Mental Health Association of Central Australia
14 Lindsay Avenue, Alice Springs | PO Box 2326 Alice Springs NT 0871
p: (08) 8950 4600 | f: (08) 8953 5577
e: info@mhaca.org.au | w: www.mhaca.org.au

MHACA

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Submission to the Mental Health and Suicide Prevention Agreement Review by the Productivity Commission

The Mental Health Association of Central Australia (MHACA) welcomes the opportunity to provide feedback on the interim findings by the Productivity Commission from the review of the National Mental Health and Suicide Prevention Agreement.

MHACA is a community managed organisation that provides individual and group based psychosocial support services, NDIS support coordination, tenancy support and homelessness assistance, aftercare supports, suicide prevention training and health promotion programs in Central Australia. We are the only specialist community based mental health NGO in the Northern Territory (NT) outside of Darwin.

MHACA has a long history in supporting people living with a range of chronic mental health conditions and is a strong advocate for raising the voices of lived experience in local, territory and national consultation processes. Whilst we provide a whole of community service, 70% of our participants are First Nations people.

As a small not-for-profit organisation in the middle of remote Australia we are delivering services to people who live with significant complexity of need, who don't have the same level of access to services that many other Australians experience.

The Northern Territory has the highest rate of suicide in Australia, and the highest rate of burden of disease in Australia. Mental health conditions contribute to 16.3% of this burden of disease, although we believe this to be under-reported and not reflective of the true levels of mental health challenges and distress in the Territory.

MHACA supports the findings in the interim report, including extending the length of this agreement to allow for more planning time for the next one, however we want to make comment on the following:

Recommendation 2.1

Significant stigma still exists in our region, including in First Nations and multicultural communities, which impacts help-seeking and health outcomes. There needs to be continued investment in targeted and culturally appropriate mental health promotion and a clear articulation of what services are available. We support the release of the National Stigma and Discrimination Reduction Strategy (which we provided a submission to in January 2023).

Recommendation 4.4

As an organisation that does provide psychosocial supports to people not on the NDIS we strongly support **Recommendation 4.4** 'Governments should immediately address the unmet need for psychosocial supports outside the National Disability Insurance Scheme.'

Whilst the Northern Territory has a small population, funding must be allocated to meet the level of distress and need that exists in our communities, particularly for First Nations people.

Gaining access to the NDIS for people living with psychosocial disability is not an easy process, and sometimes it requires multiple attempts with multiple stakeholders involved to be able to provide the level of evidence required. This can be very difficult for First Nations people, where English may not be not a first language, and requires support from organisations like MHACA to enable an application to be made.

Not everyone living with mental health challenges meet NDIS requirements but they require similar levels of support to be able to engage in a journey of recovery and improve their quality of life.

Recommendation 4.5

We also support **Recommendation 4.5** 'The next agreement should clarify responsibility for carer and family supports.' The burden of responsibility for families and carers is high when supporting people living with mental health issues, and dedicated supports must be put in place. For people living in remote communities, true co-design (including utilising interpreters, visual aids etc) must occur to understand how family members can be better supported in these locations.

Information request 4.2

There are barriers to participation for people living with mental health challenges to engage in governance forums, particularly in regional and remote areas. As our organisation supports people living with severe mental health conditions this can include impacts from medications, confidence to share stories, English not being a first language, not having access to technology.

The most successful way to engage our participants is for the various organisations seeking feedback to come here to our premises and work with us to provide a safe and comfortable space for people to engage. Participant renumeration (through vouchers) also provides incentive and acknowledgement of people's time and experiences.

This has worked well in the past with the National Mental Health Commission visiting MHACA and dedicating the time to spend with our participants. MHACA will also often provide food and promotion of the session in partnership with the visiting organisation to facilitate the lived experience voices of our participants.

Recommendation 4.12

MHACA particularly supports the statement that 'the next agreement should provide PHN's with sufficient flexibility to commission locally relevant services.' It is essential in funding allocation decisions that smaller localised programs and initiatives are not forgotten. In the Northern Territory funding can be allocated to national or larger organisations that don't always have a local context and can be hard to collaborate with.

With significant national investment in mental health services and suicide prevention, we advocate that some of this funding must reach the on-the-ground organisations who work locally in regions across Australia and are engaged in front line service provision.

We would also like to draw attention to the fact that the evidence-base of what works in mental health and suicide prevention is often from metropolitan areas from larger organisations that have funding to evaluate programs. Smaller organisations often do not have the resources to evaluate the impact of programs, so 'evidence based' must not be a pre-requisite for all funding allocation.

In a NT context, with a small and remote population, it is more the localised solutions that are from the grassroots or community-based programs that have more impact.

Recommendation 4.13

With critical staffing shortages here in the Northern Territory, and indeed more broadly in the health sector, quality of care whilst seeking support for mental health and suicidal distress is an ongoing issue that needs focus.

We strongly support staff in acute and community-based roles to be upskilled around compassionate responses to people in distress and experiencing suicidal ideation, including culturally safe responses for First Nations, CALD and LGBTQIA+ community members. It must be clear on how workforce initiatives will be delivered and funded.

Recommendation 4.14

We strongly advocate that funding needs to be assigned to provide the skills development and wrap around supports to ensure peer workers are successful in roles. As an organisation that facilitates peer workers, we feel the scaffolding is not there to ensure successful outcomes and no extra funding is provided to us to ensure peer workers are supported. Organisational systems must have resourcing to facilitate this in a safe way for everyone.

Recommendation 5.1

MHACA strongly supports an Aboriginal and Torres Strait Islander schedule in the agreement. We note there is a distinct lack of culturally appropriate mental health services and suicide prevention training opportunities for remote Aboriginal community members where there are high levels of need.

Continuity of care is also very difficult in a remote context, with poor access to specialists and other providers (often fly-in fly-out).

Accessing phone support lines is not often a viable solution due to challenges in accessing working phones and reception.

There is much more work that needs to be done to support First Nations people in accessing the same supports that many other Australians receive.

Recommendation 6.1

MHACA is a signatory to the recent calls for a National Suicide Prevention Act to ensure shared responsibility for suicide prevention across all levels of government.

In acknowledging that there are many factors that sit outside of mental health that may lead someone to feel suicidal, a separate schedule for suicide prevention would support more targeted actions and responsibilities.

I am happy to discuss any points raised in this submission further.

Warm regards,

Nicole Pietsch
CEO, Mental Health Association of Central Australia