Australian Government
Productivity Commission

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Mental Health and Suicide Prevention Agreement Review

Interim report

This is an interim report prepared for further public consultation and input. The PC will finalise its report after these processes have taken place.

June 2025

The Productivity Commission acknowledges the Traditional Owners of Country throughout Australia and their continuing connection to land, waters and community. We pay our respects to their Cultures, Country and Elders past and present.

The Productivity Commission

The Productivity Commission (PC) is the Australian Government's independent research and advisory body on a range of economic, social and environmental issues affecting the welfare of Australians. Its role, expressed most simply, is to help governments make better policies, in the long-term interest of the Australian community.

The PC's independence is underpinned by an Act of Parliament. Its processes and outputs are open to public scrutiny and are driven by concern for the wellbeing of the community as a whole.

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Opportunity for comment

The PC thanks all participants for their contribution to the review and now seeks additional input for the final report.

You are invited to examine this interim report and comment on it by written submission to the PC, preferably in electronic format, by 31 July 2025. If you are unable to make a written submission, you can make a submission by phone or you can provide a video submission.

Further information on how to provide a submission is included on the review website: www.pc.gov.au/inquiries/current/mental-health-review

The PC will prepare the final report after further submissions have been received, and it will hold further discussions with participants. Public hearings will be held in August 2025. Further details on locations, dates and registering for hearings can be found on the review website.

Commissioners

For the purposes of this review and interim report, in accordance with section 40 of the *Productivity Commission Act 1998* the powers of the PC have been exercised by:

Selwyn Button, Commissioner

Angela Jackson, Commissioner

Terms of reference

I, the Hon Dr Jim Chalmers MP, Treasurer, pursuant to Parts 2 and 3 of the *Productivity Commission Act 1998*, hereby request that the Productivity Commission (the PC) undertake the Final Review into the National Mental Health and Suicide Prevention Agreement.

Background

Mental health is a key component of overall health and wellbeing. In any year in Australia, an estimated 1 in 5 people aged 16–85 will experience a mental disorder, and reported mental wellbeing has declined over the past decade. Poor mental health has broader impacts, as it is associated with poorer social, physical health and economic outcomes for individuals, and can impact workforce participation and productivity. Strengthening the wellbeing and capabilities of Australians is key to underpinning continued growth in Australia's productivity and living standards.

Suicide remains one of the leading causes of death for Australians, with more than 3,000 people dying by suicide every year. Suicide prevention is complex; given the range of factors that can contribute to suicidal distress. In addition to efforts to strengthen the mental health system, effective suicide prevention requires targeted approaches to ensure a range of supports are available to individuals in need.

Australian Governments are making significant investments to improve Australians' mental health and prevent suicide. During 2021–22, national recurrent spending on mental health and suicide prevention related services was estimated to be almost $12.2 billion. Annual average spending has increased by 3% since 2017–18 in real terms, reflecting the priority placed by Australian Governments on investing in Australians' mental wellbeing. The National Mental Health and Suicide Prevention Agreement (National Agreement) sets out the shared intention of Commonwealth, state and territory governments to work in partnership. Australian governments are collaboratively seeking to improve the mental health and reduce the incidence of suicide of all Australians.

A central component of the National Agreement is a shared commitment to transform and improve Australia's mental health and suicide prevention system (Clause 20), including to provide an effective approach to the needs of people at risk of suicide (Clause 122). The Final Review of the National Agreement will assess the objectives, outcomes, and outputs of the National Agreement and its intent to strengthen the evidence base for policy development and identify opportunities for systemic reform. The Final Review will play a key role in identifying opportunities to improve the effectiveness of this significant investment in Australia's human capital.

While the National Agreement sets out the national objectives, outcomes, and outputs for mental health and suicide prevention, individual bilateral agreements (as schedules to the National Agreement) detail the jurisdiction-specific commitments, including funding, which have been adapted to local contexts (Clause 4 and 16). Therefore, the Final Review will assess existing commitments, including those outlined in Schedule A and the bilateral schedules, which support the broader goals of the National Agreement. The Final Review will also provide valuable insights to inform the design of any future arrangements beyond June 2026, ensuring continued progress in mental health and suicide prevention efforts.

The PC is focused on improving understanding of opportunities to improve Australia's national prosperity and economic progress more broadly. Through reporting functions such as the Report on Government Services and Closing the Gap reporting, the PC plays a central role promoting improvements in public service delivery across jurisdictions and over time. The PC's 2023 5-Year Productivity Inquiry also identified that the productivity of Australia's services sector, especially non-market services, will become increasingly important to Australia's productivity going forward. Reflecting this, the Commonwealth Government identified 'Delivering quality care more efficiently' to be one of five pillars of its Productivity Agenda. Commissioning the PC to complete the Final Review of the National Mental Health and Suicide Prevention Agreement is an acknowledgement of the central importance of mental health and suicide prevention to Australia's overall wellbeing and the opportunity for evidence-based policy to support quality and productivity improvements in service delivery.

Scope of the inquiry

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

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

a. the impact of mental health and suicide prevention programs and services delivered under the National Agreement to Australia's wellbeing and productivity
b. the effectiveness of reforms to achieve the objectives and outcomes of the National Agreement including across different communities and populations
c. the opportunities under the National Agreement to adopt best practice approaches across Australia, particularly where productivity improvements could be achieved
d. the extent to which the National Agreement enables the preparedness and effectiveness of the mental health and suicide prevention services to respond to current and emerging priorities
e. whether any unintended consequences have occurred such as cost shifting, inefficiencies or adverse consumer outcomes
f. effectiveness of the administration of the National Agreement, including the integration and implementation of Schedule A and the bilateral schedules that support its broader goals
g. effectiveness of reporting and governance arrangements for the National Agreement
h. applicability of the roles and responsibilities established in the National Agreement
i. without limiting the matters on which the PC may report, in making recommendations the PC should consider the complexity of integrating services across jurisdictions and ensuring that the voices of First Nations people and those with lived and/or living experience of mental ill-health and suicide, including families, carers and kin are heard and acted upon.

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

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

Process

The PC is to undertake an appropriate public consultation process including holding hearings, inviting public submissions and releasing an interim report to the public.

The PC's comprehensive and culturally appropriate consultation should include Commonwealth, state and territory government agencies, commissioning bodies, service providers, peak body organisations, people with lived and/or living experience of mental ill-health and suicide, First Nations communities, priority cohorts and other relevant stakeholders.

In undertaking the review, the PC should have regard to previous inquiries where relevant, including but not limited to the PC's inquiry into Mental Health completed in June 2020 and the final advice of the National Suicide Prevention Advisor in December 2020, as well as other work that may have explored complementary themes. The PC will also consider reports delivered through the National Agreement and Bilateral Schedules.

The PC should make recommendations for the National Agreement that aim to enhance the effectiveness, accessibility, affordability and safety of the mental health and suicide prevention system.

Deliverables

An interim report followed by a final report and recommendations should be provided to the Parties of the National Agreement by 17 October 2025.

The Hon Dr Jim Chalmers MP
Treasurer

[Received 30 January 2025]

Disclosure of interests

The *Productivity Commission Act 1998* specifies that where Commissioners have or acquire interests, pecuniary or otherwise, that could conflict with the proper performance of their functions they must disclose those interests.

Commissioner Selwyn Button is Chair of the Aboriginal Centre for the Performing Arts, Commissioner for Australian Sports Commission and Director of the Queensland Rugby Union. He was also formerly Chairperson of the Lowitja Institute and Director of the Institute for Urban Indigenous Health (IUIH).

Commissioner Angela Jackson is Chair of the National Committee of the Women in Economics Network, Adjunct Associate Professor at the University of Tasmania and was previously a non-Executive Director of Melbourne Health.

Acknowledgments

The Commissioners express their appreciation to the staff who worked on the interim report – Assistant Commissioner Miriam Veisman-Apter, who leads the Review, and other team members including Erin Turner, Peter Daniel, Anna Law, Brian Vandenberg, Rachel Burgess, Claire Heeps, Patrick Chappell, Erin Massey and Samantha Thomas. Our thanks are also extended to Tracey Horsfall for administrative and project support.

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Mental Health and Suicide Prevention Agreement Review

Interim report

Overview

Key points

- **The mental health and suicide prevention system is fragmented and out of reach for many people. The National Mental Health and Suicide Prevention Agreement represents the commitment of governments to work together towards a person-centred, integrated mental health and suicide prevention system.**

  Under the Agreement, the Australian, state and territory governments committed to progress an ambitious set of outcomes through national outputs and specific actions contained in bilateral schedules.

- **The actions in the Agreement do not advance system reform.**

  As a result, consumers, carers and practitioners report that services remain unaffordable and difficult to access and are not always able to respond to people's needs. This is despite governments' progress in implementing actions under the Agreement and the substantial efforts of many working across mental health and suicide prevention services.

- **Key commitments in the Agreement have not been delivered and should be completed as a priority. Governments should immediately work to resolve the commissioning and funding responsibilities for psychosocial supports outside the National Disability Insurance Scheme – a service gap affecting 500,000 people.**

  Governments should immediately release the completed National Stigma and Discrimination Reduction Strategy and comprehensive guidelines on regional planning and commissioning for primary health networks to deliver greater access to mental health and suicide prevention services.

- **A new policy architecture is needed to articulate the collective actions that will deliver changes to the mental health and suicide prevention system and improve outcomes.**

  To be effective, the new policy architecture should be developed by governments in a process of co-design with people with lived and living experience of mental ill health and suicide, their supporters, families, carers and kin as well as service providers and practitioners.

- **The current Agreement should be extended until June 2027 to allow sufficient time for co-design of the new policy architecture. This architecture should contain:**
  - **a long-term strategy for reform**
  - **a five-year national agreement to tackle key priorities**
  - **bilateral schedules to direct funding of services that respond to local needs**
  - **new separate schedules on services to support the social and emotional wellbeing of Aboriginal and Torres Strait Islander people and suicide prevention.**

- **The next national agreement should comprise:**
  - **a clear set of objectives relating to the long-term vision set out in the National Suicide Prevention Strategy and a renewed National Mental Health Strategy**
  - **a set of specific and measurable outcomes focusing on what is achievable within the scope of a five-year agreement and clear accountability structures**
  - **tangible commitments clearly linked to the objectives and outcomes it aims to achieve.**

- **The next agreement should formalise the role of the National Mental Health Commission as the entity responsible for independent assessment and reporting on progress.**

Governments signed the National Mental Health and Suicide Prevention Agreement to strengthen collaboration and improve the outcomes of people with lived and living experience of mental ill health and suicide. But in the three years since the Agreement was signed, little has changed for the people who access mental health and suicide prevention services, their supporters, families, carers and kin. The consumers, carers and service providers we surveyed spoke of ongoing access and affordability challenges and uncoordinated services not responding to need (box 1).

There are many reasons for this – mental health and suicide prevention reform takes substantial time and effort and a three-year timeframe is relatively short to achieve meaningful change. External events, such as the COVID-19 pandemic and the Voice referendum, affected the mental health and wellbeing of all Australians.

Nonetheless, the Agreement itself has fundamental flaws, meaning it is not supporting progress towards a person-centred, integrated mental health and suicide prevention system.

The Agreement expires in June 2026. This gives governments the opportunity to start again and create a policy architecture, including a new national agreement, that enables collaboration and responds effectively to the needs of people with lived and living experience, their supporters, families, carers and kin.

Box 1 – 'Alienating, inadequate, ill-informed, and under-resourced': consumers, carers and practitioners reflect on the mental health and suicide prevention system

The reflections of consumers, carers and service providers are a central part of assessing progress under the Agreement. The PC asked consumers, carers and mental health and suicide prevention workers and volunteers about their experiences and views on the system during the period of the Agreement. The responses from consumers reflected four key themes.

- Costs and waiting times are a major barrier to accessing mental health and suicide prevention services.
- There are gaps and service shortages across the system, including GPs, specialist providers and acute care.
- Crisis support is inadequate and services are not responsive to people's needs.
- Experiences of discrimination when accessing services are common.

Carers reflected on a lack of support as well as experiences of exclusion and not being able to access information they needed to support the person they were caring for. Practitioners spoke about the need for change in the way services are staffed and funded.

The survey also captured people's positive experiences of the system and the factors contributing to them. Where people felt safe, respected and listened to and had opportunities to meaningfully engage with others (which often came about when interacting with peer workers), this contributed to positive experiences.

Box 1 – 'Alienating, inadequate, ill-informed, and under-resourced': consumers, carers and practitioners reflect on the mental health and suicide prevention system

> Intake processes are not trauma informed and have often left myself and my loved ones re-traumatised
>
> **Consumer**

> When I first went to hospital people kept saying 'you will be okay with supports in the community' but no one told me what they were or how to access them
>
> **Consumer**

> There are mental health lines … however these are strictly crisis management, do not provide multiple sessions and are not tailored to early intervention
>
> **Consumer**

> In regional areas the availability, access and affordability has dramatically reduced (and it was poor to begin with)
>
> **Consumer**

> A lot of times you are unable to get support if you don't fit into a certain box. This creates hesitancy to reach out as it becomes too much to try and work through
>
> **Consumer**

> Services are increasingly difficult to access and navigate, hard to get the most vulnerable and individuals in need seen in a timely and appropriate manner without having to share exhausting accounts of why the service is needed
>
> **Practitioner**

> I am consistently excluded from care plan discussions. During the first hospital admission, clinicians refused to share updates, citing confidentiality, even though my involvement is critical to my loved one's recovery
>
> **Carer**

> I think the system is worse than ever and seems to be going backwards. There are mental health service providers in our area who will not refer (or speak to) each other because they are the competition for funding
>
> **Practitioner**

> I live in a cross-border area and there is dispute over whose responsibility services are. I have had to navigate through how to get the right services with the extra pressure of where we can find them and be accepted
>
> **Carer**

> We do not have enough staff, we are underfunded and cannot offer the services people need in our area
>
> **Practitioner**

> I don't feel like we are seen at all
>
> **Carer**

> Inadequate services, wait times too long, couldn't stay on hold any longer
>
> **Consumer**

The Agreement is not fit for purpose

The National Mental Health and Suicide Prevention Agreement was signed in 2022, replacing the Fifth National Mental Health and Suicide Prevention Plan and introducing co-funding commitments agreed between the Australian, state and territory governments. The Agreement recognises the role of a whole-of-government approach to system reform incorporating education and broader social services, rather than having a narrow health focus. It covers the important intersection between the Australian government and state and territory government responsibilities across the many domains contributing to mental health and suicide prevention.

In signing the Agreement, governments agreed to an ambitious set of tasks. The Agreement covers five objectives, five outcomes, 13 outputs, 15 priority populations, 14 policy principles and a plethora of commitments for national and jurisdictional actions – with no obvious links between them (figure 1). Without an articulated and evidence-based logic connecting the actions set out in the Agreement and its overarching goals, it is difficult to assess the Agreement's effectiveness. It is hard to see what is being achieved and how, and to hold governments accountable for their commitments.

Unlike other national agreements, the National Mental Health and Suicide Prevention Agreement contains only limited funding commitments. In an average year, funding commitments in the Agreement total about $360 million, or 3% of the $12 billion governments spend on mental health services.[1] Over the past decade, governments' real expenditure on mental health services has grown by 30%. In 2022-23, real expenditure per person was nearly 16% higher than it was in 2013-14.

In the Agreement, funding commitments for specific services are included in bilateral schedules signed by the Australian Government with each state and territory government. The 11 core initiatives included in the schedules are largely based on initiatives the Australian Government introduced prior to the Agreement's negotiations. In some cases, schedules also reflect pre-existing commitments of state governments, such as reforms the Victorian Government committed to in response to the Royal Commission into Victoria's Mental Health System.

Many key commitments in the Agreement are not funded. For example, governments committed to align the implementation of the Agreement with the National Agreement on Closing the Gap and improve services that support the social and emotional wellbeing of Aboriginal and Torres Strait Islander people. However, there are no specific measures or funding in the Agreement relating to improving services for Aboriginal and Torres Strait Islander people. Greater investment in prevention and early intervention is one of the Agreement's objectives, but there are no actions aiming to achieve this. There is also no funding allocated to enable collaboration between different parts of government working to improve mental health and suicide prevention outcomes. This is a core objective of the Agreement, and review participants told the PC collaboration is still lacking in many areas. Where it does occur, this is due to the goodwill of staff and their strong commitment to improving consumer outcomes.

The Agreement emphasises the need to incorporate the voices of people with lived and living experience in all aspects of the system but says little on how this should be achieved. Review participants have told the PC the Agreement was developed with limited input from people with lived and living experience, their supporters, families, carers and kin, as well as service providers. Consumers and carers have limited involvement in governance arrangements.

[1] The bulk of this spending is on clinical services and is managed under the Medicare Benefits Schedule, the Pharmaceutical Benefits Scheme and hospital funding in the National Health Reform Agreement.

Figure 1 – The National Mental Health and Suicide Prevention Agreement aims to achieve broad objectives and outcomes – while outputs are not clearly linked to systemic reform

Objectives	Outcomes	Outputs
• To work collaboratively to implement systemic, whole-of-government reforms that improve mental health outcomes for all people living in Australia, progress the goal of zero lives lost to suicide, and deliver a mental health and suicide prevention system that is comprehensive, coordinated, consumer-focused and compassionate to benefit all Australians • To work together in partnership to ensure that all people living in Australia have equitable access to the appropriate level of mental health and suicide prevention care they need, and are able to access this care when and where they need it • As a priority, to work together to address areas to: – reduce system fragmentation – address gaps in the system – prioritise further investment in prevention, early intervention and effective management of severe and enduring mental health conditions	• Improve the mental health and wellbeing of the Australian population, with a focus on priority populations • Reduce suicide, suicidal distress and self-harm through a whole-of-government approach • Provide a balanced and integrated mental health and suicide prevention system • Improve physical health and life expectancy for people living with mental health conditions and for those experiencing suicidal distress • Improve quality, safety and capacity in the Australian mental health and suicide prevention system	• The analysis of psychosocial support services outside of the National Disability Insurance Scheme (NDIS) • Commonwealth-State implementation plans and annual Jurisdiction Progress reports • An annual National Progress Report • Improvements to data collection, sharing and linkage • The development of a National Evaluation Framework • Shared evaluation findings • Consideration and implementation of relevant actions of the National Stigma and Discrimination Reduction Strategy • The establishment of the National Suicide Prevention Office • The development of national guidelines on regional commissioning and planning • The development of the National Mental Health Workforce Strategy and identification of priority areas for action • Report on progress toward increasing the number of mental health professionals per 100,000 population • A submission to the mid-point National Health Reform Agreement review • A final review of this Agreement provided to all Parties

Source: Adapted from the National Mental Health and Suicide Prevention Agreement.

Review participants were largely critical of the Agreement, as reflected in the views of the National Mental Health Commission and National Suicide Prevention Office (sub. 70, p. 4):

> The National Agreement goes some way towards defining mental health and suicide prevention reform objectives and activities, however, falls short of providing a national strategic framework that can adequately guide unified efforts and investment across governments, services, and communities. In its current format, it more closely resembles an implementation plan with discrete activities for the Commonwealth, state and territory governments substantially defined in adjunct agreements and schedules, predominantly focused on specific service models rather than broader system improvements. This lack of cohesion contributes to increased fragmentation of the service system, with gaps remaining in services and their integration as well as an inadequate focus on building sustainable and effective mechanisms to support reforms.

Mental health and suicide prevention outcomes have not improved over the term of the Agreement

The Agreement aims to achieve improvements across a range of mental health and suicide prevention outcomes. However, many of these outcomes are not easily measurable, as they are broad in their scope and lack specific definitions. Data is not available to measure some aspects of the Agreement's outcomes. Where data is available, it cannot be readily used to assess progress. The most recent data collections are at least two years old and the intended improvements to data collections included in the Agreement are yet to be fully realised.

Overall, measures of mental health and suicide have not improved in recent years (figure 2). One notable exception is the suicide rate of Aboriginal and Torres Strait Islander people, which has worsened.

Governments have delivered most of the Agreement's outputs – but this has not translated to meaningful reform

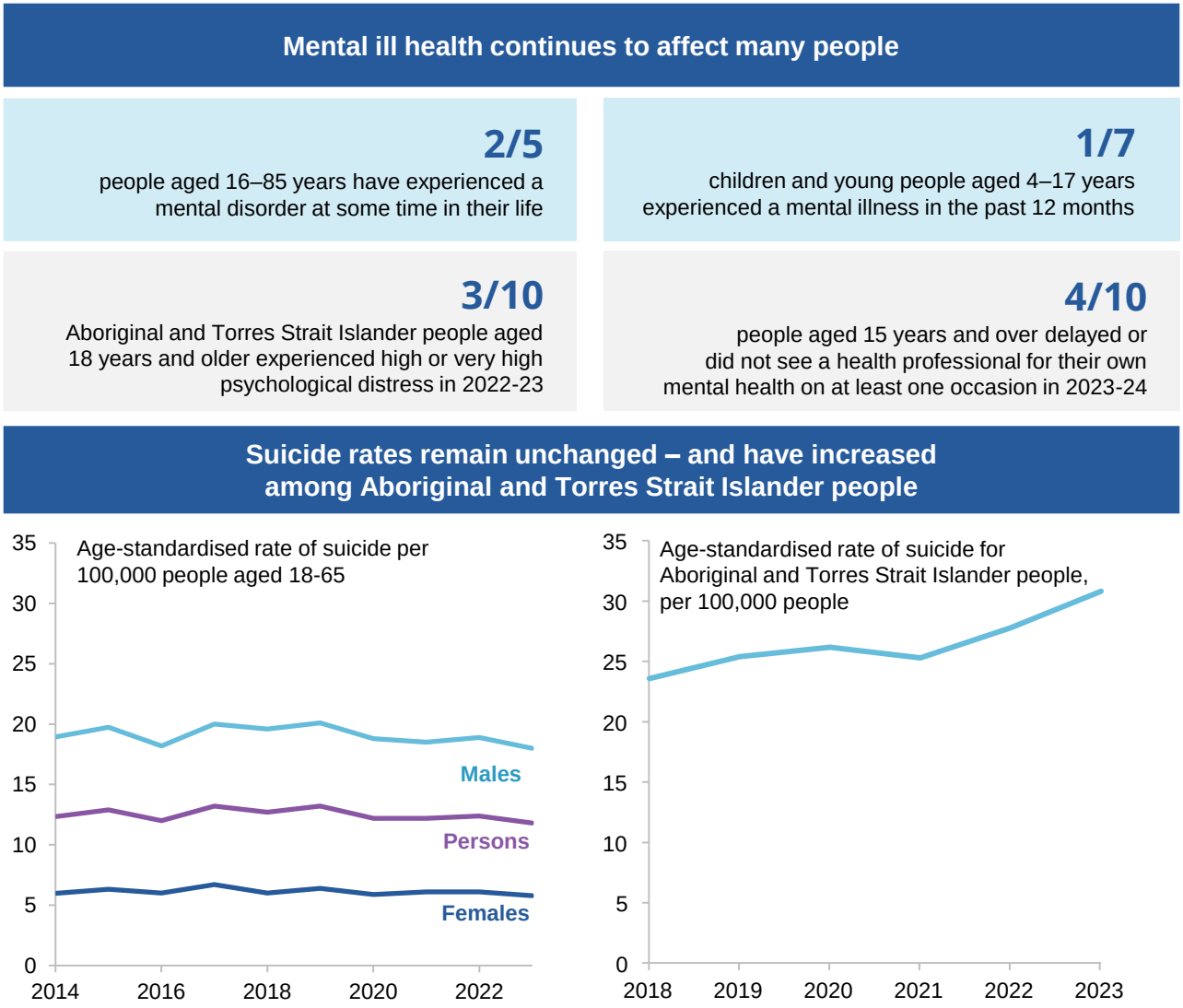
Governments have delivered eight of the 13 outputs listed in the Agreement, with a further two difficult to assess. They have progressed initiatives listed in the bilateral schedules signed between the Australian Government and each jurisdiction.

Some of the outputs, such as the establishment of the National Suicide Prevention Office (NSPO), have been well received by people with lived and living experience and service providers. The NSPO has delivered the National Suicide Prevention Strategy (discussed below). The Agreement led to increased data sharing among government bodies. But there are still significant knowledge gaps about Australia's mental health and the performance of mental health and suicide prevention services, despite the substantial volumes of information services need to report as part of funding requirements. Some of the initiatives under the bilateral schedules, such as the Medicare Mental Health Centres, have improved access to services, but their reach is limited.

Most outputs have not necessarily led to better outcomes nor had a significant effect on policy or planning.

- The analysis of psychosocial support services outside the National Disability Insurance Scheme (NDIS) was done at a high level and does not provide guidance on the regional gaps that need to be addressed.
- The National Mental Health Workforce Strategy does not contain any funding commitments or clear accountability structures.
- The National Evaluation Framework was only released in early 2025, and it is too early to tell if it is being used.

Figure 2 – The need for mental health and suicide prevention services remains high



National governance arrangements set up under the Agreement have emphasised the perspectives of government agencies and the health system, rather than fully incorporating the voices of people with lived and living experience of mental ill health and suicide. These arrangements tend to be opaque; there is very limited public reporting on the structure and progress of working groups convened under the Agreement.

The governance structures put in place to implement specific initiatives vary significantly at the local level. These structures involve primary health networks (PHNs), funded by the Australian Government, and state-funded local hospital networks (LHNs). Where these structures are collaborative, PHNs and LHNs can plan and commission comprehensive services suitable to the needs of local communities and incorporate the voices of people with lived and living experience. But where local governance is not effective, there is little joint planning and limited links between community mental health services funded by state and territory governments and those funded by the Australian Government. This hinders integration and collaboration between services and makes it much harder for consumers and carers to find the support they require.

Accountability under the Agreement is limited to annual high-level progress reports published by the National Mental Health Commission, with no consequences for stalled progress. Governments are only required to report against the initiatives for collaboration in the bilateral schedules, not the Agreement's objectives and outcomes. Progress assessments are based on input from jurisdictions, which self-assess the progress made and any risks to the implementation of initiatives. The National Mental Health Commission has only been able to complete one report in three years due to jurisdictional delays.

Urgent actions are needed before the Agreement expires

Governments have made some headway on the Agreement's commitments. But there are unfulfilled commitments they should progress immediately to address urgent issues in mental health and suicide prevention services.

Deliver the two remaining Agreement outputs

Governments have not delivered two key outputs included in the Agreement. Both should be completed as a matter of priority.

- The National Stigma and Discrimination Reduction Strategy was developed but not released and there is no indication its recommendations are under consideration. Stigma and discrimination continue to have a devastating effect on people with lived and living experience of mental ill health and suicide, and this was reflected in the responses to the PC survey (box 1).
- Comprehensive national guidelines on regional commissioning and planning have not been developed, leading to inconsistencies and inefficiencies in the way PHNs approach their role in commissioning mental health and suicide prevention services and working with state-funded services. This has negative effects on the availability of mental health and suicide prevention services and consumer experiences of care.

Develop arrangements for psychosocial supports outside the NDIS

In the Agreement, governments agreed to work together to develop arrangements for psychosocial supports for people who do not qualify for the NDIS. This is yet to occur. Governments should use the time remaining in the Agreement to develop solutions for this significant service gap.

Psychosocial supports are non-clinical services for people experiencing mental illness that enable them to live independently and safely in the community. Examples of these supports include help finding and connecting with services, socialising and maintaining relationships and building daily living skills.

People with psychosocial disability who qualify for the NDIS can access psychosocial supports, but they represent only a very small proportion of the people who need these services. In response to the introduction of the NDIS, the Australian, state and territory governments withdrew much of the funding for programs providing these supports to people with a psychosocial disability. This left an estimated 230,500 people with severe mental illness and 263,100 people with moderate mental illness without support in 2022-23, according to analysis commissioned under the Agreement.

While the next agreement is being negotiated, state and territory governments should immediately begin commissioning services to address unmet need. PHNs currently commission some psychosocial supports and have experience and existing relationships; they are well placed to work with state and territory governments and providers to support this expansion and transition.

The next agreement should:

- confirm the roles and responsibilities for psychosocial support and the funding split between the Australian, state and territory governments
- include Australian Government funding to the state and territory governments to help cover the shortfall in support, if needed
- include a detailed plan and timeline for the expansion of services, with the aim of fully addressing the unmet need by 2030.

Reinvigorate the National Mental Health Commission

The National Mental Health Commission (NMHC) was established to 'provide independent policy advice and evidence on ways to improve Australia's mental health and suicide prevention system.' It was responsible for monitoring progress under the national mental health plans that preceded the Agreement and developed a range of national policy documents. Since September 2024, the NMHC has been operating as a non-statutory office within the Department of Health, Disability and Ageing, following a review of its culture, capability and efficiency. In the 2024-25 Budget, the Australian Government announced its intention to 'reset and strengthen' the NMHC.

As a priority, the Australian Government should finalise this process and provide the NMHC with the necessary resourcing and legal powers to fulfil its role in keeping governments accountable for progress in mental health and suicide prevention reform. The next agreement should formalise the role of the NMHC as the entity responsible for ongoing monitoring, reporting and assessment of progress against the agreement's outcomes. The NMHC should be empowered to conduct ongoing independent assessments of policy implementation and provide advice on system improvement.

A new agreement can improve consumer outcomes

As it stands, the Agreement is not an effective tool to achieve cross-government collaboration towards mental health and suicide prevention reform. Therefore, a reasonable question is whether the Agreement should be renewed or replaced with a different policy tool.

Incorporating mental health and suicide prevention as a schedule in the National Health Reform Agreement or returning to national plans is unlikely to create the necessary authorising environment for reform. A well-designed, dedicated national agreement for mental health and suicide prevention can resolve outstanding policy gaps and clarify the distinct roles and responsibilities for each level of government in progressing reform. It can build momentum for reform and create a policy framework, including dedicated funding, for collaboration and joint commissioning of services.

The next agreement should clearly outline how systems will work together to achieve outcomes and create accountability mechanisms that ensure governments take meaningful action. In the development of the next agreement, governments should realise their commitment to embed the voices of people with lived and living experience and supporters, carers, families and kin across the system. In the survey conducted by the PC, consumers, carers and service providers made valuable suggestions for ways to improve services (box 2).

Box 2 – 'Working together for best outcomes is what works': ideas from consumers, carers and practitioners for a better mental health and suicide prevention system

In the online survey, the PC also asked people for ideas on how to improve the mental health and suicide prevention system, to inform the draft recommendations in this report. Suggestions included:

- respectful and person-centred engagement with service providers that recognises the agency of consumers and enables them to take an active part in their recovery
- greater involvement for people with lived and living experience and peer workers
- creating more safe spaces for people experiencing crisis or suicidal distress
- focusing on prevention of factors contributing to crisis, such as unstable employment and housing issues
- providing better information for consumers and support with system navigation
- offering more holistic and trauma informed care
- increasing community awareness about mental ill health.

Carers emphasised the need for more dedicated supports as well as greater recognition of their role in the treatment of the people they care for. Service providers called for sustained funding and greater investment in the workforce, including the peer workforce.

Box 2 – 'Working together for best outcomes is what works': ideas from consumers, carers and practitioners for a better mental health and suicide prevention system

> Services needed to be expanded include: respite care, post-suicide follow-up (to prevent cycle of many attempts), better education of emergency staff of various conditions and how to best treat them, more clinical psychologists & psychiatrists, more access to psychology under Medicare.
>
> **Carer**

> All services both government and non government, private and public, charities and places of education should have the ability to have a clear defined path of referral in times of crisis and emergency other than the E.D.
>
> **Consumer**

> We need more buy-in from the government as to the value and importance of the peer-led workforce
>
> **Practitioner**

> You need some sort of advocacy support out here. Like a support coordinator for folks who are really struggling just to eat or whatever let alone figure out which hoops to jump through and actually do it. I needed my hand held
>
> **Consumer**

> We need more non clinical peer led services and peer support. Peer support saved my life
>
> **Consumer**

> I think the service system continues to be far too fragmented and way too reliant on clinical services. The only way I see this changing is by communities being given more say over how supports are delivered locally
>
> **Consumer**

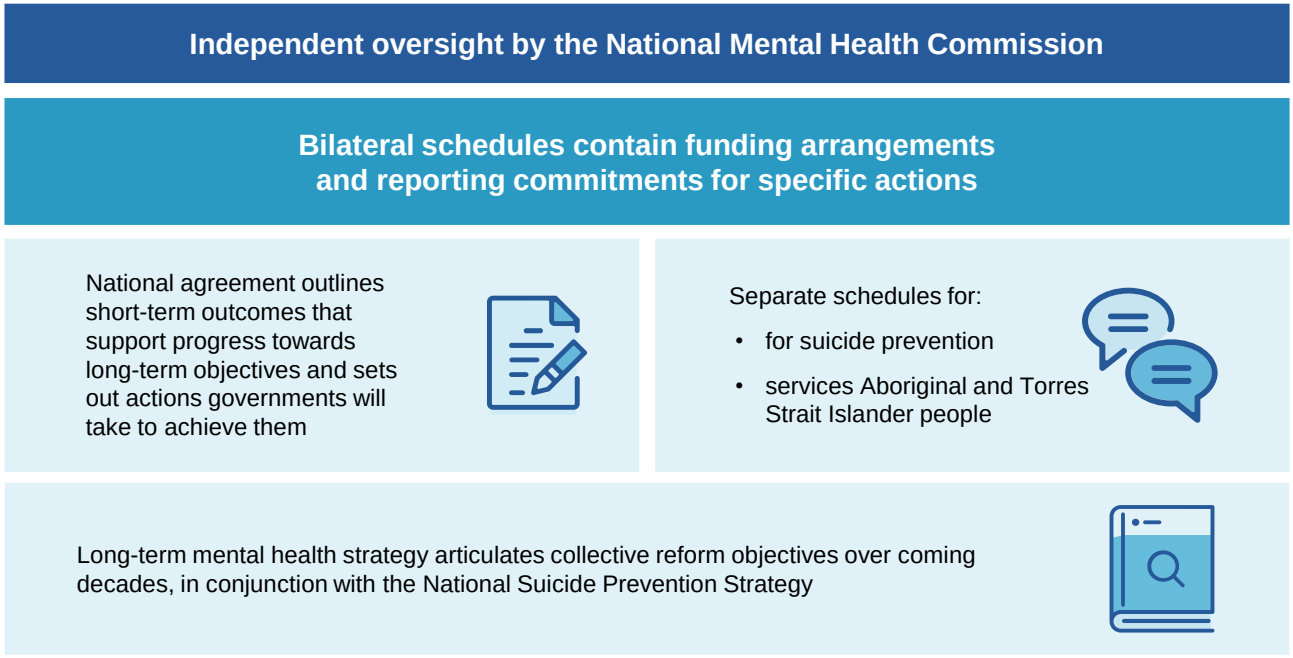
> More funding, long term commitment so these services are sustainable and can provide long term support
>
> **Practitioner**

> Let's make more services available for young people before their mental health concerns develop further, and remove the road blocks of having to have a relationship with a GP, and gaining a mental health plan
>
> **Carer**

Achieving change in the mental health and suicide prevention system requires a long-term strategy extending beyond the period of one agreement. The current Agreement contains high-level commitments but does not specify the long-term objectives of reform nor does it provide strategic direction on how to achieve them. A renewed National Mental Health Strategy, in conjunction with the recently released National Suicide Prevention Strategy, can articulate these objectives and a clear vision for reform. The strategy can extend

over a longer period, while the agreement can outline the priorities governments will focus on in the next five years (figure 3).

Figure 3 – The components required for effective national reform in mental health and suicide prevention



Setting up the next agreement for success

Three main components are needed to make the next agreement more effective:

- a transparent, well-resourced process of co-design centring the needs, experiences and priorities of people with lived and living experience, their supporters, families, carers and kin
- an extended timeframe for negotiation, to enable the development of a long-term strategy for mental health alongside an agreement to tackle the most urgent policy gaps, as determined through co-design
- a clear theory of change articulating the outcomes the agreement intends to achieve, the actions governments will take to achieve these outcomes and the ways in which these outcomes will be monitored. Bilateral schedules should also demonstrate or outline how each jurisdiction's actions will progress nationally agreed outcomes.

To ensure the next agreement contributes to cross-government actions, the Department of the Prime Minister and Cabinet should convene negotiations with the support of a reinvigorated, independent National Mental Health Commission.

The process for renegotiation should start with co-design

A genuine co-design process values the contributions of consumers and carers, alongside those of policymakers, funders, providers and practitioners. In the context of mental health and suicide prevention services, co-design has numerous benefits, including:

- designing services that are relevant to consumer needs
- improved attitudes, interactions and understanding between service users and providers

- better outcomes such as improved wellbeing
- reduced discrimination, stronger social networks and better inclusion in services.

Through co-design, governments, consumers, carers and service providers will be able to articulate the long-term objectives of the system, the outcomes it seeks to achieve and the priority action areas for the next agreement.

But successful co-design needs adequate time and resourcing to enable people with lived and living experience to take part. Under the current Agreement, policy design and service commissioning often do not allow sufficient time for genuine co-design, and this can have detrimental consequences.

> Very short time frames make important aspects of service development such as co-design and evaluation unviable, particularly in terms of meaningfully embedding the views of people with lived experience as per the Agreement's commitments, which risks reducing these commitments to tokenism.
>
> The rushed approach to co-design diminishes these activities to merely consultative exercises and makes the needed time to develop trust and effective engagement with key populations, such as culturally and linguistically diverse communities or people in rural and remote areas largely impossible. When there is also no requirement for co-design results to be utilised by the service, this risks undermining community confidence further. (Roses in the Ocean, sub. 19, p. 4)

The co-design process underpinning the next agreement should avoid the pitfalls of the current approach. Peak bodies should be sufficiently resourced to take an active role in co-design, which should have a balanced representation of people with lived and living experience of mental ill health and suicide, alongside supporters, families, carers and kin.

Successful co-design also requires government agencies to be genuinely willing to share decision-making power. This is likely to require a substantial shift in organisational cultures within government.

The time frame for negotiation should be extended

The final report of this review will be handed to government less than a year before a new agreement needs to be signed. Given the complexity of negotiations and the need for genuine engagement with people with lived and living experience, it is unlikely this timeframe will be sufficient to design an effective strategy and agreement. Therefore, the current agreement should be extended for one year, to enable the negotiation process to run its course (figure 4).

Accountability for outcomes should be a major focus of the next agreement

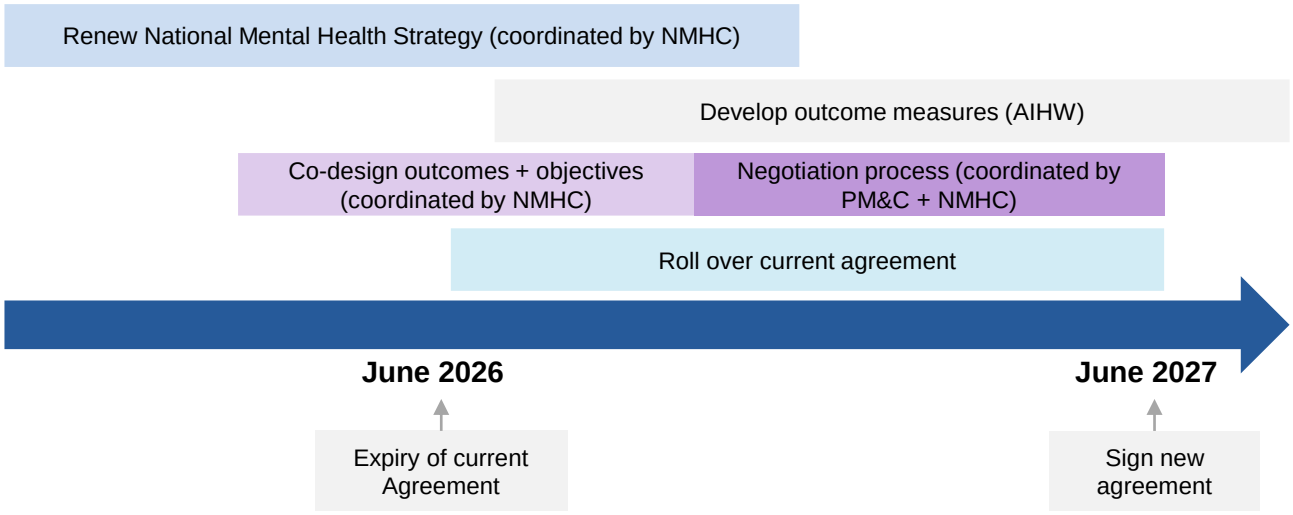
The greatest areas of focus for governance in the next agreement – and the issues raised most often in consultation for this review – should be stronger accountability and greater transparency. Clear designation of roles and responsibilities for different levels of government will be an important step in this direction. The agreement should outline the roles of PHNs and LHNs in planning and commissioning services addressing the needs of their local communities, in line with national objectives.

The outcomes the next agreement works towards should be clear and measurable, so progress can be readily tracked. The Australian Institute of Health and Welfare (AIHW), as the custodian of national health data sets, should provide input on how outcomes could be measured using currently available data, as well as continuing to pursue improvements to data collections.

The next agreement can lay the foundations for an outcomes-based approach to funding mental health and suicide prevention services. National agreements based only on delivering specific outputs, without any real focus on outcomes in the community, do little to achieve systemic reform.

Moving to an outcomes-based approach requires a comprehensive set of outcome measures and timely collection of data. As a first step, the AIHW should be tasked with leading the development of a nationally consistent set of outcome measures for mental health and suicide prevention, in consultation with people with lived and living experience. Accountability relies on timely and relevant data, which can also help consumers to make informed choices and providers to plan better services.

Figure 4 – Suggested timeline for building the foundations for the next agreement



The next agreement should include tangible actions to progress existing priorities

Some of the commitments that have been progressed in the current Agreement can have a material effect on the services delivered by the mental health and suicide prevention system. More sustained effort is required in the next agreement to maintain progress.

The mental health workforce is a key example. The National Mental Health Workforce Strategy was completed under the current Agreement. The next agreement needs to include specific funding commitments and designated roles and responsibilities to implement the actions included in the strategy. The peer workforce has grown over the term of the Agreement and its contribution to improved outcomes has been highlighted by many consumers (box 2). The next agreement can support the development of a scope of practice for the peer workforce, which can recognise their contribution in clinical and non-clinical care.

There are other important areas that have no funding commitments in the current Agreement. The next agreement should include funding for collaborative initiatives, such as bringing together service providers to share examples of best practice. Prevention and early intervention (engaging early in distress) are critical areas where the next agreement can introduce funding commitments as well as designated responsibility for action outside of health portfolios.

Publishing national commissioning guidelines – a commitment under the current Agreement – will support better practices among PHNs. The Australian Government could do more to strengthen PHNs, including boosting their planning capacity (in particular, supporting greater use of the National Mental Health Service Planning Framework) and investigating ways to increase funding flexibility and standardise procurement and data collection processes. The Australian Government is currently reviewing the PHNs business model, including the way they plan and commission mental health services.

A new schedule to strengthen Aboriginal and Torres Strait Islander social and emotional wellbeing

Improving the services supporting the social and emotional wellbeing (SEWB) of Aboriginal and Torres Strait Islander people requires consideration of their unique aspects. The current Agreement mentions Aboriginal and Torres Strait Islander people and the National Agreement on Closing the Gap but does not include any specific actions to support them.

The next agreement should include a separate schedule to recognise the factors affecting the social and emotional wellbeing of Aboriginal and Torres Strait Islander people, the contributions of Aboriginal and Torres Strait Islander Community Controlled Health Organisations and the Aboriginal and Torres Strait Islander SEWB workforce, and the need to promote cultural safety in all services. Similar schedules are being developed in other agreements; a First Nations Schedule to the National Health Reform Agreement is currently under negotiation.

The new schedule should be developed through a co-design process as a way of better addressing the priorities of the community. This reflects Closing the Gap Priority Reforms to build formal partnerships and shared decision making (PR1) and transform government organisations (PR3).

The schedule should also better articulate the agreement's links with the National Agreement on Closing the Gap, the Social and Emotional Wellbeing Policy Partnership established to oversee progress against its goals, and other important documents such as the Gayaa Dhuwi (Proud Spirit) Declaration. Currently these links are unclear and do not provide meaningful direction on how the Agreement can work within the broader policy space to support better outcomes for Aboriginal and Torres Strait Islander people.

The schedule should include dedicated outcome measures co-designed with Aboriginal and Torres Strait Islander people. A community-led evaluation of the schedule at the conclusion of the next agreement would offer important insights for future investment.

A schedule for suicide prevention to support action under the new National Suicide Prevention Strategy

Many of the factors that affect mental ill health and suicide can be similar, such as trauma and disadvantage. But there are also issues unique to suicide prevention policy, such as the availability of supports for people following a suicide attempt. Suicide prevention services are currently embedded in the Agreement without due consideration for the aspects setting them apart from mental health services.

The next agreement should include a separate schedule on suicide prevention enabling whole-of-government collaboration focusing on the distinct factors affecting suicide, suicidal distress and self-harm. The schedule should be co-designed with people with lived and living experience of suicide, their supporters, families, carers and kin.

The schedule should adopt the National Suicide Prevention Strategy as governments' long-term strategy in suicide prevention and should focus on key priorities to be progressed over the term of the agreement. The NSPO should be responsible for monitoring and reporting on the schedule, as part of the NMHC annual reporting processes.

Next steps for the review of the Agreement

The PC welcomes feedback on this interim report, as well as ideas on areas that are still under consideration such as funding arrangements and the development of a data dashboard. These are outlined in the information requests below.

Individuals and organisations can make submissions to the review through our website. Submissions are requested by 31 July 2025. The PC will also hold public hearings in August. Further details will be published on our website.

The final report of this review will be provided to government on 17 October 2025.

Draft recommendations, findings and information requests

Draft finding 2.1
Progress has been made in delivering the Agreement's commitments, but there has been little systemic change

Assessing the progress made under the National Mental Health and Suicide Prevention Agreement is difficult. Recent data is not readily available and jurisdictions have not adhered to all their monitoring and reporting commitments. The effects of significant external factors, such as the COVID-19 pandemic, are difficult to disentangle.

Since the Agreement was signed in 2022:

- governments have delivered most of the Agreement's outputs. Some key commitments have not been completed. This includes resolving issues affecting the delivery of psychosocial supports outside the National Disability Insurance Scheme, publication of the National Stigma and Discrimination Reduction Strategy and development of the National Guidelines on Regional Commissioning and Planning
- there has been little change in measures related to the Agreement's outcomes, which focus on improving mental health and reducing suicide rates
- progress towards the Agreement's intent to create an integrated, person-centred mental health and suicide prevention system has been piecemeal.

Draft finding 2.2
The Agreement has not led to progress in system reform

Overall, actions taken as a result of the National Mental Health and Suicide Prevention Agreement have not led to real progress towards improvements in the mental health and suicide prevention system.

Draft recommendation 2.1
Deliver key documents as a priority

By the end of 2025, the Australian Government should publicly release:

- the National Stigma and Discrimination Reduction Strategy
- detailed National Guidelines on Regional Planning and Commissioning that meet the needs of primary health networks and local hospital networks.

Draft finding 3.1
The National Mental Health and Suicide Prevention Agreement is not effective

The National Mental Health and Suicide Prevention Agreement is not an effective mechanism for facilitating collaboration between governments to build a better person-centred mental health and suicide prevention system for all Australians.

Some aspects of the Agreement are commendable, including its ambition, whole-of-government approach and commitments to improve services and address gaps in several important areas. However, a range of problems are limiting its effectiveness.

- The Agreement does not set out clear and focused objectives and outcomes, and actions connected to their achievement.
- Roles and responsibilities at the national and regional level are still unclear.
- People with lived and living experience of mental ill health and suicide, their supporters, families, carers and kin have not been meaningfully included in the governance arrangements, or the design, planning, delivery and evaluation of services under the Agreement.
- The governance structures are not effective, and monitoring and accountability is lacking.
- The Agreement does not address key barriers to reform, including system fragmentation, insufficient collaboration, a lack of flexibility in funding arrangements and workforce shortages.

Draft recommendation 4.1
Developing a renewed National Mental Health Strategy

A National Mental Health Strategy is needed to articulate a clear vision, objectives and collective priorities for long-term reform in the mental health system over the next 20–30 years. The National Mental Health Commission should oversee the development of this Strategy and undertake a co-design process with people with lived and living experience, their supporters, families, carers and kin.

The National Mental Health Strategy should take account of the objectives and actions included in the National Suicide Prevention Strategy, which was released in early 2025.

The next National Mental Health and Suicide Prevention Agreement should include actions governments will take over the agreement's term that are aligned with the long-term objectives articulated in the strategies.

Draft finding 4.1
A new and more effective agreement is needed

A national agreement can be an effective mechanism to advance reform in the mental health and suicide prevention system, especially to facilitate joint actions by governments. To achieve this, the next agreement will need:

- a clear set of objectives that relate to the long-term visions set out in the National Suicide Prevention Strategy and a renewed National Mental Health Strategy
- a set of specific and measurable outcomes that focus on what is achievable within the scope of a five-year agreement
- commitments that are explicitly linked to the objectives and outcomes the agreement aims to achieve.

Draft recommendation 4.2
Building the foundations for a successful agreement

The current National Mental Health and Suicide Prevention Agreement, including funding commitments, should be extended until June 2027, to give sufficient time to develop the foundations of the next agreement and renew the National Mental Health Strategy.

To support the next agreement:

- the National Mental Health Commission should run a co-design process with people with lived and living experience, and their supporters, families, carers and kin to identify relevant and measurable mental health and suicide prevention objectives and outcomes
- the Department of the Prime Minister and Cabinet should convene negotiations with the support of the National Mental Health Commission, and facilitate engagement between the Australian, state and territory governments on their shared priorities
- commitments and actions intended to improve collaboration across all government portfolios should be included in the main body of the agreement rather than a separate schedule. Governments should allocate dedicated funding for collaborative initiatives and enablers of collaboration
- the Australian Institute of Health and Welfare should lead the development of a nationally consistent set of outcome measures for mental health and suicide prevention. Implementation plans to develop any new indicators should be in place within 12 months of the agreement being signed.

Draft recommendation 4.3
The next agreement should have stronger links to the broader policy environment

The next agreement should articulate its role within the policy environment and specify the way it links with other key policy documents. This will require consideration of the interactions with a range of policy areas including housing, justice, disability supports and more. As a starting point, the next agreement should link to:

- the National Health Reform Agreement, which provides much of the funding for the mental health and suicide prevention system
- key policies in relevant non-health portfolios, such as the Better and Fairer Schools Agreement which will support the whole-of-government approach needed to improve mental health and suicide prevention outcomes (draft finding 4.1)
- jurisdictional mental health and suicide prevention policy documents, which should inform the bilateral schedules developed under the agreement
- policy documents related to Aboriginal and Torres Strait Islander social and emotional wellbeing, including the National Agreement on Closing the Gap (draft recommendation 5.1).

Information request 4.1

The PC is seeking views on whether there should be an additional schedule in the next agreement to address the co-occurrence of problematic alcohol and other drug use and mental ill health and suicide.

Draft recommendation 4.4
Governments should immediately address the unmet need for psychosocial supports outside the National Disability Insurance Scheme

The Australian, state and territory governments need to immediately agree to responsibilities for psychosocial supports outside the National Disability Insurance Scheme. State and territory governments should be responsible for commissioning services and commence work to address the unmet need.

The next agreement should:

- confirm the roles and responsibilities for psychosocial supports and the funding split between the Australian, state and territory governments
- include Australian Government funding to the state and territory governments to help cover the shortfall in support
- include a detailed plan and timeline for the expansion of services, with the aim of fully addressing the unmet need by 2030.

Draft recommendation 4.5
The next agreement should clarify responsibility for carer and family supports

The next agreement should clarify the level of government responsible for planning and funding carer and family support services for supporters, families, carers and kin of people with lived and living experience of mental ill health and suicide.

Draft recommendation 4.6
Increase transparency and effectiveness of governance arrangements

The effectiveness of the next agreement's governance arrangements should be improved by:

- including a governance framework that emphasises transparency and collaboration, and outlines accountability, reporting and evaluation functions
- embedding and formalising the participation of people with lived and living experience of mental ill health and suicide in the design and implementation of governance arrangements
- clarifying the role of the Social and Emotional Wellbeing Policy Partnership established under the National Agreement on Closing the Gap as the decision-making forum over issues that relate to Aboriginal and Torres Strait Islander social and emotional wellbeing (draft recommendation 5.1).

To support effective operation of the agreement's governance arrangements, the Australian Government should:

- establish the National Mental Health Commission as an independent statutory authority and task it with monitoring and reporting on progress and outcomes (draft recommendation 4.8)
- publish information about the composition and activities of the working groups established under the agreement
- adequately resource the agreement's administrative functions and ensure timely and effective information sharing across working groups.

Information request 4.2

The PC is seeking examples of barriers to the genuine participation and influence of people with lived and living experience in governance forums. How could successful inclusion and engagement of people with lived and living experience in governance be measured?

Draft recommendation 4.7
The next agreement should support a greater role for people with lived and living experience in governance

The Australian, state and territory governments should address barriers to the effective involvement of people with lived and living experience in the governance of the next agreement. This should include limiting the use of confidentiality agreements with lived and living experience representatives, opening greater opportunities for communication between lived and living experience working groups, other working groups and the senior officials group, and appropriately remunerating lived experience representatives.

The makeup of governance forums for the next agreement should be reconfigured to ensure:

- adequate representation of people with lived and living experience at each level of governance
- balanced representation between people with lived and living experience of mental ill health and lived and living experience of suicide
- governance roles for carers commensurate with the significant role they play in Australia's mental health and suicide prevention system.

The next agreement should articulate formal roles for the two recently established national lived experience peak bodies in its governance arrangements. These bodies should be adequately resourced to fulfill these roles.

Draft recommendation 4.8
A greater role for the broader sector in governance

The next agreement should support a greater role for service providers and the broader mental health and suicide prevention sectors in governance. Both mental health and suicide prevention providers should take part in governance mechanisms.

Draft recommendation 4.9
Share implementation plans and progress reporting publicly

The Australian, state and territory governments should publish all implementation plans and jurisdictional progress reports developed under the next agreement.

The National Mental Health Commission should be empowered to assess and report on progress independently, using information beyond what is reported by governments. The Commission should publish national progress reports as they are finalised, without requirements for jurisdictions' sign-off.

Draft recommendation 4.10
Strengthening the National Mental Health Commission's reporting role

The next agreement should formalise the role of the National Mental Health Commission as the entity responsible for ongoing monitoring, reporting and assessment of progress against the agreement's outcomes.

The Commission should have legislative provisions to compel information from Australian, state and territory government agencies to fulfil its reporting role.

The National Suicide Prevention Office should be given an advisory role in monitoring and reporting on the next agreement. It should also be responsible for the monitoring and reporting on progress against the separate suicide prevention schedule (draft recommendation 6.1).

Information request 4.3

The PC is seeking views on the value and feasibility of having a public dashboard to track and report on progress under the next agreement's objectives and outcomes and any other measurable targets set throughout.

Which bodies should be responsible for the collation and publication of dashboard data? What metrics should be included in the dashboard?

Draft recommendation 4.11
Survey data should be routinely collected

The Australian Government should fund the routine collection of the National Study of Mental Health and Wellbeing and the National Child and Adolescent Mental Health and Wellbeing Study, running the surveys at least every five years.

Draft recommendation 4.12
Funding should support primary health networks to meet local needs

The next agreement should emphasise national consistency in areas where there are efficiency gains, including standardising reporting requirements across primary health networks (PHNs) and jurisdictions where possible and investigating ways to standardise procurement and data collection processes.

Funding arrangements in the next agreement should provide PHNs with sufficient flexibility to commission locally relevant services or support existing services where they have been positively evaluated. National service models should not limit the ways in which PHNs meet their communities' needs.

Draft recommendation 4.13
The next agreement should support the implementation of the National Mental Health Workforce Strategy

The next agreement should support the implementation of the National Mental Health Workforce Strategy. This should include:

- clear commitments to, and timelines for, priority actions under the National Mental Health Workforce Strategy
- an explicit delineation of responsibility and funding for workforce development initiatives.

Information request 4.4

The PC is looking for case studies to highlight best practice in integrating peer workers in clinical mental health and suicide prevention settings, particularly by improving clinician awareness of the peer workforce. Are there examples of best practice that could be adopted in other organisations or settings?

Draft recommendation 4.14
The next agreement should commit governments to develop a scope of practice for the peer workforce

The next agreement should commit governments to develop a nationally consistent scope of practice for the peer workforce, in consultation with the peer workforce, that:

- promotes safer work practices for peer workers
- contributes to better outcomes for people accessing mental health and suicide prevention peer support
- improves public understanding of the profession, allowing for greater recognition of peer workers' capabilities and contributions.

Draft recommendation 4.15
The next agreement should build on the evaluation framework and guidelines

The next agreement should require timely evaluations to be conducted for all funded services in line with the National Mental Health and Suicide Prevention Evaluation Framework and associated guidelines and require sharing of evaluation findings, including sharing publicly where possible.

Draft finding 5.1
Limited improvements in Aboriginal and Torres Strait Islander social and emotional wellbeing over the course of the Agreement

There is no comprehensive data to assess the contribution of the National Mental Health and Suicide Prevention Agreement to Aboriginal and Torres Strait Islander social and emotional wellbeing. The data available shows that one in three Aboriginal and Torres Strait Islander people experience high psychological distress and suicide rates are worsening.

While the Agreement is intended to align with the National Agreement on Closing the Gap and improve social and emotional wellbeing outcomes for Aboriginal and Torres Strait Islander people, limited progress has been made in system reform. There is insufficient transparency and clarity in the Agreement about actions, progress, monitoring and reporting, and governance.

Draft recommendation 5.1
An Aboriginal and Torres Strait Islander schedule in the next agreement

The next agreement should include a separate schedule on Aboriginal and Torres Strait Islander social and emotional wellbeing. This schedule should be developed in a process of co-design with Aboriginal and Torres Strait Islander people.

The schedule should:

- align with the National Agreement on Closing the Gap and other important documents and include tangible actions, with commensurate funding, to improve the social and emotional wellbeing of Aboriginal and Torres Strait Islander people, including better mental health and suicide prevention outcomes
- clarify governance for its design and implementation, including the role of the Social and Emotional Wellbeing Policy Partnership established under the National Agreement on Closing the Gap as the decision-making forum over issues relating to Aboriginal and Torres Strait Islander social and emotional wellbeing
- measure progress in a strengths-based way, with community-led evaluation
- articulate and embed priorities highlighted by community such as cultural safety in all services, and greater investment in the community-controlled sector and the Aboriginal and Torres Strait Islander social and emotional wellbeing workforce.

Draft finding 6.1
The Agreement has supported positive policy developments in suicide prevention, but outcomes remain unchanged

The National Mental Health and Suicide Prevention Agreement has led to some positive changes in suicide prevention policy, including the establishment of the National Suicide Prevention Office. The bilateral schedules provided funding for suicide prevention services in most jurisdictions.

However, there has not been substantial progress in achieving the Agreement's objective of zero lives lost to suicide. Since 2015, every year about 3,000 people have died by suicide.

Draft finding 6.2
The Agreement's approach to suicide prevention lacks clarity

The approach to suicide prevention policy commitments as outlined under the National Mental Health and Suicide Prevention Agreement does not enable effective reform.

- The Agreement does not outline a clear link between actions and expected outcomes.
- Roles and responsibilities are not sufficiently clear, specifically regarding areas of joint responsibility. This contributes to gaps in service delivery and reduced accountability.

Draft recommendation 6.1
Suicide prevention as a schedule to the next agreement

The next agreement should include a separate schedule on suicide prevention. This schedule should be developed through a process of co-design with people with lived and living experience of suicide, their supporters, families, carers and kin and service providers.

The schedule should:

- only include actions in policy areas of suicide prevention that are distinct from mental health
- reflect a clear link between the short-term objective and outcomes of the schedule and progress towards the long-term objectives of the National Suicide Prevention Strategy
- align with the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy
- include monitoring and reporting indicators that align with the forthcoming National Suicide Prevention Outcomes Framework
- require the National Suicide Prevention Office be responsible for the monitoring and reporting of the schedule.

Mental Health and Suicide Prevention Agreement Review

Interim report

What we've heard so far

Key points

- **Understanding the experiences of people when they need mental health and suicide prevention services is a key part of reviewing the National Mental Health and Suicide Prevention Agreement. The reflections of consumers, carers and service provides underpin the PC's assessment of progress under the Agreement and the recommendations for future policy directions.**
- **To gather people's perspectives, the PC undertook meetings and site visits, received submissions and conducted an online survey. The PC spoke to people with lived and living experience, their families and carers, peer workers, service providers, practitioners and researchers, peak bodies and associations, primary health networks, hospitals, mental health commissions and government departments in all states and territories.**
- **In meetings and submissions, people reflected on the limited progress achieved under the Agreement and the need to develop stronger accountability mechanisms in future. Many spoke about the limited involvement of people with lived and living experience in the development of the Agreement and the urgent need to embed consumers' and carers' perspectives in policy and service delivery.**
- **In the online survey, consumers reflected on four key themes, including:**
  - **costs and waiting times**
  - **gaps and shortages in services**
  - **inadequate crisis support**
  - **experiences of discrimination when accessing services.**
- **Carers reflected on experiences of exclusion and not being able to access information and support. Practitioners spoke about the need for change in the way services are staffed and funded.**
- **Consumers, carers and practitioners also spoke about positive experiences of compassionate, person-centred services and the difference these made to their lives.**

At the core of the mental health and suicide prevention system are the experiences of the people who need it. For some, these experiences are positive and contribute to healing and recovery. But for many, finding the right services at the right time and receiving the support they need for themselves or their loved ones is a very difficult task.

The National Mental Health and Suicide Prevention Agreement aims to create a person-centred system, improving the experiences of people who use mental health and suicide prevention services as well as their supporters, family, carers and kin. To assess progress under the Agreement, the PC undertook extensive engagement with a wide range of people and organisations. This chapter summarises what we've heard so far.

Throughout this review, we used the principles of the Review of the National Agreement on Closing the Gap (PC 2022b), to ensure engagement was:

- fair and inclusive
- transparent and open
- ongoing
- reciprocal.

To inform this review, the PC has spoken to people with lived and living experience, their supporters, families and carers, peer workers, service providers, practitioners and researchers, peak bodies and associations, primary health networks, hospitals, mental health commissions and government departments in all states and territories.

The PC thanks all review participants and acknowledges in particular the contributions of the people with lived and living experience of mental ill health and suicide and the organisations that represent them. Working towards embedding the voices of people with lived and living experience throughout all aspects of the mental health and suicide prevention system – including this review – ensures that reforms contribute to the delivery of comprehensive, compassionate and person-centred services.

The perspectives of people and organisations were gathered through meetings, submissions and an online survey. Following the receipt of the review's terms of reference in January 2025, the PC released a call for submissions. In response to this paper, the PC received 94 public submissions.[2] We also held 72 meetings and visited services and organisations in Hobart, Launceston, Brisbane and Ipswich. Between 11 February and 21 March 2025 the PC invited people to share their views and experiences of mental health and suicide prevention services via an online survey. We hosted a webinar on early messages from consultations on 11 April 2025, as part of our commitment to ongoing and reciprocal engagement.

This interim report is the next stage in the engagement process. The PC invite all interested people and organisations to share their feedback on this report through submissions and public hearings (chapter 1).

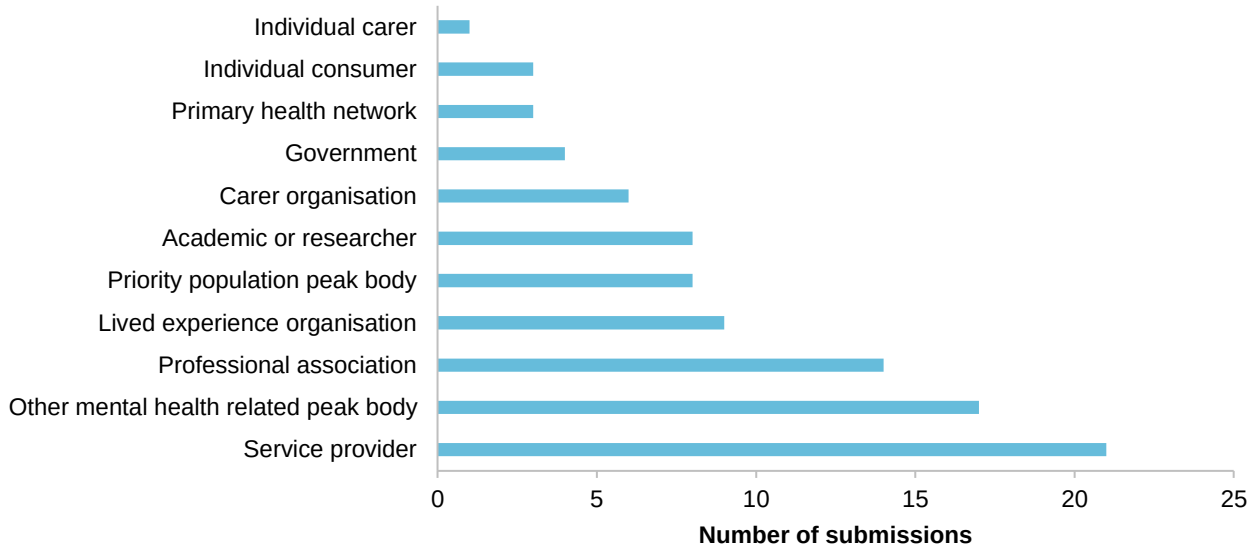
Reflections from submissions

A wide range of organisations made a total of 94 submissions, including representative bodies for consumers, carers and service providers as well as individual service providers, government agencies and a small number of consumers, carers and researchers (figure 5). We received two submissions from Aboriginal and Torres Strait Islander organisations (counted in one of the other categories related to what the organisation does). Public submissions were published on the PC website and are listed in appendix A.

Table 1 lists key themes raised across submissions. These themes have been common to multiple or many submissions. However, some submissions included information and recommendations about specific mental health conditions, specific groups of people disproportionately impacted by mental ill health or suicide, specific types of services or specific groups within the workforce. While these specific themes are not listed in the table, they have all informed our analysis. Other chapters in the report draw on specific suggestions and information in submissions and include many direct quotes and citations. Readers are encouraged to read individual submissions on the PC website to understand the range of ideas contributed by participants.

[2] The PC received 95 submissions for publication but one was later withdrawn. The numbering of submissions on website and quoted in the interim report includes a number assigned to the submission that was provided but later withdrawn.

Figure 5 – Public submissions by type of organisation or person[a]



a. 'Priority populations' are those listed in the National Mental Health and Suicide Prevention Agreement (clause 111).

Table 1 – Key themes from submissions

The overall value of the National Agreement	Strong support for having a National Agreement on mental health and suicide prevention and for the principles within it. Concern the Agreement had failed to achieve many of its objectives and it was not designed in a way to transform the mental health and suicide prevention system. The creation of new Medicare Mental Health Centres was seen as a success of the Agreement. Delays and slower progress than planned in developing and implementing services agreed under the bilateral schedules.
The need for a national strategy on mental health	Some highlighted the absence of an overall national strategy on mental health and suggested a national strategy (linking to the National Suicide Prevention Strategy) should be developed as a foundation for the next and future national agreements.
People with lived and living experience should inform the Agreement and its governance	Many submissions highlighted the lack of input from people with lived and living experience into the development and ongoing governance of the Agreement. There was strong support for co-design of the next agreement with people of lived and living experience; and ensuring people with lived and living experience would be part of ongoing decision making in the implementation and measurement of progress for the Agreement.
Cooperation between the Australian, state and territory governments	Views were mixed about the extent to which the Agreement had improved cooperation between the Australian, state and territory governments. Some examples were provided of improved cooperation and planning in developing and implementing services. Other submissions highlighted examples of duplication, lack of consistency, poor communication and coordination and competition for qualified staff and resources between the Australian Government and state-funded services.

Contracting and commissioning of services	Many submissions called for improvements in contracting and commissioning of mental health and suicide prevention services. There have been inconsistent contracting, commissioning and reporting processes between different primary health networks (PHNs) and variations in PHN capabilities. Inconsistencies between PHNs increases costs and creates challenges for service providers working across multiple PHN regions. There is variation in the degree of communication, cooperation and coordination between PHNs (funded by the Australian Government) and state and territory government local health networks in regional planning, contracting and commissioning.
Gaps and priorities in mental health services	Submissions highlighted numerous gaps in mental health services, including: • insufficient availability of community-based care. There is a lack of coordination and communication between different services for people with mental ill health – including limited information sharing causing consumers to frequently retell their story • the importance of prevention and engaging early in distress (early intervention services) and how these can reduce the number of people needing acute care • the lack of, or limitations in digital health services as a supplement to face-to-face services and for consumers in locations where face-to-face services are unavailable • a need for greater investment in psychosocial support services for people not receiving support from the National Disability Insurance Scheme • the difficulties people in rural and remote areas have in accessing mental health services • the high cost of private mental health services and suggestions for increasing Medicare rebates for services provided by psychiatrists, general practitioners, psychologists and other mental health professionals • insufficient funding to improve access to mental health and suicide prevention services for all who need them • specific recommendations for improving the accessibility and appropriateness of mental health services for groups disproportionately impacted (priority populations) including: – children – young people – people from culturally and linguistically diverse, migrant and refugee backgrounds – LGBTQIASB+ people – veterans – older people – people in occupations with higher rates of mental ill health and suicide.
Aboriginal and Torres Strait Islander people	Aboriginal and Torres Strait Islander people should be involved in the co-design and governance of the Agreement. Cultural capability in service provision is essential. The National Mental Health and Suicide Prevention Agreement should deliver on priorities identified in the National Agreement on Closing the Gap. Strong support for the Gayaa Dhuwi (Proud Spirit) Declaration Framework and Implementation Plan and the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy.
Carers	The role of carers is vital to improving outcomes for people with mental ill health but there is little support for carers under the Agreement. Carers need greater information, support and resources.

	Clinicians should ensure carers are informed about the treatment needed by those they are caring for as they are the people providing care every day and need to know about treatments and medications.
Addressing social determinants – a whole-of-government approach	Social determinants such as housing and homelessness, education, employment and interactions with the justice system have significant implications for mental health and suicide prevention. Action from agencies across governments is required to improve outcomes for people with mental ill health.
Mental health and suicide prevention workforce	There are workforce shortages across most professions working in mental health and suicide prevention. Peer and lived experience workers were identified as particularly important for improving outcomes. Improved training is needed across the mental health and suicide prevention workforce
Accountability and evaluation	There has been little accountability for delays or lack of progress against outputs under the Agreement. There is strong support for regular, timely public reporting of progress against key indicators of outcomes, with reporting overseen by an independent body Programs and activities funded under the Agreement should be evaluated to inform policy and practice.
Data	Many submissions called for a national data framework, consistent data standards and a national minimum data set to provide a foundation for measuring performance against the Agreement.
Evidence-based practice	Research and evidence of good practice and what works in services and treatments are readily available but do not always inform mental health and suicide prevention services.
Suicide prevention	There was widespread support for the National Suicide Prevention Strategy. Many submissions called for a greater focus on suicide prevention in the Agreement.

Reflections from meetings and visits

The PC held 72 meetings with organisations and individual people between February and May 2025. Of these, 18 were in person meetings in Canberra, Brisbane, Ipswich, Hobart and Launceston, and the remaining 54 meetings were virtual online meetings. People and organisations the PC met with are listed in appendix A.

Of the 72 meetings and visits:

- nine were with organisations representing people with lived and living experience of mental ill health and suicide
- four were with organisations representing carers of people with mental ill health and suicidality
- 25 were with government agencies (six mental health commissions and 19 other government agencies)
- nine were with organisations providing services to people with mental ill health and suicidality
- five were with primary health networks (PHNs) and PHN representative bodies
- five were with other advocacy and peak bodies in the mental health and suicide prevention sector
- three were with organisations representing professions working in mental health and suicide prevention
- seven were with Aboriginal and Torres Strait Islander people and organisations

- four were with individual people with lived and living experience of suicide or mental ill health
- one was with academics/researchers.

As might be expected, there is overlap in the themes identified from meetings and visits with the themes found in submissions. However, each type of engagement highlighted different aspects of these themes.

Table 2 – Key themes from meetings and visits

The overall value of the Agreement	General support for having an Agreement in principle, but concern the current Agreement has failed to achieve many of its objectives and commitments The Agreement has resulted in some increase in coordination between Australian, state and territory governments' commissioning of services but with scope for much more improvement. Expansion of Medicare Mental Health Centres has been valuable There is not a clear connection between the Agreement and the bilateral schedules between the Australian, state and territory governments. A desire from some participants for greater consistency across jurisdictions and bilateral schedules and some funding for national services (such as telephone or digital services). However, some providers, state and territory governments and primary health networks favoured more regional and local flexibility.
The need for a national strategy on mental health	Support for a longer term national mental health strategy to provide a foundation for any future national agreements. A strategy could provide a program logic or theory of change that is lacking in the current Agreement.
People with lived and living experience should inform the agreement and its governance	The Agreement was developed with very limited input from people with lived and living experience and there is limited lived and living experience input into the ongoing governance and implementation of the Agreement. The next agreement should be co-designed with people with lived and living experience who should also be part of decision-making in the ongoing governance and implementation of the next agreement. Input from people with lived and living experience is gradually becoming a more common feature in mental health and suicide prevention services and the creation of new peak bodies for consumer and carer lived experience is valuable.
Cooperation between the Australian, state and territory governments	Inconsistency in how the Agreement has been implemented between states and territories. Cooperation and coordination between Australian, state and territory government agencies varies, some going well and others problematic.
Contracting and commissioning of services	Inconsistent contracting and commissioning processes across the 31 primary health networks (PHNs) increases administrative burdens and costs for service providers. Some PHNs and state and territory government local health networks have good relationships and are working well together to provide co-commissioned, collocated and coordinated services, planning and avoiding duplication, whereas in other regions they are not working well together. PHNs do not always have autonomy to commission services that best meet local needs as they are required to adhere to national policies and guidelines about locations, the nature of the services and who is eligible for them. This makes it difficult for service providers to meet local community needs. Commissioning processes are sometimes rushed.

	Short term contracts impose uncertainty and create insecurity for service providers, staff and consumers. The Agreement does not provide an opportunity for funding of services that might be better commissioned nationally such as digital or telephone services.
Gaps and priorities in mental health services	Medicare Mental Health Centres are providing services for people who do not require hospitalisation but whose needs are greater than can be met by some other services in the community. The rebranding of Head to Health services to Medicare Mental Health Centres dissuades some people from using them. Restrictions on eligibility to receive services is preventing access for some people but some providers and PHNs are working to make services as accessible as possible. Some Medicare Mental Health Centres have attracted large numbers of consumers and have waiting lists. People in rural and remote areas have significantly less access to services than those in urban areas. Some people need acute care and there is need for additional beds in hospitals but greater focus on prevention and engaging early in distress (early intervention) can reduce the need for hospitalisation.
Aboriginal and Torres Strait Islander people	Separate funding streams for social and emotional wellbeing and mental health services from the National Indigenous Australians Agency and the Australian Government Department of Health, Disability and Ageing create additional administrative burdens for service providers. The transition of funding of services for Aboriginal and Torres Strait Islander people from mainstream to Aboriginal and Torres Strait Islander community-controlled organisations as required under the National Agreement on Closing the Gap is slow or yet to happen. The Aboriginal and Torres Strait Islander peer workforce should be expanded. The Social and Emotional Wellbeing Policy Partnership and Aboriginal and Torres Strait Islander people should have a much greater role in shaping and overseeing the next agreement. Governments, PHNs and mainstream service providers talk about the importance of Aboriginal and Torres Strait Islander people but do not genuinely partner with or hand over control to Aboriginal and Torres Strait Islander people and organisations.
Carers	Clinicians do not always recognise carers and include them in conversations about the care of the person with mental ill health. Some clinicians make an effort to include carers, but consumer privacy and confidentiality can preclude this, as can restrictions on Medicare and other funding for clinicians to spend time with carers. Carers do not always identify themselves as carers, which creates a barrier to obtaining support and information as well as care for their own physical and mental health. Caring for someone with mental ill health can be very isolating and difficult and increased availability of respite care is important.
Addressing social determinants – a whole-of-government approach	Housing and homelessness, education and interactions with the justice system are important social determinants that affect the outcomes of mental health and suicide prevention services. The Agreement has relatively little effect on agencies across governments that provide services and oversee policies related to these social determinants, despite the inclusion

	of Schedule A (chapter 1) and the existence of cross agency groups and committees in each jurisdiction. Many participants called for a greater focus on social determinants, particularly housing and homelessness.
Mental health workforce	Shortages were identified across a range of professions in the mental health and suicide prevention workforce. Addressing workforce needs is an important part of the Agreement and the National Mental Health Workforce Strategy was welcomed but there was concern that it was yet to be implemented. Australian, state and territory government funded services in local areas were often competing for workers. State and territory health services were also competing against each other for the same workforce. A range of participants suggested extending Medicare funding – increasing the total number of sessions covered, increasing payments to reduce gap fees for clients and extending eligibility to a wider range of clinicians and workers. The peer workforce was identified as important to improved consumer outcomes but required more training and support.
Accountability and evaluation	Many participants noted a lack of accountability mechanisms under the Agreement and that this contributed to a lack of progress. There should be financial consequences if jurisdictions fail to achieve outcomes or to provide data, financial reports or information for reporting. There was strong support for restoring the independence of the National Mental Health Commission and its ability to monitor and report on outcomes and progress against the Agreement. Evaluation is important but the data for evaluation is not always available.
Data	There is a lack of data on suicide and suicide attempts. A dashboard publishing data on outcomes from the Agreement would improve accountability and transparency. There is very little transfer of data and information between hospitals and community providers with negative impacts on continuity of care for consumers. Developing new data sets can be slow because of the need to ensure confidentiality, negotiate data linkage with different jurisdictions and data custodians and ethics approval processes. Developing consistent national data sets is difficult, not all jurisdictions have resources to implement new data specifications, and data specifications may not be consistent with clinical practice. Service providers can have contracts with multiple funding sources each with different data requirements. A lot of data collection is focused on outputs and not outcomes. Good data is a foundation for sound evidence upon which to base services.
Suicide prevention	Aftercare following a suicide attempt is sometimes only available to those who have presented to a hospital emergency department. People should be able to seek aftercare directly and not via a hospital. Many people attending emergency departments following suicide attempts do not receive any ongoing support. There is insufficient suicide prevention support for people in a suicide crisis.

Reflections from the online survey

The online survey was designed to explore three broad research questions that map onto the Terms of Reference for the review of the Agreement:

- what gaps and shortcomings in mental health and suicide prevention services have people experienced?
- what changes in service provision have people seen in the past three years?
- what are some examples of good service provision and system improvement that people have experienced or would recommend?

Appendix A provides details of the methods used and sample characteristics. A total of 293 people participated in the survey (table A.3). 10 of these were excluded from analysis because they left the main questions unanswered, and a further nine were excluded from analysis because they did not provide consent.

Respondents could identify as a consumer, carer or worker/volunteer in service provision. We categorised respondents as consumers if they selected 'I have used mental health or suicide prevention services'. This is intended to be inclusive of people who identify as having lived (past) and/or living (current) experience of mental ill health, irrespective of whether they have a formal diagnosis, who have accessed mental health services and/or received treatment, and inclusive of people who have accessed suicide prevention services and people who have experienced distress, attempted suicide, cared for a person experiencing distress or have been bereaved by suicide.

Of the 283 respondents who answered the main survey questions, nearly 75% identified as consumers. About one third identified as carers and about one quarter as workers/volunteers in service provision. Many respondents identified as belonging to more than one of the three main respondent categories. For example, 39 respondents identified as both a consumer and worker/volunteer in service provision, 38 identified as both a consumer and carer and 17 identified as a consumer, carer and worker/volunteer in service provision. The location that respondents reported as their primary residence broadly reflected the distribution of the Australian population. About 2% (n=5) of respondents identified as Aboriginal or Torres Strait Islander.

Care should be taken interpreting the findings of this qualitative study. The study is based on a non-probability sample (convenience sample) and therefore the findings are not generalisable to the population level. The recruitment methods used have meant some potential respondents have been systematically excluded (for example, people who are too unwell to participate and people who cannot access the survey online). The open-ended questions we asked meant some individual respondents could share views and experiences from multiple perspectives (consumer, carer and/or volunteer/worker) and raise issues outside the scope of the Agreement or the Terms of Reference for the review. The subjective interpretation of the data, which may reflect the researchers' positions and perspectives on the issues raised, will have influenced the findings of the thematic analysis.

A description of the main themes in responses from consumers, carers and service providers is presented below, including some illustrative extracts (verbatim quotes). Minimal edits have been made to the verbatim quotes and only where necessary to improve clarity, remove any obvious typographical errors contained in the original and to preserve anonymity and confidentiality. Labels in brackets after each extract refer to the identification number we assigned to each survey respondent (sr.).

Main themes in the survey responses from consumers

The survey showed many consumers feel unable to access sufficient and appropriate care and support for their mental ill health. Many point to similar obstacles, such as inadequate availability and accessibility of some essential services (e.g. shortages of psychiatrists, psychologists, crisis support), long waiting times and high costs for using services as well as experiences of discrimination when using services (figure 6).

Positive experiences and feelings towards the mental health and suicide prevention service system were reported by some consumers, but these were less common. Sentiment analysis found 64% of consumer responses to the survey questions were very negative/moderately negative and 36% were very positive/moderately positive.

Figure 6 – Main themes identified in consumer responses

Consumer theme 1: Waiting times and costs

A major theme in what we've heard from consumers is that there are significant barriers to accessing services because of the long waiting times and high costs. Many respondents told us about their experiences of long waiting times for accessing treatment and support, in acute settings as well as in primary, specialist and allied care settings. In acute settings such as hospital emergency departments (EDs), the long waiting times before receiving treatment often added to the distress people were experiencing at the time.

> The ED department would have been fine, except i sat there alone for 12 hours only to have a psychiatrist at the end of sitting there for 12 hours telling me i can go home. If anything it made me more distressed. (sr. 226)

> Hospital made me wait 6 hours to be seen for 5 minutes sent me back out to the waiting room so I left without being properly assessed. (sr. 237)

The waiting times for accessing mental health services in community settings can also be substantial.

> It's now almost 12 months since hospital and I still have not been able to access any support for my mental health or my living conditions exacerbating the issues. I am on a 16 week wait list to see a general mental health worker at the local health centre. (sr. 140)

> I was on waiting lists for close to a year. (sr. 246)

Because of the long waiting times experienced, some people felt their mental health and wellbeing was put at risk or declined further.

> The services that are accessible with a mental health care plan are difficult to get into (with long wait times and long times in between appointments) which does not facilitate mental health. (sr. 63)

> I have the highest level of health insurance & have been on a waiting list to be admitted for almost 6 months with no time frame at all … While my condition is getting worse (sr. 227)

The experience of long waiting times also appears to discourage some people from seeking the help they need.

> Inadequate services, wait times too long, couldn't stay on hold any longer. (sr. 142)

> The waiting lists are getting longer, bulk billing is disappearing, and people are avoiding doctor visits due to financial issues. (sr. 149)

> The services simply ask for consumers to show respect, but it seems that respect isn't always reciprocated. Just take a look at those long waiting times! (sr. 149)

We also heard that combined with the long waiting times, the financial costs individuals face for obtaining mental health care and support can put services out of reach for many people.

> Mental health and suicide prevention services are incredibly expensive or time consuming. If you request a mental health plan from non-bulk billing GPS (as bulk billing GPS are incredibly difficult to get appointments), you are already out of pocket. This means these life saving services are inaccessible. (sr. 63)

> I stopped seeing my psychologist because I couldn’t afford it. (sr. 37)

People on a fixed and/or low income told us that high costs of services represent a major barrier to them accessing treatment and support.

> when I have needed to most, it’s been completely cost prohibitive and I could not access the care I needed. There is almost no support available for the unemployed or underemployed. (sr. 89)

> outpatient services are overbooked and have lengthy delays or are massively expensive. And as someone who is currently unable to work due to the exacerbation of my mental illness during and after covid, it is very difficult to access the appropriate level of support. (sr. 135)

> I am forced to rely on welfare meaning even with a mental health plan, appropriate care is entirely unaffordable. (sr. 137)

Some consumers also said they did not have any support navigating through the service system to overcome barriers such as long waiting times and out-of-pocket costs.

> They tell you to see a gp and get a mental health care plan. That's not immediate help and there's a large out of pocket cost also. (sr. 211)

> I took a day off work (unpaid) to see GP for a mental health plan, he did not know who to refer me to and told me to go and find a service myself. when I did the research I found zero services available in Dubbo, only one service had open books with a six month waitlist. (sr. 213)

Regarding the private system, we heard that the high costs of such services are also prohibitive for many people.

> I cannot afford private mental health admissions so I suffer alone at home. (sr. 122)

> I was referred to residential treatment programs but these were all in the private sector. I had to drop my private insurance due to financial constraints which means I could not access them. (sr. 89)

When asked about any changes in services they've noticed over the past three years, many respondents said they felt waiting times had become longer and costs had also increased, making services less accessible and less affordable for them.

> In regional areas the availability, access and affordability has dramatically reduced (and it was poor to begin with). (sr. 126)

> Getting worse, less services available, longer wait times or all have closed books. (sr. 213)

> When we had COVID was allowed 20 sessions covered. This was great. Now back down to 10 that may cover 10 months going once a month. Does not help the long term patients at all. (sr. 248)

Consumers gave a range of suggestions for reducing the barriers to services and improving accessibility (figure 7).

Figure 7 – Suggestions for reducing barriers and improving access to services

Increase information for consumers and support with system navigation

> You need to advertise services and to everyone not just certain age groups. Parents need to know where to take their child and friends need help in helping others. (sr. 048)

> Public awareness campaigns need to continue with open mental health discussions to 'normalise' diagnosis and treatment options. Mental health needs to become a recognised part of health as a whole. (sr. 209)

> You need some sort of advocacy support out here. Like a support coordinator for folks who are really struggling just to eat or whatever let alone figure out which hoops to jump through and actually do it. I needed my hand held. (sr. 252)

Provide better resourcing for the mental health service system

> More funding, resources and options in the public system to stop people falling through the cracks. (sr. 019)

> People need greater access to affordable and timely ongoing care and management of mental ill health. This would ultimately lead to less times of reaching "crisis" point. (sr. 043)

> Please provide better fast responses and people focused services in rural and remote places. (sr. 056)

> There needs to be more funding for services outside of the system that has alternative ways of doing things. That don't involve calling police or CATT or sectioning or risk assessments. Fund peer support outside of the system. (sr. 270)

Reduce pressure on the mental health service system by increasing the range and flexibility of services on offer

> I think the service system continues to be far too fragmented and way too reliant on clinical services. The only way I see this changing is by communities being given more say over how supports are delivered locally. (sr. 189)

> There needs to be more help within the community to support families with respite, continuity of care, and options other than going to the ER for 20 hours. (sr. 206)

Increase the supply, quality and capacity of workers to provide mental health and suicide prevention services

> GPs should receive greater training in medication and have the right tools and funding to follow up with patients in an emergency. (sr. 089)

> We need nurse practitioners that make home visits to mentally ill people (public and privately funded) to support outpatient care. (sr. 231)

> Increase the number of psychiatrist trainees annually to reduce the wait times for private psychiatry. (sr. 262)

Consumer theme 2: Gaps and shortages in services

Many consumers have experienced gaps in services. The context of many such experiences is hospital-based services. Consumers told us about experiences of not receiving adequate treatment for their mental health care needs when presenting to hospital emergency departments or when admitted to inpatient facilities.

> I have been taken to hospital numerous times and every time they have said the mental health team isn't here, theres no beds, go home and someone from the mental health team will call you. (sr. 30)

> When I first went to hospital people kept saying "you will be okay with supports in the community" but no one told me what they were or how to access them. (sr. 148)

Many also said they did not feel their needs were recognised or respected while in hospital.

> Services at hospital are judgemental, rude, disrespectful and make everything worse. Hospital is not a safe place for someone suicidal due to staff ignorance and restrictive practices. (sr. 256)

> The treatment from the mental health team was not good for the most part in the acute care space. They made me feel like I was not worthy of help. (sr. 265)

However, some respondents also described positive experiences when they've used hospital-based services.

> Psychiatric treatment involving medication and Hospitalisation have saved my life on a number of occasions. (sr. 245)

> The hospital staff were really compassionate and listened to me when I was voluntarily admitted. (sr. 135)

Beyond hospitals, many respondents told us about experiencing difficulties getting access to key mental health services across the primary, specialist and allied care system in the community. For example, many told us about difficulties accessing psychiatrists.

> I have been unable to find a psychiatrist and psychologist (both public and private) who are accepting new patients in the past 4 years after my old ones retired. (sr. 30)

> During a period of severe mental illness, the only way I was able to get on a psychiatrist's books in under 6 months was to check into hospital privately, at significant expense too (top tier insurance premiums). (sr. 34)

Similarly, many respondents told us about difficulties accessing psychologists, with several highlighting the limited access to publicly subsidised consultations.

> I can only get 12 visits to a psychologist - how is that going to fix years of trauma and clinical major depressive disorder and PTSD? (sr. 25)

> 10 psychologist sessions a year is not enough. (sr. 116)

> There are no bulk-billing psychologists available within reach. (sr. 137)

> No psychologist will treat me as i can only get 10 govt funded mental health sessions per 12 months, I have been told again and again that unless I can afford 40 sessions over a year they cannot help. (sr. 173)

Difficulties accessing general practitioners (GPs) for primary mental health care were also reported by many respondents.

> Can't get a gp that's less than a months wait. (sr. 109)

> Can’t get and afford a Gp or psychologist. (sr. 188)

> GPS have closed books in our region also, at least a three week wait for appt it you can get one. (sr. 213)

Experiences of local gaps and shortages in service provision, particularly in rural and remote areas, were also reported by many consumers

> There is a single sub-acute mental health service in the NT that is based in Darwin, and is only available for people who can physically get to the office. (sr. 76)

> Live in regional NSW and people need to travel over 200kms (minimum) for inpatient support where the is rarely adequate support provided and they are released to find their own way home whilst still unwell. (sr. 111)

In addition to concerns about limited availability and accessibility, many people raised concerns about the quality of mental health services.

> Have no confidence in the local services, poorly staffed (attitude, skills, training or experience), too quick to apply medications, no holistic approach. (sr. 126)

> This system is alienating, inadequate, ill-informed, and under-resourced to the point where it is literally costing lives. (sr. 137)

We also heard how the poor quality of some services had sometimes adversely impacted people.

> The reason I haven't used any mental health or suicide prevention services in the past 3 years is because of the large number of very negative experiences I have had in the past when I've tried to reach out for help. (sr. 36)

> Trying so hard to find help for myself drove me even further into suicide because of the trainees in these services. They couldn't care less. (sr. 68)

> Intake processes are not trauma informed and have often left myself and my loved ones re-traumatised. (sr. 98)

> Feeling invisible when left to wait for hours to be seen. Nurses ignoring my distress. Psychs not respecting identity and questioning my experiences. (sr. 230)

Based on consumer responses, it appears gaps and shortages in service availability and the inconsistent quality of services are sometimes exacerbated by fragmentation in the service system and by a lack of coordination and continuity in care.

> I've not once had a clinician interact with another, apart from when I was hospitalised for an extended period of time. (sr. 05)

> In-patient programs only take us so far. No reintegration and community care/support once discharged. No offer of outpatient programs. (sr. 54)

> Emergency services called. Taken to ED - spoke with MH Nurse/Social workers then discharged with no plan, no referral to other services, no safety plan. (sr. 91)

In terms of changes over recent years, some consumers said they had seen some slight improvements, such as a wider range of services becoming available. To some extent, these have addressed gaps in services.

> The existence of more alternatives to ED is a positive change. (sr. 18)

> There have been lots of positive introductions into the system over the past few years, like safe spaces and head to health centres. (sr. 22)

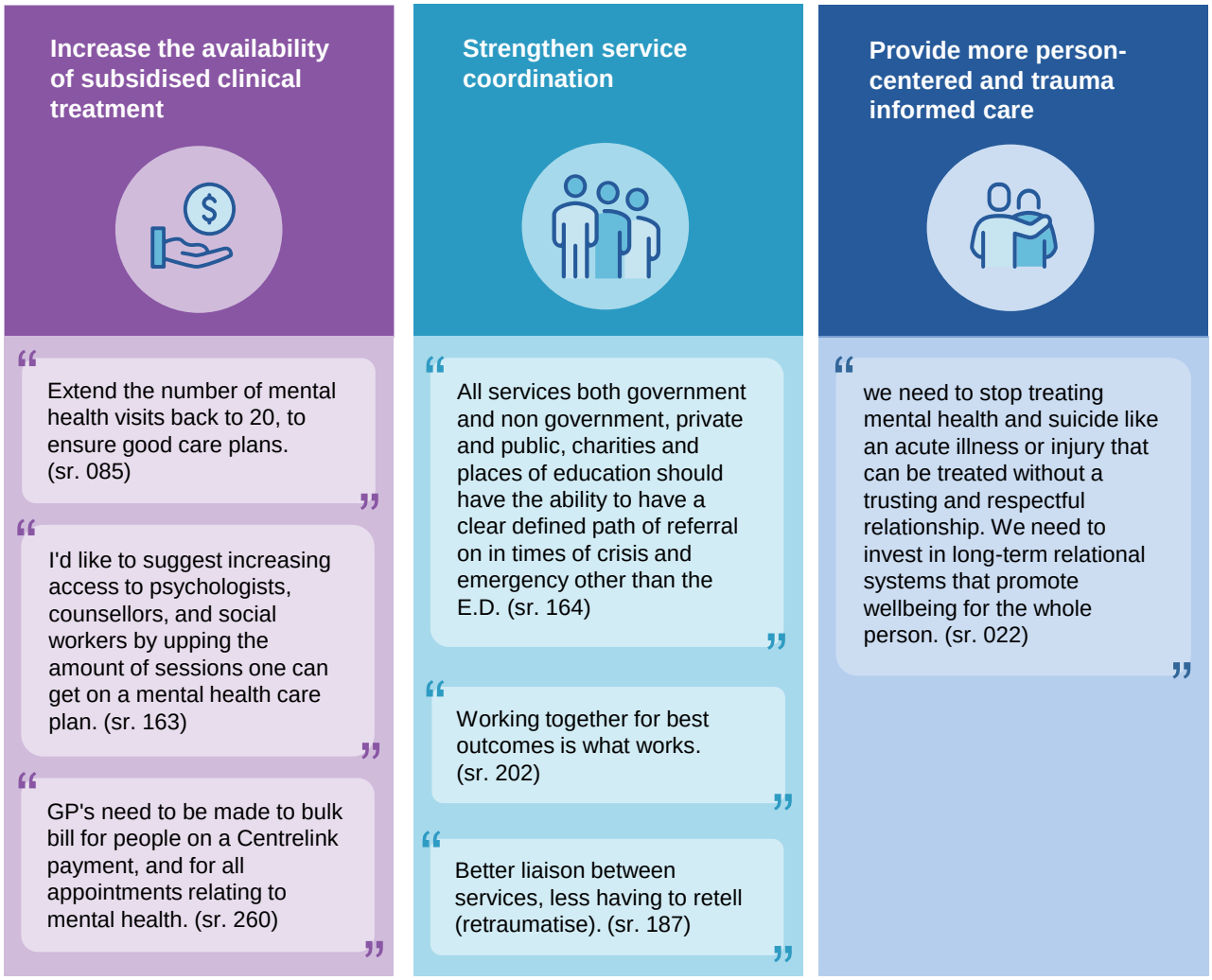
> as some services are starting to focus on including lived experience people in the workforce, services are becoming kinder. (sr. 76)

> There seems to be a few bulk billed organisations that offer services now. (sr. 183)

> There seems to be more support available, but the waitlists are longer, prices are higher, and accessibility doesn't seemed to have effectively changed. (sr. 196)

Consumers gave a range of suggestions for improving service accessibility, system integration and service quality (figure 8).

Figure 8 – Suggestions for reducing gaps and shortages in services



Consumer theme 3: Inadequate crisis support

The inadequate availability of appropriate care and preventive supports for people who are experiencing a mental health crisis or suicidal distress is another major theme in consumers' survey responses. Many consumers felt these services are not always as accessible, responsive or appropriate as they need to be.

> emergency departments not equipped for mental health crises. (sr. 06)

> It has been hard to navigate available services. There is a lot of information available online, but sometimes it's not exactly what you need in the moment. (sr. 56)

> at times in the last 3 years I have been suicidal but there are not many services which could have helped me. (sr. 202)

> A lot of times you are unable to get support if you don't fit into a certain box. This creates hesitancy to reach out as it becomes to much to try and work through. (sr. 254)

> There are no services to help in a crisis. (sr. 256)

We heard many examples of poor continuity of care following treatment for a crisis and a lack of ongoing suicide prevention support.

> There are mental health lines … however these are strictly crisis management, do not provide multiple sessions and are not tailored to early intervention (sr. 38)

> Whenever I have a crisis or suicide attempt, they have kept me overnight in ED then send me home the next morning with no follow up usually! (sr. 122)

> There's no continuity of care in the public mental health system, and therefore trauma-informed care is not possible. (sr. 132)

> Only crisis care and then you're thrown to the community with no follow up at all and just hopes that you'll figure it out yourself. (sr. 123)

> Services are still only geared for people in crisis … There is no on-going suicide prevention support for people not in crisis, this hasn't changed and I don't see it even on the radar. (sr. 212)

Safe spaces are seen by many respondents as valuable and important during a crisis. Safe spaces are drop-in services for people experiencing suicidal crisis that provide welcoming and supportive environments aimed at reducing distress. These recognise that clinical services such as hospitals emergency departments are often not ideally suitable or safe for people in distress. However, many told us these are difficult to access.

> The only public service I've interacted with was the local Safe Haven while suicidal. When I could access it, it was incredibly helpful and high quality … but such limited hours. (sr. 34)

> I would like more availability of non-clinical drop in services so they can be accessed 24/7. (sr. 83)

> I desperately needed help, my family were trying everything, but there is nowhere safe to go. (sr. 134)

> When I needed suicide prevention services, alternatives to hospital were not available. It is great to see that now there are more services you can access when feeling suicidal. I think if these

services were available when I needed them it would have been a better experience than hospital. (sr. 194)

There are no services for urgent situations besides going to the ER, which is a terrible place to go when you are in crisis and results in exhaustion and no actual help. (sr. 206)

Many respondents also told us about experiencing poor quality care or negative experiences when they had used services during a crisis.

Clinicians who didn't listen to me, misdiagnosed me or left me in dangerous situations. (sr. 41)

Let me just remind you that, if you want to seek medical help while your feeling suicidal your going to be forced to pay over 1000$ for an ambulance to come and lock you in a mental ward. (sr. 58)

In many instances they have been incredibly harmful and damaging, and this has left me with trauma that has had and continues to have a significant negative impact on my life. (sr. 65)

I have yet to find any public hospital settings to help with a crisis which wouldn't make me more suicidal and depressed. (sr. 89)

The impatient psychiatric ward was extremely unhelpful. Even though it kept me safe, I experienced a lot of traumatic events there. (sr. 112)

Presenting to emergency suicidal and being sat in the waiting room 8 plus hours, then spending the night in a hard chair with little to no support. (sr. 184)

Though not common, involuntary services (restrictive practices/interventions) were highlighted by some respondents as a source of distress they have experienced when receiving treatment during a time of crisis.

The involuntary service made me lose my job, has left me physically worse off and discredited me further. (sr. 57)

Public mental health services and community treatment order made me suicidal. (sr. 118)

When I present to hospital suicidal, they treat me like a prisoner and give me no support. (sr. 122)

Experiences of using phone services during a period of suicidal distress or in a crisis were reported by many respondents. Overall, there are mixed feelings and experiences about these services. Some people told us about negative experiences when they have used crisis phone services.

Both services actually increased my suicide risk. Neither informed me at the start they had a 20 minute limit, so conversation was wound up unexpectedly when I was unprepared. I felt vulnerable, foolish, even more worthless than at the start of the call, and more suicidal. (sr. 31)

At times where I've used crisis lines, the hold music has made me more suicidal, and the lack of instant grounding techniques used have been a struggle. (sr. 93)

all called triple 0 when all i needed was someone to talk to in person. Doing this, forced me to go into hospital where i was stuck in the ED for over 12 hours. (sr. 226)

However, some also told us about positive experiences of using phone services.

> The phone lines help you connect to a human who is empathetic to your situation … The human connection is vital for isolated individuals. (sr. 42)

> The person on the phone helped. I hear they use volunteers a lot, that's why they are so busy. But very helpful. (sr. 181)

> an amazing service, I can tell the responders are better trained. (sr. 231)

And some people told us about having inconsistent experiences.

> I have had a good experience where the person and I talked for an hour, taking me out of a crisis state and calming me down. However, I have had other times where they either do not answer or provide extremely unhelpful comments/advice that further escalated the state I was in. (sr. 112)

> it was relief to talk to someone and to make a plan for how I am going to get support/manage the immediate crisis. However, this experience isn't consistent as i have had some people from [service provider] be less helpful (eg. I'm telling them I have thoughts of suicide and she tells me to have a cup of tea) (sr. 162)

Many said they benefited from person-centred and less clinical services, particularly where services employ peer workers or involve people with lived and living experience in service delivery.

> We need more non clinical peer led services and peer support. Peer support saved my life. MH clinical support services were traumatizing and harmful as was the ED experience (sr. 110)

> Thank god for peer support workers liaising with medical professionals to advocate with me (sr. 202)

> i wanted to talk to someone who had been through what i had and not give me the pity look which i hate (sr. 255)

Respondents (including consumers, carers and people working/volunteering in service provision) gave a range of suggestions for addressing suicidal distress and mental health crises and improving the support available for people at risk or experiencing these issues (figure 9).

Figure 9 – Suggestions for preventing and responding to mental health crises and suicide

Consumer theme 4: Discrimination when using services

Another major theme that has come through consumers' responses to the survey is their experience of mental health-related stigma and discrimination when using services. The experiences, feelings and impacts of this ranged from being disapproved of, excluded, devalued, shamed and negatively stereotyped.

Many people feel they have experienced discrimination in the service system related to their mental health issues and their perceived support needs. Some said this impacted the care and support they receive from services.

> In the psych ward and some other instances (like a psychiatrist and a different psychologist) however, I often felt disrespected and invalidated by staff and unsafe even though I was in a locked ward. (sr. 112)

> Mental health is either ignored or blamed for every physical condition! (sr. 240)

> I feel like they didn't really listen to me when making a safety plan and I wasn't respected. I've also made complaints and didn't feel listened to. (sr. 265)

And for some, the experience of mental health related discrimination from services appears to have contributed to self-stigma (internalising and applying public stigma to oneself).

> Being diagnosed with Borderline Personality Disorder, most health professionals call me a trouble maker or difficult when I'm just struggling and in pain. (sr. 163)

> I feel forgotten about, even when I am with a doctor or other mental health practitioner. Just another pain in the bum with no real problems. (sr. 193)

> Felt stigmatised and judged for suicidal ideation. (sr. 251)

Many consumers who said they had experienced discrimination related to their mental ill health also shared that this made them feel socially marginalised and that the experience of discrimination worsened their mental health and wellbeing.

> As a survivor of domestic violence but having a diagnosis I was discriminated against and left in a worse situation due to this. (sr. 57)

> I have been disrespected, dehumanised and degraded whilst receiving mental health treatment. (sr. 65)

> Psychosis is demonised and misunderstood … and people are terrified. (sr. 134)

> When you're being told you are a liar, with a diagnosis, and they treat us like we're acting, makes us question our own sanity and has us thinking about suicide. (sr. 232)

Some told us that having experienced mental health related discrimination led them to anticipate stigma. It meant they felt excluded from services, had negative feelings towards services and avoided using them.

> The fear of losing work, being deemed unfit for work due to the discrimination of people with lived experience prevented me from trusting services. (sr. 13)

> I have always avoided other mental health services because I know too many people who have been treated poorly and harmed by the system intended to help them. (sr. 70)

We also heard that some people's experiences of mental health related discrimination were related to their gender, sexuality, cultural identity or other personal attributes.

> My Aboriginality was ignored. My own voice was ignored. My cultural situation was ignored. (sr. 25)

> Language barriers, stigma, and a lack of culturally competent professionals make it even harder. I've seen how mental health struggles in CALD communities are often dismissed as "just stress" or "family problems," rather than recognized as serious issues needing proper support. (sr. 67)

> I have been knocked back from 2 private mental health hospitals due to weight discrimination. (sr. 155)

> I do not feel safe to fully disclose my gender identity/sexuality because of the limited knowledge of most of the services I have accessed. (sr. 171)

> Psychiatrists and others judgement on sexualising and gender has impacted my recovery and sent me backwards. Deciding that these issues were the main cause of my MH issues was detrimental and I felt completely unheard! (sr. 230)

Some people also told us they felt discriminated against by mental health services because of their neurodivergence and the lack of understanding and awareness of this by mental health services.

> As an autistic person I was not often understood or felt heard. Many of my experiences with crisis services or mental health professionals left me feeling worse. (sr. 100)

> I am autistic and this was ignored when receiving mental health treatment – and I was turned away from some public services for being autistic because they felt they "weren't best suited to help me". (sr. 119)

> My experience has been that there is a lack of knowledge in drs and mental health professionals regarding women having and seeking a late diagnosis for Autism and ADHD, and the myriad of conditions and difficulties that accompany this. (sr. 172)

Though less common, some people also told us of experiences where they had felt respected, recognised and protected by services, rather than discriminated against. Some common features to consumers' positive experiences of services include a sense of being sympathetically and non-judgementally heard and treated.

> Clinicians were very caring and supportive. (sr. 66)

> People let me talk, and asked questions. I can't remember anyone telling me what to do. They listened! I also had some great peer worker support when I was in the acute ward. (sr. 168)

> In treatment for more severe mental health issues, I felt seen, heard and supported. (sr. 196)

> Always open honest interactions that were non judgemental, respectful and aimed to work together for my best interest (sr. 202)

> Everyone was kind and gentle. (sr. 245)

> The psychologist I currently see always makes me feel safe and respected, letting keep control while guiding me through ways to help. (sr. 234)

> Sometimes individual workers provided a sense of recognising and respecting my individual needs. (sr. 269)

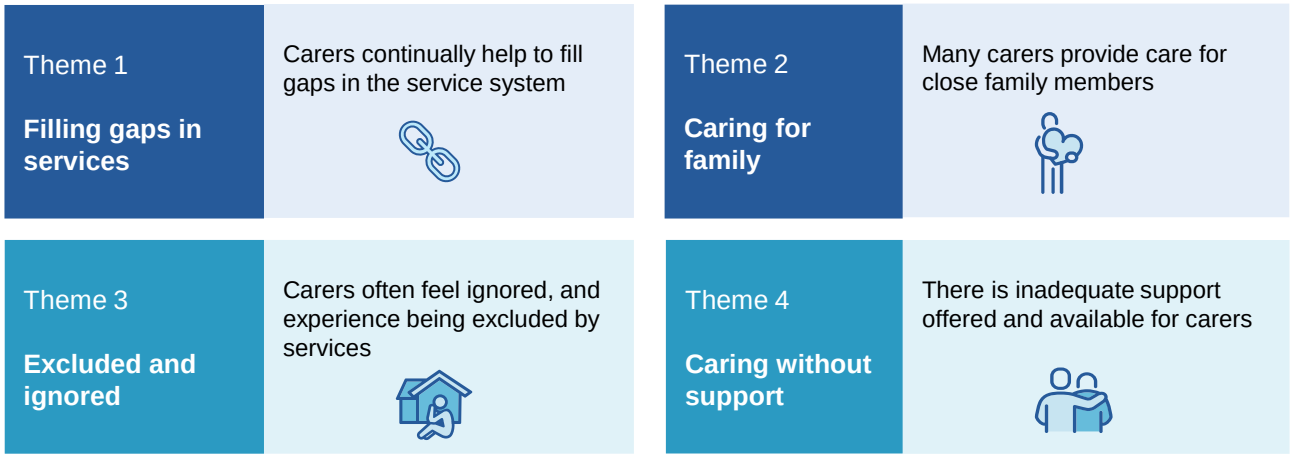
Consumers gave a range of suggestions for preventing experiences of discrimination when using mental health and suicide prevention services and in the community more broadly (figure 10).

Figure 10 – Suggestions for preventing discrimination

Main themes in the survey responses from carers

Many carers told us about their continuing struggles to fill gaps in the service system to meet the needs of the people they care for. Many also told us about the pressure and distress they sometimes experience associated with the dual role of being a carer and being a close family member of a person needing care, such as their child, spouse/partner or parent. We also heard about many carers' experiences of feeling excluded and ignored when interacting with services and a lack of support from the service system for their own needs associated with being a carer (figure 11).

Figure 11 – Main themes identified in carer responses



Carer theme 1: Filling gaps in services

Many carers shared experiences of caring for someone with mental ill health spanning several years. They told us how the gaps in the service system often meant services did not meet that person's needs.

> Services often fail to address the complexity of my loved one's needs. For example, crisis support is inconsistent, do not know how to support and help at home, and no follow-up after discharge from hospital care. (sr. 09)

> Navigating mental health services via the ACT mental health system was slow and cumbersome. My son didn't trust the community services agency due to his distrust of frontline workers with poor communication skills. (sr. 78)

> We have been supporting a family member for the last fifteen years and have not seen significant changes required to support Mental health and Suicide Prevention. (sr. 95)

> Need greater crisis support and post-crisis support/care. Our experience is that these services are non-existent. Support for patients and carers to prevent suicide attempts are better than hospital care after. (sr. 16)

Some carers told us how, out of necessity, they had become proficient in understanding and accessing the service system and more assertive in help-seeking for the benefit of the person they care for.

> Getting to the point of service delivery does tend to rely heavily on my own knowledge of the system and ability to speak their language. That earns me more respect than anything else. (sr. 22)

> I introduced myself to my son's clinicians as a mental health consumer representative which seems to have helped with this. (sr. 78)

> In the private sector I managed to set up a good support team. (sr. 85)

> My loved one also lives with a physical disability since birth. I have mostly been my loved one's case manager/advocate even when we lived in Darwin. (sr. 98)

But many carers also told us about the ongoing concern and stress they experience when trying fill service gaps and deal with the complexities of the mental health service system.

> it felt like it was deliberately confusing and impossible to understand and navigate. (sr. 80)

> The system is complicated to navigate and relies on short term bandaid fixes. (sr. 82)
>
> Coordination between Private Medical (GP and Psychiatrist) and private Therapy services was done by Carer which was stressful and inefficient. (sr. 84)
>
> As we were having so much trouble getting care from the public system we tried the private sector as well and were turned away by every private provider with the same message - my person was too complex. (sr. 254)
>
> Psychiatrist waitlist was 12 months, for a vulnerable teen with suicidal ideation, attempts, self-harm. This was completely untenable, and the GP prescribed life-saving medication in this absence. (sr. 263)

Geographic gaps in service accessibility and availability are an issue many carers told us about.

> I live in a cross-border area and there is dispute over whose responsibility services are. I have had to navigate through how to get the right services with the extra pressure of where we can find them and be accepted. (sr. 22)
>
> There is a severe lack of child and adolescent mental health services in my area. (sr. 37)
>
> No beds available in mental health unit during crisis. The only public non-acute mental health care program available was in Nowra over 2h from Sydney. (sr. 40)
>
> There are no in-person services locally for psycho-social wellbeing for people without a NDIS plan. (sr. 50)

Where services were available, many carers told us they often faced substantial costs to access them. This could impact significantly on their own financial situation, as well as affect the quality of support and treatment received by the person they care for.

> considerable out of pocket expenses which impacts choice on the number of appointments made and therefore on the quality of care as per given optimum treatment models. (sr. 02)
>
> Mental health care costs means that I have to work more to pay for treatments. (sr. 42)
>
> Had to go privately which is costly. He would have benefited from more frequent care, however due to affordability, appointments were spread out and only when really unwell. (sr. 43)
>
> We need to pay to see a private psychiatrist every 6 months for a medication review to be conducted. The private psychiatrist is excellent but expensive. There is no way my loved one could afford to see a private psychiatrist if they didn't live with me. (sr. 98)

While many carers told us about challenges and negative experiences of using the mental health services system, we also heard some positive experiences.

> Dedicated GPs, holistic experienced psychologists, person centred psychiatrists exist and contribute positively to a persons recovery and support during a MH crisis. (sr. 02)
>
> Found a good psychologist for my son who saw him via Telehealth. (sr. 37)
>
> Initial consultations with my son's psychiatrist and psychologist seem to have been the most helpful, including providing the right level of anti depressants and talking therapy. (sr. 78)
>
> The staff do their best with what little resources they have … a junior psychiatrist went above and beyond for my daughter and was a key player in her transition from 20 months in a mental health unit into the community. (sr. 87)

took time to understand my son and his family supports, and valued my child as a person rather than a diagnosis. (sr. 262)

My teen's positive experience came only from a private psychologist who is actively working to learn from neurodivergent advocates/trainers. She is validated, she is seen, she is seen as the expert over her own life, she is empowered to trust her own capacities to navigate her life, and access supports. (sr. 263)

However, we also heard many carers had not seen positive changes in recent years, with many believing there has been a general worsening of the mental health service system.

core issues (e.g., fragmented care coordination, underfunded rural services) persist. Improvements feel superficial rather than systemic. (sr. 09)

The system is broken and in total collapse in NSW. (sr. 87)

There seems to be more options of services that a person can access until you actually try to access one. (sr. 111)

services in general around mental health are just lacking there is not a lot funding allocated and services are becoming more thin all the time due to not real investment. (sr. 141)

I would say the system has deteriorated. There is a lot of talk of change but all I see are busier ED's. (sr. 150)

Carer theme 2: Caring for family

While carers have diverse backgrounds and fulfill widely varying roles, we heard carers often have a close family relationship (parent, spouse, partner, or child) to the care recipient experiencing mental ill health. For many carers this underpins their motivations and experiences in providing care.

Many carers in this dual role told us about the heightened concern and distress they experience when trying to access care and support through the mental health service system for the person they care for.

My mother is 90 and has mental health issues for the past year - she tends to be disregarded because of her age and overlooked - she has to wait months at a time to see the mental health professional at the hospital. (sr. 14)

My son attempted suicide. On hospital discharge he was referred to his GP. While developing my son's mental health plan the GP admitted that he wasn't qualified to refer him to any mental health services. (sr. 78)

Another instance was my daughter was refed to an eating disorder. When she went back to the mental health rehab unit the dietician was unable to consult her due to no funding. (sr. 87)

The public health system failed us and it took months of calling multiple private practices and begging for appointments - then being charged fees for 'intake' sessions and told later they could not help us - before I found someone who can see my son next month. (sr. 206)

Many also described the distress they experience as a carer when observing inadequate or poor-quality services being provided to a member of their family.

Patients, including my partner who was experiencing psychosis and mania [in hospital ward] were treated incredibly disrespectfully by staff. (sr. 52)

> When my wife was experiencing a crisis, we tried to get her supports which ended up with an inappropriate admission to the inpatient unit, and a bungled transition to home which resulted in further and worse SHSI (self-harm screening inventory) that went unaddressed for months. (sr. 76)

> psychologist told my son and I in the waiting room, in front of other waiting clients, that my son was likely too severe for their service … I was emailed a list of private and public services to contact myself to source a psychologist for my son – all of these services had month-long wait lists. This effectively left my son with no psychology services just after an inpatient psychiatric admission. (sr. 262)

Some also told us about wanting to focus on prevention rather than acute treatment, to maintain the health and wellbeing of the person they care for and avoid potential crises.

> My children are not needing services for severe mental illness, but rather ongoing wellbeing matters that could turn into further issues as they get older. With both of them I have had trouble accessing services, to the point where we have still not seen anyone, it has left me managing how their wellbeing is. (sr. 08)

Carer theme 3: Excluded and ignored

Many carers reported that despite often needing to communicate and interact with mental health services as part of their role in providing care for someone, they often felt excluded and ignored by services.

> I am consistently excluded from care plan discussions. During the first hospital admission, clinicians refused to share updates, citing confidentiality, even though my involvement is critical to my loved one's recovery. (sr. 09)

> staff ignored me as a primary person providing care. (sr. 25)

> They are less likely to involve me in the planning and delivery of services aspect. Basically services will try to tell you what is going to happen regardless of what my thoughts are. (sr. 98)

> They wouldn't even speak with me. (sr. 103)

> I am often excluded because the person I provide care for is over 18yo. (sr. 187)

> Being excluded from her treatment and care because of delusions and advanced health directives not even looked at made me feel excluded when I was her primary carer and only advocate. (sr. 216)

Many parents, guardians and other adults caring for a child with mental ill health reported feeling dismissed, ignored and negatively impacted by services.

> It is usually more as having any inclusion sidelined or advice not sought – this was especially when my person was younger. (sr. 02)

> Despite considerable advocacy for my daughter I was often dismissed and had to fight tirelessly to get support for her. (sr. 74)

> Myself, my wife, daughter and other children have been traumatised by this system. (sr. 87)

> I think mental health professionals tend to judge you as an over reacting mother without understanding your own education, experience and background. A mother's input is not highly valued. (sr. 124)

In contrast, some carers told us about more positive experiences in recent times where they had a sense of being more included and supported by services.

> Carers are generally treated very well by mental health services. This is a valuable part of the mental health system. (sr. 88)
>
> I am able to contact my son's case manager if I have concerns. (sr. 158)
>
> I feel privileged that the social worker keeps us connected. Its focused on my child, and they take my lead if I have ideas. (sr. 186)
>
> GP has checked in carefully with myself regarding my service user to be supportive and to provide support for both myself and the service user. (sr. 209)
>
> Private psychiatrist and [clinic name] have provided excellent communication … Our private psychiatrist has always listened to us when we have flagged escalations in my son's depression. (sr. 262)

However, some carers told us they have had mixed experiences across services and told us how they have had to persevere for some time in order to overcome being excluded and ignored by services.

> While some staff acknowledged my role as a carer, others dismissed my insights. For example, a GP once said, "You're not the patient; your opinion doesn't matter." (sr. 09)
>
> After decades of being dismissed and labelled an over-anxious parent, I feel there has been some improvement in some professions of the acceptance of family/parental involvement being crucial in support of the person with mental health conditions. Specifically Therapists and GPs. (sr. 84)
>
> I have had to fight to be involved despite being legally appointed guardian by QCAT and financial administrator. I have received so much push back, including being belittled and ignored until i finally complained to the health ombudsman who accepted the complaint and directed the hospital health service to attend to the complaint. It should never have gotten to that point. (sr. 254)

Carer theme 4: Caring without support

Many carers told us they experience ongoing stress and adverse impacts on their wellbeing from being a carer, especially where they encounter difficulties accessing adequate and quality treatment and support for the person they care for.

Many said they often felt undervalued, unprotected and unsupported by the service system in their role as a carer.

> there was no service capacity to protect my child nor my other children…. Let alone myself. (sr. 69)
>
> Being told to go home and someone would follow up and no one ever did. (sr. 176)
>
> I don't feel like we are seen at all. Respected would be meaning we are treated like a somebody and we are not. Protected would be knowing how to help us and protecting us from ourselves when needed and this doesn't happen. (sr. 177).
>
> The person you are caring for has all the rights because to get any service they have to agree to it. Sometimes they don't have the mental capacity to agree and can walk out at any time even if the carers are in danger or the person is suicidal. (sr. 199)
>
> I was never supported in the carers role. (sr. 240)

Some carers said they felt under considerable pressure because they carry substantial responsibilities and perform major roles in a person's care and support, often filling gaps in the service system that are not properly recognised or supported.

> My person was given new medication without my knowledge or consent and when asking for information around the new medication i was emailed the pamphlet out of the box and told if i needed further information to google it. I have had the psychiatrist sit in a meeting a week ago and try to shift blame onto myself and other supports in front of my person which put our relationship at risk. That entire appointment was psychologically unsafe. (sr. 254)

> At my son's most acute periods of illness (immediately before or after his suicide attempts), the onus of keeping him safe and from preventing him from re-attempting suicide has been placed on my husband and I. In contrast, if my child presented to an emergency department with an acute presentation of asthma that threatened his life, he wouldn't be sent home for us to manage his acute symptoms. A major depressive disorder and suicidal ideation is just as life threatening as other physical conditions. (sr. 262)

Some carers also told us about the difficulties they face in navigating the service system and that carers are not well supported with this.

> The lack of centralised official information makes it difficult to know what services exist. For instance, I discovered a local peer support group only by accident after months of searching, highlighting gaps in outreach and communication. (sr. 09)

However, some also said they had experiences of receiving help and support with their role as a carer.

> Service has been amazing. Person centred, care tailored to him, Resources provided with strategies to read/review at home and share with me. (sr. 43)

> Roses in the ocean were able to support me across suicide bereavement, carer, and personal distress in an understanding way. They mapped out the services for me, checked wait times and helped me navigate into services that suited me. (sr. 110)

> Carer Gateway are outstanding. (sr. 152)

> The psychologist was thoughtful and kind. Always clear about her plans and kept us informed. (sr. 205)

> [Clinic name] provide a psychologist for my son, and a family liaison for my husband, which has been invaluable in supporting and skilling our whole family. (sr. 262)

Respondents made a range of suggestions for how services could be improved to better meet the needs of carers and the people they care for.

> I think the problem here is that there isn't enough opportunities for carers to be part of service design. (sr. 189)

> Prevention is better than cure. Let's make more services available for young people before their mental health concerns develop further, and remove the road blocks of having to have a relationship with a GP, and gaining a mental health plan. (sr. 08)

> Services needed to be expanded include: respite care, post-suicide follow-up (to prevent cycle of many attempts), better education of emergency staff of various conditions and how to best treat them, more clinical psychologists & psychiatrists, more access to psychology under medicare. (sr. 16).

Some also highlighted the importance of tailored support for carers that recognises their specific needs and circumstances.

> not nearly enough services and or support or support groups for carers. Groups usually that are running are during the day when most people have to work. (sr. 42)

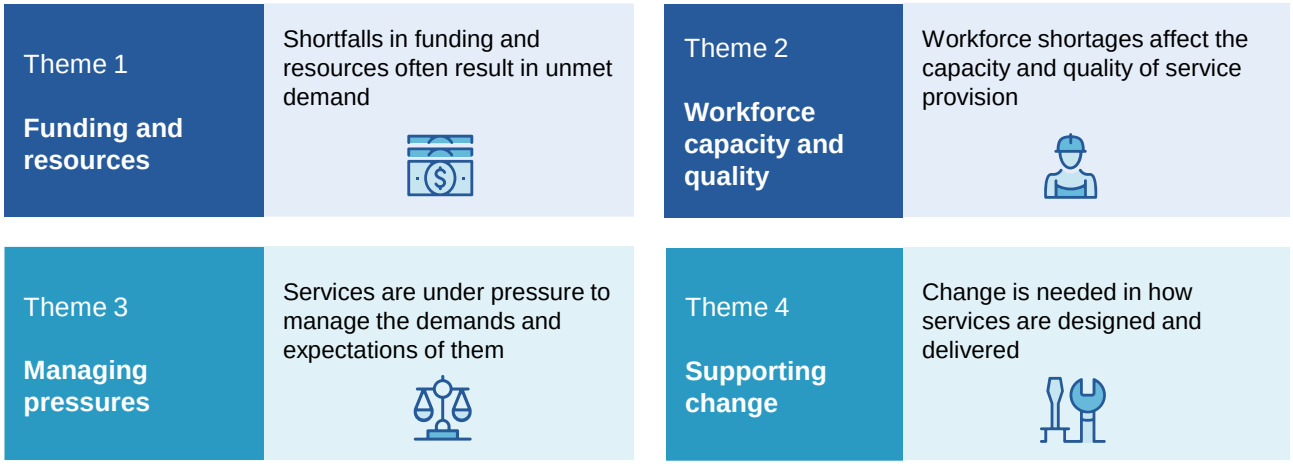
> Because we aren't linked to a government run community based service (even a bad one) it can be quite isolating at times because there is no one responsible for checking in to see how things are going. (sr. 98)

> I was asked about my feelings about whether my partner was safe to go home, and whether I was okay with this. What was really good was that they asked this question privately, and asked about how I was coping etc. (sr. 168)

Main themes in responses from workers and volunteers in service provision

In the survey responses from people who work or volunteer in mental health and suicide prevention services, we heard a lack of funding and resources to meet current service demands is a major issue. We also heard from many about workforce shortages and the impacts of this on service capacity and quality. Many workers told us about the need for the service system to evolve to better meet the needs of consumers and improve the quality of care provided to them, and many offered suggestions for how this could be progressed (figure 12).

Figure 12 – Main themes identified in service provider responses



Service provider theme 1: Funding and resources

Many workers and volunteers told us they believe there are underlying shortfalls in funding and resources for mental health and suicide prevention services, and this is negatively impacting their ability to meet consumers' needs.

> There is only so much services can provide without adequate funding. (sr. 63)

> closing times/access, infrastructure, lack of funding, outdated models of care and all due to not enough money. (sr. 71)

> No positive changes, only negative - less funding across the board particularly for early intervention services. (sr. 147)

> lack of resourcing and funding preventing us from being able to adequately reach the people who need us. (sr. 196)

> We do not have enough staff, we are underfunded and cannot offer the services people need in our area. (sr. 242)

In this context, many told us more funding is needed for mental health and suicide prevention services.

> More funding for more safe spaces. (sr. 18)

> More funding, long term commitment so these services are sustainable and can provide long term support to people bereaved by suicide. It is unacceptable for people to have to wait 8 weeks to access suicide bereavement and peer support services. (sr. 110)

> More funding for community MH - it is too uncertain and not enough staff. (sr. 153)

> More funding being channelled into the most under-resourced teams to ensure our practice is actually sustainable. (sr. 196)

> FUNDING!!! Help us continue to save the lives of the men and women who have or are still serving. (sr. 255)

> Funding for postvention services should be increased, stabilised over the long-term and better integrated with the broader mental health and suicide prevention system. This would ensure services can respond promptly to people who have lost a loved one to suicide. (sr. 266)

Some told us that without more funding to support subsidised access to clinical services, consumers face significant financial barriers to ongoing care and treatment.

> I would like to see more brokerage funding available so that we are better able to support assessments that may be required to confirm diagnoses to ensure that the support they are receiving is beneficial to them. Unfortunately, there is a large gap in the mental health sector when it comes to people being able to access psychiatry. Psychology is becoming more accessible, but psychiatry is still a large issue. (sr. 01)

> Increase DVA and Medicare fees to private providers of mental health services like mental health social workers and psychologists. (sr. 37)

> The introduction of additional sessions during COVID was a positive move towards addressing the mental health support needs of Australians during times of crisis … Unfortunately there were financial barriers that meant that this increased access to treatment did not reach those with less financial resources. This needs to be addressed by increasing the affordability of psychological treatment services. (sr. 128)

Service provider theme 2: Workforce capacity and quality

Many people who work or volunteer in mental health and suicide prevention services told us about significant workforce shortages in the sector, and how this is negatively affects the capacity and quality of service provision.

> It is extremely difficult to recruit psychologists and counsellors to deal with the huge demand of clients who need one on one support. (sr. 15)

> Lack of trained mental health professionals. (sr. 42)

> Staff shortages have already emerged as an issue. Short term pilot programs make it hard to recruit staff. (sr. 166)

Many saw retention of existing workers and volunteers in mental health and suicide prevention services as essential to strengthening and stabilising the sector's workforce. Many respondents recommended improving wages, working conditions and career pathways.

> We need funding and more staff. We can train staff but we have no funds for this. (sr. 39)

> The service has real difficulty with turnover of volunteers and resorts to quite amateurish means to try to resolve that. (sr. 53)

> Increase wages, increase staff, fund charities and non profits with sustainable long term funding for confidence in jobs and long term planning and service delivery, empower community groups with such funding, more GPs in regions and rural, train GPs with mental health skills and make sure they know what services are available locally. (sr. 213)

> The workforce also need support to ensure their own mental health is not impacted by significant service demands. (sr. 242)

Many suggested there should be a greater focus on developing workforce capacity and quality.

> We also need to train up and employ a workforce that has a passion for supporting people experiencing suicidality, rather than just using the existing mental health workforce. (sr. 36)

> more funding for services to educate clinicians in contemporary, evidenced based, practices. (sr. 170)

> I would like to see a shift towards a more intentional service delivery model, taking better care of staff and ensuring they have access to safety procedures etc., providing staff with different training opportunities to improve their knowledge and upskill, being more consistent with services delivered to client… When you invest in the workers providing the labour, you will gain more as they will be better trained, more motivated and passionate, and are being paid well for what they do. (sr. 162)

> More access to funding for further education to other health and teaching staff on mental health and mental illness and the importance of early identification of risk and vulnerability to aim to prevent secondary damage/trauma. (sr. 164)

> Continued commitment to learning and growth for all staff with opportunities for training and access to resources … Recruitment strategies and policies that attract and retain a diverse workforce. (sr. 230)

Service provider theme 3: Managing pressures

We heard from many workers and volunteers that as the expectations and demands placed on services have increased in recent years, and as the accessibility and availability of services has been stretched, there is growing unmet need among consumers.

> Again not enough space, resources and staff makes access difficult. People are being turned away even when they are voluntarily reaching out for help. MH has no quick fix a lot of the time and we mustn't assume a few follow up phone calls will be sufficient. Our alternative to emergency departments do NOT have enough environmental space or funding to meet demand. (sr. 47)

> it's now a lot harder to get an appointment with a psychologist or psychiatrist. (sr. 72)

> as we are non-clinical and therefore when someone is in crisis, the hospitals, ambulances, psychologists have been unable to help and therefore we feel we let our members down as are left in suicidal crisis. (sr. 153)

> services are increasingly difficult to access and navigate, hard to get the most vulnerable and individuals in need seen in a timely and appropriate manner without having to share exhausting accounts of why the service is needed. (sr. 164)

Respondents felt the growing pressure on services and unmet need in recent years can be attributed to a range of factors such as increases in the underlying demand for mental health care in the community and increases in the complexity of some people's mental health care needs.

> Increase in client complexity, exacerbated by Covid fracturing support systems and increasing individual and family stressors. A lot of services had to just focus on their internal service needs, and a lot of networking and collaboration opportunities went by the wayside during Covid. We are not back to where we were and this has a real impact on both services and clients. (sr. 94)

> Services are overstretched. Secondary services have wait lists that are long. Especially for people that have deteriorated mental health. (sr. 42)

> Homelessness and social issues are driving mental health crisis presentations. (sr. 71)

> Increased service demand and increased reliance on mental health services; lower resilience in the population; conversely the destigmatisation of mental illness has lowered the threshold at which individuals seek help. (sr. 218)

Many told us the co-occurrence of mental health and alcohol and other drugs (AOD) issues is contributing to increased pressure on mental health care services.

> in the intersection between co-occurring mental health and alcohol and other drug (AOD) issues. We would often have clients 'stuck' between the 2 - with AOD services saying 'we'll work with that client once you manage their mental health concerns', but equally other mental health services saying to AOD services 'we'll work with them once you manage the AOD side of things'. This is not a holistic approach, treating the person as a whole person rather than isolated 'issues'. (sr. 94)

> There needs to be more support for people in active addiction with substance abuse and mental illness. This is something that is falling to the wayside. (sr. 162)

Some also said that while they had seen an increase in the range of service options become available in recent years, they still had concerns about the accessibility and quality of new services.

> There are certainly more services around now to provide the support needed, and it is becoming more accessible for people who may not have previously had access to mental health services prior to COVID. (sr. 01)

> Less wait times for service but less holistic and supportive. (sr. 242)

Many highlighted fragmentation in the service system and believed there needs to more effort made to improve integration, coordination and collaboration between services to help manage overall demand pressure in the system and improve the quality of care provided to consumers.

> We are supposed to have "Universal aftercare" funded under the bilateral agreement. However, in our region, "Universal" is limited to one LGA (our region covers 3 LGAs) and the aftercare program (Wayback) can only be accessed via specific pathways. For example, there is no pathway from the intensive care unit or general hospital wards into the Wayback service. Thus if

someone made a near-fatal suicide attempt such that they spend time in ICU, they will not be offered the Wayback service. (sr. 36)

There is a strong desire for state and PHN to work together through the bilateral agreements but it isn't working as well at the frontline. People are still having trouble navigating services and equally frustrating for referrals across services – even within large HHS. (sr. 71)

Some told us competition between services for limited funding is contributing to system fragmentation and lack of collaboration between services.

I think the system is worse than ever and seems to be going backwards. There are mental health service providers in our area who will not refer (or speak to) each other because they are the competition for funding. (sr. 111)

it's getting worse with the siloing and division of service funding. (sr. 76)

However, in contrast, some told us they had seen some improvements in collaboration and coordination between services.

Suicide prevention networks, Anglicare WA metro postvention response services, StandBy, Roses in the ocean, are all new to the Perth metro area in the past 3 years and this has seen coordinated responses to critical incidents and high impact suicides as well as more suicide specific and peer support service options for communities. (sr. 110)

Being from another state it has taken time for the local services and GPs to accept my provision of service, but I find that now I am known and GPs refer clients using my name not the service, this is very rewarding. (sr. 209)

Service provider theme 4: Supporting change

We heard from many respondents about the need for changes to the way services are designed and offered to better meet the needs of consumers. Many believed services should continue or begin to involve people with lived and living experience of mental ill health or suicide in the planning and delivery of services. This was seen as important for improving the quality of service provided and the experience and outcomes for consumers.

We need more buy-in from the government as to the value and importance of the peer-led workforce. Lived experience workers are a safe, holistic, unique and sustainable alternative to traditional clinical care, and are especially important now, whist psychiatrists and clinical care is almost impossible to source. (sr. 21)

The service puts lived experience at the forefront – it is crucial that those with experience of mental ill-health and/or suicide are the ones volunteering, informing and guiding the delivery of mental health services. (sr. 70)

Peer-to-peer support offers a compassionate space where individuals facing mental health challenges can find understanding and care. It fosters connections that help people feel seen, heard, and empowered on their journey to well-being. (sr. 149)

Lived experience being added to the mental health system, people are feeling more understood and safe. This has been a great change in the mental health system. (sr. 194)

However, some expressed concern about the inadequate institutional and workplace support provided for peer workers and people with lived and living experience.

> We also need a more genuine focus on the expertise that people with a Lived Experience of suicide bring. Far too often, it is painfully apparent that the Lived Experience representative(s) on a committee are only there to tick a box, rather than because they are seen as bringing something of genuine value to the committee. It is often the case that the LE representatives are the only people in the room who have knowledge of and experience in the suicide prevention sector, yet they are still dismissed by the rest of the committee, which, as I said, is generally made up of mental health clinicians. (sr. 36)

> Erosion of LEW workforce. They are so desperately needed. We need to expand not deplete these colleagues. The issues are not emerging, they are well known and very apparent. Refusal to address them is the problem and that is the priority area to fix. Law breaches, EBA breaches, it's a disgrace. (sr. 249)

We also heard from some respondents about the need for services to go beyond the rigidities of a medical model-based approach in how they provide support to people.

> I have seen repeatedly the enormous harm done to patients, patient's families, and clinicians by the medicalisation of suicide. (sr. 20)

> for many people a health response to mental health issues and distress just doesn't work, isn't even needed. (sr. 80)

> all too often, we find ourselves surrounded by medical staff who seem more like automatons, mechanically adhering to heartless regulations. (sr. 149)

Some respondents highlighted service improvements that had been implemented, where providers had adopted more person-centred, holistic and trauma informed approaches to care and support.

> I have seen an increase in commitment from mainstream services to providing an inclusive service for marginalised groups of people. Provision of person centred and trauma informed practices. (sr. 230)

> Services have also improved due to being re-designed with a stronger focus on being person-centred. (sr. 266)

Many positive experiences of working in the service system were highlighted by respondents. Often this was the opportunity to support people heal and recover from mental ill health or a suicide crisis and see improvements in their wellbeing over time. We heard from many respondents about the satisfaction they gained from helping others and how this underpinned their motivation working or volunteering in the service system.

> Celebrating the small wins with some of my clients and seeing them determined to achieve their goals and continually work on their recovery. (sr. 01)

> Listening to people and validating their experience, sometimes making a difference. (sr. 31)

> It’s great to see them when they get well often after many months, sometimes several years, working with them. (sr. 37)

> It is the best experience working with someone’s own goals of recovery. (sr. 71)

> Seeing positive relationship changes, engagement, less admissions in crisis, consumer returned to work and living life best they can. (sr. 91)

> Seeing a person who was at their lowest point now working, in a healthy relationship and looking to the future. (sr. 111)

> Getting to meet new people and deliver my lived-experience story to students – something I wish I had when I was in school. It feels incredibly empowering to feel like you are helping contribute to a better mental health system and reducing the stigma around it. (sr. 112)

> We are able to empower young people to normalise talking about mental health in a really meaningful way. Seeing that happen is beautiful. (sr. 196)

> I love working in mental health and being able to speak with service users. Seeing the positive impacts for the people I work with. (sr. 242)

> There are many from over the years, but simply put, when a consumer, their family and carers, are supported, engaged and have agency and informed choice over their mental health care. Watching their journey of recovery and being in the privileged position of sharing their outcomes. (sr. 249)

Respondents made suggestions for how improvements to mental health and suicide prevention responses could be achieved by working outside the silos and confines of the mental health system through greater coordination across systems, particularly with the AOD treatment system.

> I had a client die by suicide who I believe would have made it through. He was an alcoholic who had relapsed after 10 years sobriety. He wanted help, and had been successful in managing alcohol and depression previously. The mental health unit declined him due to his alcoholism. Detox declined him due to his suicide risk. He hung himself in his unit. (sr. 31)

> Further work needs to be done to stop the slipping of mental health and alcohol and drug services. They both need a harm reduction approach. They both need to recognise they are interdependent and are serviced poorly through separated provision. (sr. 71)

> Dual diagnosis is a huge issue in rural and regional areas. If a person has a disability they are often told to access NDIS, NDIS will no longer support mental health needs and if the person has a drug and/or alcohol history they are not able to access NDIS or Mental health support. (sr. 111)

We heard a range of suggestions from workers and volunteers in service provision for how the service system could be improved to better meet people's needs. Some highlighted specific parts of the service system they saw as important.

> Bereavement support is a critical component of the mental health and suicide prevention system. Researchers have found that bereaved people are 65% more likely to attempt suicide if they are grieving for loved ones who took their own lives. Beyond the tragic loss of a person to suicide, the impact of suicide deaths are felt by up to 135 people, including family members, friends, work colleagues and first responders at the time of death. (sr. 266)

> There needs to be a huge increase in public campaigns and awareness as to what mental health and suicide prevention orgs do and what services and supports they offer. (sr. 21)

> Given the increasing demand for psychology services and increasing waiting lists to access psychologists, we believe the deployment of provisional psychologists is one of many ideal solutions to swiftly improve the availability of much-needed mental health care support for Australians. (sr. 128)

> Health departments and health service providers need funding incentives to develop seamless care and to take responsibility for the gaps and blockages between systems instead of washing their hands of it. (sr. 166)

Mental Health and Suicide Prevention Agreement Review

Interim report

Chapters

1. The role of the Agreement and this review

Key points

- **The National Mental Health and Suicide Prevention Agreement is the first of its kind. Under the Agreement, governments committed to work towards whole-of-government reform to address gaps in the mental health and suicide prevention system and ensure services are responsive to the needs and preferences of people with lived and living experience of mental ill health and suicide, their supporters, families, carers and kin.**
- **The Agreement operates alongside many other policies aiming to improve mental health and suicide prevention outcomes. It contributes about 3% of the annual public funding of mental health and suicide prevention services.**
- **Funding commitments are contained in bilateral schedules signed by the Australian Government with each state and territory. A range of services are funded through the Agreement, such as peer-led drop-in centres, supports to people following a suicide attempt and perinatal mental health screening.**
- **The Agreement is set to expire in June 2026, and this interim report is part of its final review process. The PC is inviting comments on this report, ahead of submitting its final report to government in October 2025.**

The Australian, state and territory governments signed the National Mental Health and Suicide Prevention Agreement in 2022, to formalise their commitment to work together to improve mental health outcomes and reduce the rate of suicide towards zero.

In January 2025, the Australian Government asked the PC to conduct the final review of the Agreement, ahead of its expiry in June 2026. The PC is seeking feedback on this interim report and will submit its final report to governments in October 2025. The PC thanks all individuals and organisations that have taken part in our consultation and acknowledges the important contributions of people with lived and living experience of mental ill health and suicide, their supporters, families, carers and kin.

1.1 The National Mental Health and Suicide Prevention Agreement

Mental health and suicide prevention funding and service delivery responsibilities are shared between the Australian and state and territory governments. The way governments work together in this space directly affects the experiences of consumers and the availability of services that suit people's needs.

Governments signed the Agreement to create 'a platform to ensure all parties work together to build a better mental health and suicide prevention system for all Australians against a range of priority areas, including prevention and early intervention, suicide prevention, treatment and support, supporting the vulnerable, workforce and governance, and quality and safety' (clause 8). The Agreement outlines commitments to enable progress towards whole-of-government reform that will 'deliver a comprehensive, coordinated, consumer focused and compassionate mental health and suicide prevention system to benefit all Australians' (clause 3).

The Agreement is the first of its kind, but it follows a series of national mental health plans in place since 1992. The Fifth National Mental Health and Suicide Prevention Plan ended in 2022. The Agreement recognises the Plan's reform directions, emphasising coordinated effort to address system gaps, and adds co-funding commitments agreed between governments (box 1.1). Signing a national agreement was a recommendation of the PC's Mental Health inquiry in 2020.

Box 1.1 – What is the role of a national agreement?

National agreements are an instrument used to support national coordination of policy areas that are primarily state responsibilities (like health) and to govern funding transfers for the delivery of services in these areas. The role of national agreements is established through the Intergovernmental Agreement on Federal Financial Relations (the IGA FFR) (CFFR 2022).

The IGA FFR recognises that the states and territories have primary responsibility for many areas of service delivery, but coordinated national action is necessary to address Australia's economic and social challenges. It outlines how national agreements should perform this role, including stating that agreements should reduce the extent to which the Australian Government prescribes the way services are delivered by state and territory governments, clarify roles and responsibilities of the parties and enhance accountability to the public (clause 9).

In signing the Agreement, governments jointly agreed to five objectives, five outcomes, 13 outputs, 14 policy principles and a plethora of commitments for national and jurisdictional actions (figure 1.1). However, unlike other national agreements, the National Mental Health and Suicide Prevention Agreement contains only limited funding commitments. In an average year, funding commitments in the Agreement total about $360 million, or 3% of the $12.6 billion governments spend on mental health and suicide prevention in 2022-23 (SCRGSP 2025 tables 13A.1-13A.3).

Of the total annual expenditure on mental health services of $12.6 billion, state and territory governments contributed $8 billion, and the Australian Government contributed $4.6 billion. The bulk of Australian Government expenditure is through the Medicare Benefits Schedule (including rebates for services from general practitioners, psychiatrists and psychologists) and the Pharmaceutical Benefits Scheme. A large part

of state and territory expenditure is for hospital services in the National Health Reform Agreement. (SCRGSP 2025 tables 13A.1-13A.3).

Figure 1.1 – Components of the National Mental Health and Suicide Prevention Agreement

Objectives	Outcomes	Outputs
• To work collaboratively to implement systemic, whole-of-government reforms that improve mental health outcomes for all people living in Australia, progress the goal of zero lives lost to suicide, and deliver a mental health and suicide prevention system that is comprehensive, coordinated, consumer-focused and compassionate to benefit all Australians • To work together in partnership to ensure that all people living in Australia have equitable access to the appropriate level of mental health and suicide prevention care they need, and are able to access this care when and where they need it • As a priority, to work together to address areas to: – reduce system fragmentation – address gaps in the system – prioritise further investment in prevention, early intervention and effective management of severe and enduring mental health conditions	• Improve the mental health and wellbeing of the Australian population, with a focus on priority populations • Reduce suicide, suicidal distress and self-harm through a whole-of-government approach • Provide a balanced and integrated mental health and suicide prevention system • Improve physical health and life expectancy for people living with mental health conditions and for those experiencing suicidal distress • Improve quality, safety and capacity in the Australian mental health and suicide prevention system	• The analysis of psychosocial support services outside of the National Disability Insurance Scheme (NDIS) • Commonwealth-State implementation plans and annual Jurisdiction Progress reports • An annual National Progress Report • Improvements to data collection, sharing and linkage • The development of a National Evaluation Framework • Shared evaluation findings • Consideration and implementation of relevant actions of the National Stigma and Discrimination Reduction Strategy • The establishment of the National Suicide Prevention Office • The development of national guidelines on regional commissioning and planning • The development of the National Mental Health Workforce Strategy and identification of priority areas for action • Report on progress toward increasing the number of mental health professionals per 100,000 population • A submission to the mid-point National Health Reform Agreement review • A final review of this Agreement provided to all Parties

Source: Adapted from the National Mental Health and Suicide Prevention Agreement.

Throughout the Agreement, governments emphasised the need to incorporate the voices of people of lived and living experience in all aspects of the system – although different clauses use different terms to describe their involvement. For example, clause 47 seeks to ensure '[t]he voices of people with lived experience are embedded in the planning, design and evaluation of services', while clause 55 states governments 'will seek advice and provide opportunities for people with lived experience of mental health and/or suicide, other experts including representatives for … priority populations … and community groups to influence matters of service design, planning, implementation, evaluation, data and governance'.

Aboriginal and Torres Strait Islander people are one of the 15 priority populations identified in the Agreement. Governments committed to align the implementation of the Agreement with the National Agreement on Closing the Gap and other key commitments, such as the Gayaa Dhuwi (Proud Spirit) Declaration, aiming to improve the social and emotional wellbeing of Aboriginal and Torres Strait Islander people. However, there are no specific measures in the Agreement that relate to improving services for Aboriginal and Torres Strait Islander people. These issues are discussed in detail in chapter 5.

The Agreement articulates a commitment to whole-of-government collaboration

The Agreement recognises the role of services within and beyond the health system in delivering mental health and suicide prevention outcomes (clause 20m). This whole-of-government approach attempts to address the social determinants of mental health and wellbeing, rather than being narrowly focused on mental health and suicide prevention services. Schedule A identifies the priority areas for whole-of-government collaboration and assigns responsibilities to portfolios outside of mental health and suicide prevention. For example, health ministers are to work with education ministers on prevention and early intervention, considering approaches to improve school-aged children's social and emotional wellbeing under the National School Reform Agreement[3] (Schedule A, clause 2). The schedule also contains commitments to the integration and strengthening of referral pathways between mental health and suicide prevention supports and services such as homelessness, financial counselling and family, and domestic and sexual violence services.

Bilateral schedules contain funding commitments for specific initiatives

The Agreement itself is a high-level document providing broad policy direction for the mental health and suicide prevention system. Specific initiatives and funding commitments are contained in bilateral schedules signed by the Australian Government with each state and territory. Bilateral schedules allow governments to incorporate a flexible approach to meeting the objectives of the Agreement and recognise the distinct circumstances of each jurisdiction.

However, there is significant similarity between the commitments in the bilateral schedules (table 1.1). The 11 common initiatives included in the bilateral schedules are largely based on initiatives the Australian Government introduced prior to the Agreement's negotiations (such as the adult mental health centres and headspace). In some cases, jurisdictions adapted the implementation of initiatives to pre-existing reforms or strategies.

The bilateral schedules outline funding commitments over the five years of the Agreement (table 1.2). The Australian Government contributes the bulk of its funding through primary health networks (PHNs), which

[3] The Better and Fairer Schools Agreement replaced the National School Reform Agreement in January 2025.

commission services in line with the commitments in the bilateral schedules. The states and territories commit funding through the bilateral schedules to co-fund many of these initiatives. The bilateral schedules reflect differences in states' contributions (including in-kind contributions) and circumstances; in Victoria's case, for example, the investment undertaken by the state government to implement the recommendations of the Royal Commission into Victoria's Mental Health system is reflected in its higher financial contributions to the bilateral schedule.

Table 1.1 – Initiatives for collaboration under the bilateral schedules reflect similar content[a,b]

	NSW	VIC	QLD	WA	SA	TAS	ACT	NT
Adult Head to Health Centres[c]	✓✓	✓	✓✓	×	✓✓	✓✓	✓✓	✓✓
Head to Health Kids Hubs	✓✓	✓✓	✓✓	✓✓	✓✓	✓✓	✓✓	✓✓
Investment in headspace centres	✓✓	✓	✓✓	✓	✓✓	✓✓	✓✓	✓✓
Universal Aftercare Services	✓✓	✓	✓✓	✓✓	✓	✓	✓✓	✓
Distress Intervention Trial Program	✓✓	✓	✓✓	×	✓✓	×	×	×
Postvention Support	✓✓	✓✓	✓✓	×	✓✓	×	×	✓✓
Perinatal Mental Health Screening	✓✓	✓✓	✓✓	✓✓	✓✓	✓✓	✓✓	✓✓
National Phone/Digital Intake Service	✓	✓✓	✓	×	✓✓	✓✓	✓	✓✓
Initial Assessment and Referral	✓	✓✓	✓	✓	✓✓	✓✓	✓✓	✓✓
Workforce	✓✓	✓	✓✓	✓	✓✓	✓✓	✓	✓✓
Regional Planning and Commissioning	✓	✓✓	✓✓	✓	✓✓	✓✓	✓✓	✓✓
Eating Disorder Services	×	×	×	✓✓	×	✓✓	✓✓	×
Aftercare referral pathways trial	×	✓✓	×	×	×	×	×	×
Aboriginal Mental Health and Wellbeing Centre	×	×	×	×	✓✓	×	×	×
Preventing and reducing suicidal behaviour	×	×	×	×	✓✓	×	×	×
Veterans' Mental Health	×	×	×	×	✓✓	×	×	×

a. ✓✓ indicates a commitment to the initiative; ✓ indicates an altered or partial model for the initiative; × indicates no commitment. **b.** Some of the initiatives have a different title under the bilateral schedule – the name of the program itself has been used above. For example, investment in headspace centres is delivered under Enhancement and Expansion of Youth Mental Health Services. **c.** Adult Head to Health Centres have been renamed Medicare Mental Health Centres.

Source: Adapted from all bilateral schedules.

Table 1.2 – Funding provided under the bilateral schedules, April 2022 to June 2026[a]

	Australian Government contribution ($mil)	State/territory government contribution ($mil)	Total funding ($mil)
New South Wales	216.0	167.2	383.2
Victoria	247.9	564.7	812.6
Queensland	150.9	109.5	260.4
Western Australia	35.1	26.5	61.5
South Australia	92.1	61.8	153.9
Tasmania	45.6	9.4	55.0
Australian Capital Territory	25.2	12.9	38.1
Northern Territory	30.6	13.3	43.9
All	**843.3**	**965.2**	**1,808.5**

a. Figures may not add up to totals due to rounding.

Source: Adapted from all bilateral schedules.

Governance and reporting requirements

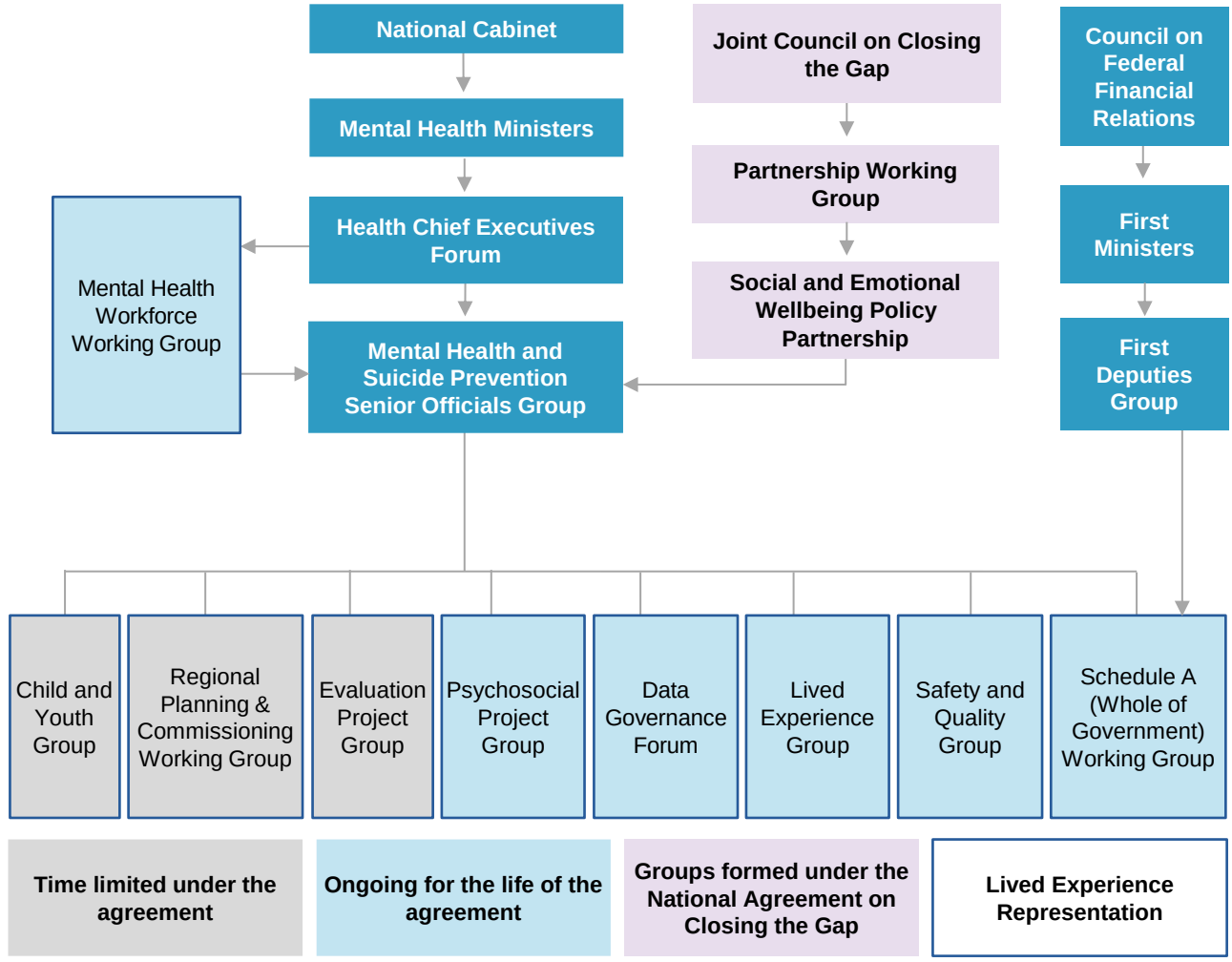
Reflecting the whole-of-government commitment, the Agreement was signed by treasurers, whereas prior national mental health plans were endorsed by health ministers. However, the Council on Federal Financial Relations, which brings together the Australian, state and territory treasurers, does not play a role in the governance of the Agreement beyond its role to oversee the Intergovernmental Agreement on Federal Financial Relations (box 1.1). Governance of the Agreement is handled primarily by departments of health, with other government agencies involved in a working group dedicated to Schedule A.

Health ministers and relevant mental health ministers from all jurisdictions have collective responsibility for the Agreement through the Health Ministers Meeting (HMM). National Cabinet (comprising the Prime Minister and state and territory First Ministers) has oversight of the Agreement (figure 1.2). Implementation of the Agreement is overseen by the Mental Health and Suicide Prevention Senior Officials Group (MHSPSO), which includes senior officials nominated from each jurisdiction who have responsibility for mental health and suicide prevention policy, alongside representatives of consumers and carers. MHSPSO is responsible for reporting on key risks and implementation issues and on new and emerging risks and lessons (clause 52).

MHSPSO is intended to operate in tandem with the Social and Emotional Wellbeing Policy Partnership established under the National Agreement on Closing the Gap. The Agreement does not specify how this should occur (chapter 5).

Six ongoing and three time-limited working groups have been established under MHSPSO to advance specific aspects of the Agreement (figure 1.2). Members of the Schedule A working group represent a wide range of departments, led by the Department of the Prime Minister and Cabinet for the Australian Government and departments of premier and cabinet for the states and territories (with the exception of Queensland, which is represented by its Mental Health Commissioner). This group is responsible for developing a work plan to guide whole-of-government implementation and for providing progress updates to MHSPSO every six months (Schedule A, clause 13b). Each bilateral schedule also includes a section on governance arrangements and the relevant committees that would oversee implementation.

Figure 1.2 – The governance structure of the Agreement includes many working groups



Source: Adapted from NMHC (2024a, p. 9).

Monitoring of progress under the Agreement occurs through an annual progress report developed by each jurisdiction. The National Mental Health Commission (NMHC) was tasked with consolidating these into an annual national progress report. Only one such report was published since the Agreement was signed.

Beyond the implementation of specific commitments, governments also agreed to 'monitor and evaluate the mental health and suicide prevention system' (clause 83a). The Agreement recognises this requires additional data collections as well as greater efforts to share and link data. The Agreement contains significant commitments to improve data collection, sharing and linkages, including a list of priority indicators that need to be developed to assess progress against the Agreement's outcomes (chapter 2).

The Agreement is one part of the policy environment

The National Mental Health and Suicide Prevention Agreement overlaps with many other key documents developed by the Australian, state and territory governments, including other national agreements.

The most significant is the National Health Reform Agreement (NHRA). Under the NHRA, governments work together towards 'improving health outcomes for Australians, by providing better coordinated and joined up

care in the community, and ensuring the future sustainability of Australia's health system' (DoHAC 2024a). It is the key mechanism for the financing and governance of Australia's public hospital system.

The NHRA establishes roles and responsibilities that apply to mental health and suicide prevention. It also includes funding for services delivered through emergency departments, hospitals and community health settings, all of which provide support to people with lived and living experience of mental ill health and suicide.

The mid-term review of the NHRA criticised the operation of the NHRA in isolation from other agreements, including the National Agreement on Mental Health and Suicide Prevention (Huxtable 2023, p. 25). It noted the need for the objectives of the National Agreement on Mental Health and Suicide Prevention to be reflected in the NHRA's next iteration with 'actions, accountabilities and milestones agreed' (Huxtable 2023, p. 1) and through the use of NHRA mechanisms, 'including models of care, financing, innovation and performance monitoring to progress … actions in … mental health' (Huxtable 2023, p. 5).

The Agreement also interacts with the National Disability Insurance Scheme (NDIS), which provides funding to eligible people with disability to access services and supports. Some mental health supports are included within the scope of the NDIS, and the transition to the NDIS has had a significant effect on the delivery of community-based mental health services (PC 2020a). The 2023 Review of the NDIS noted the need for expanded psychosocial supports outside of the NDIS to be managed and delivered under the Agreement, improved interface between the NDIS and mental health system, and better management of the interdependencies of the NDIS and the mental health system (PM&C 2023).

Many other policy documents, developed by the Australian Government, sit alongside the Agreement (table 1.3 lists examples). States and territories have also developed mental health and suicide prevention strategies, frameworks, plans and policies, which affect the operation of the bilateral schedules.

Table 1.3 – Key mental health policy documents developed by the Australian Government

National Mental Health Policy (Australian Health Ministers Conference 2009)	Provides a strategic framework to guide coordinated efforts in mental health reform across all levels and areas of government
Mental health statement of rights and responsibilities (Standing Council on Health 2012)	Clarifies the rights and responsibilities of consumers, carers, support persons, service providers and the community, consistent with international obligations and state and territory human rights instruments
Equally Well Consensus Statement (NMHC 2016)	Statement of commitment, agreed by the Australian, state and territory governments, to improve the quality of life of people living with mental ill health, with the aim of bridging the life expectancy gap between people living with mental ill health and the general population
National Strategic Framework for Aboriginal and Torres Strait Islander peoples' Mental Health and Social and Emotional Wellbeing (PM&C 2017)	Aims to provide a comprehensive and culturally appropriate stepped care model that is equally applicable to Aboriginal and Torres Strait Islander-specific and mainstream health services. The National Indigenous Australians Agency is currently overseeing development of a new National Strategic Framework
National Mental Health and Wellbeing Pandemic Response Plan (NMHC 2020)	Identifies the specific challenges to mental health and wellbeing associated with the COVID-19 pandemic and outlines measures to address them
National Children's Mental Health and Wellbeing Strategy (NMHC 2021a)	Long-term vision for supporting the mental health and wellbeing of all children and improving outcomes

National Suicide Prevention Strategy (NSPO 2024b)	A comprehensive long-term strategy that aims to coordinate the efforts of governments, communities and service providers to improve suicide prevention outcomes
National Aboriginal and Torres Strait Islander Suicide Prevention Strategy (DoHAC 2024e)	Aims to achieve a significant and sustained reduction in suicide and self-harm of Aboriginal and Torres Strait Islander people towards zero through Aboriginal and Torres Strait Islander community leadership and governance

1.2 How the PC is assessing the Agreement

In January 2025, the Australian Government asked the PC to conduct the final review of the Agreement. The terms of reference ask the PC to holistically consider, assess and make recommendations on the effectiveness and operation of the Agreement. The PC has been asked to:

- consider the wellbeing and productivity impacts of the mental health and suicide prevention programs and services delivered under the Agreement.
- assess the effectiveness of the administration of the Agreement, including reporting and governance.
- ensure the voices of Aboriginal and Torres Strait Islander people and those with lived and living experiences are heard.

In conducting this review, the PC has sought to centre the insights and experiences of people with lived and living experience of mental ill health and suicide, their supporters, families, carers and kin as well as service providers, peer workers and practitioners. These experiences provide a critical reflection on what the Agreement has achieved and how it can be improved. A detailed summary of the consultation undertaken is included the *What we've heard so far* paper.

In line with the frameworks developed by the Australian Centre for Evaluation and the approach taken by the PC in previous reviews of national agreements, this report uses theory of change and program logic principles to assess the current Agreement and develop recommendations for the future (PC 2022c, 2024b; Treasury 2025b). A theory of change seeks to 'capture all of the essential elements necessary to understand how a program or activity will achieve the intended outcomes' (Treasury 2025b). A program logic sets out the pathways through which the inputs and activities of the policy are expected to lead to its outputs and intended outcomes (figure 1.3). A key question for this interim report is whether these pathways have been articulated clearly in the structure of the current Agreement (chapter 3).

Some of the benefits of using a theory of change include:

- ensuring policy works towards advancing long-term outcomes, and all stakeholders hold similar views about the problem the policy is seeking to address and what success looks like (Goldsworthy 2021)
- creating a policy that is evidence-based and increasing the likelihood of success (Ecorys 2023, p. 15). A program that is evidence-based is more likely to succeed as there has been proven efficacy for the links in the components. This process also highlights where there is a need for more evidence
- increasing transparency and accountability. Explicitly mapping how inputs and activities contribute to outcomes provides transparency and holds those designing and implementing the policy to account
- reducing the risk of waste. Articulating how activities and actions contribute to the intended policy outcomes and objectives reduces the risk of resources being used on activities that do not contribute to the outcomes of the policy

- facilitating evaluation and improving the evidence base (BetterEvaluation 2025). By setting out the outcomes and outputs of a policy, data can be collected on those measures and used in an evaluation of the policy. This evaluation also adds to the evidence base.

Figure 1.3 – Linking objectives and outputs in policy development

Rationale or objective: Sets out the problem that the intervention is trying to address					
Inputs	**Activities**	**Outputs and targets**	**Short-term outcomes**	**Medium-term outcomes**	**Long-term outcomes**
What we invest (funding, people, time, infrastructure)	What we do (to implement the program or activity)	What the program team does What are the targets? How will this deliver short-term outcomes?	The difference we make in the short term How will this deliver medium-term outcomes?	The difference we make in the medium term How will this deliver long-term outcomes?	The difference we make in the long term
Assumptions: Assumptions made as part of the theory of change – for example, beliefs about how or why the program will work, and who the stakeholders and participants are			**External factors:** areas of influence external to the entity that affect outcomes – for example, economic, geographic, cultural, competition and technology factors		

Source: Adapted from the Commonwealth Evaluation Toolkit (Treasury 2025a).

1.3 Next steps for the review

In undertaking this review, the PC has considered progress against the Agreement (chapter 2), the effectiveness of the Agreement (chapter 3) and necessary changes and areas of focus for the future (chapter 4). We have also examined the unique aspects affecting the way the Agreement can support the social and emotional wellbeing of Aboriginal and Torres Strait Islander people (chapter 5) and improve suicide prevention services (chapter 6).

This is an interim report, and the PC welcomes further input from the community as it develops the final report. The PC is requesting submissions by 31 July 2025 and will hold public hearings in August. Further information can be found on our website. The final report will be submitted to government on 17 October 2025.

2. What has the Agreement achieved?

Key points

- **The National Mental Health and Suicide Prevention Agreement set out to achieve an ambitious reform agenda. Assessing progress against this agenda is a complex task.**
  - There is limited publicly available information about actions taken by governments as part of the Agreement.
  - There are still significant data gaps, including a lack of current data on the outcomes achieved under the Agreement.
  - In the three years since the Agreement was signed, significant external factors have also influenced outcomes and services. These effects are difficult to disentangle.
- **While there has been progress in achieving elements of the Agreement, these actions have not led to meaningful improvements across the system for people with lived and living experience of mental ill health and suicide.**
  - Eight of the Agreement's 13 outputs have been delivered. However, some outputs, such as the analysis of gaps in psychosocial supports and the National Mental Health Workforce Strategy, lack sufficient depth and structure to enable progress.
  - There is insufficient information to assess the progress of all the initiatives included in the bilateral schedules signed by the Australian Government with each state and territory.
- **Key outputs of the Agreement have not been delivered or need further work. Government action is urgently needed to:**
  - **release the National Stigma and Discrimination Reduction Strategy by the end of 2025 to prevent any further delays to action**
  - **release the National Guidelines on Regional Commissioning and Planning by the end of 2025 to improve commissioning and planning at the regional level**
  - **finalise arrangements for the provision of psychosocial supports outside the National Disability Insurance Scheme.**
- **Achieving a person-centred system that empowers people to choose services that meet their clinical and non-clinical needs is the main objective of the Agreement. This will take time to realise, but change to date has been minimal and the system remains fragmented.**
  - There is still a high level of need for mental health and suicide prevention services in Australia, with little improvement experienced over the past decade. The balance of evidence suggests the mental health and suicide prevention system is not meeting people's needs.

The National Mental Health and Suicide Prevention Agreement represents a commitment from governments to undertake actions to improve the mental health and wellbeing of Australians and reduce the rates of suicide, suicidal distress and self-harm. This chapter assesses the progress achieved under the Agreement.

Understanding the mental health and suicide prevention system within which the Agreement operates is important for our assessment of whether the system is meeting people's needs (section 2.1). Assessing progress against the Agreement is not straightforward, due to a lack of relevant data as well as a range of external factors that influence outcomes (sections 2.2). This chapter assesses progress across two parts of the Agreement:

- specific outputs listed in the main Agreement and bilateral schedules (sections 2.3 and 2.4)
- and governments' intent to work together to deliver a coordinated, person-centred mental health and suicide prevention system, which is the core purpose of the Agreement (section 2.5).

This review can only examine what progress has been made by governments to date in realising the commitments in the Agreement. The Agreement does not expire until 30 June 2026 and therefore further progress may be made within the final year.

2.1 What do we know about the state of the mental health and suicide prevention system?

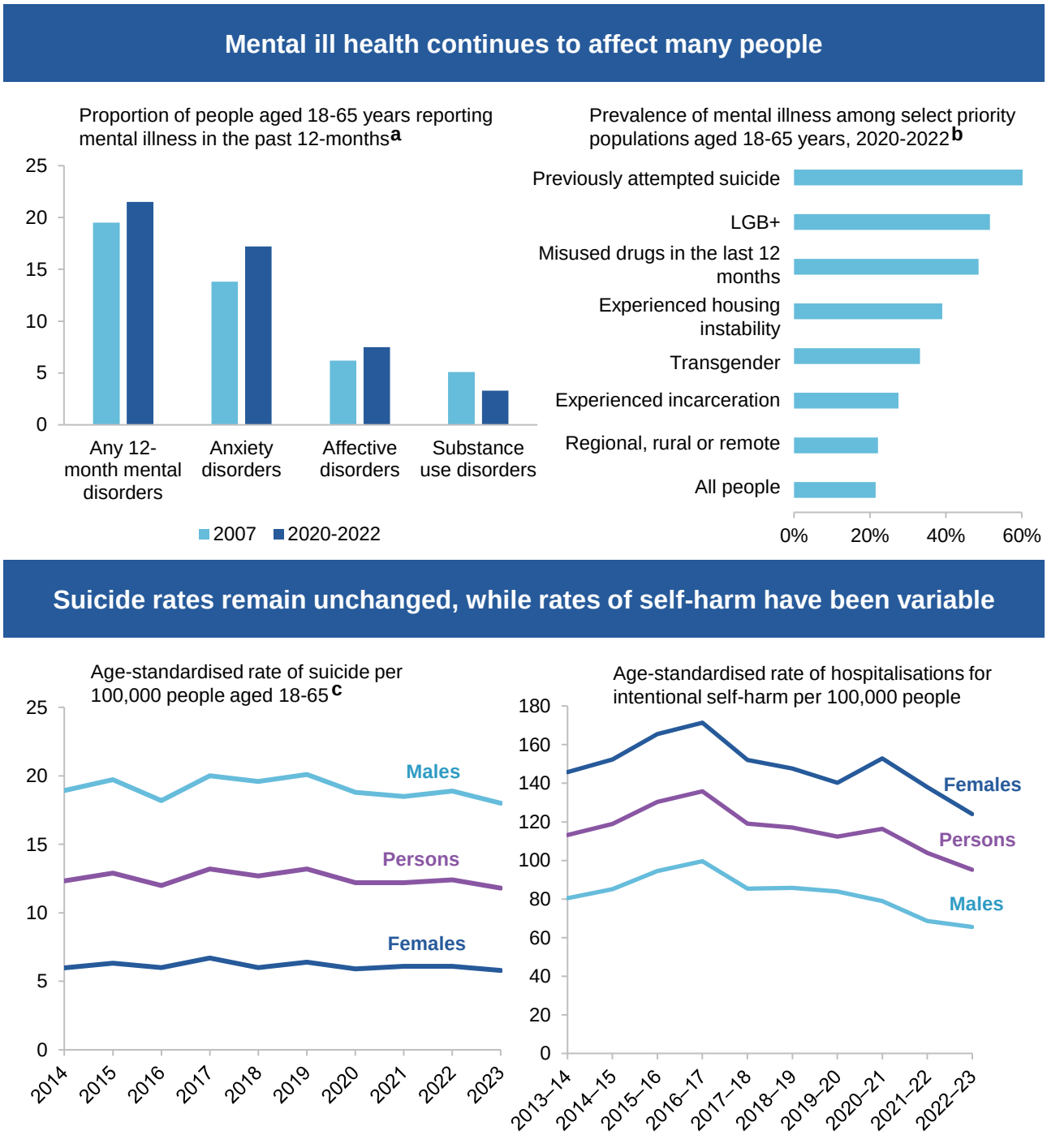
There is no data available to describe trends in the mental health and suicide prevention system over the term of the Agreement. Most of the data was last collected in 2022 – the year the Agreement was signed. However, this data provides a useful baseline to understand the outcomes of the mental health and suicide prevention system in which the Agreement operates. This will build an understanding of where things are working, where they are not and where more information is needed. The data presented below pertains to the entire population; changes in outcomes for Aboriginal and Torres Strait Islander people are examined in chapter 5.

Understanding the demand for mental health and suicide prevention services

Almost half of all Australian adults will experience mental ill health at some stage of their life. The effects of mental ill health are felt not only by the individual but by their supporters, family, carers and kin and Australia as a whole (DoHAC 2024b). Most Australians will also be affected by suicide, suicide attempts or suicidal distress at some point in their lives (NSPO 2025, p. 11). The effects of suicide are devastating to not only friends and family but the wider community (NSPO 2025, p. 11).

The prevalence of mental ill health has increased slightly between 2007 and 2020–2022 (figure 2.1). Anxiety disorders have also increased in prevalence and remain the most reported type of disorder (figure 2.1). The effect of mental ill health is not felt uniformly across the population, with many of the priority populations designated in the Agreement reporting a higher prevalence than the general population (figure 2.1).

Figure 2.1 – High level of need for mental health and suicide prevention services



a. People could report more than one disorder and therefore the sum of the three disorders is greater than the proportion of people who reported a mental disorder in the past 12 months. **b.** Questions on gender orientation were asked separately to questions on sexual orientation in the ABS' survey, and so mental health prevalence has been reported separately for LGB+ and Transgender people to avoid double counting. LGB+ includes Lesbian, Gay, Bisexual and different terms. The ABS notes that different terms that people may use to describe their sexual orientation include Asexual, Pansexual and Queer. **c.** Deaths are counted according to year the death was registered by the Registries of Births, Deaths and Marriages, not necessarily the year in which the death occurred.

Source: ABS (2008, 2023); AIHW (2025e, table Deaths due to suicide 2023-National Mortality Database, 2025f, table Hospitalisations for intentional self-harm 2022–23 – National Hospital Morbidity Database).

There has been minimal progress in reducing suicide rates, which have remained unchanged over the past decade (figure 2.1). In 2023, there had been a reported 3,214 deaths by suicide, or 11.8 deaths per 100,000 population[4] (AIHW 2023a). Review participants indicated some concerning trends in rising suicide rates in priority population groups, in particular Aboriginal and Torres Strait Islander people (Carers WA, sub. 43, p. 10; Lifeline Australia, sub. 8, p. 3). This is supported by data published under the National Agreement on Closing the Gap (PC 2025a).

Hospitalisations for intentional self-harm have declined from their peak in 2016-17 (figure 2.1). Women and young people were much more likely than the rest of the population to be hospitalised for self-harm.[5]

More recent qualitative information suggests there are rising levels of distress in Australia. Lifeline Australia (sub. 8, p. 3) recorded the busiest year in their history in 2024, receiving 1.36 million contacts across their phone, text and chat services. Surveys run by service providers and advocacy groups can provide insights into trends. For example, the March 2025 Community Tracker survey by Suicide Prevention Australia (sub. 59, p. 7) found:

> … 73% of Australians say they're feeling more distress than this time last year due to a range of causes including cost-of-living, social isolation and loneliness, housing affordability and relationship breakdown. In addition, nearly one in five (19%) young Australians (18-34) have experienced suicidal distress in the last 12 months, including having serious thoughts of suicide, making a suicide plan, or attempting to take their life.

The mental health and suicide prevention system is not meeting community need

Both quantitative and qualitative data demonstrates the system is not meeting people's needs in many cases. In 2023-24, some people delayed or did not see a health professional for mental health concerns when they needed to (figure 2.2). One in five people said cost was the reason for delaying or not seeing a health professional (ABS 2024c).

Waiting times and costs came through as a key theme from the PC's online survey, with people feeling it put their mental health and wellbeing at risk (*What we've heard so far* paper). Survey participants highlighted the personal impact of long wait times on their mental health.

> I won't go to a hospital again. You are left there in the waiting room waiting and waiting. (sr. 48)

> i was diagnosed by the psychiatrist, which i had to wait a year to get an appointment. was then phoned to say to that i had to go back on the waiting list which doesnt get reviewed until july before i had even been given my treatment plan. leaving me still unmedicated and supported indefinitely. (sr. 175)

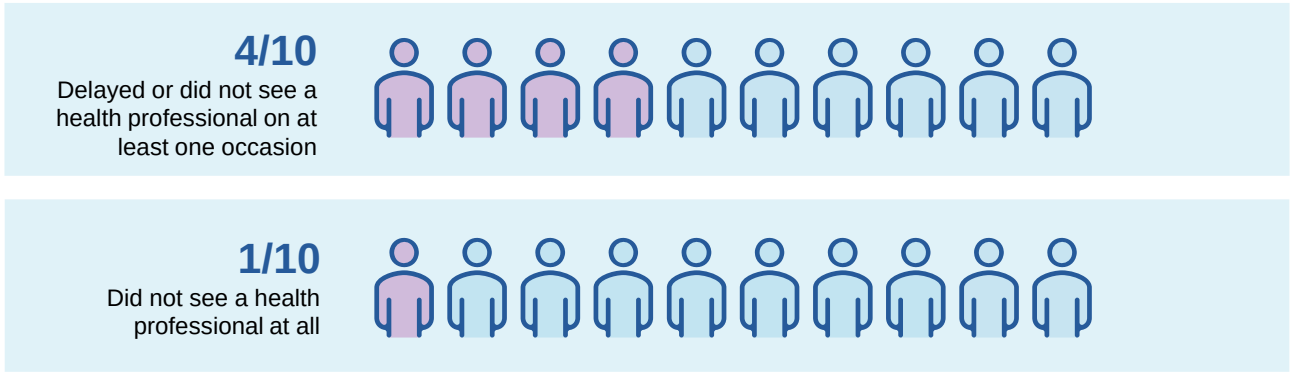
Survey respondents also reflected on positive experiences in the mental health and suicide prevention system, where they experienced compassionate, holistic care (*What we've heard so far* paper). Data available on consumer experiences shows there has been an increase in the proportion of consumers who experience significant improvement following an episode of mental health care (figure 2.3).

[4] This is the age-standardised rate, which is an incidence rate that enables comparisons to be made between populations that have different age structures.

[5] The rate of hospitalisations was highest for young people, especially young women aged 15-19 years with 499 hospitalisations per 100,000 population (AIHW 2025f). The rate for all females was 124 hospitalisations per 100,000 population compared to all men with the rate of 66 hospitalisations per 100,000 population (AIHW 2025e).

Figure 2.2 – People are postponing or not seeking professional help when needed

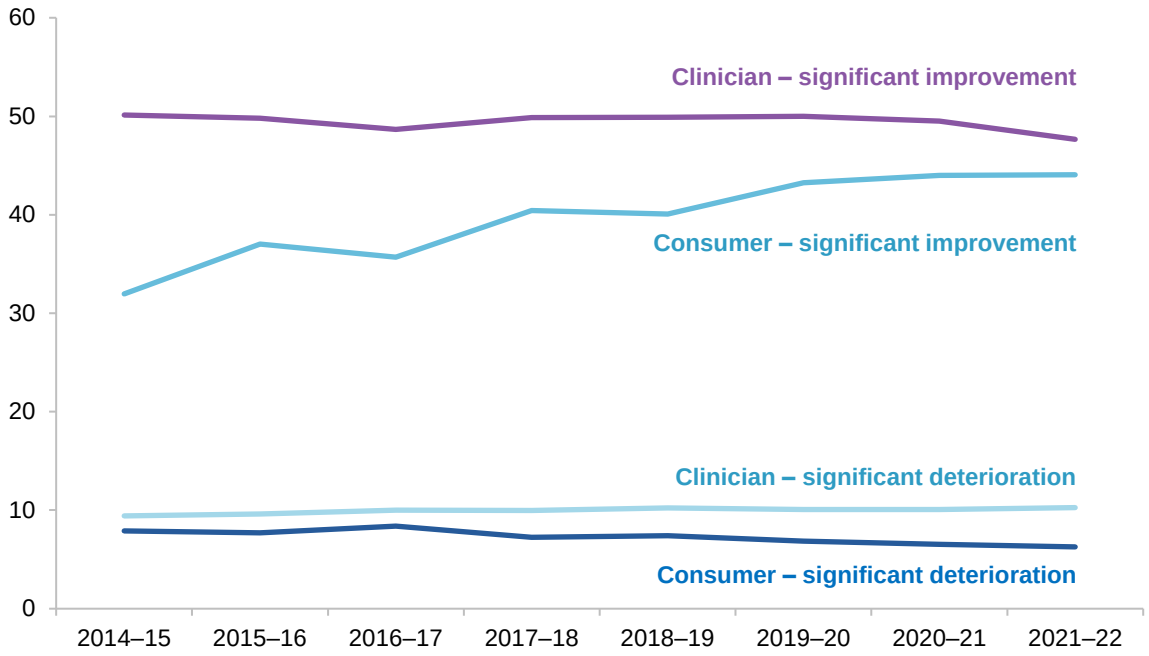
People aged 15 years and over, who needed to see a professional for their mental health, 2023-24



Source: ABS (2024c).

Figure 2.3 – Outcomes for episodes of mental health care over time[a]

Proportion of episodes assessed as leading to a significant change in outcomes



a. In the National Outcomes Casemix Collection, data is collected on consumer and clinicians' evaluations of episodes of mental health care, where an episode can either be rated as leading to a significant improvement, no significant change, or a significant deterioration. This includes both patients who experienced inpatient and ambulatory mental health care. The data presented is for consumers aged 18-64 years.

Source: AIHW (2023).

2.2 Assessing progress is not straightforward

Monitoring and reporting commitments under the Agreement have not been fully adhered to

Monitoring and reporting provide a way to measure governments' progress against their commitments and objectives in the Agreement. It can help the jurisdictions assess whether policies and programs are effective and what changes need to occur. It can also help the community to assess governments' actions and hold them to account.

Not all jurisdictions have met the reporting requirements of the Agreement within the prescribed deadline (figure 2.4). The National Mental Health Commission (NMHC) and National Suicide Prevention Office (NSPO) (sub. 70, p. 11) state:

> Both the 2022–2023 and the 2023–2024 National Progress Reports were not published by the timelines specified in the National Agreement due to substantial delays in the Parties providing the required information to the Commission. For the 2023-2024 report some inputs from Parties are still outstanding (as of 18 March 2025). There are currently no provisions available under the National Agreement to require Parties to provide their data in the stated timeframes and limited repercussions if the reporting requirements are not adhered to.

Figure 2.4 – Unfulfilled reporting requirements

Committed reporting requirements

Annual cycle

Implementation plans	Jurisdictional progress report	National progress
Commonwealth-state Implementation plans (within 12 months, then updated annually)	Annual jurisdiction progress reports (first due 31 August 2023)	National progress report (first due 30 November 2023 and made public within three months of completion)

Reporting delivered

Implementation plans	Jurisdictional progress report	National progress
Completed 3 of the 8 plans were delivered after the first 12 months	**2022–2023 progress** Substantial delays	**2022–2023 progress** A summary report was publicly released in December 2024
	2023–2024 progress Substantial delays	**2023–2024 progress** No report has been made public

Source: PC analysis, clauses 75, 76, 78 and 79, NMHC (2024a), NMHC and NSPO, (sub. 70, pp. 10–11).

All 2023-24 jurisdictional progress reports were received by May 2025, and the NMHC is expecting to complete and provide the 2023-24 national progress report to Mental Health and Suicide Prevention Senior Officials Group (MHSPSO) by July 2025 (NMHC, pers. comm., 4 June 2025).

The NMHC and NSPO (sub. 70, pp. 11–12) critiqued the reporting requirements, stating they focused on progress against commitments rather than the effectiveness of the initiatives being implemented. headspace (sub. 23, p. 6) similarly questioned whether the monitoring and reporting requirements under bilateral schedules can capture meaningful data, as the data collected is high level and does not offer sufficient insights into consumer outcomes.

In the Agreement, governments committed to continue building data and systems to improve evaluation, transparency, reporting and accountability (clause 82c) and improving the transparency of mental health and suicide prevention services spending and outcomes delivered (clause 138c). However, their actions do not reflect this intent as neither the implementation plans nor annual jurisdiction progress reports are publicly available. Furthermore, only a summary of the National Progress Report is publicly available and it was significantly delayed (figure 2.4).

The delay in reporting and lack of public reporting has made it difficult to assess what progress has been made against the Agreement's commitments. Many submissions also noted that due to a lack of reporting, it was difficult or infeasible to assess the impact of the Agreement on outcomes in mental health and suicide prevention (Community Mental Health Australia, sub. 84, p. 6; Consumer Health Forum of Australia, sub. 22, pp. 5–6; Mental Health Australia, sub. 76, p. 16; Queensland Nurses and Midwives' Union, sub. 16, p. 5).

Despite some progress, key data gaps remain

In the Agreement, governments stated that comprehensive, accurate and accessible information is critical to reform in the mental health and suicide prevention space (clause 80). The Agreement emphasises the need to improve data collection and sharing, to improve data linkage, reporting and transparency, and to better use data to build an evidence base for system improvement (clauses 80–103). Governments agreed they would use the 2020 National Mental Health Performance Framework to monitor and evaluate this system, and they committed to establishing a data governance forum to coordinate the data reforms (clauses 83a, 84).

The Data Governance Forum (DGF) was established by June 2023, and is responsible for overseeing and facilitating the commitments to data and performance measurements within the Agreement (NMHC 2024a, p. 17). There is minimal public reporting on the progress in meeting these commitments. However, the PC understands there has been substantial progress in data sharing and linkage (DGF, pers. comm., 20 May 2025).

The Agreement helped facilitate the continuation of monthly intergovernmental data sharing meetings, a secure data sharing portal and an agreement to allow increased uses of aggregate data by governments. The AIHW has also established an integrated reporting dashboard to monitor trends in the shared data. A key output from this increased sharing was the development of detailed integrated regional profiles, for public access and use by commissioning organisations (DGF, pers. comm., 20 May 2025).

In response to linked data commitments, the DGF was able to initiate and facilitate a pilot data linkage project to connect state and territory community and residential mental health care data with broader systems data in the National Health Data Hub. Two indicators in Annex B of the Agreement (life expectancy gap and avoided hospitalisations) are expected to be reported against using this linked data (DGF, pers. comm., 20 May 2025).

Despite the vast collections of data, there are still significant knowledge gaps about Australia's mental health (Black Dog Institute, sub. 61, p. 11; NMHC 2024a, p. 18; Pagliaro et al. 2024, p. 212; Ruah Community

Services, sub. 14, p. 8). One reason for this is that the data collected is not always fully used (including through sharing and linkages) (PC 2020a, pp. 1191–1192).

Review participants provided examples of how existing data could be used better.

> Data linkage within the AIHW will be essential to understanding where the gaps in patient access are in the community, and how to better engage with populations at high risk of mental health and suicidality. (Australian Medical Association, sub. 72, p. 5)

> Enable increased data sharing at the regional and jurisdictional level, including data linkage of PHN and jurisdictional datasets, to support joint regional mental health and suicide prevention planning and commissioning. (PHN Cooperative, sub. 69, p. 9)

There are also still areas where there is insufficient data (box 2.1), which makes assessing progress under the Agreement difficult.

Box 2.1 – Gaps identified in data holdings

The development of mental health and suicide prevention data collections at a national level has primarily been based on the Leginski framework. The Leginski framework states data collection must be sufficient to answer the question: *who receives what from whom at what cost and with what effect?*

Applying the framework in 2020 for the PC's Mental Health inquiry demonstrated there is insufficient data on the following areas:

- outcomes data that measures the outcomes of service users
- mental health services provided by NGOs and MBS-rebated providers (psychologists and psychiatrists)
- data on the priority population groups
- the prevalence of mental ill health and suicidal distress and services provided in non-health sectors.

Data availability has improved since 2020. The ABS released the 2020–2022 National Study of Mental Health and Wellbeing. New indicators were developed, such as a measure of self-harm in an inpatient facility and discharge against medical advice included in the Report on Government Services.

However, submissions to this inquiry have reiterated that some major data gaps still exist.

Current data collections focus on measuring service provision rather than measuring the effectiveness of service delivery on improving outcomes (Black Dog Institute, sub. 61, p. 11; Marathon Health, sub. 10, p. 4). Specific categories of missing data include:

- mental health outcomes of priority populations (Australasian Institute of Digital Health, sub. 12, p. 5, National Rural Health Alliance, sub. 86, p. 10)
- all 'late maternal deaths' (43 to 365 days post-birth), perinatal data for expecting and new fathers and non-birthing partners, data for rural parents requiring emergency perinatal psychiatric care (Perinatal Anxiety & Depression Australia, sub. 24, p. 3)
- mental health needs of families, carers and kin supporting individuals with mental ill health or suicidality (Mental Health Carers Australia, sub. 73, p. 14)
- children's mental health and wellbeing (The Centre for Community Child Health, sub. 79, p. 14)

Box 2.1 – Gaps identified in data holdings

- the social determinants of mental health[6] (Black Dog Institute, sub. 61, p. 11)
- regional mental health workforce data (PHN Cooperative, sub. 69, p. 9).

Source: PC (2020a); Leginski et al (1989).

Annex B to the Agreement contains an ambitious set of indicators for development and there is still more work to be done. As at May 2025, one indicator is publicly available, eight indicators have been reported to the NMHC for inclusion in the Annual National Progress Report (2023-24) under the Agreement and 14 are still in development. The development for some indicators is expected to take longer than the life span of the Agreement due to the vast number of indicators, the detailed research, negotiations in determining data definitions, and the need for dedicated funding (DGF, pers. comm., 20 May 2025).

Given the limited quantitative data, qualitative information has been used throughout this report to strengthen our understanding of what the Agreement has achieved (*What we've heard so far* paper). This includes:

- 293 responses to our online survey, provided by people with lived and living experience of mental ill health and suicide, carers and service providers. This survey asked about their experiences and views of the mental health and suicide prevention system during the period of the Agreement
- 94 public submissions from organisations, including representative bodies for consumers, carers and service providers as well as individual service providers, government agencies and a small number of consumers and carers. Public submissions were published on the PC website and are listed in appendix A
- 72 meetings and site visits. The people and organisations we met with are listed in appendix A.

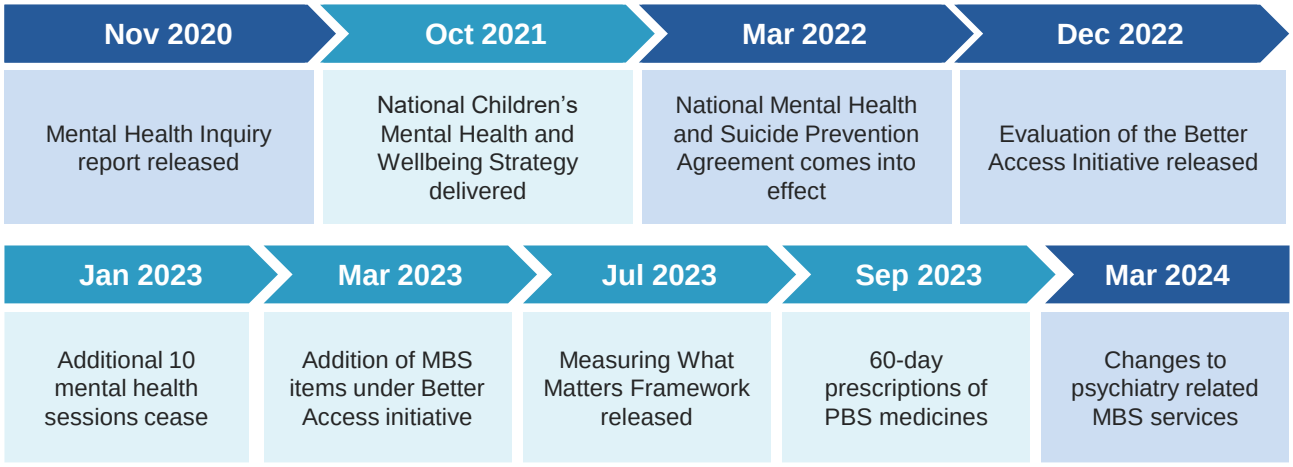
Understanding the direct impact of the Agreement is difficult

Even if data were readily available in a timely manner, significant external factors affect our ability to understand the direct impact of the Agreement. The external landscape in which the Agreement operates can have a substantial effect on the progress and impacts of the reform (NMHC 2024a, pp. 6–7).

The Agreement makes up only 3% on average of the annual government expenditure on mental health and suicide prevention, which totalled $12.6 billion in 2022-23 (SCRGSP 2025). It is only one small element of governments' efforts to improve mental health and suicide prevention outcomes (figure 2.5 and chapter 1). These other policies and areas of overlapping reform influence the mental health and suicide prevention outcomes. For example, the National Children's Mental Health and Wellbeing Strategy was delivered in 2021 and is likely to have an influence on children's mental health and wellbeing outcomes. Separating the impact of the different policies is difficult and beyond the scope of this review.

[6] Social determinants of mental health are structural conditions that can influences someone's mental health, such as income, employment, socioeconomic status, education, food security, discrimination (Kirkbride et al. 2024).

Figure 2.5 – National policy developments and system reform that influence outcomes



Source: PC adapted from AIHW (2024a).

Several significant events have also occurred during the period of the Agreement that are likely to have affected mental health and suicide prevention outcomes and make it difficult to isolate the impact of the Agreement itself. This includes the COVID-19 pandemic, which resulted in heightened psychological distress and an increase in demand for mental health services (AIHW 2021b). In response to these events, governments significantly increased the rate of expansion in mental health funding. Between 2020-21 and 2022-23, real mental health funding per capita grew by an average of 2.6% a year, compared to 1.5% a year between 2017-18 and 2019-20 (SCRGSP 2025, table 13A.1).

The issues in reporting, data gaps and external factors mean pinpointing the effects of the Agreement on mental health and suicide prevention outcomes is often not possible. The PC has used information gathered from review participants and government sources, alongside the latest available data, to ascertain what commitments have been delivered against the Agreement and their effect on progress towards the Agreement's objectives.

2.3 Some progress has been made on the Agreement's commitments

Most national outputs have been delivered

Governments have delivered most of the 13 high level outputs listed in the Agreement (table 2.1). There are two outputs with unclear progress and two that have not yet been completed (section 2.4). This review is also considered an output of the Agreement.

Table 2.1 – Governments committed to deliver national outputs[a]

Output	Delivered?
Analysis of psychosocial support services outside of the National Disability Insurance Scheme	✓
Commonwealth-state implementation plans and annual jurisdiction progress reports	✓
National Progress Report	✓
Improved data collection, data sharing and data linkage	?

Output	Delivered?
National Evaluation Framework	✓
Shared evaluation findings using the framework and associated guidelines	?
Consideration/implementation of actions of the National Stigma and Discrimination Reduction Strategy	×
National Suicide Prevention Office	✓
National guidelines on regional commissioning and planning	×
National Mental Health Workforce Strategy and identification of priority areas for action	✓
Progress reporting on increasing FTE mental health professionals to meet community need	✓
Submission to the mid-term review of the National Health Reform Agreement 2020–25	✓
Final review of the Agreement	Commissioned

a. A tick means the output has been delivered, a question mark means it is unclear if the output has been delivered and a cross means the output has not been delivered.

Source: PC analysis.

The outputs delivered have had varying results. For example, the establishment of the National Suicide Prevention Office (NSPO) has been well received by review participants (Black Dog Institute, sub. 61, p .1). The NSPO has developed a long-term whole-of-government strategy for suicide prevention and is developing frameworks required for its implementation (chapter 6).

But completion of outputs alone does not tell us if these improve outcomes. It appears as though most outputs have not had a significant effect on improving policy or planning. For example:

- the analysis of psychosocial support services outside of the NDIS was done at a very high level and does not provide guidance on the regional gaps that need to be addressed (section 2.3)
- the National Mental Health Workforce Strategy has been delivered but does not contain any funding commitments or clear accountability structures (discussed further in section 2.4)
- the National Evaluation Framework was only released in early 2025, and it is unclear how it will be used (Black Dog Institute, sub. 61, p. 1).

Limited information on progress in the bilateral schedules

Each state or territory has signed a Bilateral Schedule on Mental Health and Suicide Prevention (bilateral schedule) with the Australian Government, set to expire with the Agreement on 30 June 2026. Each bilateral schedule contains details of specific initiatives and funding commitments. Our assessment of progress in the bilateral schedules is heavily restricted by the lack of official public reporting and publicly available information on the initiatives.

The establishment of Medicare Mental Health Centres (MMHCs) is a major commitment under the bilateral schedules. The National Service Model for MMHCs states centres will provide immediate support to reduce distress through a range of services provided under one roof, providing care coordination and warm referrals to other services, and assistance with managing stressors such as financial problems, civil and legal issues, family support, accommodation instability and social isolation (DoHAC 2025b, pp. 11–13). As at May 2025, 39 centres have been established (DoHDA 2025a). An 'implementation co-evaluation'[7] of the MMHCs found the centres were helping to meet a gap in the mental health system and divert people away from hospitals

[7] An implementation co-evaluation is described as a joint evaluation between services and research organisations to encourage two way learning (The ALIVE National Centre for Mental Health Research Translation 2024, p. 1).

(Neami National, sub. 63, p. 7). Information on the centres is available on the Department of Health, Disability and Ageing website (DoHDA 2025a), rather than in any reporting on the Agreement.

As there is very little public reporting on the bilateral schedules, it is difficult to ascertain what progress has been made. Governments are not required to make their annual reports public, nor have they. Furthermore, each bilateral schedule has an associated implementation plan, which is likely to contain more detail on the planned delivery of initiatives but none of them have been made public. Review participants reported there was delayed and slow progress in developing and implementing the services agreed under the bilateral schedules (headspace, sub. 23, p. 3; Northern Territory Mental Health Coalition, sub. 54, pp. 2–3; *What we've heard so far* paper).

The National Mental Health Commission has been able to publish one summary report, which was based on the progress reports completed by the states and territories. This summary report reflects some movement on commitments under the bilateral schedules (NMHC 2024a, pp. 12–13). The report states that of the 81 bilateral initiatives reported against, one was 'complete', nine were 'well progressed', three were 'yet to commence' but still 'on track' and 65 were 'partially progressed' as at June 2023 (NMHC 2024a, p. 13). For the remaining three initiatives, the Commonwealth and the relevant state disagreed on the status of the initiative.

The summary report does not include sufficient detail to ascertain which initiatives were reported against and what progress has been made, with only aggregate information provided. The assessments of progress are done by the jurisdictions themselves, without independent verification. This limits the ability to draw conclusions on progress:

> The data provided to the Commission to inform reporting is primarily qualitative data, self-assessed by the Parties. While Parties are required to report on key performance indicators under the National Agreement, to date this data has been very limited, with Parties frequently rating KPIs as 'not applicable'. An absence of quantitative data has limited the Commission's ability to draw meaningful and objective insights on implementation progress. (NMHC and NSPO, sub. 70, p. 11)

headspace (sub. 23, p. 5) reflected on the way jurisdictions implemented the bilateral schedules, which may further obscure the contribution of the Agreement.

> … the wording of bilateral agreements has allowed jurisdictions to interpret their commitments differently, including re-badging existing work and allocated funding as discharging their bilateral commitments.

A greater level of transparency and accountability is needed to accurately measure progress against actions listed in the bilateral schedules (chapter 4).

Insufficient data to assess progress towards the Agreement's outcomes

In signing the Agreement, governments committed to achieving five system-level outcomes (table 2.2). The barriers to assessing progress (section 2.2) make it difficult to measure outcomes and understand what changes have occurred during the period of the Agreement. Since the Agreement did not match outcomes to available indicators, we have reviewed national data sets and found there were insufficient indicators that are relevant and up to date to measure progress against the outcomes. In most cases, the data is released infrequently and does not allow measurement during the period of the Agreement. Furthermore, it would not be possible to ascertain what contribution the Agreement made to the changes in outcomes compared to

other factors. The Agreement lists a set of priority data and indicators for development for each outcome but these are not available yet (Annex B).

Table 2.2 – Data reporting on the Agreement's outcomes is limited[a]

Outcome	Indicators of progress and data availability
Improve the mental health and wellbeing of the Australian population, with a focus on improving outcomes for priority populations	There is no current data to assess whether improvements have occurred during the period of the Agreement. The latest national data for adults is from 2020–2022.[b] Data on the mental health of young people was last collected in 2013–2014, but a new survey is underway.[c] There are no plans to run another survey for adults at this stage.
Reduce suicide, suicidal distress and self-harm through a whole-of-government approach to coordinated prevention, early intervention, treatment, aftercare and postvention supports	The latest data on deaths by suicide and rates of hospitalisations for intentional self-harm is from 2023,[d] and data on suicidal behaviours from 2020–2022.[b] There is limited information to assess the effect of a whole-of-government approach on suicide rates.
Provide a balanced and integrated mental health and suicide prevention system for all communities and groups	There are no indicators available for this outcome. The indicators listed for development to measure this outcome focus on regional planning and commissioning, but they are yet to be developed.
Improve physical health and life expectancy for people living with mental health conditions and for those experiencing suicidal distress	There is no current data to assess whether improvements have occurred in physical health during the period of the Agreement. The latest data is from 2022.[e] There is no measure of life expectancy for people living with mental health conditions or experiencing suicidal distress.
Improve quality, safety and capacity in the Australian mental health and suicide prevention system	There is no current data to assess whether improvements have occurred during the period of the Agreement. This outcome encompasses many facets of the system; data is either not available or not able to be used to assess progress.

a. No current data means there is no national data set that reports regularly within the period of the Agreement and would allow the tracking of an outcome. **b.** National Study of Mental Health and Wellbeing 2020–2022. **c.** Australian Child and Adolescent Survey of Mental Health and Wellbeing 2013–2014. This survey has been funded to occur again between 2024-2027 (Curtin University 2025). **d**. Suicide and Self-harm Monitoring, National Mortality Database **e.** Report on Government Services 2025.

2.4 Key commitments have not been fulfilled

The National Stigma and Discrimination Reduction Strategy has been developed – but not released

Many of the participants in the PC's survey commented on the devastating effects of stigma and discrimination (*What we've heard so far* paper).

Stigma and discrimination pose barriers to help-seeking and impact on people's ability to participate in employment, education and other social and community activities. batyr Australia (sub. 27, p. 1) identified stigma was a major barrier deterring young people from seeking support. Stigma and discrimination can also

lead to adverse outcomes in care settings and in interactions with police, justice and social services. As social and cultural phenomena, stigma and discrimination are hard to shift; they require a long-term, comprehensive and coordinated approach. As such, a national strategy is well-placed to shift the dial and has been met with support from participants.

The National Stigma and Discrimination Reduction Strategy was agreed to prior to the Agreement in 2020. In the Agreement, governments committed to the 'consideration and implementation of relevant actions' of the strategy once finalised (clause 27g).

The draft strategy was delivered to Government in June 2023 following a consultation process. The then Minister for Health and Aged Care asked the Department of Health and Aged Care to consider actions from the strategy and to share the strategy across governments to support joint action (NMHC 2024b).

The current status of the National Stigma and Discrimination Reduction Strategy and whether there has been any action taken under the strategy is unclear. Given the finalisation of the strategy was tasked to the NMHC, some delay may be explainable due to internal and structural changes during this period. However, considering the strategy seems to have been well advanced in mid-2023 – and the critical importance to tackling stigma and discrimination – it should be released by the end of 2025 to prevent any further delays to action.

National Guidelines on Regional Commissioning and Planning are needed

Effective commissioning is essential to addressing service gaps, duplication and fragmentation, and to providing integrated and coordinated care. In the Agreement, governments committed to the development of national guidelines on regional commissioning and planning (clause 27i and 133). These guidelines would help to strengthen regional planning and commissioning of mental health and suicide prevention services.

To allow additional time to develop meaningful guidance and undertake sufficient consultation MHSPSO approved a six months extension for the National Guidelines on Regional Commissioning and Planning to be delivered by December 2023 (NMHC 2024a, p. 10). The PHN Cooperative (sub. 69, p. 7) and Western Queensland PHN (sub. 45, p. 7) submissions to this review referred to a one-page National Principles for Regional Planning and Commissioning of Mental Health and Suicide Prevention Services. Both critiqued the document as shallow and lacking useful guidance. It is not clear from public information whether the National Principles are intended to fulfill the role of the National Guidelines.

The delay in releasing the National Guidelines has likely contributed to the issues observed by review participants, including:

- uncertainty at the regional level (PHN Cooperative, sub. 69, p. 7; WQPHN, sub. 45, p. 7)
- variations in commissioning practices between PHNs and LHNs, with little national or state and territory coordination (Australian Psychosocial Alliance, sub. 55, p. 10; Mental Health Australia, sub. 76, p. 27; PHN Cooperative, sub. 69, p. 7)
- variations in approaches to commissioning and joint commissioning across PHNs (Mental Health Carers Australia, sub. 73, p. 12) with some PHNs being very effective and others not.

The PHN Cooperative (sub. 69, p. 7) is calling for the guidelines to have a similar level of guidance and practical advice to that of the now outdated resources released in 2018. The previous guidance outlined the expectations of and roles of PHNs and LHNs, the process for developing a joint regional plan and how to plan for integration. It was supported by a compendium of detailed resources, data and tools to assist in regional planning (Integrated Regional Planning Working Group 2018).

Detailed National Guidelines on Regional Planning and Commissioning that meet the needs of PHNs and LHNs should be publicly released before the end of 2025.

Better utilisation of the National Mental Health Service Planning Framework (NMHSPF) would also improve regional commissioning and planning. The NMHSPF is 'an evidence based framework designed to support coordinated planning across Australia's mental health system' (AIHW 2024e). The NMHSPF appears to be used on an ad hoc basis.

Draft recommendation 2.1
Deliver key documents as a priority

By the end of 2025, the Australian Government should publicly release:

- the National Stigma and Discrimination Reduction Strategy
- detailed National Guidelines on Regional Planning and Commissioning that meet the needs of primary health networks and local hospital networks.

Psychosocial supports outside the NDIS remain in limbo

Many people experiencing mental ill health would benefit from psychosocial supports to improve their wellbeing and engage with their communities (PC 2020a). Psychosocial supports refer to 'non-clinical and recovery-oriented services, delivered in the community and tailored to individual needs, which support people experiencing mental illness to live independently and safely in the community' (Psychosocial Support Group 2023c, p. 1). They include services assisting people with mental ill health to manage daily living skills, obtain and maintain housing, access other services (such as clinical care), socialise build and maintain relationships, and engage with education and employment (HPA 2024, p. 13).

However, many people who should receive and would benefit from such service do not receive sufficient – or any – support. In 2022-23, about 230,000 people with severe mental illness and 263,100 people with moderate mental illness aged 12–64 years who required psychosocial supports were not receiving it through the NDIS or other government-funded programs (HPA 2024, p. 76). Participants in the PC's survey commented on the difficulty in finding psychosocial supports and the effect this has had on them:

> My condition is a psychosocial disorder and the lack of groups makes it very hard to find people I can connect and interact with (sr. 202)

> There are no community groups funded by local government or free/cheap programs for those with mental health issues or past suicidal ideation. Leading to isolation and less awareness of other services that might help (sr. 116)

> There are no in-person services locally for psycho-social wellbeing for people without a NDIS plan (sr. 50)

While the Australian and some state and territory governments continue to fund psychosocial supports (MIFA, sub. 88, p. 7), service provision has long been hampered by inefficient and duplicative funding arrangements. In addition, the introduction of the NDIS led to a significant shift in how psychosocial supports are funded and exacerbated the longer-term issues. Many people with a psychosocial disability who should be eligible for the NDIS have had trouble accessing support. At the same time, governments withdrew much of the funding for psychosocial supports outside of the NDIS (PC 2020a).

In 2020, the PC (2020a, pp. 826, 1134) recommended governments 'ensure all people who have psychosocial needs arising from mental illness receive adequate psychosocial support', and to achieve this:

- the shortfall in psychosocial supports outside the NDIS should be estimated at a regional and state and territory level
- state and territory governments, with support from the Australian Government, should be responsible for commissioning psychosocial supports and should increase funding to address the shortfall
- the proposed national agreement should clarify psychosocial support responsibilities.

In the Agreement, governments note they recognise the importance of psychosocial supports and commit to working together to 'develop and agree future psychosocial support arrangements (including roles and responsibilities) for people who are not supported through the NDIS' (clause 127). To achieve this, governments committed to several actions, including:

- developing and agreeing to a common definition for psychosocial supports (clause 128a)
- estimating demand for psychosocial supports outside the NDIS, to be completed as soon as possible within the first two years of the Agreement (clause 128b)
- once demand has been estimated, developing clauses related to future arrangements and attaching them to the current Agreement as a schedule (clause 129)
- maintaining current investments in psychosocial supports outside the NDIS while the analysis was undertaken (clause 130).

While some progress has been made, governments have not fully met their commitments. MHSPSO established the Psychosocial Project Group, which was tasked with undertaking the analysis on a common definition and estimating demand. This group is intended to meet quarterly, however, the last publicly available information on meetings was released in November 2023 (Psychosocial Support Group 2023c).

The Group agreed to a common definition of psychosocial supports and engaged a consultant to estimate unmet need (Psychosocial Support Group 2023a, 2023b). The resulting report was provided to governments in August 2024 and has since been publicly released (HPA 2024). The report provides estimates of the number of people who require psychosocial supports and those receiving services at the jurisdiction level, which does not enable planning of local services. It is difficult to assess whether governments maintained their investments in psychosocial supports while the analysis of demand was undertaken, as there is incomplete public information on governments' investments (MIFA, sub. 88, p. 7).

In August 2024, Australian health and mental health ministers agreed the Psychosocial Support Group would develop the plan for future arrangements. Publicly available information indicated further information on consultations on this plan would be available in 2025 (DoHAC 2025c).

As at early June 2025, governments have not developed and agreed to future psychosocial support arrangements, including roles and responsibilities, delaying access to much needed support for nearly 500,000 people with moderate and severe mental illness. Review participants were critical of the lack of progress (Australian Psychosocial Alliance, sub. 55, p. 5). Community Mental Health Australia (sub. 84, p. 4) stated:

> The Agreement has achieved somewhere between little and nothing in addressing these significant barriers, nor begun the process of transitioning systems …

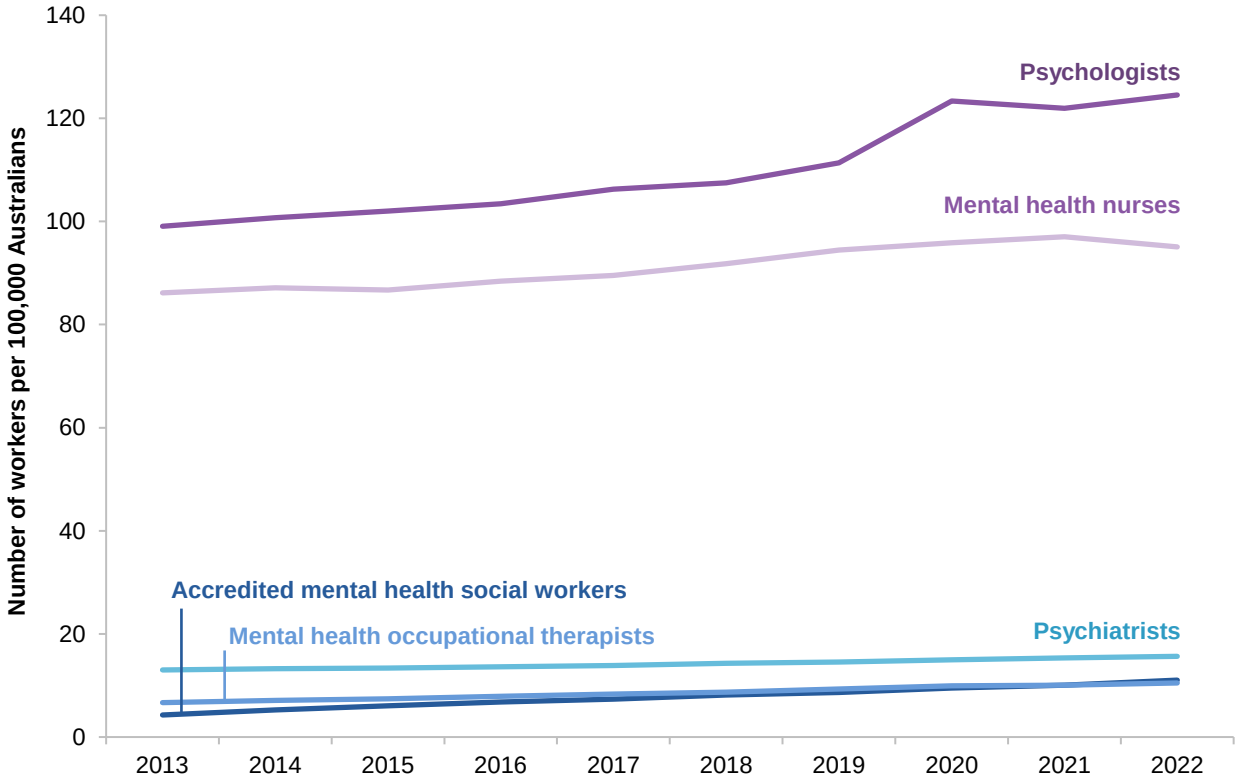
Governments should finalise arrangements for the provision of psychosocial supports outside the NDIS as soon as possible, and the next agreement needs to articulate these roles and responsibilities, including any necessary funding transfers (chapter 4).

Actions have failed to impact chronic workforce issues

Similarly to psychosocial supports, governments delivered the required output, but more work is needed to reduce the chronic shortage in the mental health workforce.

Since 2013, there has been minimal growth in the number of mental health professionals per 100,000 Australians, except for psychologists (figure 2.6). However, it is not at a rate required to meet need given the extensive wait times (section 2.1 and *What we've heard so far paper*).

Figure 2.6 – Minimal growth in mental health workforce



Source: PC analysis using AIHW (2024g) and ABS (2024b).

In the Agreement, governments recognised that a high-quality workforce is an enabling element of the mental health and suicide prevention system. They committed to addressing workforce challenges by:

- Supporting workforce development and sustainability across sectors, especially in areas of thin markets (clause 149)
- Developing the National Mental Health Workforce Strategy (clauses 150–151) and supporting the development of the National Suicide Prevention Workforce Strategy (clause 156)
- Working together to take action to increase the number of full-time equivalent (FTE) mental health professionals per 100,000 population (FTE rate) over the life of the Agreement for professional groups identified, including psychiatry, psychology, mental health nursing, Aboriginal and Torres Strait Islander mental health and suicide prevention workers, lived experience (peer) workforce and other relevant allied health professionals (clause 154 and 159)
- Supporting the governance and use of the National Mental Health and Services Planning Framework and sharing program level and other data to achieve optimal workforce planning at the regional level (clause 153).

Published in 2023, the National Mental Health Workforce Strategy presents a vision and actions to build a sustainable mental health workforce (box 2.2). It is too early to tell if the Strategy has been effective, as many of its actions have not yet been delivered and others take time to affect the workforce. However, there are no funding commitments or clear accountability structures included in the Strategy. The Royal Australian and New Zealand College of Psychiatrists (sub. 7, p. 4) stated:

> Immediate and sustained funding commitments are essential to support the National Mental Health Workforce Strategy (the Strategy), including the expansion of training programs and incentives for professionals in underserved regions. Clear definitions of governmental responsibility for funding and workforce development are necessary to ensure accountability and the successful implementation of the Strategy.

The National Suicide Prevention Workforce Strategy is yet to be developed (chapter 6).

Box 2.2 – The National Mental Health Workforce Strategy

The National Mental Workforce Strategy provides 'a vision and roadmap to build a sustainable workforce that is skilled, distributed and supported to deliver mental health treatment, care and support that meets the current and future population needs' (DoHAC 2023, p. 23).

The Strategy has four strategic pillars that focus on:

- attracting capability and capacity to meet future demand and address thin markets, supported by a training and education system that equips the workforce to meet the needs of the community
- maximising and connecting the workforce to ensure there is coordination of care, workforce distribution and opportunities to best use the skills and strengths of all workers
- supporting workplaces and addressing issues that impact retention
- better use of data, planning, evaluation and technology.

The Strategy outlines key roles and responsibilities.

- **The Australian, state and territory governments** have joint responsibility to ensure equitable access to effective mental health and suicide prevention services.
- **Education providers** are responsible for training the mental health workforce.
- **Australian Health Practitioner Regulation Agency (AHPRA) and National Boards** are responsible for setting standards and policies for all AHPRA-registered health practitioners.
- **Professional peak bodies and colleges** are responsible for representing and supporting members, defining training and education standards, continuing professional development requirements and administering self-regulated occupational schemes, and sharing expertise.
- **Unions** are responsible for representing and supporting their members.
- **Health and community service providers, including Aboriginal Community Controlled Health Organisations, and practitioners** are responsible for delivering services, employment, supervision and support to attract and retain the mental health workforce.
- **Consumer and carer organisations** ensure the needs and preferences of people with lived and living experience, their supporters, families, carers and kin are reflected in governments' actions to grow and support the mental health workforce.

Box 2.2 – The National Mental Health Workforce Strategy

The Strategy contains a detailed list of actions to support these pillars, which correspond to implementation plans that identify the parties involved and a timeline for delivery.

Source: DoHAC (2023).

Despite the commitments in the Agreement, shortages in the workforce have continued. The Occupation Shortage List continues to show shortages across the mental health workforce nationally and across the different jurisdictions (table 2.3).[8] Estimates show the number of mental health professionals would need to grow by at least 42% by 2030 to fully respond to community demand (DoHAC 2023).

Table 2.3 – Shortages in the Australian mental health workforce, 2024[a,b]

Occupation	Aus	NSW	VIC	QLD	WA	SA	TAS	ACT	NT
Psychologist	S	NS	S	S	S	S	S	S	S
Psychiatrist	S	NS	S	S	S	S	S	S	S
Registered Nurse (Mental Health)	S	NS	S	S	S	S	S	S	NS
General Practitioner	S	S	S	S	S	S	S	S	S
Indigenous Health Worker	S	NS	S	S	S	S	NS	NS	S
Occupational Therapist	S	S	S	S	S	S	S	S	S
Psychotherapist	NS	NS	S	NS	NS	NS	NS	NS	NS

a. This analysis covers the Australian labour market and therefore includes both the public and private system. **b.** NS indicates no shortage and S indicates shortage

Source: Jobs and Skills Australia (2024).

The analysis in the National Mental Health Workforce Strategy found workforce shortages were more pronounced in rural areas (DoHAC 2023, p. 16). This conclusion has been supported through participants' input to this review, with several noting the continued critical shortages in rural, regional and remote workforces (Australian Association of Psychologists Incorporated, sub. 13, p. 5; Consumer Health Forum of Australia, sub. 22, p. 9; Marathon Health, sub. 10, p. 3; National Rural Health Alliance, sub. 86, p. 5).

[8] A shortage is defined as when employers are unable to fill, or have considerable difficulty filling, vacancies for an occupation or cannot meet significant specialised skill needs within that occupation, at current remuneration, employment conditions and in reasonably accessible locations.

One area of progress is an increase in the peer workforce.[9] There is little reliable data on the total number of peer workers in Australia due to the variation in peer workers' engagement in the mental health sector. There is, however, data on lived experience workers in specialised mental health care facilities, which showed an 18% increase in the peer workforce per year between 2017-18 and 2021-22, to reach 360 FTE paid peer workers (AIHW 2024g). During this period, the number of carer peer workers in specialised mental health care facilities grew by an average of 23% per year, but with only 158 FTE staff by 2022. This disparity between consumer and carer peer workers was supported by anecdotal evidence in submissions.

> There remains a concerning lack of carer peer workers across government, government-funded, and PHN-funded mental health and suicide prevention services. Consultations with our members also indicate a significant disparity between the number of carer peer workers and consumer peer workers. (Mental Health Carers Australia, sub. 73, p. 23)

The peer workforce is discussed further in chapter 4.

Draft finding 2.1
Progress has been made in delivering the Agreement's commitments, but there has been little systemic change

Assessing the progress made under the National Mental Health and Suicide Prevention Agreement is difficult. Recent data is not readily available and jurisdictions have not adhered to all their monitoring and reporting commitments. The effects of significant external factors, such as the COVID-19 pandemic, are difficult to disentangle.

Since the Agreement was signed in 2022:

- governments have delivered most of the Agreement's outputs. Some key commitments have not been completed. This includes resolving issues affecting the delivery of psychosocial supports outside the National Disability Insurance Scheme, publication of the National Stigma and Discrimination Reduction Strategy and development of the National Guidelines on Regional Commissioning and Planning
- there has been little change in measures related to the Agreement's outcomes, which focus on improving mental health and reducing suicide rates
- progress towards the Agreement's intent to create an integrated, person-centred mental health and suicide prevention system has been piecemeal.

2.5 Progress towards a coordinated, person-centred system is very slow

Under the Agreement, governments committed to working together to implement a mental health and suicide prevention system that is comprehensive, coordinated and person-centred (clause 23). Such a system would offer the full range of services and supports, including prevention, early intervention, treatments and recovery supports for people with lived and living experience of mental ill health and those experiencing suicidal distress, as well as their supporters, family, carers and kin. It also incorporates coordination with services

[9] The peer workforce comprises people who are employed in paid positions that require lived and living experience as an essential employment criterion, regardless of position type or setting (Byrne et al. 2021, p. 4).

beyond health, such as housing and unemployment, which are known to contribute to mental distress and suicidality (National Mental Health and Consumer Alliance, sub. 66, p. 10). A person-centred system focuses on the needs and preferences of service users, rather than service providers and funders, and enables people to access the services and supports best suited to their needs.

At the core of such a system is better integration. In the health system, integration means governments, organisations and individuals collaborating and aligning their practices and policies to efficiently deliver high quality, person-centred, outcome-focused healthcare (Bywood et al. 2015, p. 1).

Integration commitments can be found throughout the Agreement

Integration appears throughout the Agreement and plays a pivotal role in its establishment, purpose, principles and objectives (box 2.3). The Agreement embeds commitments to three types of integration:

- cross-jurisdictional integration, bringing together services funded by different levels of government
- whole-of-government integration, including areas beyond the health system
- integration of lived and living experience. The Agreement commits parties to embedding the voices of people with lived and living experience in the design, planning, delivery and evaluation of services.

Box 2.3 – Integration plays a pivotal role in the Agreement

Integration is central to the very idea of a national agreement. The Agreement, which is a commitment between the Australian, state and territory Governments to work together, is in and of itself, an example of integration.

Integration also implicitly or explicitly appears in:

- eight of the 14 principles that guide the implementation of the Agreement
- four of the five objectives, with the first objective being the aim 'of moving towards a unified and integrated mental health and suicide prevention system'. Three other objectives discuss the requirement to work together and work collaboratively to improve the system and reduce fragmentation
- The overarching outcome to 'implement arrangements for a unified and integrated mental health and suicide prevention system' (clause 26).

Cross-jurisdictional integration commitments

This approach is primarily embedded in the governance mechanisms of the Agreement. Health and Mental Health Ministers from all jurisdictions are responsible for implementation of the Agreement. Additional commitments were made to:

- support PHNs and LHNs and other commissioning bodies to develop and/or strengthen joint regional plans (clause 134)
- assess and share evidence about the effectiveness of different models through testing and evaluating innovative planning and commissioning arrangements (clause 136)
- use the National Mental Health Service Planning Framework and/or other tools appropriate for their local population to support regional planning and commissioning (clause 139).

Whole-of-government integration commitments

Box 2.3 – Integration plays a pivotal role in the Agreement

The vision of a whole-of-government approach to mental health is explicitly mentioned in the purpose, principles, objectives and outcomes of the Agreement and set out in Schedule A.

Schedule A to the Agreement provides an outline of the activities to be undertaken to implement the commitment to a whole-of-government approach. It identifies priority areas for integration with education, work environments, homelessness, alcohol and other drugs, financial counselling, family, domestic and sexual violence and justice.

Lived and living experiences integration commitments

The Agreement includes commitments to centre the voices of people with lived and living experience in the Agreement itself, and in services and system reform, including:

- ensuring people with lived and living experience and their families and carers are consulted throughout the implementation of the Agreement, including seeking advice and providing opportunities for people with lived and living experience 'to influence matters of service design, planning, implementation, evaluation, data and governance' (clause 55)
- people with lived and living experience having input into the Agreement's governance (clause 84)
- co-designing place-based approaches while ensuring 'the voices of people with lived and living experience are embedded in the planning, design and evaluation of services … ' (clause 47h(i))
- developing suicide prevention services and programs in collaboration with communities and people with lived and living experience (clause 124c).

The importance of integration flows through to the bilateral schedules, which include commitments by the Australian, state and territory governments to improve coordinated care, such as through the Medicare Mental Health Centres.

Limited progress towards an integrated system

The Australian, state and territory governments have made limited progress implementing integration initiatives. Fragmentation remains across the system, with consumers seeing no progress at the service level. These experiences were shared by many of the participants in the PC's survey (*What we've heard so far* paper).

Unclear progress in cross-jurisdiction integration

Six permanent and three time-limited, working groups have been established under the Mental Health and Suicide Prevention Senior Officials Group (MHSPSO). These working groups promote cross-jurisdictional integration by including representatives for the jurisdictions, holding regular meetings and progressing work (chapter 1).

Due to the lack of public reporting on actions from the various working groups, we are unable to assess what impact they have made on cross-jurisdiction integration. However, the NMHC and NSPO found there was variable momentum across the groups (sub. 70, p. 13).

There have been examples of improved cross-jurisdictional integration in the alignment between Australian Government-funded services and state-funded services. Reflecting on their experiences of services implemented under the Agreement, headspace (sub. 23, pp. 10–11) pointed to mixed progress, with:

> … some shift at the structural and relational level, where unprecedented levels of State government funding in service integration have improved policy alignment between headspace and State-funded services and prompted the establishment of new relationships at the strategic and service delivery level. … However, there is little indication that this has translated to aligning deeply held beliefs relating to service integration across the system, noting that this is a complex system change initiative that is at a relatively early stage of implementation.

At the local level, as discussed above, the failure to deliver the National Guidelines on Regional Commissioning and Planning has led to ad hoc progress on collaboration between PHNs and LHNs (section 2.4).

Minimal progress in whole-of-government integration

The primary mechanism in the Agreement to encourage whole-of-government integration is Schedule A. The Schedule A Working Group is responsible for coordinating efforts across government areas and jurisdictions (chapter 1).

The focus of the group has been on sharing examples of best practice across jurisdictions, including mental health and suicide prevention support in school settings, mental health and suicide prevention literacy and capability of public sector workforces, and legislative reform for work-related psychological health (NMHC 2024a, p. 16). The Tasmanian Government (sub. 78, p. 5) said information sharing and lessons from other jurisdictions had been a key achievement that allowed other states to refine their own approaches.

However, the NMHC and NSPO (sub. 70, p. 8) stated:

> … there has been minimal evidence of targeted progress with the [Schedule A] working group primarily focused on information sharing as opposed to reporting against tangible actions …. The information provided did not articulate concrete evidence of how actions translated to outcomes aligned with the objectives of Schedule A.

Failing to turn information sharing into tangible actions reduces the impact on whole-of-government integration.

There has been some evidence of better whole-of-government integration and coordination between services within the mental health and suicide prevention system. However, this appears to be on an ad hoc basis. For example, the Medicare Mental Health Centres the PC visited (as well as other community-based mental health services) supported people to access a broad range of supports beyond health. The Australian Psychosocial Alliance (sub. 55, p. 6) notes:

> … in the case of Medicare Mental Health services there are some that provide predominantly clinical therapeutic care while others are providing a holistic approach which incorporates psychosocial support, including peer led support.

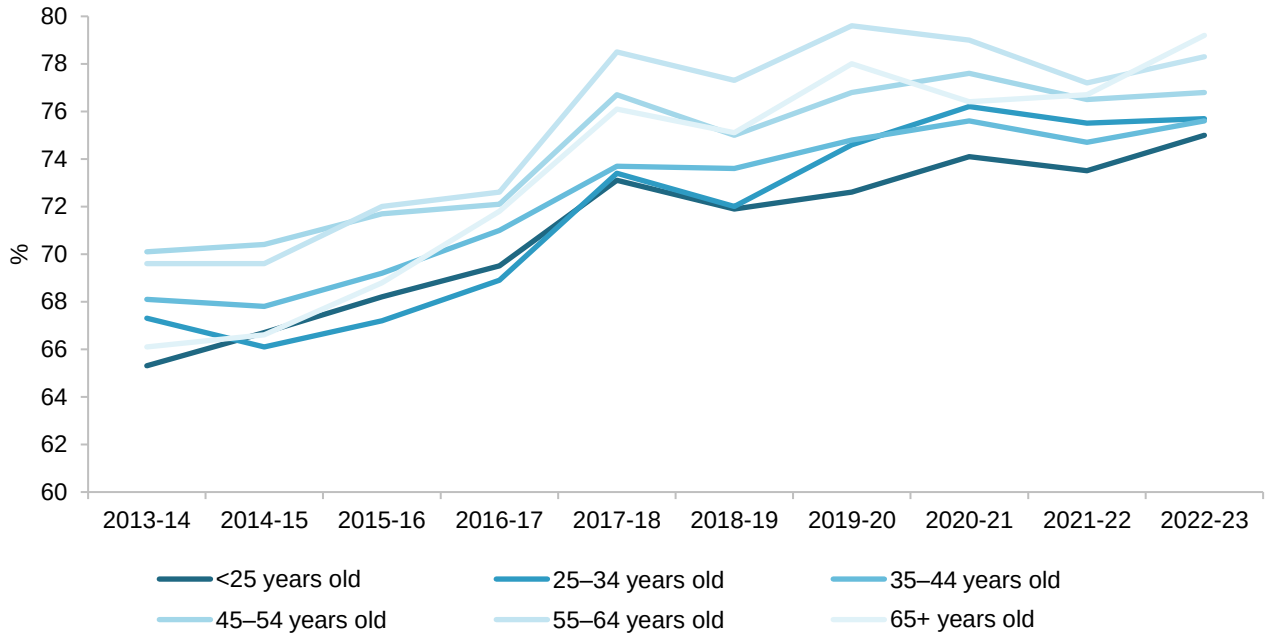
Participants in this review critiqued the renaming of Head to Health Centres to Medicare Mental Health Centres, stating it ‘is seen as reducing accessibility and desirability of the services by invoking the stigma associated with clinical mental health services’ (Roses in the Ocean, sub. 19, p. 6).

Further evidence of better coordination between services is the steady improvements in the proportion of people receiving community follow-ups within seven days of discharge from psychiatric admission

(figure 2.7). This suggests there has been an improvement in coordination and continuity of care between hospitals and the community sector.

Figure 2.7 – Rates of community follow up have been steadily rising

Proportion of people who received community follow ups within seven days of discharge from psychiatric admission or hospitalisation[a]



a. 'Community follow-up after psychiatric admission/hospitalisation' is defined as the proportion of state and territory governments' specialised public admitted patient overnight acute separations from psychiatric units for which a community-based ambulatory contact was recorded in the seven days following separation.

Source: SCRGSP (2025).

Integrating lived and living experience is improving in parts of the system

There has been progress in integrating the voices of people with lived and living experience in the Agreement's governance. The Australian Psychosocial Alliance (sub. 55, p. 14) noted 'the Governance arrangements have improved over the life of the National Agreement, including better representation of, and participation by, people with lived experience'.

Five lived experience representatives sit on MHSPSO (DoHAC 2024d). A separate National Mental Health and Suicide Prevention Lived Experience Group was established in February 2024. Mental Health Australia (sub. 76, p. 21) welcomed the establishment of the Lived Experience Group to inform MHSPSO and encouraged governments to ensure lived experience informs tangible actions.

However, some participants in this review found the inclusion of people with lived and living experience in governance has been tokenistic (Consumers of Mental Health WA, sub. 49, p. 8; National Mental Health Consumer and Carer Forum, sub. 68, p. 6).

> Lived experience representatives refer to an imbalance of power being evident and a high turnover of lived experience representatives further contributing to dysfunction in the Agreement's governance. There is little flow of information from the various working groups' back to the lived experience advisory group, which was developed substantially later than the signing of the

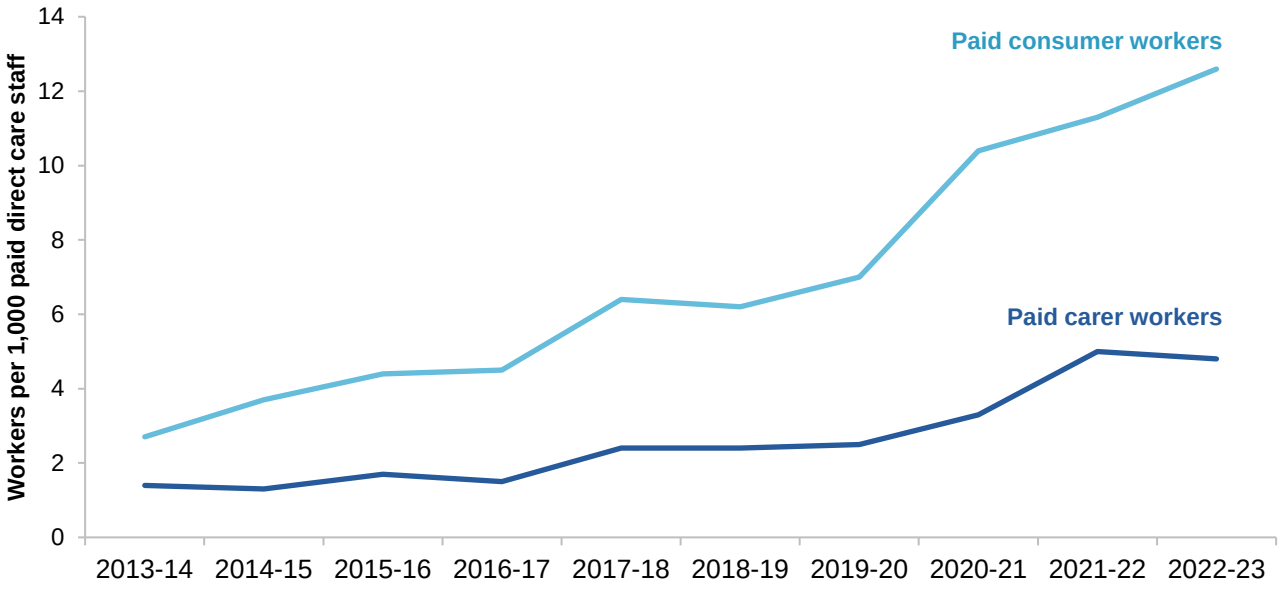
> Agreement and has struggled to be integrated into the Agreement's broader governance arrangements. (Roses in the Ocean, sub. 19, p. 2)
>
> The rollout of the bilateral agreement has not been informed by the lived experience of consumer or carers. (Northern Territory Mental Health Coalition, sub. 54, p. 3)

Several review participants also called for improved balance in lived and living experience representation, to address insufficient representation of lived and living experience of suicide (NMHC and NSPO, sub. 70, p. 15; NSW Health, sub. 90, p. 3; Roses in the Ocean, sub. 19, p. 2).

The 2022-23 National Progress Report noted several examples of good practice in incorporating the voices of people with lived and living experience, including collaborating with the National Mental Health Consumer and Carer Forum and nationwide co-design to develop aftercare best practice guidelines (NMHC 2024a, p. 18). These issues are discussed further in chapters 3 and 4.

Another example of the greater role people with lived experience have in some mental health services is a rise in the number of consumer and carer peer workers[10] (figure 2.8). This measure reflects the representation and active participation of those with lived and living experience with mental ill health within the mental health system.

Figure 2.8 – Rate of consumer and carer peer workers has been steadily increasing[a,b]



a. Full time equivalent of direct care staff employed in specialised public mental health services. Direct care staff include 'salaried medical officers, nurses, diagnostic and allied health professionals and other personal care' (AIHW 2011, p. 11).
b. ACT data is not available for 2013-14 to 2015-16 or 2021-22 and 2022-23, as such it is not included in the Australian total.

Source: SCRGSP (2025).

The system remains fragmented

The Agreement's focus and commitment to integration is commendable; however, review participants overwhelmingly argued that the system remains fragmented (box 2.4).

[10] A consumer peer worker is someone who has lived experience of a mental health issue and is employed to use that experience, working with others who are recovering from a mental health issue (AIHW 2024c). A carer peer worker is someone with lived experience of caring for someone with a mental health issue and uses their experience to support other carers (AIHW 2024c).

While initial advancements have laid some of the groundwork for integration, their impact on service delivery is limited. Consumers who find the system easy to navigate and receive comprehensive, coordinated care to address their needs remain the exception rather than the norm.

Box 2.4 – Review participants' views on fragmentation within the mental health and suicide prevention system

Overall, consumers are still experiencing an expensive, fragmented mental health system, and while the Agreement has had some positive impact, more needs to be done. (Consumer Health Forum of Australia, sub. 22, p. 9)

Over the last three years, the mental health and suicide prevention service system has become increasing[ly] fragmented and at the same time Australia's mental health has worsened. (Australian Psychosocial Alliance, sub. 55, p. 8)

There are significant challenges facing the mental health and suicide prevention sector, including … a fragmented and complex network of services that is difficult to navigate. (Lifeline Australia, sub. 8, p. 10)

Mental health and suicide prevention services remain fragmented across prevention, primary care, and specialist settings. Many individuals fall through the gaps, particularly those with severe and enduring conditions. (Australian Association of Psychologists Incorporated, sub. 13, p. 5)

Despite these well-documented recommendations, systemic fragmentation has hindered real change, leaving a persistent gap between policy aspirations and actual service delivery on the ground. (Ruah Community Services, sub. 14, p. 1)

Duplication and ambiguity of responsibilities in mental health and suicide prevention systems continues to result in inefficiently targeted resources, services and associated system gaps. (PHN Collective, sub. 69, p. 6)

The fragmentation between federal and state health systems compounds these challenges. While federal initiatives such as the National Mental Health and Suicide Prevention Agreement outline broad objectives, state-level implementation often operates independently, creating parallel systems rather than fostering collaboration and joint strategic health responses. (Michael Thorn, sub. 6, p. 2)

Draft finding 2.2
The Agreement has not led to progress in system reform

Overall, actions taken as a result of the National Mental Health and Suicide Prevention Agreement have not led to real progress towards improvements in the mental health and suicide prevention system.

3. Is the Agreement effective?

Key points

- **The National Mental Health and Suicide Prevention Agreement has not enabled systemic reform that would support improved consumer and carer outcomes.**
- **The Agreement's top-down approach and inflexible funding are restricting the ability of services to respond to local need. The initiatives implemented under the Agreement are limited in their scope and reach, affecting only a small proportion of the people who need mental health and suicide prevention services.**
- **The Agreement has ambitious objectives and outcomes, but it is not clear how the commitments in the Agreement and the bilateral schedules are helping achieve these.**
  - There are some objectives, such as greater investment in prevention and early intervention, that are not well reflected in any of the actions governments have committed to under the Agreement.
  - Many of the commitments included in the Agreement do not have any funding allocated to them.
  - The Australian, state and territory governments share the responsibility for the major outcomes of the Agreement, but there are no clear accountability mechanisms to ensure progress is made. Unclear responsibilities affect the availability of services for consumers. For example, governments are yet to determine who is responsible for psychosocial services – leaving 500,000 people without the support they require.
- **The Agreement does not adequately embed the voices of people with lived and living experience of mental ill health and suicide, or their supporters, family, carers and kin. They were not involved in the design and negotiation of the Agreement and are not meaningfully included in all aspects of its governance and implementation.**
- **The Agreement's governance arrangements mostly serve as mechanisms for information sharing across governments. The governance arrangements do not reflect the need for whole-of-government action, are slow to make progress and lacking in transparency and accountability.**

The National Mental Health and Suicide Prevention Agreement sets out ambitious intentions for governments to work together to 'improve the mental health of all Australians and ensure the sustainability and enhance the services of the Australian mental health and suicide prevention system' (clause 1).

It includes commitments in several important areas, including:

- establishing a National Suicide Prevention Office (NSPO)
- addressing the gap in psychosocial supports
- undertaking regional planning and commissioning

- developing several important frameworks and strategies, including a National Evaluation Framework, National Stigma and Discrimination Reduction Strategy and a National Mental Health Workforce Strategy
- working with Aboriginal and Torres Strait Islander people, communities, organisations and businesses to progress targets set by the National Agreement on Closing the Gap.

The Agreement also commits governments to a whole-of-government approach to improving mental health and suicide prevention in the priority areas of education, work environments, homelessness, alcohol and other drugs, financial counselling, family, domestic and sexual violence, including sexual harassment, child maltreatment and justice. The bilateral schedules to the Agreement signed by the Australian Government and each state and territory government include funding for some specific services, such as adult and child mental health services and supports for people after a suicide attempt.

However, there is broad consensus among review participants that, despite the importance of the commitments and the progress made towards achieving some of them, the Agreement has not been an effective mechanism for achieving the shared intentions of governments to improve the mental health and suicide prevention system (*What we've heard so far* paper).[11]

> … while the National Agreement has made a good start in establishing system architecture and has facilitated much-needed investment in mental health services, it falls short of delivering a truly national mental health and suicide prevention system. (Mental Health Australia, sub. 76, p. 5)

> … consumers are still experiencing an expensive, fragmented mental health system, and while the Agreement has had some positive impact, more needs to be done. (Consumers Health Forum of Australia, sub. 22, p. 9)

> The [Agreement], in its current form, does not adequately address the needs of the communities it aims to serve. Without meaningful lived experience leadership, an integrated whole-of-government approach, and a commitment to addressing the social determinants of mental health, the Agreement risks perpetuating the same systemic failures. (National Mental Health Consumer and Carer Forum, sub. 68, p. 10)

> We are concerned that the National Mental Health and Suicide Prevention Agreement … whilst being well written with good intentions, [has] not yet made a profound impact on mental disorder and suicide rates in Australia (Australian College of Nursing and Australian College of Mental Health Nurses, sub. 30, p. 4)

This chapter discusses why the Agreement has lacked effectiveness and not met its objectives. There are several reasons for this.

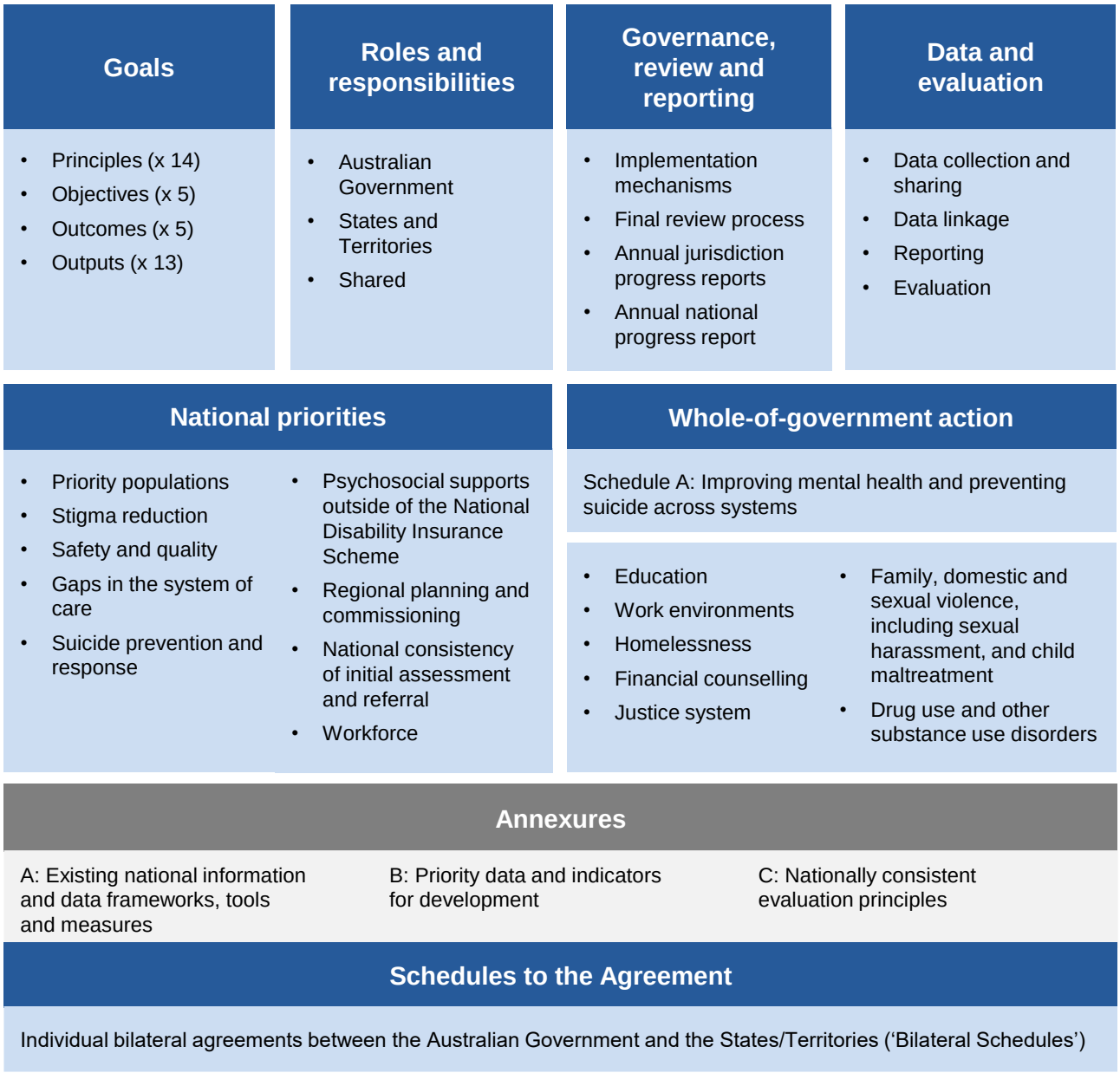
- There is insufficient clarity around many of the Agreement's components, including the objectives, intended outcomes, priority populations, roles and responsibilities, performance monitoring and reporting and funding. There is also no clear link outlining how these components work together (section 3.1).
- The Agreement does not adequately embed the voices of people with lived and living experience of mental ill health and suicide and their supporters, family, carers and kin (section 3.2).
- The governance arrangements are ineffective and lack accountability (section 3.3).
- The Agreement does not include many of the elements needed to progress system reform (section 3.4).

[11] AAPi, sub. 13, p. 4; Michael Thorn, sub. 6, p. 2; Movember Institute of Men's Health, sub. 80, p. 1; NMHCCF, sub. 68, p. 5; NMHC and NSPO, sub. 70, p. 4; PHN Cooperative, sub. 69, p. 6; Ruah Community Services, sub. 14, p. 1.

3.1 The Agreement has not been set up for success

The Agreement is an aspirational and direction-setting document that includes principles and priorities, objectives, outcomes and outputs, roles and responsibilities, governance arrangements, reporting, data and evaluation and financial arrangements. It describes agreed national priorities for reform and separate bilateral schedules contain commitments for each state and territory (figure 3.1).

Figure 3.1 – Main components of the Agreement



For the Agreement to be effective, each individual component needs to be well defined and functioning. All components need to be clearly linked and work together through a program logic and theory of change (chapter 1). For example, specific activities in the Agreement and in the bilateral schedules, such as establishing new services, should clearly link to and contribute to improving consumer outcomes.

Many key components of the Agreement lack sufficient specificity. The objectives and national priorities are too broad to constitute clear reform direction, the outcomes are not easily measurable and roles and responsibilities are not well defined. Many of the commitments in the Agreement do not have funding attached to them. Where funding is allocated, it is unclear how the specific commitments will achieve the agreed objectives and outcomes.

The goalposts are not clear and measurable

Objectives and outcomes are typically used within national agreements to set goalposts. Objectives speak to the vision of the agreement (what is the agreement trying to achieve?) (Ramia et al. 2021). Outcomes are tangible measures that illustrate the intended effect of the agreement (how will we know when we've made progress?) (WYCA 2023, pp. 16–17).

The objectives are too vague to articulate a direction for reform

The objectives should articulate clearly what change the Agreement is aiming to achieve. Objectives should provide a long-term goal that is relevant and supported by governments as well as people with lived and living experience of mental ill health and suicide, their supporters, families, carers and kin and the broader mental health and suicide prevention sector. Without shared goals and benchmarking, it is harder to achieve change and hold governments to account for a lack of progress (Muir and Bennett 2014, p. 13).

The Agreement's objectives are described in five clauses, reflecting governments' commitment to working together to improve mental health and suicide prevention outcomes (box 3.1). Some participants were supportive of the objectives (for example, Australian Psychosocial Alliance, sub. 55, p. 3; Royal Australian and New Zealand College of Psychiatrists (RANZCP), sub. 7, p. 3). Mental Health Australia (sub. 76, p. 22) stated 'the National Agreement articulates sound principles and objectives for interjurisdictional collaboration to progress mental health and suicide prevention system reform'.

But while the objectives describe positive aspirations, they are not sufficiently clear. The Western Australian Association for Mental Health (sub. 82, p. 8) said 'these stated objectives are very bold, broad and not particularly well-defined'.

Box 3.1 – Objectives of the Agreement

- The Commonwealth and the States recognise that this Agreement provides an opportunity to work together to lay the foundations for delivering landmark mental health and suicide prevention reform, with the aim of moving towards a unified and integrated mental health and suicide prevention system (clause 21).
- This Agreement acknowledges the significant, and often cumulative, challenges for people living in Australia including drought, bushfires and COVID-19. These challenges have amplified the need to improve our mental health and suicide prevention system to address the increased impact on mental health, increased levels of mental illness, and increased levels of suicidal risk, self-harm and distress (clause 22).
- The Parties agree on their shared objective to work collaboratively together to implement systemic, whole-of-government reforms that improve mental health outcomes for all people living in Australia, progress the goal of zero lives lost to suicide, and deliver a mental health and suicide prevention

Box 3.1 – Objectives of the Agreement

system that is comprehensive, coordinated, consumer-focused and compassionate to benefit all Australians (clause 23).

- The Parties will work together in partnership to ensure that all people living in Australia have equitable access to the appropriate level of mental health and suicide prevention care they need, and are able to access this care when and where they need it (clause 24).
- As a priority in the first instance, the Parties agree to work together to address areas identified for immediate reform as informed by the Productivity Commission's Inquiry Report on Mental Health (PC Report), the National Suicide Prevention Adviser's Final Advice (NSPA Final Advice) and other relevant inquires including to:
  - reduce system fragmentation through improved integration between Commonwealth and State-funded services (clause 25a)
  - address gaps in the system by ensuring community-based mental health and suicide prevention services, and in particular ambulatory services, are effective, accessible and affordable (clause 25b) prioritise further investment in prevention, early intervention and effective management of severe and enduring mental health conditions (clause 25c).

Some of the objectives are not objectives at all and are instead contextual information or statements about how the objectives will be achieved. For example, acknowledging the effect of recent, cumulative challenges, such as natural disasters and COVID-19 is essential to building a better system that meets people's needs, but it is not an objective in its own right.

The way the objectives are articulated in the Agreement makes it difficult to determine whether they have been met. The National Mental Health Consumer Alliance (sub. 66, p. 9) said consumers felt the objectives were not measurable, which made it difficult to assess progress:

> This lack of clarity undermines the transparency of the agreement and makes it seem superficial.

Not all the outcomes are measurable

Under the Agreement, governments seek to achieve five outcomes, across a wide range of mental health and suicide prevention domains (chapter 2).

Outcomes should describe the desired change resulting from the Agreement. To be effective, they should be specific, measurable, achievable, relevant and time-bound (WYCA 2023, pp. 16–17). Not all the outcomes in the Agreement meet these criteria.

The outcomes are highly ambitious given the Agreement's term is only four years. Some outcomes are also hard to measure (chapter 2). For example, existing data is insufficient to measure improvements in mental health and wellbeing of all 15 'priority populations' listed in the Agreement. Mental Health Australia (sub. 76, p. 16) argued:

> It is inherently difficult to ascertain whether these outcomes have been achieved. First, there is little timely, public data reported against these outcomes. Second, even where there is data available, it is difficult to ascertain whether any changes identified are attributable to the reforms outlined in the National Agreement.

Measurement of other outcomes is complicated by ambiguity over what they are trying to achieve or how they would be measured. For example, it is not clear what a 'balanced' mental health system means, or how 'balanced and integrated' would be measured, as these terms are not defined. While the Agreement contains commitments to develop indicators for this outcome, these indicators are not clearly linked to balance and integration; instead, they are related to accessibility of services (chapter 2). This lack of precision and specificity leaves the perceived progress on the outcome up to the discretion of the evaluators, who can pick and choose between indicators to evaluate progress.

'Priority populations' are listed – but their needs are not addressed

The Agreement lists 15 'priority populations' disproportionately impacted by mental ill health and suicide (clause 111). Implementation of initiatives under the Agreement needs to consider and support the mental health and wellbeing of these groups (chapter 2).

The Agreement does not articulate why these 15 groups were chosen. Many of these groups have a higher prevalence of mental ill health than the general population, but other groups who also experience mental ill health and suicidality at high rates are not included. For example, review participants argued carers (particularly young carers and Aboriginal and Torres Strait Islander carers), supporters, family and kin should be added to the list or more fully recognised in the Agreement (Carers ACT, sub. 60, p. 6; Everymind, sub. 32, pp. 3–4; Mental Health Carers Australia, sub. 73, pp. 16–17).

> Despite the cost of the caring role to many people in Australia, and the vulnerability of this cohort, this has not been adequately addressed in the National Mental Health and Suicide Prevention Agreement. Carers and young carers have not been identified as priority cohorts within the Agreement, and have primarily been mentioned in the Agreement in the context of their caring responsibilities, not in the context of ensuring they are also being supported as an individual at high risk of mental ill health and suicidal ideation. (Carers WA, sub. 43, p. 6)

Despite the requirement that initiatives under the Agreement consider these groups, there is minimal reference to the listed priority populations in other parts of the Agreement or in the bilateral schedules.

> … it is difficult to find a link between the priority populations identified, and tangible actions or funding allocated through the National Agreement and Bilateral Agreements. (Mental Health Australia, sub. 76, p. 16)

Gayaa Dhuwi (Proud Spirit) Australia (sub. 75, p. 6) and Mental Health Australia (sub. 76, pp. 13–15) noted that commitments related to Aboriginal and Torres Strait Islander people, culturally and linguistically diverse communities and refugees, and LGBTQIA+SB people are not reflected in the bilateral schedules. The National Mental Health Consumer Alliance (sub. 66, p. 16) added:

> The National Agreement includes commitments to mental health consumer involvement and the inclusion of specific marginalised groups including people who identify as LGBTIQA+, Aboriginal and Torres Strait Islander, and culturally and linguistically diverse communities. However, there is no clear accountability mechanism to ensure these commitments have led to meaningful action.

Roderick McKay (sub. 17, p. 2) stated:

> Despite being listed as a priority population, no actions are focused on improving services to older Australians in any Commonwealth-State Agreements beyond continuation of existing state mental health services for this population …

It is important people receive support that meets their diverse needs and priorities. However, it is questionable whether a long list of groups disproportionately impacted will lead to better targeting of support.

As the PC (2022a, p. 113) has previously noted when reviewing the National Housing and Homelessness Agreement, 'if everyone is a priority, no one is a priority'.

Roles and responsibilities are not well defined and accountability mechanisms are missing

In its Mental Health inquiry, the PC (2020a, p. 1135) found the roles and responsibilities of the Australian, state and territory governments for mental health and suicide prevention are often unclear and overlapping. The inquiry recommended a national agreement to help clarify 'the responsibilities of each level of government for providing mental healthcare, psychosocial supports, mental health carer supports and suicide prevention services' (PC 2020a, p. 1149).

The Agreement describes the broad roles and responsibilities of the Australian, state and territory governments, which align with other policies, legislation and constitutional responsibilities.

However, review participants noted the roles and responsibilities for implementing the Agreement remain unclear (*What we've heard so far* paper).[12] The Agreement does not clearly define who is responsible for particular actions to help address gaps and overlaps in support.

Much of the lack of clarity is due to the inclusion of a substantial number of 'shared responsibilities' (clauses 41–46). Responsibility for the Agreement's major commitments is shared by all governments, including, for example, an overarching shared responsibility 'to ensure equitable access to effective mental health and suicide prevention services for all people living in Australia' (clause 41).

> Articulation of joint responsibilities in the National Agreement introduces potential unintended consequences through lack of clear lines of accountability, and opportunity for cost shifting and lack of transparency. (Mental Health Australia, sub. 76, p. 19)

> There is not enough clarity around the roles and responsibilities, and too many shared responsibilities without consideration of how these roles will be shared. (Australian Psychosocial Alliance, sub. 55, p. 14)

> The blurring of Federal and State and Territory government responsibilities for community-based specialist services has added to confusion, with piecemeal funding from both Federal and State and Territory governments contributing to fragmentation, and both overlaps and gaps in service commissioning. (Orygen, sub. 26, p. 4)

Many review participants also reflected on the lack of clear accountability for actions governments committed to carrying out under the Agreement (*What we've heard so far* paper).[13] The majority of the Agreement's commitments do not have defined deadlines and funding transfers are not linked to outcomes being achieved. In effect, even when actions are not completed as intended or not completed at all, this carries no consequences for governments.

> Without enforceable accountability measures, governments can shift responsibility without ensuring services are delivered effectively. (Australian Association of Psychologists Incorporated, sub. 13, p. 10)

[12] AAPi, sub. 13, pp. 9–10; Mental Health Australia, sub. 76, p. 24; Orygen, sub. 26, p. 4; RANZCP, sub. 7, pp. 3–4; WAAMH, sub. 82, pp. 14–16; Western Queensland PHN, sub. 45, p. 4.

[13] AAPi, sub. 13, p. 10; AMA, sub. 72, pp. 5; Mental Health Australia, sub. 76, p. 2; MIFA, sub. 88, pp. 10–11; NMHCA, sub. 66, p. 9; Northern Territory Mental Health Coalition, sub. 54, pp. 1–2; Orygen, sub. 26, p. 5; RANZCP, sub. 7, p. 4; Roses in the Ocean, sub. 19, p. 2; Skylight Mental Health, sub. 91, p. 2.

> While there are commitments from the federal, state and territory governments to work together, clear definitions of governmental responsibility for funding and workforce development are necessary to ensure accountability and the successful implementation of the National Agreement. (AMA, sub. 72, p. 3)

Unclear responsibilities are affecting services for consumers

As discussed in chapter 2, governments have not fully met their commitments in the Agreement regarding psychosocial supports outside the National Disability Insurance Scheme (NDIS). This is partly due to how the commitments in the Agreement were designed – addressing gaps in psychosocial supports is a shared responsibility of the Australian, state and territory governments.

Governments took a conservative approach, committing to agreeing to a definition of psychosocial supports and estimating the level of unmet need, before working out roles and responsibilities. As review participants noted, this approach is further delaying progress on reform.

> Critically, the National Agreement has (perhaps inadvertently) stalled action in addressing the growing gap in the provision of psychosocial support ("unmet need"). In part this is because it prioritised the re-visiting of the Productivity Commission analysis of need in this area over action, while simultaneously failing to provide a pathway or framework for addressing the gap or addressing the interface issues between the NDIS and the mental health service system. (Australian Psychosocial Alliance, sub. 55, p. 3)

As a result, people are not receiving the support they need, which was reflected in the survey conducted by the PC. One consumer stated:

> There are no in-person services locally for psycho-social wellbeing for people without a NDIS plan. (sr. 50)

There is a pressing need to determine responsibilities for funding and commissioning psychosocial supports, given almost 500,000 people with a mental illness are missing out (HPA 2024, p. 77). This is discussed further in chapter 4.

Performance monitoring and reporting requirements are insufficient to measure progress under the Agreement

Jurisdictions have failed to adhere to their reporting requirements under the Agreement (chapter 2). However, even if the commitments had been met, it is unlikely they would have provided sufficient information, transparency and accountability.

Performance monitoring

Strong performance monitoring is crucial to improve outcomes in mental health and suicide prevention. The Agreement recognises the importance of performance monitoring through several commitments to data collection, sharing and linkage (chapter 2), as well as commitments to develop specific indicators included in Annex B. The Data Governance Forum (DGF), established under the Agreement, has facilitated notable progress, particularly in the areas of data sharing, linkage and indicator development (chapter 2). This will help to improve aspects of performance monitoring. However, this progress is limited relative to the Agreement's targets, as many commitments were too ambitious and vague, and the requisite resources were not provided to achieve them.

Annex B set out indicators for data development, some of which are already being internally reported to the National Mental Health Commission (NMHC) (DGF, pers. comm., 20 May 2025), and some of which will take time to develop. However, once developed, the indicators may not be an effective tool to measure progress in meeting this Agreement's outcomes. For some outcomes, the indicators flagged for development are too narrow relative to the broad outcome they are tied to. For example, under 'improving the mental health and wellbeing of the population', while indicators are appropriately being developed for Aboriginal and Torres Strait Islander mental health and wellbeing, measurement gaps for other priority populations are not addressed (Annex B). Some of the indicators will only be finalised and publishable after the Agreement ends, meaning they will not be used at all over the life of the Agreement (DGF, pers. comm., 20 May 2025).

While some commitments to improving performance monitoring are clear and specific, such as the goal to establish an appropriate governance forum (clause 84), others are too broad, making it difficult to determine how they could be achieved, such as the goal to '[s]treamline the collection and management of existing datasets to minimise collection burden, reduce duplication and improve national consistency' (clause 88d). No clear roadmap was provided on how to complete these data commitments, and there was no clear mechanism to motivate governments to act on them, outside of tasking the DGF to coordinate them.

Despite the progress the DGF have facilitated, they lack the necessary powers to motivate states and territories to act on commitments such as increasing data sharing and linkage – commitments requiring high levels of interjurisdictional collaboration and collaboration between levels of government.

Performance reporting

The Agreement requires each state and territory develop an annual progress report by 31 August each year. These progress reports must be consolidated into an annual national progress report, which is to be finalised and endorsed by Health Chief Executives and Mental Health CEOs where relevant and provided to Ministers and Mental Health Ministers by 30 November each year. The national progress report is required to be made public within three months of its completion, unless it is not reasonable, appropriate or practical to do so at the time. Jurisdiction progress reports should include both qualitative and quantitative elements, incorporating key performance indicators as relevant and appropriate (part 6).

However, the way monitoring and reporting requirements have been established does not lend itself to transparency. Jurisdictional progress reports are based on self-assessment and focus too heavily on qualitative data (such as brief comments on progress made) (NMHC and NSPO, sub. 70, p. 11). Reports are not required to be made public, limiting their effectiveness as an accountability tool and preventing public scrutiny on their assessment of progress.

> [T]he failure to meet reporting requirements set out in Part 6 of the Agreement undermined the transparency and accountability of the Agreements in delivering service improvement for young people experiencing mental ill-health and suicide prevention. Implementation and evaluation are instrumental in realising the aims of public policy. Effective administration is required to for transparency and accountability. (Orygen, sub. 26, p. 5)

> The fact that we have seen only one progress report since 2022 raises significant concerns about the Parties' commitment to accountability, transparency and efficacy. (MIFA, sub. 88, p. 10)

> Without this public reporting and monitoring across jurisdictions, the community, the mental health sector and government will not be able to compare performance, highlight success and identify areas for future effort. (Equally Well Australia, sub. 53, p. 18)

In addition, while reporting is meant to include monitoring of progress against the Agreement's objectives and outcomes, for the most part, the data reported publicly focuses on activities and whether outputs have

been delivered (NMHC 2024a). While it may be helpful to report on activity, progress is not reported on in a way meaningful for consumers.

> … clear and consistent monitoring and reporting, not just on outputs but also on outcomes, are essential in determining the impact of the agreement. (Lifeline Australia, sub. 8, p. 3)

The NMHC has been tasked with preparing the national progress report. However, it has no powers to compel governments to provide information. This substantially limits its effectiveness as an oversight body (NMHC and NSPO, sub. 70, pp. 10–12; Community Mental Health Australia, sub. 84, p. 6). This issue is discussed further below.

Many of the commitments have no funding allocated to them

While the Australian, state and territory governments contribute funding for initiatives in the bilateral schedules, many important commitments in the Agreement itself are not funded. This includes commitments such as addressing gaps in the system of care, supporting the workforce and improving referral pathways between mental health and suicide prevention services and other services outside the health system, such as housing.

Not funding these activities means there is a risk they will not be completed. The little publicly available information to date suggests this is the case. For example, the NMHC and NSPO (sub. 70, p. 8) stated:

> … there has been minimal evidence of targeted progress with the [Schedule A] working group primarily focused on information sharing as opposed to reporting against tangible actions. In the Annual National Progress Report 2022-23, it was reported that the working group had shared best practice examples and/or case studies concerning a range of topics (e.g. mental health supports in school settings, legislative reform for work-related psychological health) and discussed a broad range of common issues or ideas. The information provided did not articulate concrete evidence of how actions translated to outcomes aligned with the objectives of Schedule A.

There is also no funding allocated to enable collaboration between different parts of government working to improve mental health and suicide prevention outcomes. This is a core objective of the Agreement, and review participants told the PC collaboration is still lacking in many areas. Where it does occur, this is due to the goodwill of staff and their strong commitment to improving consumer outcomes (*What we've heard so far* paper).

It is not clear how the different components of the Agreement are connected

The objectives and outcomes of the Agreement are highly ambitious, aiming for system reform and improved outcomes. But it is unclear how the outputs, priorities and actions in the rest of the Agreement, even if achieved, will meet these ambitions.

> While the current principles offer a high-level framework for Australia's mental health policy, clearer and more actionable steps are needed to make meaningful progress. The current principles need to be underpinned by specific, measurable actions from both federal and state governments to ensure tangible improvements in mental health service delivery across the country. (RANZCP, sub. 7, p. 3)

> The National Agreement specifies priority indicators for development (Annex B), which are categorised against the five high-level outcomes specified in the Agreement (Clause 26). Beyond this, it is difficult to discern a clear overarching logic for these indicators and how they map to the outputs or initiatives underpinning the National Agreement. (NMHC and NSPO, sub. 70, p. 11)

The Agreement's outputs are generally focused on providing or improving information about progress, improving evaluation processes and the development of strategies and guidelines (clause 27). While they are all worthwhile activities, and some contribute to the building blocks for reform, on their own they will not improve outcomes (chapter 2).

Review participants talked about a lack of theory of change to explain how activities funded under the Agreement will lead to the expected outcomes (*What we've heard so far* paper). Some of the outcomes appear to have few or no commitments linked to them. For example, while the need to 'improve physical health and life expectancy for people living with mental health conditions and for those experiencing suicidal distress' is identified as an outcome of the Agreement (clause 26d), there do not seem to be any actions or initiatives within the Agreement or the bilateral schedules that seek to shift this outcome.

The Agreement states governments will prioritise further investment in prevention and early intervention (clause 25c). This is a key priority for consumers, carers and service providers, was one of the main recommendations of the PC's Mental Health inquiry, and offers significant returns for any scale of government investment (PC 2020a, pp. 344–345). But beyond the initial objectives (clause 25c), there is no further mention of how these investments will occur.

> While the Agreement currently mentions prevention as an area for joint action across Commonwealth and State governments, there are no current prevention priorities included, meaning that collaborative evidence-based action on prevention is missing from the Agreement. (Wellbeing and Prevention Coalition in Mental Health, sub. 31, p. 3)

There are also commitments made within the Agreement not included in some or all of the bilateral schedules. For example, Gayaa Dhuwi (Proud Spirit) Australia (sub. 75, p. 6) noted the commitments related to Aboriginal and Torres Strait Islander people's social and emotional wellbeing in the Agreement are not included in the bilateral schedules (chapter 5).

The activities in the bilateral schedules, where implemented, can have positive effects on their local communities but they are limited in their reach. An early evaluation of the Medicare Mental Health Centres (MMHCs), one of the main initiatives under the Agreement, showed positive results. The people who attended the centres felt welcomed and understood and they valued the expertise of peer workers working alongside clinicians (Neami National 2024). However, in 2023-24 the five centres evaluated supported an average of about 1,450 consumers every month. While the experience of each consumer is important and increasing the reach of mental health and suicide prevention services is a critical goal of the Agreement, there would need to be a significantly larger investment in MMHCs to achieve the Agreement's objectives.

3.2 The Agreement does not embed the voices of people with lived and living experience

Including people with lived and living experience of mental ill health and suicide, their supporters, family, carers and kin in the design and governance of policy and services is essential for achieving system reform (Beyond Blue, sub. 37, p. 5; Consumers of Mental Health WA, sub. 49, pp. 10–12; National Mental Health Consumer Alliance, sub. 66, p. 7). Involving people with lived and living experience can improve the quality of planning and decision making in governance and ultimately enhance performance of the mental health system (PC 2020a, p. 724). As noted in the Agreement:

> There is widespread recognition that Australia's mental health and suicide prevention system requires significant reform to focus on better mental health and wellbeing outcomes. Achieving this requires collaboration from all governments, as critical players in policy and service delivery,

> as well as meaningful engagement with key stakeholders, particularly those with lived experience. (clause 29)

Since the Agreement was signed, there has been progress in including people with lived and living experience, not just in the governance and actions covered by the Agreement (chapter 2), but in policy and service design and delivery in the wider mental health and suicide prevention system.

For example, the PC's Mental Health inquiry recommended the Australian Government fund two national peak bodies, one representing consumers and the other carers and families, to help facilitate the inclusion of consumers and carers in the design of policies and programs (PC 2020a, p. 81). In response, in 2024, the Australian Government funded the National Mental Health Consumer Alliance and Mental Health Carers Australia to be the national peaks. This was seen as a positive step by review participants (Tasmanian Government, sub. 78, p. 4; Beyond Blue, sub. 37, p. 5; Consumer Health Forum of Australia, sub. 22, p. 6).

However, we have heard these peaks have limited resourcing. The effectiveness of these bodies and the level to which they can engage will be constrained unless they are adequately resourced.

> Funding for Peak bodies provides an informed and ready voice to provide thought leadership, high-level committee representation and deep policy advice to Governments. They should be funded adequately to perform this important role, noting that most mental health consumer peaks receive core funding covering wages for 3-4 staff plus funds for paid participation and general operating expenses. This is inadequate to cover the breadth of tasks required of them (which extends beyond health into areas such as NDIS and social services) and therefore does not indicate a commitment to lived experience leadership by governments despite their placations. (National Mental Health Consumer Alliance, sub. 66, p. 23)

People with lived and living experience were not involved in the negotiation and design of the Agreement

Review participants stated that people with lived and living experience were not involved in the negotiation and design of the Agreement. Mental Health Australia (sub. 76, p. 2) reflected that 'lived experience and sector engagement in development of the National Agreement was very poor'. And Community Mental Health Australia (sub. 84, p. 5) said:

> The existing Agreement was developed by a small group of non-sector and non-Lived Experience actors without consultation with the broader sector or transparency. This Review is the only opportunity Lived Experience has had to be consulted for feedback on the suitability of the Agreement or its implementation.

It is highly unlikely governments are meeting their commitments in the Agreement to centre the voices of people with lived and living experience when they were not sufficiently involved in its design.

> The Agreement was developed without meaningful consultation with lived experience communities, leading to ineffective service models and governance structures. (National Mental Health Consumer and Carer Forum, sub. 68, p. 6)

> The exclusion of Lived Experience expertise and leadership in the process of both developing and implementing the Agreement condemned the Agreement activities to [business as usual]. (Community Mental Health Australia, sub. 84, p. 4)

> Significantly, the National Agreement itself was not developed in consultation with those with a lived or living experience of mental ill-health or suicide, nor families, kin and carers. This

> represents a critical missed opportunity to harness this wisdom and experience in shaping the direction of this important reform from the outset. (NMHC and NSPO, sub. 70, pp. 16–17)

In addition, there is only minimal recognition of carers in the Agreement:

> Carers remain largely invisible in the mental health system, and this agreement's failure to adequately include carers has likely contributed to this reality. The Agreement does not align with the *Carer Recognition Act 2010* (Cwth) as it does not recognise carers or acknowledge their needs, neither as individuals or as carers, nor does it commit to providing them with meaningful support. (Carers ACT, sub. 60, p. 3)

The Agreement uses a range of terms, including co-design, when referring to the commitments to embed consumer voices. Across many parts of the mental health and suicide prevention system, co-design has been used to develop effective, community-based solutions that address the needs of consumers and carers (CERIPH 2024). Authentic co-design can have substantial benefits, but it does not appear to have been used in the development and implementation of the Agreement (box 3.2).

Box 3.2 – Co-design brings substantial benefits if done well

Co-design occurs when decision-making power is shared and when consumer voices are heard, valued, debated and acted upon (Slay and Stephens 2013, p. 4). Valuing and supporting the unique contributions consumers and carers have to offer, alongside those of policymakers, funders, providers and workers, makes the most of people's skills, experiences and capabilities (NMHCCF 2021, p. 1). The benefits of lived and living experience engagement have become increasingly evident as the practice has grown. Projects engaging people with lived and living experience through co-design have reported:

- increasing relevance of their information and services
- improved social networks and inclusion
- reduced stigma
- better attitudes, interactions and understanding between service users and providers
- improved outcomes such as improved wellbeing, reduced severe and acute mental health needs, and improved skills and employability (Hawke et al. 2024; Slay and Stephens 2013).

Genuine co-design requires several conditions be met. People with lived and living experience and the peak bodies that represent them must be adequately resourced to participate in any co-design process, they should have the information, agency and support to actively participate, and their knowledge and expertise should be valued and respected (Roper et al. 2018, p. 22).

> Genuinely engaging and co-designing with community takes time. Funding and contract terms must allow time to establish trust and credibility with communities, for people to meaningfully contribute, and for organisations to learn from the people we serve. (Beyond Blue, sub. 37, p. 5)

Review participants highlighted that there may be some way to go in ensuring these conditions are met. Policy design and service commissioning often do not allow sufficient time for genuine co-design:

> Very short time frames make important aspects of service development such as co-design and evaluation unviable, particularly in terms of meaningfully embedding the views of people with lived experience as per the Agreement's commitments, which risks reducing these commitments to tokenism.

Box 3.2 – Co-design brings substantial benefits if done well

> The rushed approach to co-design diminishes these activities to merely consultative exercises and makes the needed time to develop trust and effective engagement with key populations, such as culturally and linguistically diverse communities or people in rural and remote areas largely impossible. When there is also no requirement for co-design results to be utilised by the service, this risks undermining community confidence further. (Roses in the Ocean, sub. 19, p. 4)

Achieving effective co-design in the mental health and suicide prevention system faces substantial barriers beyond insufficient funding and time. Shifting the organisational culture underpinning these process and addressing power imbalances and stigma take time and significant effort from all participants in the process (CERIPH 2024, pp. 22–24). If these barriers are not addressed, this can have significant consequences.

> Tokenistic co-design and misuse of the participatory label, when a project has not involved equitable decision-making of people with lived experience, will likely perpetuate marginalisation (CERIPH 2024, p. 21).

People with lived and living experience are not sufficiently involved in the Agreement's governance and delivery of commitments

People with lived and living experience are included in the memberships of the Mental Health and Suicide Prevention Senior Officials (MHSPSO) group and project and working groups. However, their involvement is mostly limited to being consulted and providing advice, rather than participating fully in the design, planning, delivery and evaluation of services under the Agreement.

> Although there is now lived experience engagement throughout the governance structures established under the National Agreement, which is a great step forward, the extent to which this is genuinely drawn upon in implementing National Agreement initiatives is questionable. (Mental Health Australia, sub. 76, p. 19)

> … whilst there was some Lived Experience on the implementation structures of the Mental Health and Suicide Prevention Senior Officials Group, it was largely tokenistic – for example the Psychosocial Unmet Needs Project Group had one person with personal lived experience included, and despite repeated requests, denied family member inclusion in the group. (Community Mental Health Australia, sub. 84, p. 4)

> Unfortunately, the National Agreement has not succeeded in embedding ongoing, curated co-design and co-development, limiting the amplification of the voice of, or providing appropriate services for, people with lived experience. (National Mental Health Consumer Alliance, sub. 66, p. 4)

There was a significant delay between the Agreement being signed and the establishment of the Lived Experience Group (Mental Health Australia, sub. 76, p. 21; Roses in the Ocean, sub. 19, p. 2).

Review participants also noted the Lived Experience Group does not receive sufficient information from other parts of the Agreement's governance.

> Lived experience representatives refer to an imbalance of power being evident and a high turnover of lived experience representatives further contributing to dysfunction in the Agreement's governance. There is little flow of information from the various working groups' back to the lived

> experience advisory group, which was developed substantially later than the signing of the Agreement and has struggled to be integrated into the Agreement's broader governance arrangements. (Roses in the Ocean, sub. 19, p. 2)
>
> There have been other issues reported to the [National Mental Health] Commission concerning the effective engagement of lived experience in the implementation of the National Agreement, such as:
>
> - irregularity/ infrequency of meetings limiting opportunities for meaningful input
> - limited communication between groups leading to a lack of visibility, effectiveness and consistency
> - varied engagement in the co-design of individual initiatives. (NMHC and NSPO, sub. 70, p. 17)

The PC has also heard that where people with lived and living experience are included, this does not reflect the diversity of experiences. For example, Roses in the Ocean (sub. 19, p. 2) and NSW Health (sub. 90, p. 3) stated the voices of people with lived and living experience of suicide need to be heard as much as those with lived and living experience of mental ill health. In addition, we heard about insufficient inclusion of Aboriginal and Torres Strait Islander people, as well as supporters, family, carers and kin (Community Mental Health Australia, sub. 84, p. 5).

> Priority Reform One of the Closing the Gap agreement committed governments to work collaboratively and in genuine, formal partnership with Aboriginal and Torres Strait Islander peoples. This level of partnership and influence was not present in the development of the National Agreement, the bilateral agreements or in the governance mechanisms that monitored progress. (Gayaa Dhuwi (Proud Spirit) Australia, sub. 75, p. 6)
>
> The failure to incorporate carers into governance structures prevents the system from addressing the full scope of mental health needs and undermines the overall effectiveness of the Agreement. (Carers ACT, sub. 60, p. 5)

3.3 The Agreement's governance lacks effectiveness and accountability

Good governance is an essential enabler of reform (PC 2020a, p. 1077). Governance arrangements and mechanisms have been established to oversee the implementation of the Agreement (chapter 1). Health Ministers and Mental Health Ministers from all jurisdictions have collective responsibility for the Agreement through the Health Ministers Meeting (HMM). MHSPSO oversees the Agreement's implementation. Several working groups have been established under MHSPSO to advance specific aspects of the Agreement (chapter 1, figure 1.2).

These governance arrangements have evolved out of a structure that was in place under the Fifth National Mental Health and Suicide Prevention Plan during 2017 to 2022 (COAG Health Council 2017) and in response to the abolishment of the Council of Australian Governments (COAG). While their structure is reasonable, governance arrangements for the Agreement have lacked effectiveness and accountability.

The current Agreement partly addresses deficiencies in governance of the mental health system the PC observed in its previous inquiry (PC 2020a, pp. 1087–1131). The Agreement incorporates, in part, governance reforms recommended in the Final Advice of the National Suicide Prevention Adviser (National Suicide Prevention Adviser 2020b), and builds on some of the important steps taken to strengthen governance under the Fifth National Mental Health and Suicide Prevention Plan. It also includes recent

national commitments and agreements to strengthen Aboriginal and Torres Strait Islander mental health and suicide prevention (chapter 5).

The Agreement's governance arrangements:

- bring together representatives across jurisdictions, through National Cabinet, the Health and Mental Health Ministers, the Health Chief Executives Forum and the MHSPSO
- include working groups focused on key gaps and areas for reform, such as workforce and psychosocial supports. The Schedule A Working Group, with oversight by National Cabinet, First Ministers and the First Deputies Group can help facilitate whole-of-government approach to reform.
- incorporate people with lived and living experience, including through representation in MHSPSO and its working groups, and a lived experience advisory group with consumer, carer and Aboriginal and Torres Strait Islander representatives (section 3.2)
- link to the Closing the Gap Social and Emotional Wellbeing Policy Partnership, which is involved in overseeing progress on improving Aboriginal and Torres Strait Islander social and emotional wellbeing.

Some review participants noted the governance arrangements provide a solid foundation to build upon (Beyond Blue, sub. 37, p. 1; Mental Health Australia, sub. 76, p. 21; NSW Health, sub. 90, p. 3; Tasmanian Government, sub. 78, p. 6).

Delays in governance arrangements have affected progress

Ideally, the Agreement's governance arrangements would have been established as the Agreement was being finalised, allowing for the various groups and forums to 'hit the ground running' on the much-needed reform.

However, some working groups took time to establish, limiting their influence on the design and early activities under the Agreement. The delays in establishing parts of the governance arrangements contributed to delays in achieving some of the agreed outputs under the Agreement.

> The National Agreement outlines a vast array of well-considered actions to improve mental health outcomes in Australia. However, implementation of many of these actions has been slow and some have completely stalled. For example, the analysis of unmet need in psychosocial support outside the NDIS, the National Evaluation Framework, the National Guidelines on Regional Commissioning and Planning, and the National Mental Health Workforce Strategy, all experienced significant delays. (Mental Health Australia, sub. 76, p. 14)

Further, a lack of clarity regarding the governance arrangements for policy decisions affecting services for Aboriginal and Torres Strait Islander people resulted in limited decision making in the first year of the Agreement on progressing actions to improve social and emotional wellbeing (NMHC 2024a, p. 12). This issue is discussed further in chapter 5.

Governance does not focus on whole-of-government reform

Through the Agreement, governments have acknowledged that achieving significant improvements in mental health and suicide prevention requires a more holistic and person-centred service system and a stronger focus on addressing the social determinants of health (beyond the health system), facilitated through a whole-of-government approach.

However, most of the Agreement's governance structures rely on departments of health. For example, delegated responsibility for implementation of the Agreement sits largely with government officials who have a focus on clinical services rather than other areas of the system such as community support

(DoHAC 2024d). The predominant focus in the Agreement and its governance on the clinical areas of mental health and suicide prevention was questioned by some groups.

> Our members see deep flaws in the National Mental Health and Suicide Prevention Agreement … in its reliance on the medical model of understanding mental health and suicidal distress. Some mental health consumers understand their mental health through this lens and seek more access to treatment through this model. However, this approach does not benefit all consumers and may cause harm, perpetuate stigma and limit a person's ability to drive their own recovery. The dominance of the medical model through the prioritisation of funding the fields of psychiatry, psychology, and epidemiology, does not serve all mental health consumers. (Consumers of Mental Health WA, sub. 49, p. 6)

There are no requirements under the Agreement that governance must involve others outside of MHSPSO in decision making or consultation (clauses 53–55). For example, where there are governance commitments to engage and collaborate with mental health commissions or Aboriginal and Torres Strait Islander bodies, the Agreement requires this only be done 'where required' (clause 54).

The Schedule A working group brings together representatives from across government. Its establishment is a welcome development, but it is highly unlikely one working group responsible for improvements across 'education, work environments, homelessness, alcohol and other drugs, financial counselling, family, domestic and sexual violence, including sexual harassment, child maltreatment, and justice' could facilitate the necessary reform in these areas. Review participants noted the lack of funding for cross-portfolio initiatives under the Agreement.

> Commonwealth and state governments have failed to adequately fund and integrate mental health and suicide prevention services across critical sectors such as justice, education, disability services, and housing. (Australian Association of Psychologists Incorporated, sub. 13, p. 9)

> … the commitments outlined in Schedule A largely focus on broad collaboration rather than tangible action. Concerningly, the Schedule has no associated funding for initiatives or services. (Mental Health Australia, sub. 76, p. 23)

Review participants also argued the main governance arrangements are heavily focused on mental health, and there needs to be a stronger focus on suicide prevention (chapter 6).

> The current arrangements for the National Agreement do not reflect the full range of suicide prevention expertise required for effective governance. This imbalance reflects the limited consideration of suicide prevention within the National Agreement and that governance structures have been established through existing mechanisms dominated by mental health expertise. (NMHC and NSPO, sub. 70, p. 14)

Governance lacks transparency

There is limited public information on the way the Agreement's governance operates, including working group membership, meetings, decision making, work plans and the outcomes of their work. There is no requirement for MHSPSO to report to any other forum or group outside of government.

The group has only released two sets of meeting minutes in the three years since the Agreement has been signed, and these documents are too generic to allow any meaningful assessment of progress (DoHAC 2024d). There is no public reporting from the Agreement's working groups.

Another area lacking transparency is the bilateral schedules. Much of the progress on the Agreement's objectives is covered by actions in the bilateral schedules, where governance is not externally visible and is

separate to the national Agreement. Jurisdictional implementation plans have never been publicly released. Progress reports have been significantly delayed and contain little detail to support an independent assessment of progress (chapter 2). Mental Health Lived Experience Tasmania (sub. 15, p. 2) reflected on their experience:

> … despite the Tasmanian Bilateral Agreement stating that implementation of the Schedule will be "informed by the lived experience of consumers and carers", aside from a generalised summary in the 2022-2023 Annual National Progress Report, any specific data relating to any consultations undertaken is not available and/or accessible.

Engagement with the sector is insufficient

Similar to the experience of consumers and carers, review participants also commented that there has been limited engagement with providers of mental health and suicide prevention services in the design and implementation of the Agreement (Western Australian Association for Mental Health, sub. 82, p. 6).

> The lack of broader mental health sector representation on governance groups under the National Agreement has hampered progress. Mental Health Australia is pleased to provide representation for the mental health sector on the Data Governance Forum and Safety and Quality Group, but such limited sector representation to only two subgroups is unacceptable. (Mental Health Australia, sub. 76, p. 21)

> … there is insufficient direct representation from the specialist [community managed mental health] sector. (Australian Psychosocial Alliance, sub. 55, p. 13)

From a service provider perspective, headspace (sub. 23, p. 7) stated:

> In practice, there is a reluctance to cede control of system design, or of clinical governance arrangements in place-based collaboration, although there has been success in overcoming these differences through a lot of time and resourcing spent on building understanding about the purpose and benefits of the headspace service model. Meaningful progress requires a willingness to engage authentically in developing new understanding between state and federally funded services.

And from a primary health network (PHN) perspective, Western Queensland Primary Health Network (sub. 45, p. 5) argued governance shortcomings affected its ability to support the community:

> The existing governance mechanisms informing the National MH & SP Agreement omit PHNs, yet they are expected to play in Australia's health system. To carry […] out our responsibilities effectively, PHNs must be empowered with a seat at the table in policy development and supported by outcomes-based funding models. Greater funding flexibility would enable PHNs to address regional challenges, innovate locally, and measure long-term impacts. Multi-year funding cycles are also essential to provide stability and ensure sustainability, especially in environments where service providers must work together (as in Western Queensland) and avoidable disruptions in service continuity can have dire consequences in communities where few alternative supports are available.

The NMHC and NSPO (sub. 70, p. 13) stated that lack of sector engagement has implications for the effectiveness of services.

> There are some key limitations within the current governance arrangements for the National Agreement, including … [l]ack of broader sector involvement: an absence of actors outside the government sector in the governance process has hampered capacity to ensure interoperability of service arrangements and limited the efficiency of monitoring.

Governments are not being held to account

As outlined in section 3.1, accountability mechanisms in the Agreement are weak.

> "Right now, we don't have any accountability mechanisms. We are relying on government to self-report on whether or not they're doing a good job, and that's never going to work." — Consumer Representative. (NMHCCF, sub. 68, p. 5)

> The National Agreement's governance is opaque, remote and lacking in accountability to the suicide prevention field and the community. (Roses in the Ocean, sub. 19, p. 2)

Monitoring and reporting on progress is a key mechanism for accountability, and it is one of the shared responsibilities of governments under the Agreement. While governments agreed to produce annual progress reports, there is no commitment to independent assessment of progress, other than a final review (clause 65).

Governments have asked the NMHC to play a role in the reporting progress through the compilation of national annual progress reports, but this role is not formalised in the Agreement. These reports rely on jurisdictions' self-assessment without additional research or consultation. Progress reports produced by the NMHC do not constitute an independent assessment of progress and play a very limited role in keeping governments to account.

The NMHC was established to 'provide independent policy advice and evidence on ways to improve Australia's mental health and suicide prevention system.' (NMHC 2024c). It was responsible for monitoring progress under the national mental health plans preceding the Agreement and developed a range of national policy documents. In its 2020 Mental Health inquiry, the PC recommended NMHC evolve into an independent statutory authority with interjurisdictional responsibilities for strategic national evaluation, monitoring and reporting on government-funded mental health and suicide prevention programs (PC 2020a, p. 1235). However, this recommended role for the NMHC has only been noted as a consideration in the Agreement (clause 102h), with no further agreed action at this stage.

Since September 2024, the NMHC has operated as a non-statutory office within the Department of Health, Disability and Ageing, following a review of the commission's culture, capability and efficiency. In the 2024-25 Budget, the Australian Government announced its intention to 'reset and strengthen' the NMHC, starting with a consultation process in late 2024, seeking views on the commission's function and structure (DoHAC 2024g).

Review participants raised concerns about the NMHC's roles and its position in the Department.

> … there are a range of issues related to a fundamental lack of transparency on progress made under the National Agreement. This includes … the current temporary position of the National Mental Health Commission within the Department of Health and Aged Care, rather than sitting as a truly independent entity … (Mental Health Australia, sub. 76, p. 19)

> This failure of 'accountability and transparency' may be traced back to the disruption within the NMHC, which in 2024 was folded back into the Department of Health and Aged Care (DoHAC). Its future – as in internal element of the Department, an independent agency, or a Statutory Authority - remains unknown. (Mental Illness Fellowship Australia, sub. 88, p. 10)

There is no current indication on the timelines for any changes in the NMHC's position within government.

3.4 The Agreement is not enabling reform

Many of the objectives in the Agreement, such as clauses 21, 23 and 25 (box 3.1), align with what people have told us about their aspirations for mental health and suicide prevention services. In the online survey undertaken for this review, people with lived and living experience of mental ill health and suicide, carers and practitioners shared with the PC ideas on how to improve the mental health and suicide prevention system, including through:

- reducing the pressure on mental health services by increasing the flexibility of services and strengthening their capacity through better training and more peer work
- improving the coordination between services
- focusing more on prevention and the underlying causes of mental ill health and suicide (*What we've heard so far* paper).

However, the way the Agreement was devised and implemented does not enable the scale of reform needed to achieve these improvements. In its 2020 Mental Health inquiry, the PC identified key enablers of reform in the mental health and suicide prevention system, including:

- better use of data to plan, monitor and evaluate services
- workforce policy that alleviates shortages and supports the peer workforce
- planning and funding approaches that are responsive to local needs
- effective governance mechanisms that underpin greater collaboration (PC 2020a).

As shown in section 3.1, the Agreement has made limited progress in creating the necessary governance mechanisms. There is also much room for improvement in the way data is used. While the Agreement has led to the creation of the National Mental Health Workforce Strategy, there is little else that supports progress towards the creation of a person-centred mental health and suicide prevention system.

Better data use and sharing remains an elusive goal

The Agreement contains many commitments to improving the availability and sharing of data about the effectiveness of mental health and suicide prevention programs and the system itself. There are provisions for increased and improved reporting and evaluation, improved data collection, linkage and sharing, and the creation of forums to support diffusion of best practice (clauses 80–103).

The roll-out of these commitments has been slow. For example, the National Evaluation Framework was only publicly released in February 2025 and while there are evaluations of jointly funded programs, it is difficult to say if their findings are supporting better practice.

The impact of these provisions may be limited where data sharing is restricted and only occurs within government or between levels of government. Data sharing with consumers, service providers and practitioners, carers and the broader public is important in supporting evidence-based decision making and encouraging improvement to services. The PHN Cooperative (sub. 69, p. 12) argued there are still significant shortcomings in data use:

> … PHNs have been disappointed that the Agreement has not enabled the development of fit for purpose regional data and tools to inform mental health service planning:
>
> - The National Mental Health Service Planning Framework is an evidence based and comprehensive planning tool but remains more geared towards the state public mental health sector than the primary mental health sector where PHNs are commissioning community managed organisations for service delivery.

- PHNs play a valuable role in collecting regional workforce data, as identified elsewhere in this submission, however there is a lack of easy access to regional mental health workforce data on a regional basis. For example, it's difficult for PHNs or LHNs to reliably know how many allied health professionals there may be available to work in mental health in a region.

There is no specific funding allocated to the extensive commitments to data improvements. In some cases, such as evaluation of funded programs, the Agreement specifies they be co-funded, but the funding amount is not set out in the Agreement or the bilateral schedules. The DGF established under the Agreement has made some headway, but substantial challenges remain (chapter 2).

The Agreement could do more to alleviate workforce shortages

Despite commitments in the Agreement to expand and strengthen the workforce, it remains a critical issue (chapter 2). Shortages persist in many key occupation groups (including consumer and carer peer workers, psychologists and Aboriginal and Torres Strait Islander mental health and suicide prevention workers), contributing to an overall under-provision of 32% (in 2019) relative to estimated need in the population (DoHAC 2023). This shortfall is projected to reach 42% by 2030 unless workforce shortages are addressed (chapter 2). Participants in this review highlighted how some parts of the country are particularly affected by workforce shortages, with the availability of key professionals (for example, psychiatrists and psychologists) lower in remote locations compared to more populated areas (*What we've heard so far* paper).

The Agreement and the bilateral schedules include commitments to improve the workforce, through:

- collaborating to develop the National Mental Health Workforce Strategy (clauses 150-151)
- building data and systems to understand and improve mental health and suicide prevention workforce planning (clause 82e)
- supporting workforce development and sustainability across sectors, including those sharing the mental health and suicide prevention workforce, and seek opportunities to address areas of thin markets (clause 149)
- working in partnership with professional peak bodies, colleges and the education and training sector to address issues related to the mental health workforce and suicide prevention pipeline (clause 152).

While some of these commitments have been achieved (chapter 2), many appear to have not been meaningfully progressed, or there is no sufficient publicly available information to assess progress. The National Mental Health Workforce Strategy has been developed, but the Agreement did not set aside funding to progress its implementation.

> The National Agreement rightly acknowledges the importance of joint action on mental health workforce priorities. However, a lack of funding, delays in delivery and implementation of the National Mental Health Workforce Strategy (the Workforce Strategy), absence of clear prioritisation and lack of accountability for delivery has meant little meaningful action. (Mental Health Australia, sub. 76, p. 20)

> The Agreement has yet to deliver tangible changes to improve the wellbeing and productivity of mental health professionals, including addressing acute workforce shortages and maldistribution, training places, reducing professional isolation, attrition from the public and not-for-profit sectors to the private sector, or burnout. (headspace, sub. 23, p. 3)

The lack of progress on workforce commitments appears to be at least partly due to a lack of detail on how commitments will be met and unclear roles and responsibilities. Insufficient funding was also raised by review participants as a constraint on progress (AMA, sub. 72, p. 2; Black Dog Institute, sub. 61, p. 10;

Mental Health Australia, sub. 76, p. 17). This lack of progress is mirrored in the workforce initiatives under the bilateral schedules.

The Agreement prioritises national approaches over place-based solutions

In its 2020 Mental Health inquiry, the PC (2020a, p. 1147) found place-based and regional approaches were essential to ensuring people had access to the support they need.

However, the approach taken in the Agreement prioritises nationally consistent models of care, such as headspace and Head to Health (which has since been rebranded as Medicare Mental Health Centres). This approach imposes rigidities on state and territory governments and PHNs in how they commission mental health and suicide prevention services, which affects the ability to tailor services to local needs. It also limits engagement with people with lived and living experience, local communities and others in designing and implementing the models of care.

Review participants (including service providers, PHNs and consumers) repeatedly highlighted the need for greater flexibility in funding and care models as being key to providing effective care (Marathon Health, sub. 10, p. 4; Orygen, sub. 26, pp. 3–5; Ruah Community Services, sub. 14, p. 9; Western Queensland PHN, sub. 45, pp. 5–9). The PC heard of cases where deviations from rigid models of care had been negotiated, but these seemed to be exceptions rather than the standard practice and added to the administrative burden (Neami National, sub. 63, p. 12; IUIH, sub. 81, pp. 9–10).

The bilateral schedules include funding for initiatives in line with nationally consistent models of care, without much acknowledgement of existing services (or lack thereof). The minimal variation between the bilateral schedules also suggests they may not be based on the needs of local communities, such as what would be identified by PHNs and local hospital networks in regional planning.

This approach has had adverse consequences for consumers.

> Very little funding is available in most mental health programs to provide the services that people are asking for – limiting the connection we can build in communities. For example, some models specify delivery of mental health services by psychologists, when social workers could be engaged more easily. (Marathon Health sub. 10, p. 3)

Funding standardised services entrenches existing programs and continues the approach whereby 'governments continue to fund what they know' (Simon Tatz, sub. 1, p. 2). While national consistency can be a positive, funding has not always been directed to services with high efficacy (Kisely and Looi 2022; KPMG 2022) and nationally consistent models of care can lack local relevance and trust. Submissions identified programs that had proven successful locally but had not been able to continue or scale up due to a lack of funding on offer for them (Ruah Community Services, sub. 14, IUIH, sub. 81). This recurring issue was noted by Occupational Therapy Australia (sub. 9, p. 6), who suggested:

> A key priority in the design [of a new agreement] will be ensuring that commissioning processes enable and strengthen existing local service capacity rather than overlaying new services with no local footprint.

The focus on national models of care may be particularly problematic for consumers who 'do not feel supported or understood by mainstream services' (Consumers Health Forum of Australia, sub. 22, p. 7) or who are not well served by them (for example, headspace has historically struggled to reach several priority populations (KPMG 2022, p. 238)). Some populations may be better served by targeted services that do not fit with the national model of care.

> Targeted services for people in rural and remote areas, First Nations people, young people, the LGBTIQA+ community and other groups with specific needs are critical to reaching vulnerable individuals. (Consumers Health Forum of Australia, sub. 22, p. 7)

The Agreement has not enabled systemic collaboration across the mental health and suicide prevention services

The Agreement's main function within the mental health and suicide prevention policy space is to enable greater collaboration and overcome the fragmented nature of the system. This critical component of reform is not funded in other agreements, but it is the 'glue' that brings together consumers, carers, providers and governments.

The PC has heard in some of its engagements that the Agreement may have encouraged discussion and collaboration between state and territory governments and PHNs beyond 'business as usual'. But this is not always the case:

> … gaps remain in cross-sector collaboration, resulting in individuals being passed between services without effective coordination. (Australian Association of Psychologists Incorporated, sub. 13, p. 9)

> The National Agreement has not achieved its goal of integrated and collaborative regional planning and commissioning. Despite guidelines requiring PHNs and Local Health Networks (LHNs) to engage in joint planning, many of the intended objectives remain unfulfilled. Key gaps include partnerships between PHNs and state/territory health systems, collaborative data-sharing agreements, and alignment with broader mental health strategies. (Mental Health Carers Australia, sub. 73, p. 22)

> Whole-of-government collaboration is weak, as suicide prevention efforts remain fragmented across portfolios, and while the National Agreement commits governments to cooperation, practical implementation and funding alignment are inconsistent. (National Mental Health Consumer Alliance, sub. 66, p. 22)

> There is a strong desire for states and PHNs to work together through the bilateral agreements but it isn't working as well at the frontline. People are still having trouble navigating services and equally frustrating for referrals across services – even within large HHS. (survey response from provider, sr. 71)

The Agreement contains many commitments to 'work together' but no practical guidance on how this will be achieved. Collaboration activities are not funded under the Agreement, and they are not included in bilateral schedules. Some review participants argued the expectations placed on PHNs are unclear and create significant challenges in the rollout of services (Adelaide PHN, sub. 62; PHN Cooperative, sub. 69). While the working groups established under the Agreement bring together officials from all jurisdictions, and in the case of Schedule A from different parts of government, there is little sense of collective purpose. This significantly limits the ability of the Agreement to achieve its key objectives such as working together, integrating and strengthening partnerships in service provision.

Draft finding 3.1
The National Mental Health and Suicide Prevention Agreement is not effective

The National Mental Health and Suicide Prevention Agreement is not an effective mechanism for facilitating collaboration between governments to build a better person-centred mental health and suicide prevention system for all Australians.

Some aspects of the Agreement are commendable, including its ambition, whole-of-government approach and commitments to improve services and address gaps in several important areas. However, a range of problems are limiting its effectiveness.

- The Agreement does not set out clear and focused objectives and outcomes, and actions connected to their achievement.
- Roles and responsibilities at the national and regional level are still unclear.
- People with lived and living experience of mental ill health and suicide, their supporters, families, carers and kin have not been meaningfully included in the governance arrangements, or the design, planning, delivery and evaluation of services under the Agreement.
- The governance structures are not effective, and monitoring and accountability is lacking.
- The Agreement does not address key barriers to reform, including system fragmentation, insufficient collaboration, a lack of flexibility in funding arrangements and workforce shortages.

4. Towards an effective agreement

Key points

- **A new National Mental Health and Suicide Prevention Agreement and a National Mental Health Strategy are needed to enable progress towards a person-centred mental health and suicide prevention system.**
- **Setting up the next agreement for success will require greater clarity on its goals and purpose, co-designed with people with lived and living experience. The next agreement must set out clear objectives and outcomes and include the specific funded commitments needed to achieve them.**
- **The structure and development of the next agreement can support greater impact.**
  - The role of the agreement within the mental health and suicide prevention policy environment should be made clear and links to other policies, including non-health policy, should be explicit.
  - A whole-of-government approach remains critical and should be elevated to the main body of the agreement, with commitments and funding attached. The Department of the Prime Minister and Cabinet should lead negotiation of the agreement with advice from the National Mental Health Commission.
  - Additional schedules to the agreement should be included where a distinct approach is needed, including for suicide prevention and Aboriginal and Torres Strait Islander social and emotional wellbeing.
- **Extending the current Agreement for one year would allow sufficient time to build strong foundations for the next agreement. This time should be used to co-design the next agreement's objectives and outcomes, improve outcome measurement and renew the National Mental Health Strategy.**
- **Governments need to finalise arrangements for the funding and commissioning of psychosocial supports outside the National Disability Insurance Scheme within the life of the current Agreement. Responsibility for psychosocial supports and carer and family supports must also be clarified in the next agreement.**
- **Governance structures can be strengthened through transparency and collaboration. Governance of the next agreement should be more transparent and involve greater participation of people with lived and living experience of mental ill health and suicide, carers and service providers.**
- **Strengthening the independence and powers of the National Mental Health Commission to oversee progress and making better use of data to report on progress can improve accountability.**
- **The next agreement should incentivise and enable best practice and support effective local commissioning, flexible service provision and evaluation.**

This chapter recommends a way forward for the next National Mental Health and Suicide Prevention Agreement. A new agreement is needed given the growing need to improve mental health and suicide prevention outcomes and persistent policy gaps (chapters 2 and 3). The next agreement should focus on reform that can be achieved within its term, while aligning with national strategies (including a renewed National Mental Health Strategy) (section 4.1).

Taking lessons from the setup of the current Agreement (chapter 3), the next agreement should make substantial changes to its goal setting, structure and development. The objectives and outcomes can be better articulated to establish transparent and focused goals. These goals should inform the commitments of the next agreement to support effective and meaningful reform (section 4.2). Extending the current agreement's funding would allow time for co-design of these goals and data developments to support them, and the development of a National Mental Health Strategy (section 4.3).

A whole-of-government approach remains vital and should be integrated throughout the main body of the agreement, with commitments and funding attached. Schedules should be used to focus on issues requiring a distinct approach, including suicide prevention and Aboriginal and Torres Strait Islander social and emotional wellbeing (section 4.3). Strengthening the links between the agreement and other mental health and suicide prevention policies can aid accountability and transparency, while links with other non-health policy documents (such as other national agreements) and systems (such as the National Disability Insurance Scheme (NDIS)) can enable a more integrated system of supports for consumers (section 4.3).

Government responsibilities for psychosocial supports and carer and family supports must be clarified in the next agreement. Additional funding and planning are needed to fill the unmet needs for psychosocial supports outside of the NDIS (section 4.4).

Governance and accountability can be strengthened in the next agreement by enhancing existing structures. Embedding transparency and more balanced representation in governance and formalising the role of the National Mental Health Commission (NMHC) are positive steps the next agreement can take (sections 4.5 and 4.6). Improvements to the collection, use and reporting of data can also improve accountability through progress reporting (section 4.6).

Ensuring the agreement results in best practice approaches to service delivery will be a matter of creating the right incentives, lowering barriers and better supporting enablers of sustainable and high-quality services (section 4.7).

4.1 A new agreement and national strategy are needed

While most outputs have been completed, the current National Mental Health and Suicide Prevention Agreement has not enabled significant progress towards reform in the mental health and suicide prevention system (chapter 2). This raises questions about the need for a new agreement, or whether reform efforts would be more effective if they were guided by, for example, a mental health and suicide prevention schedule to the National Health Reform Agreement (NHRA), or a sixth National Mental Health and Suicide Prevention Plan (chapter 1).

The PC's Mental Health inquiry (2020a, p. 1149) recommended the development of a national agreement, and the reasons for this are still relevant today. These included the need to:

- clarify the Australian, state and territory governments' and the NMHC's roles and responsibilities
- specify minimum funding commitments by both levels of government
- transfer responsibility to state and territory governments for psychosocial supports outside the NDIS
- facilitate regional planning and commissioning

- set out clear and transparent performance reporting requirements.

These goals would be hard to achieve without a national agreement and would likely not receive adequate attention if they were incorporated into an existing agreement or policy document. A separate mental health and suicide prevention agreement (rather than integrating commitments into the NHRA) protects and assures mental health and suicide prevention funding by separating it out from broader health funding. A dedicated agreement can also create helpful policy infrastructure to promote collaboration in mental health and suicide prevention (Mental Health Australia, sub. 76, p. 2). Review participants broadly affirmed the need for an agreement focused on mental health and suicide prevention.[14] For example:

> CHF supports the existence of a National Agreement and its whole-of-government approach to transforming and improving Australia's mental health and suicide prevention systems. (Consumers Health Forum of Australia, sub. 22, p. 4)

In addition, there is still a need for a separate mental health and suicide prevention agreement to enable a focus on cross-government collaboration. However, other policy tools are also needed to support an agreement. In particular, participants highlighted the need for a strategy to set out long-term policy objectives.[15]

A renewed national mental health strategy would help to set long-term objectives

The current Agreement sets many objectives, some of which speak to the long-term goals of the mental health and suicide prevention system (chapter 1). However, these do not provide clear strategic direction, and the term of the agreement does not allow adequate time for these goals to be achieved (chapter 3).

The recent National Suicide Prevention Strategy establishes the objectives of the suicide prevention system (chapter 6). However, it is difficult to identify a consistent objective within the mental health system.

Objectives for the mental health system can be found in a range of policy documents outside the Agreement.

- The last National Mental Health Strategy was first endorsed by governments in 1992 and is now over 30 years old. It encapsulates the *National Mental Health Policy*, *Mental Health Statement of Rights and Responsibilities* and the five successive National Mental Health Plans, which the Agreement has replaced. The role of the National Mental Health Strategy was not specified in the Agreement (COAG Health Council 2017, pp. 1–2).
- The *National Mental Health Policy*, first endorsed in 1992 and later updated in 2008, aspires to create a mental health system that:
  - enables recovery
  - prevents and detects mental illness early
  - ensures all Australians with a mental illness can access effective and appropriate treatment and community support to enable them to participate fully in the community (Australian Health Ministers Conference 2009, p. 2).
- The *Vision 2030: Blueprint for Mental Health and Suicide Prevention* document produced by the NMHC (2022, p. 3) contains a single vision statement of 'a connected, effective, person-centred and

[14] For example, Carers WA, sub. 43, p. 4; Consumers Health Forum of Australia, sub. 22, p. 4; Neami National, sub. 63, p. 4; Roses in the Ocean, sub. 19, p. 2.

[15] Community Mental Health Australia, sub. 84, p. 6; Health Justice Australia, sub. 65, p. 3; Mental Health Australia, sub. 76, p. 2; Michael Thorn, sub. 6, p. 2; NMHC and NSPO, sub. 70, p. 2.

sustainable mental health and suicide prevention system designed to meet the needs of all individuals and their communities'.

More specific objectives sit within targeted strategies. For example, the National Children's Mental Health and Wellbeing Strategy sets 14 objectives across the four focus areas of family and community, the service system, education settings and evidence and evaluation (NMHC 2021a, p. 8).

Setting the long-term goals of the system enables focused policy work and avoids ongoing short-termism undermining investment in longer-term goals such as prevention. National strategies in mental health and suicide prevention also have the capacity to align the collective efforts of health and non-health sectors for a whole-of-government approach (NMHC and NSPO, sub. 70, pp. 4-5; PC 2020a, p. 1078). Renewing the National Mental Health Strategy with a view to providing an agreed objective for the mental health system for the next 20–30 years would provide greater direction for the next and subsequent agreements. The next agreement should include a five-year plan for short-term progress towards the long-term objectives set out in the national strategies.

The next agreement should be explicitly linked to the renewed National Mental Health Strategy as well as the existing National Suicide Prevention Strategy. To some extent, the objectives defined in these strategies will overlap. Suicide prevention and mental health are intersecting policy areas with substantial cross over. For example, both suicide prevention and mental ill health prevention services may look to address social and economic factors. Similar social and economic factors can be associated with mental ill health and suicide, such as unemployment and economic disadvantage (AIHW 2025d; Kirkbride et al. 2024).

The NMHC is well-placed to develop a renewed strategy as their remit extends beyond health (Community Mental Health Australia, sub. 84, p. 6). The strategy should be renewed in a co-design process with people with lived and living experience, mental health carers, the mental health sector and state and territory governments. Consideration should also be given to aligning with the National Suicide Prevention Strategy where appropriate and were doing so is supported by those with lived and living experience of mental ill health and suicide and the mental health sector. The renewed strategy should also align with the forthcoming National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing.

Draft recommendation 4.1
Developing a renewed National Mental Health Strategy

A National Mental Health Strategy is needed to articulate a clear vision, objectives and collective priorities for long-term reform in the mental health system over the next 20–30 years. The National Mental Health Commission should oversee the development of this Strategy and undertake a co-design process with people with lived and living experience, their supporters, families, carers and kin.

The National Mental Health Strategy should take account of the objectives and actions included in the National Suicide Prevention Strategy, which was released in early 2025.

The next National Mental Health and Suicide Prevention Agreement should include actions governments will take over the agreement's term that are aligned with the long-term objectives articulated in the strategies.

4.2 Effective goal setting and connected actions for the next agreement

Clear and consistent objectives, supported by well-defined outcomes, will help to set transparent goal posts for the next agreement and increase its effectiveness (chapter 1). Co-design on these elements can ensure the goal posts are meaningful to consumers, carers and service providers (chapter 3).

In line with the theory of change principles (chapter 1), agreed priorities, commitments and initiatives should be informed by the objectives and outcomes. Creating logical, evidence-based connections throughout the agreement can increase the likelihood actions taken under the agreement lead to tangible improvements in consumer and carer outcomes and experiences. Embedding this structure will require the development of necessary policy architecture, better data collection and use, and a genuine co-design process. A longer lead up to the next agreement is needed for this foundational work.

Agreement objectives should link to strategic long-term goals

The National Suicide Prevention Strategy and a renewed National Mental Health Strategy (draft recommendation 4.1) should set the long-term direction of the system. The next agreement should identify clear and achievable objectives, which progress the system towards that strategic direction during its term.

Explicit links between national strategies and the next agreement would support long-term coordinated efforts towards shared goals (Consumers Health Forum of Australia, sub. 22, p. 6; RANZCP, sub. 7, p. 3). Such links would focus actions across successive agreements, even where short-term priorities may shift, and new challenges emerge (NMHC and NSPO, sub. 70, pp. 4–6).

Objectives in the next agreement should be simple and relevant to those engaging with the mental health and suicide prevention system. They should set goals for the agreement that are both ambitious and achievable. Participants suggested a focus on prevention, integration and a person-centred system in the next agreement, among other objectives.

> Prevention of mental ill-health to be included as a national priority, with the opportunity to use the next National Mental Health and Suicide Prevention Agreement to set, coordinate and monitor progress on two to five national priorities. (Everymind, sub. 32, p. 3)
>
> The Agreement should prioritise the delivery of connected services that allow a smooth transition and a clear referral pathway for people seeking help. (Lifeline Australia, sub. 8, p. 11)
>
> The RANZCP has previously highlighted in its Position Statement: Principles for a mental health system, which include equitable access, culturally safe, and person-centred. (RANZCP, sub. 7, p. 3)

Respondents to the PC's survey mentioned similar aspirations and emphasised the need for a more accessible and responsive system that provides seamless and comprehensive support and works to prevent crises before they arise (*What we've heard so far* paper). Co-design with people with lived and living experience (discussed further below) and collaboration between Australian, state and territory governments to identify and agree on the right objectives for the next five-year agreement will be essential.

The next agreement should focus on meaningful outcomes

The agreement should include a set of outcomes articulating what governments intend to achieve and that are more tangible than the high-level objectives. These outcomes should inform and guide reform efforts in the next agreement.

Achieving outcomes in the next agreement requires outcomes that are clear, measurable and relevant. Clear outcomes linked to the agreement's commitments increase the likelihood of effective and evidence-based activities being undertaken. Well-designed outcomes also support meaningful reporting. Progress assessments focusing on outcomes rather than service throughputs and activities can better measure the scale of the problem and the effect of the agreement on consumers (Lifeline Australia, sub. 8, p. 3; Marathon Health, sub. 10, p. 4; Ruah Community Services, sub. 14, p. 8; section 4.6).

This is a departure from the current approach, which places the focus on commitments and actions without explicitly linking them back to intended outcomes (chapter 3).

Outcomes in the next agreement should be relevant to consumers, carers and service providers and should be achievable within the term of the agreement. How an outcome is designed affects how it can be operationalised. The SMART framework is useful for designing functional outcomes (Lee and Jongenelis nd), and lessons should also be taken from past experiences with agreement outcomes (box 4.1). Identifying outcomes that are measurable will be particularly challenging given the gaps in outcomes data (chapter 2, box 2.1), but better use of existing data may help (discussed below).

Box 4.1 – Framework for developing effective outcomes

Outcomes should be specific, measurable and relevant to the sector. Some agreements, such as the National School Reform Agreement, include targets to focus their outcomes on achievable and time-bound commitments. The cumulative effective of these outcomes and targets is goal-setting that follows the SMART framework:

- Specific: the goal should be clear, detailed and well defined.
- Measurable: progress should be easy to demonstrate and evaluate.
- Achievable: the goal should be challenging but realistic and achievable.
- Relevant: the goal should relate to overarching objectives.
- Timed: the goal should have a clear timeline (Lee and Jongenelis nd).

Whether using outcomes or a combination of outcomes and targets, the next agreement should adhere to this framework to improve clarity, direction and accountability. Lessons should also be taken from the design of outcomes in the current Agreement (chapters 2 and 3). For example:

- key terms must be defined and widely understood
- outcomes should not be unduly constrained by how they should be achieved (for example, not restricting an outcome to only being addressed through a whole-of-government approach)
- outcomes should have buy-in from the sector to focus the collective efforts of the sector (which can be achieved through effective co-design, discussed in section 4.3)
- outcomes must be linked to indicators which are either already measured or feasibly able to be measured in the near term (discussed below).

The next agreement should enable a shift to a more outcomes-based approach in future mental health and suicide prevention policy. Refining the outcomes of the agreement, focusing monitoring and reporting on outcomes rather than activities, and supporting better measurement of outcomes are steps towards this goal.

This would also support greater outcomes-based funding in the mental health and suicide prevention system (World Economic Forum 2023, p. 10). Outcomes-based funding can incentivise high-quality and effective services (WQPHN, sub. 45, p. 8). Doing so would embed more flexibility into the system by allowing governments to focus on improving outcomes through place-based solutions. However, outcomes-based funding is complex to implement, and Australia's mental health and suicide prevention system is not yet mature enough for it be done effectively (section 4.7). The next agreement can help lay the foundations necessary to progress towards outcomes-based funding models.

Ensuring outcomes are measurable

Current data holdings need to improve to ensure outcomes in the next agreement can be robustly measured and tracked. Data is collected on outcomes within the mental health and suicide prevention system, but key data collections are sporadic (section 4.6), and some gaps remain (chapter 2). Data development has been underway, but more is needed to continue filling gaps (chapter 2). The ongoing development of a National Suicide Prevention Outcomes Framework by the National Suicide Prevention Office (NSPO) will support the measurement of outcomes (NSPO 2024c).

Existing data may be better used to support reporting within the next agreement (chapter 2). For example, sharing and linkage of minimum dataset collections at the primary health network (PHN) level would provide substantial information about the outcomes achieved through mental health and suicide prevention services (PHN Cooperative, sub. 69, pp. 16–17). Involving the Australian Institute of Health and Welfare (AIHW) in the design of outcomes for the next agreement would help make the most of existing data holdings and identify areas for feasible immediate improvements.

The AIHW is a central repository for health data and has existing expertise and relationships within the mental health and suicide prevention sector and with state and territory governments. It holds several relevant national minimum data sets (NMDSs), including the Community Mental Health Care NMDS, Mental Health Establishments NMDS and the Residential Mental Health Care NMDS. Under the current agreement, the AIHW worked with the Data Governance Forum to progress data developments identified in Annex B and support improvements to data sharing and linkage. Consultation with the AIHW throughout the process of identifying and designing outcomes for the next agreement should be facilitated by the NMHC. This consultation should be used to refine proposed outcomes, think through how existing data can be better used to support the next agreement and determine the feasibility of the development of new indicators. Ensuring outcomes are measurable and the necessary data is being collected to track them will aid future progress reporting and accountability.

Following the selection of outcomes for the next agreement, the AIHW should be tasked with developing a set of nationally consistent indicators to support their measurement. Implementation plans must be in place to develop any new indicators within 12 months of the agreement being signed. Involvement in the design stage should allow the AIHW more time for the development of these indicators and ideally reduce any additional data collection needed.

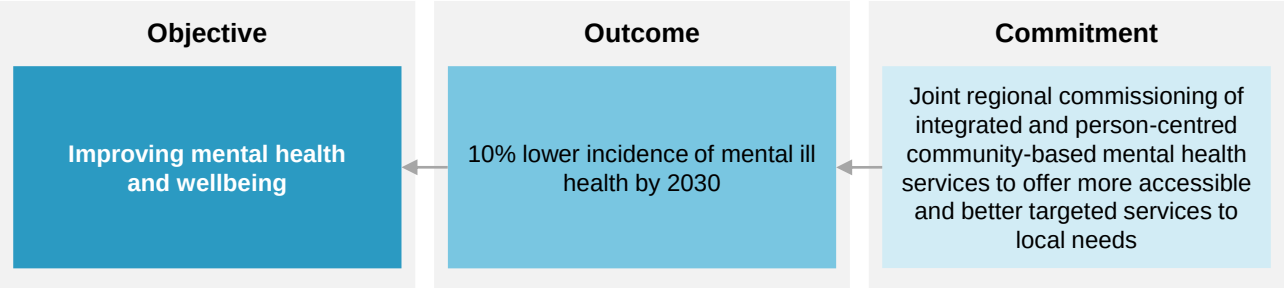
Commitments should be linked to the objectives and outcomes

The next agreement should explicitly link the objectives and outcomes of the agreement and the commitments agreed to by governments (chapter 1). Articulating these links helps ensure actions undertaken within the agreement are focused and relevant. Where commitments contribute to the achievement of agreed goals, the likelihood of evidence-based action increases. For consumers, carers and the broader sector, an agreement with clear links throughout provides transparency, demonstrating how it intends to affect change.

The Fifth National Mental Health and Suicide Prevention Plan (Fifth Plan) created these links by identifying priority areas for reform, specifying actions sitting within the priority area, followed by descriptions of how change will be measured including the direct impact on consumers and carers (COAG Health Council 2017).

These links are also illustrated in a worked example, showing how the elements of an agreement can inform one another (figure 4.1). This worked example is not intended as a recommendation for which objectives, outcomes or commitments should be in the next agreement. Rather, this example is intended to show how potential objectives and outcomes can be linked to agreement commitments.

Figure 4.1 – Worked example: Linking agreed commitments to objectives and outcomes



Embedding this approach throughout the next agreement will require sequencing. The development of objectives and outcomes must occur prior to negotiations on the commitments for the next agreement. A robust evidence base is also necessary to be able to link specific activities to the objectives and outcomes. A continuing emphasis on building an evaluation culture in the mental health and suicide prevention system will support this (section 4.7). The links between elements of the agreement can also be tested and refined through progress reporting where it includes reporting on outcomes, not just activities, to track whether the agreement is having the intended effect (section 4.6).

Draft finding 4.1
A new and more effective agreement is needed

A national agreement can be an effective mechanism to advance reform in the mental health and suicide prevention system, especially to facilitate joint actions by governments. To achieve this, the next agreement will need:

- a clear set of objectives that relate to the long-term visions set out in the National Suicide Prevention Strategy and a renewed National Mental Health Strategy
- a set of specific and measurable outcomes that focus on what is achievable within the scope of a five-year agreement
- commitments that are explicitly linked to the objectives and outcomes the agreement aims to achieve.

4.3 Changes to the structure and development of the next agreement

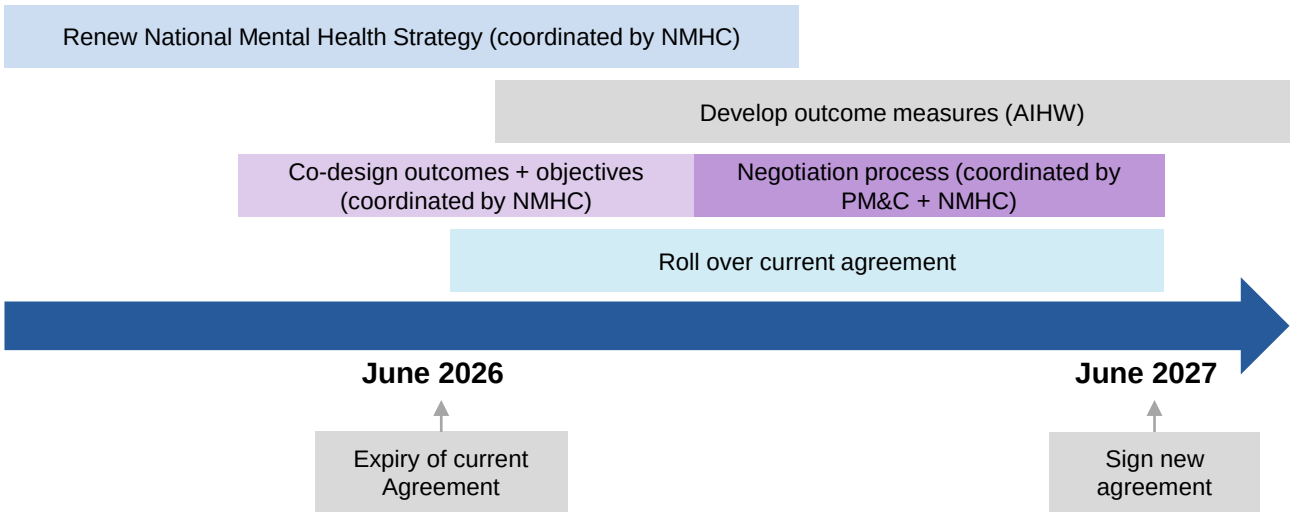
Governments should take the time to get the next agreement right

The foundational work required to improve the next agreement, including co-design processes and data developments, will take time. The eight months between the completion of this review and the signing of the next agreement (currently scheduled for June 2026) are insufficient to do this well. Rushing the development of the next agreement risks creating a document that has limited buy-in and relevance for those participating in the mental health and suicide prevention system.

The current agreement should be rolled over for a period of one year, including extending funded programs for the full period, with the aim of the next agreement being in place by June 2027.

The additional lead-in time created by rolling over the current agreement should be used to conduct a co-design process to develop objectives and outcomes for the next agreement, progress outcome measurement and data developments, and for the NMHC to renew the National Mental Health Strategy through a process of co-design (figure 4.2, section 4.1). The development of a renewed mental health strategy (comprising a long-term overarching plan and short-term implementation priorities) is likely to require 18–24 months to allow sufficient time for consultation, policy development and governmental endorsement (NMHC, pers. comm., 4 June 2025).

Figure 4.2 – Timeline for building the foundations for the next agreement



The process for renegotiation must start with co-design

The next agreement (including bilateral schedules) would benefit from a co-design process to establish a set of relevant and meaningful outcomes and objectives. Genuine co-design would allow people with lived and living experience of mental ill health and suicide and their supporters, families, carers and kin to be a part of defining the problem and setting the reform direction (chapter 3). The input of people with lived and

living experience at this stage has been welcomed by governments. For example, NSW Health (sub. 90, p. 3) stated:

> People with a lived and living experience of mental health issues and suicidality need to have a clear voice and opportunity to input into the scoping, development and decision making associated with the next Agreement.

This is a first step in the genuine engagement of people with lived and living experience that should continue throughout the execution of the next agreement in service planning, design, implementation and evaluation.

Running a genuine co-design process for the next agreement will take time. Lived and living experience peak bodies need to communicate and consult with their memberships, many of whom may not be well-resourced to contribute in a timely way (chapter 3).

Time should also be allowed to enable those engaged in co-design to build working relationships and trust, and work towards shared understandings (Tindall et al. 2021). This may also require a cultural shift within governments (chapter 3).

The co-design process could be facilitated by a re-invigorated, independent NMHC, similar to the process undertaken by the NSPO to develop the National Suicide Prevention Strategy. The outcome of this process should then be used to inform the rest of the negotiations.

Enabling whole-of-government reform

A whole-of-government approach to mental health and suicide prevention is one that addresses the social determinants of mental ill health and suicide and supports prevention, early intervention and seamless person-centred care (chapter 2). The need for a whole-of-government approach to mental health has been progressed since the first national mental health plan and carries through to the current agreement (COAG Health Council 2017, p. 3) with commitments to whole-of-government integration within the Agreement itself and in a separate schedule (chapter 1).

The current Agreement recognises the social determinants of mental ill health and suicide and commits to creating an integrated and unified system. Progress has been slow (chapter 2), and review participants emphasised the need to continue policy efforts towards integration across the health sector and relevant government portfolios.[16]

The next agreement should retain its focus on coordination across the health sector and whole-of-government integration while taking a more practical approach, prioritising areas for action in the five-year agreement period. Priorities should be in line with the renewed long-term strategy (section 4.1) and determined in conjunction with consumers and carers.

Whole-of-government priorities should be embedded in the core of the agreement rather than in a schedule to reflect the importance of collaboration to the delivery of an effective and person-centred system. Commitments to whole-of-government initiatives should be explicitly linked to the improvement of outcomes (section 4.2) and may require dedicated funding to ensure they are enacted. Funding should be considered for both collaborative initiatives and enablers of collaboration (such as information sharing and relationship building forums).

[16] For example, Beyond Blue, sub, 37, p. 2; Carers WA, sub 43, p. 4; Consumer Health Forum of Australia, sub. 22, p. 1; Health Justice Australia, sub. 65, p. 1; MATES in Construction, sub. 33, p. 5; Mental Health Australia, sub 76, p. 20; Michael Thorn, sub 6, p. 2; Neami National, sub. 63, p. 4; PHN Cooperative, sub. 69, p. 6.

Reflecting the need for cross-agency involvement in the next agreement, negotiations should be convened by the Department of the Prime Minister and Cabinet (PM&C), with advice from the NMHC. PM&C has a mandate for coordinating the policy approach to cross-cutting issues and ensuring the alignment of policies, programs and actions across the care and support economy (PM&C 2024). They have the positional authority to progress systemic change, while the NMHC has subject matter expertise and established cross-sectoral relationships. Having PM&C convene negotiations may help overcome the siloed approach to mental health and suicide prevention reform, enabling integration and collaboration across portfolios, and promoting a community approach to the mental health and suicide prevention system, rather than the current focus on clinical services.

Negotiations of bilateral schedules will determine some of the funding transfers and commitments agreed between each state and territory government and the Australian Government. While commitments, including funding, that are nationally consistent should be included in the main agreement, the bilateral schedules will include specific commitments that respond to the local circumstances in each state and territory. Current bilateral schedules primarily include pre-existing policies introduced by the Australian Government, with limited adaptation to local needs (chapter 1). Negotiations for future bilateral schedules will need to strike a balance between national consistency and flexibility for each jurisdiction to meet the needs of their communities while working with their existing services and capabilities (section 4.7).

Draft recommendation 4.2
Building the foundations for a successful agreement

The current National Mental Health and Suicide Prevention Agreement, including funding commitments, should be extended until June 2027, to give sufficient time to develop the foundations of the next agreement and renew the National Mental Health Strategy.

To support the next agreement:

- the National Mental Health Commission should run a co-design process with people with lived and living experience, and their supporters, families, carers and kin to identify relevant and measurable mental health and suicide prevention objectives and outcomes
- the Department of the Prime Minister and Cabinet should convene negotiations with the support of the National Mental Health Commission, and facilitate engagement between the Australian, state and territory governments on their shared priorities
- commitments and actions intended to improve collaboration across all government portfolios should be included in the main body of the agreement rather than a separate schedule. Governments should allocate dedicated funding for collaborative initiatives and enablers of collaboration
- the Australian Institute of Health and Welfare should lead the development of a nationally consistent set of outcome measures for mental health and suicide prevention. Implementation plans to develop any new indicators should be in place within 12 months of the agreement being signed.

Improving the interface with related policy areas

An agreement on mental health and suicide prevention must interact with the breadth of policy in the mental health and suicide prevention space and with other areas of social policy, such as housing, employment, justice, and family and domestic violence policy. It should be clear how the agreement intends to work with other mental health and suicide prevention policies and with the wider health and non-health systems.

Mental health and suicide prevention is a crowded policy space. There are several national policy documents and strategies for suicide prevention, workforce and children's mental health and wellbeing. States and territories have their own mental health legislation and many relevant strategies, plans and frameworks, many of which are independent from national policy. The agreement sits among these policy documents to enable collaboration and coordination between the two levels of government. Its purpose is to align the efforts of Australian, state and territory governments towards shared objectives and outcomes, to allocate funding, and to manage collective actions. This is a unique role unfulfilled by other policy documents.

Review participants noted the need for stronger connections between the agreement and other important policies such as the National Children's Mental Health and Wellbeing Strategy (Centre for Community Child Health, sub. 79, p. 8), the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy (RANZCP, sub. 7, p. 3), the Gayaa Dhuwi (Proud Spirit) Declaration, the forthcoming National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Social and Emotional Wellbeing (chapter 5; Gayaa Dhuwi (Proud Spirit) Australia, sub. 75, pp. 4–5) and the National Suicide Prevention Strategy (Roses in the Ocean, sub. 19, p. 6). Connecting the next agreement to the direction set in the various national strategies and clearly identifying where the agreement is seeking to progress specific outcomes or reforms listed in these documents would create a more unified and transparent policy space.

Already noted in the current Agreement are the important interfaces with the NDIS, NHRA and National Agreement on Closing the Gap. The mid-term review of the NHRA noted the need for the Agreement's outcomes to be progressed through the use of NHRA models of care, financing, innovation and performance monitoring (Huxtable 2023, pp. 1, 5). The recent review of the NDIS also stated the need for expanded psychosocial supports outside of the NDIS to be managed and delivered under the agreement (PM&C 2023, pp. 63–64), improved interface between the NDIS and mental health system (PM&C 2023, p. 70), and better management of the interdependencies of the NDIS and the mental health system (PM&C 2023, pp. 131–132). Alignment with the National Agreement on Closing the Gap should be improved, with detail on how the agreement intends to contribute to the Priority Reforms (chapter 5).

Interactions with broader non-health systems are also crucial to providing integrated, whole-of-person care. Mental ill health and suicidal distress have a reciprocal relationship with the economic and social conditions of a person's life (for example, homelessness can be a risk factor for mental ill health just as mental ill health can be a risk factor for homelessness) (Dunbar 2023, p. 3; Pirkis et al. 2023). These intersections are managed through select cross-sector commitments in Schedule A of the Agreement. Participants noted the need for integration efforts to go beyond referral pathways and co-location (Movember Institute of Men's Health, sub. 80, p. 5), and opportunities to improve integration through other national agreements, such as those on social housing and homelessness and school reform (Orygen, sub. 26, pp. 2–3). Links to other relevant sectors should be detailed in the main body of the agreement. Further opportunities to establish connections with other portfolios should be explored in the policy documents relevant to that portfolio (such as the commitments made to student wellbeing in the National School Reform Agreement).

Draft recommendation 4.3
The next agreement should have stronger links to the broader policy environment

The next agreement should articulate its role within the policy environment and specify the way it links with other key policy documents. This will require consideration of the interactions with a range of policy areas including housing, justice, disability supports and more. As a starting point, the next agreement should link to:

- the National Health Reform Agreement, which provides much of the funding for the mental health and suicide prevention system
- key policies in relevant non-health portfolios, such as the Better and Fairer Schools Agreement
  - which will support the whole-of-government approach needed to improve mental health and suicide prevention outcomes (draft finding 4.1)
- jurisdictional mental health and suicide prevention policy documents, which should inform the bilateral schedules developed under the agreement
- policy documents related to Aboriginal and Torres Strait Islander social and emotional wellbeing, including the National Agreement on Closing the Gap (draft recommendation 5.1).

New schedules in the next agreement

Agreement schedules can be used to give separate attention to specific issues. This is particularly useful where aspects of these issues are distinct from the broader mental health and suicide prevention system. Suicide prevention and the social and emotional wellbeing of Aboriginal and Torres Strait Islander people are two such issues (chapter 5 and 6).

Aboriginal and Torres Strait Islander people have distinct and diverse concepts and experiences of wellbeing (often described through the framework of social and emotional wellbeing). A separate, co-designed Aboriginal and Torres Strait Islander schedule would locate commitments to improving social and emotional wellbeing together, recognising the need for specific actions and increased visibility and accountability. While broader reforms will be relevant to Aboriginal and Torres Strait Islander social and emotional wellbeing, a separate schedule allows a focus on their unique needs (chapter 5).

The suicide prevention system also has areas that are distinct from the mental health system, such as the management of suicidal behaviours, means restriction and aftercare and postvention services. The National Suicide Prevention Strategy, forthcoming National Suicide Prevention Outcomes Framework and the NSPO form a policy environment that could be drawn on to support suicide prevention activities within the agreement. Areas that are unique to suicide prevention should be included in a separate schedule to ensure they receive sufficient attention (chapter 6).

Participants also raised the interaction between alcohol and other drugs and mental health and suicide prevention and the need to include consideration of issues related to alcohol and other drugs in mental health and suicide prevention policy (Movember Institute of Men's Health, sub. 80, pp. 4–5; sr. 94; sr. 162). The approach to alcohol and other drugs is different across jurisdictions; some have integrated it into the mental health and suicide prevention space while others treat it separately. A schedule to the next agreement, focused on alcohol and other drugs, could be one way to enable national leadership and consistency. However, tying alcohol and other drugs in with mental health and suicide prevention may also be overextending the resourcing and capacity of this agreement.

Information request 4.1

The PC is seeking views on whether there should be an additional schedule in the next agreement to address the co-occurrence of problematic alcohol and other drug use and mental ill health and suicide.

4.4 Addressing unresolved issues from the current Agreement

Psychosocial supports require an urgent solution

As discussed in chapter 2, governments have not met their commitment to develop and agree to future psychosocial support arrangements (including roles and responsibilities) for people who are not supported through the NDIS (clause 127). This has left a critical gap in support for about 500,000 people (HPA 2024, p. 11).

The PC previously recommended a national agreement clarifying state and territory government responsibility for commissioning and increases funding for psychosocial supports with contributions from the Australian Government (2020a, pp. 1146–1147).

In 2023, a review of the NDIS recommended National Cabinet agree to jointly invest in psychosocial supports outside the NDIS as a targeted foundational support, including expanding Australian, state and territory government services to address unmet need. It also recommended the expansion of services for people with severe and persistent mental ill health be managed and delivered under the Agreement. Alongside this, it recommended National Cabinet agree to jointly design, fund and commission an expanded set of foundational disability supports outside individualised NDIS budgets (PM&C 2023, pp. 60–64). In December 2023, National Cabinet agreed that the Australian, state and territory governments should jointly commission foundational supports, and consultation has begun on the design and implementation of these supports (Albanese 2023; DSS 2025).

While governments should be mindful of the processes for determining how foundational supports are designed and funded (Tasmanian Government, sub. 78, p. 7), this should not delay decisions about how psychosocial supports are commissioned and funded outside the NDIS.

Review participants strongly argued that a resolution is needed.[17] The Queensland Alliance for Mental Health (sub. 83, p. 5) stated 'without urgent clarification, people will continue to be excluded from services, falling through the cracks'. The Mental Illness Fellowship of Australia (sub. 88, p. 15) suggested under the next agreement:

> The Commonwealth, States and Territories unilaterally commit to addressing the psychosocial support gap for individuals and family carers and chosen supporters within four years based on the proportion of the need they currently address while system improvements are underway.

[17] Australian Psychosocial Alliance, sub. 55, p. 4; Community Mental Health Australia, sub. 84, p. 7; Mental Health Australia, sub. 76, p. 24; NSW Health, sub. 90, p. 3; Skylight Mental Health, sub. 91, p. 2; Western Australian Association for Mental Health, sub. 82, p. 4.

Governments need to finalise arrangements for the funding and commissioning of psychosocial supports immediately, within the life of the current Agreement. These arrangements need to be clearly defined. To achieve this, states and territories should be responsible for commissioning psychosocial supports. The Australian, state and territory governments should jointly fund psychosocial supports, with the Australian Government providing funding to the state and territory governments to help cover the shortfall in support.

While the next agreement is being negotiated, state and territory governments should immediately begin commissioning services to address unmet need. PHNs should work with state and territory governments, and providers to support this expansion and transition. PHNs have experience commissioning psychosocial supports and existing relationships. For example, Partners in Recovery was a long-standing service commissioned across PHNs from 2012 until 2019 to support people with mental health conditions to access services and supports in partnership with local organisations (Mental Health Coordinating Council nd; Trankle and Reath 2019).

The next agreement should:

- confirm the roles and responsibilities for psychosocial supports and the funding split between the Australian, state and territory governments
- include Australian Government funding to the state and territory governments to help cover the shortfall in support, if needed
- include a detailed plan and timeline for the expansion of services, with the aim of fully addressing the unmet need by 2030.

Draft recommendation 4.4
Governments should immediately address the unmet need for psychosocial supports outside the National Disability Insurance Scheme

The Australian, state and territory governments need to immediately agree to responsibilities for psychosocial supports outside the National Disability Insurance Scheme. State and territory governments should be responsible for commissioning services and commence work to address the unmet need.

The next agreement should:

- confirm the roles and responsibilities for psychosocial support and the funding split between the Australian, state and territory governments
- include Australian Government funding to the state and territory governments to help cover the shortfall in support
- include a detailed plan and timeline for the expansion of services, with the aim of fully addressing the unmet need by 2030.

Responsibility for carer and family supports should be clarified in the next agreement

Nearly one million Australians cared for someone with mental illness, with about 273,000 acting as the primary carers for a person with mental illness in 2018 (PC 2020a, pp. 872–873). Carers play a vital role in the mental health and suicide prevention system, often at the expense of their own physical and mental health, employment prospects, financial security and social participation.

The issues carers face are many and complex (*What we've heard so far* paper). Caring for someone with mental ill health or supporting someone through suicidal distress can have a negative impact on the carer's own physical and mental health (Phillips et al. 2022, p. 2). The wellbeing of carers and consumers is interdependent. As one carer put it:

> If I were to stop helping, the consequences for my daughter would be catastrophic - more hospitalisations, homelessness, or worse. My wellbeing is directly tied to my daughter's survival. This is the reality for many of us, caught in a system that expects everything but offers little in return. (Mental Health Carers Australia, sub. 73, p. 7)

Mental ill health and suicide can also significantly affect family dynamics (Robinson et al. 2008, p. 1) and different family members are likely to be affected in different ways (SANE 2015). Review participants reflected on some of these impacts.

> Despite considerable advocacy for my daughter, I was often dismissed and had to fight tirelessly to get support for her. (sr. 74)

Many crucial supports for carers and families, such as income supports and the carer gateway, are funded by the Australian Government outside of the Agreement. The PC's Mental Health inquiry recommended the Agreement clarify that state and territory governments are responsible for the planning and funding of carer support services for mental health carers and family support services for families affected by mental illness (2020a, p. 868). However, the current Agreement makes no mention of responsibilities for carer or family supports, resulting in adverse outcomes for consumers and carers, inconsistencies in service provision and insufficient support for carers (Carers ACT, sub. 60, p. 5).

> Supports for Carers and family members of people with mental health has been incredibly difficult to access and availability of needed help has decreased … (sr. 84)

While carer and family supports can help people grapple with the difficulties associated with a person's mental ill health or suicidal distress, carers take on additional roles and responsibilities that come with their own unique difficulties. Carers would benefit from greater consideration of their needs and communication with mental health and suicide prevention services. The Mental Health Statement of Rights and Responsibilities highlights these as rights for carers, including the right to 'comprehensive information, education, training and support to facilitate their care and support roles' and, with the consent of the consumer and where appropriate, 'participate in treatment decisions and decisions about ongoing care' (Standing Council on Health 2012, pp. 19–20). To some extent, these objectives should be pursued outside of the agreement, for example, by amending the Medicare Benefits Schedule to include rebates for family and carer consultations (PC 2020a, p. 77). However, given the agreement's role in embedding lived and living experience and fostering collaboration, the services it funds could also look for opportunities to improve the way they work with carers and address their needs.

Carer involvement in the design and implementation of the next agreement – for example, through the co-design processes recommended in draft recommendation 4.2 and in the working groups established under the agreement (section 4.5) – will go some way to recognising the contributions and challenges faced by carers and ensuring the next agreement is informed by carers' perspectives and needs.

Draft recommendation 4.5
The next agreement should clarify responsibility for carer and family supports

The next agreement should clarify the level of government responsible for planning and funding carer and family support services for supporters, families, carers and kin of people with lived and living experience of mental ill health and suicide.

4.5 Opportunities to strengthen governance

Building on established governance arrangements

Effective governance is critical to any health system (WHO 2007, p. 23). Good governance can aid integration of services, promote public trust in decision-making and help governments to implement their commitments.

Existing governance arrangements provide an appropriate structure for an intergovernmental agreement (chapter 3). Review participants reflected positively on aspects of the current arrangements, with a particular focus on interjurisdictional collaboration.[18] There are similarities with the current structures and those recommended by the PC for other agreements, such as a ministerial council, relevant working groups including data governance forums and connections to relevant Aboriginal and Torres Strait Islander partnerships or working groups (PC , p. 41, 2021, p. 64, 2022a, p. 35).

Despite some positive steps, aspects of the current governance arrangements lack effectiveness and have faced criticism (chapter 3).[19] Rather than dismantling this framework, there is a clear opportunity to enhance it and make it more suitable for a strengthened whole-of-government agreement. Improvements to accountability will also support existing governance structures to be more effective (section 4.5).

Increase transparency of governance arrangements

Openness and transparency around government decisions are key drivers of public trust (APSC 2018). Transparency and accountability can motivate governments to take effective action. Existing governance arrangements are opaque; the next agreement should embed greater transparency throughout its governance structures to enable public accountability and trust.

Working groups can be an effective mechanism for assigning responsibility, focusing effort and convening key actors. The 2022–2023 National Progress Report (NMHC 2024a, p. 11) noted working groups reported implementation was ‘progressing well’ as at June 2023. However, it remains unclear what the intended activities of each group is and what outcomes have been delivered through these groups. The 2022–2023 National Progress Report also noted the Schedule A Working Group had developed a work plan for its first year of operation. However, there is no public information on what was included in the work plan, nor whether this plan was followed (NMHC 2024a, p. 16). Similarly, the Social and Emotional Wellbeing Policy Partnership was endorsed as the primary governance body advising on Aboriginal and Torres Strait Islander mental health and wellbeing; however, it is unclear, outside of having representatives on the Mental Health

[18] For example, Beyond Blue, sub. 37, p. 1; Mental Health Australia, sub. 76, p. 21; NSW Health, sub. 90, p. 3; Tasmanian Government, sub. 78, p. 6.
[19] Mental Health Australia, sub. 76, p. 21; NMHC and NSPO, sub. 70, p. 13; RANZCP, sub. 7, p. 4; Roses in the Ocean, sub. 19, p. 2.

and Suicide Prevention Senior Officials Group (MHSPSO), how these two groups are intended to interact (chapter 5). Specifying clear roles in the agreement for the different governance bodies and providing public information on the participants and represented organisations on each working group allows for greater public scrutiny of these working groups. To support transparency of governance arrangements, this information should be published alongside public reporting on meeting frequency and detailed information on responsibility for deliverables and progress of working groups (like the Implementation Plan Action Status Report published as part of the National Agreement on Closing the Gap reforms).

Transparency among working groups, and between the working groups and MHSPSO, should also be pursued. While working groups are formed with a focus on a specific policy issue, there is substantial overlap both in subject matter and stakeholders. For example, the perspectives shared by the Lived Experience Working Group would be beneficial to all other working groups (discussed below). Likewise, the sharing of information between the working groups and MHSPSO would allow the working groups to be better informed about decisions made and to provide feedback and advice prior to decision making. A lack of transparency regarding MHSPSO was noted by Mental Health Australia (sub. 76, p. 23):

> … public communiques on the outcomes of MHSPSO meetings are important, to date they have lacked adequate information to support transparency monitoring and accountability for delivery of the Agreement.

Adequately resourcing the agreement's administrative function and developing information-sharing processes to ensure timely and effective communication across working groups and to the public, would support collaboration and transparency of governance.

Centring the voices of people with lived and living experience in governance

A lack of consumer and carer involvement in strategy, programs and accountability lowers the quality of decision-making and system performance. The perspectives of people lived and living experience of mental health ill health and suicide are grounded in the realities of navigating the mental health and suicide prevention system. The inclusion of empowered, balanced and remunerated representation of people with lived and living experience is essential to building an equitable, effective and person-centred system (Sartor 2023; World Health Organization 2022, pp. 92–94).

There is increasing recognition of the value of including people with lived and living experience in governance (Lumby 2024, p. 6). The Agreement rightly acknowledges this value and the commitment to embedding lived experience is enshrined in its principles. However, as discussed in chapter 3 and noted by Mental Health Australia (sub. 76, p. 21):

> … there are inconsistencies in the integration of lived experience and carer, family and supporter representation in the governance structures of the National Agreement. This is a fundamental flaw in the implementation of the governance arrangements of the National Agreement.

Review participants acknowledged the positive step of including people with lived and living experience in the governance structures of the Agreement (Mental Health Australia, sub. 76, p. 21; Mental Health Carers Australia, sub. 73, p. 11; NMHC and NSPO, sub. 70, p. 16). However, they expressed a general sentiment that the presence of lived and living experience representatives in these forums had not ensured meaningful participation or the ability to influence the strategic direction or implementation of the agreement (NMHC and NSPO, sub. 70, pp. 16–17). Some described existing efforts as 'tokenistic' (Community Mental Health Australia, sub. 84, p. 4) and reported high turnover of lived and living experience representatives (Roses in the Ocean, sub. 19, p. 2).

The next agreement should reflect authentic partnership between government, the sector and lived and living experience representatives in governance forums. Unnecessary barriers to engagement with people with lived and living experience of mental ill health and suicide should be removed in the next agreement. Barriers such as confidentiality agreements should be limited, as they could prevent lived and living experience representatives in governance forums from seeking feedback on issues raised in working groups from their peers. Lived and living experience representatives should have greater opportunities to share their expertise with other working groups.

Draft recommendation 4.6
Increase transparency and effectiveness of governance arrangements

The effectiveness of the next agreement's governance arrangements should be improved by:

- including a governance framework that emphasises transparency and collaboration, and outlines accountability, reporting and evaluation functions
- embedding and formalising the participation of people with lived and living experience of mental ill health and suicide in the design and implementation of governance arrangements
- clarifying the role of the Social and Emotional Wellbeing Policy Partnership established under the National Agreement on Closing the Gap as the decision-making forum over issues that relate to Aboriginal and Torres Strait Islander social and emotional wellbeing (draft recommendation 5.1)

To support effective operation of the agreement's governance arrangements, the Australian Government should:

- establish the National Mental Health Commission as an independent statutory authority and task it with monitoring and reporting on progress and outcomes (draft recommendation 4.8)
- publish information about the composition and activities of the working groups established under the agreement
- adequately resource the agreement's administrative functions and ensure timely and effective information sharing across working groups.

Information request 4.2

The PC is seeking examples of barriers to the genuine participation and influence of people with lived and living experience in governance forums. How could successful inclusion and engagement of people with lived and living experience in governance be measured?

Improving the composition of lived and living experience representation in governance will enable greater diversity of perspectives. Review participants raised issues with the current composition of working groups. Many participants noted the imbalance of perspectives on mental ill health and suicide, noting the underrepresentation of people with lived and living experience of suicide.[20] The NMHC and NSPO (sub. 70, p. 16) suggested a 'more balanced approach to representation between lived experience of mental ill health

[20] NMHC and NSPO, sub. 70, p. 16; NSW Health, sub. 90, p. 3; Roses in the Ocean, sub. 19, p. 2.

and suicide on the [Lived Experience Group] would be beneficial'. The need for representation of carers in governance forums was similarly raised (Carers ACT, sub. 60, p. 4).

> In order to authentically represent a perspective with integrity in governance spaces, both carer and consumer experiences must be recognised as independent and separate of each other and both be given opportunities for involvement and representation matched to the context and issue being explored. (Hodges et al. 2023, p. 10)

Since the finalisation of the Agreement, the Australian Government has funded two national peak bodies – the National Mental Health Consumer Alliance, representing consumers, and Mental Health Carers Australia, representing carers and families. Initial funding has facilitated the establishment of these two bodies. However, they are operating with limited resourcing. These bodies play a complex role, representing the diverse experiences of carers and consumers, and their role is growing as the need for co-design to underpin system planning, design, monitoring and implementation is increasingly recognised. If adequately resourced, these peak bodies are likely to be well placed to play an expanded role across the governance structures of the next agreement.

In conjunction with people with lived and living experience, carers and relevant peak bodies, governments should review the governance structures of the next agreement to ensure balanced representation between people with lived and living experience of mental ill health and people with lived and living experience of suicide and the representation of carers in the governance structures.

The incorporation of lived and living experience expertise and peak bodies also requires adequate remuneration and resourcing. Participation in governance forums by people with lived and living experience and the peak bodies representing them is resource intensive. Participants should be adequately remunerated and peak bodies adequately resourced to support and incentivise meaningful participation.

Draft recommendation 4.7
The next agreement should support a greater role for people with lived and living experience in governance

The Australian, state and territory governments should address barriers to the effective involvement of people with lived and living experience in the governance of the next agreement. This should include limiting the use of confidentiality agreements with lived and living experience representatives, opening greater opportunities for communication between lived and living experience working groups, other working groups and the senior officials group, and appropriately remunerating lived experience representatives.

The makeup of governance forums for the next agreement should be reconfigured to ensure:

- adequate representation of people with lived and living experience at each level of governance
- balanced representation between people with lived and living experience of mental ill health and lived and living experience of suicide
- governance roles for carers commensurate with the significant role they play in Australia's mental health and suicide prevention system.

The next agreement should articulate formal roles for the two recently established national lived experience peak bodies in its governance arrangements. These bodies should be adequately resourced to fulfill these roles.

Review the role of the sector in governance arrangements

Australia has a diverse and engaged mental health sector. This is reflected in the level of engagement from the sector in this review and the PC's 2020 Mental Health inquiry, as well as many other government processes. Despite this deep expertise, review participants noted a lack of engagement with the broader sector in governance arrangements (chapter 3).21 The NMHC and NSPO (sub. 70, p. 13) identified this as a key limitation within current governance arrangements.

> [A]n absence of actors outside the government sector in the governance process has hampered capacity to ensure interoperability of service arrangements and limited the efficiency of monitoring.

The next agreement should support a greater role for the broader sector in governance. For example, the agreement could include designated roles for representatives from the sector, including peer workers, in the working groups, enriching them with a more practical perspective on the implementation of the agreement. Alternatively, a sector reference group could be established to inform decision making of the MHSPSO group and other working groups. Both mental health and suicide prevention expertise should be included in an expanded governance role for the broader sector.

Draft recommendation 4.8
A greater role for the broader sector in governance

The next agreement should support a greater role for service providers and the broader mental health and suicide prevention sectors in governance. Both mental health and suicide prevention providers should take part in governance mechanisms.

4.6 Strengthening accountability mechanisms through better use of data

Accountability in the next agreement can be strengthened through increased public reporting and further empowering the NMHC to undertake their monitoring and reporting responsibilities.

Public reporting should be improved

Monitoring and reporting can support greater accountability by requiring reports to be made publicly available. It is difficult to assess progress under the current Agreement without a clear understanding of what commitments have been progressed or completed. Aggregation across all states and territories in the national progress report, without detailed information on each jurisdiction being made available, further hinders this transparency.

> Reporting on the National Agreement itself remains inadequate. The most recent annual report covers the 2022–2023 financial year but lacks substantive evidence beyond indicating the number of initiatives assigned a completion rating. There is little detail regarding which initiatives have

[21] Australian Psychosocial Alliance, sub. 55, p. 14; Mental Health Australia, sub. 76, p. 22; Neami National, sub. 63, p. 17; Western Australian Association for Mental Health, sub. 82, pp. 6–7.

> progressed, stalled, or experienced inaction. This highlights the poor quality of reporting and the lack of accountability. (Mental Health Carers Australia, sub. 73, p. 13)

There is also limited transparency over how the Agreement is rolled out, with implementation plans not publicly available. The publication of implementation plans would allow consumers and the broader sector to understand how the agreement is set to progress, and to hold governments to account if commitments are not delivered in a timely way. The Fifth Plan and Gayaa Dhuwi (Proud Spirit) Declaration set a precedent for this practice by publishing implementation plans (Gayaa Dhuwi (Proud Spirit) Australia 2025; NMHC 2021b). Progress reporting should be seen as an opportunity for the public to hold governments to account for their commitments and the effect of their commitments on consumers and carers. It should be clear what has been delivered and the impact it has had, and what commitments have been delayed and why.

Performance reporting at the jurisdictional level, full national progress reports (rather than the summary that has been published to date) and implementation plans should be in the public domain. Further, the scope of assessment should not be confined to jurisdictional reporting. The NMHC should be empowered to report on progress using information gathered from service providers, consumers, lived and living experience groups and commissioning agencies. Removing requirements for reports to be agreed to by MHSPSO prior to their finalisation and publication will further enable transparency.

Publication of progress reports and implementation plans is just one part of strengthening accountability. Improvements to the reporting itself would also support greater accountability with the public. Review participants argued improvements to the quality of reporting should include a stronger focus on outcomes, including for carers (Mental Health Carers Australia, sub. 73, p. 13), reporting on whole-of-government commitments (Lifeline Australia, sub. 8, p. 6), including by non-health departments (Ruah Community Services, sub. 14, p. 11), and reporting on the activities and outcomes of the various agreement working groups (section 4.5).

Current reporting commitments only allow for the NMHC to consolidate the information provided to them by the state and territory governments. Future reporting would benefit from allowing the NMHC to act as an independent assessor of progress (discussed below). A stronger emphasis on reporting how agreement activities have shifted outcomes would also be an improvement. The 2022-23 National Progress Report noted the intent to report on progress towards the Agreement's objectives and outcomes in the future using a range of indicators and outcome measures that are yet to be developed (NMHC 2024a, p. 17). It may take some time to develop a set of measures to report on agreement objectives and outcomes and existing data should be used to fill this gap to the extent possible.

Draft recommendation 4.9
Share implementation plans and progress reporting publicly

The Australian, state and territory governments should publish all implementation plans and jurisdictional progress reports developed under the next agreement.

The National Mental Health Commission should be empowered to assess and report on progress independently, using information beyond what is reported by governments. The Commission should publish national progress reports as they are finalised, without requirements for jurisdictions' sign-off.

The next agreement should empower oversight bodies

Bolstering the role and capacity of bodies tasked with monitoring and reporting could also help overcome data and information gathering issues (Mental Health Carers Australia, sub. 73, p. 15).

The current Agreement states that through the governance forum, governments will consider a role for the NMHC in monitoring (clause 102h). The next agreement should formalise the role of the NMHC as the entity responsible for genuinely independent and ongoing monitoring, reporting and assessment of the progress under the agreement.

The PC has previously recommended legislative powers for the NMHC to compel information from Australian, state and territory government agencies when required to fulfil its statutory functions (2020a, p. 1127). In a submission to this review, the NMHC and NSPO (sub. 70, p. 11) recommended:

> Future monitoring and reporting must be conducted by an appropriately resourced oversight body with independent authority to collect data and publish its reports …

The NMHC reporting on the current Agreement was significantly delayed as jurisdictional reporting was late. Given the importance of the NMHC's monitoring and reporting role in maintaining accountability within the Agreement, the NMHC should be given legislative powers to make reasonable requests for information in the course of its monitoring and reporting responsibilities.

The NSPO should also play a role in overseeing the next agreement and assessing its effectiveness. The subject matter expertise and stakeholder relationships of the NSPO will be beneficial in this process. However, consideration should also be given to minimising additional reporting burden. The NSPO should be tasked with monitoring and reporting on progress against the suicide prevention schedule (chapter 6) and be given an advisory role in the monitoring and reporting requirements of the core agreement, enabling them to contribute to assessing progress where it is most relevant to suicide prevention.

Draft recommendation 4.10
Strengthening the National Mental Health Commission's reporting role

The next agreement should formalise the role of the National Mental Health Commission as the entity responsible for ongoing monitoring, reporting and assessment of progress against the agreement's outcomes.

The Commission should have legislative provisions to compel information from Australian, state and territory government agencies to fulfil its reporting role.

The National Suicide Prevention Office should be given an advisory role in monitoring and reporting on the next agreement. It should also be responsible for the monitoring and reporting on progress against the separate suicide prevention schedule (draft recommendation 6.1).

Monitoring progress under the agreement

Improving the public reporting on service performance and outcomes should be a priority for the next agreement. Good performance monitoring and reporting systems help to identify, measure and learn from instances of good practice, support consumer choice and information and create a reputational incentive to improve quality (Hibbard et al. 2005; Medicare Benefits Schedule Review Taskforce 2020, p. 35).

Performance reporting of mental health and suicide prevention services is currently done nationally, disaggregated to the state and territory level. The Report on Government Services benchmarks the performance of each state and territory on a range of indicators related to their mental health system's equity, effectiveness and efficiency (SCRGSP 2025), although there is little data on the community sector. The NMHC (2023) publishes an annual National Report Card on the performance of Australia's mental health system over time under three broad domains; key national mental health and wellbeing outcomes, social determinants of mental health and system inputs and activities. The AIHW reports on a set of KPIs for public mental health services developed under the national mental health performance framework, and on National Healthcare Agreement indicators for clinical services, which can be disaggregated at the state and territory level (AIHW 2025c). Some states and territories also have their own benchmarking mechanisms. For example, the Mental Health Commission of NSW (2025) has a dashboard of Living Well Indicators, which includes metrics of mental health and suicide prevention outcomes, system investment, use and experiences at the state level. This reporting provides a picture of state and territory performance although outcome reporting is not always present and data cannot be disaggregated, for example, to the service provider level. More granular reporting and more outcome reporting, including at the service provider level, could enable greater consumer choice and incentivise performance improvements (PC 2020a, pp. 1220–1221).

While mental health and suicide prevention are data rich areas, existing reporting mechanisms make insufficient use of this data to track and demonstrate progress. There is likely to be benefit in drawing together disparate data sources to report on improvements within the mental health and suicide prevention system and changes to consumer and carer outcomes. Feeding back this information to service providers, PHNs and local hospital networks (LHNs) in a timely way would also support better service planning and commissioning. Neami National (sub. 63, p. 10) advocated for a similar approach to that taken under the National Agreement on Closing the Gap framework, including a public dashboard showing progress on agreement activities across priorities, targets and outcome areas. Doing so would require substantial improvement in the clarity and measurability of the agreement's outcomes (draft finding 4.1). The final report will explore ways of reporting on agreement progress and consumer and carer outcomes, including whether a public dashboard should be used. The PC will also be looking at critical data gaps, particularly gaps in outcomes data, that must be filled to be able to report meaningfully on progress.

Information request 4.3

The PC is seeking views on the value and feasibility of having a public dashboard to track and report on progress under the next agreement's objectives and outcomes and any other measurable targets set throughout.

Which bodies should be responsible for the collation and publication of dashboard data? What metrics should be included in the dashboard?

Select population surveys should be run more frequently

Several population surveys provide detailed information on mental health and suicidality in Australia, but they are run too infrequently to provide current information or to track progress.

For example, the National Study of Mental Health and Wellbeing is the main source of population level mental health data, but it has only been run in 1997, 2007 and, most recently, 2020–2022 (ABS 2023). There

is no information available on when it will next be run. The PC's previous Mental Health inquiry recommended the survey be run no less than every 10 years (2020a, p. 1198). However, given the lack of up-to-date data on prevalence of mental ill health, and concerning trends in recent years, there would be benefit in running the survey more frequently. Running the survey every five years would improve the ability to establish and track trends and aid evidence-based and targeted policy.

Given the growing prevalence of mental health ill health and lack of understanding about suicidality in young people, survey data collection on young people's mental health and suicidality should be routinely available, with surveys run at least every five years. The National Study of Mental Health and Wellbeing collects data on those aged 16–85 years, excluding young people. The Young Minds Matter survey provides the latest data on children and adolescents aged 4–17 years and was run in 2014 (Kids Research Institute 2013). Following a recommendation of the National Children's Mental Health and Wellbeing Strategy, funding has been allocated for a child and adolescent mental health and wellbeing study to be run in 2025 (DoHAC 2024f). This study is not a regular data collection exercise as discussed in the strategy (NMHC 2021a, p. 84).

Survey data provides a valuable picture of the population as it can reach those who are not accessing mental health and suicide prevention services and investigate a broad range of questions. However, it is costly to run population surveys. For example, the National Study of Mental Health and Wellbeing was funded as part of the Intergenerational Health and Mental Health Study comprising four population surveys which cost $89.5 million (DoHAC 2021a).

Both the National Study of Mental Health and Wellbeing and the child and adolescent mental health and wellbeing study should be made routine data collections to inform ongoing policy efforts and direct funding in mental health and suicide prevention. Doing so is likely to require additional funding provided to those running the surveys.

Draft recommendation 4.11
Survey data should be routinely collected

The Australian Government should fund the routine collection of the National Study of Mental Health and Wellbeing and the National Child and Adolescent Mental Health and Wellbeing study, running the surveys at least every five years.

4.7 Enabling adoption and diffusion of best practice services

Best practice refers to the most effective and efficient systems, policies and services that are repeatable and proven through research and experience to deliver the desired outcomes. Enabling best practice also relies on innovation and the generation of evidence to improve services in the long run.

Survey respondents identified variability in the quality and outcomes of existing mental health and suicide prevention services but some also pointed to improvements to service offerings over recent years, including alternatives to emergency departments, safe spaces, Medicare Mental Health Centres (previously known as Head to Health Centres) and peer workers (*What we've heard so far* paper).

The adoption and diffusion of best practice mental health and suicide prevention services is affected by the incentive structures and enabling environment in which those services are provided. The next agreement should play a role in continuing to shift services towards best practice.

The next agreement can play a role in incentivising innovation and adoption of best practice

Performance reporting (section 4.6) and funding are levers within the agreement that can be used to incentivise innovation and the adoption of best practice. Creating reputational incentives through improved performance monitoring and reporting is a good first step for the next agreement (draft recommendation 4.8), while funding mechanisms should be considered in the long term.

There are known benefits of performance monitoring and public reporting for quality improvement in health systems (OECD 2017a, pp. 51–53). Public reporting creates reputational incentives to improve performance in two main ways – by informing consumer choice (Frølich et al. 2007, pp. 181–182) and promoting self-improvement by providers (Totten et al. 2012, p. 27).

Funding is another way of incentivising quality improvement. The ideal funding mechanism to improve the quality of mental health and suicide prevention services would tie financial incentives to consumer outcomes. This can be done by paying per outcome (outcomes-based funding) or by offering reward payments for improvement or attainment of specific outcomes (incentive payments, or in the inverse, penalties). In practice, the use of funding mechanisms to incentivise quality improvements has had mixed effects, partly depending on mechanism design (OECD 2017b, pp. 97–99; Scott et al. 2018).

Such funding mechanisms can be difficult to implement. Outcomes are sometimes hard to measure and/or are not sufficiently measured (chapter 2). Tying funding or payments to specific outcomes can also create perverse incentives. Data may be misreported to attract funding, particularly where collection is not already well-established, making verification difficult. Funding can also be re-distributed towards services that are already high-performing or have resourcing for improvement, and away from poor performing services, further entrenching existing inequalities (Hsu et al. 2020; Kim et al. 2022). Good design of funding mechanisms can mitigate these unintended consequences to some extent (Scott and Ouakrim 2011, p. 9). For example, funding mechanisms that align with the beliefs and values of the sector and its workforce, and which are viewed as fair can prevent some of these distortions and are more likely to be effective (Scott and Ouakrim 2011, p. 10).

Participants also stressed the negative impact of unstable and short-term funding for mental health and suicide prevention services (IUIH, sub. 81, pp. 11–12; Neami National, sub. 63, pp. 12–13; QAMH, sub. 83, p. 4).

> Shorter contracts can preclude the opportunity to invest in the people or infrastructure required to deliver effective services for community. For example, shorter grant terms constrain charities' and not-for-profit organisations' ability to successfully recruit and retain staff. Additionally, service delivery costs are generally higher when funding is brief or unstable. (Lifeline Australia, sub. 8, p. 12)

Short-term and unstable funding can prevent providers from investing in collaboration and relationship building and detract from the time and resources available to deliver and improve services (PC 2017, p. 24). Outcomes-based funding may introduce additional uncertainty in funding for these services. Incentive payments may be one way to overcome this concern.

The benefits of funding mechanisms incentivising performance improvement can be substantial but getting these mechanisms right is challenging. Given the relative immaturity of the data collections on outcomes within

the mental health and suicide prevention community sector (which receives much of the funding provided under the Agreement), and the ongoing issues with funding security and stability, the use of funding to incentivise innovation and best practice is not advised in the immediate term. Outcomes-based funding should be revisited in the long term for consideration once outcomes data is more established. The PC intends to investigate funding models in mental health and suicide prevention further in the final report of this review.

Enablers of best practice can be better supported in the next agreement

Enhancing the effectiveness of commissioning models

Services funded under the current Agreement are often commissioned by PHNs; for example, PHNs commissioned providers to establish Medicare Mental Health Centres, which are one of the key commitments of the Agreement. PHNs are independent organisations funded by the Australian Government to coordinate primary health care services in their regions and ensure they meet the needs of the community (DoHAC 2021c). They do this through commissioning services and working with providers and other funding bodies, such as LHNs[22] and Aboriginal and Torres Strait Islander Community Controlled Health Organisations (ACCHOs).

The Agreement resulted in a significant change to the role of PHNs, focusing on collaboration with state-funded services delivered through LHNs. The PHN Cooperative (sub. 69, p. 6) described this shift in the role of PHNs as:

> … moving from a primarily vertical alignment under Department of Health and Aged Care (DoHAC or the Department) direction, to include a horizontal operating model in partnership with jurisdictions and LHNs for joint planning, co-investment, co-commissioning, and reporting.

However, review participants argued this new role is not well defined in the Agreement (Adelaide PHN, sub. 62, p. 1; PHN Cooperative, sub. 69, p. 5; Northern Territory Mental Health Coalition, sub. 54, p. 2; WQPHN, sub. 45, p. 4).

Effective PHN-LHN collaboration enables a 'no wrong door' approach whereby consumers can be easily referred to the right support for them, stepping up and down seamlessly between levels of care and across care settings without being subject to complex system navigation or the re-telling of their story to each new service. This type of service system is what consumers have told us would be most beneficial (*What we've heard so far* paper).

However, throughout the consultation for this review, the PC heard collaboration was highly variable and was not routinely occurring across all PHNs (*What we've heard so far* paper).

> Service coordination is a nightmare in our region. Our PHN and LHD just plain don't like each other and consequently, meaningful collaboration between them is virtually non-existent (sr. 036)

There are many reasons for this, and some are outside the scope of the Agreement. However, some aspects of the Agreement can limit effective collaboration. For example, review participants argued where LHNs and PHNs have developed joint needs assessments and plans, the current Agreement does not sufficiently

[22] Local hospital networks (LHNs) are independent authorities set up by state and territory governments to manage and fund public hospital services in their region, including outpatient mental health services reasonably considered a public hospital service (DoHAC 2022; NHFB 2025). Local hospital network is a national term; states and territories use local terms to refer to them, including; local health districts (NSW), hospital and health services (QLD), local health networks (SA), health organisations (Tas) and health services (NT, Vic, WA) (DoHAC 2022).

empower them to commission services based on these assessments and plans (PHN Cooperative, sub. 69, p. 6; WQPHN, sub. 45, p. 7). PHNs identified other barriers to their capacity, including:

- delays in the delivery of the Guidelines for Joint Regional Mental Health and Suicide Prevention Planning (chapter 2)
- a lack of guidance and training of staff to use the National Mental Health Service Planning Framework for joint planning (PHN cooperative, sub. 69, pp. 7–8)
- being excluded from the planning and implementation of the bilateral schedules (Adelaide PHN, sub. 62, p. 1).

As recommended in chapter 2, as a matter of urgency the Australian Government should deliver the National Guidelines for Joint Regional Mental Health and Suicide Prevention Planning.

The next agreement should play a greater role in facilitating the integration of services. An agreement between governments serves as a high-level commitment to working together but collaboration at the service level will need deliberate funding and incentives. On the ground, integration across the health sector requires role clarity, partnership and communication between PHNs, LHNs and ACCHOs.

To some extent, integration is challenged by factors outside of the agreement. For example, joint commissioning can be difficult in practice due to misaligned funding cycles and poorly matched geographical borders of PHNs and LHNs in most states and territories. The readiness of PHNs and LHNs to coordinate their efforts is also substantially varied. However, the next agreement can lower some barriers to integration. In the next agreement, funding should enable PHN-LHN partnerships to carry out their joint plans where they have been established. Greater flexibility in the way funding is assigned in the next agreement would support this (discussed below). Dedicated funding for integration could also incentivise PHN-LHN partnerships.

The roles and responsibilities of PHNs are currently under review, with the aim of examining the PHN business model and whether it is suited to the changing operating environment and structured to meet the Australian Governments objectives (DoHAC 2025d). The PC will further consider options for the next agreement to support PHN-LHN partnerships and effective commissioning in the final report.

National leadership should not prevent flexibility in service delivery

There are benefits to be gained from greater national consistency and leadership within the mental health and suicide prevention system, but excessive rigidities can prevent innovation and the adoption of best practice. Taking a national approach to governance and data collection, for example, can help realise efficiencies.

- Guidelines for commissioning can support PHNs to undertake more effective and nationally consistent commissioning while still allowing for local adaptation where necessary and encourage further joint commissioning with LHNs to improve service integration.
- Standardised reporting requirements across PHNs and jurisdictions would ease the administrative burden on service providers. Several service providers access multiple streams of funding with varying reporting requirements and funding timelines, reducing the resources available to provide support. And disparate reporting requirements across PHNs and jurisdictions can create barriers to service providers in scaling up.
- Further standardisation in the process of data collection (for example, through the use of a shared data collection software) could simplify reporting requirements and create efficiencies in the sharing, linking and aggregation of data and in evaluations.

Service provision, however, should retain flexibility to allow for innovation and adaptation to local needs and resources. The PC heard about local initiatives that had been positively evaluated but had either ended or had difficulties continuing to operate due to a lack of secure and reliable funding (National Mental Health Consumer Alliance, sub. 66, p. 12; Ruah Community Services, sub. 14, p. 8). There are efficiency gains to be made from allowing PHNs to fund successful services or which fill locally assessed gaps and respond to

localised need, rather than tying funding to nationally determined service models. This is especially true where these service models do not have a strong evidence base. Allowing funding to support existing services would also prevent the loss of trust that comes with the ongoing trialling and discontinuation of new services (Consumers of Mental Health WA, sub. 49, p. 14). Flexibility was raised frequently by participants throughout submissions (box 4.2).

Box 4.2 – Participants called for more flexible funding

Flexibility was supported to allow for local adaptation …

> That flexibility be introduced to allow the adaptation of national mental health service models to suit local community needs, especially in thin markets where the workforce is limited. (Marathon Health, sub. 10, p. 4)

> … there has been little flexibility or sufficient time to roll out place-based models that actually adapt to the local circumstances, provide long-term security for their workforces, or seek community input to inform and design those models locally. (Lived Experience Australia, sub. 42, p. 7)

> In this context, Tasmania considers there is an opportunity during the development of a new National Agreement to allow Parties more flexibility in commissioning approaches, such as enabling flexible funding and shared working arrangements between government and community-sector organisations, which would ultimately enhance collaboration and innovation. (Tasmanian Government, sub. 78, p. 7)

… responsiveness to emerging challenges …

> We are also frequently constrained in responding to emergent needs, such as disaster recovery, because funding programs do not reflect localised needs, including those identified through joint assessments. (WQPHN, sub. 45, p. 4)

> … funding arrangements under the Agreement, particularly those delivered through the PHNs, do not enable services to respond to current and emerging priorities. Almost without exception, the level of funding and restrictive, inflexible program KPIs hinder the ability of services to pivot when circumstances change. (Neami National, sub. 63, p. 15)

… and to ensure lived and living experience is effectively embedded in service design and commissioning.

> The localised approach enables close-to-community planning and the provision of tailored and targeted approaches to address the needs that have been identified. (FASSTT, sub. 64, p. 14)

> Allow for funding flexibility that is not attached to Commonwealth-prescribed services and outcomes, but the values, principles, and needs identified by Lived Experience at the community level. (National Mental Health Consumer and Carer Forum, sub. 68, p. 8)

But some also noted flexibility can add to fragmentation across the system.

> A further challenge for achieving joint integration through National and Bilateral Agreements is the flexibility PHNs have in commissioning services. While this flexibility enables service to be tailored to local service needs, it can be a barrier to developing a systems-based approach to suicide prevention. (Orygen, sub. 26, p. 3)

Box 4.2 – Participants called for more flexible funding

A critical challenge is balancing regional flexibility with national consistency. While PHNs' regional focus allows them to tailor services to local needs, this flexibility has resulted in significant variability and fragmentation across the 31 PHNs. (Mental Health Carers Australia, sub. 73, p. 22)

Participants highlighted barriers to effective and timely service provision created by inflexibility in service models. Service delivery has been hindered by specifications about workforce (Marathon Health, sub. 10, pp. 3–4), requirements for a diagnosis in order to access services (Ruah Community Services, sub. 14, p. 4) and contract negotiation (Neami National, sub. 63, p. 15).

National consistency can be beneficial where it means consumers have access to comparable services in different jurisdictions. The commissioning approaches of PHNs vary greatly (Mental Health Carers Australia, sub. 73, p. 12; Neami National, sub. 63, p. 11), but adhering to national guidelines might reduce the risk of this affecting the services delivered. Similarly, national procurement policies may assist PHNs and reduce the administrative burden on providers. PHN performance reporting, particularly with regard to mental health, is regularly undertaken and could support quality assurance (ANAO nd, pp. 29, 41).

Funding in the next agreement should provide PHNs with sufficient flexibility to commission locally relevant services, align with their joint regional plans and use funds to support existing services where they have been positively evaluated. Service models should not be dictated through the agreement so as to limit the ways in which PHNs can meet their community's needs.

Draft recommendation 4.12
Funding should support primary health networks to meet local needs

The next agreement should emphasise national consistency in areas where there are efficiency gains, including standardising reporting requirements across primary health networks (PHNs) and jurisdictions where possible and investigating ways to standardise procurement and data collection processes.

Funding arrangements in the next agreement should provide PHNs with sufficient flexibility to commission locally relevant services or support existing services where they have been positively evaluated. National service models should not limit the ways in which PHNs meet their communities' needs.

There would be benefit in considering how funding outside of the Agreement could be freed up for innovative models of mental healthcare and suicide prevention. The funding allotted by the Agreement accounts for only about 3% of an estimated $12.6 billion of recurrent government expenditure on the mental health and suicide prevention system in 2022-23 (chapter 1; SCRGSP 2025). Additional expenditure on community mental health services is provided by state and territory governments ($3.2 billion in 2022-23 (AIHW 2025a)).

Much of the funding provided to the community sector is through small, time-limited grants, creating funding insecurity and discontinuity of services. On the other hand, hospital mental health and suicide prevention services receive ongoing funding at their nationally efficient cost. In some cases, the community sector works with hospitals to provide care (for example, by supporting safe discharge back into the community). Doing so

reduces the overall cost of care and reduces time spent in hospital settings. Yet activity-based funding is typically not diverted to the community sector to provide this sort of care.

Ruah Community Services highlighted the Choices Post-Discharge program as an example of this in their submission. The Choices Post-Discharge program – which has since ended due to a lack of funding (Ruah Community Services, sub. 14, p. 5) – used peer workers to support those frequently presenting to the emergency department by connecting them into community and primary health services. In the six months following support from Choices there was a 37% reduction in presentations to the emergency department and a 38% decrease in length of stay, resulting in over $1 million reduction in hospital costs (Wood et al. 2019, p. vi).

Finding ways of freeing up activity-based funding to support the nexus of hospital and community-based care, where there are known efficiency gains and benefits to consumers, would support innovation and the adoption of best practice. Consideration will need to be given to how the next agreement interacts with the NHRA to free up funding for innovation in mental health and suicide prevention services. The PC's final report will explore funding mechanisms further.

The workforce should be supported to improve consumer outcomes

A well-supported and skilled workforce is crucial to high-quality mental health and suicide prevention services. Workforce development is needed for the sustainability of the system over coming years and peer workers are emerging as an important enabler to best practice services, particularly in the community sector (*What we've heard so far* paper).

> Action through the next National Agreement to grow, strengthen and appropriately distribute the mental health workforce must be proportionate to the urgency and significance of this issue. (Mental Health Australia, sub. 76, p. 18)

The National Mental Health Workforce Strategy, completed in October 2023, was a commitment under the current Agreement. The strategy provides a framework for action and a vision for a sustainable mental health workforce. The goals of the strategy are to attract, train, support and retain an appropriately skilled, motivated and coordinated mental health workforce to meet the evolving needs of the mental health system into the future. These goals are designed to build on the strengths of the existing mental health workforce, integrating core principles of practice, while growing size and capability over time. Government support for the NSPO to develop a National Suicide Prevention Workforce Strategy was a commitment under the current Agreement (clause 156). This is yet to be delivered but was identified as a recommended action in the recently released National Suicide Prevention Strategy (NSPO 2025, pp. 84–85).

The next agreement should help progress the strategy by identifying priorities requiring national leadership or collaboration between or across levels of government, and by funding these activities where necessary. Included in the strategy is a list of 74 actions for workforce development. To progress the strategy, assigned responsibilities and a prioritisation or staging of actions, as well as public reporting on progress, will be needed.

Participants highlighted some areas of the strategy that should be considered for inclusion and funding in the next agreement (box 4.3).

Box 4.3 – Areas where the next agreement might support the National Mental Health Workforce Strategy

Review participants supported the use of the next agreement to identify priorities within the National Mental Health Strategy and assign funding.

> The next National Agreement should include significant investment to fully deliver the National Mental Health Workforce Strategy, with public prioritisation of actions and improved accountability. (Mental Health Australia, sub. 76, p. 18)

Participants pointed to the need to attract more people into the mental health and suicide prevention workforce …

> Fund and scale workforce education and training to respond to children and family's mental health and wellbeing as part of the National Mental Health Workforce Strategy. (Melbourne Children's Campus Mental Health Strategy, sub. 35, p. 8)

> Funding is required to … address widespread workforce shortages and invest in a sustainable pipeline of mental health and suicide prevention workers, including lived-experience workers. (Neami National, sub. 63, p. 5)

… and target investment to areas of need.

> In particular, the Agreement should increase investment in building under-developed elements of the mental health workforce. Namely, coaches, prevention and promotion practitioners, First Nations social and emotional wellbeing workers, peer and lived experience workforces, and multi-disciplinary workforces responsible for supporting children and young people. (Beyond Blue, sub. 37, p. 5)

Draft recommendation 4.13
The next agreement should support the implementation of the National Mental Health Workforce Strategy

The next agreement should support the implementation of the National Mental Health Workforce Strategy. This should include:

- clear commitments to, and timelines for, priority actions under the National Mental Health Workforce Strategy
- an explicit delineation of responsibility and funding for workforce development initiatives.

Recognising the contribution of peer workers

The next agreement should support the development of a national scope of practice for the peer workforce to alleviate issues of underutilisation and unsafe work practices.

Peer workers have been found to have positive relational and role modelling impacts on consumers (Davidson et al. 2012). Survey respondents and submissions pointed to peer workers as being an important

part of effective service delivery (*What we've heard so far* paper).[23] The PC's Mental Health inquiry also recognised the ability of peer workers to assist consumers navigating the system and provide organisations a consumer perspective to help make services more person-centred (PC 2020a, p. 725).

Despite the benefits they provide, peer workers are often not enabled to contribute to their full potential. A lack of understanding of the peer workforce and cultural inertia throughout the system mean they are not well supported (Lived Experience Australia, sub. 42, pp. 5–6). Limiting peer workers to working within existing medical models fails to take full advantage of their skills and capabilities and can lead to peer workers working outside of their scope (Consumers of Mental Health WA, sub. 49, pp. 10–11). This heightens the risk of unsafe work practices for the peer worker and unsafe outcomes for the consumer. These issues may result from the varying levels of organisational readiness for peer work across services where peer workers are asked to operate in environments that are not yet fully equipped to support them.[24]

Information request 4.4

The PC is looking for case studies to highlight best practice in integrating peer workers in clinical mental health settings, particularly by improving clinician awareness of the peer workforce. Are there examples of best practice that could be adopted in other organisations or settings?

The 2024-25 Federal Budget committed $7.1 million over four years to establish a national professional association for peer workers, deliver a workforce census and explore further training pathways (DoHAC 2024h). The next agreement should look to build on this momentum by further improving the awareness and understanding of peer roles in mental health and suicide prevention (information request 4.4).

Building understanding from senior management, role clarity and career pathways are effective tools for increasing commitment to developing and supporting the peer workforce (Byrne et al. 2017). Developing a consistent understanding of the scope of practice for peer workers would help clinicians and other practitioners understand the role they can play. It would also be protective for peer workers, helping them to reinforce the boundaries of their work. While standardisation might be worthwhile to improve the credibility and accountability of the peer workforce, this must be managed sensitively. Much of the value of the peer workforce is in the personalised, adaptable nature of their work. Standardisation of the workforce may risk this approach being co-opted into more traditional and rigid ways of working through inflexible practice standards or monitoring (Byrne et al. 2017, p. 79). It also might have adverse implications for organic or issue-focused peer support by increasing barriers to entering the profession (Faulkner and Kalathil 2012, p. 34). This must be carefully considered in the future development of a nationally consistent scope of practice for the peer workforce.

The professionalisation of the Aboriginal and Torres Strait Islander Health Workforce (box 4.4) can be seen as setting a precedent for the standardisation of a community-based occupation with clinical and non-clinical roles.

[23] Consumers of Mental Health WA, sub. 49, pp. 10–11; National Mental Health Consumer Alliance, sub. 66, p. 15; National Mental Health Consumer and Carer Forum, sub. 68, p. 8, Mental Health Carers Australia, sub. 73, p. 28.
[24] Australian Psychosocial Alliance, sub. 55, p. 10; Mental Health Carers Australia, sub. 73, p. 23; Queensland Alliance for Mental Health, sub. 83, p. 7.

Box 4.4 – Parallels between the Aboriginal and Torres Strait Islander Health Workforce and the peer workforce

There are clear parallels between the Aboriginal and Torres Strait Islander Health Workforce and the mental health and suicide prevention peer workforce, in their respective recognition of the individual contexts of people accessing services and relational approach to care. There is an opportunity for the peer workforce to learn from the journey of the Aboriginal and Torres Strait Islander Health Workforce towards professionalisation to assess whether this would be worthwhile in the mental health and suicide prevention sector.

The Aboriginal and Torres Strait Islander Health Workforce emerged from a recognition by Aboriginal and Torres Strait Islander people that their health needs were not being adequately met by mainstream services (Aboriginal and Torres Strait Islander Health Practice Board 2020, p. 3). The workforce embeds a unique person-centred model of care, focusing on culturally informed and community-led healthcare and a holistic understanding of health and wellbeing (National Aboriginal Community Controlled Health Organisation 2021, p. 3).

The National Association of Aboriginal and Torres Strait Islander Health Workers and Practitioners (NAATSIHWP) is the national peak organisation with responsibility for supporting and promoting the professional interests of the Aboriginal and Torres Strait Islander Health Workforce. NAATSIHWP (2024, p. 9) have developed a Professional Scope of Practice for the workforce to:

- address the underutilisation and undervaluing of the professions that exists nationally
- develop shared and consistent understandings about the baseline capabilities that qualified Aboriginal and/or Torres Strait Islander Health Workers and Health Practitioners are educated and trained to perform
- help establish nationally consistent standards of practice for the professions, and
- illustrate how the professions should be used in models of care and multidisciplinary health care teams.

Many of the considerations raised in NAATSIHWP's recent Professional Scopes of Practice Project are also true for the peer workforce in mental health and suicide prevention.

Draft recommendation 4.14
The next agreement should commit governments to develop a nationally consistent scope of practice for the peer workforce.

The next agreement should commit governments to develop a nationally consistent scope of practice for the peer workforce, in consultation with the peer workforce, that:

- promote safer work practices for peer workers
- contributes to better outcomes for people accessing mental health peer support
- improves public understanding of the profession, allowing for greater recognition of peer workers' capabilities and contributions.

Evaluation efforts should be carried over into the next agreement

High-quality evaluations are a critical enabler for best practice and essential to improving consumer and carer outcomes.

Several initiatives funded under the bilateral schedules to the Agreement have been evaluated in recent years (although mostly prior to the Agreement's signing). For example, there have been recent evaluations of headspace (KPMG 2022), the Head to Health Digital Mental Health Gateway (Bassilios et al. 2022) and The Way Back Support Service (Nous Group nd). There has also been an early implementation evaluation of five Medicare Mental Health Centres (Neami National 2024).

Evaluations rely on data collected through program delivery (including administrative data and clinical files) and consultations (including surveys, interviews and community yarns) with consumers and providers (Bassilios et al. 2022; DoHAC 2021b; KPMG 2022; Ninti One and First Nations Co 2024; Nous Group nd; Pirkis et al. nd). This poses several limitations:

- data collected through service provision often has gaps (Ninti One and First Nations Co 2024, p. 172)
- completion rates of consumer surveys can be quite low, making for small sample sizes and creating data gaps (Bassilios et al. 2022, p. 90; Kisely and Looi 2022, p. 388; Nous Group nd, pp. 12–13)
- the lack of control or comparison groups limits the ability to make robust findings about the impact of programs and initiatives (Bassilios et al. 2022, p. 90; KPMG 2022, p. 83; Nous Group nd, p. 13)
- reporting of data can be fragmented and inconsistent where reporting is required to multiple program funders (KPMG 2022, p. 83).

Data developments in the current Agreement, including those listed in Annex B, and the National Mental Health and Suicide Prevention Evaluation Framework and associated guidelines developed under the Agreement are likely to support better evaluation practices. Routine data collection on outcomes, data sharing and linkages would support more rigorous and usable evaluation. The framework may improve the quality of evaluations and create greater consistency (for example, establishing the domains that the program should be evaluated in) across evaluation practices so programs can be compared. Realising these benefits requires the evaluation framework to be implemented.

Not all ongoing monitoring and evaluation of programs is made public. One evaluation of headspace suggested there is an ongoing process of evaluation occurring internally but only select findings from this process were made public (KPMG 2022, p. 81). Evaluation findings should be shared beyond providers, government agencies or PHNs. Publishing evaluation findings supports consumers to exercise choice when accessing services and strengthens accountability for public expenditure and service delivery.

The next agreement should build on the progress of the evaluation framework and guidelines by requiring evaluations to be conducted for all funded services in line with the framework and require sharing of evaluation findings.

Draft recommendation 4.15
The next agreement should build on the evaluation framework and guidelines

The next agreement should require timely evaluations to be conducted for all funded services in line with the National Mental Health and Suicide Prevention Evaluation Framework and associated guidelines and require sharing of evaluation findings, including sharing publicly where possible.

5. Services for Aboriginal and Torres Strait Islander people

Key points

- **The National Mental Health and Suicide Prevention Agreement includes several commitments to improve Aboriginal and Torres Strait Islander social and emotional wellbeing outcomes, including:**
  - **aligning with the National Agreement on Closing the Gap and other relevant documents**
  - **boosting the Aboriginal and Torres Strait Islander social and emotional wellbeing workforce**
  - **state and territory specific commitments outlined in the bilateral schedules.**
- **There is no funding attached to the Agreement's commitments that relate to Aboriginal and Torres Strait Islander people.**
- **Some commitments in the Agreement have been achieved, including a number or commitments within the bilateral schedules that have been implemented or are on track to be delivered. Governance arrangements aim to include Aboriginal and Torres Strait Islander perspectives.**
- **Aboriginal and Torres Strait Islander social and emotional wellbeing does not appear to have improved since the Agreement was signed, with Aboriginal and Torres Strait Islander suicide rates worsening.**
  - There is limited up-to-date data available to monitor progress achieved under the Agreement.
- **The Agreement has not enabled the improvement in services necessary to support improved outcomes.**
  - Governance arrangements are not fit for purpose and there is a lack of detail on how commitments will be implemented.
  - Addressing barriers to access and cultural safety in mental health and suicide prevention services remains a priority for Aboriginal and Torres Strait Islander people. While the Agreement contains commitments to address these issues, it does not include any tangible actions that governments agreed to undertake.
- **The next agreement should include a separate schedule that outlines substantive commitments to improve Aboriginal and Torres Strait Islander social and emotional wellbeing. This schedule should:**
  - **align with the National Agreement on Closing the Gap, including target 14 (significant and sustained reduction in suicide of Aboriginal and Torres Strait Islander people towards zero) and the Priority Reforms**
  - **align with other relevant documents including the Gayaa Dhuwi (Proud Spirit) Declaration and implementation plan**
  - **address key priorities including cultural safety, funding and workforce**
  - **improve and clarify governance for the design and implementation of the agreement**
  - **measure progress in a strengths-based way, with community-led evaluation.**

The National Mental Health and Suicide Prevention Agreement sets out a commitment to work together to close the gap and improve mental health and wellbeing outcomes for Aboriginal and Torres Strait Islander people, including a focus on delivering culturally and locally appropriate services.

The Agreement's objectives aim to contribute to those of the National Agreement on Closing the Gap, and some progress has been made in implementing specific actions related to improving social and emotional wellbeing (SEWB). However, outcomes for Aboriginal and Torres Strait Islander SEWB have not improved over the term of the Agreement.

The next agreement needs a stronger approach to addressing Aboriginal and Torres Strait Islander SEWB to ensure Aboriginal and Torres Strait Islander priorities are acted upon and progress is made.

This chapter:

- provides an overview of Aboriginal and Torres Strait Islander SEWB (section 5.1)
- discusses how Aboriginal and Torres Strait Islander SEWB is incorporated into the Agreement and its commitments (section 5.2)
- discusses whether the Agreement has improved Aboriginal and Torres Strait Islander SEWB (section 5.3)
- includes recommendations and provides suggestions for the next agreement (section 5.4).

5.1 Aboriginal and Torres Strait Islander social and emotional wellbeing

Understanding the Agreement's effectiveness requires an understanding of Aboriginal and Torres Strait Islander SEWB, the services available to support SEWB and what governments are doing to improve SEWB.

This section provides an overview of Aboriginal and Torres Strait Islander SEWB, including the most up to date data, the current services for Aboriginal and Torres Strait Islander people and the policy landscape within which the Agreement operates.

The social and emotional wellbeing of Aboriginal and Torres Strait Islander people

Aboriginal and Torres Strait Islander SEWB is a holistic concept acknowledging the multiple and interrelated social, cultural, historical and political determinants of mental health and wellbeing for Aboriginal and Torres Strait Islander people (Dudgeon et al. 2020). The framework encompasses a broad range of interconnected factors, including autonomy, empowerment and recognition; family and community; culture, spirituality and identity; Country; basic needs; work roles and responsibilities; education; physical health; and mental health (Butler et al. 2019). This notion of SEWB also recognises Aboriginal and Torres Strait Islander people come from diverse nations, cultures and language groups with many perspectives, meaning not all communities will share the exact same concepts and experiences of wellbeing.

The Aboriginal and Torres Strait Islander population is more likely to experience poor SEWB and higher levels of psychological distress and suicide relative to the non-Indigenous population (discussed below). Many of the negative effects on the SEWB and mental health of Aboriginal and Torres Strait Islander people arise from their experience of historic, enduring and interrelated stressors. These factors include intergenerational trauma originating from colonisation, institutional racism, inherent biases and discrimination in mainstream services and, inequality across social determinants of mental health such as access to adequate housing, education and employment (PC 2024a).

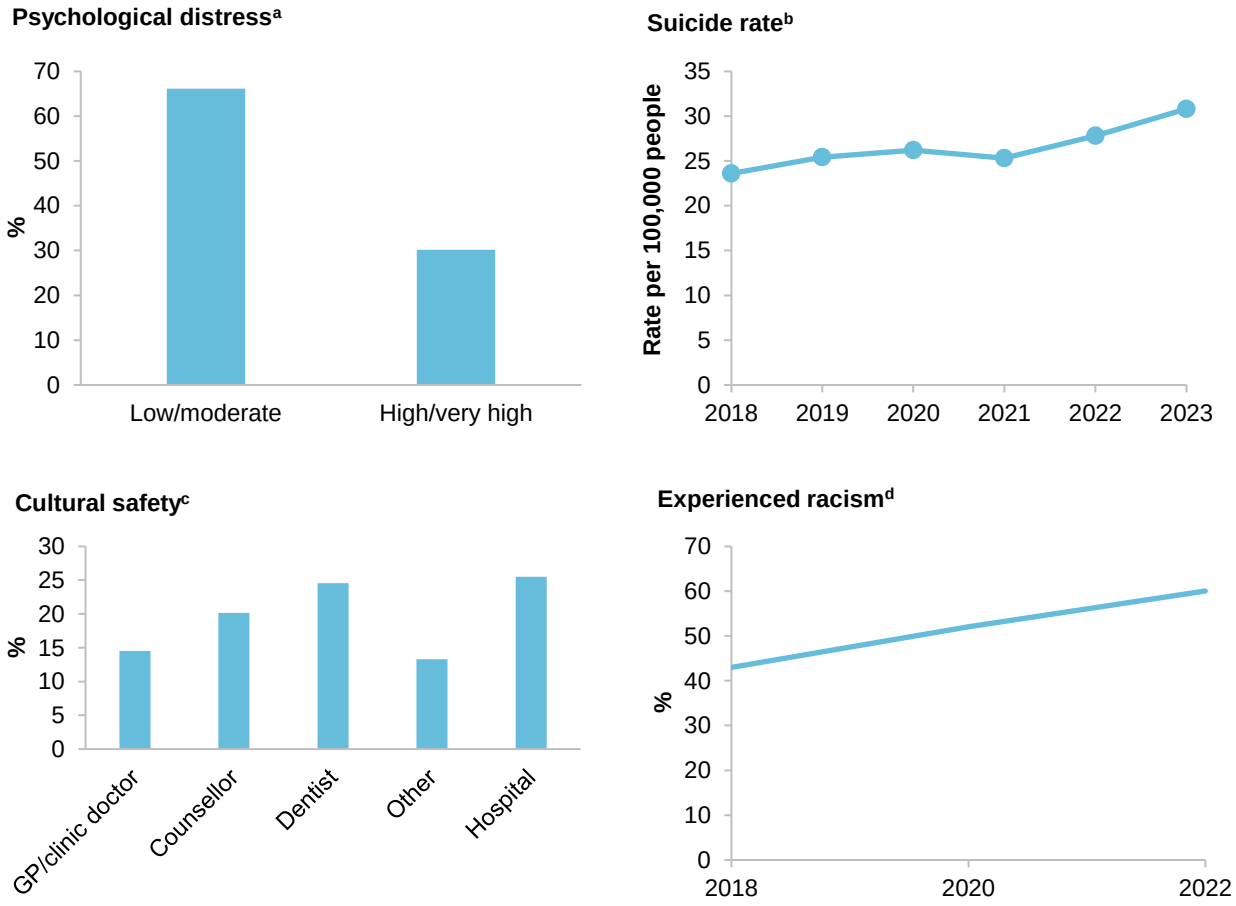
The presence of these factors underscores the need for cultural safety in the delivery of services. The National Agreement on Closing the Gap (2020, p. 52) defines cultural safety as:

> … overcoming the power imbalances of places, people and policies that occur between the majority non-Indigenous position and the minority Aboriginal and Torres Strait Islander person so that there is no assault, challenge or denial of the Aboriginal and Torres Strait Islander person's identity, of who they are and what they need.

Many Aboriginal and Torres Strait Islander people experience distress

In 2022-23, one in three Aboriginal and Torres Strait Islander people (30.2%) experienced high or very high levels of psychological distress (figure 5.1). This represents a slight increase compared to 2004-05.

Figure 5.1 – Indicators of Aboriginal and Torres Strait Islander social and emotional wellbeing



a. Proportion of Aboriginal and Torres Strait Islander people aged 18 years and older who had low/moderate or high/very higher psychological distress in 2022-23. **b.** Age-standardised rate of suicide for Aboriginal and Torres Strait Islander people, 2018–2023. **c.** Proportion of Aboriginal and Torres Strait Islander people who did not visit a health service due to concerns about cultural safety in 2018-19. **d.** Proportion of Aboriginal and Torres Strait Islander people aged 18 years or older who reported they had experienced at least one form of racial prejudice in the past 6 months in 2018, 2020 and 2022.

Source: ABS (2024a, table 1.3); PC (2025b, tables CtG14A.1, SE14e.1-5 and CtGSE14g.1).

Aboriginal and Torres Strait Islander people experience higher levels of psychological distress than the general population. In 2020-22, 16.7% of people aged 16–85 years had experienced high or very high levels of psychological distress in the 4 weeks prior (ABS 2023, table 16). Experiencing high or very psychological distress was more likely among Aboriginal and Torres Islander people who are younger, female and living in non-remote areas (ABS 2024a, table 6.3).

There are particular groups within the Aboriginal and Torres Strait Islander population that are more likely to experience poor SEWB. For example, in 2018-19 survivors of the Stolen Generations aged 50 years and over were 1.4 times more likely to have poor mental health and 1.3 times more likely to have been diagnosed with a mental health condition than other Aboriginal and Torres Strait Islander people of the same age (AIHW 2021a). Aboriginal and Torres Strait Islander people in the criminal justice system are also at high risk of experiencing poor mental health outcomes. In 2022, about two in five (42.6%) Aboriginal and Torres Strait Islander prison entrants reported having been told they had a mental health condition (AIHW 2023c, table S31).

Aboriginal and Torres Strait Islander LGBTQIASB+ youth experience high levels of psychological distress. A survey found 91.9% of participants aged 14–25 years scored in the high/very high range for psychological distress. The number of participants who had attempted suicide was also high, with 45.4% of participants having attempted suicide in their lifetime and 19% having attempted suicide in the past 12 months (Liddelow-Hunt et al. 2023).

The Closing the Gap target for a significant and sustained reduction in suicide of Aboriginal and Torres Strait Islander people is not on track to be met

A decline in SEWB is associated with an increased risk of self-harm and death by suicide (Dudgeon et al. 2014, p. 13). In 2023, 265 Aboriginal and Torres Strait Islander people died by suicide in New South Wales, Victoria, Queensland, Western Australia, South Australia and the Northern Territory, compared with 196 in 2018. This is a rate of 30.8 per 100,000 people, up from 23.6 in 2018 (figure 5.1). The suicide rate for non-Indigenous people in 2023 was 11.1 per 100,000 people, down from 12.0 in 2018 (PC 2025b, table CtG14A.1).

There are barriers to accessing services

Many Aboriginal and Torres Strait Islander people experience barriers to accessing health services. This is due to a range of factors including services not being available in their area (especially for those living in remote areas), lack of transport, cost, waiting times, and the availability of culturally safe and responsive health services (AIHW 2024b).

In 2022-23, 26.1% of Aboriginal and Torres Strait Islander people reported they would have liked to seek support for their mental health but did not do so in the past 12 months. Reasons for not seeking support included being too busy, transport factors, cost, discrimination and the service not being culturally appropriate (ABS 2024a, table 10.3).

Cultural safety is a key reason Aboriginal and Torres Strait Islander people do not seek support. One in four of the Aboriginal and Torres Strait Islander people who avoided going to hospital in 2018-19 reported that this was at least in part due to cultural safety concerns (figure 5.1).

Discrimination and racism affect social and emotional wellbeing

Discrimination and racism have established long-term effects on Aboriginal and Torres Strait Islander people's SEWB. Experiences of racism affect SEWB long after direct exposure has ended (ANU 2021; Ferdinand et al. 2012).

A growing number of Aboriginal and Torres Strait Islander people report experiences of racism. In 2022, 60% of Aboriginal and Torres Strait Islander people reported experiencing racism in the past 6 months, an increase from 43% in 2018 (figure 5.1). This proportion is significantly higher than the general community, with about 25% of all Australians reporting racism in 2022 (PC 2025b, table SE14g.1). Significant events that push Aboriginal and Torres Strait Islander people to the forefront of public discussions can also exacerbate their experiences of racism and affect SEWB. For example, the Aboriginal and Torres Strait Islander crisis support line 13YARN experienced a 40% increase in calls during the Voice to Parliament Referendum (Lifeline Australia 2024).

Aboriginal and Torres Strait Islander people report experiencing racism in health settings. In 2022-23, 5.1% of Aboriginal and Torres Strait Islander people reported GPs rarely or never respected cultural, traditions, customs and beliefs, and 10.8% reported staff at their most recent hospital admission did not respect cultural, traditions, customs and beliefs (ABS 2024a, table 9.3). One of the respondents to the survey undertaken by the PC for this review shared their experience:

> My Aboriginality was ignored. My own voice was ignored. My cultural situation was ignored (sr. 25)

Services for Aboriginal and Torres Strait Islander people

Social and emotional wellbeing services for Aboriginal and Torres Strait Islander people are delivered through a variety of providers. Some providers are Aboriginal and Torres Strait Islander specific such as Aboriginal and Torres Strait Islander Community Controlled Health Organisations (ACCHOs) and Aboriginal Medical Services (AMSs). These services are committed to delivering culturally safe, integrated and holistic care to support SEWB. These services can provide tailored care to meet the needs of the local population, including:

- psychological therapies
- complex mental health support
- case management
- clinical care coordination (DoHAC 2025a).

They are also able to provide care in other areas, such as drug and alcohol services, suicide prevention and other relevant services (DoHAC 2025a).

Funding for ACCHOs comes from a variety of sources, including funding for primary care through the Medicare Benefits Schedule and grant funding provided by different Australian Government departments, the National Indigenous Australians Agency (NIAA) and Primary Health Networks (PHNs).

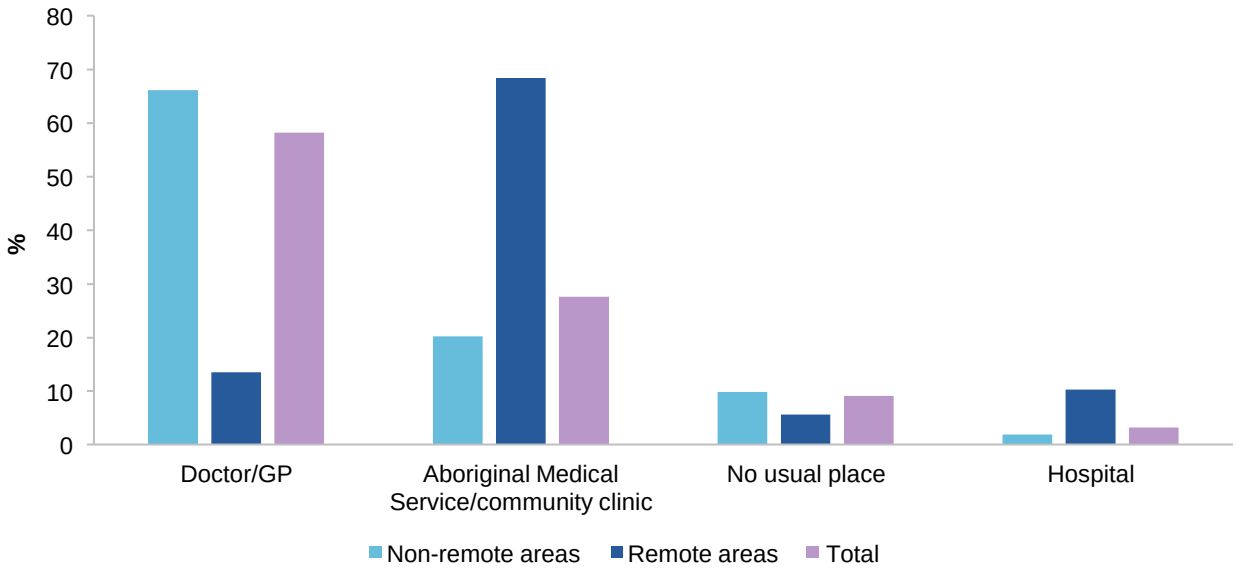
Funding tends to be fragmented, with ACCHOs funded from more sources than most other healthcare organisations of their size (DoHAC 2020; Lowitja Institute 2010). Funding is delivered through a series of specific purpose grants that usually last for only 12 months before the recipient needs to reapply. The various agencies issuing these grants often try to use funding to achieve their differing policy and program priorities. This fragmentation puts strain on ACCHOs, challenging the continuation and long-term nature of many of their programs (VACCHO nd), and creating broader barriers for ACCHOs to provide the comprehensive care they are designed for (Lowitja Institute 2010; PC 2024b).

PHNs administer many of the funding sources for Aboriginal and Torres Strait Islander mental health and suicide prevention services. This type of funding arrangement can create further structural barriers to effective service delivery as PHNs may lack the cultural expertise and community connections of ACCHOs. It can also create unnecessary layers of complexity that limit the ability of ACCHOs to design and implement services (Institute of Urban Indigenous Health, sub. 81, p. 12).

Depending on where they live, many Aboriginal and Torres Strait Islander people access mainstream services in addition to, or instead of, Aboriginal and Torres Strait Islander specific services (figure 5.2).

Figure 5.2 – Aboriginal and Torres Strait Islander people access ACCHOs, AMSs and mainstream services

Type of health service Aboriginal and Torres Strait Islander people usually access if they have a problem with their health, 2022-23



Source: ABS (2024a, table 9.3).

The policy landscape includes many documents and organisations

There are multiple agreements and strategies affecting the Aboriginal and Torres Strait Islander mental health and suicide prevention service system in different ways. The Agreement aims to align with some of these national commitments.

The National Agreement on Closing the Gap

The National Agreement on Closing the Gap is an agreement between all Australian governments and the Coalition of Peaks. It is the first agreement of its kind to be developed in genuine partnership and seeks to change the way governments work with Aboriginal and Torres Strait Islander people.

This agreement sets out a strategy to close the gap, underpinned by Aboriginal and Torres Strait Islander people's priorities, with targets and socio-economic outcome indicators reported on as an accountability measure (Coalition of Peaks and all Australian Governments 2020).

The Agreement highlights four Priority Reforms:

- Formal partnerships and shared decision-making.
- Building the community-controlled sector.
- Transforming government organisations.
- Shared access to data and information at a regional level.

These Priority Reforms should be reflected in all policies and activities that Australian, state, and territory governments implement in relation to Aboriginal and Torres Strait Islander people, including agreements such as the National Mental Health and Suicide Prevention Agreement.

The National Agreement on Closing the Gap provides a broad framework for governments to enact changes across all levels, jurisdictions and outcome areas. However, it leaves space for concrete funding arrangements and implementation processes required to achieve improvements in the socio-economic outcome areas. It also does not contain any funding commitments or direct the implementation processes of any specific policies to improve SEWB.

The Social and Emotional Wellbeing Policy Partnership

The Social and Emotional Wellbeing Policy Partnership was established under the National Closing the Gap Agreement. Its focus is to improve SEWB and mental health and reduce suicide rates among Aboriginal and Torres Strait Islander people (box 5.1).

The partnership has 20 members, and representation is split equally between Aboriginal and Torres Strait Islander parties and government parties. The partnership is co-chaired by an Aboriginal and Torres Strait Islander senior representative of Gayaa Dhuwi (Proud Spirit) Australia and an Australian Government deputy secretary from the Department of Health, Disability and Ageing. There is also a deputy Aboriginal and Torres Strait Islander co-chair, who is the Chief Executive Officer of Gayaa Dhuwi (Proud Spirit) Australia. The Aboriginal and Torres Strait Islander members include five representatives from the Coalition of Peaks and five independent representatives (DoHDA 2025b).

The Australian Government committed $8.6 million from 2022-23 to set up the partnership. This included funding for Gayaa Dhuwi (Proud Spirit) Australia to provide joint administrative support with the Department of Health, Disability and Ageing. In 2024-25, the Social and Emotional Wellbeing Policy Partnership received an additional $2.25 million over one year to continue its work until June 2026 (DoHDA 2025b).

Box 5.1 – Social and Emotional Wellbeing Policy Partnership objectives

- Establish a ‘joined-up’ approach between all governments and Aboriginal and Torres Strait Islander representatives.
- Improve social and emotional wellbeing and mental health outcomes and reduce suicide rates.
- Give a focus to the Priority Reforms in the National Agreement on Closing the Gap (national agreement), and how they can make the changes needed to accelerate improved levels of social and emotional wellbeing in the lives of Aboriginal and Torres Strait Islander people.
- Identify specific measures to accelerate improved levels of social and emotional wellbeing and mental health outcomes and reduce suicide rates.
- Identify opportunities to work more effectively across governments, reduce service gaps and duplication and improve outcomes under the national agreement.
- Support efforts to implement the national agreement. This includes meeting targets for the Priority Reform areas and socioeconomic outcomes.
- Enable Aboriginal and Torres Strait Islander community-led outcomes on Closing the Gap, and support community-led development initiatives.
- Enable Aboriginal and Torres Strait Islander representatives, communities and organisations to negotiate and implement agreements with governments to address all Priority Reforms and policy strategies to support the national agreement.

Source: DoHDA (2025b).

Gayaa Dhuwi (Proud Spirit)

Gayaa Dhuwi (Proud Spirit) Australia is the national peak body for Aboriginal and Torres Strait Islander SEWB, mental health and suicide prevention. The Agreement includes a specific commitment to support the implementation of the Gayaa Dhuwi (Proud Spirit) Declaration. This Declaration focuses on Aboriginal and Torres Strait Islander leadership across all parts of the Australian mental health system to achieve the highest attainable standard of mental health and suicide prevention outcomes for Aboriginal and Torres Strait Islander people (box 5.2).

The Gayaa Dhuwi (Proud Spirit) Declaration Framework and Implementation Plan, launched in early 2025, sets out a 10-year plan to implement the Declaration. The framework describes the goals and strategies and the implementation plan describes the priority actions, strategies and goals for the themes identified in the Declaration (Gayaa Dhuwi (Proud Spirit) Australia 2025). This plan aligns with key documents, including the National Agreement on Closing the Gap. Priority actions to complete within the next year include promoting concepts of SEWB, identifying funding streams enabling Aboriginal and Torres Strait Islander people to access culturally safe services, and developing guidance on how governments and services can work with Aboriginal and Torres Strait Islander communities and organisations to develop policies services and programs. The plan was developed in partnership with Aboriginal and Torres Strait Islander leaders, mental health professionals and community stakeholders (Gayaa Dhuwi, sub. 75, p. 4).

Box 5.2 – Gayaa Dhuwi (Proud Spirit) Declaration

The Declaration focuses on a 'best of both worlds approach', highlighting five themes.

1. Aboriginal and Torres Strait Islander concepts of social and emotional wellbeing, mental health and healing should be recognised across all parts of the Australian mental health system, and in some circumstances support specialised areas of practice.
2. Aboriginal and Torres Strait Islander concepts of social and emotional wellbeing, mental health and healing combined with clinical perspectives will make the greatest contribution to the achievement of the highest attainable standard of mental health and suicide prevention outcomes for Aboriginal and Torres Strait Islander peoples.
3. Aboriginal and Torres Strait Islander values-based social and emotional wellbeing and mental health outcome measures in combination with clinical outcome measures should guide the assessment of mental health and suicide prevention services and programs for Aboriginal and Torres Strait Islander peoples.
4. Aboriginal and Torres Strait Islander presence and leadership is required across all parts of the Australian mental health system for it to adapt to, and be accountable to, Aboriginal and Torres Strait Islander peoples for the achievement of the highest attainable standard of mental health and suicide prevention outcomes.
5. Aboriginal and Torres Strait Islander leaders should be supported and valued to be visible and influential across all parts of the Australian mental health system.

Source: Gayaa Dhuwi (Proud Spirit) Australia (2015).

The National Aboriginal and Torres Strait Islander Suicide Prevention Strategy

The National Aboriginal and Torres Strait Islander Suicide Prevention Strategy was recently renewed by Gayaa Dhuwi (Proud Spirit) Australia, providing an updated Strategy for 2025–2035. The Strategy's purpose statement is to 'achieve a significant and sustained reduction in suicide and self-harm of Aboriginal and Torres Strait Islander people towards zero through Aboriginal and Torres Strait Islander community leadership and governance' (DoHAC 2024e, p. 10). To achieve this purpose, the Strategy draws on key elements of the Gayaa Dhuwi (Proud Spirit) Declaration, incorporating Aboriginal and Torres Strait Islander cultural concepts with clinical approaches.

The Strategy is centred around the core principles of being Aboriginal and Torres Strait Islander led; underpinned by culture; lived experience informed; holistic and integrated systems and services; and place-based responses (DoHAC 2024e, p. 10).

The National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing

The NIAA is overseeing the development of a new National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing. The previous framework concluded in 2023, just after the Agreement was signed. The refreshed framework, once released, will provide practical guidelines on how governments and services can embed Aboriginal and Torres Strait Islander SEWB (Gayaa Dhuwi (Proud Spirit) Australia, sub. 75, p. 4).

5.2 The Agreement includes extensive commitments to improve social and emotional wellbeing

The Agreement aims to improve SEWB for Aboriginal and Torres Strait Islander people, though most commitments are high level. This section outlines the commitments made through the Agreement for Aboriginal and Torres Strait Islander SEWB. The commitments include:

- contributing to the National Agreement on Closing the Gap (clause 47i)
- working in partnership with Aboriginal and Torres Strait Islander through formal partnership arrangements (clause 110)
- strengthen the Aboriginal and Torres Strait Islander workforce (clause 159d)
- improving monitoring and evaluation of the National Agreement on Closing the Gap commitments (clause 82d).

While these commitments are important, the Agreement provides little detail on how they will be implemented, how success will be measured and how governments will be held accountable if commitments are not met. This is discussed in more detail in section 5.3. Similarly, the Agreement lists Aboriginal and Torres Strait Islander people as one of 15 priority populations, though there is minimal detail on how these groups are to be prioritised (chapter 3).

Alignment with the National Agreement on Closing the Gap

All governments have a shared commitment to implement the National Agreement on Closing the Gap. The National Mental Health and Suicide Prevention Agreement seeks to ensure alignment with the National Agreement on Closing the Gap Agreement and highlights a commitment to the target of significantly and sustainably reducing suicide rates towards zero (target 14).

Commitments in the National Mental Health and Suicide Prevention Agreement to action the National Agreement on Closing the Gap include:

- empowering Aboriginal and Torres Strait Islander peoples to share decision-making authority with governments through formal partnership arrangements (clause 47i(ii))
- building a strong, sustainable community-controlled sector to meet the needs of Aboriginal and Torres Strait Islander people across the country (clause 47i(iii))
- ensuring all services funded by governments are culturally safe and responsive to the needs of Aboriginal and Torres Strait Islander peoples (clause 47i(iv))
- ensuring Aboriginal and Torres Strait Islander people have access to, and training and support to use, locally relevant data and information to set and monitor the implementation of efforts to close the gap, their priorities, and drive their own development (clause 47i(v))
- continued collaboration to build the data and systems needed to understand and improve progress under the National Agreement on Closing the Gap, including outcome 14 (Aboriginal and Torres Strait Islander people enjoying high levels of social and emotional wellbeing) and target 14 (significant and sustained reduction in suicide of Aboriginal and Torres Strait Islander people towards zero) (clause 82d).

There is limited direction and transparency in how governments intend to implement these commitments. The bilateral schedules outline some specific actions, though there is a lack of consistency between the Agreement and the bilateral schedules (section 5.3).

Co-design and collaboration

Under the Agreement, the Australian, state and territory governments agree to be jointly responsible for co-designing place-based approaches with community at a local level. This includes ensuring the voices of people with lived and living experience, experts and non-government organisations are included in the planning and implementation of these approaches.

The Agreement outlines a series of commitments to work in partnership with Aboriginal and Torres Strait Islander people, their communities, organisations and businesses to improve social and emotional wellbeing, and access to, and experience with, mental health and wellbeing services (clause 110a–e). These commitments include:

- supporting the implementation of the Gayaa Dhuwi (Proud Spirit) Declaration
- ensuring alignment with the National Agreement on Closing the Gap and associated Implementation Plans
- ensuring alignment with other relevant national commitments and agreements for Aboriginal and Torres Strait Islander mental health and suicide prevention, including the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy and the National Strategic Framework for Aboriginal and Torres Strait Islander Peoples Mental Health and Social and Emotional Wellbeing
- recognising and enabling leadership of Aboriginal and Torres Strait Islander peoples throughout the mental health, wellbeing and suicide prevention system
- collaborating with ACCHOs and other service providers wherever possible to improve Aboriginal and Torres Strait Islander access to mental health, wellbeing and suicide prevention services and deliver services in a culturally and locally appropriate manner.

Similarly to the Agreement's commitments related to Closing the Gap, while important, actions related to co-design are high level and details on how they will be undertaken are not included.

Other commitments

The Agreement outlines several other commitments related to Aboriginal and Torres Strait Islander SEWB. These commitments are scattered throughout, and like previous commitments outlined, there is little detail on how they will be implemented or success monitored.

Table 5.1 – Other commitments in the Agreement

Topic	Commitment
Bilateral schedules	**Victoria** committed to working with the Australian Government to increase the representation of Aboriginal and Torres Strait Islander peoples in the mental health workforce and upskill the mental health workforce in culturally appropriate care (VIC Bilateral Schedule clause 85e). **Western Australia** committed to working with the Australian Government on Aboriginal and Torres Strait Islander-specific Aftercare arrangements in partnership with Aboriginal and Torres Strait Islander stakeholders (WA Bilateral Schedule clause 48). **The ACT** committed to continuing to implement a culturally safe Aboriginal and Torres Strait Islander integrated suicide prevention, intervention, aftercare and postvention service (ACT Bilateral Schedule clause 47). **South Australia** committed to: • establishing an Aboriginal Mental Health and Wellbeing Centre to improve access to culturally appropriate, multidisciplinary mental health and wellbeing services for Aboriginal and Torres Strait Islander peoples and improve service integration (SA Bilateral Schedule clauses 11h, 13d, 48). • focusing on supporting the mental health and social and emotional wellbeing of Aboriginal and Torres Strait Islander people in the implementation of joint regional mental health and suicide prevention plans between the SA Government and Primary Health Networks (PHNs) (SA Bilateral Schedule clause 13l).
Workforce	Governments agreed to: • seek opportunities to grow and support the representation of Aboriginal and Torres Strait Islander peoples in the mental health and suicide prevention workforce, in effort to achieve population parity, through training, recruitment and retention strategies and through supporting culturally safe workplaces (clause 161) • allocate a minimum number of scholarships, traineeships, clinical placements and employment placements that reflect the Aboriginal and Torres Strait Islander population in each jurisdiction, for allocation to Aboriginal and Torres Strait Islander peoples as first priority, over the life of the Agreement (clause 161a) • build on and leverage existing efforts to build the capability of the mental health and suicide prevention workforce, including the peer and Aboriginal and Torres Strait Islander workforces, to provide support and appropriate clinical treatment to people with co-occurring alcohol and other drug use and mental ill health and suicidality (clause 8f).
Monitoring and evaluation	Governments agreed to build the data and systems needed to improve progress against the National Agreement on Closing the Gap commitments (clause 82d). Under the Agreement's priority data indicators for development (Annex B), the first focus area is 'Improving health and wellbeing for Aboriginal and Torres Strait Islander Australians'. The Agreement sets out its priority data and indicators for development as: • specific prevalence estimates for Aboriginal and Torres Strait Islander health status

Topic	Commitment
	• growth in Aboriginal and Torres Strait Islander mental health workforce • social and emotional wellbeing measures for Aboriginal and Torres Strait Islander Australians. Furthering commitments to the National Agreement on Closing the Gap, the Agreement continues the commitment for all Australian governments to ensure Aboriginal and Torres Strait Islander people have access to, and support to use locally relevant data and information to set and monitor the implementation of efforts to close the gap, their priorities, and drive their own development (clause 47iv).

5.3 What progress has been made?

Governments have made some progress implementing the Agreement and actions aimed at improving Aboriginal and Torres Strait Islander SEWB. However, the overall ineffectiveness of the Agreement (chapter 3) means it is unlikely to have led to improved mental health and suicide prevention outcomes. Assessing the contribution of the Agreement is hampered by a lack of current data (chapter 2). Significant external events, such as the Voice to Parliament Referendum, have influenced outcomes but these effects are difficult to disentangle (NMHC 2024a).

Some commitments have been actioned ...

Co-design and collaboration

One key area of progress is the establishment of an Aboriginal and Torres Strait Islander governance mechanism to aid the Agreement and its implementation.

The Mental Health and Suicide Prevention Senior Officials Group (MHSPSO) and the Closing the Gap Joint Council endorsed the Social and Emotional Wellbeing Policy Partnership (SEWB PP) as the primary governance body advising on Aboriginal and Torres Strait Islander mental health and wellbeing. To strengthen this governance, two SEWB PP representatives and two First Nations members with lived experience were appointed to MHSPSO in May 2023 (NMHC 2024a).

The formalisation of governance arrangements after the Agreement was signed meant decisions were made without adequate consultation with Aboriginal and Torres Strait Islander people and decisions on implementation were delayed (NMHC 2024a).

Bilateral schedules

Only four jurisdictions included specific commitments in their bilateral schedules. These appear to be mostly on track, with Victoria, South Australia, and the ACT all having either delivered, or on track to deliver their commitments (table 5.2). There is no publicly available information on whether commitments are being met for Western Australia and South Australia's commitment to 'focus on supporting SEWB in the implementation of joint regional mental health and suicide prevention plans'. New South Wales, Queensland, Tasmania and the Northern Territory did not provide any specific commitments to improve Aboriginal and Torres Strait Islander SEWB and therefore do not have any commitments to measure progress against.

Where state and territory governments have made progress, it is not always connected explicitly to the Agreement. For example, Victoria committed to increasing Aboriginal and Torres Strait Islander SEWB workforce representation in its bilateral schedule. It appears they have been successful in progressing this

commitment, but they align this progress with the Royal Commission into Victoria's Mental Health System, not the National Mental Health and Suicide Prevention Agreement (Victorian Department of Health 2024).

Table 5.2 – Bilateral schedules progress

Jurisdiction	Commitment	On track?
Victoria	Increase workforce representation	✓
Western Australia	Aboriginal and Torres Strait Islander-specific Aftercare arrangements	?
South Australia	Aboriginal Mental Health and Wellbeing Centre	✓
	Focusing on supporting SEWB in the implementation of joint regional mental health and suicide prevention plans	?
ACT	Continuing to implement a culturally safe Aboriginal and Torres Strait Islander integrated suicide prevention, intervention, aftercare and postvention service	✓

Source: SA Health (2025); Victorian Department of Health (2024); ACT Government (2022).

Workforce

Some state and territories have made progress against workforce commitments within the Agreement. There is not enough publicly available information to assess whether this progress has improved Aboriginal and Torres Strait Islander workforce numbers and retention, though Black Dog Institute indicates there has been little improvement.

> Regarding workforce retention and turnover, accurate figures on these issues are limited but high turnover is well recognised within this sector and noted as a significant issue within a workforce that is already in high demand. (Black Dog Institute, sub. 61, p. 6)

… but the Agreement has not been an effective mechanism to address the issues affecting Aboriginal and Torres Strait Islander people

While it is hard to measure the impact the Agreement has had on Aboriginal and Torres Strait Islander SEWB, the most recent available data shows a lack of improvement. Among other concerning trends, while the Agreement commits to Closing the Gap target 14, Aboriginal and Torres Strait Islander suicide rates are worsening.

Beyond its stated intent to contribute towards the Closing the Gap targets, the Agreement includes commitments to improve access to culturally safe services. But submissions to this review show Aboriginal and Torres Strait Islander people continue to experience barriers to access:

> Negative and harmful experiences at services remains a barrier for Aboriginal and Torres Strait Islander peoples accessing suitable services and failure to address these in the current National Agreement is a catastrophic gap. (Suicide Prevention Australia, sub. 59, p. 11)

> Despite the National Agreement's recognition of First Nations peoples as a priority group, there are still significant gaps in mental health care for Aboriginal and Torres Strait Islander peoples. The role of governments in the delivery and design of mental health services for First Nations communities must be more comprehensively addressed in the National Agreement. (RANZCP, sub. 7, p. 3)

The Agreement has not been set up effectively to improve outcomes. Some of the contributing factors are explained below.

Lack of detail on how commitments should be implemented

The Agreement provides little detail on how commitments for Aboriginal and Torres Strait Islander SEWB will be implemented. This is reflected within the state and territory bilateral schedules; the commitment to implementing the Gayaa Dhuwi (Proud Spirit) Declaration, which is one of the commitments in the Agreement, is absent from the schedules (Gayaa Dhuwi (Proud Spirit) Australia, sub. 75, p. 6). This inconsistency means there are no details on how states and territories, as well as the services funded in the Agreement, will implement the Declaration.

There are other key documents referenced within the Agreement without clear guidance on appropriate outcomes, principles and initiatives.

> The National Agreement commits governments to support implementation of the Gayaa Dhuwi (Proud Spirit) Declaration, and in implementing activities of the National Agreement to ensure alignment with the National Agreement on Closing the Gap, the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy and the National Strategic Framework for Aboriginal and Torres Strait Islander Peoples Mental Health and Social and Emotional Wellbeing. However, this has not flowed through to tangible actions being funded through the bilateral agreements to deliver practical reform. (Mental Health Australia, sub. 76, p. 13)

The lack of detail is not only prevalent within the bilateral schedules. The whole Agreement lacks detail on how to implement, measure and achieve commitments. This can be seen in key areas such as commitments to cultural safety and increasing access to services, where detail is necessary but missing.

> A gap in the National Agreement is its failure to mention or commit governments to enhancing cultural safety in the mental health system. Some of the bilateral agreements include a measure around the proportion of services delivered to the Aboriginal and Torres Strait Islander population that are culturally appropriate, however there are no initiatives on how appropriate services will be delivered or measured. (Gayaa Dhuwi (Proud Spirit) Australia, sub. 75, p. 5)

The governance arrangements have not been fit for purpose

Review participants reflected on the limited involvement of Aboriginal and Torres Strait Islander people and communities in the development and implementation of the Agreement.

> Priority Reform One of the Closing the Gap agreement committed governments to work collaboratively and in genuine, formal partnership with Aboriginal and Torres Strait Islander peoples. This level of partnership and influence was not present in the development of the National Agreement, the bilateral agreements or in the governance mechanisms that monitored progress. (Gayaa Dhuwi (Proud Spirit) Australia, sub. 75, p. 6)

The Agreement does not provide guidance on the way its governance mechanisms should incorporate the views of Aboriginal and Torres Strait Islander people to ensure their perspectives are heard and acted upon throughout the Agreement's implementation.

The SEWB PP was eventually endorsed by MHSPSO and the Closing the Gap Joint Council as the primary governance body advising on Aboriginal and Torres Strait Islander mental health and wellbeing and two representatives were appointed to MHSPSO in May 2023. However, it is unclear how these governance bodies are intended to interact and how decisions are expected to be made. This means there is little accountability for these governance mechanisms to ensure they adequately embed Aboriginal and Torres Strait Islander voices. Overall, governance arrangements do not appear to be fit for purpose.

> The governance of the implementation of the National Agreement was not conducive to Aboriginal and Torres Strait Islander self-determination, leadership and influence. (Gayaa Dhuwi (Proud Spirit) Australia, sub. 75, p. 6)

Support and funding of the community-controlled sector is inadequate

In the Agreement, governments commit to collaborating with ACCHOs to improve Aboriginal and Torres Strait Islander mental health, wellbeing and suicide prevention services. However, review participants have argued the Agreement fails to recognise the capability and expertise of ACCHOs and these resource-constrained organisations must undertake uncompensated engagement to make their voices heard.

> There is no formal recognition of ACCHSs leadership, expertise, or the demonstrated effectiveness of our models within the NMHSPA. Instead, we are often required to participate in regional planning committees and working groups without appropriate resourcing, placing significant strain on our capacity. While we value participation, this unfunded engagement leaves ACCHSs at a structural disadvantage, perpetuating power imbalances where government agencies and mainstream providers retain disproportionate control over mental health policy, funding, and service design affecting Aboriginal and Torres Strait Islander peoples. (Institute of Urban Indigenous Health, sub. 81, p. 8)

The only funding commitment in the Agreement designated to Aboriginal and Torres Strait Islander SEWB services is to establish an Aboriginal mental health and wellbeing centre in South Australia. This means where funding may apply for ACCHOs, there are no mechanisms or requirements for directly funding ACCHOs delivering SEWB services. This is particularly problematic as ACCHOs are left finding ways to fit into mainstream funding processes, which creates significant challenges. This fragmented system restricts holistic and culturally informed approaches that make ACCHOs best placed to deliver effective SEWB services.

> Despite consistent evidence that community-controlled, preventative models deliver better outcomes, funding continues to flow predominantly to mainstream-designed, acute services. This reflects the same systemic issues described above: ACCHSs are expected to deliver services within inflexible, mainstream frameworks or as subcontractors, rather than being resourced and trusted to design culturally safe, community-led prevention approaches from the start. (Institute of Urban Indigenous Health, sub. 81, p. 10)

A lack of suitable funding mechanisms for services can have significant effects for consumers.

> The failure to distribute funds efficiently means that First Nations communities are left waiting for essential mental health care, often until crises escalate to hospitalisation, incarceration, or tragic loss of life. These delays contradict the commitments under the Closing the Gap Agreement, which calls for timely, equitable, and needs-based investment in Aboriginal and Torres Strait Islander-led services. (Institute of Urban Indigenous Health, sub. 81, p. 11)

Insufficient reporting and accountability

The data indicators outlined within the Agreement should provide an ability to measure progress against its intended outcomes. However, review participants have noted data is not available to determine if the Agreement and bilateral schedules have had any impact on outcomes for Aboriginal and Torres Strait Isander SEWB (Northern Territory Mental Health Coalition, sub. 54, pp. 1–2).

> Data and performance information between the National Agreement and the bilateral agreements is similarly misaligned. For example, the National Agreement includes a priority performance indicator as social and emotional wellbeing (SEWB) measures for Aboriginal and Torres Strait

> Islander peoples, however none of the bilateral agreements include such measures. Similarly, the National Agreement includes an indicator related to growth in Aboriginal and Torres Strait Islander mental health workforce that is not represented in the bilateral agreements. (Gayaa Dhuwi (Proud Spirit) Australia, sub. 75, p. 6)

The insufficient and misaligned data results in a lack of transparency and accountability for commitments within the Agreement. More information on the monitoring and accountability commitments can be found in chapter 2. Monitoring commitments in the Agreement specific to Aboriginal and Torres Strait Islander SEWB face mostly the same challenges highlighted more broadly.

Draft finding 5.1
Limited improvements in Aboriginal and Torres Strait Islander social and emotional wellbeing over the course of the Agreement

There is no comprehensive data to assess the contribution of the National Mental Health and Suicide Prevention Agreement to Aboriginal and Torres Strait Islander social and emotional wellbeing. The data available shows that one in three Aboriginal and Torres Strait Islander people experience high psychological distress and suicide rates are worsening.

While the Agreement is intended to align with the National Agreement on Closing the Gap and improve social and emotional wellbeing outcomes for Aboriginal and Torres Strait Islander people, limited progress has been made in system reform. There is insufficient transparency and clarity in the Agreement about actions, progress, monitoring and reporting, and governance.

5.4 The next agreement

The next agreement provides an opportunity to make meaningful and tangible commitments that contribute to better outcomes for Aboriginal and Torres Strait Islander SEWB.

In order to achieve this, the next agreement should:

- ensure meaningful alignment with the Closing the Gap targets, Priority Reforms and other key documents
- include a separate Aboriginal and Torres Strait Islander schedule
- address key priorities including cultural safety, funding and workforce
- improve and clarify governance arrangements
- co-design how the agreement and Aboriginal and Torres Strait Islander SEWB outcomes are monitored
- include a commitment to a community-led evaluation of the schedule.

The next agreement should align with Closing the Gap and other important policy documents

The National Agreement on Closing the Gap is an important platform for cross government reform. However, it does not provide the required detail on how parties will improve Aboriginal and Torres Strait Islander SEWB. Therefore, the National Agreement on Closing the Gap does not replace the need for a comprehensive, informed and co-designed national mental health and suicide prevention agreement.

While the current Agreement does outline a commitment to align with the National Agreement on Closing the Gap, the next agreement would benefit from clarity on how it aims to work alongside the National Agreement on Closing the Gap. Providing clarity on how the two agreements interact can ensure governance arrangements and accountability are embedded within a national mental health and suicide prevention agreement.

> A clear articulation of the relationship between governance of the National Agreement and Closing the Gap is essential given the overlap in purpose to improve social and emotional wellbeing and mental health and reduce suicide rates for First Nations people. A key area requiring clarification is the intention for the governance and activity of the National Agreement to embed Closing the Gap reforms, such as 'building the community-controlled sector' and 'formal partnerships and shared decision-making'. (National Mental Health Commission and National Suicide Prevention Office, sub. 70, p. 15)

The next agreement needs to demonstrate genuine commitment to other key documents that already exist in the Aboriginal and Torres Strait Islander SEWB space. The agreement needs to commit to the implementation of the:

- Gayaa Dhuwi (Proud Spirit) Declaration and Implementation Plan
- National Aboriginal and Torres Strait Islander Suicide Prevention Strategy
- forthcoming National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing.

The next agreement should not just commit to aligning with these documents as a commitment but include tangible actions that progress their implementation. These actions need to be consistent between the agreement and the bilateral schedules to ensure meaningful, co-ordinated and adequately funded implementation.

The agreement should include an Aboriginal and Torres Strait Islander schedule

Commitments to Aboriginal and Torres Strait Islander outcomes are scattered throughout the National Mental Health and Suicide Prevention Agreement and there is no coordinated approach to their implementation.

As part of the negotiations of the new National Health Reform Agreement (NHRA), governments are finalising a separate First Nations Schedule (DoHAC 2024c). This allows for all commitments specific to Aboriginal and Torres Strait Islander people to be located in the same place, while also influencing the overall NHRA to better meet the needs of Aboriginal and Torres Strait Islander people. This supports transparency and enables consideration of the unique factors Aboriginal and Torres Strait Islander communities experience, which are important to an effective agreement.

The next mental health and suicide prevention agreement should include a separate schedule outlining ways to improve the services supporting Aboriginal and Torres Strait Islander people's SEWB. Aboriginal and Torres Strait Islander people should be involved in a co-design process with governments to develop the new schedule and ensure it reflects the SEWB needs of the community. This is in line with governments' commitments under Closing the Gap to work in partnership with Aboriginal and Torres Strait Islander people, their communities, organisations and businesses to improve SEWB. This interim report recommends the current agreement be extended for 12 months, to allow time for the process of co-design (draft recommendation 4.2).

The schedule should be framed around the Closing the Gap Priority Reforms for joint national action, namely: formal partnerships and shared decision-making; building the community-controlled sector;

transforming government organisations; and shared access to data and information at a regional level (Coalition of Peaks and all Australian Governments 2020).

The schedule should address several priorities

While the next agreement should be co-designed with Aboriginal and Torres Strait Islander people, there are a few key areas we heard consistently throughout our engagement should be considered as priorities. Many of these priorities are consistent with what has been discussed throughout this chapter and are key to an agreement that improves outcomes for Aboriginal and Torres Strait Islander SEWB.

Cultural safety as a priority

The focus on culturally safe services and the need for this to be meaningfully embedded into the agreement was brought up by review participants (Carers WA sub. 43; Ruah Community Services, sub. 14; Suicide Prevention Australia, sub. 59). While cultural safety was mentioned in the Agreement, there needs to be clear and implementable commitments in the next agreement reflected in the bilateral schedules to ensure that outcomes are achieved. Gayaa Dhuwi (Proud Spirit) Australia (sub. 75, p. 5) outlines some of the principles and actions required to establish culturally safe services:

> … services and their workforce must recognize the inherent aspects of delivery of care that may prevent culturally safe care from occurring, including the impact of intergenerational trauma, the historical impact of colonisation, the inherent biases of westernized models of healthcare and unconscious individual bias.

Funding the community-controlled sector

Many participants in this review spoke of the need to strengthen the capacity and boost funding to the Aboriginal and Torres Strait Islander community-controlled sector to deliver SEWB services. This includes consolidating the various funding streams for SEWB and mental health programs, alongside specific calls by review participants to transfer the commissioning of SEWB funding from PHNs to ACCHOs, while prioritising flexibility and sustainability (Black Dog Institute, sub. 61; Institute of Urban Indigenous Health, sub. 81). The Institute of Urban Indigenous Health suggests this would:

- reduce delays and inefficiencies associated with PHN-led commissioning
- ensure funds are allocated according to community-identified needs, rather than external funding priorities
- strengthen the role of ACCHSs as the primary providers of culturally safe mental health care
- align with the Closing the Gap Priority Reforms, particularly formal partnerships and shared decision-making (sub. 81, p. 12).

Workforce investment

Increasing the Aboriginal and Torres Strait Islander SEWB workforce is another commitment within the Agreement review participants noted as a key focus. There have been calls to increase investment to this workforce (Beyond Blue, sub. 37, p. 5), and include dedicated funding for professional development, clinical supervision and workforce support.

> The lack of dedicated funding for professional development, clinical supervision, and mental health workforce support further exacerbates workforce fatigue and turnover, limiting the capacity of ACCHSs to meet increasing demand and the critical and rising levels of poor mental health discussed earlier. (Institute of Urban Indigenous Health, sub. 81, p. 11)

The Black Dog Institute (sub. 61, p. 6) highlighted a need to include specific measures to invest in the SEWB of Aboriginal and Torres Strait Islander Healthcare Workers in the future bilateral schedules:

> Provide expanded SEWB Support to First Nations healthcare workforce: First Nations health workers face heavy workloads, racism, and the ongoing impact of colonial load—contributing to high turnover.

The Agreement needs to improve and clarify governance for its design and implementation

The agreement should designate a specific Aboriginal and Torres Strait Islander governance mechanism to lead the schedule design and broader implementation. Review participants noted the importance of Aboriginal and Torres Strait Islander governance:

> Future agreements, bilateral agreements and governance mechanisms must be developed in partnership with Aboriginal and Torres Strait Islander peoples. (Gayaa Dhuwi (Proud Spirit) Australia, sub. 75, p. 6)

Aboriginal and Torres Strait Islander governance is necessary to improving SEWB outcomes. This is because Aboriginal and Torres Strait Islander governance structures hold an understanding of lived and living experience, community needs, cultural safety and have greater capacity for meaningful engagement. Effective governance arrangements are also required to fulfil governments commitments to the Closing the Gap Priority Reforms, namely Priority Reform 1 (formal partnerships and shared decision-making) and Priority Reform 3 (transforming government organisations).

While it is not referenced in the current agreement, the SEWB PP has acted as the primary governance body for Aboriginal and Torres Strait Islander SEWB. This is an appropriate and effective governance mechanism for this agreement as it is a well-structured group bringing together the experiences and voices of community and government, to act in collaboration and ensure communities voices are heard and acted upon.

The next agreement should leverage this current governance mechanism. The SEWB Policy Partnership should play a more explicit governance role in the process of designing and implementing the next agreement.

> The government should look to the example of the five policy partnerships established under the Closing the Gap Agreement that exemplify how self-determination and shared governance can work in practice (Gayaa Dhuwi (Proud Spirit) Australia, sub. 75, p. 6)

In order to fully implement the Closing the Gap Priority Reforms, the next agreement and its governance arrangements need to give the SEWB PP decision-making power and authority over issues in the agreement that relate to Aboriginal and Torres Strait Islander SEWB. These arrangements should be formally set out within the next agreement to ensure commitment and transparency.

The way the agreement monitors and evaluates Aboriginal and Torres Strait Islander SEWB needs to be co-designed

The current Agreement includes plans to develop specific indicators for Aboriginal and Torres Strait Islander SEWB but as discussed in section 5.3, monitoring of progress has been insufficient. Monitoring enables transparency and an ability to measure what is and is not working within the agreement therefore is important to consider.

The next agreement should reconsider how it measures success and introduce consistent indicators in the agreement and its bilateral schedules. This should be done alongside Aboriginal and Torres Strait Islander people in partnership, creating an opportunity to move away from deficit-based narratives and to shift to a

strengths-based framework. This shift would align with key documents such as the Gayaa Dhuwi (Proud Spirit) Declaration.

> Future agreements provide an opportunity to shift towards a strength-based framework for measuring progress in recognition of the complex and interrelated factors that underpin the social and emotional wellbeing and mental health of Aboriginal and Torres Strait Islander peoples. This aligns with the Gayaa Dhuwi (Proud Spirit) Declaration and the National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing which emphasise how strength in culture, community and connection support outcomes … This shift is essential in moving away from deficit-based narratives and creating policies and programs that genuinely promote systemic and lasting change. Outcomes measurement in future Agreements should be designed in partnership with Aboriginal and Torres Strait Islander organisations and be committed to in bilateral agreements. (Gayaa Dhuwi (Proud Spirit) Australia, sub. 75, p. 6)

The final review of the next agreement should also be an opportunity for a community-led evaluation of the Aboriginal and Torres Strait Islander schedule when it concludes. This would allow community to provide their own insight and perspectives on areas of achievement and how the schedule can continue to improve. A community-led evaluation for the schedule could be undertaken by Gayaa Dhuwi (Proud Spirit) Australia. The evaluation would need to be appropriately resourced in order to not create extra burden for those who are already delivering outcomes within community.

Draft recommendation 5.1
An Aboriginal and Torres Strait Islander schedule in the next Agreement

The next agreement should include a separate schedule on Aboriginal and Torres Strait Islander social and emotional wellbeing. This schedule should be developed in a process of co-design with Aboriginal and Torres Strait Islander people.

The schedule should:

- align with the National Agreement on Closing the Gap and other important documents and include tangible actions, with commensurate funding, to improve the social and emotional wellbeing of Aboriginal and Torres Strait Islander people, including better mental health and suicide prevention outcomes
- clarify governance for its design and implementation, including the role of the Social and Emotional Wellbeing Policy Partnership established under the National Agreement on Closing the Gap as the decision-making forum over issues relating to Aboriginal and Torres Strait Islander social and emotional wellbeing
- measure progress in a strengths-based way, with community-led evaluation
- articulate and embed priorities highlighted by community such as cultural safety in all services, and greater investment in the community-controlled sector and the Aboriginal and Torres Strait Islander social and emotional wellbeing workforce.

6. Suicide prevention

Key points

- **Suicide prevention in Australia is in a period of transition. There has been a shift towards an integrated, whole-of-government approach that addresses the social and emotional drivers of suicide and recognises that the suicide prevention system sits alongside the mental health system, not within it.**
- **The National Mental Health and Suicide Prevention Agreement recognises this shift. It includes ambitious priorities and commitments to improving Australia's suicide prevention services and reducing the rate of suicide, suicidal distress and self-harm through a whole-of-government approach.**
- **The establishment of the National Suicide Prevention Office (NSPO) is the only national output in the Agreement specifically for suicide prevention.**
  - The NSPO was established by the Australian Government and is working to implement a national whole-of-government approach to suicide prevention. It published the National Suicide Prevention Strategy 2025–2035 and is developing an outcomes framework for suicide prevention.
- **Governments also committed to invest in specific suicide prevention services through the bilateral schedules. While some progress has been achieved, significant gaps remain, which affect the availability of supports to people who need them.**
- **Since the Agreement was signed, there has been no change in the suicide rate and anecdotal evidence points to an increase in rates of distress.**
  - The contribution of the Agreement to any changes in suicide, suicidal distress and self-harm is difficult to assess. Governments share responsibility for key commitments, leading to ineffective accountability mechanisms. Reporting of progress has been significantly delayed.
- **Suicide prevention in the next agreement should be guided by the National Suicide Prevention Strategy. Areas where mental health and suicide prevention policy overlap should be included in the main agreement. A separate schedule to the agreement should tackle progress in areas where policy intervention is relevant specifically to suicide prevention. This schedule should:**
  - **articulate short-term objectives, outcomes and actions that are clearly linked to the long-term goals of the National Suicide Prevention Strategy**
  - **utilise and align with the forthcoming National Suicide Prevention Outcomes Framework**
  - **require that the NSPO be responsible for the monitoring and reporting of the schedule.**

Suicide, self-harm and suicidal distress are a significant issue in Australia. On average, every day nine people die by suicide and more than 150 people attempt to take their own life (NSPO 2025, p. 7). Since 2015, about 3,000 people have died by suicide every year (AIHW 2023a).

The distress of the people who died by suicide and those people who have lost someone to suicide is immeasurable. However, trying to contextualise the impact in numbers helps to mobilise efforts and hold government accountable for the lack of progress (PC 2020a, p. 409). Each death of a person by suicide is estimated to impact 135 people (Cerel et al. 2019, p. 529), which means approximately 1,215 people are affected by suicide each and every day in Australia. At some point in their lives, one in six Australians aged 16–85 years had serious thoughts of attempting suicide (AIHW 2024f). In 2020, it was estimated suicide and suicidal distress cost $30.5 billion each year as a result of the healthy years of life lost due to disability or premature death and other direct and indirect costs such as medical costs (PC 2020a, pp. 416 and appendix H).

The approach to suicide prevention in Australia is currently in a period of transition (Bassilios et al. 2024, p. 1). Australia's previous response to suicide prevention relied on the person in distress seeking help, primarily through the health or hospital system (National Suicide Prevention Adviser 2020a, p. 5). But this approach is not effective, as one in 10 people who died by suicide did not access any health services in their last year of life (AIHW 2025b).[25] It also misses engaging early when people experience distress to reduce the factors contributing to suicidality. There has been a shift towards an integrated, whole-of-government approach addressing the social and emotional factors affecting suicidality and recognises the suicide prevention system as sitting alongside the mental health system, not within it (Lifeline Australia 2021; National Suicide Prevention Adviser 2020a, pp. 5–6; NSPO 2025, pp. 13, 68; PC 2020a; Suicide Prevention Australia and Mental Health Australia 2022).

Assessing progress in suicide prevention through the National Mental Health and Suicide Prevention Agreement is not straight forward for the same reasons as assessing progress against the Agreement as a whole (chapter 2).

- Monitoring and reporting commitments under the Agreement have not been adhered to.
- Key data gaps remain.
- Understanding the specific impact of the Agreement is difficult due to external factors such as the COVID-19 pandemic occurring during the period of the Agreement and other government policies impacting the suicide prevention system.
- The Agreement has only been in operation for three years, which is a relatively short period to realise change across the system.

This chapter considers the progress the Agreement has made to implementing an integrated, whole-of-government suicide prevention system that contributes to reducing suicides to zero (section 6.1). It examines the commitments made in the Agreement that affect suicide prevention (section 6.2) and outlines a new way of incorporating suicide prevention for the next agreement (section 6.3).

[25] This study looked at access to hospitals, services covered under the Medicare Benefits Schedule and the Pharmaceutical Benefits Scheme for people who died by suicide between of 1 July 2010 and 31 December 2017.

6.1 What progress has been made?

There has been mixed progress under the Agreement

The Agreement addresses suicide prevention largely in combination with mental health services. Only a limited number of elements are directly related to suicide prevention (box 6.1).

Box 6.1 – Suicide prevention in the Agreement

Objective

Governments agree on their shared objective to work collaboratively together to implement systemic, whole-of-government reforms … progress the goal of zero lives lost to suicide, and deliver a … suicide prevention system that is comprehensive, coordinated, consumer-focussed and compassionate.

Outcomes

Reduce suicide, suicidal distress and self-harm through a whole-of-government approach to coordinated prevention, early intervention, treatment, aftercare and postvention supports.

Outputs

Establishment of the National Suicide Prevention Office (NSPO). A related commitment is that governments support the NSPO to develop a National Suicide Prevention Workforce Strategy.

Commitments to specific suicide prevention services are contained in the bilateral schedules (table 6.1).

National priorities

Governments agree, in collaboration, to:

- seek to reduce suicide deaths, suicide attempts, and self-harm towards zero
- progressively meet the different needs of identified priority population groups and increase accessibility to services through evidence informed care and targeted approaches
- develop suicide prevention services and programs in collaboration with communities and people with lived experience to identify gaps in service provision and to gain insights into individual experiences
- improve joint regional planning for suicide prevention to drive development of evidence-based services in areas of identified need to address gaps in service provision nationally
- improve the quality of suicide prevention services by establishing standards either developed specifically for the program or by an external organisation to improve outcomes of service provision
- incorporate suicide prevention training into service modelling to develop skills for building capacity and fostering suitably skilled workers that are empathetic to the needs of people in suicidal distress
- build competency within the suicide prevention workforce, including the peer workforce, through evidence informed training
- seek to avoid or minimise service gaps, fragmentation, duplication, and inefficiencies in joint suicide prevention activities.

Box 6.1 – Suicide prevention in the Agreement

Schedule A

Governments commit to working together to pursue whole-of-government approaches to mental health and suicide prevention in priority areas (such as education, work environments and homelessness).

Source: Clauses 23, 26b, 27h, 124 and 156; Schedule A: clause 1.

A sound objective that has lacked progress

The Agreement sets out an overarching objective to 'progress the goal of zero lives lost to suicide' (clause 23). The objective provides a clear and simple, long-term unifying purpose for all governments.

The objective is in line with previous government actions, such as the National Suicide Prevention Advisor and National Suicide Prevention Taskforce commencing in 2019 (National Suicide Prevention Adviser 2020b), and present day strategies such as the National Agreement on Closing the Gap (Coalition of Peaks and all Australian Governments 2020).

There has been minimal progress in reducing suicide rates, which have remained almost unchanged over the past decade (chapter 2). In 2023, there had been a reported 3,214 deaths by suicide, or 11.8 deaths per 100,000 population (AIHW 2023a).[26] Preliminary data has indicated a decline in the age-standardised rate of suicide of young people (aged up to 25 years) since 2020 (AIHW 2025f). However, caution should be used in interpreting this data as it is subject to change and comes following a decade of rising rates of suicide deaths in young people.[27] Anecdotal evidence from review participants indicated concerning trends in rising suicide rates among groups disproportionately impacted by suicide, in particular Aboriginal and Torres Strait Islander people (Carers WA, sub. 43, p. 10; Lifeline Australia, sub. 8, p. 3). This is discussed further in chapter 5.

There is mixed evidence on the rates of suicidal distress and self-harm (chapter 2). Hospitalisations from self-harm have declined from their peak of 136 hospitalisations in 2016-17 to 95 hospitalisations per 100,000 population in 2022-23 (AIHW 2024d, table S2). However, evidence from service providers and advocacy groups suggests there has been no change, or in some cases a worsening of incidents of self-harm and suicidal ideation, particularly in young people (chapter 2). For example, yourtown (sub. 71, p. 12) stated:

> Over the past five years, there has been a 48% rise in the number of young people from [rural and remote] areas presenting to the service with suicidal ideation. Suicide-related concerns have increased from affecting one-in-six of these young people to one-in-four over the same five-year period.

[26] Incidence rates enable comparisons to be made between populations that have different age structures. AIHW (2023b) explains their methodology as 'the age structures of the different populations are converted to the same 'standard' structure, and then the rates that would have occurred with that structure are calculated and compared. Rates are expressed as per 100,000 per population years.'

[27] As death by suicide is a statistically rare event, relatively small changes in numbers can result in large fluctuations in the rate (AIHW 2023a).

The Agreement contains commitments to improve suicidality data, which have been led through the Data Governance Forum (DGF) (Annex B). The DGF have assisted to progress initiatives, such as by supporting data development and technical discussions on the development of a priority indicator for emergency department self-harm presentations (DGF, pers. comm., 20 May 2025). Improvements in data sharing supported by the DGF (chapter 2) have led to regular reporting of data on suicide and self-harm monitoring for smaller geographic areas (DGF, pers. comm., 20 May 2025). However, our understandings are still restricted by infrequent collection of national surveys of mental health and remaining data gaps (chapter 2).

It remains difficult to understand from data and reporting whether there has been a realisation of a whole-of-government approach to suicide prevention activities, as outlined in the Agreement (box 6.1). Advocacy groups and services providers have stated there is limited evidence of a whole-of-government approach on the ground.

> Effective whole-of-government reforms seeking to drive a reduction in social determinants of suicide would expect to be paired with a reduction in Lifeline's contact data. However, this is not what is being witnessed on the ground at Lifeline. We are seeing more people than ever reach out to Lifeline's crisis support offerings. (Lifeline Australia, sub. 8, p. 6)

> … despite repeated commitments to integration, mental health and suicide prevention are still treated as the responsibility of the health system alone, rather than a whole-of-government priority. (Ruah Community Services, sub. 14, p. 10)

> A whole of government approach to suicide prevention is key. Still, an investment in building capabilities across government agencies and clear mechanisms to monitor and support cross-jurisdictional and cross-portfolio action is needed. (Everymind, sub. 32, p. 3)

> Australia still lacks a whole-of-system approach and a shared understanding of the drivers of suicidality … Whole-of-government collaboration is weak, as suicide prevention efforts remain fragmented across portfolios, and while the National Agreement commits governments to cooperation, practical implementation and funding alignment are inconsistent. (National Mental Health Consumer Alliance, sub. 66, pp. 15, 22)

One possible explanation for the lack of progress is the scale of the task governments have signed up to. The Agreement was only signed in 2022, and achieving ambitious commitments such as whole-of-government integration in a four-year time frame is a large-scale task that is unlikely to be feasible. It is also plausible some of the changes in policy and service delivery arising from the Agreement have not yet had time to flow through to the system.

The National Suicide Prevention Office is a key output of the Agreement

As part of its commitments under the Agreement, the Australian Government established the National Suicide Prevention Office (NSPO). The creation of the NSPO was announced in May 2021, and it operates as a non-statutory office within the Department of Health, Disability and Ageing (NSPO 2024a). The NSPO has been set up to lead a whole-of-government approach to suicide prevention (box 6.2).

Box 6.2 – About the National Suicide Prevention Office

The Agreement tasked the NSPO with leading a national whole-of-government approach to suicide prevention (clause 125). Significant progress has been made in achieving this task.

- The NSPO worked with people with lived and living experience, service providers, peak bodies and governments to develop and release the National Suicide Prevention Strategy 2025–2035. The Strategy outlines 'a comprehensive approach to suicide prevention, aligning national efforts with the latest evidence and insights about what works' (NSPO 2025, p. 17).
- The NSPO is undertaking the development of a national outcomes framework for suicide prevention (NSPO 2024a). It is also responsible for working with all jurisdictions to set priorities for suicide prevention research and knowledge sharing (NSPO 2024a).

The NSPO was tasked on establishment with the development of a National Suicide Prevention Workforce Strategy. This is reflected in the Agreement. However, this work has not yet started due to prioritisation of the development of the National Suicide Prevention Strategy and the National Suicide Prevention Outcomes Framework (NSPO, pers. comm., 23 May 2025).

The establishment of the NSPO has been well received by people with lived and living experience and service providers.

> The development of the National Suicide Prevention Office … represent[s] [a] significant step forward in enhancing the sustainability and services provided by the Australian mental health and suicide prevention system. (Lifeline Australia, sub. 8, p. 5)

> The Agreement has brought about significant progress in mental health system governance and planning. This includes the establishment of the National Suicide Prevention Office … (Black Dog Institute, sub. 61, p. 1)

> The National Suicide Prevention Office is a good step towards coordinated suicide prevention. (Movember Institute of Men's Health, sub. 80, p. 7)

Lack of accountability for the national priorities

There are eight national priorities governments agreed to progress collaboratively and are specifically in relation to suicide prevention (box 6.1). These priorities are not well-defined, and this makes it challenging to assess whether there has been any progress. It is also difficult to tell what actions in the Agreement or the bilateral schedules are linked to what priorities.

As part of the national priorities, governments committed to 'develop suicide prevention services and programs in collaboration with communities and people with lived experience to identify gaps in service provision and to gain insights into individual experiences' (box 6.1). One example of progress towards this priority has been the development of the Lived Experience of Suicide Service Guidelines by Roses in the Ocean (box 6.3). The Guidelines are not stated as an output of the Agreement but arose from the Agreement and were funded by the Department of Health, Disability and Ageing (Roses in the Ocean and Folk 2024). These Guidelines align with the types of services funded under the Agreement and are likely to improve the quality of suicide prevention services. Roses in the Ocean have heard through their engagement with PHNs and service providers that many organisations have used the Guidelines to help establish or deliver suicide prevention support services (Roses in the Ocean, pers. comm., 21 May 2025).

Box 6.3 – Lived Experience of Suicide Services Guidelines

In 2023, Roses in the Ocean collaborated with 260 people with lived and living experience of suicide, to develop a set of Lived Experience service guidelines. These guidelines provide practical ideas and recommendations for the design and delivery of aftercare services for people following a suicide attempt or caring for a loved one who has made a suicide attempt, postvention for people with lived and living experience of suicide bereavement, and distress brief support services.

The documents provide guidance from people with lived and living experience on what is required from the different service types to best meet the needs of their users. For example, the Lived Experience of Suicide Service Guidelines: Distress Brief Support advocated that:

- support should be individually responsive and holistic
- anyone in distress is eligible
- referral into the service should be widely available
- peer workers have a primary role
- support should be practical, not just emotional
- flexible access is required
- communicate the briefness of support early
- no one leaves a clinical setting without support or to a waitlist
- provision for 24-hour support is required
- follow up is an essential component of the service.

Source: Roses in the Ocean and Folk (2024, 2024).

Other priority areas have shown little improvement. For example, there is evidence of service gaps and fragmentation continuing in the system, suggesting there is more work to be done on reducing service gaps. Ruah Community Services (sub. 14, p. 2) stated there were many people 'at risk of suicide [that] are falling through the cracks of a fragmented, clinical-centric mental health system'. In the survey conducted by the PC, respondents provided many examples of poor continuity of care following treatment for crisis, lack of engagement early in distress and limited ongoing suicide prevention support.

> I have yet to find any public hospital settings to help with a crisis which wouldn't make me more suicidal and depressed. (sr. 89)

> Whenever I have a crisis or suicide attempt, they have kept me overnight in ED then send me home the next morning with no follow up usually! (sr. 122)

> At times in the last 3 years I have been suicidal but there are not many services which could have helped me. (sr. 202).

> Services are still only geared for people in crisis … There is no on-going suicide prevention support for people not in crisis, this hasn't changed and I don't see it even on the radar. (sr. 212)

Some progress through the bilateral schedules

The bilateral schedules provide a greater level of information on the initiatives co-funded by the Australian Government and the state or territory governments to fulfil their commitments under the Agreement (table 6.1).

Table 6.1 – Suicide prevention initiatives in bilateral schedules

Initiative	Jurisdiction	Description	Is funding attached?
Universal Aftercare Services	All. (VIC, SA, TAS and NT altered)	Commitment to a two-part approach to universal aftercare services: • Implement services to support those who have been discharged from hospital following a suicide attempt. • Implement a pilot to expand referral and entry pathways to aftercare services from other health settings to capture those who have experienced a suicidal crisis without being admitted to hospital. Aftercare services transitioned to the bilateral schedules on 30 June 2023. Victoria's model for the second part of this initiative is listed as a separate initiative under 'Aftercare referral pathways trial'.	✓
Distress Intervention Trial Program	NSW, VIC, QLD, SA. (VIC altered)	Distress Intervention Trial sites with the objective of preventing and reducing suicidal behaviour through early intervention in non-mental health settings. Bilateral schedules provide very little further information on this initiative.	✓
Postvention Support	NSW, VIC, QLD, SA, NT. (SA altered)	Co-funding Youturn Ltd to deliver postvention support, so all people who are bereaved or impacted by suicide can access postvention services.	✓
Preventing and reducing suicidal behaviour	SA only	A shared commitment from SA and the Australian Government to work collaboratively to prevent and reduce suicidal behaviour in SA, including to improve early responses to psychological distress and expand delivery of aftercare services.	×

All funding in the Agreement is specified through the bilateral schedules. Only three types of services distinct to suicide prevention are funded, with most funding is allocated to universal aftercare services (table 6.2).

Table 6.2 – Funding contributions by activity and government level[a]

2021–2026, $m

	States and territories	Australian Government	Total
Universal Aftercare Services	185.5	288.5	**474.0**
Distress Intervention Trial Program	9.8	8.2	**18.0**
Postvention Support	20.3	17.1	**37.4**
Total	**215.5**	**313.9**	**529.4**

a. Rows and columns may not add due to rounding.

Source: PC analysis of bilateral schedules.

Lack of transparency around commitments and progress

To date, the only progress report completed under the Agreement reflects the status of initiatives in 2022-23 (chapter 2).

Information gathered from the bilateral schedules and the 2022-23 National Progress Report suggests most aftercare services had not been established by September 2023 (NMHC 2024a, p. 21). With the delay in the national reporting for 2023-24, it is unclear whether further progress in implementing these services has been made.

There is insufficient public reporting to establish whether commitments in the bilateral schedules have now been completed. For example, while jurisdictions have committed to work towards universal aftercare services in the bilateral schedules, it is not clear to what extent these have been funded or achieved (Suicide Prevention Australia, sub. 59, p. 5). Jurisdiction implementation plans, which may contain details on aftercare models and providers, have not been made public.

Review participants raised concerns about gaps in services persisting despite commitments in the Agreement.

> Even with a narrow definition of universal aftercare that applies only to hospital admissions, we have not yet reached the point where 100% of people presenting to Emergency Departments (ED) for suicide attempts or distress are being referred to aftercare. Additionally, delays in funding for some aftercare services further hinder the development of universal aftercare. Insights from Suicide Prevention Australia's members, and publicly available information, both indicate that significantly greater action is required in moving towards genuinely universal aftercare and postvention. (Suicide Prevention Australia, sub. 59, p. 5)

> Without making aftercare available and accessible for people who have not been admitted to hospital, we miss an opportunity to help these people to avoid future self-harm and suicide. (Lifeline Australia, sub. 8, p. 8)

> … there are areas of the country where there is no feasible access to aftercare and postvention, with some postvention services having closed their books to new clients due to excessive waiting lists having accrued. It remains the case that people in regional, rural and remote areas are especially disadvantaged in this regard. If services are available, they will be limited to telehealth, which brings access issues dependent on communications infrastructure, and can present problems for privacy and confidentiality. (Roses in the Ocean, sub. 19, p. 4)

> We continue to hear stories of people's only option being to attend emergency departments – where they often receive inadequate care in an inappropriate environment. For example, a carer shared the story of taking her suicidal daughter to the emergency department, where they waited for 7 hours before seeing an ED doctor, only to be told to wait in the public waiting room overnight before eventually seeing a mental health nurse. In total they waited 36 hours before being seen by an appropriate person. We also hear stories of staff being reluctant to admit suicidal consumers due to a lack of beds. … We also continue to hear reports of a lack of follow up or connection to aftercare services for people who have had a suicidal crisis or acute mental health episode, and those caring for them. (Consumer Health Forum of Australia, sub. 22, pp. 10–11)

There is insufficient data to determine whether the jurisdictions have met their commitments through the bilateral schedules. However, anecdotal evidence suggests more work is needed so people who require suicide prevention services can access the support they need.

Draft finding 6.1
The Agreement has supported positive policy developments in suicide prevention, but outcomes remain unchanged

The National Mental Health and Suicide Prevention Agreement has led to some positive changes in suicide prevention policy, including the establishment of the National Suicide Prevention Office. The bilateral schedules provided funding for suicide prevention services in most jurisdictions.

However, there has not been substantial progress in achieving the Agreement's objective of zero lives lost to suicide. Since 2015, every year about 3,000 people have died by suicide.

6.2 Suicide prevention is not well set up in the Agreement

Components are not clearly linked or well defined

While there are numerous commitments to improve suicide prevention policy and services in the Agreement (box 6.1), it lacks a coordinated and holistic approach that outlines how specific actions are linked to outcomes.

Without consideration of the logic between the components linking the objective and the outputs, there is a risk the actions will not be evidence-based and long-term outcomes will not be achieved (chapter 1).

> Suicide prevention initiatives funded under the first Agreement, whilst valuable, significantly underrepresent what is considered evidence-based and best-practice suicide prevention support for Australian communities. Black Dog Institute has highlighted nine strategies—of which aftercare and crisis care represent only one element—that, when implemented together in a defined community, are likely to reduce the rate of suicide. (Neami National, sub. 63, p. 14)

The outcome the Agreement is working towards is not specific and measuring progress against it is a complex task (box 6.4).

Box 6.4 – Applying the SMART Framework to the suicide prevention outcome

To provide effective guidance for policy design and for the actions funded under the Agreement, its outcome needs to be clearly defined. The SMART framework is a useful tool for designing functional outcomes that will guide behaviour in a way that is specific, measurable, achievable, relevant and time-bound (chapter 4).

There is only one outcome in the Agreement related to suicide prevention. Through the Agreement, governments aim to 'reduce suicide, suicidal distress and self-harm through a whole-of-government approach to coordinated prevention, early intervention, treatment, aftercare and postvention supports' (clause 26b).

- **Specific**: The outcome is not specific. It seeks to address a broad range of issues (suicide, suicidal distress and self-harm), which are closely connected but may also require separate government

Box 6.4 – Applying the SMART Framework to the suicide prevention outcome

actions. It is also not clear what scale of reduction would constitute progress in achieving this outcome.

- **Measurable**: It is difficult to measure progress even if it was specific. For example, understanding whether the prevalence of self-harm has changed is difficult as there is underrepresentation in the data. Similarly, understanding whether the reduction is through a whole-of-government approach is currently not assessable as there is no way to measure a whole-of-government approach.
- **Achievable**: The outcome is achievable in the sense that it is possible to reduce suicide, suicidal distress and self-harm through a whole-of-government approach. Furthermore, a whole-of-government approach is within the control and influence of governments. However, it is difficult to achieve the outcome within the short period of the Agreement.
- **Relevant**: The outcomes are in line with the objectives of the Agreement, especially in relation to the creation of an integrated system that provides comprehensive, timely, consumer-focused and equitable access to suicide prevention and support services (clauses 23–25).
- **Time-bound**: There is no consideration of the time required to achieve the outcome.

There is only one output in the Agreement directly related to suicide prevention (clause 27h). Establishing the NSPO is an important starting point but completing this output alone will not enable governments to achieve progress towards the agreed outcome within the term of the Agreement. The bilateral schedules contain additional actions, but there is insufficient information to assess their impact. Similarly, Schedule A of the Agreement contains several statements about cross-agency action to support suicide prevention. There is no funding attached to these commitments and limited information about progress is publicly available (NMHC 2024a, p. 16).

The national priorities within the Agreement overlap and are duplicative (box 6.1). For example, there are three separate national priorities to identify or address gaps in service provision and two priorities to upskill the workforce.

There is continued confusion around roles and responsibilities

Under the Agreement, the role of the Australian Government is described as a 'national leadership role.' In addition, 'it is responsible for funding and delivering whole-of-population suicide prevention activities in a nationally consistent way' (clause 35).

The Australian, state and territory governments have joint responsibility in the Agreement (clause 47d-f) for:

> Improving system capacity to respond to people who are at risk of suicide, experiencing suicidal distress or crisis or following a suicide attempt. This includes working together to focus on prevention and early intervention, improving leadership to increase integration, prioritising lived experience knowledge, using data and evidence to drive outcomes and increasing the workforce and community capability.
>
> Providing and/or funding of suicide prevention, early intervention, aftercare and postvention programs which reflect and respond to local needs and circumstances.

> Contributing to closing the gap in Aboriginal and Torres Strait Islander peoples' disadvantage and life expectancy and achieving the Closing the Gap targets, including a significant and sustained reduction in suicide of Aboriginal and Torres Strait Islander peoples towards zero (Target 14).

The bilateral schedules provide additional detail on the roles and responsibilities relating to the initiatives included within them. Similar to the national priorities, responsibility for those initiatives relating to suicide prevention is largely shared between levels of government. There are three exceptions to this, where the state or territory take on sole responsibility for certain aspects of universal aftercare services.[28]

Having joint responsibilities over major issues in the suicide prevention system has resulted in a lack of clarity and ownership about what joint responsibility means or how it is operationalised. The National Mental Health Commission (NMHC) (2024a, p. 19) called for:

> … consistent and ongoing communication and engagement between the various governance groups (coordinated by MHSPSO) and the jurisdictions to ensure roles and responsibilities for the implementation of commitments are clearly identified and stakeholders are aligned in their views on governance, responsibilities, timeframes and milestones.

Aspects of this call have been echoed in the National Suicide Prevention Strategy (NSPO 2025, pp. 68–69) and in submissions to this review (Australian Association of Psychologists Incorporated, sub. 13, p. 10; Roses in the Ocean, sub. 19, p. 5; Suicide Prevention Australia, sub. 59, pp. 10–11).

Having unclear roles and responsibilities can act as a barrier to progress on joint initiatives as neither party is clearly responsible for the task. This contributes to a lack of accountability and transparency for the community. Suicide Prevention Australia (sub. 59, p. 10) reflected:

> There is a lack of transparency around roles established in the National Agreement, which meant that it was often unclear how decisions were being made about funding allocations or the location of services. This means that it can be difficult to establish where delays are occurring when funding is late, given services that are impacted no recourse, and increasing uncertainty by making it difficult to predict how significant delays to funding will be.

Furthermore, unclear roles and responsibilities can create an environment where gaps in services can emerge and persist, as each level of government can plausibly claim support should have been delivered by the other (PC 2019, p. 82). This can also make it difficult for the community to hold the different levels of government to account for service provision and outcomes as they cannot tell who the responsible party is (Suicide Prevention Australia, sub. 59, p. 10, Roses in the Ocean, sub. 19, p. 5).

In the Mental Health inquiry the PC recommended the Agreement include 'precise detail about the responsibility of each tier of government to fund and deliver mental health services and suicide prevention activities' (2020a, p. 441). Providing clarity regarding articulated roles and responsibilities is fundamental for achieving accountability to the community and ensuring adequate supports are available to the people who need them (PC 2019, p. 70).

[28] The Victorian Government has the responsibility for oversight of the services; the Queensland Government has responsibility for co-commissioning arrangements and the ACT Government has responsibility for services for Aboriginal and Torres Strait Islander people.

Draft finding 6.2
The Agreement's approach to suicide prevention lacks clarity

The approach to suicide prevention policy commitments as outlined under the National Mental Health and Suicide Prevention Agreement does not enable effective reform.

- The Agreement does not outline a clear link between actions and expected outcomes.
- Roles and responsibilities are not sufficiently clear, specifically regarding areas of joint responsibility. This contributes to gaps in service delivery and reduced accountability.

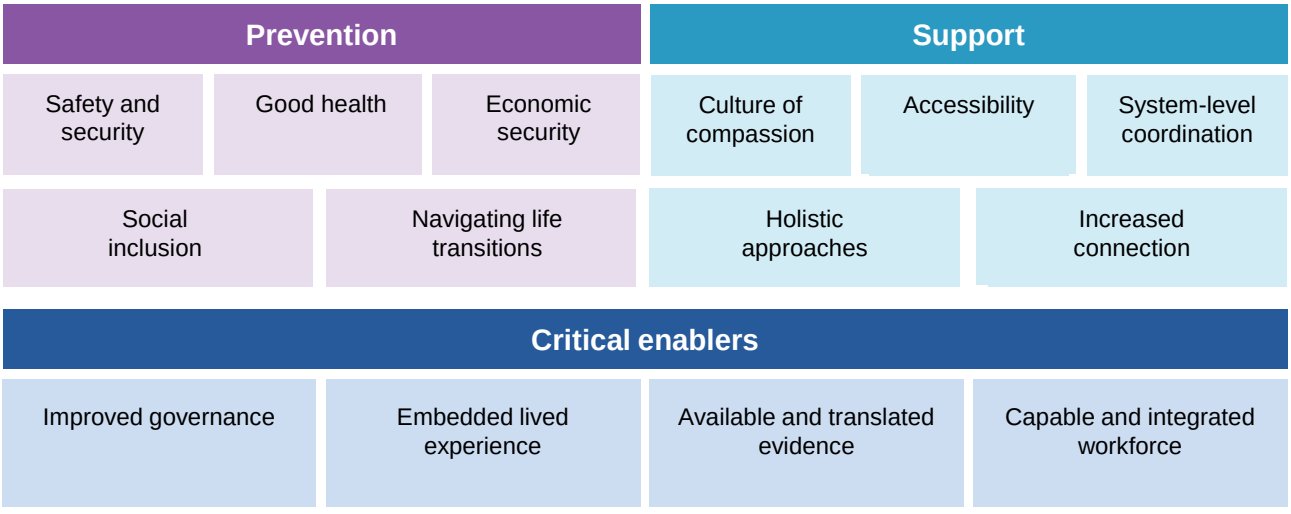
6.3 Suicide prevention in the next agreement

The agreement should contribute towards the implementation of the National Suicide Prevention Strategy

Progressing the goal of zero lives lost to suicide will take time. The short duration of the Agreement limits its ability to guide the long-term structural changes required for a whole-of-government approach to suicide prevention (chapter 3). An overarching long-term strategy can provide a clear vision for what Australia's suicide prevention system should look like in the medium to long term. It can help coordinate not only a whole-of-government response but a whole-of-system response to suicide prevention (chapter 4).

The recently released National Suicide Prevention Strategy 2025–2035 sets out the pathway to achieve a comprehensive approach to suicide prevention, with the aim of aligning expenditure and activity with evidence and insights about what works (NSPO 2024d, p. 17). It does this by adopting a model focusing on the prevention of suicidal distress and supports for people experiencing suicidality and those who care for them, and by identifying the critical enablers of an effective suicide prevention system (figure 6.1).

Figure 6.1 – A national model for suicide prevention in Australia



Source: PC stylised version of NSPO (2024d, p. 17).

The Strategy was developed by the NSPO in collaboration and consultation with people with lived and living experience, the suicide prevention sector, academia and all governments (NSPO 2024d).

> … [the Strategy] was formally endorsed by all states and territories as well as all relevant Commonwealth portfolios, ensuring critical buy-in from all jurisdictions and portfolios. It represents a clear commitment to coordinated, consistent and evidence-based suicide prevention reform and aligns with other relevant strategies, including the *National Aboriginal and Torres Strait Islander Suicide Prevention Strategy 2025 - 2035*. (NMHC and NSPO, sub. 70, p. 5)

There was strong support from review participants for the Strategy to set the overarching direction for suicide prevention in the next agreement (Roses in the Ocean, sub. 19, p. 6; Consumers Health Forum of Australia, sub. 22, p. 6; Everymind, sub. 32, p. 3; PHN Cooperative, sub. 69, p. 13; NMHC and NSPO, sub. 70, p. 5).

The PC agrees the Strategy should provide the long-term direction for suicide prevention in the next agreement. In conjunction with people with lived and living experience, supporters, family, carers and kin and relevant peak bodies, governments should identify a clear and achievable set of objectives for the next agreement, which progress the system towards the direction set in the Strategy. These should address the most pressing priorities for existing services and focus on actions that can be completed over the life of the agreement and lay the foundation for long-term reform. There should be a clear link between the objectives, inputs, activities and outputs for suicide prevention (chapter 4).

Where suicide prevention services are specifically for Aboriginal and Torres Strait Islander people and communities, the next agreement should be guided by the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy 2025–2035 (chapter 5).

Suicide prevention as a separate schedule to the agreement

The need for a suicide prevention schedule

Mental health and suicide prevention are often discussed simultaneously, and this is because there are many elements of each domain that affect the other (Lifeline Australia 2021).

However, there are many people with mental ill health not affected by suicidal thoughts, and there are many people who have suicidal thoughts or die by suicide who do not have mental ill health (Lifeline Australia 2021). This means there are also parts of each system distinct from the other. The areas of the suicide prevention system distinct from mental health include assessment and management of suicidal behaviours, means restriction and aftercare and postvention services (PC 2020a).

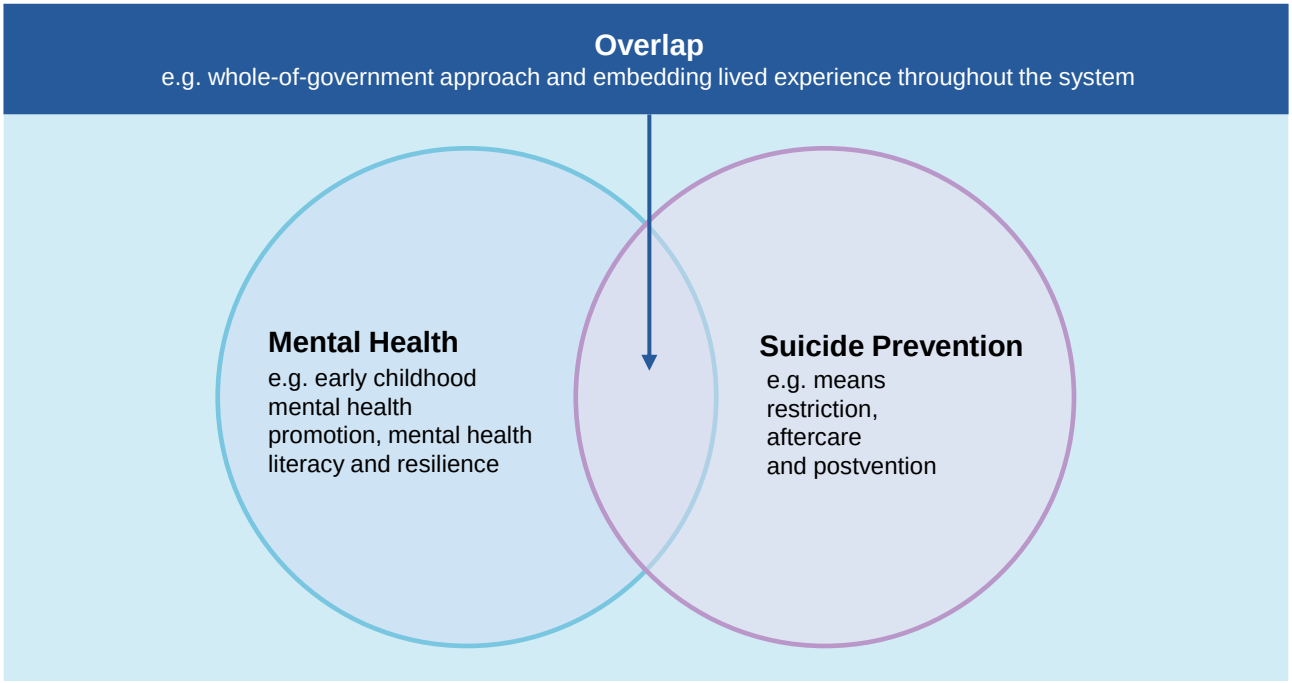
Submitters were divided on whether suicide prevention should be considered in the same agreement as mental health. The Consumer Health Forum of Australia (sub. 22, p. 6) argued mental health and suicide prevention were two distinct issues and combining them in the Agreement risked focusing only on mental health. The National Mental Health Consumer and Carer Forum (sub. 68, p. 8) argued the 'artificial separation of suicide prevention and mental health services leads to inefficiencies and missed opportunities for holistic care'. The PHN Cooperative (sub. 69, p. 13) argued for a joint approach:

> Future agreements should reflect the emerging suicide prevention system, particularly in prevention which is distinct from the mental health system, as well as the areas in which mental health and suicide prevention are united.

On balance, the PC considers where mental health and suicide prevention policy overlaps it should be contained in the body of the next agreement and bilateral schedules. This will help to promote integration

and avoid duplication (figure 6.2). However, areas unique to suicide prevention should be included in a separate suicide prevention schedule.

Figure 6.2 – The relationship between mental health and suicide prevention



The suicide prevention schedule should act as a work plan for governments that aligns with and would result in progress towards the National Suicide Prevention Strategy. The short-term objectives and outputs of the schedule should be clearly linked with the long-term objectives of the Strategy (chapter 1).

Developing the schedule

Like the agreement, the schedule needs to be co-designed with people who access suicide prevention services, people with lived and living experience, supporters, family, carers and kin and services providers. The co-design process should emphasise lived and living experience of suicide rather than solely mental ill health to address concerns about unbalanced representation in the current Agreement (chapters 3 and 4). In line with best practice frameworks for co-design, people and organisations with lived or living experience representatives need to be adequately resourced and supported to enable true participation in the development of the schedule (chapter 4). Co-design processes should also include the voices of service providers.

Given the expertise and remit of the NSPO, it should be responsible for coordinating the development of the schedule. This can help to ensure alignment with the National Suicide Prevention Strategy and related works.

In the development of the schedule, governments should provide further clarification regarding areas of joint responsibility. At a minimum, the next agreement should establish which government agency at either the Australian or state/territory level is responsible for planning, implementing, monitoring and reporting on each commitment. Given the necessity of a whole-of-government response to suicide prevention, the roles and responsibilities should extend to agencies outside of health where appropriate (PC 2020a, p. 442).

The PC considers the current Agreement should be extended for 12 months, to give sufficient time for the negotiation of the next agreement (draft recommendation 4.2). The development of the schedule should

allow Primary Health Networks (PHNs) enough time to ensure services are in place for those who need them, and prevent delays experienced previously.

> The delays in the South Australian Bi-lateral agreement have resulted in schedules for service not having made their way to PHNs e.g. AfterCare. This limits the level and type of commissioning (unable to co-design and do large approaches to market) the PHNs can undertake due to timeframes and duration of the agreement e.g. Bilateral agreement is ending 30 June 2026, PHN does not have the schedule at the time of writing this document. (Adelaide PHN, sub. 62, p. 1)

Monitoring and reporting mechanisms for the schedule

Measuring the right things means selecting outcomes that describe the desired change resulting from the schedule; they should be measurable, well-defined and achievable within the period of the schedule (chapter 4).

The NSPO is developing the National Suicide Prevention Outcomes Framework aligned with the direction of the National Suicide Prevention Strategy (NSPO 2024c, p. 4). The Framework is intended to translate the Strategy into person-centred outcomes that define the desired impact and measurement methodology to allow monitoring of progress. It is expected to be finalised by mid-2026 (NSPO 2024c, p. 9). As part of the development, the NSPO is creating an outcomes map that includes outcomes, indicators and measures, as well as the logic that connects them. The NSPO (2024c, p. 8) considers the intended users of the Outcomes Framework to be:

- All levels of government to help gauge the impact of their activities, improve coordination, guide investment towards activities that are most impactful, and track progress against outcomes;
- The suicide prevention sector to link activities to population wide outcomes and to utilise data in their own planning and evaluation of suicide prevention programs and services;
- Researchers to identify areas of suicide prevention where evidence needs to be strengthened;
- Data custodians to better understand what data is needed, identify gaps in data collection and integration, and to guide prioritisation of efforts to address these gaps; and
- Communities and workforces with an interest in suicide prevention to deepen their understanding of the suicide prevention system, and of the ways in which they can contribute to suicide prevention efforts.

The outcomes selected for the schedule should be from the list of short-term outcomes in the Framework. The outcomes need to align with the logic established in the schedule. Given the time it takes for data to be developed, only outcomes with data indicators that currently exist or can be developed within the first six months of the next agreement should be chosen to ensure reporting can be completed.

Improving the regularity and depth of public reporting of the next agreement should be a priority (chapter 4). But it needs to be done efficiently to avoid an excessive reporting burden.

> The next Bilateral Schedule should avoid data collection or reporting requirements which are inconsistent with national agreements and systems … Joint performance and reporting arrangements need to be established for co-funded initiatives to reduce fragmentation and duplication of effort. (NSW Health, sub. 90, p. 4)

Having an independent authority appropriately resourced to undertake monitoring and reporting is important for improving transparency and community trust (Neami National, sub. 63, p. 5). The NMHC should undertake monitoring and reporting in the next agreement, with a strengthening of its legislative powers to collect information (draft recommendation 4.10). Given the expertise of the NSPO, it should support the NMHC by being responsible for monitoring and reporting on the schedule. This analysis will be fed into the

NMHC annual reporting processes. Progress reporting in relation to the schedule should form part of annual reporting but be clearly signposted as reporting for the suicide prevention schedule.

Information used to report progress should not be limited to that provided by governments. The NMHC should be empowered to report on progress using information gathered from service providers, consumers, lived and living experience groups and commissioning agencies (draft recommendation 4.9). The NSPO should be similarly supported to report on progress using information gathered from a broad range of stakeholders.

The NSPO should also publish evaluations of programs and services funded through the schedule. Having the evaluations published in one spot will assist consumers and commissioning bodies compare the effectiveness of different services. This can be especially helpful for consumers and those impacted by suicide in making decisions about the service that best meets their needs. Enabling consumers to make informed decisions is aligned with the desired person-centred approach to suicide prevention (chapter 2).

Draft recommendation 6.1
Suicide prevention as a schedule to the next agreement

The next agreement should include a separate schedule on suicide prevention. This schedule should be developed through a process of co-design with people with lived and living experience of suicide, their supporters, families, carers and kin and service providers.

The schedule should:

- only include actions in policy areas of suicide prevention that are distinct from mental health
- reflect a clear link between the short-term objective and outcomes of the schedule and progress towards the long-term objectives of the National Suicide Prevention Strategy
- align with the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy
- include monitoring and reporting indicators that align with the forthcoming National Suicide Prevention Outcomes Framework.
- require the National Suicide Prevention Office to be responsible for the monitoring and reporting of the schedule.

Appendix

A. Public consultation

This appendix provides information about the consultation process undertaken for the review of the National Mental Health and Suicide Prevention Agreement. It lists the organisations and individuals who participated in consultation and submissions received (section A.1). It also provides information about the online survey undertaken by the PC (section A.2). The PC would like to thank everyone who participated in this review.

A.1 Consultation and submissions

Table A.1 – Consultation

Participants
ACT Health Directorate
Alcohol and Drug Foundation
Arafmi
Australian Association of Psychologists
Australian Government Department of Health, Disability and Ageing
Australian Government Department of the Prime Minister and Cabinet
Australian Psychological Society
Australian Institute of Health and Welfare
Australian Psychosocial Alliance
Bayliss, Dean
Black Dog Institute – Aboriginal and Torres Strait Islander Lived Experience Centre
Brisbane North Primary Health Network (PHN)
Carers Australia
Coalition of Peaks
Data Governance Forum
Darling Downs West Moreton Primary Health Network (PHN)
Davison, Dr Sophie, Chief Psychiatrist
Frith, Jordan
Gayaa Dhuwi (Proud Spirit) Australia
headspace
Health Consumers Queensland

Participants
Heggie, Peter
Holdsworth, Graeme
Institute for Urban Indigenous Health (IUIH)
Ipswich Medicare Mental Health Service, Open Minds,
LGBTQIA+ Health Australia
Lifeline Australia
Lived Experience Australia
Medicare Mental Health Centre Launceston, Stride
Mental Health and Wellbeing Commission Victoria
Mental Health Australia
Mental Health Carers Australia
Mental Health Commission of New South Wales
Mental Health Council Tasmania
Mental Health Family and Friends Tasmania
Mental Health Lived Experience Peak
Mental Health Lived Experience Tasmania
Mental Illness Fellowship Australia
Micah Projects
Mind Australia
New South Wales Mental Health Commission
New South Wales Ministry of Health
National Mental Health Commission
National Mental Health Consumer Alliance
National Mental Health and Suicide Prevention Lived Experience Group
National Rural Health Alliance
National Suicide Prevention Office
Northern Territory Health
Peacock Centre, Hobart
Primary Health Network (PHN) Cooperative
Primary Health Tasmania
Queensland Alliance for Mental Health
Queensland Centre for Mental Health Research (QCMHR)
Queensland Department of Health
Queensland Mental Health Commission
Queensland Network of Alcohol and Other Drug Agencies (QNADA)

Participants
Robotham, Julie, University of Western Australia School of Indigenous Studies
Roses in the Ocean
Royal Australian and New Zealand College of Psychiatrists (RANZCP)
SANE
South Australian Department of Health and Wellbeing
South Australian Mental Health Commissioner
Staying Deadly Hub, IUIH
Tasmanian Department of Health
Te Hiringa Mahara (Mental Health and Wellbeing Commission) New Zealand
Thirrili
Victorian and Tasmanian PHN Alliance
Victorian Department of Health
West Moreton Hospital and Health Service – Mental Health Service Wacol
Western Australian Department of Health
Western Australian Mental Health Commission
Western Australian Primary Health Alliance

Table A.2 – Submissions received

Participants	Submission no.
Simon Tatz	1
Name withheld	2
Ethnic Communities Council of Queensland (ECCQ)	3
Ailsa Rayner and Paula Arro	4
Massage & Myotherapy Australia	5
Michael Thorn	6
Royal Australian and New Zealand College of Psychiatrists (RANZCP)	7
Lifeline Australia	8
Occupational Therapy Australia (OTA)	9
Marathon Health	10
Kevin Bell, Tim Heffernan, Maria Katsonis and Mark Orr	11
Australasian Institute of Digital Health (AIDH)	12
Australian Association of Psychologists Incorporated (AAPi)	13
Ruah Community Services	14
Mental Health Lived Experience Tasmania (MHLET)	15
Queensland Nurses and Midwives' Union (QNMU)	16

Participants	Submission no.
Roderick McKay	17
Queensland Network of Alcohol and Other Drug Agencies (QNADA)	18
Roses in the Ocean	19
Australian Alcohol and other Drugs Council (AADC)	20
Youth Climate Policy Centre (YCPC)	21
Consumers Health Forum of Australia (CHF)	22
headspace National Youth Mental Health Foundation	23
Perinatal Anxiety & Depression Australia (PANDA)	24
Australian Veterinary Association (AVA)	25
Orygen	26
batyr Australia	27
Birth Trauma Australia (BTA)	28
Raise Foundation	29
Australian College of Nursing (ACN) and Australian College of Mental Health Nurses (ACMHN)	30
Wellbeing and Prevention Coalition in Mental Health	31
Everymind	32
MATES in Construction (MATES)	33
Multicultural Communities Council of South Australia (MCCSA)	34
Melbourne Children's Campus Mental Health Strategy	35
St Vincent's Health Network Sydney and THIS WAY UP	36
Beyond Blue	37
Rural Health Research Institute	38
Australian BPD Foundation	39
Emerging Minds	40
Western Australian Network of Alcohol and Other Drug Agencies (WANADA)	41
Lived Experience Australia	42
Carers WA	43
National Eating Disorders Collaboration (NEDC)	44
Western Queensland Primary Health Network (WQPHN)	45
e-Mental Health in Practice (eMHPrac)	47
Advanced Pharmacy Australia (AdPha)	48
Consumers of Mental Health WA (CoMHWA)	49
Name Withheld	50
Occupational Therapy Society for Invisible and Hidden Disabilities (OTSi)	51
Australian Suicide Prevention Foundation (ASPF)	52

Participants	Submission no.
Equally Well Australia	53
Northern Territory Mental Health Coalition	54
Australian Psychosocial Alliance (APA)	55
Manna Institute	56
Carers NSW	57
Federation of Ethnic Communities' Councils of Australia (FECCA)	58
Suicide Prevention Australia	59
Carers ACT	60
Black Dog Institute (BDI)	61
Adelaide PHN	62
Neami National	63
Forum of Australian Services for Survivors of Torture and Trauma (FASSTT)	64
Health Justice Australia (HJA)	65
National Mental Health Consumer Alliance (NMHCA)	66
Australian Commission on Safety and Quality in Health Care	67
National Mental Health Consumer and Carer Forum (NMHCCF)	68
Primary Health Network (PHN) Cooperative	69
National Mental Health Commission (NMHC) and National Suicide Prevention Office (NSPO)	70
yourtown	71
Australian Medical Association (AMA)	72
Mental Health Carers Australia (MHCA)	73
Carers Australia	74
Gayaa Dhuwi (Proud Spirit) Australia	75
Mental Health Australia	76
Basic Rights Queensland (BRQ)	77
Tasmanian Government	78
Centre for Community Child Health (CCCH)	79
Movember Institute of Men’s Health (Movember)	80
Institute for Urban Indigenous Health (IUIH)	81
Western Australian Association for Mental Health (WAAMH)	82
Queensland Alliance for Mental Health (QAMH)	83
Community Mental Health Australia (CMHA)	84
Australian Psychological Society (APS)	85
National Rural Health Alliance	86
Victorian Women Lawyers (VWL)	87

Participants	Submission no.
Mental Illness Fellowship of Australia (MIFA)	88
The Royal Australian College of General Practitioners (RACGP)	89
NSW Health	90
Skylight Mental Health	91
Genspect Australia	92
Monica M	93
Justice Action (JA)	94
Mental Health Victoria	95

A.2 Online survey methods and sample

Study design

Including a qualitative research component in this review was considered important given the limited available data to understand people's experiences and views of initiatives introduced under the Agreement. As highlighted in the National Mental Health and Suicide Prevention Evaluation Framework (artd Consultants 2025, p. 68), collecting qualitative data has the advantage of not only helping to fill gaps where quantitative data is lacking, it also provides a more in-depth understanding of issues:

> Standard outcomes measures and administrative data alone are likely to be insufficient to capture the full value of a program to the people accessing it. Qualitative data can help to understand what matters to people accessing the program and its value to them, as well as help interpret the administrative data. It can also help to understand the experiences of people who had trouble accessing the program or service, and who did not feel safe to do so although it can be difficult to reach these groups in evaluation.

The PC conducted an online survey of consumer, carer and service provider experiences and views of the Agreement and the mental health and suicide prevention system. A qualitative descriptive research study design was adopted for data collection, analysis and reporting of the findings (Doyle et al. 2020; Sandelowski 2000). This is a well-established approach for qualitative research and evaluation of mental health services (Palinkas 2014). Some advantages of qualitative descriptive research include that it is relatively simple and flexible, useful for exploring new, poorly understood or hard-to-measure issues in detail and it provides a comprehensive description of different individuals' experiences and views in context (Ayton 2023). In a qualitative descriptive study design, the focus is on understanding the 'who', 'what, 'where' and 'when' of the phenomenon or situation being investigated.

Research questions and assumptions

The online survey was designed to explore three research questions that map to the terms of reference for the review of the Agreement:

- what gaps and shortcomings in mental health services have people experienced?
- what changes in service provision have people seen in the past three years?
- what are some examples of good service provision and system improvement that people have experienced or would recommend?

Data collection

The survey was administered online through the District Engage platform. A convenience sample was recruited by disseminating a web link to the survey via:

- a call for submissions on the PC's home page
- an email to people and organisations who registered their interest in the review or made submissions to the PC's previous Mental Health inquiry (PC 2020a) as well as stakeholders, such as lived experience peak bodies in all jurisdictions
- advertising (paid and unpaid) about the survey on social media platforms (Facebook, Instagram, LinkedIn) and through newsletters of peak bodies.

This wide dissemination strategy aimed to recruit respondents who could provide detailed and in-depth information from a diverse range of perspectives. The survey was open to the public for about six weeks (11 February to 21 March 2025). Recruitment extended further than the point of data saturation (i.e. beyond where no new information was emerging) to allow time for as many people as possible to submit responses and to include these in the analysis (Guest et al. 2006).

The online survey environment and the survey questions were refined through consultation with experts in the sector (e.g. Aboriginal and Torres Strait Islander engagement consultants, peak bodies representing carers) and user testing before going into the field. We also followed guidance in the National Mental Health and Suicide Prevention Evaluation Framework, by including open questions (artd Consultants 2025, p. 69):

> Open text questions in surveys are useful for allowing people to explain their responses to closed questions and describe their experiences and outcomes of a service in their own words. However, questions should be focused on the respondent's experiences and outcomes from the service to avoid the risk of distress and re-traumatisation… Online forums (i.e. a webpage where participants respond to prompts, questions and material) allow people to participate at times that suit them without being publicly identified …

All questions could be left unanswered, and responses could be submitted anonymously. We aimed to collect only relevant information we could use to inform the review. Therefore, each set of survey questions was closely framed around the review terms of reference. One broad, open-ended question was also asked to allow respondents to submit any views or experiences not captured in the main set of questions ('Is there anything else about your experiences of services that you think we should know that could be helpful for our review?').

We did not apply any exclusion criteria for participation. However, respondents were asked to identify as either (i) a consumer (ii) a carer or (iii) a worker/volunteer in mental health or suicide prevention services, or some combination of these three categories. Self-selection into one or more of these categories determined conditional branching of respondents into the relevant path of survey questions. Where a respondent identified as an Aboriginal or Torries Strait Islander person, they were asked three additional questions (box A.1).

Respondents were asked to consent to their responses being analysed (96.8% consented) and for extracts (quotes) from their responses to be included in the PC's reporting (93.3% consented).

Box A.1 – Online survey questions

Consumer: has used mental health or suicide prevention services

- Do you feel that mental health and suicide prevention services have met your needs? (Tell us more)
- Have you ever been unable to find a service or unable to use a service you needed? (Tell us more)
- Can you tell us about some positive experiences of services?
- Did you feel recognised, respected and protected while using a service? (Tell us more)
- Have you noticed any changes in services over the past three years (e.g. improvements in service coordination)? (Tell us more)

Carer: has been a carer for someone with mental ill health

- Do you feel that services are meeting the needs of the person/s you provide care to and support? (Tell us more)
- Have you ever been unable to find a service or unable to access services for the person/s you provide care to and support? (Tell us more)
- As a carer, were you ever asked by services whether you needed any support, including for your own mental health? (Tell us more)
- Are you involved by services in the planning and delivery of services to the person you care for? (Tell us more)
- Can you tell us about some positive experiences of services?
- Did you feel recognised, respected and protected while using a service? (Tell us more)
- Have you noticed any changes in the services over the past three years (e.g. improvements in service coordination)? (Tell us more)

Service provider: has worked or volunteered with a mental health or suicide prevention service

- Do you feel that your service is meeting people's needs?
- Has your service ever been unable to meet somebody's needs?
- Can you tell us about some of your best experiences working or volunteering in mental health service provision?
- Are there any changes you have noticed over the past 3 years? (e.g. improvements in service coordination). And any improvements you've seen in the wider service system?
- Thinking about the service where you work, what improvements would you like to see? What is needed to make these improvements possible?
- What do you see as the emerging issues and priorities for services like yours?

Respondents who identified as an Aboriginal or Torres Strait Islander person

The same questions as above, plus:

- What has been your experience in accessing Aboriginal and Torres Strait Islander specific services?
- What has your experience been in accessing mainstream services?
- How much say does your community have in planning and management of the services you use?

All respondents: additional questions

- Is there anything else about your experiences of using/working in services that you think we should know that could be helpful for our review?
- Location of your primary residence (select from list of States/Territories)

Box A.1 – Online survey questions

- Which of the 15 priority population groups listed apply to you (select from a list of 15 priority populations as per clause 111 of the Agreement)

Sample description

A total of 293 people participated in the survey (table A.3). Ten of these were excluded from analysis because they left the main questions unanswered, and a further nine were excluded from analysis because they did not provide consent.

The location respondents reported as their primary residence broadly reflects the distribution of the Australian population, with most respondents based in New South Wales (28.3%), Victoria (19.1%) or Queensland (18.4%). Around 2% (n=5) of respondents identified as Aboriginal or Torres Strait Islander.

Of the 283 respondents who answered the main survey questions, most self-identified as consumers (n=210, 74.2%). About one third identified as carers (n=88, 31.1%) and about one quarter as workers/volunteers in service provision (n=70, 24.7%). Some respondents identified as belonging to more than one category. For example, 39 respondents identified as both a consumer and worker/volunteer in service provision, 38 identified as both a consumer and carer and 17 identified as a consumer, carer and worker/volunteer in service provision.

Table A.3 – Description of survey respondents

	Number of respondents	Percentage of the total complete survey responses (%)
Total survey responses submitted	293	-
Complete survey responses	283	100.0
Respondent category[a]		
Consumer	210	74.2
Carer	88	31.1
Worker/Volunteer in service provision	70	24.7
Location of primary residence:		
New South Wales	80	28.3
Victoria	54	19.1
Queensland	52	18.4
Western Australia	18	6.4
South Australia	23	8.1
Tasmania	9	3.2
Australian Capital Territory	20	7.1
Northern Territory	2	0.7
Prefer not to say	1	0.4

	Number of respondents	Percentage of the total complete survey responses (%)
Not stated	24	8.5
Identified as:		
Aboriginal person	5	1.8
Torres Strait Islander person	0	0.0
Aboriginal and Torres Strait Islander person	0	0.0
Non-Indigenous person	176	62.2
Prefer not to say	17	6.0
Not stated	85	30.0
Consent		
Consented for responses to be analysed	274	96.8
Consented for responses to be reported anonymously	261	92.2

a. Respondents could select more than one category.

Respondents were also asked to indicate whether they identified as one or more of the priority populations listed in the Agreement (table A.4). Most respondents (n=195, 71.2%) provided a response to this question.

On average, respondents provided free-text responses to about seven survey questions. However, many respondents answered more questions. For example, 16.4% (n=45) answered 8-12 questions and 8.8% (n=24) answered 13-19 questions. In total, the survey yielded 1,254 free-text responses for analysis.

Analytic method

Thematic analysis and thick description were used to interpret, understand and report on the data collected from the survey. Thematic analysis involves an iterative process of data familiarisation, data visualisation, coding, theme development, theme refinement and reporting of themes with illustrative extracts (verbatim quotes) (Braun et al. 2022, pp. 27–28). Thick description involves providing a detailed account and interpretation of people's views and experiences in context (Patton 2002, pp. 437–438).

For the thematic analysis, we used a combination of deductive coding (i.e. we organised the raw data into broad categories according to the topics explored in each survey question and undertook the initial coding) and inductive coding (i.e. we iteratively read, visualised, and interpreted meanings in the data and refined the initial codes, renaming or combining some as required). A key advantage of deductive coding is ensuring *a priori* issues of interest are explored, while a key advantage of inductive coding is revealing themes that become apparent in the data. Themes were constructed by grouping together codes with similar or related meanings. We used NVIVO 15 software to help organise, code and visualise the data during the thematic analysis (Lumivero Pty Ltd 2024).

We applied several strategies to increase the reliability and robustness of the analysis, including: a systematic coding process; documentation of coding decisions; checks of data interpretations (multiple coders); standardised reporting; presentation of supporting extracts for each theme and adopting some reflective practices.

Table A.4 – Survey respondents who identfied as a priority population[a]

	Number of respondents	Percentage of survey responses included in analysis (%)
People who have made a previous suicide attempt or who have been bereaved by suicide	125	45.6
People with complex mental health needs, including people with co-occurring mental health and cognitive disability and/or autism	118	43.1
People with a disability	108	39.4
People experiencing socioeconomic disadvantage	66	24.1
People living in regional, rural and remote areas of Australia	59	21.5
LGBTQIA+SB people	56	20.4
People experiencing or at risk of abuse and violence, including sexual abuse, neglect and family and domestic violence	34	12.4
People with harmful use of alcohol or other drugs, or people with substance use disorders	31	11.3
People experiencing homelessness or housing instability	30	11.0
Older Australians (over 65, or over 50 for Aboriginal and Torres Strait Islander people)	17	6.2
Culturally and linguistically diverse communities and refugees	15	5.5
Children and young people, including those in out-of-home care	10	3.7
Aboriginal and/or Torres Strait Islander	9	3.2
People who are (or were previously) in contact with the criminal justice system	9	3.3
Australian Defence Force members and veterans	5	1.8
Prefer not to say	4	1.5
Not stated	79	28.8
Survey responses included in analysis	274	100.0

a. Respondents could select more than one priority population group.

Glossary and abbreviations

A note on language

The PC has used a range of resources and consulted with sector experts to develop this glossary, which contains the key terms used throughout the report. The terms chosen aim to reflect inclusive language and recognise the variety of ways people engage with mental health and suicide prevention services.

Glossary

Term	Description
Aboriginal and Torres Strait Islander Community Controlled Health Organisations (ACCHOs)	Community-run primary healthcare services that provide comprehensive, culturally informed care for Aboriginal and Torres Strait Islander people. These services address not only physical health but also the social, emotional, and cultural wellbeing of individuals, families, and communities.
accessibility	The extent of people's ability to access services, which may be affected by factors such as affordability, waiting times, geographic proximity, awareness, discrimination and cultural barriers.
aftercare	Services that provide support to people following a suicide attempt with the aim of preventing repeated self-harm by increasing access to and engagement with care.
Agreement	When written with the capital letter 'A' refers to the current National Mental Health and Suicide Prevention Agreement.
agreement	When written in lowercase letter 'a' refers to future national agreement/s relating to mental health and/or suicide prevention.
Annex	A supplementary document that forms part of the Agreement and contains specific details about a program of work, project or other information relevant to the Agreement. Annexes in the current Agreement include Annex A (existing national information and data frameworks, tool and measures), Annex B (priority data and indicators for development), Annex C (nationally consistent evaluation principles) and Annex D (glossary).
ambulatory services	Non-admitted, community-based mental health care, including services provided to individuals who are not staying in a hospital or inpatient facility, but still require ongoing mental health support and treatment.
availability	The extent to which services exist and are offered to people, which may be affected by factors such as the infrastructure in place, operating hours, and workforce capacity.
bilateral schedules	Agreements made between the Australian Government and an individual state or territory government that set out the details of funding arrangements for particular initiatives and/or program areas.
co-design	The process where governments work in equal partnership with people with lived and living experience to design a service or service improvement.
comorbidity	The presence of two or more diseases or medical conditions in a person.
community managed sector	Non-government, not-for-profit organisations that provide a range of community-based mental health supports and services.
community mental health care	A range of specialised, non-admitted mental health services that are provided in community settings (not in hospitals) and are usually the responsibility of state and territory governments.
discrimination	Treating or viewing people unfairly or unequally because of their mental ill health. This form of discrimination is unlawful under Australian, state and territory legislation.

Term	Description
distress	Non-specific symptoms of stress and concern that affect someone's thoughts and emotions.
engaging early in distress	Identifying and responding to early signs of mental or emotional distress before it escalates into more serious mental health conditions. This term is generally preferred over 'early intervention' by people with lived and living experience.
Gayaa Dhuwi (Proud Spirit) Declaration	A declaration launched by the National Aboriginal and Torres Strait Islander Leadership in Mental Health in 2015 to promote Aboriginal and Torres Strait Islander social and emotional wellbeing, mental health and suicide prevention.
Local Hospital Networks	Geographically defined organisations that deliver public hospital services jointly funded by the Australian, state and territory governments under the National Health Reform Agreement. Each LHN can include one or more hospitals and may also manage community-based health services.
Medicare Mental Health	The Australian government's free and confidential mental health and wellbeing support (non-crisis). Services include face-to-face support at local Medicare Mental Health Centres (formerly 'Head to Health') Kids Hubs (formerly 'Head to Health Kids') and a national free call phone service to speak with a trained professional about mental health and wellbeing for people seeking support and guidance, including supporters, families, carers and kin.
mental health challenge	Includes reduced cognitive, emotional or social abilities, but not to the extent that it meets the criteria for a mental health condition diagnosis. These challenges can result from life stressors and often resolve with time or when the person's situation changes. A mental health challenge may develop into a diagnosed mental health condition if it persists or increases in severity.
mental health condition	Includes mental health conditions diagnosed by a medical professional of varying severity and duration.
mental ill health	Overarching term that includes both (i) mental health challenges/concerns and (ii) diagnosed mental health conditions (see above).
Mental Health and Suicide Prevention Senior Officials Group (MHSPSO)	Intergovernmental body responsible for supporting governance, reporting, advice, consultation and implementation of the National Mental Health and Suicide Prevention Agreement. Members include senior officials delegated by the Australian, state and territory governments, along with people with lived and living experience and representatives of the Closing the Gap Social and Emotional Wellbeing Policy Partnership.
National Health Reform Agreement (NHRA)	An agreement between the Australian, state and territory governments on shared goals for health system reform and funding towards state and territory management and operation of public hospital services.
National Mental Health Commission (NMHC)	A non-statutory body within the Department of Health, Disability and Ageing that monitors and reports on investment in mental health and suicide prevention initiatives, provides evidence-based policy advice to government and disseminates information on ways to continuously improve Australia's mental health and suicide prevention system.
National Mental Health Service Planning Framework (NMHSPF)	A model designed to help plan, coordinate and resource mental health services to meet population demands that includes an evidenced-based framework providing national average benchmarks for optimal service delivery across the full spectrum of mental health services in Australia.
National Suicide Prevention Office (NSPO)	A non-statutory body within the Department of Health, Disability and Ageing that was established in 2021 with responsibilities that include developing a National Suicide Prevention Strategy, leading the development of a national outcomes framework for suicide prevention, working with all jurisdictions to set priorities for suicide prevention research and knowledge sharing and leading the development of a National Suicide Prevention Workforce Strategy.
participants	People and organisations who have engaged with the PC during this review through meetings (online and in-person), visits, submissions, surveys and webinars.

Term	Description
person-centred	Refers to a model of treatment, care and support that places the person at the centre of their own care and considers the needs of the person's supporters, families, carers and kin.
Parties	The signatories to the current Agreement including the Australian, state and territory governments.
peer worker	Professionals with expertise gained from their own lived and living experience of mental ill health or suicide who are employed in clinical and non-clinical settings to provide peer support and advocacy to people experiencing mental ill health and/or suicidality and/or their supporters, families, carers and kin.
people with lived and living experience	People who have experienced (in the past) and/or are experiencing (at present) mental ill health or suicidality, and/or who care for a person experiencing mental ill health or suicidality and/or who have been bereaved by suicide.
people with lived and living experience of suicide	People who have experienced (in the past) and/or are experiencing (at present) suicide, suicidal thoughts or a suicide attempt, and/or who care for someone during a suicidal crisis, bereavement by suicide or being impacted by suicide in another way.
place-based services	Refers to planning, designing and providing services in ways that consider the needs of people who reside in or visit a specific geographic location
Primary Health Networks (PHNs)	Independent organisations funded by the Australian Government to manage health regions with the goals of improving the efficiency and effectiveness of health services, improving the coordination of health services, and increasing access and quality of support for people.
program logic	A structured framework that supports program implementation and evaluation by outlining how a program is intended to work. It visually and logically connects the resources, activities, outputs, and outcomes of a program to show the pathway to achieving its goals.
psychosocial supports	Non-clinical services that help individuals with mental ill health manage their daily lives, build skills, and participate more fully in their communities.
residential mental health care	Specialised, non-hospital mental health services provided in a domestic-like setting for people who stay overnight for a period of time and receive more intensive support than can be provided in the community, but for whom acute hospital care is not required.
respondents	People who submitted responses to the PC's online survey during the review. Also referred to as survey respondents (sr.).
Schedule	The detailed part of a Federation Funding Agreement (discussed above) that sets out the specific terms, funding amounts, objectives, performance measures, and reporting requirements for particular programs or initiatives under the Agreement.
self-harm	Deliberately injuring or hurting oneself, with or without the intention of dying.
social determinants	Social, economic, and environmental conditions that influence an individual's mental health and risk of suicide, which can include socio-economic status, cultural and historical factors, education, employment, housing, social inclusion and community connectedness.
social and emotional wellbeing (SEWB)	A community led framework that encompasses the mental, emotional, cultural and spiritual health of Aboriginal and Torres Strait Islander people.
stigma	The negative attitudes, beliefs, and behaviours directed towards people with lived and living experience of mental ill health and suicide, which can include public stigma (negative societal attitudes), self-stigma (where a person internalise these negative attitudes), and structural stigma (discriminatory policies or practices within institutions).
stigma reduction	Involves reducing self-stigma among people who experience mental ill health and suicidality and those who support and care for them, reducing public stigma by changing attitudes and behaviours towards people with lived and living experience and their supporters, family, carers and kin, and taking steps towards eliminating structural (institutional) stigma and discrimination.
suicidal distress	The experience of unbearable emotional and psychological pain, which can be associated with thoughts or plans to end one's life as a means of escaping that unbearable pain. This

Term	Description
	experience is also referred to as suicidal crisis, especially when this emotional and psychological pain intensifies for a period and the person considers themselves at imminent risk of taking action to end their life.
suicidality	Encompasses suicidal ideation (thinking about ending one's own life), making suicide plans and making suicide attempts (intentional and voluntary action taken to end one's own life that does not result in death).
suicide	Intentional and voluntary action taken to end one's own life that results in death.
suicide prevention	Policies, programs and supports that aim to reduce the incidence of people dying by suicide or attempting suicide, reduce the prevalence of people that live with suicidal thoughts and support people who have lost someone to suicide. Prevention efforts focus on reducing the risk factors and strengthening the protective factors that may prevent suicide and suicidal behaviour.
supporters, family, carers and kin	People and groups who play various roles in supporting and caring for a person who is experiencing mental ill health or suicidality.
thematic analysis	A method for analysing qualitative data that involves interpreting the meanings and patterns in the data by following systematic and iterative steps, including reading and familiarising, visualising and coding (labelling), grouping codes into themes and reporting themes with illustrative excerpts.
theory of change	A comprehensive description and illustration of how and why a desired change is expected to happen in a particular context. A theory of change helps support strategic planning and alignment of programs.
trauma	Experiences that cause intense physical and psychological stress reactions. May include a single event, multiple events or a set of circumstances experienced by person that are physically and emotionally harmful or threatening and have lasting adverse effects on the person's physical, social, emotional or spiritual wellbeing.
trauma informed	Institutional or practice approaches to care and support directed by an understanding of the neurological, biological, psychological and social effects of trauma and its prevalence in society. Includes a strengths-based framework that emphasises physical, psychological and emotional safety for consumers, their supporters, family, carers and kin.

Abbreviations

ABS	Australian Bureau of Statistics
ACCHOs	Aboriginal and Torres Strait Islander Community Controlled Health Organisations
AIHW	Australian Institute of Health and Welfare
AOD	Alcohol and Other Drugs
CALD	Culturally and Linguistically Diverse
CFFR	Council on Federal Financial Relations
COAG	Council of Australian Governments
DGF	Data Governance Forum
DoHAC	Department of Health and Aged Care (from July 2022 until May 2025)
DoHDA	Department of Health, Disability and Ageing (from May 2025)
ED	Emergency Department

FFA	Federation Funding Agreements
FFR	Federal Financial Relations
GP	General Practitioner
IGA FFR	Intergovernmental Agreement on Federal Financial Relations
KPI	Key Performance Indicator
LGBTQIASB+	Lesbian, Gay, Bisexual, Trans and/or Gender Diverse, Queer, Intersex, Asexual, Sistergirl, Brotherboy plus other identities not explicitly listed
LHD	Local Hospital District
LHN	Local Hospital Network
MBS	Medicare Benefits Schedule
MHSPSO	Mental Health and Suicide Preventions Senior Officials Group
MMHC	Medicare Mental Health Centre
NDIS	National Disability Insurance Scheme
NGO	Non-Government Organisation
NHRA	National Health Reform Agreement
NMDS	National Minimum Dataset
NMHC	National Mental Health Commission
NMHSPF	National Mental Health Service Planning Framework
NSPA	National Suicide Prevention Adviser
NSPO	National Suicide Prevention Office
PBS	Pharmaceutical Benefits Scheme
PC	Productivity Commission
pers. comm.	Personal communications
PHN	Primary Health Network
RANZCP	Royal Australian and New Zealand College of Psychiatrists
SEWB	Social and Emotional Wellbeing
SEWB PP	Social and Emotional Wellbeing Policy Partnership
sr.	Survey respondent
sub.	Submission

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