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MIFA'S submission

into the Productivity Commission's Review of the

National Mental Health and Suicide Prevention Agreement 2022-2026

4 April 2025

1. A vision for the Next Mental Health And Suicide Prevention Agreement 2026 - 2030

Page 1 | Psychosocial supports outside the NDIS

From 1 January 2026:

1. The Parties (First Ministers, Treasurers, Health and Mental Health Ministers) are individually and collectively responsible for addressing the psychosocial support gap for *all* people with a high-need mental health challenge and family carers and chosen supporters by 30 June 2030.

2. The Parties affirm and recognise the value and primacy of rights-based, Recovery-oriented, peer-based community supports which actively help people with a high-need mental health challenge and family carers and supporters live well in the community during the term of this Agreement (1 January 2026 - 30 June 2030).

3. The Parties will be held to account externally for these reforms by ongoing public, transparent and universally accessible Lived Experience-led, human-rights centred, monitoring, evaluation and learning reporting conducted by a genuinely independent body with the powers to demand data and information from the Parties and their governments covering the term of this Agreement.

4. The Parties will be held to account internally by a Lived Experience-led, human-rights centred governance structure covering the period 1 January 2026 and 30 June 2030. The Governance team have the power to penalise the Parties for non-compliance with the Agreement.

5. The Parties commit to addressing the gap between 1 January 2026 and 30 June 2030 by:

5.1. 50/50 co-investment in accountability and governance structures for the term of this Agreement with the bodies to be established and start work no later than 1 March 2026

5.2. 50/50 investment in establishing the Lived Experience-led, human-rights centred, Recovery-focused Psychosocial Support Co-Design teams during the term of this Agreement. The team will be established and ready to start work no later than 1 March 2026.

5.3. Commissioning the Co-Design team with the development, prototyping, testing and implementation of a fit for purpose psychosocial service supply chain (funding, commissioning, workforce, service, service experience) (the new model) which integrates with the rest of the mental health system to enable *all* people with high need mental health challenges and family carers and chosen supporters to live well in the community and experience seamless, rights-based mental health journeys between 1 March 2026 and 30 June 2030.

5.4. Unilaterally expanding investment in the existing service supply chain and its enablers by 25 percent a year between 2026 and 2030 as the default mechanism to address the unmet need unless advised to migrate some or all funding into the new model by the Co-Design team during its term.

2. Executive Summary

The National Mental Health and Suicide Prevention Agreement (the Agreement) has comprehensively failed to deliver community-based supports for the 230,500 people with high-need mental health challenges and their family carers and chosen supporters who are currently missing out on these vital services.

Despite the Productivity Commission's (PC) 2020 finding that 154,000 people with high-need mental health challenges were missing out on these supports (p.827), the Agreement, ratified two years later, and now three years in, has failed to address that gap. Since then, the estimate of those missing out now has increased by 76,500 according to the Analysis of unmet need for psychosocial supports outside of the National Disability Insurance Scheme – Final Report (Unmet Needs Report) (Health Policy Analysis, 2024).

This submission outlines progress to date on psychosocial support deliverables. The submission was completed in the absence of the official Progress Report for 2023-2024 as this has not yet been published by the National Mental Health Commission (NMHC). This submission finds the Agreement itself is a major factor in the failure to address the unmet psychosocial need. Finally, this submission provides recommendations on how to remedy this intrinsic design flaw.

Through a close examination of page 29 'Psychosocial Supports Outside of the NDIS' it finds the lack of clarity around what 'shared responsibility' means, lack of internal and external accountability measures, an inability by multiple actors to meet deadlines, and the waterfall approach which means nothing can be done until the previous step is completed, have combined to generate the current state: a massive failure by the Commonwealth, State and Territory governments to deliver on a 30 year old promise to the Australian people.

3. About MIFA

MIFA is a national advocacy body for people with high-need mental health challenges and their family carers and kin. Originally known as the Schizophrenia Fellowship, MIFA was founded in 1995 by families of people with schizophrenia following the closure of Australia's psychiatric institutions.

4. Scope

This submission focuses on the Agreement's role in addressing the gap in psychosocial supports for people with high-need mental challenges and their family carers and chosen supporters outside the NDIS.

Psychosocial supports are defined as 'non-clinical and recovery-oriented services, delivered in the community and tailored to individual needs, which support people experiencing mental illness to live independently and safely in the community.

They include services that assist people with mental illness to:

- manage daily living skills;
- obtain and maintain housing;
- identify client needs for other services (such as the NDIS, alcohol and other drug treatment services, clinical care);
- connect with and maintain engagement with these services;
- socialise, build and maintain relationships; and
- engage, and maintain engagement, with appropriate education (including vocational skills) and employment opportunities' (Health Policy Analysis, 2024, pp.5-6)

5. Language

MIFA uses the following terms in this submission:

From	To
Mental illness	Mental health challenge
Severe and complex	High need
Consumer	Person who uses a mental health service
Carers	Family carers and chosen supporters

Please note that we will use language from the 'From' column if it occurs in a direct quote.

6. Alignment with Vision 2030

This submission is designed to contribute to the principles underpinning Vision 2030 (National Mental Health Commission, 2022).

> 'At the first sign of mental ill-health or suicidal thought, I know where I can go for help. I know I will be treated with respect and my experience taken seriously because I live in a community that really values mental and social wellbeing. Lots of agencies work together in my community, including the hospital, primary care, and non-government agencies, to provide a range of treatment and support options. I know I can quickly access the services I need and that I, and my family, will have choice in shaping and working collaboratively in the delivery of my care and support. Whatever my family and I need, the different services will work seamlessly together to support us. There is no risk that we will fall through cracks in the system. As I work towards my personal recovery, I will have support to help me to re-engage and move forward in my life with confidence.'

7. How this document works

This document addresses page 29 of the Agreement which deals with future psychosocial support arrangements.

It provides:

- a **progress report** on each clause;
- an **analysis** of each clause to demonstrate why the Agreement has not delivered for people who need psychosocial supports; and
- **recommendations** for the next Agreement (inclusive of, but not limited to, the Psychosocial Supports section).

8. Introduction

The Agreement may look solid but is actually slow-moving and a mass of cracks and fissures – glacial in nature.

The Agreement (2022-2026) is the head agreement between the Commonwealth, States and Territories (the States) outlining priority areas, roles and responsibilities and key actions. The Agreement is augmented by discrete Bilateral Agreements between the Commonwealth, States and Territories (the Parties).

The Agreement, 'sets out the shared intention of the Commonwealth, State and Territory governments to work in partnership to improve the mental health of all Australians and ensure the sustainability and enhance the services of the Australian mental health and suicide prevention system. The Parties will collaborate on systemic, whole-of-government reform to deliver a comprehensive, coordinated, consumer focused and compassionate mental health and suicide prevention system to benefit all Australians' (The Agreement, 2022, p.4).

The Agreement was ratified in 2022, two years after the Productivity Commission found 690,000 Australians would benefit from psychosocial supports, 290,000 of them had a 'severe and persistent mental illness', and of these, 154,000 had no access to psychosocial supports (2020, p.827).

One of the reasons behind this gap was the 2019 axing of two highly regarded, Commonwealth-funded psychosocial support programs, Partners in Recovery (PiR) and Personal Helpers and Mentors (PHaMs), and the migration of their funding to the National Disability Insurance Scheme (NDIS).

The psychosocial disability stream element of the NDIS was the last part of the scheme to be established and has historically been difficult to access for people with psychosocial disabilities. Mellifont, Hancock, Newton, Scanlon, and Hamilton's investigation of this issue found a range of access barriers for people with a psychosocial disability including 'social inequities acting as barriers to applying; stigma, trauma and previous negative experiences; barriers to finding supports needed to apply; challenges understanding the relevance of the Scheme; and experiences and symptoms of mental illness extend and exacerbate barriers' (2022, p.262). Currently around 62,000 people with a psychosocial disability are on the NDIS (Australian Institute of Health and Welfare, 2025).

To manage the negative impact for people with a high-need mental illness caused by the creation of the NDIS, the Commonwealth commissioned three new programs in 2019:

- Continuity of Support program – provision of services for people with a disability ineligible for the NDIS;
- National Psychosocial Support Measure - delivered through PHNs and now known as the Commonwealth Psychosocial Support Program (CPSP). This program was, and is, aimed at people outside the NDIS and the state system and services around 25,000 people nationally.
- National Psychosocial Support Transition (2019-2020) - a 12-month program to support former PiR and PHaMs clients to access NDIS.

This was the psychosocial landscape for people with high-need mental health challenges in March 2022 when the Agreement was signed off by the Parties:

- No PiR and PHAMs
- An inaccessible NDIS (currently servicing around 62,000 people)
- The CPSP program (currently servicing around 25,000 people)
- State-funded programs for people engaged with the tertiary system
- 154,000 people with no access to psychosocial supports

Page 29 of the Agreement, the focus of this submission, outlines an (ostensible) plan to deal with this challenge

9. Report on the progress of Psychosocial Supports Outside of the NDIS

127. The Parties will work together to develop and agree future psychosocial support arrangements (including roles and responsibilities) for people who are not supported through the NDIS.
• To date, the Parties have failed to agree on future psychosocial support arrangements, and there is no established timeframe to achieve this, • The Parties established the multi-jurisdictional Psychosocial Project Group (PPG) in September 2022 to inform future psychosocial support arrangements. Members include senior mental health officials and Lived Experience representatives. • Development work is taking place including a recent consultation, led by the Department of Health and Aged Care (DoHAC), to inform future psychosocial support arrangements • Future psychosocial support arrangements, including roles and responsibilities, have at time of writing (March 2025) not yet been agreed. • The PPG will provide recommendations in relation to future psychosocial support arrangements to the biannual Health Minister and Health Minister's meeting scheduled for June 2025
128. To inform future arrangements, the Parties agree to undertake further analysis of psychosocial supports outside of the NDIS, to commence within the first twelve months from the commencement of this Agreement and be completed as soon as possible within the first two years of this Agreement.
• The analysis was not commenced within the first twelve month, and was not completed as 'soon as possible,' or even within the 'first two years of this Agreement'. • Commissioned in March 2023, the Analysis of unmet need for psychosocial supports outside of the National Disability Insurance Scheme (Unmet Needs Report) (Health Policy Analysis, 2024) was endorsed by the PPG and publicly released on 15 August 2024, two years and five months from the start date of the Agreement.
This work will include: **(a) Developing and agreeing a common definition for psychosocial support that builds on the work already being undertaken through the National Mental Health Service Planning Framework, or other nationally agreed frameworks.**
• Achieved. • 'Psychosocial supports are non-clinical and recovery-oriented services, delivered in the community and tailored to individual needs, which support people experiencing mental illness to live independently and safely in the community. They include services that assist people with mental illness to manage daily living skills, obtain and maintain housing, identify client needs for other services (such as the NDIS, alcohol and other drug treatment services, clinical care), connect with and maintain engagement with these services, socialise, build and maintain relationships, engage, and maintain engagement, with appropriate education (including vocational skills) and employment opportunities' (Health Policy Analysis, 2024, pp.5-6).

(b) Estimating demand for, compared to current availability of, psychosocial supports outside of the NDIS according to the agreed common definition.
• Achieved after the agreed timeframe. • The Unmet Needs Report (2024) found 230,500 people with a high-need mental health challenge unable to access psychosocial supports (p. 9), 76,000 more than the PC's 2020 estimate.
129. The Parties agree that further clauses relating to future arrangements for psychosocial supports outside of the NDIS will be developed after the analysis work has been completed and attached to this Agreement as a Schedule.
• The analysis has not yet been attached as a Schedule • MIFA has no information on whether it will be included in the next Agreement (scheduled for October 2025).
130. To ensure continuity of psychosocial support services for Australians with severe mental illness and enable the sector to retain a skilled workforce, the Commonwealth and the States will maintain investments in current psychosocial support programs outside the National Disability Insurance Scheme while the further analysis work is undertaken.
• There is no published, comprehensive data on the baseline and current investments by jurisdiction. • The Commonwealth has maintained funding for the Commonwealth Psychosocial Support Program (CPSP) (Australian Department of Health and Aged Care, 2025) which supports around 25,000 people outside the NDIS • QLD has expanded its funding (Queensland Health, 2024) • NSW has maintained its funding (Mental Health Coordinating Council, 2025) • SA has increased their investment by $2m per annum (Mental Health Coalition of South Australia, 2025) • ACT has maintained its funding with one addition - a new eating disorder clinic (Mental Health ACT, 2025) MIFA was not able to obtain investment data for the Northern Territory, Victoria, Western Australia, or Tasmania

9. Analysis

127. The Parties will work together to develop and agree future psychosocial support arrangements (including roles and responsibilities)…
Current state Clause 43 of the Agreement states: 'The Parties affirm their shared responsibility to address existing gaps over time in the funding and delivery of new and additional community-based mental health services to support equitable access to treatment, care and support for people experiencing mental illness and psychological distress' (The Agreement, 2022, p.13). While this is a laudable position, the Parties, have, to date, been unable to achieve consensus on how to share responsibility and the costs to address the psychosocial support gap. A potential driver of this is the history of who paid for what in the past. Because of the Commonwealth's past investment in PHaMs and PiR, its current investment into the CPSP and its leadership role in the delivery of the NDIS, the States may see psychosocial supports as a Commonwealth responsibility and the agreement to share costs as no more than cost-shifting by the Commonwealth. Another issue with this part of the clause is it does not contain the word 'deliver.' The most it asks of the Parties is to agree on (not fund or implement) a set of arrangements. Given the fact that two years earlier the Productivity Commission identified 154,000 people were missing out on psychosocial supports, the lack of genuine commitment to do something about this is a comprehensive failure in the Parties' duty of care. Finally, this part of the clause fails to include timeframes. It does not ask the Parties to agree (let alone fund or implement), on a new set of arrangement within the life of the Agreement, or even the next one. Again, this is a comprehensive failure to take the need seriously by the Parties.
How this clause contributes to the failure to address the psychosocial support gap • Lack of specificity on what 'shared' means (especially in relation to the funding split between the Commonwealth and the other Parties) may cause division and delay • Lack of specificity on 'roles and responsibilities' mean no Party is responsible for ensuring progress occurs or can be held accountable if it doesn't • Lack of commitment to fund and implement new services • Lack of timeframes

…for people who are not supported through the NDIS.
Current state The Commonwealth is currently developing a new program, Foundational Supports, for people outside the NDIS. The program has two parts – General Supports for all people with a disability and those that care for them, and Targeted Foundational Supports aimed at children and young people, and adults with a psychosocial disability. It is understood that the tranche aimed at children and young people will likely be rolled out first, followed by the psychosocial program (we have unconfirmed advice this will be offered to the community in the 2027 calendar year). There is also a new, planned early intervention program within the NDIS on its way. The program will offer a 'new specialist early intervention pathway into the NDIS for most new participants with psychosocial disability to support personal recovery as soon as possible. Participants could stay in this new pathway for up to three years (NDIS, 2023, p.2). It is not yet clear when this program will be available. As MIFA has researched these programs, a range of unanswered questions has emerged: • How many people with a psychosocial disability are Targeted Foundational Supports expected to serve? • How many people with a psychosocial disability is the Early Intervention Program expected to serve? • Are they aimed at existing NDIS clients, at those engaged with state and commonwealth programs outside the NDIS, or at addressing the unmet need? • If the latter, what proportion of the unmet need will be addressed? • What is the difference between the two programs? • What is the access pathway? • How will they work as discrete offerings, as well as alongside existing Commonwealth, State and Territory psychosocial offerings? • What impact will these programs have on an already stretched workforce? • How will they inform, integrate, or merge with future psychosocial arrangements, and the broader mental health system, outside the NDIS?
How this clause contributes to the failure to address the psychosocial support gap The lack of specificity and information about these programs means that those planning future psychosocial support arrangements do not have clear parameters to help them quantify reach, client numbers, workforce requirements and systems integration for future psychosocial supports outside the NDIS.

128. To inform future arrangements, the Parties agree to undertake further analysis of psychosocial supports outside of the NDIS, to commence within the first twelve months from the commencement of this Agreement and be completed as soon as possible within the first two years of this Agreement.

Current state

According to the Progress Report, the Unmet Needs Report did not get commissioned until June 2023 (National Mental Health Commission, 2024, p.10). Given the Agreement was ratified in March 2022, a full 12 months elapsed before the procurement process began. In the event, the Unmet Needs Report was handed down in May 2025, and publicly released in August 2024 – two years and five months since the Agreement was signed, and five months past deadline.

How this clause contributes to the failure to address the psychosocial support gap

The fact this pivotal report was delivered one year and five months past deadline points to a clear lack of governance, leadership, genuine accountability and clarity of roles and responsibilities within and between the key actors: the Parties, the PPG, and the (NMHC) – responsible for monitoring progress against Agreement deliverables.

It is worth noting the most recent publicly available National Mental Health and Suicide Prevention Agreement Annual National Progress Report Summary covers 1 July 2022 – 30 June 2023 (National Mental Health Commission, 2024).

It took a year to produce and was released in June 2024, a *year* after the period it covers.

Taking this timeline as a template, the 2023-2024 Progress Report will be delivered in June 2025: concurrent with the Productivity Commission's delivery of the draft report on the Agreement, which the Progress Reports were designed to inform (National Mental Health Commission, 2024, p.5).

The 2022 – 2023 Progress Report (cataloguing progress which occurred in the first year of the three-year Agreement) found most initiatives were 'Partially Progressed' (National Mental Health Commission, 2024, p.14).

What's happened since then?

Officially nothing, as no public information has been released on the progress of the Agreement, despite the fact that:

> 'Annual reporting is a key accountability and transparency mechanism for the National Agreement. Reporting should inform understanding of how mental health and suicide prevention reform delivered through the National Agreement benefits the Australian community and whether it is delivering on its intended outcomes' (National Mental Health Commission, 2024, p.4).

The fact that we have seen only one progress report since 2022 raises significant concerns about the Parties' commitment to accountability, transparency and efficacy.

This failure of 'accountability and transparency' may be traced back to the disruption within the NMHC, which in 2024 was folded back into the Department of Health and Aged Care (DoHAC). Its future – as in internal element of the Department, an independent agency, or a Statutory Authority - remains unknown.

Despite this disarray, ensuring there was an independent body to continue or take over the work of monitoring and reporting on the progress of the most significant mental health agreement in the nation should have remained a priority.

Lastly, reporting on progress is not the same thing as understanding whether it is 'delivering on its intended outcomes' (National Mental Health Commission, 2024, p.4).

To enable this, National Mental Health and Suicide Prevention Evaluation Framework (DoHAC, 2025) has been developed and publicly shared on 7 February 2025. It is unclear whether this falls into NMHC's portfolio or is the basis for the Productivity Commission's review or something else, as there is no information available on its use. Intriguingly, the date on the publication is December 2023, suggesting the Department took over 12 months to publish it.

This work will include:

(a) Developing and agreeing a common definition for psychosocial supports….

(b) Estimating demand for, compared to current availability of psychosocial supports outside of the NDIS according to the agreed common definition.

Current state

The definition of psychosocial support is built on an, and around, the needs of an individual:

> 'Psychosocial supports are non-clinical and recovery-oriented services, delivered in the community and tailored to individual needs, which support people experiencing mental illness to live independently and safely in the community.'

This definition informs service design predicated on the needs, and numbers, of *individuals*.

While this makes sense on one level, it does not reflect the reality in which 'more than 240,000 Australians care for someone with mental health challenges, providing up to $13.2 billion worth of unpaid care annually' (Monash University 2024).

How this clause contributes to the failure to address the psychosocial support gap

Developing future psychosocial support arrangements informed by a definition and data set centred on the individual means we fail to consider the needs of those caring for them. In turn, we fail to understand and address the scope of the unmet need (if most people with a high-need mental health challenge are cared for by one – two people the unmet need expands to around 460,000 at a minimum).

If we design supports for individuals while ignoring the needs of those that care for them, we are perpetuating a selective system which serves some and overlooks others and fails to recognise the interdependence between those who care, and those needing care. It is also recognised mental health carers need unique care models. Victoria is leading the nation in this field, opening Mental Health and Wellbeing Connect centres across the state (Department of Health, 2024).

Another model worth noting, in which the needs of people *around* the individual are recognised, is Open Arms (2025) – a national, free mental health service for the veteran community which provides individual, and group supports to:

- Current members of the Australian Defence Force (ADF);
- People transitioning out of the ADF;
- Ex-service members;
- Partners of serving members / veterans
- Children of serving members / veterans
- Parents of serving members / veterans
- Siblings of serving members / veterans
- Paid carers
- Employers

While this submission does not have the scope to discuss the role that prejudice and discrimination plays in mental health, it is worth considering:

- Why some Australians can access this level of care, but others can't
- What this says about who and what we value
- The plurality of Open Arms as a leading example of holistic care (noting that we may need different services for individuals and those that care for them)

As the Open Arms and Mental Health and Wellbeing Connect examples show us, we need to look after individuals and those around them. If we focus on the individual only, we fail the individual.

129. The Parties agree that further clauses relating to future arrangements for psychosocial supports outside of the NDIS will be developed after the analysis work has been completed and attached to this Agreement as a Schedule.
Current state This clause embeds the waterfall model - discrete steps, with the next step reliant on the achievement of the previous step, rather than multiple, concurrent work streams – and is responsible for the fact that three years into the Agreement there is no agreement whatsoever on future psychosocial support arrangements: funding split, roles and responsibilities, the commissioning model, the program model, work force development.
How this clause contributes to the failure to address the psychosocial support gap The impact of the waterfall model is as clear as it is damning: the Parties agreed to wait on the delivery of the Unmet Needs analysis before doing anything else, with the full knowledge that there were at least 154,000 people with high-need mental health challenges in need of psychosocial supports. Parties could have acted straight away to address known unmet need while simultaneously refining the numbers. The upshot of this is we are FIVE years on from the Productivity Commission Mental Health Inquiry, THREE years into the Agreement, six months on from the release of the Unmet Needs Report, and there is no publicly available agreement on how the Parties will share responsibility, split the cost, coordinate and commission the services, or roll them out. This timeline resulted in DoHAC running a hurried consultation process in the Christmas / New Year holiday period (December 2024 - January 2025). This work should have occurred much earlier, and could have commenced as early as 2020. .
130. To ensure continuity of psychosocial support services for Australians with severe mental illness and enable the sector to retain a skilled workforce, the Commonwealth and the States will maintain investments in current psychosocial support programs outside the National Disability Insurance Scheme while the further analysis work is undertaken.
Current state • The Commonwealth has maintained funding for the Commonwealth Psychosocial Support Program (CPSP) (Australian Department of Health and Aged Care, 2025) which supports around 25,000 people outside the NDIS. • QLD has expanded its funding (discussion with senior Queensland Health Official) • NSW has maintained its funding (Mental Health Coordinating Council, 2025) • SA has increased their investment by $2m per annum (Mental Health Coalition of South Australia, 2025) • ACT has maintained its funding with one addition - a new eating disorder clinic (Mental Health ACT)

How this clause contributes to the failure to address the psychosocial support gap

The Parties for which we could find investment data for (noting this information was *not* available through the official reporting process) maintained and are currently maintaining a wholly inadequate funding arrangement in the full knowledge this did not and does not meet the need outlined in the Productivity Commission's 2020 report or the Unmet Needs Report (handed down before MYEFO and the 2025 federal budget). That the Agreement provided them with an excuse to hold off on increased investment by asking them to wait for further analysis is a major failure given what was already known about the level of need in the community

10. Recommendations

The next Agreement must embed the following recommendations:

1. Whole of Agreement

1.1. Elevate the Agreement to ratification by First Ministers in recognition of the need for a whole-of-government approach consistent with broader health, disability and social determinants of health portfolios

1.2. External accountability and transparency

Clear accountability and transparency provisions:

- Robust internal accountability measures for decision-makers and operational teams
- Robust, timely, regular, frequent, genuinely independent and impartial publicly available progress, monitoring, evaluation and learning reporting conducted by an agency with the power to demand and obtain data
- Other robust external accountability measures as needed

1.3. Internal accountability

Lived Experience-led, rights-base governance structure to monitor the progress of the Agreement

2. Psychosocial Supports Outside the NDIS

2.2. Shared responsibility

The Parties must specify what 'shared responsibility' means, especially in relation to roles and responsibilities, accountability measures and funding by 30 June 2025, and these arrangements must be embedded in the next Agreement

2.3. Unilateral action during reform process

The Commonwealth, States and Territories unilaterally commit to addressing the psychosocial support gap for individuals and family carers and chosen supporters within four years based on the proportion of the need they currently address while system improvements are underway.

2.4. Expand membership of Biannual Health and Mental Health Ministers meeting

Expand membership of the Biannual Health and Mental Health Ministers meeting to Premiers and First Ministers with support from Health and Mental Health Ministers.

2.5. Expand membership of the Psychosocial Project Group

At the same time, expand membership of the Psychosocial Project Group to representatives from the above departments and the First Nations community.

2.6. Investment in reform enablers

At the same time invest in reform enablers (Lived Experience-led co-design, rights-based approaches, data sharing, Monitoring, Evaluation and Learning, progress reporting, needs analyses, regional planning networks, social commissioning, systems integration, and workforce development including peer worker training, professional development and support).

2.7. Deadlines

All clauses must have clear deadlines.

2.8. End to end journey

Guaranteed, fully funded, implementable investment plan for future psychosocial supports

2.9. Definitions

The definition of the unmet psychosocial support need expanded to include family carers and chosen supporters

2.10. Process

The processes underpinning the Agreement change from a discrete task-by-task process (waterfall) to multiple concurrent

2.11. Funding

- The Parties commit to unilaterally addressing one quarter of the unmet need of individuals and family carers and chosen supporters in the next budget cycle and to addressing the gap completely by 2030

- That, regardless of other measures considered by Ministers within the National Agreement, immediate investment in new psychosocial support is the first priority. Broader reforms of roles, responsibilities and commissioning are needed and should occur concurrently with immediate investment in new services. People living with severe mental health challenges, should not, and must not, pay the price of successive Government's failure to address broader system reforms.

2.12. Approach

- Current and future psychosocial support arrangements are led by Lived Experience and informed by best-practice human rights models.

- Share decision-making power with people with lived experience of high-need mental health challenges, those that care for them and people from across the psychosocial support supply chain

- Build a working understanding, among decision makers of the value of the Recovery model, the community mental health sector, and psychosocial supports

- Build a fit for purpose, psychosocial support, integrated service supply chain, rather than focusing on components in isolation

Additional Measures

- **That an appropriate Parliamentary Committee be tasked with investigating and reporting on the barriers to addressing the gap in psychosocial support and to recommend measures to address this gap**

- **That the Government task the National Audit Office to investigate the efficiency and effectiveness of the National Agreement for Mental Health and Suicide Prevention addressing the issues related to psychosocial support recommended by the Productivity Commission.**

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