THE UNIVERSITY OF SYDNEY

Brain and Mind Centre

Submission to the Productivity Commission Inquiry into the Bilateral Agreements on Mental Health and Suicide Prevention

Professor Ian Hickie
A/Prof Sebastian Rosenberg
University of Sydney, Brain and Mind Centre
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Contents

Recommendations

1. A new national mental health strategy should be underpinned by shared principles.

2. These principles should configure not only the next Bilateral Agreement but also the next National Health Reform Agreement, with the states and territories provided with incentives or sanctions encouraging the establishment of alternatives to hospital-based mental health care, covering inpatient, outpatient and ED services. Funding should be allocated to prioritise development of these community mental health services, including both clinical and psychosocial care. The psychosocial contributions made by governments could be part of addressing the unmet needs already identified.

3. Any new agreement should set clear and measurable goals and targets, with adequate resources to enable the collection of the data required to assess progress. Agreements must emphasise measurement-based care (using new technologies), underpinning the rollout of any future new health programs.

4. Pooled funding approaches should be considered to spur more regional cooperation, with clear community stewardship of decision-making, supported by state and PHN planning.

5. A similar kind of overarching stewardship group should be established to report on progress against these goals and targets. This group could be part of the work a new independent National Mental Health Commission.

6. For the Commission to operate effectively it not only needs to be able to compel information from agencies, it also needs access to current, accurate and regional data. Right now, data sources are typically late and often incomplete. Good planning and equitable resource allocation depends on accurate information, to enable monitoring, benchmarking and public reporting. Such systems can build community confidence in systemic improvement, even where results are negative.

7. A data observatory should be established to deliver this information collection function in mental health.

8. The National Mental Health Commission needs to employ people with skills already identified in the Picone review.

9. The new consumer and carer peak bodies could be properly resourced and charged with collection of validated experience of care data, allied to an explicit process of reporting aimed at systemic quality improvement.

10. A national learning health system and digital infrastructure to support technology-enabled models of care and quality improvements.

11. Australia should establish a multidisciplinary mental health training facility, like TePou in New Zealand.

12. Future mental health planning should call on a range of resources and techniques, building on the Service Planning Framework.

13. Part of the next round of national mental health reform should be detailed workforce role design, going beyond consideration of how best to boost numbers of professionals, to giving proper consideration as to roles and how best to sponsor and fund desirable models of multidisciplinary care, and how to leverage digital technologies to support and enhance workforces.

14. As outlined by the Commission already in relation to Aboriginal and Torres Strait Islander mental health and suicide prevention matters, special consideration should be given to properly understanding and responding to the needs of Australians from Culturally and Linguistically Diverse (CALD) backgrounds.

15. Future mental health agreements and associated reporting on progress should, like the National Mental Health Commission, reflect the broader mental health ecosystem, to include issues of drug and alcohol, housing, employment, education, justice health and more.

16. Better stratification of suicide prevention initiatives would assist with targeting, evaluation and service improvement.

17. There should be an audit of existing quality standards in mental health to ensure currency, appropriateness and usefulness.

Introduction

There are surely fewer more examined areas of public service and spending in Australia than mental health. It has been estimated that there have been more than 55 statutory or parliamentary inquiries into mental health since the National Mental Health Strategy began in 1992. These inquiries have generated thousands of submissions and recommendations.

Even among this deluge, the Commission's interim report into the Bilateral Agreements was both welcome and unusual.

From our point of view, the Commission's interim findings point to some of the key reasons why previous, well-informed and carefully crafted inquiries and recommendations have failed to generate desired positive reform of mental health in Australia, and indeed why the Commission has now found the Bilateral Agreements unfit for purpose. These reasons include:

- No clear strategy
- Poor governance
- Poor accountability
- Poor planning
- Poor services

This submission provides some further thinking around these issues, and some others, including our perspective on the recommendations the Commission has already made. Our reflections are derived from our experience in both research and service provision. We also draw on work we have done with the Sydney Mental Health Policy Forum, a multidisciplinary group of mental health stakeholders.

While government spending on mental health in Australia has increased from $3.2bn in 1992, when the National Mental Health Strategy began, to $12.5bn in 2023, mental health's share of Australia's total health budget hasn't changed - it was about 7.3% in 1992 and the same in 2023.

At the same time, despite this funding and greater community acceptance and awareness of mental health, rates of mental distress have increased in the last decade. Mental disorders are the most commonly reported serious illness in people under 55. Clinics, hospitals and emergency departments are overwhelmed.

There is also evidence that a quarter of all acute inpatient mental health beds are being occupied by people who would be better off in other care settings, if those options were available.

Of the 17 categories of disability covered by the National Disability Insurance Scheme (NDIS), psychosocial disability ranks as the fourth largest, with just over 64,000 participants, at a cost of $4.25bn (an average package costs $71,600 per participant).

Suicide is the leading cause of death for young Australians (15-44). Mental health and the drug and alcohol disorders which often co-occur, now account for 15% of the total burden of disease in Australia.

And mental illness is not just a public health issue. It has enormous impact not just on the lives of individuals and their families but on whole communities and the national economy. The Productivity Commission previously found the cost to the Australian economy of mental illness and suicide to be up to about $70 billion per year.

They suggested that improvements in Australia's response to mental illness could save around $18 billion annually. To put this in perspective, total Government payments for all Medicare services (not just mental health) cost just under $33 billion in 2024-25.

Repeated inquiries and reports have found that our existing mental health service system is not fit for purpose. Recent data has shown that the rate of public access to services has not increased between 2013 (46%) and 2024 (47%). The proportion of new clients into Medicare mental health services was 35.4% in 2014-15 and is now just over 25%. 41.5% of hospital-based mental health services were provided to new clients in 2013-14, 41.8% in 2022-23. Existing systems cannot increase their scale or availability. Repeat clients appear stuck, not recovering.

2025 is the 20th anniversary of publication of the seminal Not For Service report, jointly prepared by the Brain and Mind Centre and the Human Rights Commission, which reported poor care, large gaps in our service system, uneven distribution, chronic workforce shortages and key populations left vulnerable. Repeated subsequent inquiries have confirmed these findings.

None of this would be acceptable to Australians in relation to cancer care. And simply providing more funding to this broken system is akin to topping up the oil in a leaky engine.

Mental health in Australia requires systemic reform underpinned by new technology and new approaches.

No Clear Strategy

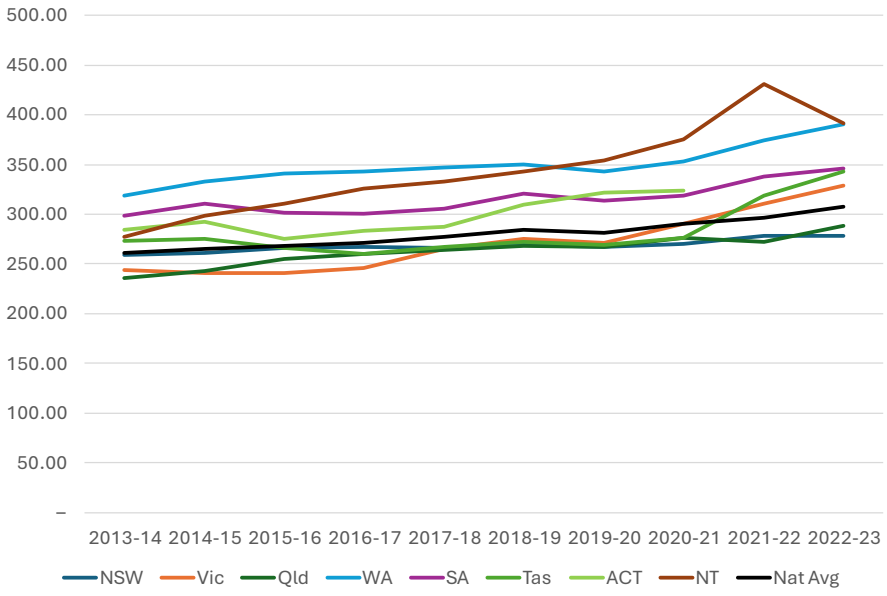
We concur with the recommendation made in the Interim report regarding the need for new, clear national mental health and suicide prevention strategy.

We would agree with a common view that of the five national mental health plans developed since 1993, each successive plan became less influential. The first plan was the only plan to be accompanied by some clear incentives and sanctions, largely designed to encourage state governments to close their psychiatric institutions. It is worth noting however that, even here, success was partial. Australia still spent $676.4m on 1555 beds in public psychiatric specialist hospitals in 2022-23 (Report on Government Services data).

Health systems are difficult to shift, with lots of moving parts. Different jurisdictions have made different investments in different types of services, at different rates. Australians access to mental health care varies considerably depending on where you live.

With split responsibilities and funding, including in mental health, there is ample opportunity for the oft-cited gaps to appear, between public and private services, state and federal, hospital and community and so on. The impact of the federal/state split, with the former responsible for Medicare-based services and the latter for hospitals, has resulted in an unhelpful bifurcation of mental health into (at least) two systems, not one. With different funders providing support to different clients, key players like local health districts and primary health networks often struggle to see clients in common. They lack a reason to plan together. There is no 'system'. Concepts like 'stepped care' in reality only cover some aspects of the service system and are unrealistic in this environment.

State and Territory Mental Health Per Capita Spending 2013-2023 (ROGS)



To begin to join up this fractured situation, a new nationwide approach to mental health reform should be underpinned by shared principles, such as prioritisation of:

- Early intervention, in life and in episode
- Community based care over hospital-based care
- Hospital avoidance and avertable burden as key constructs
- Development of common planning standards
- Opportunities for data linkage and regional benchmarking
- Opportunities for intelligent use of new technology to support decision-making, care coordination, and continuity of care
- Opportunities to fill workforce gaps using new technologies
- A service system with consumers at its heart, that properly reflects their needs beyond the mental health sector, to include issues such as physical health, drug and alcohol, housing, employment, education and social connection
- Systems which permit direct consumer and carer feedback to drive clear processes of quality improvement across this broader ecosystem.

Together, these principles would set a new national agenda for reform which would, over time, rebalance mental health care in Australia towards a more desirable, community-based focus, as originally intended by the National Mental Health Strategy more than 30 years ago.

Poor Governance

Tools like planning standards could contribute to better governance by parties that do not immediately recognise the need for, or benefit from, more integrated approaches to planning. The relationship between state and federal planning bodies is out of alignment with funding. Primary Health Networks (PHNs) probably account for only 10% of total spending in mental health but seem central to regional planning, while local health districts account for most regional funding but focus their planning around hospital-based services – inpatient, outpatient and emergency care in particular.

Community services in Australia are weak, where they should be central. Proven models of community outreach have been largely dismantled. Funding for psychosocial services has always been a peripheral element of the total funding mix. Despite strong evidence of the impact these services can have on people's lives, these services only garner about 6% of total mental health funding. By contrast, they account for around 25% of funded mental health services in New Zealand, giving that jurisdiction many more community-based service alternatives than are available in Australia.

This leaves clinical and medical services without a strong, vibrant psychosocial partner and narrows the service options available to consumers and their families seeking mental health support.

Funds pooling was an idea initially considered at the time PHNs began but has faded from view. There can be little doubt that system fragmentation is facilitated by the separate funding streams which exist. Pooled arrangements would surmount this blockage.

While we support the Commission's recommendation in relation to a new national mental health strategy, a key element of reform, as identified by the previous Commission Inquiry into mental health, is regionality. Currently, most data on mental health is presented at the jurisdictional level. But comparing WA with Tasmania is not always helpful. Rather, benchmarking and comparisons, and indeed governance itself, is best undertaken at a regional level.

Similarly, while a new national strategy implies the application of national approaches and standards, there is a tension here to ensure that mental health service design and resources properly responds to regional needs and variations. Effective planning at the regional level needs to reflect demographic, economic, social and other factors, in addition to ensuring national standards about services or quality are upheld.

One possibility is for broad, regional stewardship groups to be formed, engaging not only existing planners, but also professionals working in the area, consumers and carers, in a process of collaborative design and stewardship of mental health care, region by region. Such groups should include the entirety of the mental health ecosystem, not just health services. Decision-making powers should rest with this stewardship group, supported by state and PHN planners.

Poor Accountability

We have reflected on the need for systems of accountability to reflect this broader ecosystem for some time, here, here and here. This work has included positing a list of suggested core measures, covering health, social and system domains.

Developing this has been vital, given the failure of successive national mental health strategies to deliver the clear accountability originally envisaged.

Extract from National Mental Health Policy 1992

Monitoring and accountability

There needs to be greater accountability and visibility in reporting progress in implementing the new national approach to mental health services. Currently mental health data collection is inconsistent and would not be adequate to enable an assessment to be made of the relative stage of development of the Commonwealth and each State/Territory Government in achieving the objectives outlined in the National mental health policy.

It is essential that such a consistent system of monitoring and accountability be created. In developing such a system, it needs to be recognised that each State and Territory will be at a different stage as a result of the historical development of its mental health system. The central approach should be to measure progress in each State and Territory.

Objectives

- To develop nationally agreed measures of performance in relation to each of the objectives in this policy and others which the Commonwealth, States and Territories regard as indications of performance in relation to this policy.
- To report annually and publicly, in a timely fashion, on the progress of the Commonwealth and each State and Territory in relation to these performance indicators and to compare them to their previous performance.

Mental health reporting has evolved over time, incorporating different national minimum datasets and reflecting the strong role played by states and territories as the main providers of care. The reporting also had a heavy emphasis on financial accountability reporting inputs like spending and staffing, and outputs, as well as administrative data such as treatment days, number of services and clients. The collection was not designed to drive a process of systemic quality improvement nor reflect perspectives on accountability held by mental health stakeholders like consumers or even health professionals. Stakeholders from across the mental health sector and outside of government would likely prioritise different accountability issues and questions to those selected by government.

Spending on development of outcome measures and accountability for mental health has been minimal. Most of the effort has gone into establishing the National Outcomes and Casemix Collection (NOCC), administered by the Australian Mental Health Classification and Outcomes Network. There is little evidence linking the NOCC data to any process of quality improvement in mental health.

Another important and more recent element of accountability has been the Your Experience of Service (YES) survey, aiming to bring the validated voices of consumers and carers to bear in improving mental health service quality. Again, there is little evidence linking YES to any process of improvement or feedback.

The collection of agreed, impactful consumer and carer reported outcome measures, married to an organised theory of change, could underpin the roles to be played by the new peak bodies representing these perspectives. Equipped with adequate resources, the peaks could lead the collection and reporting of findings directly from consumers and carers, into new structured processes of regional system improvement. Beyond their general advocacy remit, this would give the peaks real responsibility as part of overall systemic change.

There is clearly a need to establish a balance across different types of accountability measures. Again, a stewardship-type approach could broaden Australia's capacity design and collect more impactful accountability measures.

A Data Observatory

Mental health needs an independent Observatory to collate and present the data necessary to drive regional benchmarking and quality improvement, and to inform the public's understanding of progress. Such a body would work with partner agencies (states and territories, AIHW etc). There are useful precedents here, such as the European Observatory and the Scottish Public Health Observatory. Operating as a Data Cooperative to assist regional planners, it could also tap into the real time data collected from consumers and carers, as well as look to better engage with data sets not currently used, from related areas of human service delivery (justice, education, employment, housing etc).

Role of the Mental Health Commissions

We have been directly involved in the establishment of the NSW Mental Health Commission, the ACT Office of Mental Health and Wellbeing and the National Mental Health Commission. While these, and the other Commissions, vary in their structure, budget and remit, in our view their shared fundamental role was always intended to revolve around independent accountability for progress in mental health. They needed authority and resources to execute this role, and given split responsibilities, probably need to work together as a network of commissions for them to be successful. We can find little evidence of their positive impact on accountability for mental health and positive reform. In the case of the WA Commission, there is evidence (from another statutory body) indicating desired measures of reform in fact went backwards.

The NZ Mental Health Commission, in its past, used to provide tailored, regional benchmarking information to mental health system leaders. This data placed local performance in context and permitted reflection and discussion. This is a 'theory of change' that could be replicated here. For this to occur, practically, mental health commissions need the kind of specific skills referred to in the 2023 Independent Investigation into the National Mental Health Commission (see extract from page 85 below).

The most recent iteration of the National Mental Health Report Card demonstrates the palpable absence of these skills still in the National Commission. Table 1 of the Report Card (page 14) shows its reliance on data that is often out of date, rarely collected, or provided from supplementary material rather than from direct surveys or collections. This is inadequate but properly reflects the meagre investment in accountability for a system responsible for more than $12bn of taxpayer expenditure.

Extract from Review into Commission (page 85)

6.5.1 Annual National Report on Mental Health and Suicide Prevention

The primary purpose of the Commission is to produce the National Report.

To produce this report, a diverse set of skills are required:

- **Data analysis:** this involves understanding statistics and probability and various data analysis techniques like regression and factor analysis.
- **Data visualization:** it is essential to know how to present data understandably. This will involve using graphs, charts, and tables.
- **Data management:** this includes understanding how databases work and how to extract data from them, as well as skills in using data analysis tools, such as SQL, Excel, or more specialised software like Tableau, Power BI, or SAS.
- **Understanding of KPIs:** these metrics measure the effectiveness of various aspects of a business. To create a National Report, it is imperative to know what KPIs are essential for the business or project being assessed.
- **Critical thinking:** this includes being able to interpret the data and understand what it means in the context of the business or project. This involves making connections between different pieces of data and making conclusions.
- **Communication skills:** this involves communicating findings clearly and effectively in writing and verbally. This might also include presentation skills.
- **Technical skills:** familiarity with business intelligence and analytics software is often required. Tools like Tableau, Power BI, or data science languages like Python or R can be essential.
- **Problem-solving skills:** this involves being able to figure out the best ways to present and analyse data, and this usually involves solving complex problems.

Fast catching up to the unaccountable health sector is the largely unaccountable disability sector, where around $4.25bn are spent on about 64,000 Australians in receipt of NDIS packages of support, with little understanding of what is provided or the impact of this spending. This is poor governance.

Poor Planning

Until recently, and still in some places, mental health planning has largely been an historical exercise, with budgets reflecting what you got last year, plus or minus whatever the budget demands. This has delivered the kind of inequity already noted in this submission.

More recently, planners have begun to use more sophisticated tools, especially the National Mental Health Service Planning Framework. There are strengths and limitations to this Framework. The Framework's picture of what services 'should' be available to meet the mental health needs of 100,000 Australians is generic, not place-based. It does not reflect local variations in prevalence, need or demography. It is also unclear the extent to which the Framework aims to promote recovery from mental illness among populations, or focus on merely addressing some unchanging level of illness in the community. The Framework operates under licence and has not been subject to broad review or assessment. This is particularly significant in areas such as psychosocial care, where expectations about the types and levels of services to be provided, and to whom, are still subject to debate.

These and other limitations to the Framework can prioritise next steps in its development.

However, it is our advice that the Framework also needs to be supplemented with other tools to be truly useful. Before considering the services which 'should' be in a region, it is important to understand what already exists. Atlases and maps of regional mental health systems have already been developed and can usefully link to the Framework, though this has yet to be done.

Similarly, new modelling techniques permit planners to consider a range of alternative scenarios, drawing on evidence about what 'is' and what 'should' be, in order to devise the best combination of services and programs to meet changing community needs over time. These techniques have already underpinned work in relation to specific population planning and in relation to place-based planning.

Our research has also demonstrated that service mapping and systems modelling approaches to service commissioning can be used to increase transparency about funding decisions, and their potential impact on community outcomes, for example in relation to young people.

In addition to providing key players with a reason to plan together, there is an urgent requirement to equip them with the tools and skills to enable good planning to occur. Brain and Mind has recent experience, in relation to improved youth mental health planning, developing and working with local groups who can lead detailed processes of co-design. We are currently building a tailored model for application in relation to modelling for Aboriginal and Torres Strait Islander people in Central Queensland.

This kind of strategic modelling can be used to aid priority setting beyond individual services and programs to consider the social determinants of mental health.

One example identified a set of preventive targets that are most likely to result in significant reductions in the prevalence of mental health problems: people's sense of financial security, local community engagement, loneliness, physical health, and paid employment or volunteering. Another example estimated the economic benefits of improving social determinants. This analysis for local decision making found that even small changes in social cohesion, childhood difficulties, substance misuse and suicide were expected in improve quality of life, prevent suicides, reduce pressure on the health care system and save millions of dollars in costs.

New groups like ACUMEN have been established and can offer assistance.

The government should focus on investing in the digital infrastructure and connectivity that allows many digital tools and providers to exist, rather than picking specific tools. No single digital organisation has the capacity to invest in the major infrastructure required to meet the scale of need, so this is where the government can provide great value – creating a platform for systemic innovation. The digital standards framework then provides the mechanism to ensure innovations can operate safely and in concert.

A key aim of better planning is to reduce the uncertainty which currently characterises mental health service delivery.

Planning can also be greatly assisted by the establishment of more evidence-based and predictable pathways of care, informed by specialised assessment and decision-support tools. Other areas of health care commonly provide such care pathways. Mental health does so only rarely. Not only does this leave professionals unsure about preferred services and treatments, it also contributes to the sense of uncertainty, stigma, and hopelessness felt by many consumers and carers as they attempt to navigate the mental health system. In this respect, the key questions are who needs what services, for how long, with what expected outcomes and what happens if the person's mental health improves or declines, what next?

One key element missing from existing consideration of these questions is in relation to mental health workforce role design. Current concern is about professional numbers. What has been missing from workforce strategies has been consideration of roles, who should do what and how best to organise the professional collaboration necessary to deliver effective multidisciplinary care. New Zealand has a specific training facility aimed at increasing the capacity and willingness of mental health professionals to work together in teams.

As previously mentioned, the development of planning standards could bring these issues together to assist local planners do better. More coordinated funding arrangements, like pooling, could further spur more joined-up planning to better meet local needs.

Poor Services

Current efforts in mental health reform, perhaps understandably, have largely been directed towards lifting rates of access to care for the Australian community. As reported earlier, these efforts have in the case of Medicare stalled, or in relation to hospital care, failed.

We also know that uneven roll out of services and workforce has created inequities, situations in which services are most available in locations where psychological distress is least. In a similar confounding situation, the evaluation of the Better Access Program found its services were being provided to people with a level of severity never intended. It also highlighted worsening delays between receiving a mental plan and attending the first treatment session as well as declines in access for new treatment-seekers as a result of 'over-servicing' of those already receiving care.

To summarise, the wrong level of the wrong services are being provided to the wrong people in the wrong places.

There is an urgent need to focus now on issues of quality and standards, as well as access and equity. As stated earlier, the community is still quite unclear about where to go to find the right mental health care to meet their needs. Simultaneously, the system is ill equipped to deliver specialised assessments to determine appropriate care pathways. What qualifies as quality mental health care is unclear. Some standards exist, such as here and here, but these could be expanded and made more prominent, to build greater community understanding about what to do. An audit of existing standards and their usefulness would be an important contribution to this process.

A national learning health system – digital and data infrastructures

For too long our mental health system has been operating without a real digital and data infrastructure to support the kind of national learning health system we require to improve the quality of mental health care.

A core feature of this model is the development of the technology infrastructure and tools that facilitate high quality specialised assessment, monitoring and data sharing. This is a critical enabler to facilitate coordination and communication across service providers, addressing the current integration problems causing fragmentation in care pathways.

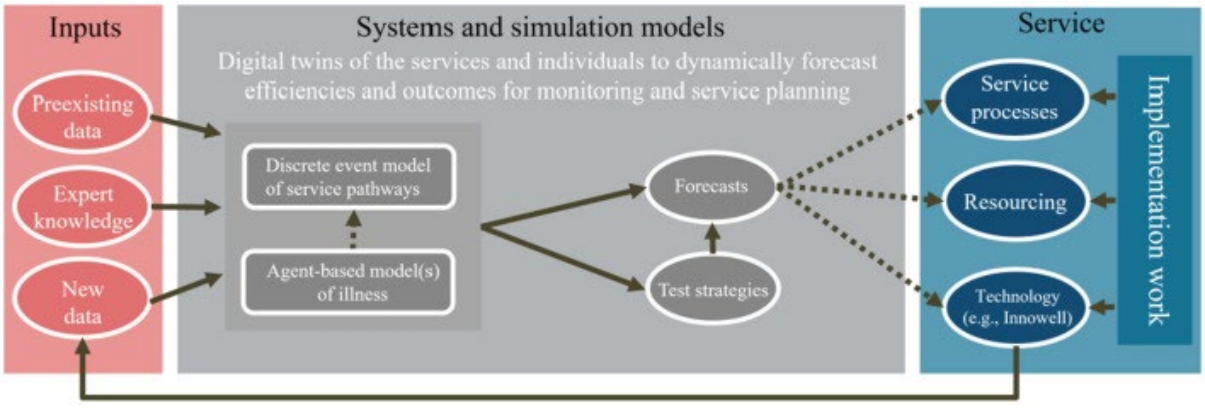
This type of system wide technology-enabled care coordination has the potential to deliver a reduction in self-harm hospitalisations and suicide deaths by 6.71% (95% interval 5.63%-7.87%), mental health–related ED presentations by 10.33% (95% interval 8.58%-12.19%), and the prevalence of high psychological distress by 1.76 percentage points (95% interval 1.35-2.32 percentage points).

Improved coordination is about expanding access to specialised care (high quality assessment, referral, monitoring with skilled professionals). An empirical case study using data from South Australia demonstrates how specialised service capacity and disease progression interact to influence mental health care systems' effectiveness and efficiency. The model shows that increasing service capacity can trigger a critical shift from persistently high unmet needs for specialised services to a stable state where immediate and effective treatment is widely available. This shift occurs through a "virtuous cycle," where treating mild to moderate cases reduces severe cases, freeing capacity to further slow disease progression (i.e., effective indicated prevention and early intervention based on staged care). So, expanding specialised services access and capacity can significantly enhance system efficiency and resilience, ensuring sustainability during future mental health challenges such as economic crises or global pandemics.

National systems that enable immediate assessment and real-time tracking of outcomes as well as system performance can transform youth mental health care into a dynamic and responsive learning health system (see figure below).

Major investments in this type of infrastructure (e.g., data platforms and learning health systems) are evident internationally in places like Canada (e.g., over $30M invested in coordination and data platforms) and Singapore and are clear indications that mental health reform should centre around technology innovations. Such innovations are the primary mechanism by which we can link expanded primary care entry points, such as headspace centres, with specialist care and psychosocial support systems. Community and digital entry points must be supported by infrastructure that ensures seamless transitions across levels of care, no matter where someone is located

A learning health system approach that leverages continuous data collection and simulation modelling to improve service planning and evaluation.



In conclusion, the limitations of the current stepped care model highlight an urgent need for a paradigm shift in mental health care. A national digital infrastructure underpinned by measurement-based care, offers a dynamic and personalised framework that can address the complexities of mental health. By leveraging technology and fostering cross-sector collaboration, Australia could create a more effective, integrated, and equitable system for its youth. This transformation is essential to meet the evolving needs of young people and ensure the long-term sustainability of mental health services.

Practical solutions towards integration for equity and quality

A major barrier to achieving truly integrated and equitable mental health care is the pervasive culture of competition between mental health services and organisations. While competition is often viewed as a driver of innovation and quality, in the context of mental health care, it has resulted in fragmentation, duplication of efforts, and inefficiencies that compromise the overall effectiveness of the system. As the digital mental health landscape grows exponentially, we are in danger of replicating the failings of existing services by making the online landscape overly complicated and difficult to navigate with greater risks to people's privacy, poor care and negligence.

To address this, there is a critical need to foster collaboration between mental health services and organisations, enabling them to work collectively toward strengthening the national mental health system as a whole. This requires shifting from a model where providers compete for dominance as the primary provider to one where they cooperate to enhance system-wide capacity, quality, and accessibility.

At the heart of this collaborative approach lies the creation of an 'information-sharing ecosystem' that balances the need for flexibility in service delivery with the necessity of interoperability. Such an ecosystem must empower individuals by giving them control over their data while simultaneously enabling distinct organisations to access relevant information in a secure and efficient manner. This can facilitate seamless care transitions, reduce redundancies, and ensure that individuals receive the right care at the right time, regardless of which service or organisation they initially engage with. Moreover, a shared information infrastructure would allow services to operate as complementary components of a unified system, rather than as isolated silos vying for superiority.

Investing in a shared information ecosystem does not mean erasing the variety and uniqueness of service delivery models or interventions currently available. Instead, it provides a framework where different organisations can retain their specific strengths while contributing to a cohesive and integrated care network. For instance, primary care providers, specialist services, community organisations, and digital platforms can collaborate to address the multifaceted needs of individuals, leveraging their unique expertise and resources to fill gaps in care. This collaborative approach ensures that mental health care remains adaptable to diverse populations and contexts while improving overall system performance.

To achieve this vision, governments and policymakers must prioritise funding and policy reforms that incentivise collaboration over competition. This includes supporting the development of interoperable digital platforms, standardising data-sharing protocols, and providing training and resources for organisations to effectively participate in a collaborative care model. Additionally, cross-sector partnerships with education, housing, and social services are vital to addressing the broader determinants of mental health and ensuring that the national mental health system evolves into a dynamic, equitable, and integrated network.

By fostering collaboration and shared investment in infrastructure, mental health services can move beyond competition to create a system that truly delivers equitable and high-quality care for all.

Other Issues

CALD

By 2020, an estimated 3 in 10 (30%, or 7.7 million) people living in Australia were born overseas. At the same time, the composition of the CALD population continues to evolve, from a broader range of countries, more often bringing experiences of war and trauma. This has implications for their ongoing mental health needs.

Despite the significance and diversity of this population and previous policy commitments made, in 2025 Australia has no overarching national policy framework or strategy in relation to CALD mental health.

In Australia, collecting data on the health of Culturally and Linguistically Diverse (CALD) populations is complex and often inadequate. While the Australian Bureau of Statistics (ABS) has developed standards for collecting this data, they are not consistently implemented, leading to gaps in understanding of CALD health needs. Structures to support CALD mental health policy are weak.

This situation means that effective planning to meet the mental health needs of around 8 million CALD Australians is problematic. It is true that not all these people will have mental health needs. However, assuming that prevalence of mental health problems is consistent across CALD and non-CALD populations, some 1.6m CALD Australians will experience some kind of mental disorder each year.

As outlined by the Commission already in relation to Aboriginal and Torres Strait Islander mental health and suicide prevention matters, special consideration should be given to properly understanding and responding to the needs of Australians from CALD backgrounds.

Suicide Prevention

There is a danger that suicide prevention activities can become too generic or lack specific focus. A recent publication encouraged planners to be much more alert to the different 'types' of suicide which exist in the community, even suggesting more than thirty such types exist. Designing interventions depends on understanding the problem you are attempting to fix. For example, future suicide prevention activities might be better targeted through the segmentation of effort into several 'categories,' so as to better organise interventions, responses and consider data/information requirements, as follows:

- those known to mental health services already
- people whose suicidality becomes known in the ED
- people whose suicidality becomes known in primary care (e.g. GP)
- people whose suicidality becomes known in non-health settings (clubs, schools, social groups etc
- those who had previously given no indication of suicidality.

Data also suggests the need for age and gender-sensitive preventive mental health strategies.

Stratification of suicide data by diagnosis and admission frequency underscores the importance of early intervention and more personalised, sustained treatment strategies as part of future suicide prevention efforts. These patterns underscore the urgent need for robust post-discharge pathways.

There is also a need to ensure funded suicide prevention activities have the resources they require to complete informative evaluations. This is to ensure every opportunity for systemic learning and improvement is taken.

Conclusion

The Brain and Mind Centre welcomes the opportunity to provide its response to the Commission's Interim Report. The Report represents a shift from the usual inquiries into mental health, calling up fundamental infrastructure currently missing from the way Australia responds to mental illness. Australia cannot hope to make progress on mental health reform in the absence of clear strategy, governance, accountability or planning.

Hopefully this submission has made it clear that many of the tools required to address current deficiencies in these areas are already available.

We would be delighted to provide the Commission with any further clarification about these tools and opportunities, at your request.