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ZSIA response to the Productivity Commission Interim Report Mental Health & Suicide Prevention Agreement Review

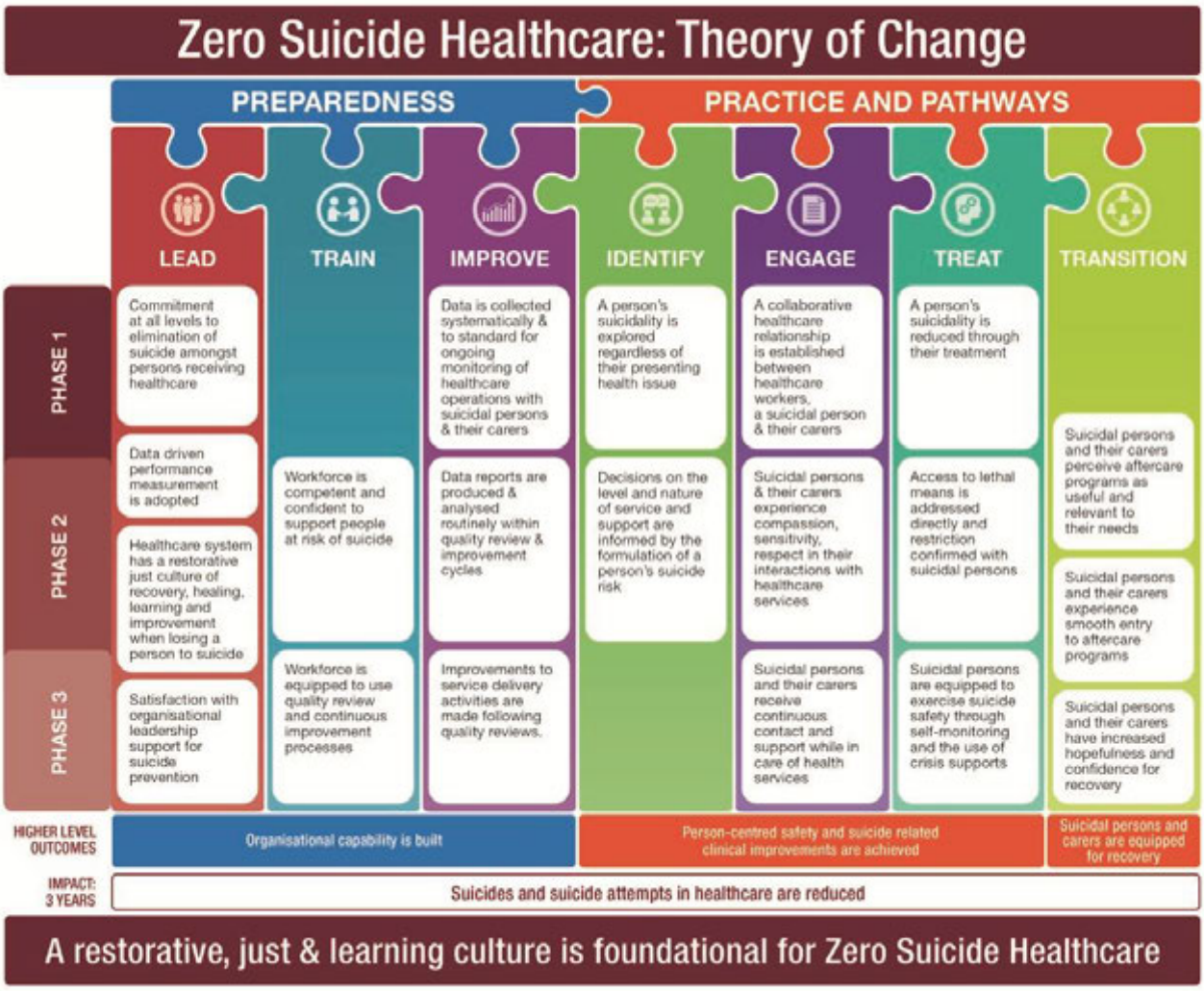
July 2025

Zero Suicide Institute of Australasia

28 July 2025

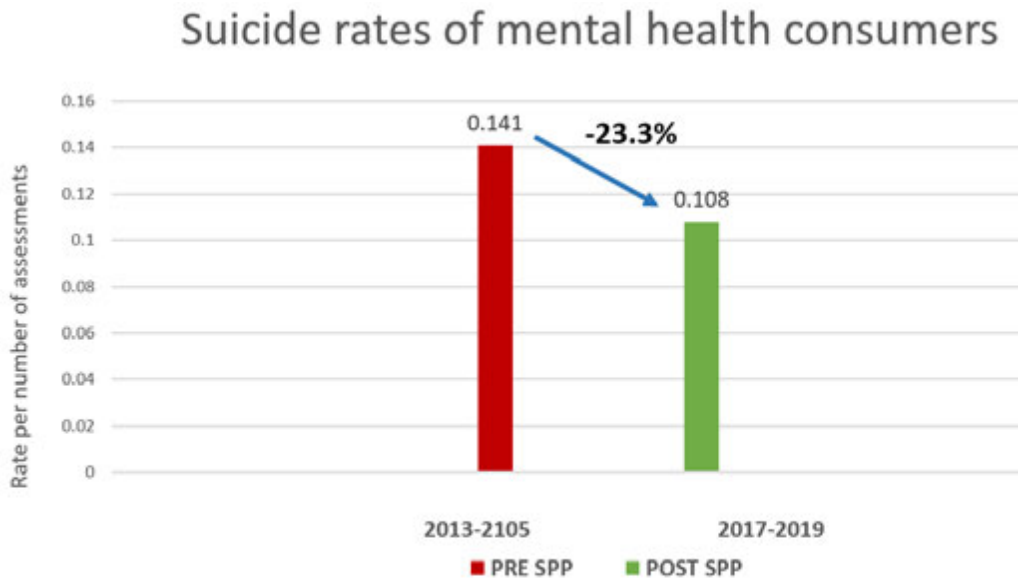
Re: Mental Health and Suicide Prevention Agreement Review Interim Report

Thank you for the opportunity to respond to the above report. I am writing on behalf of the Zero Suicide Institute of Australasia which has a specific focus on reducing suicide and suicide attempts within healthcare settings through the promotion of the Zero Suicide healthcare framework.

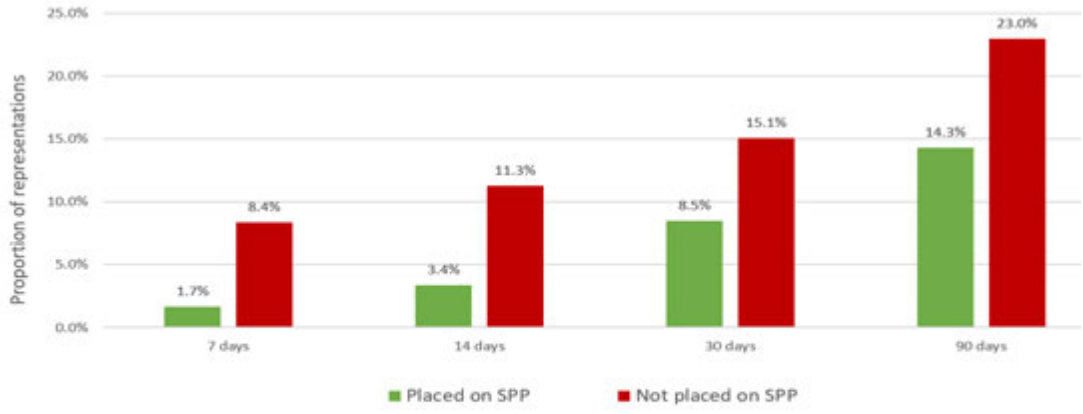


The aim of advocating for this framework is to provide greater consistency within healthcare settings across jurisdictions in the way in which people are received, assessed, supported and discharged when

presenting with suicidality. The basis for this focus is on the international experience and evidence published by the Gold Coast Specialist Mental Health Service. This service demonstrated a 23% reduction in suicides for people placed on the Suicide Prevention Pathway and a 35% reduction in re-presentations.



Turner et al **Approach to Suicide Prevention in a Mental Health Service using the Zero Suicide Framework.** *Australian New Zealand Journal of Psychiatry.*



Re-presentations with a suicide attempt at 7, 14, 30 & 90 days by placement on the SPP

Stapelberg et al **Efficacy of the Zero Suicide Framework in reducing recurrent suicide attempts: cross-sectional and time-to-recurrent-event analyses**. *British Journal of Psychiatry*

Currently four states, Queensland, New South Wales, South Australia and Victoria are in various stages of implementing this framework. There remains work to be done to bring the remaining states and territories on board to improve their healthcare response to suicidal behaviours.

While the Review calls for much broader reform than within the health system, ZSIA response is based on the Zero Suicide Healthcare Framework and therefore is limited to this portfolio area.

Support for the Recommendations

The framework, if implemented across Australia, directly complements the following recommendations listed in the Interim Report:

4.2 Building the foundations for a successful agreement

The framework has lived experience leadership is an integral part of design, implementation and measurement within health systems.

A consistent framework for healthcare settings, across jurisdictions, will foster opportunities for collaboration and sharing of scarce resources. ZSIA currently facilitates a Knowledge Network of health systems implementing the framework for this purpose.

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

A key part of the framework requires engagement with the support networks which a person needs both while in the care of a health service and following discharge. Clarifying both policy and funding responsibilities will improve health systems engagement with family and carers.

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

ZSIA strongly supports this recommendation however in our experience there are significant barriers to its successful implementation. See information request 4.2 below.

4.9 Share implementation plans and progress reporting publicly

With a consistent framework in operation across the country there is opportunity to further improve sharing of plans and resources. The collection and release of data on

progress with implementation is a key driver for improvement. Making such information available will give people presenting to the health service greater agency in their decision-making.

4.12 Funding should support Primary Health Networks to meet local needs

Because this is a framework it enables the local context to be taken into consideration when planning for programs and services. With all jurisdictions operating under a unified framework PHNs will be able to draw on knowledge from others about commissioning local services for local needs.

In regard to other recommendations ZSIA supports:

4.6 The need for greater transparency and effectiveness in governance.

Transparency and accountability certainly need to be improved.

4.10 Strengthening the National Mental Health Commission's reporting role

ZSIA strongly supports strengthening both the National Mental Health Commission and the National Suicide Prevention Office to take the role on monitoring progress with the Agreements. This would be enhanced by the ability to work independently of government departments providing the agency with the required flexibility to call to account signatories to the Agreement.

4.13 The implementation of the National Mental Health Workforce Strategy

This should align with the National Suicide Prevention Office Workforce strategy.

5.1 An Aboriginal and Torres Strait Islander schedule in the next agreement

This is supported with the expectation that it will further strengthen the implementation of the Aboriginal and Torres Strait Islander National Suicide Prevention Strategy and the Implementation Plan.

6.1 Suicide prevention as a schedule to the next agreement

Often, suicide is a response by a person experiencing an overwhelming number of factors leading to distress and that conflagrate at that single moment in time.

While these factors will be causing mental distress, this is different to a diagnosable mental illness. For this reason a separate schedule related to suicide prevention is supported so that the Agreements build on the prevention aspect of the National Suicide Prevention Strategy.

Zero Suicide Institute of Australasia

Response to Requests for Information

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.*

As noted in response to recommendation 6.1 a separate schedule that responds to distress factors contributing to suicidal behaviours would be a positive addition to the Agreements.

Many mental health services are already well integrated with the Alcohol and Other Drugs teams however this is often driven by resource constraints rather than integrated healthcare. Identifying AOD as an important factor in mental ill-health and suicide would further strengthen this integration, especially when the mental distress is not related to a mental illness diagnosis.

Given the highest number of people who take their own life are of working age this could help to increase the responsibility of non-health related government departments ensure safe and supportive work environments. It will be an opportunity to highlight Safe Work Australia Code of Practice for Managing Psychosocial Hazards at work.

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?*

A critical workforce and health systems issue.

This question relates to an area of the report which, in ZSIA's experience, is the most challenging to overcome - that is the inclusion of lived and living expertise in mental health and suicide prevention.

As noted above lived experience leadership is an integral component of the Zero Suicide Healthcare framework. However, in ZSIA's experience supporting health systems across jurisdictions plan for and implement the ZSH framework, this is one of the weakest areas of implementation.

Health systems are by nature risk averse. There is a high level of acceptance and willingness to involve people with lived and living experience in health system reform in the consultation and design stage. However, once it comes to decision-making about service system change, especially if this requires moving away from the status quo, healthcare leaders become risk averse and shy away from making any significant changes.

This is further demonstrated if an adverse event, like suicide or attempted suicide, occurs within the health system. This same risk aversion takes hold and is even more pronounced. Executives and their reviewers tend to exclude those who were closest to the event, and/or the person. More often than not health systems adopt a punitive response by excluding families and carers and staff often experience a culture of blame and retribution.

Hibbert et al published Perceptions and Experiences of Consumer Representatives on Patient Safety Investigation Teams: A Qualitative Analysis. The paper includes examples of the challenges and risks that both consumer representatives and health service staff experience when involved in safety reviews.

Similarly Loughhead et al published Pathways for Strengthening Lived Experience Leadership for Transformative Systems Change: Reflections on Research and Collective Change Strategies. This is an example of research that could support reform but like much research it is likely to take some years for the model to be adopted within organisations.

Figure 1

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A model for lived experience leadership.

What these two papers highlight is an important need that is not evident in the recommendations in the Interim Report but is raised in the information request 4.4.

There is considerable need for workforce training to ensure that those with lived expertise are able to provide that expertise without fear of reprisal, in respectful and supportive environments.

This is a different facet of the workforce training. The current focus on training is largely directed towards supporting the person with lived experience to participate in reforms. The gap in training is supporting healthcare staff to effectively engage with peer workers as professional colleagues whose expertise comes from their experience. There is an important need to weed out the long-held risk-aversion that persists within health systems which creates a barrier to participation. Leadership needs

to be given licence to not respond negatively when there is bad news or an adverse event – their political leaders also need to take heed of the impact their behaviour has on the system.

These barriers to participation must be addressed if the significant changes proposed in the recommendations of the Interim Report are to be realised.

Strengthening support for healthcare staff

Health systems across Australia are not known for their compassionate response to public criticisms or adverse incidents, rather their reputation more closely resembles retribution. To this end it is necessary to shift away from a culture of blame to one focused in healing, recovery and learning for improvement. For healthcare staff, there is a need to feel that participating in a review of an incident is not akin to blame but rather recognition of their expertise and understanding of how work gets done and the complexities in which healthcare staff operate. To this end ZSIA positions a Restorative Just & Learning Culture (RJLC) as a foundation for the Zero Suicide Healthcare framework. The principles of RJLC incorporate an understanding of human error; responding to failure; retributive and restorative just cultures; and building psychological safety. These are universal ideas, not limited to health systems. and thus fit the cross-portfolio recommendations contained in the Interim Report.

The importance of a Restorative Just and Learning Culture

Organisational culture is the set of shared values, beliefs, practices, and behaviours that shape how employees interact, make decisions, and work together within an organisation. It influences the overall work environment, employee satisfaction, and organisational performance. Everyday healthcare professionals apply their knowledge and practise their skills within excessively complex situations. At times, this results in unintended outcomes for the patient. All those involved are impacted by these unintentional errors – the person, their supports, healthcare professionals and the organisation. A restorative just and learning culture (RJLC) is one built on trust, is forward looking in its accountability and seeks to learn from adverse incidents.

Developing RJLC requires leadership. Leaders who embrace recovery, healing, learning and improvement for all who have been impacted by an adverse event, such as suicide. Leaders who role-model the desired organisational culture rather than react with a punitive response as noted above. A retributive, or punitive approach, creates anxiety and distress among healthcare workers by focusing on the individual. A restorative just and learning culture is system oriented and asks three key questions: Who is hurt? What do they need? Whose obligation is it to meet those needs?

Applying these questions to address risks to safety are proven to improve outcomes for patients, lower levels of turnover and increase levels of wellbeing and commitment within the workforce.

Psychological safety is at the heart of a RJLC. It is underpinned by a comprehensive program of engagement that facilitates a continuous process of listening and dialogue that challenges thinking, provides the reality check, informs strategic priorities, and reinforces shared accountability for quality and organisational culture. To mobilise everyone in the health system to transform care for people, it is essential to create the conditions where:

- Speaking up is encouraged and celebrated.
- Ideas for improvement are welcomed.
- There is mutual respect among all team members.
- Mistakes are reported and openly discussed.

But real and lasting culture change needs not only leadership buy-in but also action to "walk the talk". Leaders need to:

- Acknowledge: recognise the uncertainties and potential that can be expected to occur when things are changing, and complex challenges are being solved
- Listen: create opportunities to listen, discuss and reflect without judgement
- Be curious: ask questions which invite people to speak up
- Be self-aware: be humble and admit that you might miss things and make mistakes and make it safe for others to do the same.

Senior leaders need honest, objective feedback and critique. When people come forward with bad news or mistakes, leaders need to respond in an appreciative and forward looking way. Practice a growth mindset - "Let's see how we can fix this together".

Another resource that could support culture shift within healthcare is from The Better Culture initiative which recently published a new curriculum guide to provide direction for healthcare professional training. This is a fit for purpose curriculum for healthcare workers at all career stages. It contains a preamble explaining the rationale for the curriculum and brief gap analysis, as well as the curriculum proper, which includes resources and suggested assessment modes.

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?*

Understanding organisational performance and designing programs and plans based on this understanding is a key lever for organisational improvement. Data collection provides this understanding and is a critical lever for system improvement. However, while localised data collection will support organisations measure their progress, publicly available data that measures progress of the agreements should be aggregated and displayed at the state and national level through the AIHW Suicide and Self-harm Monitoring System.

While self-harm is coming under greater scrutiny in data collection globally, a gap in the current data is clearer understanding of suicide ideation. In a recent podcast "Never the Same" Dr David Jobes noted that in the US the number of people nominating severe suicidal ideation was 300 times greater than the number who died by suicide. This has significant potential for prevention and should be considered in enhancements to current registry data. Efforts to improve data linkages must be supported so more accurate and timely data is available for health services.

Conclusion

As with many other organisations advocating for improvements in mental health and suicide prevention ZSIA welcomes the scrutiny provided through the Productivity Commission Review of the Mental Health and Suicide Prevention Agreement.

Given the lack of progress highlighted in the report it is critically important for Government to have time to respond and prepare to resource the new Agreement. Therefore extending the current Agreement through to 2027 as recommended in the Interim Report makes sense.

However, there are immediate actions that can be taken.

1) Identifying the Zero Suicide Healthcare framework as a basis for improving healthcare's response to people presenting with suicidality. This would harmonise the processes and practices across all jurisdictions providing greater consistency in language, pathways of care and follow-up after discharge.

2) Another would be to recognise the need for the independent role of the National Mental Health Commission. While establishing it as a Statutory Authority would be ideal at the very least legislative provisions that support its reporting role and allow it to compel information from Australian, state and territory government agencies should be enacted as soon as practicable.

ZSIA looks forward to the release of the final report and to advocating with governments to implement key reforms that will improve the mental wellbeing of people in Australia and reduce the incidence of suicide and self-harm.