12 March 2025

Australian Government

Productivity Commission

Mental Health and Suicide Prevention Agreement Review

Submission via Review webpage

Mental Health and Suicide Prevention Agreement Review

headspace National appreciates the opportunity to provide input into the review of the impact of mental health and suicide prevention programs and services delivered under the National Agreement to Australia's wellbeing and productivity.

Context for headspace National's response

headspace is the Australian government's flagship, youth mental health primary platform. It delivers specialist supports to thousands of young Australians aged 12 to 25 through a national network of 169 centres in metropolitan, regional, rural and remote communities, and through digital mental health programs, phone counselling services, vocational services, and presence in schools.

Centre services are operated by Lead Agency Operators under licence from headspace National, which is funded by the Commonwealth Department of Health and Aged Care ('the Department') to provide day to day clinical and operational support, education and training, data collection, benchmarking and reporting. Lead Agency operators are commissioned, contracted and performance managed by Primary Health Networks (PHNs) on behalf of the Department.

Bilateral agreements to the National Partnership Agreement include varying commitments by Federal, State and Territory governments (with the exception of Western Australia) relating to:

- establishing new headspace services
- providing enhancement funding to existing services
- increasing integration between headspace and other Federal and state-funded services

In addition, as a preeminent government-funded service provider, headspace National is committed to supporting broader National Agreement commitments relating to young people and family, and to priorities under the National Agreement on Closing the Gap.

I look forward to meeting with the Commission on Tuesday 8 April at 11.00am, but in the meantime please do not hesitate to contact me to discuss any aspect of our submission with you in more detail.

Yours sincerely

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Submission to the Productivity Commission Mental Health & Suicide Prevention Agreement Review

KEY POINTS RELATING TO SHARED COMMITMENTS ON YOUTH MENTAL HEALTH

Implementation was slow to commence, with isolated progress in 'first-mover' states.

How jurisdictions interpret, prioritise and actively progress commitments varies greatly, creating inefficiencies and impeding consistent, best practice-aligned approaches.

The Department of Health and Aged Care had insufficient capacity, inter-departmental relationships and depth of knowledge about clinical and operational governance to drive implementation of shared commitments.

Planning, engagement and communication has been inconsistent across government departments, Primary Health Networks and headspace as a national service provider.

Barriers to implementing greater service integration include: lack of capacity, limited inter-service understanding, clinical governance responsibilities for shared care, and data systems and recording requirements. Pre-existing relationships between services, and tertiary service leaders with experience within primary care have been enablers.

Many opportunities afforded by the National Agreement–to improve access to the right care at the right time, to more consistently embed evidence-based practice, and to achieve stronger individual and societal outcomes– remain unrealised.

In particular, governments must prioritise and sustain commitments to: address workforce shortages and maldistribution; reduce service fragmentation and remove barriers to continuity of care; and improve outcomes under the National Partnership on Closing the Gap.

Responses are provided below in relation to each of the Terms of Reference of the Review.

National Agreement commitments relating to headspace are summarised in **Appendix I**.

Responses below reflect findings from headspace National's internal evaluation of the initial implementation phase of bilateral commitments. The evaluation covers FY2023 and FY2024 and focusses on initiatives to increase integration between headspace and other government funded services. The evaluation Executive Summary is reproduced in **Appendix II**.

a) The impact of mental health and suicide prevention programs and services delivered under the National Agreement to Australia's wellbeing and productivity

Implementation of the National Partnership through bilateral agreements has been too slow and too short lived to meaningfully assess impact.

Implementation was inevitably impacted by the change of Federal Government after the bilateral schedules were signed, and capacity within the Department of Health and Aged Care (the Department) to initiate and drive implementation planning with each State and Territory health department.

Shared commitments relating to stronger integration of headspace services have made little progress except in Queensland, where a state-led approach is being progressively implemented. It is too soon to attribute any causal outcomes to the early work.

The Agreement has yet to deliver tangible changes to improve the wellbeing and productivity of mental health professionals, including addressing acute workforce shortages and maldistribution, training places, reducing professional isolation, attrition from the public and not-for-profit sectors to the private sector, or burnout. It would be instructive to consider what contribution the National Agreement has made towards priorities identified in the National Mental Health Workforce Strategy.

The Productivity Commission's 2019 report recommended expanding the Individual Placement and Support model operating in 50 headspace services to reach and support young people to engage in study, work or training, contribute productively to the economy and avoid long-term benefits dependency. The National Agreement has not facilitated any expansion to date.

b) the effectiveness of reforms to achieve the objectives and outcomes of the National Agreement including across different communities and populations

For national services such as headspace, variation across bilateral commitments–including interpretation and prioritisation–has hindered a consistent, collaborative approach to planning and implementation.

Reforms have begun to initiate greater integration between services in selected locations. Queensland is the only state to have developed and implemented an approach to increased integration, but it is still too early for measurable and attributable outcomes. There has been little to no progress in other jurisdictions.

National youth mental health data collected from headspace services and submitted to the PMHC-MDS (per National Agreement Annex B: Priority Data and Indicators) can now be reported to states in a standardised way , although it took considerable time for a national approach to be determined by the Department.

c) the opportunities under the National Agreement to adopt best practice approaches across Australia, particularly where productivity improvements could be achieved.

In relation to integration of youth mental health services specifically, headspace offered Federal and State departments to help frame a nationally consistent principles-based approach to implementing youth mental health service integration reforms, based on leading international and Australian research.

However, states have preferred to engage in their own planning, and have shown limited interest in learnings from the research or from relevant experiences in other jurisdictions. This is resulting in duplication of effort, re-generation of existing knowledge, and re-inventing implementation approaches and innovations.

More broadly, best clinical and economic practice is to invest in multidisciplinary prevention and early intervention; this is particularly true for young people. The National Agreement focusses predominantly on treatment and care which is necessary but has less productivity benefit.

Young peoples' experiences of mental ill health are different to adults, and best practice is age-appropriate. There is an opportunity for the National Agreement to actually address well-documented and long-standing barriers to service access and continuity of care in accordance with paras 118 and 119 of the Agreement, specifically:

- nationally consistent age-and-stage service access thresholds for 18-25 year olds (i.e. Child & Adolescent Mental Health Services (CAMHS) and Child & Youth Mental Health Services (CYMHS) that consistently support young people up to the age of 25).
- geographical barriers to service access based on PHN and jurisdictional boundaries.

There is also a yet-to-be-realised-opportunity for the National Agreement to drive consistent data standards, rules and mechanisms to support consented data sharing between service providers, to reduce duplication and case management and shared care (para 92).

Expansion and diversification of digital options has increased choice and accessibility for users, and facilitates inter-disciplinary consultation and case management where specialist expertise is available. There is a particular opportunity to grow and scale services such as headspace Telepsychiatry so that clinicians and service users in under-serviced locations can access appropriate advice.

d) the extent to which the National Agreement enables the preparedness and effectiveness of the mental health and suicide prevention services to respond to current and emerging priorities

The National Agreement includes a shared commitment to support workforce development and sustainability, including collaborating to develop the National Mental Health Workforce Strategy, priority areas for action, and implementation. The National Strategy was delayed, received a muted launch, and there appears to be little evidence of partnership working to "to address issues related to the mental health workforce and suicide prevention pipeline" (para 152).

As the national experts in youth mental health service provision, headspace National was not engaged in the development of bilateral commitments relating to headspace services, and was not able to inform current and emerging priorities or responses. There has been little interest from individual jurisdictions to learn from leading practice international research, or from examples of service integration initiatives involving headspace in other states.

Steps towards greater service integration have potential to create more effective responses to individual presenting needs through sharing of trust, capacity and expertise. For youth mental health, this is not yet evident at any scale and requires cultural change across the sector as well as strong leadership and operational and clinical governance innovations.

headspace has played an integral role in design and nationally consistent implementation of the adolescent Initial Assessment and Referral (IAR) Tool (para 142), and continues to provide guidance and training across its national network of community-based service providers. There is greater opportunity to leverage the footprint and local knowledge of national services in the implementation of bilateral commitments.

e) whether any unintended consequences have occurred such as cost shifting, inefficiencies or adverse consumer outcomes

As noted above, the wording of bilateral agreements has allowed jurisdictions to interpret their commitments differently, including re-badging existing work and allocated funding as discharging their bilateral commitments.

Whilst not cost-shifting, this hasn't really created shared responsibility and resourcing across national and state governments; nearly all funding investment realised to date has come from Federal Government, and there are limited levers to require states to engage with or accelerate shared commitments.

For service integration, a lack of national leadership in clinical and data governance for shared care arrangements across services is delaying progress, duplicating problem-solving, and perpetuates challenges with inter-organisational collaboration. As a result, young people being delayed access to shared care and seamless referral pathways, and sub-optimal experiences and outcomes that result.

Making nationally defined and licenced services the subject of bilateral commitments may have unintended consequences for consistency of service access, experiences and outcomes. Such inconsistencies–which are explained further in the responses (f) and (g) below–arise from different approaches across PHNs and states relating to governance, decision-making and funding arrangements. headspace National notes that The PHN Advisory Panel on Mental Health (2018) observed that, whilst service planning should be based on a thorough understanding of regional needs, adherence to a consistent national framework is also essential. The Select Committee for Mental Health and Suicide Prevention (2021) subsequently endorsed the PHN Advisory Panel recommendation that *"[n]ationally coordinated and delivered services with high levels of national standardisation and shared evidence bases, like… headspace services, should retain their singular contract arrangements with the Commonwealth to avoid discrepancies in the delivery of care, and to avoid unnecessary complexity in service commissioning…[and recommends a review of the decision to devolve commissioning for previously nationally-coordinated, single contract services"*.

f) effectiveness of the administration of the National Agreement, including the integration and implementation of Schedule A and the bilateral schedules that support its broader goals; and

g) effectiveness of reporting and governance arrangements for the National Agreement

As noted above, greater leadership capacity and commitment at all levels of government is required to drive implementation of shared commitments under bilateral schedules.

The Agreement states clearly that no provisions are intended to be legally enforceable although "this does not lessen the Parties' commitment to this agreement" (para 48). Noting that Parties can vary or withdraw from the Agreement at any time (para 60), it can only really be said to capture shared interests at a point in time. For example, some states have not provided

committed funding, or have re-badged or discontinued existing funding rather than investing additional resourcing.

The agreed approach to rely on existing governance structures wherever possible has limited utility in implementing service integration, where service funding, commissioning and governance relationships are complex and decision-making governance mechanisms rarely include all parties (e.g. state government, PHNs and service providers).

An independent review of headspace Governance arrangements commissioned by the Department found that good governance is enabled by "the development and communication of detailed guidance that explicitly outlines…roles and responsibilities". This is modelled in the Agreement document, but not in implementation planning and delivery. The review highlighted the detailed guidance co-developed between the Department and headspace National to support implementation of enhancement funding as a successful approach, and that development of tripartite communication, discussions and decision-making promotes awareness and builds trust.

The Agreement commits parties to engage and collaborate with other relevant national and jurisdictional bodies who are accountable to Government (para 54). Whilst headspace is not named, it would be included as a national primary care service platform. Engagement and collaboration around commitments impacting headspace has been highly variable, and largely instigated by headspace National.

More specifically, in relation to regional planning and commissioning, the Parties agree to mechanisms that "have genuine representation from the communities they serve and enable appropriate oversight and accountability to governments". To date, headspace the largest youth mental health service in the country, embedded within communities and regional service networks, has not been included in any such arrangements.

Particular states have proposed changes to the commissioning, governance and funding arrangements of headspace services within their jurisdiction (i.e. headspace services to be commissioned and funded through state services rather than PHNs). As well as challenging established arrangements for a nationally defined and licenced model of care–and thereby endangering consistency of access and standards of care–there has been little engagement with headspace National and no apparent resolution between Federal and State departments.

As a national service, it is hard to see how monitoring and reporting requirements under bilateral agreements can capture meaningful data. What is being collected is high level, aggregated, and lacks longitudinal required to capture outcomes.

headspace National has developed its own evaluation framework for service integration activities (see **Appendix II**), as has Queensland Health, noting that the Department was not able to provide direction or scope of its own evaluation of youth mental health-related activities until year 3 of the Agreement.

h) applicability of the roles and responsibilities established in the National Agreement

Responsibility for headspace as a Commonwealth-funded activity is specified as a Commonwealth responsibility under paragraph 36 (c), in line with the National Health Reform Agreement 2020-25 (NHRA).

headspace National supported the Department to determine the allocation of Commonwealth enhancement funding under the bilateral schedules, and to develop implementation guidance for PHNs as conduits for the funding investments. However the funding model implemented by the PHNs means that many services will be capped at a new ceiling floor in most jurisdictions.

Most headspace services will receive enhancement funding under the Agreement but not all; a commitment to enhance remaining centres in subsequent years is not documented in the Agreement.

Addressing service gaps, integrating systems and services, and facilitating "seamless" treatment and care are defined as shared responsibilities (paras 43, 44, 47b), as is contributing to the National Agreement on Closing the Gap (para 47i).

In practice, there is a reluctance to cede control of system design, or of clinical governance arrangements in place-based collaboration, although there has been success in overcoming these differences through a lot of time and resourcing spent on building understanding about the purpose and benefits of the headspace service model. Meaningful progress requires a willingness to engage authentically in developing new understanding between state and federally funded services.

i) without limiting the matters on which the PC may report, recommendations the PC should consider the complexity of integrating services across jurisdictions and ensuring that the voices of First Nations people and those with lived and/or living experience of mental ill-health and suicide, including families, carers and kin are heard and acted upon.

headspace is particularly concerned at "toughening" of state-level policies relating to youth justice and incarceration, which disproportionately impact First Nations young people and communities. Such policies are in complete contravention of the agreement to improve mental health and suicide prevention outcomes for those who interact with the justice system (Schedule A, Part 1, para 7).

There is much greater opportunity to use the National Agreement to drive commitment and activities that deliver against Closing the Gap priorities more broadly, for example by commissioning more ACCHO-led organisations to operate community-based services, and to prioritise work to make all services and models of care culturally safe and appropriate.

Appendix I - National Agreement provisions relating to headspace

Summary of government commitments relating to headspace under bilateral schedules

Funded policy	C'wth	ACT	NSW	NT	QLD	SA	Tas	Vic	WA
Establishment of new centres	✓		✓		✓	✓	✓	✓	
Enhancement of centres	✓		✓	✓	✓	✓	✓	✓	
Integration with other services	✓	✓	✓	✓	✓	✓	✓	✓	✓
In-reach and clinical support models of care					✓			✓	
Workforce training	✓							✓	
Regional planning and commissioning	✓	✓	✓	✓	✓	✓	✓	✓	✓

Role	ACT	NSW	NT	QLD	SA	TAS	VIC	WA
Shared	Improve **integration** of youth mental health services, including headspace and PHN-commissioned youth-specific services.	Co-fund operational costs for three new headspace sites. **Enhance**, through funding or in-kind contribution, headspace services to increase **access**, consistent with the headspace model. Ensure **integration** with existing services. NSW will work with headspace sites to provide support for complex and /or severe presentations and facilitate transitions to state-based services	**Enhancement** of two existing headspace sites. Increase **access** and ensure **integration** with existing services without causing increased fragmentation	**Enhancement** of headspace services, and streamline transition between headspace and QLD mental health and AOD services Improve **access** whilst supporting **integration** with existing services in QLD.	**Enhancement**, through funding or in-kind contribution, current and planned headspace services Increase **access** aligned with the headspace model and ensure **integration** with existing services without causing increased fragmentation	**Enhancement** of all four existing headspace sites	Work with hN to develop operational guidelines for **enhanced** hs services t **Integration:** Support partnerships, referral pathways, shared staff and infrastructure and co-location of hs centres and Infant, Child and Youth Area Mental Health & Wellbeing (ICYMHW) Services Consider opportunities for ICYMHW Services to become preferred providers of headspace centres	Increase **access** and ensure **integration** with existing services without causing increased fragmentation
C'wth	**Enhance** existing headspace service	**Three** new headspace sites		**Two** new headspace sites **Enhance** existing headspace services	**One** new headspace site	**One** new headspace site	**Two** new headspace sites Contribute to **enhancement** of headspace services	
State / Territory				Fund tertiary services to provide clinical in-reach and consultation-liaison to headspace sites			Fund tertiary services to provide clinical support and consultation to headspace sites	

Appendix II – headspace National internal evaluation of bilateral agreement implementation July 2023 – June 2024

Executive Summary

The National Mental Health and Suicide Prevention Agreement (the National Agreement) came into effect in March 2022, committing all governments to build a better people-centred mental health and suicide prevention system for all Australians. The National Agreement and bilateral schedules make several commitments relating to youth mental health, naming headspace as a funding recipient or as a key service delivery partner.

This evaluation report explores the implementation of these commitments (referred to as the "Bilaterals and Integration initiative") at headspace during FY 2022-23 to 2023-24, with a focus on the commitment made by all governments to reducing system fragmentation through improving the integration of Federal and State-funded youth mental health services.

The report explores the implementation of the initiative at headspace and presents findings on the early outcomes achieved by the initiative thus far. The report also discusses implications for consideration to inform ongoing implementation of the initiative and future policy, service delivery and advocacy at headspace.

The evaluation examined program data (for example, intergovernmental agreements and initiative guidelines; implementation data collected by the Bilaterals and Integration team at headspace National through headspace centre check-ins and webinars); headspace service activity data recorded through the headspace Application Platform Interface (hAPI) from 1 March 2024 to 30 May 2024; data collected through interviews with representatives from headspace National and the centre network; and survey results exploring the level of integration between headspace services and other local services (98 respondents representing 110 headspace services or 70 per cent of services at the time).

Key findings

Status of implementation

Of the four jurisdictions (NSW, VIC, QLD and SA) that have made specific bilateral commitments to improve the integration of youth mental health services via funding/in-kind support to headspace services, two jurisdictions (NSW and QLD) have commenced an approach with both States pursuing an in-reach model to improving integration. Both approaches involve resourcing dedicated clinical positions within State-funded services to provide a range of onsite specialist care to a targeted cohort of young people accessing headspace services.

- QLD is in the implementation phase where 'active delivery' has commenced at six centres (in-reach clinician recruited); most centres in QLD are still in the early stages of developing models of care and supporting the recruitment of in-reach clinicians at HHS and their induction to headspace.
- NSW is in the establishment phase where EOI outcomes have yet to be communicated to the headspace network and defined implementation guidelines to be developed.

Implementation readiness at headspace

There appears to be a high level of motivation among the headspace centre network to implement the initiative. Survey respondents identify largely positive expected outcomes of the Bilaterals such

as improved relationships between services, improved service delivery and better care pathways for young people.

"Our hope is that this approach results in dedicated positions integrated within headspace centres locally. This will result in better access to care for complex presentations, seamless transition of care between primary care and tertiary services, improved working relationships and enhancing the capacity of headspace teams" – NSW respondent, Integration Survey

However, the level of innovation-specific capacity (content-specific knowledge and skills relating to service integration) and general implementation capacity (adequate resourcing, staff and leadership) may impact on the ability of the network to support the initiative.

Service integration is a key component of the headspace model and 79 per cent of survey respondents report their headspace service has medium to high levels of integration with their local child/youth mental health service. However, respondents also report a lack of existing structural enablers in place to support integration, such as agreed protocols for the delivery of shared/ concurrent care. There is also a marked difference in the level of integration with adult mental health services – just over half (51 per cent) of respondents report a low level of integration and 41 per cent report no enablers in place to support integration with adult mental health services.

Experiences of implementation

The experiences of QLD headspace services in implementing the Bilaterals are consistent with the barriers and enablers to implementation experienced by the headspace centre network in pursuing service integration more broadly. Respondents to the Integration Survey identified strong relationships between services as the top enabler to effective service integration, and this was highlighted as a key enabler to successful early implementation of the QLD approach:

"My strong belief is that you will have better success at anything and everything if you have good relationships in place…those that have good relationships with their HHS are making more progress" – Early Implementation Interviews, QLD

The QLD experience provides further lessons about some of the pre-conditions or sequencing of implementation activities that may inform the rollout of approaches in other jurisdictions. Enablers identified by QLD headspace centre representatives that are specific to the QLD approach include the value of having dedicated implementation support, both at headspace National and at the HHS region through allocated roles such as HHS Team Leader/ Project Lead/ Project Officer. Key barriers reported include challenges negotiating clinical governance arrangements (including needing psychiatry oversight before commencing discussions) and determining processes for recording service activity (for example, the use of hAPI by in-reach clinicians).

Indications of systems change

The evidence base on integrated care supports a system-level approach to strengthening integration between services, which involves shifting conditions of varying levels of difficulty. The findings indicate some shift at the structural and relational level, where unprecedented levels of State government funding in service integration have improved policy alignment between headspace and State-funded services and prompted the establishment of new relationships at the strategic and service deliver level. One headspace centre representative shared:

"I never thought I would see an initiative like this in my lifetime, so I'm really pleased and privileged to be involved in this. It's a huge change for the mental health system – for this to be mandated"

– Early Implementation Interviews, QLD

However, there is little indication that this has translated to aligning deeply held beliefs relating to service integration across the system, noting that this is a complex system change initiative that is at a relative early stage of implementation.

Implications for consideration

The findings highlight the following key themes for consideration in the ongoing implementation of the initiative at headspace:

- Dedicated resourcing for initiative set-up at headspace National and State-funded services, particularly to support services with less structural processes and relationships in place that enable service integration.
- Coordinated communications across all partner organisations on key implementation issues, such as clinical governance and information systems (for example, the use of the headspace Application Platform Interface (hAPI)).
- Establishing relationships at the strategic level to support local level discussions, with a focus on engaging key roles/personnel (for example, psychiatry roles) at the outset to gain early buy-in for the initiative.
- A system-level approach to integrated care, underpinned by shared values and a shared vision for integration, through the sharing of exemplary practice at headspace with key partner organisations.

Conclusion

Since the National Agreement came into effect in 2022, the Bilaterals and Integration initiative at headspace is still in its infancy, with only QLD in the implementation phase. While there is limited service activity being reported at this stage, there are some indications of structural and relational change that could be foundational for improved service delivery and care outcomes in the future. The implementation experiences of the QLD in-reach approach are consistent with the centre network's experiences of service integration more broadly, reinforcing the need for a systems-level approach to integrated care to achieve deeper cultural shifts across youth mental health services.