# National Mental Health and Suicide Prevention Agreement Review

March 2025

# Who is QAMH?

The Queensland Alliance for Mental Health is the peak body for the state's Community Mental Health and Wellbeing Sector and people with experiences of psychosocial disability in Queensland. We represent more than 120 members and stakeholders, involved in the delivery of Community Mental Health and Wellbeing Services.

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

At a national level, we have a formal collaboration with Community Mental Health Australia and provide input and advice to the work of Mental Health Australia and the National Mental Health Commission where appropriate. Locally, we work alongside our members, government, the Queensland Mental Health Commission and other stakeholders to add value to the sector and act as a strong advocate on issues that impact their operations in Queensland communities.

# QAMH Contact Details

For any further information please contact:

**Chloe Jesson**
Deputy Chief Executive Officer
109 Logan Road, Woolloongabba QLD 4102
Email: cjesson@qamh.org.au | Web: www.qamh.org.au

### Acknowledgement of Country

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

### Recognition of Lived Experience

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

# Introduction

Queensland Alliance for Mental Health (QAMH) welcomes the opportunity to contribute to the Productivity Commission's Final Review of the National Mental Health and Suicide Prevention Agreement (the Agreement). This submission reflects the lived realities and insights of our member organisations across Queensland, gathered through recent consultations including in-person engagement in Townsville and an online member consultation. This submission also builds on feedback we provided to the Australian Government in October 2024 regarding the Strategy. QAMH also supports the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy 2025–2035 and the role of Gayaa Dhuwi in leading self-determined, culturally safe approaches.[1]

Successive inquiries and strategies have reiterated the same critical priorities: the need for systemic integration, sustainable funding, a strong community mental health sector, an empowered and supported workforce (especially lived experience workers), and early intervention supports grounded in community[2][3][4]. Despite this, we continue to see fragmentation, a lack of cohesive planning, and insufficient investment in the parts of the system that support people to live well in the community. While the Agreement acknowledges the need for a holistic approach to mental health, it lacks direction on funding allocation to support and implement this approach fully.

Australia's mental health response remains skewed toward acute care, with increasing expenditure on hospital beds, clinical hours, and medications, while community-based, preventative and psychosocial supports remain underfunded, under-recognised, and poorly integrated into the broader system. What's more, community mental health services are a more cost-effective approach to care.

## Summary of Recommendations

1. Increase sustainable, flexible, and indexed funding for Community Mental Health and Wellbeing Services.
2. Clarify and finalise the roles of federal, state and territory governments, including integration with NDIS reforms.
3. Establish a national social prescribing scheme to strengthen prevention and early intervention, including stronger GP engagement.
4. Expand and fund crisis alternatives to Emergency Departments, including Safe Spaces.
5. Invest in the development and sustainability of the lived experience and peer workforce.
6. Improve mechanisms for data collection and service mapping.
7. Ensure culturally responsive, safe, and targeted support for high-risk communities.
8. Treat digital mental health tools as complementary, not replacements.
9. Recognise and support families and unpaid carers.

In this submission, the Community Mental Health and Wellbeing Sector refers to non-government organisations that receive grant funding from both State and Commonwealth governments. These organisations may also deliver services under the National Disability Insurance Scheme (NDIS).

# QAMH Recommendations

## 1. Increase sustainable, flexible, and indexed funding for Community Mental Health and Wellbeing Services

The Health Policy Analysis (2024) report revealed that 493,600 Australians need psychosocial support but cannot access it[5]. Despite this, investment remains inadequate. In Queensland, funding for community mental health dropped from 4.8% of the state's mental health budget in 2021–22 to just 4.6% in 2022–23[6]. This contrasts with the growing demand on the sector.

Community mental health services are critical in providing recovery-oriented care that helps people maintain housing, rebuild social connections, gain employment, and avoid hospitalisation. While primarily focused on mental health and wellbeing, these services often generate broader, far-reaching outcomes. As one QAMH member, NDIS provider Compass House, reflected, "We've had people off drugs for three and a half years since starting with us", illustrating the ripple effect of psychosocial, person-centred support. However, current funding is fragmented, short-term, and often restricted to rigid service models that limit innovation and adaptability. Services must be funded in ways that allow for local design and responsiveness to community needs. As Rae Elliot from Community Focus Association notes, "We have had more impact with $300,000 of flexible funding than we have with $1,000,000 of restricted funding." Flexible models that meet people where they are drive better engagement and outcomes.

**QAMH recommends:**

- Long-term, indexed, and flexible funding tied to demand and outcome targets.
- Transparency and equity in allocation across jurisdictions.
- Inclusion of the sector in funding strategies as part of foundational supports.
- Reduced reliance on short-term pilot funding with no sustainability.

## 2. Clarify the Roles of Federal, State and Territory Governments

Fragmented funding and responsibilities between levels of government have led to service duplication, inefficiency, and gaps. The Agreement must establish a unified mental health and suicide prevention ecosystem with shared goals and clear governance. It is widely accepted that collaborative approaches between lived experience workers, families, allied supports and clinical teams lead to better outcomes. As Natalie White from Wellways explains, "when services work together, real change happens."

This is especially urgent considering the 2023 NDIS Review, which identified a lack of integration between mental health and disability service systems[7]. The Agreement must be updated to define how psychosocial supports will be delivered outside the NDIS and clarify the interface between systems.

**QAMH recommends:**

- Defined responsibilities for acute, community-based, and psychosocial supports.

- Clarification of accountability for people with psychosocial disability who are not eligible for the NDIS.
- Shared planning between the Department of Health and Aged Care, State Governments, and the National Disability Insurance Agency.
- A national funding and monitoring framework for foundational supports.

Without urgent clarification, people will continue to be excluded from services, falling through the cracks.

*When services work together, real change happens*

– Natalie White, Wellways

## 3. Develop a National Social Prescribing Scheme

Social prescribing is a community-based approach to mental wellbeing that connects people to non-clinical supports such as peer groups, art classes, community gardening, walking groups or volunteering, through referrals from health professionals and service providers. These activities promote social connection and purpose, which are key protective factors for mental health[8]. At the heart of this model are link workers, who collaborate with individuals to identify needs, navigate local services and connect them to the right supports. As trusted connectors, they ensure referrals are actioned and care remains holistic and person-centred.

General Practitioners (GPs) and mental health service providers, often the first contact point for people in distress, need clear referral pathways into these types of supports. Yet many GPs report limited awareness of non-clinical options, leading to over-medicalisation, long wait times for psychologist and psychiatrist appointments, inaccessible and not fit-for purpose referrals, and missed opportunities for early intervention. Link workers embedded in community organisations offer a vital alternative, enabling confident referrals into local, non-clinical support.

Social prescribing is already showing strong results both internationally and in Australian pilots. A 2023 evaluation by Brisbane North PHN found that social prescribing significantly improved wellbeing across key domains such as social connection, symptom management and self-care, with the most substantial gains seen in participants who completed the program. The evaluation also recorded significant and lasting reductions in loneliness and social isolation, two of the strongest predictors of poor mental health[9]. To unlock its full potential nationally, the National Agreement must include mechanisms to embed and sustainably fund social prescribing, particularly through ongoing investment in link worker roles as part of a coordinated Social Prescribing Scheme. This must be matched by local investment in the community infrastructure such as green spaces, walking groups and arts programs that link workers rely on to connect people with meaningful support.

**QAMH recommends:**

- Establish a nationally coordinated social prescribing framework to guide implementation and ensure consistency across jurisdictions.

- Provide recurrent funding for link worker or connector roles embedded in community-managed services, as part of a broader national Social Prescribing Scheme.
- Deliver training and resources for General Practitioners and other health professionals on social prescribing pathways and available community supports.
- Embed social prescribing and peer support options into mental health care plans and referral pathways.
- Support the development and maintenance of localised, up-to-date community service directories to improve visibility and accessibility of non-clinical supports/

## 4. Scale Up Alternatives to Emergency Departments (EDs)

EDs remain a default point of contact for many people in mental distress, despite being widely acknowledged as inappropriate and sometimes harmful. They are often overwhelming, noisy, and lack the peer-led, trauma-informed approaches needed to support people effectively.

Services like Safe Spaces offer a more appropriate alternative, providing calm, welcoming environments where people can receive immediate support from peers and other trained staff. Evaluations of Queensland's Safe Space Network show improved experiences for guests, reduced ED presentations, and better integration with follow-up support.[10] In addition to positive health outcomes, the Safe Space Network also delivers a strong return on investment. With an annual operating cost of $3.7 million across four sites, the model generates estimated net savings of $5.4 million per year—demonstrating both economic value and system efficiency.[11] During our consultation, QAMH Members also highlighted the need for mobile, outreach-based crisis responses and after-hours services in regional and rural areas. Without access to these, people face long travel times or simply go without help, often until their distress escalates further.

**QAMH recommends:**

- National expansion of peer-led crisis alternatives.
- Funding for after-hours access, particularly in regional and rural areas.
- Integration with ambulance and police services for safe referrals.

> *With $3.7 million in funding, Safe Spaces are saving the system over $5.4 million a year."*
>
> – Brisbane North Safe Space Network Evaluation

## 5. Workforce Development, Particularly for Peer Workers

The peer workforce plays a vital role in creating accessible, person-led mental health services. By drawing on their own lived experience, peer workers offer insight, empathy and hope to those navigating distress, particularly in suicide prevention, where feelings of isolation and disconnection can be overwhelming. Research shows that peer workers,

through their lived experience and relational approach, are uniquely positioned to support people experiencing suicidal distress—offering effective care across both clinical and non-clinical settings.[12]

Despite their value, peer workers often operate in environments not yet fully equipped to support them. Many organisations lack the infrastructure, policies and supervisory frameworks necessary to maintain peer worker wellbeing and effectiveness. Opportunities for career development and pathways to leadership are also limited. A recent NSW study found that peer workers frequently cited poor workplace culture, lack of role recognition, and emotional exhaustion as reasons for considering leaving their roles, with isolation especially common in community-managed settings[13].

Community-managed organisations face ongoing challenges in recruiting and retaining peer workers, especially in rural and remote areas where professional support is scarce, and isolation is heightened. High rates of burnout, underpayment and a lack of systemic recognition contribute to a workforce that urgently requires sustained investment. Furthermore, people experiencing suicidal distress may engage with the system through a variety of entry points such as community services, emergency departments or through first responders. It is essential that wherever someone enters the system, the response is compassionate, consistent, and informed by best practice in supporting suicidal distress, which can differ significantly from responses to chronic mental illness.

**QAMH recommends:**

- National recognition of the peer workforce in workforce strategies.
- Mandatory and funded training for all frontline workforces—including community-based mental health staff, peer workers, emergency department clinicians, and first responders—in responding to suicidal distress.
- Funded professional development, supervision, and peer-led networks.
- Workplace mental health policies tailored to support the unique demands of peer work.

## 6. Improve Mechanisms for Data Collection and Service Mapping

The community mental health sector continues to face challenges with fragmented and inconsistent data collection. Unlike clinical services, which benefit from national datasets and standardised reporting frameworks, community-based services, particularly those commissioned through Primary Health Networks, often operate with disparate systems and have limited visibility at the national level.

While the National Mental Health and Suicide Prevention Agreement acknowledged these challenges and recommended improved data collection and service mapping across all parts of the mental health system, implementation has been slow in some areas and seemingly non-existent in others. There remains no centralised mechanism to map services or capture outcomes in ways that reflect what matters to people accessing community-based care. As a result, it is difficult to monitor equity, measure impact, identify duplication, or scale successful models. This continues to limit the sector's ability to tell a cohesive story about its effectiveness and contribution.

QAMH members have also highlighted the need to broaden our understanding of what counts as evidence. Indicators such as social connection, housing stability, vocational engagement and reduced hospitalisation are critical markers of success in community settings. Equally, stories of personal transformation and community belonging must be valued alongside quantitative measures and formally integrated into reporting frameworks. Co-designed evaluation methods, developed in partnership with people with lived experience are essential to ensure data collection is meaningful, strengths-based and fit for purpose.

**QAMH recommends:**

- Development of a national minimum dataset for community mental health and psychosocial supports.
- Standardised qualitative and quantitative reporting that reflects consumer priorities and meaningful outcomes.
- Publicly available service maps to identify gaps, reduce duplication and inform investment decisions.

## 7. Tailored, Culturally Safe Supports for High-Risk Communities

Certain population groups are at heightened risk of experiencing mental distress and face additional barriers when seeking support. These include refugees and people seeking asylum, LGBTQI+ communities, First Nations peoples, people from culturally and linguistically diverse backgrounds, and fly-in-fly-out workers. For many, mainstream services are not culturally appropriate, accessible or trusted. As Stephanie Long from QPASTT (Queensland Program of Assistance to Survivors of Torture and Trauma) explains, “Humanitarian arrivals frequently do not access primary health care until they are in a state of crisis,” highlighting the need for more proactive, culturally safe support.

QAMH members highlighted the effectiveness of local programs designed and delivered by people with lived experience from within these communities. However, funding structures often make it difficult for small community-led organisations to participate in commissioning processes or sustain their programs.

**QAMH recommends:**

- Co-design of services with lived experience and cultural knowledge.
- Investment in multilingual, trauma-informed, and community-based models.
- Formal recognition of the importance of families of choice and kinship carers.
- Commissioning processes that enable smaller, culturally responsive and safe providers to access funding.

## 8. Reframe Digital Supports as Additions, Not Replacements

Digital mental health supports, including telehealth, online counselling, and self-guided programs, have expanded rapidly and can play a valuable role in a blended care model. For people in remote areas or with limited mobility, digital tools provide vital access. However, they are not suitable for all situations.

Privacy concerns, technology access, and digital literacy all present barriers, particularly for carers, older people, and those in unstable living situations. A Queensland study found that prior to the COVID-19 pandemic, 76% of mental health clients in Central West and Far North Queensland preferred face-to-face consultations over telehealth, with the majority indicating they would return to in-person care as soon as possible once restrictions eased.[14] Another scoping review of rural digital mental health access in Australia identified barriers including limited resources, complex system navigation, technological limitations, and a lack of culturally appropriate practices.[15] QAMH Members also raised concerns that digital supports are increasingly seen as a replacement for in-person services, rather than an addition to them. While digital tools offer flexibility and convenience, they must be integrated thoughtfully and equitably to avoid excluding those who are unable or unwilling to engage in digital-only care.

**QAMH recommends:**

- Continued investment in digital tools that complement, not replace, face-to-face services.
- Development of blended care models.
- Involvement of people with lived experience in the design and evaluation of digital tools.

*76% of mental health clients in Central West and Far North Queensland preferred face-to-face consultations over telehealth*

- Queensland Cross-Sectional Survey

## 9. Recognise and Support Families and Carers

Families and carers play an essential but often invisible role in supporting people with mental health challenges. Despite this, they are largely absent from the Agreement's language, definitions, and implementation. Carers need their own support to maintain wellbeing, manage complex care responsibilities, and navigate the service system. This includes children and young people who care for parents or siblings, as well as chosen families and kinship carers. Carer-inclusive practices remain inconsistent, and formal supports are difficult to access. Services that do exist are often short-term or not well known. Arafmi' s 2024 *At What Cost* report highlights the systemic gaps carers face, including limited recognition within treatment planning, difficulties navigating services, and the need for greater financial and emotional support for unpaid mental health carers.[16]

**QAMH recommends:**

- Formal inclusion of carers in Agreement language and accountability structures.
- Funding for family-inclusive practice training and peer-led carer supports.
- Support for young carers and families of choice, especially in culturally diverse and LGBTQI+ contexts.

# Effective Community-Based Models

**The Home of Expressive Arts – QPASTT**

The Home of Expressive Arts and Learning (HEAL) is a school-based early intervention and prevention program led by QPASTT, designed to support young people from refugee backgrounds who are navigating trauma, racism, and the complex process of settlement. Delivered in partnership with schools, HEAL uses expressive arts therapies—such as art, dance movement, yoga, and storytelling—grounded in trauma-informed practice and cultural safety to support students' mental health and wellbeing.

The program creates safe and inclusive environments where students can build trust, process emotions, and strengthen their sense of belonging. Facilitators observed that students *began "developing a bond that allowed them to feel safe to encourage each other… A sense of trust and kinship was developed and formed amongst students who did not know each other when they began their HEAL workshops."* Workshops also provided opportunities for self-reflection and emotional regulation through culturally resonant, embodied practices. One student shared, *"What I have enjoyed the most about these sessions is talking about my problems in a safe and comfortable place,"* while another noted, *"I like making things while we talk. Gives me another way of seeing things."*

HEAL demonstrates how culturally grounded, relational approaches in school settings can improve mental health outcomes by reducing isolation, building confidence, and promoting respectful relationships among young people with refugee experiences.

**Brisbane North PHN Safe Space Network – Stride Mental Health**

Stride's Safe Space in Caboolture supported a young woman in her early 20s who had complex trauma, substance use issues and was experiencing homelessness. She had not engaged with mental health services previously and arrived at the Safe Space highly distressed, disoriented, and without any belongings.

Over multiple visits, staff provided her with sensory tools, safety planning, and referrals to housing and support services. The consistent, non-judgemental environment helped her stabilise enough to reconnect with family and begin attending outpatient programs. As the team noted, this progress was only possible because the Safe Space model allowed her to return when she was ready — no pressure, no appointments, just a safe, supportive place to land.

This case demonstrates the power of peer-led, low-barrier alternatives to emergency departments in building trust and engagement with people who may otherwise fall through service gaps.

# Conclusion

The Agreement must move beyond rhetoric to deliver systemic, sustainable reform. This means recognising the central role of the community mental health sector in prevention, recovery, and wellbeing. Our submission reflects the voices of those working on the ground—people who understand what needs to change.

QAMH urges the Productivity Commission to act on the evidence, fund what works, and build a system that empowers people to live well in the community, not just avoid crises. We stand ready to support this transformation.

---

[1] Gayaa Dhuwi (Proud Spirit) Australia. (2024). National Aboriginal and Torres Strait Islander Suicide Prevention Strategy 2025–2035. Canberra, ACT: Author.
[2] The Victorian Royal Commission. (2021). Royal Commission into Victoria's Mental Health System-final report. Accessed 24/03/25 https://rcvmhs.archive.royalcommission.vic.gov.au/
[3] Australian Government. (2022). The National Mental Health Workforce Strategy 2022-2032. Accessed 20/03/2025 www.health.gov.au/sites/default/files/2023-10/national-mental-health-workforce-strategy-2022-2032.pdf
[4] Commonwealth of Australia. (2021). Mental Health and Suicide Prevention-Final Report. ISBN: 978-1-76092-304-4
[5] Department of Health and Aged Care. (2024, August). Analysis of unmet need for psychosocial supports outside of the National Disability Insurance Scheme: Final report. Australian Government.
[6] Australian Institute of Health and Welfare. (2024). Report on Government Services (RoGS). Accessed 20/03/2025 rogs-2024-partE-section13-services-for-mental-health-data-tables.xlsx
[7] NDIS Review Panel. (2023, December). Working together to deliver the NDIS: Final report. Department of the Prime Minister and Cabinet. https://www.ndisreview.gov.au/publications/final-report
[8] Foster, A. et al (2021). Impact of social prescribing to address loneliness: A mixed methods evaluation of a national social prescribing programme. Journal of Health and Social Care in the community, 29, 1439–1449. DOI: 10.1111/hsc.13200
[9] Sharman, L. S., Jones, A., & Dingle, G. A. (2024). *1-year evaluation of the social prescribing trial in Brisbane North*. Brisbane North PHN. Retrieved from https://footprintscommunity.org.au/wp-content/uploads/2024/11/SP-24-BNPHN_1year.pdf
[10] Nous Group. (2024). *Safe Space Network evaluation summary report*. Brisbane North PHN. https://brisbanenorthphn.org.au/web/uploads/downloads/Mental-health-services/REP_Safe-Space-Evaluation-Interim-Report-May-2023_FINAL.pdf
[11] Brisbane North Primary Health Network. (2024). *Safe Space Evaluation: Summary of evaluation findings*. Retrieved March 27, 2025, from https://brisbanenorthphn.org.au/web/uploads/downloads/Mental-health-services/2025-17-01-Safe-Space-Evaluation-Summary-of-evaluation-findings-6-pages.pdf
[12] Barlow, S., Leamy, M., Bird, V., Shaw, J., & Larsen, M. (2023). Peer support in suicide prevention: A qualitative study of the views and experiences of peer workers. *Crisis*, *44*(1), 29–37. https://doi.org/10.1027/0227-5910/a000939
[13] Scanlan, J. N., Still, M., Radican, J., Henkel, D., Heffernan, T., Farrugia, P., Isbester, J., & English, J. (2020). *Workplace experiences of mental health consumer peer workers in New South Wales, Australia: A survey study exploring job satisfaction, burnout and turnover intention*. BMC Psychiatry, 20, 270. https://doi.org/10.1186/s12888-020-02688-9
[14] Pretorius, R. A., Karunaratne, N., Fairbrother, D. I., & Gillman, L. (2022). Preference for face-to-face mental health services among rural Australians: Evidence from a cross-sectional survey. *International Journal of Environmental Research and Public Health, 19*(3), 1876. https://doi.org/10.3390/ijerph19031876 (Accessible via: https://pmc.ncbi.nlm.nih.gov/articles/PMC8894617)
[15] Holloway, K., Brophy, L., & Meehan, T. (2023). Barriers and facilitators to the use of digital mental health services in rural and remote Australia: A scoping review. *BMC Health Services Research, 23*, 775. https://doi.org/10.1186/s12913-023-10034-4
[16] Arafmi. (2024). *At what cost? The experiences of unpaid mental health carers in Queensland 2023–2024*. https://arafmi.com.au/at-what-cost/

QAMH warmly thanks the following Member organisations whose insights, time and lived experience shaped this submission: Community Focus, Compass House, Each, Lutheran Services, QPASTT, Stride, Uniting Care Community, and Wellways.