7 August 2025

Mental Health and Suicide Prevention Agreement Review
Productivity Commission
GPO Box 1428
Canberra City ACT 2601

Via email: mentalhealthreview@pc.gov.au

ANGLICARE WA RESPONSE: MENTAL HEALTH AND SUICIDE PREVENTION AGREEMENT REVIEW INTERIM REPORT

Dear Commissioners,

Anglicare WA is pleased to make the following submission to the Productivity Commission (PC) with reference to the National Mental Health and Suicide Prevention Agreement Review Interim Report.

Anglicare WA is a leading not-for-profit organisation in Western Australia that reaches over 82,000 people each year in times of need. We provide support, counselling, accommodation, and advocacy for people impacted by poverty, homelessness, domestic violence, grief by suicide, and mental health. This includes direct support to 1,878 people through mental health and wellbeing services. These services include:

- Active Response Bereavement Outreach (ARBOR)
- Bounce Wellbeing
- Children and Young People Responsive Suicide Support (CYPRESS)
- Early Intervention Social Support Service
- headspace
- Metro Postvention Service
- Pilbara Integrated Primary Mental Health Care Service
- Senior Therapeutic Service at Foyer
- StandBy Support after Suicide
- Student Wellbeing Officers Services
- Youth Psychosocial Support Packages

The discussion points and recommendations contained within the submission have been collated from practice areas across Anglicare WA, incorporating the views and responses of front-line workers and practice leaders.

Anglicare WA is a member of Suicide Prevention Australia, the Western Australian Association for Mental Health, and a partner of Youturn. Anglicare WA supports and endorses the Youturn submission.

Our recommendations include:

- Address social determinants of health through an interdepartmental and cross-sector approach.
- Elevate postvention as a standalone pillar with dedicated funding.

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- Embed Lived Experience in decision-making roles in all funded programs.
- Strengthen accountability and outcomes through transparent monitoring and evaluation frameworks.

We thank you for the opportunity to share our insights. For any questions relating to this submission, please contact Katie Carter, General Manager, Practice Excellence,

Yours faithfully,

Mark Glasson
Chief Executive Officer

OVERVIEW

Our submission contains the following sections:

- Support for Interim Report
- Response to information requests
- Additional priorities
- Recommendations for the new Agreement

SUPPORT FOR INTERIM REPORT

Anglicare WA welcomes the Interim Report of the Mental Health and Suicide Prevention Agreement Review and acknowledges the work of the Productivity Commission (PC). We support the Interim Report's draft findings and recommendations and highlight the following as being of particular importance:

- Aboriginal and Torres Strait Islander Wellbeing and the need for a dedicated schedule to strengthen social and emotional wellbeing.
- The necessity of a focussed schedule on Suicide Prevention under the National Suicide Prevention Strategy.
- Stronger governance frameworks and accountability, including increased involvement of people with Lived Experience in decision-making roles.
- A renewed and more effective National Mental Health Strategy, with stronger links to the broader policy environment.
- A focus on building the mental health and peer support workforce to include a dedicated scope of practice.
- Ensuring better integration of psycho-social supports outside the National Disability Insurance Scheme (NDIS).
- Building on the evaluation framework and ensuring clear metrics for tracking suicide prevention and mental health efforts.

RESPONSE TO INFORMATION REQUESTS

Response to Information request 4.1 – The PC is seeking views on whether there should be an additional schedule in the next agreement to address the co-occurrence of problematic alcohol and other drug use and mental ill health and suicide.

Current bi-lateral schedule initiatives fail to account for the high prevalence and implications of co-occurring mental health, alcohol and other drug (AOD) use, and suicide. Furthermore, the limited data being collected under these initiatives overlooks the necessity of integrated care models. The consequences of co-occurrence are significant, including greater health care system burden, higher suicide risk, more frequent relapses, hospitalisation and homelessness.

The Western Australian Association for Mental Health (WAAMH) estimates that 1 in 5 Australians living with a mental health condition also have a co-occurring AOD disorder, highlighting a

substantial overlap in these issues. Likewise, broader national data outlines that nearly 50% of people engaging in AOD treatment have current mental health comorbidities.[1]

Aligning schedule initiatives with national evidence on co-occurring conditions will enhance responsiveness, support integrated care models, and improve health and suicide prevention outcomes.

Response to Information request 4.2 – The PC is seeking examples of barriers to the genuine participation and influence of people with lived and living experience in governance forums. How could successful inclusion and engagement of people with lived and living experience in governance be measured?

Anglicare WA believes the meaningful inclusion of people with Lived Experience (LE) is vital for ethical governance. Evidence demonstrates that LE contributions improve decision-making, however achieving impact requires structured, well supported frameworks. To overcome barriers for genuine LE participation and influence, critical components for organisational governance should include the following:

- Development of LE governance frameworks to embed LE in leadership
- Establishment of LE Advisory Groups for strategic input
- Inclusion of LE on boards and committees, ensuring co-decision roles
- Targets for LE participation and decision-making roles
- Documentation of qualitative impact to track LE input on influence and outcomes
- Equitable compensation for LE contributions to ensure fairness.

Anglicare WA has established a Lived Experience Advisory Group (LEAG) and Lived Experience Framework as commitment to learning and growing alongside people with LE. This commitment acknowledges life experiences, expertise and specialist skills as central to championing the voices of people who use our services.

Additionally, a cultural security framework was developed, outlining a way of operating that ensures all individuals and groups are treated with regard to their unique cultural needs and differences whilst amplifying the LE and voice of Aboriginal people.

Response to Information request 4.4 – The PC is looking for case studies to highlight best practice in integrating peer workers in clinical mental health and suicide prevention settings, particularly by improving clinician awareness of the peer workforce. Are there examples of best practice that could be adopted in other organisations or settings?

Anglicare WA recognises that LE is vital, not only shaping individual recovery journeys, but also enhancing organisational culture. Peer- led roles are central to our workforce, enriching diversity, expertise, and capacity of services we offer. Embedding LE frameworks and advisory groups endorsed by executive leadership and our Board ensures that peer-led contributions are

[1] Alcohol and Drug Foundation.

integrated, not peripheral. Below are examples of how Anglicare WA has embedded LE.

- Anglicare WA ARBOR Peer group: LE peer volunteers co-design and co-facilitate suicide bereavement groups, offering empathy, genuine peer connection, and shared understanding.

- StandBy National: LE is embedded in a jointly owned governance structure, with a National Lived Experience Advisory group informing strategy, training, and service design. This structure diversifies and strengthens StandBy's suicide postvention support.

- Roses in the Ocean: Developed an accredited suicide prevention peer workforce model to deliver timely, compassionate support and contribute to system reform, reducing clinician pressure and expanding response capacity.

ADDITIONAL PRIORITIES

We wish to highlight two interrelated priorities that must be emphasised at the core of the next Agreement: a robust focus on social determinants of health and the critical role of suicide postvention.

The Agreement must prioritise an understanding in suicide prevention that goes beyond clinical diagnoses and recognises social and economic factors such as housing insecurity, financial distress, family and domestic violence and childhood adversity. Further embedding a social determinants lens to guide postvention across policy areas and ensure universal access to well-resourced and evaluated suicide bereavement supports is paramount.

Social Determinants of Health

While the link between suicide and mental health conditions and a previous suicide attempt is well established, many suicides happen in a moment of crisis.[2] No mental health and suicide prevention framework can succeed in isolation from the social and economic factors that shape wellbeing.

These non-medical factors, known as social determinants of health, are defined by the World Health Organisation as "the conditions in which people are born, grow, live, work and age, and people's access to power, money, and resources."[3] Key determinants include:

- Housing stability and secure tenure
- Employment opportunities and fair workplaces
- Access to quality education and early-childhood supports
- Affordable, culturally safe healthcare and community services
- Social inclusion, anti-discrimination measures, and community connectedness.

For Aboriginal and Torres Strait Islander people, social determinants of health also include

[2] World Health Organisation. (n.d.). Social Determinants of Health.
[3] World Health Organisation. (n.d.). Social Determinants of Health.

factors such as cultural identity, family and kinship, country and caring for country, knowledge and beliefs, language and participation in cultural activities, and access to traditional lands.[4]

Social determinants have a significant impact on health, accounting for 30-55% of health outcomes.[5] They also account for health inequities due to unequal access to social and economic resources.

Research presented by the Australian Institute of Health and Welfare (AIHW) outlines that people experiencing social disadvantage face higher rates of mental illness and suicidal distress.[6] Furthermore, individuals who experience discrimination based on race have an increased likelihood of developing suicidal thoughts and attempting suicide.[7]

For Aboriginal and Torres Strait islander people, colonisation and ongoing inter-generational trauma have had a fundamental impact on the health inequities and rates of suicidal distress that they experience.[8] The impact of the Voice Referendum is of particular note.

Charities and health organisations observed a rise in suicide rates and suicidal distress among First Nations communities during the referendum debate due to an increase in racism and discrimination.[9] At Anglicare WA this observation was reflected by our Aboriginal Advisory Group, which consists of Elders and other Aboriginal community members who are well respected within their communities. Furthermore, the reflections were seconded internally through the Aboriginal Staff Network.

These observations and reflections on the rise in suicidal rates and suicidal distress among First Nations communities are supported by a study by the Australian National University's National Centre for Aboriginal and Torres Strait Islander Wellbeing Research. The study found that discrimination increased in daily life and in healthcare settings for Aboriginal and Torres Strait Islander adults during the Referendum, leading to an increase in high or very high psychological distress. Feelings of rejection, anxiety, and cultural disconnection were also prevalent.[10]

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[4] Australian Institute of Health and Welfare. (2024). Determinants of health for First Nations people.
[5] Australian Institute of Health and Welfare. (2024). Determinants of health for First Nations people.
[6] Australian Institute of Health and Welfare. (2025). Prevalence and impact of mental illness. First Nations people, LGBTQIA+ people, people with a disability, and people not in education, employment or training generally experience higher psychological distress than the rest of the population.
[7] Coimbra, B. M., Hoeboer, C. M., Yik, J., Mello, A. F., Mello, M. F., & Olff, M. (2022). Meta-analysis of the effect of racial discrimination on suicidality. *SSM - Population Health*, 20, 101283.
[8] Australian Institute of Health and Welfare. (2024). Determinants of health for First Nations people; Productivity Commission. (2025). Closing the Gap: Annual Data Compilation Report.
[9] French, E., & Vyver, J. (2023, October 3). *Voice to Parliament referendum impacting mental health of Indigenous Australians as charities report increase in racism*. ABC News. https://www.abc.net.au/news/2023-10-03/indigenous-mental-health-impacts-of-voice-referendum-debate/102923188
[10] Wilkes, B., Hasan, M., Thandrayen, J., Colonna, E., Evans, O., McKay, C., Nguyen, MTH., Sedgwick, M., Thurber, KA., & Lovett, R. (2024). Research Summary: Aboriginal and Torres Strait Islander mental health and wellbeing in the lead up to the Voice to Parliament Referendum. National Centre for Aboriginal and Torres Strait Islander Wellbeing Research. During the Referendum period, 71.2% of Aboriginal and Torres Strait Islander adults experienced everyday discrimination, up from 66.4% pre-Referendum. Healthcare discrimination also increased from 41% pre-Referendum to 46.3% during the Referendum. Consequently, psychological distress also increased, with 44.4% of Aboriginal and Torres Strait Islander adults experiencing high or very high psychological distress during the Referendum period, up from 39.5% pre-Referendum. This increase equates to an additional 17,000 Aboriginal and Torres Strait Islander adults experiencing psychological distress.

More broadly, the cost-of-living crisis and housing crisis have become the most significant drivers of psychological distress and suicide risk in Australia, affecting individuals across income levels, age groups, and regions.

According to a 2024 Suicide Prevention Australia survey, 86% of frontline services said that the greatest risks to suicide rates over the next 12 months are cost of living and personal debt while 83% noted housing access and affordability.[11] Community insights from their 2024 YouGov polling were similar, with 91% of Australians believing that social and economic circumstances will pose a significant risk to suicide rates in Australia this time next year.[12] And almost half (49%) of Australian adults reported elevated distress due to cost of living and personal debt compared to the same time last year.

Meanwhile, the latest BCEC Housing Affordability in Western Australia Report noted the links between poor housing and poor health outcomes, with 43% of those in unaffordable housing reporting poor physical health and 41.4% reporting poor mental health.[13]

These trends in social determinants reflect what Anglicare WA's services are observing on the frontline. Our housing and financial services have seen an uptick in clients co-presenting with mental health issues related to housing stress and financial stress. Below are some of their insights.

A financial counsellor from the Financial Wellbeing Collective reported:

> Mental health challenges are frequently disclosed, particularly anxiety and depression linked to financial hardship and unstable housing. [There is an] increase in clients presenting who are now linked in with mental health services due to attempting suicide due to debt worries.

[11] Suicide Prevention Australia. (2024). State of the Nation in Suicide Prevention: A survey of the suicide prevention sector, p.16
[12] Suicide Prevention Australia. (2024). State of the Nation in Suicide Prevention: A survey of the suicide prevention sector, p.18. Australians cited cost of living and personal debt (70%) and housing access and affordability (55%) as the most significant risks to suicide rates in Australia.
[13] Crowe, A., Duncan A., and Rowley S. (2024). Housing Affordability in Western Australia 2025: A long way from home, Bankwest Curtin Economics Centre (BCEC), p 90

An Anglicare WA housing support worker noted:

> At Anglicare WA, we see firsthand the impact of housing stress and homelessness on people's mental health. Since collecting data along with other community services through the By-Name List (BNL), it's become alarmingly clear how deeply intertwined homelessness and mental health are in our region. In Mandurah, 88.2% of people experiencing homelessness have reported a mental health condition, with even higher rates in Rockingham and Kwinana at 95.9%.
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> Across our programs, we've seen a significant increase in individuals presenting in acute distress due to rental stress, eviction risk, and homelessness. Our staff are receiving more phone calls from clients experiencing suicidal ideation, and we're seeing more people walk into our offices overwhelmed and at breaking point. These aren't isolated incidents—they reflect a growing crisis where housing instability is contributing to deteriorating mental health and increased suicide risk.
>
> The social determinants of health—particularly access to safe, secure housing—must be front and centre in any mental health and suicide prevention strategy. Without meaningful housing interventions, we will continue to see mental health supports pushed beyond capacity and lives placed at risk

A staff member from a support service for young people (18-21) leaving the out of home care system reflected:

> We've seen an increasing number of young people presenting with poor mental health due to the housing crisis and cost of living. Housing stability affects your mental health because if you're in crisis you don't have anywhere to live and if you don't have anywhere to live you can't get a job so it's a self-fulfilling cycle of stress. And the cost of living is so much higher than it was previously, so young people working casually and in part-time roles can't afford to live independently, especially young people without safety supports such as family and friends.
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> A few of our staff, who have lived experience of the care system and homelessness, are also struggling with the cost of living and have poor mental health because they're focusing on housing security, and it impacts their day-to-day functioning. It's particularly hard for our staff who are single parents. People are too busy surviving to thrive. There's a lack of hope for the future because they don't know how they're going to survive.

When it comes to our mental health and wellbeing services, Anglicare WA StandBy staff have noted multiple cases in 2025 where an individual has died by suicide where a core contributor identified by a next of kin or family member has been financial distress resulting from being financially scammed. It is important to note that it is not encouraged to identify individual and specific causes and contributors to suicide, particularly prior to a completed coronial investigation.

StandBy and the WA Police Force (WAPF) established and signed a Memorandum of Understanding (MoU) in July 2023 that facilitates data sharing on deaths by suicide. In the MoU, suspected suicide incident details are provided, with consent, by WAPF to the StandBy team,

enabling timely and equitable opportunities for support. The data captured through this agreement heavily evidences contributors of suicide related to social determinants of health.

Addressing the social determinants of health through cross-sector policy—in health, housing, education, justice, and social services—is essential to reduce health inequities and improve health outcomes in the long-term for Australians.

CASE STUDY 1: FINANCIAL STRESS AND RISK OF SUICIDE

Fiona is a 77-year-old aged pensioner. She attended a financial counselling appointment at Anglicare WA's Rockingham location in an extremely emotional state, expressing how she had been to many other services in the area, and no one could help her. She was unsure what we could do to help.

Fiona explained to the financial counsellor that she had joined a dating site hoping to meet new friends, but her kindness was quickly exploited in an elaborate romance scam. Consequently, she was scammed out of $117,000. Fiona emphasised that she felt 'stupid' having fallen for her friend's lies and disclosed that for the first time in her life she had contemplated suicide.

Fortunately, Fiona was able to receive support from the financial counsellor, as well as her doctor. She is now debt free and no longer feels suicidal.

Suicide Postvention

Effective suicide prevention does not end with attempting to reduce deaths by suicide. It must also include compassionate, coordinated, culturally appropriate and holistic support for those bereaved by suicide. This type of support after the loss of a loved one from suicide, known as postvention, includes immediate and long-term suicide grief support, trauma-informed counselling, peer-led support groups, and support from family and friends.[14]

According to Postvention Australia, people bereaved from suicide are up to eight times more likely to die by suicide than the general population, therefore postvention is a critical form of support and suicide prevention.

In addition to providing support to those impacted by suicide, postvention:

- Implements safe messaging guidelines, as recommended by Mindframe[15], to reduce connected deaths in schools, workplaces, and the broader community.
- Equips frontline services—hospitals, coroners' courts, emergency responders—with clear protocols and guidance for responding to a death by suicide.
- Builds community resilience by training local leaders, cultural advisers, faith groups and the broader community in postvention response, support, and best practice.

[14] Postvention Australia. (2019). What is postvention?
[15] Mindframe. (n.d.). Guidelines.

As per the Agreement, postvention services aim to support individuals and communities bereaved or impacted by suicide, and to reduce the possibility of connected deaths. Anglicare WA has four postvention services that work toward these outcomes:

- ARBOR
- CYPRESS
- Metro Postvention Response Group (MPVRG)
- StandBy

The work and outcomes achieved by these services highlight the importance and effectiveness of postvention for individuals, families, and communities impacted by suicide. Over 2,000 individuals were supported through these postvention services across WA in the FY24-25 period, with steady trends highlighting increased demand for support since 2022.[16]

Further resourcing for Aboriginal-led postvention support, either through specialised services such as Thirrili, or through social and emotional wellbeing programs provided by ACCOs, would provide a breadth of support options for Aboriginal people impacted by suicide. Increased collaboration is welcomed and encouraged, ensuring all individuals, families and communities have appropriate, timely and culturally specific offerings of self-directed support.

Increased and consistent funding and embedding postvention into the Agreement will ensure all states have equal opportunity to provide supports to communities. Additional to the bi-lateral agreements, initiatives such as the live suicide monitoring system, similar to NSW and other states, will allow consistent and detailed data on suicides in Western Australia. This initiative is imperative to improve the quality and timing of postvention interventions, and more importantly, critical for preventing further suicides.

[16] These trends have been highlighted in service progress reports to funders. For example, the FY24-25 progress report for CYPRESS noted, "Risk factors present in the CYPRESS client cohort are moderated through provision of a longer-term suicide postvention counselling model. However, as the waitlist for services increased, additional funding was required to triage CYPRESS clients into longer-term counselling and provide support while clients are waitlisted for services."

CASE STUDY 2: THE POSITIVE IMPACT OF POSTVENTION SUPPORT

Dylan is a 15-year-old male whose mother recently died by suicide. His father also died by suicide five years earlier. In addition to the loss of his parents, he lost his younger brother, who was hit by a vehicle while walking and passed away, one year ago.

Prior to his mother's death, Dylan had been living with his mother and her boyfriend, but this relationship had not been recognised by Centrelink or Dylan's school. This meant that following his mother's death, Dylan faced housing and guardianship uncertainty.

StandBy's involvement began at Dylan's grandmother's request, ensuring his agency in engaging with support. StandBy provided direct, trauma-informed assistance supporting Dylan in navigating guardianship conversations, resolving worries about entering statutory care, and facilitating mediation between family members.

Dyland received practical support around housing stability, food relief, school engagement, and Centrelink matters. Dylan's voice and autonomy were prioritised throughout, helping him remain connected to his personal network and empowered in decisions about his future.

RECOMMENDATIONS FOR THE NEW AGREEMENT

Anglicare WA recommends the following for the new Mental Health and Suicide Prevention Agreement:

1. Establish interdepartmental and cross sector working groups to tackle social determinants, ensuring mental health outcomes are explicitly considered in housing, employment, and education policies.
2. Embed postvention as a standalone pillar, with dedicated funding for workforce training, bereavement services, and safe-messaging campaigns.
3. Require all funded programs to include Lived Experience leadership, particularly from those bereaved by suicide and from communities facing structural disadvantage.
4. Build transparent monitoring and evaluation frameworks that track both postvention uptake and progress on social determinants indicators.

CONCLUSION

By elevating suicide postvention alongside a strong social-determinants lens, a new Mental Health and Suicide Prevention Agreement will be more compassionate, equitable, and effective. We look forward to collaborating with governments, service providers, and communities to turn these priorities into concrete action.