
# Submission: Response to Productivity Commission Mental Health and Suicide Prevention Agreement Review: Interim Report

August 2025

## About the Submitter

JFA Purple Orange is an independent, social-profit organisation that undertakes systemic policy analysis and advocacy across a range of issues affecting people with disability and their families. Our work is characterised by co-design and co-production and includes hosting a number of user-led initiatives. We host a range of peer networks for people with disability including people with intellectual disability, physical and sensory disability, younger people, people from culturally and linguistically diverse backgrounds, and people in regional South Australia. As such, we are in a unique position to provide a genuine insight into issues affecting people with disability, including in response to the mental health crisis.

We also work extensively in multi-stakeholder consultation and collaboration, especially around policy and practice that helps ensure people with disability are welcomed as valued members of the mainstream community.

Our work is informed by a model called *Citizenhood*.

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# 1. Recommendations

We recommend:

**Recommendation 1: The Productivity Commission should draw on the Model of Citizenhood Support as a useful lens to inform the Final Report and recommend it be applied in the formulation of the next National Mental Health and Suicide Prevention Agreement.**

**Recommendation 2: The Productivity Commission should recommend in its Final Report that the new National Mental Health and Suicide Prevention Agreement include targeted actions and funding to address service gaps, unmet need and the barriers preventing people with disability accessing accessible and appropriate services.**

**Recommendation 3: The Productivity Commission should continue to recommend and emphasise the importance of co-design towards establishing and implementing a new National Mental Health and Suicide Prevention Agreement, and a National Mental Health Strategy in the Final Report.**

**Recommendation 4: The Productivity Commission should recommend that there continue to be a list of priority populations for the next National Mental Health and Suicide Prevention Agreement, and that the two existing priority populations focussed on people with disability, should remain.**

**Recommendation 5: The Productivity Commission should continue to recommend urgent action towards funding and commissioning of additional psychosocial supports outside the NDIS, to meet unmet need amongst people not eligible for the NDIS. The Productivity Commission should ensure any such arrangements are co-designed with people with lived/living experience including people with disability and that services are continued until a new arrangement is in place.**

**Recommendation 6: The Productivity Commission should recommend the inclusion of an additional schedule in the next agreement to address the co-occurrence of problematic alcohol and other drug use, and mental health and suicide. This schedule should also be inclusive of co-occurring disability.**

**Recommendation 7: The Productivity Commission should recommend appropriate funding levels and funding architecture are provided to ensure that the new national agreement achieves both its outcomes and also substantial and meaningful reform.**

**Recommendation 8: That the Productivity Commission recommend in its Final Report that a measurable outcomes framework be developed, through co-design, with a comprehensive set of measurable and timebound targets, to sit alongside a new National Mental Health and Suicide Prevention Agreement.**

**Recommendation 9: That the Productivity Commission recommend in its Final Report that there be a high-level commitment by the Commonwealth and the States to accessible data collection, reporting requirements and accountability measures, including the mental health experiences of people from priority populations, including disability.**

**Recommendation 10: That the Productivity Commission recognise in their Final Report that:**

- **There are known barriers and limitations to achieving accurate data collection in relation to priority populations* experiencing mental ill health or suicide; and**
- **That even if the frequency, comprehensiveness and accuracy of data collection were to be improved, that traditional data collection methods cannot give a full picture of the needs and experiences of priority populations; and**

- **That having a more fulsome picture is important to addressing health inequities; and**
- **As a result – that there is an additional need to co-design with priority populations a set of approaches to complement and strengthen the available data and what it can tell us of intersectional experiences and needs.**

***By priority populations, we intend people/communities who experience intersectional barriers. This is inclusive of people with disability.**

## 2. Introduction

Thank you for the opportunity to provide input on the Productivity Commission's (the Commission) Mental Health and Suicide Prevention Agreement (the Agreement) – Interim Report (the Report).

As an independent, social-profit organisation that undertakes systemic policy analysis and advocacy on issues affecting people with disability and their families, JFA Purple Orange has a strong interest in mental health and suicide prevention.

Overall, we welcomed the Report, and the proposed draft recommendations made and agree with the general direction the Report.

It is clear that the current Agreement has not led to the systemic change and meaningful reform that is so urgently needed. We support the Commission's assessment that a stronger and more effective Agreement is needed, one which articulates an evidence-based logic connecting the actions with its' over-arching goals.

JFA Purple Orange concurs with the Commission's observations regarding the need for increased awareness of the policy context, as well as funding commitments to be tied with the actions of the next Agreement to achieve the outcomes sought. It is important also that there is increased transparency and effectiveness of governance arrangements, especially the embedding and formalising the participation of people with lived and living experience of mental health and suicide in the design and implementation of governance arrangements.

JFA Purple Orange strongly supports the need for a co-design process with a range of stakeholders, lived experience and priority cohorts, including people with disability to identify mental health and suicide prevention objectives and outcomes.

We support also the need for a co-designed National Mental Health Strategy to support progress towards transforming mental health and suicide prevention services to improve the experiences of mental health consumers and carers.

We will provide further commentary throughout this submission.

## 3. Citizenhood lens to new Agreement

The work of our organisation is underpinned by the Model of Citizenhood Support[i]. This model sets out a framework for how people can be supported to build their chances of a good life and maximise their Citizenhood. This term Citizenhood is defined below but is different from citizenship.

The work of JFA Purple Orange is anchored on the principles of Personhood and Citizenhood and is guided by values centred on human rights and social inclusion. Every human being seeks to build a good life for themselves. As set out in the Model of Citizenhood Support[ii], a good life is characterised by the presence of:

- authorship of an individual's own life according to personally defined priorities and goals, termed Personhood (sometimes described as choice and control); and
- having active valued roles in community life and the economy, termed Citizenhood (often referred to as inclusion).

A good life largely depends on the availability of life chances – the assets and opportunities available to a person. Unlike citizenship, Citizenhood is a dynamic experience: it can rise and fall.

The Model asserts that our life chances comprise four different, but interrelated, types of assets we can call upon, termed the Four Capitals. These are:

- Personal Capital: how the person sees themselves;
- Knowledge Capital: what the person knows and can apply
- Material Capital: money and the tangible things in our lives; and
- Social Capital: having people in our lives who we know and know us.

These apply to any person and can help explain what might be helpful for someone to build a good life for themselves. Good health and wellbeing, including good mental health can impact all the Four Capitals. Mental ill health may at times significantly impact on a person's life chances. The availability of a mental health system that is responsive to individual

needs, can heavily influence a person's ability to have authorship of, and build their own good life.

To further explore this framework for how people can be supported to build their chances of a good life and maximise their Citizenhood, we encourage the Productivity Commission to access the full paper on the Model of Citizenhood Support via our website[iii].

**Recommendation 1: The Productivity Commission should draw on the Model of Citizenhood Support as a useful lens to inform the Final Report and recommend it be applied in the formulation of the next National Mental Health and Suicide Prevention Agreement.**

## 4. Prevalence of mental ill-health amongst people with disability

Adults with disability are more likely to experience high or very high levels of psychological distress than adults without disability – an average of 28% compared with 6.8% of those for whom the distress score is known, with much higher distress ratings amongst those with what was considered more severe disability[iv]. Research has also confirmed that "people with disability experience worse mental health than people without disability"[v].

There is strong evidence that some cohorts of people with disability and/or neurodiversity in particular experience higher prevalence of mental ill health. For example: There is a high prevalence of health inequities, and higher prevalence of mental ill health amongst people with intellectual disability[vi] as also acknowledged in the ten-year National Roadmap for Improving the Health of People with Intellectual Disability (2021-2031). (The corresponding Our Health Still Counts campaign[vii] earlier this year highlighted a lack of progress in meeting the short- and medium-term actions in this Roadmap, and in addressing the serious health inequalities).

There is also a high prevalence of mental ill health amongst people with autism, with recent international research placing lifetime prevalence of anxiety and depression at

approximately 40%, observing the risks of other psychiatric conditions are substantially raised and noting that autistic people are three times more likely to die by suicide[viii].

The Australian Institute of Health and Welfare (AIHW) additionally reported in 2024 that in 2018, 26% of all people with disability in Australia had psychosocial disability. The AIHW definition included disability related to nervous or emotional condition, mental illness or condition, memory problems or periods of confusion, or social or behavioural difficulties[ix].

Mental ill health can cause disability, and can also be an effect of disability[x], including an effect of the disability-related discrimination, and barriers that people might face. As was implied by some of the choices of priority populations in the last Agreement[xi], there can be other life circumstances that impact prevalence and experiences of mental ill health, including but not limited to homelessness or housing instability, unemployment, socioeconomic disadvantage, experiences of abuse/violence/neglect etc. People with disability are over-represented amongst many with these experiences[xii] and are also over-represented amongst most of the other priority groups listed in the last Agreement, including but not limited to: LGBTQIA+ communities, older people (1 in 2 older people experience disability[xiii]), people experiencing or at risk of abuse, and violence[xiv], including sexual abuse, neglect, and family and domestic violence etc. Experiences of mental ill health can also increase amongst people with disability who also have one or more intersectional identities, and can be experiencing compounded oppression or disadvantage for example, amongst Aboriginal and Torres Strait Islander people, LGBTQIA+ communities, people from culturally and linguistically diverse communities etc.

## 5. Barriers people with disability experience in accessing mental health supports and services

In the Interim Report, the Productivity Commission provided consumer reflections that spoke to the mental health system being alienating, inadequate, ill-informed, and under-resourced[xv], unfortunately these experiences did not surprise us. There are a series of barriers that people with disability can face in accessing mental health supports and services. This include, but are not limited to:

- **Lack of accessible information and communications**: As the Disability Royal Commission observed: "people with disability have a right to access information and communications, on an equal basis with others. Information and communications are accessible if people with disability can use and understand them in a way that suits their needs"[xvi]. At present however, there continues to be many accessible information and communication barriers, including insufficient mental health and mental health rights information available in plain English, Easy English, or multiple formats inclusive of video and audio, accessible websites etc across each of the states and territories. More work continues to be needed to urgently address information and communication barriers.
- **Lack of disability awareness and training**: Quality health worker training about disability and disability rights is acknowledged in the literature as being essential to equitable, quality healthcare[xvii]. Disability awareness and inclusion training needs to be proactively and structurally embedded across government, health and community organisations (and across the community) to assist in addressing health inequality, ensuring inclusion and to ensure people with disability are treated as equals.
- **Lack of accessible building design and transport options**: Accessibility is the quality of being easy to reach, enter, obtain, use, understand, or appreciate.[xviii] When a building or space is accessible it allows everyone the ability to access and use it appropriately. An environment should be designed to meet the needs of all people who wish to use it; this is a fundamental condition of good design[xix]. Despite the advancements made by international and national agreements such as the United

Nations Convention on the Rights of Persons' with Disabilities (UNCRPD) and the Disability Discrimination Act (DDA), many buildings and services remain physically inaccessible with a lack of connecting accessible transport options.

- **Lack of culturally appropriate and sensitive responses:** Staff are often unaware of the importance of understanding intersectional identities. For example, Aboriginal and Torres Strait Islander people with disability may not identify with the term disability but may require disability supports to access mental health services and/or address mental ill health needs
- **Siloed services:** Many people with disability experiencing mental ill health, especially those in complex circumstances, require holistic, person-centred, cross-sector service responses, and for service gaps and intersectional barriers to be addressed. At present, there is insufficient cross sector knowledge, collaboration and workforce training.
- **Navigational barriers**: Service systems can be challenging to navigate, especially if people are needing to interact with multiple service systems simultaneously. Assistance to navigate cross-sector service systems and barriers (if needed), is not always available.
- **Service gaps/unmet need**: Whilst in some states there can be targeted services to address particular service needs (for example support for people with intellectual disability experiencing mental ill health), in many instances demand doesn't match supply. The 2023 report commissioned by the South Australian Government on "Unmet mental health service need in South Australia that could be met by the NGO sector", highlights the extent of service gaps in South Australia, noting a very substantial shortfall for psychosocial support services ($125 funding shortfall)[xx]. When cross-sector collaboration and workforce training is not occurring, true person-centred care, inclusive of people with intersectional identities and/or those who are needing or having to engage across systems, can be very difficult to achieve.
- **Diagnostic over-shadowing**: People with disability at times have assumptions made by others about their health or disability. Health symptoms misattributed to disability can cause delays or restrict equitable access to appropriate services.

- **Financial barriers:** People with disability are over-represented amongst those with low incomes,[xxi] however, a person with disability faces significantly higher costs in accessing services compared to non-disabled people, with research[xxii] from the National Centre for Social and Economic Modelling (NATSEM) in 2019 indicating a household including a person aged 16 and over with disability required an additional $107 per week to obtain the same standard of living as similar households without a person with disability. It is fair to say that this amount would be much higher now.
- **Stigma and discrimination:** People with disability and mental ill health can experience many types of stigma/discrimination and a variety of attitudinal barriers[xxiii], and there is not enough independent advocacy support available to assist people to address issues occurring.

Despite decades of knowledge about the need to comply with anti-discrimination legislation, there continues to be lack of awareness and/or knowledge and siloed service systems. There are also very limited mental health systems and services that have made an active commitment towards ongoing structural change, i.e. committing to universal design approaches or co-designing services and supports with people with disability and the disability community. It is imperative that the next national Agreement includes tangible actions to address these barriers.

We emphasise the additional impacts that occur for people with disability experiencing mental ill health and concur with the Productivity Commission on the need for urgent and meaningful reform across the entire service system, in the interests of equitable outcomes.

**Recommendation 2: The Productivity Commission should recommend in its Final Report that the new National Mental Health and Suicide Prevention Agreement include targeted actions and funding to address service gaps, unmet need and the barriers preventing people with disability accessing accessible and appropriate services.**

## 6. Co-design and people with disability

As you know, co-design is an inclusive, collaborative process whereby a diverse range of people with relevant skills, experience or interests come together to provide advice and make decisions on a project, policy, program or initiative. Co-design, which was endorsed by the Disability Royal Commission, for example in Recommendation 4.19 re new complaints mechanisms, ensures that the diverse perspectives of communities are considered.

JFA Purple Orange welcomed and strongly support the Commission's recommendation that a co-design process with people with lived and living experience as the process by which a renewed National Mental Health Strategy is developed (Draft recommendation 4.1).

We also strongly support 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, to inform the foundations of the next Agreement (in Draft recommendation 4.2). We also suggest disability advocacy and/or representative organisations be included as members of the co-design.

In doing this, it is important that any people with lived experience participating in such processes, outside of a paid work capacity, be paid for the expertise that they provide. We acknowledge, the Commission may have intended similarly, given your comment in the body of the report about the need for processes of co-design to be transparent and well-resourced[xxiv].

**Recommendation 3: The Productivity Commission should continue to recommend and emphasise the importance of co-design towards establishing and implementing a new National Mental Health and Suicide Prevention Agreement, and a National Mental Health Strategy in the Final Report.**

## 7. Priority populations

As part of the draft interim report, the Productivity Commission queried the high number (fifteen) and choices of the priority populations in the previous Agreement. The report stated the following: "it is questionable whether a long list of groups disproportionately impacted will lead to better targeting of support. As the PC (2022a, p. 113) has previously noted when reviewing the National Housing and Homelessness Agreement, 'if everyone is a priority, no one is a priority'."[xxv] Whilst we loosely agree that naming priority populations is an imperfect mechanism towards equitable outcomes and ensuring actions and funding are targeted appropriately, we strongly contend that a robust priority population list can still be important in helping develop actions, and assist stakeholders to know which populations to think about and work together with in seeking to address disadvantage.

We do however agree with the need to ensure that any such list accurately and fairly captures the groups where additional action is needed, including those most disproportionately impacted. We agree also that the connection between actions, outcomes and the priority populations need to be strengthened in the next agreement.

We would encourage introducing the concept of intersectionality and intersectional response in the way that your final report is framed, as a more holistic way of capturing the impacts of intersecting and compounding experiences of disadvantage. We recommend this in addition to the naming of a robust list of priority populations.

The most recent National Agreement included two priority populations that explicitly mentioned people with disability:

- People with disability
- People with complex mental health needs, including people with co-occurring mental health and cognitive disability and/or autism.

Given the unique needs and particular barriers that people with disability face, and the known health inequalities faced by the second cohort listed, we consider that both priority

cohorts should continue to be present for the next agreement.

**Recommendation 4: The Productivity Commission should recommend that there continue to be a list of priority populations for the next National Mental Health and Suicide Prevention Agreement, and that the two existing priority populations focussed on people with disability, should remain.**

## 8. NDIS and additional funding for psychosocial supports outside the scheme

JFA Purple Orange appreciate the Commission highlighting that governments have not fully met their commitments in the current Agreement regarding the development of psychosocial supports for people who do not qualify for the National Disability Insurance Scheme (NDIS), and the comments that this needs to be prioritised[xxvi]. We agree that there needs to be action as a matter of urgency to finalise the arrangements for funding and commissioning of additional psychosocial supports outside the NDIS, to meet unmet need. It is important that any reform in this care be co-designed with mental health consumers and their families and supporters, including people with disability.

Negotiations between the Commonwealth and the States are currently occurring in relation to foundational supports. Whilst it appears that psychosocial supports are, at this stage, intended to sit under the foundational supports' framework, it is still early days, and at this stage there is not enough information available to fully understand how foundational supports and psychosocial supports, will interact. It is imperative, however, that people in need of psychosocial supports have access to them, whether they are an NDIS participant or not. Only approximately 13% of people with disability in Australia are NDIS participants, so there are a lot of people with disability, many of whom are likely to be experiencing mental ill health, who need access to these supports. It is equally important, that no changes are made to the current structure in relation to removing or cutting services, without alternative appropriate and well-funded supports in place.

JFA Purple Orange, however, believe that the need for psychosocial supports outside the NDIS to be **in addition** to continued offerings of supports within the NDIS for people with psychosocial disability, and/or other disabilities with co-occurring mental ill health.

**Recommendation 5: The Productivity Commission should continue to recommend urgent action towards funding and commissioning of additional psychosocial supports outside the NDIS, to meet unmet need amongst people not eligible for the NDIS. The Productivity Commission should ensure any such arrangements are co-designed with people with lived/living experience including people with disability.**

## 9. Information requests

In this section, we will provide responses to two of the Productivity Commission's information requests, those for which we felt we had the most to contribute.

In response to Information request 4.1: we agree that 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. In the experiences of our staff, it is not unusual in our experience for people to have psychosocial or other disabilities also in these situations (whether psychosocial disability, alcohol induced dementia or others).

**Recommendation 6: The Productivity Commission should recommend the inclusion of an additional schedule in the next agreement to address the co-occurrence of problematic alcohol and other drug use, and mental health and suicide. This schedule should also be inclusive of co-occurring disability.**

In response to information request 4.2: there are many barriers to the genuine participation and influence of people with lived and living experience in governance forums. Many of these barriers are the same as those outlined in section 5 above, although there can be additional barriers, depending on attitudes/beliefs/stigma how receptive others within the governance forums are.

We would advise that the best measures for successful inclusion and engagement of people with lived and living experience in governance, include a combination of – regular feedback being actively sought (via formats that best suit the person) from people with lived and living experience themselves and their families/carers/supporters, alongside reports from (ideally) independent advocacy/representative orgs involved in the same governance forums, and feedback from other members of the governance forum.

## 10. Funding

According to a recent South Australian Government commissioned report[xxvii], there is a mental health system funding shortfall in South Australia of about $125 million per year. Adequate service system funding is vitally important. It allows for early support, and better immediate outcomes for the person experiencing mental ill health and their family/carers/supporters. It can avert crisis, thus reducing the pressure on hospitals and emergency departments, whilst also being cost effective. It supports recovery and enables a closer focus on achieving equitable outcomes for all, including people with disability experiencing mental ill health. It can contribute towards addressing inequality and strengthening the entire community.

The Commission stated in the Report that "The Agreement is not fit for purpose" and highlight the complexity of funding arrangements, the lack of funding commitments, and the ways that funding commitments were structured, have negatively impacted the effectiveness of the last Agreement[xxviii].

Therefore, it is imperative that similar issues are not repeated in the next Agreement and the government ensures that:

- there are adequate levels of funding to achieve the outcomes sought;
- funding is targeted effectively, giving particular attention to addressing systemic and intersectional gaps and barriers in services and supports; and
- funding architecture is fit for purpose and co-designed with people with lived and living experience, including people with disability.

**Recommendation 7**: **The Productivity Commission should recommend appropriate funding levels and funding architecture are provided to ensure that the new national agreement achieves both its outcomes and also substantial and meaningful reform.**

## 11. Measurable Outcomes Framework

The Report acknowledges that the current Agreement has not achieved the desired objectives and lacked targeted and measurable actions and states that accountability is

essential in ensuring the success of the next Agreement. The Commission recommends moving to an outcomes-based approach with comprehensive measures. JFA Purple Orange strongly agrees with this conclusion.

A measurable outcomes framework should be developed, using a genuine co-design approach, and include a comprehensive set of measurable targets that reflect the outcomes of the Agreement. These targets should be meaningful, timebound and measurable, and should be accompanied by actions for implementation including commitment of the necessary resources.

**Recommendation 8: That the Productivity Commission recommend in its Final Report that a measurable outcomes framework be developed, through co-design, with a comprehensive set of measurable and timebound targets, to sit alongside a new National Mental Health and Suicide Prevention Agreement.**

## 12. Robust Data Collection

Throughout the Report, the Commission emphasises the need for and importance of better data collection, noting the pivotal role that improved collection, use and reporting of data can have for both accountability and progress reporting. The interim report also noted the National Mental Health Commission and National Suicide Prevention Office's lack of provisions to implement repercussions when monitoring and reporting commitments were not fully adhered to.

JFA Purple Orange acknowledges the benefits of strong data architecture and reporting, on measuring progress and improvements. The quality of data about the experiences of mental health consumers, family and carer needs to be improved, both in support of higher quality policy making and measuring progress. Data needs to reflect greater nuance in circumstances to seek to better understand and respond to the diverse experiences of various cohorts, such as people with disability.

Improved and more frequent data collection about Australians with disability (including those with co-occurring mental ill health and disability) is crucial to underpin the design and implementation of policies and programs to address the full range of areas in which outcomes for this group of Australians fall well short of those for non-disabled people. Closing these gaps will have great enduring benefits for people living with disability and for the nation. As a signatory to the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD), Australia has significant international obligations to protect the rights and dignity of people living with disability and to address the discrimination, exclusion, and disadvantage that continues to be experienced by this group of Australians.

The Commission comments on the complexity of obtaining data on outcomes in relation to priority populations. Whilst a focus on data and evidence-based approaches is commendable and necessary, we are conscious also of the natural limitations to the nature of the data that is available or can be collected. Data collection processes that are not inclusive or accessible to people with disability may exclude people and not provide an

accurate representation of the issues being explored. Additionally, privacy considerations, cultural differences, experiences of stigma and discrimination or other factors can contribute to data collected not being accurate or truly representative.

Given this, to achieve mental health system reform that genuinely offers equitable outcomes for all (proportionate to need), it is important to take account of, but also go beyond, quantitative data and evidence. To find ways to continue to partner with and listen to people with lived and living experience (and their families, carers, supporters, advocates and representatives) and to centre their experiences, for example using a genuine co-design process.

**Recommendation 9: That the Productivity Commission recommend in its Final Report that there be a high-level commitment by the Commonwealth and the States to accessible data collection, reporting requirements and accountability measures, including the mental health experiences of people from priority populations, including disability.**

**Recommendation 10: That the Productivity Commission recognise in their Final Report that:**

- **There are known barriers and limitations to achieving accurate data collection in relation to priority populations* experiencing mental ill health or suicide; and**
- **That even if the frequency, comprehensiveness and accuracy of data collection were to be improved, that traditional data collection methods cannot give a full picture of the needs and experiences of priority populations; and**
- **That having a more fulsome picture is important to addressing health inequities; and**
- **As a result – that there is an additional need to co-design with priority populations a set of approaches to complement and strengthen the available data and what it can tell us of intersectional experiences and needs.**

***By priority populations, we intend people/communities who experience intersectional barriers. This is inclusive of people with disability.**

## 13. Conclusion

It is clearly evident that the current National Mental Health and Suicide Prevention Agreement has been unsuccessful. However, it is vitally important to achieve a mental health system which takes a holistic approach and provides equitable access to and quality of support, proportionate to need, for all.

Transformational change is required, and we hope that the Commission's report contributes to this. We hope this submission provides useful feedback to further strengthen the Final Report and include people with disability. People with disability are over-represented amongst those experiencing mental ill health, and must be part of forthcoming co-design processes and system-redesign to ensure more equitable outcomes and to reduce the barriers they experience in accessing appropriate supports

Thank you again for the opportunity to provide feedback to this important consultation, we look forward to continuing to contribute to the next steps.

If there are additional ways we can support the inclusion of people with disability as this work progresses, please let us know. We are available to discuss the issues raised in this submission further. To arrange this, please contact Ms Selena Maddeford, Manager of Policy and Projects at JFA Purple Orange,

## 14. Endnotes

[i] R. Williams, 'Model of Citizenhood Support', 2nd edition, 2013, Julia Farr Association Inc, Unley, South Australia. See https://purpleorange.org.au/what-we-do/library-our-work/model-citizenhood-support, accessed in July 2025.
[ii] R. Williams, 'Model of Citizenhood Support', 2nd edition, 2013, Julia Farr Association Inc, Unley, South Australia. See https://purpleorange.org.au/what-we-do/library-our-work/model-citizenhood-support, accessed in July 2025.
[iii] R. Williams, 'Model of Citizenhood Support', 2nd edition, 2013, Julia Farr Association Inc, Unley, South Australia. See https://purpleorange.org.au/what-we-do/library-our-work/model-citizenhood-support, accessed in July 2025.
[iv] Australian Institute of Health and Welfare (2024), Health of people with disability, web article: release date 02 July 2024). Available online at: https://www.aihw.gov.au/reports/australias-health/health-of-people-with-disability# , accessed in July 2025.
[v] Bishop, G., Kavanagh, A., Disney, G., Aitken, Z. (2023), 'Trends in mental health inequalities for people with disability, Australia 2003 to 2020', *Australia and New Zealand Journal of Psychiatry*, 2023: Aug 22:57 (12): 1570-1579. Available at: https://doi.org/10.1177/00048674231193881, accessed in July 2025.
[vi] The Royal Australian & New Zealand College of Psychiatrists (2022), *Intellectual disabilities: Addressing the mental health needs of people with ID Position Statement*. Reference PS #109, Last updated December 2022. Available via: https://www.ranzcp.org/clinical-guidelines-publications/clinical-guidelines-publications-library/intellectual-disabilities-id-addressing-the-mental-health-needs-of-people-with-id# accessed in April 2025. AND
SA Health (2023), *Intellectual disability and mental illness webpage*, on the SA Health website. Available via: https://www.sa.gov.au/topics/care-and-support/disability/health/intellectual-disability-and-mental-illness , accessed in April 2025 AND
Commonwealth of Australia (2023), *Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability Final Report: Volume 6, Enabling Autonomy and Access*. Page 322 onwards. Available via: https://disability.royalcommission.gov.au/publications/final-report, accessed in April 2025.
[vii] Council for Intellectual Disability (2025), Our Health Still Counts Campaign, information available online at: https://cid.org.au/our-campaigns/our-health-still-counts/, accessed in July 2025.
[viii] Wechsler, D. et al (2025) Advancing health-care equity for autistic people, mental health as a key priority, *The Lancet*, Volume 405, Issue 1049, 1723-1726.
[ix] Australian Institute of Health and Welfare (2024), Health of people with disability, web article: release date 02 July 2024). Available online at: https://www.aihw.gov.au/reports/australias-health/health-of-people-with-disability# , accessed in July 2025.
[x] Australian Institute of Health and Welfare (2024), Health of people with disability, web article: release date 02 July 2024). Available online at: https://www.aihw.gov.au/reports/australias-health/health-of-people-with-disability# , accessed in July 2025.
[xi] Commonwealth of Australia and States and Territories (2022), National Mental Health and Suicide Prevention Agreement (2022), available via: https://federalfinancialrelations.gov.au/agreements/mental-health-suicide-prevention-agreement, accessed in July 2025.
[xii] Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disabilities (2023), Final Report, available online at: https://disability.royalcommission.gov.au/publications/final-report
[xiii] Australian Bureau of Statistics (2024), *Disability, Ageing and Carers, Australia: Summary of Findings, web report*, reference period 2022, released 4/7/2024. Available at: https://www.abs.gov.au/statistics/health/disability/disability-ageing-and-carers-australia-summary-findings/latest-release, accessed in July 2025.

[xiv] Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disabilities (2023), Final Report, available online at: https://disability.royalcommission.gov.au/publications/final-report
[xv] Productivity Commission (2025), *Mental Health and Suicide Prevention Agreement Review – Interim Report June 2025.* Canberra. Available at: Interim report - Mental Health and Suicide Prevention Agreement Review, accessed in June 2025.
[xvi] Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disabilities (2023), Final Report, Volume 6: Enabling Autonomy and Access, page 39, available online at: https://disability.royalcommission.gov.au/publications/final-report
[xvii] Rotenberg, S., Rodriguez Gatta, D. Wahedi, A., Loo, R., McFadden, E. and Ryan, S. (2022), Disability training for health workers: A global evidence synthesis, *Disability and Health Journal*, Volume 15, Issue 2, April 2022. Available online via: https://linkinghub.elsevier.com/retrieve/pii/S1936657421002405, accessed in July 2025.
[xviii] National Centre for Universal Design(2014), What is Universal Design, quoted via: https://inclusiveschoolcommunities.org.au/resources/toolkit/accessibility-and-universal-design#
[xix] Centre for Excellence in Universal Design, https://universaldesign.ie/about-universal-design
[xx] David McGrath Consulting (2023), *Unmet Mental Health Service Need in South Australia that could be met by the NGO sector: An analysis on behalf of the South Australian Government. Final Report,* February 2023, available at: https://www.chiefpsychiatrist.sa.gov.au/news/release-of-the-unmet-needs-report-for-psychosocial-support-services-in-sa-2, accessed in July 2025.
[xxi] Australian Institute of Health and Welfare (AIHW) (2024), People with disability in Australia, web report: Income, available at: https://www.aihw.gov.au/reports/disability/people-with-disability-in-australia/contents/income-and-finance/income, accessed in July 2025.
[xxii] Li, J. Brown, L, La, H., Miranti, R., and Vidyattama, Y. (2019) *Inequalities in Standards of Living: Evidence for Improved Income Support for People with Disability*. Report by National Centre for Social and Economic Modelling (NATSEM) at the University of Canberra, prepared for the Australian Federation of Disability Organisations (AFDO). Report available online at: https://researchsystem.canberra.edu.au/ws/portalfiles/portal/29996777/02A_NATSEM_Online_Disability_Report.pdf, accessed in July 2025.
[xxiii] Bollier AM, Sutherland G, Krnjacki L, Kasidis V, Katsikis G, Ozge J & Kavanagh AM. (2021). *Attitudes Matter: Findings from a national survey of community attitudes toward people with disability in Australia*. Centre of Research Excellence in Disability and Health, The University of Melbourne. doi: 10.26188/15176013, accessed in July 2025.
[xxiv] Productivity Commission (2025), *Mental Health and Suicide Prevention Agreement Review – Interim Report June 2025.* Canberra. Available at: Interim report - Mental Health and Suicide Prevention Agreement Review, accessed in June 2025.
[xxv] Productivity Commission (2025), *Mental Health and Suicide Prevention Agreement Review – Interim Report June 2025.* Canberra. Available at: Interim report - Mental Health and Suicide Prevention Agreement Review, accessed in June 2025.
[xxvi] Productivity Commission (2025), *Mental Health and Suicide Prevention Agreement Review – Interim Report June 2025.* Canberra, page 129. Available at: Interim report - Mental Health and Suicide Prevention Agreement Review, accessed in June 2025.
[xxvii] SA's $125m mental health gap leaves 19,000 with unmet needs - News | InDaily, Inside South Australia
[xxviii] Productivity Commission (2025), *Mental Health and Suicide Prevention Agreement Review – Interim Report June 2025.* Canberra, page 76. Available at: Interim report - Mental Health and Suicide Prevention Agreement Review, accessed in June 2025.