Mental Health Australia

Mental health and economic inclusion

Submission for the Economic Inclusion Advisory Committee Nov 2025

About Mental Health Australia

Mental Health Australia is the national, independent peak body for the mental health sector. We unite the voices of the mental health sector and advocate for policies that improve mental health. We have over 150 member organisations, including service providers, professional bodies, organisations representing people with lived experience of mental health challenges, family, carers and supporters, researchers and state and territory mental health peak bodies.

This submission is informed by contributions from members through both a consultation webinar, and targeted consultations with members and key stakeholders. This submission is also informed by recent research on economic inclusion and mental health; consideration of recommendations yet to be implemented from previous national inquiries; and existing policy priorities Mental Health Australia has developed with our members.

Mental Health Australia would like to thank the many members and individuals who contributed their expertise to this submission.

Introduction

We can significantly boost our national productivity, and strengthen communities across Australia, by better investing in mental health.

People experiencing mental health challenges **face significant barriers to full social and economic participation** – including inequitable access to mental health supports, inappropriate income and employment supports, and workplace stigma and discrimination.

As such, **people who experience mental health challenges, and their family, carers and kin, have some of the lowest rates of economic participation in Australia**. People with psychosocial disability fare far worse on all employment indicators than people with other disabilities – with an employment rate of 39% compared to 57%.[1] People experiencing a long-term mental health condition report far higher rates of financial distress than others in the community,[2] and nearly 80% of people with complex mental health issues report experiencing employment related stigma or discrimination.[3]

Mental ill-health has been described as "the primary threat to the health, wellbeing and productivity of young people" as they develop and transition from childhood to adulthood.[4]

Australia's mental health service system should be responding to this challenge - supporting people to manage their mental health, and live fulfilling 'contributing lives' – where people have a good home, meaningful activity, valued friendships, proper health care and opportunities for education and training, without experiencing discrimination.[5] While dedicated mental health professionals and services continue to make enormous contributions every day, **the mental health system is itself fragmented, chronically underfunded and inequitably distributed**.

The **gap in access to mental health supports between high-income and low-income groups has almost doubled over the past decade** – with people on lower incomes being far less likely to receive psychological support after a diagnosis and increasingly relying on medication alone.[6] Geographically, areas with the highest levels of mental ill-health have the lowest rates of mental health service use.[7] And overall, while mental ill-health represents 15% of the total disease burden,[8] it attracts just 7% of health funding,[9] and there is an estimated 32% current shortfall in mental health workers.[10]

This failure of government policies and systems to provide equitable and effective mental health care is itself a reflection of the failure to support full social and economic inclusion for all people in Australia.

Further, our universal safety nets created to ensure no-one is left behind – including income support and employment services – have been failing people with experiences of mental health challenges, by not adequately considering their particular needs.

The enormous costs here are not just personal, but also social and economic. While the human impact of mental ill health is unquantifiable, the cost to the economy is conservatively estimated to be $70 billion each year in lost productivity, direct healthcare costs and informal care by family and friends, as well as an additional $150 billion in reduced health and life expectancy.[11,12]

These systemic failures fundamentally represent a lack of future-thinking and a massive missed opportunity. Australia could break intergenerational cycles of mental ill-health and disadvantage by investing in the systems and supports that will have the greatest impact for future generations.

Investing effectively in systems that prevent, and support all people experiencing mental health challenges and their family, carers and kin, will pay both social and economic dividends, as we remove barriers to people living full, healthy, meaningful and contributing lives.

This submission outlines specific actions to improve support systems to achieve this by:

1. Supercharging investment in mental health services and supports
2. Ensuring social safety nets are mental health responsive
3. Boosting employment for people with mental health challenges
4. Intensifying the focus on child developmental supports and mental health promotion and prevention

By addressing barriers to full social and economic participation for people experiencing mental health challenges and their family, carers and kin, we can uplift the Australian community to achieve greater economic prosperity, social connection and overall community wellbeing.

Summary of recommendations

Supercharge investment in mental health services and supports

1. Recognise that tackling dire mental health service shortages and equity gaps is critical to boosting economic participation

- Strengthen regional governance for highly collaborative, effective and impactful place-based commissioning that connects mental health services, regardless of which level of government is funding them.
- Expand the rollout of Medicare Mental Health Centres and Kids Hubs to reach more communities. Refine the service model to maximise impact and integration.
- Build stronger linkages between mental health, community and human services including social security, employment, education and financial counselling.
- Make urgent headway on addressing the gap in psychosocial support and rapidly invest in capabilities needed to expand delivery of supports.
- Advance national scale up of housing with support to prevent chronic homelessness among people with psychosocial disability.
- Monitor service use by low socio-economic groups and people experiencing structural discrimination and promote uptake.
- Embed peer workers in service and systems models and lived experience representation in governance.

Ensure social safety nets are mental health responsive

2. Conduct a detailed assessment of the mental health impacts of social security and income support settings, identifying approaches that contribute to mental health harms and that support recovery and wellbeing.

Use the findings to strengthen EIAC's earlier recommendations for:

- a refreshed mandate for the social security to promote economic inclusion and wellbeing
- ending immediate harms and reforming the compliance framework
- substantially increasing the rate of Youth Allowance, JobSeeker and related payments.

3. Examine the operation of the Disability Support Pension for people with psychosocial disability:

- Advocate for removal of unfair access barriers
- Explore ways to reduce "cliff-edge risk" disincentives to work
- Identify improvements that could be made to the Program of Support (which sunsets April 2026), including safer compliance requirements.

4. Draw attention to the rising and inequitable denial of NDIS access for people with psychosocial disability

- Call for swift action to address this, including implementation of the psychosocial access pathway recommended by the NDIS Review.

5. Encourage strong connections between social services such as financial counselling and mental health services, leveraging Financial Wellbeing Hubs and Medicare Mental Health Centres

Boost employment of people with mental ill health

6. Advocate for employment services, including the next version of Workforce Australia, to drive better outcomes for people with mental ill health.

- Integrate employment services with mental health and psychosocial supports
- Provide personalised, intensive and place-based support to jobseekers
- Recognise sustained engagement and recovery as success measures
- Expand delivery of services by providers with expertise in mental health
- Embed mental-health responsiveness as a core service requirement
- Proactively monitor and report on employment services (all programs) outcomes for people experiencing mental ill health.

7. Recognise Individual Placement and Support (IPS) as a proven model for boosting employment of people with mental ill health and explore levers to scale up delivery.

8. Grow and develop the peer and lived experience mental health workforce by aligning efforts across the national skills, employment services and broader human services systems.

9. Recognise the importance of a systematic approach to tackling stigma and discrimination in employment, education and training and the need for the National Stigma and Discrimination Reduction Strategy to be released and funded

10. Highlight the need for workers' compensation reforms to reduce perverse outcomes for people making psychological injury claims

Intensify the focus on mental health promotion and prevention

11. Make child and family mental health and wellbeing a core part of the universal Early Childhood Development System recommended in EIAC's 2025 Report.

- Apply the National Guidelines for mental health and wellbeing in Early Childhood Health Checks into universal early childhood development screenings
- Connect Kids Medicare Mental Health Hubs and Perinatal Mental Health Centres with the broader network of integrated early years hubs that are growing across Australia
- Strengthen access to supports aimed at preventing child maltreatment.

12. Develop a coordinated and comprehensive approach to mental health and wellbeing in schools and other education settings.

- Leverage the focus on student wellbeing in new Better Fairer Schools Agreement.

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Actions to strengthen economic inclusion

Supercharge investment in mental health services and supports

1. **Recognise that tackling dire mental health service shortages and equity gaps is critical to boosting economic participation**

    - Strengthen regional governance for highly collaborative, effective and impactful place-based commissioning that connects mental health services, regardless of which level of government is funding them.
    - Expand the rollout of Medicare Mental Health Centres and Kids Hubs to reach more communities, with a strong focus on refining the service model to maximise impact and integration.
    - Build stronger linkages between mental health, community and human services including social security, employment, education and financial counselling.
    - Make urgent headway on addressing the gap in psychosocial support and rapidly invest in capabilities needed to expand delivery of supports.
    - Advance national scale up of housing with support to prevent chronic homelessness among people with psychosocial disability.
    - Monitor service use by low socio-economic groups and people experiencing structural discrimination and promote uptake.
    - Embed peer workers in service and systems models and lived experience representation in governance.

There is a major shortfall of mental health services and supports

Under-investment in mental health services is a major handbrake on economic inclusion. Too many people are unable to engage in work, study and community because they cannot get help when and where they need it. Huge gaps, shortages and fragmentation in care cost lives and cost the economy billions through preventable distress, disengagement and lost productivity. Headline data below shows enormous unmet need in mental health services and psychosocial supports.

Less than half of people with a mental health condition access mental health treatment	Approx 4.3m people had a mental health condition in 2020-2022 but only 45% saw a health professional for mental health treatment.[13]
There is a huge gap in access to psychosocial supports outside the NDIS	Approx 493,600 people aged 12 to 64 have unmet need for psychosocial supports outside the NDIS. This includes 230,500 people with severe mental illness. [14]
There is a dangerous shortfall in funding and services for people with chronic severe mental health conditions	There is an estimated funding shortfall of more than $8 billion for adequate services for people with chronic severe mental health conditions (around 2% adult population), and an associated life expectancy gap of 18 years.[15]

There is a major workforce shortage	Current estimates are a 32% shortfall in mental health workers, anticipated to grow to 42% by 2030 if current shortages are not addressed.[16] Workforce challenges are even more acute in rural and remote communities.

The latest Report on Government Services shows mental health access gaps remain wide and community supports are still insufficient. Spending has grown, but mostly due to higher costs, not greater reach or impact.[17]

Mental health is one of the biggest drivers of lost participation in Australia. It is the primary threat to the health, wellbeing and productivity of young people as they develop and transition from childhood to adulthood.[18]

Mental ill health represents 15% of the total disease burden,[19] yet attracts just 7% of health funding.[20] Better investment would deliver significant returns by unlocking education, employment and productivity gains.[21]

There is a huge equity divide in access to mental health support

There is a stark and growing equity divide in mental health. Mental health outcomes are worse in lower income areas, and access to care is lower. People on low incomes are less likely to receive mental health treatment even after a diagnosis, and cost remains one of the biggest barriers. For people on low and fixed incomes, the gap between need and access is widening.

Suicide rates are high and rising in Australia's most disadvantaged areas	In 2023 people living in the lowest socioeconomic areas had a suicide rate more than double that of those in the highest socioeconomic areas (17.3 compared with 7.4 deaths per 100,000). In contrast, rates are much lower in more advantaged areas and have changed little.[22]
Access to mental health care is highly unequal: the income gap has doubled	People with lower incomes are far less likely to receive psychological support after a diagnosis and are increasingly relying on medication alone as the costs of psychological support rise and free services are tightly rationed. The gap in access between high-income and low-income groups has almost doubled over the past decade, meaning income now plays a much stronger role in determining whether a person gets the psychological care they need.[23]
Areas with the highest levels of mental ill health have the lowest rates of mental health service use	The Mapping Mental Health Care Tool (developed by the University of Canberra with Mental Health Australia) shows:[24] • Access to Medicare-subsidised mental health services is almost twice as high in affluent areas compared with low SES areas • Almost 29% of people in remote areas report a long-term mental health condition, yet only 5% receive relevant mental health services (compared with 12% in major cities)

	• There are nearly twice as many psychologists per 100,000 people in major cities than in regional areas; and more than twice as many psychiatrists in cities compared to remote regions. • Groups least able to access support despite high need include people living in regional and remote areas, younger people, people on low incomes, people who are unemployed and single-parent households.
Less service availability in areas of highest need	Regions with the highest prevalence of mental health need for infants and children, often have the lowest availability of services and workforces.[25]
Cost is a major barrier, particularly for young people	One in five people delay or avoid seeking mental health support due to cost pressures.[26] For people on low and fixed incomes, the gap between need and access is widening. [27] 60% of young people (18-24) report cost as a significant barrier – more than any other age group.[28]
People with long-term mental health conditions have the highest levels of financial stress	People with a long-term mental health condition reported the highest levels of financial stress, with almost one in three experiencing financial stress. This is significantly higher than people with other long term health conditions (14.5%) and people with no long-term health conditions (10.2%).[29]
Aboriginal and Torres Strait Islander communities are more likely to experience poor mental health	• While suicide rates are unchanged across the broader population, they have increased among Aboriginal and Torres Strait Islander communities.[30] • 3 in 10 Aboriginal and Torres Strait Islander adults are experiencing high or very high levels of psychological distress.[31]
Mental ill health has significant cross and intergenerational impacts	Mental health and economic inclusion are closely linked for parents, carers and families. If a parent is struggling, their ability to work or study suffers. If a child is struggling, parents often reduce work to provide care. When both occur, financial and wellbeing impacts compound, especially for low-income households.

An integrated system of free, safe and responsive care is needed

Australia lacks a coherent mental health system. There is no national mental health strategy to guide design, investment or accountability for mental health. Fragmentation across federal, state and regional responsibilities and different portfolios adds to this dislocation. The current National Mental Health and Suicide Prevention Agreement is narrow in scope and does not provide the unifying framework needed for a connected, coordinated system. This lack of coordination drives inequity, inefficiencies, weakens outcomes and leaves people to navigate a system that does not

match the realities of their lives. The extent to which existing Federal and State players cooperate at the regional level varies greatly.[32]

> *The mental health service landscape could be described as "looking like someone has scattered a bucket of random Lego bits onto the floor. There are some great pieces, but it is not clear how they fit together. Some bits are missing."*

A strong public and community mental health system is essential to increasing access to supports and closing the equity divide. Australia has key building blocks in place: Medicare Mental Health Kids Hubs, headspace, adult Medicare Mental Health Centres, Perinatal Mental Health Centres and Primary Health Networks as place-based commissioning bodies. Additionally, the new National Early Intervention Service is being introduced to deliver low-intensity support nationally. Collectively, these services need greater capacity, stronger reach into high need communities, integrated approaches and the capability to deliver the right combination and intensity of support at the right time. There also needs to be seamless pathways to support across services.

Primary Health Network (PHN) commissioned mental health services

Regional codesign, delivery and accountability are critical for building a more responsive, accessible and impactful mental health system and creating greater equality between different regions. Stronger regional governance that brings services together, regardless of which level of government is funding them, is needed.

PHNs are the main mechanism for commissioning of community based primary mental health services that respond to local needs, including Medicare Mental Health Centres. However, in the absence of a clear national mental health strategy, what is available and how it is delivered varies greatly between PHN regions.

The sector is eagerly awaiting the outcomes and response to a Review of PHN Business Model and Mental Health Flexible Funding Stream. Improving equity, efficiency and effectiveness must be central to the next phase of scaling up services and supports. There are clear opportunities to increase the reach and impact of PHN commissioned services, including:

- establishing core national elements, consistent outcomes measures and reporting across regions
- embedding lived experience expertise in PHN governance
- adjusting funding formulas to reflect socioeconomic status and need, not just population size
- enabling and encouraging collaborative and integrated approaches between community-based supports and hospitals
- streamlining grants and providing longer contracts to support workforce stability and reduce service disruptions.

Importantly, there must be clear and close connections between the mental health system and adjacent systems that are key drivers of mental health, including education, employment, social security, housing, family services and financial counselling.

Medicare Mental Health Centres

If delivered well, Medicare Mental Health Centres could be game changing. They promise a new, easy entry platform for support that should help narrow equity and access gaps.

Governments have committed to 61 adult Medicare Mental Health Centres by mid-2026. To date, rollout has been uneven across states, with some sites heavily delayed.

Mental Health Australia believes that getting the model right is a high priority. Results of the recent independent evaluation of the adult Centres are yet to be released. Earlier findings[33] showed that Centres improved access for people who would not otherwise seek help. Navigation support and the 'no wrong door' approach were valued. However, service integration and data systems were found to be weak. Attracting and retaining the workforce was also a challenge.

Provider co-evaluation findings show the Centres are improving access and equity. At Neami-run Centres, almost one in three visitors are seeking mental health support for the first time and 26% say they would not have sought help elsewhere.[34] Centres are also reaching people with complex needs. Neami's findings point to key system improvement opportunities which warrant system wide attention. These include the need for stronger transition pathways into ongoing care; better links with housing and social services; action to address shame, stigma and racism so Aboriginal and Torres Strait Islander and LGBTQIA+ communities feel safe; clearer staff roles with consistent training; and lifting awareness of Centres across the community and referrer networks.

To realise their potential, strong links between Medicare Mental Health Centres, local hospitals and community mental health supports are essential, so people are seamlessly connected to longer term and tailored care when needed and not left to fall between services. Although the National Service Model[35] calls for such integration, Mental Health Australia members report this is not yet consistently occurring in practice.

Members see clear opportunities to maximise impact. The next phase of rollout should sharpen the focus on equity and system integration, ensuring this significant infrastructure delivers marked improvements in mental health and economic inclusion. Priorities include:

- improving consistency with the national model (supported by PHN commissioning reforms)
- targeting underserviced communities and enabling flexible models that suit outer regional, rural and remote areas
- embedding peer support and psychosocial support, alongside clinical care
- coordinating care for families where multiple members experience mental health challenges, including strong links between adult, child and headspace services
- strengthening connections with adjacent service systems including social security, housing and homelessness, employment services, financial counselling, alcohol and other drug treatment and family violence support.

headspace and youth models of care

headspace provides the major primary mental health platform for young people via a national network of over 170 centres offering integrated services for young people. Given the increasing demand for youth mental health supports, both in terms of the number of young people seeking

care and the complexity of their needs, a sector-led review has provided advice to government on new/refined models of care to better meet needs now and into the future.[36]

Mental Health Australia welcomes the government's commitment to strengthen and expand youth mental health care, including through establishing headspace plus services and 20 Youth Specialist Care Centres for young people with complex needs.[37] Funding is also being directed to upgrade existing headspaces centres, increase access to multidisciplinary care, and scale outreach and digital supports so more young people can get help earlier. Design and implementation of these commitments in partnership with lived experience representatives and the sector, along with a full response to the review of youth models of care, are imperative opportunities to improve equitable access to effective mental health support for young people.

Medicare Mental Health Kids Hubs

Governments' joint investment in a national network of Medicare Mental Health Kids Hubs has introduced a much-needed layer of free mental health support for children aged 0 to 12 and their families. Progress has been slower than planned however. Just 11 of an initial 17 hubs are operational, with all expected to come online by mid-2026.

Kids Hubs offer multidisciplinary supports including assessment, diagnosis, therapies, care coordination and family systems support. They bring together paediatric, psychiatric, psychological and allied health expertise without the need for a referral.

Children with complex needs often interact with multiple systems. Kids Hubs are designed to be a single front door that connects mental health care with education, housing, disability and social services. The national service model[38] emphasises co-locating hubs with universal child and family services such as schools, childcare and parenting centres to make help easier to find and easier to use. Integrated one stop models are showing strong potential to improve outcomes and reduce inequities in access. [39]

National monitoring and evaluation must keep pace with rollout to ensure hubs are reaching children across metropolitan, regional and remote communities. Hub and spoke outreach and linked wellbeing roles should be explored to extend access where service infrastructure is limited. Ongoing engagement with the mental health sector is needed to refine the model, strengthen integration with the broader system and build shared referral pathways.

Prioritising completion of the rollout and planning for expansion of Kids Hubs to be more widely available across Australia will be key to preventing early mental health concerns from from escalating and strengthening lifelong economic inclusion.

Urgent headway is needed on the critical gap in psychosocial support

Psychosocial supports are essential for people with enduring or severe mental ill health. They help people maintain housing, stay connected and participate in work and community life. They also enable families and carers to remain in employment and sustain their own wellbeing.

Australia shifted from psychiatric institutions to community-based care last century, but the investment needed to underpin that shift has not followed. Too many people cannot access the supports required to live well in the community. Families and carers often become the default system of support, sometimes leaving work to provide care. This limits the impact of other health and social investments and undermines economic security and participation.

We heard from our members:

> *Mothers, mostly, are the ones who end up full time caring for adult children to keep them safe.*
>
> *Dread the discharges [from hospital] into insecure housing or homelessness, knowing it quickly erases the gains.*
>
> *It's true when you hear people say prisons have become modern day asylums because the supports to live safely in the community are not there.*

Programs that once bridged this gap, such as Partners in Recovery and Personal Helpers and Mentors, were reduced as funding shifted into the NDIS, widening the gap for those outside the scheme. Recent estimates show almost half a million people need psychosocial supports but cannot access them, including more than 230,500 people with severe mental illness.[40] PHNs and State and Territory Governments currently commission various psychosocial supports at a modest scale, well below the level of need.

Governments have agreed on the need to address this gap, but negotiations on how and when this will occur are still underway. As mental health, health and disability agreements are renegotiated, urgent headway should be made on workforce development, lived-experience co-design, planning for commissioning and rollout. [41]

Mental Health Australia has urged the Australian Government to provide immediate, short-term funding to support an initial expansion of psychosocial supports in the 2025 Mid-Year Economic and Fiscal Outlook, with an expectation that states and territories match this funding in 2026-27 budgets. In the 2026–27 Federal Budget, we hope to see a commitment to funding certainty for psychosocial supports (currently funded to June 2027), and increased investment to fully address unmet need for these essential services as part of the next National Mental Health and Suicide Prevention Agreement.

Guidance developed by Mental Health Australia and the National Mental Health Consumer and Carer Forum identifies evidence informed psychosocial models that are ready to scale. Examples include outreach and mobile support, housing linked supports, employment focused supports, individual recovery support, alcohol and drug rehabilitation and community participation. The guidance also sets out clear principles for design and commissioning. [42]

Given the escalation of people with severe mental health conditions seeking supports for homelessness,[43] urgent national action to scale up proven models of housing with mental health support is needed.

A National Supportive Housing and Homelessness Prevention Program

Australia has a known group of around 30,000 people[44] that are experiencing or at high risk of chronic and repeated homelessness. Many have psychosocial disability and other complex support needs. They represent the bulk of repeat, long-term users of homelessness services despite being a small proportion of those that experience homelessness.

A dire lack of safe and recovery focused supportive housing options means they are unnecessarily cycling between chronic homelessness, crisis accommodation, health and acute mental health services, correctional facilities and exploitative institutional-style settings.

This has tragic consequences for individuals and their families and supporters. It also impacts public health and safety and creates repeated and intense avoidable demand for publicly funded services – resulting in substantial wastage of taxpayer funds.

Proven models of supportive housing - such as Housing First and Permanent Supportive Housing - provide security of tenure, alongside recovery and wellbeing supports, to enable people to sustain their housing, spend less time in care and institutional settings and be involved in community life.

Support to sustain tenancies is also critical to stop people with psychosocial disability falling out of housing.

Despite delivering strong returns on investment, these approaches are few and far between. They need to be scaled up to create a nation-wide response. Queensland's 2024 **Supportive Housing Policy** provides inspiration for a national program approach.

Ensure social safety nets are mental health responsive

2. **Conduct a detailed assessment of the mental health impacts of social security and income support settings, identifying approaches that contribute to mental health harms and that support recovery and wellbeing.**

   Use the findings to strengthen EIAC's earlier recommendations for:

   - a refreshed mandate for the social security system to promote economic inclusion and wellbeing
   - ending immediate harms and reforming the compliance framework
   - substantially increasing the rate of Youth Allowance, JobSeeker and related payments.

3. **Examine the operation of the Disability Support Pension for people with psychosocial disability:**

   - advocate for removal of unfair access barriers
   - explore ways to reduce "cliff-edge risk" disincentives to work
   - identify improvements that could be made to the Program of Support (which sunsets April 2026), including safer compliance requirements.

4. **Draw attention to the rising and inequitable denial of NDIS access for people with psychosocial disability**

   - call for swift action to address this, including implementation of the psychosocial access pathway recommended by the NDIS Review.

5. **Encourage strong connections between social services such as financial counselling and mental health services**

   - Leverage Financial Wellbeing Hubs and Medicare Mental Health Centres as key connection points.

Mental health impacts of social security settings need examination

A detailed examination of the mental health impacts of social security settings is urgently needed. In its 2025 report, EIAC undertook an important deep dive into how the social security system responds to family and domestic violence. We recommend that EIAC apply a similar lens to people with mental ill-health in 2026. Prevalence is rising, reliance on social security is high and the system can either stabilise people's lives and support recovery or push them into deeper distress and despair.

We heard from our members about community members struggling to access social security because of their deep disadvantage.

Super ID Clinics supporting access to Centrelink

Meeting ID and application requirements can be a major barrier to Centrelink payments, especially for people experiencing homelessness, mental health challenges or complex disadvantage. In Western Australia, RUAH runs regular Super ID Clinics that bring key agencies together in one place, including the Registry of Births, Deaths and Marriages and volunteer Justices of the Peace, to help people secure the documents they need.

At a recent clinic, 100 birth certificates, 59 photo IDs and 37 certified documents were issued. These clinics operate within a broader service hub that also connects people to housing, legal, health and advocacy support.

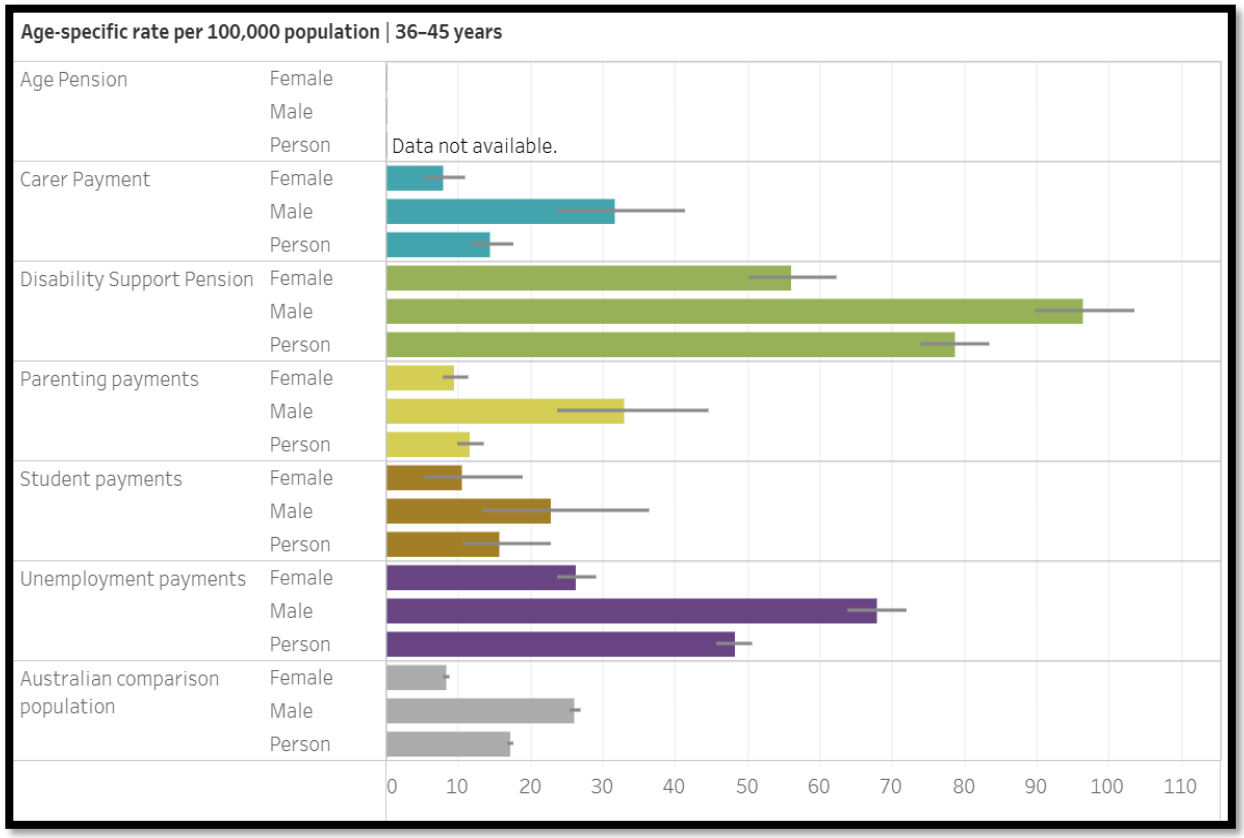
The social security system is not a core area of Mental Health Australia's expertise. We thank Economic Justice Australia and the Mental Health Legal Centre for their guidance in shaping this section.

Wellbeing and economic inclusion are strong future mandates for our social security system

People receiving income support experience some of the poorest mental health outcomes in the country. EIAC commissioned research from Mandala Partners found people on JobSeeker are almost twice as likely to experience high or severe depression or anxiety as those not on the payment.[45] ACOSS and UNSW similarly show that half of people under 65 who rely on government income support report mental health issues, compared with 18% of those whose main income is wages.[46]

Suicide rates are also dramatically higher. The highest rates are for people aged 36- 45 receiving unemployment payments, followed by people aged 46-65 receiving the Disability Support Pension.[47] The table below shows the 36–45-year-old comparisons.

Table 1: Death by suicide by payment type



Extracted from Productivity Commission (2025) Mental Health and Suicide Prevention Agreement Review, Interim Report (using AIHW data)

The flip side of these confronting figures is a major opportunity. Social security can be a significant lever for reducing mental ill health and suicide risk when it is delivered with decency and dignity, and when it actively connects people with a network of supports. The following anecdote provides a glimpse of what might be possible when a therapeutic approach is used to address the drivers of unemployment and promote wellbeing:

> *The employment services provider is supporting clients to access psychology and funding gym memberships. These clients are the few that have reported a positive experience with their provider or have wanted to continue their obligations voluntarily.*
> **Mental Health Legal Centre**

Mental Health Australia endorses EIAC's call for economic inclusion and wellbeing to sit at the heart of a renewed social security mandate. Income support is not just financial assistance. It is a foundation for mental health, recovery and participation in the community. We encourage EIAC to articulate, in detail, what this mandate should look like in practice for people with experience of mental ill health.

Punitive compliance regimes impact psychological wellbeing

Mental Health Australia supports EIAC's earlier calls to replace the current mutual obligations regime and reduce punitive compliance mechanisms in income support. Every problem EIAC has identified tends to be magnified for people experiencing mental health challenges.

The parliamentary inquiry into Workforce Australia found clear and direct harm to psychological wellbeing from punitive compliance. The Committee warned that forcing people who are unwell or not job ready to apply for jobs does more harm than good. It called for a system that addresses barriers like poor mental health, homelessness and trauma before imposing work related requirements, and for obligations that are tailored and genuinely supportive rather than punitive.[48]

Additional concerns raised by Mental Health Australia members and partners include the significant psychological harm flowing from unfair suspension and cancellation of payments, worsened by flaws in automated systems and failures in administrative oversight.[49] [50]

Raising the rate delivers improved mental health

Mental Health Australia supports EIAC's earlier calls to substantially increase the base rates for Youth Allowance, JobSeeker and other working-age payments.

Research by Mandala Partners[51] for EIAC in 2024 shows a direct link between the adequacy of income support and mental health. People on the lowest payments experience the highest levels of psychological distress. Modelling suggests that lifting payment rates by around $128 per week could reduce severe distress by a quarter. Higher and more stable payments reduce chronic stress, improve wellbeing and enable people to take part in work, education and community life.

People with psychosocial disability need fair and equitable access to DSP

Around 37% of DSP recipients (about 286,000 people) have a primary medical condition in the psychological/psychiatric category.[52] This is the largest disability group on the DSP.

The 2022 Senate inquiry into the DSP found overwhelming evidence that the system is overly complex and distressing to navigate, leading to unfair outcomes. Mental Health Australia members and partners report that, despite some improvements, people with psychosocial disability continue to face major barriers to accessing the DSP. Key challenges include:

- the application process is highly complex to navigate and can significantly exacerbate mental health symptoms. There is limited support available to navigate the process.
- eligibility requires mental health conditions to be diagnosed, reasonably treated and stabilised, which is often unachievable due to cost, barriers to services and the nature of mental illness.
- psychosocial disability applicants face a more onerous evidentiary burden than other disability groups. They must provide medical evidence from a psychologist or psychiatrist that covers diagnosis, treatment history, prognosis, symptoms, functional impact and work capacity.
- low understanding of the DSP and its evidentiary requirements among medical professionals contributes to a high claim rejection rate.

DSP eligibility is assessed through impairment tables that score the impact of a condition on a person's ability to work. These tables cover different areas of function. Applicants need at least 20 points to qualify. However, if those points are spread across more than one table, which is often the case for people which psychosocial disability, the person must also meet the Program of Support requirement.

The Program of Support requires participation in approved job seeking, training or rehabilitation activities for at least 18 months in the three years before claiming DSP. Periods where a person is exempt due to illness do not count. This leaves many people stuck on JobSeeker, too unwell to meet obligations but unable to qualify for DSP without meeting them. Centrelink can waive the Program of Support requirement, but this appears to be poorly understood and inconsistently applied. Some people on DSP under 35 can even continue to face mutual obligation requirements after they are granted the payment.

With the Program of Support due to sunset in April 2026, there is a critical opportunity to ensure people with psychosocial disability are assessed fairly and supported without harmful compliance pressures.

> *The PoS rule has led to an expanding pool of people with disability on JobSeeker Payment who are unable to comply with mutual obligation requirements.*
> **Economic Justice Australia** [53]

We anticipate that many people with psychosocial disability, particularly those experiencing multiple layers of disadvantage, should qualify for DSP but are unable to access it due to the barriers summarised above. Recent DSP rejection data, reproduced in Table 2 below, is revealing.

Table 2: DSP rejection reason (reasons most relevant to psychosocial disability applicants displayed)	**2021-22**	**2022-23**	**2023-24**	Jul-Oct **2024**
Medical conditions not diagnosed, reasonably treated and stabilised	32,164	25,542	29,620	12,596
Less than 20 points impaired	8,776	7,620	9,585	5,287
Insufficient medical evidence	3,388	2,919	3,364	1,337
Manifest - diagnosis criteria not met	1,859	1,434	1,398	546
Has not actively participated in a program of support	824	684	861	440
Failed to reply to correspondence	1,746	1,548	1,172	384
Failed to supply documents	125	99	47	27

Data extracted from response to questions in Senate estimates hearings, November 2024.[54]

The “cliff-edge risk” is a work deterrent

Described by the Productivity Commission as a “cliff edge risk”, they found income support eligibility and assessment processes do not adapt well to fluctuating mental health. The design of supports can create risks for people trying to work, such as where people fear losing the DSP (as a secure form of income support) and not being able to regain it quickly if employment does not last. They highlighted the need to reduce these financial disincentives to work.[55]

Mental Health Australia members contributing to this submission reported that people are afraid of losing the DSP safety net, losing concessions and facing higher medication costs. People worry that if their symptoms return or a job does not last, they will not be able to get the support they need back in time. These risks can discourage people from attempting to find employment.

People with mental health conditions need to be able to test work without risking the income and supports they rely on. We call on EIAC to explore and advocate for protections that:

- guarantee quick DSP reinstatement if work does not last
- keep concessions and core supports in place while people test work
- coordinate employment and mental health services during transitions.

People with psychosocial disability are being unfairly shut out of the NDIS

The NDIS was established to increase inclusion and independence for people with disability. Yet access for people with psychosocial disability has become significantly harder – particularly for people facing intersecting disadvantage.

This exclusion is occurring at the worst possible time: alternative mental health and psychosocial supports outside the NDIS remain scarce. Without access to the Scheme, many people are left with no meaningful support at all. This has serious impacts on individuals and the families and carers who support them.

Recent analysis by the Australian Psychosocial Alliance[56] highlights alarming trends:

- Access approvals for psychosocial disability have fallen sharply in recent years - far more than for other disability types - despite no formal changes to eligibility criteria.
- Eligibility decisions frequently show limited understanding of psychosocial disability and disregard expert clinical evidence.
- Assessment responses are inconsistent, lack individualisation and sometimes rely on inappropriate assumptions about “untested treatments” to reject meeting a threshold of “permanent” disability.
- Assessment processes create disproportionate barriers for people facing disadvantage, including: high out-of-pocket costs for required clinical evidence; preference for specialist reports that are expensive and less accessible; duplicated ID checks even where identity is already verified by government; administrative demands that assume literacy, executive functioning and support that many do not have; requirements to attend multiple appointments despite risks to wellbeing; difficulty completing applications without a fixed address; lengthy delays preparing applications and waiting for decisions.

Meanwhile, key reforms recommended over many years remain unimplemented. The NDIS Review (2023) called for a dedicated psychosocial pathway, early intervention supports and clearer interfaces with state mental health systems, but progress has stalled. There is urgent need to act on these long-agreed reforms and take immediate steps to ensure people for whom the NDIS was intended are not unfairly shut out.

Connecting financial wellbeing and mental health supports will drive benefits

Financial wellbeing hubs offer a strategic site for early intervention, by connecting financial stability supports with mental health services, promoting prevention, participation and resilience.

The 2022 ASIC and Beyond Blue research[57] confirmed a strong two-way relationship between financial wellbeing and mental health. People experiencing financial challenges are at least twice as likely to have mental health problems, and people with mental health difficulties are twice as

likely to experience financial hardship. Debt, unpaid bills, income instability, unemployment, social isolation and stigma compound over time. Financial stress increases anxiety and depression, and financial stability protects wellbeing and supports recovery.

This connection is clearly visible in national data. Almost one in three people with a long-term mental health condition experience financial stress, significantly higher than those with other long term health conditions and those with none. People experiencing severe psychological distress are far more likely to be in financial stress: 68% compared with 30% of those without distress.

Connecting financial counselling, income support navigation and mental health help together can stabilise lives, prevent harm and support social and economic participation. Financial wellbeing hubs and Medicare Mental Health Hubs are a strategic access point for approach.

Boost employment of people with mental ill health

6. **Advocate for employment services, including the next version of Workforce Australia, to drive better outcomes for people with mental ill health.**
    - Integrate employment services with mental health and psychosocial supports
    - Provide personalised, intensive and place-based support to jobseekers
    - Recognise sustained engagement and recovery as success measures
    - Expand delivery of services by providers with expertise in mental health
    - Embed mental-health responsiveness as a core service requirement
    - Proactively monitor and report on employment services (all programs) outcomes for people experiencing mental ill health.

7. **Recognise Individual Placement and Support (IPS) as a proven model for boosting employment of people with mental ill health and explore levers to scale up availability.**

8. **Grow and develop the peer and lived experience mental health workforce by aligning efforts across the national skills, employment services and broader human services systems.**

9. **Recognise the importance of a systematic approach to tackling stigma and discrimination in employment, education and training and the need for the National Stigma and Discrimination Reduction Strategy to be released and funded**

10. **Highlight the need for workers' compensation reforms to reduce perverse outcomes for people making psychological injury claims. Support rapid access to treatment and faster returns to work.**

Employment and mental health are inherently linked

Engagement in meaningful activity, including work, helps prevent mental ill health and supports recovery and wellbeing. Unemployment, on the other hand, is associated with higher psychological distress, declining mental health and increased suicide risk.[58] Recent data clearly illustrates this. In 2023, among people aged 18–64, a high or very high risk of mental distress was reported by:[59]

- 51% of those who were unemployed
- 39% of those not in the labour force
- 23% of those employed.

Despite this strong relationship, there are no national targets for improving employment outcomes for people with mental ill health. The systems that should work together to support recovery and participation remain largely disconnected.

People with psychosocial disability face the worst employment outcomes

Across all key employment related indicators, people with psychosocial disability fare worse than other disability groups. Table 3 below uses ABS Survey of Disability, Ageing and Carers 2022 data[60] alongside broader ABS labour force data[61] to illustrate this.

Table 3: Employment outcomes for people with psychosocial disability compared with others

Metric	Psychosocial disability	Other disability	All disability	Working age population	Source
Labour force participation	**45.7%**	68.9%	60.5%	70%	ABS SDAC 2022 ABS Labour Force (Sep 2025)
Employed *Employment-to-population ratio*	**39%**	57%	56%	64%	ABS SDAC 2022 ABS Labour Force (Sept 2025)
Full-time employed	**18%**	42%	—	45–46% *(derived)*	ABS SDAC 2022
Employment restrictions *Barriers to gaining or keeping work reported by people employed or wanting to work*	**80%**	52%	—	—	ABS SDAC 2022
Main income source wages/salary	**31%**	59%	47%	—	ABS SDAC 2022
Main income source pension/allowance	**46%**	19%	36%	—	ABS SDAC 2022
Median personal weekly income	**$450**	$803	—	**$1,250** *(employed only)*	ABS SDAC 2022 ABS Employee Earnings May 2023 (overall)

For people with psychosocial disability receiving the NDIS, employment-related outcomes are worse still. Fewer than 10% are in paid work, less than half the rate of other disability groups. Table 4 below uses a combination of AIHW and NDIA data[62] to make this comparison.

Tabe 4: NDIS participant employment outcomes	Psychosocial as primary disability	Other primary disability	Source
Any paid employment *Share of all working-age NDIS participants with a primary disability in paid work*	**9–10%**	~22%	AIHW (2022–23)
Open employment — full award wage *Those in the labour force*	**24%**	~33%	AIHW (2024)
Not in labour force *Proportion of workforce age not able to work or job-seek — key indicator of severe workforce exclusion*	**70%+**	50–55%	NDIA Quarterly Reports (2023–24) & AIHW outcomes (2022–24)

Responsive employment services could make a big difference

People living with mental ill health face some of the worst experiences and outcomes in employment services.

Disability Employment Services (now Inclusive Employment Australia)

About 41% of DES participants, around 110,000 people, have a primary psychiatric disability.[63] This group often experience poor service fit and negative wellbeing impacts in DES.[64] Mental Health Australia is eager for the new Inclusive Employment Australia, commencing November 2025, to deliver better results. Our members advise new program design is more person-centred and has increased emphasis on integrated supports, community-based innovation, lived experience and long-term outcomes. However, providers specialising in mental health are few and far between.

Promising example: mental health specialist Ostara

Ostara is one of few providers whose entire service model is designed around supporting people with mental health conditions and psychosocial disability. Under the new Inclusive Employment Australia program, they have been contracted to deliver services across 21 Employment Service Areas in NSW and Vic, as well as eight National Panel of Assessors regions.

Ostara's approach is grounded in recovery, inclusion, and capability building. Each participant's journey begins with a comprehensive, strengths-based assessment using trauma-informed and motivational interviewing techniques to identify barriers, aspirations, and support needs. Participants then co-design an individual Employment and Wellbeing Plan that integrates vocational, psychosocial, and health goals. Employment is positioned as both a goal and a pathway to recovery. Meaningful work can offer purpose, structure and social connection, but only when the environment is supportive, inclusive and stable.

Recognising the importance of mental health care alongside employment support, Ostara self-funds a partnership with Logic Lounge Psychology. This offers participants not already engaged with mental health supports direct access to psychologists, counsellors, diagnostic assessments and jobseeker wellbeing groups. The integration of therapy and vocational support has led to marked improvements in participants' confidence, functioning and ability to sustain work.

Participants are supported into open employment that suits their skills, interests and capacity. Support continues well beyond placement that tapers over two to three years to match each person's stability and need. Regular mental-health check-ins, employer mediation, and access to psychological services ensure challenges are addressed early, reducing job loss risk.

Ostara recognises that sustainable employment outcomes depend as much on employer readiness as on participant readiness. Its employer-facing program delivers Mental Health and Disability Inclusion Training through short, practical workshops that build managers' confidence in supporting staff experiencing mental health challenges. The training covers reasonable adjustments, psychological safety, early intervention and stigma reduction.

Ostara also runs "Meet the Boss" sessions, where participants can connect with supportive employers in a relaxed setting to discuss career pathways, ask questions and build confidence before interviews. This initiative helps reduce anxiety and improves job-matching success.

Ostara intentionally employs staff with lived experience of mental health recovery, ensuring empathy and authenticity are embedded in service delivery. More than 90% of the frontline team identify as having personal experience with mental health conditions, either directly or

through caring roles. Staff are trained in Mental Health, trauma-informed practice and suicide-prevention first aid, complemented by clinical supervision. The lived-experience workforce forms a critical bridge between participants, clinicians and employers. It allows staff to model recovery, reduce stigma, and respond sensitively to fluctuating mental health.

For many participants, achieving job readiness requires concurrent access to mental health, housing or financial supports. Ostara's model seeks to bridge these systems. Ostara partners with hospitals, mental health and housing services and has a strong track record with people subject to treatment orders and recent offending histories.

Workforce Australia

Mainstream employment services are largely failing people with mental health challenges. Our members report that jobseekers are routinely "parked" by providers who lack the understanding, time and flexibility to offer the tailored support needed to prepare for and sustain work. The current service and funding model does not allow for sustained engagement or a recovery focused approach.

These experiences reflect the findings of the Productivity Commission's Mental Health Inquiry[65] and the parliamentary inquiry into Workforce Australia Employment Services.[66] Both identified a disconnect between employment services and the mental health system, which too often work at cross purposes.

- A 'one size fits all' model fails to provide the coordinated mental health, housing and social supports some people need to move toward work.
- A short-term focus on any job placement works against recovery and long-term participation.
- Many providers and frontline staff lack mental health capability.
- People with mental ill health face higher risks of unmet need, penalties, disengagement and dropping out of services.

Both inquiries called for wholesale reform. They identified design features needed to improve outcomes for jobseekers with mental ill health, including:

- Personalised support that can be more intensive when required.
- Place based models that link employment support with mental health and other community services.
- Social participation pathways for people not yet ready for work.
- Flexible, supportive requirements instead of rigid participation rules and punitive compliance.
- Strong mental health capability across the employment services workforce and access to specialist providers.

As government moves toward redesigning or replacing Workforce Australia in 2027, Mental Health Australia echoes EIAC's calls for a comprehensive overhaul.

Individual Placement and Support: a proven model for expansion

Individual Placement and Support (IPS) is the strongest evidence-based model for supporting people with mental health conditions to get and keep real jobs. It embeds employment

specialists within mental health services, focuses on rapid placement in competitive work, avoids "work readiness" barriers and provides personalised ongoing support once someone is in work or study.[67]

More than 100 international studies, including over 30 randomised controlled trials, show that IPS achieves around twice the employment outcomes of traditional employment programs, with faster job entry, better earnings and longer job tenure.[68][69] IPS also improves recovery outcomes more effectively than clinical services alone.[70]

IPS has tested well in Australia. Evaluation of the DSS funded IPS trial in headspace centres found participants achieved higher rates of employment and education, better engagement and improved mental health compared with those in standard employment services.[71]

The IPS model has now expanded to 50 headspace centres across Australia, funded by the Department of Social Services. This expansion has been supported by IPS WORKS Australian IPS Centre of Excellence at the Western Australia Association for Mental Health, headspace national, and the Orygen Youth IPS Centre of Excellence. The service model is carefully structured around 8 core practice principles that contribute to IPS success. These include systematic job development, zero exclusion, financial planning (including any changes to social security), integrating support with clinical care, prioritising recovery and personal goals, enabling quick placement in competitive jobs or education, and providing time unlimited support.

Pilot programs are currently being conducted at select headspace centres to test a variety of innovative approaches. These pilots include embedding peer workers within IPS teams and implementing trauma-informed IPS for young people in Out of Home Care settings - extending support outside of the headspace centre.

Beyond the youth-focused headspace centres, IPS is also being piloted in adult public mental health services and non-government organisations (NGOs). Notably, employment specialists have been embedded in two Medicare Mental Health Centres: one in Midland, Western Australia, and another in Darwin, Northern Territory; as well as in an NGO within the Perth metropolitan area. However, the availability of these services is currently limited, and outcomes from these pilots have not yet been publicly reported.

Despite these positive developments, IPS is not yet widely available across Australia, nor is it systematically embedded within employment services. While there are encouraging examples of employment service providers integrating IPS within their teams and co-locating IPS specialists in adult public mental health services in South Australia, New South Wales, Western Australia, and within NDIS supports, these efforts are isolated and driven by local initiatives rather than by broader system design.

The experiences to date demonstrate that collaboration between employment and mental health services is both feasible and beneficial. However, this collaborative approach has not yet been fully embedded or scaled at a national level. Furthermore, young people participating in Transition to Work programs are frequently excluded from accessing IPS through headspace, while those engaged with Disability Employment Services (DES) or Workforce Australia programs face inconsistent eligibility criteria and weak incentives for collaborative service delivery.

Mental Health Australia supports sector calls for national expansion of IPS as a proven model of employment supports for both adults and young people – to support the economic participation of people experiencing mental health challenges, wherever they live.

Fostering the peer and lived experience workforce will drive economic inclusion

Peer support and lived-experience roles are a growing driver of economic inclusion, both for the peer workers themselves and for the people they support. Peer workers strengthen recovery, confidence and connection, and help bridge gaps between mental health, housing and employment systems. Services that employ peer workers report safer care, greater cultural responsiveness and stronger engagement from people who have previously disengaged.[72]

> *The lived experience perspective is a way of knowing, reducing discrimination and prejudicial attitudes, modelling the effectiveness of hope and purpose as drivers of mental health policy and system reform, self-determined recovery.*[73]

> *Having an Aboriginal and Torres Strait Islander Lived Experience-led Peer Workforce is economically beneficial for organisations, peer workers and the communities they serve.*[74]

Promising example: Two Ways Mentoring Program (TeamHEALTH, NT)

The Two Ways Mentoring Program in Darwin supports people with mental health challenges to prepare for and sustain work. Participants are matched with peer mentors who provide practical, non-judgmental support focused on confidence, self-advocacy, job skills and navigating workplace expectations. The program also trains employers and colleagues to reduce stigma and make reasonable adjustments.

By supporting both the worker and the workplace, the program has improved job readiness and workplace inclusion for participants It shows how mental health support can be aligned with successful employment participation for people with psychosocial disability.[75]

Peer workers are one of the fastest growing parts of the mental health workforce. The National Mental Health Workforce Strategy 2022–2032 identifies lived experience roles as essential to future workforce supply, and the National Suicide Prevention Strategy 2025–2035 positions peer workforce development as a key enabler of recovery-oriented care. The Gayaa Dhuwi (Proud Spirit) Declaration highlights the opportunity to expand Aboriginal and Torres Strait Islander lived experience-led peer roles to deliver culturally grounded support and economic participation.

A national qualification - Cert IV Mental Health Peer Work - provides a recognised pathway into paid roles and supports consistency in capability. However, training is not yet available in all jurisdictions, and some students need more wrap-around support to successfully complete and transition into work.[76]

Multiple peer workforce frameworks now exist,[77] alongside strong research on what enables peer roles to thrive. In the 2024-25 Budget, the Australian Government committed seed funding to establish a National Mental Health and Suicide Prevention Peer Workforce Association to drive standards, supervision and ongoing workforce development.

Peer work is a tangible employment pathway that could be better aligned with the national skills agenda and employment services. A coordinated approach that links fee-free training, job pathways and employment supports will help foster the peer workforce in mental health and adjacent services and deliver clear participation and productivity benefits.

Building psychologically safe workplaces requires concerted effort

Supportive workplaces can play a pivotal role in protecting mental health and promoting recovery. However, workplaces can also cause harm. Stigma and discrimination against people with mental ill health remain major hazards at work. They cause psychological injury, reduce inclusion and push people out of employment.

SANE's Stigma Report Card, informed by a survey of nearly 2000 people with complex mental health issues revealed that 78% experienced employment stigma or discrimination[78]. This included being denied jobs, treated unfairly once employed or dismissed after disclosure.

Workplace stigma is a structural barrier to economic inclusion. It shapes whether people are offered work, how they are treated at work and whether they can remain employed. Research identifies four pathways through which stigma undermines work outcomes:[79]

- Employer and manager bias: negative attitudes reduce hiring, fair treatment and support
- Disclosure dilemmas: disclosure can trigger discrimination; non-disclosure blocks access to adjustments and assistance
- Self-stigma and the 'Why Try' effect: anticipated judgement reduces motivation to stay in work or seek new work
- Delayed treatment: fear of stigma leads to untreated symptoms and unstable employment.

Stigma and discrimination are recognised psychosocial risks in workplace safety law that employers must prevent and manage.[80] Boards must exercise due diligence in overseeing how psychological risks are identified, controlled and monitored, including culture, leadership and interpersonal behaviour.[81]

National policy acknowledges this issue. The National Mental Health and Suicide Prevention Agreement identify workplaces as a priority for prevention and psychological safety. However, the Productivity Commission's review of the Agreement found weak delivery on workplace commitments and limited accountability for progress.

The National Mental Health Commission's Blueprint for Mentally Healthy Workplaces[82] and the related **Mentally Healthy Workplace platform** shows what good looks like and gives practical guidance to eliminate psychosocial hazards, build supportive culture and enable safe disclosure. There are some promising examples across different industries showing improvements in workplace culture, safety and support.

The NMHC has established a national monitoring framework for mentally healthy workforces, with a baseline report published in 2023.[83] The Framework aggregated data from ABS Work Related Injuries, ABS Characteristics of Employment, Thriving Workplace Survey, Safe Work Australia workers compensation and return to work data.

The National Stigma and Discrimination Reduction Strategy, expected to focus on employment and training as key priorities for building economic inclusion, has yet to be delivered.

Workers' compensation reforms are needed to promote recovery

Workers' compensation processes are delivering unintended consequences for people making psychological injury claims. Comprising around 10% of serious claims, psychological injuries

have the longest duration, highest cost and highest rate of dispute. Delays in liability decisions can block access to early treatment, prolong absence and hinder recovery.

To support earlier access to care and reduce time away from work, the Productivity Commission has recommended that people with psychological injury claims have funded mental health treatment from claim lodgement for up to six months, regardless of liability.

Intensify the focus on mental health promotion and prevention

11. Make child and family mental health and wellbeing a core part of the universal Early Childhood Development System recommended in EIAC's 2025 Report.

- Apply the National Guidelines for mental health and wellbeing in Early Childhood Health Checks into universal early childhood development screenings
- Connect Kids Medicare Mental Health Hubs and Perinatal Mental Health Centres with the broader network of integrated early years hubs that are growing across Australia
- Strengthen access to supports aimed at preventing child maltreatment.

12. Develop a coordinated and comprehensive approach to mental health and wellbeing in schools and other education settings.

- Leverage the focus on student wellbeing in new Better Fairer Schools Agreement.

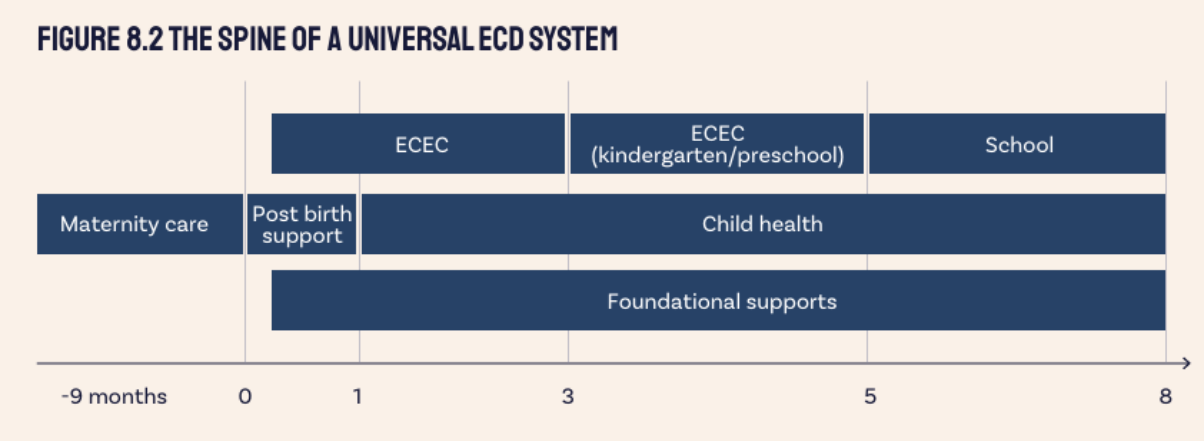
The prevalence of mental ill health in Australia is rising	• More than 40% of people in Australia have experienced a mental disorder at some point in their lives.[84] • 21.4% of people in 2020-21, up from 17.5% in 2014-15 experienced a mental health disorder each year.[85] • Young people are disproportionately affected. 38.8% of 16–24-year-olds experience a mental health condition each year, including 45.5% of young women. • Mental health challenges are the most common reason people see a GP.[86]
Psychological distress is also increasing	• Psychological distress increased from 13% in 2017-18 to 15.4% in 2020-21. 20% of young people experience high or very high psychological distress, twice the rate of older adults.[87]
Mental health challenges can start early	• Symptoms at 5 years of age are associated with increased likelihood of future mental health concerns.[88] • 13% of children aged 0 -12 have a mental health condition with 38% at risk of future mental health challenges.[89] • Around 1 in 7 children aged 4-17 years have experienced mental illness in the past year.[90]

	• 62.5% of mental illnesses emerge before age 25, with age 15 the average onset. [91]
Prevention delivers a high return on investment	• Investing in prevention pays off: for every dollar invested in school or university-based prevention of anxiety or depression, there is a $3.10 return in health care savings and productivity.[92]

To reduce the incidence of mental ill-health and promote high levels of mental wellbeing across the community, prevention must become a public policy priority. Targeted action on well-established underlying factors that increase the risk of mental health conditions must be prioritised.

Mental health and wellbeing should be embedded in the universal early childhood development system

Embedding mental health and wellbeing in Australia's universal early childhood development system must be a core design principle. EIAC has already set the right foundations: early childhood education and care and maternal and child health as universal entry points, well-connected to developmental and disability supports and schools. Mental health and wellbeing ought to be explicitly named as an integral part of this system from the start, to build the founddations for lifelong mental health and wellbeing. We recommend adding it to the depiction of the universal ECD system spine, shown below (from EIAC's 2025 report).



Mental health and wellbeing needs to be incorporated into universal child health checks

The new National Guidelines for including mental health and wellbeing in Early Childhood Health Checks[93] provide a nationally consistent approach to supporting children's mental health from birth. They make clear that mental health is a core part of child development, not just the absence of illness, but the social, emotional and behavioural foundations that grow over time and are influenced by family wellbeing.

The Guidelines also highlight the critical role of a child's environment. Housing stability, financial security, caregiver mental health, access to early learning, safety and culture all shape children's outcomes. When these needs are not met, interventions are less effective.

Government has signalled its intention to expand universal child development checks across maternal and child health, early childhood education and general practice, as recommended by the NDIS Review. Embedding the mental health and wellbeing Guidelines in this expansion is a major prevention opportunity that will help families identify concerns early.

Critically, identification must be backed by timely support. Our early childhood development systems must be designed not only to identify early mental health and wellbeing concerns, but to respond to them.

Child maltreatment is a major cause of mental ill health that can be prevented

Childhood maltreatment is one of the largest preventable contributors to mental ill-health in Australia, [94] with significant long-term economic and social impacts. [95]

Although maltreatment crosses all demographic backgrounds; rates are higher in families facing socioeconomic hardship and other overlapping risks such as racism, gender-based violence, intergenerational trauma and housing stress. International evidence shows that policies which reduce family stress, such as affordable housing and income supports, together with initiatives that build capabilities such as integrated child and family hubs, and sustained nurse home-visiting programs make a difference. [96] Strengthening access to support that strengthens parenting skills, reduces family stress and prevents harm could be game changing.

Strong connections are needed between Kids Mental Health Hubs, Perinatal Mental Health Centres and local child and family hubs opening across Australia

More than 460 local child and family hubs of various types operate across Australia. These hubs bring together supports across health, education and social care and give families a welcoming local entry point to services, as well as opportunities to build social connections. They are often co located with early years services, primary schools, Aboriginal Community Controlled Organisations and primary health care. This approach is gaining momentum, with models integrating health, education, social care, legal and financial support to meet the diverse needs of families.[97]

Building stronger connections between these local hubs and specialist Kids Mental Health Hubs and Perinatal Mental Health Centres can improve access to targeted support for families who need it. This is especially important in areas where specialist infant and child mental health workforces are limited. [98]

Models such as hub and spoke arrangements, and local mental health and wellbeing roles that are connected into local child and family hubs should be explored to particularly uplift capability and across regional and remote areas.

Absent a currently national plan for local hubs should be set up, the **National Child and Family Hubs Network** is helping build a cohesive approach and drive coordinated efforts to optimise hubs and improve outcomes for children, families and communities.

Schools are a powerful universal platform for prevention

Schools offer a universal platform to build children's and young people's mental health skills, identify emerging concerns and connect students with specialist supports. The effectiveness of school based mental health interventions is well established. [99] However, the current landscape is cluttered and fragmented, with varied use of evidence-based programs, duplication in some areas and significant gaps and inequities in others

The new Better and Fairer Schools Agreement is a major opportunity to embed a coordinated approach to mental health in education and strengthen links between schools and mental health services. The commitment by Health, Mental Health and Education Ministers to better integrate supports and improve "wellbeing for learning and engagement" as a core priority is very welcome. This includes stronger connections between schools and other services and initiatives such as in school wellbeing coordinators and mental health workers.

The upcoming review of the national Measurement Framework for Schooling must include mental health sector expertise and support nationally consistent tools for measuring student wellbeing.

To deliver shared priorities across the Better and Fairer Schools Agreement and the National Mental Health and Suicide Prevention Agreement, we need Health, Mental Health and Education Ministers need to come together. A practical framework is needed to improve equitable access to promotion, prevention, early intervention and specialist supports through schools, and to ensure existing investments work together effectively.

Attachment 1: The changing national mental health policy and program landscape

The next National Mental Health Suicide Prevention Agreement needs to be negotiated

The current NMHSPA expires 30 June 2026. It underpins collaborative interjurisdictional action on mental health.

The Productivity Commission is scathing about the current Agreement

The Productivity Commission has just reviewed the agreement (final report release forthcoming). Its **interim report** was highly critical, finding the Agreement is not fit for purpose and fundamentally flawed. Outputs have not translated to meaningful system reform; some are yet to be delivered.

The PC highted key commitments in the Agreement are not funded, such as the National Mental Health Workforce Strategy and funding to enable collaboration between different parts of government working to improve mental health and suicide prevention outcomes.

The interim report calls for governments to urgently:

- resolve the commissioning and funding responsibilities for psychosocial supports outside the NDIS - a service gap affecting 500,000 people.
- release the long-delayed National Stigma and Discrimination Reduction Strategy. Intended to tackle stigma and discrimination across financial services, education and training, employment, social services, income support and housing, the current status of it is unclear. The **National Mental Health Commission** led its development and delivering a draft to Government in June 2023.
- release comprehensive guidelines on regional planning and commissioning for primary health networks to deliver greater access to mental health and suicide prevention services.

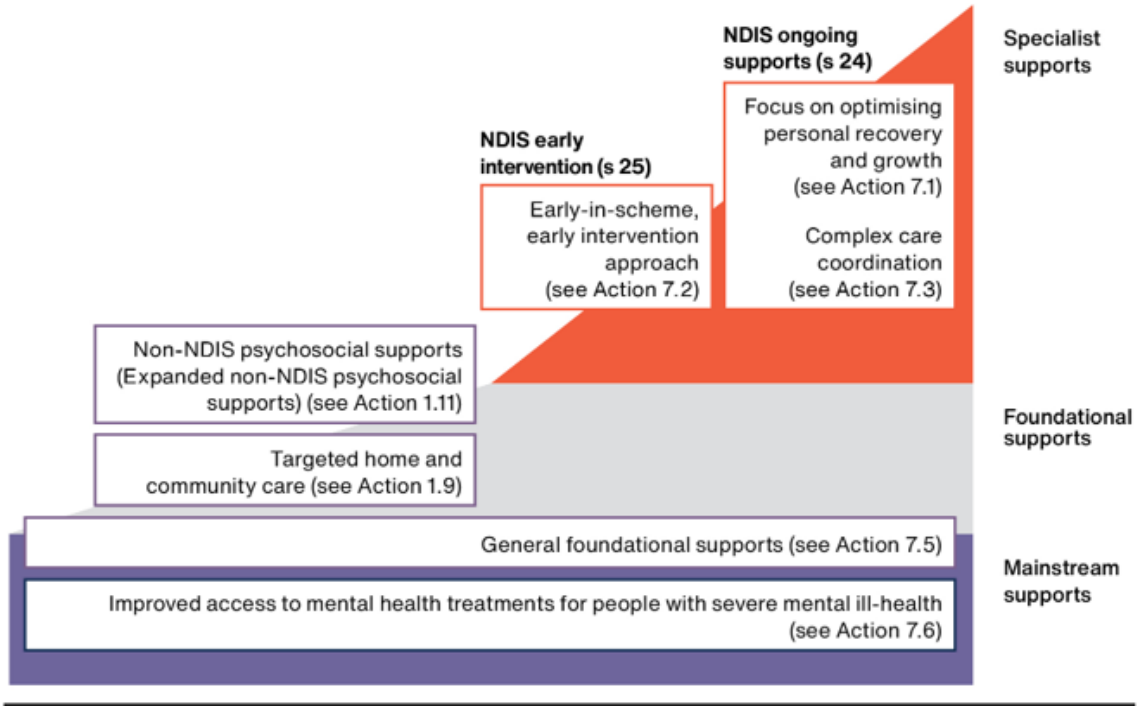
New mental health commissioning guidelines expected for Primary Health Networks

The sector is eagerly awaiting the outcomes of national review of PHN mental health commissioning and the Mental Health Flexible Funding Stream. The Review is being conducted by the Department of Health and Aged Care.

The NDIS Review provided a vision for continuum of mental health and psychosocial support

The **NDIS Independent Review** (2023) provided a vision for a connected system of mainstream, foundational; supports (outside NDIS) and NDIS supports (reproduced below). Mainstream supports include those universally available and delivered through adjacent systems: health, education; employment services; housing etc. It envisages navigators to advise and assist with connecting with NDIS, mainstream and foundational supports.

Figure 7: Overview of the continuum of mental health and psychosocial support



Negotiations on the delivery of foundational supports, including psychosocial supports outside of NDIS are underway

Following the NDIS review, governments have agreed to establish an enhanced and connected ecosystem of mainstream and foundational supports (general and targeted) outside of the NDIS.

General foundation supports (available to all):
Include information, individual and family capacity-building. Priority areas: mutual peer support; recovery colleges where people can learn about mental health; family psychosocial education. Outside the exploring ILC program, it is unclear if advanced have been made.

Targeted foundation supports (rationed)
Expanded psychosocial supports. Governments have agreed to joint responsibility for expanding psychosocial supports outside the NDIS.[100] Jointly commissioned analysis identified huge unmet need of around 500,000 people.[101] Progress appears to have stalled.

NDIS Review recommendations for in Scheme reforms are yet to be acted on

Key in-Scheme reforms called for by the **NDIS Independent Review**:

- A new approach to psychosocial disability in the NDIS based on personal recovery and optimising independence (Action 7.1). Access and assessment processes to be tailored to the specific needs of participants with psychosocial disability, delivered more consistently and equitably, including through an uplift in the capability of NDIA staff. Navigators should have competencies in

psychosocial supports to assist people to access evidence-based NDIS, mainstream and foundational services.

- A time limited early intervention pathway for most new participants with psychosocial disability (Action 7.2). It will deliver evidence-based psychosocial early interventions: supported employment, support to find and maintain housing, illness self-management, cognitive remediation, family psychosocial education and social skills training
- Integrated complex care coordination approach with public mental health systems (Action 7.3). A joint initiative between the NDIS and public mental health systems for participants with complex support needs and active mental health management issues.

New models for youth mental health supports are being developed

A sector-led review has provided advice to the Department of Health and Aged Care on new/refined youth mental health models of care to better meet needs now and into the future.

Related government commitments include strengthening and expanding youth mental health care, including through establishing Youth Specialist Care Centres. Funding is also being directed to upgrade existing headspaces centres, increase access to multidisciplinary care, and scale outreach and digital supports so more young people can get help earlier. Final outcomes of the review are yet to be announced.

Existing national strategies related to mental health

(note: there is no national mental health strategy)

National Suicide Prevention Strategy 2025-35

This new Strategy is intended to drive a long term, whole of government approach to reducing suicide by addressing the social, economic and cultural factors that contribute to suicidal distress. It is designed to strengthen early intervention, improve responses after a suicide attempt, and ensure supports are coordinated across systems such as health, housing, education and justice.

The PC's review of the NMHSPA recommends that the next Agreement include a dedicated suicide prevention schedule that aligns with the Suicide Prevention Strategy and focuses on actions outside clinical mental health care, monitoring and reporting.

National Mental Health Workforce Strategy 2022–2032

Workforce shortages are one of the most urgent system challenges. The Workforce Strategy sets out agreed actions for governments and the sector to attract, train, support and retain the workforce needed to meet current and emerging demand for mental health services.

Priority actions include increasing access to training through more subsidies, placements and traineeships; targeted measures to grow and sustain the community-managed mental health and lived experience workforces; national standards and accreditation to support safe and sustainable delivery of low-intensity services; and implementing key

recommendations of the Scope of Practice Review to enable primary care and allied health professionals to work to their full scope.

Substantial additional investment is needed to progress the Strategy's immediate and high-impact actions. The Productivity Commission's review of the NMHSPA highlights the need for the next Agreement to directly support delivery of the Workforce Strategy, with clear commitments, timelines, and explicit funding responsibility for workforce development.

National Children's Mental Health and Wellbeing Strategy 2021

The Children's Strategy provides a national framework for prevention and early intervention across family, education and community settings. It outlines what is needed for a well-coordinated system that supports children's development and wellbeing, with earlier responses to emerging concerns.

Key priorities include: building mental health capability in early education and family services; stronger coordination across health, education and social services; integrated child and family hubs that make it easier for families to navigate support; research and evaluation to improve evidence and guide investment.

Progress has been uneven. Navigation support, cross-system integration and capability building in education settings have not advanced at the consistency or scale needed, leaving significant gaps in early help for children and families.

The Productivity Commission has recommended that the next National Mental Health and Suicide Prevention Agreement explicitly align with and deliver on the Children's Strategy, including clear actions, timelines and funding.

Aboriginal and Torres Strait Islander peoples

Gayaa Dhuwi (Proud Spirit) Declaration and Implementation Plan

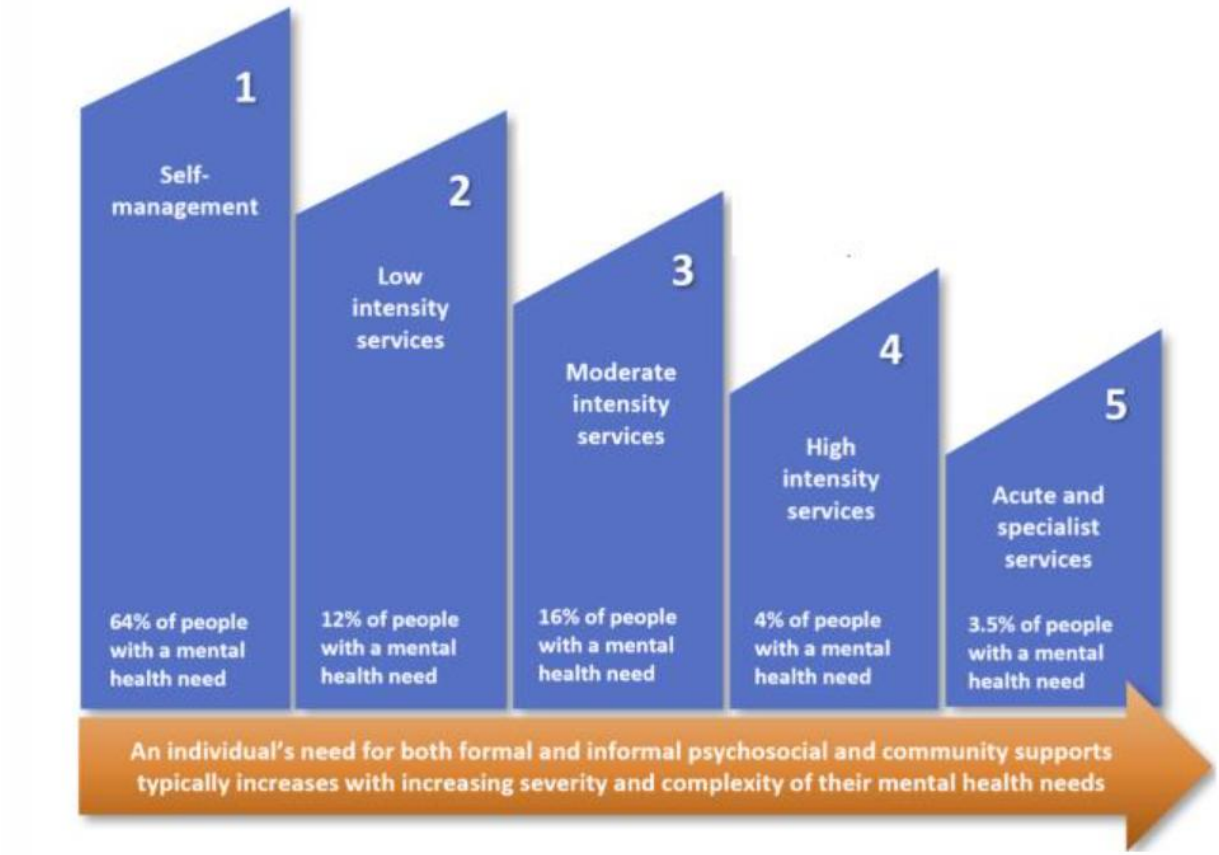
Led by Aboriginal and Torres Strait Islander mental health organisations and leaders, the Declaration sets a national expectation for culturally strong mental health and social and emotional wellbeing supports for Aboriginal and Torres Strait Islander peoples.

The Productivity Commission has stressed that the next NMHSPA must include a new schedule co-designed with Aboriginal and Torres Strait Islander peoples to reflect community priorities and strengths. This should include dedicated outcome measures and a community-led evaluation to guide future investment. Clear links are also needed between the Agreement and the broader Closing the Gap architecture, including the Social and Emotional Wellbeing Policy Partnership and the Gayaa Dhuwi Declaration.

Attachment 2: terminology and taxonomy of stepped care

Term	Definition	Key prevalence data	Data sources	Notes
Mental disorder (mental illness)	Clinically significant disturbance in cognition, emotional regulation or behaviour (includes anxiety, affective and substance use disorders).	• 42.9% lifetime prevalence (16–85 years). • 21.5% 12-month prevalence (17.2% have a 12-month anxiety disorder). • 38.8 percent of 16–24-year-olds have a 12-month disorder.	ABS National Study of Mental Health and Wellbeing 2020–21	Most common reason for GP visits.
Psychological distress (symptom indicator, not a diagnosis)	Feelings of anxiety, depression and agitation affecting daily life (Kessler scales).	• 15.4% of adults report high or very high distress. • 20% of young people. • Higher among low-income, unemployed and renters.	ABS 2020–21; NMHC analysis of HILDA, National Report Card 2024	Strong link to unemployment, poverty, suicide risk.
Psychosocial disability	Functional impairments from mental illness that limit daily living, relationships and participation.	• 6.5% of adults (1.7m people) by self-report • 65,272 NDIS participants (primary psychosocial disability).	ABS Survey of Disability, Ageing and Carers (SDAC) 2022; NDIA Quarterly Reports	High rates of isolation, poverty, homelessness and justice involvement.
Severe mental illness	Causes major role impairment and requires multidisciplinary care.	• Around 3.3% of adults per year.	Productivity Commission Mental Health Inquiry (2020)	Includes psychotic illness, severe bipolar, severe depression.
Severe and persistent mental illness	Severe mental illness that is ongoing, complex and disabling.	• About 1.1% of adults.	National Mental Health Service Planning Framework (NMHSPF)	Requires long-term coordinated clinical and psychosocial supports.

Primary Health Network model of stepped care



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[1] ABS (2025) **Psychosocial disability in Australia: Key findings from SDAC 2022**. Note: The ABS 2022 psychosocial data uses new definitions, beware comparing with earlier surveys. **And** ABS **Employee Earnings May 2023**, ABS **Labour Force Sept 2025**

[2] National Mental Health Commission. (2025) **National Report Card 2024** (Using HILDA Survey Data from 2023)

[3] SANE Australia (2021) **National Stigma Report Card: Employment and Education**.

[4] P McGorry et al. (2024). **The Lancet Psychiatry Commission on youth mental health**. The Lancet Psychiatry, Volume 11, Issue 9, 731 – 774, p733

[5] National Mental Health Commission (N.D.) **Contributing Life Framework**

[6] Monash University (2025) ***The Growing Divide: Income Inequities in Access to Mental Healthcare in Australia***. Centre for Health Economics Working Paper, Monash University, Melbourne.

[7] MHA and University of Canberra (NATSEM) **Mapping Mental Health Care** tool

[8] Australian Institute of Health and Welfare, Australian Burden of Disease Study (2023) **Mental health conditions and substance use disorders a leading cause of disease burden in 2023**

[9] AIHW (2025) **Expenditure on mental health services** and AIHW (2024) **Health expenditure Australia 2022–23**

[10] Department of Health and Aged Care (2022) **National Mental Health Workforce Strategy 2022-2032**

[11] Productivity Commission (2020) **Inquiry into Mental Health [Final Report].**

[12] Butterfly Foundation (2024) **Paying the Price**

[13] ABS, **National Study of Mental Health and Wellbeing** 2020-2022

[14] Health Policy Analysis for Australian Governments (2024) **Analysis of unmet need for psychosocial supports outside of the National Disability Insurance Scheme – Final Report**.

[15] Australian National University (2024) **Don't Walk By: Unmet Need in Chronic Severe Mental Health Conditions**

[16] Department of Health and Aged Care (2022) **National Mental Health Workforce Strategy 2022-2032**

[17] Productivity Commission (2025) Report on Government Services 2025, **Section 13: Services for Mental Health**

[18] P McGorry et al. (2024). **The Lancet Psychiatry Commission on youth mental health**. The Lancet Psychiatry, Volume 11, Issue 9, 731 - 774

[19] Australian Institute of Health and Welfare, Australian Burden of Disease Study (2023) **Mental health conditions and substance use disorders a leading cause of disease burden in 2023**

[20] AIHW (2025) **Expenditure on mental health services** and AIHW (2024) **Health expenditure Australia 2022–23**

[21] KPMG and Mental Health Australia (2018) **Investing to Save: the economic benefits for Australia for investment in mental health reform**

[22] AIHW (2024) **Suicide & self-harm monitoring**

[23] Monash University (2025) ***The Growing Divide: Income Inequities in Access to Mental Healthcare in Australia***. Centre for Health Economics Working Paper, Monash University, Melbourne.

[24] MHA and University of Canberra (NATSEM) **Mapping Mental Health Care** tool

[25] M Goodyear et al. (2024) **Scoping child mental health workforce capability: Final report.**

[26] ABS (2023-24), **Patient Experiences 2023-2024 financial year**,

[27] Productivity Commission (2025) **Mental Health and Suicide Prevention Agreement Review [Interim Report]**

[28] Black Dog Institute (2024) **Navigating Australia's mental health system in 2024: Consumer report.**

[29] National Mental Health Commission. (2025) **National Report Card 2024** (Using HILDA Survey Data from 2023)

[30] AIHW (2023) **Suicide and Self-harm Monitoring. Trends in Indigenous suicide rates**

[31] ABS (2022) **National Aboriginal and Torres Strait Islander Health Survey**; NMHC (2025) **National Report Card 2024**

[32] Brain and Mind Centre (2022) **Strategic, Systemic and Structural Options for Mental Health Reform in Australia**, Sydney University

[33] Nous (2022),, **Independent Evaluation of HeadtoHelp and AMHCs Final Report** Department of Health

[34] ALIVE National Centre for Mental Health Research Translation (2024) **Early implementation findings from co-evaluation research of Medicare Mental Health Centres delivered by Neami**.

[35] Medicare Mental Health Centres **National Service Model** 2025

[36] Dandalo Partners et al. (2025) **Sector led advice on new and/or refined models of youth mental health care**

[37] Media Release (8 April 2025) **Labor to deliver $1 billion for more free mental health services**

[38] **Medicare Mental Health Kids National Service Model**

[39] Honisett S., et al. (2023) **Child and family hubs: an important 'front door' for equitable support for families across Australia**, National Child and Family Hubs Network

[40] Health Policy Analysis for Australian Governments (2024) **Analysis of unmet need for psychosocial supports outside of the National Disability Insurance Scheme – Final Report**

[41] MHA (2025) **Renewed Statement on Addressing Unmet Need for Psychosocial Support Outside the National Disability Insurance Scheme**

[42] MHA and the National Mental Health Consumer and Carer Forum (2024) **Advice to governments on evidence-informed and good practice psychosocial services**.

[43] AIHW (2024) **Specialist Homelessness Services Collection data cubes 2011–12 to 2023-24**. Most recent data identify 3,952 people who accessed a specialist homelessness support service, who also had a diagnosed mental health condition and a disability such that they required assistance in one or more core activity areas. 47% of this group (1,875 people) were homeless at the time of requesting assistance, while the remainder were at risk of homelessness. Show 41% increase over time

[44] Productivity Commission (2020) **Inquiry into Mental Health [Final Report].** Reported that more than 31,000 are experiencing or at risk of homelessness have an unmet need for long-term housing; over 2,000 are stuck in institutional care because of a lack of other options; many more are living in "unsuitable accommodation"

[45] Mandala Partners (2024) **The Social Dividend: An Actuarial Case for Higher Income Support**

[46] Australian Council of Social Service (ACOSS) & UNSW Sydney (2025). **Poverty in Australia 2025**

[47] AIHW, **Suicide & self-harm monitoring**

[48] Parliament of Australia (2024) **Rebuilding Employment Services**, Report of the Select Committee on Workforce Australia Employment Services.

[49] Economic Justice Australia (2025) **Briefing: Analysis of payment cancellations under 42AM of the Social Security Administration Act 1999**

[50] Economic Justice Australia (2025) **Briefing: Concerns regarding the Integrity of the Targeted Compliance Framework**

[51] Mandala Partners (2024) **The Social Dividend: An Actuarial Case for Higher Income Support**

[52] AIHW, **Mental Health Income & employment support data** (last updated July 2024)

[53] Economic Justice Australia (2024) **Disability Support Pension: Program of Support – Briefing and Reform Recommendations**. See also Economic Justice Australia (2021) **Report: Barriers To Disability Support Pension Access For People With Psychiatric Impairments And Their Experiences On Jobseeker Payment**

[54] Parliament of Australia, Question on notice no. 245, portfolio question number: SA SQ24-000944

2024-25 Supplementary budget estimates, Community Affairs Committee, Services Australia Portfolio, 15 November 2024

[55] Productivity Commission (2020) **Inquiry into Mental Health [Final Report].**

[56] D Threlfall et al. (2025) **Access Denied: Psychosocial disability and the NDIS**, Australian Psychosocial Alliance (APA).

[57] ASIC and Beyond Blue (2022) **Money and Mental Health Social Research Report.**

[58] AIHW, **Suicide & self-harm monitoring**

[59] AIHW, **Welfare 2025**

[60] ABS (2025) **Psychosocial disability in Australia: Key findings from SDAC 2022**. Note: The ABS 2022 psychosocial data uses new definitions, beware comparing with earlier surveys.

[61] ABS **Employee Earnings May 2023**, ABS **Labour Force Sept 2025**

[62] AIHW: **Psychosocial disability — income & employment support *(2022–23)***, **NDIA Quarterly Reports *(2023–24)***

[63] AIHW, **Mental Health Income & employment support data** (last updated July 2024)

[64] Productivity Commission (2020) **Inquiry into Mental Health [Final Report].** Vol 3, Ch 19: Income and employment support

[65] Productivity Commission (2020) **Inquiry into Mental Health [Final Report].** Vol 3, Ch 19: Income and employment support

[66] Parliament of Australia (2024) **Rebuilding Employment Services**, Report of the Select Committee on Workforce Australia Employment Services.

[67] OECD **Mental Health and Work**; Bond, G et al. (2020). **Individual Placement and Support (IPS): An evidence-based approach to supported employment.** *World Psychiatry*, 19(3), 390–391.

[68] M Modini et al. **Supported employment for people with severe mental illness: systematic review and meta-analysis of the international evidence.** *British Journal of Psychiatry*, 209(1), 14–22.

[69] H Bruggeman et al. (2024) **The relationship between mental health and employment: a systematic review of cohort studies**, *European Journal of Public Health*, Volume 34, Issue Supplement_3, November 2024, ckae144.1106

[70] N Telford et al (2024) **Mental Health Outcomes for Young People Accessing Individual Placement Support Services: A Cohort Study**. *Journal of Primary Care & Community Health*. 2024;15. doi:**10.1177/21501319241296786**

[71] KMPG (2019) **Evaluation of the Individual Placement and Support Trial**; KPMG (2020), **Report on value for money of the IPS Trial**. Both reports prepared for the Department of Social Services.

[72] J Meagher and G Naughtin (2018) "Scope, role and contribution of peer work," in Peer Work in Australia: A new future for mental health, ed. J. Meaghre et al, PRA and Mind Australia

[73] National Mental Health Consumer & Carer Forum (2025), **The peer workforce: advocacy brief**

[74] T Lee et al. (2024) **Aboriginal and Torres Strait Islander Lived Experience-led Peer Workforce Guide:** Black Dog Institute

[75] Menzies School of Health Research (2022). ***Evaluation of the Two Ways Mentoring Program*.**

[76] MHCC (2025) **Ten years of peer work** (web content and video)

[77] T Lee et al. (2024) **Aboriginal and Torres Strait Islander Lived Experience-led Peer Workforce Guide:** Black Dog Institute; NMHC (2023) **National Lived Experience (Peer) Workforce Development Guidelines**

[78] SANE Australia (2021) **National Stigma Report Card: Employment and Education**.

[79] EPM Brouwers (2020) **Social stigma is an underestimated contributing factor to unemployment in people with mental illness or mental health issues: position paper and future directions**. *BMC Psychol* **8**, 36 (2020).

[80] Safe Work Australia (2022) **Model Code of Practice: Managing Psychosocial Hazards at Work.**

[81] Australian Institute of Company Directors. (2025). **Governing WHS psychosocial risks**.

[82] National Mental Health Commission (2024) **Blueprint for Mentally Healthy Workplaces**.

[83] C Kobel et al. (2024) **National Baseline Report for Mentally Healthy Workplaces**, National Mental Health Commission,

[84] ABS (2022) **National Study of Mental Health and Wellbeing**

[85] ABS (2022) **National Study of Mental Health and Wellbeing**

[86] Royal Australian College of General Practitioners (2024). **General Practice: Health of the Nation 2024**.

[87] ABS (2022) **National Study of Mental Health and Wellbeing**

[88] M Mulraney et al. (2021) **A systematic review of the persistence of childhood mental health problems into adulthood**. Neuroscience & Biobehavioral Reviews, 129, 182-205.

[89] M Goodyear et al. (2024) **Scoping child mental health workforce capability: Final report**. Emerging Minds. See also D Lawrence et al (2023). **Regional estimates of child and adolescent mental disorders [Data set]**, Curtin University.

[90] AIHW (2025) **Targeted analysis.**

[91] M Solmi et al. (2022) **Age at onset of mental disorders worldwide: Large-scale meta-analysis of 192 epidemiological studies**. Nature: Molecular Psychiatry, 27(1), 281–295.

[92] C Mihalopoulos et al (2019) **The economic case for investing in mental health prevention**. National Mental Health Commission, Canberra.

[93] National Mental Health Commission (2025) **National Guidelines for including mental health and wellbeing in early childhood health checks**.

[94] DM Haslam et al.E. (2023) **The Australian Child Maltreatment Study (ACMS), a national survey of the prevalence of child maltreatment and its correlates: methodology**. Medical Journal of Australia,

[95] L Grummit et al.(2024) **The Burden of Mental Disorders and Suicide Attributable to Child Maltreatment in Australia**. JAMA Psychiatry.

[96] K Maidment et al. (2024) **Preventing child maltreatment to prevent mental ill-health**. Prevention United.

[97] S Honisett et al.(2023) **Child and family hubs: an important 'front door' for equitable support for families across Australia**. National Child and Family Hubs Network.

[98] M Goodyear et al. (2024) **Scoping child mental health workforce capability: Final report.**

[99] L Birrell et al. (2024) **School-based mental health and wellbeing programs. What's working, what's not?** Prevention United.

[100] Health and Mental Health Ministers (2025) **Joint Health and Mental Health Ministers' Meeting Communique.**

[101] Health Policy Analysis for Australian Governments (2024) **Analysis of unmet need for psychosocial supports outside of the National Disability Insurance Scheme – Final Report**.