Allied Health Professions Australia

Consultation response

Productivity Commission Review of the National Mental Health and Suicide Prevention Agreement - Interim Report

July 2025

This submission has been developed in consultation with AHPA's allied health association members.

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Introduction

Allied Health Professions Australia (AHPA) thanks the Commission for the opportunity to provide feedback on the Interim Report released as part of the review of the National Mental Health and Suicide Prevention Agreement. AHPA is the national peak body for Australia's allied health professions, working on behalf of 30 professional allied health bodies, and collectively representing more than 185,000 practitioners.

Allied health professionals are a key mental health and psychosocial workforce, supporting the mental health and wellbeing of the Australian community across a wide range of mental health and psychosocial supports across public acute, justice and community settings, school-based mental health programs, community mental health and non-government programs, Commonwealth programs such as Medicare Mental Health and Headspace services, psychosocial disability supports under the National Disability Insurance Scheme (NDIS), and private mental health services funded under the Medicare Better Access and Eating Disorder programs, as well as private health insurance and privately funded supports. Allied health professionals work independently and as part of multidisciplinary teams alongside medical, nursing, and peer workforces to deliver therapeutic interventions and support recovery, manage illness and symptomology, and support psychosocial outcomes.

Despite well-established and long-standing roles for allied health professionals in mental health and psychosocial disability, the sector often experiences significant challenges working effectively as a result of current policy and funding program design approaches. Limited involvement of the sector by governments in the design and development of future programs also risks exacerbating these issues even as governments seek to undertake reforms. AHPA and its members are consistently experiencing the issue that where there are opportunities for input and engagement, they bring a large and diverse group of stakeholders together leaving little room for some of the specific issues and opportunities associated with a key section of the mental health and psychosocial workforce delivering services. Provider and peer workforce perspectives are very important but should not result in the exclusion of allied health perspectives.

Some of the key challenges the sector experiences include:

1. The allied health workforce is not well recognised by funders and those commissioning mental health and psychosocial services. While psychology is extremely well recognised, social work and occupational therapy are still often excluded from programs despite their eligibility for the Medicare Better Access program. Other professions such as music and art therapy are generally excluded despite strong evidence of their role in supporting recovery and mental health outcomes.[i] [ii] There is also little consideration given to the large volume of evidence showing the correlation between diet and exercise and mental health,

and the role of allied health professions in supporting approaches that use diet and exercise to support mental health and wellbeing.[iii] [iv]

2. The allied health mental health workforce experiences significant workforce shortages, but governments have been slow to invest in workforce initiatives to support allied health workforce development overall as well as the mental health workforce more specifically. Where funding has been made available, it has been time limited, and it is not yet clear if further funding will be committed.[v]
3. A lack of distinction between mental health and psychosocial workforce needs and structure also means that workforce planning is not considering the role of allied health professionals in psychosocial programs and the extent to which there is an available workforce. A positive emphasis on peer workforce development appears to be dominating psychosocial workforce development discussions.
4. Mental health workforce shortages appear to have driven a shift toward more generic mental health and psychosocial support roles that limit opportunities for individual professions to draw on and develop the unique skills and approaches that they have been trained in with impact on the attractiveness of roles for allied health professionals and their longer-term capability development.
5. Artificial distinctions continue to be made between mental health and psychosocial supports, often on the basis that mental health supports are clinical while psychosocial supports are non-clinical approaches. This distinction is inaccurate and fails to account for the psychosocial support role of many allied health professions, which draw on evidence-based, clinical approaches to achieve functional, psychosocial outcomes in partnership with people with psychosocial disability.
6. The roles, skills and capabilities needed for mental health and psychosocial workforces are not well established despite clear evidence that understanding scope and role alongside other disciplines is an important foundation for those working in mental health and psychosocial programs.
7. Current commissioning approaches are undermined by an overall lack of allied health expertise and local allied health provider understanding in Primary Health Networks (PHNs) and other commissioning bodies that can result in arbitrary exclusion of professions from participating in commissioned programs. Short timeframes for undertaking commissioning processes and a tendency to see preferencing of existing large providers as the safer option also tend to limit opportunities for local allied health providers with relevant expertise and experience to participate in delivering programs and services.

Feedback on the draft recommendations

AHPA is pleased to see that the interim report acknowledges some of these issues and has recommendations that may address some or all of these. Below we have addressed recommendations of particular relevance to the allied health sector and their potential role in addressing the challenges outlined above. Where our response does not specifically reference a draft recommendation, we are supportive of the proposal.

- **Draft recommendation 2.1** recognises the inconsistency and variation in commissioning by PHNs, recommending that the Commonwealth delivers National Guidelines on Regional Planning and Commissioning for PHNs and local hospital networks by the end of 2025. This is an important piece of work that should be released as soon as practical but will need to ensure that it brings in the findings from the Review of Primary Health Network Business Model & Mental Health Flexible Funding Model, which included a focus on regional planning and commissioning as part of the Mental Health Flexible Funding Stream. In addition, there is an urgent need to engage with the allied health sector to identify and address the key barriers to participation in commissioning opportunities by allied health providers. Future approaches will need to better support the involvement of existing local providers with relevant mental health and psychosocial expertise as well as established relationships within the local health and mental health system. This could include ensuring that contracting and sub-contracting or provider panel approaches as well as support for consortia of smaller providers are available as part of commissioning approaches, and that planning and commissioning approaches require the prioritisation of existing supports.
- **Draft recommendation 4.1** recognises the lack of clear objectives and priorities for our mental health system and recommends the development of a renewed mental health strategy. We argue strongly that a strategy should more clearly define the roles of mental health, psychosocial supports, and the intersection between these. We also argue strongly that while people with lived and living experience, supporters, families, carers and kin should be involved in co-design, there is also an important role for the allied health sector and other workforces involved in delivering mental health and psychosocial service to be involved in contributing to the design of the strategy. The private provider voice in particular, represented by allied health peaks, is one that is too often left out of strategic discussions despite the significant role they play in delivering services.
- **Draft recommendation 4.3** notes the importance of contextualising the agreement in the broader policy environment. We support the proposed agreements and policies listed by the Commission in this report but also argue for the need to align Medicare, private health insurance and NDIS funding policy with the review, noting

the role each of these funding programs play in supporting (or not) relatively consistent national access to mental health and psychosocial supports. Policy changes in these programs should also reflect the outcomes, priorities and actions in a future agreement.

- **Draft recommendation 4.4** recognises the lack of progress governments have made in addressing unmet need outside the NDIS and, indirectly, the lack of progress to respond to the NDIS Review recommendations for foundational psychosocial supports outside of the NDIS, calling for finalising of funding and commissioning arrangements within the life of the current Agreement. AHPA strongly supports the call for immediate action and commitment of funds to address unmet need but questions the finding that PHNs are ready to commission appropriate services based on their experience commissioning psychosocial supports, their previous experience with programs such as Partners in Recovery, and their existing relationships with community mental health providers. The introduction of the NDIS has had a significant impact on the mental health and psychosocial support ecosystem and shifted a large proportion of the workforce into private practice. New models and approaches are needed to address the changes in the system and to support access to an appropriately trained and experienced workforce. A focus on commissioning models and regional planning is key to addressing these changes. AHPA also notes that the Commonwealth Psychosocial Support Program is currently undergoing independent evaluation and while the evaluation will be undertaken between 2025 and 2027, there is an opportunity to draw on initial evaluation findings, and to focus evaluation activities, to better support understanding of the strengths and weaknesses of this PHN commissioned program.[vi]
- **Draft recommendation 4.5** recognises the importance of carer and family supports and the lack of clarity about responsibility for planning and funding these supports. AHPA and the sector strongly support this recommendation, with practitioners describing frequent examples of where they are limited in being able to work with, and support carer and family supports despite the essential role they play in supporting recovery and the well-established need to address their health and wellbeing alongside that of the person receiving services.
- **Draft recommendation 4.8** recommends a role for the broader sector in governance, recognising the gap in current arrangements. AHPA strongly support this recommendation but argue that representation must be broader than only providers and provider groups, but also clinical representation from the allied health sector that represent the workforces delivering many services. There are potentially significant differences in the perspectives of providers delivering commissioned services and the workforces working at the coalface with people with mental health challenges and psychosocial support needs that must be incorporated into governance arrangements.

- **Draft recommendation 4.12** recommends an emphasis on national consistency in commissioning work by PHNs while still allowing sufficient flexibility to support locally relevant and existing services. We note in this context that the use of local services should not require previous evaluation but instead focus should be placed on ensuring appropriate monitoring and evaluation frameworks for future services. Requiring previous evaluation risks continuing the emphasis on status quo rather than allowing greater participation in commissioning approaches by allied health providers. If governments were to only expand current commissioning approaches, there are significant risks of exacerbating workforce issues and excluding an experienced and important part of the workforce. We also emphasise the impact of short timelines for establishing programs that have been noted by a range of stakeholders in relation to PHN commissioning. The sector considers this a key contributor to more conservative and less innovative approaches that reduce opportunities for involvement of allied health providers.
- **Draft recommendation 4.13** notes the importance that the next agreement supports implementation of the National Mental Health Workforce Strategy. AHPA strongly supports this recommendation, noting the need for an ongoing workforce development program for allied health mental health and psychosocial workforces. We also note that Health and Mental Health Ministers have committed to the development of a mental health capability framework by June 2026 as a support for the workforce strategy. This capability framework should establish both the capabilities needed for different mental health and psychosocial roles, but also the professions that have the scope and capabilities associated with those. The next agreement should require services to be delivered in line with the capability framework and its findings about workforce requirements.
- **Draft recommendation 4.14** recommends the development of a scope of practice for the peer workforce under the next agreement, noting that this could promote safer work practices for peer workers, better outcomes for people accessing mental health and suicide prevention peer support, and improve public understanding of the profession. AHPA strongly supports this recommendation, noting that the allied health sector is very supportive of peer workforces and the role of lived experience, and has a long history of supporting the development of peer programs and working alongside peer workers. That experience also shows the importance of establishing not only a scope of practice but more consistent requirements for peer workforces to have access to supervision and training. Many peer workforces experience limited access to appropriate supervision and support structure, impacting on their mental health and wellbeing. AHPA argues that there is a need to establish clinical governance and supervision frameworks alongside a scope of practice to establish nationally consistent standards for how peer workforces work with alongside other mental health and psychosocial workforces and how clinical governance structures can ensure the safety and wellbeing of both those accessing services and those

providing them. In addition, AHPA cautions strongly about the push by governments to address workforce shortages and costs in mental health and other workforces through role substitution with assistant and peer workforces rather than focusing on the development of effective multidisciplinary team arrangements that draw on the strengths and focus of individual professions. A range of reviews have noted potential benefits but also limited evidence of outcomes from peer work and the need to take a conservative approach when designing programs.[vii]

- **Draft recommendation 4.15** notes the importance of timely evaluation of funded programs with public sharing of evaluation findings. AHPA supports this, noting the value of including in evaluation frameworks greater consideration of the workforce models that underpin programs. Evaluations of psychosocial and mental health programs regularly note the variation in workforces across different providers delivering the same program and the potential impact on outcomes associated with those.
- **Draft recommendation 5.1** recognises the different needs associated with supporting Aboriginal and Torres Strait Islander social and emotional wellbeing, calling for a separate schedule in the next agreement. AHPA strongly supports this proposal, noting that co-design should not only include Aboriginal and Torres Strait Islander people, but also organisations with specific expertise in this area, the Aboriginal and Torres Strait Islander allied health workforce, and the allied health professionals working in communities with a strong understanding of community need and service ecosystem structures.

Information requests

AHPA agrees that there should be an additional schedule to address the co-occurrence of problematic alcohol and other drug use and mental ill health and suicide as flagged in **information request 4.1**. We argue that a key focus needs to be addressing the integration between different supports and services with co-occurring need regardless of whether these are Commonwealth, state and territory, or privately funded. Currently practitioners report significant barriers to working with other public services if, for example, a person is accessing services funded by the NDIS or private health insurance.

A public dashboard as outlined in **information request 4.3** has value and would be a helpful way to ensure greater accountability for all governments to deliver on the objectives and outcomes of the next agreement. AHPA notes that consideration is needed for which stakeholders will wish to access information on a dashboard and which information they would likely be interested in accessing. For example, we expect that there may be differences in the information the broader public is seeking when compared with the information that professional peaks with a role in supporting their own workforces as well as guiding and supporting government policy and program

development might need. The allied health sector would be particularly interested in metrics associated with the volume of supports being provided and the number of individual consumers being supported, workforce profiles (which services are being delivered by which professions), outcomes measurements associated with outcomes in key areas such as housing, employment and education, and cost of services (what is it costing us to deliver those services). The latter in particular would help to better compare the cost of delivering individualised services through private providers (and which some stakeholders are suggesting is more expensive) with the cost of delivering block funded programs. AHPA argues that the Commonwealth should be responsible for the collation of Commonwealth data, and the publication of all data, with the states and territories responsible for gathering and sharing data with the Commonwealth.

Final notes

AHPA and its members support the Commission's findings in relation to the failures of the current agreement and view the draft recommendations as forming a strong basis for improvements in a future agreement. We particularly support the need for greater ambition and accountability under a future agreement and the need to move more quickly to address the high volume of psychosocial support need. We look forward to working with all governments to make these much needed reforms.

When taking a systems view as any national agreement must do, there is too often a tendency to consider the role of the professions that deliver services, the models that underpin approaches, and how we are engaging them in the design and delivery of services. We strongly urge the Commission to recognise the role and value of the allied health sector and to consider how they can play a more significant role in the development and governance of future agreements and the supports and services that underpin those agreements.

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[i] Tríona McCaffrey, Jane Edwards, Dominic Fannon. Is there a role for music therapy in the recovery approach in mental health? The Arts in Psychotherapy, Volume 38, Issue 3, 2011, Pages 185-189, ISSN 0197-4556, https://doi.org/10.1016/j.aip.2011.04.006.

[ii] Im ML, Lee JI. Effects of art and music therapy on depression and cognitive function of the elderly. Technol Health Care. 2014;22(3):453-8. Doi: 10.3233/THC-140803. PMID: 24704654.

[iii] Chang de Pinho, I., Giorelli, G. & Oliveira Toledo, D. A narrative review examining the relationship between mental health, physical activity, and nutrition. Discov Psychol 4, 162 (2024). https://doi.org/10.1007/s44202-024-00275-7

[iv] https://exerciseismedicine.org.au/wp-content/uploads/2021/04/EIM-FactSheet_Depression_Professional-2020.pdf

[v] The National Mental Health Pathways to Practice program has created important opportunities for placements for psychologists, occupational therapists and social workers but ended as of 30 June 2025

with no announcements about extensions to the program. See for example: https://news.csu.edu.au/latest-news/university-receives-millions-to-boost-mental-health-workforce.

[vi] https://www.health.gov.au/our-work/commonwealth-psychosocial-support-program

[vii] Simmons MB, Cartner S, MacDonald R, Whitson S, Bailey A, Brown E. The effectiveness of peer support from a person with lived experience of mental health challenges for young people with anxiety and depression: a systematic review. BMC Psychiatry. 2023 Mar 24;23(1):194. Doi: 10.1186/s12888-023-04578-2. PMID: 36964523; PMCID: PMC10038377