Suicide Prevention Australia

July 2025

Productivity Commission Review of the Mental Health and Suicide Prevention Agreement

Submission for Final Report

Contents

Executive Summary

Suicide Prevention Australia has welcomed the Interim Report of the Productivity Commission's review of the National Mental Health and Suicide Prevention Agreement. This submission provides input for the Productivity Commission's consideration in undertaking work on the Final Report.

There are a number of draft recommendations from the Interim Report that we strongly support and in some cases could be strengthened. In working on the Final Report we recommend that the Productivity Commission consider:

- Maintaining draft recommendations 2.1, 4.3, 4.4, 4.6, 4.8, 4.9, 4.10, and 4.11.
- Strengthen draft recommendation 6.1 by including in the recommendation that:
    - short-term objectives of the National Suicide Prevention Strategy be embedded in the schedule, as well as alignment with long-term objectives
    - the National Suicide Prevention Office should be responsible for coordinating the development of the suicide prevention schedule as well as monitoring, and be fully resourced for these tasks
    - additional dedicated funding for the schedule is required
- Strengthen draft recommendation 4.2 by including in the recommendation that:
    - co-design of the new agreement should include lived experience of both mental ill-health and of suicide
    - service providers and/or sector peak bodies should be involved in the development of a new agreement
    - concerns around the delay of reforms and the extension of service delivery funding should be addressed
- Strengthen draft recommendation 4.7 by including the need for formal roles for suicide prevention lived experience representation
- Strengthen draft recommendation 4.14 by including in the recommendation that the development of a nationally consistent scope of practice for the peer workforce should recognise the unique aspects of suicide prevention peer work
- Strengthen draft recommendation 5.1 by including in the recommendation that a future national agreement should also include a focus on eliminating racism in services and dedicated funding

We welcome that the Final Report will contain additional information on funding arrangements. There are two other key areas where we would recommend further work in the Final Report:

- Include in the Final Report analysis and recommendations on the suicide prevention workforce including consideration of a funded suicide prevention workforce initiative with resourced actions implemented under a strategic framework
- Include in the Final Report analysis and recommendations on suicide prevention research and evaluation including consideration of the research funding supports needed to drive evaluation and service improvement

There are two areas where the Productivity Commission has requested further information on which we have recommendations:

- 4.1 We recommend that alcohol and other drug issues are addressed in the main agreement and in the suicide prevention schedule by ensuring that mental health and suicide prevention services are resourced and capable of addressing co-occurring alcohol and other drug issues
- 4.3 We recommend that a public dashboard to track and report on progress under the next agreement should be collated and publicised by the National Mental Health

Commission and National Suicide Prevention Office, including both activities and outcomes measures such as:

- allocation and expenditure of funds towards agreement commitments
- service usage measures for aftercare, postvention, safe spaces/havens, and crisis lines
- measures of services addressing need
- outcome indicators aligned with the forthcoming National Suicide Prevention Outcomes Framework

Introduction

Suicide Prevention Australia is the national peak body for the suicide prevention sector. We exist to provide a clear, collective voice for suicide prevention, so that together we can save lives. We represent more than 350 members ranging from national household name agencies to small community-based organisations and local collaboratives in every State and Territory; as well as individual service providers, practitioners, researchers, students and people with lived experience. This includes more than 140,000 employees and volunteers across Australia. We believe that through collaboration and shared purpose, we can work towards our ambition of a world without suicide.

Suicide Prevention Australia welcomes the opportunity to contribute to the Productivity Commission's public consultation the Final Report of the review of the *National Mental Health and Suicide Prevention Agreement*.

In producing this submission Suicide Prevention Australia has consulted with a range of organisations in the sector, including having representative review this submission and conducting in-depth discussions on its recommendations. Many of the recommendations also draw on previous consultations with the sector addressing on-going issues with the national agreement and other issues relevant to this inquiry.

The suicide prevention sector has welcomed the Productivity Commission's *Interim Report - Mental Health and Suicide Prevention Agreement Review* (Interim Report). Our consultations with the sector show strong support for the Interim Report's findings and for its draft recommendations. The sector has indicated that there are some areas where further work from the Productivity Commission in the final report would be welcomed. In addition, there has been discussion in the sector on the information requests in the Interim Report.

Based on our consultations and analysis, this submission comprises three sections, respectively covering:

- Interim Report draft recommendations that are strongly supported including suggestions to strengthen some recommendations
- Areas where further work may be needed in the Final Report
- Responses to the Interim Report requests for information

Support for Interim Report Recommendations

Overall Suicide Prevention Australia supports the findings and draft recommendation of the Interim Report. There are a number of draft recommendations in the report of particular importance to the suicide prevention sector. We have listed the recommendations we strongly support. In addition there are a number of recommendations that we support, but have suggestions to strengthen these recommendations. These are outlined below. We urge the Productivity Commission to maintain and strengthen all these recommendations in the Final Report.

Recommendations strongly supported

We strongly support the following recommendations with no further comments and urge for them to be included in the Final Report:

- Draft recommendation 2.1: Deliver key documents as a priority
- Draft recommendation 4.3: The next agreement should have stronger links to the broader policy environment
- Draft recommendation 4.4 Governments should immediately address the unmet need for psychosocial supports outside the National Disability Insurance Scheme
- Draft recommendation 4.6: Increase transparency and effectiveness of governance arrangements
- Draft recommendation 4.8: A greater role for the broader sector in governance
- Draft recommendation 4.9: Share implementation plans and progress reporting publicly
- Draft recommendation 4.10 Strengthening the National Mental Health Commission's reporting role
- Draft recommendation 4.11: Survey data should be routinely collected

Draft recommendation 6.1: Suicide prevention as a schedule to the next agreement

We support the recommendation that the next agreement should include a separate schedule on suicide prevention. Poor mental health is, of course, a significant driver of suicide risk, but there are also a range of risks factors outside mental health.[1] Mental health services are important supports for those at risk of suicide, but many at risk primarily require support from services addressing these other factors, or from specialised suicide prevention supports such as aftercare services. The drivers of suicide, and the supports needed, are both in and outside of the mental health area. Having a suicide prevention schedule within the agreement facilitates the collaboration needed between these areas, while also allowing action on suicide prevention outside of mental health.

While we support the recommendation overall, we do have a number of suggestions for strengthening this recommendation:

The recommendation includes that the schedule should reflect a clear link between the short-term objective and outcomes of the schedule and progress towards the long-term objectives of the National Suicide Prevention Strategy. However, the strategy contains both long-term and short-term objects. For example, action 8.2b: "Integrate suicide prevention peer workers into all aftercare services by resourcing dedicated roles and support structures, such as peer supervision and communities of practice." This is an initiative that could be achieved within the next agreement. Another example of a short-term initiative is action 10.2a to design, trial and evaluate a model of social prescribing for people with suicidal thoughts and behaviours. We suggest that the recommendation include that short-term objectives of the strategy be embedded in the schedule, as well as alignment with long-term objectives.

The recommendation also includes that National Suicide Prevention Office (NSPO) be responsible for the monitoring and reporting of the schedule. It is important to note that the NSPO has limited resources and we suggest that the recommendation include that the NSPO is fully resourced to undertake this task.

[1] Suicide Prevention Australia (2023) *Socio-economic and Environmental Determinants of Suicide: Background Paper*, https://www.suicidepreventionaust.org/wp-content/uploads/2023/08/SPA-SEDS-Background-Paper-August-2023-Designed.pdf

The text associated with the recommendation states that the NSPO should be responsible for coordinating the development of the schedule. However, this is not made explicit within the recommendation itself. We suggested that this should be made explicit in the recommendation, and, as with monitoring, it should also be included that the NSPO be resourced to undertake this task.

The Interim Report has stated that there will be further consideration of funding arrangements in the Final Report. As part of this we suggest that this recommendation include the need for the suicide prevention schedule to have dedicated additional funding to address its commitments.

Draft recommendation 4.2: Building the foundations for a successful agreement

We support the recommendation of the Interim Report to extend the existing agreement until June 2027 in order to provide additional time to develop and co-design the next agreement. In particular, we support a number of aspects of the recommendation such as that Australian Institute of Health and Welfare should lead the development of a nationally consistent set of outcome measures, and that commitments and actions intended to improve collaboration across all government portfolios should be included in the main body of the agreement.

The recommendation recognises the need for a co-design process with people with lived and living experience. We support this but would suggest that the recommendation makes clear that co-design must include lived experience of both mental ill-health and of suicide, included suicidal ideation, attempts, bereavement and caring roles. There have been occasions where lived experience representation has not included sufficient range of perspectives, such as those who have experienced suicidal ideation primarily due to non-mental-health factors. There are concerns that co-design with lived and living experience of suicide may be contained only to the separate schedule. Given that this schedule is intended only to contain issues specific to suicide, there will be a range of factors relating to suicide that will be in the main agreement. So lived and living experience of suicide should be included in all co-design activities and we would suggest that, to ensure this, it should be explicitly included in this recommendation.

There is no provision in this recommendation for the involvement of community sector service providers in the design of the agreement. Given that community sector service providers are likely to play a significant role in the implementation of the agreement, this is a critical perspective in order to ensure that the provisions of the agreement are practical. In some cases there may be probity or conflict of interest concerns in involving service providers in discussion that influence service funding. However, these concerns can be navigated through mechanisms such as declarations of interest, involvement in high-level rather than specific agreement development, and involving sector peak bodies who represent services, but are not service providers. We would suggest this recommendation include the need for involving service providers and/or sector peak bodies in the development of a new agreement.

Some of Suicide Prevention Australia's members have expressed concerns around the extension of the existing agreement. They have raised that a National Mental Health Strategy may not be able to be completed in time to guide the new agreement even with this extension. There are also concerns that the extension may delay progress on reforms, such as on psychosocial supports. We would suggest that the Final Report consider how best to address these concerns.

There are also some potential implications around the extension for funding of services. Many services are funded until June 2026 to align with the end of the agreement, including

funding in grants outside the agreement. We would suggest that the recommendation include the need for government to rapidly move to extend all such funding by one year in order to give certainty to these services. This would allow them to focus on continuing to provide supports during this period.

Draft recommendation 4.7: The next agreement should support a greater role for people with lived and living experience in governance

We support this recommendation to increase the effective involvement of people with lived and living experience in the governance of the next agreement. The recommendation includes the need for formal roles for the two recently established national lived experience peak bodies. The inclusion of these bodies is important, but both have a focus on people with a lived or living experience of mental health challenges. It is important that there are also formal roles for representation of suicide lived experience in governance. This could be achieved by resourced roles for existing bodies in the suicide prevention space that require broad representation, or by other methods of national suicide lived and living experience representation.

Draft recommendation 4.14: The next agreement should commit governments to develop a nationally consistent scope of practice for the peer workforce

We support this recommendation that the next agreement should included the development of a scope of practice for the peer workforce. However, we would suggest that this initiative must recognise the unique aspects of suicide prevention peer work.

An essential component of an effective suicide prevention response is the availability of employees who can approach their work through the lens of lived and living experience of suicide. Peer workers have been effective in providing constructive coping, support, empowerment, hope and if they bring lived experience of a suicide attempt, can help someone rediscover meaning in life.[2] A number of recent literature reviews have found that peer support programs were effective in reducing grief symptoms, improving psychosocial and suicide related outcomes, and increasing personal growth and well-being in bereaved suicide survivors.[3] National prioritisation of suicide prevention peer work could reduce the pressure on over-stretched emergency departments, phone lines and Medicare-funded services.[4]

However currently despite the increasing recognition of their value, suicide prevention peer workers are often not fully supported or integrated within suicide and mental health services. This is due in part to a lack of systemic understanding, cultural resistance, and insufficient organisational readiness. They are also often constrained by traditional clinical models or unclear role boundaries, such as in safe havens, and their unique capabilities are underused. This not only diminishes the quality and authenticity of peer support but can also create risks for both workers and service users.

Specific reference to suicide prevention peer work in this recommendation could help address these concerns by helping to ensure that distinct aspects of suicide prevention are addressed in developing a nationally consistent scope of practice for the peer workforce.

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[2] Chi MT, Long A, Jeang SR, Ku YC, Lu T, Sun FK. Healing and recovering after a suicide attempt: a grounded theory study. J Clin Nurs. 2014;23(11–12):1751–9.

[3] Andriessen K, Krysinska K, Hill NT, Reifels L, Robinson J, Reavley N, et al. Effectiveness of interventions for people bereaved through suicide: a systematic review of controlled studies of grief, psychosocial and suicide-related outcomes. BMC Psychiatry. 2019;19(1):49.

[4] Roses in the Ocean (2023) Expanding the Suicide Prevention Peer Workforce: An Urgent and Rapid Solution to Australia's Suicide Prevention Challenge, https://rosesintheocean.com.au/wp-content/uploads/2023/01/230329-Peer-Worker-Paper.pdf

Draft recommendation 5.1: An Aboriginal and Torres Strait Islander schedule in the next Agreement

We support the creation of a specific schedule to address improving Aboriginal and Torres Strait Islander social and emotional wellbeing (SEWB). This recommendation contains a number of important points such as the need to align with the National Agreement on Closing the Gap and other important documents that already exist in the Aboriginal and Torres Strait Islander SEWB space, and the need for initiatives focused on enhancing cultural safety in all services and empowering the SEWB Policy Partnership as the formal governance structure. To strengthen these points we would suggest that the recommendation include the need for dedicated funding for the Gayaa Dhuwi (Proud Spirit) Declaration Framework and Implementation Plan.

In addition, A future national agreement should also include a focus on eliminating racism in services. Negative and harmful experiences at services remains a barrier for Aboriginal and Torres Strait Islander peoples accessing suitable services and failure to address these in the current National Agreement is a catastrophic gap. Efforts to address this must be coordinated and directed by national mechanisms such as the National Agreement and in consultation with Aboriginal and Torres Strait Islander peoples.

Further Work in the Final Report

In addition to support for the recommendations of the Interim report, our consultations with the suicide prevention sector identified two key areas where further work in the final Report would be highly beneficial: the suicide prevention workforce, and suicide prevention research funding.

Suicide Prevention Workforce

The Interim Report makes a number of key findings and recommendations regarding the mental health workforce, but analysis and advice specifically on the suicide prevention workforce is limited.

In our previous submission, we identified that the agreement fails to address suicide prevention workforce issues which significantly reduces extent to which it enables the preparedness and effectiveness of suicide prevention services.

Each year Suicide Prevention Australia conducts a survey of the sector. In 2024, the *State of the Nation in Suicide Prevention* survey showed an increasing demand for suicide prevention services.[5] Almost three out of four (71%) of respondents have seen increased demand for services over the past 12 months, whilst four out of five respondents (80%) require increased funding to meet increased demand. In addition, only 7% of respondents indicated that priority populations at risk of suicide are appropriately funded, resourced and responded to. They are therefor likely to lack staff to meet this demand.

As noted in the Interim Report, the National Suicide Prevention Office has been tasked with developing a workforce strategy, a commitment under the current Agreement, which has not yet been delivered. Suicide Prevention Australia has been advocating for such a workplace strategy for over five years. We are now at a point where a strategy is not sufficient and a funded workforce initiative is required with resourced actions implemented under a strategic framework. This would incorporate national, regional and local strategies for accessibility,

[5] Suicide Prevention Australia (2024) *State of the Nation in Suicide Prevention*, https://www.suicidepreventionaust.org/wp-content/uploads/2024/09/SPA-State-of-the-Nation-Report-AUG24-Web.pdf

capability, skills, supply, retention, sustainability, support and workforce safety, with dedicated funding allocations for implementation.

Suicide Prevention Australia will shortly be releasing a comprehensive report on the reforms needed for the suicide prevention workforce. A draft copy of that report will be provided to the Productivity Commission along with this submission. In summary the report calls for a workforce initiative which would incorporate:

- Governments embedding a universal wellbeing support framework for all suicide prevention workers, and accompanying resources, within funding agreements.
- Provision of funding incentives to employers who accept trainees in suicide prevention roles, to cover the cost of mentoring, supervision, onboarding resources and workplace learning supports.
- All vocational education and training and tertiary programs specifically preparing individuals for roles likely to be supporting this at risk of suicide, including peer work education, should be reviewed and redeveloped in partnership with people with suicide lived experience, community service providers and sector experts.
- All suicide prevention organisations and relevant social sectors (such as health, education, domestic and family violence, justice and housing) must embed mandatory lived experience education into onboarding, ongoing training and daily practice standards.
- Provide sustained funding to support the creation and expansion of paid lived experience and peer work roles across the suicide prevention sector.
- Develop a targeted mentoring initiative to support men – particularly those transitioning from blue-collar or non-human services backgrounds – into roles within the suicide prevention sector.
- Fund diversity-focused workforce development grants to support the recruitment, training and retention of individuals from underrepresented communities, including First Nations peoples, culturally and linguistically diverse (CALD) backgrounds, LGBTQIA+ communities, young people and men.

The suicide prevention workforce has requirements distinct from the mental health workforce. Specific consideration of the suicide prevention workforce in the final report would help ensure these unique needs are recognised and addressed in the next agreement.

Research Funding

Whilst the Interim Report recommends evaluation and calls for best practice in service delivery, it doesn't include any reference to funding research as part of the next Agreement. Effective evaluation is often a complex research project, especially in innovative models. Ongoing research into models of suicide prevention, care models, ways to reduce stigma, and research implementation are required in order to ensure that organisations, programs and government are using best practice models in suicide prevention. Research funding will be required to develop new models of care, as models of delivery are tested, and then evaluated in suicide prevention.

An important initiative driving research in this area has been the National Suicide Prevention Research Fund.[6] The aim of the fund is to support world-class Australian research and facilitate the rapid translation of knowledge into more effective services for individuals,

[6] More information is available here: https://www.suicidepreventionaust.org/research-grants/

families and communities. Unfortunately, government support for the National Suicide Prevention Research Fund has ceased as of June 2025.

Without dedicated funding, research projects to evaluate and improve services will struggle to find the needed resources. We would suggest that it would be beneficial if the Final Report included analysis and recommendations on the research funding supports needed to drive evaluation and service improvement.

Requests for information

This section addresses two of the information requests in the Interim report, 4.1 and 4.3.

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.

There is substantial evidence that the harms from alcohol and other drugs are a significant driver of suicide risk,[7] and so recognising the need to address these issues in the national agreement is welcome. However, a separate schedule may not be the most effective way to achieve this at this point in time. Outside of the new agreement establishing an effective national governance structure for the alcohol and other drugs sector will be critical to enable better engagement with existing national mental health and suicide prevention governance structures. Decisions around an alcohol and other drugs schedule may be best deferred the form of such as structure is finalised. Instead the intersections of suicide and problematic alcohol and other drug use can be addressed in the main agreement and in the suicide prevention schedule by ensuring that mental health and suicide prevention services are resourced and capable to address co-occurring alcohol and other drug issues. Specific actions such as in workforce capacity building should be included in the main agreement and schedule along with linkages to national AOD policy and commitments.

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?

Suicide Prevention Australia supports the development of a public dashboard to track and report on progress under the next agreement. The development of a dashboard would be a strong show from the government of commitment towards action on mental health and suicide prevention. And it would address a key weakness in the current agreement of a lack of transparency around progress.

Three bodies are well placed to be responsible for collation and publication of the data.

The Productivity Commission already has experience with the Closing the Gap Information Repository. The Productivity Commission's national prominence and well-established independence would help ensure that this information would receive attention, which would help drive progress on the agreement.

[7] Suicide Prevention Australia (2023) *Socio-economic and Environmental Determinants of Suicide: Background Paper*, https://www.suicidepreventionaust.org/wp-content/uploads/2023/08/SPA-SEDS-Background-Paper-August-2023-Designed.pdf

The Australian Institute of Health and Welfare runs the National Suicide and Self-harm Monitoring System. The Suicide and Self-harm Monitoring Unit that runs this system has significant experience with communication on suicide related data and already collects a substantial amount of data that would likely be included such a dashboard.

The National Mental Health Commission and NSPO would also be well placed due to their monitoring function, and there would no-doubt be strong alignment with the National Suicide Prevention Outcomes Framework that the NSPO is currently developing.

On balance we would recommend that responsibility sit with the National Mental Health Commission and NSPO, but all three options would have advantages.

The metrics on the dashboard should include both activity and outcome measures. For suicide prevention it should at minimum show levels of funding allocated and expended towards commitments, and service usage measures for aftercare, postvention, safe spaces/havens, and crisis lines. Ideally it would also include suicide deaths, indicators of suicide attempts, and measures of community distress. The measurement of suicide attempts and distress are both complex, but there are means of providing indicators.

The dashboard should also give an indication of the extent to which need is being addressed by services. This can be done in a number of ways. One set of important metrics is diversions and referrals from hospital emergency departments of those in suicidal distress. For example, the percentage of referrals to aftercare is an important indicator, as is the percentage of those attending an emergency department who have no, or non-serious, injuries who are diverted to safe spaces.

Another indicator of addressing needs would be to combine the measure levels of distress in the community with service usage levels. This would give important information. For example, an increase in service usage accompanying an increase in distress levels shows the support system responding to a crisis, an increase in service usage with distress levels going up shows that more people are willing to reach out for help. Likewise a decrease in service use may be a positive indicator if distress is falling, but a concerning sign if distress is stable or increasing. Similar work could be done looking a postvention service usage as compared with numbers of deaths.

Outcome indicators should be aligned with the forthcoming National Suicide Prevention Outcomes Framework wherever possible.

It should be recognised that there may be substantial challenges with the collation of some of the metrics. It is important that the content of the dashboard is codesigned with both government and community sector service providers, as well as with those with lived experience, prior to the finalisation of the agreement to ensure that these challenges are understood at the outset. Achieving metrics that are both useful and possible will require sufficient resources, and agreement on data provision across jurisdictions built into the new National Agreement. A phased approach to some of the metrics on the dashboard may be required with clear and realistic deadlines for the introduction of the more challenging metrics.

Acknowledgements Statement

Suicide Prevention Australia acknowledges the unique and important understanding provided by people with lived and living experience. This knowledge and insight is critical in all aspects of suicide prevention policy, practice and research. Advice from individuals with lived experience helped guide the analysis and feedback outlined in this submission.

As the national peak body for suicide prevention, our members are central to all that we do. Advice from our members, including the largest and many of the smallest organisations working in suicide prevention, as well as practitioners, researchers and community leaders is key to the development of our policy positions. Suicide Prevention Australia thanks all involved in the development of this submission.

If you or someone you know require 24/7 crisis support, please contact:

Lifeline: 13 11 14
www.lifeline.org.au

Suicide Call Back Service: 1300 659 467
www.suicidecallbackservice.org.au

For general enquiries

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