Response to the Mental Health Commission Mental Health and Alcohol and Other Drugs Strategy 2025-2030 Consultation Discussion Paper

December 2024

WAAMH

Western Australian Association for Mental Health

Acknowledgement of Country

The Western Australian Association for Mental Health (WAAMH) acknowledges the traditional custodians of 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 respect to their culture and Elders, past and present and emerging and acknowledge their ongoing contribution to WA society and the community.

Acknowledgement of Lived & 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

The Western Australian Association for Mental Health (WAAMH) is 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. WAAMH has been engaged in the mental health sector for nearly 60 years.

WAAMH's 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 WAAMH engages 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.

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1. Introduction

The Western Australian Association for Mental Health (WAAMH) welcomes the opportunity to provide feedback on the Mental Health Commission's (the Commission) Mental Health and Alcohol and Other Drugs Strategy 2025-2030 Consultation Discussion Paper.

WAAMH is very supportive of the State Government's commitment that the new strategy will deliver a recovery oriented, community focused, integrated system and the intention to focus on early intervention, prevention, community-based services to support smooth transitions across systems and services and equitable access to care. WAAMH's lived experience members and stakeholders have called for such a system for many years, and our organisational members play a key role in supporting such outcomes and see the strategy as an opportunity to affirm, support and strengthen that role.

Given the limited consultation window available to respond to the Discussion paper, WAAMH's submission focuses primarily on parts of the Discussion Paper directly relevant to the non-government community mental health sector. WAAMH's submission is based on brief consultation with WAAMH Board members and other organisational members and other non-government service providers in metropolitan and regional areas; targeted engagement with Lived Experience leaders; and a review of relevant literature and analysis of WAAMH's existing strategic directions and priorities for the sector.

This submission includes an overview of feedback on the scope of the Discussion paper itself as the foundation for a strategy and a number of key priorities that WAAMH, our members and stakeholders believe should be front and centre in the 2025-2030 Strategy if it is to realise the intention to deliver a mental health system that is recovery oriented, community-focussed and integrated and that prioritises capacity building and contemporary understandings of mental health. Our response also identifies other emerging evidence about mental health and mental health systems which WAAMH believes are of strategic importance given the focus on recovery-oriented, community-focussed, integrated care.

In responding to the Discussion Paper, we seek to identify what we believe needs to happen to realise the State Government's commitment that the Strategy would deliver- a recovery-oriented, community-focused and integrated system that has a strong focus on early intervention, prevention and community-based supports.

2. Overarching Feedback on Scope, Priorities and Strategic Risks

System Wide Plan vs Targeted Strategic Priorities

In consulting with members and stakeholders WAAMH received consistent feedback about the scope, direction and priorities of the strategy. Several people were generally supportive of the broad and ambitious vision put forward in the Discussion Paper and commended the document's fulsome coverage of the diverse

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challenges and opportunities facing the system. They felt that it provided a comprehensive background about what is known about the current state of the system including experiences of different cohorts. However, there was also consistent feedback that people were concerned about whether the breadth of issues covered in the Paper and the ambitious vision it suggests is realistic with the limited five-year timeframe and the likely available resources. In reflecting on the Discussion Paper, the experience and outcomes of the current Mental Health and AOD Services Plan 2015 – 2025 (the Plan) were front of mind for many of WAAMH's members and stakeholders, who were particularly conscious of the lack of progress in balancing the mental health system under the Plan. Several stakeholders reported that the Discussion Paper and consultations felt like 'the 10-year plan all over again', as one stakeholder expressed it, and that it wasn't clear to them whether the final product would be another system wide plan like the previous Plan, albeit shorter, or a targeted and focussed strategy that would have a limited range of priorities and have the greater likelihood of being resourced. There were also questions about what should sit within a strategy, as distinct from what should be considered business as usual in terms of managing the system or implementing current commitments.

There is also concern that by listing and seeking feedback on such an extensive list of aspirations, possibilities and questions, the Paper potentially creates expectations amongst stakeholders that these would all be canvassed within the strategy, as distinct from articulating clear and specific priorities that are achievable within five years. There is also concern that a consultation process on such a broad document would generate a significant amount of new data on a wide range of matters that the Commission would feel the need to include. There is concern that to do so would create unreasonable expectations of the Commission about what it could achieve in the 5-year time frame of the Strategy. This had been the experience of many stakeholders under the previous Plan where aspirations and expectations were created in relation to achieving a balanced system in which investment was to be increased in areas of community support, and prevention, promotion and early intervention but without an authorising environment to enable this. Many members and stakeholders also raised as a concern that without a resolution to the question of resourcing for a community focussed system, expectations would again be created amongst the sector and the Lived Experience community for significant change which they would then continue to advocate for on the assumption it had the support of Government but without success. People talked about the significant burden and tension this potentially creates in relationships between funders and stakeholders.

Members and stakeholders expressed the view that it is important that the new strategy mitigate against the risks that prevented progress under the Plan, specifically the inclusion of too many priorities and the lack of a funding model to balance the system. These and the lack of broader government support were specifically identified by the recent Executive Summary of the Mental Health Commission's Agency Capability Review as barriers to the Plan.

There is a view that a more contained consultation to affirm or challenge identified strategic priorities based on analysis of the current state, and seeking input into how these could be actioned considering the challenges

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and opportunities identified, would have provided greater clarity, set clearer expectations and helped to improve the quality of the consultation and that data it generates. Members and stakeholders expressed a clear desire for a first draft of the strategy to have a significantly clearer and more limited scope than is suggested in the Discussion Paper for there to be confidence in it as a means of realising change.

There also seems to be confusion amongst stakeholders about whether the document stood as an effective first cut of a strategy or a consultation document that would be used to further refine a final strategy. Some stakeholders reported to WAAMH that they had been told by the Commission that the Discussion Paper was a first cut of the strategy with the consultation serving to provide more detail.

Feedback indicated a hope that the strategy:

- Have a very clear vision that is grounded in what can be achieved within the five years, as distinct from high level aspirational and community-wide statements that might better suit the broader organisational mandate of the Commission;
- Include specific but limited priorities that are explicitly directed at realising the commitment for a recovery oriented, community-focussed and integrated system;
- Articulate clear actions to realise those strategic priorities, and;
- Be supported by an implementation plan and ideally by immediate funding commitments that enable early progress and demonstrate commitment to the strategic direction over the forward estimates to ensure sustainable and continuous funding across the life of the Strategy.

Identifying and managing critical strategic risks

Feedback indicates that in addition to concerns about the inclusion of too many system-wide priorities, unresolved questions about resourcing are seen as the most significant risk to realising the stated intention to deliver a community-focussed system and to managing expectations. Members and stakeholders have also talked about this in terms of ensuring there are reasonable expectations of the Commission and what it can reasonably be held accountable for delivering.

With this in mind, WAAMH recommends that the strategy not be funder neutral but rather be clear about what the State can directly deliver and fund; how it will work with or seek to influence the Commonwealth to shape funding priorities an system reform vis a vis the National MH & Suicide Prevention Agreement and the NDIS reform agenda; and how it will work with other stakeholders including peak bodies to deliver strategic actions.

WAAMH also recommends that the strategy does not need to claim to be provider neutral, because the reality is that it is unlikely to be genuinely provider neutral in its operationalisation. Rather, WAAMH believes the strategy should acknowledge the existing expertise across the public, private and community sectors and seek to leverage off and growth these capabilities and strengthen capacities not only in terms of specific service delivery expertise but also in terms of features such as adaptability and responsiveness. For example,

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many NGOs already include clinical services within their offerings and there may well be opportunities for further growth in their capacity here to support other parts of the system in addition to the potential expansion of Commonwealth funded initiatives.

Validation of strategic priorities through data

WAAMH noted that the Discussion Paper didn't appear to clearly articulate the outcomes of the work of the Technical Advisory Group, of which we were a member, as we had anticipated. WAAMH expected that this data would be a key feature of the Discussion Paper given that it provides important evidence about the current spending priorities relative to the National Mental Health Service Planning Framework. WAAMH believes that if this data had been made more prominent alongside a clearer prioritisation of specific parts of the system and the adoption of a place-based approach for planning and commissioning with discussion questions seeking feedback on particular priorities within this scope then this would have significantly addressed some of the concerns which members and stakeholders have articulated to us and given greater confidence that the Commission is moving towards a focussed strategy as distinct from a new system-wide plan.

WAAMH does note that the regional analysis did include some specific insights by region which is helpful but we also think this could have been presented in such a way as bring greater clarity to how the Strategy might service to address inequities in access across the State, such as through a clear strategic priority to develop capability for place based planning and commission to address specific system gaps by region.

Elevating Social Determinants as a Uniting Theme for the Strategy

While the Discussion Paper notes the issue of social determinants, WAAMH thinks that the strategy could be an opportunity to bring specific attention to the significant role that social determinants play in shaping people's mental health and wellbeing and inadequate detail is provided about the specific actionable strategies that might be implemented. The Strategy needs to identify how these social and structural drivers of mental ill-health will be tackled both in terms of prevention, in access to community support which plays a critical role in ameliorating social determinants for people with moderate and severe mental health challenges, and in cross-sector collaboration in policy and service delivery. WAAMH's view is that any focus on social determinants needs to be translated into prescriptive policy action, dedicated funding commitments and cross-sectoral action.

Further detail is provided on this later in the paper.

3. Specific recommendations for the Strategy

The 10 priorities WAAMH believes need to be established in the Strategy to achieve a consumer and family/significant other recovery-oriented, community-focused and integrated system are:

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Commit to concerted intersectoral action to address the social determinants impacting on people's mental health

WAAMH recommends that the Strategy not only acknowledge the effects of social determinants but identify the actionable strategies that will be taken to identify, reverse and mitigate the harmful political, social, economic and cultural policies and practices that undermine mental health and wellbeing.

Mental health and many common mental health conditions are shaped largely by the social, economic, physical and cultural environments in which people live. There is compelling evidence of causal links between social determinants and mental health outcomes at both the individual and wider social levels.[1]

WAAMH members and stakeholders told us about the major impact that social determinants are having on the mental health and wellbeing of the people who seek their assistance and support.

More and more people are presenting to community mental health services with high levels of distress and mental health concerns compounded or caused by rising costs of living, poverty, the cost of housing and the precarious nature of their housing circumstances, unhealthy housing (mould, heat, cold), family and domestic and sexual violence, inadequate income (due to lack of an income, low levels of income support, low wages, irregular income, lack of money), lack of food to feed their children and families, homelessness or risk of homelessness, to name a few.

Agencies funded to provide mental health support that are WAAMH members find themselves having to respond to mental health concerns that primarily have their origins in social determinants, without the mandate or level of resourcing to respond to and address those social determinants. In addition, non-mental health sectors whose clients often present with complex mental health issues may not have the mandate, the funding, nor the requisite level of expertise, understanding and capacity to support those clients.

Community mental health services require better resourcing and funding support to enable them to respond to people whose mental health concerns and conditions are either compounded by or the result of social determinants.

However, mental health interventions alone are not sufficient to address the influence of social determinants. Effective interventions to promote mental health and wellbeing and prevent mental health disorders (as well as address problematic alcohol and other drug use) requires engaging non-mental health sectors. As such mental health and wellbeing is a cross-sectoral issue for all parts of government.

A recent review[2] has identified key targets for intervention from the perspective of social determinants to improve mental health outcomes. The benefits of such investment cover several government portfolios,

[1] Lund C (2024) Addressing social determinants of mental health; a new era for prevention interventions, *World Psychiatry*, 23:1, February 2024: 91-92
[2] Kirkbride JB., Angin, D., Colman I., et.al.(2024) The social determinants of mental health and disorder: Evidence, prevention and recommendations, *World Psychiatry*, 23:1, February 2024.

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including but not limited to health, education, employment, housing, social services, criminal justice system etc.

WAAMH believes the 2025-2030 Strategy needs to adopt an explicit Mental Health in All Policies approach[3] (MHiAP) that focuses on the ways that practices and initiatives of different sectors can have an impact on mental health and wellbeing. This approach aims to initiate and facilitate action within different non-mental health public and social policy areas. This could involve:

- Engage other agencies and sectors to ensure mental health and wellbeing is incorporated into their funding, policy and decision-making processes.
- Recognise the role of NGOs outside the mental health sector who provide activities and support which support and divert people from emergency and crisis services.[4]
- Strengthen understanding of the mental health impacts of all policies such as housing, income support, family support, education, child protection, family and domestic violence, employment and labour market etc., including those that may not appear to be linked to mental health e.g. economic policy, welfare policy, climate change policy, disaster planning.
- Broaden understanding of mental health and wellbeing and its determinants within and across sectors.
- Mainstream and integrate mental health issues and responses in policies and services within non-mental health sectors.
- Invest resources in building the capacity of non-mental health sectors so they can respond to people who present to their services with significant levels of mental health concerns. This includes the housing and homelessness sector, child protection, family support, tenancy, financial counselling, community legal
- Allocate funding in different sectors and programs to support efforts to implement mental health in all policies approach.
- Jointly plan, commission and fund initiatives, programs and services and supports to facilitate access to mental health support and services in different non-mental health sectors.[5]

Some initiatives designed to address the social determinants of mental health include:

- Supported housing programs such as the Wellways Doorway Program, which is a high-fidelity Housing First program that supports people who are affected by mental ill health, and are homeless

[3] European Union Policy Platform Thematic Network (2023) *Mental Health in All Policies: A Mental health in All Policies approach as a key component of any comprehensive initiative on mental health*, European Union, Health Policy Platform.
[4] This is particularly important in regional and remote areas where few mental health services or crisis services exist and non-mental health community services, as well as local groups including Community Resource Centres and Neighbourhood and Family Centres play a key role in supporting local people.
[5] Examples could include joint or co-commissioning and funding of mental health support workers in non-mental health service contexts where clients present with significant mental health concerns, such as homelessness and housing services, family and domestic violence services, alcohol and other drug services, youth accommodation services & youth services to name a few.

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or at risk of homelessness, to secure and sustain a safe and affordable home using the private rental market.

- The Individual Placement and Support program (IPS) is an evidence-based model of supported employment designed to support individuals to achieve meaningful paid employment in the open labour market. Originally developed for people with serious mental illness, including people with co-occurring substance use disorders, IPS has since been used and found effective in various other target demographics including youth, veterans, justice system, homelessness, first episode psychosis, older adults and physical injuries.
- Initiatives to address gendered inequalities in mental health, such as the work done by Women's Health Victoria to provide an evidence base for system wide approaches to address gender inequalities in women's mental health.[6] In 2025, Women's Health Victoria will release a report which describes good practice examples of gender transformative mental health practice to address women's mental health needs.
- Health Justice Partnerships (HJP) brings together health, legal and other services to address complex problems, including mental health issues. HJP integrate legal help into services that support health or wellbeing, including mental health. Many health justice partnerships target assistance to people experiencing mental ill-health or issues associated with alcohol and other drug use. An example in WA is RUAH Legal Services, which is an integrated legal and non-legal support service located in a service provider agency that provides mental health, homelessness and family and domestic violence services. The service has a specialist mental health team, as well as financial counsellors and social workers. A Health justice partnership is not a fixed 'model' replicated in different places; rather, it is a strategy of working in partnership that is adapted to suit the needs of clients, the goals of the partnering services, available resources, and other opportunities and constraints

Establish a clear funding model or stream to address growing gaps in mental health prevention, early intervention and mental health community support

As indicated in our opening comments the question of resourcing of the strategy, and in particular the resourcing of community based mental health prevention initiatives and psychosocial supports was identified by WAAMH members and stakeholders as a critical risk to the success of a strategy. This is affirmed by the Agency Capability Review of the Mental Health Commission which identified the lack of a funding model as one of three critical barries to the realisation of a balanced system under the Plan.

[6] Barr M, Anderson R, Morris S, Johnston-Ataata K (2024) *Towards a gendered understanding of women's experiences of mental health and the mental health system*. Discussion Paper 17.2, 2nd ed., Women's Health Victoria. 2024, Melbourne.

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It is widely recognised that there is an over reliance on expensive and at time overwhelmed clinical services. Many people are better served by community support responses and earlier interventions. Investment in community based mental health support and psychosocial services can support recovery, enable people to live well in the community and reduce hospital admission and readmission, thereby reducing pressure on costly acute, inpatient, hospital and emergency services.

Increased funding is needed for community based mental health prevention, early intervention and psychosocial support to prevent further deterioration in mental health and unnecessary interface with more expensive and restrictive acute services. WAAMH believes that a key priority for the strategy needs to be for the State Government to commit resources into an expanded role for community mental health supports either in partnership with the Commonwealth, as discussed later in our submission, or independently by building on existing investments in the community mental health sector through both expanding existing services and the strategic commissioning of new services that respond to key priorities or gaps.

The reality is that for many years government funders have been reluctant to fully fund the cost of delivering programs and services. The result is underinvestment leading to a sector starved of the necessary core funding required to remain resilient and sustainable and deliver long term outcomes for increasingly complex mental health issues for clients and communities.

Research across the community services and mental health sector has identified a common concern whereby funders do not provide adequate funds for the full cost of providing services and supports, leading to reduced capacity. This is a particular problem where funding does not adequately cover agency administrative and overhead costs, or the real costs associated with project planning and start up, delivery of services, support and programs and project evaluation.[7]

The goal stated on page 6 of the Strategy Discussion Paper which is to "focus on prevention, early intervention and community-based services with an emphasis on smooth transitions across systems and services and equitable access to care cannot be achieved without a sustained and significant funding injection into the community managed mental health sector across the 5-year life of the Strategy.

Funding is a crucial system enabler, particularly in those parts of our system that are relatively under resourced, as are mental health prevention and community support service streams. This increase in funding needs to include uplifts to current service agreements where price hasn't been renegotiated for some time to ensure that funding matches service costs. Increased funding is also needed to address gaps in access in response to the unmet need for psychosocial supports outside the NDIS through expansion of existing services and the introduction of new service models.

[7] Social Ventures Australia & The Centre for Social Impact (2022) *Paying what it Takes: Funding indirect costs to create long term impact*, Social Ventures Australia; Corcoran, S & Cowden, M (2023) *Making regional development grants good policy as well as good politics.* Nous Group, https://nousgroup.com/insights/regional-development-grants/

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When considering the imperative to increase funding for community-based support and services many members specifically raised concerns about any growth in funding occurring vis a vis individualised funding models.

Individualised fundings models, such as the NDIS, have been found in the Australian context to be very problematic. [8] Individualised funding models are highly complex and require a high level of sophistication to establish an appropriate pricing mechanism and other associated functions that would be necessary to make it work in a way that supports quality outcomes for consumers, as well as service sustainability. It is WAAMH's view that the Commission does not currently have the necessary capability to support an effective shift to individualised funding and we recommend that this not be included in any new strategy or as a commissioning priority.

Take advantage of the current national opportunity to secure new investment in psychosocial supports outside the NDIS

It is essential that WA is positioned to take advantage of the current national opportunity for new investment in psychosocial supports outside the NDIS to ensure investments meet Western Australia's needs and are responsive to localised needs and priorities, through place-based planning and commissioning.

WAAMH calls for the inclusion of psychosocial supports outside the NDIS as an explicit and specific priority in the Mental Health and AOD Strategy 2025-2030. This is critical to respond to the 48,500 Western Australians with severe or moderate mental illness with unmet need for psychosocial support.[9]

WAAMH seeks a *WA psychosocial support plan* that includes 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. Responsive 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. Development of a proactive funding plan for future investments in psychosocial support outside the NDIS across the 5-year lifespan of the Mental Health and Alcohol and Drug Strategy 2025-2030.

[8] Davidson B (2024) Neoliberalism and Human Services: The National Disability Insurance Scheme in Toner P., & Rafferty M Eds.,(2024) Captured: How Neoliberalism transformed the Australian State Sydney University Press, Sydney, 2024.
[9] Health Policy Analysis.(2024) *Analysis of unmet need for psychosocial supports outside of the National Disability Insurance Scheme – Final Report* for the Department of Health and Ageing, August 2024.

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5. Expansion of existing service models, such as supported accommodation, strengthening the capability and extending the accessibility of successful existing models, for example supported accommodation and residential rehabilitation for specific cohorts and those with greater levels of acuity and complexity, as well as the development of new service models to respond to identified gaps.

6. Inclusion of the *Individualised Placement & Support (IPS) employment program* across adult mental health services and other priority community services 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[10] 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 British National Health Service's mental health services[11] and is currently delivered across headspace sites Australia-wide and is being trialled in two adult head to health centres. It is readily scalable as it can be delivered through existing support structures and builds capability within those services.

7. Is supported by *workforce planning and development that is based on current, quality data specific to WA* 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 work already undertaken in NSW by our colleagues at the Mental Health Coordinating Council, which has now completed three biennial surveys and reports[12], 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.

[10] Drake, R,E., & Wallach, M.A. (2020) Employment is a critical mental health intervention. *Epidemiology and Psychiatric Sciences*, 29, e178. https://doi.org/10.1017/S2045796020000906

[11] National Health Services England. (2024) I*ndividual Placement and Support offers route to employment for people with severe mental health conditions.* https://www.england.nhs.uk/mental-health/case-studies/severe-mental-illness-smi-case-studies/individual-placement-and-support-offers-route-to-employment-for-people-with-severe-mental-healthconditions/#:~:text=IPS%20is%20an%20employment%20support,people%20find%20and%20retain%20employment

[12] Human Capital Alliance.(2023) *Mental Health Workforce Profile: Community Managed Organisations Mental Health Workforce Report*, Mental Health Coordinating Council, Sydney, NSW 2023. https://mhcc.org.au/wp-content/uploads/2023/11/Mental-Health-Workforce-Profile_2023_WEB.pd

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Work with the Commonwealth and the sector to maximise the positive impact of NDIS reforms and ensure solutions are found to address the limitations of the NDIS for people with psychosocial disability in Western Australia

WAAMH members are reporting that the NDIS is becoming more challenging for people with psychosocial disabilities.

They report that the NDIS is becoming more difficult for people with psychosocial disability to access and packages are smaller and restricted to certain types of support. For people with psychosocial disability processes to access the NDIS are becoming more restrictive, eligibility criteria are tighter, and wait times are long. When people are successful, packages are much smaller and even when people have packages, they may not be able to access services and support from providers with the requisite knowledge and expertise in working with people with psychosocial disability.

Members also report that Health Service Providers can be reluctant to test eligibility of consumers for the NDIS on the grounds that they believe it is unlikely they will be successful or out of concern that needs will not be met due to limited availability of NDIS providers with dedicated psychosocial expertise.

Many people with lived experience are also reluctant to test their eligibility because they don't wish to identify as having a disability, are concerned about the process of testing their eligibility, or they have known other people who have had adverse experiences of the NDIS or not been able to find the support that they need on the NDIS.

WAAMH would like the 2025-2030 Strategy to specify how the Western Australia Government and the Commission will work with the Commonwealth on the implementation of the NDIS Review to address the inadequacies and problems emerging from the current reform process to maximise the positive impact of the NDIS in Western Australia.

To support a more overt strategic engagement with the NDIS vis a vis the new Strategy, WAAMH would also like to see dedicated resourcing as a peak for our organisation to properly represent and support psychosocial disability providers. This has been something we have called for over several years. As a complex system the NDIS warrants dedicated capacity to ensure WAAMH can stay up to date with ongoing developments in the NDIS and engage with members and stakeholders to understand the specific impacts for providers delivering psychosocial supports and people with psychosocial disability.

WAAMH is best placed to provide this support given our comprehensive understanding of psychosocial disability, as distinct from other forms of disability and given the multiple unmet needs which many people with psychosocial disability experience. The important role of the NDIS as part of the delivery of the community supports service stream, as per the National Mental Health Planning Framework, and its unique interface with other forms of psychosocial support, the public mental health system, the forensic justice

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system and other systems such as the Criminal Law (Mental Impairment) Act means it is imperative that this expertise exist within WAAMH as the community mental health sector peak.

WAAMH did significant work in relation to the NDIS through a Department for Communities funded project to support the transition to the National Quality and Safeguarding Commission Standards, and while the resources created to support that project remain available, there is no other form of dedicated resource for the psychosocial disability sector to support the sector in delivering the NDIS.

Establish a concerted 5 Year plan to address the need for locally based, community-led mental health support in regional WA

Strategic Pillar 8 of the Discussion Paper (page 76) highlights the importance of improving access to mental health services and support in regional and remote WA. While some issues for each region are identified, the Discussion Paper does not provide detail about the aspirations, needs and views of people living in regional WA about the service types and service models they believe are required.

WAAMH was also hoping to see the data provided to the Technical Advisory Group to provide further insight into regional variations in the need for mental health support and services.

WAAMH's report *Going the Distance: Making Mental Health Support Work Better for Regional Communities*[13] documents the need for a targeted mental health support strategy rolled out across regional WA to fund community and psychosocial support initiatives that address mental health prevention, early intervention and mental health support, as is identified by people living in regional WA. This should have a place based and local focus, be local community-led and driven and respond to needs and issues identified by local communities. It also requires a dedicated and targeted funding strategy across the 5-year life span of the 2025-2030 Strategy.

The Report also describes the failings of the current models of funding and commissioning used in regional WA by State and Federal Governments and calls for a greater focus on place-based and local commissioning.

The Going the Distance report identified that regional communities face significant life challenges and limited access to support for mental health and other needs. These communities lack comprehensive support systems that encompass social connections, financial security, and physical well-being. Focusing solely on treating mental health in isolation and providing clinical and crisis care without early intervention is ineffective, especially in areas with high stigma and low mental health literacy and way from the main

[13] Kaleveld L., Crane E., & Hooper, Y., (2023) *Going the Distance: Making Mental Health Support work Better for Regional Communities,* Western Australian Association for Mental Health & Centre for Social Impact University of Western Australia, Perth, June 2023.

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regional centres where mental health services are located. Generic solutions do not work for regional communities, necessitating context-specific approaches.

The report outlines key priorities for action based on community input:

- Address social determinants as key drivers of poor mental health.
- Promote mental health literacy and help-seeking behavior locally.
- Enhance the accessibility of clinical and non-clinical supports.
- Engage local leadership for relevant and sustainable support.
- Review funding models for mental health support and servicers in rural areas, recommending alternative approaches to ensure effective support for these communities.

Prioritise reforms to community treatment services – complementarity between community treatment and community support

Delivering a community-focussed and integrated system requires not only a strengthening of community psychosocial supports but also community treatment services. Therefore, WAAMH recommends that along with prioritising the strengthening of community supports, the strategy prioritises reforms to community treatment services to support them to offer more holistic, contemporary care and to maximise opportunities for integration with community psychosocial supports. The Community Treatment and Emergency Response project was a significant initiative to consider reform priorities for community treatment.

Given their mutual focus on people with moderate and severe mental health challenges, WAAMH sees community support and community treatment services as highly complementary to each other and there are many examples of collaboration between the two already in place in Western Australia that can be built upon. Personal recovery is an important foundation for clinical recovery and can help give people a reason and motivation to persist with treatment and to maintain their recovery. Community treatment services often rely on community psychosocial support services to hold people in between their clinical appointments. Community treatment services are also important to the functioning of community psychosocial support services in terms of being able to support people to re-engage with community treatment services where they might observe someone's mental health deteriorating.

Incorporate a gendered understanding of women's mental health and their experiences of the mental health system

"A key consequence of the biomedical approach to treatment of mental ill-health is heavy reliance on medication and hospitalisation, while largely ignoring the impacts of trauma. Evidence indicates that women may be overprescribed medication for mental health conditions, while attempts to treat trauma and

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distress using medication and coercive practices can cause further trauma." (pg 3, Towards a Gendered Understanding of Women's Mental Health & the Mental Health System; Women's Health Victoria; 2023)[14]

The current mental health system is built around a largely biomedical approach to mental health which relies heavily on medication and hospitalisation, and the development of a new Mental Health and AOD strategy and the stated intention to deliver a recovery-oriented community-based system that priorities prevention and early intervention is an ideal opportunity to start to unpack the dominance of that model.[15]

This shift is part of is the underlying foundation of genuine transformation of the system that lies behind the calls by people with Lived Experience for a more balanced system that provides them with a greater range of options and supports them to be empowered to take control of their mental health. It's also a shift that is essential to providing a mental health system that is responsive to gendered experiences of mental ill health.

In January 2023, Women's Health Victoria (WHV) launched an issues paper on a gendered understanding of women's experiences of mental health and the mental health system.[16]

The current focus on women and girl's experiences of gendered violence such as sexual, family and domestic violence has brought attention to the mental health impacts for women of these experiences. As in the mental health system, attention is primarily on prevention and the immediate role of FDV and sexual violence responses and services. The Centre for Women's Safety and Wellbeing has recently highlighted the need to expand the focus to include recovery and healing, and mental health must be an important part of such a response.

The paper by WHV highlights the need for a gendered understanding of the mental health system to ensure that it doesn't compound this trauma by further reinforcing structural oppression and disempowerment and further removing choice and control. Written in the wake of Victorian system reforms following that State's Royal Commission into mental health, Women's Health Victoria highlights how 'policy settings, funding, workforce, and research and data collection can both contribute to and reduce gender inequality.'

WHV notes that women are twice as likely to experience mental ill-health due to a combination of factors which can vary by age and life stage: biological sex factors related to hormonal systems and reproductive capacity; unique experience of social determinants and risks associated with gender inequity including

[14] Barr M, Anderson R, Morris S, Johnston-Ataata K (2024) *Towards a gendered understanding of women's experiences of mental health and the mental health system*. Discussion Paper 17.2, 2nd ed., Women's Health Victoria. 2024, Melbourne.
[15] See Permanent Mission of Australia to the United Nations (2023) UN General Assembly Resolution ' Mental Health and psychosocial support for sustainable development and peace- joint explanation of position, Statement delivered Sofija Korac, Economic and Social Counsel Advisor, United States Mission to the United Nations. 26 June 2023.
[16] Barr M, Anderson R, Morris S, Johnston-Ataata K (2024) *Towards a gendered understanding of women's experiences of mental health and the mental health system*. Discussion Paper 17.2, 2nd ed., Women's Health Victoria. 2024, Melbourne.

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domestic, family and sexual violence which are significant risk factors; and intersectionality such as Indigeneity, disability or CALD background that exacerbates gender inequities.

WHV argue that the dominant bio-medical model relies heavily on medication and hospitalisation and is not responsive to the unique social causes and contexts of women's distress. They note that the complex relationship between gendered violence, trauma and mental health is poorly understood and that this can lead to women's distress being overlooked, dismissed, pathologised and misdiagnosed.

WHV also note that the use of medications is gendered such that clinical trials have historically excluded women and that most medications have largely only been studied on men. This suggests that women are potentially overmedicated and experiencing unique side effects due to their biological sex differences. This is a particular area which could be the attention of research to improve mental health outcomes for women.

Western Australia can benefit from the paper's insights for its own reforms to the structure of the system and the interventions and services it offers women and their accessibility; the culture of mental health service delivery and the structure of workforce; and research and data collection.

A recent journal article using linked health records to study patterns of mental health utilisation in Western Australia between 2005 and 2021 found that 53.8% of people who accessed public mental health services were female. [17] People, including females, accessing public mental health services were also more likely to be Aboriginal and/or Torres Strait Islander people, or live outside major cities or in the most disadvantaged areas – indicating compounding social determinants for mental ill health.

The study found that most people included in the study had their first contact with the state mental health system in a community setting and that they were also likely to have conditions that required ED or inpatient treatment at some point in time. It also found that while EDs had experienced the greatest percentage increase in presentations during this period public community mental health services experienced a greater increase in the number of people they are supporting than inpatient and ED.

This indicates how important it is to ensure that our mental health system is responsive to the unique experiences of girls and women and that community treatment services are a critical point at which we can have a positive impact for women. It is also possible that by improving their experience in community settings that they will be less likely to require EDs and inpatient services. The Government's response to the Community Treatment and Emergency Response project is therefore a key opportunity for improving the experiences and outcomes for women in our mental health system.

An unpublished 2023 review of the NGO managed Step-Up Step-Down services in WA found that the majority (approximately 70%) of the users of these services were female and females were far more likely

[17]Ying Lee, C., Chai, K., McEvoy, PM et.al. (2024) Patterns of Mental Health Service Utilisation: A Population-Based Linkage of Over 17 Years of Health Administrative Records, *Community Mental Health Journal*, 60: 1472–1483, 2024

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to present with behavioural and emotional disorders, personality disorders, stress related disorders – all disorders which are particularly associated with social determinants. That review also showed that Step-Up Step-Down services were predominantly acting as Step-up services, highlighting their key role in avoiding hospitalisation. This model is also a good example of a model that is predominantly a psychosocial support model and workforce with clinical support integrated, indicating that this approach is highly effective at keeping women safe and out of hospital.

Acknowledging the potentially negative impacts of the biomedical model of mental health on girls and women highlights an imperative to change our system to offer women a broader range of options that can be more equal in power and more trauma informed and indeed trauma-based options.[18]

Avoiding hospitalisation is particularly important given its significant potential to retraumatise women through seclusion, restraint and exposure to violence. The Government has implemented several measures to reduce the risks to women of hospitalisation and provide more gender informed experiences and to try and avoid hospitalisation, however hospitals still play a disproportionate part in our mental health system.

Re-forming community treatment services and what they offer and supporting this through a strengthening in access to psychosocial supports, provides a significant opportunity to provide women with support that helps mediate the structural inequities and in particular denial of choice and control. In particular, there is an opportunity to increase the emphasis on non-biomedical supports within our community treatment services. The non-government community mental health sector already provides this broader range of supports and these can be expanded to increase access, strengthened to address the needs of particular cohort groups, and locally integrated to directly complement the work of public community treatment services. The current strategic opportunity at the national mental health Ministers' meetings re unmet need for psychosocial supports is an opportunity to access resources.

There are also opportunities to consider the current transformation of ICA services through a gendered lens to ensure that as we change this very early intervention in girls' experiences of the mental health system, we are doing so in a way that takes into account what we now know about how gender shapes mental health and the experience of the system. One example of this could be the acknowledgement of gender in the implementation of new models of care. The Personality Disorders Model of Care published in December 2022 as part of the ICA implementation program for example gives no acknowledgement to gender even though there are significant gendered variations in diagnoses of personality disorders. This

[18] See Permanent Mission of Australia to the United Nations (2023) *UN General Assembly Resolution ' Mental Health and psychosocial support for sustainable development and peace- joint explanation of position*, Statement delivered Sofija Korac, Economic and Social Counsel Advisor, United States Mission to the United Nations. 26 June 2023.

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lack of acknowledgement of gender in both the risk factors for mental health and in care appears to be common across the ICA models.

In addition to the development of the new strategy, there are several current and anticipated systemic initiatives which provide important opportunities to implement a gendered lens and the structure of our mental health system and its impacts for girls and women. These include Implementation of Infant Child and Adolescent (ICA) taskforce recommendations; response to the Community Treatment and Emergency Responses project; Commonwealth-State negotiations on unmet need for psychosocial supports outside the NDIS; the anticipated cultural change piece post IGR; and the anticipated release of the WA mental health research strategy.

Maximise lived experience and service provider leadership, expertise, experience and voice

The Government's response to the Independent Governance Review included a commitment to ensure lived experience expertise and leadership. It also acknowledged the need for cultural change. Actively building capability and supporting lived experience leadership development is essential for this to occur and must be prioritised in the Strategy not only in the public mental health workforce but beyond. The commitment to a more recovery-oriented and community-focussed service system also requires a stronger partnership with the community managed mental health sector which goes beyond a purchaser-provider relationship.

As the community mental health sector is a major employer and supporter of the Lived Experience and Peer workforces, WAAMH would like the Strategy to include particular attention to the growth, development and support for Lived Experience and peer workforces in the community mental health sector and implementation of the various Lived Experience Frameworks and Strategies developed in WA and nationally.

People with lived and living experience bring unique knowledge, insights and expertise which makes them an essential component of the community mental health workforce. Their core value and competency arises from their lived and living experience of mental health challenges or supporting someone close to them, and their emphasis on hope, empowerment, self-management and social inclusion has the capacity to improve outcomes for people with mental health challenges and their families/significant others. [19]

The community mental health sector plays a key role in building and sustaining the Lived Experience workforces and supporting Lived Experience leadership within the sector, and this role will become even

[19] Queensland Alliance for Mental Health (2023) Community Mental Health and Wellbeing Workforce Strategy 2024-2029., Brisbane.

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more important considering Federal and State Government policy frameworks and strategies that give priority to the expansion of the Lived Experience workforce.

The community mental health sector is well placed to support and operationalise national and state Lived Experience workforce frameworks and guidelines, and some agencies are already doing so,[20] including implementing the Lived Experience Governance Framework developed by the National Mental Health Consumer and Carer Forum.[21]

Government agencies and funders need to acknowledge and commit resources to enable the sector to actively engage and maximise the active participation of people with lived and living experience, both in the co-design and roll-out of services and programs and as active participants in the governance, planning and implementation of systems change. Co-design and co-production and active partnerships involving consumers, carers and families/significant other should be the standard approach for all policy and service delivery.

However, resources are not always provided to ensure that consumers and families/significant others can actively participate in the governance, planning and implementation of services and support. We propose that separate funding agreements/streams be established to enable payment of people with lived and living experience (including service users and carer payments) in the planning and design of services and support and the delivery of services and programs, and to support community mental health agencies, particularly smaller agencies and those in regional areas, to implement the various Lived Experience and Peer workforce strategies.

In addition to resourcing, the reality of rigid or short timeframes and pre-defined outputs, strategies and outcomes also hinder effective engagement and authentic co-design and co-production with people with lived experience.

We would also like the Strategy to reflect a more consistent and proactive engagement across the Commission as an organisation with the sector and WAAMH as a peak as key partners in system change.

As well as continuing to strengthen the engagement and participation of people with lived experience, WAAMH and its member agencies believe that the service provider experience and expertise of the community mental health sector, including WAAMH as the peak body, could be better used by the Commission.

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[20] See in particular Mental Commission of WA (2023) *The Western Australian Lived Experience (Peer) Workforces Framework for the Mental Health, alcohol and other drug and suicide prevention systems*, Government of Western Australia; 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.

[21] Mind Australia has already developed its own Lived Experience Governance Framework and other community mental health agencies in WA are actively supporting Lived Experience leadership and governance through different strategies.

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This should involve not just informing or consulting with service providers, but actively engaging service providers on issues that affect them, the work they do and the people the sector serves.

WAAMH would like to acknowledge the proactive efforts by the Commission's current leadership to engage directly with organisations in the sector and WAAMH as the sector peak.

We would like to see this engagement occur more consistently, proactively, deeply and much earlier on in processes at all levels within the Commission to make decisions in partnership to make better use of the expertise and experience of the sector and ourselves as the peak.

The need for improved engagement was recognised in the Agency Capability Review that the Mental Health Commission which found that the Commission hadn't "sufficiently engaged in genuine consultation with providers or paid sufficient attention to change management."

Ensure state and federal commissioning bodies have the capability and capacity required for statewide, regional and local planning, place-based and innovative and effective commissioning

The challenges arising from government funding models and approaches that rely on market approaches such as competitive funding, commissioning and contracting and procurement process are a concern to the community mental health sector. After three decades of market-based funding and procurement approaches, such as contracting, competitive tendering, individualized funding, procurement and commissioning, there is mounting evidence that these processes are outdated and ineffective.[22]

Much of the funding, procurement, contracting and commissioning of mental health services is based on a competitive market-based model that has created a series of problems and produced frustrating and overly complicated processes that make it harder for NGOs to deliver effective and quality services and which often excludes people with lived and living experience for whom the services are designed.[23]

[22] See for example Toner M., & Rafferty M., (2024) *Captured: How Neoliberalism Transformed the Australian State*, Sydney University Press, Sydney 2024.; Considine, M (2022) *The Careless State: Reforming Australia's Social Services*, Melbourne University Press: Meagher, G., Stebbing, A & Perche, D (2022) *Designing Social Service Markets: Risk Regulation and Rent Seeking*, ANU Press, Canberra; Lee, M., (2023) *Lifeboat: Disability, Humanity and the NDIS*, Quarterly Essay, Issue 91, 2023; Cahill, D & Toner. P (2018) *Wrong Way: How Privatisation and economic reform backfired*, Latrobe University Press Melbourne: Meagher, G & Goodwin, S (2015) *Markets, Rights and Power in Australian Social Policy*, Sydney University Press, Sydney: King, D & Meagher, G (2009) *Paid Care in Australia: Politics, profits, practices,* Sydney University Press, Sydney; O'Sullivan, S., McGann, M., & Considine, M (2022*) Buying and Selling the Poor: Inside Australia's Privatised welfare-to-work market*, Sydney University Press.

[23] Ibid

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In the mental health sector current funding and commissioning approaches and models do not adequately support improvements in mental health and wellbeing or promote service continuity and localized innovation.[24]

These market-based models influence the funding and delivery of mental health services and support and combined with the influence of the biomedical discourse within mental health policy and service delivery, make it more difficult to implement the types of reforms and contemporary approaches supported by people with lived and living experience, service providers and other key stakeholders.

In a recent submission, WAAMH described some of the problems with current funding and commissioning approaches that have been identified by WAAMH members and other service providers and stakeholder groups:

- Currently, government processes, rules and procedures for funding mental health services have been created to manage contracts and fund outputs of government departments and entities, rather than wellbeing outcomes for people. This is perpetuated by commissioning processes that are inflexible, transactional, and opaque.
- Short-term contracts (1-3 years) make it difficult to retain staff and ensure service continuity, particularly in regional areas.
- Reporting requirements often conflict with the achievement of desired outcomes for clients.
- Prescriptive contracts are often inflexible, administratively onerous and result in staff spending a disproportionate amount of time managing reporting and administrative systems, rather than delivering services or engaging with communities. Proposals and bids for services form the basis of contracts which pre-define approved activities and outputs. Deviation from these is often considered a breach of contract. Often flexibility is limited, or difficulty arises in trying to adapt to changing local circumstances or ideas.
- Key functions such as advocacy, consultation, technology, policy analysis and input, quality standards and accreditation, evaluation and reporting and other administrative and support functions are often considered unfunded functions or are poorly funded, despite expectations from government that that these functions will be provided.
- Partnerships and collaboration with other agencies and sectors is required, but the costs and time involved is often not included in contract prices and funding levels.

[24] National Mental Health Commission (2023) *Submission for the Mid-Term Review of the National Health Reform Agreement Addendum 2020-2025*, May 2023.

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- State and Federal Governments and other funding providers, such as Primary Health Networks, have difficulty streamlining their own regulatory, tendering and compliance processes.
- The way mental health services are funded and commissioned can be complicated, confusing and frustrating for many service providers and consumers in rural and remote Australia.[25]
- These approaches produce significant instability to mental health organisations, service users and workers, including the emergence of precarious employment and increased worker insecurity. Competitive funding models and short-term funding cycles encourage short-term contracts for staff and pay that is not commensurate with the nature and skill of the work performed, thereby affecting employee financial security, and creating adverse implications for the recruitment and retention of staff and service quality.
- Current funding and contracting arrangements favor bigger and better resourced agencies because they are more experienced at writing grant and tender application documents and are perceived by Governments as presenting less risk.

An accumulation of inquiries, reports and research over the last two decades has consistently highlighted these negative impacts, however limited action has been taken to implement the findings and recommendations.[26] There has been minimal systemic or strategic action to address the root causes of these issues.

What is required is a transformation of the funding and commissioning of mental health services and support in WA. This should:

- recognise the complexity of work being undertaken and close the gap between contract costs and the price of delivering the services, including recognising place-based differences and the costs of administration and reporting requirements.
- place a much higher priority on trust and establishing meaningful relationships with mental health service providers, rather than the current focus on competition, prescriptive contracts, competitive tendering and contractual probity and compliance.

[25] Kaleveld, L., Crane, E., & Hooper, Y (2023) *Going the Distance Making mental health support work better for regional communities*, Reported prepared for the WA Association for Mental Health by the Centre for Social Impact, University of WA, June 2023.
[26] See McGregor, M (2023) *Are there any more recommendations worth implementing from nearly 30 years of Commonwealth Nonprofit Reform Reports*, The Australian Centre for Philanthropy and Nonprofit Studies, University of Queensland, February 2023.

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- provide greater flexibility so that providers can respond to and address local needs and ensure a much stronger focus on outcomes that matter to local communities, and to people who use services and their families and carers.
- allow agencies to respond to the needs in their local community by expanding specialist areas as required and supporting collaboration between organisations.
- recognise the ongoing need for the services that are currently being delivered and commit to closing the discrepancy between the public and community mental sectors. This could be achieved by mirroring the benefits available to staff in government positions and assisting to establish career progression pathways, thereby reducing job insecurity.
- extend funding cycles and lead times for new funding commitments and the commencement of programs to enable organisations sufficient time for contract renewals and or recruitment of appropriate staff.

There is an urgent need to develop more effective and innovative approaches and models for the funding and commissioning of mental health services as well as community services more generally.

WAAMH believes the 2025-2030 Strategy should give priority to the reform of commissioning and funding processes. and ensure that commissioning bodies have the capability and capacity required for more effective and innovative commissioning processes, including more relational commissioning, place-based commissioning and co-commissioning. These innovative approaches are discussed in more detail in a recent WAAMH submission to the Federal Government.[27]

Commit to and fund proactive workforce planning for the community sector workforce

The 2025-2030 Strategy needs to be supported by workforce planning and development that is based on current, quality data specific to WA 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 work already undertaken in NSW by our colleagues at the Mental Health Coordinating Council, which has now completed three biennial surveys and

[27] WAAMH (2023) *Response to the Australian Government Issues Paper A stronger, more diverse and independent community sector,* November 2023

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reports[28], 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.

WAAMH would like to see the Strategy support proactive and informed sector and workforce planning and development to build capability, including by investing in a local Western Australian community sector workforce survey as occurs in New South Wales, and to advocate to the Commonwealth for a national survey via state and territory peaks to build national workforce data for our sector.

[28] Human Capital Alliance.(2023) *Mental Health Workforce Profile: Community Managed Organisations Mental Health Workforce Report*, Mental Health Coordinating Council, Sydney, NSW 2023. https://mhcc.org.au/wp-content/uploads/2023/11/Mental-Health-Workforce-Profile_2023_WEB.pd

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