Submission to Mental Health and Suicide Prevention Agreement Review

Consumers of Mental Health

March 2025

Consumers of Mental Health WA

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1. Acknowledgement of Country

Consumers of Mental Health WA proudly acknowledge Aboriginal people as Australia's First Peoples and the Traditional Owners and custodians of the land and water on which we live and work. We acknowledge Western Australia's First Nation's communities and culture and pay respect to Aboriginal Elders past, present and emerging.

We recognise that sovereignty was never ceded and the significant and negative consequences of colonisation and dispossession on Aboriginal communities.

Despite the far-reaching and long-lasting impacts of colonisation on First Nations communities, Aboriginal people remain resilient and continue to retain a strong connection to culture. We acknowledge the strong connection of First Nations Peoples to Country, culture and community, and the centrality of this to positive mental health and wellbeing.

2. Preamble

2.1 About the Respondents

Consumers of Mental Health WA (CoMHWA) is Western Australia's peak body for and by mental health consumers (people with a past or present lived experience of mental health issues, psychological or emotional distress). We are a not-for-profit, systemic advocacy organisation independent from mental health services that exists to listen to, understand and act upon the voices of consumers. We work collaboratively with other user-led organisations and a diversity of stakeholders to advance our rights, equality, recovery and wellbeing.

2.2 Request for Feedback

CoMHWA works to uphold the dignity and human rights of consumers, through providing advocacy in leading change with and for consumers. We appreciate notification of the outcomes of our submission to this consultation in order to understand and communicate the difference made through our work.

Please provide feedback via the contact details on this submission's cover page.

2.3 Language

CoMHWA uses the term mental health 'consumer' throughout this submission. Mental health consumers to refer to people who identify as having a past or present lived experience of psychological or emotional distress, irrespective of whether they have received a diagnosis of mental illness or accessed services. Other ways people may choose to describe themselves include "peer", "survivor", "person with a lived experience" and "expert by experience".

This definition is based on consumers' call for respect, dignity and choice in how we choose to individually identify. As individuals we choose different ways to name and describe our experiences that may confirm or trouble ideas about 'mental illness'.

CoMHWA endorses Black Dog Institute's Aboriginal and Torres Strait Islander Lived Experience Centre's universal definition of lived experience for First Nation communities:

> *A lived experience recognises the effects of ongoing negative historical impacts and or specific events on the social and emotional wellbeing of Aboriginal and Torres Strait Islander peoples. It encompasses the cultural, spiritual, physical, emotional and mental wellbeing of the individual, family or community.*

People with lived or living experience of suicide are those who have experienced suicidal thoughts, survived a suicide attempt, cared for someone through a suicidal crisis, been bereaved by suicide or having a loved one who has died by suicide, acknowledging that this experience is significantly different and takes into consideration Aboriginal and Torres Strait Islander peoples' ways of understanding social and emotional wellbeing.

This definition recognises that there are fundamental differences to how Aboriginal and Torres Strait Islander people experience and define mental health challenges and suicide compared to mainstream definitions.

2.4 About the consultation

Information reproduced from: https://www.pc.gov.au/inquiries/current/mental-health-review/call

On 11 February 2025, the Productivity Commission (PC) issued a call for submissions on the Mental Health and Suicide Prevention Agreement Review. The PC outlined the scope of the review as follows:

"The PC is to conduct the Final Review of the National Mental Health and Suicide Prevention Agreement.

In undertaking the review, the PC should holistically consider, assess and make recommendations on the effectiveness and operation of these programs and services in line with the National Agreement, including, but not limited to:

a) The impact of mental health and suicide prevention programs and services delivered under the National Agreement to Australia's wellbeing and productivity
b) the effectiveness of reforms to achieve the objectives and outcomes of the National Agreement including across different communities and populations
c) the opportunities under the National Agreement to adopt best practice approaches across Australia, particularly where productivity improvements could be achieved
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
e) whether any unintended consequences have occurred such as cost shifting, inefficiencies or adverse consumer outcomes
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
g) effectiveness of reporting and governance arrangements for the National Agreement
h) applicability of the roles and responsibilities established in the National Agreement, and

- *without limiting the matters on which the PC may report, in making 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.*

In doing so, the scope should include assessment of the integration of social and emotional wellbeing principles, and cultural safety and responsiveness for First Nations people.

The National Agreement is intended to complement other agreements, including the National Health Reform Agreement and the National Agreement on Closing the Gap, and should be examined in this context."

3. Introduction

CoMHWA welcomes the opportunity to provide feedback to Productivity Commission on the Mental Health and Suicide Prevention Agreement (the "Agreement"). As the peak body in WA for mental health consumers, we focus in this submission on providing feedback informed by the experiences of our members who are mental health consumers and/or have lived experience of suicidal thoughts, feelings or actions.

CoMHWA acknowledges the deep discomfort of our members concerning the process of Productivity Commission review, as they fear the process reduces complex human experiences into economic terms. The privatisation of many formally public services and the adoption of market-driven approaches to mental health has left mental health consumers feeling that their life is measured in dollars and cents. In mental health and suicide prevention, terms such as *disability adjusted life years* or *productivity loss* ignore key pieces of the puzzle of mental health and suicide prevention. One consumer commented that "*the understanding of suicide as an economic issue misses the real human experience and nuance that is needed in the suicide prevention space*."

Our members see deep flaws in the National Mental Health and Suicide Prevention Agreement ("the Agreement") in its reliance on the medical model of understanding mental health and suicidal distress. Some mental health consumers understand their mental health through this lens and seek more access to treatment through this model. However, this approach does not benefit all consumers and may cause harm, perpetuate stigma and limit a person's ability to drive their own recovery. The dominance of the medical model through the prioritisation of funding the fields of psychiatry, psychology, and epidemiology, does not serve all mental health consumers.

"*It is important to recognise that when one framework (such as the 'illness model') is dominant, it silences and marginalises other ways of knowing and explaining human experience and or distress*" [1]

We call for a distinct paradigm shift where there is space within the mental health and suicide prevention funding model for the use and exploration of alternative models of understanding and recovery.

We base our submission on:

- Consultations with our members who contribute to CoMHWA's National Mental Health Policy Positions through a Consumer Advisory Group formed for this purpose.
- Ongoing data collection and input from CoMHWA's Individual Advocacy and Peer Pathways (service navigation) programs.

In this submission, CoMHWA will discuss the three important areas of feedback:

1. How can ways of understanding outside the medical model be incorporated into service delivery?

[1] Western Australian Mental Health Commission. (2022) *The Western Australian Lived Experience (PEER) Workforces Framework*. The Government of Western Australia Mental Health Commission. Retrieved on 3 March 2025 from https://livedexperienceworkforces.com.au/wp-content/uploads/2022/10/mhc-lived_experience-pw-framework-oct2022-digital.pdf 9

2. How can services deliver a more helpful way including to Aboriginal and Torres Strait Islander mental health consumers?
3. How can the Agreement be drafted in a way that reflects the views of people with lived experience?

3.1 Summary of discussion and recommendations

Lived Experience Governance

- Lived experience leadership must be embedded throughout the Agreement in decision-making, oversight, and evaluation.
- Governance structures should ensure lived experience perspectives shape mental health and suicide prevention policies.
- Lived experience governance should not be tokenistic but should be a fundamental accountability mechanism.

Peer Work Integration & Alternatives to Medical Model

- Expand peer work within multidisciplinary teams to improve patient outcomes.
- Develop and fund peer-led, community-based alternatives to the medical model (e.g., Alternatives to Suicide approach).
- Address the underutilisation of peer workers in clinical settings and ensure stable funding for peer-led programs.

Aboriginal and Torres Strait Islander Leadership & Cultural Safety

- Implement the Gayaa Dhuwi Declaration and its Implementation Plan.
- Support Aboriginal-led, governed, and culturally safe mental health services.
- Recognise distinct cultural understandings of suicide and mental health.
- Strengthen social and emotional well-being (SEWB) approaches for Indigenous communities.

Improved Service Delivery & Accountability

- Ensure funding stability for successful programs instead of short-term projects.
- Improve regional and remote mental health service access, focusing on local solutions.
- Enhance care continuity and holistic aftercare, including peer support post-hospital discharge.
- Address discrimination and systemic racism in mental health services, adopting an anti-racist framework.

Refinement of Agreement Language & Scope

- Strengthen definitions of person-centred care and self-harm.
- Fully integrate Alcohol and Other Drugs (AOD) throughout the Agreement.

- Update language to reflect lived experience perspectives, including LGBTIQA+SB.
- Establish accountability measures to ensure marginalised groups receive appropriate services

4. Discussion

4.1 Lived Experience Governance

Mental health consumers identified that peer workers and lived experience governance is important at a whole-of-system level to transform the system to be more helpful and less harmful.

The definition of Lived Experience Governance used in this submission is as follows:

> *"Lived experience governance intentionally embeds organisational cultures and systems that give primacy to centring or being led by lived experience perspectives, principles, and ways of working in the decision-making, oversight and evaluation of systems, structures, policies, processes, practices, programs and services.*
>
> *Lived experience governance aligns with and supports other forms of governance. It does so while ensuring that the voices and contributions of people with lived experience are central to the effective governance and management of organisations and systems. It is an essential component in, but not limited to, peer led services and programs, and is applicable across diverse communities and sectors, in both clinical and non-clinical settings. Lived experience governance is not just an accountability mechanism, it demands that the dignity, rights and self-determination of people, and the stewardship and leadership of people with lived experience are embedded in the bloodstream of an organisation which changes organisational cultures and, ultimately, changes lives."*[2]

One mental health consumer stated that "*Lived Experience governance must be meaningful and not a tokenistic effort*." Others stated they were hopeful that the system is ready for change, stating that, "*Lived Experience governance needs to be embedded into the sector as a whole, not just limited to a consultation framework. It appears that there is a willingness to be open to lived experience but the "how" of including lived experience governance is not clear*."

Mental health consumers argue for the following:

1. *That there is space for diversity of perspectives in the Lived experience governance space.*
2. *We need to embed the Lived Experience theory of change into the perspectives of how we deliver mental health.*
3. *"Lived Experience based practice" needs to be included in addition to "evidence-based practice" when assessing the usefulness of programs or service delivery.*
4. *Peer workers are the best equipped to identify systemic gaps as they emerge, and this is not utilised enough. Lived Experience and the peer workforce are the best placed to quickly respond to emerging community crises and experiences.*

[2] Hodges, E., Leditschke, A., Solonsch, L. (2023). *The Lived Experience Governance Framework: Centring People, Identity and Human Rights for the Benefit of All*. Prepared by LELAN (SA Lived Experience Leadership & Advocacy Network) for the National Mental Health Consumer and Carer Forum and the National PHN Mental Health Lived Experience Engagement Network. Mental Health Australia, Canberra. 12

4.2 How Can Ways of Understanding Outside the Medical Model Be Incorporated into Service Delivery?

Mental health consumers raised with us the lack of available peer-led alternatives to the medical model and that the Agreement has not delivered on its commitments outlined in paragraph 20 (e) and paragraph 124(c) and (g). Which state the following:

20. This Agreement will build upon the agreed principles […] *and will underpin whole-of-governments efforts to transform and improve Australia's mental health and suicide prevention system. Parties commit to:*

> *(e) Evaluate new models of care to drive improvement and ensure the best reforms are implemented, with consideration given to outcomes achieved and value for money;*

124. The Parties agree, in collaboration, to:

> *(c) Develop suicide prevention services and programs in collaboration with communities and people with lived experience to identify gaps in service provision and to gain insights into individual experiences. […]*
>
> *(g) Build competency within the suicide prevention workforce, including the peer workforce, through evidence informed training.*

4.2.1 Peer Work Within Multidisciplinary Teams

Peer workers within the clinical framework provide excellent value and assistance to mental health consumers.[3] Consumers have identified the benefits as:

1. Increased understanding of the process that was taking place;
2. Fewer incidents of hospitalisation, re-admissions and shorter stays in hospital[4];
3. Fewer visits to the Emergency Departments due to distress;
4. Less acute crisis including less medical admission after serious self-harm attempts;
5. Better understanding of their treatment protocols and the expectations of the clinical environment;
6. De-escalation assistance when they are emotionally activated;
7. System navigation assistance; and
   For many consumers, a source of hope that they will recover, be able to return to the workforce, have jobs of value, have connection to the community, relationships and family.[5]

An excellent example is the MIFWA Hospital to Home program which is a peer-led service returning home after a hospital stay due to mental distress.[6] The program supports people for up to eight weeks after discharge and engages between 9 and 13 participants a week with the following aims:

[3] Jackson, F., Heffernan, T., Orr, M., Young, R. B., Puckett, C., & Daly, S. (2020). Peer work in rural and remote communities and mental health services. In *Springer eBooks* (pp. 1–28). Retrieved 11 March 2025 from https://doi.org/10.1007/978-981-10-5012-1_21-1

[4] Hancock, N., Scanlan, J.N., Banfield, M., Berry, B., Pike-Rowney, G., Salisbury, A. & Norris, S. (2021). Independent Evaluation of NSW Peer Supported Transfer of Care initiative (Peer-STOC): Final report. The University of Sydney & Australian National University, Australia. www.health.nsw.gov.au/ mentalhealth/professionals/Pages/peer-supported-transfer-of-care.aspx

[5] Joo, J. H., Bone, L., Forte, J., Kirley, E., Lynch, T., & Aboumatar, H. (2022). The benefits and challenges of established peer support programmes for patients, informal caregivers, and healthcare providers. *Family practice*, *39*(5), 903–912. https://doi.org/10.1093/fampra/cmac004

[6] MIFWA (2024) *Hospital to Home A peer-led program.* Brochure retrieved 11 March 2023 from https://www.mifwa.org.au/miwp/wp-content/uploads/2024/11/MIFWA-Hospital-to-Home-Brochure.pdf

"• Optimise the transition to home following a hospital stay due to mental health challenges

• Connect people with local community and other relevant organisations and the supports they need to stay safe and well

• Support people to regain confidence and build resiliency

• Support and facilitate navigation of the mental health system

• Reduce feelings of distress and re-admission to hospital" [7]

These aims are achieved through peer workers assisting the participants to develop a plan about the services they will need, providing practical supports to participants that align with their goals and needs, provide fact-to-face and telephone check ins, attend appointments with participants, engage in confidence building activities and facilitating referrals for service providers.[8]

The program has overwhelmingly positive feedback from participants some of which was reported in MIFWA annual report as follows:

> "My mindset has been more positive and as things started to fall into place for me, I became more settled. With the help of my Peer worker, I was able to see myself as a deserving person, which is a massive deal."[9]
>
> "I have learned many new skills to help me cope and mitigate with the negative emotions so that I can deal with setbacks better. I have also been able to communicate more effectively my emotions and learnt how to self-reflect better."[10]

4.2.2 The underutilisation of peer and Lived Experience in the clinical setting

CoMHWA welcomes supports the Agreement's commitment to funding peer work scholarships and calls on the PC to investigate the career paths available to peer workers within the clinical model. We note that the instability of funding and career path for peer workers, has serious effects on the ability of the programs to deliver services, the diversion of resources from front line delivery to the advocacy for funding each year, and a barrier to access & trust for participants who are fearful that a service may end.

One mental health consumer noted "*Peer workers who have come from previous careers within the medical, social work and service provision are an untapped community and their skills are underutilised."*

4.2.3 Peer Work and Lived Experience Alternative Models

Limiting peer roles to working within the medical model fails to take full advantage of the skills that peers possess. Failure to utilise the diversity of peer skills leads to a serious gap in the mental health delivery space, which in turn fails to realise the economic benefits of reaching people outside the clinical care space.

From our consumer feedback:

"[R]*eal alternatives to the medical model need to be made available to people experiencing suicidal thoughts and feelings. We need innovation outside the clinical models."*

[7] Ibid

[8] Ibid

[9] IFWA (2024) *MIFWA Annual Report 2023-2024.* Mental Illness Fellowship of Western Australia Incorporated. Retrieved 11 March 2025 from https://www.mifwa.org.au/miwp/wp-content/uploads/2024/12/MIFWA-Annual-Report-2024-Web-Spreads.pdf 14

[10] Ibid 15

"That suicidal thoughts and feelings need to be contextualised outside the traditional individualistic ways we discuss it. This includes approaches that discuss community suffering and distress."

Peer-led services for people who experience suicidal thoughts are some of the most cost-effective interventions that can be delivered by the government. Yet they remain without stable funding or widespread application.

It is the opinion of CoMHWA that there has been a missed opportunity to deliver stably funded, widely available peer-led alternatives to the clinical interventionist approach. Instead, peer workers tend to be employed mainly as part of multi-disciplinary teams where they are expected to work outside of their discipline to conform with the medical model.

Peer services can target two groups of people that are not currently captured by the current clinical approach. The first is the group of individuals who avoid clinical services due to fear of intervention. The second is the group of people who leave hospital without hope, having experienced iatrogenic harm or who have not had their needs sufficiently met by what the clinical system has to offer. In 2014, a review of discharge practices noted that "data informs us that patients are at high risk of suicide around the time of discharge."[11] For those who died of suicide, 15 per cent of men and 20 per cent of women completed suicide on the day of discharge from a private or public mental health hospital.[12]

We acknowledge that health services have sought to strengthen discharge planning and create clearer referral pathways. We also acknowledge that for some consumers, hospital stays have been positive. However, for some consumers, hospitals can be a deeply disempowering and negative experience. No single factor can be attributed to why a person decides to end their life.[13] However, some survivors of suicidal actions talk about a deep loss of hope, and despair when the things they believed would 'fix' them have made no real impact on their emotional distress.[14]

For this cohort, there needs to be accessible alternatives to the medical model. Peer-led services can provide a low-cost alternative to the medical model where this cohort can be reached. Mental health consumers highlighted the role of these alternatives where they exist. One such service model is the Alternatives to Suicide (Alt2Su) approach.

Alt2Su is described by one of the services that deliver it as follows:

> "*Alt2Su is highlighted as distinctly different from suicide prevention efforts. The approach offers an alternative to the clinical focus on risk assessment, pathology, and coercive practices by shifting from problematising the suicide itself, to instead recognising the conditions that create this distress. With the focus away from reducing, eradicating, or assessing suicide within individuals, Alt2Su opens up new avenues for speaking about, sitting with, or moving through suicidal thoughts."*[15]

[11] Stokes, B. (2012). *Review of the admission or referral to and the discharge and transfer practices of public mental health facilities.* The Government of Western Australia Mental Health Commission. Retrieved on 11 March 2025 from https://www.health.wa.gov.au/Reports-and-publications/Review-of-the-admission-referral-and-discharge-transfer-practices-of-public-mental-health-facilities 39.

https://www.health.wa.gov.au/Reports-and-publications/Review-of-the-admission-referral-and-discharge-transfer-practices-of-public-mental-health-facilities page 39

[12] Ibid

[13] Australian Institute of Health and Welfare. (2024). *Suicide & self-harm monitoring: Deaths by suicide in Australia.* Australian Government. Retrieved on 11 March 2025 from https://www.aihw.gov.au/suicide-self-harm-monitoring/data/deaths-by-suicide-in-australia

[14] Rhodanthe, L., Wishart, E., Watts, L. & Hodgson, D. (2022). *Clarifying the Alternatives to Suicide Approach: An Evaluation of the Theory, Values, Purpose and Practice.* ConnectGroups, Curtin University. Retrieved on 11 March 2025 from https://connectgroups.org.au/wp-content/uploads/dlm_uploads/2023/05/Alt2Su_Evaluation.pdf 12

[15] Ibid

Alt2Su is particularly important as an example of a peer-led program that explicitly champions the experiences of consumers and their desires over and above the clinical framework of risk management and intervention that has traditionally dominated the medical responses to suicidal thoughts and plans. Alt2Su programs thus provide a critically important space for consumers who have felt abandoned or traumatised by their experiences in clinical environments, and who are seeking a genuine alternative without the threat of welfare checks or involuntary treatment and/or restrictive practice in the name of their personal safety.

As the program sits outside the clinical treatment space, the peers are not hamstrung by the processes of traditional clinical service provision. The barriers for this cohort are significantly reduced.

CoMHWA recommends the Productivity Commission to investigate whether the State/Territory and Commonwealth Governments have undertaken any serious or methodical introduction of programs that deliver services outside of the clinical models of treatment.

4.2.4 Whole of Community Approach and Under-served Cohorts

Mental health consumers drew our attention to the distress that communities can feel that it is not recognised in the individualised medical approach, stating:

1. *That a whole of community approach needs to be adopted for the broader community that draws inspiration from the SEWB* [Social and Emotional Wellbeing] *model. However, the SEWB approach needs to remain a non-clinical approach self-directed by Aboriginal and Torres Strait Islander people for implementation in those communities.*

2. *Understanding community distress such as the distress for the trans community when the political discourse is villainising them, and the distress for Aboriginal people after the 'no' vote*.

Peer-led services that include members of the communities they serve are vital for reaching underserved cohorts who do not feel safe or able to access mainstream services. CoMHWA members made the following recommendations concerning the makeup and role of a peer workforce delivering peer-led services:

1. *A diverse and unified peer workforce.*

2. *Peer workers from a multicultural background are needed to engage with non-English speaking people. Also, the need for Multicultural Peer worker to engage with new migrant populations. We need Interpreters on site for all major hospital, not just one the phone.*

3. *There needs to be a better understanding across mental health treatment of how cultural practices affect mental health and having more multicultural peer work programs would assist this.*

4. In reference to people who are experience complex mental health issues and may be also street present or otherwise outside traditional supports.

   "*Make spaces for non-indigenous people to access Aboriginal ways of healing and speaking about mental health. Non-indigenous people often seek out Aboriginal and Torres Strait Islander people in the community when they are facing significant mental health challenges. The process of connecting with Aboriginal and Torres Strait Islander people can assist people to make sense of their distress or have a community that will walk beside them. This is an area of untapped potential for creating spaces for healing by allowing people to access Indigenous cultural understanding as a foundational support for their recovery.*

4.3 How Can Services Deliver a More Helpful Way, Including to Aboriginal and Torres Strait Islander Mental Health Consumers?

Mental health consumers identified ways in which the clinical and non-clinical services can deliver services to mental health consumers in a more helpful way.

In 2020, the South Australian Lived Experience Leadership and Advocacy Network (LELAN) published the results of a survey with 101 participants "with lived experience of suicidal distress or crisis".[16] Of the participants, 76% strongly disagreed /disagreed that services and supports adequately met their needs, 63% felt that care and support the first time they reached out was much worse than expected, 54% felt their previous history affected their subsequent care, 66% stated their opinion of supports available changed for the worse after their experience.

While we do not have more recent Western Australian data to share with the Productivity Commission, these statistics are unsurprising to mental health consumers and many CoMHWA members express similar sentiments.

4.3.1 Aboriginal and Torres Strait Islander Service Delivery

Aboriginal mental health consumers expressed to us that they want Aboriginal-led and governed organisations. They emphasised that it is important that Aboriginal-led and controlled organisations can flexibly respond to community demand and are not simply providing the same models of care of general service delivery.

Aboriginal mental health consumers asked for recognition for their distinct cultural understanding of suicidal distress that differ from the mainstream. The Black Dog Institute's Aboriginal and Torres Strait Islander Lived Experience Centre defines '*lived experience of suicide*' as "*People with lived or living experience of suicide are those who have experienced suicidal thoughts, survived a suicide attempt, cared for someone through a suicidal crisis, been bereaved by suicide or having a loved one who has died by suicide**, acknowledging that this experience is significantly different and takes into consideration Aboriginal and Torres Strait Islander peoples ways of understanding social and emotional wellbeing***" (emphasis added).[17]

Aboriginal mental health consumers raised that the dynamic between communities and service providers can often feel disempowering. This can manifest as organisations duplicating or replacing local community driven places for connection. One consumer stated "[w]*e need to upskill current community organisations including small Aboriginal community organisations rather than replicating or replacing local community initiatives*."

CoMHWA has set up an advisory group comprised of Aboriginal mental health consumers living in WA, called the Aboriginal Lived Experience Advisory Group (ALEAG). This advisory group informs CoMHWA's position on issues that relate to the provision of mental health services to Aboriginal and Torres Strait Islander Communities:

[16] LELAN (2020) *Learning from Lived Experience Suicide Prevention Project.* LELAN (SA Lived Experience Leadership & Advocacy Network). Retrieved 3 March 2025 from https://www.lelan.org.au/wp-content/uploads/2020/12/LfLE-one-pager-Final-Final.pdf

[17] Black Dog Institute (2020) *Lived experience definition released for Aboriginal and Torres Strait Islander communities*. Black Dog Institute. Retrieved March 5, 2025, from https://www.blackdoginstitute.org.au/media-releases/lived-experience-definition-released-for-aboriginal-and-torres-strait-islander-communities/

- That systemic racism against Aboriginal people is at work in any health service where a person is not allowed to practice their culture or access culturally appropriate support, and where culturally safe practices are seen as secondary, extraneous or tokenistic up against the dominant medical model of mental health.
- That there needs to be a commitment to self-determination and the right to choose alternatives to dominant approaches are at the forefront of mental health consumer rights and we strongly believe that these principles must be adhered to by all mental health services.
- It is important to support the development and empowerment of Aboriginal mental health consumers and Aboriginal mental health or social and emotional wellbeing service providers.

- CoMHWA wholeheartedly welcomes the principles set out in the Gayaa Dhuwi declaration. CoMHWA echoes Gayaa Dhuwi's call for the Declaration Framework and Implementation Plan to be taken up and implemented by all health service providers to allow for equity and justice for Aboriginal people to have their health needs met in a culturally safe way.
- CoMHWA endorses the nine principles of social and emotional wellbeing as adopted by the Declaration and argues that these principles must be recognised, understood and meaningfully used in any health or community service that works with Aboriginal people.

4.3.2 The Improvement of All Service Provision

CoMHWA regularly undertakes consultation on various aspects of policy and service provision throughout Western Australia. Communities are deeply frustrated by funding models used in community mental health and recovery services. Mental health consumers express frustration about the constant roll-out of "pilot projects", or indeed any project that is fixed-term, e.g. short-term, standalone government-funded projects such as those funded through Department of Social Services' Information, Linkages and Capacity Building (ILC) grants. A service will open as a "pilot project" or standalone project where it will then go through the process of co-design and planning, building trust with mental health consumers and the community. Some people will attend the service and start to use the service to support their recovery; despite positive results reported by consumers, the project's funding will end. The end of the service can deeply destabilise the consumers' access to care, which can be deeply distressing. Each time a "pilot program" ends, consumers lose institutional trust, the effort consumers have contributed to codesign and create a barrier to building trust in the future.

An excellent example is the MIFWA Hospital to Home program that was discussed above which is a peer-led service returning home after a hospital stay due to mental distress.[18] Despite the excellent feedback and positive change that the program has made, the providers have "the uncertainty of future funding".[19]

Mental health consumers identified ways that service provision could be improved or where the Agreement can reflect a change in approach:

1. *Autistic people need neuro-affirming care to be a priority.*
2. *We know continuity of care is a such an important thing, yet this doesn't seem to be prioritised in mental health. And the systems aren't built to enable continuity.*

[18] MIFWA (2024) *Hospital to Home A peer-led program.* Brochure retrieved 11 March 2023 from https://www.mifwa.org.au/miwp/wp-content/uploads/2024/11/MIFWA-Hospital-to-Home-Brochure.pdf

[19] MIFWA (2024) *MIFWA Annual Report 2023-2024.* Mental Illness Fellowship of Western Australia Incorporated. Retrieved 11 March 2025 from https://www.mifwa.org.au/miwp/wp-content/uploads/2024/12/MIFWA-Annual-Report-2024-Web-Spreads.pdf

3. *Aftercare is imagined as service referral after hospital stays. This does not address the needs of people being discharged who are just placed on waitlists. After care needs to be holistic and delivered regardless of the status of the person's referrals to other organisations.*
4. *Discharge planning needs to include a right to peer support while in hospital and after discharge.*
5. *Regional and Remote experiences and needs are often lumped together and this is not useful. Western Australia is very large, and the access and barriers are very different in different places. Local conditions and solutions that work in one place may be inefficient, ineffective, or damaging in another. Co-design and service delivery should happen based on local community needs rather than if they fit into a "regional and remote" grouping.*
6. *The main issues for those living in regional and remote locations need to be solved at a local level but are often:*
    a. *Transport issues*
    b. *Staffing issues*
    c. *Staff accommodation issues*
    d. *Lack of beds in our hospitals*
    e. *Lack of Step Up/ Step Down facilities*
    f. *Need to go to city for specialist help*

4.4 How Can the Agreement Be Drafted in a Way That Reflects the Views of People with Lived Experience?

Mental Health Consumers identified that the language in the Agreement describes them and their experiences in ways that they find unhelpful and indicate an understanding of their experience that they do not agree with.

They made the following suggestions:

1. *The definition of "person centred care" is very vague and does not outline the holistic care that a person needs to have self-directed recovery.*
2. *The definition of self-harm is not framed in a way that is useful in understanding the thoughts, feelings, and actions of people who engage in self-harm*.
3. *The inclusion of Alcohol and Other Drugs needs to be specifically reflected at all stages throughout the agreement. i.e. Mental Health and AOD not just mental health with occasional mentions of AOD.*
4. *The document needs more consideration of the perspectives of LGBTIQA+SB not just funding but a holistic approach.*
5. *We need to update the tired language and over medicalisation that appears across the document. Definitions need to be up to date and 'verified' by the communities they are speaking for.*

6. *The use of the term "imitative suicidal behaviour" is a misunderstanding of the distress that is felt by people who have been affected by a loved one or community member die by suicide. Further, it feeds into the idea that by talking about people's suicidal thoughts feelings or actions, we are encouraging them to die by suicide*.

7. *The Agreement does not go far enough in addressing discrimination. There are no accountability measures for services that carry out discriminatory or stigmatising practices. What accountability measures are in place to make sure the populations listed in paragraph 111 are actually being serviced and not just "recognised". It should go beyond just addressing stigma and discrimination and adopted an anti-racist framework.*

5. Conclusion

CoMHWA is grateful for the opportunity to feed the voice and priority of our member into the Agreement review. We are optimistic that the PC will be able to look beyond the current clinical models of service delivery and investigate broader opportunities for mental health and suicide prevention initiatives. We believe that it is an important time in the development of the mental health and suicide prevention systems as there is collective will to transform and rebalance the way that services are delivered. The PC is in a unique position to take a macro lens to the systems as a whole and make recommendations that enable rebalancing the system. Further, with the release of the Gayaa Dhuwi Implementation Framework and Plan, we now have a pathway to significantly improve the effectiveness of services delivered to Aboriginal and Torres Strait Islander mental health consumers. We believe that the best way to enable transformative change is through embedding and engaging the expertise of people with Lived Experience (including Aboriginal and Torres Strait Islander Lived Experience) in all aspects of system reform, design and implementation of initiatives, and especially in enabling Lived Experience leadership and governance.

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