



# Mental Health and Suicide Prevention Agreement Review

## Interim report Overview



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.

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## The Productivity Commission

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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](http://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



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Full interim report available from [www.pc.gov.au/inquiries/current/mental-health-review](http://www.pc.gov.au/inquiries/current/mental-health-review)





# 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.<sup>1</sup> 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.

<sup>1</sup> 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   |
|---|---|---|
| <ul style="list-style-type: none"> <li>• 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</li> <li>• 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</li> <li>• As a priority, to work together to address areas to: <ul style="list-style-type: none"> <li>– reduce system fragmentation</li> <li>– address gaps in the system</li> <li>– prioritise further investment in prevention, early intervention and effective management of severe and enduring mental health conditions</li> </ul> </li> </ul> | <ul style="list-style-type: none"> <li>• Improve the mental health and wellbeing of the Australian population, with a focus on priority populations</li> <li>• Reduce suicide, suicidal distress and self-harm through a whole-of-government approach</li> <li>• Provide a balanced and integrated mental health and suicide prevention system</li> <li>• Improve physical health and life expectancy for people living with mental health conditions and for those experiencing suicidal distress</li> <li>• Improve quality, safety and capacity in the Australian mental health and suicide prevention system</li> </ul> | <ul style="list-style-type: none"> <li>• The analysis of psychosocial support services outside of the National Disability Insurance Scheme (NDIS)</li> <li>• Commonwealth-State implementation plans and annual Jurisdiction Progress reports</li> <li>• An annual National Progress Report</li> <li>• Improvements to data collection, sharing and linkage</li> <li>• The development of a National Evaluation Framework</li> <li>• Shared evaluation findings</li> <li>• Consideration and implementation of relevant actions of the National Stigma and Discrimination Reduction Strategy</li> <li>• The establishment of the National Suicide Prevention Office</li> <li>• The development of national guidelines on regional commissioning and planning</li> <li>• The development of the National Mental Health Workforce Strategy and identification of priority areas for action</li> <li>• Report on progress toward increasing the number of mental health professionals per 100,000 population</li> <li>• A submission to the mid-point National Health Reform Agreement review</li> <li>• A final review of this Agreement provided to all Parties</li> </ul> |

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.

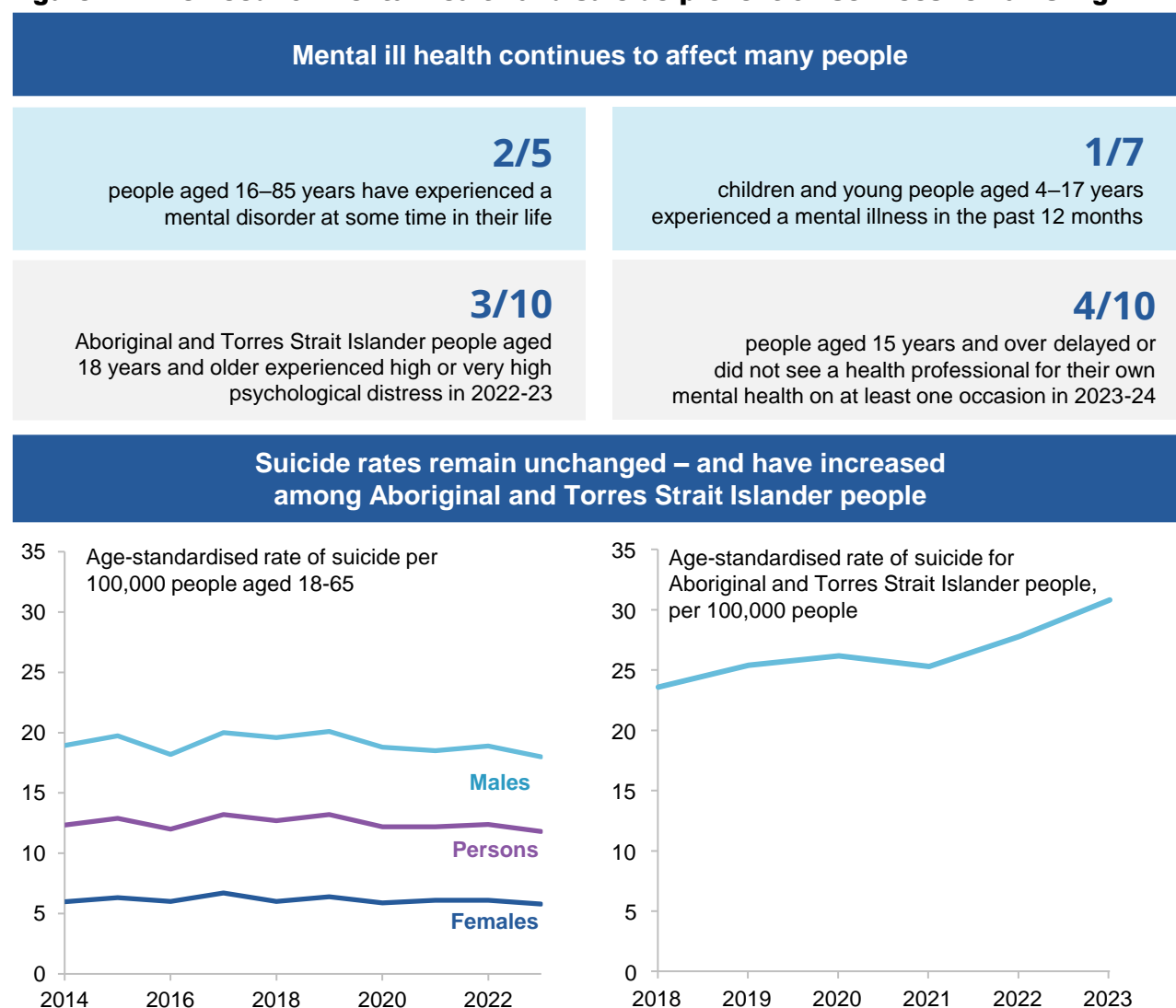
Some of the outputs, such as the establishment of the National Suicide Prevention Office (NSPO), have been well received by people with lived and living experience and service providers. The NSPO has delivered the National Suicide Prevention Strategy (discussed below). The Agreement led to increased 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**

“

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

”

**Consumer**

“

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**

“

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**

“

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

”

**Practitioner**

“

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

”

**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**

“

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

”

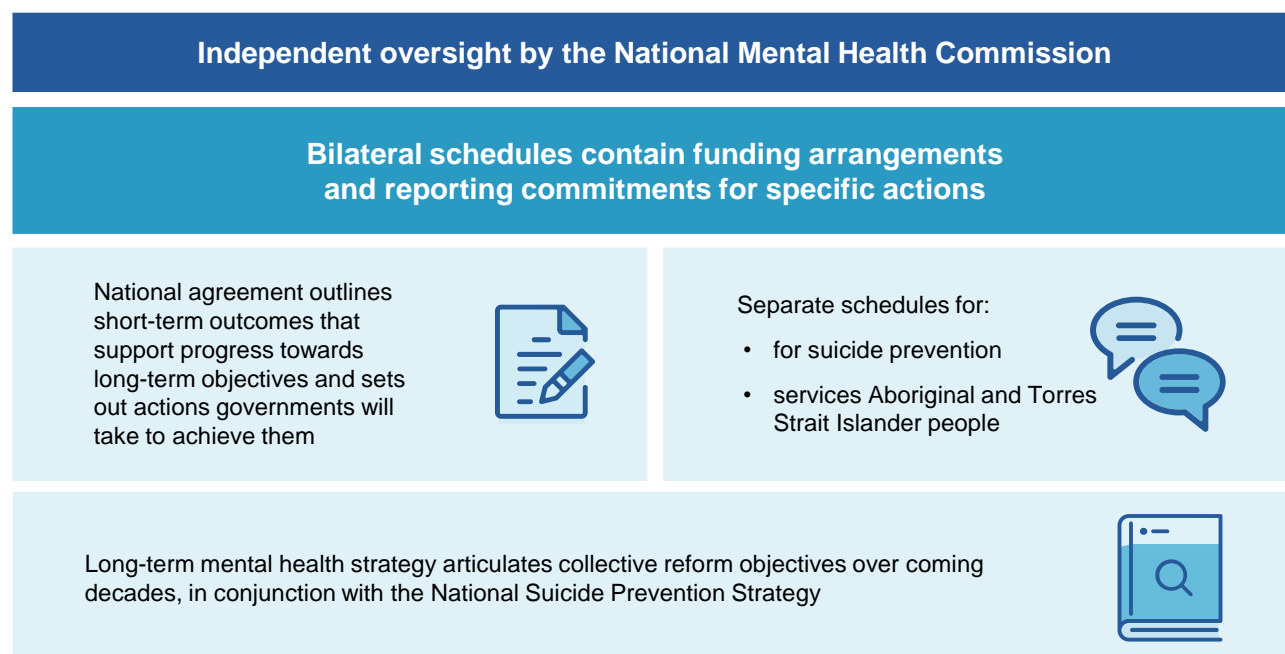
**Carer**

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**

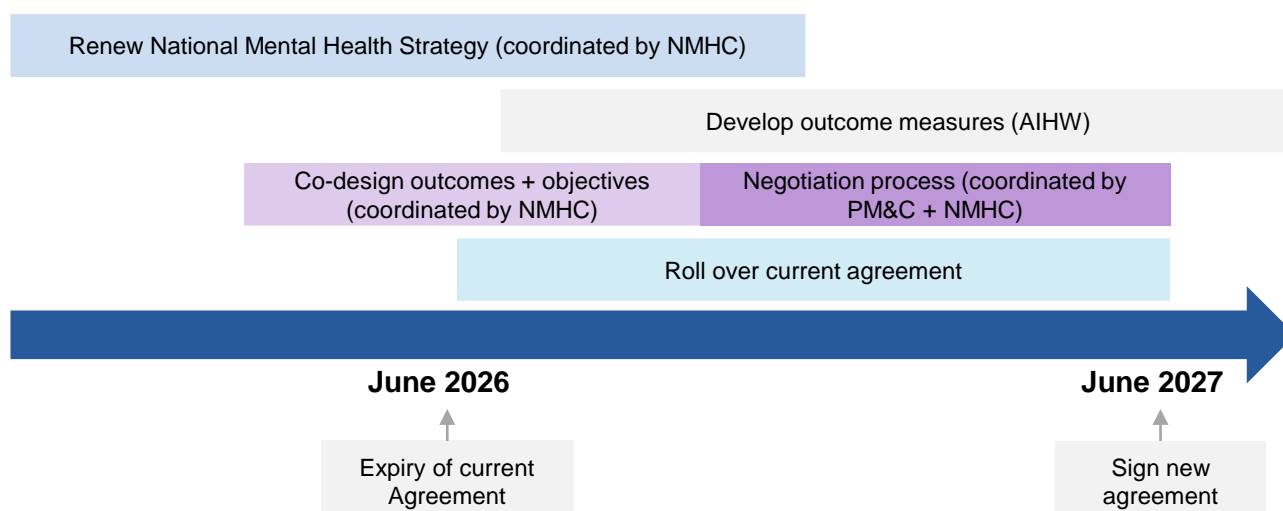
The greatest areas of focus for governance in the next agreement – and the issues raised most often in consultation for this review – should be stronger accountability and greater transparency. Clear designation of roles and responsibilities for different levels of government will be an important step 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.

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## **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.