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

Contact

Amanda Proposch
CEO, Gippsland PHN
Chair of the Mental Health and Alcohol and Other Drugs Coordination Committee | PHN Cooperative

Philip Amos
National Policy and Capacity Building Manager | Mental Health and Alcohol and Other Drugs

Primary Health Network (PHN) Cooperative

Contents

Executive Summary

The Productivity Commission's Interim Report on the National Mental Health and Suicide Prevention Agreement (the Agreement) Review offers a clear and unambiguous assessment of the limitations of the current Agreement together with practical measures to ensure the next Agreement is fit for purpose.

The PHN Cooperative is pleased that the PC Interim Report has accepted much of the feedback of PHNs' experience of the current Agreement articulated in our initial Review submission.

The PHN Cooperative agrees with the Productivity Commission's (PC's) findings of why the Agreement has not been effective, correctly identifying the challenges created by weak governance structures, a failure to align the Agreement's objectives with funding and activities, and a lack of appropriate monitoring and reporting requirements.

While the current Agreement has yielded limited progress on some issues, for PHNs the benefits are outweighed by the administrative burden of navigating bi-lateral governance structures, and responsibility for deliverables that are not appropriately aligned with system reform objectives or incentives.

The PHN Cooperative has broad agreement for the recommendations of the Interim Report which should inform the development of the next Agreement.

The PHN Cooperative supports the recommended foundations for a successful next Agreement including NMHC led co-design with the lived and living experience community, clearly agreed national priorities negotiated by the Department of the Prime Minister and Cabinet, dedicated funding for collaborative initiatives and enablers of collaboration, and development of a nationally consistent set of outcome measures for mental health and suicide prevention.

The PHN Cooperative supports action to address the unmet need for psychosocial supports outside the National Disability Insurance Scheme; however, we oppose the recommendation that state and territory governments should be responsible for commissioning these services. As the current commissioners of the Commonwealth Psychosocial Support Program, PHNs should be retained as commissioners of new psychosocial support services to align with these new services with regional community needs and system gaps, and to leverage the complementary primary mental health care programs PHNs commission.

We note the proposed reliance on the National Mental Health Commission and National Suicide Prevention Office for monitoring and reporting roles has risks given the current uncertainty over the future status and independence of these bodies.

The scope of recommendations and timelines for implementation are ambitious. Even with the recommended extension of the current Agreement to June 2027, there is substantial risk that foundational work such as developing a new National Mental Health Strategy and establishing the National Mental Health Commission as an independent statutory authority would not be sufficiently progressed to inform negotiations for the next Agreement.

Overall, the Interim Report findings and recommendations articulate a clear direction for a more effective mental health and suicide prevention system under the next Agreement.

PHN Cooperative Response to Findings, Recommendations, and Information Requests

Draft finding 2.1 **Progress has been made in delivering the Agreement's commitments, but there has been little systemic change**
Assessing the progress made under the National Mental Health and Suicide Prevention Agreement is difficult. Recent data is not readily available and jurisdictions have not adhered to all their monitoring and reporting commitments. The effects of significant external factors, such as the COVID-19 pandemic, are difficult to disentangle. Since the Agreement was signed in 2022: • governments have delivered most of the Agreement's outputs. Some key commitments have not been completed. This includes resolving issues affecting the delivery of psychosocial supports outside the National Disability Insurance Scheme, publication of the National Stigma and Discrimination Reduction Strategy and development of the National Guidelines on Regional Commissioning and Planning. • there has been little change in measures related to the Agreement's outcomes, which focus on improving mental health and reducing suicide rates. • progress towards the Agreement's intent to create an integrated, person-centred mental health and suicide prevention system has been piecemeal.

The PHN Cooperative agrees with this draft finding.

PHNs experience of progress under the Agreement is that the translation of objectives into bilateral actions has been fragmented and inconsistent. These actions have been interpreted variably, applied unevenly, and often lacked coherence with the overarching national intent.

Moreover, the absence of a uniform compliance and assurance framework, coupled with inconsistent and, in some cases, absent monitoring mechanisms, has led to an evidentiary base that is weak and highly variable across jurisdictions. This undermines the capacity to assess progress meaningfully and to ensure accountability in delivering on the Agreement's objectives.

Draft finding 2.2 **The Agreement has not led to progress in system reform**
Overall, actions taken as a result of the National Mental Health and Suicide Prevention Agreement have not led to real progress towards improvements in the mental health and suicide prevention system.

The PHN Cooperative agrees with this draft finding.

For PHNs, the Agreement is intended to enable a significant system reform in our role as regional commissioners, coordinators, and capacity builders. That is, from primarily being a vertically aligned funding model of planning and commissioning with Commonwealth funding to a joint integrated model where we work in formal partnership with LHNs and States and Territory Governments to jointly plan and co-commission services under a joint investment model.

This shift has yielded minimal real progress towards improvements in the mental health and suicide prevention system because of the significant challenges in the governance and operational mechanisms of the Agreement and bi-laterals.

PHNs agree that, although the Agreement outlines important objectives, the absence of clear implementation plans, agreed-upon outcome measures, and effective joint funding models has entrenched fragmentation and forced undue reliance on locally led relationships to drive implementation.

Some PHNs have been successful using the bi-lateral relationships to open new discussions on system issues, however other PHNs have found resistance at the regional level due to a lack of clear expectations and accountability mechanisms.

PHNs support a new Agreement that includes improved governance, participation, and accountability arrangements as outlined in the PC's Interim Report.

Draft recommendation 2.1 **Deliver key documents as a priority**
By the end of 2025, the Australian Government should publicly release: • the National Stigma and Discrimination Reduction Strategy • detailed National Guidelines on Regional Planning and Commissioning that meet the needs of primary health networks and local hospital networks.

The PHN Cooperative agrees with this draft recommendation.

National Guidelines on Regional Planning and Commissioning

PHNs are well placed to contribute to a tripartite development process with the Commonwealth and State and Territory Governments in the development of National Guidelines and to share our learnings from joint regional planning and commissioning under the current Agreement.

While the recently released National Principles for Regional Planning and Commissioning of Mental Health and Suicide Prevention Services provide a valuable starting point, they do not yet offer the level of operational guidance needed to support safe, equitable, and effective planning envisaged in the Agreement to join up systems across the national, jurisdictional, and regional levels.

We note the reported complexity and challenges of developing National Guidelines that would meet the needs of all parties to the Agreement, however PHNs support a renewed attempt to co-develop guidelines that are fit for purpose and reflect the seriousness of intent underpinning the Agreement.

Within a stronger governance model, National Guidelines could formalise the role of regional planning and commissioning within bilateral agreements informed by a clear articulation of expectations, accountability structures and shared governance.

PHNs would benefit from National Guidelines that articulate:

- roles and responsibilities for joint regional planning and commissioning across each of the participants, that is, the baseline expectations for participation
- clarity on the Agreement's systemic purpose and intended outcomes of joint regional planning and commissioning so that participants can avoid duplicating existing PHN or LHN planning activities
- guidance on responsibilities for planning inputs such as data sharing between PHNs and LHNs
- practical guidance on joint planning and implementation methodologies appropriate to the Agreement context
- examples of joint regional governance models
- approaches to capability building that enable planning to mature into integrated commissioning.

National Guidelines of this nature would help to create an authorising environment conducive to PHNs, LHNs, and State and Territory governments delivering effective jointly planned and commissioned services at the regional level.

An option to support National Guidelines are standards and quality mechanisms that treat planning and commissioning as an impactful practice that underpins the success of the next Agreement. Development of planning standards and quality mechanisms would be a practical means to establish a baseline level of consistency at the regional level, to clarify roles and responsibilities, and strengthen accountability for these activities under the next Agreement.

Another national mechanism to strengthen planning and commissioning is the establishment of a national mental health knowledge translation platform - a What Works Networks based on similar projects in the Australian and UK health systems (www.gov.uk/guidance/what-works-network).

These Networks collate existing evidence on the effectiveness of programs and practices and would support PHN and LHN commissioners and policymakers to use these findings to implement the next Agreement. This collaborative initiative would improve decision-making by focusing on understanding the conditions under which programs and practices are effective, systematically gathering, evaluating, and sharing evidence to reveal not just what works or doesn't, but critically in what contexts and for whom.

A national What Works Network would help embed a culture of learning and accountability by enabling planners to understand not just what works, but under what conditions, supporting the adaptation of proven approaches to local settings.

National Stigma and Discrimination Reduction Strategy

PHNs support the release of the National Stigma and Discrimination Reduction Strategy, viewing it as a valuable framework to align national and regional efforts to reduce stigma which impact service access and safety.

Release of the National Strategy should be a priority. This Strategy could underpin other key strategic initiatives, such as advancement of the lived experience workforce and lived experience participation in all stages of commissioning cycles, noting stigma and discrimination impacts adversely on these aspirations.

Draft finding 3.1 **The National Mental Health and Suicide Prevention Agreement is not effective**
The National Mental Health and Suicide Prevention Agreement is not an effective mechanism for facilitating collaboration between governments to build a better person-centred- mental health and suicide prevention system for all Australians. Some aspects of the Agreement are commendable, including its ambition, whole-of-government approach and commitments to improve services and address gaps in several important areas. However, a range of problems are limiting its effectiveness. • The Agreement does not set out clear and focused objectives and outcomes, and actions connected to their achievement. • Roles and responsibilities at the national and regional level are still unclear. • People with lived and living experience of mental ill health and suicide, their supporters, families, carers and kin have not been meaningfully included in the governance arrangements, or the design, planning, delivery and evaluation of services under the Agreement. • The governance structures are not effective, and monitoring and accountability is lacking. • The Agreement does not address key barriers to reform, including system fragmentation, insufficient collaboration, a lack of flexibility in funding arrangements and workforce shortages.

The PHN Cooperative agrees with this finding.

The Agreement requires significant reform if it is to achieve its intended purpose of facilitating collaboration between governments, PHNs, LHNs, and the community to build a better person-centred- mental health and suicide prevention system for all Australians.

As detailed in our first Review submission, PHNs have experienced acute implementation challenges arising from the national and bi-lateral governance structures, and the unclear roles and responsibilities at the national and regional level under the Agreement.

At the regional and service levels, the shortcomings in the current Agreement have contributed to the failure of bi-lateral activities being operationalised with the spirit and intent of recommended reforms and activities. The lack of transparent monitoring and accountability mechanisms to measure progress has led to poor information flows at the regional level.

PHNs support clearly defined roles and responsibilities at both national and local levels to translate high-level objectives into tangible outcomes, noting that ambiguity only perpetuates inertia and service gaps.

PHNs support a new Agreement that aligns national priorities with strengthened regional planning and commissioning authority, underpinned by appropriate legislative levers and funding.

Draft recommendation 4.1 **Developing a renewed National Mental Health Strategy**
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. 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. 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.

The PHN Cooperative agrees with this recommendation.

PHNs agree that systemic reform would benefit from a National Mental Health Strategy that articulates a clear vision, objectives and collective priorities, however we note that it will be challenging to develop a National Strategy in sufficient time to inform the next National Agreement even if this is delayed until July 2027 as recommended by the PC. The current uncertainty over the status and future role of the National Mental Health Commission increases this risk.

PHNs support the development of a renewed National Mental Health Strategy with clear, long-term objectives to unify and simplify the current array of guidance documents. Long-term objectives and strategy should then be enabled through funding, planning and commissioning cycles that provide stability and certainty for providers and consumers.

To enable an effective Agreement, a renewed National Mental Health Strategy must also align with existing jurisdictional mental health and suicide prevention strategies. This alignment is important as it can address the current challenge of mis-aligned expectations between PHNs and LHNs at the regional level which have limited the benefits of joint regional planning and commissioning.

Draft finding 4.1 **A new and more effective agreement is needed**
A national agreement can be an effective mechanism to advance reform in the mental health and suicide prevention system, especially to facilitate joint actions by governments. To achieve this, the next agreement will need: • a clear set of objectives that relate to the long-term visions set out in the National Suicide Prevention Strategy and a renewed National Mental Health Strategy

The PHN Cooperative supports this finding.

A new Agreement can be more effective if it is:

- informed by a new National Mental Health Strategy and the National Suicide Prevention Strategy
- implemented within a governance framework that better defines and authorises PHN action
- is supported by a specific and measurable outcome framework to ensure parties are accountable.

While the current Agreement has created challenges for PHNs, the PHN Cooperative believes the Agreement's intent of joined up planning and commissioning, with a co-investment model between Commonwealth and jurisdictions, is appropriate to achieve progress towards joined up systems that deliver better outcomes for the community.

Draft recommendation 4.2 **Building the foundations for a successful agreement**
The current National Mental Health and Suicide Prevention Agreement, including funding commitments, should be extended until June 2027, to give sufficient time to develop the foundations of the next agreement and renew the National Mental Health Strategy. To support the next agreement: • the National Mental Health Commission should run a co-design process with people with lived and living experience, and their supporters, families, carers and kin to identify relevant and measurable mental health and suicide prevention objectives and outcomes • the Department of the Prime Minister and Cabinet should convene negotiations with the support of the National Mental Health Commission, and facilitate engagement between the Australian, state and territory governments on their shared priorities

• commitments and actions intended to improve collaboration across all government portfolios should be included in the main body of the agreement rather than a separate schedule. Governments should allocate dedicated funding for collaborative initiatives and enablers of collaboration

• the Australian Institute of Health and Welfare should lead the development of a nationally consistent set of outcome measures for mental health and suicide prevention. Implementation plans to develop any new indicators should be in place within 12 months of the agreement being signed.

There is high support for this recommendation among PHN Cooperative members, while noting the need to move away from the current top-down approach to collaboration and instead create an authorising environment for PHNs and other participants to drive system reform at the regional and jurisdictional levels.

A successful next Agreement will create the conditions at the regional level for PHNs to exercise our full capacity as coordinators of system reform, commissioners to address local needs, and capacity builders of local service providers and markets.

Regarding the proposed supports for the next Agreement:

- Co-design led by the National Mental Health Commission: will be a welcome step to ensure the next Agreement's objectives and outcomes are aligned with the needs of Australian people across urban, regional, rural, and remote communities.
- Department of Prime Minister and Cabinet to convene negotiations with jurisdictions on shared priorities: PHNs will welcome clear direction from Government on the key national challenges that the Agreement is intended to address, to inform our regional implementation role.
- Governments should allocate dedicated funding for collaborative initiatives and enablers of collaboration: in our Review submission, PHNs reported the high burden and costs associated with navigating the current Agreement's governance and undertaking regional deliverables in planning and co-commissioning. Funding for the enablers of collaboration should focus on engaging Agreement participants at the regional and jurisdictional level to clarify expectations, promote innovation, and demonstrate good practice.
- Australian Institute of Health and Welfare should lead the development of a nationally consistent set of outcome measures for mental health and suicide prevention: PHNs support this activity and are motivated to contribute, noting the high relevance of outcome measures to our regional planning and commissioning role.

Draft recommendation 4.3

The next agreement should have stronger links to the broader policy environment

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. As a starting point, the next agreement should link to:

• the National Health Reform Agreement, which provides much of the funding for the mental health and suicide prevention system

• key policies in relevant non-health portfolios, such as the Better and Fairer Schools Agreement which will support the whole-of-government approach needed to improve mental health and suicide prevention outcomes (draft finding 4.1)

• jurisdictional mental health and suicide prevention policy documents, which should inform the bilateral schedules developed under the agreement

• policy documents related to Aboriginal and Torres Strait Islander social and emotional wellbeing, including the National Agreement on Closing the Gap (draft recommendation 5.1).

The PHN Cooperative agrees with this finding.

The lack of alignment and integration between the current Agreement, its bilateral schedules, and other key policy documents and governance processes (such as under the National Health Reform Agreement) has been a significant barrier to reform. This disconnect has undermined coherence, accountability, and strategic alignment, limiting the capacity of PHNs, jurisdictions and stakeholders to plan and implement reforms effectively.

To enable meaningful progress, the next Agreement must be explicitly aligned with established governance structures, ensuring that reforms are embedded within the broader system architecture and supported by consistent oversight, coordination, and assurance mechanisms.

PHNs support greater recognition of the social determinants of mental health and suicide prevention in the next Agreement, such as housing, employment, cost of living pressures, and rurality, along with other social factors relating to disability and community supports. Creating formal collaboration mechanisms between health and non-health sectors would support wider interagency focus upon mental health and wellbeing.

PHNs agree that referencing broader agreements (e.g. NDIS reforms, the National Plan to End Violence Against Women and Children 2022–2032, and the National Partnership Agreement on Family, Domestic and Sexual Violence Responses 2025–2030) will help identify opportunities to fund activities such as linking with housing support services to assist people experiencing homelessness, and to foster enduring cross-sector partnerships.

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.

The PHN Cooperative supports an additional schedule in the next Agreement, if that schedule is enabled in the through improved governance, planning and commissioning mechanisms for the integration of AOD, mental health and suicide prevention activities.

Without enabling reform for integration at the regional level, PHNs note a high risk that the additional schedule could create funding silos that do not align with the Agreement's intent.

The PHN Cooperative notes the proposed additional schedule will require preliminary work to align governance, strategy and workforce capacity across AOD, mental health and suicide prevention.

PHNs recognise there may be advantages in an additional schedule, including the ability to target investment towards people with co-occurring conditions who are often excluded from services, and the potential for improved care coordination through integrated, cross-sector models.

However, PHNs note the AOD policy and funding environment is highly siloed and not easily integrated by PHNs at the regional level, where competing funding, reporting, and regulatory frameworks limit the innovation and scalability of AOD, mental health, and suicide prevention service integration.

For example, funding, planning, and commissioning of community based AOD treatment is divided between Commonwealth Government national commissioning (including from DHDA and NIAA), PHN regional commissioning, and jurisdictional statewide and LHN programs.

We also note the absence of a formal national governance mechanism for AOD collaboration between the Commonwealth and jurisdictional partners, as the National Drug Strategy inter-governmental arrangements were disbanded during the COVID pandemic.

As such, an additional schedule will be dependent on preliminary work to institute joint governance and collaboration mechanisms across AOD, mental health, and suicide prevention funders, commissioners, peaks, providers and community.

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 would require clear delineation of roles and responsibilities across AOD funders and commissioners, and clear and effective guidance on the purpose and intended outcomes of new activities to integrate AOD, mental health and suicide prevention at the regional level.

AOD providers report to PHNs that there are significant funding and workforce challenges in the sector at present. It is not clear that there are available workforces in all regions that are trained and skilled to deliver integrated models of care for people experiencing co-occurring AOD, mental ill health and suicide prevention needs.

Successful implementation will require workforce development via cross-sector training, mentoring and supervision, thereby enhancing staff capacity to deliver holistic care.

As such, PHNs also acknowledge risks with this proposal: if underpinning governance is not properly established then existing silos may persist; without additional investment, staff could face unsustainable workloads; and introducing another schedule risks adding complexity, duplication and funding confusion to an already siloed system.

Draft recommendation 4.4 **Governments should immediately address the unmet need for psychosocial supports outside the National Disability Insurance Scheme**
The Australian, state and territory governments need to immediately agree to responsibilities for psychosocial supports outside the National Disability Insurance Scheme. State and territory governments should be responsible for commissioning services and commence work to address the unmet need. The next agreement should: • confirm the roles and responsibilities for psychosocial supports and the funding split between the Australian, state and territory governments • include Australian Government funding to the state and territory governments to help cover the shortfall in support • include a detailed plan and timeline for the expansion of services, with the aim of fully addressing the unmet need by 2030.

The PHN Cooperative supports action to address the unmet need for psychosocial supports outside the National Disability Insurance Scheme; however, we oppose the recommendation that state and territory governments should be responsible for commissioning these services. As the current commissioners of the Commonwealth Psychosocial Support Program, PHNs should be retained as commissioners of new psychosocial support services to align with these new services with regional needs and system gaps, and to leverage the complementary primary mental health care programs that PHNs commission.

Future funding arrangements for psychosocial supports

The interdependent relationship between psychosocial support services and PHN-commissioned treatment activities and outcomes should be explicitly recognised and prioritised for action in the next Agreement. This conjoint dependency is critical to achieving sustained recovery and improved mental health outcomes, particularly for individuals with complex needs.

PHNs are ideally placed to deliver the Agreement's objectives of a more integrated approach that ensures that psychosocial supports are systematically embedded within treatment pathways and resourced accordingly. As commissioners of the Commonwealth Psychosocial Support Program, PHNs currently plan and commission psychosocial supports according to regional needs that are integrated with complementary mental health, suicide prevention, and AOD programs that we are responsible for.

Effective mental health treatment cannot be delivered in isolation from the broader psychosocial context, and the proposal for state and territory governments to be responsible for commissioning risks undermining the coherence and effectiveness of care.

Retaining PHNs' commissioning role in new psychosocial supports would enable new services to be commissioned according to demonstrated local needs and avoid fragmentation and duplication. This approach would leverage existing capacity, provider relationships, and consumer access pathways of the existing PHN allocation under the Commonwealth Psychosocial Support Program.

Planning and commissioning data should be shared

Access to regionally specific locational data that informed The Analysis of Unmet Need for Psychosocial Supports outside of the National Disability Insurance Scheme Report (2024), would greatly assist PHNs to commission psychosocial support services in priority locations with identified unmet psychosocial need.

Draft recommendation 4.5 **The next agreement should clarify responsibility for carer and family supports**
The next agreement should clarify the level of government responsible for planning and funding carer and family support services for supporters, families, carers and kin of people with lived and living experience of mental ill health and suicide.

The PHN Cooperative agrees with this draft recommendation.

Consistent with the draft recommendations 4.5 and 4.7, PHNs support the next Agreement to include clear roles for supporters, families, carers and kin of people with lived and living experience of mental ill health and suicide.

PHNs recognise the opportunity for flexible funding that enables service providers to integrate family and carer support within their broader models of care (when and where appropriate), rather than relegating it to standalone carer-only programs.

Draft recommendation 4.6

Increase transparency and effectiveness of governance arrangements

The effectiveness of the next agreement's governance arrangements should be improved by:

• including a governance framework that emphasises transparency and collaboration, and outlines accountability, reporting and evaluation functions

• embedding and formalising the participation of people with lived and living experience of mental ill health and suicide in the design and implementation of governance arrangements

• clarifying the role of the Social and Emotional Wellbeing Policy Partnership established under the National Agreement on Closing the Gap as the decision-making forum over issues that relate to Aboriginal and Torres Strait Islander social and emotional wellbeing (draft recommendation 5.1).

To support effective operation of the agreement's governance arrangements, the Australian Government should:

• establish the National Mental Health Commission as an independent statutory authority and task it with monitoring and reporting on progress and outcomes (draft recommendation 4.8)

• publish information about the composition and activities of the working groups established under the agreement

• adequately resource the agreement's administrative functions and ensure timely and effective information sharing across working groups.

The PHN Cooperative has a high level of agreement with this draft recommendation.

Improved governance arrangements

PHNs support improved governance arrangements in the next Agreement that emphasise transparency and collaboration. In the next Agreement PHNs are seeking to be formally recognised in the national and bilateral governance commensurate with our roles and responsibilities for deliverables, and to have increased opportunities to contribute our subject matter expertise as regional planners and commissioners.

PHNs support the recommendation for embedding and formalising the participation of people with lived and living experience of mental ill health and suicide in the design and implementation of governance arrangements. Implementing this recommendation can strengthen the effectiveness and responsiveness of governance for the next Agreement.

Effective operation of governance

PHNs support improved monitoring, reporting, and public information sharing of the composition and activities of the working groups established under the agreement.

PHNs note that the National Mental Health Commission may be well-placed to serve as a central entity with the expertise to monitor and report on Agreement progress, if the Commission is re-established as an independent statutory authority. However, PHNs recommend greater clarity on how the Commission's role aligns with bilateral schedules and local implementation partners, including state and territory Mental Health Commissions. PHNs also highlight the practical challenges the Commission may face in assessing, monitoring, and reporting on progress at the regional level, particularly across PHNs and LHNs, where local context and variation are significant.

It remains extremely difficult to obtain a clear and comprehensive understanding of who is receiving what services, from whom, at what cost, and with what effect—within any given community, town, city, or region. While data provided by agencies such as the Australian Institute of Health and Welfare is extensive, it is not sufficiently focused on answering these critical questions.

To support meaningful reform and accountability, data systems must be reoriented to provide actionable insights at the local level, enabling stakeholders to assess service reach, equity, and effectiveness in real terms. This is essential for identifying gaps, targeting investment, and ensuring that care is both accessible and impactful for all population groups.

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?

Examples of barriers to the genuine participation and influence of people with lived and living experience in governance forums.

PHNs recognise that tokenistic engagement of people with lived and living experience (LLE) in governance continues to undermine genuine participation and co-design.

PHNs recognise that inadequate support, preparation and remuneration for LLE participants create unfair barriers, including expectations that personal stories are shared without context; these experiences, if managed poorly, can re-traumatise people.

PHNs have strong support for recommendations to embed and formalise the participation of people with lived and living experience of mental ill health and suicide in the design and implementation of governance arrangements.

PHNs support a diversity in LLE representation, including actively recruiting Aboriginal and Torres Strait Islander peoples, LGBTIQA+SB communities and culturally and linguistically diverse voices, and for the elimination of exclusionary clinical or bureaucratic jargon that alienates non-professional experts.

How could successful inclusion and engagement of people with lived and living experience in governance be measured?

PHNs propose that meaningful inclusion requires robust measures of both participation and influence.

Quantitatively, PHNs suggest reporting the number and proportion of governance roles held by LLE participants and establishing co-designed governance structures with terms of reference developed in partnership.

Qualitatively, PHNs suggest the collection of feedback from both active and disengaged LLE participants on whether they feel heard, respected and able to shape outcomes.

PHNs support best-practice support mechanisms, including capacity building, mentoring, flexible participation modalities, regular debriefs, and transparent, fair remuneration policies that value LLE expertise on par with professional contributions.

Draft recommendation 4.7

The next agreement should support a greater role for people with lived and living experience in governance

The Australian, state and territory governments should address barriers to the effective involvement of people with lived and living experience in the governance of the next agreement. This should include limiting the use of confidentiality agreements with lived and living experience representatives, opening greater opportunities for communication between lived and living experience working groups, other working groups and the senior officials group, and appropriately remunerating lived experience representatives.

The makeup of governance forums for the next agreement should be reconfigured to ensure:

• adequate representation of people with lived and living experience at each level of governance

• balanced representation between people with lived and living experience of mental ill health and lived and living experience of suicide

• governance roles for carers commensurate with the significant role they play in Australia's mental health and suicide prevention system.

The next agreement should articulate formal roles for the two recently established national lived experience peak bodies in its governance arrangements. These bodies should be adequately resourced to fulfill these roles.

The PHN Cooperative agrees with this draft recommendation.

PHNs support greater involvement of people with lived and living experience of mental health and suicide and for carers and family in governance and regional co-design processes to inform what is working well, what is missing, and what requires funding.

Under the current Agreement, PHNs are engaging and collaborating with people with lived and living experience, and call for sustained, dedicated resourcing to include people with lived and living experience (including carers, families and kin) in all aspects of governance, planning and service delivery.

Clarifying the requirements of parties to the Agreement at national, jurisdictional and regional levels to include representatives with lived and living experience will create a stronger authorising environment for their participation.

PHNs agree that comprehensive Peer Workforce Frameworks, with investment in support structures, supervision and career development pathways, are essential to professionalise and sustain this workforce. PHNs want remuneration models rethought to recognise lived experience as an asset in staffing and governance, ensuring fair compensation and empowering contributors.

PHNs would support inclusive representation in the next Agreement that extends to those with lived experience of alcohol and other drug use and for appropriate participation from other priority populations such as culturally and linguistically diverse, LGBTIQA+SB and Aboriginal and Torres Strait Islander communities, and those living in remote and very remote communities, to ensure that governance and service design benefit from the full diversity and intersectionality of lived perspectives.

Draft recommendation 4.8 **A greater role for the broader sector in governance**
The next agreement should support a greater role for service providers and the broader mental health and suicide prevention sectors in governance. Both mental health and suicide prevention providers should take part in governance mechanisms.

PHN Cooperative members broadly support this finding.

PHNs agree that addressing complex needs, service gaps and systemic issues, and achieving holistic care that incorporates social determinants of health, requires both vertical integration across levels of government and horizontal engagement across sectors.

Under the current Agreement, governance participation was limited and opaque and failed to enable broader sector participation commensurate with the scope, intent, and need for mental health and suicide prevention system reform.

As detailed in our initial submission, PHNs would welcome greater participation in regional, jurisdictional and national governance, commensurate with our significant role and responsibilities for delivering activities under the Agreement.

At the regional level, PHNs lead collaborative, cross-sector engagement in mental health and suicide prevention planning and commissioning that brings together service providers, General Practitioners, people with lived and living experience, first responders, education, peak bodies, and local and state government agencies.

To support this, appropriate funding should be allocated to enable meaningful participation, including mechanisms for engagement, capacity building, and remuneration. Embedding these voices within governance structures will strengthen accountability, improve service relevance, and promote more equitable outcomes.

Draft recommendation 4.9 **Share implementation plans and progress reporting publicly**
The Australian, state and territory governments should publish all implementation plans and jurisdictional progress reports developed under the next agreement. The National Mental Health Commission should be empowered to assess and report on progress independently, using information beyond what is reported by governments. The Commission should publish national progress reports as they are finalised, without requirements for jurisdictions' sign-off.

PHN Cooperative members broadly support this finding.

PHNs advocate for transparency built upon clear, well-informed implementation plans and reporting metrics that are developed from the ground up and grounded in real-world experience.

Requirements for governments, PHNs and providers to report on activities and outcomes must be balanced with the cost and administrative burden of collection. PHNs support further development of reporting frameworks to focus on data that inform service improvement and accountability under the next Agreement.

Public sharing of implementation plans and reporting will also inform, align, and motivate regional action under the next Agreement. Visibility of implementation plans including good practice examples, and progress reports are a valuable tool for PHNs and LHNs to engage local stakeholders and are essential for reviewing implementation progress and ensuring plans remain responsive to evolving local needs. Seeing regional-level activity in the context of a national program provides further impetus for local stakeholder participation.

Similarly, any development and implementation of changes to implementation and progress reporting measures should be communicated transparently to stakeholders at the regional level.

Empowering the National Mental Health Commission to assess and report on progress independently will support greater accountability among Agreement parties.

Draft recommendation 4.10 **Strengthening the National Mental Health Commission's reporting role**
The next agreement should formalise the role of the National Mental Health Commission as the entity responsible for ongoing monitoring, reporting and assessment of progress against the agreement's outcomes. The Commission should have legislative provisions to compel information from Australian, state and territory government agencies to fulfil its reporting role. The National Suicide Prevention Office should be given an advisory role in monitoring and reporting on the next agreement. It should also be responsible for the monitoring and reporting on progress against the separate suicide prevention schedule (draft recommendation 6.1).

PHN Cooperative members broadly support this finding.

PHNs support the formalisation of the National Mental Health Commission as the principal body responsible for monitoring, reporting and assessing progress under the Agreement, underpinned by a clear legislative mandate to ensure independent, transparent and consistent oversight.

The proposal for the Commission to have legislative provisions to compel information from Australian, state and territory government agencies to fulfil its reporting role is appropriate. However, we note the current uncertainty over the status and future role of the National Mental Health Commission. Should the Commission not be established as independent of Government, the legislative provisions may not be exercised effectively.

There is PHN support for this authority to enable the Commission to deliver accurate, evidence-based assessments, identify gaps or delays in implementation, and drive system-wide transparency and continuous improvement.

Regarding the role of the National Suicide Prevention Office, PHNs note that the PC Interim Report has not recommended the National Suicide Prevention Office be re-established as an independent statutory authority, as it has for the National Mental Health Commission (draft recommendation 4.6).

Given the uncertainty over its future status, independence and authority, it is unclear whether the National Suicide Prevention Office would be able to effectively monitor and report on the proposed suicide prevention schedule.

In principle, there is PHN support for the recommendation for the National Suicide Prevention Office to be assigned an advisory role in monitoring and reporting on the Agreement alongside responsibility for its dedicated suicide prevention schedule, ensuring that suicide prevention receives the specialist focus and oversight it requires within the Agreement. However, this is conditional on the National Suicide Prevention Office being established with the requisite independence and authority for the role.

PHNs note the limitations of national reporting to illuminate regional variation and local implementation issues. Appropriate transparency for regional deliverables and outcomes should be considered as per our response to Information request 4.3.

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?

To support meaningful reform and accountability, a new and dedicated national repository for mental health data is required. This repository should enable regional-level analysis and tracking of jurisdictional progress, aligned with the objectives of the next Agreement.

In conjunction with data collected by the National Mental Health Commission, this repository should aggregate information in a non-disclosive format, allowing public access to key metrics—such as the cost and outcomes of publicly funded services at the local level—using the NMHSP Indicator Specification and disaggregated by relevant population groups as defined in the revised Agreement.

Consideration should be given to the development by AIHW of a public-facing mental health observatory, like the UK Government's Office for Health Improvement and Disparities Spend and Outcome Tool. Such a platform would allow the public to see how investment in mental health services translates into outcomes across regions and populations. It would also reinforce the intent of the Agreement by embedding transparency within a regional governance framework.

In parallel, a system of authorised access to more sensitive data should be developed, drawing on models such as the Health Demand and Supply Utilisation Patterns Planning (HeaDS UPP) Tool and the National Suicide and Self-Harm Monitoring System, to support deeper analysis and informed decision-making by planners, commissioners, and researchers.

In addition to national dashboards, PHN could be resourced for the development of locally governed public dashboards consistent with the national outcomes of the next Agreement. Dashboard design would be co-designed with the practitioners and community members to ensure accuracy, relevance and meaningful interpretation.

PHNs support subject-matter expertise to guide tailored metrics for specific activities, acknowledging that mental health indicators are not always appropriate for suicide prevention services, and highlight that the Primary Mental Health Care Minimum Data Set is currently unfit for purposes such as bereavement support services and some community-based prevention programs.

PHNs support data collection and reporting to be aligned with existing platforms and measurement frameworks, avoiding duplication and minimising administrative burden.

Draft recommendation 4.11 **Survey data should be routinely collected**
The Australian Government should fund the routine collection of the National Study of Mental Health and Wellbeing and the National Child and Adolescent Mental Health and Wellbeing Study, running the surveys at least every five years.

The PHN Cooperative agrees with this draft recommendation.

The routine collection of the National Study of Mental Health and Wellbeing and the National Child and Adolescent Mental Health and Wellbeing Study would complement regional and jurisdictional datasets that PHNs use for regional needs assessments, co-design, and commissioning.

Draft recommendation 4.12 **Funding should support primary health networks to meet local needs**
The next agreement should emphasise national consistency in areas where there are efficiency gains, including standardising reporting requirements across primary health networks (PHNs) and jurisdictions where possible and investigating ways to standardise procurement and data collection processes. Funding arrangements in the next agreement should provide PHNs with sufficient flexibility to commission locally relevant services or support existing services where they have been positively evaluated. National service models should not limit the ways in which PHNs meet their communities' needs.

The PHN Cooperative agrees with this draft recommendation.

Reforms to the next Agreement should empower PHNs' distinct capability as independent regional planning, system integration and commissioning bodies that align community needs with sector capacity to deliver effective mental health services for priority population groups.

Regional flexibility and variation should be managed through robust governance, review, and assurance mechanisms that enable balancing delivery of national policy goals with locally adapted solutions. Monitoring and evaluation should be informed by data and grounded in local context, recognising that meaningful improvement depends on understanding how services perform in the communities they are designed to serve. This approach supports more locally responsive, accountable, and sustainable service delivery.

The next agreement should emphasise national consistency in areas where there are efficiency gains

The PHN Cooperative recognises the need to balance responsive regional planning and commissioning with consistency and efficiency across activities under the next Agreement.

As detailed in our response to draft recommendation 2.1 regarding National Planning and Commissioning Guidelines, PHNs support the development of mechanisms that will maximise the value of planning and commissioning as impactful activities that underpin the success of the next Agreement. The examples of What Works Networks, planning standards, and quality mechanisms are practical examples of how to balance consistency with regional responsiveness, and to identify opportunities for efficiency gains across PHNs' and LHNs' regional roles in the mental health and suicide prevention system.

New PHN frameworks must be designed with sensitivity to the diverse needs of metro, regional, rural and remote communities, ensuring national models remain adaptable to local contexts. PHNs are seeking that any standardised tools be co-designed with deep input from PHNs, harnessing their ten years of commissioning experience, to leverage our capacity to translate needs assessments, evidence and population data into regional planning and commissioning outcomes.

PHNs are seeking their commissioning authority to be underpinned by investment in capacity and capability building, enabling us to design and evaluate tailored models of care. By embedding co-design principles into reporting, procurement, and data collection requirements, PHNs believe the system can strike a balance between national consistency and the agility required for locally driven solutions.

Funding arrangements in the next agreement should provide PHNs with sufficient flexibility to commission locally relevant services or support existing services where they have been positively evaluated.

PHNs support funding arrangements in the next Agreement that would enable the flexible allocation funding through our commissioning processes to deliver the Agreement's systemic purpose aligned with a fit for purpose monitoring and reporting framework.

To ensure accountability, safety, and consistency, PHN-led initiatives must be supported by structured oversight frameworks that reflect the complexity and risk profile of mental health service delivery. Without these safeguards, the system risks fragmentation and variability that could compromise care quality and equity.

Draft recommendation 4.13 **The next agreement should support the implementation of the National Mental Health Workforce Strategy**
The next agreement should support the implementation of the National Mental Health Workforce Strategy. This should include: • clear commitments to, and timelines for, priority actions under the National Mental Health Workforce Strategy • an explicit delineation of responsibility and funding for workforce development initiatives.

The PHN Cooperative agrees with this draft recommendation.

PHNs support the embedding of the National Mental Health Workforce Strategy in the next Agreement to provide a clear, evidence-informed framework that addresses critical workforce shortages, builds capability and strengthens coordination across the entire mental health system.

PHNs agree that long-term planning, shared accountability, and targeted investment by all levels of government are essential to developing a skilled, sustainable, and culturally responsive workforce.

PHNs are seeking local implementation support for the Strategy, backed by guidance on workforce development requirements within commissioned service contracts, to ensure workforce initiatives translate into practical capacity building on the ground.

The next Agreement can support implementation of the Strategy by focusing on emerging challenges, including the digital transformation of care (with AI integration), an aging workforce and the rapid growth of the peer and lived-experience workforce, which will require regulation and clear scope-of-practice frameworks.

PHNs support efforts to broaden the scope of workforce development to recognise the role of non-mental health clinicians (such as GPs and ED nurses) in mental health care.

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?

Murrumbidgee Case Study

In the MyStep Western program (commissioned by Murrumbidgee PHN and delivered through Murrumbidgee LHD), three full-time equivalent peer worker roles, including a First Nations-identified position, and a 0.5 FTE senior peer worker operate alongside clinicians under structured supervision. These peers draw on their lived experience to build engagement and trust, support people on the waitlist through regular check-in calls, and escalate risks when needs change.

South West Sydney PHN Case Study

Similarly, South West Sydney PHN's Peer Support Program embeds peers within its "You in Mind" clinical service for moderate-to-high-needs clients; peers provide psychoeducation, self-advocacy and navigation support, and collaborative care sessions are jointly funded to ensure clinicians and peer workers can consult effectively.

Beyond these two case studies, PHNs note the emergence of blended peer/clinical models, such as Medicare Mental Health Centres, safe spaces, urgent care clinics and after-hours services, as important additions to the mental health and suicide prevention system. Designed as alternatives and complements to emergency departments, these services demonstrate how integrated teams can efficiently address emotional, psychological and suicidal distress, reducing pressure on acute care and offering more accessible, community-based crisis support.

Draft recommendation 4.14 **The next agreement should commit governments to develop a scope of practice for the peer workforce**
The next agreement should commit governments to develop a nationally consistent scope of practice for the peer workforce, in consultation with the peer workforce, that: • promotes safer work practices for peer workers • contributes to better outcomes for people accessing mental health and suicide prevention peer support • improves public understanding of the profession, allowing for greater recognition of peer workers' capabilities and contributions.

The PHN Cooperative agrees with this draft recommendation.

PHNs support the recommendation for the next Agreement to commit governments to develop a nationally consistent scope of practice for the peer workforce, co-designed with people with lived and living experience. PHNs agree that clear role definitions, covering expectations, boundaries, and responsibilities, will foster safer work environments by reducing burnout, role confusion, and underutilization.

A national scope of practice can also increase acceptability of the peer workforce within PHN commissioned programs and primary care settings. Noting peer workers often work within multidisciplinary teams, the scope of practice should not be developed in isolation but should incorporate learnings from other healthcare professions.

In commissioning, PHNs align peer work with evidence-based guidelines, to enable peers to leverage their lived experiences in ways that enhance trust, hope, and connection, fundamental to recovery-oriented care.

PHNs support this initiative to be prioritised within the National Mental Health Workforce Strategy and to build upon existing frameworks and peak-body efforts.

Draft recommendation 4.15 **The next agreement should build on the evaluation framework and guidelines**
The next agreement should require timely evaluations to be conducted for all funded services in line with the National Mental Health and Suicide Prevention Evaluation Framework and associated guidelines and require sharing of evaluation findings, including sharing publicly where possible.

PHN Cooperative members broadly support this finding.

PHNs support the transparency of evaluation findings and that summary reports be published publicly in a manner that safeguards the confidentiality of service users and participants.

PHNs support a shift towards value-based healthcare commissioning approaches in the next Agreement that embed economic and health outcomes into evaluation processes and rely on community engagement to contextualise findings and adapt services responsively to social, economic, policy and legislative influences.

Comments on current data sources

While the use of the Primary Mental Health Care Minimum Data Set (PMHC-MDS) and the PHN Program Performance and Quality Framework is acknowledged, there are significant limitations in their current capacity to support transparent and meaningful performance reporting. These limitations must be explicitly recognised, and targeted investment should be prioritised to address these deficiencies.

Without such improvements, the use of these datasets as the basis for assessing PHN performance risks misinforming the public and stakeholders, potentially undermining trust and accountability. A robust and fit-for-purpose data infrastructure is essential to ensure that performance reporting reflects the true impact and quality of services delivered.

Draft finding 5.1

Limited improvements in Aboriginal and Torres Strait Islander social and emotional wellbeing over the course of the Agreement

There is no comprehensive data to assess the contribution of the National Mental Health and Suicide Prevention Agreement to Aboriginal and Torres Strait Islander social and emotional wellbeing. The data available shows that one in three Aboriginal and Torres Strait Islander people experience high psychological distress and suicide rates are worsening.

While the Agreement is intended to align with the National Agreement on Closing the Gap and improve social and emotional wellbeing outcomes for Aboriginal and Torres Strait Islander people, limited progress has been made in system reform. There is insufficient transparency and clarity in the Agreement about actions, progress, monitoring and reporting, and governance.

The PHN Cooperative agrees with this draft finding.

PHNs recognise that the Agreement has failed to deliver measurable or meaningful improvements for Aboriginal and Torres Strait Islander people, despite its stated alignment with the Closing the Gap framework.

PHNs agree that without culturally grounded accountability mechanisms, co-designed and led by Elders and community members, progress will remain limited, as structural drivers of distress such as intergenerational trauma, systemic racism and social inequality demand targeted, sustained reform at the regional level.

PHNs support the development of a separate Aboriginal and Torres Strait Islander Social and Emotional Wellbeing Agreement.

PHNs support the introduction of outcome measures and reporting frameworks that are culturally relevant and co-designed with First Nations peoples, enabling transparent monitoring and genuine shared decision-making.

Draft recommendation 5.1

An Aboriginal and Torres Strait Islander schedule in the next agreement

The next agreement should include a separate schedule on Aboriginal and Torres Strait Islander social and emotional wellbeing. This schedule should be developed in a process of co-design with Aboriginal and Torres Strait Islander people.

The schedule should:

• align with the National Agreement on Closing the Gap and other important documents and include tangible actions, with commensurate funding, to improve the social and emotional wellbeing of Aboriginal and Torres Strait Islander people, including better mental health and suicide prevention outcomes

• clarify governance for its design and implementation, including the role of the Social and Emotional Wellbeing Policy Partnership established under the National Agreement on Closing the Gap as the decision-making forum over issues relating to Aboriginal and Torres Strait Islander social and emotional wellbeing

• measure progress in a strengths-based way, with community-led evaluation

• articulate and embed priorities highlighted by community such as cultural safety in all services, and greater investment in the community-controlled sector and the Aboriginal and Torres Strait Islander social and emotional wellbeing workforce.

The PHN Cooperative agrees with this draft recommendation.

PHNs support a schedule on Aboriginal and Torres Strait Islander social and emotional wellbeing in the next Agreement, while noting that responsibility for equitable access and outcomes must be embedded throughout the entire Agreement. This approach is essential to uphold the principles of inclusion, accountability, and shared responsibility in meeting the needs of Aboriginal and Torres Strait Islander people and communities.

PHNs agree that separate schedules for priority areas (such as suicide prevention and alcohol and other drugs) can enhance transparency and focus attention on priority population needs.

To be effective, this schedule should be genuinely co-designed with Aboriginal and Torres Strait Islander communities, Elders, and organisations, ensuring policies and programs are shaped by lived and living experiences, cultural knowledge, and community-led governance.

Draft finding 6.1

The Agreement has supported positive policy developments in suicide prevention, but outcomes remain unchanged

The National Mental Health and Suicide Prevention Agreement has led to some positive changes in suicide prevention policy, including the establishment of the National Suicide Prevention Office. The bilateral schedules provided funding for suicide prevention services in most jurisdictions.

However, there has not been substantial progress in achieving the Agreement's objective of zero lives lost to suicide. Since 2015, every year about 3,000 people have died by suicide.

The PHN Cooperative agrees with this draft finding.

PHNs recognise that despite current national suicide prevention policy and programs, and increased bilateral funding, suicide rates have not demonstrably declined. This reflects the impacts of social determinants of health and wellbeing, and the limitations of current responses to suicidality and distress.

PHNs support a rebalancing of the current system's emphasis on intervention-based models with greater investment in prevention measures that address upstream drivers of distress to avert crisis before it occurs.

Consistent with the National Suicide Prevention Strategy, the next Agreement would benefit from suicide prevention being reframed as a whole-of-government and whole-of-community issue, requiring coordinated action across portfolios and sustained, dedicated funding underpinned by clear implementation timeframes and evaluation.

Draft finding 6.2 **The Agreement's approach to suicide prevention lacks clarity**
The approach to suicide prevention policy commitments as outlined under the National Mental Health and Suicide Prevention Agreement does not enable effective reform. • The Agreement does not outline a clear link between actions and expected outcomes. • Roles and responsibilities are not sufficiently clear, specifically regarding areas of joint responsibility. This contributes to gaps in service delivery and reduced accountability.

The PHN Cooperative agrees with this draft finding.

PHNs agree that the Agreement's lack of a clear link between actions and outcomes is a barrier to effective reform.

The approach to suicide aftercare varies significantly across jurisdictions and levels of care, including primary and secondary services. This variability has resulted in gaps in the transfer of care, particularly in the absence of functional integration and interoperable information-sharing systems.

At the regional level, PHNs agree that ambiguous roles and responsibilities, particularly in areas of joint Commonwealth–jurisdictional accountability for suicide prevention, are contributing to fragmentation, overlaps and service gaps.

Addressing these issues requires a coordinated national effort to establish clear, evidence-based frameworks and ensure system-wide conformance and integration.

Draft recommendation 6.1 **Suicide prevention as a schedule to the next agreement**
The next agreement should include a separate schedule on suicide prevention. This schedule should be developed through a process of co-design with people with lived and living experience of suicide, their supporters, families, carers and kin and service providers. The schedule should: • only include actions in policy areas of suicide prevention that are distinct from mental health • 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 • align with the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy • include monitoring and reporting indicators that align with the forthcoming National Suicide Prevention Outcomes Framework • require the National Suicide Prevention Office be responsible for the monitoring and reporting of the schedule.

PHN Cooperative members broadly support this finding.

There is broad support among PHNs for the inclusion of a dedicated Suicide Prevention Schedule in the next Agreement, developed through genuine co-design with people with lived and living experience of suicide, their supporters, families, carers and kin and service providers.

The National Suicide Prevention Strategy provides a comprehensive roadmap of strategies and actions that should guide the development of a schedule on suicide prevention. The Strategy's critical enablers chapter proposes that PHNs have a stronger role in creating comprehensive joint regional suicide prevention plans, in partnership with LHNs, and State, Territory and Local Governments.

A suicide prevention schedule should create a clear authorising environment for PHN activities in suicide prevention aligned to a clear systemic purpose based on principles set out in the National Suicide Prevention Strategy.

There is broad support among PHNs for a clear delineation between mental health and suicide prevention in the next Agreement but note that both sectors will benefit from a comprehensive, whole-of-system approach that spans prevention, treatment, aftercare and postvention.

Some PHNs do not support quarantining suicide prevention in a separate schedule if this prevents a whole-of-system approach to this issue.

PHNs agree that coordinated action across government portfolios (including education, justice, housing and employment) is required, and PHNs support alignment with the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy to embed culturally safe, community-led approaches for First Nations peoples.

Data, reporting and monitoring

To drive transparency and accountability, a suicide prevention schedule should have an appropriate data collection, monitoring, reporting and performance framework aligned to the forthcoming National Suicide Prevention Outcomes Framework.

PHNs note the recommendation that the National Suicide Prevention Office be responsible for the monitoring and reporting of the schedule.

In principle, PHNs would support an appropriately independent and authorised National Suicide Prevention Office taking this role, however as per our comments in response to draft recommendation 4.10, there is uncertainty regarding the future status and role of the National Suicide Prevention Office.

PHNs note that the PC Interim Report has not recommended the National Suicide Prevention Office be reestablished as an independent statutory authority, as it has for the National Mental Health Commission.

The rationale for these differing recommendations is not stated, however PHNs note that if the National Suicide Prevention Office has inferior authority to undertake monitoring and reporting compared to the National Mental Health Commission this would undermine the effectiveness of the proposed suicide prevention schedule.