Military and Emergency Services Health Australia (MESHA), a charity of The Hospital Research Foundation Group

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Submission in response to the Productivity Commission's *Mental Health and Suicide Prevention Agreement Review*, interim report

Introduction

Military and Emergency Services Health Australia (MESHA) is a profit-for-purpose research, training and programs centre that supports the mental health and wellbeing of current and former Australian Defence Force (ADF) members, current and former emergency service personnel, and their families. MESHA conducts co-designed and impact-driven research in priority areas of unmet need. We embed lived experience in the design and delivery of our evidence-based training, programs, resources, and services to ensure authentic and sustainable wellbeing outcomes for service communities.

In MESHA's view, the Productivity Commission's *Mental Health and Suicide Prevention Agreement Review*, interim report, tells a troubling story of increasing system fragmentation, inequity and opaqueness. But it also shows there are many individuals, organisations and governments with strong expertise, deep care, and a genuine appetite for systemic change. And the interim report shows that, as a nation reckoning with mental health and suicide prevention, we are at a critical moment where we must elevate lived experience experts into policymaking, planning, service delivery, research, and evaluation.

MESHA is grateful for the chance to respond to the Productivity Commission's interim report. Our recommendations for short- and long-term change are grounded in evidence, urgent positivity, and a certainty that the community, the sector, and governments want to collaborate rather than compete. Because of the specificity of MESHA's mission, our submission focuses on military and emergency services populations. We do not wish to downplay the needs of other sections of the community, including priority population groups. Rather, we situate the needs of military and emergency services populations in the context of system-wide reform. Our commentary and recommendations relate to:

- a renewed National Mental Health Strategy
- priority populations groups
- Postvention
- social return on investment
- standardising and appraising the evidence base
- lived experience governance
- peer workforce.

A renewed National Mental Health Strategy

The Productivity Commission's draft recommendation 4.1 reads that:

> A National Mental Health Strategy is needed to articulate a clear vision, objectives and collective priorities for long-term reform in the mental health system over the next 20–30 years. The National Mental Health Commission should oversee the development of this Strategy and undertake a co-design process with people with lived and living experience, their supporters, families, carers and kin.
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> The National Mental Health Strategy should take account of the objectives and actions included in the National Suicide Prevention Strategy, which was released in early 2025.
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> The next National Mental Health and Suicide Prevention Agreement should include actions governments will take over the agreement's term that are aligned with the long-term objectives articulated in the strategies.

At a high level, MESHA endorses the Productivity Commission's draft recommendation 4.1. A renewed National Mental Health Strategy, along with the next National Mental Health and Suicide Prevention Agreement, is essential to bring governments, organisations, service providers, and the community together to build an ecosystem of policies, programs and research that is collaborative, practical, and grounded in co-design and the expertise of people with lived experience – and that pursues both short- and long-term outcomes. In MESHA's view, it is essential and urgent that the Strategy and National Agreement reckon with system complexity by:

- committing governments and policymakers to genuinely collaborate with people with lived experience and to give them the skills, understanding, resources, and access to training to do so
- prioritising co-design, including:
    - delivering training programs for the peer workforce to improve quality and overcome workforce shortages
    - supporting and, when necessary, provoking cultural shifts among policymakers, governments, the clinical workforce, and researchers
- requiring governments to provide targeted funding to develop strategies that directly address system dysfunction and inefficient, destructive competition – including competition for funding.

System cohesion and jurisdictional cooperation will not emerge spontaneously or via goodwill alone. We need evidence-based planning and evaluation, we need funding arrangements that encourage collaboration and enable efficiencies, we need better clinical governance, and we need evidence-based evaluations of pilots and programs. For military and emergency services personnel, the system is often even more complex, with cohort-specific as well as state-based and national agencies, strategies, policies, programs, and resources. The Strategy and New Agreement must recognise that this complexity can itself be a barrier to effective care. Sector-wide collaboration and cohesion will not come from positive intentions alone – we need a shared understanding of purpose, of implementation, of training for the peer workforce, of review and measurement of progress, and of research.

MESHA **endorses** the Productivity Commission's recommendation that governments should extend the current National Mental Health and Suicide Prevention Agreement for 12 months, on

the strict proviso that governments use the additional time to build firmer foundations for the Agreement. There is no case for a New Agreement that perpetuates or exacerbates systemic flaws and inefficiencies and that continues to aspire to supporting lived experience without providing the environment for people with lived experience to genuinely influence change.

Priority populations groups: MESHA notes with approval that the current Agreement includes 'Australian Defence Force members and veterans' as one of 15 priority populations groups. The evidence shows that serving and former serving ADF members have higher rates of suicidal thoughts, attempts and deaths than the general Australian community. The evidence also shows that both military and emergency services populations have higher rates of post-traumatic stress, depression, anxiety, and stress than the general community. Regarding priority populations groups, MESHA **recommends** that the new Agreement:

- continues to recognise former and serving ADF members as a priority population group but extends this recognition to their families. Supporting Defence families is critical to maintaining a healthy and high-performing ADF workforce, supporting recruitment and retention targets, and contributing to overall morale, wellbeing, and injury recovery. In turn, the families of serving and former serving members face unique challenges. They need and deserve targeted supports
- recognises emergency services personnel and their families as a priority population group. The Australian community consistently asks emergency services personnel to step up in times of crisis – to face trauma as a routine part of their jobs. The impact of suicide in these populations is estimated to be at least double that of the general population due to the unique context and close-knit emergency service community who are the ones attending a colleague's suicide. As a community, we must recognise the unique challenges that emergency services and their families face – and we must do more to support their wellbeing. In turn, we should recognise that the general community benefits if emergency services agencies meet and exceed recruitment and retention targets to ensure community safety
- provides targeted funding, programs, services, and resources for priority populations groups, including research into the effectiveness of services. Programs, whether new or improved, must be subject to evidence-based evaluation and accountability that is consistent and transparent
- recognise that the government cost of psychosocial injury and suicide could be directly reduced through an evidence-based strategy, and this needs to be piloted and evaluated more broadly across the nation for these populations. MESHA's proven track record and evidence base of programs developed over the past 10 years in world-leading research conditions (including under funding from the Royal Commission into Defence and Veteran Suicide) has produced a suite of three key interventions: Psychosocial Safety education program, GEARS (mental health skills program), and Transition programs. These programs, which directly impact suicide prevention for these high-risk populations, need core funding to complement significant philanthropic investments into scalability for pilots in these population groups nationally to evaluate the health economics and the social return on investment.

Postvention: According to the Productivity Commission interim report, suicide prevention in Australia is 'in a period of transition' as it moves towards 'an integrated, whole-of-government

approach addressing the social and emotional factors affecting suicidality and recognises the suicide prevention system as sitting alongside the mental health system, not within it'. The Productivity Commission suggests the New Agreement be guided by The National Suicide Prevention Strategy 2025-35, and that areas unique to suicide prevention should be included in a separate schedule to ensure they receive sufficient attention.

MESHA **recommends** that:

- the New Agreement explicitly recognises postvention as a key element of prevention for priority population groups and the broader community, incorporated in psychosocial risk legislation
- governments allocate protected funding for the evidence-based development of postvention frameworks for these populations, followed by implementation of targeted postvention services and evaluation for military and emergency services populations, and that this commitment be expressed clearly in the proposed new Schedule.

While the existing Agreement acknowledges the importance of postvention resources and services, there remains an urgent need to translate this recognition into cohesive implementation of policy, delivery of pilots and services, targeted funding, and evaluation. MESHA's research has found that many organisations recognise the importance of postvention but may lack the expertise, trained staff, or resources to deliver effective and timely services. We have seen the significance of suicide bereavement and postvention for military and emergency services populations a research and programs priority, including by:

- continuing to work for with Defence to create a postvention framework and network of services, responding to recommendations 76 and 77 of the Royal Commission into Defence and Veteran Suicide final report
- publishing an environmental scan of postvention after suicide research, services and guidelines for former and serving military members, former and serving emergency services personnel, and their families.
- undertaking a comprehensive needs assessment of current and former emergency services personnel and their families who have been impacted by the suicide death of emergency services personnel (for public release in August 2025).

Social return on investment: The Productivity Commission's interim report notes the significant investments the Australian Government and state and territory governments are making in mental health and suicide prevention – an estimated $12.2 billion in national recurrent spending in 2021-22.

MESHA **recommends** that efficiency and productivity measures routinely include evidence-based social return on investment measures. MESHA's research into art therapy for military and emergency services personnel experiencing post-traumatic stress syndrome found that for every $1 invested there was a $3.05 return in social value. This kind of research can help measure effective policy and interventions to reduce the cost-burden of suicide and the impact value of these investments.

Standardising and appraising the evidence base: the Productivity Commission's interim report states that its final review 'will assess the objectives, outcomes, and outputs of the

National Agreement and its intent to strengthen the evidence base for policy development and identify opportunities for systemic reform'. MESHA **recommends** that:

- the new Agreement help progress the creation of a concrete, nationally consistent understanding of robust evidence and best practice, as well as consistent and outcomes-based evaluation measures for programs, pilots, resources and services
- the new Agreement explicitly set out the critical importance of lived experience expertise as part of the evidence base, including guidelines about how to weigh lived experience evidence with other forms of expert knowledge.

Lived experience governance: the Productivity Commission's draft recommendation 4.7 states that the next Agreement 'should support a greater role for people with lived and lived experience in governance'. MESHA **endorses** this recommendation as a matter of urgency. The interim report's information request 4.2 asks for '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?' MESHA **recommends**:

- using existing organisations who already facilitate and coordinate best practice lived experience models to channel these members into appropriate government forums as an effective way to engage these community members
- recognising that organisations such as MESHA invest heavily in recruiting and training lived experience members who can be accessed as articulate and proactive lived experience representatives to inform government consultations and forums.

Peer workforce: the Productivity Commission's draft recommendation 4.13 states that the next National Agreement should support implementation of the National Mental Health Workforce Strategy, including 'an explicit delineation of responsibility and funding for workforce development initiatives'. Recommendation 4.14 states that '[t]he next agreement should commit governments to develop a nationally consistent scope of practice for the peer workforce'.

MESHA has developed an evidence-based paraprofessional model for its peer workforce, including extensive training and associated clinical governance processes. MESHA **recommends** development of a nationally consistent, evidence-based approach to peer workforce training, while also emphasising that some population groups, including military and emergency services populations, have distinct cultures, experiences and needs. MESHA has 10 years of evidence-based research into the development of an effective and productive lived experience workforce training model. We can provide guidance and modelling on the "how to" with key principles to inform frameworks and guidelines, including clinical and corporate governance structures, nationally across government and other service provision sectors.