Mind Australia Limited

Submission in response to the Productivity Commission Mental Health and Suicide Prevention Agreement Review *Interim Report*

July 2025

About Mind Australia

Mind Australia Limited (Mind) is one of Australia's leading community-managed specialist mental health service providers. We have been supporting people dealing with mental health challenges—as well as their families, friends, and carers—for over 40 years. We employ more than 1,200 staff who deliver services both in our own centres, and through outreach programs and residential services in partnerships with clinical agencies, around Australia. In 2023-24, Mind supported more than 11,000 people. This number grows to over 20,000 with the reach of our subsidiaries: One Door Mental Health, a specialist community-managed mental health provider in New South Wales, and The Haven Foundation, a community housing provider for people with psychosocial disability.

Mind is committed to an evidence-informed, recovery-oriented approach to mental health and wellbeing that considers the whole person in the context of their daily life, and focuses on the social determinants of mental health. We value lived experience[1] and support the ongoing development of lived expertise-led innovation and transformation in service design and development[2], alongside improvements in experience, support, and opportunity for lived experience workforces. We value the role that carers, families, and friends play in providing significant emotional, practical, and financial support to those experiencing mental ill-health and psychosocial disability.

Mind invests significantly in research on mental health recovery and psychosocial disability, and we share this knowledge. We also develop new evidence-informed service models, evaluate outcomes[3], and provide training for peer workers and other mental health professionals.

Mind also advocates for, and campaigns on, basic human rights. We constantly challenge the stigma and discrimination experienced by people with mental health challenges.

Mind is a member of the Australian Psychosocial Alliance (APA). APA members comprise the largest specialist providers of community-managed mental health and wellbeing services in the country. Member organisations operate in rural, regional, and metropolitan areas across all of Australia's states and territories.

Questions about Mind's submission should be directed to policy@mindaustralia.org.au

Written correspondence can be directed to Mind Australia c/o the Policy team at PO Box 5107, Burnley, Victoria, 3121

[1] See Mind's *Lived Experience Governance Framework*: Mind_Lived_Experience_Framework.pdf.
[2] See Mind's *Connection and Community: Transformative Lived Expertise-led Approaches 2024-2029*: Connection_and_community.pdf.
[3] See Research and evaluation projects | Mind Australia.

Mind submission in response to the Productivity Commission's National Mental Health and Suicide Prevention Agreement Review *Interim Report*

Executive Summary

Mind welcomes the opportunity to contribute to the Productivity Commission's (the Commission) ongoing review, following our discussion with Commissioner Button, Assistant Commissioner Veisman-Apter and Erin Massey in addition to our initial submission as a member of the Australian Psychosocial Alliance (APA). The Productivity Commission's review of the National Mental Health and Suicide Prevention Agreement (the Agreement) provides a timely and invaluable opportunity to take a whole of system approach to reform, meeting community need across the country in all its diversities.

Mind supports the broad direction set out in the Productivity Commission's Interim Report, and the majority of its findings and recommendations. With such high levels of unmet need across the country, the Commission is correct in its assessment that the Agreement has not been set up for success and is not fit for purpose in its current form.

In recognition of the Productivity Commission's detailed work to date, Mind's submission focusses on opportunities for systemic reform, particularly around the opportunity this review provides for the Commission, and the Australian Government, to consider reform across the broad continuum of mental health, centring lived experience. This includes the at times siloed approaches to mental health, psychosocial support and psychosocial disability, including the critical intersection with the NDIS.

Mind's submission should be read in conjunction with the submission of the Australian Psychosocial Alliance (APA), to which Mind has contributed. Our standalone submission relates to areas of Mind's specific expertise.

Our submission first summarises our recommendations, before providing advice to the Commission regarding five key issues. Response to some of the Commission's recommendations, findings and information requests can be found in bold throughout. The format of our submission is as follows:

- Recommendations
- Unmet need, mental health reform and the NDIS: a more integrated system of supports for consumers
- Supported housing, mental health and psychosocial disability
- The critical contribution of community-managed mental health
- Focus on youth mental health, including psychosocial support
- System transformation through a lived experience lens

Recommendations

Mind recommendation 1: Immediate action should be taken to fund existing psychosocial services (e.g. the Commonwealth Psychosocial Support Program (CPSP)) and develop new services to address the significant amount of unmet psychosocial needs (**draft recommendation 4.4**) of any proposed extension to the current agreement (**draft recommendation 4.2**). This funding is more urgent given that people with psychosocial disability are increasingly unable to access the National Disability Insurance Scheme (NDIS).

Mind recommendation 2: The Productivity Commission should note that NDIS access and experience for people with psychosocial disability are impacting negatively on services funded through the Agreement, and on consumers and their families and carers. The Commission should encourage the NDIA and federal government to enact reform that minimises the human, equity and system risks from current outcomes for this group, per Mind recommendations 4 and 5.

Mind recommendation 3: The Productivity Commission should acknowledge the poor integration of the National Disability Insurance Scheme (NDIS) with the mental health system, and the impact this has on mental health services and outcomes of direct relevance to the Agreement.

Mind recommendation 4: The Productivity Commission's final report should advise governments that responses to unmet need and psychosocial disability Foundational Supports may serve a similar cohort, and move towards funding appropriate reform measures to achieve an integrated, responsive, accessible continuum of psychosocial supports to meet diverse need across the country.

Mind recommendation 5: The Productivity Commission's final report should demand progress on NDIS reform, broadly in line with NDIS Review recommendation 7, to ensure better fit-for-purpose support for people with psychosocial disability. This should include development of a psychosocial disability-specific home & living product within the NDIS. Reform should however proceed with clear understanding of the diversity and complexity of the psychosocial disability cohort.

Mind recommendation 6: The Productivity Commission should encourage full inclusion of the community-managed mental health (CMMH) sector in development and delivery of the next Agreement. The Commission should likewise see the CMMH sector as essential in work to address unmet need (**draft recommendation 4.4**).

Mind recommendation 7: The Productivity Commission should encourage reform of the youth mental health service delivery system through the next national Agreement. This reform should prioritise fuller establishment of an integrated youth mental health service ecosystem with breadth and a diversity of offerings, rebalancing away from the high prevalence of clinical-centric approaches to youth mental health. Such rebalancing should emphasise the critical nature of holistic psychosocial support (and peer support), including focus on ongoing engagement with education and (preparation for) employment, and maintenance of social connection, during provision of supports. Clinical support will remain an essential but not sole component of youth mental health support.

Mind recommendation 8: The Productivity Commission should ensure its final report on the Agreement encourages broad and deep involvement of lived and living experience and expertise at all levels of the operation of the Australian mental health system. Separation of lived experience services, governance, workers, design and leadership promotes a transactional rather than transformational model of lived and living experience involvement in mental health system reform.

Mind recommendation 9: The Productivity Commission should refer to existing best practice materials and approaches to lived experience governance, leadership, service design and development in preparing its final report. Co-design is critical in many cases, but much developmental work has been undertaken already to inform next steps in lived experience service design and system reform through the next Agreement.

Unmet need, mental health reform and the NDIS: a more integrated system of supports for consumers

The Commission is correct in arguing in **draft recommendation 4.4** that "Governments should immediately address the unmet need for psychosocial supports outside the National Disability Insurance Scheme". Mind strongly supports this recommendation, however the Commission and governments should not allow any potential extension to the current Agreement (per **draft recommendation 4.2**) to mean current, inadequate funding and service delivery arrangements continue *as currently* without additional concerted action and investment in the interim. Such interim measures could include consideration of short-term increased investment in the Commonwealth Psychosocial Support Program (CPSP) and related state programs (e.g. EIPSR, IPRS and analogues). Regardless of the timing of the finalisation of the next Agreement, Mind supports the development of a new National Mental Health Strategy—but given the need for co-design, consultation and other developmental work, completion of a strong Strategy may extend beyond the recommended extension timeline for the Agreement.

> **Mind recommendation 1:** Immediate action should be taken to fund existing psychosocial services (e.g. the Commonwealth Psychosocial Support Program (CPSP)) and develop new services to address the significant amount of unmet psychosocial needs (**draft recommendation 4.4**) of any proposed extension to the current agreement (**draft recommendation 4.2**). This funding is more urgent given that people with psychosocial disability are increasingly unable to access the National Disability Insurance Scheme (NDIS).

Mind strongly supports the Commission's desire for a more integrated system of supports for consumers. In seeking to achieve such integration, the Commission is right to argue the "next agreement should have stronger links to the broader policy environment" (**draft recommendation 4.3**). However **draft recommendation 4.3** does not explicitly name a key barrier to integration of the mental health system, and one unintended cause of unmet need across the country: the National Disability Insurance Scheme (NDIS). Due to decisions about the design and funding of the NDIS, and the late inclusion of psychosocial disability into the Scheme design and operations, many state-funded community mental health programs have ceased to exist since the creation of the NDIS. This has meant loss of social connection and participation, and absence of diverse community programs with lower entry criteria and multiple intensities of support. We understand the Commission has heard about the challenges of the two tiers of support created since the NDIS commenced: intensive support for NDIS participants, and minimal support outside the Scheme. As such, the Commission's final report should be more explicit about the integration required not just within the mental health sector as traditionally understood and within the purview of the Agreement, but in the intersection of mental health with the disability support sector for people with psychosocial disability as well. It is very important that some urgency is given to increasing these services given that people with psychosocial disability appear to be being excluded from the NDIS,

with only 23% of applicants who apply getting access to the scheme (in the most recent quarterly figures).

Achieving such integration will require progress on government reform processes in parallel to the next Agreement, such as Foundational Supports outside the NDIS *and* (with regards to psychosocial disability) reform of support within the NDIS broadly in line with NDIS Review recommendation 7 (thus more recovery focussed, with careful consideration of the diversity and complexity of the psychosocial disability cohort, some of whom will still require assistance with activities of daily living in addition to recovery focussed supports). It is important that these programs are intentional and focus on recovery goals, with some services focussing on engagement with education and employment outcomes and not just psychosocial support. The Commission and governments should consider how design and funding of Foundational Supports, for those people with psychosocial disability but not in the NDIS, may serve a similar cohort to additional funding for unmet psychosocial need, in the short term before commencement of a new Agreement, and through the Agreement itself.

As such, the Commission's final report should mention Foundational Supports explicitly, rather than the more general reference to "disability supports" in **draft recommendation 4.3** currently.

In order to achieve the goal of a more integrated system of supports for consumers, the Commission is right to call for release of key documents (**draft recommendation 2.1**)—but the list in this recommendation does not go far enough. The government should also prioritise:

- Publishing a formal response to the NDIS Review, from 2023. Given the need for integration of support for people with psychosocial disability, and both recalibration and uplift of psychosocial support services within and outside the NDIS, the federal government must respond to this landmark review and its proposals for psychosocial disability. Without clarity on this critical point of system design, it will be harder to achieve the Commission's recommendation to develop a renewed National Mental Health Strategy (**draft recommendation 4.1**)and to align this with negotiation of an effective new Agreement.

- Publication of or response to recent consultation processes on:
    - The Primary Health Networks (PHNs)
    - General Foundational Supports
    - NDIS legislation and regulation, such as changes to registration.

Mind believes the Department of Health, Disability and Ageing (DoHDA) holds critical expertise to assist in achievement of the goal of integration. While the Department of Prime Minister & Cabinet (DPM&C) may ably support some elements of the process given cross-

departmental outcomes, cabinet- and department-level machinery of government changes in this term of federal government should already promote good, integrative outcomes.

Mind is supportive of a separate schedule on Aboriginal and Torres Strait Islander social and emotional wellbeing (**draft recommendation 5.1**), and encourages the Commission to promote a genuine, deep co-design process to achieve best possible outcomes in this regard.

Finally, Mind is particularly concerned about recent trends in NDIS funding decision making that impact on the broader mental health system (and parallel systems of homelessness, criminal justice, and alcohol & other drugs (AOD)). This is demonstrated most clearly with psychosocial disability access numbers to the NDIS (mentioned earlier). The rate of successful access for psychosocial disability has dropped from 51% in quarter 2 of 2022-23 to just 23% in the most recent quarter (Q3) of 2024-25. This is compared to 79% in the same Q3 data for all disabilities (*including* psychosocial disability). This all-disability number has held steady across this same time period (78% all disability access met in Q2 of 2022-23), demonstrating the specific psychosocial disability concern.

These numbers are directly relevant to the negotiation of the next Agreement. In recent months, Mind has observed multiple new clients report having just lost their NDIS funding, before immediately coming to Mind for psychosocial support to replace their former NDIS-funded supports. This trend will only *increase* psychosocial unmet need in the community, and is a clear case of federal-to-state cost shifting that produces worse outcomes on a human level. State and territory governments will be particularly conscious of the budgetary effect of such a trend, as negotiations regarding the new Agreement commence.

Moreover, given the complexity and frequent marginalisation of the cohort of prospective and current NDIS participants with psychosocial disability, we hold grave concerns that the trajectory of "reform" (cost reduction) within the NDIA and through NDIS processes is unintendedly discriminating against people with psychosocial disability. Our evidence for this claim includes cases demonstrating the following barriers to NDIS access for people with psychosocial disability:

- Cost. For example, the cost to see a psychiatrist and get a report (large gap fees of $500 in some cases, and reports from $400 up to over $1700), or GP record access ($800-1200 in one case)
- Challenging or unrealistic evidence requirements. For example, preference for psychiatrist reports (despite cost and 6+ month wait times in many cases), requesting and re-requesting multiple reports, ignoring functional assessments performed by expert independent practitioners
- Push back from the NDIA on "permanence", even for e.g. schizophrenia diagnosed 20+ years prior
- Administrative burden. For example, demands for multiple forms and reports, even when these don't produce new or relevant evidence

- Arbitrary and inconsistent processes. For example, poor communication, evidence requests changing, not actually reading material specifically requested, lack of trauma-informed practice
- Psychosocial discrimination. For example, NDIA responses actively favouring non-psychosocial disability access (e.g. for someone with a dual disability), and questioning whether psychosocial disability needs should be met by the mental health system (despite this being a matter related to the disability (i.e. impairments), not the mental health condition)
- Wait times. For example NDIS decision making, or to see a psychiatrist or access services

Mind recommendation 2: The Productivity Commission should note that NDIS access and experience for people with psychosocial disability are impacting negatively on services funded through the Agreement, and on consumers and their families and carers. The Commission should encourage the NDIA and federal government to enact reform that minimises the human, equity and system risks from current outcomes for this group, per Mind recommendations 4 and 5.

Mind recommendation 3: The Productivity Commission should acknowledge the poor integration of the National Disability Insurance Scheme (NDIS) with the mental health system, and the impact this has on mental health services and outcomes of direct relevance to the Agreement.

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Mind recommendation 5: The Productivity Commission's final report should demand progress on NDIS reform, broadly in line with NDIS Review recommendation 7, to ensure better fit-for-purpose support for people with psychosocial disability. This should include development of a psychosocial disability-specific home & living product within the NDIS. Reform should however proceed with clear understanding of the diversity and complexity of the psychosocial disability cohort.

Supported housing, mental health and psychosocial disability

The distorting effect of the NDIS is particularly acute for members of the community with psychosocial disability who experience housing insecurity or have supported housing needs. The relationship between housing and mental health is well-established, but not currently highlighted sufficiently by the Agreement or the Productivity Commission's Interim Report.

The Commission will be aware of the statistics here. Poor mental health is a risk factor for homelessness and the experience of being homeless can contribute to mental ill health.

People with a reported mental health condition are also twice as likely as people without a mental health condition to have experienced homelessness in the last 10 years and throughout their lifetime.

Mind and AHURI's *Trajectories* report[4] found that poor mental health contributes to financial hardship and forced housing moves. A diagnosed mental health condition significantly increases the likelihood that people will be forced to move from their home within one year.

Housing instability and mental ill health are also associated with ongoing challenges, such as:

- Stigma, loneliness and isolation;
- Inadequate access to required supports;
- Low availability of suitable housing opportunities.

Safe, secure housing is the foundation for good mental health and social and emotional wellbeing. It is also a basic human right.

Our particular concern at Mind, especially through our community housing subsidiary The Haven Foundation, is that some people living with severe and persistent mental illness need ongoing support which may include long-term housing, mental health care, tenancy support and/or psychosocial support (support with daily living activities) that is available 24/7.

In our supported housing portfolio, in addition to the broad concerns of psychosocial disability access and discrimination listed above, we have observed a trend towards slower NDIS decision making, more frequent rejections of clients we would formerly have considered deserving of NDIS support, and lower average package sizes (often increased on review, thus favouring prospective NDIS participants with informal or formal support and also with more resources—a major equity concern).

The Commission should acknowledge in its final report that there is a component of the Australian community with severe and enduring mental health concerns, who experience a

[4] See https://www.mindaustralia.org.au/trajectories-interplay-between-mental-health-and-housing-pathways

level of impairment—no matter the episodic nature of their condition—that indeed qualifies as psychosocial *disability*. This cohort frequently has supported housing needs. The unannounced, *ad hoc* removal of members of this cohort from the NDIS is incredibly disruptive to these clients' lives and will have a major impact on state and territory mental health and other budgets. In line with our prior **Mind recommendations 2–5**, the Commission should help to ensure the federal government promptly:

- Reviews psychosocial disability access to the NDIS
- Directs the NDIA to work with organisations like Mind and The Haven Foundation to develop a psychosocial disability-specific home & living pathway (as they are often ineligible now for supported independent living (SIL) due to their episodic needs falling below standard SIL thresholds for hours per day of support)
- Responds to the NDIS Review, with a focus on Recommendation 7 for psychosocial disability, but with clear understanding of the diversity and complexity of the psychosocial disability cohort, for whom *recovery* will mean different things depending on personal circumstances, impairment and other factors.

The critical contribution of community-managed mental health

Responding to unmet need, integrating the mental health system, and ensuring people with psychosocial disability have their needs met both within and outside the NDIS will require much revision of current funding practices through the Agreement.

In order to achieve a good outcome here, the Commission should emphasise more strongly the critical contribution of the community-managed mental health (CMMH) sector. The Royal Commission into Victoria's Mental Health System provides a good (but not yet fulfilled) template for the necessary rebalancing of mental health service delivery. People should have access to services where they are, in community.

The CMMH sector and CMMH organisations are often overlooked in conversations about mental health, despite providing more than 25% of services nationally. This is partly due to the higher visibility and understanding of clinical mental health, and the dominance of tertiary delivery in state and territory funding decision making. Such imbalance should not discourage the Commission from seeing the CMMH sector as critical to delivering the types of programs required to successfully reduce unmet need across the country, as well as delivering foundational supports for psychosocial disability (once implemented) and also providing early intervention supports as identified by the NDIS Review.

Mind is supportive of the proposal set out in **draft recommendation 4.2: Building the foundations for a successful agreement**, but notes the absence of inclusion of the CMMH sector in the consultation, collaboration and development plans set out by this recommendation. The Commission should ensure inclusion of CMMH in its final report.

Finally, Mind is strongly supportive of greater involvement of the sector in governance (**draft recommendation 4.8**), and wants to ensure this means broad representation from the CMMH sector as well. Mind hopes the Commission's work, and the development of the next Agreement, can promote the broader goal of rebalancing the Australian mental health system in line with community needs—more services, delivered where people are, in community.

> **Mind recommendation 6:** The Productivity Commission should encourage full inclusion of the community-managed mental health (CMMH) sector in development and delivery of the next Agreement. The Commission should likewise see the CMMH sector as essential in work to address unmet need (**draft recommendation 4.4**).

Focus on youth mental health, including psychosocial support

One of the key themes in earlier submissions to the Productivity Commission concerned the need for specific recommendations to improve the accessibility and appropriateness of mental health services for children and young people.

Mind believes the Productivity Commission should pay particular attention to this suggestion—and the recommendations of the Interim Report are lacking in this regard currently.

Mind provides this feedback from a position of expertise and difference in youth mental health service delivery. We have been working with young people for more than 25 years. Like many in the youth mental health service system, and government, we are concerned about a rise in need for youth mental health services. It is encouraging that growing awareness of the scale of the problem has seen increasing government attention and resources dedicated to addressing issues of youth mental health and youth suicide in Australia. The federal government's main contribution to the youth mental health system is a network of over 150 headspace centres across the country, and state governments in Queensland, WA, and Victoria have commissioned new youth services such as YPARCs, psychosocial outreach programs, and residential services.

Unfortunately, despite increased awareness, dedicated funding and the network of headspaces and other services, the youth mental health system remains predominantly clinical. This means that the gap between the diverse needs of young people and what is offered by the service system remains wide.

In part this is a *supply* problem: a dependence on clinical mental health services and approaches, delivered by a scarce workforce, has led to long waiting lists. Things can get worse for young people while they wait. But this is also a *suitability* problem: the narrow

selection of endorsed, predominantly clinical approaches does not always meet the broad range of needs and challenges affecting young people in an increasingly uncertain and volatile world.

This creates a particularly pernicious productivity issue, whereby young people with serious mental health challenges can end up on a life trajectory that is solely about their mental health—diagnosis, medical regime, coping strategies—and thus they often become isolated from education, preparation for employment, engagement with society and the usual milestones of a critical formative period. Given most mental health challenges first present during the crucial period of development from the age of 12 to 25 years, disruption caused by such challenges can significantly impact a young person's life—in the short term and the long term. Not only is the prevalence of mental health challenges highest in people aged 16-24, we note growing evidence suggesting that people are experiencing these challenges earlier in life.

If and when mental health challenges emerge, it is essential that young people can access services that attend to the range of challenges they may be facing—in addition to their immediate mental health challenges. Otherwise, ultimately, the lack of suitability of youth mental health services, combined with the ensuing life disruption from mental health challenges during this formative period, can create lifelong dependence on, for example, the Disability Support Pension (DSP). This comes at great cost to the person and indeed the Commonwealth Government.

For example, research involving young people accessing Australian mental health services states that up to a third[5] of these young people were not engaged in education, employment or training, compared to 9% of young people in the general population. Avoiding disruptions to study and employment (alongside formation of identity and friendships) is crucial for young people to improve future employment prospects, reduce financial stress, and achieve better overall quality of life.[6]

This should be an issue of great relevance and concern to the Commission, given the productivity consequences, and likewise to the federal government. Truly addressing the problem demands a rebalancing away from the high prevalence of clinical-centric approaches to youth mental health.

Mind's approach to working with young people offers something different to the most prevalent clinical models that many people are familiar with. We work together on managing daily activities, rebuilding and maintaining connections, engaging with education and employment, feeling connected to their community, and support with access to housing and

[5] Caruana, E et al., 2019. *Vocational engagement among young people entering mental health treatment compared with their general population peers.* Early Intervention in Psychiatry. **13**(3): p. 692-696.
[6] Brinchmann, B et al., 2020. *A meta-regression of the impact of policy on the efficacy of individual placement and support.* Acta Psychiatrica Scandinavica. **141**(3): p. 206-220.

income support if necessary. We endorse their right to live a life that is meaningful and optimal for each young person, defined by them and based on their goals. We have compelling evidence that our approach works, through the outcome measurement data we collect and analyse.

Despite this evidence and even taking into account our national footprint, Mind's broad psychosocial approach has not received the same level of resources or attention in youth mental health service delivery. Our holistic, person-led approach when working with young people is not recognised and/or undervalued by policymakers and funders, suggesting that holistic psychosocial and peer supports are still not well understood as a vital contributor to a young person's wellbeing.

The Commission should pay attention to the psychosocial gap in the current youth mental health system, and ensure the next national Agreement prioritises the fuller establishment of an integrated youth mental health service ecosystem with breadth and a diversity of offerings.

> **Mind recommendation 7:** The Productivity Commission should encourage reform of the youth mental health service delivery system through the next national Agreement. This reform should prioritise fuller establishment of an integrated youth mental health service ecosystem with breadth and a diversity of offerings, rebalancing away from the high prevalence of clinical-centric approaches to youth mental health. Such rebalancing should emphasise the critical nature of holistic psychosocial support (and peer support), including focus on ongoing engagement with education and (preparation for) employment, and maintenance of social connection, during provision of supports. Clinical support will remain an essential but not sole component of youth mental health support.

System transformation through a lived experience lens

Mind welcomes the Commission's emphasis on lived experience as a critical component of developing and implementing the next Agreement, and achieving the outcomes it sets out. We concur with many of the comments from submissions presented in the Interim Report, about the transformative nature of integration of lived and living experience and expertise in reform of mental health service delivery and the mental health system.

However, the direction set out by the Interim Report at present is unlikely to achieve the transformative potential from centring of lived experience at all levels of the mental health system. This is because the Commission's framing for the next Agreement seems to be based on a *participation* model of lived experience involvement in system reform. This means that it separates, for example, governance (**draft recommendation 4.6**) from lived experience governance (**draft recommendation 4.7**), in a way that suggests lived experience should only hold a consultative role in general system governance. Likewise, **information request 4.4** could be taken to suggest peer work is an add on to dominant clinical models, rather than lived experience workforce development and service delivery representing both a complement and a true alternative to current, traditional models in our mental health system.

At the broadest level, the process of developing the next Agreement should enhance greater protection of human rights and support a mental health and wellbeing system that centres the rights, needs and agency of the person most impacted by distress—people with lived experience of mental health challenges. Much like some of the feedback the Commission has received in preparing its Interim Report, consumers tell us that the standard model of (clinical) care in the current mental health system is often about crisis containment rather than genuine healing.[7] People can experience deprivation of their dignity, agency, liberty and rights, resulting in harm and trauma. This is compounded when people also experience racism or lack of recognition of cultural rights. Family and carers describe a flawed system that is "largely experienced as unsafe and not inclusive of families and friends who care for people with mental health issues".[8] Acknowledging these systemic issues in the traditional model, our experience suggests that best practice mental health care and treatment—and improved longer-term public health outcomes—comes from openness to alternative approaches to mental health system design and delivery. This does not mean wholesale replacement of traditional, clinical models, but rather a conscious rebalancing of the system towards community, non-clinical, and strongly lived experience-centred and -led models of practice. Such a rebalancing would also offer benefits from the perspective of productivity—diverse and fit-for-purpose mental health services, delivered where people are in community—and enhance efficiency of government expenditure—away from predominantly clinical, acute, crisis-driven responses that cost more and too often disproportionately manage risk in ways

[7] Mind Australia, 2023. *Healing Place Consumer and Peer Design Team: Workshops Thematic Analysis Report*.
[8] Tandem, 2019. *Submission to the Royal Commission into Victoria's Mental Health System*, p.3. https://rcvmhs.archive.royalcommission.vic.gov.au/Tandem.pdf

that cause harm and impinge on human rights. This rebalancing requires commitment and investment. At present, there are pockets of innovative, best practice lived experience work across Australia and internationally. These are creating great outcomes for people most impacted by mental health challenges. But greater investment will allow these pockets to scale their innovation, while promoting more widespread testing and trialling of new approaches—to then get better and more widespread outcome measurement for these innovative directions in responsive mental health programs. Ongoing demands to produce the evidence from a system *acknowledged to be failing consumers and families and carers*, whether by the Commission in its interim report or more generally, suggests longstanding pushback to new approaches is unproductive and centres the wrong model of "risk".

Thus, overall, given the importance of the Commission's work in "[b]uilding the foundations for a successful agreement", there is a missed opportunity in the Commission's Interim Report to push for a more transformative, deep embedding of lived experience in the operation and leadership of the Australian mental health system through the next Agreement. This will involve not only representation through lived experience positions (at all levels, including senior leadership), but an ability, willingness and demonstration from policy makers and service providers to re-shape responses to mental health through a lived expertise lens. This will ensure future responses are better aligned to issues of human rights and social justice, and prompt critical exploration of new evidence and approaches that provide stronger alternatives to medical and clinical interpretations, ineffective risk management models and the continued improvement of current system responses to mental health challenges.

At Mind we have committed substantial organisational time, effort and resources into developing a model of lived experience involvement across all levels of the organisation, from the board and executive throughout our service delivery and back-office workforce, and in various capacities across our processes and ways of working. The Commission should understand lived experience participation on a spectrum, from lived experience-*engaged*, to lived experience-*informed*, then lived experience-*centred* and finally, at the level of strongest lived experience ownership and decision-making authority, lived experience-*led*. The Interim Report in its current form does not seem to promote stronger forms of lived experience-centred and -led transformation of the Australian mental health system through the vehicle of the next Agreement.

> **Mind recommendation 8:** The Productivity Commission should ensure its final report on the Agreement encourages broad and deep involvement of lived and living experience and expertise at all levels of the operation of the Australian mental health system. Separation of lived experience services, governance, workers, design and leadership promotes a transactional rather than transformational model of lived and living experience involvement in mental health system reform.

More specifically, Mind does support the recommendation for development of the next Agreement through co-design with people with lived and living experience (**draft recommendation 4.2**), and the proposal for greater lived experience governance (**draft recommendations 4.6** and **4.7**)—noting our earlier concern about the level of genuine power sharing through these development processes. Design and negotiation of the next Agreement should provide the fora within which we critique our current systems of governance and see how they might be improved, to better meet the needs of people with distress.

In thinking through this task, we encourage the Commission to draw on existing best practice materials and approaches in preparing its final report. We recommend future mental health policy and service design and development incorporates nationally recognised lived expertise approaches to governance, leadership[9], service design and development. With regards to **draft recommendations 4.6** and **4.7** on governance, Mind recommends the Commission refer to the National Lived Experience Governance Framework[10]. In partnership with the Lived Experience Leadership and Advocacy Network (LELAN), Mind has also expanded and built on these concepts for use in the delivery of lived experience-led service delivery, reflected in two foundational documents to shape Lived Experience Practice and Governance approaches:

- Connection and Community: Transformative Lived Expertise-Led Approaches[11]
- Mind's Lived Experience Governance Framework[12]

On matters related to workforce, per **draft recommendations 4.13** and **4.14**, the Commission should refer to the National Lived Experience (Peer) Workforce Development Guidelines[13] as a starting point as opposed to other potential development processes. We also recognise and encourage the adoption of Intentional Peer Support (IPS) as the primary practice and training model for lived experience workforces. Mind's own peer work framework will also be relevant to **draft recommendation 4.14**.[14]

> **Mind recommendation 9:** The Productivity Commission should refer to existing best practice materials and approaches to lived experience governance,

[9] Hodges E et al., 2021. *The Model of Lived Experience Leadership*, SA Lived Experience Leadership and Advocacy Network and University of South Australia; https://www.lelan.org.au/wp-content/uploads/2021/08/Model-of-Lived-Experience-Leadership_ALEL-Project.pdf
[10] National Mental Health Consumer & Carer Forum, 2023. *The Lived Experience Governance Framework: Centring People, Identity and Human Rights for the Benefit of All*; https://nmhccf.org.au/our-work/discussion-papers/the-lived-experience-governance-framework-centring-people-identity-and-human-rights-for-the-benefit-of-all
[11] Mind Australia, 2024. *Connection and Community: Transformative Lived Expertise-led Approaches*; https://www.mindaustralia.org.au/sites/default/files/2024-08/Connection_and_community.pdf
[12] Mind Australia in partnership with LELAN, 2024, *Mind's Lived Experience Governance Framework*; https://www.mindaustralia.org.au/sites/default/files/2024-09/Mind_Lived_Experience_Framework.pdf
[13] Byrne, L et al., 2021. *National Lived Experience Workforce Guidelines*., National Mental Health Commission; https://www.mentalhealthcommission.gov.au/sites/default/files/2024-03/national-lived-experience-peer-workforce-development-guidelines.pdf
[14] Childs, B 2021. Mind's peer work framework. Mind Australia; https://www.mindaustralia.org.au/sites/default/files/2023-04/Mind_peer_work_framework.pdf

leadership, service design and development in preparing its final report. Co-design is critical in many cases, but much developmental work has been undertaken already to inform next steps in lived experience service design and system reform through the next Agreement.

Long-term, secure funding of the recently established lived experience peaks is also essential to achieving good reform outcomes, whether on governance, workforce, leadership, or service design and delivery.

Finally, a response to the information requests in the Interim Report. With regards to **information request 4.2**, one clear barrier to lived experience participation in governance forums is structural, i.e. that the perspectives and voices of people with lived experience have long been underrepresented and/or devalued in decision-making within mental health services. As part of our *Lived Experience Strategy 2021-2024*[15], Mind is committed to shifting power in decision-making by establishing benchmarks for lived experience positions across organisational committees. Measurement of successful inclusion of people with lived experience could start with similar benchmarks in other organisations and governance fora. Organisations should also:

- Select members with relevant lived expertise
- Create conditions for genuine involvement in *decision making, not just consultation*—actively working towards power sharing and partnership, and
- Seek to develop lived expertise and leadership capability.

Genuine commitment to inclusion of lived expertise should also mean appropriate remuneration for time served.

On **information request 4.4**, we provide the following material to demonstrate two examples of current best practice, one lived experience-centred (Mind's delivery of three of the Mental Health and Wellbeing *Locals* in Victoria) and a longer case study of one that is lived experience-led (*Aftercare*, a LGBTIQA+ post-suicidal ideation support service).

In the case of the Locals, the critical point for the Commission to take away is the approach to commissioning of these services. In the case of most Locals locations, CMMH organisations are the lead partner, in a consortium with (regional) health services and other smaller specialised local providers. While all CMMH organisations take slightly different approaches to embedding of lived experience and the practice of peer work, the dynamic brought by CMMH organisations being the *lead* means the Commission's point about clinician awareness and integration (in **information request 4.4**) is front of mind in consortium governance conversations that then feed into practice. Mind would be pleased to share more about its

[15] Mind Australia, 2021. *Mind's Lived Experience Strategy*. Mind Australia; https://www.mindaustralia.org.au/sites/default/files/2023-05/Mind_Lived_Experience_Strategy.pdf

model of peer and clinical integration in the Locals services with the Commission, as we have worked to ensure lived experience-centred service design and delivery in all three of our current Locals locations.

Mind lived experience case study

Aftercare
A peer-led service for LGBTIQA+ people having thoughts or intentions of suicide

Mind's Aftercare service is based in Melbourne. It has been running for more than 6 years, and over 3 with Victorian government funding. A service of this kind was directly recommended in Recommendation 27.2b of the Royal Commission into Victoria's Mental Health System (delivered in 2021).[16]

The service is the only one of its kind in Victoria, offering longer-term support from both peer practitioners and allied health. Every member of the LGBTIQA+ Aftercare team has lived experience of what it feels like to be in those dark places and wanting to end their life. This makes the service unique: when someone comes through the door and they are talking to either a peer practitioner or the programme manager, they know that person understands what they are going through.

In 2024, LGBTIQA+ Aftercare helped 180 individuals; that is 180 people who are still alive today. In the 6.5 years that the LGBTIQA+ Aftercare programme has been operating, no one has taken their life.

Aftercare offers counselling, peer support, case management and outreach support. The average age of participants ranges from approximately 20 to 40, and there are a large number of participants engaged with Aftercare who are culturally diverse.

For the purposes of responding to the Commission's **information request 4.4**, the approach at Aftercare—particularly where participants have both a clinician and peer worker—emphasises collaboration as part of practice. Clinical and Peer practice is communicated as being equally valuable throughout the service (for example within intake processes, and onboarding of staff). The Aftercare model has been developed to challenge traditional perspectives on role power and hierarchy within the service, prioritising collaborative relationships between clinical and lived experience roles when providing service to people

[16] See State of Victoria, 2021. *Royal Commission into Victoria's Mental Health System*, Final Report, Summary and recommendations, Parl Paper No. 202, Session 2018–21 (document 1 of 6), p.63; https://www.vic.gov.au/sites/default/files/2024-01/RCVMHS_FinalReport_ExecSummary_Accessible.pdf

accessing the service. Clinical workers have previously utilised their lived experience in a designated role and their current clinical role is also designated.

Critically, and building on our earlier point about traditional approaches to management of *risk* that impinge on human rights, the model at Aftercare is one of *care* as opposed to being *fear-based*. Although the intentional process of deconstructing traditional approaches—to both suicide prevention and mental health service delivery—may be uncomfortable for some within the system, the results of this innovative, responsive and deeply necessary service speak for themselves.

Importantly, we know too well that suicide and suicidality disproportionately impact LGBTIQA+ people. Indeed, there is significant and rising need for action on suicide prevention. Aftercare saw a substantial, 65% increase in referrals from 2023 to 2024. Behind this referral statistic sits deepening evidence of hardship in the broader community, in the midst of a housing and cost-of-living crisis. 49% of our service users report financial and/or housing issues, 40% were unemployed and many report skipping meals or experiencing food insecurity. In addition and specific to the LGBTIQA+ cohort, 33% of service users report homophobia or transphobia, while 23% report safety concerns. To underline the complex co-occurrence of determinants indicating disadvantage and other physical and demographic risk factors, an increasing number of our service users report living with chronic pain, and asylum seekers and refugees are also prevalent, fleeing persecution based on their identity. The demands on the service are many but the work of the team is responsive, creative, caring and deeply human.

Mind would be pleased to share more about its Aftercare model with the Commission. This is a fully lived experience-led service.