MATTER FOR NOTING

Title:	Productivity Commission Final Review of the National Mental Health and Suicide Prevention Agreement Submission
Report to:	Productivity Commission
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1 Executive Summary

Productivity Commission Final Review of the National Mental Health and Suicide Prevention Agreement Submission by Ruah Community Services March 2025

Ruah Community Services welcomes the opportunity to provide this submission to the Productivity Commission's Final Review of the National Mental Health and Suicide Prevention Agreement (the Agreement). As a leading provider of integrated health and social services in Western Australia, Ruah is committed to ensuring that mental health and suicide prevention services are effective, accessible, and culturally safe.

It is clear that previous national mental health plans have consistently identified the same priorities—systemic integration, peer support, evidence-based care, early intervention, and culturally responsive services. Despite these well-documented recommendations, systemic fragmentation has hindered real change, leaving a persistent gap between policy aspirations and actual service delivery on the ground.

One of the fundamental barriers is the continued siloing of services, peer support remains supplementary rather than central to care and fully integrated across all levels of care additionally crisis and recovery services remain underfunded or inaccessible in regional and remote areas. Many programs, such as headspace, have demonstrated success in early intervention and prevention, yet a lack of longitudinal evaluation frameworks providing long-term data makes it difficult to determine their long-term effectiveness in reducing suicide rates and improving overall mental health outcomes.

Mental health recovery and suicide prevention do not follow a linear path, yet they continue to be measured through traditional biomedical frameworks, which aim for a fixed treatment outcome of acute symptom reduction rather than long-term well-being, resilience, and social integration. Instead, a holistic, trauma-informed approach is required—one that shifts evaluation metrics from crisis intervention towards sustained improvements in mental, emotional, and social health.

By embedding peer- integrated models, trauma-informed frameworks, and robust national data collection standards, Ruah seeks to drive meaningful, evidence-based change that ensures mental health services are truly accessible, responsive, and impactful for those who need them most.

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2 Ruah's Scope of Services & Contribution to Suicide Prevention

Ruah Community Services provides specialist mental health, suicide prevention, housing, justice, and trauma recovery services across Western Australia. Through an integrated service model, Ruah supports individuals facing complex challenges, ensuring that mental health care does not exist in isolation but is embedded within broader systems of social and economic wellbeing.

While suicide prevention is a core focus, Ruah's strategic work highlights that suicidality is rarely a standalone issue—it intersects with housing instability, domestic and family violence (DFV), justice system involvement, and cultural and systemic barriers to care. Many individuals at risk of suicide are falling through the cracks of a fragmented, clinical-centric mental health system, reinforcing the need for peer-led, community-based, whole of person and trauma-informed approaches.

Ruah's work demonstrates that suicide prevention must extend beyond emergency responses—it requires long-term, sustainable solutions that address the underlying causes of distress, including trauma, marginalisation, and unmet social needs.

1. SUICIDE PREVENTION & MENTAL HEALTH SERVICES

1.1 The Luminos Project – A Suicide Sanctuary for young people experiencing thoughts of suicide.

Ruah alongside the Samaritans, provide The Luminos Project , a first-of-its-kind, non-medical alternative to hospital emergency departments for young people (16-24 year old)s experiencing suicidal distress. Based on the Maytree model from the UK the service has been co designed with the young people, their families/careers and stakeholders to fit the context and meet the need of young people in WA.

The service:

- Provides a safe, home-like environment designed for emotional regulation and healing utilising trauma informed principles.
- The team is staffed by peer workers, counsellors, a clinical lead, and volunteers, all of whom have lived experience of suicide and recovery. With the clinical lead providing guidance, the integrated team contributes uniquely to the experience of the young person.Offers short-term intensive intervention with a focus on skills development, understanding one's own experience of suicidal thoughts and built on relational practices.

- It works in close partnership with other services, hospitals, and mental health networks, providing support at the appropriate times through strong referral pathways to ensure continuity of care.. The evaluation conducted by the University of Western Australia (UWA) and the Kids Institute on the Luminos Project is a longitudinal, mixed-methods study that tracks the mental health outcomes of young people, staff, and volunteers over time through quantitative measures such as suicidal ideation, psychological distress, and quality of life, as well as qualitative interviews, to assess the impact of the peer-integrated support service, staff wellbeing, burnout, and satisfaction at multiple time points, including baseline, 1-week, 3-month, and 6-month follow-ups.
- The interim report on The Luminos Project has shown a significant reduction* in suicidal ideation, particularly for young people with intent. Young people in the "Suicidal Ideation/With Intent" cluster experienced the greatest decrease in suicidal thoughts, with scores dropping from an average of 4.71 at baseline to 2.67 one week after their stay. This improvement continued over the following months, demonstrating the project's impact in addressing and reducing suicidal ideation(The reduction in suicidal ideation was measured using the **Columbia-Suicide Severity Rating Scale** Ref: Posner, K., Brown, G. K., Stanley, B., Brent, D. A., Yershova, K. V., Oquendo, M. A., & Mann, J. J. (2011). The Columbia–Suicide Severity Rating Scale. *American Journal of Psychiatry*, 168(12), 1266-1277).

Luminos addresses the growing need for alternatives to hospital-based crisis care by offering a safe, non-traumatising space for young people experiencing suicidal distress, as emergency departments can often be overwhelming. It provides support that focuses on wellness, helping young people manage and live with experiences of suicidal thoughts rather than relying solely on acute care and crisis management. *Ruby* had a long history of suicidal ideation and distress, which began in their late teens, compounded by significant trauma and neurodiversity. When they first contacted The Luminos Project, Ruby had attempted suicide just days before the initial contact with our service. During their time staying at the house, Ruby began to unravel what the experience of suicide meant and the hidden emotions that were driving it. Ruby found the group sessions especially helpful, where hearing from other guests gave her insight into different ways of coping when life felt too overwhelming. In one-on-one sessions with clinical lead, Ruby started to view herself with more empathy and understanding, untangling the many threads that had been pulling her toward suicidal thoughts. Since leaving the house Ruby has re-engaged with TAFE and told us they are able to tolerate their thoughts of suicide much better.*

This brief snippet on Ruby's story is one of many that speaks to the profound impact The Luminos Project has on the lives of young people who are experiencing thoughts of suicide. Through our comprehensive care, personalized support, and the power of lived experience, are helping young people reconnect with hope. As we look ahead, we remain steadfast in our commitment to providing this vital sanctuary to more young people ensuring that we work toward suicide not being the leading cause of death for young people in Western Australia.

** name changed to protect the privacy of young people that have accessed our service.*

It's important to recognize that not all suicide risk is tied to a diagnosed mental health condition; many individuals experiencing suicidality are dealing with situational distress, trauma, and social disconnection. The requirement for a diagnosis or mental health condition can create barriers, such as stigma and challenges in accessing support and services, leaving limited options outside of mental health settings or hospitals. Luminos bridges s this gap by offering a supportive space where young people can receive care, regardless of their diagnosis or clinical history.

1.2 Ruah's Choices program – a Peer integrated approach

From 2017 to 2024 Ruah ran the innovative Choices Peer Program which was a Peer led and imbedded across six hospital emergency departments. Choices aimed to identify clients who regularly presented to emergency departments with distress usually related to suicide who did not feel there was any other option, however would be better supported in community and were experiencing psychosocial challenges.

Choices was able to offer brief intervention within the hospital setting, in 2023-2024 year this stream provided 3614 instances of support provided by Peer workers with a focus on relating, understanding unmet need and navigating the system.

Choices main service was a 3-month intervention within the community, supported by a team including community workers and peer workers, following the person and providing support that was individualised and tailored to personalised needs and goals. In 2023-2024, 352 people were supported within this program. Evaluation of the program was able to show that for many clients connection to appropriate services with the community was essential, navigating the system and walking with someone to support initial access ensure long term outcomes that kept people from representing to hospital and started a recovery journey.

The Choices program utilises highly trained peer workers to provide meaningful engagement based on their Lived Experience that helps support people who frequently present to Emergency Departments (ED) by connecting them back into the community and primary health system. In doing so it reduces ED presentations and prevents escalating acuity of mental health issues. The Choices model:

• Acknowledged the complex, intersectional social factors that contribute to poor mental health outcomes. It works to address underlying issues such as social isolation, addiction, family breakdown, homelessness, financial and legal challenges, trauma, and domestic violence—factors that often lead to frequent emergency department visits. By addressing these needs, the service helped individuals access support in the community rather than relying on the hospital system.

- Provided individualised, peer-led support to 'break the cycle.' Our highly skilled and passionate peer workforce complemented the work of hospital staff by helping clients navigate immediate mental health needs and supporting longer-term recovery through case coordination and connection to community-based services. The program worked to build the peer workforce in Western Australia.

At the end of the 2024 financial year, the Choices program came to an end due to the lack of recurrent funding. This has created a gap in the WA system, affecting the recovery of those who accessed the program and putting additional pressure on the broader system. Hospitals have recognized the unmet need created by the cessation of Choices, especially since no similar or complementary service has been implemented. Data from the program showed that, after one year of operation at Royal Perth Hospital, there was a 35% reduction in the number of clients presenting to the emergency department (ED), as well as a 38% decrease in inpatient length of stay. This resulted in over $1 million in hospital cost savings across 392 clients (equating to $3,462 per person). The loss of this intervention, which has proven efficacy through data, is significant. The program integrated key elements of the strategy, such as peer support in hospital and clinical settings, and provided clients with options to navigate the system. Its absence has wide-ranging impacts, as individuals presenting to the ED are once again faced with the limited options of being either admitted or discharged without ongoing support, often leading to re-presentation and a cyclical experience that increases distress and delays the recovery journey.

Appendix attached at the end provide further insight into the evaluation, impact and program.

1.3 Community-Based Mental Health & Psychosocial Support

Suicidality is often compounded by complex mental health challenges, including severe psychological distress, co-occurring conditions, and systemic barriers to accessing care. Ruah provides:

- Community-based and residential mental health recovery programs tailored to long-term wellbeing.
- Psychosocial support for individuals with complex needs, including NDIS participants.
- Peer-led recovery programs that embed lived experience at the core of service delivery.
- Culturally safe services for Aboriginal and Torres Strait Islander people, ensuring that care is holistic, accessible, and community-driven.
- Individualised goals that are led by the client and focus on outcomes that will impact clients ongoing wellness in domains that impact life satisfaction and long term recovery beyond symptomology.

  Bob joined good days in late 2023, Bob is a 45-year-old male who describes himself as someone who has experienced the symptoms of schizophrenia for many years and is recovering from a long period of social isolation.*

Bob explained that during covid and the lockdowns bob became more isolated and said "everything went south" and that he "dropped out of everything". He described he knew he had do something and would have done nothing if I hadn't got connected to activities. Bob expressed that "I'd still be sitting at home drinking till someone came and took me to hospital" if it wasn't for Ruah.

Bobs goal was to engaged in the social elements of Ruah's good days program , he found that the activity combined with connections were key to his supports and recovery. Bob described that good days, "has had a huge impact on me", after, "being totally isolated for a long time".

Bob has found the Good Days activities accessible because they are not too early, not super late, and easy to access by public transport. Bob has taken up watercolour painting, "something I never thought I'd do" and says he enjoys giving back by encouraging others with painting and other activities.

Bob says that the activities have helped him reduce his drinking by giving him 'better things to do" and helped him take the decision to get reconnected and engage with other services to work on his recovery.

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2. SUICIDE RISK & INTERSECTIONAL UNMET NEEDS

2.1 Family and Domestic Violence – Karlup Service

There is a clear connection between family and domestic violence (FDV) and suicide risk. Women experiencing FDV are at significantly higher risk of suicide, and children exposed to violence often carry the trauma into adulthood, increasing the likelihood of poor mental health outcomes.

Ruah's Karlup Service is designed as a healing and recovery model for women and children impacted by FDV. Unlike crisis accommodation services, Karlup provides:

- Trauma and violence-informed, long-term recovery support that goes beyond immediate crisis response.
- Integrated legal, housing, and mental health services to create stability and long-term pathways out of violence.
- Culturally safe spaces for Aboriginal women and children, embedding self-determination and community leadership.
- Peer and lived experience support to empower survivors in their recovery journey.

Recognising the intergenerational impact of violence, Karlup also focuses on children and young people—breaking cycles of trauma and ensuring they receive the emotional, psychological, and social support needed to heal.

2.2 Housing & Homelessness – Addressing Suicide Risk in Marginalised Groups

Up to 80% of individuals experiencing homelessness also experience mental health distress, with suicide risk significantly elevated among those facing housing insecurity, financial hardship, and social isolation. Ruah integrates housing and mental health support to ensure that individuals in distress are not just provided with a bed but a connected system of care that addresses their underlying distress and suicidality.

Key priorities include:

- Embedding suicide prevention strategies within homelessness services, ensuring that frontline workers are trained in brief intervention, trauma informed support , and suicide intervention.
- Strengthening mental health and housing integration, so individuals exiting crisis services have ongoing, stable support that prevents relapse into distress.
- Developing peer-integrated models within homelessness services, ensuring that those with lived experience of housing instability, trauma, and suicide play a central role in shaping care responses.

2.3 Justice & Legal Support

Many individuals caught in the justice system have untreated or poorly managed mental health conditions. The intersection between mental illness, suicidality, and the criminal justice system remains a critical gap in service provision, with individuals often cycling between incarceration, homelessness, and acute mental health crises.

Ruah works to:

- Provide specialist legal support for individuals experiencing mental illness within the justice system.
- Advocate for diversion programs and decriminalisation approaches to reduce incarceration of people with mental health conditions.
- Ensure that mental health law and policy reform prioritises trauma-informed, community-based alternatives to punitive responses.

Without early intervention and post-release support, individuals leaving the justice system often face isolation, financial hardship, and housing insecurity—all key contributors to suicide risk.

3. KEY ISSUES & INSIGHTS FOR THE REVIEW

It is clear that previous plans have identified the same priority areas repeatedly—systemic integration, peer support, evidence-based care, early intervention, and culturally responsive services. Despite this, implementation remains a significant challenge, leaving a persistent gap between policy vision and real-world outcomes.

The Second, Fourth, and Fifth National Mental Health Plans have each emphasised the need for integrated care, peer support, and social determinants of mental health, yet these remain largely unrealised due to systemic fragmentation and a lack of sustained investment. The next phase of reform must move beyond rhetoric and commit to meaningful structural coordination, sustainable funding, and the adoption of peer-led and trauma-informed models.

A key barrier to progress is the lack of a national data framework that tracks long-term outcomes in mental health and suicide prevention. Without accurate, up-to-date data on mental health outcomes, suicide rates, and the effectiveness of interventions, we are left in the dark about the true scale of the problem and the impact of our collective efforts.

We need a unified national data framework that tracks key metrics—currently, data is fragmented, and in many cases, not consistently gathered across states and territories. This makes it difficult to assess the effectiveness of programs, determine resource needs, and understand which approaches are most successful in different populations. For example, while some programs, like The Luminos Project (TLP), are showing promising results, we need to track how these results translate across different states, demographics, and risk factors.

Building a more robust, nationally coordinated data system is vital for creating targeted, evidence-informed interventions. This data should be shared, disaggregated, and accessible across all levels of government to inform both policy development and service delivery models. By implementing a national tracking system, we can move away from guesswork and move towards data-driven, effective strategies that save lives and provide the right support at the right time. Without consistent data collection and evaluation across states and service providers, it remains difficult to determine which interventions are most effective and where resources should be allocated.

The Luminos Project (TLP), along with international examples like Trieste and Soteria, provide strong examples of holistic, community-led care. These models show that integrating peer support, culturally safe approaches, and addressing social determinants of mental health leads to improved outcomes. However, in Australia, the lack of funding for models like Trieste and Soteria, combined with systemic funding constraints and a fragmented policy landscape, limits the scalability of such initiatives. The future of TLP beyond its pilot phase remains uncertain.

3 Recommendations

1. **Expand Non-Clinical, Peer-Led Suicide Prevention Services**
    - Increase investment in **community-based suicide sanctuaries** like Luminos as alternatives to emergency departments.
    - Embed **peer workers with lived experience** in all suicide prevention services.
2. **Strengthen Cultural Safety & First Nations-Led Approaches**
    - Fund and expand **Aboriginal Community Controlled Organisations (ACCOs)** to lead mental health and suicide prevention initiatives.
    - Implement **culturally responsive service models** across all government-funded programs.
3. **Address Funding & Workforce Sustainability**
    - Shift to **long-term, flexible funding agreements** to improve workforce retention and service stability.
    - Invest in **mental health workforce development**, including peer work and culturally safe practice training.
4. **Enhance Service Integration & Coordination**
    - Establish **clear referral pathways** between hospitals, community mental health services, housing, and social supports.
    - Implement **joint commissioning models** between federal, state, and local governments to reduce duplication and improve service alignment.
5. **Develop a National Mental Health & Suicide Prevention Data Framework**
    - Implement **consistent data collection and evaluation standards** across all states and territories.
    - Establish a **national interdepartmental task force** to oversee integration of mental health data with housing, education, and justice sectors.
6. Te Whare Marie, a kaupapa Māori mental health service in New Zealand blends tohunga-led cultural therapy with clinical methods to offer a holistic approach to mental health care for young Māori. The integration of cultural healing and clinical care in this program represents a

model of care that not only respects cultural identity but also provides young people with the tools to understand, rather than fear, their experiences.

The Soteria Model, similarly, operates on the belief that peer integrated, community-based care can provide an alternative to hospitalization for individuals experiencing psychosis. The Soteria Model has been successful in several countries by prioritizing a non-coercive, supportive environment, where individuals with severe mental health conditions are given the space to heal without the trauma often associated with psychiatric hospitalization.

Both Te Whare Marie and Soteria prove that community-led, culturally safe, and peer integrated care are not only possible but are proven to work in fostering recovery. What remains lacking, however, is the systemic support and funding to scale these programs and fully implement their innovative approaches. We need a mental health system that embraces both clinical models and peer-driven care—balancing the strengths of both to offer the best possible outcomes for people experiencing mental health challenges.

- Looking at the recommendations from previous National Mental Health Plans, we see that the next plan must address the same recurring issues: integration of care, early intervention, and community-based services.

• The Second National Mental Health Plan (2003) stressed the need for integrated service delivery across different sectors to prevent fragmentation. Yet, we still find ourselves working in silos.

• The Fourth National Mental Health Plan (2009) emphasized the importance of lived experience integration, but peer support remains underutilized in many services.

• The Fifth National Mental Health Plan (2017) included actions like improving access to mental health services and addressing social determinants of mental health—principles that align with the success of the Trieste Model, TLP and Te Whare Marie, but have not yet been fully realized.

• The need for a whole of government approach: despite repeated commitments to integration, mental health and suicide prevention are still treated as the responsibility of the health system alone, rather than a whole-of-government priority. The reality is that mental health outcomes are deeply connected to housing, employment, education, social services, and the justice system—yet these sectors continue to operate in silos. If we are serious about meaningful reform, one that will produce a difference on the ground, a whole-of-government approach must be not only embedded in the next plan but also actioned across the actioned across the states. This could look like:

• Structural coordination between government departments to address the social determinants of mental health.

• A mandated national interdepartmental suicide prevention task force to ensure cross-sector accountability.

• A reporting framework requiring all government portfolios (housing, education, justice, and social services) to include measurable mental health and suicide prevention strategies.

Without these mechanisms, the next plan risks repeating the failures of previous plans—well-meaning but lacking the structural coordination needed to translate vision into action. It is time to stop treating mental health as an isolated issue and instead embed it across all areas of government responsibility. I believe we must take a bolder stance on what we know works and stop waiting before we take action. We cannot afford to let more time pass with well-meaning plans that remain theoretical. The next plan should be the one that moves from rhetoric to action.

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5. CONCLUSION

Ruah is committed to advocating for a more integrated, accessible, and culturally safe mental health system in Australia. We urge the Productivity Commission to prioritise investment in community-led, peer-based, and culturally responsive solutions that support those most at risk.

By embedding trauma-informed care, long-term evaluation frameworks, and holistic social support models, we can move beyond crisis intervention and build a sustainable, effective mental health system that truly meets the needs of communities across Australia.

Appendix

Everyone, regardless of ability, age, culture, gender, race, sexual identity or intersex status are free to be themselves. Free to celebrate our differences. We are building a workplace where difference is embraced and encouraged.