Productivity Commission interim findings in relation to the Mental Health and Suicide Prevention Agreement Review

Contents

Overview of MATES

MATES in Construction (MATES) is a leading, industry-owned and led mental health and suicide prevention charity, operating across Australia and New Zealand. MATES delivers evidence-based programs to the construction, mining, energy and manufacturing industries, providing on-site support, training, and connection to services where it's needed most.

MATES works in partnership with employer associations and trade unions in each jurisdiction, seeking a bi-partisan mandate to ensure the program is embedded across all levels of the industry.

Established in 2008 in Queensland, MATES was developed in direct response to alarming suicide rates in the construction industry—supported by the AISRAP Report from the Australian Institute for Suicide Research and Prevention. The program has since grown nationally and internationally, recognised for its practical, peer-led approach and strong outcomes.

At its core, MATES is about creating networks of safety on worksites by upskilling workers to recognise the signs of mental distress, connect their mates to help, and foster a culture of care and concern. The MATES program includes:

- General Awareness Training (GAT): Mental health and suicide prevention training for all workers on site
- Connector Training: Equipping workers to safely connect mates to help
- Applied Suicide Intervention Skills Training (ASIST): A two-day suicide prevention workshop
- Respond*: Peer support for workers impacted by critical incidents or suicide
- Apprentice and Supervisor Training*: Building mentally healthy workplace cultures from the ground up

(*Respond and Apprentice/Supervisor Training are in the final stages of national rollout)

These training programs are supported by professional case management, a free 24/7 helpline, the MATES Toolbox App for peer volunteers, and the MATES Hub—a central resource for mental health and suicide prevention tools.

MATES recognises that organisations vary in their readiness, capacity and resources. That's why the program is designed to meet industries where they are—offering scalable, practical steps that build toward long-term culture change.

MATES believes suicide prevention is everyone's business. Through on-site engagement, peer leadership, and a commitment to evidence-informed practice, we empower workers to take the lead in creating safer, more supportive workplaces.

For more information about the MATES program and the evidence base behind it, see the attached Supporting & Reference Document.

Interim findings, recommendations and requests for information

MATES has structured this submission to directly address draft findings, recommendations and requests for more information. The MATES response is based on organisational experience, our mandate to advocate for and represent workers in high-risk industries and MATES' significant folio of research. To provide clarity and brief responses in this document, MATES has attached a document outlining the evidence base for our response, as an appendix to this submission.

Where recommendations or requests for information falls outside MATES area of expertise they have not been included in this document.

Draft Finding 2.1 Progress has been made in delivering the Agreement's commitments, but there has been little systemic change.

Assessing the progress made under the National Mental Health and Suicide Prevention Agreement is difficult. Recent data is not readily available, and jurisdictions have not adhered to all their monitoring and reporting commitments. The effects of significant external factors, such as the COVID-19 pandemic, are difficult to disentangle.

Since the Agreement was signed in 2022:

- Governments have delivered most of the Agreement's outputs. Some key commitments have not been completed. This includes resolving issues affecting the delivery of psychosocial supports outside the National Disability Insurance Scheme, publication of the National Stigma and Discrimination Reduction Strategy and development of the National Guidelines on Regional Commissioning and Planning.
- There has been little change in measures related to the Agreement's outcomes, which focus on improving mental health and reducing suicide rates.
- Progress towards the Agreement's intent to create an integrated, person-centred mental health and suicide prevention system has been piecemeal.

Draft finding 2.2 The Agreement has not led to progress in system reform

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

Draft recommendation 2.1: Deliver key documents as a priority

By the end of 2025, the Australian Government should publicly release:

- the National Stigma and Discrimination Reduction Strategy
- detailed National Guidelines on Regional Planning and Commissioning that meet the needs of primary health networks and local hospital networks.

Systemic change

As a national organisation supporting and engaging workers that are mobile between jurisdictions, MATES acknowledges the need for a National Mental Health and Suicide Prevention Agreement.

While it is difficult for MATES to assess the success of the Agreement overall, experience as an advocate and service provider indicates that the mental health and suicide prevention sector remains distant from the goals outlined in the agreement.

This includes a continued lack of integration between mental health and suicide prevention interventions, and further their integration with the broader service structures that address social determinants associated with mental health and suicide.

MATES suggests this manifests as a lack of:

- access to mental health services, particularly in remote locations,
- choice of provider,
- case management and coordination, and
- capacity for shared interventions for people with inter-related social, mental health and health issues.

MATES also notes a disconnection between services in the community sector and mental health services provided through the public health system. This missing link between community based psychosocial and public health biomedical support is currently a barrier to help acceptance and recovery.

MATES recognises the role of social stigma when seeking to improve mental health and prevent suicide and research tells us that the cohorts MATES seeks to engage on mental health are particularly affected. MATES' General Awareness Talk is specifically designed to reduce the stigma associated with mental health challenges and suicidality in male dominated, high-risk workplaces (Gullestrup et al. 2023).

MATES understands that a key barrier for workers in seeking or receiving help is concern about how they will be perceived by co-workers, supervisors and employers, including the impact on their ongoing employment. This supports the value of industry based, stigma reducing, interventions like the MATES program.

MATES endorses the release of the National Stigma and Discrimination Reduction Strategy and hopes that the strategy will acknowledge stigma as a key consideration for service funders and providers. MATES notes that stigma consists of public, self-stigma and structural stigma. While MATES focus on public and self-stigma in our work, we submit that significant work needs to be done to reduce structural stigma if public and self-stigma is to be overcome.

The National Mental Health and Suicide Prevention Agreement

Draft finding 3.1: The National Mental Health and Suicide Prevention Agreement is not effective.

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

Draft recommendation 4.1: Developing a renewed National Mental Health Strategy

A National Mental Health Strategy is needed to articulate a clear vision, objectives and collective priorities for long-term reform in the mental health system over the next 20–30 years. The National Mental Health Commission should oversee the development of this Strategy and undertake a co-design process with people with lived and living experience, their supporters, families, carers and kin.

The National Mental Health Strategy should take account of the objectives and actions included in the National Suicide Prevention Strategy, which was released in early 2025.

The next National Mental Health and Suicide Prevention Agreement should include actions governments will take over the agreement's term that are aligned with the long-term objectives articulated in the strategies.

Draft finding 4.1: A new and more effective agreement is needed

A national agreement can be an effective mechanism to advance reform in the mental health and suicide prevention system, especially to facilitate joint actions by governments. To achieve this, the next agreement will need:

- a clear set of objectives that relate to the long-term visions set out in the National Suicide Prevention Strategy and a renewed National Mental Health Strategy.
- a set of specific and measurable outcomes that focus on what is achievable within the scope of a five-year agreement.
- commitments that are explicitly linked to the objectives and outcomes the agreement aims to achieve.

Draft recommendation 4.2: Building the foundations for a successful agreement

The current National Mental Health and Suicide Prevention Agreement, including funding commitments, should be extended until June 2027, to give sufficient time to develop the foundations of the next agreement and renew the National Mental Health Strategy.

To support the next agreement:

- the National Mental Health Commission should run a co-design process with people with lived and living experience, and their supporters, families, carers and kin to identify relevant and measurable mental health and suicide prevention objectives and outcomes.
- the Department of the Prime Minister and Cabinet should convene negotiations with the support of the National Mental Health Commission, and facilitate engagement between the Australian, state and territory governments on their shared priorities.
- commitments and actions intended to improve collaboration across all government portfolios should be included in the main body of the agreement rather than a separate schedule. Governments should allocate dedicated funding for collaborative initiatives and enablers of collaboration the Australian Institute of Health and Welfare should lead the development of a nationally consistent set of outcome measures for mental health and suicide prevention. Implementation plans to develop any new indicators should be in place within 12 months of the agreement being signed.

MATES welcomes the inclusion of long-term objectives like those set out in the National Suicide Prevention Strategy. In particular, these long-term objectives should be linked to evaluation data to help organisations demonstrate impact level outcomes.

Collaboration between jurisdictions, services and across organisations is central to success in improving mental health and preventing suicide. MATES case management data indicates that mental health is inextricably linked to a range of associated matters such as family relationships, drug and alcohol use or financial hardship. In this regard collaboration between jurisdictions and between entities responsible for the full range of social determinants in each jurisdiction should be engaged in the development and delivery of a refreshed agreement.

MATES is a lived experience informed organisation, arising from and drawing on the sector-wide lived experience of workers in the construction sector. Many MATES Field Officers, other employees and trained volunteers were attracted to collaborating with MATES as a result of their lived experience. Research has shown that this peer focus amongst the MATES field staff is essential to the success of the program. MATES staff have a broad awareness of suicide and mental health but also a specific awareness of what it is like to work in the Construction, Mining, Energy and Manufacturing industries.

MATES is ongoingly capturing and incorporating lived experience as a structural part of our program development, monitoring, and evaluation. We endorse any additions to the agreement that encourages or requires meaningful participation by people with lived experience of poor mental health or suicidality. All funded activities should be required to demonstrate meaningful co-design with people with relevant lived experience; however, we caution about specifically mandating how this should be done as lived experience engagement should be organic and always developing.

The Policy Environment

Draft recommendation 4.3: The next agreement should have stronger links to the broader policy environment

The next agreement should articulate its role within the policy environment and specify the way it links with other key policy documents. This will require consideration of the interactions with a range of policy areas including housing, justice, disability supports and more. As a starting point, the next agreement should link to:

- the National Health Reform Agreement, which provides much of the funding for the mental health and suicide prevention system.
- key policies in relevant non-health portfolios, such as the Better and Fairer Schools Agreement which will support the whole-of-government approach needed to improve mental health and suicide prevention outcomes (draft finding 4.1).
- jurisdictional mental health and suicide prevention policy documents, which should inform the bilateral schedules developed under the agreement.
- policy documents related to Aboriginal and Torres Strait Islander social and emotional wellbeing, including the National Agreement on Closing the Gap (draft recommendation 5.1).

MATES' case management data indicates that the top five presenting issues for workers seeking support are:

- Mental ill-health,
- Relationships,
- Family,
- Employment, and
- Financial.

This demonstrates the importance of compatibility between the full range of government strategy and policy, toward a 'whole of government' response to mental ill-health and suicide prevention.

We submit that while systems approaches should be whole-of-community and whole-of-government services engaging with individuals in any way should be person centred, and trauma informed.

Information request 4.1

The PC is seeking views on whether there should be an additional schedule in the next agreement to address the co-occurrence of problematic alcohol and other drug use and mental ill health and suicide.

The link between drug and alcohol use and mental health and suicide is well established and MATES endorses the addition of a schedule to address this relationship. We favour a harm-minimisation approach as the most realistic and practical approach. Prohibition and restriction approaches tends to ignore underlying issues and may at times lead to substance substitution and may be harmful.

In addition to higher rates of suicide, recent research from Western Australia indicates that workers in high-risk industries are more likely to drink more per week and binge drink more often than the general population.

In the same study participants recorded that the prevalence of drug use in the last 12 months was more than double that of the general population.

Carer and family support

Draft recommendation 4.5: The next agreement should clarify responsibility for carer and family supports

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

MATES information, support and case management extends to partners and families of the workers we engage on mental health and suicide. This is in recognition of the determinants of good mental health and the key role family, friends and peers plays in supporting workers to identify and respond to mental health concerns or suicidality.

MATES research supports the importance of these relationships, in particular for vulnerable workers or workers grappling with mental health issues. Research shows that being away from supports, lacking communication platforms and increased stressors means that Fly in/Fly out workers and their families can be at increased risk.

In a recent survey, 40% of workers that received MATES training reported that they have used those skills to support family and friends, expanding the impact of the MATES program into the community.

Governance

Draft recommendation 4.6: Increase transparency and effectiveness of governance arrangements

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

- including a governance framework that emphasises transparency and collaboration, and outlines accountability, reporting and evaluation functions.
- embedding and formalising the participation of people with lived and living experience of mental ill health and suicide in the design and implementation of governance arrangements.
- clarifying the role of the Social and Emotional Wellbeing Policy Partnership established under the National Agreement on Closing the Gap as the decision-making forum over issues that relate to Aboriginal and Torres Strait Islander social and emotional wellbeing (draft recommendation 5.1).

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

- establish the National Mental Health Commission as an independent statutory authority and task it with monitoring and reporting on progress and outcomes (draft recommendation 4.8).
- publish information about the composition and activities of the working groups established under the agreement.
- adequately resource the agreement's administrative functions and ensure timely and effective information sharing across working groups.

Draft recommendation 4.8: A greater role for the broader sector in governance

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

MATES encourages changes to the agreement that require greater transparency and formalise the nature and scope of collaboration expected. This includes meaningful engagement of people with lived experience in governance structures as well as program development, monitoring, evaluation and review.

Re-establishment of the National Mental Health Commission is desirable but in the context of that entity working alongside existing bodies and projects. From MATES' perspective this includes ensuring suicide prevention is acknowledged as a stand-alone domain for action and the National Mental Health Commission. MATES supports a level of independence for the National Suicide Prevention Office with an all-of-government reporting line. Despite strong alignment between mental health and suicide prevention the unique nuances of difference in approach for suicide prevention risk being subsumed into general mental health approaches without a separate voice. We suggest that both the National Mental Health Commission and the National Suicide Prevention Office must have a strong requirement to work with the non-government sector and in particular with peak organisations like Suicide Prevention Australia.

MATES endorses any activities to share actions, outcomes and practices across entities and jurisdictions. This not only ensures the emergence and support of better practice

but invites government and service providers to monitor, report on and adjust policy settings and delivery in real time.

MATES agrees that providers and the sector should be engaged by government in governance, ranging from advisory positions to participation in policy review activities. This includes specialists in suicide prevention and industry-based responses.

Lived experience

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

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

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

- adequate representation of people with lived and living experience at each level of governance.
- balanced representation between people with lived and living experience of mental ill health and lived and living experience of suicide.
- governance roles for carers commensurate with the significant role they play in Australia's mental health and suicide prevention system.

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

Information request 4.2

The PC is seeking examples of barriers to the genuine participation and influence of people with lived and living experience in governance forums. How could successful inclusion and engagement of people with lived and living experience in governance be measured.

Lived experience is a feature of the MATES program, evidenced by the significant lived experience of MATES employees, many of whom were attracted to MATES informed by their own experience of suicidality or by experiences with colleagues, friends and family. Research has shown the importance of peers disclosing relevant lived experience in a safe way in breaking down stigma and improving help-acceptance and even help-seeking amongst men.

MATES exists because of a shared lived experience of suicide in the construction sector. A recent study amongst Western Australian construction workers reported that 10.3% of workers had experiences of suicide planning or attempts, three times higher than the general population. Higher suicide rates were particularly strongly associated with loneliness and isolation often resulting from unsociable working hours and conditions.

Despite being integrated into the program and structure, MATES recognises that lived experience engagement is a journey and should be ever evolving. MATES like all organisations should be, is on a journey to ensure the program is defined by the mantra

of 'nothing about us without us.' MATES is working with lived experience bodies such as Roses in the Ocean, to continue developing a lived experience integration in program delivery and development.

MATES supports requirements to meaningfully engage with lived experience in both program delivery and development. We are cautious about a specific model or standards for lived experience engagement as this risks tokenistic or even harmful engagement. Lived experience practitioners should be included in reporting requirements.

Published plans and reporting

Draft recommendation 4.9: Share implementation plans and progress reporting publicly

The Australian, state and territory governments should publish all implementation plans and jurisdictional progress reports developed under the next agreement.

The National Mental Health Commission should be empowered to assess and report on progress independently, using information beyond what is reported by governments. The Commission should publish national progress reports as they are finalised, without requirements for jurisdictions' sign-off.

Draft recommendation 4.10: Strengthening the National Mental Health Commission's reporting role

The next agreement should formalise the role of the National Mental Health Commission as the entity responsible for ongoing monitoring, reporting and assessment of progress against the agreement's outcomes.

The Commission should have legislative provisions to compel information from Australian, state and territory government agencies to fulfil its reporting role.

The National Suicide Prevention Office should be given an advisory role in monitoring and reporting on the next agreement. It should also be responsible for the monitoring and reporting on progress against the separate suicide prevention schedule (draft recommendation 6.1).

Draft recommendation 4.11: Survey data should be routinely collected

The Australian Government should fund the routine collection of the National Study of Mental Health and Wellbeing and the National Child and Adolescent Mental Health and Wellbeing Study, running the surveys at least every five years.

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?

MATES encourages transparency and accountability for the delivery of the agreement.

A National dashboard provides impetus to government and other entities to meet their obligations under the agreement and can also highlight policies, practices and jurisdictions that have been most effective, encouraging shared better practice.

Similarly, weaknesses in the structure or implementation of the agreement can be identified and rectified more quickly.

The report should include progress against the identified areas for reform, and key outputs and outcomes, contained in the agreement. Information should be provided on how implementation of the agreement met expectations of collaboration, partnership and cooperation.

Developing a national dashboard will require significant engagement and consultation. It is important that the dashboard seeks to highlight desired change as most of the existing metrics are focused on past ways of doing business. Much of the reform required is about better integration between services and service levels which may be difficult to measure with existing metrics as progress will be found in the quality of implementation over the quantity of implementation.

PHN funding

Draft recommendation 4.12: Funding should support primary health networks to meet local needs

The next agreement should emphasise national consistency in areas where there are efficiency gains, including standardising reporting requirements across primary health networks (PHNs) and jurisdictions where possible and investigating ways to standardise procurement and data collection processes.

Funding arrangements in the next agreement should provide PHNs with sufficient flexibility to commission locally relevant services or support existing services where they have been positively evaluated. National service models should not limit the ways in which PHNs meet their communities' needs.

MATES engages with PHNs, particularly in service of workers based or working in rural and remote locations. Where partnerships have been most effective, they provide additional pathways to services, funding for delivery of suicide prevention activities and a greater understanding of the policy and service environment in that area. PHNs have been helpful in understanding and responding to local issues.

MATES notes previous recommendations of the Productivity Commission for structural reform in the planning process between PHNs and local state and territory-based hospital and health regions. While acknowledging the political difficulty in achieving such reforms we submit that the reform sought is dependent on effective regional planning where community, commonwealth and state provided/funded services collaborate more effectively as a network of both psychosocial and biomedical services.

National Mental Health Workforce Strategy

Draft recommendation 4.13: The next agreement should support the implementation of the National Mental Health Workforce Strategy

The next agreement should support the implementation of the National Mental Health Workforce Strategy. This should include:

- clear commitments to, and timelines for, priority actions under the National Mental Health Workforce Strategy.
- an explicit delineation of responsibility and funding for workforce development initiatives.

Information request 4.4

The PC is looking for case studies to highlight best practice in integrating peer workers in clinical mental health and suicide prevention settings, particularly by improving clinician awareness of the peer workforce. Are there examples of best practice that could be adopted in other organisations or settings?

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

The next agreement should commit governments to develop a nationally consistent scope of practice for the peer workforce, in consultation with the peer workforce, that:

- promotes safer work practices for peer workers.
- contributes to better outcomes for people accessing mental health and suicide prevention peer support.
- improves public understanding of the profession, allowing for greater recognition of peer workers' capabilities and contributions.

MATES supports the development and support of a skilled and trained mental health promotion and treatment workforce. In keeping with the MATES model this includes an informed, trained and engaged volunteer workforce. While supporting upskilling and training we also note concerns that we need to remove barriers to a growing peer workforce and the risk in inadvertently "professionalising" and "coopting" peer work into the existing often clinical models of service delivery.

MATES volunteers are peer workers working outside the clinical paradigms; however, volunteers are offered skills training in order to contribute to:

- Mental health literacy and stigma reduction
- Early intervention and referral
- Protecting vulnerable cohorts and communities
- Fostering fair, inclusive and respectful work cultures
- Building the capacity of Employee Assistance Programs

In undertaking their support of peers, MATES volunteers draw on their own lived experience. MATES supports the training and employment of lived experience peer workers to:

- Normalise help seeking and professional support.
- Model appropriate behaviours amongst peers.

- Respond to their peer's needs in a timely and culturally acceptable way.

Noting the success and necessity of workplace-based interventions, MATES proposes that workers would benefit from building the capacity of organisations providing first line professional support for workers such as Employee Assistance programs (EAPs). This would include an understanding of:

- Barriers and enablers for help seeking and offering in predominantly male industrial cultures
- High stigma and low mental health literacy in worker cohorts
- Stigmatising views of construction workers
- The unique stressors of remote, fly-in/fly-out, drive-in/drive-out workers
- Working conditions including shift work, remote settings, access to services and the importance of supervisor/worker relationships.

Worker facing organisations such as MATES are in a prime position to offer the counselling and broader mental health service sector insights into these issues and advice about engaging with and better serving workplace focused providers.

Evaluation framework and guidelines

Draft recommendation 4.15: The next agreement should build on the evaluation framework and guidelines

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

MATES have developed a substantial program logic map to support evaluation of the program. While evaluations focusing on inputs and outputs are relatively simple, evaluations measuring outcomes in large scale population-based programs are notoriously difficult and very expensive.

MATES supports an evaluation framework that includes consistent evaluation methodologies, guidance domains, and measures. Evaluation outcomes should be shared to drive accountability and encourage shared practice.

Improved evaluation of funded programs will require significantly increased allocation of funding towards quality evaluations. Specifically, MATES recommends a diversified approach to evaluation, combining descriptive population-based surveillance, non-experimental implementation and effectiveness evaluation of on-going programs, and experimental evaluation studies of specific programs including predictors of suicidal behaviour as outcomes, and—where feasible—measures of suicidal behaviours. In this way, insights for the continuing improvement of programs can be gleaned and applied. To illustrate, the MATES program:

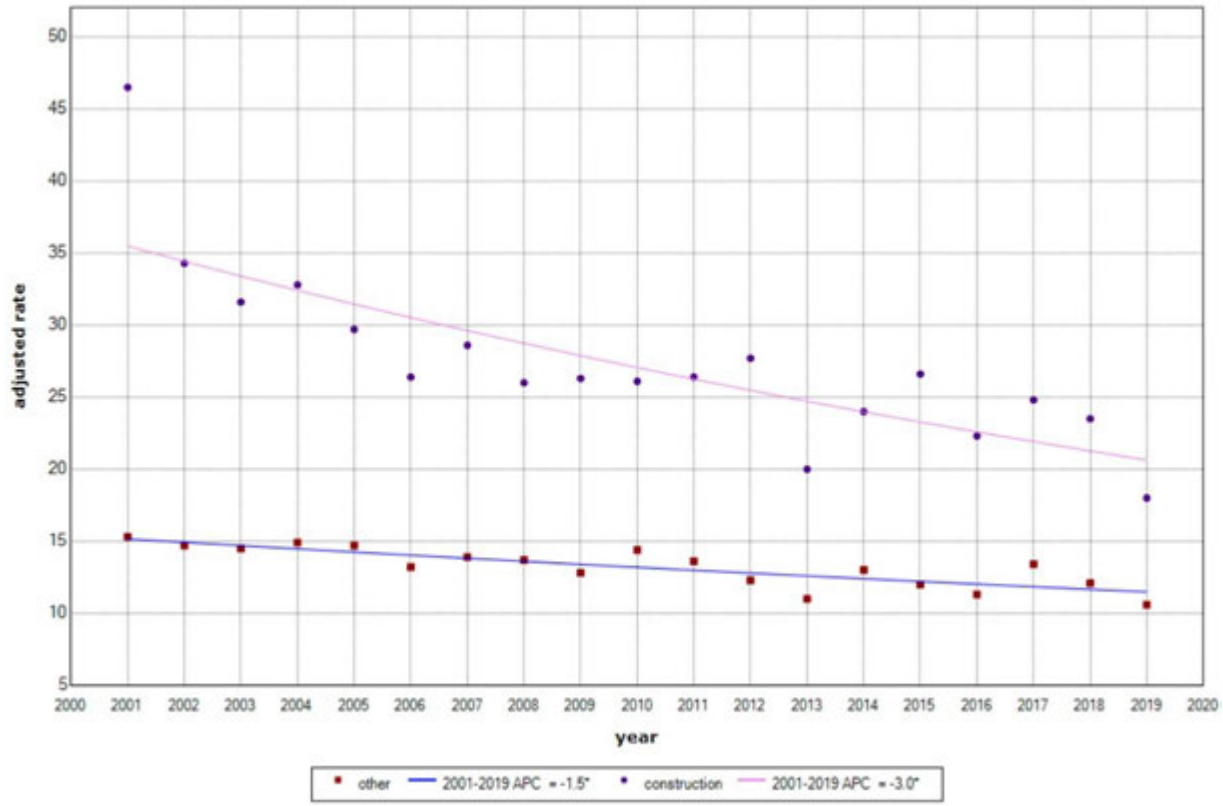
- Supports and conducts national population-level surveillance of suicide rates in the sectors MATES works in (King et al. 2024; King et al. 2023). Most notably, based on this work over many years, we have recently shown a significant

decline in suicide rates among male construction workers nationally over the past two decades, and that decline is significantly greater in construction compared to other working males (see Figure 1), while over the same time the overall male rate has increased slightly (Maheen et al, 2023). This decline is most likely attributable to the totality of efforts over the last two decades—including population-wide national initiatives such as depression, mental health literacy and related interventions (e.g., Beyond Blue) and improvements in mental health care, as well as sector-specific contributions from programs such as MATES;

- Non-experimental evaluations of on-going MATES programs have shown evidence of the effectiveness in improving mental health and suicide prevention literacy, reducing stigma, and improving helping intentions and behaviours leading to increased demand for case management support (Gullestrup et al. 2011; Gullestrup et al. 2023; Doran et al. 2021);
- Experimental studies have been conducted through NHMRC and Million Minds funding in partnership with MATES which have informed efforts to complement face to face with digital interventions (King et al. 2023) and the adaptation of the MATES program to the manufacturing sector (LaMontagne 2025).

Figure 1:

From: Suicide trends among Australian construction workers during years 2001–2019



Comparision for annual percentage change in age-standardised suicide rates of construction vs other workers (final model: 0 joinpoint (s) for both groups).

Suicide prevention

Draft finding 6.1: The Agreement has supported positive policy developments in suicide prevention, but outcomes remain unchanged

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

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

Draft finding 6.2: The Agreement's approach to suicide prevention lacks clarity

The approach to suicide prevention policy commitments as outlined under the National Mental Health and Suicide Prevention Agreement does not enable effective reform.

- The Agreement does not outline a clear link between actions and expected outcomes.
- Roles and responsibilities are not sufficiently clear, specifically regarding areas of joint responsibility. This contributes to gaps in service delivery and reduced accountability.

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

The next agreement should include a separate schedule on suicide prevention. This schedule should be developed through a process of co-design with people with lived and living experience of suicide, their supporters, families, carers and kin and service providers.

The schedule should:

- only include actions in policy areas of suicide prevention that are distinct from mental health.
- reflect a clear link between the short-term objective and outcomes of the schedule and progress towards the long-term objectives of the National Suicide Prevention Strategy.
- align with the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy.
- include monitoring and reporting indicators that align with the forthcoming National Suicide Prevention Outcomes Framework.
- require the National Suicide Prevention Office be responsible for the monitoring and reporting of the schedule.

As an organisation originating in and targeting workplace-based suicide prevention, MATES endorses the recommendation to develop a separate schedule for suicide prevention in the agreement and would go as far as recommending a specific Suicide Prevention Agreement acknowledging the importance of all of community approaches to preventing suicide.

Suicide carries with it specific domains, measures and prevention activities, for example directly asking about and addressing suicide in interventions. Peer workers and advisors with lived experience of suicide are better placed to inform suicide prevention programs than those with other experiences of mental health interventions and systems.

Measures included in a separate schedule provide opportunities to better understand and compare differences across jurisdictions and providers. While MATES has noted that suicides in the construction sector have slightly reduced in recent years it has been

difficult to attribute this solely to the MATES program. A well-resourced National Suicide Prevention Office would be empowered to collect and analyse national data and identify the contribution of policy, strategy and service provision to suicide prevention.