neami
national
Improving Mental Health and Wellbeing

Submission to the Productivity Commission
National Mental Health and Suicide Prevention Agreement

March 2025

Acknowledgments

About Neami National (Neami)

We're a values-based, national not-for-profit organisation and big believers in everyone having the opportunity to live a full life.

We support people to achieve the wellbeing and mental health outcomes that matter to them.

We provide services for mental health and wellbeing, housing and homelessness, and suicide prevention. Our team of over 1,200 people supports 38,000 people each year.

Acknowledgment of Country

We acknowledge Aboriginal and/or Torres Strait Islander peoples and communities as the Traditional Custodians of the land we work on and pay our respects to Elders past and present. We recognise that their sovereignty was never ceded.

A word on language

Throughout this submission, we use the term *mental health challenges* which is the preferred terminology for the majority of people with lived experience of mental ill-health surveyed by Neami in preparation for this and other recent policy submissions. We may use the term mental ill-health depending on the context.

Contents

Introduction

Neami National (Neami) welcomes the opportunity to contribute to the Productivity Commission's review of the National Mental Health and Suicide Prevention Agreement (Agreement).

Neami is a national provider of mental health and wellbeing, safety and homelessness, and suicide prevention services. We deliver a wide range of mental health and suicide prevention and postvention services under the National Agreement and bilateral agreements. To do this work, we employ a diverse workforce comprising lived experience roles, community mental health workers, and clinical roles, including psychiatrists, mental health nurses, and allied health professionals.

The Agreement plays an important role in fostering national commitment, guiding investment, and clarifying governance arrangements for mental health and suicide prevention reform. However, while the Agreement has led to significant investments in improving access to services, the system remains fragmented, and many of these investments have been made in the absence of a clear, unified vision for reform.

In preparing our submission, Neami has engaged with peak bodies, Mental Health Australia (MHA) and Suicide Prevention Australia (SPA). Further, Neami is a member organisation of the Australian Psychosocial Alliance (APA) and has contributed to the APA's submission. Neami supports and endorses these submissions but has aimed to prepare a submission that reflects our experience and knowledge as one of Australia's largest providers of community mental health services.

Key reflections

The Agreement is a vital instrument for driving reform and has laid the foundation for establishing improved governance and securing a commitment from all levels of government to deliver key reform activities.

The Agreement fills a significant gap left by the dissolution of the Council of Australian Governments (COAG) in May 2020, which coincided with the release of the Productivity Commission's Inquiry Report on Mental Health. The Agreement is critical because it recognises the need for a whole-of-government approach to addressing current and future mental health and suicide needs, including the lasting impact of disasters such as bushfires, floods, and the COVID-19 pandemic, which have caused unprecedented distress in communities.

Neami acknowledges the progress made on the deliverables under the Agreement to date. However, the first Agreement has fallen short of creating a fully integrated mental health system that addresses existing gaps and fragmentation in the ecosystem. As the current Agreement's term comes to a close, it is increasingly evident that critical issues—such as significant gaps in psychosocial support services and widespread workforce challenges—need urgent attention. These fundamental challenges must be prioritised for the next Agreement and for mental health and suicide prevention reform to be successful.

In preparing our response to the terms of reference questions, we have identified seven priority areas for the next Agreement, summarised as follows:

— **Address unmet community needs:** The driving principle of the next Agreement should be addressing the community's unmet mental health needs. This requires a comprehensive mapping of existing gaps in care and a deep understanding of the barriers individuals face in accessing services. Clear, actionable steps must be developed to close these gaps, supported by targeted funding.

— **A vision and blueprint to guide the reform:** The current Agreement lacks a clear and compelling vision and does not connect initiatives to an overarching framework or blueprint for a coordinated, integrated, and responsive mental health and suicide prevention system. Additionally, there seems to be no alignment or integration with Vision 2030. Clarification is needed on whether Vision 2030 has been abandoned or if a new blueprint will underpin the next Agreement.

— **Enhancing accountability, transparency, and reporting:** Comprehensive system-wide reform is needed to ensure that all stakeholders—federal, state, and territory governments, Primary Health Networks (PHNs), and service delivery partners—clearly understand their responsibilities under the Agreement. Accountability must be articulated, with increased public transparency regarding deliverables, timelines, and reporting schedules. Oversight should be vested in an independent statutory body.

— **Enhance the National Mental Health Commission (NMHC) and the National Suicide Prevention Office's (NSPO) role and accountability functions:** To improve reporting, transparency, and community trust, the NMHC and NSPO should be independent, ideally statutory bodies, adequately resourced to fulfil their roles effectively.

— **A comprehensive governance framework:** Existing governance arrangements are too broad and lack mechanisms to ensure the mental health system functions as an integrated, connected ecosystem of care. Individuals should be able to access the right care at the right time, no matter where they seek help. Seamless coordination must be standard across all mental health and suicide prevention services.

— **Enhance cooperation and reciprocity between federal and state/territory governments:** The Agreement lacks a shared vision for reform, resulting in a transactional approach rather than genuine collaboration among federal, state, and territory governments. To address this, clear frameworks and implementation plans are needed to guide cooperation, establish mutual accountability, and ensure coordinated efforts.

— **Ensuring adequate funding for the next agreement:** Inadequate funding has created barriers to the full and consistent rollout of Agreement deliverables. The rollout has highlighted significant long-standing gaps, including workforce shortages, data collection deficits, and substantial unmet psychosocial needs. However, the Agreement did not contain any provisions to address these. Funding is required to:

  — develop and expand necessary community mental health programs to meet the significant gaps in the mental health system.

  — address widespread workforce shortages and invest in a sustainable pipeline of mental health and suicide prevention workers, including lived-experience workers.

  — address the lack of accurate workforce data to inform accurate workforce planning.

Terms of reference

The impact of mental health and suicide prevention programs and services delivered under the National Agreement to Australia's wellbeing and productivity

The first Agreement has driven the establishment of new mental health infrastructure. Programs such as the Medicare Mental Health Centres (MMHCs), Headspace and Kids Hubs are providing universal access to mental health support to people residing in our major cities and towns. These services are diverting people away from hospitals and emergency departments and reducing the burden on other parts of the mental health, health, and broader social systems. Similarly, aftercare, postvention and the Distress Intervention Trial are important elements of an ecosystem of care. Together, these services represent a much-needed investment in mental health and suicide prevention.

Medicare Mental Health Centres and Mental Health and Wellbeing Locals

Walk-in mental health care centres are one element of an accessible and effective mental health and suicide prevention system. Under the Agreement, Neami delivers eight MMHCs, including the Urgent Mental Health Care Centre (UMHCC) in Adelaide, and two Victorian Mental Health and Wellbeing Locals (Local Services).

MMHCs and Local Services are:

— enabling people to access support and treatment before they reach crisis, but are also proving capable of assisting people in crisis to manage their distress safely in the community.

— supporting people with high-acuity needs. The blend of clinical, psychosocial, and peer expertise is effective in helping people manage their distress safely, reducing the likelihood of consumers using inpatient treatment and other high-cost or avoidable interventions.

— assisting people in navigating the mental health system to ensure they receive the right support at the right time.

— increasing help-seeking and mental health literacy and encouraging people to be proactive in addressing their mental health.

— providing service coordination to individuals with complex support needs and those engaged with multiple services.

— supporting people to identify and access support for needs beyond mental health including assisting people to address the social determinants of health and mental health.

Evidence of effectiveness

Neami partnered with the Alive National Centre for Mental Health Research Translation to undertake a co-evaluation of the MMHCs and UMHCC.[1] The UMHCC operates similarly to MMHCs but is designed as an alternative to emergency department presentation, offering extended hours of care and a service model tailored to higher acuity needs.

The data showed that these services support people with very high levels of distress. At services branded as MMHC, the most common principal diagnosis reported was anxiety and depression. At the UMHCC, a service designed to divert people away from hospital presentation, suicidal ideation was the most common reason people accessed the service.

Results from the co-evaluation indicate that the MMHCs/UMHCC are meeting a gap in the mental health system and successfully diverting people away from hospitals:

— Approximately one-third of guests were seeking mental health support for the first time.

— In a survey, 50% of guests said they were unsure where they would have sought help, with 27% stating they wouldn't have sought support at all if the service didn't exist.

— Data routinely collected from the UMHCC reported that 44% would not have sought support elsewhere.

— 42% of UMHCC guests indicated that they would otherwise have attended an emergency department, whilst survey data across all services found 11% of people would have attended an emergency department.

Challenges in delivering effective MMHCs and Local Services

The co-evaluation demonstrates that MMHCs and Local Services are addressing the 'missing middle', enabling individuals to navigate a complex and fragmented service system and reducing the likelihood of requiring inpatient treatment and other high-cost or avoidable interventions. However, there are several challenges that limit the effectiveness of these services and that are not adequately addressed by the Agreement.

Workforce

MMHCs rely on service providers' ability to recruit and retain a highly skilled, multidisciplinary workforce comprising clinical staff, community mental health workers delivering psychosocial support, and peer workers. Neami's experience echoes the findings of the *Productivity Commission Inquiry Report on Mental Health*, which found widespread mental health workforce shortages, including significant shortages of clinical staff, including psychiatrists, mental health nurses and allied health professionals.[2]

Recruiting a multidisciplinary complement of professionals for MMHCs and Local Services is challenging. When funding is short-term and unsustainable, as is the acknowledged experience in Australia's mental health funding landscape, service providers cannot offer ongoing contracts and competitive remuneration.[3] For these practitioners, the likelihood of secure employment and higher pay can make working in the health or private sector more attractive.

Recruiting high-quality peer and community mental health workers is also challenging. There is some data on the number of peer workers working in the community mental health sector, but there is limited, accurate data on the number, roles, and distribution of community mental health workers undertaking psychosocial support across

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[1] The Alive National Centre for Mental Health Research. 2024. An Implementation Co-Evaluation of four First Wave Medicare Mental Health Centres and the Urgent Mental Health Care Centre (SA). With Neami National.
[2] Productivity Commission. 2020. Inquiry Report: Mental Health; p. 710.
[3] Productivity Commission. 2020. Inquiry Report: Mental Health; Chapter 23.

Australia.[4] There was a community expectation that this issue would be addressed through the *National Mental Health Workforce Strategy*; however, the lack of data has resulted in a 10-year strategy that lacks provisions for the growth and development of a psychosocial workforce.[5]

Integration of MMHCs with the broader system

MMHCs are opening the door to the mental health system, putting choice and control into the hands of the community and reducing pressure on already stretched health and hospital systems. MMHCs offer an alternative support option that provides immediate response. In consultations that Neami undertook with mental health consumers to prepare a response to the NSW Inquiry into equity and accessibility in outpatient and community mental health services, the consumers we spoke to reported that they were frequently being turned away from services for a range of reasons, placed on waiting lists, or told that the service—particularly in the case of psychiatry or GP access—is not accepting new clients.[6] Further, specialist clinical and GP appointments are increasingly unaffordable for many people.

There continues to be a high degree of fragmentation with different service types across the continuum of mental health care operating in isolation, which means the benefits of stepped care are not routinely delivered. When MMHCs and Local Services are established in the community, it falls to the provider to embed the service, including proactively reaching out to the other providers in the local ecosystem, building the service profile and driving consumers towards the service. Despite the benefits that these services deliver in reducing pressure on other parts of the mental health system and reducing the likelihood of consumers requiring crisis support, many health and hospital districts do not feel they have any responsibility to assist in socialising and integrating MMHCs and Local Services into the community despite being in an ideal position to do so.

The Agreement, ideally through joint implementation planning, should clearly articulate the roles that all parties play in achieving the goal of a coordinated, integrated, and responsive mental health and suicide prevention service system, including collaboration to develop seamless pathways between services.

Psychosocial support

Funding community-based psychosocial support is critical to an effective mental health system. However, the *Analysis of unmet need for psychosocial supports outside the National Disability Insurance Scheme final report* has shown that there is a significant unmet need in our community.[7] The next agreement must rectify this.

Psychosocial support enables individuals to stay connected within their communities while managing a decline in mental health. The work comprises care coordination, recovery support, goal setting and attainment, and trauma-informed care at a minimum. Beyond facilitating access to various health and mental health services, psychosocial support is crucial in helping individuals overcome significant social, economic, and health challenges. These challenges, which contribute to distress and impairment, include housing insecurity, homelessness, unemployment, rising living costs, and domestic or family violence.

To illustrate the link between social determinants and mental health, Neami has undertaken work to understand the relationship between legal stressors and mental health. In partnership with Health Justice Australia, Neami surveyed our mental health workforce to determine the frequency with which they support individuals with legal

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[4] Health Policy Analysis. 2024. Analysis of unmet need for psychosocial supports outside of the National Disability Insurance Scheme Final Report. 15 August 2024.

[5] Department of Health and Aged Care. 2022. National Mental Health Workforce Strategy 2022-2032.

[6] Neami National. 2024. Submission to the Legislative Council Inquiry into the equity, accessibility and appropriate delivery of outpatient and community mental health care in New South Wales.

[7] Health Policy Analysis. 2024. Analysis of unmet need for psychosocial supports outside of the National Disability Insurance Scheme Final Report. 15 August 2024.

issues—around two-thirds of Neami staff reported spending 50% or more of their time supporting consumers in navigating legal issues. The study found that a broad range of legal matters affected people's wellbeing, including tenancy issues, domestic and family violence, issues related to visas and immigration, and financial concerns, such as debts, fines, and Centrelink issues.[8] Further, mental health challenges and legal stressors are often mutually reinforcing.

While most individuals can seek help from community legal centres or financial counselling services to address legal issues, many people facing mental health challenges require specialised support. Most legal and related services are not equipped to effectively assist individuals in distress or those experiencing emotional dysregulation related to a mental health condition. This highlights the crucial role of psychosocial support in enhancing community mental health, providing essential assistance, and bridging the gap until individuals are well enough to manage their needs independently.

Neami supports Suicide Prevention Australia's recommendation to prioritise a social determinants approach to mental health and suicide prevention. Isolating treatment from social, environmental, and economic factors risks ineffectiveness, worsening disparities, or prolonged mental health care.

Underinvestment in psychosocial support

The community mental health sector offers the solution to addressing the 493,600 Australians who are missing out on psychosocial support in our communities.[9] However, underinvestment continues to undermine the effectiveness of psychosocial support services. The community mental health sector struggles to recruit and sustain the full complement of psychosocial workers, and the 10-year workforce strategy does not provide any strategies to grow the workforce.

The sector requires a dedicated psychosocial workforce plan and investment to expand and develop more programs in areas of unmet need. Funding needs to be provided to increase the workforce, with an emphasis on diverse workforces, including Lived Experience professionals, bicultural and LGBTIQA+SB workers, First Nations-identified roles, and specialists in psychosocial support for older and younger persons. The sector requires workers who can effectively reach underserved communities, particularly those in regional, remote, rural, and culturally diverse populated areas. To inform future mental health planning and resource management, the Agreement must commit to establishing ongoing data collection, analysis, and monitoring of the workforce.

To achieve this, all levels of government must be compelled, through the next Agreement, to commit funding to address the gap in psychosocial services. Funding must be adequate to address current and future needs.

The effectiveness of reforms to achieve the objectives and outcomes of the National Agreement including across different communities and populations

Australian mental health reform is further complicated by multiple streams of reform occurring in tandem, including the renegotiation of the National Health Reform Agreement, the Government's response to the Strengthening Medicare Taskforce Report, the National Disability Insurance Scheme (NDIS) Review, and the design of foundational supports outside the NDIS. There is a sense within the community that we are trying to reform a system before we have the necessary evidence or agreement on what successful reform should look like. This has resulted in a seemingly piecemeal reform that has delivered some necessary infrastructure and innovation but without the guidance of a clear vision or blueprint to articulate a plan, measure progress, and determine if deliverables have been successful.

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[8] S and O'Connor, S. 2024. Assessing legal need and capability for health justice partnership, Health Justice Australia, Sydney
[9] Health Policy Analysis. 2024. Analysis of unmet need for psychosocial supports outside of the National Disability Insurance Scheme Final Report. 15 August 2024.

We acknowledge that the government has outlined goals to improve mental health and reduce suicide; these are contained in the National Mental Health and Suicide Prevention Plan (the Plan) and elsewhere. The plan is a valuable tool for demonstrating how the government is responding to the recommendations of the Productivity Commission's Inquiry Report into Mental Health and the National Suicide Prevention Adviser's Final Advice; however, it does not deliver a comprehensive national plan for whole-of-system reform. We do not have a clear vision of how we want the mental health system to operate for people in our community who require support, nor do we have a plan for achieving this goal. Additionally, we lack a strategy for engaging and holding each stakeholder involved in the reform's success accountable.

> When a person presents to a service—whether it is the right part of the continuum of care or not—and is directed to the most appropriate support for their needs with compassion and accuracy, **that is when we can say the system is working for people.**

The Agreement is an instrument developed to support the Australian Government's goal of reforming the Australian mental health system. It outlines the investment and responsibilities by level of government. As the Productivity Commission reviews the Agreement, it is essential to ask whether it has been a successful instrument in achieving the objective of reform.

Given this, it is challenging to comment accurately on the effectiveness of the Agreement; however, we can offer guidance on how to enhance the sector's ability to assess its efficacy for subsequent Agreements. Whilst we know what is being funded under the Agreement and by whom, there is little public transparency on progress and whether the actions have been successful. How will the community and stakeholders know if system fragmentation has been reduced? How will we know if we have addressed gaps in the system? Do we know the locations of those gaps with local accuracy?

Having a vision for how a reformed mental health and suicide prevention system will operate is a foundational piece of work. From Neami's perspective, the most important hallmark of successful reform is when the gaps in the mental health system have been addressed, and there is no unmet need. When a person presents to a service —whether it is the right part of the continuum of care or not—and is directed to the most appropriate support for their needs with compassion and accuracy, that is when we can say the system is working for people. .

The following mechanism that supports the rollout of the Agreement and other reform activities must be in place or at minimum, contained in the Agreement with commitment by all levels of government, including:

— Establish the NMHC and the NSPO as independent statutory bodies that can objectively report mental health and suicide prevention system reform activities, funding, performance and service delivery across Australia.

— Adequately fund the NMHC and NSPO to carry out the above objectives proactively and transparently. Reporting on the effectiveness of the mental health system, including reform activities under the Agreement and beyond, should be comprehensive, publicly available and transparent.

— A commitment to deliver a yearly progress report on time. This should be linked to a publicly visible dashboard showing progress on activities. Neami would welcome the approach taken in the Closing the Gap reform, which includes a comprehensive mapping of priorities, targets, and outcome areas.

— Joint Implementation Plans completed before the commencement of the next Agreement. Joint Implementation Plans should articulate who is responsible for the activities and which stakeholders, persons or bodies are integral to the activity's success. The should be available for stakeholder and community discussion before being agreed upon for implementation and must be accompanied by an Implementation Plan Action Status report as is being done by the National Indigenous Australians Agency for Closing the Gap.

The opportunities under the National Agreement to adopt best practice approaches across Australia, particularly where productivity improvements could be achieved

Mapping the ecosystem of care

Neami recommends that in preparation for the next Agreement, the ecosystem of care must be mapped to ensure that any future decisions and investments are made on the basis of good evidence. When we have a comprehensive understanding of how the elements are, or are not, working effectively together, we can establish targeted joint implementation plans with clarity of accountability and ensure effective mechanisms are in place to support effective processes. Without this work, future actions outlined under the Agreement will continue to be piecemeal and likely to result in continued fragmentation of the system.

A system that directs consumers to the right care at the right time, that supports people before they reach crisis and that commissions services that people genuinely need and want will improve community productivity and reduce inefficiency in mental health service delivery and in commissioning and funding. One simple small step towards a better approach to this over time would be for funding agreements to require that service mapping undertaken by a provider be transferred to a new provider at the completion of a contract where a new provider is appointed. However, this should be a PHN or funder responsibility overall.

Improving integration between systems and programs will address further inefficiencies in the mental health system. Too many people are being moved between services that are not appropriate for their needs or are being exited from the system without adequate support in place, resulting in them returning to the system in a worse state than when they arrived. This is partly due to the different elements of the system not understanding or being aware of the other services in the continuum of care. The system lacks formalised pathways between the support types offered within the ecosystem and along the mental health support continuum. For example, improving integration would enable hospital-based mental health care services to work safely and with confidence with community-based psychosocial services that are working to their full scope of practice. Operating in concert, these services could provide effective, responsive, person-centred and holistic support that improves the person's long-term mental health and well-being.

PHNs already undertake a significant proportion of this work to assess where to commit funding. However, as this is a foundational piece of work that will improve efficiency and is likely to save money over time, PHNs should be adequately resourced to complete it.

The second reason for the significant gaps in the care ecosystem is that, on a practical level, inequities in service provision and funding persist in regional, rural, and remote areas. Addressing this needs to be part of a larger conversation about reforming funding and commissioning for community mental health, as we discuss below.

Reforming commissioning and funding for community mental health

There is significant inefficiency in how programs are planned, commissioned and established across Australia. In addition to Commonwealth and state/territory government departments funding different parts of the mental health system, services are commissioned on behalf of the Commonwealth through 31 Primary Health Networks (PHNs), which employ varying commissioning and funding approaches. As one of the largest providers of community-based mental health support, this has meant that Neami is often subject to a wide range of reporting expectations and is paid different rates for funding for the same or similar services, often with no clear rationale. This administrative burden is amplified, diverting resources away from consumers and service delivery.

Leveraging service provider expertise is a lost opportunity in service commissioning. Neami welcomes the growing level of engagement of commissioning bodies with communities in codesigning services and programs; however, service providers are often left out of this process despite the wealth of local knowledge, operational expertise

and the role they will play in delivering funded services. Service providers possess a comprehensive understanding of the gaps and challenges within the system that hinder communities' access to care.

PHNs represent a large portion of commissioning for mental health and suicide prevention services, and they do this predominantly through competitive tendering. According to the PHN's own commissioning guidelines, a key benefit of the model is that it enables PHNs to work in partnership with stakeholders, providers, and service users (as practicable) in the design, funding, and delivery of services. This includes PHNs engaging with potential providers well in advance of procuring services, where feasible'.[10] However, PHNs rarely collaborate with the community to plan and commission services, continuing to favour competition over cooperation.

The significant gaps in regional, rural and remote Australia are key areas where PHNs and service providers should collaborate to develop a plan to ensure equitable distribution of services across these regions. Service providers are unable to commit to working in these communities as funding does not adequately cover the costs of working in geographically dispersed and low-infrastructure environments. PHNs should engage with providers to develop solutions and realistic cost settings. There should be room for flexibility and innovation across all commissioning bodies.

Contract lengths and conditions

Short-term funding contracts create financial insecurity for organisations, resulting in their inability to offer employees long-term or ongoing employment contracts. This makes it harder to attract staff and disincentivises careers in community mental health. The ability to offer ongoing or long-term contracts provides employees with financial stability. Furthermore, the proliferation of short-term and pilot programs does not lend itself to program maturation. Mature programs are those that have been embedded in their communities and integrated into the community service system in a manner that creates efficiencies, reduces service duplication, and addresses gaps in the sector. Short-term contracts rarely achieve sustainable change.

Indirect costs

Indirect costs fund an organisation's effective, safe and compliant operation and include, at minimum, organisational governance, quality and compliance, risk management, cyber security and human resources. The Paying What It Takes report found that funding agencies were paying indirect costs at a rate significantly less than the true cost; average corporate costs of community service providers amounted to 33%, yet most funding contracts only allow for 10-20% overheads. Continuing to underfund these costs affects the safety and wellbeing of consumers, carers and workers. It puts pressure on the workforce and limits the ability of the providers to invest in the development of their workforce.

Indexation

Indexation on funding in the community mental health sector represents a key area where productivity is lost. Community mental health providers are seeing a growing divide between the cost of delivering high-quality and sustainable services and the level of funding being provided. There is significant disparity and inconsistency in how indexation is applied to contracts in community mental health. The key drivers for change in costs of delivering these services are primarily Award increases and increases in superannuation payable.

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[10] Department of Health. N.D. A commissioning overview in the PHN context. Australian Government Department of Health.

In FY25, Neami's employment costs rose by 4.25%, driven by the Fair Work decision (3.75%) and the Superannuation Guarantee increase (0.5%). The following represents a selection of funder responses to this increase:

State government departments

NSW Department of Communities & Justice – 3.75%

NSW Ministry of Health – 3.75%

QLD Department of Communities, Child Safety and Disability Services – 3.94%

Primary Health Networks

Western Sydney PHN – 0% indexation

Adelaide PHN – 1.6%

Northern Queensland PHN – 1.47%

Western Victoria PHN - 1.47%

Country SA PHN – 1.6%

South Western Sydney PHN - 1.4%

The approach to indexation in PHN programs funded by the Commonwealth is complex and unnecessarily resource-intensive, often requiring PHNs to report back to the Department of Health and Aged Care on underspends and requiring multiple levels of authorisation. Delays to indexation are also common. The one case the Victorian Department of Health and Human Services delayed passing on indexation by approximately six months.

Indexation adjusts service agreement remuneration over a service's life in response to cost increases, including those arising from growth in the Consumer Price Index (CPI), the Superannuation Guarantee, and Fair Work decisions. Inadequate indexation is effectively a funding cut that affects the quality and continuity of services, workforce, and organisational sustainability. Delays in passing indexation on, and lack of transparency regarding how much indexation will be provided to service providers impacts the ability of providers to plan for, develop and sustain their services and workforce.

Best practice suicide prevention under-represented in the Agreement

Suicide prevention initiatives funded under the first Agreement, whilst valuable, significantly underrepresent what is considered evidence-based and best-practice suicide prevention support for Australian communities. Black Dog Institute has highlighted nine strategies—of which aftercare and crisis care represent only one element—that, when implemented together in a defined community, are likely to reduce the rate of suicide.[11]

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[11] Black Dog Institute. 2026. An evidence-based systems approach t suicide prevention: guidance on planning, commissioning and monitoring.

Suicide Prevention Australia (SPA) has said in their submission to this review that they are concerned that the current Agreement has taken a narrow approach to suicide prevention and recommends that the next Agreement should commit to investing in a diverse range of suicide prevention initiatives. Further, SPA's submission strongly echoes Neami's recommendation that there is a need to embed an acknowledgement of and a commitment to responding to mental health and suicide prevention through the lens of the social determinants of health and mental health.

Neami has supported many people who have had contact with the hospital system whilst experiencing mental health distress or suicidal ideation. Many of the people we have supported have shared that their experience of trying to access inpatient treatment and their experience of post-hospital engagement had been distressing. In our experience, significant gaps persist in aftercare and postvention support. The lack of resourcing for these services has meant that consumers are either being actively diverted away from hospital admission via triage when they are in distress or are being encouraged to exit inpatient treatment before they are ready.[12]

Services such as Safe Spaces are providing a much-needed alternative to emergency department presentations and delivering positive results for people experiencing suicidal ideation. An independent evaluation of the Safe Spaces network in Brisbane North found that Safe Spaces improved safety and reduced distress for people who engage with the services. Safe Spaces were highly effective in improving the integration of support for guests across emergency services, hospitals, other health services, and broader community services. And importantly,

Safe Spaces have been proven to be cost-effective, diverting individuals from EDs and reducing repeat presentations. Safe Spaces has helped alleviate pressure on emergency services, generating estimated cost savings of between $16.2 million and $16.3 million from avoided emergency department presentations and subsequent acute admissions across the pilot's lifespan (April 2022-September 2024).

All levels of government must invest in programs that people want and need. Community members should be able to exercise choice and control over how they address their mental health and wellbeing. Safe Spaces should be one of a diverse selection of options that support people experiencing suicidal ideation.

The extent to which the National Agreement enables the preparedness and effectiveness of the mental health and suicide prevention services to respond to current and emerging priorities

Three key challenges limit the preparedness and effectiveness of the community mental health and suicide prevention services to respond to current and emerging priorities.

Funding

Inadequate government funding, including insufficient indexation and underpayment for necessary and often mandated corporate overheads, as well as a lack of transparency regarding whether contracts will be extended or terminated, creates funding uncertainty for the community mental health sector. Funding uncertainty hinders service providers' ability to recruit and sustain a high-quality and robust workforce, leaving little in reserve for addressing emerging priorities. The community mental health workforce is one of the best resources Australia has to respond to increasing and unprecedented mental health needs; however, the investment in community mental health is insufficient to meet current or future demand.

Workforce

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[12] Neami National. 2024. Submission to the Legislative Council Inquiry into the equity, accessibility and appropriate delivery of outpatient and community mental health care in New South Wales.

Conservatively, almost half a million people are missing out on vital psychosocial support in Australia. Further, there are widespread shortages of professions across the mental health system, including the psychosocial workforce; however, the lack of workforce data collection for community mental health means we cannot qualify for the shortfall.

As identified previously, the community mental health sector, particularly the psychosocial support workforce, has been subject to underinvestment, and this is likely to continue if the next Agreement does not rectify the gap in the National Mental Health Workforce Strategy. Neami recommends:

— a dedicated psychosocial workforce strategy

— commencement of ongoing workforce data collection, analysis and monitoring to inform future mental health planning and resource management

— establishing fair and sustainable funding and contracting practices that enable the community mental health sector to attract, train and retain highly skilled, effective, multidisciplinary psychosocial workforces.

Inflexible commissioning structures

As discussed in the previous response, funding arrangements under the Agreement, particularly those delivered through the PHNs, do not enable services to respond to current and emerging priorities. Almost without exception, the level of funding and restrictive, inflexible program KPIs hinder the ability of services to pivot when circumstances change.

To illustrate this, a community-based psychosocial support program on the mid-north coast of NSW could be leveraged to support SES and other community services during unexpected flooding, providing trauma-informed support for distress as well as practical support. However, in our experience, this requires significant administration and contract negotiation, which delays action. The solution is for commissioning bodies to consider flexible or unrestricted funding models.

A further example can be found in the recruitment of the community mental health workforce. The Agreement has driven, in some cases, the rapid establishment of new models of care that require large numbers of diverse professionals. The MMHCs and the Local Services require a range of clinical and non-clinical staff as well as specialist roles such as bicultural workers, LGBTIQA+SB workers, social-emotional and wellbeing workers and family support roles. In a sector experiencing by workforce shortages, it is challenging to recruit and retain the full complement of the workforce. Whilst some commissioning bodies will work flexibly with providers, it is not a whole-of-sector expectation and can result in performance management or unmet KPIs.

Whether any unintended consequences have occurred such as cost shifting, inefficiencies or adverse consumer outcomes

The landmark independent review of the NDIS found that people with a psychosocial disability were one of three cohorts most likely to experience an unmet need for psychosocial support, along with children and people with chronic health conditions. The review recommended increasing foundational support and diversifying support options, along with additional funding to expand psychosocial support beyond the NDIS. At the same time, the sector had been engaged in consultation and planning to inform the development of psychosocial support outside the NDIS, and a significant piece of work was in progress to analyse the level of unmet psychosocial needs in Australian communities.

With multiple streams of work aimed at understanding gaps in psychosocial support, a response akin to a 'holding pattern' emerged as government departments awaited further direction regarding the future of psychosocial support. During this time, funding for psychosocial support programs outside the NDIS was rolled over for periods of between 1-2 years, providing little certainty to providers and service users.

During this time, recognising the growing gap in psychosocial support, the Australian Psychosocial Alliance (a group of eight of the largest psychosocial service providers in Australia) advocated to the government for a two-year extension to the Commonwealth Psychosocial Support Program.[13] The APA also analysed its own service data and compared this to publicly available NDIS data and found that there was a decreasing rate of access met decisions for people with psychosocial disability as their primary disability.

According to the analysis, which has been shared with the government, there was a 42% rate of access met decisions for people with a primary psychosocial disability compared to 85% for all disabilities in the Q3 2023/24, evidence of a rapidly growing chasm in support for people with moderate to severe support needs.

The Agreement has not provided a framework that supports rapid action in response to psychosocial support. Over a short period, the gaps in the system have widened, and little clarity has emerged regarding the fate of psychosocial support and the people who rely on it. This has delivered significant uncertainty to consumers and service providers.

Critically, there has been no central coordination point in the Commonwealth to enable the oversight of possible changes to the NDIS as they impact people with mental health challenges and the impact of those services or activities funded under the Agreement. The government has yet to provide a cohesive response to the reforms suggested by the NDIS review, making it impossible to assess the potential impact of these reforms on services funded under the Agreement.

Effectiveness of reporting and governance arrangements for the National Agreement

Reporting

Since the signing of the national and bilateral agreements, the government has published one progress report. The report provides a high-level overview of progress but lacks clarity on why some deliverables have stalled and whether any variations have resulted from changes and/or reforms in interconnected systems, such as the health sector or the NDIS. Furthermore, it is unclear, beyond the level of government, who is responsible for many of the Agreement's deliverables. It's worth noting that the National Indigenous Australians Agency provide good transparency over the Closing the Gap reform via a comprehensive annual Implementation Plan Actions Status report.[14]

The National Agreement outlines high-level governance arrangements for the agreed-upon deliverables; however, these are too broad and lack sufficient detail regarding which stakeholders, departments, and bodies are responsible for the deliverables and how they will collaborate. Further, as stated previously, there is no public accountability or transparency on the progress of outcomes under the Agreement.

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[13] Australian Psychosocial Alliance. 2024. Letter to Minister Mark Butler; Commonwealth Psychosocial Support Program continuation.

[14] National Indigenous Australian Agency. ND. Closing the Gap: Commonwealth 2024 Implementation Plan Actions Status.

It is Neami's position that responsibility for reporting on the Agreement should sit with independent bodies. We recommend that the NMHC and the NSPO be tasked with and adequately funded to undertake monitoring and reporting on the progress of mental health and suicide prevention commitments in the Agreement.

Roses in the Ocean's submission to this review identified that the Agreement's governance arrangements predominantly comprise mental health professionals and government officials, overlooking the expertise of the suicide prevention sector and people with lived experience. Neami supports this position and further recommends that representation should be extended to people with lived experience of psychosocial disability and expertise from service providers who specialise in the delivery and design of psychosocial services. To date, genuine targeted engagement with psychosocial service providers and people with lived experience of psychosocial impairment, even in the context of significant reforms regarding the delivery of psychosocial support outside the NDIS and the independent review of the NDIS, has been woefully limited and ineffectual.

Governance

One of the major shortcomings of the current Agreement is the lack of a shared vision for reform across federal, state, and territory governments. As it stands, the Agreement functions as a transactional record of agreed actions rather than a dynamic tool that fosters genuine collaboration and cooperation between parties. Without a unified vision, the current approach misses the opportunity to harness the collective resources, knowledge, and efforts of all levels of government to create a truly integrated mental health and suicide prevention system. To address this, there is a pressing need for a clearly defined framework and implementation plans that will guide both the cooperation and the execution of reforms. It is unclear how the Vision 2030 Blueprint for Mental Health and Suicide Prevention is currently related to the Agreement.

This framework should establish:

— A shared vision for mental health reform that is agreed upon by all parties.

— Joint implementation plans that articulate a roadmap for both the commitments of each government stakeholder but also the mechanisms by which they will collaborate to deliver on the actions of the Agreement.

— Targets and outcome measures to measure the effectiveness of this collaboration in terms of outcomes for consumers and communities.

Moreover, cooperation between governments should extend beyond transactional agreements to foster an environment of reciprocity, where all parties actively contribute to and benefit from shared resources and knowledge and are committed to the long-term goals of reform.

Although developing and implementing a framework encompassing mental health and suicide prevention reform is a significant and complex task, it would bring substantial long-term benefits, including greater system efficiency and improved productivity.

Applicability of the roles and responsibilities established in the National Agreement

The Agreement only reflects the level of government that is responsible for an initiative. Neami would like to see greater transparency regarding which departments, agencies, or other parties are responsible for outputs under the next Agreement, including clarity on shared accountability for initiatives. We acknowledge that the Agreement may not be considered appropriate for that level of detail and suggest that it can be documented in Joint Implementation Plans as an alternative, which should be publicly accessible.

Further, Neami echoes the concerns shared in the APA's submission to this agreement. There is a heavy reliance on Primary Health Networks (PHNs) to commission services and provide oversight of services within the mental health system, despite some of these services being funded by other agencies and levels of government.

The PHN business model, as it is currently implemented, is at odds with a system reform that aims to drive seamless integration between services and reduce fragmentation. We acknowledge that the PHN Network has the aspirations to play a key role in a joined-up mental health system but is hampered by a range of factors, including but not limited to:

— Funding constraints

— Lack of unity across of the thirty-one PHNs in terms of how they commission and manage contracts

— A business model that lacks the capability to incentivise innovation and cross-PHN collaboration

— Use of different data systems and collection and management approaches.

The above limitations and inefficiencies are passed on to service providers and the mental health and suicide prevention system.

Without limiting the matters on which the PC may report, in making recommendations the PC should consider the complexity of integrating services across jurisdictions and ensuring that the voices of First Nations people and those with lived and/or living experience of mental ill-health and suicide, including families, carers and kin are heard and acted upon.

Putting investment behind the commitment to embed Lived Experience throughout the mental health and suicide prevention systems

The Agreement seeks to ensure that people with lived experience of mental illness or suicide are engaged in the design, delivery and evaluation of programs and services delivered through the Agreement (Clause 55). Given that the Agreement has identified a diverse range of priority populations, it would be good practice to ensure that in seeking lived experience perspectives, these experiences reflect the diversity of our communities and these priority groups.

For each of the priority groups listed in Clause 111, different barriers impact the person's or community's ability to access support and information for mental health and suicidal ideation. These include, but are not limited to, language barriers, stigma, financial constraints, privacy concerns, and geographical limitations. Similarly, the opportunities for improving the effectiveness of support and information distribution can be significantly enhanced through co-design and engagement with communities to understand their experiences with the service and their unmet needs.

Codesign is increasingly being built into service specifications for new programs and services that are being tendered. Codesign can be stipulated as part of the tender process; alternatively, a program can be awarded a tender with the expectation that codesign will be undertaken before the program commences service delivery.

In Neami's experience, funding bodies do not provide adequate time for genuine codesign. We are also aware via our membership with Suicide Prevention Australia that in the commissioning of aftercare services under the Agreement, there is an expectation of codesign; however, some commissioning bodies are providing little more than two weeks for codesign.

Further, funding for codesign work is inadequate, if provided at all. In addition to the operational costs of codesign, funding is rarely, if ever, provided to compensate individuals with lived experience for their time and contribution. Neami has committed to paying consumers and people with lived experience for their expertise and

has policies to support this. When codesign is stipulated but not funded, organisations such as Neami need to draw on our reserves. The community mental health sector is already drawing on its reserves to cover other gaps as a result of poor investment in our sector.

Addressing the Social Determinants of Mental Health with Psychosocial Support

The psychosocial support sector is poorly understood and, subsequently, underinvested. Instead of being acknowledged as a profession that possesses a highly multidisciplinary skillset, strong social justice values, and with the knowledge and skills to support people with a wide range of challenges and mental health conditions, psychosocial support is predominantly viewed by our clinical health and mental health partners, as a catch-all for all of the practical activities that people need, that get in the way of clinical mental health carrying out their role. It the words of one highly skilled practitioner, psychosocial support is viewed as daily living skills support and a taxi service.

There are two major drivers of this. The first is that the social determinants are not fully recognised as the predominant drivers of distress for most people. Psychosocial support workers help individuals stay in their communities, maintain safe and affordable housing, and remain engaged in employment and education. This reduces the likelihood of inpatient treatment and other high-cost or avoidable interventions.[15] It contributes to productivity and reduces individuals' use of various services, including welfare and justice services.

Our recent state and federal budgets have continued to fund the crisis end of the mental health support continuum instead of investing in programs and services to create the conditions for wellbeing. We are funding more hospitals, mental health inpatient beds and clinical programs rather than investing in improving help-seeking, early intervention and prevention and programs that work towards sustainable self-care, community connection and reducing isolation.

The second driver is that psychosocial support is not clearly articulated in the mental health ecosystem. It lacks a defined scope of practice that would enable psychosocial support workers to operate to their full scope of practice. Furthermore, the workforce lacks a clear career progression path, and there are limited, targeted opportunities for quality professional development and supervision.

The Agreement committed to delivering a 10-year National Mental Health and Workforce Strategy; the sector was disappointed to see that psychosocial work was overlooked due to a lack of data. This meant that not only were there no meaningful strategies to grow and develop the workforce, but the work was wholly overlooked, reinforcing a lack of value placed on this critical work and its workforce.

Without a clear scope of practice and a widespread lack of understanding of the breadth of activities and knowledge held by psychosocial practitioners, other disciplines within the mental health sector lack the understanding and confidence to work collaboratively with psychosocial support workers in supporting consumers to address their challenges. Psychosocial support can be an important lever for clinicians, increasing people's trust in clinical services, enhancing treatment compliance, and bridging barriers such as financial constraints, transportation challenges, and low motivation levels.

Psychosocial support is a critical gap in the ecosystem. The next Agreement must strike a balance between investing in expanding psychosocial support and developing a robust, diverse and multidisciplinary psychosocial workforce.

The next Agreement must embed a commitment by all levels of government to adopt a national psychosocial support workforce strategy. To ensure efficient and equitable workforce distribution, all parties must commit to aligning national and state/territory workforce planning and funding. The Strategy must include at minimum:

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[15] Mental Health Australia & National Mental Health Consumer & Carer Forum. 2024. Advice to governments: evidence-informed and good practice psychosocial services. January 2024.

- an agreed scope of practice that articulates the multidisciplinary and often complex nature of psychosocial support work.

- competency standards to articulate the knowledge, skills and attributes required by workers supporting people experiencing mental health and wellbeing challenges.

- the development of workforce education, training, professional development and supervision requirements.

Further, community mental health providers must engage as expert stakeholders in federal, state, and territory-level discussions about workforce development and planning to represent the professional, educational, and workforce needs of the psychosocial support workforce.

More information

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