



National Mental Health and Suicide Prevention Agreement

Response to the Productivity Commission Interim Report

July 2025

We acknowledge the Traditional Custodians of all the lands on which Jesuit Social Services operates and pay respect to their Elders past and present. We express our gratitude for their love and care of people, community, land and all life.

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Jesuit Social Services:

Who we are and what we do

Jesuit Social Services is a social change organisation working to build a just society where all people can thrive. For almost 50 years, we have accompanied the most disadvantaged members of the community, providing services and advocacy in the areas of justice and crime prevention; mental health and wellbeing; multiple and complex needs; settlement and community building; education, training and employment; gender justice; and ecological justice.

We are a national organisation with a significant footprint in Victoria, New South Wales and the Northern Territory, where we work with some of the most marginalised individuals and communities.

Mental ill health, suicide and suicidal distress impact the people we work with across several programs, in particular:

- **Mental Health and Wellbeing Connect – Western Metro:** The *Mental Health and Wellbeing Connect* service offers a warm and welcoming space for family, carers, kin and supporters of people who are experiencing mental health challenges, psychological distress, mental illness, or substance use issues. It is one of eight centres established around Victoria following the Royal Commission into Victoria's Mental Health System (2021). It offers a range of supports including information, resources, counselling, individual support, and group programs to those who care for others with mental health and substance use issues. The service is committed to employing people with lived experience.
- **Connexions:** The *Connexions* program supports young people aged 16 to 28 who have a dual diagnosis of mental health and substance use issues. It provides assertive counselling, casework and advocacy to participants, and also offers secondary consultation, training and support to other workers. We also partner with the Mental Health and Wellbeing Local in Brimbank to provide outreach and after hours support to adults with co-occurring mental health and substance use issues.
- **Support After Suicide:** *Support After Suicide* has been supporting Victorians bereaved by suicide since 2004 and assists children, young people and adults. The program provides specialist bereavement and trauma counselling, support groups and online resources free of charge and for as long as they are needed. The service is delivered by qualified and experienced postvention clinicians with strong links to local communities and other services. Since its establishment, people with lived experience of bereavement due to suicide have been involved in the design and delivery of the program. We also deliver training to health, welfare and education professionals. The service has partnered with other sectors and organisations to develop resources tailored for specific communities that experience higher rates of suicide than the general population.
- **StandBy Support after Suicide (StandBy):** *StandBy* is a national service established in 2002 that provides free, practical support to anyone who has been bereaved or impacted by suicide, at any stage in their life. Jesuit Social Services delivers this service in metropolitan Melbourne and Gippsland. As part of its

standard program, *StandBy* offers one initial in-person session followed by several phone sessions for up to two years. Some peer support and counselling sessions are available as part of its enhanced service.

- **Programs working with people with multiple and complex needs:** We also deliver a range of programs that work with people with multiple complex and intersecting needs, including mental ill health, substance misuse, histories of trauma, homelessness and disability. These include the *Individual Support Program*, which provides tailored support for young people with multiple and complex needs, and *Dillon House*, which provides supported accommodation and case management for young people involved with the justice system at risk of homelessness.

Submission overview

Jesuit Social Services welcomes the interim report of review by the Productivity Commission (the Commission) of the National Mental Health and Suicide Prevention Agreement (the Agreement) and the opportunity to make a submission.

Summary of key recommendations

We agree with the Commission's view that the Agreement has not delivered significant progress towards an integrated, accessible and person-centred mental health and suicide prevention system. Fragmentation persists, and systemic gaps continue to place vulnerable people at risk. The next Agreement must:

- Enable states and territories to deliver services that are responsive to local needs
- Improve service access, system navigation and continuity of care for people with multiple and complex needs, supported by fit-for-purpose funding models
- Prioritise whole-of-government collaboration to enable more holistic approaches to policy-making and service delivery, especially for people with complex and multiple needs, with a focus on ensuring access to stable and secure housing
- Improve access to (co-designed) supports for carers, families, supporters and kin
- Prioritise equitable service provision, especially for people in rural and regional communities
- Reduce the complexity of funding and reporting arrangements for service providers at the local level.

We broadly support the Commission's draft findings and draft recommendations, including the draft recommendations to establish separate schedules on co-occurring mental ill health, substance use and suicide, and on suicide prevention.

Focus of our submission

Our submission is structured around key themes arising from the interim report,¹ and is informed by the practice experience of our staff and participants, including those with lived and living experience of mental ill health, substance misuse and bereavement by suicide, and as carers, families and supporters. We have taken a selective approach in our submission, responding only to those draft findings, draft recommendations and information requests where Jesuit Social Services has specific expertise to offer.

In particular, we have expertise to share in relation to:

- **Arrangements for the provision of postvention services for people bereaved by suicide**, drawing on 20 years of experience delivering *Support After Suicide* and, more recently, *StandBy Support After Suicide*
- **Design and delivery of support services for families, carers and supporters of people with mental ill health or substance use issues**, informed by our experience

¹ Responses to draft findings and recommendations from the Commission are grouped by theme in this submission, with relevant draft findings and recommendations referenced in square brackets. For example, [F2.1, R4.2] refers to draft finding 2.1 and draft recommendation 4.2.

designing and delivering the *Mental Health and Wellbeing Connect* service in western metropolitan Melbourne

- **Innovative models for integrating the peer workforce into mental health services**, including the unique workforce model we have adopted at our *Mental Health and Wellbeing Connect* service, where all roles are carer lived experience positions
- **Integrated service responses for people with co-occurring mental ill health, substance use issues and suicide risk/distress**, drawing on 30 years of experience delivering the *Connexions* dual diagnosis service.

In addition, we have significant experience working with people with multiple and complex needs – including intersecting needs related to mental health, substance use, disability, housing insecurity, family violence and criminal justice involvement – and offer insights into the challenges they face in navigating and accessing mental health, substance use and suicide prevention services.

Lack of progress towards the Agreement’s intent to create an integrated, person-centred mental health and suicide prevention system [F2.1, F2.2, F3.1, R4.2]

We agree with the Commission’s finding that progress towards the Agreement’s intent to create an integrated, person-centred mental health and suicide prevention system has been piecemeal, and that services remain unaffordable, difficult to access for many people and do not always respond to need. We must continue to work towards the development of a holistic and integrated national system of care that is accessible, grounded in a culture of compassion, and involves families, carers and kinship networks.

We have outlined below some of the ongoing challenges faced by our program participants, as well as an example of promising practice in person-centred care:

People at risk of suicide, people with multiple and complex needs, and their families, carers and supporters continue to face barriers to service access

We hear from families participating in our postvention services that people at risk of suicide, as well as their family and carers, attempted to navigate the mental health system – including presenting to emergency departments when in crisis or acute distress – but encountered barriers to care, poor quality or a lack of support services, as well as people being discharged from care prematurely or without support, including following a suicide attempt. 79 per cent of family members who completed our survey said they felt there were barriers to them accessing information or help in caring for their family member.²

Participants in our programs supporting people with multiple and complex needs, like *Connexions*, continue to encounter barriers to service access, including restrictive eligibility

² Flynn, L. 2020. “We were fighting the system as well as the illness”: Family perceptions of how Victoria responds to people at risk of suicide and their loved ones. Melbourne: Jesuit Social Services [Available at: <https://jss.org.au/programs/support-after-suicide-2020-report/>]. This report was compiled from an online survey completed by family members of people who took their own lives. The survey was completed by 142 former and current participants of *Support After Suicide*’s counselling services, from which 28 were chosen for in-depth interviews. While this report is from 2020, prior to the establishment of the National Mental Health and Suicide Prevention Agreement and the Royal Commission into Victoria’s Mental Health System, we continue to hear stories about similar experiences.

criteria that exclude people with dual or multiple diagnoses, rigid service models, stigma and negative attitudes, and lack of communication and collaboration between services. It is often the people with the greatest need for support who are excluded from services – including the most acute services (such as Area Mental Health and Wellbeing Services) – due to “complexity”.

Families, carers and supporters are excluded from care and care planning

We also hear distressing stories of people close to someone experiencing mental ill health or at risk of suicide – partners, parents, siblings and children – being excluded from care planning and not having their concerns listened to. This includes family members being excluded from treatment and discharge planning, not being told of their family member’s discharge from hospital, and experiencing negative attitudes from mental health professionals. While family members recognise concerns about patient/consumer privacy, they feel that services/practitioners often do not acknowledge their role as carers or listen to their concerns.³

Some recent reforms represent promising practice in provision of integrated, person-centred care and support

One example of promising practice in delivering integrated, person-centred care is the Victorian Mental Health and Wellbeing Local model, rolled out following the Royal Commission into Victoria’s Mental Health System. While implementation of this model is still in its early stages, our experience of partnering with the Brimbank Local in Melbourne’s western suburbs to deliver outreach support for adults with co-occurring mental health and substance use issues is that the Local model is helping to address the need for step up/step down support for people with mental health conditions of moderate acuity, and assisting people with lived and living experience as consumers and carers/ families/ supporters to navigate the service system.

Recommendation

1. In line with Action 9.1a in the National Suicide Prevention Strategy, the next Agreement should prioritise resourcing to develop and implement national best practice guidance for crisis support services, including emergency departments, to support people in suicidal crisis, including: professional development for staff; new workforce models integrating suicide prevention peer workers; and inclusive practice that involves and supports families, carers and kin (with consent).

National Stigma and Discrimination Reduction Strategy [R2.1]

We echo the Commission’s call for the National Stigma and Discrimination Reduction Strategy to be delivered by the end of 2025.

The next Agreement should commit resourcing to combat stigma and discrimination

It is essential that all mental health, Alcohol and Other Drug, and social services treat people with compassion and respect. Many of our participants (both consumers and families/ carers/ supporters) report being poorly treated during their interactions with mental health and other social services (including Centrelink and employment services). This contributes to stigma, shame, isolation and reluctance to seek help again. In particular,

³ Flynn, L. 2020. *“We were fighting the system as well as the illness”*.

people with substance use issues, and their families, carers and supporters, continue to experience judgment and stigma from service providers and practitioners.

A shift in workplace culture, practices and systems is needed to reorient services that work with people experiencing mental ill health, substance misuse or suicidal distress – as well as their families, carers and supporters – towards the provision of person-centred support which is grounded in compassion and instils a sense of hope and self-worth.

Recommendation

2. The next Agreement should commit resourcing to implement the National Stigma and Discrimination Reduction Strategy.

Local-level governance, planning, coordination, commissioning and funding arrangements [R2.1, R4.5, R4.12]

Funding for suicide postvention services is fragmented

The experience of bereavement after suicide can be complex and prolonged, and carries risks for suicidality, mental ill health and substance use, and isolation from community. Research has shown that people bereaved by suicide are 65 per cent more likely to attempt suicide than people bereaved by sudden natural causes.⁴ Delivery of effective, ongoing and community-based postvention services is therefore a critical part of suicide prevention. However, funding arrangements for suicide postvention services are disjointed and complex, creating a patchwork of support across different regions, with reduced service access for people in regional areas, who are up to twice as likely to die by suicide as people living in major cities.⁵

For example, Jesuit Social Services is currently funded to deliver two suicide postvention programs in Victoria – *Support After Suicide* and *StandBy Support After Suicide*:

- **Support After Suicide** is funded by the Commonwealth only, via regional and metropolitan Primary Health Networks (PHNs), as part of Targeted Regional Initiatives for Suicide Prevention (TRISP) program. Jesuit Social Services has been delivering this program for more than 20 years, and is currently funded to deliver this program in metropolitan Melbourne and parts of Gippsland (four out of six PHNs). *Support After Suicide* is not funded by the two remaining PHNs.

Support After Suicide provides tailored, ongoing support for people bereaved by suicide, for as long as it is needed. In addition to counselling and online resources, *Support After Suicide* offers group programs and peer support, fostering a sense of belonging and community for participants. The service is delivered by qualified counsellors with specialist expertise in grief and trauma.

- **StandBy Support After Suicide** is co-funded by the Commonwealth and Victorian Governments, under the bilateral schedule to the Agreement. Jesuit Social Services

⁴ Pitman, A, Osborn, D, Rantell, K, & King, M. 2016. *Bereavement by suicide as a risk factor for suicide attempt: A cross-sectional national UK-wide study of 3432 young bereaved adults*. BMJ Open, 6, e009948. 10.1136/bmjopen-2015-009948.

⁵ See Australian Institute of Health and Welfare, *Suicide and intentional self-harm hospitalisations among regional and remote communities* [Available at: <https://www.aihw.gov.au/suicide-self-harm-monitoring/population-groups/regional-remote-communities>]

delivers this service in metropolitan Melbourne and Gippsland (contracted by YouTurn Ltd), and another provider delivers the program in other Victorian regions.

While *StandBy* is evidence-based and supported by evaluation, it offers a narrower service than *Support After Suicide*. As part of its standard model – funded through the Agreement – *StandBy* offers one in-person session followed by several follow-up phone calls at specified intervals, for up to a maximum of two years. Support is delivered by support workers rather than qualified postvention practitioners.

Additional “enhanced support” (involving up to six peer support sessions and up to ten counselling sessions) is funded outside the Agreement (through the National Suicide Prevention and Leadership Support Program – NSPLSP) for jurisdictions that have included postvention services in their bilateral schedule and named *StandBy* as the program. Jurisdictions that did not include postvention services in their bilateral schedule are still funded to deliver the standard *StandBy* model, but do not have access to enhanced support.

These complex funding arrangements have given rise to inequitable service access, with both service gaps and duplication across regions. People in metropolitan Melbourne and Gippsland have access to two complementary postvention programs with a degree of duplication, while people in other parts of Victoria only have access to the *StandBy* program. People in jurisdictions that did not include postvention services in their bilateral schedule still receive *StandBy*, but do not have access to the enhanced service (counselling and peer support).

Both *Support After Suicide* and *StandBy* receive only short-term funding (currently due to expire in June 2026), and our waitlist for *Support After Suicide* is growing, with funding insufficient to meet demand.

The current Agreement restricts jurisdictions from choosing the most suitable postvention service

Current bilateral schedules restrict some states (including Victoria) from choosing a postvention service provider/model that suits the needs of their own jurisdiction. Only Youturn Ltd was funded in the bilateral schedule to deliver a prescribed program – *StandBy* *Support After Suicide*. While *StandBy* provides a valuable initial response for people bereaved by suicide, a program like *Support After Suicide* can provide ongoing support that is tailored to the needs of the individual.

We strongly support the Commission’s draft recommendation that “funding arrangements in the next agreement should provide PHNs with sufficient flexibility to commission locally relevant services or support existing services where they have been positively evaluated. National service models should not limit the ways in which PHNs meet their communities’ needs” (Draft recommendation 4.12).

PHNs lack a strong understanding of the mental health and alcohol and drug service systems

While PHNs have a strong understanding of the primary health care system, their understanding of the mental health, suicide prevention and alcohol and other drug service system is more limited. This constrains their ability to plan and commission local mental health, alcohol and other drug and suicide prevention services effectively, and creates

challenges for service providers advocating to improve services for their participant cohorts.

Current funding arrangements create a high administrative burden

We support collaborative local governance structures involving PHNs that encourage planning and commissioning of services that are responsive to local needs. However, programs that are commissioned by multiple PHNs face an onerous reporting environment involving a high number of reports, with inconsistent reporting requirements and templates.

We support the development of national guidelines for regional planning and commissioning local services that would balance the need for more effective, nationally consistent commissioning while still allowing for local services that are responsive to need (Draft recommendation 2.1). We support standardisation of reporting requirements across PHNs to reduce the administrative burden on service providers.

Recommendations

3. Ahead of the next Agreement, funding arrangements for suicide postvention services should be reviewed to reduce service gaps and duplication.
4. In line with Action 5.2f in the National Suicide Prevention Strategy to provide universal access to postvention services, the next Agreement should:
 - a. provide secure and increased funding for comprehensive and responsive suicide postvention support, to reach a greater number of people bereaved by suicide, including those in regional and remote communities
 - b. not prescribe a service model or service provider, but allow all states and territories to deliver evidence-based, best-practice postvention services that meet the needs of their communities
 - c. better integrate funding for postvention support from Commonwealth and state governments.
5. Ahead of the next Agreement, the Commonwealth and states and territories should work with PHNs to enhance their capability to effectively plan and commission local mental health, drug and alcohol, and suicide prevention services by increasing their understanding of these service systems.

Unmet need for psychosocial supports [R4.4]

We strongly support draft recommendation 4.4 that governments should immediately address the unmet need for psychosocial supports outside the National Disability Insurance Scheme (NDIS), and that the Australian, state and territory governments need to immediately agree responsibilities for psychosocial supports outside the NDIS.

We outline below some challenges specific to our program participants in need of psychosocial supports, in particular those with justice system contact.

People with multiple and complex needs struggle to access both the NDIS and other services

People with co-occurring psychosocial disability and other complex needs, such as substance use or involvement with the criminal justice system, experience significant barriers to accessing supports both within and outside the NDIS.

Our experience shows that people with psychosocial disability and other complex needs often have difficulty proving they are eligible for the NDIS. This can be due to: complicated, expensive and burdensome evidentiary requirements; challenges proving their disability is “permanent”; difficulties engaging with or completing assessment processes to prove that they have an acquired brain injury or other intellectual or neurodiverse diagnosis; or substance use issues making assessments challenging. Those who do receive NDIS funding may receive a package that does not appropriately address their support needs.

At the same time, people with psychosocial disabilities are often excluded from state-funded mental health and drug and alcohol services because they have multiple diagnoses or are considered too complex. As a result, we witness people with severe and complex needs being excluded from both the NDIS and other services, and having to manage without supports. In some cases, this can create a risk to the person themselves and/or the community.

Arrangements for psychosocial supports must ensure continuity of care

Jesuit Social Services delivers transitional support programs for people exiting custody, many of whom have disabilities, including psychosocial disabilities.

As part of determining responsibilities for the funding and delivery of psychosocial supports outside the NDIS, governments must consider how to ensure continuity of care during periods of transition, particularly for people with multiple and complex needs.

For example, people with disabilities with a funded NDIS package are not usually able to access NDIS-funded services while in custody. Many disability services within prisons are funded by state/territory governments. However, once a person is released back into the community, reactivation of NDIS services does not happen automatically, and there is no trigger advising when a person has exited custody. In such instances, confusion about responsibility for service provision, and the lack of smooth transition in service delivery, can result in a person lacking critical supports during a vulnerable time.

People with psychosocial disabilities need information and support to navigate services

Participants often describe navigating the NDIS as complex and time consuming. It is often unclear what services/supports are funded by the NDIS and which are not (and if so, whether and where these might be available elsewhere). For people with multiple and complex needs, navigating service systems is even more challenging. It will be critical to ensure that information that clearly describes what supports are funded and available for people with psychosocial disabilities inside and outside the NDIS is easily accessible to participants, families/carers and service providers.

Embedded disability liaison officers could be considered (perhaps as part of arrangements for the provision of Foundational Supports) to help people to navigate between support systems. This could draw on successful examples of disability liaison officers embedded in other services, such as in Victoria's child protection system, where they have been effective in supporting access to NDIS assessments.

Recommendations

6. Urgently, and ahead of the next Agreement, governments should prioritise the resolution of roles and responsibilities for the funding and provision of psychosocial supports outside the NDIS, taking into account the following considerations:

- a. To minimise barriers to access, eligibility for psychosocial supports outside the NDIS should be based on a broader definition of disability that is inclusive of psychosocial disability, other forms of intellectual and developmental disability and neurodiversity, with reasonable evidentiary requirements to prove eligibility (for example, use of previous assessments).
- b. Arrangements for provision of psychosocial supports outside the NDIS should include consideration of continuity of care for people transitioning between service systems, especially those with multiple and complex needs.
- c. Clear information about what supports are funded and available for people with psychosocial disabilities inside and outside the NDIS should be made easily accessible to participants, families/carers and service providers.
- d. People with psychosocial disabilities should be supported to navigate between the NDIS and other support systems, for example through disability liaison officers embedded in other service systems.

Inclusion of people with lived and living experience of mental ill health and suicide, including carers, families, supporters and kin in governance, design, planning, delivery and evaluation of services [F3.1, R4.1, R4.2, IR4.2, R4.7]

We support inclusion of people with lived and living experience of mental ill health and suicide, including carers, families, supporters and kin in governance, design, planning, delivery and evaluation of services under the Agreement, and in the co-design of a renewed National Mental Health Strategy (Draft recommendation 4.1). We also support greater representation of people with lived and living experience of suicide distress/ bereavement within governance arrangements, in recognition of their current underrepresentation.

The important role of carers, families, supporters and kin is often not recognised

Through the *Mental Health and Wellbeing Connect* service we operate in western metropolitan Melbourne, and our suicide postvention services, we work with family members, supporters and carers of people with lived and living experience of mental ill health and suicide. As previously outlined, our participants report that, in too many instances, the advice and insights of carers has not been acted upon by clinicians. Families, carers, supporters, and kin should be treated as fundamental to support and care planning, with their role recognised within system-level coordination and governance.

Co-design with families and carers delivers better services

It is essential that family members and carers are part of conversations about strengthening our national mental health and suicide prevention system at all levels – both in terms of the insights they can share about the experiences of the person they care for in accessing supports, and as people navigating and using support services themselves.

From the outset, the *Mental Health and Wellbeing Connect* service has been shaped by people with lived and living experience as carers, families and supporters of people with mental ill health or substance use issues – from planning and service design through to implementation and service delivery. A Community Reference Group comprising carers, families and supporters of people with mental ill health and substance use issues continues to provide advice to support continuous improvement of the service. The leadership of

people with lived and living experience as carers, families and supporters in the design and implementation of the service has been essential to ensure it best meets the needs of this cohort. In evaluation research recently undertaken by RMIT University Social Equity Centre, both workforce and family and carer participants referenced how the service felt fully family- and carer-led, with family and carer needs placed at the heart of planning and decision making.⁶

Provision of support for families, carers, supporters and kin [R4.5]

We support the Commission's draft recommendation (4.5) that the next Agreement clarify the level of government responsible for planning and funding carer and family support services for supporters, families, carers and kin of people with lived and living experience of mental ill health and suicide.

As is a theme throughout this submission, many carers, family members and supporters of people experiencing mental ill health, substance use issues or suicidal distress report that they are not respected or listened to, excluded from care, and often pathologised and/or regarded as a nuisance.

Families, carers and supporters want flexible and tailored service offerings

Our experience co-designing and delivering the *Mental Health and Wellbeing Connect* service with and for carers, family members and supporters of people with mental health or substance use issues, indicates that providing a diversity of service offerings, rather than imposing a rigid service model, enables participants to choose the type(s) of support that best meets their needs.

Service offerings at *Mental Health and Wellbeing Connect* include assertive outreach, counselling, group-based support, and social and recreational activities, with appointments and activities also available after hours (evenings and weekends). For many carers, family members and supporters, opportunities to build community and connection with people with similar experiences is one of the most valued aspects of the *Mental Health and Wellbeing Connect* service. Recognising that carers may be living full and complex lives, flexibility with the timing, location and modality of service delivery is essential.

Family and carer participants in the evaluation research conducted by RMIT University experienced positive mental health outcomes. The tailored counselling fostered feelings of being understood, enabling carers to "keep going" and helping them to navigate their ongoing caring/support commitments. Counselling also helped them to build skills for managing their relationships with the person they were caring for/ supporting. The group-based sessions offered the opportunity for peer support and fostered the establishment of new social connections and networks.⁷

Recommendation

7. The next Agreement should enable the funding and delivery of a diverse and flexible range of co-designed supports for carers, families and supporters of people with lived and living experience of mental ill health, substance use and suicidal distress,

⁶ Seal, E. et al. 2025. *Western Metro Mental Health and Wellbeing Connect Centre: Evaluation Research Interim Report*, RMIT University Social Equity Centre, pp 4, 22.

⁷ Seal, E. et al. *Western Metro Mental Health and Wellbeing Connect Centre: Evaluation Research Interim Report*, pp 5, 23, 31.

enabling carers, family members and supporters to choose those supports that best meet their needs.

Integration of the peer workforce [IR4.4]

We note that the Commission is seeking case studies highlighting best practice in integrating peer workers in clinical mental health and suicide prevention settings.

In our *Mental Health and Wellbeing Connect* workforce model, all roles are carer lived experience positions

Jesuit Social Services has adopted a unique, integrated workforce model for its *Mental Health and Wellbeing Connect* service in western metropolitan Melbourne in which all roles are carer lived experience positions. This contrasts with other providers of Connect services where the clinical workforce is separate from the peer workforce. All staff at Jesuit Social Services' *Mental Health and Wellbeing Connect* service are required to have the necessary skills, qualifications and experience for the role (for example, counselling, assertive case management), but they are also expected to have lived experience as a carer.⁸

Staff are invited to intentionally use a lived experience lens to inform their practice, for the benefit of the carers and families they work with. Through the active and intentional use of lived experience in everyday practice, staff could be said to be utilising "lived expertise", that is the "knowledge, insights, understanding and wisdom gathered through lived experience".⁹

Integration of the peer workforce benefits both participants and staff

In the evaluation research conducted by RMIT University, there was strong consensus among all family and carer participants that Jesuit Social Services' *Connect* service and its staff are compassionate, caring and empathetic. Participants reflected that all encounters and interactions had been welcoming and friendly and the support available was non-judgemental and highly attuned to their needs. Family and carer participants described the authentic understanding and empathy they felt from staff with lived experience and how other supports they accessed in the past often lacked this.¹⁰

All staff who participated in the evaluation research reported that they felt highly valued and supported in their roles, and that the organisation showed a high level of trust and understanding towards family and carer lived experience staff. Staff reported that the service offers a psychologically safe working environment where people can bring their

⁸ Lived experience as a carer is listed as 'highly desirable' in position descriptions.

⁹ Sandhu makes a distinction between lived experience and lived expertise. Lived experience is "the experience(s) of people on whom a social issue, or combination of issues, has had a direct personal impact" (p 5). Lived expertise refers to the "knowledge, insights, understanding and wisdom gathered through lived experience" (p 5): Sandhu, B. 2017. *The value of lived experience in social change: The need for leadership and organisational development in the social sector* [Available at: <https://knowledgeequity.org/wp-content/uploads/2021/06/The-Value-of-Lived-Experience-in-Social-Change.pdf>], cited in Seal, E. et al, *Western Metro Mental Health and Wellbeing Connect Centre: Evaluation Research Interim Report*, p 4.

¹⁰ Seal, E. et al. *Western Metro Mental Health and Wellbeing Connect Centre: Evaluation Research Interim Report*, pp 3, 4, 27, 30.

“authentic selves” to the workplace. Having a workforce consisting entirely of lived experience roles assists to build a strongly inclusive culture that values lived experience.¹¹

Recommendation

8. The next Agreement should enable the development and implementation of innovative models for integration of the peer workforce into mental health and suicide prevention services.

Development of a new Agreement and extension of existing Agreement [R4.1, F4.1, R4.2]

We support the development of a new Agreement with clearer objectives and outcomes linked to the National Suicide Prevention Strategy and a renewed National Mental Health Strategy (Draft Recommendation 4.1).

Prescriptive requirements for postvention services should be removed

As noted on page 10 of this submission, the bilateral schedule to the current Agreement prescribes a sole provider/service model for postvention services which restricts the ability of those states and territories that have included postvention services in their bilateral schedule to choose alternative evidence-based services that may be more responsive to the needs of their populations.

We support the extension of the current Agreement to June 2027 (Draft Recommendation 4.2), subject to an amendment being made to the bilateral schedule to the Agreement (by the end of June 2026 when the current Agreement is due to expire) to remove the requirement for states and territories that have included postvention services in their bilateral schedule to use one specific service provider/service model.

Funding should enable both intergovernmental and intersectoral collaboration

We also support the Commission’s recommendation that governments should allocate dedicated funding for collaborative initiatives and enablers of collaboration in the next Agreement. Collaborative initiatives should include both *intergovernmental* collaborations in mental health and suicide prevention and *cross-sector collaborations* with intersecting service areas (e.g. housing, substance use, disability, criminal justice). This would support more holistic approaches to policy-making and service delivery, especially for people with complex and multiple needs, as outlined further in the next section.

Recommendation

9. Extension of the current Agreement to June 2027 should be subject to removal of the requirement for states and territories that have included postvention services in their bilateral schedule to use one specific service provider/service model, enabling states and territories to choose evidence-based services that are most responsive to the needs of their populations.
10. The next Agreement should include dedicated funding to enable both intergovernmental and cross-sector collaboration.

¹¹ Seal, E. et al. *Western Metro Mental Health and Wellbeing Connect Centre: Evaluation Research Interim Report*, pp 3, 14, 15.

Stronger links to the broader policy environment in next Agreement [R4.3]

We support the next Agreement having a stronger focus on a whole-of-government approach to mental health and suicide prevention, including clearer articulation of how it interacts with the broader policy environment across a range of areas, such as housing, justice and disability support.

When people have complex and intersecting needs, it is not possible to work on a single issue

Many of the people we work with experience multiple and complex forms of disadvantage. For example, of the young people aged 15–24 who participate in our programs addressing complex needs, 61 per cent experience four or more of the following: unemployment, disengagement from school, disability, family violence, justice system involvement, insecure housing, mental ill-health and/or alcohol and drug misuse (and these factors are likely underreported for a range of reasons).¹² In our experience, it is not possible to work with a participant on a single issue separately from the other issues and challenges they are facing in their lives.

Homelessness and housing insecurity have an enormous impact on our participants

Through our programs, we have witnessed how homelessness and housing instability is a major contributing factor impacting overall wellbeing – disrupting employment and education pathways and increasing risks of social isolation and justice system contact. Without stable housing, it is difficult for people and the services that support them to make progress in relation to other interconnected challenges such as mental ill health, substance use and potential justice system involvement. Our programs spend significant time and resources managing crises, which are often related to housing insecurity.

Targeted housing solutions are needed to support people with multiple and complex needs. This could include specialist housing programs with wraparound support and/or social housing targets for people with the greatest need, including victim-survivors of family violence and those exiting custody.

Services for people with complex needs are under-funded

As highlighted above, many of Jesuit Social Services' programs are dedicated to working with people experiencing the greatest complexity. In addition to support from practitioners with a higher skill level, participants with high levels of complexity require enduring rather than episodic support, and flexibility in how and when support is provided, including access to assertive outreach (often involving significant travel time) and after-hours support. However, current funding models for programs like *Connexions* do not accommodate the higher costs associated with supporting this cohort. In addition, lack of indexation for some programs means that funding has not kept up with costs, leading to an erosion of the workforce and decreased service capacity over time.

Recommendations

¹² Jesuit Social Services' complex needs programs include [Connexions](#), [Navigator](#), [Individual Support Program](#) and youth justice programs.

11. The next Agreement should articulate its role in addressing the social determinants of mental health, with a particular focus on the provision of stable and secure housing for people experiencing mental ill health, substance use issues or suicidal distress, including targeted housing solutions for people with multiple and complex needs.
12. The next Agreement should provide secure and increased funding for programs that is sufficient to cover the real costs of working with people experiencing mental ill health, substance use issues and/or suicidal distress who have other complex and intersecting needs.

Additional schedule on co-occurrence of problematic and other drug use and mental ill health and suicide [IR4.1]

We note that the Commission is seeking views on whether there should be an additional schedule in the next Agreement to address the co-occurrence of problematic and other drug use and mental ill health and suicide. We support the establishment of this additional schedule.

Siloed service systems exclude those with the most complex needs

Comorbidity of substance use disorders and other mental illnesses is common. People living with a substance use disorder and another co-occurring mental illness experience greater combined disease severity and poorer outcomes than those who experience these conditions individually.¹³

However, the mental health and alcohol and other drug systems remain highly siloed, despite multiple inquiries, such as the Royal Commission into Victoria's Mental Health System, recommending the creation of a more integrated system.

People with substance use issues continue to be excluded from mental health services and vice versa, either explicitly through exclusive eligibility criteria, or indirectly through demand management and risk assessment practices. In some cases, even people with very severe mental illness are excluded from tertiary mental health services due to co-occurring substance use issues.

Funding models do not support service integration

Jesuit Social Services has been delivering the *Connexions* program, which supports young people aged 16 to 28 with a dual diagnosis of mental health and substance use issues, for nearly 30 years. *Connexions* was the first dual diagnosis program for young people in Victoria. It provides assertive counselling, casework and advocacy to participants, and also offers secondary consultation, training and support to other workers. The flexible service model – including assertive outreach and flexible appointment times – is essential for working with this cohort.

While *Connexions* does not maintain a waitlist, every program vacancy is oversubscribed. As the recent joint statement by Mental Health Victoria and the Royal Australian College of Psychiatrists on the role of mental health services in the provision of alcohol and other drug

¹³ Australian Institute of Health and Welfare, *Mental health and substance use* [Available at: <https://www.aihw.gov.au/mental-health/snapshots/mental-illness-and-substance-use>].

responses in Victoria highlights, “many services and roles are stretched beyond their capacity in an effort to support consumers with acute and complex needs”.¹⁴

Existing funding models are not suited to the delivery of integrated services. In order to deliver *Connexions*, Jesuit Social Services must pool state mental health funding and Commonwealth alcohol and other drug funding. This results in duplication of reporting, while misaligned funding periods make recruitment and retention of staff difficult. The degree to which we can manage some of these complexities is often dependent on our relationship with individual contract managers. Lack of indexation of Commonwealth alcohol and drug funding has also resulted in staff reductions.

Co-occurrence of substance use and suicide risk/distress is common

We support the inclusion of suicide within the proposed additional schedule. There is limited recognition of the intersections between substance use and suicide in policy and program design, yet suicide risk and suicidal distress are prevalent among our *Connexions* participants. The prevalence of suicide among this cohort is likely higher than recorded, due to people who take their lives through overdose without that being identified as suicide. The historically narrow view of suicide as a symptom of mental ill health rather than a complex interaction of factors means these deaths – and their prevention through effective holistic interventions – are often overlooked in suicide prevention efforts. Further, the use of substances as a coping mechanism for mental ill health and trauma, and the risks this creates for overdose and suicide, should be considered.

Recommendations

13. A new schedule on co-occurrence of problematic and other drug use and mental ill health and suicide should commit governments to specific actions to:
 - a. identify and address current barriers to service access for people with co-occurring substance use, mental ill health and suicide risk/distress
 - b. develop a more integrated system architecture – supported by integrated service models and adequate, fit-for-purpose funding – to better respond to comorbid substance use and mental ill health, as well as suicide risk/distress
 - c. address capacity constraints across the workforce and service system to ensure equitable access to treatment, care and support across both metropolitan and regional and remote areas
 - d. ensure services are accessible, for example through flexible engagement options such as assertive outreach and after hours access.

Separate suicide prevention schedule [F6.2, R6.1]

We support the development of a separate schedule on suicide prevention, co-designed with people with lived and living experience of suicide distress/bereavement, their supporters, families, carers and kin and service providers. The schedule should clearly align

¹⁴ Mental Health Victoria and Royal Australian College of Psychiatrists. 2025. *The role of mental health services in the provision of Alcohol and Other Drug responses in Victoria* [Available at: https://mcusercontent.com/bef3d4502de8e4da07df417fc/files/541834fe-2f01-d13e-4994-360782fedd28/MHV_RANZCP_AOD_Policy_Position_FINAL_2_.01.pdf]

with the National Suicide Prevention Strategy and forthcoming National Suicide Prevention Outcomes Framework, and be overseen by the National Suicide Prevention Office.

A separate schedule has potential advantages as well as risks

The development of a separate schedule has the potential to support greater prioritisation of suicide prevention within the next Agreement. However, it will be essential to ensure that it does not deepen silos between mental health and suicide prevention, given the important interconnections between them, and the transformation required within mental health services to better meet the needs of people at risk of suicide or experiencing suicidal distress.

It will also be important to mitigate the risk that suicide prevention actions that appear in the schedule will be prioritised at the expense of those integrated with mental health actions in the main body of the Agreement, because the former will be more visible and specific.¹⁵

We are pleased the Commission recognises the importance of a whole-of-government approach to suicide prevention, and agree that the schedule should include roles and responsibilities that extend outside of health where appropriate.

Clarification of roles and responsibilities should include design and evaluation of services tailored to local needs

There is a need to clarify responsibilities for suicide prevention across federal, state and local governments. We agree that this should include clarifying responsibilities for planning, implementing, monitoring and reporting on each commitment. It should also include clarification of responsibility for the design and evaluation of regional approaches to suicide prevention, including postvention services, to ensure that services are appropriately tailored to the unique needs of communities – particularly in regional and remote areas.

The new schedule should prioritise resourcing for rural and remote communities

The new schedule on suicide prevention should prioritise resourcing for suicide prevention and postvention services in regional and remote areas. People living in rural and remote areas are up to twice as likely to die by suicide as people living in major cities.¹⁶ People we work with in regional and remote areas continue to face additional barriers to accessing suicide postvention services, including cost, isolation and distance from services.

Recommendations

14. It should be made explicit in the next Agreement that actions in the main body of the Agreement are inclusive of suicide prevention.
15. The next Agreement should clarify responsibilities for suicide prevention across federal, state and local governments, including responsibilities for the design and

¹⁵ The Commission appears to define suicide prevention-related actions that are distinct from mental health as: assessment and management of suicidal behaviours; means restriction and aftercare and postvention services (Interim report, pp 198–199).

¹⁶ See Australian Institute of Health and Welfare, *Suicide and intentional self-harm hospitalisations among regional and remote communities* [Available at: <https://www.aihw.gov.au/suicide-self-harm-monitoring/population-groups/regional-remote-communities>]

evaluation of tailored regional approaches to suicide prevention and postvention services.

16. The next Agreement should prioritise resourcing for suicide prevention and postvention services in regional and remote areas.