SUBMISSION

Response to Productivity Commission Interim Report: Review Mental Health and Suicide Prevention Agreement

31 July 2025

NATIONAL MENTAL HEALTH CONSUMER ALLIANCE

The National Mental Health Consumer Alliance (the Alliance) has prepared this submission in response to the invitation to provide input into the Productivity Commission's Final Review into the National Mental Health and Suicide Prevention Agreement. This submission is based on input from State and Territory mental health consumer peak bodies.

All references to 'Consumer' and 'lived experience' in this submission refer to mental health consumers with lived experience of mental health challenges and/or suicidality. We use the term "mental health consumers" as a catchall term due to its connection with our movement's history, but we acknowledge that different people self-identify with different terms. We do not include family, carers, kin or the bereaved in our definition of lived experience as it appears in this report.

The Alliance

The Alliance is the national peak body representing mental health consumers. We work together to represent the voice of all mental health consumers on national issues. We are the people experiencing mental health issues/distress; at the table advocating with government and policy makers; and working with a robust network of grassroots communities.

More information is available on the Alliance's website: nmhca.org.au.

Acknowledgement of Country

We acknowledge Aboriginal and Torres Strait Islander Peoples as the traditional custodians of the land on which we work and pay our respects to Elders past and present. Sovereignty was never ceded.




Members of the Alliance have all endorsed this submission.

The Alliance recommends the Commissioners read the submissions that have been submitted by these organisations for more specific State/Territory content.

Contents

Executive Summary

The Productivity Commission *Mental Health and Suicide Prevention Agreement Review - Interim Report* [1] (Interim Report) sees Australian mental health policy and funding at a crossroads. Among other things, the Productivity Commission has recommended the Australian Government take this moment in time to be the world leader in ensuring people with lived experience of mental health challenges are included in every step of the design, implementation, governance and evaluation of the next Mental Health and Suicide Prevention Agreements (Agreement) at the national and state/territory level.

The National Mental Health Consumer Alliance (Alliance) commends Commissioners for recognising what mental health consumers have been saying for some time: the National Mental Health and Suicide Prevention Agreement (Agreement) has delivered little systemic change, has not progressed system reform and is not effective.

We commend the Commissioners for identifying the necessity of including the voices of people with lived experience of mental health challenges in all parts of the next Agreement from early inception, negotiation and governance to ensure the next Agreement works for the people who use the mental health services the Agreement talks about and funds.

We commend the Commissioners for highlighting what we, the people who use the mental health services and supports funded and designed by the system have been saying: the current Agreement has not included us, and consequently has let us down.

The Alliance acknowledges that the Royal Commission into Victoria's Mental Health System identified many of the same systemic issues that have been raised by the Productivity Commissioners in the Interim Report: that the mental health system is a crisis-driven, fragmented, and overly medicalised system which persistently excludes people with lived experience of mental health challenges from meaningful participation in service design and delivery.

While the Royal Commission in Victoria laid out a comprehensive roadmap for transformation, its implementation has unfortunately faltered. This serves as a sobering reminder that disrupting entrenched models of mental health service provision and funding is inherently complex and requires sustained commitment.

As the Commissioners' draft Recommendations are considered, it is imperative that all levels of government work collaboratively alongside people with lived experience of mental health challenges to ensure the necessary resources are allocated to support genuine reform.

This includes:

- embedding the lived experience of people with mental health challenges at the centre of decision-making by investing in, and working with, the national, state and territory mental health peak bodies
- upholding principles of genuine co-design with people with lived experience of mental health challenges from the outset
- reinstating the National Mental Health Commission (NMHC) as an independent commission that can make fierce and fearless comment on the development and delivery of mental health supports/services
- embedding lived experience leadership in the NMHC and a Chief Consumer Officer in the Department of Health, Disability and Ageing
- developing mental health consumer centric outcomes, including collecting, analysing and reporting data that is important and accessible to, interpreted and applied by people with lived experience of mental health challenges
- the development, with people with a lived experience of mental health challenges, of a public, transparent national benchmarking system that compares jurisdictions management and delivery of funding and including consumer specific outcomes data such as seclusion and restraint numbers. To increase accountability, the benchmarking reports should be tabled in Federal Parliament.
- investing in the peer workforce and embracing a rights-based approach to mental health, moving away from clinical support models.

Only through coordinated, inclusive, and well-resourced action can we achieve a mental health system that is equitable, responsive, and recovery-oriented.

Summary of Recommendations

1. Embedding Lived Experience Leadership

- Embed meaningful engagement of people with lived experience in all levels of the next Agreement.
- Prioritise the voices of the Alliance and Indigenous Australian Lived Experience Centre (IALEC) without diluting consumer self-determination.
- Embed the Alliance in national governance structures with secure, protected, and indexed funding.
- Replicate Alliance's role at state and territory levels with equal support for jurisdictional peaks and IALEC.
- Ensure fair remuneration for lived experience participation in co-design.
- Guard against medical model dominance and reinforce support for peer-led, trauma-informed, culturally safe approaches.

2. Negotiation and Co-Design

- Support a 12-month delay in negotiations to scale peak capacity, reform the National Mental Health Commission (NMHC), and embed co-design—while continuing urgent psychosocial work.
- Ensure the next Agreement is negotiated by Prime Minister and Cabinet with all relevant Ministers.
- Include a co-chaired lived experience-government advisory structure on cross-cutting issues.
- Implement true co-design from the outset of the next Agreement and across related strategies and data development.

3. Psychosocial Supports Outside the NDIS

- Immediately fund and deliver psychosocial supports outside the National Disability Insurance Scheme (NDIS) without delay.
- Remove commissioning responsibilities from Primary Health Networks (PHNs) and create a lived experience-governed body.
- Establish long-term funding commitments to address unmet need by 2030.

4. Transparent Reporting and Data

- Tie Agreement funding to performance and reportable progress benchmarks.
- Develop a public, consumer-designed report card with lived experience-defined outcomes.

- Track and publish seclusion, restraint, and coercive practices by jurisdiction, provider, and psychiatrist.
- Incorporate indicators related to housing, income, employment, and discrimination.

5. Reforming the NMHC

- Reinstate the NMHC as an independent statutory body.
- Appoint lived experience Commissioners, who hold power, to the NMHC.
- Clarify Alliance's roles and responsibilities in relation to other statutory bodies.
- Include the NMHC in formal reporting processes like Mental Health and Suicide Prevention Senior Officials (MHSPO) meetings to hold governments to account.

6. Peer Workforce

- Develop a national scope of practice for peer workers.
- Fund and commission peer-run organisations directly.
- Shift emphasis from acute psychiatric care to community-led, rights-based alternatives.

7. Social Determinants

- Explicitly link the next Agreement to frameworks including the Disability Strategy, Closing the Gap, National Housing and Homelessness Plan, and the National Plan to End Violence Against Women.
- Track and report on social and economic indicators such as housing, income security, and employment.

8. Public Release of Strategy Documents

- Immediately release the Stigma and Discrimination Reduction Strategy and the National Guidelines on Regional Planning and Commissioning.

9. Aboriginal and Torres Strait Islander Schedule

- Include a dedicated Schedule for Aboriginal and Torres Strait Islander peoples, led by IALEC.
- Work with IALEC, the lived experience peak body for Aboriginal and Torres Strait Islander peoples, ensure the next Agreement meets the needs of Aboriginal and Torres Strait Islander peoples
- Ensure equitable distribution of resources and Indigenous-led co-design.

10. Suicide Prevention

- Replace current suicide prevention frameworks with harm reduction models grounded in dignity, human rights, and peer leadership.
- Remove coercive practices such as involuntary hospitalisation from suicide prevention policy.
- Link the Suicide Prevention Schedule to the National Suicide Prevention Strategy without reinforcing restrictive practices.

11. Responding to Suicidality

- Expand peer-led supports such as HOPE, Alt2Su and Distress Brief Support Services.
- Provide post-crisis care focused on compassion and human connection, not risk containment.

12. Non-Clinical Crisis Alternatives

- Secure long-term funding for peer-led, community-based services like Safe Haven Cafés, Safe Spaces and Alt2Su programs.
- Protect grassroots alternatives from clinical governance overreach and fund successful pilots sustainably.

13. Chief Consumer Officer

- Establish a Chief Consumer Officer in the Department of Health, Disability and Ageing to ensure lived experience leadership is on equal footing with clinical, allied health and economic voices.

14. Language

- Adopt the Alliance's Preferred Language Guide in all government documents.
- Avoid deficit-based, clinical, or pathologising language.

15. AOD and Mental Health Intersection

- If a separate schedule is developed, co-design it with AIVL and DUOs.
- Avoid stigmatising or deficit language like 'problematic alcohol use'.
- Support collaboration across mental health and AOD sectors with dedicated funding.

16. Lived Experience Governance

- Adopt and apply the LELAN-developed Lived Experience Governance Framework.
- Centre human rights, identity, and values across all governance systems.

17. Dashboard Monitoring

- Create a consumer-relevant, non-clinical language public dashboard developed with NMHC and the Alliance.
- Include lived experience-defined metrics, disaggregated restrictive practice data, and jurisdictional progress.

1. Response to Draft Recommendations

1.1 Centre Lived Experience Leadership (Draft Recommendation 4.7, 4.8)

The Alliance strongly supports the Interim Report's recognition of the lack of meaningful lived experience involvement in the current Agreement and we strongly support the Commissioners' recommendation for the inclusion of meaningful engagement with people with lived experience of mental health challenges in all levels of the creation, development, implementation and governance of the next Agreement. Not only does this recognise that the current Agreement does not involve people with lived experience of mental health challenges, it puts a stamp on the importance and value of including the voices of the people who use services.

The Alliance's voice, along with the voices of First Nations people with lived experience, must be prioritised. While we agree that a range of perspectives are valuable, this must not override or dilute consumer self-determination.

We endorse the recommendation to embed the Alliance in governance arrangements for the next Agreement. To ensure this is possible, the Alliance must be funded appropriately and have that funding protected, and indexed, beyond year-to-year budget decisions to carry out this important work. This would put the Alliance in a position of being able to provide frank and fearless governance advice.

Additionally, to ensure people with mental health challenges' involvement in the commissioning and negotiation process, the centrality, role and influence of the Alliance must be replicated at the State/Territory level through the jurisdictional peaks. The jurisdictional peaks, along with Indigenous Australian Lived Experience Centre (IALEC), must be funded appropriately, with the same protections outlined above for the Alliance. Where these bodies barely exist, such as in the Northern Territory, they must be developed and funded in line with the other jurisdictions. Payments for people living with mental health challenges to participate in the co-design work must be paid appropriately and this funding needs to be separated, or factored into, the funding received by the peaks.

The Alliance has concerns that service providers will advocate for measures in the next Agreement that will reinforce medical models and perpetuate institutional practices to the detriment of those with lived experience of mental health challenges. This could result in a bias towards clinical services away from consumer-led, trauma-informed, culturally safe, and recovery-oriented services. In addition, provider-led systems can result in stifling innovation or reform if it challenges entrenched clinical hierarchies.

1.2 Negotiations carried out by Prime Minister and Cabinet and Lived Experience (Draft Recommendation 4.2)

The Alliance supports the negotiation and development process, led by people with lived experience of mental health challenges, to be managed by Prime Minister and Cabinet, providing guaranteed involvement of all relevant Australian Government Ministers. We call for this recommendation to also include the establishment of an interdepartmental government advisory structure, with a mental health consumer co-Chair inclusive of government and people with lived experience of mental health challenges to advise on cross-cutting issues impacting people with mental health challenges in Australia. It could do this through ensuring whole-of-government approaches, commissioning and market stewardship, proposing and evaluating budget measures.

Having lived experience involvement in the development and negotiation of the Agreement will ensure consumer perspectives inform policies across all sectors by being front and centre of discussions and negotiations. In addition, by ensuring cross-portfolio discussions during development and negotiation of the agreements, the social and economic determinants of mental health can be addressed.

1.3 Co-design (Draft Recommendation 4.7)

The Commissioners support the inclusion of 'co-design' of the next Agreement and in other areas of the Interim report. To ensure people with lived experience of mental health challenges are truly included, 'true' co-design must be implemented in determining the Agreement, the new Mental Health Strategy, the development of nationally consistent outcome measures and NMHC work to ensure decision-making power is led by mental health consumers. It is more than simply being consulted or invited to participate after key decisions have been made. Tokenism must be avoided.

1.4 Delay the negotiation of the next Agreement (Draft Recommendation 4.1, 4.2)

The Alliance supports the 12 months delay in negotiation of the new Agreement to ensure that all the recommendations in the Interim Report can be put in place prior to negotiations, with some caveats including ensuring psychosocial disability supports are developed during the timeframe of the current Agreement (see comment on p. 8) and transitional funding is made available to the Alliance and State/Territory mental health consumer peak bodies to fund the extensive co-design proposed.

Delaying for 12 months will provide the time to:

A. Scale up the lived experience of mental health challenges peak bodies required to ensure the proposed inclusion of people with lived experience of mental health challenges in the development, negotiation and governance of the new Agreement.

B. Develop reporting and accountability frameworks with people with lived experience of mental health challenges including working with the National and State/Territory data reporting organisations. This will ensure data is relevant to what is important to people with lived experience of mental health challenges allowing for outcomes to be measured in a tangible and comparable way. This includes removing deficits-based language in measurement tools and looking beyond the clinical outcomes of the Agreement. The inclusion of people with lived experience of mental health challenges should also be included in the development of data improvement plans.

C. Ensure the Productivity Commission's recommendations regarding the National Mental Health Commission (NMHC) are completed and enacted.

D. Ensure true co-design with people with lived experience of mental health challenges is included in the renewed Agreement.

1.5 Urgent Need for Psychosocial Supports availability outside of the NDIS and role of PHNs (Draft Recommendation 4.4 and 4.12)

The interim report confirms what consumers and advocates have long known: psychosocial supports for people not eligible for the NDIS remain fragmented, underfunded, and poorly integrated. The unmet need report is proof that unmet need is central to the failure of the Agreement's implementation.

The Alliance unequivocally states that by supporting the 12 month set-up period for the negotiations of the next Agreement, it does not support any delay to the work and funding required to address the unmet need for psychosocial supports outside of the NDIS as evidenced in the *Analysis of unmet need for psychosocial supports outside of the National Disability Insurance Scheme – Final Report*[1].

[1] Analysis of unmet need for psychosocial supports outside of the National Disability Insurance Scheme – Final Report | Australian Government Department of Health, Disability and Ageing, accessed 16 July 2025

The Alliance notes the Mental Health Ministers' communique of 13 June 2025[2] explicitly stating that "*Ministers agreed that addressing unmet psychosocial needs will be one of the central priorities in consideration of the next National Mental Health and Suicide Prevention Agreement*" and see this as an agreement to ensure Psychosocial Supports are a central priority to be addressed over the next twelve months, 2025 – 2026, with or without a new Agreement. Waiting for the development of Foundational Supports – Targeted Supports (Psychosocial) will only leave this vulnerable population without services.

We reiterate the comments in our submission to the Review that while the Primary Health Networks (PHNs) and Local Hospital Networks (LHNs) were identified in the current Agreement to coordinate regional care, PHNs have struggled to deliver core parts of the Agreement and the commissioning process that PHNs have run has been disappointing.

For these reasons, the Alliance calls for dedicated, long-term funding to address unmet need by 2030 with clear delineation of funding responsibilities between levels of government. We restate the need identified in our initial submission for this funding to be removed from the PHNs and an independent, lived experience governed and run commissioning body to be formed that would block-fund community-based services. Commissioning of mental health services needs to be rebalanced towards community-based and lived experience-led services through the next Agreement.

1.6 Sharing of implementation plans and progress reports and sharing and collection of data (Draft Recommendations 4.2, 4.3)

The Alliance notes that the Commissioners agreed with our submission to the Review that the current Agreement lacks measurable outcomes and enforcement mechanisms. Data needs to be collected and evaluated for traditional and new services to ensure alternative therapies continue to be funded.

Ensuring the NMHC is independent, as recommended by the Alliance in our submission to the *Reforms to Strengthen the NMHC and National Suicide Prevention Office*[3] will go some way to ensuring some transparency and accountability. The accountability and enforcement measures need to be clear and include external evaluation. Jurisdictions should not be able to self-report without question or investigation that the outcomes reported on have been beneficial for mental health consumers.

[2] Health Ministers Meeting (HMM) – Special Communique 13 June 2025, accessed 16 July 2025
[3] NMHCA Submission_Advice on the Reforms to Strengthen NMHC and NSPO

Having specific requirements in the Agreement that each jurisdiction needs to meet, with funding tied to these requirements, and with progress against these requirements available publicly through a report card, will provide the impetus required to ensure these outcomes are met.

A report card, developed and reviewed by people with lived experience of mental health challenges should be central to the reporting structure providing clear, transparent and public identification of how each jurisdiction is progressing towards ensuring key outcome measures are being reached through reporting of data and sharing of jurisdictional implementation plans (see our answer to Information Request 4.3, p 12).

The report card should also include the negative experiences people with lived experience of mental health challenges encounter when using services and supports. Negative experiences with mental health services – including coercive practices, seclusion, and involuntary treatment – cause significant trauma, increase suicide risk, and discourage future help-seeking. To ensure safety is defined by consumers the next Agreement must also:

- include consumer-defined safety as a core outcome.
- track and publish the use of restrictive practices and seclusion at the service level, disaggregated by provider, authorising psychiatrist, and jurisdiction.

To address the social and economic determinants of mental health, the next Agreement must explicitly link to all relevant national frameworks such as Australia's Disability Strategy 2021-2031, the National Suicide Prevention Strategy 2025-2035, the National Housing and Homelessness Plan, Closing the Gap, and the National Plan to End Violence Against Women.

Additionally, indicators related to income security, housing access, discrimination, and employment, not just clinical metrics, should be included in the data collection and report card.

1.7 National Mental Health Commission (Several Draft Recommendations)

The Alliance agrees with the Commissioners that the NMHC should be reinstated as an independent, statutory body outside of the Health Department to allow it "to conduct ongoing independent assessments of policy implementation and provide advice on system improvement". The Alliance agrees that the NMHC, with designated lived experience Commissioners, working alongside the National and State/Territory Peak Bodies for mental health consumers, be the organisation charged with ensuring lived experience involvement in all aspects of the next Agreement.

As outlined in our submission regarding the *Reforms to Strengthen the National Mental Health Commission and National Suicide Prevention Office*[4], the Alliance supported the role of the NMHC in elevating mental health consumers.

The Alliance also advised that the NMHC will work in areas and on issues where there is a risk of duplication of effort and/or role with other stakeholders/statutory bodies. This may include in respect to complaints and the Human Rights Commission, professional standards and Australia Health Practitioner Regulation Agency, Department of Health, Disability and Ageing on mental health policy advice, peak bodies around consultation functions and, possibly, in relation to other matters and other stakeholders. It will be important for NMHC to be able to collaborate without compromising independence and for role boundaries and interface with other bodies to be clear and well-articulated.

To promote accountability and transparency of jurisdictional progress towards the outcomes identified in the Agreement, the Alliance recommends that the NMHC be involved in a reporting capacity in the Mental Health and Suicide Prevention Senior Officers[5] meeting.

1.8 Peer Workforce (Draft Recommendation 4.7, 4.14)

The Alliance supports the Commissioners' recommendations for the peer workforce, along with the jurisdictions, to develop a scope of practice.

Ensuring Peer-run organisations are commissioned directly rather than embedded within clinical teams will elevate peer work as a stand alone profession. Australia's mental health system remains dominated by clinical models, despite evidence that many consumers prefer peer-led, community-based, and non-pathologising supports. Emerging global research shows that the future of effective mental health care lies in community-led, rights-based approaches, not over-reliance on psychiatry or acute care.[6]

[4] Ibid.

[5] https://www.health.gov.au/committees-and-groups/mental-health-and-suicide-prevention-senior-officials-group-mhspso, accessed 29 July 2025.

[6] Bruno Ortiz, T. N., et al. (2025) 'Community Health Workers Research: Where Are We Now? A Narrative Review of an Expanding Workforce for Mental Health,' *Harvard Review of Psychiatry,* 33(3): 103-113. oi:10.1097/HRP.0000000000000427

1.9 Socio-economic determinants (Draft Recommendation 4.3)

The Alliance welcomes the Commissioners' recognition that the root causes of distress – including poverty, housing instability, and structural discrimination – remain under-addressed in the current Agreement. The Commission goes some way to ensuring that these factors are considered by recommending the next Agreement should articulate its role within the policy environment and specify the way it links with other key policy documents. This will require consideration of the interactions with a range of policy areas including housing, justice, disability supports and more.

1.10 Release publicly key documents outlined in current Agreement (Draft Recommendation 1)

The Alliance agrees with the Commissioners that the Australian Government should release the National Stigma and Discrimination Reduction Strategy and the detailed National Guidelines on Regional Planning and Commissioning.

We know the Stigma and Discrimination Strategy was completed at least 12 months ago. No reasoning has been provided as to why this Strategy has not been released.

1.11 Aboriginal and Torres Strait Islander Schedule (Draft Recommendation 5.1)

The National Mental Health Consumer Alliance stands in solidarity with the Indigenous Australian Lived Experience Centre (IALEC). We refer the Commissioners to the lived experience peak body for Indigenous people, IALEC, for all Aboriginal and Torres Strait Islander content and consideration of the recommendations throughout this Interim Report.

IALEC have provided the following information to the Alliance:

"IALEC endorses the inclusion of a dedicated Schedule for Aboriginal and Torres Strait Islander peoples within the new Agreement. IALEC advocates for the equitable and transparent distribution of resources, the genuine inclusion of lived experience at all levels of decision-making, and the prioritisation of co-design, leadership, and decision-making power held by Aboriginal and Torres Strait Islander peoples- not just rhetorical commitment, but meaningful structural change."

1.12 Suicide Prevention Schedule (Draft Recommendation 6.1)

People with lived experience of mental health challenges are calling for a shift in the language and approach used to discuss suicidality in Australia. We urge the Commission to embrace this pivotal moment to adopt more respectful and inclusive language—moving away from discriminatory references and coercive treatment practices. The Alliance advocates for replacing the traditional Suicide Prevention model—which often relies on policing and involuntary hospitalisation—with a harm reduction framework grounded in human rights, compassion, and dignity.

The Commissioners recommend that the new Suicide Prevention Schedule should reflect a clear link between the short-term objective and outcomes of the schedule and progress towards the long-term objectives of the National Suicide Prevention Strategy. The Alliance brings to the attention of the Commissioners that the Strategy gives implicit support for restrictive practices, the result being those experiencing suicidality will continue to be punished and ostracised for experiencing what are common human thoughts and feelings[7].

Restrictive practices are inconsistent with the United Nations Convention on the Rights of Persons with Disabilities[8] (UN-CRPD)and its Optional Protocol. In addition, with recent recommendations of the Royal Commission into Victoria's Mental Health System[9] to reduce restraint, seclusion and involuntary treatment and the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability[10] recommending the removal of seclusion and restraint in all treatment settings, it is recommended that the Strategy includes alternative best practice and removes these restrictive practices nationwide. They are not treatments, they do not aid our recovery, and they do not assist those of us experiencing suicidality.

1.13 Suicidality and Suicidism

Mental Health Consumers overwhelmingly report poor access to follow-up care and distress support following a suicidal crisis. It is important to consider that recovery-orientated approaches do not work for some people living with suicidality. We would prefer a harm reduction approach to suicidality which means peer led services that supports people through crisis.

[7] Position-Statement-no.6-Suicidality-Suicide-Suicidism.pdf, accessed 16 July 2025
[8] https://humanrights.gov.au/our-work/disability-rights/united-nations-convention-rights-persons-disabilities-uncrpd, accessed 17 July 2025
[9] Royal Commission into Victoria's Mental Health System - final report | vic.gov.au, accessed 16 July 2025
[10] Final Report - Complete Volume - formats | Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, accessed 16 July 2025

We support the national expansion of peer-led alternatives to suicide hotlines, and place-based supports that focus on connection, not crisis containment to support people's choice to recovery. Examples of such programs include:

- HOPE (Hospital Outreach Post-Suicidal Engagement)[11] – a peer-informed model offering personalised follow-up after ED presentations.
- Distress Brief Support Services[12] – avoid risk assessments and instead provide compassionate, sustained relational support.

1.14 Safe, non-clinical alternatives – crisis and ongoing services

The Interim Report highlights deep consumer dissatisfaction with crisis responses centred on Emergency Departments, which are often unsafe, retraumatising, or actively harmful.

Moving from risk management to harm minimisation will provide a person with dignity of risk, a human right under the UN-CRPD to which Australia was one of the first signatories. This would allow people the right to live the life they choose, even if that choice involves some risk or does not fit into social norms. The Alliance supports the expansion of non-clinical, often peer led, alternatives funded in the long term to ensure certainty for people using the service.

However, it is our experience that these non-clinical alternatives are only funded on a short-term basis, relying on year-by-year State/Federal government budgets to ensure their continuation. Currently, most safe havens are funded through State/Territory Governments, either directly or through Primary Health Networks. A service inherently suited to being authentically designed, run and managed by lived experience governance frameworks, some are being overrun by clinical governance.

In addition, many of these non-clinical alternatives are driven through the grassroots of the consumer movement. While they may receive funding to pilot a new service, when the service is proven successful, ongoing funding is not available and so the service closes. This, again, leaves people living with mental health challenges facing the loss of something that worked, forcing them to revert to using clinically focused services.

[11] https://www.westernhealth.org.au/Services/Mental_Health_and_Wellbeing/Pages/HOPE, accessed 21 July 2025
[12] https://www.health.vic.gov.au/mental-health-reform/recommendation-27, accessed 21 July 2025

The Alliance supports the national expansion of non-clinical alternatives that have been successfully developed and run in different jurisdictions – as long as they are run as they were designed to run. Examples of such programs include:

- Safe Haven Cafés[13], as trialled in Victoria, Safe Havens and Safe Spaces growing in the Australian Capital Territory, New South Wales and Queensland
- Mental Health Ambulance Co-Response services (Western Australia[14], South Australia[15]) pairing paramedics with mental health clinicians and peer workers to reduce hospital transport.
- Alternatives 2 Suicide (Alt2Su) as run in Queensland, South Australia[16] and Western Australia[17] as well as online.

2. What needs to be included

2.1 Chief Consumer Officer, Department of Health, Disability and Ageing

To ensure the voices of lived experience are included at senior level discussions across the Department and cross-portfolios, we recommend a role of Chief Consumer Officer be established in the Department of Health, Disability and Aging. This will not only ensure the voice of mental health consumers is at an equal footing to the clinical voices (Chief Psychiatrist, Chief Medical Officer, Chief Nurse, Chief Allied Health) and health economics voice (Chief Health Economist) within the Department, it will dismantle the power of the clinical voice being the predominant voice in mental health policy and ensure that mental health consumers are included in discussions that impact the social and economic determinants of mental health.

2.2 Language

We remind the Productivity Commission of the importance of language used when referring to mental health consumers. Despite our inclusion of a section on language in our submission, and sharing our Language Guide, we were disappointed to note some deficit based, clinical language in the Interim Report. We again ask the Productivity Commission to use our preferred language and to recommend that future documents about mental health consumers are written using the language that we use.

[13] https://www.safercare.vic.gov.au/improvement/projects/mental-health/safe-haven-cafe
[14] Successful Mental Health Ambulance Co-Response service expands | Western Australian Government
[15] Successful community mental health program to expand to all of Adelaide | Premier of South Australia
[16] Alt2Su | LELAN, accessed 21 July 2025
[17] http://discharged.asn.au/our-groups, as accessed 21 July 2025

3. Answers to Information Requests

3.1 Information Request (4.1)

The PC is seeking views on whether there should be an additional schedule in the next agreement to address the co-occurrence of problematic alcohol and other drug use and mental ill health and suicide.

To answer this information request, the Alliance has worked with Australian Injecting and Illicit Drug Users League (AIVL), the national peak body representing lived and living experience in the Alcohol and Other Drugs (AOD) sector. To ensure that any additional schedule and associated language within the Commissioners' recommendations reflect best practice and genuinely support people who use AOD, the Alliance recommends the establishment of a direct communication channel with AIVL.

There is a well-documented intersection between mental health and AOD use, particularly among individuals with complex needs. While the Alliance, AIVL, and our respective members are well-positioned to coordinate efforts in this space, meaningful collaboration will require dedicated resourcing to both peak bodies to ensure the work is undertaken effectively and inclusively.

Importantly, the separation of mental health and AOD sectors is often intentional and necessary to uphold a non-stigmatising, rights-based approach to AOD use. Many individuals who use AOD do not experience co-occurring mental health challenges or suicidality and should not be systematically framed within a deficit-based or clinical lens. For many, AOD use is a proactive, self-determined strategy to support health and wellbeing, grounded in bodily autonomy.

There is potential value in developing an additional schedule that addresses the intersection of mental health and AOD use—provided it is approached with care. Specifically, it must:

- avoid framing AOD use as inherently "problematic" or pathologising it through clinical language.
- be co-designed with lived and living experience peak bodies, including Drug User Organisations (DUOs).
- empower AOD and mental health consumers, their representative organisations, and peak bodies to collaborate across jurisdictions.
- be adequately resourced to ensure meaningful engagement and impact at both state and national levels.

Finally, we note with concern that the language used in the current information request—particularly references to "problematic alcohol use"—is clinically centred, judgemental, and inappropriate. Such terminology undermines efforts to build inclusive, respectful, and rights-based systems of support.

The Alliance urges the Commissioners to adopt a strengths-based, consumer-led approach in all future work related to AOD and mental health intersections, and to ensure that lived and living experience voices are central to the design, implementation, and governance of any related initiatives.

3.2 Information Request (4.2)

The PC is seeking examples of barriers to the genuine participation and influence of people with lived and living experience in governance forums. How could successful inclusion and engagement of people with lived and living experience in governance be measured?

The Alliance recommends the Commissioners read *The Lived Experience Governance Framework: Centring People, Identity and Human Rights for the Benefit of All*[18].

Co- funded by the National Mental Health Consumer and Carer Forum and Mental Health Lived Experience Engagement Network, the framework was co-produced by the South Australian Lived Experience Leadership & Advocacy Network (LELAN) with lived experience and sector leaders across Australia.

As stated in the framework,

> **"this Framework was written in response to calls from the mental health and other sectors for changes in the way systems are governed to align them more strongly with human rights approaches and to meaningfully embrace lived experience. To transform systems and improve lives, a formal framework is needed to embed lived experience perspectives, values, principles, expertise and leadership in all aspects of governance.**

[18] 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

Its applicability and reach span a spectrum of settings and sectors, including and beyond health systems, structures, policies, processes, practices, programs and services and peer-led initiatives."

3.3 Information Request (4.3)

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

A public dashboard would be valuable for people with lived experience of mental health challenges if the data that was shown is relevant to us, the outcomes measured and reported are important to us and the data in the dashboard was kept up to date. The language used in the dashboard must also be non clinical and not deficits based. People with lived experience of mental health challenges should be consulted as to what language they want to see used. Please see our recommendations on language earlier in this submission.

The bodies responsible for collecting the data should commission lived experience leadership to ensure relevant and meaningful data is collected and reported against key indicators of interest to mental health consumers. The dashboard could be developed and published by the independent NMHC, in partnership with the Alliance and provide regular reports tracking progress and identify continued gaps to ensure real progress is made in delivering tangible outcomes to people with lived experience of mental health challenges. This will provide an accessible way for individuals and peak bodies to hold state, territory and national governments accountable to the outcome requirements in the new Agreement. Please see our recommendations on data earlier in this submission.

The dashboard should include data on restrictive practices and seclusion at the service level, disaggregated by provider, authorising psychiatrist and jurisdiction. Taking this data out of the shadows will provide people with lived experience of mental health challenges, as well as state/territory and national jurisdictions, with the opportunity to identify good practice that does not use restrictive practices and seclusion, as well as call out and stop providers using it in large numbers.

The dashboard is also the perfect place to publicly demonstrate jurisdiction progress with planning and provision of supports and services identified in the next Agreement.

3.4 Information Request (4.4)

The PC is looking for case studies to highlight best practice in integrating peer workers in clinical mental health and suicide prevention settings, particularly by improving clinician awareness of the peer workforce. Are there examples of best practice that could be adopted in other organisations or settings?

The Alliance directs the Commissioners to the Consumers of Mental Health Western Australia (CoMHWA) submission that includes a literature review and lived experience examples of best practice in integrating people with lived experience of mental health challenges into the clinical health and suicidality treatment settings, including:

- CoMHWA's Peer Work Positives training, an organisational readiness training on the value and needs of the peer workforce in clinical spaces.
- CoMHWA's proposed 'First Step Support Program' that would make peer support available to the majority of people who access mental health supports through their GP and GP-referred specialist services.
- Neami's 'Co-creating safety' program, which aims to rethink traditionally ineffective and traumatic risk assessment processes through co-creation with consumers.

4. Recommendations

1. Embedding Lived Experience Leadership

- Embed meaningful engagement of people with lived experience in all levels of the next Agreement.
- Prioritise the voices of the Alliance and Indigenous Australian Lived Experience Centre (IALEC) without diluting consumer self-determination.
- Embed the Alliance in national governance structures with secure, protected, and indexed funding.
- Replicate Alliance's role at state and territory levels with equal support for jurisdictional peaks and IALEC.
- Ensure fair remuneration for lived experience participation in co-design.
- Guard against medical model dominance and reinforce support for peer-led, trauma-informed, culturally safe approaches.

2. Negotiation and Co-Design

- Support a 12-month delay in negotiations to scale peak capacity, reform the National Mental Health Commission (NMHC), and embed co-design—while continuing urgent psychosocial work.
- Ensure the next Agreement is negotiated by Prime Minister and Cabinet with all relevant Ministers.
- Include a co-chaired lived experience-government advisory structure on cross-cutting issues.
- Implement true co-design from the outset of the next Agreement and across related strategies and data development.

3. Psychosocial Supports Outside the NDIS

- Immediately fund and deliver psychosocial supports outside the National Disability Insurance Scheme (NDIS) without delay.
- Remove commissioning responsibilities from Primary Health Networks (PHNs) and create a lived experience-governed body.
- Establish long-term funding commitments to address unmet need by 2030.

4. Transparent Reporting and Data

- Tie Agreement funding to performance and reportable progress benchmarks.
- Develop a public, consumer-designed report card with lived experience-defined outcomes.
- Track and publish seclusion, restraint, and coercive practices by jurisdiction, provider, and psychiatrist.
- Incorporate indicators related to housing, income, employment, and discrimination.

5. Reforming the NMHC

- Reinstate the NMHC as an independent statutory body.
- Appoint lived experience Commissioners, who hold power, to the NMHC.
- Clarify Alliance's roles and responsibilities in relation to other statutory bodies.
- Include the NMHC in formal reporting processes like Mental Health and Suicide Prevention Senior Officials (MHSPO) meetings to hold governments to account.

6. Peer Workforce

- Develop a national scope of practice for peer workers.
- Fund and commission peer-run organisations directly.
- Shift emphasis from acute psychiatric care to community-led, rights-based alternatives.

7. Social Determinants

- Explicitly link the next Agreement to frameworks including the Disability Strategy, Closing the Gap, National Housing and Homelessness Plan, and the National Plan to End Violence Against Women.
- Track and report on social and economic indicators such as housing, income security, and employment.

8. Public Release of Strategy Documents

- Immediately release the Stigma and Discrimination Reduction Strategy and the National Guidelines on Regional Planning and Commissioning.

9. Aboriginal and Torres Strait Islander Schedule

- Include a dedicated Schedule for Aboriginal and Torres Strait Islander peoples, led by IALEC.
- Work with IALEC, the lived experience peak body for Aboriginal and Torres Strait Islander peoples, ensure the next Agreement meets the needs of Aboriginal and Torres Strait Islander peoples
- Ensure equitable distribution of resources and Indigenous-led co-design.

10. Suicide Prevention

- Replace current suicide prevention frameworks with harm reduction models grounded in dignity, human rights, and peer leadership.
- Remove coercive practices such as involuntary hospitalisation from suicide prevention policy.
- Link the Suicide Prevention Schedule to the National Suicide Prevention Strategy without reinforcing restrictive practices.

11. Responding to Suicidality

- Expand peer-led supports such as HOPE, Alt2Su and Distress Brief Support Services.
- Provide post-crisis care focused on compassion and human connection, not risk containment.

12. Non-Clinical Crisis Alternatives

- Secure long-term funding for peer-led, community-based services like Safe Haven Cafés, Safe Spaces and Alt2Su programs.
- Protect grassroots alternatives from clinical governance overreach and fund successful pilots sustainably.

13. Chief Consumer Officer

- Establish a Chief Consumer Officer in the Department of Health, Disability and Ageing to ensure lived experience leadership is on equal footing with clinical, allied health and economic voices.

14. Language

- Adopt the Alliance's Preferred Language Guide in all government documents.
- Avoid deficit-based, clinical, or pathologising language.

15. AOD and Mental Health Intersection

- If a separate schedule is developed, co-design it with AIVL and DUOs.
- Avoid stigmatising or deficit language like 'problematic alcohol use'.
- Support collaboration across mental health and AOD sectors with dedicated funding.

16. Lived Experience Governance

- Adopt and apply the LELAN-developed Lived Experience Governance Framework.
- Centre human rights, identity, and values across all governance systems.

17. Dashboard Monitoring

- Create a consumer-relevant, non-clinical language public dashboard developed with NMHC and the Alliance.
- Include lived experience-defined metrics, disaggregated restrictive practice data, and jurisdictional progress.

Recognition of Lived Experience

As a consumer lived experience-led organisation, the National Mental Health Consumer Alliance values the skill and expertise of consumers with lived experience. We pay tribute to those we have lost for the work that they have done to advocate for our rights. We acknowledge that we stand on the shoulders of giants who have paved the way for the rights we have today, and we will continue their work today and every day until the mental health system recognises and upholds our human rights. Nothing about us without us.

Submission prepared July 2025. National Mental Health Consumer Alliance.

See nmhca.org.au for more information about the Alliance.

For questions about this submission, please contact us at policy@nmhca.org.au.