What we've heard so far - National Mental Health and Suicide Prevention Agreement Review

Webinar transcript

Friday 11 April 2025

Selwyn Button (Commissioner)

Thanks everyone for joining and dialling in today. I really appreciate your time and certainly it's great to see that there's lots of interest in what's been happening through the process of the public inquiry.

This is a short session for us to give a bit of an update to interested people and stakeholders in relation to what we've heard so far.

A couple of quick housekeeping pieces. You'll notice that there is a Q&A chat component that's in there. It's absolutely okay for everyone who is asking questions along the way to start to populate that as we're going through. We do have a team that's monitoring the Q&A chat line and if there are simple questions that can be answered those things will happen instantly.

If there are pieces that need to be referred to by Stephen and I as we're talking, then certainly we'll make sure we come back and reflect on those and address those questions throughout the session as well.

So we will get kicked off. My name is Selwyn Button. I'm one of the Commissioners with Stephen King and we're leading this inquiry.

And so we'll start by acknowledging Country and we do want to acknowledge that I'm in Sydney today on the lands of the Gadigal people and want to acknowledge their custodianship of this Country and their connection to this Country for thousands of years and acknowledge where everyone else is located around the place and certainly acknowledge the connection to Country, that those people have traditional owners in those places as well.

A quick reminder that as we're going through this process, we are currently in a caretaker period. So everyone would be aware the election has been called for Saturday, 3rd of May. The caretaker period started on the 28th of March and so during that time whilst the inquiry is still continuing we're still going out and about having interviews and doing site visits and meeting with people and still capturing thoughts and ideas in relation to the review of the agreement. For those things during the caretaker period we're going to focus on the factual issues, matters of administration and really today is about playing back what we've heard so far.

So it won't necessarily look at influencing anything that's going on through that period. It's very much focused on a snapshot in time of what we've heard, and we want to make sure that we're

playing that back to give people an opportunity to hear what the collective views of people are across the country that are providing input through both the interviews as well as submissions.

Stephen King (Commissioner)

Okay, so just a bit of background on the Agreement, which is what we're reviewing. So, it was signed in 2022 and it's an agreement between federal, and state/territory governments and with the objective, the shared intention, to work in partnership, to improve the mental health of all Australians and to reduce the rate of suicide towards zero. It's got two parts to the broad Agreement. It's got the first part, which is the high level objectives. So making sure that the mental health system in Australia is consumer centred, making sure that the mental health system in Australia cuts across both state territory and federal divides. But also you know, divisions between parts of government so not just health, but corrections, housing, education and so on.

The second part of the agreement is the bilaterals. All States and territories signed bilaterals with the Australian Government, and these bilaterals are essentially laying out the funding of local initiatives. So, for example, many of you will be aware of Medicare Mental Health Centres, the old head to health centres, that have opened up and have been funded by the bilateral initiatives.

Now the National Mental Health Commission published progress reports last year, and those progress reports were essentially the state and territory reports brought together. The state and territory reports showing that the initiatives in the bilaterals were generally on track in mid 2023. The agreement expires in the middle of 2026.

So our process is to provide recommendations to government about the next agreement and hopefully that will underpin the next agreement when this one expires.

So the aim of the agreement is an improvement in health and wellbeing for the Australian population, focusing in particular on outcomes for priority populations such as First Nations people, CALD communities, rural and regional communities, LGBTQ+ communities and so on, to reduce suicide, and distress and self-harm through a whole of government approach.

And again, note that whole of government approach, it's not just health. It's across all parts of government and across all levels of government and through coordinated prevention, early intervention, treatment, aftercare and postvention, to provide a balanced and integrated mental health and suicide prevention system for all communities and groups.

And improve physical health and life expectancy, and help reduce that gap in physical health and in life expectancy that people with mental health issues currently have. And generally improve the quality, safety and capacity of the Australia's mental health system and suicide prevention system.

So, what was promised and what has been delivered? So, an analysis of psychosocial services outside of the NDIS, that was published in December last year. That’s sort of an update from the Productivity Commission's report.

And Commonwealth-state implementation plans and national progress reports have all been delivered. There's a question mark there next to improve data collection, data sharing, data linkage as we'll reflect back in what we've heard. Data collection of the relevant data to see what's happening around Australia is at best patchy. A national evaluation framework has been delivered for shared evaluation findings using the framework and associated guidelines.

Unfortunately, as we found in the mental health inquiry, evaluation of services is still rather patchy. Finding out what works and actually getting the data to show what works and how it works and why it works is unfortunately as, you know, a work in progress. But the progress hasn't been as fast as we'd like.

Consideration and implementation of national stigma and discrimination reduction strategy. Again, that was one of the core recommendations from the Productivity Commission's Mental Health inquiry. And unfortunately we have not seen that strategy. So that's in the not delivered category there.

We now have a national suicide prevention office, national guidelines and regional commissioning and planning. Unfortunately, they're also absent, so particularly with the PNS, who are a significant commissioning body, those guidelines on how to do it, how to get consistency across the country in terms of commissioning there, they're just not there now. Workforce strategy to progress increasing full time equivalent mental health professionals is a work in progress.

And a submission to the mid-term review of the National Health Reform Agreement has been done. And obviously we are the final review of this agreement.

Selwyn Button

So, what have we been asked to do? Essentially, in January the Australian government asked the Productivity Commission to conduct the final review.

This agreement, and the terms of reference the PC has been provided with from government, is to consider the wellbeing and productivity impacts of the mental health and suicide prevention programmes and services delivered under the agreement to assess the effectiveness of the administration of the agreement, including reporting and governance. And then to ensure that the voices of First Nations people and those with lived and or living experience are actually heard in the process as well.

For the engagement and consultations we've undertaken, we've certainly heard from people with lived experience and their families and carers, peer workers, service providers, practitioners and researchers, peak bodies and associations, PHNs, hospital networks, mental health commissions and government departments in all states and territories.

So up to this point, we've had 44 online meetings. There's been an online survey that people have provided information to. And five days of in-person meetings, in Brisbane, Hobart and Launceston. We've had 92 submissions and to 283 responses to our online survey. And so we've heard lots of

different perspectives and lots of different voices to this date in respect of what we need to consider as part of the review of the agreement.

Stephen King

Okay. So what have we heard?

Through our online survey, if I had to give the short summary, unfortunately what we're hearing is that we still have a disconnected system that is not consumer focused. It's not consumer centred. So what do we mean by that? So we still have issues where finding the right services at the right time for individuals can be difficult or impossible. There's still significant barriers to accessing services and the sort of services that people need, and the ability and assistance to navigate those services. So, we still have a very much fragmented system where individuals who are accessing services often go from one service to the next, sort of starting again at each service retelling their story, each time that they try and engage with a new service with a new practitioner to get the services that they need.

That being said, it's not a wasteland out there and we haven't heard that it's a wasteland. There are great services out there. There are great people out there providing services that help those in need of assistance for mental health issues. Sometimes they are whole services. Sometimes they are individual practitioners. There is great stuff being done. The problem that we've heard is that it's not joined up. There's just gaps everywhere and it's very easy for people to fall into those gaps as they try and find the right services.

We've had some wonderful visits and let me start off just by saying thank you so much to those people who have allowed us in to see first-hand on site what work is being done. How services are being provided, but even more importantly, hearing from people with lived experience. Hearing from people with mental health issues, with lived experience, hearing from carers, with lived experience. And understanding, being invited to have a glimpse into their world is something that that we recognise as a privilege. And we're incredibly thankful to all those people who have allowed us to get some insight that way. It is a privilege that both Sel and I and the team are incredibly thankful for. We can't review the National Mental Health and Suicide Prevention Agreement without understanding lived experience. Otherwise, it's just a pointless exercise. So thank you so much. You make our task possible.

And again the story that we heard from our visits very much mirrors the stories that we've heard from the online survey and the stories that we've heard from the submissions. There are many examples of excellence and best practice. But the policies don't help and policies often don't align with the way that consumers need care across the system. There are still just too many gaps. There are still too many times when a consumer has to retell their story to be able to access the care they need.

So, from our submissions, we thought we'd put together a bit of a word map. Just looking at the keywords people raised in submissions with us, and the size of the word reflects how many times the word was used in the submissions. This gives you a bit of guidance as to what people feel are

the key issues. And notice that big ones there – ‘people’, ‘support’, ‘care’, ‘experience’, ‘community’, ‘workforce’, ‘wellbeing’. They're the words that capture both the positives and the negatives around this agreement. ‘People’, because it needs to be people centred. The ‘support’ people need, needs to be there. The ‘care’ that people need. Notice the word ‘community’ there. One of the constant themes is the need for mental healthcare, but not just a clinical system, but it’s those community based supports that individuals with mental health issues value and need for their health. ‘Workforce’ issues are a huge challenge in the system.

And I also just want to touch on ‘wellbeing’, because that's the word that comes up a lot. In some ways what we're hearing is, you know, we need to step back and we need to think about this as a social and emotional wellbeing framework agreement, that it needs to move beyond just that clinical setting, but it tends to be called into.

Selwyn Button

So some of the key messages that we've heard from the engagement process so far, so there has been some progress made against the commitments, but it's not supported meaningful improvements for people with lived experience, the carers and families that Stephen alluded to, it's very much about making sure that we can actually focus on the things that are going to make a difference.

There are some big opportunities that we do see and so these have come out in conversations through the submissions as well as discussions that we've had with people.

When you look at improving on the next agreement, centering voices of people with lived experience and mental health challenges and suicidality and their carers and families, ensuring that those voices are heard and are part of the process strengthening the governance accountability and what that looks like, we heard a lot of I'm with, we've had lots of feedback in relation to accountability and public reporting and what that looks like and how do you keep systems accountable when there is no public reporting, how do you keep services accountable when there's no way of actually monitoring that?

Accountability - what's that look like in a reporting context?

So that the public can actually have a look at the system to understand how the system is tracking against a range of things.

At the moment, there's an absence of those, so it's about what do we do to look at that as an opportunity to strengthen those arrangements for the future and even some simple things like when you have lived experience, people sitting at the table as part of those governance processes and practices, how do you make sure that they're also able to go back and have conversations on a regular basis with their groups and their membership to ensure that those things continue?

And I think that we heard of some structural barriers, some simple structural barriers to that through the process that some of those things, because you're involved in discussions that in some cases may be potentially in confidence that people are actually asked not to provide it, not to

provide that information back, but that then limits the ability to get collective voices sitting at the table or inputting into some of these governance mechanisms.

So how do we improve those sorts of things?

And then the last one is ensuring the commitments in the agreement have a clear link to the objectives and that's been a strong theme that we've heard.

Is that what are those collective objectives that we're trying to achieve with the national agreement, that there's a clear link between the agreement with the objectives and what's in the bilaterals to ensure that there's a sense of collectivity across not just the national agreement, but across all jurisdictions that are focusing on these issues?

And the other things we've heard is around gaps and across the mental health and suicide prevention system that we want that people are asking for the next national agreement to address.

One simple thing that we've heard quite often is that there is no overarching national strategy for mental health, and potentially that is something that people, people are calling for. Do we actually need to have a national strategy for mental health so that there's a set of collective priorities that all systems are working towards to say, yes, these are the big these are the big rocks, if you like.

These are the big rocks that exist in the system right across the country.

How do we make sure we're focusing on those things?

And Stephen mentioned workforce challenges and certainly in the word bubble that was a significant theme around workforce challenges, those things to persist not just at a local level, but certainly right across the country.

So there's workforce challenges in relation to what we're attempting to achieve

So how do we actually have a focus on that?

And is it necessary again to go to develop a specific strategy that focuses on the workforce challenges to ensure that we've got some piece of paper, paying attention to the things that are actually preventing the outcomes that we want, the prevention of mental ill health and suicide is lacking.

So there's that focus that yes, we do have suicide prevention within the agreement.

But is it getting the attention that it requires?

And how do we ensure that there is an explicit focus on that component of the overall agreement as well?

Then last one, I alluded to planning data collection and evaluation being very inconsistent and we had lots of stories about data being fed into different systems and data going to different sources and going to different agencies.

And there is certainly a role here that we can see.

And what we've heard around some work that needs to be done in terms of data linkage, knowing that there's multiple data sources, knowing that there's multiple reporting arrangements that exist across the system.

How do you look? What's the approach that we need to take in respect of the data linkage piece to ensure that when we're talking about community based care, when we're talking about hospital-based care when we're talking about a whole range of different systems, those systems are actually speaking to each other and we get a true reflection of how the entire system, both in community based but in hospital settings and other places - they're actually all effectively working towards the single outcomes of improving what happens in the system.

We can't do that if we've got multiple collection points and multiple data points that don't necessarily talk to each other.

So that's certainly something that we think is necessary that has come out of our conversations with people across the country about making sure we focus on doing those things better.

Stephen King

Okay so.

Where are we in the process?

So I guess one of the things just to remember about this, we are not re-prosecuting a mental health and suicide prevention inquiry.

We are just looking at the agreements.

So apologies to those in advance.

So that the people who sort of say,

But what about this particular issue and we say agree completely that is an issue there, but it's not something for the agreement.

So we are focused in on the agreement which does limit the areas that we're looking at.

The agreement has to be able to underpin the support that people need.

But it's obviously, you know, an agreement is not a system.

So yeah, so just a bit of background there.

So we're reporting the final report to government on October 17.

We're looking at having our interim report released in June.

So for those of you who haven't had any formal input yet we'd love to hear from you and the best time is after that interim report.

Have a read through.

Have a look at what we're suggesting and give us feedback.

In particular, tell us where we're wrong.

You know we don't come to this thinking, hey, we're we've got some magical ability to come up with all the right answers, and it's really important to understand what we've got right, but also what we've got wrong and why.

So really keen to hear from you after that interim report comes out in June.

The team's putting together that interim report as we speak.

And we do want to close the loop as often as we can, so that's part of the reason for this webinar.

So that we're able to close that loop, give you a very short summary of what we've heard, but also then enable you to, you know, quiz us, you know, have we heard the right things?

Have we missed things?

And so on.

And that's really part of the point of the inquiry, and that's what this webinar's about.

Thank you for those who have popped some questions in the Q&A.

Please, if you've got questions, got issues, pop them in there.

Miriam is our wonderful team leader, has been keeping an eye on the Q&A because Selwyn and I can't do that in real time as well as talk because yeah, we can't walk and chew gum at the same time.

I guess that means Miriam's going to pop up and try and summarise cause a lot of questions will cover similar issues.

She's going to pop up and ask us some questions which Sel and I will do our best to answer.

Miriam Veisman-Apter (Assistant Commissioner)
Thank you, Stephen.

I've had a number of questions and as you said, thank you very much to everyone for coming and joining us today.

The first question is about the lived experience that we've spoken about and the reflection of the agreement of the need to consider and incorporate the views of people with lived experience.

So the question was reflecting on the fact that health services are often quite risk averse and it can be quite difficult for lived experience to be heard.

Have we heard about practical ideas and the ways that services are looking to people with lived experience and incorporating their views?

Stephen King

Yeah, perhaps.

So if I start off with that one, but I'd love to pass back to Selwyn for a bit on the peer workers and so on.

So let me start off at the high level.

One of the achieved objectives of the agreement and again coming out of our mental health inquiry was to have high level lived experience groups able to put their views to government, both carer lived experience and those with lived experience of mental health issues.

They're both moved forward.

They're relatively new and, but hopefully that provides a bit of an input.

At the individual service level, we've seen some great examples where a lived experience has been there right through the service process so from, you know who you meet at the front door through to the governance of the service with people who have lived experience essentially running the service in the sense of being at that governance level and making decisions about how the service will run.

We've seen some great examples of that.

Unfortunately they're not that common.

And unfortunately we do still see, particularly outside the community sector once we get into the clinical sector, less incorporation of lived experience, views and voices than we would like to see, in many cases. And yeah, in some cases it feels tokenistic to us - happy for people to say no, it's not. But the lived experience voices are really having an impact in those clinical services. And I do think it varies across Australia, but sometimes it seems to be working, but sometimes it does seem a bit tokenistic.

But on the workforce side and the importance here Selwyn, can I pop across to you just on that?

Selwyn Button

And just to pick up that comment, certainly where we were seeing the most effective use of people with lived experience involved in the process is very much at the beginning and we heard a couple of great examples where people with lived experience were actually involved in the co-designers services prior to contracting.

And so that provides a good practical example of showing, OK, this stuff can work because you're actually having people have those regular conversations. People involved in the co-design of services to understand what that looks like and then ensure when the frontend delivery starts, those voices are still being heard throughout the process to make sure it's actually meeting what the requirements are and what's expected from people with lived experience, which is great.

Then as Stephen alluded to - the peer support worker process has been something that's been an interesting one and certainly for me hearing the conversations and having discussions with peer support workers and lived experience workers that we've met with so far both online as well as throughout our visits.

The varying degrees of the value of the role and the recognition of the role in different types of settings and if I draw on one of the comparisons that I often draw on when having conversations with people about where do we take the process and have this conversation about professionalisation of the role and what that might look like within the system itself?

Is the comparison of where Aboriginal health workers were many years ago, the Aboriginal health workers were in a place where it was something that was designed by the community.

It wasn't something that was designed by the system and the reason why we still have Aboriginal health workers just because they play a vital role, not just about understanding the clinical needs, but they understand the social economic needs, they understand the demographics, understand the backgrounds and the culture.

That's what people bring to services.

And so how do we learn from the experience of Aboriginal health workers and bring that and apply some of those principles to peer support workers?

Certainly lots of learnings from existing pieces that we think we may apply in the future.

Miriam Veisman-Apter

Thank you so much.

We're seeing some questions about the interactions between consumers and services, including the interface between privacy regulation and care provision and care planning.

Are you able to reflect on things that we've heard regarding that aspect of consumer experience?

Stephen King

Yes.

So let me have a shot at that one.

The key issue -- Sort of conflicting issues or perspectives here that have got to be balanced in the system.

So the starting point is the importance to the consumer of the privacy of their rights over their data, of their rights around their care, or their transparency to them of what is being said and done, and understanding that fundamental human right around the consumer and their data, their information, At the same time that has to be done within a secure system that allows - allows is the wrong word - enables the consumer to access care where they just don't have to repeat their story over and over again, where when they go and see, say, a community support worker, that worker can easily understand and see what else they need to know.

Uh, about the other services that consumers access, that consumer is able to get support to access the services that they need in their local community. We've heard that that sort of navigation side is still a mess. Non-existent in many situations. In many communities, we've heard the transparency isn't there. We've heard, as you know, as soon as you get into the clinical system, quite frankly that the data and the information tends to be used - in some cases people that have lived experience - feel it's used against them, which shouldn't be the case. They should have access to and transparency to that.

So there are trade-offs there which need to be addressed within the mental health and suicide prevention system, but they're broader than that system. So some of you will be aware that there's been reviews of the Privacy Act, and that they're looking at amendments of the Privacy Act to increase individual rights under that act.

Some of you will be aware that the Productivity Commission is also looking at some of those issues around data, so it is part of a broader system, but the objective and the aim of making sure that consumers are empowered through their information, through their data, is critical.

So I'm not sure if you want to mention anything else Selwyn - I mean the other side is data on evaluating the system and the services which I haven't touched on.

Selwyn Button

Yeah, thanks Stephen.

The other piece, so I would add in there is a consistent thing that we are hearing as well is about carers access to information when they're supporting someone who is dealing with mental health concerns and issues and what does that look like in terms of the information that's provided to the carer because in many cases what we've heard is that carers are quite often locked out of the system because of privacy issues.

But the on the flipside of that, the carers are spending the majority of the time with the person and supporting her and the individual is going through a process and they're not getting access to relevant information to help them through the care process. And so there's a system that's provided for an individual and the care planning that's done, then clinicians are having regular conversations with the individual, but the translation that information relies upon the person being able to disclose it as opposed to the carers being able to have conversations with clinicians to get a better understanding.

And that's purely about privacy issues and it's purely about saying that some individuals don't want that information to be related to carers, which is completely OK because it does require consent, but it does present problems in that entire care planning process.

If the person is spending the majority of time with an individual carer, how does that individual carer better equip themselves to make sure that they're able to support the person that they're caring for much, much better and have an understanding of the process they're going through as well.

Miriam Veisman-Apter
Thank you.

We've heard a number of questions come through about the role of the agreement and what we've heard in consultation about prevention and early intervention, especially as it relates to priority populations, children, young people, Aboriginal and Torres Strait Islander people.

Can you reflect on that please?

Stephen King

Yet again, I'm happy to go first. Let me start with the early intervention sort of process.

So one of the areas where far too little progress has been made under the agreement.

Around that prevention and early intervention in family support.

The actionable item, really under the bilaterals was setting up of kids hubs.

And Miriam will correct me on the number, but is it the case that there is one?

Miriam Veisman-Apter
Two that we're aware of, but we still checking.

Stephen King

Two that we are aware of?

Yes, after three years so.

Whether or not you think kids hubs are an appropriate approach to prevention and early intervention for young Australians, after three years, we got two of them. So that is not in any sense success.

Certainly it is not in line with what we suggested through the Productivity Commission's inquiry into mental health, it is not consistent with what the NDIS review recommended with regards to support for young Australians.

And so the progress there under the agreement has been limited at best.

I think we need to rethink how early intervention and prevention and support for families and young Australians is done. The evidence is quite clear on the need for support for families and the role of childhood trauma in mental health issues.

And just the fact that if we don't support families and children and that's not just through medical system or NDIS stuff, it's not just through OT and speech therapists, it's through supportive services for families, which goes across childcare, which goes across education, which goes across the maternal health system. Without those, we're just not going to make progress.

So I think the evidence is there and unfortunately I think the agreement in early intervention prevention for children and family support, that is one of the areas that, so far - and again happy to be told that we're wrong and happy to be shown that we're wrong - but at the moment, our situation is that it seems to be a yawning chasm. Perhaps Selwyn you would like to deal with some of the other aspects, I went in one direction because this is one of the things that I'm very passionate about and that we haven't seen progress, but other priority communities, other areas of prevention and early intervention.

Selwyn Button

Thanks Stephen.

And if I focus on two things, First Nations communities first, what we what we've heard and what we are seeing is that there's a fragmentation in the system right from the get go because you've got already two separate agencies that are funding activities in the social, emotional wellbeing space.

You have large contracts with providers and community control services, as well as some peak bodies who talked to us about lots of social, emotional wellbeing activities that are funded through community controlled organisations across the country and is done by one agency, National Indigenous Australians Agency.

But the strategy in the agreement sits with Department of Health and there's a fragmentation in the approach because they have these different funding cycles, different approaches and different ways of doing business and understanding the needs of local communities etcetera.

So that creates some issues for them.

One is the administrative burden in terms of reporting, because if you got a contract with Department of Health and you've also got a contract with NIAA, there's multiple masters that you are talking to whilst you're trying to deliver services to the same client group.

And so that's certainly a significant issue for First Nations prevention.

I guess the other, the other piece stepping away from that is that there's been a lot of activity that's been happening. You've got a lot of the work that Professor Pat Dudgeon and her team had done through University of WA to then come up with some models and ways of delivering services and looking at social and emotional wellbeing models.

But those things aren't necessarily being reflected in the shift and change of way the government is contracting and commissioning services, the way that PHNs, the commissioning services and how services then are being delivered through local hospitals.

So the fragmentation I guess does exist and is real and it's working out, now we need to make sure that certainly in the First Nations communities and for community controlled organisations, if we're talking about mental health, suicide prevention and social and emotional wellbeing, that if we actually have that sitting in a single policy space, one federal agency, will that start to at least reduce some of the duplication that occurs to ensure that things are actually getting to the services on the ground, are being provided to the people in in need.

So that certainly one of the one of the big issues that that we've seen Miriam, I did have a second one, but I've taken too long.

We need to make sure we get some other questions in.

Miriam Veisman-Apter
Thank you.

One of the focus areas of the agreement is collaboration and joint planning to address those issues of system and fragmentation that we've heard about in here and in the previous PC enquiry. We have a question here about what sort of feedback have we had about the effectiveness and quality of planning at all levels to address some of the gaps and if I can quote this question verbatim, can we plan our way out of system fragmentation? is that what was the feedback that we've heard about planning?

Stephen King
Yep, happy to go.

Can we plan our way out of system fragmentation? By itself, the answer is no, but it's a step. It's part of the solution, but it's not the whole solution by itself if we don't get the collaboration and joint planning happening at a regional level, then we simply will not have the services that we need that reflect for local needs.

The local demands the local requirements so you know, it's not the whole answer.

So for example, you know, the issue of data and making sure that the information flows are right, and that the information flows are empowering for consumers, is also an element. Having the input, the voice of people with lived experience, both people with mental health issues and carers is important and critical.

And so there's a whole group of issues that are needed to get the services we need on the ground, collaboration and joint planning though, is one above.

You know, it's one of the pillars, if I can put it that way.

What have we seen happen?

So again, Miriam alluded to the Productivity Commission Mental Health Inquiry that said as a first step in moving forward in mental health, there needs to be an understanding of what services are available, what the local needs are, where the gaps are, and then a collaborative approach to planning how to provide the services to fill those gaps.

That challenge was taken up by the National Mental health and Suicide Prevention Agreement.

But unfortunately I think we can say that the outcome so it's one of the things that has been delivered, that analysis of what's available, but which was in the agreement and it was published in December last year but at least on our take and from what we've heard, it really hasn't moved the debate forward, because it's using the national Mental Health Service Planning Framework to say, well, what are the needs, it's not really looking at addressing that need.

And it still isn't driving that collaboration that is needed between different parts of the sector and even if we just stick with it, the clinical part of the sector is still getting that collaboration between the Primary Health sector with the PHN and the tertiary part.

But even if we say just that clinical part, we're not seeing that collaboration there in most parts of Australia, in some parts of Australia, it's working really well, but it doesn't seem like the agreement's driving that.

The agreement doesn't seem to have set up the foundations that are needed for that collaboration and joint planning to occur because unless you know what you're collaborating and joint planning about, you're not going to succeed.

Selwyn Button

Just to build on that as well Stephen, you touched on the National Mental Health Service Planning Framework and we heard that there's an inconsistent application and the use of the planning framework in the first instance.

So when you've got inconsistent applications or directions in the way that you're undertaking service planning in the 1st place, you're going to get different perspectives and different views around things.

So certainly one of the things that we would think might be something to consider in this process is to say look if we're all singing off the same hymn sheet, and using the mental health service planning framework to then inform what service needs are, that they are commissioned in local communities, it might be a better place to start, gives you a similar base point.

The other piece that we did hear, we heard a lot about, is the fact that planning, service planning is a function and the entire process of rolling out not just the agreement but the bilateral initiatives. It's not a funded activity, so it's an add on.

So that becomes an extra piece and it becomes an extra piece for people to get to, to sit at the table to be a part of, and when it's not prioritised because it's not prioritised by being a funded activity, it becomes an afterthought.

It doesn't become a priority, so how do we ensure that we're doing those things and it's then very much in the forefront of people's minds that we need to do this in order to then inform the next steps of commissioning models etcetera. The other piece and it sort of touches on my second point that I was going to mention earlier, but is very much connected to this conversation once the planning's done and once you've identified where the gaps are and what the needs are in terms of local communities commissioning and commissioning actually happening - It's then about the service integration.

What do we need to do to ensure that there's some governance arrangements to ensure that services that are actually performing roles and are within local systems are actually having regular conversations about integration because you do hear a lot about duplication as well that clients are going to different services and in some cases going to going to similar services, but services themselves aren't having those regular conversations between each other about how to collaborate, how to integrate and how to provide the best support and the best care to individuals who are going to different services in similar locations?

Miriam Veisman-Apter
Thank you.

We have a quite a few questions now and some of them go to intended future recommendations, so I think we can apologise to the people who are asking their questions that we are not necessarily able to answer those today given the caretaker conventions, but also given the fact that we are very much still in a thinking phase.

So we would encourage everyone to look at other draft report when it comes out in just over 2 1/2 months and that will give you a greater clarity of what, how we're reflecting on the inputs that we're getting.

A question on process that we had is the balance between the bilaterals and the overarching agreement in our review, are we going to look specifically at each and every one of the initiatives in the bilaterals and how they have affected consumer groups or is our focus is going to be different, and how are we intending to think about the whole of government aspect of the agreement?

Stephen King

So will we be going line by line through the bilaterals?

No, because there's various bits.

Yeah, there's one with each state and territory.

We're broadly going to evaluate what has been done under the bilaterals and we will certainly have things to say about how they've been done differently between different jurisdictions, because the inconsistency of the bilaterals and in the inconsistency in application, although it was built in right on day one.

When the bilaterals were negotiated between each of the States and territories and the federal government, that inconsistency will be something that we will be commenting on.

So for example, you know some states and territories, say, Medicare mental health centres, some states and territories brought money to the table.

Some states and territories said we don't bring money to the table, but we'll bring in kind contributions whatever they are.

Some states and territories said not interested, so that sort of inconsistency over why we're approaching mental health in Australia and particularly top down inconsistency is not a great starting point.

So we'll be making some comments about that sort of process.

And again, it's sort of the opposite of what the PC recommended in a mental health inquiry, which was very much that bottom up type approach.

So the objective isn't to have the same thing everywhere.

That is not consistency, that is poor service delivery.

I suspect in practise the objective is to have bilaterals and agreements between states, territories and the federal government that facilitate the introduction of services where they're needed.

And sometimes they won't be limited by state boundaries, and that has to be taken into account.

But you know, a magic line on the map does not somehow mean that Tweed Heads and Coolangatta have completely different mental health needs and requirements.

The whole of government part, yes, we will have, I suspect, quite a bit to say on that because despite the objective for the national mental health and suicide prevention agreement of having a whole of government approach, what we've heard so far really belies any progress there.

I'm trying desperately to think of a situation where someone said oh yes, it's really worked across education or it's really worked across corrections or somewhere else in that whole of government approach I can't think of one, Sel you might be able to come up with an example of the top of your head because I don't want to give the impression that we've only heard of failure in that case, but I can't think of hearing of a success but that may be me.

Selwyn Button

Look, I can't think of a success right at the top of my head at the moment, Stephen, but I think it connects back to an early conversation and certainly some of the things we've heard so far through the process around strengthening governance and accountability and certainly when you look at the bilaterals themselves would if you take a step back to the current agreement, there is a role in the current agreement as we mentioned for the National Mental Health Commission in relation to accountability and much of that is then being about the report carding process.

So for us certainly in the conversations in the, in the discussions feedback we've heard so far is do we need to think about a role for the jurisdictional mental health commissions in strengthening governance accountability at a local level in relation to bilaterals and certainly having conversations across government agencies to ensure that where there are obligations on outside of health, on education, on housing, unpractised services, etcetera, that there is a body in each jurisdiction that is able to have those conversations and actually set up governance arrangements to make sure that those cross-agency discussions are occurring on a regular basis.

So I don't have any perfect examples of how it's working well at the moment, but certainly we've heard lots about the need to ensure that governance and accountability not only sits at a national level, but also sits at a jurisdiction level to ensure that the roll out of the bilateral discussions are occurring regularly to make sure that the health stuff's done, but also cross government work is happening to.

Miriam Veisman-Apter

We are at time.

Stephen King

Oh, well, can I just say thank you to those people who've put up a questions in the Q&A and I noticed our numbers have been increasing during the webinar so thank you to those on the webinar who have said to friends, colleagues, oh you should listen to this. So hopefully we'll have a good report, but I'm sure you'll let us know either way. Yes, so that went very fast. We will look at the rest of the questions and yeah, we'll take them on board even though we haven't been able to get to anywhere near all.

But even for a summary of all of the questions in our time, thanks so much for joining us.

And if I can just say thank you and look forward to engaging further during this review.

Selwyn, anything you want to add as the last comment?

Selwyn Button

Just really appreciate everyone dialling in today, the comments and the questions have been great and we'll make sure that we can try and get back to each person that's posted a question that we haven't answered today.

We'll make sure at least we can get back in some shape or form to let people know what the response is to some of those questions are as well, but thank you very much for joining us today.

Stephen King

Thanks folks.

[END]