

Deakin University's Faculty of Health Response to the Productivity Commission Interim Report on Mental Health and Suicide Prevention Agreement Review

Deakin University's Faculty of Health is pleased to provide a submission for the Productivity Commission's review of the Mental Health and Suicide Prevention Agreement. Our submission strongly aligns with the Commission's findings and supports the development of a new policy architecture that addresses the structural shortcomings of the current Agreement.

Deakin's Faculty of Health is one of the largest and fastest growing health faculties in Australia. The Faculty is comprised of five schools (School of Exercise and Nutrition Sciences; School of Health and Social Development; School of Medicine; School of Nursing and Midwifery; School of Psychology), three research institutes (The Institute for Health Transformation; The Institute for Physical Activity and Nutrition; The Institute for Mental and Physical Health and Clinical Treatments), two strategic research centres and numerous specialist units.

We conduct a broad range of multidisciplinary and translational research that addresses important individual and population health problems. Our research programs are supported by our collaboration with industry partners and governments to put findings into practice. Together, we tackle some of the most urgent and important clinical and public health problems of our time.

With input from members across the faculty, with their expertise in multiple disciplines and wide-ranging research methodologies, and their experience undertaking research into the vast array of health and medical research topics that the Mental Health and Suicide agreement relates to, we hope our submission provides a balanced and holistic response that is of The Productivity Commission in its review of the Statement. The new Centre for Excellence in Consumer Engagement in Health, The Health Consumers Centre, is part of the Institute for Health Transformation and supports our whole organisation, and others, to undertake best practice Consumer and Community Involvement and build capabilities. The Deakin CO-LEADS Network brings together diverse expertise and lived experience across research, social work, and mental health peer support. Using systems thinking, dynamic modelling, and trauma-informed co-design methods—such as Community-Based System Dynamics (CBSD), Group Model Building (GMB), and implementation science—the Network translates evidence into practical, scalable solutions for mental health policy and service reform. Deakin, and the Institute for Health Information has a number of world leading experts who have contributed to this submission.

Associate Professor Debbie Scott, from the Institute for Health Transformation, has over 20 years of experience in intentional injury, suicide prevention, mental health, and alcohol and other drugs-related harms data, surveillance, policy and public health approaches to prevention. She previously led the National Addiction Mental Health and Suicide Surveillance Unit at Monash University, advising government and non-government bodies on data-driven policy where she received a Google AI for Good Grant to automate the capture of suicide surveillance data from ambulance patient records.

Dr James Lucas, Ms Stephanie Bennetts and Dr Tari Forrester-Bowling are leading research experts in the use of Group Model Building methodologies of co-design applied to mental health settings and vulnerable populations.

Dr Ruth Tatnell from the School of Psychology has 15 years' experience working in suicide prevention and developing understanding of non-suicidal self-injury. With A/P Glenn Melvin, she is working on a novel intervention for children and adolescents (and their parents) to prevent youth suicide.

Professor Anthony LaMontagne, from the Institute for Health Transformation, is an international leader in work-related suicide epidemiology and workplace suicide prevention intervention research. Further, he actively applies his subject matter expertise to policy and practice through his volunteer roles as Chair of a National Research Reference Group and Board membership for the MATES in Construction suicide prevention charity.

Distinguished Professor Alison Hutchinson is nationally and internationally recognised for her work spanning more than 25 years in the field of implementation science. Over the past 2 years she has overseen research in regional Victoria to understand the barriers and enablers to implementation of integrated multi-disciplinary services to facilitate safe, high-quality mental health care.

Drawing on the findings of the Productivity Commission's interim report, and our experience in research and service delivery, we identify 8 key areas for urgent attention and reform to strengthen Australia's mental health and suicide prevention system.

1. A Public Health Approach

We advocate for a comprehensive public health approach to mental health and suicide prevention. This requires investment across three levels:

- **Primary prevention and early intervention** directed at the whole of population that addresses stigma, supports help seeking behaviour and educates the population about when to seek help, what resources are available and where to find/access them
- **Targeted interventions** for populations at high risk of mental ill health and suicidal thoughts and behaviours, including culturally and linguistically diverse communities, LGBTIQ+ people, Aboriginal and/or Torres Strait Islander peoples, young people, and those affected by structural disadvantage.
- **Tertiary responses** that support long-term recovery, wellbeing and community reintegration for those living with mental ill health or who are affected and impacted by suicide.

This reflects the Commission's recommendation for a long-term strategy supported by a five-year agreement and bilateral schedules that align services to local needs.

2. Urgent Structural System Reform

Mental health services are increasingly hard to access, unaffordable and are often reportedly unfit for purpose (Forrester-Bowling et al., 2024; McLure J. et al., 2023; McLure, J., 2025). These concerns are especially acute in regional and rural communities. Key priorities include:

- **Immediate action on psychosocial supports** for the 500,000+ people with serious mental ill health the Agreement highlighted as not eligible for service by the NDIS; an area that has not progressed.
- **Release and implementation of the National Stigma and Discrimination Reduction Strategy**, with oversight and evaluation led by people with lived and living experience. Services, service providers and language used in public health information can be stigmatising, even when unintended, with service users less likely to engage in available services due to negative past experiences (e.g., discrimination and stigma when being treated for past non-suicidal self-harm, which is the best predictor of death by suicide,

barring past attempt, but is often treated poorly in Emergency Departments (EDs) and by nurses and GPs incorrectly labelling the behaviour ‘attention seeking’.

- **Expansion of trauma-informed, co-designed, peer-led services**, particularly crises alternatives to emergency departments (Lubman, D., et al, 2019) and ongoing community support structures. Due to lack of service availability in regional and rural areas, the inability of crisis lines to adequately support ongoing needs, and the prevalence of suicidal risk across all parts of our communities, there is growing need for co-designed, peer-led and clinically supported services.
- **Integration of mental health and suicide prevention** services is urgently warranted to overcome existing fragmentation, which hampers effective communication, collaboration, and continuity of care. A unified and interoperable service system would foster timely information sharing among providers, ensuring individuals receive coordinated, person-centred support across their recovery journey.

3. **Social Determinants and Whole-of-Government Action**

The causes of mental ill health and suicidality are complex and rooted in social determinants such as:

- housing and job insecurity
- childhood trauma and adverse experiences
- racism, discrimination, and gender-based violence
- climate-related anxiety particularly among young people

Addressing these social determinants requires investment in early intervention and a whole-of-government approach, identifying and integrating population level risk factors, including health, job and housing insecurity, education, justice, disability, and social services. A future agreement must embed shared accountability across all jurisdictions, sectors government and non-government agencies.

4. **Addressing Stigma and Discrimination**

Those accessing services frequently cite experiences of discrimination in healthcare settings, particularly in relation to non-suicidal self-injury, which is among the strongest predictors of suicide (Kiekens et al., 2018). Stigma not only deters help-seeking but worsens mental health outcomes (Hasking et al., 2022).

There are fears of governments reducing access to care for people most at risk (e.g., trans and gender diverse individuals, First Nations peoples, young people with growing climate anxiety to name a few). Identities and factors associated with increased risk of poor mental health outcomes should be identified and targeted with public health campaigns to raise awareness rather than waiting until people are overwhelmed with illness and/or have attempted suicide.

Non-stigmatising help should be available so that people can reach out for support and receive it at early stages. There is currently no funding directed at prevention and early intervention. This level of response will require a whole of government response and involvement – not just health-based services and sectors. The role of adverse childhood experiences and their associated trauma cannot be discounted and should be a focus of early intervention. Children who have been involved in the child protection system are more likely to engage in suicidal thoughts and behaviours than those who have not (Baldwin, R. et al., 2024)

We support the Commission's call for the immediate release of the National Stigma and Discrimination Reduction Strategy and recommend that its implementation be community-led, trauma-informed, and evaluated independently.

5. Suicide Prevention Beyond the Health System

Suicide is not always linked to mental ill health, and prevention must extend beyond the health system to include cross-sector responses to: alcohol and other drug services, gambling harm reduction, family and domestic violence services (including child protection services), and community development and social connection initiatives, as well as changes to Justice /disability support services/ Education/Health – and all should be trauma-informed and responsive.

We support the Commission's proposal for a separate suicide prevention agreement and agree that the current agreement does not appear to impact suicide and related harms. Overall suicide rates have not decreased over the term of the Agreement, with some populations showing upward trends in mental health and suicide harms. While we acknowledge the lack of progress on suicide rates across the population, we also wish to highlight some good news in terms of rate reduction in one high risk group: Workers in predominantly male blue-collar occupations and industries.

MATES in Construction, demonstrates how suicide prevention can be effectively deployed outside of the health system through industry-led, workplace-based initiatives (LaMontagne, AD., et al, 2025; Maheen, H., et al, 2022) . Originating in response to disproportionately high suicide rates among male construction workers, MATES has shown a significant national decline in suicide rates among male construction workers—greater than that of other working males—highlighting the impact of sector-specific interventions. MATES combines peer support, mental health literacy, and stigma reduction within the workplace, supported by ongoing population-level surveillance and both non-experimental and experimental evaluations. This model illustrates the value of embedding suicide prevention in everyday work environments, and future Agreements should support diversified intervention research and cross-sector partnerships to replicate and scale such successes beyond clinical settings.

Those who require access to mental health support argue that the current system is structurally unresponsive and often exacerbates distress, particularly for those with complex needs or marginalised identities. Community level support and support for those in rural and remote areas is lacking and significantly under serviced.

The causes of poor mental health and suicide are multi-factorial and often associated with social determinants of health and so responses to system reform must also be multi-factorial and should consider social determinants of health. The role of trauma in mental health and suicide is also key, often this trauma stems from early childhood exposure to adversity. Trauma-informed responses that acknowledge and seek to prevent child adversity could have a significant impact on reducing rates of poor mental health and suicide in the community. Where a child is identified as being exposed to adverse childhood experiences (ACES), early intervention should be initiated and culturally informed. A focus on supporting parents with their own mental health concerns or adverse experiences is also recommended. Existing lived and living experience groups, for example Roses in the Ocean, Standby, CHARLEE and Gayaa Dhuwi, should be engaged in the development of services as well as campaigns to support people in the population to know about available services.

There is also a need for focussed attention on separate suicide prevention that is not related to a known decline in mental health. For example, suicide can be triggered by sudden life stressors (suicidal crises) such as job loss, relationship breakdown, gambling and alcohol and other drug response, therefore measures should be taken to provide financially supported work to prevent these factors contributing to suicidal thoughts and behaviour. The National Suicide Prevention Office (2025) has widely been praised for its holistic and compassionate approach to addressing suicidal crises, however the lack of integration across services results in the systems that require rapid, coordinated responses, still operating in silos (Australian Government: Productivity Commission, 2025). Furthermore, the Interim Report handed down by the Productivity Commission (2025) also highlighted that the lack of clear accountability mechanisms, increases the difficulty for tracking whether the support for suicidal crises is reaching those in need.

6. Co-design, Lived Experience Leadership, and Workforce Sustainability

A reformed Agreement must be co-designed with people with lived and living experience to determine mental health and suicide prevention initiatives, responses, and policies. Service responses must be tailored, community centred, supported, and driven, rather than delivered through a top-down, one size-fits-all approach. This requires:

- Funded participation and governance roles,
- Respect for community-controlled organisations and peer-led models,
- Avoidance of tokenism through transparent co-design frameworks and shared decision-making
- Embedding lived experience leadership in governance, commissioning, evaluation, and workforce development.

In addition, the sustainability of the peer workforce is essential for realising the lived experience leadership in practice. The peer workforce must be supported through:

- Proper remuneration, career development pathways, and professional recognition
- Wellbeing supports and protections from burnout, particularly for those working in crisis or acute care contexts.
- Targeted investment in workforce development across metropolitan, and rural and regional settings, including training in trauma-informed practice and cultural capability for all roles in the mental health and suicide prevention workforce.

Workforce sustainability and genuine lived experience inclusion must go hand in hand to ensure the next Agreement delivers person-centred and responsive care.

7. Valuing Carers and Support Persons

Carers play a critical role in the mental health and wellbeing of those they support. However, their knowledge and contributions are often dismissed or excluded from care planning. We support:

- Involvement of carers and support persons into any response and support of those who require mental health and suicide prevention services.
- Inclusion of carers in service co-design and policy reform ensuring that their concerns, expertise and care is incorporated and valued by health care teams responsible for caring for those involved in the mental health system.
- Transparent and trauma-informed information-sharing protocols, and
- Dedicated support and recognition of carers as partners in recovery.

8. Funding, Governance, and Accountability

The current Agreement lacks clear logic connecting objectives, outputs, and outcomes. For system reform to be achieved, the Agreement needs to clearly identify tangible, goals with clear measurable outcomes, and timelines that are feasible. Further, the initiative needs to be fully funded over the term of the agreement. This should not sit with one level of government or policy but rather should be incorporated as a whole of government response across all levels from local government, State and Territory governments and the Commonwealth – a unified, national approach is necessary to effect real change.

Key reforms should include:

- A transparent theory of change
- Measurable and time-bound indicators
- Independent, public reporting of progress
- Long-term, pooled funding across Commonwealth, State and Territory, and local government levels.

Conclusion

We commend the Productivity Commission for acknowledging the shortcomings and opportunities to improve the current Agreement, proposing a more inclusive, accountable, more comprehensively evaluated, and coordinated future approach. We urge that the next Agreement be ambitious, equitable, and truly co-designed to improve the lives of all Australians affected by mental ill health and suicide.

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