31 July 2025

Productivity Commission
Commissioners Selwyn Button and Angela Jackson

Submission: Mental Health and Suicide Prevention Agreement Review, Interim Report

Introduction

Mental Health Coordinating Council (MHCC) is the peak body predominately for community-managed mental health organisations (CMOs) in New South Wales (NSW) and is a Registered Training Organisation (RTO) delivering accredited and non-accredited programs. We largely represent community based, not-for-profit/non-government organisations who support people living with mental health challenges. MHCC's 150 members assist people to live well in the community by delivering mental health and psychosocial supports including social inclusion, rehabilitation, and clinical services. Our purpose is to promote a strong and sustainable community-managed mental health sector with the investment, resources, and workforce it needs to provide effective psychosocial, health and wellbeing programs and services to the people of NSW.

MHCC provides policy leadership, promotes legislative reform and systemic change, and develops resources to assist community-based organisations build their capacity to deliver quality services informed by a human rights-based, trauma-informed, recovery-oriented practice approach. MHCC works closely with Mental Health Australia on matters of national interest to the sector, including cross-governmental collaboration, bilateral agreements, and the NDIS. We also collaborate with the Mental Health Alliance, a partnership of state-based peak bodies and professional associations, on matters of mutual interest in NSW.

We welcome the opportunity to respond to the findings of the Interim Report and to provide further information to inform the final report of the Review, which will be handed to Government in October 2025. We appreciate the depth of the review findings and the evidence provided that gives additional weight to what we and others in the sector have expressed to Government. They clearly replicate much of the evidence that has been demonstrated through a multitude of reviews and gap analyses conducted over the last couple of years, and what we have consistently heard from members and the sector.

We understand that the final report to Government by the end of October is to be tabled within 25 sitting days and we hope that it will be made available as soon as possible. We are keen not to see the response lose momentum and get lost in the long Christmas break; and that we are provided with adequate time early in the new year to make a submission to the Government's response.

It is disappointing but unsurprising that: *"The Productivity Commission (PC) has found the National Mental Health and Suicide Prevention Agreement is fundamentally flawed, and that the interim report of the PC's review of the agreement finds that achieving reform in the mental health and suicide prevention system will require a new approach in the next agreement"*.

We understand the recommendation that negotiating the Agreement fall under Premier and Cabinet responsibility, as this is more likely to result in improved cross-government collaboration, commitment and investment. However, we are concerned, particularly in relation to community-managed mental health services, that the expertise embedded in the Department of Health may be lost; and the nuanced understanding of context, models and practice approaches may subsequently also be lost. We are keen to see that under Premier and Cabinet cross-government commitment across the social determinants of health is emphasised, and that development and implementation of the National Mental Health and Suicide Prevention Agreement be Health led.

It is necessary for governments to foster a new era of acceptance of cross departmental funding and program development that understands and accepts that costs expended in one portfolio area will impact savings in other areas and vice versa. In this context we reference the work of Professor Henry Cutler who writes that, *"A coordinating government department or agency representing the mental healthcare sector could help develop, communicate, and gain support for a long-term mental healthcare value-based payment reform agenda. It could also participate in the evaluation and learning phase of each trialled value-based payment model."* [1]

The Agreement expires in June 2026, and as the PC said this *"gives governments the opportunity to start again and create a policy architecture, including a new national agreement, that enables collaboration and responds effectively to the needs of people with lived and living experience, their supporters, families, carers and kin."* Whilst in principle we support the redesigning of the agreement, we have fundamental concerns about the lack of progress to address unmet need for psychosocial support – a still as-yet undelivered joint commitment from the original agreement. We categorically do not support a delay without immediate Government action towards addressing this gap which requires urgent attention.

We agree with the PC that key commitments in the Agreement have not been delivered and should be completed as a priority. Governments should also immediately work to resolve the disagreement in relation to commissioning and funding responsibilities for psychosocial supports outside the National Disability Insurance Scheme representing a service gap affecting approximately 500,000 people.

MHCC support that policy architecture should include:

- a long-term strategy for reform
- a five-year national agreement to tackle key priorities
- bilateral schedules to direct funding of services that respond to local needs, and
- new separate schedules on services to support the social and emotional wellbeing of Aboriginal and Torres Strait Islander people and suicide prevention

MHCC also agree that a 'no wrong door' approach to mental health and co-occurring alcohol and other drug (AOD) challenges should be included in the Agreement. Currently there remains a mostly siloed service delivery environment which is problematic for people living with co-existing conditions, and many people with mental health conditions have co-occurring difficulties related to substance use.

There has been growth in co-commissioning activities through the PHNs in NSW, and it is imperative that people receive joined up services that address a multitude of mental health, AOD and psychosocial needs. MHCC advocate a major expansion in co-commissioning of AOD/Mental Health service programs including community based residential services for all ages and diverse groups; and that this must be reflected in the Agreement.

We also recommend in the context of an ageing population that an additional schedule for improved mental health and psychological services for older age groups of older people should be included in the Agreement. Males aged 85 years and over experience the highest rate of suicide across all age groups and in 2022, females aged 85 years had the highest suicide rate of all female age groups. There needs to targeted suicide prevention initiatives to address suicide in older people [2] [3]. The stigma related to ageing and mental health is known to prevent older people seeking and accessing help for mental health concerns, the need for a systematic approach to supporting mental health promotion, prevention and early intervention for older people, and the need to consider specific psychosocial support for older people with mental illness (particularly given neither the NDIS nor the aged care system provide this for older people in any systematic way)[4].

MHCC strongly support the immediate release and implementation of the National Stigma and Discrimination Reduction Strategy as well as the comprehensive guidelines on regional planning and commissioning for primary health networks to deliver greater access to mental health and suicide prevention services. Likewise, we agree that the amended agreement should *"formalise the role of the National Mental Health Commission as the entity responsible for independent assessment and reporting on progress."*

In NSW, the *Inquiry into Equity, accessibility and appropriate delivery of outpatient and community mental health care in NSW* recommendations highlight the value of Peer Workers who walk alongside people with lived experience and their families, carers and kin. This approach has effectively demonstrated the efficacy of the model in assisting people to live well in their communities. A return-on-investment study in 2022 found that for every $1 invested in a peer-led mental health service, approximately $3.27 of social and economic value was generated [5].

The PC requested further information that demonstrates best practice for integrating peer workers in service delivery contexts. MHCC provide a number of examples of service models in which peers are integral to the service delivery model:

- **Independent Community Living Australia's** Bondi Prevention and Recovery Centre (PARC) Evaluation Report was launched on the 31 March 2025. This important academic report demonstrates the value and effectiveness of a community-based recovery model that provides an alternative to inpatient care. Key elements of the Bondi PARC approach were the lived experience leadership principles and priority focus on personal wellbeing during a person's stay, and investment in personalised recovery through fostering autonomy, choice, skills building, identity acceptance, hope and personal meaning, social connections and community integration.

  The following PARC processes contributed to achieving lived experience focus and peer support:

  - Delivering support that was not medicalised – minimal clinical staffing, terminology, practices and procedures
  - Peer support workers supporting guests through 'modelling' everyday life skills and mental health self-management skills (e.g. breathing techniques, identify triggers and personal responses to stress management)

- Intentional, socially conducive social environment building social skills and confidence (e.g. interactions through shared mealtimes, social group activities, outings)
- Activities of daily living and social context raising guests' hope, confidence, self-reliance and independence (e.g. cooking, developing daily practices and routines)
- Peer acknowledgement, illness validation and stay environment breaking down social isolation, internalised stigma and increasing self-acceptance
- Use of trauma informed practice, peer-based knowledge and meeting guests with empathy and kindness • Guests' identifying their 'own recovery journey', setting personalised goals and intentions and expectations from their stay
- Supportive context, 'nudging' guests towards achieving intentions and goals rather than working from pre-scribed, fixed or firm externally set objectives.

The evaluation report shows PARC runs at $400 per day or $146,000 per annum, versus inpatient admission costs at $1,280 per day or $467,200 per annum. This is only a third of the cost of inpatient care and has achieved a 33-44% reduction in emergency department visits.

- **Flourish's Resolve Social Benefit Bond** is Australia's first social impact investment aimed at improving mental health outcomes through the Resolve Program, a community-based program supporting people with serious mental health challenges who have spent long periods in hospital. The final Investor Report reveals the success of the Resolve community-based program with a 54% reduction in hospital admissions and a 66% decrease in time spent in hospital. The report can be accessed here.

  Flourish's peer work model is consistent with the 2021 National Lived Experience (Peer) Workforce Development Guidelines which provide a consistent approach to peer work. The selection criteria identify that peer workers must have either have a relevant degree, Certificate IV or Diploma or two years' experience working in mental health. Flourish have confirmed that they define their peer workforce as qualified professionals who intentionally use their lived experience in their practice. Program partners, LHD clinicians and Flourish staff agreed that to be a Resolve peer worker, they must hold a tertiary qualification (in fields such as psychology, social work, or health and community services) and have a lived experience of a mental health condition. Flourish management reported their model intends that peer workers utilise recovery-oriented practice to support the client recovery journey. This involves intentionally sharing their lived experience of mental health issues, to provide a supportive and transformative space for clients to achieve their recovery goals.

- Some of the key findings in the **HASI/ CLS Evaluation** (2022) of Community Living Supports (CLS) and Housing and Accommodation Support Initiative (HASI) included: that consumer contact with community mental health services decreased by 10% in the first year of contact with HASI-CLS supports and was 63.7% less if they remained in the programs for more than one year; hospital admissions due to poor mental health decreased by 74% following program entry, and the average length of stay decreased by 74.8% over two years; consumers with a new charge in the criminal justice system and with community corrections orders dropped to almost zero in the year after program entry and finally the programs are generating more in cost offsets than the cost of the programs, with a net cost saving per person of about $86,000 over 5 years.

  The peer support work strategy has been a long-term aim in HASI/CLS services, whereby they have progressed towards embedding peer workers in the program and ensured that they have a professional identity in service.

This includes the availability of senior peer workers providing clinical supervision to peer workers and peer workers attending supervision together with non-peers. The long-term relationships between worker and consumer have been shown to contribute effectively to consumer engagement with support workers and the positive impact on mental health and social engagement.

- The introduction **Safe Havens** in NSW is an important initiative providing a place to go when people feel distressed or have suicidal thoughts. These are environments where people can talk to peer workers and be connected to a mental health professional. Consumers do not need an appointment and services are free. People generally report they feel safer and more comfortable using services when they are community initiated and managed rather than services based within clinical/medical services.

  Taylor Fry and ARTD consultants were engaged by the Mental Health Branch in 2020 to evaluate six NSW suicide prevention initiatives over a three period. These initiatives formed part of the Towards Zero Suicides (TZS) program. Evaluation of the Safe Haven Initiative completed in September 2024, provided a summary of the key findings which demonstrated promising recovery outcomes and consumer experience of service use, leading to the roll out of 21 centres and the recent commitment to ongoing funding from the Minister. These services need to be more broadly available across NSW especially in regional and remote areas; and be accessible 24/7.

  One of the unique aspects is that the service provides peer led, non-clinical support (and operates in a home-like rather than hospital-like setting). People who access the service and the majority of staff and referring organisations were highly positive about the peer workers at the Safe Havens. People accessing the service appreciated being able to access support from people who had related experiences. Stakeholders said that the value of peer support was in their skills in holding space for distress, providing hope to people, and creating a non-judgemental and welcoming environment. This non-clinical, peer led approach was particularly valued by people who had previously had negative or traumatic experiences in clinical settings. There was substantial positive feedback about the quality of staff, which is a significant enabler. Having a diverse range of staff was also noted by many as being critical for service provision to a diverse community. This was particularly true where sites had been able to recruit peer workers from Aboriginal communities and the LGBTQIA+ community.

  People were highly positive about receiving support from peer workers and valued the lived experience approach. This created a feeling of safety and care that was markedly different from previous experiences. They also said that they felt they received care that was personal, supportive and non-judgemental. They appreciated being able to access support without fear of being subject to escalation without their consent (for example, psychiatric assessment or involuntary admission).

The PC has demonstrated that whilst the Agreement has gone some way towards defining mental health and suicide prevention reform objectives and activities, that it has failed to provide a national strategic framework that *"adequately guides unified efforts and investment across governments, services, and communities,"* and that "*in its current format, it more closely resembles an implementation plan with discrete activities for the Commonwealth, state and territory governments substantially defined in adjunct agreements and schedules, predominantly focused on specific service models rather than broader system improvements."*

We agree that this has contributed to the increased fragmentation of the service system and exacerbated the gaps which have become a barrier to integration across the service system. The poor attention to building a sustainable and effective mechanisms to support reform is lamentable.

We welcome recommendations to increase the transparency and effectiveness of governance arrangements, including by increasing the involvement of lived experience and sector representatives in both co-design and governance forums, and ensuring a stronger role for the National Mental Health Commission to independently monitor the progress of delivery of the Agreement.

Such actions offer a pathway to creating the strong, shared foundation for the future that is integral to ensuring effective system reform and implementation. Some actions identified, such as increasing transparency of existing governance forums and reporting mechanisms – could be actioned now, without needing to wait for the next Agreement.

MHCC thanks the Productivity Commission for its work and for providing us with the opportunity to input into the final report. I and my colleague Corinne Henderson, Director, Policy & Systems Reform are happy to be consulted at any further stage in the process.

Evelyne Tadros
Chief Executive Officer
Mental Health Coordinating Council
Adjunct Associate Professor
School of Clinical Medicine
Psychiatry and Mental Health, UNSW

References

[1] Professor Henry Cutler et al., 2023, *Getting more value from mental healthcare funding and investment: Workshop.* Available: https://www.mq.edu.au/research/research-centres-groups-and-facilities/prosperous-economies/centres/centre-for-the-healtheconomy/publications

Consultation paper: https://www.mq.edu.au/__data/assets/pdf_file/0005/1271750/Embedding-value_Consultationpaper_230809.pdf

[2] NSW Health website: Available: https://www.health.nsw.gov.au/towardszerosuicides/Pages/suicide-prevention-older-people.aspx

[3] AIHW 2024, *Mental health in aged care.* Available: https://www.aihw.gov.au/reports/aged-care/mental-health-in-aged-care/contents/about

[4] Elshaikh, U., Sheik, R., Saeed, R.K.M. et al. 2023, *Barriers and facilitators of older adults for professional mental health help-seeking: a systematic review*. BMC Geriatr 23, 516 (2023). https://doi.org/10.1186/s12877-023-04229-x

[5] Mental Health Coordinating Council, 2022, *Shifting the Balance: Investment Priorities for Mental Health in NSW.* Available: https://mhcc.org.au/publication/shifting-the-balance/