MENTAL HEALTH AND SUICIDE PREVENTION AGREEMENT REVIEW

SUBMISSION

Orygen welcomes the opportunity to provide a submission to the Productivity Commission's review of the Mental Health and Suicide Prevention Agreement.

ABOUT ORYGEN

Orygen is the world's leading research and knowledge translation organisation focusing on mental ill-health in young people. At Orygen, our leadership and staff work to deliver cutting-edge research, policy development, innovative clinical services, and evidence-based training and education to ensure that there is continuous improvement in the treatments and care provided to young people experiencing mental ill-health.

Orygen conducts clinical research, runs clinical services (five headspace centres), supports the professional development of the youth mental health workforce and provides policy advice relating to young people's mental health. Our current research strengths include: early psychosis, mood disorders, personality disorders, functional recovery, suicide prevention, online interventions, neurobiology and health economics.

This submission was written on the lands of the Wurundjeri people of the Kulin Nation. Orygen acknowledges the Traditional Owners of the lands we are on and pays respect to their Elders past and present. Orygen recognises and respects their cultural heritage, beliefs and relationships to Country, which continue to be important to the First Nations people living today.

CONTACT DETAILS
For further information, please contact:
David Baker
Senior Manager, Policy

IMPROVING THE COVERAGE AND IMPLEMENTATION OF THE NEXT NATIONAL AGREEMENT

SUPPORTING YOUNG PEOPLE'S WELLBEING AND WORKFORCE PARTICIPATION

Between childhood and adulthood, most young people establish independent social relationships and make the transition from education to employment. This life stage is also the period when a majority of lifetime experiences of mental ill-health first emerge.(1) Meaningful social and workforce participation and wellbeing are interlinked. Identifying emergent symptoms and providing early support is critical in minimising the possible impact of mental ill-health on young people's social and vocational transitions. If unaddressed, mental ill-health will likely affect a young person's future workforce participation.(2) Investment in mental health and psychosocial support delivers individual, community and economic benefits. This needs to be recognised across National Agreements. A mechanism for recognising intersections between Agreements, including cross-sector investment and outcomes needs to be developed, implemented and evaluated.

A PERSON-CENTRED APPROACH TO PRIORITY POPULATIONS IS REQUIRED

The list of priority populations in the current Agreement (Clause 111) is a combination of population groups and social determinants of health. Some young people experiencing mental ill-health will also be part of one of these population groups (e.g., multicultural youth); and many will also experience one or more intersecting social determinants. While membership of a population group and experiences of social determinants can both shape a young person's mental health and potentially present barriers to accessing services and treatment; combining both under the banner "priority populations" does not provide a workable structure for responding to young people's mental health needs.

A more strategically focused approach is required in the next Agreement to support priority populations groups, and through integration with other Agreements address the social determinants of health. Disentangling population groups and social determinants will enable a person-centred approach to service design and delivery that can more effectively address young people's support needs. This model would also provide a structure for integrating youth mental health services with other services.

For example, funding delivery of mental health and suicide prevention services for young people experiencing homelessness or housing instability (Clause 111 (d)) needs to intersect with the National Agreement on Social housing and Homelessness. There is no mention of mental health in the current National Agreement on Social housing and Homelessness. This disconnect is a barrier to supporting better life outcomes for young people and more efficient service delivery and return on investment through National Agreements.

Integrating Agreements will require cross-portfolio integration. A challenge to integration is the accounting for funding expenditure in one portfolio that delivers savings in another. Cross-portfolio integration is a challenge for the Federal government and the Australian public service. A 2019 review of the Australian public service suggested the Federal government:

> *could consider providing additional legislative authority to ensure effective funding and accountability mechanisms for the delivery of cross-portfolio priorities.*(3)

Improving budget and accounting instruments would enable the potential of Agreements to be more fully realised.

Integration between Agreements

Future National Agreements will be strengthened through cross-portfolio integration. Young people's lives are not partitioned between school, work, and home. The social determinants of health have effects across these life domains. An integrated service response is required. The National Agreements provide a policy instrument for delivering service integration.

MAXIMISING AVAILABLE SUPPORT THROUGH EVIDENCE-BASED PRACTICES

The quality of mental health care a young person receives is important. Delivering evidence-based treatment will maximise the quality of available support. The current Agreement stipulates that:

> *All government funded mental health and suicide prevention services should be able to demonstrate they are delivering evidence-based interventions safely, effectively and efficiently, to the people and communities who need them.* (Annex C)

Despite the emphasis on delivering evidence-based services in the Agreement; the 2022-2023 annual National Progress Report Summary made only two references to evidence-based services: (1) in responses to communities affected by disasters, and (2) service commissioning. If the delivery of evidence-based practice is to be realised, future Agreements need to include requirements for implementation and evaluation.

Implementation of evidence-based services and treatment requires a model of care that can be monitored for accountability, fidelity and evaluation. Orygen has been engaged by the Department of Health and Aged Care to lead a consortium of leading organisations in youth mental health around Australia to deliver advice to the Federal government on models of youth mental health care. This advice should inform the development of the next Agreement.

Implementation and evaluation

Achieving evidence-based practices through the development and funding of Agreements is dependent on the full implementation and evaluation of agreed service commitments. Reporting and accountability measures within Bilateral Agreements need to demonstrate evidence-based practice.

SUICIDE PREVENTION

Responding to current and emerging needs for suicide prevention services requires a coordinated approach. Recognising the shared responsibility across governments for suicide prevention services the Agreement focussed on:

- improving joint regional planning for evidence-based services where gaps exist (124(d)) and
- developing services and programs in collaboration with communities (124(c)).

The success of the current Agreement has been mixed with the community sector left to fill gaps not met through Bilateral Agreements.

Joint regional planning requires integration of suicide prevention activities at primary and acute service levels, including schools through integration with a renewed National Schools agreement. This intersection faces the same challenges as mental health services; the acuity of suicide risk and the division of services between low and high risk leaves the many young people stuck in the “missing middle” without suicide prevention support. Specialist services do not have the capacity to meet the level of service demand. Enhanced primary services are required to provide the scope and reach of suicide prevention and postvention that can respond to current and emerging service needs.

A further challenge for achieving joint integration through National and Bilateral Agreements is the flexibility PHNs have in commissioning services. While this flexibility enables service to be tailored to local service needs, it can be a barrier to developing a systems-based approach to suicide prevention. This tension is more challenging in jurisdictions with multiple PHNs. An evaluation of The National Suicide Prevention Trial (across 11 PHNs) identified the need for that a mechanism or agency to facilitate sector engagement, including community-based services and state, territory and Federal governments.(4) Incorporating a mechanism or agency in a future Agreement would enable improvements in joint regional planning. The National Suicide Prevention Office could perform this role.

INTEGRATION AND IMPLEMENTATION

A lack of service integration has been a barrier to the implementation of Bilateral Agreements. The scale of these barriers and resultant impediment to implementation varies between jurisdictions.

Service focus is a key barrier to integration. Primary mental health services (in the Agreements) are intended to provide early interventions to reduce the demand of acute services. This focus results in broader eligibility and longer service engagement. Whereas state services are centred around high acuity needs and service delivery shorter in response to immediate, high-risk presentations. Falling between these two services is the “missing middle service gap” in which service needs are typically more complex.(5) The Productivity Commission has previously recognised the need to meet this service gap.(6) Enhanced services are intended to meet this gap in service need; however, this service model was not identified in the Agreements which has been a barrier to implementation and integration with acute services.

Conflicting funding models have also been a barrier to implementation. For example, activity funding for state-funded acute services is determined by having full capacity which provides a perverse disincentive to referring young people to enhanced or primary services. Whereas the greater complexity and longer service engagement required by young people accessing enhanced services requires greater per person funding. The Productivity Commission has previously recognised that current funding arrangements contribute to 'persistent gaps in care' including the "missing middle".(6) By not funding non-activity-based activities, such as care coordination, to enable meaningful collaboration further exacerbates the barriers to integration.

MAXIMISING EFFICIENCIES IN COMMISSIONING

The current Agreement included the commissioning of youth mental health and suicide prevention services. It set out what governments would do to support regional commissioning, such as joint commissioning between PHNs and Local Hospital Networks (LHN) to maximise available resources and avoid duplication. An intent of decentralised service commissioning was to enable the selection of services that will meet a local need. There is, however, recognised 'strengths and challenges' across jurisdictions and regions (Clause 134).

The decentralising of service commissioning has resulted in administrative duplication and service fragmentation and uneven availability. Most PHNs are too small to resource and staff required activities such as service needs assessments and mapping, evaluation of the evidence-based merits of service tender applications, and monitoring of service fidelity. Centralised service commissioning informed by regional/local knowledge is required to effectively resource and implement these processes. This could be done within the existing PHN model through a combination of central and regional offices with duties and responsibilities allocated to maximise efficiencies while maintaining local connections.

The blurring of Federal and State and Territory government responsibilities for community-based specialist services has added to confusion, with piecemeal funding from both Federal and State and Territory governments contributing to fragmentation, and both overlaps and gaps in service commissioning. Clearly demarcated service responsibility with an agreed referral process between services would enable greater coordination and accountability in service delivery.

A tiered service model (primary, specialist, and acute) would address the "missing middle" gap. This model would enable Federal, and State and Territory governments to respectively focus on primary (PHNs) and acute (LHNs) services; with responsibility for a national commissioning model for community-based specialist services through the National Mental Health Commission (an agency of the Federal Department of Health and Aged Care). This three-tier service model would permit the next Agreement to focus on establishing a national model for community-based specialist services, including the integration with primary and acute services, shared funding, and governance and accountability.

Defined responsibilities support efficiency

The National Agreements provide an instrument for collaboration between Federal and State and Territory governments. Clearly defined responsibilities are required to increase the efficiency of service funding. The next Agreement should incorporate a three-tier service model delivering primary, enhanced and acute youth mental health services.

POTENTIAL OF JOINT FUNDING

Joint funding responsibilities enhance continuity of care and enable efficiencies and economies of scale by minimising duplication while maximising resource utilisation, ultimately enhancing the overall investment from governments.

MOST - a digital mental health service for young people developed by Orygen Digital - provides a positive example of how a mixed funding approach from Federal and State and Territory governments

has achieved efficient, streamlined care for young people with mental ill-health, across the severity spectrum.

Through joint government funding, Federal and State and Territory resources are combined to provide comprehensive mental health support for young people. Digital services can be made available in primary care through to specialist and acute mental health services as well as directly to young people. Together, Federal and State and Territory investment enables digital services to maintain continuity of care across a young person's mental health journey, reducing fragmentation and duplication and in line with the complexities of mental health journeys and navigating care systems.

EFFECTIVE ADMINISTRATION OF THE NATIONAL AGREEMENT

There was only one review of the Agreement publicly published by the National Mental Health Commission (Commission). Disruptions at the Commission – which resulted in the previously independent body being moved into the Department of Health and Aged Care – likely contributed to disruptions within reporting mechanisms. Nevertheless, the failure to meet reporting requirements set out in Part 6 of the Agreement undermined the transparency and accountability of the Agreements in delivering service improvement for young people experiencing mental ill-health and suicide prevention. Implementation and evaluation are instrumental in realising the aims of public policy. Effective administration is required to for transparency and accountability. The Australian National Audit Office has identified a potential audit of the coordination and targeting of mental health funding in 2024-25.(7)

REFERENCE

1. Solmi M, Radua J, Olivola M, Croce E, Soardo L, Salazar de Pablo G, et al. Age at onset of mental disorders worldwide: large-scale meta-analysis of 192 epidemiological studies. Molecular Psychiatry. 2021.
2. de Oliveira C, Saka M, Bone L, Jacobs R. The Role of Mental Health on Workplace Productivity: A Critical Review of the Literature. Applied Health Economics and Health Policy. 2023;21(2):167-93.
3. Department of the Prime Minister and Cabinet. Our public service, our future: independent review of the Australian public service. Canberra: Commonwealth of Australia; 2019.
4. Currier D, King K, Oostermeijer K, Hall T, Cox A, Page A, et al. National suicide prevention trial: Final evaluation report. The University of Melbourne; 2020.
5. Menssink JM, Gao CX, Zbukvic I, Prober S, Kakkos A, Watson A, et al. The missing middle service gap: Obtaining a consensus definition of the 'Missing Middle' in youth mental health. Australian & New Zealand Journal of Psychiatry. 2025;59(2):152-61.
6. Productivity Commission. Mental Health. Canberra; 2020. Report No.: 95.
7. Australian National Audit Office. Coordination and targeting of mental health funding Online: Commonwealth of Australia; 2024 [Available from: https://www.anao.gov.au/work/performance-audit/coordination-and-targeting-of-mental-health-funding].