



Final Submission

The Productivity Commission's Final Review of the National Mental Health and Suicide Prevention Agreement

July 2025

Consumers Health Forum of Australia (2025)
*Final submission to the Final Review of the
National Mental Health and Suicide Prevention Agreement*

P: 02 6273 5444

E: info@chf.org.au

twitter.com/CHFofAustralia

facebook.com/CHFofAustralia

Office Address

Level 5, 15 Moore St
Canberra ACT 2601

Postal Address

PO Box 308
Collins Street West VIC 8007

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Introduction

Consumers Health Forum Australia (CHF) is the national peak body representing the interests of all healthcare consumers and those interested in healthcare consumer affairs. CHF works to achieve safe, quality, and timely healthcare for all people living in Australia, supported by accessible health information and systems. At the heart of CHF's policy agenda is consumer-centred care.

CHF welcomes the opportunity to provide a final submission to the Productivity Commission's Final Review of the National Mental Health and Suicide Prevention Agreement (the Agreement), and a response to the Interim Report.

CHF provided an initial submission to the Review of the Agreement in March 2025. In this submission, we highlighted that consumers are still struggling to access mental healthcare and suicide prevention services when they need to, that waiting times and out-of-pocket costs continue to be significant barriers, that stigma and discrimination is an ongoing problem and that many aspects of the system – in particular acute mental health and suicide distress treatment in emergency departments – remain inappropriate. We emphasised the need to place lived experience at the centre of reform, and as part of this to ensure that the newly established mental health lived experience peak bodies have the remit and resources to facilitate lived experience input into and influence over system reform. We also called for greater investment into prevention and early intervention.

The Productivity Commission's Interim Report was released in June 2025, and this final submission focuses on responding to the recommendations and requests for information made in that Report.

Overall, CHF strongly supports the key findings and recommendations of the Interim Report. We agree that the current Agreement has not led to meaningful change and lacks clear objectives and achievable, measurable outcomes. There is a clear need for a new approach to next Agreement, one that is grounded in meaningful co-design with those with lived experience, their carers, families and kin, and the broader mental health sector.

In summary:

- CHF broadly supports the findings and recommendations from the Interim Report
- CHF supports action on outstanding current Agreement commitments – namely addressing unmet needs for psychosocial supports and releasing and resourcing the Stigma and Discrimination Reduction Strategy
- CHF strongly supports the development of a new Agreement and National Mental Health Strategy that are co-designed with people with lived experience, as well as the broader mental health sector
- CHF calls for integration to be considered a core design principle in all future reforms
- CHF strongly supports embedding lived experience across governance mechanisms
- CHF calls for consumer peak bodies (both national and state and territory) to be adequately funded to actively contribute to planning, implementation and governance of the new Agreement
- CHF supports increased transparency in data collection and reporting and requiring timely evaluations with findings made public

- CHF calls for the implementation and funding of the National MH Workforce Strategy to be a priority of the next Agreement and for implementation to be co-designed with people with lived experience and the sector
- CHF would like to emphasise the importance of prioritising and investing in prevention, early intervention and alternative models of care in the next Agreement.

Responses to Recommendations

We have provided below our responses to the key recommendations and requests for information in the Interim Report. Overall, we support the Interim Report recommendations, noting that they will have significant implementation and resourcing implications. We'd like to highlight that change management and capacity building must be properly resourced to ensure the successful implementation of changes to current practices required by the new Strategy and Agreement. We have provided more detailed responses below to the recommendations or information requests where we have specific advice, clarification or suggestions.

Delivering outstanding commitments

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**

CHF supports these recommendations. As recommended in our initial submission to this review, the Stigma and Discrimination Reduction Strategy and an associated resourced implementation plan to progress reform in this area should be released as soon as possible. As CHF highlighted in our submission in response to the Consultation draft Strategy in 2023, the Strategy should be widely accessible – not just to organisations and governments, but to consumers. The implementation plan for the Strategy must be co-designed with people with lived experience of mental health challenges and/or suicide, their carers, families and kin, and the broader mental health and suicide prevention sectors. The next Agreement must also ensure funding is specifically allocated to implementation of the Stigma and Discrimination Reduction Strategy.

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

CHF strongly support this recommendation. There is a significant and urgent need for more psychosocial supports in the community. Data from 2022-23 demonstrates that almost

500,000 Australians with moderate to severe mental illness are unable to access the psychosocial supports they need.¹

We agree with the Interim Report's recommendation that state and territory governments should immediately begin work to address this unmet need. Essential to this will be working closely with national and jurisdictional lived experience peak bodies and the sector – in particular the community managed mental health sector as key deliverers of psychosocial programs. Building and supporting the peer workforce, promoting self-care and investing in community development programs can all contribute to rapid expansion of the supports available to people experiencing mental health challenges.

We also agree that psychosocial supports should continue to be a key priority within the next Agreement and it should include clear delineation of roles and responsibilities for delivery of these supports, funding commitments from federal and state/territory governments and a detailed, plan and timeline for service expansion, co-designed with people with lived experience, family, carers and kin, service providers (including peer workers) and other stakeholders, with the aim of fully addressing unmet need by 2030.

A new policy architecture centred around lived experience

CHF strongly supports the Interim Report's call for the co-design of a new policy architecture that is centred around lived experience and incorporates a long term National Mental Health Strategy, as well as a new Agreement.

Draft recommendation 4.1 Developing a renewed National Mental Health Strategy

CHF supports the development of a renewed National Mental Health Strategy that sets a strategic national vision and provides clear objectives and collective priorities for long-term reform in the mental health and suicide prevention system over the next 20–30 years. Importantly, this Strategy must be co-designed with people with lived experience of mental health challenges, suicidality, their families, carers and kin, and the sector (incorporating public, private and community-managed service providers). It should also align with and complement the current National Suicide Prevention Strategy.

Draft recommendation 4.2 Building the foundations for a successful agreement

CHF strongly supports and applauds the Interim Report's focus on embedding lived experience in the next Agreement.

Co-designing a new Agreement with people with lived experience of mental health challenges and/or suicide should incorporate engaging with the full breadth and diversity of consumers. In particular, representatives of the fifteen identified priority population groups must be involved, including (but not limited to) First Nations people, people living in rural and remote locations, people with disability, culturally and linguistically diverse communities and refugees, LGBTIQ+ communities, older Australians, and children and young people.

¹ Health Policy Analysis (2024) *Analysis of Unmet Need for Psychosocial Supports outside of the NDIS*, available: <https://www.health.gov.au/sites/default/files/2024-08/analysis-of-unmet-need-for-psychosocial-supports-outside-of-the-national-disability-insurance-scheme-final-report.pdf>

CHF supports extending the current Agreement to allow for the co-design of the next; however, we recommend that timelines for this process are developed in consultation with lived experience peak bodies and the sector, taking into account the time required for meaningful co-design to occur. Importantly, extending the current Agreement should not delay any urgent action.

As organisations who represent people with lived experience, mental health consumer and carer peak bodies, both national and jurisdictional, must be appropriately funded to enable them to actively contribute to the planning, implementation, and governance of the National Agreement. They should also be adequately funded to provide advice to all levels of Government, and to provide support to individual lived experience representatives. Funding for peak bodies should be provided as five-year contracts (aligned with the life of the Agreement) and be appropriately indexed. This will provide stability for these important organisations and allow for more effective planning and service delivery. Similarly, adequate support needs to be provided to appropriate organisations and peak bodies to allow priority populations to participate in co-design processes.

We support a refreshed, independent National Mental Health Commission facilitating the co-design process to develop objectives and outcomes for the new Agreement. However, the two national mental health lived experience peak bodies should be equal partners in this process, and as outlined above should be adequately resourced to enable this. State and territory level lived experience peak bodies should also be closely engaged. Further, the wider mental health sector must also be a part of the co-design process, including service providers, health professionals, national and jurisdictional peak bodies, researchers and other key stakeholders.

We strongly support the call for commitments and actions intended to improve collaboration across all government portfolios being included in the main body of the agreement and for the allocation of dedicated funding for collaborative initiatives and enablers of collaboration.

We also support the Department of Prime Minister and Cabinet convening negotiations and facilitating engagement between governments – as this responds to the sector’s call for a whole-of-government approach to addressing mental health. This is important given that broader social, economic, cultural, environmental and political factors shape the circumstances of people’s lives, including their mental health.

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

It is critical to acknowledge that mental health does not sit in isolation. Mental, physical, social, and spiritual health are inextricably linked. Consumers do not experience their health in silos, nor should they be forced to navigate disconnected systems. A person’s mental health may be deeply affected by, for example, chronic pain, untreated physical illness, medication interactions, housing instability, or traumatic healthcare experiences, just as their capacity to manage a physical condition may hinge on timely mental health support. An integrated system must reflect the reality of people’s lives, not impose artificial boundaries between domains of care.

The next Agreement and Strategy must articulate how mental health policy will intersect with other major health and social strategies, including those relating to chronic disease, ageing, disability, primary care, drug and alcohol treatment, and social determinants such as poverty

and homelessness. Creating separate, standalone systems that require consumers to build and navigate distinct care pathways is not only inefficient but unsafe. CHF calls for a clear governance mechanism to coordinate implementation across relevant national strategies, and for integration to be considered a core design principle in all future reforms.

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

Ensuring the provision of tailored supports for families, carers, and kin must be a focus of the next Agreement. CHF continues to hear that families, carers and kin are not receiving the support and access to services that they need. We support the recommendations made in Mental Health Carers Australia's initial submission to the Review, which includes an analysis of the unmet needs of families, carers and kin; ensuring state and territory governments fund a mental health family, carer and kin peak body where they don't exist; and the development of a dedicated, resourced Mental Health Carer Strategy.²

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

CHF strongly supports embedding lived experience in the new Agreement's governance mechanisms. How this is achieved should be guided by the existing *Lived Experience Governance Framework*. This Framework "provides a mechanism for organisations and sector leaders to have a clear understanding and oversight of expectations, objectives, accountabilities and performance that ensures the voice, contributions and decision-making power of people with lived experience is evident at all levels".³ Lived experienced peak bodies should be actively engaged in embedding this framework within the Agreement's governance to ensure that diverse people with lived experience are leading and influencing reform at all levels. Being guided by the framework will help to avoid common barriers to the genuine participation and influence of people with lived and living experience, such as a lack of shared decision-making power, or tokenistic involvement. As per recommendation 4.6 of the Interim Report, transparency of governance arrangements will also be a critical element of embedding and maintaining meaningful lived experience representation throughout the life of the Agreement.

Another significant barrier to genuine participation is inadequate funding and support for both people with lived experience and the organisations that represent them. It is essential that lived experience representatives are well-supported and remunerated appropriately for their time. Further, as per our response to recommendation 4.2, lived experience peak bodies must be allocated ongoing adequate funding.

² Mental Health Carers Australia (2025) *Submission to the National Mental Health and Suicide Prevention Agreement Review*, available: https://www.pc.gov.au/_data/assets/pdf_file/0018/392112/sub073-mental-health-review.pdf

³ Hodges, E., Leditschke, A., Solonsch, L. (2023). *The Lived Experience Governance Framework: Centring People, Identity and Human Rights for the Benefit of All*. Prepared by LELAN (SA Lived Experience Leadership & Advocacy Network) for the National Mental Health Consumer and Carer Forum and the National PHN Mental Health Lived Experience Engagement Network. Mental Health Australia, Canberra. Available: <https://nmhccf.org.au/our-work/discussion-papers/the-lived-experience-governance-framework-centring-people-identity-and-human-rights-for-the-benefit-of-all>

To embed lived experience in the Agreement's governance mechanisms, lived experience representatives should be present across all levels of governance. Importantly, the high-level advisory group (currently the Mental Health and Suicide Prevention Senior Officials Group), should include equal representation of government (cross-jurisdictional), sector/service providers, and people with lived experience. We would also like to emphasise the importance of ensuring diverse representation and achieving a balance between lived experience of mental health challenges, lived experience as a carer, family or kin, and lived experience of suicide. To formally embed lived experience leadership, CHF also recommends considering including national lived experience peak bodies as signatories to the new Agreement.

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

CHF supports this recommendation and recognises that a lack of sector representation has been a significant issue for the current Agreement. Representation of the sector in governance mechanisms is critical to effective implementation. The national peak body for the sector, Mental Health Australia, as well as jurisdictional mental health peaks, must be represented within governance structures. Service providers, health professionals, peak bodies representing priority cohorts, and researchers should all also be well represented in governance structures. We would particularly like to emphasise the importance of ensuring that the community mental health sector is well-represented across governance structures.

Reporting, data collection and transparency

Draft recommendation 4.9 Share implementation plans and progress reporting publicly

Transparency in implementation and reporting is essential. Regular and timely public reporting has not occurred under the current Agreement, which has been highly problematic for the sector. CHF strongly support implementation plans and regular progress reports being made public and support formalising the role of the National Mental Health Commission as the entity responsible for genuinely independent and ongoing monitoring, reporting and assessment of the progress under the agreement. We would also call for implementation plans and reports to be clear, plain language documents that are accessible to as wide an audience as possible. Co-designing these documents with a diversity of people with lived experience will help to ensure this.

Information request 4.3 – Public dashboard

CHF supports the proposal of a public dashboard to track and report on progress against objectives, outcomes and targets. This would be a welcome approach to ensuring transparency and accountability. We would strongly recommend that such a dashboard is co-designed with people with lived experience to ensure it is accessible, easy to use, and relevant.

Draft recommendation 4.11 Survey data should be routinely collected

While CHF supports regular collection of survey data, we would also like to emphasise that surveys need to be appropriate, relevant and collect data that is directly linked to the Agreement's co-designed objectives and outcomes. Achieving this may require reviewing and redesigning existing national surveys. As outlined in the Mental Health Consumer Alliance's initial submission, data needs to be collected in a way that is meaningful and relatable to mental health consumers. Data must also go beyond service metrics - consumer-driven data and qualitative lived experience reporting must also be collected and

used.⁴ Survey tools should also be co-designed with people with lived experience to ensure they are accessible, user-friendly, inclusive and relevant.

As surveys increasingly occur online, it is vital to address privacy, cyber security, digital literacy, and digital exclusion to ensure safe and inclusive participation. Collecting potentially sensitive mental health data requires strong data protection measures and transparent communication with respondents about how information will be used, stored, and safeguarded. Further, people with limited digital literacy or access—such as older adults, remote communities, or people with disability—may struggle to participate, risking underrepresentation. Surveys should be provided in alternative formats (such as paper or phone-based options) to reduce the risk of digital exclusion. Empowering people with the knowledge and tools to engage safely will help to ensure that diverse experiences are captured, supporting evidence-based decision-making.

Further, sufficient funding must be allocated to collect and evaluate effective data for both current and new services and supports.

Tailoring support to local needs

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

CHF agree that funding arrangements in the next Agreement must provide enough flexibility to commission and support appropriate, locally relevant services and supports. Funding should not be attached to nationally-prescribed services and outcomes, but should be flexible enough to respond to the values, principles, and needs identified by those with lived experience in their communities. This is particularly critical in rural and remote locations where inflexible funding models can lead to needs not being met and communities losing or under-utilising funding allocations.⁵ We support the call for the next Agreement to incentivise and enable best practice and support effective local commissioning that can respond to emerging challenges and offer tailored and targeted approaches to address the needs.

Workforce development

Draft recommendation 4.13 The next agreement should support the implementation of the National Mental Health Workforce Strategy, including clear commitments to actions, timelines, and responsibility for funding

CHF strongly supports this recommendation. There is an urgent need for coordinated action on workforce as this is a key driver of lack of access to mental health services. As outlined in the National Mental Health Workforce Strategy, there is currently an estimated 32%

⁴ National Mental Health Consumer Alliance (2025) *Submission to Productivity Commission Review – Mental Health and Suicide Prevention Agreement*. Available: https://www.pc.gov.au/_data/assets/pdf_file/0010/392077/sub066-mental-health-review.pdf

⁵ National Rural Health Alliance (2025) *Submission to Review of the National Mental Health and Suicide Prevention Agreement*. Available: https://www.pc.gov.au/_data/assets/pdf_file/0003/392196/sub086-mental-health-review.pdf

shortfall in mental health workforce, which is projected to grow to 42% by 2030 if not addressed.⁶

The next Agreement must support and fully fund the implementation of the National Mental Health Workforce Strategy, with public prioritisation of actions and improved accountability. Importantly, the implementation of the strategy should be co-designed with the mental health sector and people with lived experience.

Currently the Agreement and Workforce Strategy do not adequately acknowledge the critical role of the community-managed mental health workforce in the delivery of mental health supports, in particular psychosocial support services, prevention and early intervention initiatives and peer-led approaches. This must be remedied, and the growth and development of the community mental health sector, and the peer workforce, must be central aspects of workforce planning and prioritised in the implementation of the Workforce Strategy.

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

As per our initial submission, the Agreement should focus on reform that enables and prioritises person-centred care, including continuing to foster and support the growth of a peer workforce. The peer workforce is growing rapidly and it is essential to ensure this continues and that barriers, including unclear role definitions and lack of adequate training and support, are addressed as a priority. CHF supports the development of a scope of practice for the peer workforce but would emphasise that this must be co-designed with the peer workforce, the broader mental health workforce/sector, and people with lived experience.

Evaluation

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

CHF supports a stronger evaluation framework that ensures timely evaluations for all services and requires public sharing of findings. We would recommend that a mid-term evaluation of the Agreement is conducted to ensure it is meeting targets and to enable response to emerging issues. Sharing of findings publicly must be done in accessible, culturally safe and appropriate ways – ideally co-designed with people with lived experience.

Separate Schedules

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

CHF supports this recommendation in principle, highlighting that the development and design of the schedule must be led by the Aboriginal and Torres Strait Islander community.

We refer to the response of Gayaa Dhuwi (Proud Spirit Australia), and their support of the Interim Report's findings and recommendations, including the call for a dedicated Social and Emotional Wellbeing Schedule in the new agreement to support outcomes for Aboriginal and

⁶ Department of Health and Aged Care (2022) *National Mental Health Workforce Strategy 2022-2032*. Available: <https://www.health.gov.au/sites/default/files/2023-10/national-mental-health-workforce-strategy-2022-2032.pdf>

Torres Strait Islander Peoples, stronger alignment with the National Agreement on Closing the Gap, and recognition of the foundational role of cultural capability in all services.⁷ They call for the next Agreement to be guided by the Gayaa Dhuwi Declaration Framework and Implementation Plan, committed to genuine co-design and sharing of decision-making power with Aboriginal and Torres Strait Islander communities, and to incorporate appropriate resourcing of the community-controlled sector.

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

CHF supports this recommendation, recognising that Suicide Prevention Australia sees it as a pragmatic compromise that will ensure suicide prevention receives dedicated focus while also remaining integrated within the broader mental health framework.⁸

It is essential, however, that this Schedule is co-designed with people with lived experience of suicide, their carers, families and kin, and service providers. We also support Suicide Prevention Australia's call for the Suicide Prevention Research fund to be reinstated urgently, for the Schedule to be aligned with and guided by the National Suicide Prevention Strategy, for the Suicide Prevention Office to have responsibility for tracking and reporting on the Schedule's implementation, and for the Schedule to include a focus on building and supporting the suicide prevention workforce.

Priorities for the next Agreement

CHF's initial submission to the Review highlights particular areas and aspects of the mental health and suicide prevention systems that require greater prioritisation and investment. We would like to again highlight the criticality that the next Agreement prioritises and ensures greater investment in promotion, prevention and early intervention.

Reversing the growing prevalence of mental health challenges requires a strategic, funded focus on prevention and early intervention. This includes a focus on building mental health literacy, at both an individual and community level, to support Australians in understanding and managing mental health and wellbeing, acknowledging risk factors, and knowing when to advocate for and seek help if needed.

Research confirms that mental health outcomes are improved by effective prevention programs and that early identification and treatment of problems, particularly amongst children and young people, can improve chances of recovery and reduce the impact of mental health challenges on a person's life and wellbeing.^{9,10}

⁷ Gayaa Dhuwi (Proud Spirit) Australia (2025) *Media Release 26 June 2025: Productivity Commission interim report confirms mental health system is failing for Aboriginal and Torres Strait Islander Peoples*. Available: <https://www.gayaadhuwi.org.au/productivity-commission-interim-report-confirms-mental-health-system-is-failing-for-aboriginal-and-torres-strait-islander-peoples/>

⁸ Suicide Prevention Australia (2025) *Media Release 26 June 2025: Peak body welcomes Productivity Commission recommendations to strengthen national suicide prevention efforts*. Available: <https://www.suicidepreventionaustralia.org.au/peak-body-welcomes-productivity-commission-recommendations-to-strengthen-national-suicide-prevention-efforts>

⁹ Victorian Department of Health (2021) *Early intervention in mental illness*, available: <https://www.health.vic.gov.au/prevention-and-promotion/early-intervention-in-mental-illness>

¹⁰ Parliament of Australia (2006) *A national approach to mental health – from crisis to community First Report. Chapter 7 – Promotion, prevention and early intervention*, available: https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Former_Committees/mentalhealth/report/c07

While there is increasing access to effective initiatives, such as parenting programs and school-based social and emotional learning programs, dedicated and ongoing funding for preventive mental health activities is required to enable widespread impact.¹¹ The next Agreement should seek to support rapidly scaling up existing evidence-based prevention and early intervention approaches, and continuing to develop new and better solutions based on research and data.

Alongside this, supporting system navigation is critical. We continue to hear from consumers that they are not aware of the different mental health and suicide prevention supports available to them, or how to access them. The next Agreement should prioritise mental health system navigation, including implementing and funding the recommendations from the 'Digital Navigation Project' commissioned by the Australian Government.¹²

Finally, greater expansion of and investment in effective models of care that offer an alternative to clinical treatment must be prioritised. For example, 'Safe Havens' (also known as Safe Haven Cafes or Safe Spaces) provide a calm, culturally sensitive and non-clinical place for people experiencing a mental health crisis or distress to access support from peer support workers.¹³ These spaces have shown promising evidence of effectiveness in reducing emergency department visits and improving overall wellbeing.¹⁴ Investing in effective community-based models of care, like Safe Havens, supports person-centred approaches to care, reduces pressure on emergency departments and will ultimately contribute to suicide prevention and improved mental health and wellbeing.

¹¹ Mental Health Australia (2025) *2025-26 Pre-Budget Submission*, available: https://mhaustralia.org/sites/default/files/docs/mental_health_australia_2025-2026_pre-budget_submission_-_jan_2025_-_final.pdf

¹² SANE Australia (2025) *Digital Navigation Project*, available: <https://www.sane.org/digitalnav>

¹³ NSW Government (2024) *Safe Haven*, <https://www.health.nsw.gov.au/towardszerosuicides/Pages/safe-haven.aspx>

¹⁴ Life in Mind (?) *Safe Spaces*, available: <https://lifeinmind.org.au/suicide-prevention/approaches/intervention/safe-spaces>;

Andrew, L., Karthigesu, S., Coall, D., Sim, M., Dare, J. & Boxall, K. (2023) What makes a space safe? Consumers' perspectives on a mental health safe space. *International Journal of Mental Health Nursing*, 32, 1355–1364. Available: <https://doi.org/10.1111/inm.13174>