Mental Health and Suicide Prevention Agreement

Ruah Community Services' Response to Interim Report

Ruah provided a comprehensive written submission to the original Review, that included the following recommendations:

- Expand Non-Clinical, Peer-Led Suicide Prevention Services
- Strengthen Cultural Safety & First Nations-Led Approaches
- Address Funding & Workforce Sustainability
- Enhance Service Integration & Coordination
- Develop a National Mental Health & Suicide Prevention Data Framework

We are pleased that these concerns have been acknowledged and reflected in the interim report, and particularly that it advocates for accountability for funding and measuring the improvement of services for Aboriginal and Torres Strait Islander people.

Ruah considers that the recommendations in the Interim Report, and areas for priority action, particularly to address psychosocial unmet need and to reinvigorate the National Mental Health Commission, are robust. If implemented, they would be significant in advancing system reform.

Alongside the Australian Psychosocial Alliance (APA) Ruah posits that:

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

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

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

- It's critical that this invisibility is addressed, and that the community mental health/psychosocial support services sector is represented, and involved, in the new proposed new policy architecture.

In relation to **Draft Recommendation 4.4: Immediately address the unmet need for psychosocial supports outside the NDIS**, we agree, alongside the APA that:

- The renegotiation of the Agreement provides a timely opportunity for governments to commit to providing support outside of the NDIS, which responds to people's needs and support preferences. It should also consolidate this response with agreed actions regarding the recommendations from the NDIS review for new foundational and early intervention supports. Our recommendation is that Governments commit to the provision of recovery focused (capacity building) community based mental health and psychosocial supports across the continuum of need, with a clear pathway into the NDIS for the provision of long term individualised "practical" support.

- The existing range of evidence based and recovery focused services are already providing a solid foundation for such a response and for the most part just need to be expanded. The APA is well placed to work with governments and the lived experience peaks to provide a roadmap as to what this would look like.

- It is important that this action is not delayed if the negotiation of the new Agreement is put back by a year. While the Commonwealth works out Foundational Supports outside of the NDIS, existing providers of Commonwealth Psychosocial Support Programs should have their funding increased commensurate with those in the unmet category – immediately. The conditions of that program, particularly duration, should be amended until there is clarity and concrete action on Foundational Supports.

We have further responses to other, specific recommendations:

Draft recommendation 4.6 Increase transparency and effectiveness of governance arrangements

Primary Health Networks (PHNs) play a major role in Commonwealth-funded mental health services, yet their commissioning practices vary widely in how they engage local communities, lived experience leaders, and psychosocial providers. We would like stronger recommendations that PHNs must be required to demonstrate how they invest in sustainable partnerships, address social determinants, and enable lived experience leadership as part of system stewardship and commitment to codesign.

Draft Recommendation 4.7: The next agreement should support a greater role for people with lived and living experience in governance.

That the next Agreement centres the Lived and Living Experience workforce, including First Nations Lived Experience workforce.
The community mental health and psychosocial workforce is the only part of the system where peer roles are embedded as standard practice. Yet, as both Ruah and the Samaritans WA highlighted in original submissions, these roles are still under-recognised in the National Mental Health Workforce Strategy. The Luminos Project demonstrates what is possible when peer workers are not supplementary but central, walking alongside people through suicidal distress, housing instability, trauma recovery, and social reconnection.

If we are serious about reform, the lived experience workforce must be a key lever—not an afterthought. There should be an increase in peer lived experience workforce, including the First Nations peer workforce, and this should be accompanied by appropriate and increased resourcing.

Draft Recommendations 4.9 and 4.11

Addressing Data Blind Spots
There is currently no national Minimum Data Set (MDS) for community-managed mental health and psychosocial support services. As noted in both the APA and Ruah/Samaritans WA submissions, this means service activities, outcomes, and workforce contributions—particularly those of peer workers—remain invisible in national reporting. AIHW classifications often conflate community services with hospital-based community care, further distorting understanding of service reach and impact. Without accurate and

disaggregated data, it is impossible to track whether we are reducing distress, reaching priority populations, or supporting social outcomes. Critically, we lack national data on suicide attempts and suicidal distress presentations—an essential gap if we are serious about suicide prevention. Public reporting, independent of government sign-off, should be led by AIHW and the National Mental Health Commission and must include peer-led, trauma-informed and community-based models like The Luminos Project.

Mental health recovery and suicide prevention do not follow a linear path, yet they continue to be measured through traditional biomedical frameworks, which aim for a fixed treatment outcome of acute symptom reduction rather than long-term well-being, resilience, and social integration. Instead, a holistic, trauma-informed approach is required—one that shifts evaluation metrics from crisis intervention towards sustained improvements in mental, emotional, and social health.

By embedding peer-integrated models, trauma-informed frameworks, and robust national data collection standards throughout the system, we can drive meaningful, evidence-based change that ensures mental health services are truly accessible, responsive, and impactful for those who need them most.