Productivity Commission Review of the National Mental Health and Suicide Prevention Agreement – Interim Report

30 July 2025

MHLEPQ
MENTAL HEALTH LIVED EXPERIENCE PEAK QUEENSLAND

Contents

Acknowledgement of Country

The Mental Health Lived Experience Peak Queensland (**MHLEPQ**) respectfully acknowledges and honours the Traditional Custodians of the Lands and Waters throughout Queensland. We thank the Elders—past, present, and emerging—for their wisdom and enduring strength.

We recognise that the legacy of colonisation has profoundly impacted First Nations peoples, contributing to unique and significant experiences of trauma within the mental health system. Colonisation has enforced systems of racism, stigma, and discrimination, leading to intergenerational social disadvantage and marginalisation. These historical and ongoing injustices have compounded the challenges faced by First Nations (Aboriginal and/or Torres Strait Islander) peoples, affecting their social and emotional wellbeing.

We acknowledge the enduring resilience and resistance of First Nations peoples in the face of these adversities. We respect their rights and autonomy to lead their own healing journeys, guided by their beliefs and traditional practices and connectedness to Country, family, and spirit. In honouring their wisdom and experiences, we commit to supporting their self-determination and promoting equitable and culturally responsive approaches to mental health care.

Who are the MHLEPQ?

The MHLEPQ is an initiative funded by the Mental Health, Alcohol and Other Drugs Branch, Department of Health. Our organisation was created in July 2021 and moved to direct contracting with Queensland Health on January 1st, 2023 (formerly auspiced by the Queensland Mental Health Commission).

The MHLEPQ was established to provide advice and advocacy informed by people with lived experience of the Queensland mental health system with a specific focus on those who are socially disadvantaged and marginalised. Our work is based on the principles of equity, access, cultural safety, recovery, and human rights.

MHLEPQ is a member of the National Mental Health Consumer Alliance (**NMHCA**) where other state and territory consumer peak bodies meet to coordinate on shared issues, including issues relating to Commonwealth policy and government-funded services.

Our response to the Interim Report

MHLEPQ supports the work and advocacy of the NMHCA, including their submission to the Productivity Commission regarding their Review of the National Mental Health and Suicide Prevention Agreement – Interim Report (**Interim Report**).

MHLEPQ is supportive of the intent and substance of the Interim Report. However, MHLEPQ does advocate that some recommendations could go further in relation to State and Territory roles. For example, the Productivity Commission (**PC**) identifies the need for making recommendations involving co-design, commissioning and accountability. Likewise, it also provides recommendations for the formalisation of the National Mental Health Commission and Consumer and Carer peak bodies.

This can only be achieved through making provision in the recommendations and the National Mental Health and Suicide Prevention Agreement (**Agreement**), for the peak consumer and carer bodies at the State and Territory level with the bi-lateral agreements and formalising and including these peaks in the governance at the state/territory level. This requires investment and commitment in co-design and regional planning and commissioning of services.

"It was great that the PC Commissioners made the effort to meet with us members of MHLEPQ to discuss this inquiry. They helped us understand the purpose of the inquiry and we all felt heard. It was

also great that they wanted to dig a bit deeper into some of the issues we raised." *MHLEPQ member and focus group participant.*

"These issues and recommendations from us are not new and have been raised in many 'consultations' and are included in many existing submissions we as members have been involved with such as the Review of the PHNs." *MHLEPQ member and focus group participant.*

Examples of existing MHLEPQ submissions and papers include:

- MHLEQP Response to the Strengthening the National Mental Health Commission and National Suicide Prevention Office Discussion Paper
- MHLEPQ Response to the Advice on the National Suicide Prevention Strategy (Draft Consultation)
- Implementing Human Rights in the Mental Health System: An MHLEPQ Position Paper
- Submission to the Review of PHNs Business Models and Flexible Funding Model

MHLEPQ would encourage the PC to review the Consumer and Carer peaks range of detailed submissions to this review.

What MHLEPQ Endorses in the Interim Report

MHLEPQ endorses the following in the Interim Report:

- ✓ The focus is on lived experience participation and engagement generally and recommendations to strengthen lived experience involvement in the future governance of the National Partnership Agreements and bi-lateral agreements.
  - MHLEPQ believes that this reflects genuine, authentic lived experience engagement.
- ✓ The conclusion that the Agreement is not fit-for-purpose.
  - MHLEPQ believes it fails to meet expectations due to limited funding resulting in some key commitments going without, outputs not changing the mental health landscape, lack of detail as to how lived experience practice is to be weaved into the Agreement etc.
- ✓ Recommendations to extend the current Agreement for an additional year.
  - MHLEPQ believes this will result in a stronger final Agreement.
- ✓ Developing a separate First Nations schedule within the Agreement.

  - MHLEPQ believes that the needs, customs and beliefs of First Nations Peoples are unique and require this schedule.
- ✓ Strengthening accountability mechanisms and supporting greater consistency across jurisdictions.
  - MHLEPQ believes that current differing processes may impact negatively. Consistency can lead to greater clarity for services and people with a lived experience.
- ✓ The need for a National Mental Health Strategy.
  - MHLEPQ believes this is a positive step towards better and more consistent outcomes for people with a lived experience, now and in the future.
- ✓ The need to immediately address the unmet needs of people with psychosocial disability.
  - MHLEPQ believes it is necessary for the Australian, State and Territory Governments to come together to account for the unmet needs of some of the most vulnerable members of society.
- ✓ Recognition of the role of the lived experience peaks in governance arrangements.
  - MHLEPQ believes that it is vital to have peak participation so as to provide effective governance structures and outcomes.
- ✓ The focus on co-design.
  - MHLEPQ believes that co-design involving people with a lived experience is necessary to effectively represent issues faced and provide viable solutions and/or mechanisms for addressing such needs.
- ✓ The recommendation of foundational supports.
  - MHLEPQ believes that it is understood, that supports necessary to lead a full life should be included.
- ✓ National stigma reduction strategy recommendations.
  - MHLEPQ believes that living without stigma is something people with a living experience of mental health challenges should be afforded and supports these recommendations.
- ✓ The focus on the issues in the current Agreement's limitations re structure and form (section 3.1).
  - MHLEPQ believes that the Agreement falls down as it does not adequately provide a roadmap of how to get to outcomes, funding is not necessarily allocated, it is unclear how some commitments will meet objectives etc.

Room for further development

The MHLEPQ encourages further attention be paid to:

- Establishment of a human rights compliance framework that underpins the Agreement to ensure the implementation of the Agreement supports, upholds and respects the rights of people with a lived/living experience of mental health challenges.
- Better lived experience partnerships at the regional implementation level of the agreement, including co-commissioning, service design and delivery, evaluation and governance at the Primary Health Network and Hospital and Health Service level. We encourage the PC to review submissions made by Consumer and Carer Peaks to the Review of PHNs Business Models and Flexible Funding.
- Better partnerships with state and territory lived experience Peak bodies in the jurisdictional oversight of the Agreement.
- Expand on the drivers affecting people's experience of the health system.
- Making provision for all mental health commissions in Australia along with Consumer and Carer peaks formalised into the governance of the Agreement.
- The acknowledgement and discussion of harm from services.
- The discussion of the purpose of the system.

Drivers of issues

In the 'Main Themes Identified in Consumer Responses to Survey' (page 39), the Interim Report, the main themes of consumers responses are, wait times, gaps and shortages of services, inadequate crisis support and discrimination from services. The Interim Report needs to include what is driving those very issues.

The substantial drivers of distress are social determinants such as homelessness, loneliness, health, income, employment etc. Such drivers need to be reflected. Moreover, the intersectional experiences of disadvantage and/or oppression mean that people face compounding barriers to good mental health and accessing safe, supportive, and voluntary services.

A lack of investment in community-based and lived experience-led prevention and early intervention supports means that there is a reliance on clinical and coercive crisis-based services. MHLEPQ believes that the social determinants of health, the intersectionality of vulnerable groups, lack of investment at prevention/early intervention stages are all drivers of issues faced by people who experience mental health challenges.

We assert that the development of the Agreement needs to clearly identify the sources of these problems: power,[1] biomedical dominance,[2] discriminatory laws,[3] and policies.

Clearly stating the problems and drivers of those problems is crucial to addressing them. Moreover, implementation of the plan will be significantly impaired again if the drivers and problems are ignored as they will likely be the primary barrier to the plan being implemented. The proposed new policy architecture, consequently, needs to include provision to address these drivers.

National, State and Territory Mental Health Commissions

The question of the role of the National Mental Health Commission (**NMHC**) in Australia as outlined in the Interim Report, produces a curious scenario. It acknowledges the need for the independence of the NMHC over the implementation of the Objectives, which MHLEPQ strongly endorses. Yet it falls short of spelling out how this level of independence is to be achieved thereby creating a gap in oversight.

MHLEPQ directs the Productivity Commission to the Commonwealth Government's current proposal (2024 Discussion Paper regarding the National Mental Health Commission)[4] which reflects a failure to create the much-needed independence. This proposal put forward by the Commonwealth Government in September 2024, still falls short of an independent statutory body. There are no powers to compel information and conduct evaluations, nor is there the ability to commence an own-motion inquiry into matters of mental health. These powers are necessary to drive systemic reform.[5]

It should be noted that although MHLEPQ endorses an independent NMHC, oversight needs to be carried out in collaboration with State and Territory Commissions. Oversight by the NMHC alone, is too great for one Commission to carry out in a federal system made up of States and Territories with their own sometimes, incompatible

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[1] https://mhlepq.org.au/wp-content/uploads/2024/11/HR-Implementation-position-paper_-FINAL.pdf Mandeville, B. (2024). Defining Dignity and its Application to Australian Mental Health Legislation. *Griffith Journal of Law & Human Dignity*, *12*(1), 66-87.

[2] World Health Organization. *Mental Health, Human Rights and Legislation: Guidance and Practice*. 2023, https://www.who.int/publications/i/item/9789240080737.

[3] https://mhlepq.org.au/wp-content/uploads/2024/11/HR-Implementation-position-paper_-FINAL.pdf Mandeville, B. (2024). Defining Dignity and its Application to Australian Mental Health Legislation. *Griffith Journal of Law & Human Dignity*, *12*(1), 66-87.

[4] https://consultations.health.gov.au/primary-care-mental-health-division/nmhc-nspo-reforms/user_uploads/discussion-paper---strengthening-the-nmhc-and-nspo-8.pdf

[5] https://consultations.health.gov.au/primary-care-mental-health-division/nmhc-nspo-reforms/user_uploads/discussion-paper-strengthening-the-nmhc-and-nspo-.pdf

Commissions/accountability and regulatory mechanisms. For example, there are the following differences amongst mental health commissions:

- Advisory functions – many mental health commissions have a primary advisory function and exist within departmental structures (e.g. the Office of Mental Health and Wellbeing (ACT), Queensland Mental Health Commission (Qld))
- Commissioning functions – the Western Australian Mental Health Commission has the function to purchase mental health services alongside broader advisory functions
- System monitoring – some mental health commissions have the function to monitor the performance of the mental health system and of the broader mental wellbeing of people in their state (e.g. NSW Mental Health Commission (NSW) and the Mental Health and Wellbeing Commission (Vic)), including the ability to open own-motion inquiries into important matters (Mental Health and Wellbeing Commission (Vic))
- Enforcement – the Victorian Mental Health and Wellbeing Commission is the only commission in the country with the power to protect the rights of individuals accessing the mental health system.

Each of these structures carry differing purposes and differing levels of independence. Without independence at both Commonwealth and State and Territory, the system will be a weak version of what could have been.

It is understood that formalising national Consumer and Carer Peaks in Governance is also required. Frameworks and resources already exist such as the Lived Experience Governance Framework and Toolkit. MHLEPQ has been working with the QLD Commission using this particular framework and toolkit and have committed to its implementation over a two-year period.

Human rights framework

The Interim Report does not discuss the coercive elements of the mental health system, nor does it address human rights as applicable to the mental health system. Human rights are mentioned once, in the body of the Interim Report.

Absent from the Interim Report is acknowledgement of the impact that issues faced such as discrimination, inequity, and stigma, has on a person's life. As a result of not applying a human rights framework across this system, it will likely lead to a continued reliance on coercion in the system through funding similar clinical/tertiary approaches.

A failure to draw out how such issues are understood legally and as systemic human rights issues, is viewed by MHLEPQ, as a shortcoming of the Interim Report.[6] As a bare minimum under Australia's obligations under the Convention on the Rights of Persons with Disabilities (CRPD) and the morally significance of the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP), human rights must be a framework applied across the recommendations made and the ultimate Agreement. In support of such a human rights focussed framework, it is recommended that it be aided by the development and implementation of a National Human Rights Act as well.

Discussing harm in services

In its present form, the Interim Agreement does not provide any deep engagement with iatrogenic (a state of ill health or adverse effect caused by medical/clinical treatment) harm from services. Two in depth reports on such harm have been produced by MHLEPQ *(Shining a Light: Eliminating Coercive Practices in Queensland Mental Health Services)*[7] and Victorian consumers and carers *(Not before Time: Lived Experience-Led Justice and Repair (Advice to the Victorian Mental Health Minister)*[8] and are relevant to this issue.

According to MHLEPQ in our report, coercive practices are "*systemic failures of care that cause harm to people subjected to them, people applying them, and people witnessing them*."

Likewise, in *Not Before Time*, it is acknowledged that, "*trauma is a feature of many people's distress. Unfortunately, trauma is also a feature of the mental health system. Many consumers and survivors have not had their trauma recognised within the system or have been traumatised by the system*."

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[6] Standing on the Shoulder of Giants: Report on Advocacy and Activism Training for Members in Queensland, https://mhlepq.org.au/wp-content/uploads/2025/02/Standing-on-the-Shoulders-of-Giants-Final-Report-Jan-2025.pdf; Human Rights and Mental Health Survey,https://mhlepq.org.au/wp-content/uploads/2024/09/MHLEPQ-HR-Survey-Report_FINAL.pbp_.pdf; MHLEPQ Submission First Review of the Queensland Human Rights Act 2019, https://mhlepq.org.au/wp-content/uploads/2024/07/MHLEPQ-Submission-to-the-Qld-Human-Rights-Act-Review-FINAL.pdf; Shining a Light: Eliminating Coercive Practices in Queensland Mental Health Services, https://mhlepq.org.au/wp-content/uploads/2023/12/MHLEPQ-CP-report_Shining-a-light-FINAL.pdf

[7] Mental Health Lived Experience Peak Queensland. *Shining a Light: Eliminating Coercive Practices in Queensland Mental Health Services*. 2023, https://mhlepq.org.au/wp-content/uploads/2023/12/MHLEPQ-CP-report_Shining-a-light-FINAL.pdf

[8] Katterl, Simon, et al. *Not before Time: Lived Experience-Led Justice and Repair (Advice to the Victorian Mental Health Minister)*. Jan. 2023, https://static1.squarespace.com/static/64509ef54c074f6f4dfb7138/t/648ed6db5216c12186d165f3/1687082792810/Not+Before+Time+-+State+Acknowledgement+of+Harm+2023+FINAL+ADVICE.pdf.

These views are held by many in the community yet iatrogenic harm from services is not adequately dealt with under the Interim Agreement.

Anchoring the purpose of the system

The Interim Agreement does not adequately engage in a discussion about the core concept at the heart of the system for which it seems to fix: what is the system's purpose? Should it be to "treat mental illness" or to "support a good life," as defined by the person? Instead, the Interim Report leaves the debate of a deficit vs strengths-based approach to another day. Arguably, this is too important a question to be ignored and underpins the very existence of the Agreement.

"Like other industries who value their 'customer base' while I hate being called a consumer, I do expect that the purpose of the system should be developed from 'what I need from the system, not what the system can 'do' to or for me." *MHLEPQ member and focus group participant.*

The NMHCA existing Project, 'Making Rights Real,' is a telltale account into creating a rights-based vision of what the purpose of the mental health system is. This Project could be used as a tool for discussion.

Specific questions raised in the report

Problematic alcohol and other drugs use and mental ill health and suicide

"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."

MHLEPQ encourages the PC to hear from Peak bodies and communities representing the specific needs of people who use alcohol and other drugs to inform the development of a specific AOD Schedule under the Agreement.

It should be noted that these priority areas along with the identified priority groups are not mutually exclusive. Any future planning therefore needs to dig deeper into the 'intersectionality' for vulnerable groups such as race, gender, class, sexual orientation that can lead to further marginalisation.

Measuring successful inclusion and engagement

"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 two key areas required to remove the barriers, and these include building the culture and commitment at the executive and governance level and intentional recruitment for LE involvement at all levels of the system (not just a tick box, got one person at the table etc … specialisations)

"Succession planning to not reinvent the wheel eg., psychosocial – PiR, threw the baby out with the bathwater'. Eg., PiR Coordinators … now investing $$$ in Peer Navigator studies." *MHLEPQ member and focus group participant.*

"There is now a big evidence base of LE led research, resources etc… that need to be promoted and used such as the Lived Experience Digital Library and the Lived Experience Leadership website." *MHLEPQ member and focus group participant.*

"The new policy architecture should include:

- *Evidence of implementation of plan for LE Governance (using framework)*
- *See submissions from NMHCA, MHCA and MHLEPQ to Review of PHN's*
- *KPI's for Government and evidence of 'co-design', LE in decision making roles.*
- *LE led monitoring, review and evaluation (this could be a role of National and State/territory peaks)."* *MHLEPQ member and focus group participant.*

Public dashboard to track and report on the progress under the next agreement's objectives and outcomes

"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?"

MHLEPQ views this as an encouraging and strong recommendation. Significantly, it provides an opportunity to develop lived experience-determined outcomes measures and human rights compliance monitoring. Currently the only publicly available measures of people's experience of service is limited to the Your Experience of Service (**YES**) survey.

The use of the YES survey has been criticised for gathering positive evidence in the face of negative experiences of individuals who are too unwell to articulate their views at the time of data collation. A clear and transparent process is therefore desirable.

Other considerations

Draft Recommendation 4.8

"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."

MHLEPQ views this Draft Recommendation as problematic.

Throughout the Interim Report it is highlighted the need for lived experience to participate in co-design and governance. NDIS and psychosocial supports by their very nature, are supposed to be driven by the needs of the individual not what the service or system is prepared to offer. Without people with a lived experience being at the forefront of the governance, we risk a similar finding to this Interim Report in another five years.

MHLEPQ is concerned about the probity of this Draft Recommendation as it:

- Dilutes the recommendation about strengthening lived experience involvement in the oversight and governance of the Agreement; and
- It is possible that Service providers who are involved in the governance of a major source of government funding could become problematic and

- The potential for real Conflict of Interest and equity issues between small and multi-national service providers.

MHLEPQ also questions whether there needs to be further sector opportunities for feedback and lobbying of government as there is already a plethora of avenues available. If anything, strengthening and resourcing Consumer & Carer peaks including the proposed lived experience workforce professional association is necessary.

"Conflict of Interest. We see this happening all the time at 'co-design' sessions where a handful of PLE are invited to participate in Regional Planning along with 90% of participants representing services who are in receipt of funding, all the services say they need more of the same where PLE are advocating for innovation and new ways of working." *MHLEPQ member and focus group participant*.

For example, review of Community Service Training Package, majority of participants are Registered Training Organisations who are by their very nature part of the problem of poor-quality workforce training and development.

Draft Recommendation 4.14

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

There has been a significant body of work carried out in the lived experience workforce space by peer leaders such as Dr. Louise Byrne, RMIT. Governments should be mindful about re-creating or commissioning work that has already been done and should instead, build upon that existing work.

MHLEPQ views this as a strong recommendation and consequently recommends that the National Mental Health and Suicide Prevention Peer Workforce Association is instrumental in leading this work. Moreover, MHLEPQ acknowledges a need to uplift the recommendations for First Nations Peoples.

Conclusion

Overall, the Interim Report provides ways to increase lived/living experience involvement. For example, it expressly stipulates such involvement throughout the process and provides for a delayed negotiated Agreement to better represent the needs of those who are the subject of it – those with a lived/living experience of mental health challenges.

Moreover, it provides comments about the need for processes to reach outcomes, which is something that has been missing. Broad statements as to what is to be achieved without the mechanisms to get there have been a major impediment to its success.

It should be noted, however, that the Interim Report does not discuss the coercive elements and mental health rights associated with the current mental health system. Those with a lived/living experience are, therefore, still vulnerable to further infringements and degradation of their individual rights. This, MHLEPQ would like to see changed.

MHLEPQ will continue to advocate for a fairer, more inclusive process and looks forward to further participating in the PC review of the Interim Agreement.

Contributions to this Submission

MHLEPQ wants to thank the PC for meeting with the MHLEPQ members focus group as part of their public consultation and acknowledges that the issues and recommendations made, reflect the discussion engaged in.

This document has been produced by MHLEPQ in consultation with one of the focus group members.

Communication

Future communication about this submission or associated matters can be made with:

Danie Williams-Brennan
Policy Director

P. 1800 271 044 (available 9am – 12 pm weekdays)

MHLEPQ: Human rights statement

Mental health is vital to human experience and is related to a person's ability to participate in society and live according to their sociocultural and political values. MHLEPQ advocates that the right to mental health is a fundamental human right and it is a whole-of-society obligation to promote, protect, and uphold that right. People have the right to their autonomy, to be treated with dignity, be protected from torture and cruel, inhuman, or degrading treatment, and live free from discrimination and stigma according to their own cultural determination.

Human rights in mental health are both a constitutional and working principle of MHLEPQ and are one of the main objectives of its advocacy work. MHLEPQ's membership guides it to prioritise the human right to mental health for all Queenslanders, including understanding the legal protections and policies across the sector.

We believe that the human right to mental health includes support with the social determinants of wellbeing such as adequate housing, a clean, healthy and sustainable environment, and health services that are affordable, effective, and culturally appropriate. We will advocate with and for Queenslanders to ensure the proper consideration and compliance with human rights regulations, ensuring that individuals with mental ill-health, distress and suicidality are not excluded or marginalised.