Mental Health
Community Coalition ACT

# MHCC ACT Response to the Mental Health NGO Commissioning Sector Investment Plan

July 2025

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# Acknowledgements

## Acknowledgement of Country

Mental Health Community Coalition ACT is located on Ngunnawal Country. We acknowledge the Traditional Custodians of the land. We pay our respects to their Elders, past and present. We further acknowledge all Aboriginal and Torres Strait Islander Traditional Custodians and Country and recognise their continuing connection to land, sea, culture and community.

## Acknowledgement of mental health lived experience

We also acknowledge the individual and collective expertise of those with a living or lived experience of mental health. We recognise their vital contribution at all levels and value the courage of those who share this unique perspective for the purpose of learning and growing together to achieve better outcomes for all.

# About MHCC ACT

The Mental Health Community Coalition of the ACT (MHCC ACT) is a membership-based organisation which was established in 2004 as a peak agency. It provides vital advocacy, representational and capacity building roles for the Not for Profit (NFP) community-managed mental health sector in the ACT. This sector covers the range of non-government organisations (NGO) that offer mental health recovery, early intervention, prevention, health promotion and community support services.

Our members make up two-thirds of Canberra's mental health system and include Canberra's soup kitchens, childcare centres, domestic violence shelters, health services for marginalised groups, and more.

We advocate for a mental health system that offers people support and belonging within their community.

For more information contact:

Lisa Kelly
CEO
Lisa.kelly@mhccact.org.au

# Executive Summary

Thank you for the opportunity to provide feedback on the Mental Health NGO Commissioning Strategic Investment Plan (SIP). We welcome the initiative to better meet the mental health needs of the Canberra community through an evidence-informed and collaborative approach. We recognise the development of a Sector Investment Plan as a necessary step towards a more sustainable and outcomes-focused mental health system in the ACT.

In achieving its aim, the SIP articulates clearly and effectively an overview of the entire ACT mental health system and its complexity, whilst also noting that the investment is only in the ACT Health-funded NGO subsector. The expectation was that the SIP would clarify how the specific allocation of funding for the subsector will be used- what specific outcomes, consumers, or services it is targeting, and to what end. The SIP lacks the detail needed to define the investment being proposed from the entirety of the Mental Health system. Rather it provides a high-level view of the depth and breadth of need, the range of outcomes possible, a long list of possible service models, and the diversity of consumers across the continuum of mental health and wellbeing. It fails to deliver clarity on what specifically is or is not being purchased for the approx. $6m investment in services across the lifespan outside of residential, advocacy, capability building and investment in an ACCO.

The intent of Commissioning was to implement “a new way of designing, funding, and delivering a fit for purpose human services system within the ACT. It is a methodology that ensures our system and the services and programs within it are meeting the needs of the community” (ACT Government, 2025). The SIP proposes options for procurement processes that mirror those that have been used traditionally. It continues to focus on procurement related to a bucket of funding through mostly select or open competitive tenders. The SIP does not provide options that include a new way of designing procurement or funding distribution. We urge the Directorate to consider ways of procuring services that better align with the delivery of human services and ensure the aims of commissioning are met.

MHCC has been in consultation with our members and others from across the community services sector to inform this response. Our submission includes direct feedback on the current plan, requests for further clarity, as well as proposed option to enhance the functionality of the SIP.

# Summary of Recommendations

1.1 The Directorate revise the use of pillars and consider structuring the investment around outcomes for particular target groups or themes more aligned with those identified in the design listening report.

2.1 The Directorate revise service model examples and outcomes included in the funding streams to clearly exclude what is already funded or outside the scope of this investment

2.2 The Directorate identify the priority pillars, outcomes and target groups for each funding stream

3.1 Outcomes are redefined to focus on system changes or enhancements that will positively impact the experience of consumers and carers

3.2 That supplementary material is provided that aligns the proposed outcomes with other existing Mental Health Outcome Frameworks

3.3 Refine the outcomes in the MH SIP to ensure that they are measurable and have a direct correlational or causational link.

4.1 Should the government continue to want to invest in a Service Innovation Fund than this should be resourced proportionately by residential, child, youth and family, Aboriginal and Torres Strait Islander and the adult, older people and people with co-occurring needs funding streams.

4.2 Funding increases to one stream should not be at the cost of another stream without further evidence to support that demand for service delivery has lowered in one stream while increasing in another.

4.3 Should recommendation 4.2 not be adopted than we present two options for consideration:

a. the government consider removing a pillar from the adult stream to ensure service delivery is prioritised in streams where there is less federal investment.
b. service supports for people with co-occurring AOD and MH needs would be best met through the work being undertaken by the ATOD-MH Alliance

5.1 It is recommended the government provides greater transparency of the factors contributing to the decision to conduct select tenders for the residential and advocacy streams.

5.2 It is recommended that government consider revising the proposed procurement methodology identified in the SIP and consider the following options:

5.2.1 Conduct select tenders of existing providers and work with the providers to design an outcome framework and redesign the services provided to reach the desired outcomes; or

5.2.2 Concurrently conduct the procurement for the Mental Health Child, Youth, and Families funding stream with the CSD Children, Youth and Family Services procurement process; and

5.2.3 Conduct a procurement process to identify a panel of suitable providers who will work collaboratively to design a collective service response and funding allocation to meet the outcomes of the Adult, Older Person and Co-occurring needs funding stream; or

5.2.4 Delay the procurement process until such time that it can run as a concurrent process with the upcoming psychosocial needs procurement process.

6.1 It is recommended the government considers a delay to the procurement process, particularly for the open tender funding streams until more work can be undertaken to understand the current context and develop a clearer sense of the gaps this funding will address.

# Comment on Commissioning

The current commissioning model continues to reinforce siloes over integration, resulting in service gaps that leave those with complex or intersectional needs underserved. This is particularly apparent in the mental health space. While people living with co-occurring mental health and AOD needs and people with mental health and justice involvement are mentioned as a target group subset there is little to no mention of people living with other co-occurring needs such as domestic violence, homelessness, poverty, chronic health conditions to name a few. Where co-occurring needs are identified in the SIP this is limited to just one of the five funding streams, this contradicts a growing body of evidence that show the reality is that many, if not most, mental health consumers experience intersecting challenges and would have needs across multiple service systems and envelopes of funding.

To create meaningful change, the SIP must acknowledge and reflect this reality. Addressing intersectionality and complexity in the framing of service design is essential to upholding the principle of person-centred care established during the Design Phase of this Commission. Population health data shows that nearly 50 per cent of alcohol and drug use occurs among people with severe mental health problems (Victoria Department of Health, 2015). Queensland Health's 2021 policy position states that "consumers with co-occurring substance use disorders and other mental health disorders are the expectation, not the exception, in MHAOD service systems." This raises an important design question: should comorbidity be treated as a discrete target group, or should it be addressed as a central outcome of a service system designed to respond to complexity?

To continue to procure based on demographics, consumer characteristics, stage of continuum, or funding envelopes does not address system failures, and prevents us from making the system changes that were clearly articulated in the Design phase. It is essential to assess whether the investment approach defined in the SIP supports the definition of Commissioning as "a new way of designing, funding, and delivering a fit for purpose human services system within the ACT. It is a methodology that ensures our system and the services and programs within it are meeting the needs of the community" (ACT Commissioning, 2024).

There is no doubt that the mental health space has some of the highest levels of complexity and breadth. There remains a question however on whether the proposed procurement processes respond well to this complexity and meet the principle of contextual and flexible: "no single way to go about commissioning. Each interaction will respond to complexity, cultural practices, safety, context and the breadth of issues at hand" (ACT Commissioning, 2021).

In consulting on the SIP the questions that continued to be raised by the sector included:

> Do we understand the change that we are trying to make? Do we have a vision for the outcome we are seeking to achieve? Have we spent enough time/focus/energy/considered thought into the changes we are seeking at a system, service, consumer and community level? Have we understood and prepared for the impact the change will make? Have we adapted our approach and thoughts from the experiences of the sectors that have gone before us?

People are complex, mental health is complex, the service system is complex, our understanding of the issues, intersectionality, help-seeking behaviours, brain and biology, interactions between environment and health, impact of modern life is complex and developing. Minds have been working on how to understand and respond to this complexity for decades. In terms of the funding bucket that has traditionally been managed in this silo called "mental health" which we are now seeking to

procure services in, have we spent enough time understanding the complexity and seeking to find new solutions?

# Connection to the Design Phase

We are concerned that there is a lack of cohesion between the design phase and the SIP. This is in small areas such as suggestions to remove funding silos and competitive approaches to service delivery, to larger areas where the focus in design on service design, sector reform, and target groups has shifted to a focus in the SIP on pillars and age/service type based funding streams. While themes such as accessibility, navigation, workforce and collaboration, all strong in the design documents, are present in the preamble of the SIP, they are all but silent in the funding streams and outcomes. The design phase explored outcomes relating to the experience of care that a service provides but these are not reflected in the SIP.

Sector providers are struggling to link the pillars in the SIP with the target groups and needs identified in the design and are confused by what the service system we are designing will look like. Conversations have moved from accessibility and collaboration to designing a program in isolation to the service system and the experience of the consumer. The different pillars in the SIP overlap with each other and are presented as being separate building blocks of a system rather than phases of intervention across demographics or particular target groups. Designing a service system separated into the pillars may actually increase siloing and reduce integration.

## Recommendation 1 – Design

**1.1 The Directorate revise the use of pillars and consider structuring the investment around outcomes for particular target groups or themes more aligned with those identified in the design listening report.**

# Clarity of investment

We recognise the mental health system is a complex and multifaceted landscape, with services funded across multiple levels of government. Mental health and wellbeing spans the whole population with a depth and breadth not replicated in other areas of human services. The SIP reflects this complexity well, providing a broad overview of the service system across the lifespan and continuum of mental health/wellbeing/illness. While this context is valuable, it is also overwhelming and the scope of what can be delivered through the available funding envelope is enormous.

We acknowledge that this Commissioning process is scoped only in the context of the ACT Health-funded NGO subsector, to a total investment of $14m. However, the SIP does not clearly define the limitations of what can realistically be purchased within this funding envelope. After accounting for allocations to residential services, advocacy, capability building, and ACCO support, approximately $6 million remains for investment across children, youth, families, adults, comorbidity and older people. This remaining funding stream suggests service models spanning prevention and promotion, early intervention, community connection and supports, while aiming to deliver to 18 outcome statements. Given the scale and complexity of need outlined in the SIP, it is difficult to see how this level of investment can achieve such broad objectives. As a result, the actual focus and purchasing intent of this investment remain unclear.

The detail in the Funding Streams attempts to provide examples that cover a wide range of programs and outcomes. Acknowledging the intent was to provide scope for organisations to design services rather than prescribing them, the depth of examples and outcomes provided exceed the

scope of what can realistically be delivered with the available funding and thus is causing confusion and concern. Refinement of this section to narrow focus on what is possible would be helpful. For example, both the “Child, Youth and Families” and “Adults, Older people, and People with co-occurring needs” streams include supported accommodation in their suggested service models. Yet $6 million has already been directly allocated to supported accommodation via the "Residential Community Supports" stream. It is therefore unclear if further supported accommodation will be funded in the open tender or if the investment in this has been expended in the select tender process.

We note that a number of the service model examples are replicative of models funded by other parts of government and that some of the outcomes extend beyond the scope of the investment (e.g. increased awareness and understanding of mental health issues by individuals, especially the general population). **We urge the Directorate to revise service model examples and outcomes included in the funding streams to clearly exclude what is already funded**.

A more focused and realistic approach, like that taken by the Child, Youth, and Families Services Program (CYFSP), would ensure funding targets what the service system currently needs to respond to – through specific, achievable outcomes for well-defined sub-populations. For example, CYFSP identifies Target Groups such as “Children, young people, families and carers whose current needs are not being met through universal services and the need for support has been identified early in the life of the challenge they may be facing” (Community Services Directorate, 2025), which is a clearer and more feasible framing than “Child” or “Youth.”

We are not looking to the SIP to define a set suite of activities that will be funded. **Rather we are looking for greater clarity and realism to what can be purchased.** We are seeking a narrower scope of outcomes and a prioritisation of the pillars and target groups. Doing so will help reduce overlap, manage sector expectations, and ensure more targeted and impactful tenders.

Without clarity, there is a risk that the investment will fall short of delivering the comprehensive, integrated, and innovative mental health system the community needs—and will not generate the best possible return on investment.

While we understand that further detail on funding priorities will be provided in the upcoming procurement and request-for-tender phase, **we strongly recommend that this clarity be built into the SIP itself**.

### Recommendation 2 – Clarity

**2.3 The Directorate revise service model examples and outcomes included in the funding streams to clearly exclude what is already funded or outside the scope of this investment**

**2.4 The Directorate identify the priority pillars, outcomes and target groups for each funding stream**

# Framing of Outcomes

In mental health, outcomes can refer to individual care outcomes which ensure consumers benefit from the treatment and care they receive, and they can refer to the outcomes of the mental health system as a whole. While they interact, they are not synonymous with each other, and it would be beneficial for consideration to be given to categorising the outcomes in the SIP into outcomes for:

- an individual consumer in relation to the benefits of care,
- to carers in relation to the benefits of responsive and appropriate care, and

- outcomes at individual and community levels from a connected and supported service system.

Currently the SIP identifies consumer outcomes in all the streams but only identifies system/service outcomes in the sector innovation fund stream.

A focus on consumer outcomes as opposed to a system change outcome shifts the focus of blame or deficit from the system to the consumer. Outcomes like "improved awareness of services" or "improved help-seeking," may indicate a deficit in a consumer rather than a deficit in a system design. As an example, in the context of access by teenagers to mental health providers, framing "improved help-seeking" as an outcome ignores structural barriers- such as services operating only during school hours, or intake models that do not cater to young people's communication preferences (e.g., online chat over phone calls)- in preference for seeing the young person having a need to have better help seeking skills to access a service. **Redefining outcomes to focus on service accessibility** returns the responsibility from the individual to the system and more accurately reflects the changes required to better meet community needs. **It is crucial that the SIP avoids framing mental ill health as a personal failing and instead highlights steps taken towards system reform.**

The Design Phase of the Mental Health Commissioning process pointed to a priority of reducing system fragmentation and improving integrations. This includes suggestions such as co-location, integrated care, shared resourcing to support transitions, opportunities to streamline record keeping and intake systems etc. These are outcomes that are missing from the SIP and are arguably the outcomes that should direct where investment should be prioritised. For example, an outcome of "consumers would be able to access the right service at the right time at the right location" would shape the service design and model of care and provide scope for innovation. Focusing on the outcome for the consumer, such as "increased help seeking to address early emerging mental ill-health", places an emphasis on teaching/educating/fixing something in the consumer rather than addressing the system barriers that impact help seeking, increase stigma, work against resilience etc. **To deliver a service system that provides good outcomes for consumers and carers a re-working of the outcome statements is required.**

Examples of outcomes that could shape a re-write can be found in the CYFSP Commissioning SIP which uses outcomes such as "having access to support at the right time and for the right duration" (Community Services Directorate, 2025). Alternatively, examples of outcome statements that reflect changes in community, services and stewardship can be found in the Victorian Government Outcomes and Performance Framework Mental Health and Wellbeing (Victoria Department of Health, 2024).

We acknowledge that the formation of an outcome measurement framework will be undertaken by the successful providers following procurement, however we urge two things in the interim:

1. How an outcome framework for the services delivered under this funding envelope intersects with other work in progress, in particular the CHN Outcome Framework, the Mental Health Services Plan, the Regional Mental Health and Suicide Prevention plan and outcome frameworks across other sectors such as Alcohol, Tobacco and other Drugs, Homelessness, Child, Youth and Family Services.
2. Refining the outcomes in the MH SIP to ensure that they are measurable and do have a direct correlational or causational link (so are the result or consequence of an action that is taken). Currently a number of the outcomes in the SIP are too broad to be measured, e.g. stigma reduction, or are not a direct consequence of an action taken by services in this funding envelope, e.g. improve social determinants of health.

Whilst the funding under the SIP will contribute to broad outcomes for the community it is not realistic to say that $3 million in funding for Adults, Older people, and People with Complex and Co-

occurring Needs will result in improvements in the social determinants of health for people with co-occurring AOD and Mental Health or people with justice involvement and mental health concerns. While this should absolutely be an outcome of the health system as a whole, including the mental health component of the health system, for fairness to providers and the Directorate it cannot be an outcome for this Mental Health NGO SIP. **Rather, outcomes should be framed as the products that will be obtained by this particular investment**.

While the SIP appropriately acknowledges the challenges faced by diverse priority population groups, it does not yet articulate this with enough clarity or focus on outcomes for these particular groups. For example, outcomes could explicitly include improving quality of life for older people or enhancing wellbeing for carers, etc. Clearly identifying such outcomes ensures these groups will be actively targeted in the procurement process.

### Recommendation 3 – Outcomes

**3.4 Outcomes are redefined to focus on system changes or enhancements that will positively impact the experience of consumers and carers**

**3.5 That supplementary material is provided that aligns the proposed outcomes with other existing Mental Health Outcome Frameworks**

**3.6 Refine the outcomes in the MH SIP to ensure that they are measurable and have a direct correlational or causational link.**

# Spread of Money

There are concerns around the difference between the current and proposed funding breakdown, and how it takes away crucial support for parts of the community.

It is noted that all of the money redistributed in the SIP has come from the Adult, Older People and People with Co-occurring issues stream. While the need is not in dispute there continues to be an existing need in the stream and the shift in funds to fill a gap in one space will simply result in a gap in a different space. It can not be argued that there has been a reduction in need in adults requiring mental health supports so it is difficult to fully understand the justifications given for this reduction. A loss of $2m in funding to this stream will have significant negative impact on service availability.

Should there be agreement for a need for capacity building and that this is to the value of $289,800 then this amount should come from all streams in an equal proportion to the overall distribution of funds. To say that this fund will focus on strengthening the overall mental health system and will be determined through collaboration and negotiation with the newly commissioned NGO Mental Health Sector but have the funding only drawn from the adult stream is unfair to adults requiring supports. This amount equates to at least 2 FTE staff who could be supporting 40 or more adults or older people or people with co-occurring issues per week. There are mixed views in the Sector as to the value of the sector innovation fund and the impact it will have. Given the commissioned services will only form a small part of the mental health sector it could be more beneficial for a fund to be established outside of the commissioning process that is accessible by all who provide mental health services. There are also questions about whether this fund will replace individual organisations training budgets or will be in addition and the impact of this on the level of funds available for direct service delivery.

Without a doubt, investment in early intervention in children and young people is necessary and is evidenced to reduce the lifelong impact of mental illness. This is not disputed. Removing $579,600 from the adult stream to the children, young people and family stream is disputed. There has been

significant investment in child and youth mental health at a federal and territory level over the past five or more years with more promised in the recent federal election. For example, on the 6th June 2025 the Minister for Mental Health announced $9.4 million investment into child and youth mental health services and in late May released the tender for the Youth Trauma Centre.

Co-occurring ATOD and MH issues and the need for service provision was identified very early in the health services commissioning cycle. At the time it was identified that it was not appropriate for this cohort to be incorporated into one sector over another and that this was a risk to a sector approach to commissioning. Further, it was identified that there was a risk that whichever sector went last would be expected to incorporate this target group into their existing funding envelope. This is what has now transpired as the ATOD sector did not specifically incorporate outcomes for people with co-occurring needs into their commissioning or tender process. To remove $2m in funding and include two new cohorts, as arguably older people's mental health needs have not previously been met, is not appropriate and will result in significant service gaps, increased demand and wait times and declines in people's mental health which will increase pressure on the acute mental health space.

Shifting funding from one demographic group to another in a funding envelope that is arguably already too small to meet the needs outlined in the SIP is not a solution to meeting the emerging needs of one group. There is no evidence to support that demand in adults, older people and people with co-occurring needs is declining, in fact as the population ages we can expect to see increasing demand from older people.

**We urge the Directorate to re-examine the allocation of funding** with consideration that an increase in Child and Youth needs does not mean there has been a decrease in the needs of Adult, Older People, and people with complex and co-occurring needs.

Should there continue to be an evidenced need to redistribute funding allocation than there would need to be a consequential reduction in the number of pillars and outcomes in the funding stream where the funding reduction has occurred. Should this continue to be the adult stream then it is suggested that the government consider removing the early intervention pillar from services that are eligible through the investment. With an increased investment in Medicare Mental Health Centres, in addition to the availability of subsidised therapy through Medicare, there has been a steady increase in the availability of support for adults when a mental health issue arises. Given that the majority of enduring mental illness has an onset in adolescence and early adulthood, the majority of new issues arising would be in the mood disorders category for which Medicare is specifically suited. If we have service supports in the community connection and prevention pillars these can be designed to prevent mental health symptoms from worsening for people with enduring mental health conditions. Currently, some of the service models and outcomes in the early intervention pillar of the adult stream are duplicative of services already available outside of this investment.

## Recommendation 4 – Funding Allocation

**4.4 Should the government continue to want to invest in a Service Innovation Fund than this should be resourced proportionately by residential, child, youth and family, Aboriginal and Torres Strait Islander and the adult, older people and people with co-occurring needs streams.**

**4.5 Funding increases to one stream should not be at the cost of another stream without further evidence to support that demand for service delivery has lowered in one stream while increasing in another.**

**4.6 Should recommendation 4.2 not be adopted than we present two options for consideration:**

**a. the government consider removing a pillar from the adult stream to ensure service delivery is prioritised in streams where there is less federal investment.**

b. **service supports for people with co-occurring AOD and MH needs would be best met through the work being undertaken by the ATOD-MH Alliance**

# Forms of Procurement

While the phases of the commissioning process have been, largely, collaborative the one area we haven't spent time discussing is the purchasing phase. The principle of contextual and flexible urges us to consider the complexity of the space and design a process that meets the unique needs of the sector. In Mental Health our context is complex, our size and scope are complex, our funding arrangements are complex, consumers live in intersectionality and our interaction with other systems is complex. The question is whether we have considered if there is a different way to procure services that better meets the principle of contextual and flexible. Could procurement be about identifying a panel of suitable and approved providers who work together to create a new service landscape with the resources available? Who work together to create a joined up, collaborative, connected, integrated system that is accessible and responsive? Could we use a deliberative democratic process to determine what is provided, by who at what cost? Could we collaborate to affect the change we are seeking?

At the commencement of Commissioning one of the agreed principles was transparency. The information provided in the SIP does not provide a satisfactory level of transparency in relation to the decisions made about procurement methodology.

Whilst the SIP asks for guidance on several different staged approaches to procurement, it fails to ask if the proposed procurement methodology is sound. The Design Listening Report points to priorities of reducing system fragmentation and improving integrations. This includes suggestions such as co-location, integrated care, shared resourcing to support transitions, opportunities to streamline record keeping and intake systems etc. While the SIP encourages collaboration and for "providers to work in partnership or in consortia", a competitive tender process may reinforce siloes, reduce innovation and eliminate opportunities to collaboratively build a system response that reduces gaps.

A. Direct Grants for Residential Community Supports

The rationale for this approach is articulated as "given the close partnership of these programs with Canberra Health Services, and their defined role in supporting people to 'step up' into community support" (SIP page 33). This rationale can apply to a range of community mental health service providers and in and off itself does not provide an isolated distinguishing factor for a procurement choice. Further information is needed to understand why this approach is being taken for this select group of services and service providers and how this is significantly different from other groups of services. Additionally, information is needed to ensure that the current providers are delivering high quality care that is not able to be replicated by others. A direct grant process is also problematic to current service providers as it prevents rescoping of costs, outputs and outcomes and locks the providers into another contract cycle without changes to these. **We also question that if service system refinement can be achieved through existing service providers, then this rationale can also apply to the part of the system going to open market procurement.**

B. Direct approach for individual advocacy

Further information is needed to understand why this approach is being taken for this service. Whilst supportive that the service should not be provided by a provider of mental health services, there are multiple options of service providers available. A direct grant process is also problematic to the current service providers as it prevents rescoping of costs, outputs and outcomes and locks the providers into another contract cycle without changes to these.

C. Staged approaches (Funding option 1 and 2)

Throughout consultations there was no clear indication of a preference for option 1 or 2 as outlined in the SIP pages 38 and 39. Additionally there was no clear indication of a preference for a 2 staged EOI followed by tender process. The bigger concern by providers was in the competitive open grant process being proposed.

We note, should option 2 be the preferred option, that conducting a tender application process across December and January is unfair on providers. Community organisation workers should be able to have an undisturbed and peaceful Christmas period and be able to choose to take leave with their children over the January school holidays. Asking providers to be focused on applying for a tender during this time is not appropriate.

Rather than the processes suggested in the SIP for the children, youth and families and for adult and older people streams we propose different options for consideration.

The proposed open market tender process may have the following potentially unintended consequences:

a. A loss of essential services that have established, often long lasting, relationships of care with people with enduring mental illness. This will destabilise consumers and increase pressure on carers to support transition to new services and new relationships. This is, in many ways, the antithesis of trauma informed care.
b. A loss of organisations/services that are well known, recognised and part of the fabric of the ACT community. Given the number of outcomes related to access, navigation, service awareness and help-seeking, a change in brands synonymous with mental health care in the community will disrupt the achievement of these outcomes. It can take many years for new organisations to build brand recognition in the community in a way that supports and promotes access.
c. A loss of workforce and corporate knowledge. An open market tender is disruptive to employees who face the very real fear of redundancy. This will cause workers to flee the market, often before transition is complete, to seek employment security taking with them years of experience. This is a wasted investment in building capability and will require additional investments to rebuild the sector.
d. Loss of programs that have an evidence base demonstrating achievement of key outcomes for consumers and carers.
e. Introduction of new providers who have no history of service delivery in the ACT and lack the relationships and knowledge to work in a collaborative fashion that meets the unique needs of the Canberra community.
f. Value for money is often the driver for open tender however this is poorly defined in the human services industry and can result in tenders who undervalue the actual cost of service delivery being success and then failing to be able to deliver to the outputs articulated in the tender.

Acknowledging the need for a procurement process that ensures government is obtaining value for money and quality service we are seeking the government to consider if an open market process provides the best outcomes. Instead, **we propose the following two-stage consortium approach**:

- Stage 1: Procuring a consortium of organisations for each funding stream. This would test the organisation viability, capability, capacity and internal systems along with their expertise and experience to deliver to the outcomes of the identified community need. The procurement

process would identify a panel of providers, of a number to be identified, who are suitable to provide the services required.

- Stage 2: Facilitate structured deliberation among selected providers to identify the full suite of services to be provided, the outcome framework, system reforms required, and a shared commitment to achieving the outcomes as a whole. Through a deliberative process the organisations would identify who would provide which parts of the service system, for who and at what funding level. This process would involve government representatives to ensure value for money and service mix.

This approach mirrors best-practice models like central intake models and consortium funding used in Victoria and Queensland, who announced the launch of the Victorian Collaborative Centre for Mental Health and Wellbeing and the Queensland Care Consortium last year. This would enable providers to partner effectively, sharing infrastructure and expertise to better meet consumer needs.

Applying a joint approach to designing models of care and holding collective accountability for achieving outcomes across a population group will result in innovative services and programs that support consumers who are complex and often fall within the gaps of a siloed designed service system. This would be an innovative approach to service design that replicates the features of place-based funding and can produce better outputs and outcomes for the sector.

Using a collaborative democratic process to design the service system, delivered by providers as a cohesive integrated care model is an innovative approach to support consumers who fall through the gaps. This would also reduce the need for a separate Capacity Building Fund as these groups of services and workers will already be incentivised to collaborate and share knowledge and information as an innate function of the system design.

Should this not be a viable option than we suggest the following options for the specific streams:

**Children, Youth and Families**

Noting that the Community Services Directorate is currently engaged in a process for commissioning for a range of services designed to meet the needs of children, young people and families across the spectrum from preventative to diversionary support and that some of the outcomes align with those in the Health Directorate Mental Health Commissioning SIP, it is proposed that consideration be given to **procuring both sets of services through the one process**.

Commissioning is “a new way of designing funding and delivering a fit for purpose human services system within the ACT. It is a methodology that ensures our system and the services and programs within it are meeting the needs of the community” (ACT Commissioning Website). Children, young people and families exist within a range of contexts and have needs that are not neatly packaged into funding envelopes. At the commencement of Commissioning the concept of commissioning for need not funding envelope was the goal and the Mental Health Design Listening Report indicates that commissioning for need rather than funding source will be the priority of the second round of commissioning.

Through a range of reasons, delays in the commissioning process has found us in a place where there is close alignment in the timeframes for the Mental Health and Children, Youth and Families procurement cycles. This provides an opportunity that was not present earlier to consider what a whole service system for a particular demographic group would look like. Doing this will reduce duplication, increase cross sector collaboration, allow for more multidisciplinary teams and programs to be developed that focus on whole person/family needs and provide for innovation. Funding allocation through procurement can continue to align with each existing funding envelope and outcomes with the joint process allowing for a whole of system look before contracts are issued.

There is support for this option from the Youth Coalition and Families ACT and broader consultation will be needed with service providers however initial discussions are indicating support for this proposal.

**Adults, Older People, and people with complex and co-occurring needs**

Conducting a select tender process where identified organisations, including those already providing services, are invited to apply to deliver services under the SIP. During this process the organisations will be able to articulate their service model and demonstrate their capability to deliver the required outcomes. This would enable innovation and service reform without disrupting the fabric of the community mental health sector and consumers currently accessing services.

**Timing of procurement**

As noted in the SIP, the services being procured through this funding envelope make up a part of the whole of the mental health system. This is a system that is currently the subject of reform including but not limited to:

- New National Mental Health and Suicide Prevention Agreement
- Strategies to meet the unmet psychosocial need in community
- Foundational supports and NDIS reforms
- ACT Regional Mental Health Plan
- ACT Mental Health Services Plan

Each of these will impact the range and type of services, programs and focus of the mental health sector over the next 2 to 3 years. A vast number of these reforms will intersect with the pillars, outcomes and target groups identified in the SIP. Rather than conducting a procurement process to secure 5 year service contracts that may result in duplication as the service system as a whole evolves, an option may be to delay the procurement process until we have clearer understanding of the funding investment, particularly in psychosocial supports, and incorporate this into a new funding envelope targeting the delivery of a wide range of psychosocial supports across the lifespan and target groups. In the meantime, current service providers could be issued a contract extension and agree to work together in agile and responsive ways to build and test service models to meet need and redesign service systems.

## Recommendation 5 – Procurement

**5.1 It is recommended the government provides greater transparency of the factors contributing to the decision to conduct select tenders for the residential and advocacy streams.**

**5.2 It is recommended that government consider revising the proposed procurement methodology identified in the SIP and consider the following options:**

**5.2.1 Conducting select tenders of existing providers and working with the providers to design an outcome framework and redesign the services provided to reach the desired outcomes; or**

**5.2.2 Concurrently conduct the procurement for the Mental Health Child, Youth, and Families funding stream with the CSD Children, Youth and Family Services procurement process; and**

**5.2.3 Conduct a procurement process to identify a panel of suitable providers who will work collaboratively to design a collective service response and funding allocation to meet the outcomes of the Adult, Older Person and Co-occurring needs funding stream; or**

**5.2.4 Delay the procurement process until such time that it can run as a concurrent process with the upcoming psychosocial needs procurement process.**

# Readiness

During the consultation much discussion was had on timing and readiness. Acknowledging that this round of commissioning commenced in November 2022 and that 3.5 years have gone by, there are a number of concerns including:

a. Despite the period of time that has passed there are concerns that we have not spent the time examining the complexity of the need or the system nor have we explored innovative service designs to meet the needs;

b. The Design Listening Report was tabled in May 2024 and the Strategic Investment Plan in May 2025. In that time we have had a territory and a federal election along with a range of new initiatives, programs and funding announced, a Productivity Commission into the effectiveness of the National Mental Health Agreement, a reform agenda for NDIS and the tabling of the unmet psychosocial needs report. In addition we have had commissioning completed in a range of intersectional areas (according to the ACT Commissioning website) that have affected service delivery and the service landscape for people with mental health challenges. What is clear is that the Mental Health Sector is an ever-evolving complex space and one that is impacted by the range of sectors and policy areas it intersects with. There is concern that complexity of the sector has not been well examined in the strategise or design phases of commissioning and that delays mean that there are questions as to the relevancy of decisions in the investment phase.

c. Ultimately, given the decisions made in the SIP, we are talking about open market procurement processes for under $4m per funding stream. Taking some time to consider the procurement options or to wait to combine this amount with new amounts agreed under the National Mental Health Agreement may result in a more comprehensive service system and avoid multiple disruptions.

d. Ideally, given the influence of social determinants on mental health, we have incorporated mental health outcomes into the commissioning process of other sub sectors. Given a number of those commissioning processes are complete it may be valuable to take time to map the new community service landscape to identify what mental health needs have been met and which remain unmet.

e. Consideration should be given to extending existing contracts and waiting till a review of commissioning has been completed and a new path forward has been identified.

## Recommendation 6 – Readiness

**1.2 It is recommended the government considers a delay to the procurement process, particularly for the open tender funding streams until more work can be undertaken to understand the current context and develop a clearer sense of the gaps this funding will address.**

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Mental Health
Community Coalition ACT

02 5104 7711 :: admin@mhccact.org.au :: www.mhccact.org.au :: ABN 22 510 998 138