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Targeted consultation on the new digital mental health National Early Intervention Service (NEIS)

Submitted via Online Survey:

Australian Government

Department of Health and Aged Care

Consultation Hub

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Introduction

Lived Experience Australia Ltd (LEA) is a national representative organisation for Australian mental health consumers and carers, families and kin, formed in 2002. Our 'friends' include more than 10,000 people with lived experience of mental health concerns across Australia. This includes lived experiences with all parts of the mental health care system, NDIS, psychosocial disability support outside the NDIS, public and private service options, and service provision across urban, regional, rural and remote Australia. All members of our Board and staff have mental health lived experience as either a consumer, family/carer/kin/supporter, or both.

Lived Experience is core to our advocacy, recognising that the impacts of policy and practice are felt not only by individuals, but also by families and whole communities. Our core business is to advocate for effective policies and systemic change to improve mental health care and psychosocial disability support services and support across the lifespan, across the whole Australian health and social care system, including within State and Territory jurisdictions.

We welcome the opportunity to provide our feedback to this new planned national service for people experiencing mild to moderate mental ill-health and distress, and their families, carers and kin in the Australian community.

Background

In the 2024-25 Budget, the Government provided $588.5 million over eight years from 2024-25 and $113.4 million per year ongoing for a new national early intervention service (NEIS) providing free digital mental health support. The NEIS will provide support for people at risk of, or experiencing, mild mental ill-health or transient distress to get the right support when they need it. This service draws on the established evidence from the UK Talking Therapies[1] and from a range of low intensity digital mental health services currently serving segments of the Australian community based on that approach.

From 1 January 2026, the service will provide free cognitive behavioural therapy (CBT), delivered by skilled and trained professionals, via phone or video. Services will be free and accessible without a diagnosis or referral from a GP. The NEIS will also provide a curated set of free, evidence-based online tools and resources for people able and willing to try self-guided support. Once fully implemented by 2029, the service is expected to support over 150,000 people each year.

Purpose of this Consultation

The Commonwealth Department of Health and Aged Care (the Department) sought feedback on the National Early Intervention Service (NEIS) draft service delivery model informed by targeted consultations with service providers, consumer and lived experience groups, priority population representatives and state and territory governments throughout October – December 2024.

This consultation sought to gather sector-wide feedback to ensure the draft service delivery model and service principles are implementable nationally, and sustainable and inclusive. We are also sought feedback on whether they meet the objectives of the service and needs of the community. The draft service delivery model was developed in partnership with Nous Group.

[1] https://www.nhs.uk/mental-health/talking-therapies-medicine-treatments/talking-therapies-and-counselling/nhs-talking-therapies/

Our Response to the Consultation

To what extent does the proposed draft service delivery model align with the NEIS' objectives?

Very aligned

On p.6 (Exec Summary section) re 'Target population and suitability criteria' the term 'therapy' within the dot point below could be ambiguous and therefore unclear in how it is applied by referring health professionals and others, and understood by the person who may self-refer to the NEIS:

- Help seekers should not be receiving therapy from another mental health service.

Therapy can mean many things to different people. Many people with established mental ill-health do not receive 'therapy'. For example, many who are case managed in public mental health community services have never been offered or received evidence-based CBT. Likewise, some GPs might consider that they are providing psychotherapy to their patients within what is essentially a very brief and unstructured consultation process. Or they may be managing medication prescription. It would be good to clarify somewhere in the model and promotion materials what is meant by 'therapy' or use an alternative term perhaps.

As the NEIS implementation will be staged, gradually building to maturity in 2029, what target populations (as identified in the draft service model) should be prioritised for access to the NEIS?

People who are identified via various types of primary care services would seem to be a useful starting point given the likelihood of early help-seeking, early awareness of distress, and early trajectory of mental health likely within the various community-based organisations with roles in supporting broader psychosocial wellbeing too, not just established mental health issues.

The Mindstep (private LiCBT) has mechanism for connecting with people who have recently had an actual contact with services for mental health, such as discharge from hospital. This could be considered for NEIS where people identified with distress leaving hospital for other reasons such as physical health, post operation for cancer or other significant physical health issue, might value this short-term support option to support their coping and recovery once home.

Somewhere down the track, I wonder if NEIS option might be suitable offering for carers (whether they be caring for people with physical and/or mental health conditions). NEIS may be able to provide some 'time out' for self-care, from the caring role and offer some focused strategies to manage distress, burden and so forth for carers.

Are there alternative low-intensity therapies that should be considered as part of the staged-roll out of the NEIS?

Existing LiCBT options, either F2F or online, (eg. offered by Beyond Blue, Remedy, etc) should be considered re how they fit within the suite of available options, to ensure there isn't confusion in the community and by healthcare providers and services.

Should specific groups be prioritised to receive these other low-intensity therapies?

For existing F2F offerings of LiCBT, these should continue to give people choice and continuity. Existing virtual offerings have likely established levels of trust with certainly groups that their serve as a priority, so these should continue at least until NEIS is well-established. Obviously, private sector LiCBT linked with insurance companies will likely choose to continue regardless, especially if it is underpinned by a different funding mechanism.

How important do you consider it is to include an SMS or other synchronous messaging channel for the NEIS?

Very important

This would provide people with connection in real time to support engagement and follow-up, linked with personal time management given life can get busy for people. Also, because this is a free service, dropout rates may be higher, given people tend to commit more to something that they pay for, even if a small amount is paid.

How important do you consider that government health services and infrastructure be utilised through the NEIS (e.g. My Health Record and MyID)?

Very important

Is there anything important you would like to add to your submission that might not have been mentioned previously?

Yes. I'm unsure whether the initial source of workforce should be those with a background in mental health (and psychotherapy). The nature of training and evidence in LiCBT is that people without clinical mental health training are just as effective in delivering LiCBT, and in many cases more effective because they stick with the program better and are not as biased or influenced by their former training/education. This is really important too given there are significant cultural concerns within mental health services and stigmatising attitudes can be a problem too. They may also come with an overly diagnostic and clinical headset which is not the intention of LiCBT (though I acknowledge that their value may well be in identifying when an individual may need to be 'stepped up' to higher level support.

p.9 of the Draft Model re Performance Indicator Framework – I wonder if this should include tracking of appropriate utilisation in more detail.

p.75 Access Domain – If possible, it would be good to have some sense of prior mental health contact, help-seeking experiences, those who are recommended/referred by don't commence LiCBT, those where there may be family/carer input to help-seeking, support during LiCBT etc.

Contact

We thank you for the opportunity to put our views forward. We wish you well with the next steps and would be pleased to contribute our lived experience perspectives to any future discussions about this important topic.

Your sincerely

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