Response to the Productivity Commission's interim report on its review of the National Mental Health and Suicide Prevention Agreement

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WAAMH

Western Australian Association for Mental Health

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1. Introduction

The Western Australian Association for Mental Health (WAAMH) welcomes the opportunity to provide feedback on the Productivity Commission's interim report on its review of the National Mental Health and Suicide Agreement (the agreement).

WAAMH welcomes the report's frank assessment that the agreement is not fit-for-purpose, citing structural and governance deficiencies, an absence of enforcement mechanisms, and the persistent lack of national accountability for outcomes, particularly those affecting Aboriginal and Torres Strait Islander peoples.

We concur with the interim report's finding that the existing agreement has made little progress towards meeting its objectives. WAAMH shares the view that the mental health system remains fragmented and under-resourced and is failing the people who need it most.

2. Support for a new national agreement, but not at the cost of action now

A key recommendation of the interim report is that the current agreement be extended for twelve months to allow for the development of a new National Mental Health Strategy to guide the next agreement.

While WAAMH supports this in principle as the best policy process to follow, we are concerned that this recommendation underestimates the amount of time that it would take government to complete such a strategy. We are concerned that this might unnecessarily delay strategically valuable reforms, informed by jurisdictional strategies that will have national benefits to the Commonwealth Government.

The Western Australian State Government is expected to finalise a new Mental Health and Alcohol and other Drug Strategy 2025-2030 by the end of the year. Rather than wait for an indeterminate period for the development of a new national strategy, WAAMH's preference would be for an immediate negotiation of a bilateral agreement on how the commonwealth and state governments can work together to address the reform priorities that are identified in the WA strategy – all of which will likely be aligned or be able to advance the commonwealth's priorities. The Commonwealth Government can then work within the context of this strategy to propose its own priorities. This should have the added benefit of improving integration within the system between the commonwealth and state governments.

A national position statement need not delay strategic actions through bi-lateral agreements, particularly by jurisdictions that are motivated and have stakeholder engagement on priority reforms.

3. Urgent action is needed on psychosocial supports through extension and expansion of existing programs

WAAMH welcomes and fully endorses the recommendation that psychosocial supports outside the NDIS be progressed as a priority, regardless of the timeframe of the agreement. We urge the Commonwealth Government in its deliberation of the report to support this recommendation, and

we urge state governments to engage with this as a strategic opportunity to strengthen a critical part of their systems.

WAAMH notes the view expressed by Associate Professor Sebastian Rosenberg that the neglect of psychosocial services reflects the structural problem, whereby responsibility for psychosocial supports and community mental health supports is split between federal and state governments.[1]

We need the two levels of elected governments (and the respective federal and state government agencies with delegated responsibility) to work collaboratively to find solutions that meet federal government requirements, whilst at the same time addressing state-based and local needs and priorities, and that integrate, build on and respond to existing systems and services.

In Western Australia and many other States and Territories, there is an existing (well-established) eco-system of psychosocial support programs and services delivered by non-government organisations, which are funded by either the State Government or the Federal Government. WAAMH believes that the most effective strategy will be to resource these existing non-government service providers to scale up and expand their offerings. The quickest way to do this is to utilise forthcoming commissioning arrangements being undertaken by commonwealth and state governments, or to extend and expand already existing services to support planned commissioning.

WAAMH believes that if the provision of psychosocial support in Western Australia is to occur through an expansion of the existing Commonwealth National Psychosocial Support program, there needs to be a review of what is currently commissioned; how, where and to whom current programs are being targeted; and the adequacy of the level of funding.

It would be helpful for the Productivity Commission to provide some advice not only on the human value of this unmet need being addressed, but to provide explicit commentary to governments about the impact of this on improving system functionality e.g., through diversions from hospital beds or reduced returns to hospital. This seems to be key for state government treasuries to support the approach.

It is generally accepted that an estimated half of deaths by suicide are by people with diagnosed mental health issues. Better mental health care, such as the provision of psychosocial support outside the NDIS, will have suicide prevention impacts.[2]

4. Urgent attention to address governance, and systemic barriers and failures, and ensure stronger focus on accountability

WAAMH welcomes and agrees with the interim report's findings of structural and governance deficiencies, an absence of enforcement mechanisms, and the persistent lack of national accountability for outcomes.

WAAMH supports some of the recommendations in the interim report to address the governance, and system-wide barriers and failings identified, including:

- A greater role for people with lived experience in planning, development and implementation.

[1] Rosenberg S (2025) 50,000, Australians live with mental illness but don't qualify for the NDIS. A damming new report says they need more support, *The Conversation*, June 26 2025.
[2] National Suicide Prevention Office (2025) *National Suicide Prevention Strategy 2025-2035*, Australian Government, Canberra 2025.

- A greater role for mental health service provider peak bodies and front-line service providers.
- Much more public transparency and reporting about planning, development, implementation and evaluation of the agreement and the planned initiatives.
- Establishing a public dashboard to track and report on progress towards achieving the objectives, outcomes and targets.

However, the report is largely silent on other barriers that WAAMH believes require attention. These include:

- Structural and policy drivers, including a top-down, metro centric, one-size-fits-all approach to the planning, funding and delivery of mental health supports and the inherent tensions of federalism.
- The dominance of the clinical paradigm in the delivery of mental health services over more holistic approaches that mediate the social determinants of mental health.
- The heavy reliance on marketised service delivery (through the use of competitive tendering processes) which potentially disadvantage smaller, community-based providers and create other significant problems, and which do not appear to leverage off the expertise in the sector to bring forward the best solution to the particular problem that needs to be addressed.
- The limited leadership role afforded to localised, state-based Lived Experience, community and sector perspectives, in planning, decision-making, governance and funding processes in relation to the agreement.
- The need for greater accountability and improved transparency about the actions to be undertaken by different levels and agencies of government, as well as health and mental health ministers and state-based mental health commissions.

5. Stronger action, rather than more rhetoric, is required on social determinants

WAAMH recognises the commission's emphasis on addressing the social determinants of mental health. However, whilst such rhetoric is common in government policy documents and strategies, including the national agreement, we have not seen sustained effort or funding by governments to address these issues through cross-sectoral policy and action.

Acting to address the social determinants of mental health requires collective planned action across sectors and across governments.

WAAMH believes the national agreement and efforts to address the unmet need for psychosocial support must ensure there is urgent action on key social determinants such as employment, housing, child maltreatment, income support, and income security and poverty, all of which have significant impacts on mental health and wellbeing.

WAAMH endorses the need for the next agreement to include commitments to address identified social determinants, as well as clearly provide designated responsibility for action outside of the health and mental health portfolios.

We provide comment on two issues below.

5.1 Employment

We note there are several references to unemployment, and also to stigma and discrimination, in the interim report.

However, WAAMH would like to see recommendations in the final report in relation to the Individual Placement and Support (IPS) program, given the program is one of the most well evidenced mechanisms for advancing employment for people experiencing mental health issues.[3]

The Productivity Commission's 2020 Mental Health Report recommended that the IPS program be rolled out nationally in all adult community mental health services. Unfortunately, there has been limited progress on this recommendation. While the Commonwealth Government has expanded access to IPS for young people through headspace sites, in the adult context there has been next to no progress. Initiatives have been limited to a very recent trial in two Medicare Mental Health Centres. This trial will run until June 2027, after which the future of the program is unknown.

Given the well-established success of the IPS model internationally, we believe there is no reason why government should not expand access to this program through the typical integrated care approach (as well as funding for successful partnerships between Disability Employment Services (DES) and mental health services, such as that between Community Bridging Services Inc and SA Health regions). This could occur as part of psychosocial supports, with IPS being embedded into community mental health services in not-for-profits. One way this could be facilitated is through federal government funding for programs delivered within state services – the use of federal grants in state services is how expansion has occurred in the United States.

The IPS model has also been applied and well-documented in various service contexts. Dr Suzanne Dawson[4] is scoping a project to further explore its application in primary care – which is where it occurs in the UK National Health Service (NHS).

In other countries, the IPS program has been expanded successfully into other community service sectors, including alcohol and other drug services, family and domestic violence services, housing and homelessness services, veterans and justice.

We note that partnerships with DES to provide IPS are undermined, by the specific provisions of DES funding, and service models which are not consistent with the evidence-based practices of IPS, such as the case numbers.

5.2 Childhood maltreatment

Recent Australian studies show that childhood maltreatment is among the single biggest contributor to mental ill-health and must be an area of priority action.. We believe it should be a prevention priority identified in the agreement.

A recent Australian study found that by eradicating childhood maltreatment, it would be possible to prevent 21 per cent of all cases of depression; 24 per cent of anxiety disorders; 32 per cent of drug use disorders; 39 per cent of self-harm; and 41 per cent of suicide attempts in Australia.[5]

[3] Term of Reference (c) of the Review specifies that the Review consider "the opportunities under the National Agreement to adopt best practice approaches across Australia, particularly where productivity improvements could be achieved". The Individual Placement and Support program is an exemplar of a best practice approach to the employment of people with mental health issues.
[4] For more information about Suzanne Dawson https://www.flinders.edu.au/people/suzanne.dawson
[5] Wellbeing and Prevention Coalition in Mental Health (2024) *Policy Brief: Preventing child maltreatment to prevent mental-ill health*.

WAAMH supports the view expressed by the Wellbeing and Prevention Coalition in Mental Health in its original submission to the review of the Mental Health and Suicide Prevention Agreement, that the prevention of childhood maltreatment should be given the same attention as efforts to reduce harms from other public health hazards such as tobacco smoking and vaping.[6]

6. Expand and develop the psychosocial workforce

We call on the Productivity Commission to recommend that the community managed mental health workforce be included in the National Mental Health Workforce Strategy.

WAAMH agrees with Community Mental Health Australia's submission that the National Workforce Strategy does not reflect contemporary understandings about rights-based approaches and psychosocial disability, and omits the critical role played by the community mental health and psychosocial support workforce.

We encourage the Productivity Commission to recommend that key commissioning and contracting issues that undermine workforce retention be addressed, including short-term contracts; contract rollovers (especially without uplifts in funding to prevent the need for services to be reduced to account for increasing costs); inadequate funding models; funding uncertainty; and commissioning and contracting processes which create barriers for a sustainable and quality workforce.

For workforce planning and development to support the future growth, WAAMH also encourages the commission to recommend funding a national survey of the community managed and psychosocial workforce, to be undertaken via state and territory peak bodies, based on the survey undertaken in NSW over the last six years. This would provide baseline and biennial data on the sector's workforce.

WAAMH believes that valuing this workforce is increasingly essential in the context of the ongoing workforce shortages in the clinical workforce, which appear likely to continue. WAAMH is concerned that government does not appear to have a 'Plan B', for how to respond to mental health needs in the community in the likely event that the clinical workforce needs will not be able to be met (given the increased demand and competition for these workforces). WAAMH would welcome scenario planning that explores how other services and workforces need to be cultivated to fill the potential gap in clinical workforces, given how clinically dominated the current system is.

7. Stronger focus on prevention in the national agreement

WAAMH notes the comments in the interim report about the contradiction between the agreement's identification of prevention and early intervention as an objective, but its failure to identify any actions or allocate any funding to achieve this objective.

We endorse the need for the next agreement to include funding commitments for prevention and early intervention initiatives, as well as clearly designated responsibility for action outside of the health and mental health portfolio.

[6] Wellbeing and Prevention Coalition in Mental Health (2025) *Submission: Final review of the Mental Health and Suicide Prevention Agreement*, Submission to the Productivity Commission, 11 March 2025.

WAAMH endorses the stance proposed by the Wellbeing and Prevention Coalition in its original submission to the review, that the national agreement must provide an opportunity for a more comprehensive approach to mental health prevention. This should include a combined focus on, and investment in, the prevention of mental ill-health, alongside investments in treatment, clinical support, psychosocial support and community support.[7]

8. Addressing the needs of regional and remote communities better

We believe the agreement has not been effective in meeting the specific needs of regional and remote communities in WA. We note the observation in the interim report that the agreement fails to provide guidance on how regional gaps will be addressed.

WAAMH's Going the Distance Report[8] provides a snapshot of three WA regions and highlights the limitations of existing responses to community mental health and psychosocial support in regional centres and particularly, communities and towns away from the main regional centres.

In a state as large as Western Australia, major geographical and demographic differences between regions (as well as variability in the existing mental health system infrastructure and mix of services) mean that a place-based approach to planning is critical.

Beyond the main regional cities and towns, psychosocial support and community support services are either not available in local communities, or where they do exist, are poorly funded or have to work beyond their capacity and capability to provide timely and effective local supports and services.

A major problem that continues to be recognised in multiple reports[9] (but has not been addressed by either level of government) is that current competitive commissioning approaches and funding models are not well aligned to the realities of rural and remote service provision.

Drive-in-drive-out models and short-term, region-wide, funding models, exacerbate the lack of services and support, and contribute to the instability of the system, particularly in communities away from the main regional centres. Federal and state governments have failed to take action to address this issue.

[7] Wellbeing and Prevention Coalition in Mental Health (2025) *Submission: Final review of the Mental Health and Suicide Prevention Agreement*, Submission to the Productivity Commission, 11 March 2025.
[8] Kaleveld L, Crane E & Hooper Y (2023) *Going the Distance: Making mental health support work better for regional communities,* Report prepared for the Western Australian Association for Mental Health (WAAMH) by the Centre for Social Impact, University of Western Australian, June 2023, Perth.
[9] Kaleveld L, Crane E & Hooper Y (2023) *Going the Distance: Making mental health support work better for regional communities,* Report prepared for the Western Australian Association for Mental Health (WAAMH) by the Centre for Social Impact, University of Western Australian, June 2023, Perth; Commonwealth of Australia (2018) *Accessibility & Quality of Mental Health Services in rural and remote Australia*. Community Affairs Reference Committee. Senate of Australia, Canberra; Perkins D, FarmerJ, Salvador-Carulla (2019) The Orange Declaration on rural and remote mental health, *The Australian Journal of Rural Health,* 27(5), 374-379; Productivity Commission (2020) *Mental Health Inquiry Report*, Report No 95, Canberra 2020; Department of Social Services (2024) *Reforms to strengthen the community sector.* Summary of submissions, Canberra March 2024; Blueprint Expert Reference Group (2024) *Not-for-profit sector Development Blueprint*

We need funding models and service models that are locally led and provided; whichbuild on and extend on existing local services; which ensure longer term, sustainable, and integrated services and support; and prioritise prevention as well as workforce recruitment and retention.[10]

9. A separate schedule to strengthen Aboriginal and Torres Strait Islander social and emotional wellbeing, and align with Closing the Gap priority reforms

WAAMH shares the view expressed by others in their submissions, including Community Mental Health Australia, that Aboriginal and Torres Strait Islander people's social and emotional wellbeing must have its own dedicated schedule in the next agreement.

We support the views expressed by Community Mental Health Australia in its submission that these efforts must be led by Aboriginal and Torres Strait Islander communities and organisations, and respect self-determination, cultural knowledge and expertise.

Acknowledgement of Country

The Western Australian Association for Mental Health (WAAMH) acknowledges the traditional custodians of the land 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 and acknowledge their ongoing contribution to Western Australian society and culture.

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, as well as the families and carers who provide support and have a lived or living experience.

About WAAMH

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.

[10] Kaleveld L, Crane E & Hooper Y (2023) *Going the Distance: Making mental health support work better for regional communities,* Report prepared for the Western Australian Association for Mental Health (WAAMH) by the Centre for Social Impact, University of Western Australian, June 2023, Perth.

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 to support people affected by mental ill-health and their families and help them live meaningful lives in their communities.