Productivity Commission Mental Health and Suicide Prevention Agreement Interim Report

Footprints Community Submission

Background and submission context

Established in 1991, Footprints Community Limited (FCL) is a well-regarded for-purpose organisation delivering community-based services across Queensland and Northern New South Wales. With a strong history of supporting people experiencing marginalisation and disadvantage, FCL has grown to offer a diverse range of specialist services.

These include targeted mental health programs funded by both Federal and State governments, as well as integrated support across homelessness, disability, social prescribing, and aged care, all of which contribute to a holistic approach to mental health and wellbeing. ***Insights for the submission were gathered from FCL workforce across this spectrum of services. 41 staff contributed across 13 programs, representing 1073 clients. It was important to gather insights from the front line of service delivery. To provide context, a snapshot of demographics, barriers to mental health services, mental health and suicide prevention priorities, and workforce matters are provided (Figure 1), along with responses to the Productivity Commission's request for information.***

FCL data represented in Figure 1 indicates a predominantly female client base, with a notable representation of non-binary individuals. A broad age distribution and presence in both urban and regional areas serving diverse client populations. The data underscores the importance of inclusive, accessible, and culturally safe services. It also points to areas where improvements are needed, especially in reducing waiting times, simplifying referrals, and addressing financial and cultural barriers.

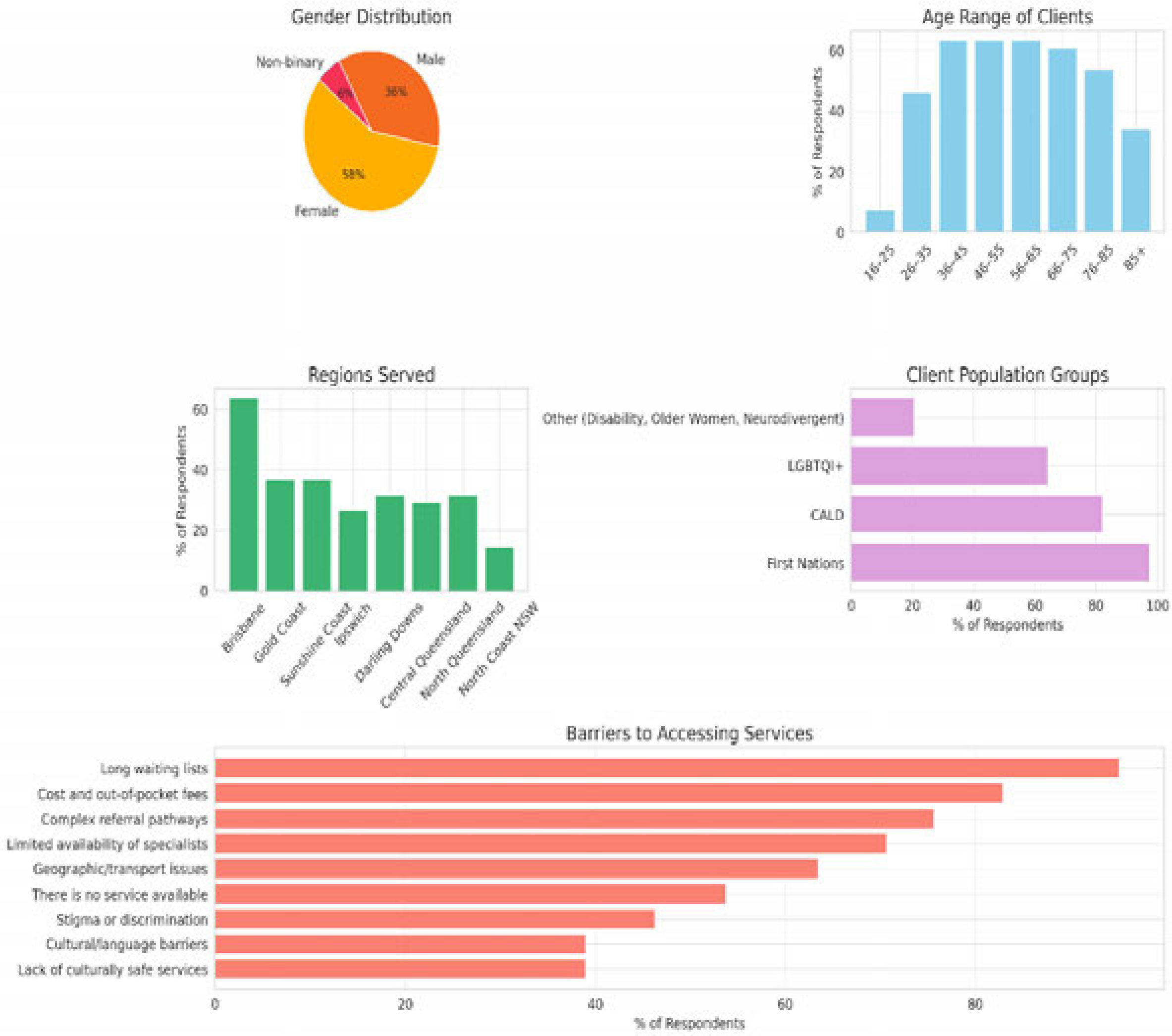


Figure 1. Snapshot of demographics and barriers to accessing mental health services for individuals accessing Footprints services (2025)

Service Gaps

From our workforce survey outlined above, the most frequently identified service gaps were affordable counselling/therapy (100%), psychosocial supports outside of the NDIS (85%), and early intervention and prevention programs (73%). Other prominent gaps included peer-led or lived-experience services (63%), specialist or acute-care access (61%), services being unaffordable (71%), and difficult to access (66%). Notably, Indigenous social and emotional wellbeing services were flagged by 44% of respondents, with some also highlighting gaps for CALD, and trauma-affected individuals.

When asked to rate service access for people experiencing mental health challenges, 73% of respondents rated access to current **crisis and after-hours services** across the sector as either *Poor* or *Very Poor*, indicating that these programs are not funded in a way that meets community need.

Respondents highlighted a consistent lack of accessible, affordable, and person-centred supports—particularly for those not eligible for the NDIS. There is a strong call for **early intervention**, **community-based lived experience leadership**, and **culturally appropriate services**, especially for Aboriginal and Torres Strait Islander peoples. The feedback reflects broad gaps across the mental health system, particularly in **non-clinical and wraparound services** essential for prevention, recovery, and inclusion.

To inform this response, Footprints Community staff were asked to identify service gaps, across the sector that they experience when providing support for client experiencing mental health challenges. Commonly missing services include:

- Mental health and psychosocial support: There is a widespread lack of accessible and affordable mental health care (e.g. psychologists, psychiatrists, grief and trauma counselling, long-term therapy), especially for older adults, men, and people with complex needs.
- Crisis and housing support: Services for homelessness, especially for First Nations clients, young males with substance use, and rural/remote populations, are notably absent.
- Accessibility barriers: Many areas report no local providers, no public transport, and high reliance on expensive or inadequate telehealth, further isolating vulnerable clients.

Responses to this survey highlighted the most **reported gaps in non-clinical mental health support** were social connection and community activities (88%), housing support navigation (80%), and capacity building in daily living skills (73%). Peer-led support groups (61%) and employment or education assistance (46%) were also frequently noted as lacking. A small number of respondents identified niche gaps such as behavioural interventions, transport, and financial resilience support.

Workforce

Approximately 60% of respondent's indicated that current workforce levels are either insufficient or very insufficient to adequately meet client needs. This suggests that many services are struggling with workforce shortages, which could impact the quality and accessibility of care provided. Meanwhile, approximately 24% of respondents felt that staffing levels were sufficient or very sufficient, reflecting that some services may be better resourced or staffed to meet demand. Overall, these responses highlight significant ongoing challenges related to workforce capacity that may require targeted strategies to improve recruitment, retention, and support for staff to better meet client needs.

The most common investments suggested to strengthen the workforce include increasing workforce levels, **developing peer-work accreditation** and clear scopes of practice, and expanding professional development and training opportunities. Many responses also emphasized the **need for longer-term funding contracts** to provide stability and flexibility. Additionally, improving supervision and support structures—offering reflective time, wellness focus, and better pay or leave entitlements—was highlighted as essential to prevent burnout and enhance workforce wellbeing.

Responses regarding recognition and support for the **peer workforce in the current service system** was mixed but generally leaned toward neutral to poor. This suggests that while some services are doing well in recognising and supporting peer workers, **many still lack the structures, respect, or integration** needed to fully value their contribution. Overall, there is a clear need for improvement in how peer workers are supported across the sector.

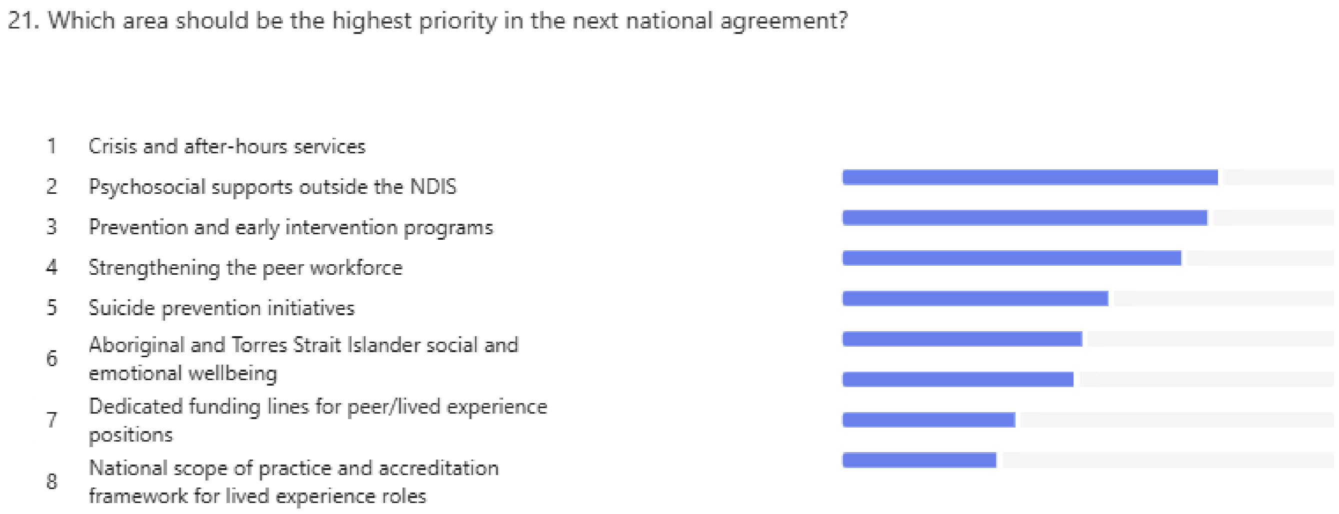
Which suicide-specific interventions need more resourcing?

Most respondents highlighted the urgent need for increased resourcing of community-based crisis safe spaces, recognising their vital role in providing immediate, accessible support during times of acute distress. Alongside this, community awareness and stigma reduction initiatives were widely emphasised as essential to foster understanding and encourage help-seeking behaviours. School and workplace prevention programs were also frequently mentioned, reflecting the importance of early intervention in everyday settings. Additionally, post-attempt aftercare and liaison services were seen as critical for supporting individuals after a suicide attempt to reduce the risk of recurrence. There was also a notable call for prevention programs tailored to specific population groups (e.g., older men, the LGBTQIA+ community, people experiencing homelessness) to address diverse needs effectively. Together, these priorities underline the need for a comprehensive, well-resourced multidisciplinary team approach, incorporating both clinical and non-clinical supports approach to suicide prevention that combines crisis support, education, and targeted interventions.

The groups identified as needing further support through targeted prevention programs include older adults, especially those over 65, who often face ageism and higher suicide rates, particularly men over 85. Young people, including teenagers, non-binary, and transgender individuals, were also frequently mentioned, along with the LGBTQIA+ community. Other vulnerable populations highlighted include people experiencing homelessness, those with disabilities or long-term diagnoses, culturally and linguistically diverse (CALD) communities, Indigenous Australians, and men who may struggle with stigma of mental health issues. There is a strong call for accessible, timely, and culturally sensitive support tailored to these specific groups to better address their unique challenges.

Which area should be the highest priority in the next national agreement?

The top priority for the next national agreement, according to respondents, is **crisis and after-hours services**, emphasising the urgent need for accessible support during critical times. One example to achieve this could embed crisis and after-hours services into existing activities, rather than a stand-alone investment. Closely following are **psychosocial supports outside the NDIS** and prevention and early intervention programs, highlighting the importance of ongoing care and early action to improve mental health outcomes. Pressing the urgency of the disability reform, including the finalisation of the Foundation Support System is priority. Strengthening the **peer workforce**, suicide prevention initiatives, and Aboriginal and Torres Strait Islander social and emotional wellbeing were also important, reflecting the need to build capacity and focus on vulnerable populations. Dedicated funding for peer/lived experience roles and a national accreditation framework for these roles are key considerations for formalising and supporting the peer workforce.



21. Which area should be the highest priority in the next national agreement?

Figure 2. Responses provided regarding the highest priority for the next Agreement

Information Request

The PC is seeking examples of barriers to the genuine participation and influence of people with lived and living experience in governance forums. How could successful inclusion and engagement of people with lived and living experience in governance be measured?

Respondents stressed the need for diverse, meaningful participation at every level of policy development, implementation, and evaluation, ensuring contributions are valued and not tokenistic. Suggestions included engaging people from varied **cultural, geographic, and social backgrounds,** especially those often overlooked in traditional consultation methods. Many called for face-to-face and **community-based engagement,** particularly for **older populations and rural communities** who may face digital access barriers. There was a clear emphasis on creating safe, respectful spaces for participation, acknowledging the uniqueness and complexity of individual lived experiences. Respondents highlighted the importance of **practical supports** such as **remuneration, training, accessible communication formats, and culturally safe environments. Peer support roles** were also identified as vital, with calls for better pay, role clarity, and support to **avoid re-traumatisation.** Feedback loops, transparency, and third-party oversight were proposed to ensure accountability and build trust. Many emphasised that **co-design must be embedded as a foundational principle**—not a one-off event—and led by those with experiential knowledge, in partnership with peak bodies and lived experience-led organisations. Overall, the responses call for systemic change to ensure lived experience is central to the mental health system, guiding not just policy design but service delivery and evaluation as well.

From an organisational, FCL is keen to understand how vulnerable and marginalised individuals experiencing mental health challenges – whose voices are often excluded from co-design processes – will be included in governance and decision-making. Highlighted is the urgent need for more inclusive, community-driven, and **flexible engagement strategies**. When seeking feedback and input it was widely emphasised the importance of going directly to people, rather than expecting them to come forward. This includes **assertive outreach** in hospitals, homes and community settings; leveraging existing relationships with trusted local organisations, peer networks, and cultural groups; and **avoiding over-reliance on digital or formal** communication channels, which often exclude the most at-risk populations. Many suggested using **face-to-face engagement, visual and audio media, storytelling, and trauma-informed practices** in safe, familiar environments to build trust and overcome communication or stigma barriers. Participants advocated for multiple, accessible participation methods, including anonymous contributions, **"Dear Diary"-style audio** recordings, and simple, low-barrier formats for those with limited literacy or internet access. Practical supports—such as transport, **interpreters**, time flexibility, and appropriate **compensation**—were seen as essential. Respondents also recommended **involving people with**

lived experience in designing and facilitating outreach, using local data and feedback systems to inform continuous improvement, and ensuring all engagement is **patient, respectful, and not time constrained**. The recurring theme was clear: genuine connection, cultural sensitivity, grassroots partnerships, and sustained, well-resourced effort are key to ensuring these overlooked voices are truly heard and incorporated into policy and service design

The responses identify a wide range of **barriers** that prevent the genuine participation and influence of people with lived and living experience in governance forums. These include **tokenism**, where participation is symbolic and not tied to real influence; **power imbalances** between professionals and participants; and **stigma** associated with mental illness or particular diagnoses. Many respondents highlighted **lack of remuneration**, **transport**, and **accessible formats**, especially for those experiencing poverty, disability, or limited digital literacy. **Burnout**, **trauma**, and **mental health fluctuations** were also commonly cited as internal challenges to sustained engagement. Others mentioned that governance settings are often overly formal, complex, or intimidating, especially for people with histories of being ignored or mistreated by systems. Additional barriers include unclear role definitions for lived and living experience, limited capacity-building, lack of feedback loops, and distrust in services due to past negative experiences.

Footprints acknowledges that **successful inclusion and engagement** of lived and living experience individuals in governance, whilst complex, is essential and proposes the following ways to measure success:

- **Representation**: the number and diversity of lived and living experience participants in governance roles, including leadership positions.
- **Influence**: evidence that their input shapes decisions, policies, and service delivery.
- **Process quality**: satisfaction of participants with how they were treated, supported, and respected (e.g. through interviews or open-ended feedback).
- **Structural supports**: presence of fair remuneration, role clarity, training, and trauma-informed practices.
- **Sustainability**: long-term, embedded roles for lived and living experience rather than one-off consultations.
- **Accountability**: use of tools like the *Lived Experience Inclusion Ladder* or *Leading the Change Toolkit* to track inclusion maturity and growth over time.
- **Feedback mechanisms**: whether participants are informed about how their contributions have been used or acted upon.

Overall, authentic inclusion requires a cultural shift from symbolic involvement to **shared power, mutual respect, and resourced support**—with measurement frameworks that reflect lived realities, not just institutional metrics.

The PC is looking for case studies to highlight best practice in integrating peer workers in clinical mental health and suicide prevention settings, particularly by improving clinician awareness of the peer workforce. Are there examples of best practice that could be adopted in other organisations or settings?

Responses underscored the importance of **recognising, formalising, and integrating** peer roles within clinical and non-clinical care. Respondents highlighted several key themes and best practices.

Firstly, **role clarity and equal status** were seen as critical—peer workers should be viewed as legitimate and essential members of care teams, with clearly defined scopes of practice, appropriate training, and equitable remuneration.

Secondly, **lived experience peer workers bring unique, person-centred, recovery-oriented support** that clinical staff often cannot provide, such as practical coping strategies, empathy, and hope through shared understanding. However, several responses flagged ongoing challenges such as **stigma, tokenism, lack of understanding of the peer role, and insufficient organisational support**. Respondents called for greater investment in workforce development, including supervision, debriefing, scope-specific accreditation, and workforce wellbeing strategies to manage burnout and mental health relapse.

Additionally, successful peer worker integration was associated with **multidisciplinary collaboration**, **trauma-informed practice**, and **consumer empowerment**. Participants also called for **system-level supports**—such as policy, funding, and national guidance—to uphold consistency and safeguard the legitimacy of the peer workforce.

The responses highlight best practices for integrating peer workers into clinical mental health settings. Key examples include Queensland's Metro South Service – Crisis Support Space in Logan, Queensland; staffed with a clinical nurse (Metro South Health) and a team of peer workers (employed by a not-for-profit) - co-designed by consumers and peer workers. This service integrates both clinical and non-clinical and government and non-government services. Another example is the Bidi Wungen Kaat Centre. This centre provides an evidence-based, innovative approach to mental health care delivered by the East Metropolitan Health Service (EMHS) in St James, within the Town of Victoria Park; the workforce includes skilled mental health clinicians and peer practitioners to ensure the consumer residents always have appropriate levels of support. Lived experience consumer and carer representatives assisted in the co-design of this service. Successful integration relies on valuing peer roles equally, avoiding tokenism, providing proper supervision and training, involving peers in decision-making, and fostering inclusive, recovery-oriented workplace cultures. They illustrate how structured integration, clinician education, and joint training can foster respectful, effective collaboration between clinical and peer staff, leading to better client outcomes and workplace cohesion.