Queensland Nurses & Midwives' Union

Submission to

Productivity Commission

Mental Health and Suicide Prevention Agreement Review: Interim Report consultation

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submission

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Introduction

The Queensland Nurses and Midwives' Union (QNMU) thanks the *Productivity Commission* (PC) for the opportunity to provide feedback on the *Mental Health and Suicide Prevention Agreement Review: Interim Report (Interim Report).*

The QNMU is Queensland's largest and only registered union for nurses and midwives, representing over 78,000 members. The QNMU is a state branch of the Australian Nursing and Midwifery Federation (ANMF) with the ANMF representing over 345,000 members.

Our members work in health and aged care including public and private hospitals and health services, residential and community aged care, maternity services, mental health, general practice, and disability sectors across a wide variety of urban, regional, rural, and remote locations.

The QNMU is run by nurses and midwives, for nurses and midwives. We have a proud history of working with our members for over 100 years to promote and defend the professional, industrial, social, and political interests of our members. Our members direct the QNMU's priorities and policies through our democratic processes.

The QNMU expresses our continued commitment to working in partnership with Aboriginal and Torres Strait Islander peoples to achieve health equity outcomes. The QNMU remains committed to the Uluru Statement from the Heart, including a pathway to truth telling and treaty. We acknowledge the lands on which we work and meet always was, and always will be, Aboriginal and Torres Strait Islander land.

General comments

The QNMU commends the PC (2025) for its comprehensive review of the Mental Health and Suicide Agreement, outlined in the Interim Report. Several of the PC's findings correspond with feedback the QNMU has received from our members and the recommendations that we included in our previous submission (QNMU, 2025). We therefore broadly endorse the PC's draft findings, namely that:

- Progress has been made in delivering the Agreement's commitments, but there has been limited systemic change
- The Agreement has not led to progress in system reform
- The National Mental Health and Suicide Prevention Agreement is not effective and
- A new and more effective agreement is needed.

Social determinants of mental health

Consistent with a key theme raised by stakeholders during the PC's review, the QNMU advocates for a holistic, whole-of-government approach to address the social determinants of mental health. The PC (2025) noted in its Interim Report:

> *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 (p. 140).*

As investment in upstream prevention strategies is far more cost effective than providing mental health services downstream, the QNMU asserts that governments must also fund strategies that address the broader structural determinants of mental health such as access to adequate housing, education and employment (PC, 2025).

The QNMU therefore supports draft Recommendation 4.3, that "the next agreement should have stronger links to the broader policy environment" (PC, 2025, p. 22).

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).

Mental health workforce

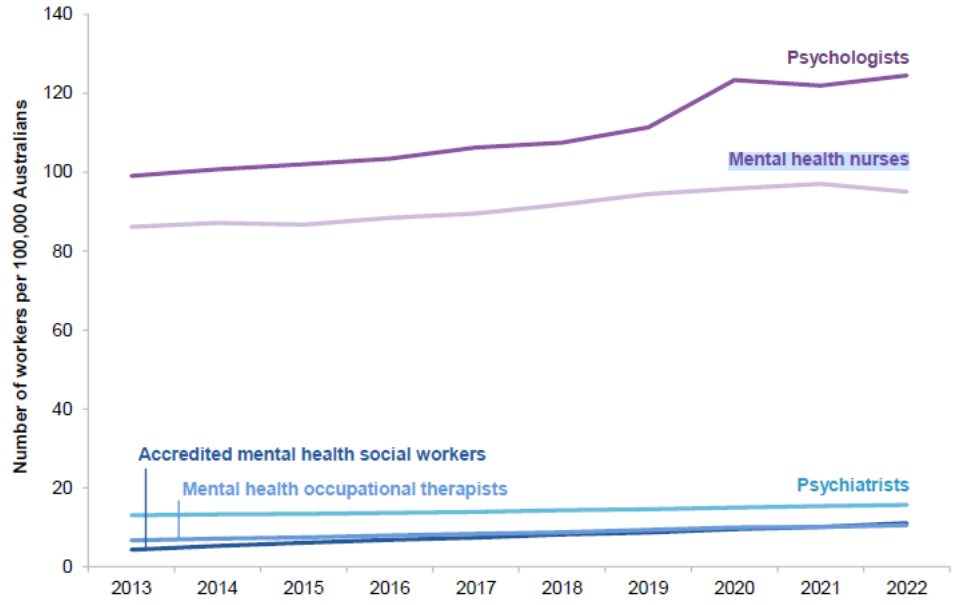
The QNMU (2025) submission recommendations primarily focussed on targeted government action to address shortages in the mental health workforce, specifically the mental health nursing workforce.

The PC (2025) stated in its Interim Report:

> *Governments committed in the Agreement to 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)'* (p. 95).

Further, the PC (2025) noted that the National Mental Health Workforce Strategy does not contain funding commitments or clear accountability structures. Despite commitments by governments to grow the mental health workforce, chronic shortages remain. As illustrated below (*Figure 2.6 - Minimal growth in mental health workforce* [PC, 2025, p. 95]), there has been limited growth in the number of mental health professionals per 100,000 Australians since 2013, apart from psychologists.

Figure 2.6 – Minimal growth in mental health workforce



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

The QNMU therefore strongly endorses draft recommendation 4.13, that the next agreement should support the implementation of the National Mental Health Workforce Strategy (PC, 2025, p.160).

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.

We reiterate the QNMU's (2025) workforce-related recommendations, namely that the PC considers:

1. How the National Agreement can address mental health nursing workforce shortages and the impact of its initiatives on building and developing the mental health nursing workforce, including supporting sustainable and attractive career progression.

2. The need to strengthen the public reporting requirements of identified workforce targets in the National Agreement to support full transparency.

3. Whether the exclusion of Enrolled Nurses constitutes a significant gap in the National Agreement's workforce development priorities.

4. How the National Agreement can support more accurate identification and reporting on the education and qualifications within the mental health workforce to aid workforce planning.

5. Whether the existing mental health nursing scholarship arrangements in Queensland are sufficient to fulfill their commitments in the National Agreement and

6. The recommendation made by the 2021 Select Committee on Mental Health and Suicide that all states and territories appoint a Chief Mental Health Nurse, as a means to support the National Agreement.

With regards to the education and qualification of the mental health workforce (4th listed recommendation), we reiterate that there is a distinction between a nurse who works in mental health and a nurse with a qualification in mental health nursing (QNMU, 2025). The QNMU considers that nurses should be supported to undertake additional mental health qualifications and remunerated accordingly in recognition of these qualifications.

Response to specific PC information requests

> **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.*

We consider there is value in establishing an additional schedule in the next agreement to address the co-occurrence of alcohol and other drug use and mental ill health and suicide, if this leads to increased funding for related initiatives.

We note that the relationship between alcohol and other drug use and mental ill health and suicide can be complex and bi-directional. For example, a lack of access to appropriate support services can lead to people using alcohol and other drugs. We also caution the use of language such as 'problematic' alcohol and drug use, as this type of language can be stigmatising for individuals.

> **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?*

There are several barriers to the genuine participation and influence of people with lived and living experience in governance forums. These include, but are not limited to:

- A lack of governance forums that are culturally diverse and safe, free from stigma
- Rurality/geographical isolation
- Socioeconomic disadvantage.

For genuine and sustained engagement in governance forums, people need to perceive that their participation is worthwhile, and not tokenistic. We recommend that successful inclusion and engagement of people with lived experience needs to incorporate patient-reported

experiences and patient-reported outcomes. For example, an indicator to measure meaningful engagement could compare the number of initiatives proposed by people with lived experience that have been actioned with the number of initiatives proposed by service providers and governments that had been actioned.

Aboriginal and Torres Strait Islander peoples have "distinct and diverse concepts and experiences of wellbeing often described through the framework of social and emotional wellbeing" (PC, 2025, p. 141) and need to be genuinely engaged in governance as well as the evaluation process. We therefore endorse the PC draft recommendation 5.1 that a separate, co-designed Aboriginal and Torres Strait Islander schedule recognises the need for specific actions, with community-led evaluation.

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.

We support calls made by other consultation stakeholders that carers (particularly young carers and Aboriginal and Torres Strait Islander carers), supporters, family and kin be added to the 'priority population' groups listed in the Agreement that are disproportionately impacted by mental health and suicide (PC, 2025, p. 110). This recommendation corresponds with feedback from QNMU members that carers often receive limited to no support, particularly when family members have survived a suicide attempt.

The QNMU also recommends that consideration is given to adding women who become mothers to the list of 'priority population' groups listed in the Agreement. Death by suicide was the leading cause of death for women in Australia aged 15-44 between 2011 and 2023, while death by suicide was one of the leading causes of maternal death in Australia between 2012 and 2021 (Australian Institute of Health and Welfare, 2024). Maternal death is defined as the death of a woman while pregnant or within 42 days of the end of pregnancy, irrespective of the duration and outcome of the pregnancy. Maternal death is disproportionately higher for First Nations women. For example, from 2015-2017, the incidence of maternal death in First Nations women was more than three times as high as that for non-Indigenous women (Australian Institute for Health and Welfare, 2020). Domestic abuse often begins or escalates

during the perinatal period, which contributes to increasing the risk of death of the woman and infant (Peacock et al., 2024).

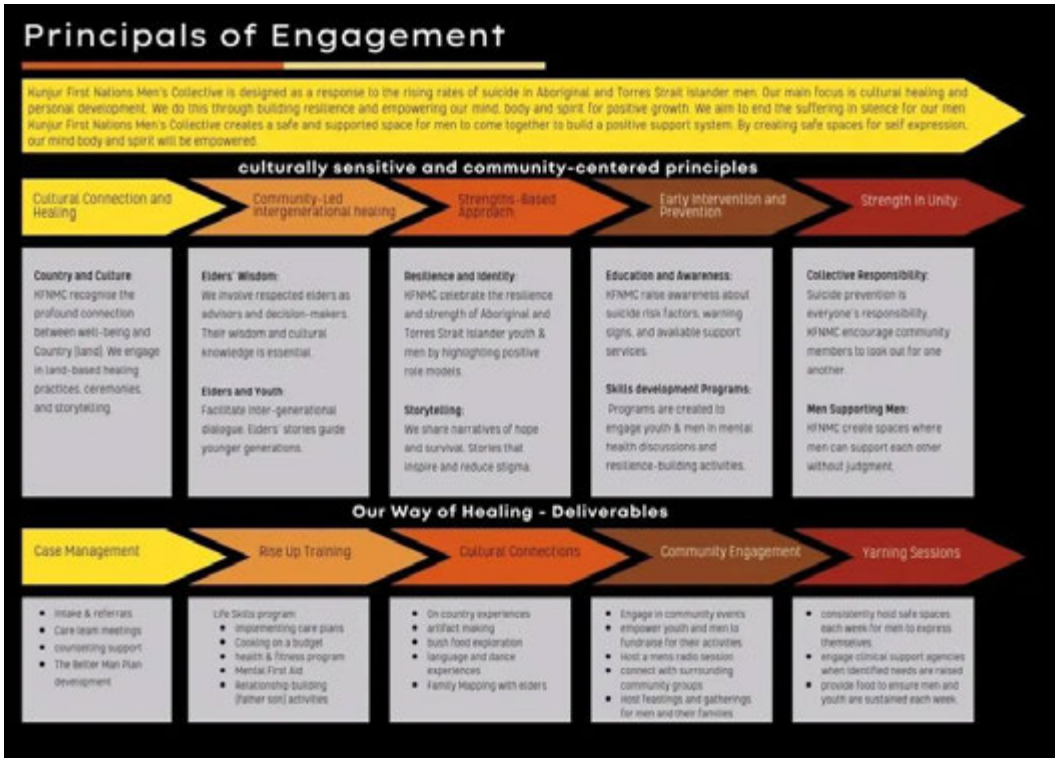
> **Information Request 4.3:** *The PC is seeking views on the value and feasibility of having a public dashboard to track and report on progress under the next agreement's objectives and outcomes and any other measurable targets set throughout. Which bodies should be responsible for the collation and publication of dashboard data? What metrics should be included in the dashboard?*

The QNMU endorses the intention underpinning this PC recommendation to improve transparency and enable the public to better hold governments accountable for implementing the next agreement. As mentioned above, the QNMU (2025) recommended in our previous submission that greater transparency is required, such as by strengthening the public reporting requirements to measure progress towards achieving mental health nursing workforce targets. Progress towards achieving workforce targets, which are inputs to the system, may be considered a useful proxy for measuring the Agreement's performance.

We note, however, that other objectives and outcomes may be more difficult to measure. For example, suicide prevention might be measured by assessing how many people are unable to access mental health services and the length of time that people wait to see a private psychologist. Given the complexity associated with measurement, there is a risk that simplistic, rather than meaningful measures will be used to populate a public dashboard. With this in mind, we propose that considerable thought is given to the best way to measure and present progress made towards achieving the next agreement's objectives and outcomes.

> **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?*

The QNMU considers a best practice example within the First Nations suicide prevention (upstream) context is the Kunjur First Nations Men's Collective (KFNMC, Deadly Inspiring Youth Doing Good, 2025). The KFNMC Principals of Engagement are outlined below and the KFNMC, which is based in Cairns, has held a range of events with the support of volunteer facilitators, with limited to no budget (Deadly Inspiring Youth Doing Good, 2025).



(Source: https://diydg.org.au/kunjur-mens-collective)

Within the context of providing support to people who are experiencing mental health crisis (downstream), the Nujum Jawa Crisis Stabilisation Unit (CSU), based at the Prince Charles Hospital, Metro North Hospital and Health Service, was established in late 2024 with funding from the Queensland Government Better Care Together funding (State of Queensland (Metro North Health), 2025). The Nujum Jawa CSU was co-designed with the community to provide a more culturally safe space than the Emergency Department to deliver intensive mental health crisis care. The short-term unit and lounge space has been designed so that family members, carers and other support people can attend and the multidisciplinary team comprises Aboriginal and Torres Strait Islander mental health workers, medical, nursing, allied health professionals and a lived experience (peer) workforce (State of Queensland (Metro North Health), 2025).

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