Productivity Commission Review of the National Mental Health and Suicide Prevention Agreement – Final Submission

Executive summary

Black Dog Institute welcomes the opportunity to provide further comment on the current National Mental Health and Suicide Prevention Agreement (the current Agreement), and the interim report recently released by Commissioners Selwyn Button and Dr Angela Jackson.

Black Dog Institute broadly endorses the findings of the interim report. We agree that the current Agreement is not fit-for-purpose and has not achieved outcomes that matter to mental health consumers.[1]

As noted in our previous submission, levels of psychological distress have risen in the Australian population since 2010, and tragically suicide remains the leading cause of death for those aged 15-44.[2] During this time and over the life of the current National Agreement, governments have made significant funding and resourcing available, but the level of funding has not kept pace with the level of need in the community.[3]

Increasing the funding available for mental health services is vitally important to stabilise the level of demand in the community, but this is something that should be a focus of the National Health Reform Agreement (NHRA), which already provides for most public mental health service funding. Nevertheless, there is a concurrent need for an outcomes-focused and integrated National Mental Health and Suicide Prevention Agreement, with funding underpinning and being tied to the targeted outcomes.

To ensure the next National Mental Health and Suicide Prevention Agreement (the next Agreement) delivers meaningful reform, BDI recommends the following:

1. **Finalise the next Agreement by June 2026**, with core funding principles, governance structures and reform priorities embedded from the outset,

[1] Productivity Commission. (2025). Mental Health and Suicide Prevention Agreement Review, p.5
[2] Australian Institute of Health and Welfare. (2025) Suicide and intentional self-harm.
[3] Australian Institute of Health and Welfare. (2025). Mental Health Expenditure

2. **Embed lived and living experience** in the new Agreement across national governance, service design, funding decisions, and evaluation,
3. **Establish a dedicated Schedule for research and innovation**, with funding for priority research and clear pathways to translation into best practice,
4. **Address workforce shortages by implementing the National Mental Health Workforce Strategy**, with joint funding commitments, targeted retention strategies, and support for peer and First Nations workforces,
5. **Expand access to digital mental health services**, supported by sustainable funding mechanisms and quality assurance standards,
6. **Include a Schedule for First Nations peoples and Social and Emotional Wellbeing (SEWB)**, led by First Nations experts and supported by culturally safe, outcomes-focused funding arrangements,
7. **Ensure a dedicated Suicide Prevention Schedule** enables cross-sectoral governance and sustained investment in research, and that it is aligned with the National Suicide Prevention Strategy and Outcomes Framework.

Section 1: Black Dog Institute does not support extending the current Agreement

Recommendation 1.1:

The next Agreement should be heavily influenced by the Productivity Commission's findings which have been drawn from extensive sector consultation. The Agreement should confirm funding principles, governance structures and reform priorities and outcomes. Governments should determine initiatives, programs and research in parallel under the next Agreement, allowing flexible delivery timeframes.

The interim report concludes that the current Agreement is not fit-for-purpose, and is inadequate for its intended purpose, a view shared by Black Dog Institute.[4] Further, Black Dog Institute agrees that the current Agreement has failed to:

- deliver improved health outcomes,
- support meaningful system reform,
- establish robust mechanisms for monitoring, evaluation, and transparency,
- engage in meaningful co-design of mental health initiatives.[5]

The Commissioners recommended extending the current Agreement until 30 June 2027, to ensure the next Agreement is effectively co-designed, informed by lived and living experience and driven by outcomes.[6]

Black Dog Institute does not support this recommendation. The Agreement should be the foundational policy architecture that allows for timely investment in services, programs and outcomes as agreed by all jurisdictions. It should set the rules for engagement and co-design.

We believe that the next Agreement should not require the same level of consultation and co-design as a new National Strategy or initiatives would. The Productivity Commission's review has engaged extensively with lived and living experience, and this should inform the next Agreement which should be finalised by 30 June 2026.

[4] Productivity Commission. (2025). Mental Health and Suicide Prevention Agreement Review, p.5
[5] Ibid, pp. 7-8 & 111 - 119
[6] Ibid p.139

Risks of delaying new National Mental Health and Suicide Prevention Agreement

Delaying the next Agreement risks exacerbating existing service gaps, particularly for those who may be excluded from foundational supports under concurrent NDIS reforms. Instead, the reforms outlined in the Productivity Commission's report must proceed in parallel with co-design of a National Strategy as well as the initiatives, interventions and research supported by the next Agreement.

Black Dog Institute is concerned that any delay would lead to inconsistencies in the delivery of three critical reform areas – the NDIS, the next Addendum to the NHRA as well as the next Agreement. The changes to the NHRA and the NDIS are due to come into effect on 1 July 2026.

It is rare for governments to have the opportunity to design, agree to and implement wide-ranging care system reform and this opportunity should not be missed. Advancing this work would also reflect a key recommendation of the Productivity Commission, to situate and align the next Agreement with the broader national policy context.

Section 2: Embedding lived experience in the next Agreement

Recommendation 2.1:

Ensure that the role for lived and living experience is clearly defined in the next Agreement. This should include national governance, program design, funding decisions and evaluation, and it should represent a diversity of views across jurisdictions.

Black Dog Institute recognises the well-documented evidence demonstrating the positive impact and value of lived and living experience in improving mental health policy and practice.[7] It is essential that lived experience continues to inform future policy directives and services at all levels of government.

As stated in the interim report, people with lived and living experience of mental ill health have contributed to this review through written submissions.[8] Black Dog Institute welcomes the inclusion of consumer and carer voices throughout the interim report, and this will be vital to inform the final Review into the current Agreement.

Future lived experience engagement

Provided that the Review's lived experience consultation informs the design of the new Agreement, Black Dog Institute considers that further broad consultation may not be necessary. The purpose of the Agreement is to guide how governments across Australia collaborate with the sector and lived experience to improve mental health and suicide prevention outcomes.

The next Agreement and bilateral agreements should include a stipulation that lived experience is embedded in national governance, particularly in:

- decision making about new mental health policy directives,
- the design and delivery of mental health services and initiatives within the new Agreement, and
- the development and translation of mental health research.

[7] Sartor, C. (2023). Mental health and lived experience: The value of lived experience expertise in global mental health.

[8] Productivity Commission. (2025). Mental Health and Suicide Prevention Agreement Review: What we' ve heard so far.

It is not enough to simply include the mention of lived experience; how lived experience is consulted with is equally important. The current Agreement uses vague terms such as "informed by lived experience" or "consulted," which lack clarity around the level of involvement, creating ambiguity in how it is applied.[9]

Instead, policymakers must embed lived experience consultation throughout the policy, research, and program design cycle—not just at the end. This includes engaging a diverse range of individuals with lived experience in the development, implementation, and evaluation of mental health initiatives.

Importantly, representation must extend beyond national peak bodies to include voices from across jurisdictions. Every state and territory has unique cultural, geographic, and systemic contexts that shape mental health experiences and these local insights are vital to inform tailored responses, improving relevance and effectiveness.

[9] Department of Health and Aged Care. (2022.) National Mental Health and Suicide Prevention Agreement. p.4 & p.16

Section 3: A place for research and innovation in the next Agreement

Recommendation 3.1:

Include a Schedule for research and innovation in the new Agreement with funding available for priority research over the term of the Agreement, and a clear pathway to translation into best practice.

The Productivity Commission's Interim Report repeatedly refers to embedding best-practice and co-design in the next Agreement. Black Dog Institute supports this; however, the Interim Report gives limited attention to the role of research, which is a critical gap that must be addressed.

As the only medical research institute in Australia that researches mental health across the lifespan, Black Dog Institute proposes that the next Agreement include a dedicated Schedule for Research and Innovation. This could mirror proposals from the NHRA Mid-Term Review to establish a national Innovation Fund.

Research and innovation in mental health

Australia is on the cusp of a new era in mental health treatment. Novel therapies and digital technologies are opening the door to more effective and personalised care, particularly for people with more complex mental health needs.

For example, depression is the leading cause of disability worldwide, yet treatment remains imprecise—especially for the one in three people who do not respond to conventional therapies. Black Dog Institute is at the forefront of research into novel treatments for this group, including the use of generic ketamine for treatment-resistant depression.

In 2023, Black Dog Institute researchers led the world's first Phase III trial of generic ketamine, showing that over half of participants experienced significant symptom reduction—and more than 20 per cent no longer met the criteria for clinical depression after just one month of treatment[10]. These are transformational outcomes for people who live with a form of depression that do not respond to

[10] Loo, C., Glozier, N., Barton, D., Baune, B. T., Mills, N. T., Fitzgerald, P., ... Rodgers, A. (2023). Efficacy and safety of a 4-week course of repeated subcutaneous ketamine injections for treatment-resistant depression (KADS study): randomised double-blind active-controlled trial. The British Journal of Psychiatry, 223(6), 533–541. doi:10.1192/bjp.2023.79

other treatments.[11] Governments should ensure broad public access to such promising treatments.

Currently, there is no clear pathway for this or other innovative treatments to become accessible to the thousands of Australians living with treatment-resistant depression.

Right now, access to ketamine treatment is limited to those who can afford the high out-of-pocket costs in the private system, and in metropolitan areas. This is driving health inequity; often innovative, high-value care is available only to those with the means to pay for it.

This narrative around ketamine, is just one example of how well-coordinated programs of research can dramatically improve mental health outcomes. Similar arguments can be made for research focused on models of care, school-based mental health programs, research to create mentally healthy workplaces and suicide prevention research programs.

To ensure the most effective mental health innovations reach the people who need them, the next Agreement must enable and prioritise groundbreaking research. This will:

- improve access to emerging, effective and safe mental health treatments such as ketamine discussed above.
- equip policymakers with the best available evidence, strengthening their capacity to design smarter, more effective mental health services and systems; and,
- position Australia as a world leader in mental health and suicide prevention.

A dedicated Schedule for Research and Innovation should be included in the next Agreement, with all jurisdictions committing funding and resources to support it. This Schedule should also establish clear governance for research investment—ensuring it directly supports the outcomes of the next Agreement and the proposed National Mental Health Strategy.

The Schedule should provide expert organisations, such as Black Dog Institute, with a formal advisory role to support governments in translating funded research into policy and practice, informed by both scientific evidence and lived and living experience.

[11] McIntyre RS et al. (2023). Treatment-resistant depression: definition, prevalence, detection, management, and investigational interventions.

Section 4: Building a mental health and suicide prevention workforce

Recommendation 4.1

A scope of practice for peer workers should be carefully developed in consultation with lived experience, the peer workforce, and the broader sector to determine the role peer workers can and should play in the provision of mental health services. It should also draw on pre-existing work such as the Aboriginal and Torres Strait Islander Lived Experience-led Peer Workforce Guide to ensure unintended consequences that might limit workforce further are considered and avoided.

Recommendation 4.2

A new Agreement should enable multidisciplinary care including from non-health workers. The current funding model does not effectively support this in the public system.

Australia's mental health workforce is under immense pressure, with critical shortages undermining access to timely and effective care.[12] In NSW, there is a significant shortfall of psychiatrists in the public system, and across the country, many Australians struggle to access appointments.[13]

While the current Agreement supported the development of the National Mental Health Workforce Strategy, its implementation has yet to commence. Black Dog Institute welcomes the Interim Report's recommendation that implementation of the Strategy is prioritised. [14]

This is a critical long-term reform and must be considered alongside broader national health workforce initiatives, including expedited pathways for Specialist International Medical Graduates, which could help to alleviate the most acute workforce shortages in the short term.

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[12] Department of Health and Aged Care. (2023). National Mental Health Workforce Strategy 2022-2032, p.17

[13] Black Dog Institute. (2024). Addressing Australia's mental health crisis: Time for bold reform.

[14] Productivity Commission. (2025). Mental Health and Suicide Prevention Agreement Review, p.160

Workforce considerations for the next Agreement

When considering how to build and sustain a capable workforce in the next Agreement, the following considerations should be kept front of mind for the Commonwealth Government:

- **Multidisciplinary teams help to deliver the best care**: High-quality mental health care, particularly for those experiencing complex concerns, is best delivered by multidisciplinary teams.[15] While psychiatrists, clinical psychologists, and mental health nurses play irreplaceable roles, models of care should be flexible and tailored to the complexity of consumer needs.
- **Funding considerations:** In a new Agreement, all jurisdictions and the Commonwealth should jointly fund the implementation of the National Mental Health Workforce Strategy and target shortages in places of most need, including in rural and remote areas.
- **Training and upskilling:** Governments should partner with sector leaders, including research institutes such as Black Dog Institute, to deliver targeted upskilling and training in delivering mental health services, and to manage their own mental health challenges in the workplace.
- **Efficient use of existing workforce to meet service gaps:** The next Agreement should leverage digital tools and telehealth to enable metropolitan clinicians to support regional teams, including through supervision and the delivery of novel treatments. Workforce enhancements like this are currently limited by funding models that do not support telehealth and virtual case conferencing.
- **Utilising the peer workforce**: The peer workforce is a critical component of the mental health and suicide prevention system, helping consumers to navigate the system and access services with confidence particularly when consumers are accessing more advanced or inpatient services.[16] The recommendation to develop a national scope of practice for peer workers is strongly supported and this should draw on considerable work done by Black Dog Institute on the Aboriginal and Torres Strait Islander Lived Experience-led Peer Workforce Guide for the Western Australia Mental Health Commission.

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[15] Durand, F., & Fleury, M. J. (2021). A multilevel study of patient-centered care perceptions in mental health teams.

[16] Australian Government Department of Health. (2021). Primary Health Networks (PHN) mental health care guidance: Peer workforce role in mental health and suicide prevention

- **First Nations workforce considerations:** When designing the peer workforce scope of practice, it is essential to consider the unique role of peer and lived experience workers within First Nations communities. Peer and lived experience workers are particularly important for First Nations peoples, given institutional mistrust and generational trauma related to accessing health services.[17] However, care must be taken to avoid placing additional strain on the already under-resourced Social and Emotional Wellbeing (SEWB) workforce.[18] The next agreement must be prioritise strategies to support First Nations workers, ensure cultural safety, and prevent burnout.

[17] Australian Institute of Health and Welfare. (2024). Barriers to accessing health services. Aboriginal and Torres Strait Islander Health Performance Framework. pp.12-15

[18] Lai et al. 2018. Factors Affecting the Retention of Indigenous Australians in the Health Workforce: A Systematic Review.

Section 5: Adopting digital to improve access and availability of mental health care

Recommendation 5.1

Develop fit-for-purpose funding mechanisms that enable effective integration of digital tools into mental health care, with a clear pathway for transitioning successful innovations into ongoing health funding arrangements within Medicare or the NHRA.

Access to mental health services remains a persistent and well-documented challenge, particularly for young people and those living in regional and rural areas.[19] Despite increasing demand, many Australians continue to face long wait times, limited local services and a lack of age-appropriate or culturally safe care.

These access challenges highlight the need to invest in innovative solutions that expand reach and improve care delivery, particularly for underserved populations. One such solution lies in digital mental health tools and technologies which offer both promise and risk.

When implemented effectively, standalone digital mental health tools, and those used to deliver blended care, play a critical role in addressing inequitable access by enabling:

- **system navigation and greater efficiency:** digital platforms direct users to the most appropriate level and type of care early, reducing delays finding the right care and improving the overall experience.[20]
- **greater clinician capacity:** blended care model that use digital tools allow clinicians to see more patients, helping to reduce waitlists.[21]
- **improve treatment outcomes:** in some settings blended care has been shown to be as or more effective than face-to-face treatment alone, with the potential to reduce both treatment duration and overall cost.[22]

[19] Black Dog Institute. (2024). Navigating Australia's mental health system in 2024: Consumer report.
[20] Black Dog Institute & eMHPrac. (2024). Health practitioner guide to digital mental health services and resources, p.8
[21] Etzelmueller et al (2020). Effects of internet-based cognitive behavioral therapy in routine care for adults in treatment for depression and anxiety: Systematic review and meta-analysis.
[22] Black Dog Institute. (2023). Reimagining digital mental health in Australia: Discussion paper, pp.12-15

- **greater treatment availability:** digital tools can provide 24/7 access to support, offering flexible care options—particularly valuable in regions with workforce shortages and limited services.[23]

It is critical that governments do not view digital tools as a replacement or cost-saving substitute for traditional services. While these tools can enhance treatment outcomes and access, they are not a like-for-like replacement for care.

The Commonwealth should embrace the potential of digital mental health solutions while actively managing the risks. Despite the promise of digital mental health innovation, the current Agreement and its associated bilateral agreements make little or no mention of digital innovation in mental health service delivery – a gap that must be addressed in the next Agreement.

Funding mechanisms

A major barrier to the effective rollout of digital mental health applications and services has been the lack of suitable funding mechanisms. Existing models – such as Medicare and Activity-Based Funding – were not designed to support the full spectrum of digital mental health innovations. As a result, some tools are only available through government grants, or direct fees to users, reducing equity and sustainability.

The proposed National Early Intervention Service and initiatives like the NSW Health Single Front Door for Mental Health will be valuable components to the mental health system. However, without sustainable, ongoing funding for evidence-based digital services, these initiatives will fall short of their potential.

Highly effective digital tools such as care navigation platforms, self-assessment modules, and blended care models often fall outside the scope of these funding streams, limiting their reach and sustainability. This is a missed opportunity—particularly as lower-intensity mental health services are often well-suited for digital delivery.

To fully harness the benefits of digital mental health, the next Agreement should explore alternative funding approaches. These could include commissioning models, innovation grants, or dedicated digital mental health funds administered by the National Mental Health Commission. In the short term, these services should be supported through the NHMSPA, rather than the NHRA.

[23] Black Dog Institute. (2025). Digital mental health research area.

Section 6: Including a Schedule for First Nations peoples and Social and Emotional Wellbeing

Recommendation 6.1

Funding for the Social and Emotional Wellbeing Schedule must be in addition to funding elsewhere in the agreement, with decisions on the allocation of funding to be made by the sector.

Black Dog Institute welcomes the Productivity Commission's recommendation to include a Schedule for First Nations peoples and Social and Emotional Wellbeing (SEWB). However, there is a risk that creating a specific Schedule could unintentionally relegate SEWB to a separate stream, rather than embedding it as a core consideration across the entire Agreement. This must be avoided.

Instead, cultural capability, equity of access, and the wellbeing of First Nations peoples should be integral to all aspects of the next Agreement—not treated in isolation.

Elements of proposed SEWB Schedule

First Nations experts and the community-controlled sector must lead the proposed SEWB Schedule. It should draw on lived and living experience and knowledge and recognise that SEWB requires engagement across government agencies and with the sector.

The Social and Emotional Wellbeing Policy Partnership is the appropriate body to lead the design of the new Schedule as well as the implementation plan, funding arrangements, and monitoring of outcomes.

A nationally consistent definition of SEWB is essential to guide this work. Peak bodies such as Gayaa Dhuwi can provide leadership in establishing standard definitions that align with existing frameworks.[24]

Peak bodies such as NACCHO, Gayaa Dhuwi, and the Indigenous Australians Lived Experience Centre (IALEC) should monitor and enhance the proposed SEWB

[24] Existing frameworks include: the National Agreement on Closing the Gap, the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy, and the National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and SEWB

schedule.[25] This will ensure genuine community input and build trust in the next Agreement and the broader governance that sits around it.

Funding arrangements

A purposeful, outcomes-driven First Nations Schedule must be backed by appropriate and dedicated funding mechanisms. This funding should sit alongside – rather than be carved out of – the broader Agreement and be delivered through bilateral agreements between States and the Commonwealth to ensure jurisdictions are held accountable for improving SEWB outcomes.

Governments should move away from blunt population-based cost-sharing models and instead adopt holistic funding approaches. Funding should be tied to outcomes, while avoiding punitive structures that disincentivise long-term investment or culturally safe care.

Given the current Agreement has not delivered meaningful improvements in outcomes or service access for First Nations peoples, a significant upfront investment is required to expand access to evidence-based, community-led and outcomes-focused SEWB services. The SEWB Policy Partnership is well placed to advise on the design, allocation and distribution of the funding arrangements.

[25] IALEC is due to be formally established in late-2025

Section 7: Including a schedule for Suicide Prevention

Recommendation 7.1

The National Suicide Prevention Office should have oversight and decision-making power over suicide prevention initiatives and funding.

Recommendation 7.2

Suicide Prevention research should be supported by the Schedule with funding set aside for research at scale that seeks to achieve the outcomes of the National Suicide Prevention Strategy.

Black Dog Institute supports the Productivity Commission's recommendation to include a dedicated Suicide Prevention Schedule in the next Agreement.[26] The current Agreement has not delivered effective reform in suicide prevention. It lacks resourcing, research, and service design focused on reducing suicide and suicidality.

Despite this, the Commonwealth has made progress through two significant pillars of suicide prevention: the release of the National Suicide Prevention Strategy and the establishment of the National Suicide Prevention Office. Both were agreed outputs of the current Agreement. The Office is now leading the development of a third key pillar – the National Suicide Prevention Outcomes Framework.

These pillars will continue to shape suicide prevention efforts in Australia. Their success relies on sustained engagement with people with lived and living experience, alongside suicide prevention experts, clinicians and carers. All jurisdictions must agree on the shared goals, a unified national direction and a standardised approach to suicide prevention.

The Schedule recommended by the Productivity Commission should ensure there are national and jurisdictional implementation plans in place for the Strategy and Outcomes Framework, outlining the steps to reducing suicide and suicidality in Australia and assessing progress towards meeting these aims.

[26] Productivity Commission. (2025). Mental Health and Suicide Prevention Agreement Review, p.201

Elements of Schedule for Suicide Prevention

A challenge that governments will face in suicide prevention is the intersection with non-Health sectors including Justice, Education, Social Services, Housing and Homelessness, Liquor and Gaming, and Disability. Additional challenges exist in rural and remote areas and amongst First Nations peoples.

This Schedule must identify and authorise a governance structure that encompasses all inputs and which holds governments, rather than individual agencies, to account for improving suicide prevention services and outcomes in Australia. Currently, the National Suicide Prevention Office is housed within the National Mental Health Commission. The Commission and the Office are statutory Health agencies, which means that while they are independent, they do not have influence over non-Health agencies. The Schedule could clarify the role of the Office and note that it could have oversight of suicide prevention initiatives that sit outside of Health. This would require agreement of First Ministers but would be a more efficient way of delivering and monitoring cross-sectoral initiatives.

Research for Suicide Prevention

There should also be a specific role for research outlined in the Schedule for Suicide Prevention. The National Suicide Prevention Strategy identifies high-quality and translated research as a critical enabler to suicide prevention activities.[27]

However, Australian governments do not currently have appropriate mechanisms to support this research. The Suicide Prevention Research Fund was wound up at the end of the 2024-25 Financial Year with no replacement fund identified.[28]

Suicide prevention research funding could instead be guaranteed through this Schedule and be distributed independently of government decision-makers by the National Suicide Prevention Office. This would ensure that research can occur over longer periods, is tied to national priorities and goals, and is determined by sector experts rather than Ministers. This should not exclude suicide prevention for funding from other sources such as the Medical Research Future Fund, but it would ensure a pathway for research that is cross-sectoral and will contribute to the outcomes of this Schedule and the National Suicide Prevention Strategy.

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[27] National Suicide Prevention Office. (2025). The National Suicide Prevention Strategy 2025–2035. Australian Government Department of Health and Aged Care, p.77

[28] Suicide Prevention Australia. (2025). Australia's life-saving Suicide Prevention Research Fund defunded today.

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