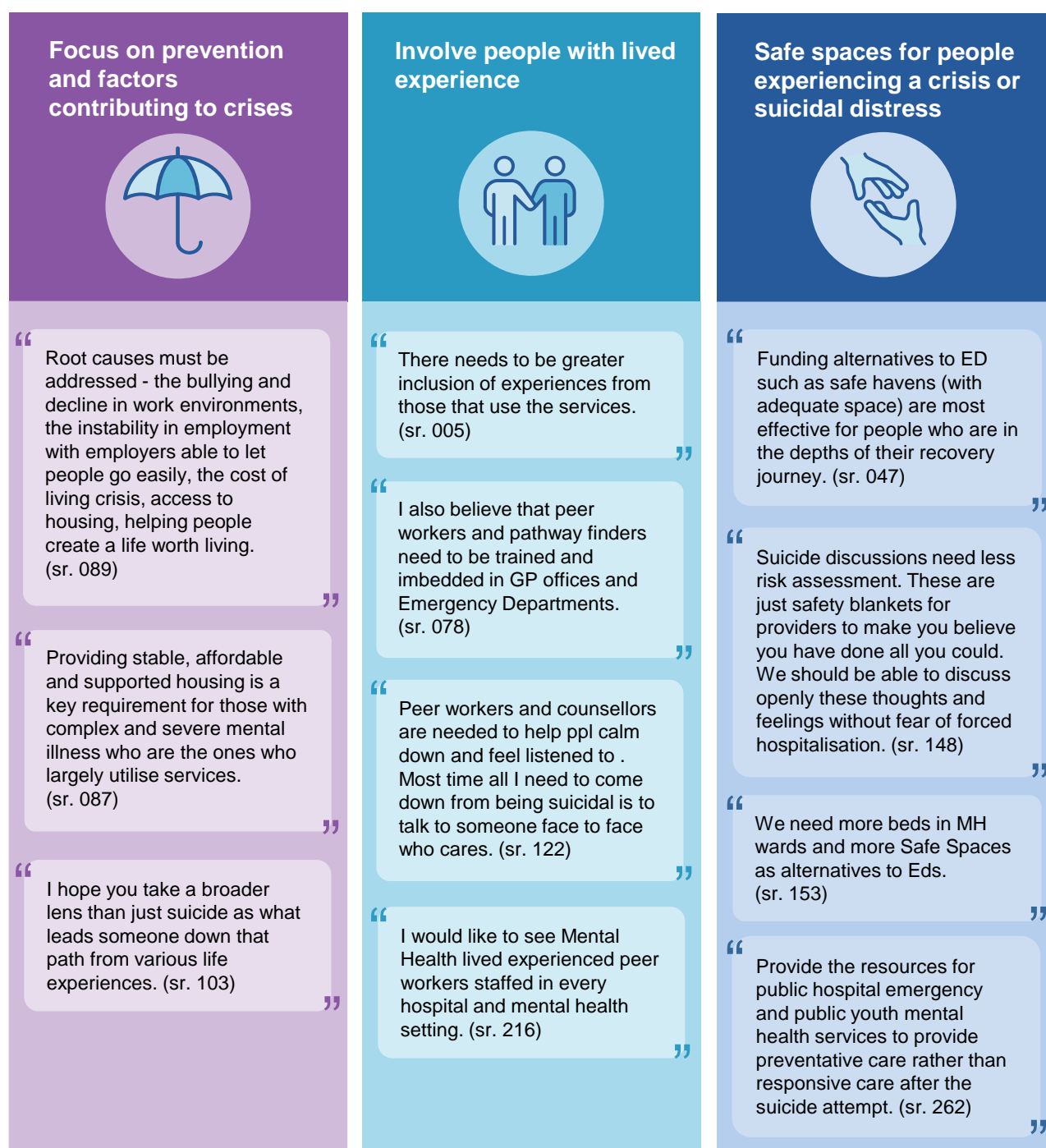
Many said they benefited from person-centred and less clinical services, particularly where services employ peer workers or involve people with lived and living experience in service delivery.

> We need more non clinical peer led services and peer support. Peer support saved my life. MH clinical support services were traumatizing and harmful as was the ED experience (sr. 110)

> Thank god for peer support workers liaising with medical professionals to advocate with me (sr. 202)

> i wanted to talk to someone who had been through what i had and not give me the pity look which i hate (sr. 255)

Respondents (including consumers, carers and people working/volunteering in service provision) gave a range of suggestions for addressing suicidal distress and mental health crises and improving the support available for people at risk or experiencing these issues (figure 9).

Figure 9 – Suggestions for preventing and responding to mental health crises and suicide

Focus on prevention and factors contributing to crises

"Root causes must be addressed - the bullying and decline in work environments, the instability in employment with employers able to let people go easily, the cost of living crisis, access to housing, helping people create a life worth living. (sr. 089)"

"Providing stable, affordable and supported housing is a key requirement for those with complex and severe mental illness who are the ones who largely utilise services. (sr. 087)"

"I hope you take a broader lens than just suicide as what leads someone down that path from various life experiences. (sr. 103)"

Involve people with lived experience

"There needs to be greater inclusion of experiences from those that use the services. (sr. 005)"

"I also believe that peer workers and pathway finders need to be trained and imbedded in GP offices and Emergency Departments. (sr. 078)"

"Peer workers and counsellors are needed to help ppl calm down and feel listened to . Most time all I need to come down from being suicidal is to talk to someone face to face who cares. (sr. 122)"

"I would like to see Mental Health lived experienced peer workers staffed in every hospital and mental health setting. (sr. 216)"

Safe spaces for people experiencing a crisis or suicidal distress

"Funding alternatives to ED such as safe havens (with adequate space) are most effective for people who are in the depths of their recovery journey. (sr. 047)"

"Suicide discussions need less risk assessment. These are just safety blankets for providers to make you believe you have done all you could. We should be able to discuss openly these thoughts and feelings without fear of forced hospitalisation. (sr. 148)"

"We need more beds in MH wards and more Safe Spaces as alternatives to Eds. (sr. 153)"

"Provide the resources for public hospital emergency and public youth mental health services to provide preventative care rather than responsive care after the suicide attempt. (sr. 262)"

Consumer theme 4: Discrimination when using services

Another major theme that has come through consumers' responses to the survey is their experience of mental health-related stigma and discrimination when using services. The experiences, feelings and impacts of this ranged from being disapproved of, excluded, devalued, shamed and negatively stereotyped.

Many people feel they have experienced discrimination in the service system related to their mental health issues and their perceived support needs. Some said this impacted the care and support they receive from services.

> In the psych ward and some other instances (like a psychiatrist and a different psychologist) however, I often felt disrespected and invalidated by staff and unsafe even though I was in a locked ward. (sr. 112)

> Mental health is either ignored or blamed for every physical condition! (sr. 240)

> I feel like they didn't really listen to me when making a safety plan and I wasn't respected. I've also made complaints and didn't feel listened to. (sr. 265)

And for some, the experience of mental health related discrimination from services appears to have contributed to self-stigma (internalising and applying public stigma to oneself).

> Being diagnosed with Borderline Personality Disorder, most health professionals call me a trouble maker or difficult when I'm just struggling and in pain. (sr. 163)

> I feel forgotten about, even when I am with a doctor or other mental health practitioner. Just another pain in the bum with no real problems. (sr. 193)

> Felt stigmatised and judged for suicidal ideation. (sr. 251)

Many consumers who said they had experienced discrimination related to their mental ill health also shared that this made them feel socially marginalised and that the experience of discrimination worsened their mental health and wellbeing.

> As a survivor of domestic violence but having a diagnosis I was discriminated against and left in a worse situation due to this. (sr. 57)

> I have been disrespected, dehumanised and degraded whilst receiving mental health treatment. (sr. 65)

> Psychosis is demonised and misunderstood … and people are terrified. (sr. 134)

> When you're being told you are a liar, with a diagnosis, and they treat us like we're acting, makes us question our own sanity and has us thinking about suicide. (sr. 232)

Some told us that having experienced mental health related discrimination led them to anticipate stigma. It meant they felt excluded from services, had negative feelings towards services and avoided using them.

> The fear of losing work, being deemed unfit for work due to the discrimination of people with lived experience prevented me from trusting services. (sr. 13)

> I have always avoided other mental health services because I know too many people who have been treated poorly and harmed by the system intended to help them. (sr. 70)

We also heard that some people's experiences of mental health related discrimination were related to their gender, sexuality, cultural identity or other personal attributes.

> My Aboriginality was ignored. My own voice was ignored. My cultural situation was ignored. (sr. 25)

Language barriers, stigma, and a lack of culturally competent professionals make it even harder. I've seen how mental health struggles in CALD communities are often dismissed as "just stress" or "family problems," rather than recognized as serious issues needing proper support. (sr. 67)

I have been knocked back from 2 private mental health hospitals due to weight discrimination. (sr. 155)

I do not feel safe to fully disclose my gender identity/sexuality because of the limited knowledge of most of the services I have accessed. (sr. 171)

Psychiatrists and others judgement on sexualising and gender has impacted my recovery and sent me backwards. Deciding that these issues were the main cause of my MH issues was detrimental and I felt completely unheard! (sr. 230)

Some people also told us they felt discriminated against by mental health services because of their neurodivergence and the lack of understanding and awareness of this by mental health services.

As an autistic person I was not often understood or felt heard. Many of my experiences with crisis services or mental health professionals left me feeling worse. (sr. 100)

I am autistic and this was ignored when receiving mental health treatment – and I was turned away from some public services for being autistic because they felt they "weren't best suited to help me". (sr. 119)

My experience has been that there is a lack of knowledge in drs and mental health professionals regarding women having and seeking a late diagnosis for Autism and ADHD, and the myriad of conditions and difficulties that accompany this. (sr. 172)

Though less common, some people also told us of experiences where they had felt respected, recognised and protected by services, rather than discriminated against. Some common features to consumers' positive experiences of services include a sense of being sympathetically and non-judgementally heard and treated.

Clinicians were very caring and supportive. (sr. 66)

People let me talk, and asked questions. I can't remember anyone telling me what to do. They listened! I also had some great peer worker support when I was in the acute ward. (sr. 168)

In treatment for more severe mental health issues, I felt seen, heard and supported. (sr. 196)

Always open honest interactions that were non judgemental, respectful and aimed to work together for my best interest (sr. 202)
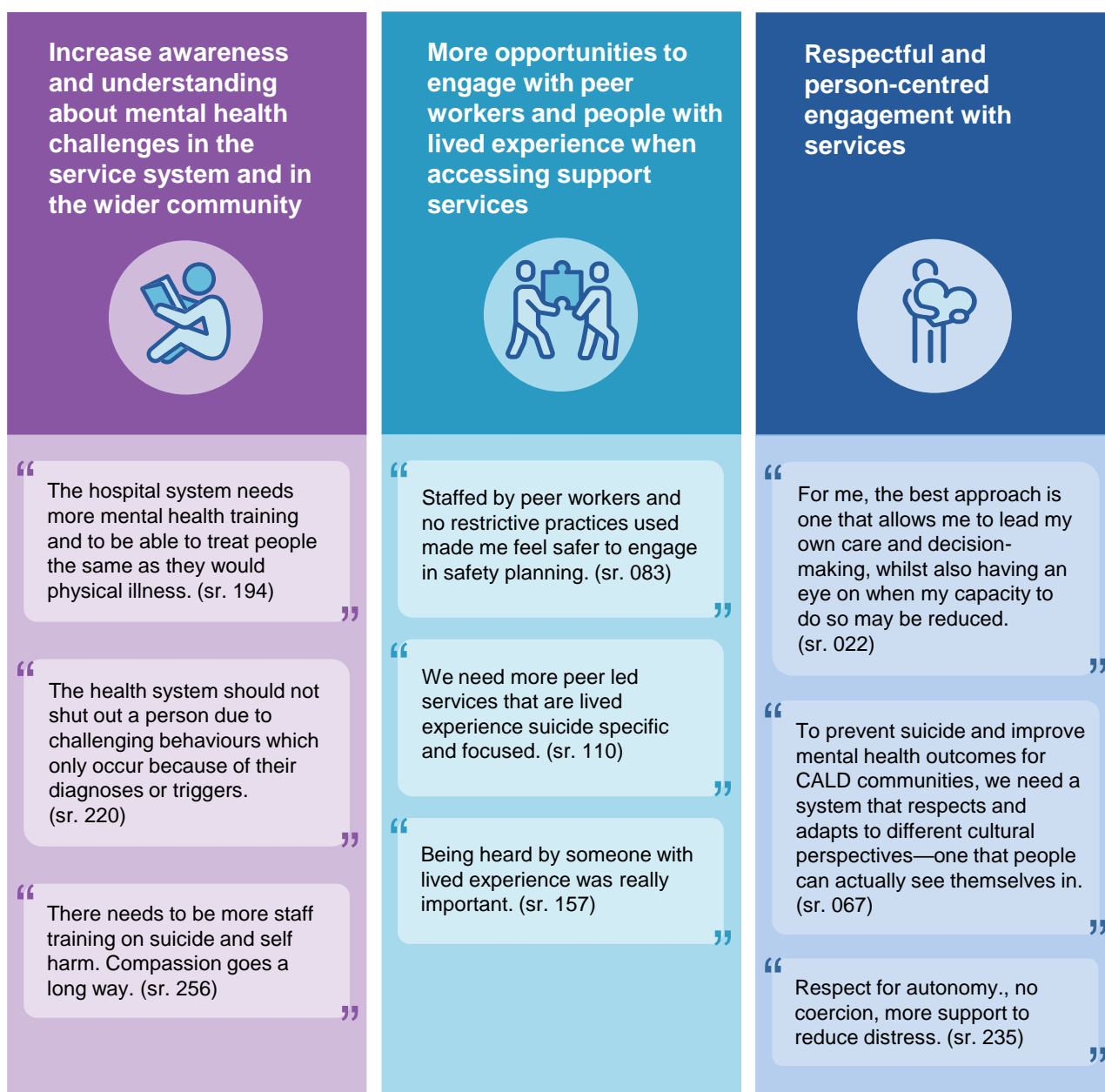
Everyone was kind and gentle. (sr. 245)

The psychologist I currently see always makes me feel safe and respected, letting keep control while guiding me through ways to help. (sr. 234)

Sometimes individual workers provided a sense of recognising and respecting my individual needs. (sr. 269)

Consumers gave a range of suggestions for preventing experiences of discrimination when using mental health and suicide prevention services and in the community more broadly (figure 10).

Figure 10 – Suggestions for preventing discrimination

Increase awareness and understanding about mental health challenges in the service system and in the wider community	More opportunities to engage with peer workers and people with lived experience when accessing support services	Respectful and person-centred engagement with services

"The hospital system needs more mental health training and to be able to treat people the same as they would physical illness. (sr. 194)"

"The health system should not shut out a person due to challenging behaviours which only occur because of their diagnoses or triggers. (sr. 220)"

"There needs to be more staff training on suicide and self harm. Compassion goes a long way. (sr. 256)"

"Staffed by peer workers and no restrictive practices used made me feel safer to engage in safety planning. (sr. 083)"

"We need more peer led services that are lived experience suicide specific and focused. (sr. 110)"

"Being heard by someone with lived experience was really important. (sr. 157)"

"For me, the best approach is one that allows me to lead my own care and decision-making, whilst also having an eye on when my capacity to do so may be reduced. (sr. 022)"

"To prevent suicide and improve mental health outcomes for CALD communities, we need a system that respects and adapts to different cultural perspectives—one that people can actually see themselves in. (sr. 067)"

"Respect for autonomy., no coercion, more support to reduce distress. (sr. 235)"

Main themes in the survey responses from carers

Many carers told us about their continuing struggles to fill gaps in the service system to meet the needs of the people they care for. Many also told us about the pressure and distress they sometimes experience associated with the dual role of being a carer and being a close family member of a person needing care, such as their child, spouse/partner or parent. We also heard about many carers' experiences of feeling excluded and ignored when interacting with services and a lack of support from the service system for their own needs associated with being a carer (figure 11).

Figure 11 – Main themes identified in carer responses

Theme 1 **Filling gaps in services**	Carers continually help to fill gaps in the service system	Theme 2 **Caring for family**	Many carers provide care for close family members
Theme 3 **Excluded and ignored**	Carers often feel ignored, and experience being excluded by services	Theme 4 **Caring without support**	There is inadequate support offered and available for carers

Carer theme 1: Filling gaps in services

Many carers shared experiences of caring for someone with mental ill health spanning several years. They told us how the gaps in the service system often meant services did not meet that person's needs.

> Services often fail to address the complexity of my loved one's needs. For example, crisis support is inconsistent, do not know how to support and help at home, and no follow-up after discharge from hospital care. (sr. 09)

> Navigating mental health services via the ACT mental health system was slow and cumbersome. My son didn't trust the community services agency due to his distrust of frontline workers with poor communication skills. (sr. 78)

> We have been supporting a family member for the last fifteen years and have not seen significant changes required to support Mental health and Suicide Prevention. (sr. 95)

> Need greater crisis support and post-crisis support/care. Our experience is that these services are non-existent. Support for patients and carers to prevent suicide attempts are better than hospital care after. (sr. 16)

Some carers told us how, out of necessity, they had become proficient in understanding and accessing the service system and more assertive in help-seeking for the benefit of the person they care for.

> Getting to the point of service delivery does tend to rely heavily on my own knowledge of the system and ability to speak their language. That earns me more respect than anything else. (sr. 22)

> I introduced myself to my son's clinicians as a mental health consumer representative which seems to have helped with this. (sr. 78)

> In the private sector I managed to set up a good support team. (sr. 85)

> My loved one also lives with a physical disability since birth. I have mostly been my loved one's case manager/advocate even when we lived in Darwin. (sr. 98)

But many carers also told us about the ongoing concern and stress they experience when trying fill service gaps and deal with the complexities of the mental health service system.

> it felt like it was deliberately confusing and impossible to understand and navigate. (sr. 80)

The system is complicated to navigate and relies on short term bandaid fixes. (sr. 82)

Coordination between Private Medical (GP and Psychiatrist) and private Therapy services was done by Carer which was stressful and inefficient. (sr. 84)

As we were having so much trouble getting care from the public system we tried the private sector as well and were turned away by every private provider with the same message - my person was too complex. (sr. 254)

Psychiatrist waitlist was 12 months, for a vulnerable teen with suicidal ideation, attempts, self-harm. This was completely untenable, and the GP prescribed life-saving medication in this absence. (sr. 263)

Geographic gaps in service accessibility and availability are an issue many carers told us about.

I live in a cross-border area and there is dispute over whose responsibility services are. I have had to navigate through how to get the right services with the extra pressure of where we can find them and be accepted. (sr. 22)

There is a severe lack of child and adolescent mental health services in my area. (sr. 37)

No beds available in mental health unit during crisis. The only public non-acute mental health care program available was in Nowra over 2h from Sydney. (sr. 40)

There are no in-person services locally for psycho-social wellbeing for people without a NDIS plan. (sr. 50)

Where services were available, many carers told us they often faced substantial costs to access them. This could impact significantly on their own financial situation, as well as affect the quality of support and treatment received by the person they care for.

considerable out of pocket expenses which impacts choice on the number of appointments made and therefore on the quality of care as per given optimum treatment models. (sr. 02)

Mental health care costs means that I have to work more to pay for treatments. (sr. 42)

Had to go privately which is costly. He would have benefited from more frequent care, however due to affordability, appointments were spread out and only when really unwell. (sr. 43)

We need to pay to see a private psychiatrist every 6 months for a medication review to be conducted. The private psychiatrist is excellent but expensive. There is no way my loved one could afford to see a private psychiatrist if they didn't live with me. (sr. 98)

While many carers told us about challenges and negative experiences of using the mental health services system, we also heard some positive experiences.

Dedicated GPs, holistic experienced psychologists, person centred psychiatrists exist and contribute positively to a persons recovery and support during a MH crisis. (sr. 02)

Found a good psychologist for my son who saw him via Telehealth. (sr. 37)

Initial consultations with my son's psychiatrist and psychologist seem to have been the most helpful, including providing the right level of anti depressants and talking therapy. (sr. 78)

The staff do their best with what little resources they have … a junior psychiatrist went above and beyond for my daughter and was a key player in her transition from 20 months in a mental health unit into the community. (sr. 87)

took time to understand my son and his family supports, and valued my child as a person rather than a diagnosis. (sr. 262)

My teen's positive experience came only from a private psychologist who is actively working to learn from neurodivergent advocates/trainers. She is validated, she is seen, she is seen as the expert over her own life, she is empowered to trust her own capacities to navigate her life, and access supports. (sr. 263)

However, we also heard many carers had not seen positive changes in recent years, with many believing there has been a general worsening of the mental health service system.

core issues (e.g., fragmented care coordination, underfunded rural services) persist. Improvements feel superficial rather than systemic. (sr. 09)

The system is broken and in total collapse in NSW. (sr. 87)

There seems to be more options of services that a person can access until you actually try to access one. (sr. 111)

services in general around mental health are just lacking there is not a lot funding allocated and services are becoming more thin all the time due to not real investment. (sr. 141)

I would say the system has deteriorated. There is a lot of talk of change but all I see are busier ED's. (sr. 150)

Carer theme 2: Caring for family

While carers have diverse backgrounds and fulfill widely varying roles, we heard carers often have a close family relationship (parent, spouse, partner, or child) to the care recipient experiencing mental ill health. For many carers this underpins their motivations and experiences in providing care.

Many carers in this dual role told us about the heightened concern and distress they experience when trying to access care and support through the mental health service system for the person they care for.

My mother is 90 and has mental health issues for the past year - she tends to be disregarded because of her age and overlooked - she has to wait months at a time to see the mental health professional at the hospital. (sr. 14)

My son attempted suicide. On hospital discharge he was referred to his GP. While developing my son's mental health plan the GP admitted that he wasn't qualified to refer him to any mental health services. (sr. 78)

Another instance was my daughter was refed to an eating disorder. When she went back to the mental health rehab unit the dietician was unable to consult her due to no funding. (sr. 87)

The public health system failed us and it took months of calling multiple private practices and begging for appointments - then being charged fees for 'intake' sessions and told later they could not help us - before I found someone who can see my son next month. (sr. 206)

Many also described the distress they experience as a carer when observing inadequate or poor-quality services being provided to a member of their family.

Patients, including my partner who was experiencing psychosis and mania [in hospital ward] were treated incredibly disrespectfully by staff. (sr. 52)

When my wife was experiencing a crisis, we tried to get her supports which ended up with an inappropriate admission to the inpatient unit, and a bungled transition to home which resulted in further and worse SHSI (self-harm screening inventory) that went unaddressed for months. (sr. 76)

psychologist told my son and I in the waiting room, in front of other waiting clients, that my son was likely too severe for their service … I was emailed a list of private and public services to contact myself to source a psychologist for my son – all of these services had month-long wait lists. This effectively left my son with no psychology services just after an inpatient psychiatric admission. (sr. 262)

Some also told us about wanting to focus on prevention rather than acute treatment, to maintain the health and wellbeing of the person they care for and avoid potential crises.

My children are not needing services for severe mental illness, but rather ongoing wellbeing matters that could turn into further issues as they get older. With both of them I have had trouble accessing services, to the point where we have still not seen anyone, it has left me managing how their wellbeing is. (sr. 08)

Carer theme 3: Excluded and ignored

Many carers reported that despite often needing to communicate and interact with mental health services as part of their role in providing care for someone, they often felt excluded and ignored by services.

I am consistently excluded from care plan discussions. During the first hospital admission, clinicians refused to share updates, citing confidentiality, even though my involvement is critical to my loved one's recovery. (sr. 09)

staff ignored me as a primary person providing care. (sr. 25)

They are less likely to involve me in the planning and delivery of services aspect. Basically services will try to tell you what is going to happen regardless of what my thoughts are. (sr. 98)

They wouldn't even speak with me. (sr. 103)

I am often excluded because the person I provide care for is over 18yo. (sr. 187)

Being excluded from her treatment and care because of delusions and advanced health directives not even looked at made me feel excluded when I was her primary carer and only advocate. (sr. 216)

Many parents, guardians and other adults caring for a child with mental ill health reported feeling dismissed, ignored and negatively impacted by services.

It is usually more as having any inclusion sidelined or advice not sought – this was especially when my person was younger. (sr. 02)

Despite considerable advocacy for my daughter I was often dismissed and had to fight tirelessly to get support for her. (sr. 74)

Myself, my wife, daughter and other children have been traumatised by this system. (sr. 87)

I think mental health professionals tend to judge you as an over reacting mother without understanding your own education, experience and background. A mother's input is not highly valued. (sr. 124)

In contrast, some carers told us about more positive experiences in recent times where they had a sense of being more included and supported by services.

Carers are generally treated very well by mental health services. This is a valuable part of the mental health system. (sr. 88)

I am able to contact my son's case manager if I have concerns. (sr. 158)

I feel privileged that the social worker keeps us connected. Its focused on my child, and they take my lead if I have ideas. (sr. 186)

GP has checked in carefully with myself regarding my service user to be supportive and to provide support for both myself and the service user. (sr. 209)

Private psychiatrist and [clinic name] have provided excellent communication … Our private psychiatrist has always listened to us when we have flagged escalations in my son's depression. (sr. 262)

However, some carers told us they have had mixed experiences across services and told us how they have had to persevere for some time in order to overcome being excluded and ignored by services.

While some staff acknowledged my role as a carer, others dismissed my insights. For example, a GP once said, "You're not the patient; your opinion doesn't matter." (sr. 09)

After decades of being dismissed and labelled an over-anxious parent, I feel there has been some improvement in some professions of the acceptance of family/parental involvement being crucial in support of the person with mental health conditions. Specifically Therapists and GPs. (sr. 84)

I have had to fight to be involved despite being legally appointed guardian by QCAT and financial administrator. I have received so much push back, including being belittled and ignored until i finally complained to the health ombudsman who accepted the complaint and directed the hospital health service to attend to the complaint. It should never have gotten to that point. (sr. 254)

Carer theme 4: Caring without support

Many carers told us they experience ongoing stress and adverse impacts on their wellbeing from being a carer, especially where they encounter difficulties accessing adequate and quality treatment and support for the person they care for.

Many said they often felt undervalued, unprotected and unsupported by the service system in their role as a carer.

there was no service capacity to protect my child nor my other children…. Let alone myself. (sr. 69)

Being told to go home and someone would follow up and no one ever did. (sr. 176)

I don't feel like we are seen at all. Respected would be meaning we are treated like a somebody and we are not. Protected would be knowing how to help us and protecting us from ourselves when needed and this doesn't happen. (sr. 177).

The person you are caring for has all the rights because to get any service they have to agree to it. Sometimes they don't have the mental capacity to agree and can walk out at any time even if the carers are in danger or the person is suicidal. (sr. 199)

I was never supported in the carers role. (sr. 240)

Some carers said they felt under considerable pressure because they carry substantial responsibilities and perform major roles in a person's care and support, often filling gaps in the service system that are not properly recognised or supported.

> My person was given new medication without my knowledge or consent and when asking for information around the new medication i was emailed the pamphlet out of the box and told if i needed further information to google it. I have had the psychiatrist sit in a meeting a week ago and try to shift blame onto myself and other supports in front of my person which put our relationship at risk. That entire appointment was psychologically unsafe. (sr. 254)

> At my son's most acute periods of illness (immediately before or after his suicide attempts), the onus of keeping him safe and from preventing him from re-attempting suicide has been placed on my husband and I. In contrast, if my child presented to an emergency department with an acute presentation of asthma that threatened his life, he wouldn't be sent home for us to manage his acute symptoms. A major depressive disorder and suicidal ideation is just as life threatening as other physical conditions. (sr. 262)

Some carers also told us about the difficulties they face in navigating the service system and that carers are not well supported with this.

> The lack of centralised official information makes it difficult to know what services exist. For instance, I discovered a local peer support group only by accident after months of searching, highlighting gaps in outreach and communication. (sr. 09)

However, some also said they had experiences of receiving help and support with their role as a carer.

> Service has been amazing. Person centred, care tailored to him, Resources provided with strategies to read/review at home and share with me. (sr. 43)

> Roses in the ocean were able to support me across suicide bereavement, carer, and personal distress in an understanding way. They mapped out the services for me, checked wait times and helped me navigate into services that suited me. (sr. 110)

> Carer Gateway are outstanding. (sr. 152)

> The psychologist was thoughtful and kind. Always clear about her plans and kept us informed. (sr. 205)

> [Clinic name] provide a psychologist for my son, and a family liaison for my husband, which has been invaluable in supporting and skilling our whole family. (sr. 262)

Respondents made a range of suggestions for how services could be improved to better meet the needs of carers and the people they care for.

> I think the problem here is that there isn't enough opportunities for carers to be part of service design. (sr. 189)

> Prevention is better than cure. Let's make more services available for young people before their mental health concerns develop further, and remove the road blocks of having to have a relationship with a GP, and gaining a mental health plan. (sr. 08)

> Services needed to be expanded include: respite care, post-suicide follow-up (to prevent cycle of many attempts), better education of emergency staff of various conditions and how to best treat them, more clinical psychologists & psychiatrists, more access to psychology under medicare. (sr. 16).

Some also highlighted the importance of tailored support for carers that recognises their specific needs and circumstances.

> not nearly enough services and or support or support groups for carers. Groups usually that are running are during the day when most people have to work. (sr. 42)
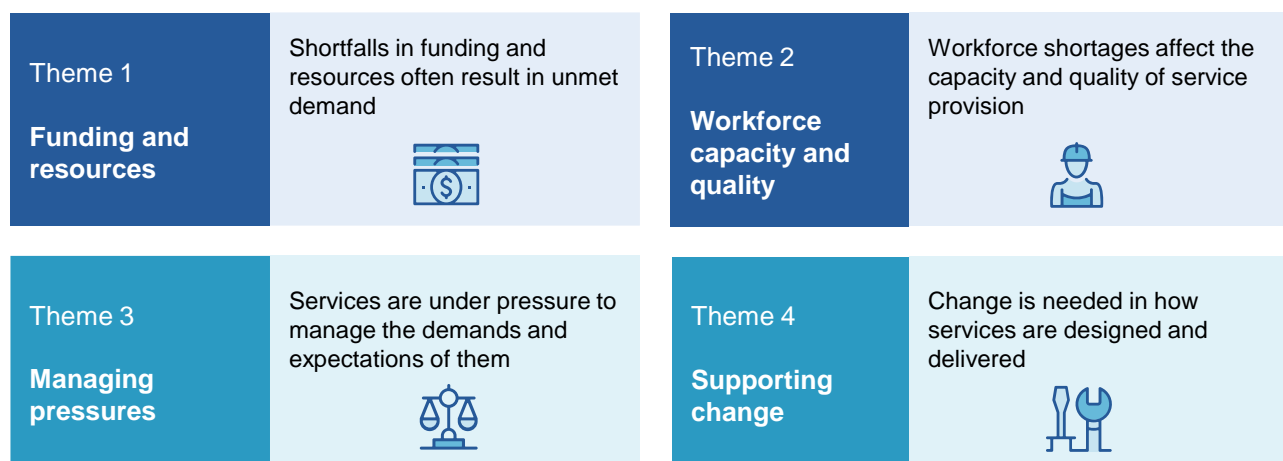
> Because we aren't linked to a government run community based service (even a bad one) it can be quite isolating at times because there is no one responsible for checking in to see how things are going. (sr. 98)

> I was asked about my feelings about whether my partner was safe to go home, and whether I was okay with this. What was really good was that they asked this question privately, and asked about how I was coping etc. (sr. 168)

Main themes in responses from workers and volunteers in service provision

In the survey responses from people who work or volunteer in mental health and suicide prevention services, we heard a lack of funding and resources to meet current service demands is a major issue. We also heard from many about workforce shortages and the impacts of this on service capacity and quality. Many workers told us about the need for the service system to evolve to better meet the needs of consumers and improve the quality of care provided to them, and many offered suggestions for how this could be progressed (figure 12).

Figure 12 – Main themes identified in service provider responses

Theme 1 **Funding and resources**	Shortfalls in funding and resources often result in unmet demand	Theme 2 **Workforce capacity and quality**	Workforce shortages affect the capacity and quality of service provision
Theme 3 **Managing pressures**	Services are under pressure to manage the demands and expectations of them	Theme 4 **Supporting change**	Change is needed in how services are designed and delivered

Service provider theme 1: Funding and resources

Many workers and volunteers told us they believe there are underlying shortfalls in funding and resources for mental health and suicide prevention services, and this is negatively impacting their ability to meet consumers' needs.

> There is only so much services can provide without adequate funding. (sr. 63)

> closing times/access, infrastructure, lack of funding, outdated models of care and all due to not enough money. (sr. 71)

> No positive changes, only negative - less funding across the board particularly for early intervention services. (sr. 147)

lack of resourcing and funding preventing us from being able to adequately reach the people who need us. (sr. 196)

We do not have enough staff, we are underfunded and cannot offer the services people need in our area. (sr. 242)

In this context, many told us more funding is needed for mental health and suicide prevention services.

More funding for more safe spaces. (sr. 18)

More funding, long term commitment so these services are sustainable and can provide long term support to people bereaved by suicide. It is unacceptable for people to have to wait 8 weeks to access suicide bereavement and peer support services. (sr. 110)

More funding for community MH - it is too uncertain and not enough staff. (sr. 153)

More funding being channelled into the most under-resourced teams to ensure our practice is actually sustainable. (sr. 196)

FUNDING!!! Help us continue to save the lives of the men and women who have or are still serving. (sr. 255)

Funding for postvention services should be increased, stabilised over the long-term and better integrated with the broader mental health and suicide prevention system. This would ensure services can respond promptly to people who have lost a loved one to suicide. (sr. 266)

Some told us that without more funding to support subsidised access to clinical services, consumers face significant financial barriers to ongoing care and treatment.

I would like to see more brokerage funding available so that we are better able to support assessments that may be required to confirm diagnoses to ensure that the support they are receiving is beneficial to them. Unfortunately, there is a large gap in the mental health sector when it comes to people being able to access psychiatry. Psychology is becoming more accessible, but psychiatry is still a large issue. (sr. 01)

Increase DVA and Medicare fees to private providers of mental health services like mental health social workers and psychologists. (sr. 37)

The introduction of additional sessions during COVID was a positive move towards addressing the mental health support needs of Australians during times of crisis … Unfortunately there were financial barriers that meant that this increased access to treatment did not reach those with less financial resources. This needs to be addressed by increasing the affordability of psychological treatment services. (sr. 128)

Service provider theme 2: Workforce capacity and quality

Many people who work or volunteer in mental health and suicide prevention services told us about significant workforce shortages in the sector, and how this is negatively affects the capacity and quality of service provision.

It is extremely difficult to recruit psychologists and counsellors to deal with the huge demand of clients who need one on one support. (sr. 15)

Lack of trained mental health professionals. (sr. 42)

Staff shortages have already emerged as an issue. Short term pilot programs make it hard to recruit staff. (sr. 166)

Many saw retention of existing workers and volunteers in mental health and suicide prevention services as essential to strengthening and stabilising the sector's workforce. Many respondents recommended improving wages, working conditions and career pathways.

We need funding and more staff. We can train staff but we have no funds for this. (sr. 39)

The service has real difficulty with turnover of volunteers and resorts to quite amateurish means to try to resolve that. (sr. 53)

Increase wages, increase staff, fund charities and non profits with sustainable long term funding for confidence in jobs and long term planning and service delivery, empower community groups with such funding, more GPs in regions and rural, train GPs with mental health skills and make sure they know what services are available locally. (sr. 213)

The workforce also need support to ensure their own mental health is not impacted by significant service demands. (sr. 242)

Many suggested there should be a greater focus on developing workforce capacity and quality.

We also need to train up and employ a workforce that has a passion for supporting people experiencing suicidality, rather than just using the existing mental health workforce. (sr. 36)

more funding for services to educate clinicians in contemporary, evidenced based, practices. (sr. 170)

I would like to see a shift towards a more intentional service delivery model, taking better care of staff and ensuring they have access to safety procedures etc., providing staff with different training opportunities to improve their knowledge and upskill, being more consistent with services delivered to client… When you invest in the workers providing the labour, you will gain more as they will be better trained, more motivated and passionate, and are being paid well for what they do. (sr. 162)

More access to funding for further education to other health and teaching staff on mental health and mental illness and the importance of early identification of risk and vulnerability to aim to prevent secondary damage/trauma. (sr. 164)

Continued commitment to learning and growth for all staff with opportunities for training and access to resources … Recruitment strategies and policies that attract and retain a diverse workforce. (sr. 230)

Service provider theme 3: Managing pressures

We heard from many workers and volunteers that as the expectations and demands placed on services have increased in recent years, and as the accessibility and availability of services has been stretched, there is growing unmet need among consumers.

Again not enough space, resources and staff makes access difficult. People are being turned away even when they are voluntarily reaching out for help. MH has no quick fix a lot of the time and we mustn't assume a few follow up phone calls will be sufficient. Our alternative to emergency departments do NOT have enough environmental space or funding to meet demand. (sr. 47)

it's now a lot harder to get an appointment with a psychologist or psychiatrist. (sr. 72)

as we are non-clinical and therefore when someone is in crisis, the hospitals, ambulances, psychologists have been unable to help and therefore we feel we let our members down as are left in suicidal crisis. (sr. 153)

services are increasingly difficult to access and navigate, hard to get the most vulnerable and individuals in need seen in a timely and appropriate manner without having to share exhausting accounts of why the service is needed. (sr. 164)

Respondents felt the growing pressure on services and unmet need in recent years can be attributed to a range of factors such as increases in the underlying demand for mental health care in the community and increases in the complexity of some people's mental health care needs.

Increase in client complexity, exacerbated by Covid fracturing support systems and increasing individual and family stressors. A lot of services had to just focus on their internal service needs, and a lot of networking and collaboration opportunities went by the wayside during Covid. We are not back to where we were and this has a real impact on both services and clients. (sr. 94)

Services are overstretched. Secondary services have wait lists that are long. Especially for people that have deteriorated mental health. (sr. 42)

Homelessness and social issues are driving mental health crisis presentations. (sr. 71)

Increased service demand and increased reliance on mental health services; lower resilience in the population; conversely the destigmatisation of mental illness has lowered the threshold at which individuals seek help. (sr. 218)

Many told us the co-occurrence of mental health and alcohol and other drugs (AOD) issues is contributing to increased pressure on mental health care services.

in the intersection between co-occurring mental health and alcohol and other drug (AOD) issues. We would often have clients 'stuck' between the 2 - with AOD services saying 'we'll work with that client once you manage their mental health concerns', but equally other mental health services saying to AOD services 'we'll work with them once you manage the AOD side of things'. This is not a holistic approach, treating the person as a whole person rather than isolated 'issues'. (sr. 94)

There needs to be more support for people in active addiction with substance abuse and mental illness. This is something that is falling to the wayside. (sr. 162)

Some also said that while they had seen an increase in the range of service options become available in recent years, they still had concerns about the accessibility and quality of new services.

There are certainly more services around now to provide the support needed, and it is becoming more accessible for people who may not have previously had access to mental health services prior to COVID. (sr. 01)

Less wait times for service but less holistic and supportive. (sr. 242)

Many highlighted fragmentation in the service system and believed there needs to more effort made to improve integration, coordination and collaboration between services to help manage overall demand pressure in the system and improve the quality of care provided to consumers.

We are supposed to have "Universal aftercare" funded under the bilateral agreement. However, in our region, "Universal" is limited to one LGA (our region covers 3 LGAs) and the aftercare program (Wayback) can only be accessed via specific pathways. For example, there is no pathway from the intensive care unit or general hospital wards into the Wayback service. Thus if

someone made a near-fatal suicide attempt such that they spend time in ICU, they will not be offered the Wayback service. (sr. 36)

There is a strong desire for state and PHN to work together through the bilateral agreements but it isn't working as well at the frontline. People are still having trouble navigating services and equally frustrating for referrals across services – even within large HHS. (sr. 71)

Some told us competition between services for limited funding is contributing to system fragmentation and lack of collaboration between services.

I think the system is worse than ever and seems to be going backwards. There are mental health service providers in our area who will not refer (or speak to) each other because they are the competition for funding. (sr. 111)

it's getting worse with the siloing and division of service funding. (sr. 76)

However, in contrast, some told us they had seen some improvements in collaboration and coordination between services.

Suicide prevention networks, Anglicare WA metro postvention response services, StandBy, Roses in the ocean, are all new to the Perth metro area in the past 3 years and this has seen coordinated responses to critical incidents and high impact suicides as well as more suicide specific and peer support service options for communities. (sr. 110)

Being from another state it has taken time for the local services and GPs to accept my provision of service, but I find that now I am known and GPs refer clients using my name not the service, this is very rewarding. (sr. 209)

Service provider theme 4: Supporting change

We heard from many respondents about the need for changes to the way services are designed and offered to better meet the needs of consumers. Many believed services should continue or begin to involve people with lived and living experience of mental ill health or suicide in the planning and delivery of services. This was seen as important for improving the quality of service provided and the experience and outcomes for consumers.

We need more buy-in from the government as to the value and importance of the peer-led workforce. Lived experience workers are a safe, holistic, unique and sustainable alternative to traditional clinical care, and are especially important now, whist psychiatrists and clinical care is almost impossible to source. (sr. 21)

The service puts lived experience at the forefront – it is crucial that those with experience of mental ill-health and/or suicide are the ones volunteering, informing and guiding the delivery of mental health services. (sr. 70)

Peer-to-peer support offers a compassionate space where individuals facing mental health challenges can find understanding and care. It fosters connections that help people feel seen, heard, and empowered on their journey to well-being. (sr. 149)

Lived experience being added to the mental health system, people are feeling more understood and safe. This has been a great change in the mental health system. (sr. 194)

However, some expressed concern about the inadequate institutional and workplace support provided for peer workers and people with lived and living experience.

We also need a more genuine focus on the expertise that people with a Lived Experience of suicide bring. Far too often, it is painfully apparent that the Lived Experience representative(s) on a committee are only there to tick a box, rather than because they are seen as bringing something of genuine value to the committee. It is often the case that the LE representatives are the only people in the room who have knowledge of and experience in the suicide prevention sector, yet they are still dismissed by the rest of the committee, which, as I said, is generally made up of mental health clinicians. (sr. 36)

Erosion of LEW workforce. They are so desperately needed. We need to expand not deplete these colleagues. The issues are not emerging, they are well known and very apparent. Refusal to address them is the problem and that is the priority area to fix. Law breaches, EBA breaches, it's a disgrace. (sr. 249)

We also heard from some respondents about the need for services to go beyond the rigidities of a medical model-based approach in how they provide support to people.

I have seen repeatedly the enormous harm done to patients, patient's families, and clinicians by the medicalisation of suicide. (sr. 20)

for many people a health response to mental health issues and distress just doesn't work, isn't even needed. (sr. 80)

all too often, we find ourselves surrounded by medical staff who seem more like automatons, mechanically adhering to heartless regulations. (sr. 149)

Some respondents highlighted service improvements that had been implemented, where providers had adopted more person-centred, holistic and trauma informed approaches to care and support.

I have seen an increase in commitment from mainstream services to providing an inclusive service for marginalised groups of people. Provision of person centred and trauma informed practices. (sr. 230)

Services have also improved due to being re-designed with a stronger focus on being person-centred. (sr. 266)

Many positive experiences of working in the service system were highlighted by respondents. Often this was the opportunity to support people heal and recover from mental ill health or a suicide crisis and see improvements in their wellbeing over time. We heard from many respondents about the satisfaction they gained from helping others and how this underpinned their motivation working or volunteering in the service system.

Celebrating the small wins with some of my clients and seeing them determined to achieve their goals and continually work on their recovery. (sr. 01)

Listening to people and validating their experience, sometimes making a difference. (sr. 31)

It's great to see them when they get well often after many months, sometimes several years, working with them. (sr. 37)

It is the best experience working with someone's own goals of recovery. (sr. 71)

Seeing positive relationship changes, engagement, less admissions in crisis, consumer returned to work and living life best they can. (sr. 91)

Seeing a person who was at their lowest point now working, in a healthy relationship and looking to the future. (sr. 111)

Getting to meet new people and deliver my lived-experience story to students – something I wish I had when I was in school. It feels incredibly empowering to feel like you are helping contribute to a better mental health system and reducing the stigma around it. (sr. 112)

We are able to empower young people to normalise talking about mental health in a really meaningful way. Seeing that happen is beautiful. (sr. 196)

I love working in mental health and being able to speak with service users. Seeing the positive impacts for the people I work with. (sr. 242)

There are many from over the years, but simply put, when a consumer, their family and carers, are supported, engaged and have agency and informed choice over their mental health care. Watching their journey of recovery and being in the privileged position of sharing their outcomes. (sr. 249)

Respondents made suggestions for how improvements to mental health and suicide prevention responses could be achieved by working outside the silos and confines of the mental health system through greater coordination across systems, particularly with the AOD treatment system.

I had a client die by suicide who I believe would have made it through. He was an alcoholic who had relapsed after 10 years sobriety. He wanted help, and had been successful in managing alcohol and depression previously. The mental health unit declined him due to his alcoholism. Detox declined him due to his suicide risk. He hung himself in his unit. (sr. 31)

Further work needs to be done to stop the slipping of mental health and alcohol and drug services. They both need a harm reduction approach. They both need to recognise they are interdependent and are serviced poorly through separated provision. (sr. 71)

Dual diagnosis is a huge issue in rural and regional areas. If a person has a disability they are often told to access NDIS, NDIS will no longer support mental health needs and if the person has a drug and/or alcohol history they are not able to access NDIS or Mental health support. (sr. 111)

We heard a range of suggestions from workers and volunteers in service provision for how the service system could be improved to better meet people's needs. Some highlighted specific parts of the service system they saw as important.

Bereavement support is a critical component of the mental health and suicide prevention system. Researchers have found that bereaved people are 65% more likely to attempt suicide if they are grieving for loved ones who took their own lives. Beyond the tragic loss of a person to suicide, the impact of suicide deaths are felt by up to 135 people, including family members, friends, work colleagues and first responders at the time of death. (sr. 266)

There needs to be a huge increase in public campaigns and awareness as to what mental health and suicide prevention orgs do and what services and supports they offer. (sr. 21)

Given the increasing demand for psychology services and increasing waiting lists to access psychologists, we believe the deployment of provisional psychologists is one of many ideal solutions to swiftly improve the availability of much-needed mental health care support for Australians. (sr. 128)

Health departments and health service providers need funding incentives to develop seamless care and to take responsibility for the gaps and blockages between systems instead of washing their hands of it. (sr. 166)