2025

Being Mental Health Consumers

Submission

The Australian Government Productivity Commission Final Review of the Mental Health and Suicide Prevention Agreement

August 2025

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About BEING – Mental Health Consumers

BEING – Mental Health Consumers is the independent, NSW peak organisation by and for people with lived/living experience of mental health challenges. 100% of BEING's staff and board are mental health consumers.

Our mission is to represent people with mental health issues to ensure that lived experience is heard and reflected in decision making, service provision and our communities. Our vision is for all mental health decisions in NSW to be decided in active partnership with people who have lived experience.

BEING is committed to human rights principles of diversity, inclusion, and equity, and believes that recovery is possible for all people who live with mental health challenges.

BEING is also a foundational member of the National Mental Health Consumer Alliance (the Alliance), the national peak body representing mental health consumers.

Acknowledgement of Country

BEING – Mental Health Consumers acknowledges the traditional custodians of various countries across New South Wales. We pay our respects to Elders past, present and emerging. We acknowledge land was never ceded, and was, is, and always will be Aboriginal land. We value your holistic management of country over the millennia and realise that Indigenous knowledge systems have much to teach us about how we thrive as a society.

Recognition of Lived Experience

BEING – Mental Health Consumers values all people with lived experience of mental health challenges, especially those from intersectional backgrounds whose experiences remind us that we need a mental health system for all. We stand alongside you, in your strength and courage, as driving forces in the work we do. Your voice will always matter.

Introduction

BEING welcomes the opportunity to make this submission to the Productivity Commission's Final Inquiry Report on the Mental Health and Suicide Prevention Agreement.

This submission responds to the Productivity Commission's Interim Report of their review of the Mental Health and Suicide Prevention Agreement released on 24 June 2025. In this submission we will raise several issues related to several of the Commission's Interim Report draft recommendations, focused on five main areas:

- Governance
- Data
- Peer workers
- Implementation of the next agreement, and
- Barriers to consumer participation.

We would like to acknowledge the important work of the National Mental Health Consumer Alliance (the Alliance), and we welcome the Alliance's submission provided to the Productivity Commission.

BEING's submission reinforces the Alliance's submission, and where possible we have referenced both the Productivity Commission's Interim Report and relevant sections of the Alliance's submission in this submission.

Summary of recommendations

Governance

Collaboration between consumers, carers and providers

Recommendation 1 – That the governance arrangements for the next agreement ensure mechanisms that support the collaboration between consumers, carers and providers, without conflating the perspectives of each primary stakeholder.

Recommendation 2 – That governing authority for the next agreement be co-led by a mental health consumer alongside the Government.

Space for constructive disagreement

Recommendation 3 – That the governance arrangements for the next agreement have mechanisms to support constructive disagreement between stakeholders, and where a consumer need differs from other primary stakeholders, that these mechanisms then support the evaluation and implementation of novel approaches.

Whole-of-government approaches

Recommendation 4 – That the governance arrangements for the next agreement embed a consumer voice in promoting interjurisdictional whole-of-government approaches.

Recommendation 5 – That the governance arrangements for the next agreement clearly define the roles and responsibilities for each jurisdiction, and that they also embed a defined appropriate role for the relevant consumer peak body/ies to support the discharging of responsibilities.

Adequate state and territory consumer peak body funding

Recommendation 6 – That all state and territory governments adequately fund their state or territory mental health consumer peak body on an equitable per capita basis, and where a jurisdiction does not have a consumer peak body, for that jurisdiction to fund the creation of one.

Recommendation 7 – That all state and territory consumer peak bodies be adequately provided with transitional funding to realise the ambition to co-design the next agreement.

Recommendation 8 – That the governance arrangements for the next agreement clearly defines a role for consumer peak bodies in the commissioning and evaluation of mental health services outside of the National Disability Insurance Scheme at the state and territory level, to ensure consumer needs are met.

Data

Equitable resources between states and territories

Recommendation 9 – That the next agreement recommends the calculation of the quantum of unmet need across all jurisdictions to inform baseline levels of unmet in each jurisdiction.

Recommendation 10 – That the next agreement empowers the Australian Government to allocate equitable funding to jurisdictions guided by the calculation of the baseline calculation of the quantum of unmet need, and for subsequent funding to be tied to jurisdictional progress in addressing the quantum of unmet need.

Inclusion of Lived Experience research

Recommendation 11 – That the next agreement defines the role of consumers in research by, for and with mental health consumers.

Recommendation 12 – That the next agreement identifies opportunities to develop the pipeline and sustainability of researchers with lived experience.

Data transparency and data improvement

Recommendation 13 – That the next agreement defines a clear role for consumers in what and how data is presented in the public dashboard, and in developing data improvement plans for the data used in the public dashboard.

Recommendation 14 – That the next agreement ensures the public dashboard is available in a variety of formats and languages to suit the wide range of mental health consumers accessing the dashboard.

Peer workers

Ensuring the sustainability of the peer workforce

Recommendation 15 – That the next agreement and the proposed National Mental Health Workforce Strategy promotes a nationally consistent approach to industrial arrangements for peer workers, to ensure peer workers are renumerated consistently across Australia.

Recommendation 16 – That the next agreement consider the role of a national accreditation framework in promoting consistent accreditation in the peer workforce, and guides peer workforce development and planning, as part of the proposed National Mental Health Workforce Strategy.

Implementing the next agreement

Additional policies to consider

Recommendation 17 – That the next agreement ensures *Australia's Disability Strategy 2021-31* is included as a key document for the development of the new agreement.

Reporting

Recommendation 18 – That the next agreement requires National Mental Health Commission reports to be tabled in the Australian Parliament, to improve the transparency and accountability of reports.

Recommendation 19 – That the next agreement requires Primary Health Networks to publicly report how they embed mental health consumers in decision-making, and how effective commissioning activity meets the needs of local consumers.

Barriers to consumer participation

Separating consumer participation and state peak funding

Recommendation 20 – That the next agreement provides protected funding for consumer participation separate to the funding provided to national, state and territory consumer peak bodies.

1. Governance

We strongly support the Interim Report's recommendation for the next agreement to support a greater role for people with lived and living experience, as well as providers, in governance.[i]

BEING agrees that future governance arrangements should include individual carers and consumers, the national carer and consumer peaks and an appropriate balance of people who have lived and living experience of mental health challenges, including providers. We recognise that there are important shared interests between consumers, carers and providers and that there is a need for collaboration between them.

Collaboration between consumers, carers and providers

However, as reflected in the creation and separation of the two recently established national lived experience peak bodies, the National Mental Health Consumer Alliance and Mental Health Carers Australia, we believe the governance design and architecture for the next agreement needs to have mechanisms that support collaboration between consumers, carers and providers, without conflating the perspectives of each primary stakeholder.

Recommendation 1 – That the governance arrangements for the next agreement ensure mechanisms that support the collaboration between consumers, carers and providers, without conflating the perspectives of each primary stakeholder.

Further, in designing the governance arrangements for the next agreement, we believe that the governing authority overseeing the implementation and evaluation of the next agreement should be co-led by a consumer alongside the Government, alongside the adequate representation of people with lived and living experience and the two recently established national lived experience peak bodies.

Recommendation 2 – That governing authority for the next agreement be co-led by a mental health consumer alongside the Government.

Space for constructive disagreement

Further, we also believe that it is vital to ensure that governance arrangements allow space for constructive disagreement between consumers and carers. There will be instances when consumers and carers disagree, for example, on approaches to involuntary treatment and suicidality and suicide prevention.

For the next agreement to better reflect the diverse needs of all mental health consumers, and for the agreement to effectively drive different approaches in both policy and service delivery that better meet the diverse needs of mental health

consumers, the governance arrangements need to have appropriate mechanisms to evaluate and implement novel approaches.

Recommendation 3 – That the governance arrangements for the next agreement have mechanisms to support constructive disagreement between stakeholders, and where a consumer need differs from other primary stakeholders, that these mechanisms then support the evaluation and implementation of novel approaches.

Whole-of-government approaches

Draft recommendation 4.2[ii] recommends that the current National Mental Health and Suicide Prevention Agreement and its associated funding should be extended until June 2027. As noted in the Alliance's submission, BEING supports the establishment of an intergovernmental government advisory structure to advise on cross-cutting issues impacting people with mental health challenges. [iii]

However, given the role of state and territory governments play in delivering mental health services and supports in their jurisdiction, and the key role that the national and state and territory consumer peak bodies like BEING plays providing advice to government in the delivery of these services and supports, the governance arrangements for the next agreement needs to ensure a consumer voice inter-jurisdictionally.

Further, the role of the intergovernmental government advisory structure needs to be clearly defined and include but not be limited to responsibilities that the jurisdiction as responsibility for, such as procurement and commissioning, market stewardship, workforce development and planning, and budget allocations, and for the consumer voice to have a defined appropriate role in supporting the discharge of these responsibilities.

Recommendation 4 – That the governance arrangements for the next agreement embed a consumer voice in promoting interjurisdictional whole-of-government approaches.

Recommendation 5 – That the governance arrangements for the next agreement clearly define the roles and responsibilities for each jurisdiction, and that they also embed a defined appropriate role for the relevant consumer peak body/ies to support the discharging of responsibilities.

Adequate state and territory consumer peak body funding

BEING welcomes the recognition that national lived experience peak body representing mental health consumers should be adequately resourced to fulfill their governance roles in the governance arrangements for the next agreement. [iv]

However, we note that in NSW, the per capita spending for consumer peak body funding is only $0.10 per person as at June 2024, the lowest per capita spending in Australia.[v] We also note that not all jurisdictions have adequate levels of consumer peak body funding on a per capita basis, with the Northern Territory glaringly having no dedicated funding for a consumer peak body.

Therefore, for the national lived experience peak body to appropriately represent mental health consumers in their governance role in the next agreement, all state and territory governments need to adequately fund the consumer peak body to represent mental health consumers in their jurisdiction.

Recommendation 6 – That all state and territory governments adequately fund their state or territory mental health consumer peak body on an equitable per capita basis, and where a jurisdiction does not have a consumer peak body, for that jurisdiction to fund the creation of one.

Lastly, given the extension of the current agreement and the Productivity Commission's calls for the co-design of the next agreement, it will be imperative that transitional funding be provided to state and territory consumer peak bodies to meet the expected demands on the resources of state and territory consumer peak bodies to engage in meaningful co-design.

In NSW, as previously mentioned, BEING is the lowest funded state and territory consumer peak body on a per capita basis. While we wholly agree on the need for the next agreement to be co-designed, existing funding levels will limit our organisation's ability to engage in co-design meaningfully. To realise the co-design ambition for the next agreement, there will need to be supplementary funding provided.

Recommendation 7 – That all state and territory consumer peak bodies be adequately provided with transitional funding to realise the ambition to co-design the next agreement.

Role of consumers in commissioning and evaluating services

In draft recommendation 4.4 [vi] it is recommended that Australian, state and territory governments need to agree to responsibilities for psychosocial service provision outside of the National Disability Insurance Scheme (NDIS). Draft recommendation 4.12 [vii] recommends that funding should be provided to Primary Health Networks to commission mental health services across Australia. This increased funding should include improvements that will support greater efficiency.

With regards to the provision of non-NDIS psychosocial services, our experience in NSW is that currently state-based mental health service provision focuses primarily on crisis management. Both emergency departments and inpatient units focus on providing care for people who are experiencing highly disabling mental health challenges, such as

major depression, or psychosis. Those who are experiencing very high levels of mental health distress, but do not satisfy the severity requirements for entry will generally not be provided with treatment. BEING would like to see a mental health system that values prevention as much as crisis response.

Consumer peak bodies like BEING have a valuable role to play in developing, commissioning and evaluating services and supports that meet the needs of mental health consumers. Examples of lived experience inclusive service model is the network of Safe Havens [viii] and in South Australia Alternatives to Suicide (Alt2Su) groups have been funded. [ix]

Therefore, we believe that lived and living experience should be included not just in co-design, but also in the commissioning and evaluation processes that will be a key part of the implementation of the plan. We will address data more specifically in the next section of our submission.

Recommendation 8 – That the governance arrangements for the next agreement clearly defines a role for consumer peak bodies in the commissioning and evaluation of mental health services outside of the National Disability Insurance Scheme at the state and territory level, to ensure consumer needs are met.

2. Data

BEING believes that it is only through the collection of the right data and with high levels of data transparency that services and policies can be improved. The inclusion of consumers and peer workers in data collection, data analysis and applying the data for service innovation and improvements will ensure that the mental health service system functions well for consumers.

Equitable resources between states and territories

As we already noted above, the NSW mental health system is significantly underfunded compared to other states. The Australian Government has an underutilised role in ensuring the equitable distribution of financial resources across states and territories, relative to population size.

Data has a role to play in understanding the level of unmet need compared to funding levels. While the National Mental Health Service Planning Framework currently guides funding decisions, in NSW we have observed the use of relative benchmarking between the states and territories and Local Health Districts as a key issue with the framework.

Relative benchmarking paints an unclear picture of the quantum of unmet need and does not advance the identification of the scale of gaps or allow for a proper assessment of progress of actions toward a more integrated service system. Therefore,

calculating the quantum of unmet need to form a baseline is needed, to improve the value of relative benchmarking.

Once such a baseline of unmet need is developed for each jurisdiction, this calculation should inform funding decisions nationally, so each jurisdiction has equitable allocation of funding required to address the level of unmet need.

Recommendation 9 – That the next agreement recommends the calculation of the quantum of unmet need across all jurisdictions to inform baseline levels of unmet in each jurisdiction.

Recommendation 10 – That the next agreement empowers the Australian Government to allocate equitable funding to jurisdictions guided by the calculation of the baseline calculation of the quantum of unmet need, and for subsequent funding to be tied to jurisdictional progress in addressing the quantum of unmet need.

Inclusion of Lived Experience research

While we welcome the Productivity Commission's recognition of the value of co-design, we also encourage the Commission to think more broadly about the ways in which lived experience can also be included in research.

Like the role of the National Disability Research Partnership, and the role the partnership plays in developing and using Australia's National Disability Data Asset, there is a need for concerted effort to ensure research is inclusive and directed to build the evidence base for solutions that mental health consumers want.

Integral to this is the role of Lived Experience in data collection, data analysis and applying the data for service innovation and improvements. Further, like the National Disability Research Partnership, there is a role for the agreement to help build the pipeline of researchers with lived experience, to improve the quality of data.

There are several different areas where greater consumer involvement would improve both what data is collected, how data is collected, and how data is applied. This includes, but is not limited to:

- The ethics around what data is collected and how it is collected
- Utilisation of data in translational and applied research
- Standardising and improving the inclusivity of data collection methods
- Identifying action research opportunities to support service innovation, and
- Supporting research partnerships, including improving consumer trust in partnerships.

Recommendation 11 – That the next agreement defines the role of consumers in research by, for and with mental health consumers.

Recommendation 12 – That the next agreement identifies opportunities to develop the pipeline and sustainability of researchers with lived experience.

Data transparency and data improvement

BEING supports the development of a public dashboard to track and report on progress under the next agreement's objectives, outcomes and any other measurable targets set throughout the agreement.

We also support the Alliance's calls[x] for the dashboard to include data on the use of restrictive practices, including seclusion and restraint, at the provider level, noting the Disability Royal Commission made a clear recommendation to prohibit the use of seclusion and restraint in mental health settings. [xi]

To improve the value of the public dashboard, the data presented needs to be accessible to mental health consumers. In NSW, data collection can be only relevant to the bureaucratic or medical management of the system in question, while at other times data is presented using unhelpful and blunt statistical measures that mask underlying issues.[xii]

Therefore, to the public dashboard is meaningful to mental health consumers, consumers should have a defined role in deciding what and how data is presented in the public dashboard, as well developing data improvement plans alongside data custodians.

Recommendation 13 – That the next agreement defines a clear role for consumers in what and how data is presented in the public dashboard, and in developing data improvement plans for the data used in the public dashboard.

Recommendation 14 – That the next agreement ensures the public dashboard is available in a variety of formats and languages to suit the wide range of mental health consumers accessing the dashboard.

3. Peer workers

Draft recommendation 4.14[xiii] recommends that all jurisdictions develop a consistent national scope of practice for the peer workforce. It is vitally important that peer workers can maintain the integrity of peer work while working within a predominantly clinical mental health service system.

BEING supports this recommendation and we recognise the lack of a clear scope of work for peer workers has been a significant problem within the NSW mental health care system.

BEING also fully supports draft recommendation 4.13[xiv] calling for the implementation of a National Mental Health Workforce Strategy.

Ensuring the sustainability of the peer workforce

However, we also believe that the next agreement needs to address the sustainability of the peer workforce, specifically by ensuring nationally consistent industrial arrangements for all peer workers and a nationally consistent approach to the accreditation and pipeline development of the peer workforce.

In NSW, peer workers in public health and Community Managed Organisations (CMO) are employed under different industrial awards, with the former primarily renumerated under the *Heath Professional and Medical Salaries (State) Award* (2023), and the latter under the *Social, Community, Home Care and Disability Services Industry Award* (SCHADS Award).

The current industrial arrangements promote renumeration inconsistency in the peer workforce, especially with CMO employers individually assessing renumeration against the grading criteria under the SCHADS Award. The well publicised recent NSW public psychiatrists industrial dispute around renumeration highlights the need for national consistency.

Recommendation 15 – That the next agreement and the proposed National Mental Health Workforce Strategy promotes a nationally consistent approach to industrial arrangements for peer workers, to ensure peer workers are renumerated consistently across Australia.

Further, peer worker accreditation is currently inconsistent, with different qualifications valued by different employers. Therefore, to ensure consistency in the development of a national scope of practice, the next agreement should consider the role of an accreditation framework that supports accreditation consistency in the workforce.

Lastly, developing a national scope of practice for the peer workforce can be further strengthened by nationally consistent approaches to developing the national peer workforce, so each jurisdiction has a ready peer workforce. An accreditation framework can also address how the peer workforce is developed nationally.

Recommendation 16 – That the next agreement consider the role of a national accreditation framework in promoting consistent accreditation in the peer workforce, and guides peer workforce development and planning, as part of the proposed National Mental Health Workforce Strategy.

4. Implementing of the next agreement

Additional policies to consider

Draft recommendation 4.3 [xv] recommends that the next agreement should have stronger links to the broader policy environment. In this regard the Interim Report notes:

- The National Health Reform agreement
- Key policies in non-health portfolios including education
- Jurisdictional mental health and suicide prevention documents and
- Mental Health and suicidality policies relating to Aboriginal and Torres Strait islander people in each jurisdiction.

We welcome the commitment to consider areas where policies and legislation in different jurisdictions come into conflict with each other. However, we believe that the relevant policy framework should be broader than the recommendation acknowledges, most relevantly the overarching policy framework for people with disability, *Australia's Disability Strategy 2021-31*.

Recommendation 17 – That the next agreement ensures *Australia's Disability Strategy 2021-31* is included as a key document for the development of the new agreement.

Reporting

Draft recommendations 4.10 and 4.12[xvi] respectively calls for the formalisation of the role of the National Mental Health Commission (NMHC) as the reporting entity and for Primary Health Networks (PHNs) to have sufficient flexibility to commission locally relevant service models to meet community needs.

BEING supports these recommendations but based on our experience in NSW, they can be strengthened by having the NMHC table reports to Parliament periodically, to improve the transparency and accountability of reports the NMHC produces.

Recommendation 18 – That the next agreement requires National Mental Health Commission reports to be tabled in the Australian Parliament, to improve the transparency and accountability of reports.

Further, given PHNs have individual and inconsistent approaches to how they engage mental health consumers in commissioning locally relevant service models that meet local needs, if PHNs are provided the flexibility to commission locally relevant service models then they should also report on how the PHN:

- Embeds mental health consumers in decision-making, and
- The effectiveness of commissioning activity to meet the needs of local mental health consumers.

This level of accountability from PHNs will better ensure consumer needs are met and promote consistency in how PHNs value and engage mental health consumers in service models designed to meet their needs.

Recommendation 19 – That the next agreement requires Primary Health Networks to publicly report how they embed mental health consumers in decision-making, and how effective commissioning activity meets the needs of local consumers.

5. Barriers to consumer participation

One of the primary barriers to greater consumer participation is having sufficient funds to pay consumers to participate. It is now a common practice to pay consumers for both their lived expertise and the time they commit to participating in activities such as co-design and committee attendance.

Separating consumer participation and state peak funding

Draft recommendation 4.2 [xvii] addresses what will be needed to build the foundations for a new successful agreement. They recommend that:

- The National Mental Health Commission should facilitate co-design processes to identify relevant and measurable mental health and suicide prevention objectives and outcomes
- With the support of the National Mental Health Commission the Department of Prime Minister and Cabinet should engage with the state and territory governments to establish shared priorities
- Commitments made to improve collaboration should be included in the main body of the agreement and not in a separate schedule.
- The Australian Institute of Health and Welfare (AIHW) should lead the development of a nationally consistent set of outcome measures.

BEING welcomes the recommendation but believes that funding for these activities should include dedicated funding for consumer participation in these processes, that is separate to funding provided national, state and territory consumer peak bodies.

We note that the National Mental Health Commission already has a participation policy, [xviii]which could provide guidance in this matter. Although it would be appropriate to undertake a review of this policy in collaboration with the national, state and territory consumer peak bodies, as a precursor to co-design activities.

Recommendation 20 – That the next agreement provides protected funding for consumer participation separate to the funding provided to national, state and territory consumer peak bodies.

[i] Australian Government Productivity Commission, 'Mental Health and Suicide Prevention Agreement Review Interim Report', Available at: https://www.pc.gov.au/inquiries/current/mental-health-review/interim/mental-health-review-interim.pdf (Accessed on 1 August 2025). See Draft Recommendation 4.7 and 4.8. See also section 1.1 of NMHCA submission to the inquiry.
[ii] Australian Government Productivity Commission, 'Mental Health and Suicide Prevention Agreement Review Interim Report', Available at: https://www.pc.gov.au/inquiries/current/mental-health-review/interim/mental-health-review-interim.pdf (Accessed on 1 August 2025). Recommendation 4.2 Pg. 21. See also section 1.2 of the NMHCA submission
[iii] See section 1.2 of the NMHCA submission.
[iv] Australian Government Productivity Commission, 'Mental Health and Suicide Prevention Agreement Review Interim Report', Available at: https://www.pc.gov.au/inquiries/current/mental-health-review/interim/mental-health-review-interim.pdf (Accessed on 1 August 2025). See Draft Recommendation 4.7.
[v] Please see Table 2, p. 12. BEING – Mental Health Consumers, 'Pre-Budget Submission', available upon request.
[vi] Australian Government Productivity Commission, 'Mental Health and Suicide Prevention Agreement Review Interim Report', Available at: https://www.pc.gov.au/inquiries/current/mental-health-review/interim/mental-health-review-interim.pdf (Accessed on 1 August 2025). Recommendation 4.4, Pg. 143. See also section 1.5 NMHCA submission
[vii] Ibid See recommendation 4.12 Pg. 158 and also section 1.5 of the NMHCA Submission
[viii] NSW Ministry of Health, 'Safe Haven', Available at: https://www.health.nsw.gov.au/towardszerosuicides/Pages/safe-haven.aspx (Accessed on 1 August 2025)
[ix] Lived Experience Leadership and Advocacy Network (LELAN), 'Alt2su', Available at: https://www.lelan.org.au/alt2su/ (Accessed on 1 August 2025)
[x] See section 3.3 of the NMHCA's submission.
[xi] See Recommendation 6.36 in the Disability Royal Commission's Final Report.
[xii] For example, in NSW, an inaccessible healthcare performance measure is the use of the blunt per thousand bed days measure, which masks underlying issues driving the measure. Likewise, obfuscating measures of things like episodes of seclusion and restraint on grounds that they risk ddisclosing too much individual data.
[xiii] Australian Government Productivity Commission, 'Mental Health and Suicide Prevention Agreement Review Interim Report', Available at: https://www.pc.gov.au/inquiries/current/mental-health-review/interim/mental-health-review-interim.pdf (Accessed on 1 August 2025). Draft recommendation 4.14 Pg. 26. See also section 1.8 of the NMHCA submission.
[xiv] Australian Government Productivity Commission, 'Mental Health and Suicide Prevention Agreement Review Interim Report', Available at: https://www.pc.gov.au/inquiries/current/mental-health-review/interim/mental-health-review-interim.pdf (Accessed on 1 August 2025). Draft recommendation 4.13, pg. 26.
[xv] Australian Government Productivity Commission, 'Mental Health and Suicide Prevention Agreement Review Interim Report', Available at: https://www.pc.gov.au/inquiries/current/mental-health-review/interim/mental-health-review-interim.pdf (Accessed on 1 August 2025). Recommendation 4.3 .Pg. 141. See also section 3.3 of the NMHCA submission.
[xvi] Australian Government Productivity Commission, 'Mental Health and Suicide Prevention Agreement Review Interim Report', Available at: https://www.pc.gov.au/inquiries/current/mental-health-review/interim/mental-health-review-interim.pdf (Accessed on 1 August 2025), pp. 25-26.
[xvii] See draft recommendation 4.2, p.21. See also Section 3.2 of the NMHCA submission.
[xviii] National Mental Health Commission, 'Paid Participation Policy', Available at: https://www.mentalhealthcommission.gov.au/sites/default/files/2024-03/paid-participation-policy-2020.pdf (Accessed on 1 August 2025).

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