Submission

Delivering Quality Care More Efficiently

Date: September 2025

Our Commitment to First Nations Wellbeing, Culture, and Self-Determination

We stand in strong support of First Nations Australians, affirming their inherent right to self-determination, cultural preservation, and sovereignty over their land and traditions. We acknowledge that for First Nations peoples, mental health is inseparable from cultural, emotional, physical, and spiritual wellbeing—a holistic understanding maintained through thousands of years of continuous culture.

The Gayaa Dhuwi (Proud Spirit) Declaration Framework and Implementation Plan, launched in Meanjin (Brisbane) on the lands of the Turrbal and Yuggera peoples where our office stands, provides a crucial 10-year roadmap. QAMH fully endorses this community-led approach to integrating First Nations leadership, cultural knowledge systems, and healing practices into Australia's mental health frameworks.

QAMH is committed to supporting truth-telling as a process of acknowledging the histories, lived experiences, and ongoing strengths of First Nations peoples, particularly in the context of mental health. By confronting the impacts of colonisation, intergenerational trauma, and ongoing systemic injustices, we can better address the historical and contemporary factors affecting the mental wellbeing of First Nations individuals and communities.

In this submission, we emphasise the importance of holistic and healing approaches to mental health that incorporate the cultural knowledges, connection to Country, and spiritual practices of First Nations peoples. We are dedicated to ensuring that the principles of self-determination, cultural safety, truth-telling, and holistic health are central to the mental health initiatives and recommendations we propose. Our goal is to help build a future where mental health systems respect and respond to the unique needs and strengths of First Nations Australians.

Acknowledgement of Country

QAMH acknowledges and pays deep respect to Aboriginal and Torres Strait Islander peoples as the Traditional Custodians of the lands and waters across Australia. We honour their Elders past and present, whose knowledge, leadership, and cultural practices have sustained these lands for millennia.

Who is QAMH?

The Queensland Alliance for Mental Health is the peak body for the state's Community Mental Health and Wellbeing Sector and people with experiences of psychosocial disability in Queensland. We represent 112 members and stakeholders, involved in the delivery of NGO Community Mental Health and Wellbeing Services.

Our role is to reform, promote and drive Community Mental Health and Wellbeing Service delivery for all Queenslanders, through our influence and collaboration with our members and strategic partners.

At a national level, we collaborate with Community Mental Health Australia, Mental Health Australia and the National Mental Health Commission where appropriate. Locally, we work alongside our members, government, the Queensland Mental Health Commission and other stakeholders to add value to the sector.

Recognition of Lived Experience

QAMH recognises that the Community Mental Health and Wellbeing Sector exists because of people with Lived Experience of mental distress, their families, carers and support people. We acknowledge the expertise and the courage of people with Lived Experience, and we commit to work with and alongside people with Lived Experience in all we do.

Definitions

Psychosocial supports are non-clinical, trauma informed, recovery-oriented services that support people experiencing mental health challenges to live independently and safely in the community. They help people stay well, avoid crisis, and participate in community life. They also reduce demand on hospitals and emergency services, making them a cornerstone of a sustainable mental health system.

NGO Community Mental Health Sector occupies a unique place within the broader mental health system. They deliver support services that address the complex realities of distress shaped by trauma, poverty, isolation, and other social determinants, focusing on social inclusion and practical assistance with housing, relationships, employment, and other key areas of life.

These services are critical for:

- People who are not eligible for the NDIS
- Those facing barriers to accessing mainstream mental health services
- People whose needs are not clinical, but still significant

Introduction

The future of Australia's care economy depends on reform grounded in prevention and recovery. While the Interim Report rightly calls for greater integration, its recommendations still focus narrowly on aged care, the NDIS, veterans' care and health. Real reform will only be possible when community-managed mental health organisations - and the supports they provide to keep people well, connected and participating - are recognised as essential.

Community-managed mental health organisations provide cost-effective psychosocial supports delivered by a skilled workforce, which improve social and economic participation, reduce demand on acute hospital services, and garner a return on investment of $3 - $4.86 for every $1 invested.[1,2] Currently in Queensland, mental health challenges and suicide are estimated to cost us $14 billion each year in direct health care, lost economic participation, absenteeism, and reduced productivity.[3]

QAMH appreciates the opportunity to contribute to this process and welcomes the Productivity Commission's recognition that collaboration between governments, services, and communities is critical to meaningful reform. This submission reflects the concerns consistently raised by our members through regional visits, project delivery and consultations. Across Queensland, providers call for a system that is better integrated, sustainably funded, and genuinely committed to community-based support.

Summary of Recommendations

QAMH urges the Productivity Commission, in shaping its Final Report, to adopt the following recommendations:

1. Recognise the critical role of community mental health, and implement proportionate and inclusive regulation
    a) Extend regulatory alignment to NGO community mental health providers, recognising their cross-sector role.
    b) Ensure proportionate safeguards for smaller, regional and First Nations providers.
    c) Value the peer workforce through flexible national screening and registration that safeguards safety without excluding lived expertise.
2. Reform commissioning to be collaborative and co-designed with a nationally agreed outcomes framework
    a) Mandate inclusion of NGO community mental health organisations, lived experience voices and ACCHOs in commissioning alongside PHNs and LHNs.
    b) Establish a co-designed national outcomes framework, capturing recovery, inclusion and participation, not only hospital throughput.
    c) Provide longer-term, stable funding to strengthen continuity, trust and local knowledge.
3. Broaden the national prevention investment framework
    (a) Explicitly recognise psychosocial supports as prevention, not only clinical interventions.
    (b) Expand evaluation frameworks to measure recovery, inclusion, housing stability and participation, alongside reductions in hospital use.

(c) Ensure the Prevention Advisory Board includes NGO and lived experience expertise, not only clinical and economic perspectives

4. Recognise and invest in the community mental health workforce
   (a) Embed peer and psychosocial roles in national workforce planning, regulation and data systems.
   (b) Resource workforce development strategies that grow and sustain this workforce alongside clinical professions.

Recommendations

Priority Reform 1: Reform of Quality and Safety Regulation to Support a More Cohesive Care Economy

Recommendation 1: Recognise the critical role of community mental health, and implement proportionate and inclusive regulation

Include NGO Community Mental Health Providers in Reform

While the interim report states its initial focus is on aged care, the NDIS and veteran care, this overlooks the connectedness of the care economy. Non-Government Organisations (NGO) community mental health services may operate across all three, providing prevention and step-up/step-down support to people with mental health challenges. Their workforce, employed under SCHADS, plays a vital role in keeping people healthy, safe and connected, while also reducing the need for acute hospital services. It makes little sense to pursue reforms that aim to reduce duplication and fragmentation across some parts of the care economy while leaving community mental health outside the scope. Excluding this sector risks creating new silos and undermining integration, when the clear purpose of reform is to support a more cohesive care economy.

For example, **Wesley Mission Queensland** delivers integrated services spanning mental health, aged care and disability support, while **Selectability** operates across regional Queensland offering psychosocial supports alongside aged care and disability services. These members illustrate how community mental health NGOs already work across multiple care economies in practice.

To achieve truly cohesive and sustainable care, community mental health must be embedded in all reform and regulatory frameworks. Without it, reforms will fall short of their purpose - an efficient, integrated care economy that delivers better outcomes for people and better value for governments.

Implement Proportionate Regulation

Smaller, regional and First Nations providers often operate with lean administrative resources. Requiring them to comply with duplicative, compliance-heavy standards imposes a disproportionate burden, reducing the capacity of these organisations to deliver essential psychosocial supports in their communities.

Evidence from Health Policy Analysis shows that more than 493,000 Australians with severe or moderate mental health challenges already miss out on care.[4] Waiting times can be lengthy, and we know those in rural and regional areas are disproportionately affected. Some Medicare Mental Health Centres, such as in Birtinya and Redland Bay, report waitlists of up to three months, demonstrating how stretched the system is. While large providers can more easily absorb complex regulatory demands, they do not always operate in regional or rural areas. In contrast, smaller, grassroots organisations with minimal back-office support remain vital sources of trusted, community-led care.

QAMH supports efforts to align regulation and reduce duplication but cautions against a one-size-fits-all approach. Proportionate safeguards that reflect provider size and risk are essential, alongside appropriate transition supports to ensure organisations can adapt appropriately. Data-sharing and central repositories could further streamline compliance, provided they protect service user privacy and focus on agreed psychosocial outcomes, not just clinical or throughput measures.

Note: QAMH raised concerns about compliance duplication in 2023 during the review of the National Safety and Quality Mental Health Standards for Community Managed Organisations in our submission here. Herein you will see our members do meet requirements under several standards.

Recognise the Peer Workforce

The peer workforce remains largely invisible in the Interim Report recommendations, and the proposed national screening clearance risks excluding them. Peer workers bring unique expertise grounded in lived and living experience that cannot be replicated through clinical training, yet regulation often frames roles within narrow, medicalised models.

The value of peer work is well established. A joint report by Mental Health Australia and KPMG estimated a return of $3.50 for every $1 invested in peer roles, driven by improved service engagement, earlier intervention, and more effective recovery-oriented care.[5] International evidence confirms that peer-led interventions are cost-effective, reduce stigma, and deliver measurable system savings, while also improving the care experience for people in distress.[6]

A national screening and registration framework must safeguard safety while protecting the distinct contribution of the peer workforce. Flexible approaches that accommodate workforce diversity are essential to ensure people are not excluded solely because of past experiences that form part of their lived expertise. Properly designed regulation can strengthen and legitimise peer roles, supporting both service quality and a sustainable mental health system.

Delivering Recommendation 1

By embedding NGO community mental health services within the care economy, tailoring safeguards, and valuing the peer workforce, the regulatory framework can drive more integrated, equitable, and sustainable care to help people lead more connected and fulfilling lives. Together, these initiatives would ensure regulation is proportionate, inclusive, and fit for purpose.

Priority Reform 2: Embed Collaborative Commissioning to Increase the Integration of Care Services.

Recommendation 2: Reform Commissioning to be Collaborative and Co-Designed with an Agreed National Outcomes Framework

QAMH is broadly aligned with Draft Recommendation 2.1 and strongly supports moves towards collaborative, flexible, place-based commissioning and integrated planning and evaluation.

Bring Community Voices into Commissioning

Current commissioning models remain dominated by hospital and clinical priorities, with NGO community mental health, lived experience representatives, and Aboriginal Community Controlled Health Organisations (ACCHOs) often excluded from decision-making. This entrenches a system suitable for acute health imperatives rather than the psychosocial supports people need to stay well.

Ensuring these voices are at the table is critical to designing services that are trusted, culturally appropriate, and responsive to local needs. Place-based commissioning that values the knowledge of community organisations and people with lived experience will create systems that meet people where they are, rather than forcing them to fit into hospital-driven models.

QAMH recommends mandating the inclusion of NGO Community Mental Health Organisations, lived experience representatives, and ACCHOs in commissioning alongside PHNs and LHNs to create genuinely collaborative, place-based systems.

Investing Fairly in Community Mental Health

Despite delivering cost-effective supports that keep people well in the community, NGO community mental health organisations remain underfunded, limiting their capacity to meet growing demand. In Queensland, the NGO community mental health sector receives only 4.6% of mental health funding.[7] These issues were outlined in full in QAMH's submission to the Department of Health and Aged Care on the PHN Business Model Review earlier this year.

Without adequate psychosocial supports, hospitals become the default system response. Both Australia and international research shows that community-based psychosocial interventions improve participation, reduce hospital demand, and foster long-term recovery.[8,9,10] QAMH's Psychosocial Approaches to Thriving Health Systems (PATHS) Project provides a practical example: co-designed in Townsville with people with lived experience, service providers, and funders, it offers a scalable, place-based model for people not eligible for the NDIS. PATHS demonstrated annual delivery costs of $1,028–$8,400 per person, compared with $1,532 for a single hospital bed day in an acute psychiatric unit, with an average stay of 16 days.[11]

Redirecting a greater share of funding to community-based psychosocial supports will reduce reliance on hospitals and address the needs of the 493,000 Australians currently missing out on the care they need.

Securing Continuity and Stability

QAMH welcomes the Interim Report's clear articulation of the barriers to continuity (p. 34), including short-term funding, rigid processes, and capability constraints. These findings mirror the experiences of our members, who consistently report that contracts end just as programs begin to demonstrate impact. This cycle creates inefficiencies, forces constant re-application, and undermines trust for both services and the people who rely on them.

In Queensland, PHN contracts vary widely across regions, creating inconsistent approaches and administrative burden. Smaller local organisations are particularly disadvantaged in competitive processes, while larger interstate providers often secure contracts despite limited local knowledge. This erodes community connections, disrupts care, and destabilises local service systems.

QAMH recommends longer-term, stable funding cycles that allow programs to mature, provide certainty for staff and participants, and sustain local knowledge and trust.

Embedding Meaningful Outcomes in Commissioning

The community-managed mental health sector continues to face significant challenges in measuring outcomes effectively. Historic underfunding has meant there are few consistent tools, limited infrastructure, and inadequate resources to support robust evaluation. Services are often required to report against fragmented and short-term indicators that do not reflect the complex and long-term nature of recovery, creating a mismatch between funder expectations and what matters to people's lives.

In 2018-2019, QAMH undertook a project to explore outcome measurement across the community mental health sector.[12] Two-thirds (66%) of participating organisations reported they were measuring outcomes for most or all services, and there was strong support for using outcome measures to improve quality and demonstrate impact. However, only 47% believed they were doing so effectively. Key barriers included lack of funding and resources, inconsistent tools and methodologies, limited access to aggregated data, and pressure to show short-term results in contexts where recovery takes time.

A co-designed, consumer-led, national outcomes framework is needed. With the right investment, such a framework, built on consistent language and measures can capture the true value of community mental health services, strengthen accountability in commissioning processes, and demonstrate their role in reducing reliance on acute care.

Delivering Recommendation 2

Embedding NGO community mental health organisations, lived experience representatives, and ACCHOs in commissioning processes, alongside longer-term funding and a national outcomes framework, will strengthen continuity, trust, and accountability. Taken together, these reforms deliver on Draft Recommendation 2.1 by ensuring commissioning reflects the full spectrum of supports people need to stay well in their communities.

Priority Reform 3: A National Framework to Support Government Investment In Prevention

Recommendation 3: Broaden the National Prevention Investment Framework

Embedding Community Mental Health in Prevention Framework

QAMH strongly supports the development of a National Prevention Investment Framework and endorses Draft Recommendation 3.1. We agree that prevention directly improves people's lives and welcome the Interim Report's recognition of improved mental health as a core priority. However, current approaches risk defining prevention too narrowly, focusing primarily on clinical risk factors and hospital avoidance. This framing overlooks the wider context in which mental health is shaped.

The World Health Organisation and national studies confirm that psychosocial supports not only reduce hospitalisation but also improve social and economic participation. For this reason, QAMH cautions against limiting prevention to clinical interventions alone. To be effective, the Framework must explicitly broaden its definition to include psychosocial supports, recognising the critical role that community-managed mental health services play in preventing poor outcomes, helping people maintain employment and promoting wellbeing.

Demonstrating Impact

Many community-based psychosocial programs currently operate with limited or no dedicated funding for evaluation, meaning their true impact is often under-reported. Where evaluations have been undertaken, the findings show clear improvements in wellbeing, social participation, housing stability, and reduced hospital use. Yet current evaluation frameworks remain narrowly focused on short-term fiscal savings or hospital throughput. These risk undervaluing community-led psychosocial supports and innovative approaches such as social prescribing, which generate long-term benefits that are harder to capture through traditional metrics. By not measuring outcomes like recovery, inclusion, and participation, the evidence base for prevention remains incomplete, and the critical role of the community mental health sector is obscured.

Expanding evaluation frameworks to recognise broader social and economic returns will ensure that prevention strategies reflect the full contribution of these supports and provide a more accurate foundation for investment decisions. Evidence from multiple evaluations and trials confirms the effectiveness of community-led and peer-led models:

- **Footprints – Working Together to Connect Care[13]:**

  This case management and psychosocial support program supported people with frequent emergency department presentations. Participants reported meaningful improvements, with 93% experiencing better psychosocial wellbeing and 91% reporting improved physical health. "Without persistence in trying to help me and assisting me with my pace, I would have been homeless."

- **Peach Tree Parenting Program (peer-led)[14]:** This peer-led early parenting support group offered connection, validation, and a sense of shared understanding for new parents. Participants experienced statistically significant improvements in wellbeing, with psychological distress reduced by 17% and rates of moderate to severe postnatal depression dropping by 27%. "I went through a very rough pregnancy (miscarriage then twin pregnancy with one foetal death) and have a toddler… Peach tree has become a crucial part of my support network, I don't know what I would have done without it."
- **Stepping Stone Clubhouse[15]**: This strengths-based Clubhouse program offers a recovery-oriented community for adults living with mental illness, grounded in connection, purpose, and peer support. New members experienced an 11% reduction in hospitalisations, while longer-term members reported significantly higher outcomes across symptom management, social connection, functioning, and quality of life. Many described feeling valued, more confident in their identity beyond a diagnosis, and supported by genuine friendships and staff relationships. "It's transformed me, and even though I've come back I'm still nowhere near as sick as I was, and I still haven't needed hospital."

While reductions in hospital use provide one measure of impact, these programs also strengthen resilience, connection, and wellbeing, preventing distress before it escalates to crisis. The most powerful impacts are often found in strengthened resilience, reduced distress, and greater social and economic inclusion. Embedding these broader measures into national evaluation frameworks will ensure that prevention investment decisions reflect the true return on community-led and peer-led programs.

Strengthen Advisory Structures

QAMH supports the Interim Report's proposal for an independent and cross-sectoral Prevention Framework Advisory Board to assess and provide expert advice on prevention funding. Current decision-making structures are often dominated by clinicians and economists, with limited input from community providers, NGOs, or people with lived experience. These risk a reinforcement of a hospital-centric model of prevention rather than one that reflects the diverse supports people need to stay well.

To ensure that prevention frameworks are equitable, effective, and responsive, advisory bodies such as the proposed Prevention Framework Advisory Board must embed NGO and lived experience voices alongside clinical and economic expertise. This will ground decision-making in the realities of service delivery and recovery, while also strengthening legitimacy, accountability, and public trust.

Recommendation 4: Recognise and Invest in the Community Mental Health Workforce

Strengthening Prevention Through a Diverse Workforce

Australia's prevention framework will only succeed if workforce planning fully values peer and psychosocial roles. This requires a clear plan for workforce development alongside the framework itself, ensuring the right mix of skills and roles are available to implement prevention in practice. Workforce strategies and data systems, however, continue to privilege clinical roles and metrics, overlooking the vital contributions of the peer and psychosocial workforce. Evidence from QAMH's Community Mental Health and Wellbeing

Workforce Project, alongside growing research, shows these roles are central to improved recovery outcomes, stronger participation, and better service engagement.[16]

To achieve genuine reform, national workforce planning must explicitly recognise and embed peer and psychosocial roles within regulation, planning, and data frameworks.

Delivering Recommendations 3 and 4

Broadening prevention to include community-based psychosocial supports and ensuring these are measured through outcomes that reflect recovery, inclusion, and participation, will capture their full value. At the same time, recognising and embedding peer and psychosocial roles in national workforce planning will provide the capacity needed to deliver these reforms in practice. Together, these changes will strengthen system sustainability and ensure Draft Recommendation 3.1 delivers lasting benefits by improving wellbeing, increasing participation, and easing pressure on the health system.

Conclusion

The Productivity Commission's Interim Report sets the stage for long-overdue reform of Australia's care economy. But unless the role of the NGO community mental health sector is fully recognised, reform will remain incomplete. These organisations already deliver cost-effective, recovery-focused supports that prevent crisis, reduce pressure on hospitals, and enable people to live well in their communities.

By embedding NGO community mental health services in regulation, commissioning, prevention, and workforce planning, governments can build a more integrated and sustainable system. This will ensure people experiencing episodic or ongoing mental health challenges receive the trusted, flexible support they need to keep them connected to family, work, and community.

In elevating the contribution of the community mental health sector, the Commission has the opportunity to deliver a reform agenda that is not only more efficient and equitable but also more humane, grounded in recovery, participation, and wellbeing for all.

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