Response to the Productivity Commission's Review of the Mental Health and Suicide Prevention Agreement

March 2025

WAAMH

Western Australian Association for Mental Health

Contents

Acknowledgement of Country

The Western Australian Association for Mental Health (WAAMH) acknowledges the traditional custodians of the country on which this submission was developed, the Whadjuk people of the Noongar Nation. We acknowledge their continuing and unbroken connection to land, sea and community. We pay our respects to their culture and Elders - past, present and emerging, and acknowledge their ongoing contribution to our society and communities.

Acknowledgement of Lived and Living Experience

WAAMH also acknowledges the individual and collective expertise of people with a living or lived experience of mental health, alcohol and other drug issues, and the families and carers who provide support and have a lived/living experience.

About WAAMH

We are the peak body for the community-managed (non-government) mental health sector in Western Australia, with organisational and individual members across metropolitan and regional WA. We have been engaged in the mental health sector for nearly 60 years.

Our membership comprises community-managed organisations providing mental health services, programs or support in community settings, as well as individuals and families with lived experience of mental health issues and suicide, with whom we engage in genuine partnership. Community-managed organisations provide a critical network of services that support people affected by mental ill-health and their families, and help them live valued lives in their community.

1. General comments

In addition to our responses to the specific terms of reference, WAAMH wishes to provide some feedback on the development of the agreement as well as its implementation and governance.

The performance of the agreement and how it might be improved in future is an urgent, strategic question for WAAMH. We anticipate a focus of the next agreement on a response to the unmet needs for psychosocial services outside the NDIS, to improve the experience of people with mental ill-health (and their families and carers) beyond the traditional healthcare system and in the community – where recovery occurs.

The Productivity Commission's 2020 inquiry report into mental health highlighted that improving the experience of people with mental ill-health (and their families and carers) beyond the health care system, was one of five areas of recommended reforms. Another was helping people to remain engaged in employment. As the Commission pointed out, these recommendations are not new. They are long-standing and were part of the commitment to ending institutional care for people living with mental ill-health and supporting recovery in the community.

The gap in support beyond the health care system has been our priority for more than a decade. This long-standing gap is a legacy of the deinstitutionalisation era, when institutions were closed without the necessary investments in community-based services and supports to assist people. Addressing this gap has also been an explicit focus in Western Australia for over a decade, since the *Mental Health & AOD Services Plan 2015 – 2025* set a specific target of 22% of mental health funding for the optimal relative investment in community support, based on the National Mental Health Services Planning Framework. Unfortunately, there has been minimal progress in addressing the structural funding inequities in mental health and an overreliance on the NDIS as being the means for providing increased access to community support. This itself is a legacy of the dominance of the hospital-based public health and mental health systems and in State Government priorities and the emphasis on clinical, treatment-based care rather than more holistic approaches to mental health care that address people's social determinants of mental ill health and in people's recovery.

WAAMH supports comments by the Australian Psychosocial Alliance (APA) in their submission that the National Agreement has delayed action to address the unmet need for psychosocial support outside the NDIS by revisiting the modelling. We appreciate that government might have wanted to ensure it had a more up-to-date figure for that unmet need, however this should not have prevented more immediate action to start to address the gap, pending the definition of a clearer target if that was deemed to be necessary. We agree with APA and other stakeholders, that the National Mental Health Planning Framework is

outdated and probably no longer the most appropriate basis for modelling, however we believe that this must not be used as a reason for governments to continue to delay action in this space.

As a state peak, WAAMH is particularly alert to the fundamental question of how to get the balance right between ensuring national consistency on the one hand, and local responsiveness and adaptiveness on the other. We do not believe that the current national agreement and Western Australian bilateral has that balance right. WAAMH also agrees with the APA when it says that the current agreement sits 'in isolation of a framework which describes what a coordinated, integrated or responsive mental health and suicide prevention service system should look like.'

WAAMH has been advocating for a localised structural element to guide how future investments in psychosocial supports outside the NDIS are delivered. The purpose of this would be to ensure that the national opportunity has the most significant local impact, as part of a broader framework of what a system should look like. These include that it:

- prioritise supports for population groups at greatest risk and facing barriers to access, including those with greater complexity of need;
- integrate with existing state mental health and other community services, and complement and strengthen existing capabilities; and
- be informed by robust regional planning and place-based commissioning to ensure people have access to pathways of mental health support in their local region.

In reflecting on the inconsistency within and across jurisdictions observed by APA, WAAMH will reflect on our experience as a state peak in our responses to the Terms of Reference. It is our view that the processes that guided the shaping of the agreement have contributed to the issues raised. We have not formed a view on whether a new National Mental Health Plan must be prioritised to inform the shape of a new agreement, as recommended by APA, largely because we do not want there to be any further excuse to delay responding to psychosocial support needs. However, we can see how logically that a plan should be the foundation for identifying what a new Agreement needs to deliver.

However, at this point our urgent priority is to ensure that the unmet need for psychosocial support outside the NDIS, and the opportunity to leverage community-based services in the face of the significant workforce and sustainability challenges that clinically dominated public mental health systems face, is maximised.

1.1 Is the agreement set up to answer the Productivity Commission's questions?

WAAMH's experience during the life of the current agreement is that we do not see the kinds of questions posed by the Commission are necessarily matters of reflection in the design or implementation of the

agreement. Our observation is that in the implementation of the agreement, at least at the bi-lateral level, there is a focus on the operationalisation of the deliverables and commitments, rather than discussions of their impact and what they might yield in terms of strategic insights for the next iteration of the agreement. To us, this reflects a broader concern about the strategic and systemic priorities for mental health reform nationally (jurisdiction by jurisdiction) and how the commonwealth and states negotiate these, and collaborate to align their activities, such as it is visible to stakeholders who are operating at the system level.

A National Mental Health Plan could have provided that clearer sense of direction and priorities and could also have ensured that stakeholders were engaged in the process of priority setting, which was not our experience in the development of the current agreement.

1.2 Maximising transparency in monitoring of the agreement and strategic insights from stakeholders

WAAMH would also like to see more transparency in the ongoing monitoring of the implementation of the bi-laterals and more transparent reporting on progress. We were pleased at the initial inclusion of non-government stakeholders in the Joint Services Planning and Governance Committee, however as of 2025 the WA Mental Health Commission has advised non-government and non-commissioning stakeholders that they will no longer be part of that group. WAAMH's CEO was on the group initially on behalf of one of the WA mental health system governance structures they sat on and then in their own right as a stakeholder.

WAAMH felt that this group was underutilised for strategic advice and insights on emerging issues and as a potential source for strategic input into emerging issues and future priorities.

1.3 Identifying priorities for the next agreement and engagement structures

WAAMH would like to see future negotiations have a much clearer planning rationale for what is included and why; more localised planning (to ensure that priorities in bilaterals are responsive to local needs and priorities and that they are able to build on particular local capacities and can be effectively integrated, rather than an apparent default of national models with possible local tweaking); and for there to be a more inclusive approach with key stakeholders.

WAAMH would also like to see the commonwealth have some kind of structure where they engage with key stakeholder groups at the state and territory levels – particularly the state and territory peak bodies – so they have an accurate national picture through more grounded intelligence on how the systems are operating and what the challenges and opportunities are.

WAAMH would like to see Community Mental Health Australia (CMHA) specifically utilised as a collective voice for the community mental health sector. CMHA must be a critical stakeholder if the future mental

health system is to be sustainable and responsive to the needs of people with Lived Experience. CMHA's federated structure provides clear accountability mechanisms and a national picture of the mental health system as the sum of its parts.

2. Comments on the Productivity Commission's Terms of Reference

2.1 The impact of mental health and suicide prevention programs and services delivered under the agreement on Australia's wellbeing and productivity

It is difficult to assess the impact of the programs and services delivered under the Western Australian bi-lateral either individually or collectively. It is also not clear how the impact on Australia's wellbeing and productivity might be measured as distinct from individual outcomes; performance of services against contracted deliverables; whether the measures improved overall system performance; whether they supported integration and reduced fragmentation; and the potential opportunity costs of these versus other potential measures.

Implementation of the measures has been staged across the life of the agreement, so not all measures have yet been implemented, and some have only recently begun to be implemented. The tender for Kids Head to Health was only awarded in the latter part of 2024, and the Aftercare Model of Care has only recently been open to tender, despite decisions by the PHN to end time-limited funding for other programs being made based on this measure being in the pipeline. There is also no publicly available reporting on the progress of the implementation of the bilateral as a collection of measures, making it difficult for all stakeholders to even be aware of the totality of measures and their progress.

As far as WAAMH is aware there is yet no formal evaluation, or reviews of publicly available data on those measures that have been implemented, such as the Adult Head to Health Centres, now known as Medicare Mental Health. We note in APA's submission that they reference Neami National's co-evaluation of their national Head to Health and Urgent Mental Health Care Centre implementation.

While these measures might have had positive impacts for individuals, it is not clear whether they have added value to the functioning of the system. Certainly, WAAMH's members delivering Medicare Mental Health Centres report many positive impacts. However, we have had mixed feedback as to whether these measures ensure integration and decrease fragmentation.

It is not clear what work has occurred to improve access to multidisciplinary youth mental health services in Western Australia, which is one of the measures in our bilateral – and whether whatever has occurred has ensured integration and not caused increased fragmentation.

WAAMH has been particularly frustrated at the pace of progress towards joint regional planning and commissioning. We understand that a joint regional planning approach has been agreed to between the Commonwealth Government and WA State Government, but this has taken a significant amount of time and as yet does not appear to have resulted in joint planning. Neither is it clear if any joint commissioning is occurring.

We support comments by APA in its submission, about PHN as a mechanism for planning and delivery of mental health services.

2.2 The effectiveness of reforms to achieve the objectives and outcomes of the agreement, including across different communities and populations

To answer this question, we shall refer to the stated objectives and outcomes – noting that the 'outcomes' of the agreement are less clear than the objectives.

The text makes no reference to outcomes other than in the title of that section. And we note that while "improving mental health outcomes for all people in Western Australia" is a desirable state, as an objective it is not very directional or clarifying in terms of what is to be achieved in the agreement. The author has highlighted key terms for reflection below.

The stated shared objective underlying the agreement is to "work **collaboratively** to implement **systemic reforms** that **address gaps** in the mental health and suicide prevention system, **improve mental health outcomes for all people in Western Australia,** prevent and reduce suicidal behaviour, and deliver a mental health and suicide prevention system that is **comprehensive, consumer-focused and compassionate**."

Their priority was to address areas identified for immediate reform as informed by the commission's final mental health report.

It is claimed that this will be achieved by reducing fragmentation through **improved integration between state and commonwealth** funded services; **address gaps by ensuring community-based mental health and suicide prevention services are effective, accessible and affordable**; and **prioritise further investment in prevention, early intervention and effective management of severe and enduring mental health conditions**.

WAAMH's first observation is that these stated objectives are very bold, broad and not particularly well-defined. Our second observation is that it is not clear how the measures included in the agreement address

these objectives, and whether the measures themselves are to be evaluated against these criteria. We would agree with APA's comment in its submission that high unmet need for psychosocial support within and beyond the NDIS presents an inherent access challenge for people with greater complexity of need.

Our third observation is that we have not observed active reflection and assessment of whether, how and how much the measures and their implementation align with the objectives.

Some critical reflection on the objective in the context of the measures might include the following questions:

- What evidence is there that the parties have worked collaboratively – how was this defined and understood as part of the agreement and has this been reflected upon?
- What makes the measures 'systemic reform' versus simply commissioned services to fill gaps – for each measure, what was the specific improvement they sought to generate and what did they change/make differently in order to realise this?
- How have these measures made the system more comprehensive, coordinated, consumer-focused and compassionate? Are these criteria for the measures – are they being evaluated against these features?
- How do the measures identified tie back to the commission's final report into mental health? Measures can be linked back to the commission's priority recommendations[1], though this mapping could be explicitly articulated for reference. Additionally, these measures respond to a very limited number of the priority reforms and there is no rationale as to why these measures were prioritised over other priority recommendations that are not articulated.
- For each measure, what is the specific component of the model that actively integrates commonwealth and state funded services? Has it been demonstrated to have achieved this, and has that been demonstrated to reduce fragmentation?
- What is the specific gap being addressed, what is the barrier that causes the gap, and how is the measure specifically responding to that gap? This is probably the most straightforward of the objectives to identify given that many of the measures are service gap responses, however each measure should be assessed as to how clear the articulation of the gap-response is and the effectiveness of the measure in closing that. WAAMH's view is that this gap-response articulation is not always

[1] Listed on page three of Volume 1 – Inquiry Report – Mental Health. New parents/School children – perinatal and Kids Head to Health; Follow up care for people after suicide attempts – Aftercare Mental Health assessment and referral processes – Intake Assessment and Referral Tool (primary care and Cth funded); Community based mental health care – Medicare Mental Health Centres (a very particular form of care for people with mild to moderate mental health challenges.)

clearly or consistently articulated, and that sometimes the gap-rationale potentially is forgotten, particularly if there is not clear integration or pathways.

    - To reflect on the impact of measures in addressing the gaps, there might be value in asking some reflective questions. Were there other services that people should have been able to access but could not? And if not, why? Or was the care they needed simply not available and so needed to be created? What is the advantage of addressing the gap in this way as distinct from expanding access to another existing service?

- Are measures particularly identified as prevention versus early intervention versus effective management of severe and enduring mental health conditions, and are they being evaluated specifically on this basis? It is not clear what measures are expected to support effective management of severe and enduring mental health conditions.

2.3 The opportunities under the agreement to adopt best practice approaches across Australia, particularly where productivity improvements could be achieved

The agreement as it stands does not seem to have a specific focus on practice and adopting or supporting best practice approaches in terms of mental health services. We note that the only specific reference to it appears to occur in Part 1 of the agreement, in relation to the whole government approaches to mental health and suicide prevention across systems (specifically in education, homelessness and justice). It is not clear to us how these parts of the agreement have progressed and we are not aware of any reporting on Part 1 of the agreement which would assist in us understanding how this has progressed.

One area of best practice which The Productivity Commission specifically highlighted in its mental health inquiry, which has not been advanced through the agreement, is the expansion of the evidence-based Individual Placement and Support (IPS) model. The commission recommended it be rolled out across adult mental health services. This is occurring in the UK's National Health Service. This measure alone would have had a significant impact on Australia's wellbeing and productivity; and several of the stated objectives of the agreement. The headspace IPS program has continued and expanded since the inquiry, and it has now been extended to a small two-site pilot in Medicare Mental Health Centres. However, the IPS model has been well established internationally and nationally over decades. It does not require further piloting in typical mental health settings. It should also be expanded into other systems (particularly homelessness, justice and veterans) as part of the whole of government response to mental health and suicide prevention.

WAAMH supports APA's comments that the agreement does not appear to have been a driver of best practice, regardless of whether pockets of good practice have been realised through its measures. Several measures in the agreement have required the development of models of care and presumably these have

been informed by best practice approaches. It might be necessary to reflect on tendering documents to understand how best practice was articulated in terms of translating the model into a grounded service. It might also be helpful to reflect on the articulated assumptions of best practice and the pricing for the model, particularly when looking at the various cooccurring needs that are identified that need to be met; the requirement to ensure a staffing profile and level necessary to meet those expectations and the expectations of ongoing workforce development and training; and the expectation of continuous improvement and evaluation.

A quick review of the Adult Head to Health Centres model of care identifies that the provision of best practice is both a principle of the centres and an underlying assumption of the model, “Sites should offer a holistic approach to care, addressing a broad range of social, physical and emotional needs, supported by **best practice in evidence-based and evidence informed care**. This should include integrated care for people concerned about AOD use which coexists with mental ill-health, other comorbidities or dual disabilities, and culturally appropriate best practice. Staffing profiles and levels will enable these needs to be met and support ongoing workforce development and training.” Evaluation is also expected. Though how this is realised might require specific examination.

The Head to Health Kids Hub identifies evidence-informed best practice and continual improvement as a principle for the model, citing a “continuous feedback loop between research, clinical practice and the outcomes for children and families.” There is also a clear expectation that evaluation is included in the delivery. Again, how this is realised might require specific examination.

The Aftercare model also went through significant research and consultation and so presumably should have a strong evidence base, however without having had the chance to review the tender it is not clear what is going to be expected from providers and what the expectations of evaluation will be.

While productivity improvements might be a consequence of best practice approaches by virtue of a presumed improvement of outcomes, we would be surprised if productivity improvements were an explicit focus of the agreement in its implementation nor how this would be measured. A question to ask would be, ‘what assumptions are being made in this question about productivity and what might the ‘baseline’ be?’ That said, we expect that if the commission looked at the value-add that the not-for-profit sector is often able to provide (and which is largely undervalued by government) then a conversation about productivity may look very different. WAAMH would certainly endorse APA’s comments on the various strengths of the community managed mental health sector.

2.4 The extent to which the agreement enables the preparedness and effectiveness of the mental health and suicide prevention services, to respond to current and emerging priorities

It is WAAMH's experience that enabling the preparedness and effectiveness of services to respond to emerging priorities (as distinct from current ones which a service has been contracted specifically for) comes down to pricing and commissioning. Pricing that is very tight, and contracts or models that are prescriptive, can limit the ability to be responsive. If, however, there is a positive commissioning relationship and capability which results in services being able to identify emerging priorities and be supported to respond either through increased capacity or adaptation of deliverables in a timely fashion, then it can be possible.

Feedback from our members would suggest that they often experience inconsistent purchasing and commissioning capability between and within funders.

It's not clear from WAAMH's point of view whether this agreement and the commissioning of its services has systematically enabled responsiveness to current and emerging priorities. We are aware of recent developments in relation to Medicare Mental Health Centres and responding to greater levels of acuity. However we have not had the opportunity to canvas our members' views on that.

We also witness just how adept the non-government sector is at responding to current and emerging priorities. This was particularly well demonstrated in the ways the sector responded during COVID to ensure people were not left without support.

WAAMH would support the comments by APA on this term of reference also.

2.5 Occurrences of unintended consequences, such as cost shifting, inefficiencies or adverse outcomes

WAAMH was recently alerted to the fact that the commonwealth is progressing to broaden the scope of Medicare Mental Health Centres, to enable them to respond to greater levels of acuity and severity. WAAMH understands that this is in response to the fact that people who would typically be supported in state public mental health services are finding it increasingly difficult to access these services (and are therefore seeking support from Medicare Mental Health Centres). In response, we understand that the commonwealth wants Medicare Mental Health Centres to be able to hold people with greater levels of acuity until they can be picked up by more appropriate services. We are curious about whether this potentially contributes to fragmentation and confusion within the system, without helping to resolve the issue of access to public mental health services, so that people can be supported by the most appropriate service. We are curious about whether this increases competition between commonwealth and state services for the same workforce to support the same people.

WAAMH would support the comments by APA on this term of reference also.

2.6 Effectiveness of the administration of the agreement, including the integration and implementation of Schedule A and the bilateral schedules that support its broader goals

WAAMH's experience of the administration of the agreement is largely in relation to the implementation of the bilateral schedules. It is not clear to us what this term of reference means when it refers to the integration of the Schedule A and bilateral schedules, and so we do not have visibility on the effectiveness of this.

We think it's likely that broader local challenges related to governance, capacity and capability will have impacted implementation of the bilateral schedule in Western Australia.

During the life of the agreement, Western Australia's mental health system governance and the WAMHC specifically was subject to significant disruption and uncertainty.

Our only visibility on the administration of the agreement came because of our participation on the Joint Services Planning and Governance Committee. We were initially invited to sit on that committee as a representative of a former WA mental health system governance committee – the Community Mental Health and AOD Council (CMC). When that council was disbanded, we negotiated to stay on the committee as the peak body. We have now been removed from that group as have other non-government/PHN stakeholders.

WAAMH did have opportunities to contribute to consultations for the development of several models of care for deliverables.

Updates on implementation flowed through to various WA mental health system governance bodies and their members, however this was typically limited to operational updates and it was often unclear what governance purpose these updates served, and members were rarely engaged in discussion of them or asked for their advice.

6.7 Effectiveness of reporting and governance arrangements for the agreement

WAAMH has already provided observations of reporting and governance arrangements throughout this submission. We note that measures included in the agreement are at various stages of implementation, so this may need to be considered when evaluating the effectiveness of reporting.

At this point a key question we have pertains to what purpose or function the reporting and governance arrangements play, and pending the answer to that question, whether the correct reporting or governance settings are therefore in place.

Key questions come to mind that would help to clarify a governance framework:

- Is the purpose of reporting to enable the commonwealth to fulfill its governance responsibilities to oversee and manage the performance of the agreement, and of PHNs and the states/territories in terms of the completion of milestones and deliverables? And by extension, to enable commissioning bodies to oversee and manage the performance of providers?
- Is the purpose of reporting to assess the effectiveness and impact of the measures included in the agreement against the objectives and desired outcomes?
- Is the purpose of reporting and governance to ensure that Western Australian stakeholders are informed about the implementation of the agreement and its effectiveness and impact?
- Is the purpose of governance to gather broader perspectives to interrogate risk assessment and mitigation, or to reflect on the stated objectives?

6.8 Applicability of the roles and responsibilities established in the agreement

WAAMH has not interrogate this part of the agreement in detail, however we think that where there is joint responsibility, there is far less clarity. This would not be unique to this agreement.

We also believe that the role of PHNs appears to have made the roles and responsibilities of the commonwealth less clear. PHNs appear to have effectively become a proxy for the DOHA at the jurisdictional level, and DOHA seems to use PHNs to deliver initiatives that do not seem to be primary health initiatives.

Where the lack of clarity about roles and responsibilities might come into sharper focus in the next agreement will be in relation to the response to unmet need for psychosocial supports outside the NDIS.

WAAMH believes that commonwealth leadership on this is essential, as states and territories have consistently demonstrated a reluctance to take a lead on this. Western Australia has not made any progress on increasing relative access to community support, despite it being a specific target in our state's previous *Mental Health & AOD Services Plan 2015-2025.*

WAAMH has been advocating for a jurisdictional plan for how a response to psychosocial supports outside the NDIS can have the greatest impact here, vis a vis the following structural elements:

1. Prioritisation of supports for **population groups at greatest risk and facing current barriers to access**, including those with greater complexity of need, such as forensic histories.

2. Integration with existing state mental health and other community services, resulting in **supports that are complementary to existing capabilities** or that strengthen those capabilities.

3. Responsiveness to local needs through **robust regional planning and place-based commissioning** to achieve the above, and to ensure all Western Australians have access to, and support navigating, pathways of mental health support in their local region.

4. Inclusion of the **Individualised Placement & Support (IPS) employment program** across adult mental health services and other priority community service settings (as recommended by the 2020 Productivity Commission report on mental health to maximise recovery outcomes for people with experience of moderate to severe mental illness, including those with co-occurring AOD issues). Evidence shows that employment is a critical mental health intervention[2] and IPS has been demonstrated to be the most effective means of supporting people with mental health issues to gain and maintain employment. IPS is being rolled out across the UK NHS's mental health services,[3] is currently delivered across headspace sites Australia-wide and is being trialled in two adult head to health centres. It is easily scalable as it can be delivered through existing support structures and builds capability within those services.

5. Support from **workforce planning and development that is based on current, quality data specific to our state** that also contributes to national data and is aligned with system and service planning. There is currently no workforce data on the community mental health sector, nor a clear alignment between workforce planning and strategic commissioning in our sector, resulting in workforce planning that is reactive and not grounded in current data. A WA workforce survey conducted by WAAMH and based on the work already undertaken in NSW by our colleagues at the Mental Health Coordinating Council, which has now completed three biennial surveys and reports[4], would allow WA to contribute to a national workforce picture. Ideally, this would form part of a national workforce survey conducted across Australia via state and territory peaks.

Given the local nature of these structural elements, we would hope to see states have a role along with key stakeholders, but with clear oversight by the commonwealth as part of a cross-stakeholder governance structure.