70 Dale Street • PO Box 3032, Port Adelaide, SA 5015
P. (08) 8440 2200 **E.** unitingsa@unitingsa.com.au
W. unitingsa.com.au unitingsa @unitingsa

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Submission to the Productivity Commission: Mental Health Inquiry – Interim Report Response

Introduction

UnitingSA welcomes the opportunity to respond to the Productivity Commission's Interim Report on the future of Australia's mental health system. We commend the Commission for its candid assessment of the national framework's current shortcomings and for elevating the call for substantial reform. The report reflects what many of us in the sector have long observed: the mental health system in Australia is not fit for purpose, particularly for people with complex needs and for communities experiencing entrenched disadvantage.

UnitingSA is a values-driven, not-for-profit community services organisation supporting more than 16,000 South Australians each year across aged care, housing and homelessness, disability, mental health, and employment services. We bring to this submission over a century of service to marginalised populations and a commitment to social justice that informs both our direct work and our systems advocacy.

UnitingSA delivers psychosocial mental health services in both metropolitan and regional locations across South Australia. Regional access remains a persistent challenge, with significant gaps in service availability, limited workforce, and fewer flexible options for people who experience fluctuating levels of need.

Psychosocial supports are non-clinical, community-based services that help people with mental illness to live independently and improve their quality of life. These supports address the social determinants of health—such as housing, relationships, daily living skills, and community participation—and play a vital role in recovery by bridging the gap between clinical services and a person's everyday functioning. They are particularly critical for people who are not eligible for the NDIS, are in the process of applying, or need interim support to bridge gaps between services.

Alignment with Key Issues Identified by the Commission

1. Fragmented and Poorly Co-ordinated Services

We echo the Commission's findings on systemic fragmentation and the difficulty people face navigating mental health and related support systems. Across our mental health, housing, and youth programs, we see people falling through gaps between primary care,

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psychosocial supports, clinical services, and housing assistance. In particular, transitions between hospital and community care remain unsafe and inconsistent.

There is a lack of integrated planning across service systems. Housing, mental health, and social services are often considered separately, even when the needs are interdependent. UnitingSA's Avalon program, which combines supported housing and psychosocial recovery, is a working example of integrated support that prevents crisis and supports long-term stability. More models of this kind are urgently needed.

Case study example:

Case Study 1: "Ben"

Relevant Submission Themes:

- Fragmented services
- Gaps in supports outside the NDIS
- Inappropriate reliance on short-term, episodic support models

Summary:

Ben is a 37-year-old man with multiple mental health diagnoses, including Borderline Personality Disorder, Post-Traumatic Stress Disorder, Obsessive-Compulsive Disorder, Attention Deficit/Hyperactivity Disorder, anxiety and depression. Living alone in social housing, he experiences chronic social isolation and significant challenges with functional living skills.

He received two episodes of a two-week Brief Psychosocial Support package. The first was highly effective—daily, practical, non-judgemental support enabled him to stabilise and engage. However, the second time, under threat of eviction, his engagement deteriorated as the limited timeframe failed to meet his escalating needs.

Psychosocial Support Provided:

Ben has repeatedly presented to the hospital emergency department in states of acute emotional distress, including suicidal ideation. These episodes have been triggered not by clinical deterioration, but by environmental stressors, such as hoarding issues, housing inspection failures, eviction threats, and interpersonal harassment, which Ben finds overwhelming and unmanageable without support.

Following hospital presentations, Ben was twice referred to a time-limited, two-week Brief Psychosocial Support Service. During the first engagement, the service provided daily in-home support, helping him manage belongings, coordinate a housing transfer, and simplify complex tasks. This consistent, non-judgemental support resulted in strong engagement, and the team referred him to a tenancy service which remained involved until relocation.

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Several months later, Ben again presented to the ED amid deteriorating mental health. Contributing factors included chronic sleep disturbance following an attempted break-in, further eviction threats, and difficulty navigating service systems. Although referred again to the Brief Support Service, his engagement deteriorated as the limited timeframe failed to meet his escalating needs, and he struggled to re-engage under escalating stress.

Implications:

Ben's experience illustrates the structural gap for people with psychosocial needs who fall outside the restricted mental health system and the NDIS. Ben is one of many individuals who would benefit from access to sustained, community-based step-up and step-down, psychosocial care. His case underscores the importance of establishing flexible and need-based support pathways and highlights the human and economic costs of failing to do so.

2. Gaps in Psychosocial Supports for People Not Eligible for the NDIS

UnitingSA supports the Commission's critique of the binary created by the NDIS for mental health consumers. Many people with psychosocial disability are not NDIS participants but still require ongoing, structured support to live well in the community. The lack of dedicated funding for non-NDIS psychosocial supports leads to system inefficiencies, exacerbates distress, and often results in preventable hospitalisation or homelessness.

Our services-including transitional housing, employment support, and mental health programs-see daily the impact of this support vacuum, particularly on those exiting inpatient units, experiencing homelessness, or living with co-occurring conditions.

However, many current funding and service models do not adequately support the episodic nature of mental illness. Step-up and step-down services, along with flexible re-entry options, are essential to sustaining recovery and avoiding preventable hospitalisation. Rigid program structures often leave people without support until they reach crisis.

Case Study 2: "Zara"

Relevant Submission Themes:

- Gaps in supports for people not eligible for the NDIS, and the impact on recovery for the application and appeal process.
- Fragmentation between clinical and psychosocial services.
- Positive impact of mental health transitional housing.

Summary:

Avalon is an 18-month supported, community-based, mental health housing program. It includes intensive, recovery-oriented psychosocial support, helping rebuild independence, connect with community and services, and transition to long-term housing.

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Zara, a former tenant, was diagnosed in adolescence with Complex Post-Traumatic Stress Disorder and Bipolar Disorder, and more recently with Dissociative Identity Disorder (DID). Two weeks after her DID diagnosis, she was discharged from clinical mental health services due to receiving short-term psychosocial support.

During her time at Avalon, Zara accessed consistent, trauma-informed support that enabled her to stabilise, re-engage with services, attend a social group, and begin the NDIS application process. After being deemed ineligible, Avalon supported her through an appeal.

This required reviewing over 20 years of records and retraumatised Zara, triggering dissociative episodes and psychological distress. She was unable to continue with the AAT process.

Zara is now reapplying for the NDIS, but the outcome is pending. She successfully transitioned into independent housing post-Avalon, but her short-term follow-up support is ending. With no clinical team, unresolved NDIS access, and no other formal supports, Zara faces significant risk.

She spends most of her income on a private psychologist and now relies on food banks. She is prescribed psychiatric medication but cannot access a bulk-billing psychiatrist. With no safe family, Zara's only connections with non-formal support is a weekly community group. Without support, Zara fears her dissociation and flashbacks may jeopardise her tenancy and lead to homelessness again.

Implications:

Zara's experience highlights the systemic failure to provide continuity of care for people with complex trauma who are ineligible for the NDIS. Despite her engagement in recovery, she has no access to further support.

Her case illustrates the need for sustained, integrated psychosocial support, particularly for those whose trauma-related barriers make navigating systems like the NDIS especially difficult.

Avalon stands out as a rare example of an effective, trauma-informed model that enabled Zara to stabilise and transition into long-term housing. However, with only 10 units and high demand, its reach is limited. Zara's journey demonstrates the need to expand and replicate models like Avalon as scalable, cost-effective solutions for people with complex mental health needs.

3. Mental Health of Aboriginal and Torres Strait Islander Peoples

We are deeply concerned by the Commission's findings about the increasing suicide rates among Aboriginal and Torres Strait Islander peoples. These statistics reflect a broader failure to deliver culturally safe, community-led, and trauma-informed mental health care.

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We support the Commission's recommendation for Indigenous-led solutions and stress the need for adequate, sustained investment in local, trusted providers and community-controlled organisations.

Recommendations

Building on our frontline experience, we recommend the following priorities for reform:

1. Design and fund an integrated, stepped-care system that is accessible across the full continuum of need and life stages, including for people not eligible for the NDIS. This must include mechanisms to support episodic engagement, step-up and step-down options, and seamless re-entry.
2. Invest in long-term psychosocial supports that are community-based, trauma-informed, and recovery-oriented, with flexible models to suit local needs. Funding arrangements must recognise and support the unique challenges of regional delivery and include outreach models.
3. Strengthen accountability and outcomes frameworks, ensuring clear indicators across service types and population groups, co-designed with lived experience input.
4. Embed mental health expertise in other service systems, including housing, justice, employment and aged care, to respond holistically to people's needs. Integrated service delivery should be prioritised, and siloed planning avoided. Avalon provides a replicable example of integrated housing and mental health support.
5. Fund culturally responsive, place-based mental health programs designed and delivered by Aboriginal and Torres Strait Islander communities.
6. Establish enduring mechanisms for service user voice, including through lived experience advisory panels and consultation processes tied to service design and evaluation.

The Role of the Sector

We strongly support the Commission's call for a re-designed, outcomes-driven National Mental Health Agreement. This must be co-designed with community sector partners and grounded in on-the-ground realities. The community sector brings not only programmatic reach, but also trusted relationships with vulnerable populations that are vital to delivering impact.

The design of the next agreement must also acknowledge how system fragmentation impairs outcomes. Different portfolios—such as housing, health, disability and social services—must be co-planned and jointly accountable where people's needs intersect.

As such, UnitingSA commits to contributing constructively to this reform process, including through the provision of service data, consumer stories, and practice insights across our portfolios. We will continue engaging our staff, clients and communities to ensure their voices inform both policy and systems design.

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Closing Statement

The Productivity Commission's Interim Report is a critical turning point in reshaping Australia's approach to mental health. UnitingSA urges governments and system leaders to act decisively on the Commission's findings, and to centre lived experience, equity, and community leadership in designing a better future.

A redesigned system must not only respond to those in acute distress but must support people over time—including through episodic need, regional access challenges, cultural needs, and through integrated service delivery that reflects the complexity of people's lives.

We look forward to ongoing collaboration with the Commission and sector partners to ensure that these recommendations lead to tangible change.

Jenny Hall | Chief Executive Officer