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Productivity Commission
Submission via Review webpage

Turner Institute for Brain and Mental Health Submission to the Productivity Commission's Interim Report on Mental Health and Suicide Prevention Agreement Review.

Introduction

The Turner Institute for Brain and Mental Health at Monash University is the research arm of the School of Psychological Sciences within the Faculty of Medicine, Nursing and Health Sciences, the largest faculty at Monash University (see Appendix 1 for a full description of the Turner Institute research and program areas). We comprise 122 world leading researchers, 70 teaching and research staff, and over 20 professional staff. We also have over 175 research higher degree students. Our research work covers all facets of brain and mental health.

The Turner Institute's focus on early intervention, community-driven research, technological innovation, and meaningful approaches to collaboration and co-design aligns with the Productivity Commission's recommendations for a more effective, accessible, and community and person-centred mental health system. The Turner is uniquely placed to translate cutting-edge research in brain and mental health into evidence-based solutions - leveraging our deep expertise in clinical and mental health, cognitive, developmental, and suicide-prevention research and service evaluation to address the systemic fragmentation and lack of psychosocial support outlined in the Productivity Commission's Interim Report.

Our world-class psychology education programs prepare a skilled workforce for the future with currently over 3260 students undertaking undergraduate, masters, graduate and clinical doctoral programs in psychology. The education offerings are continually adapted to meet the evolving needs of the community.

The Turner Clinics are the service delivery and mental health workforce development arm of the Turner Institute, delivering psychological services to over 3,000 clients across Victoria each year, focusing on themes such as Trauma, Child, Youth and Family, Healthy Sleep, and Neuropsychology. The Clinics provide accessible, evidence-based (including trauma-based) care while operating as a translational research hub.

The Turner Institute welcomes the opportunity to contribute to improving Australia's mental health and suicide prevention system reform.

Our Submission

In our submission, we highlight broad challenges and barriers identified with the Interim Report itself as well as provide specific responses to the Interim Report's Recommendations.

This submission should be considered in conjunction with the submissions made by other key players at Monash University, such as the Faculty of Medicine, Nursing and Health Sciences, Turning Point, Monash Addiction Research Centre and the HER Centre Australia.

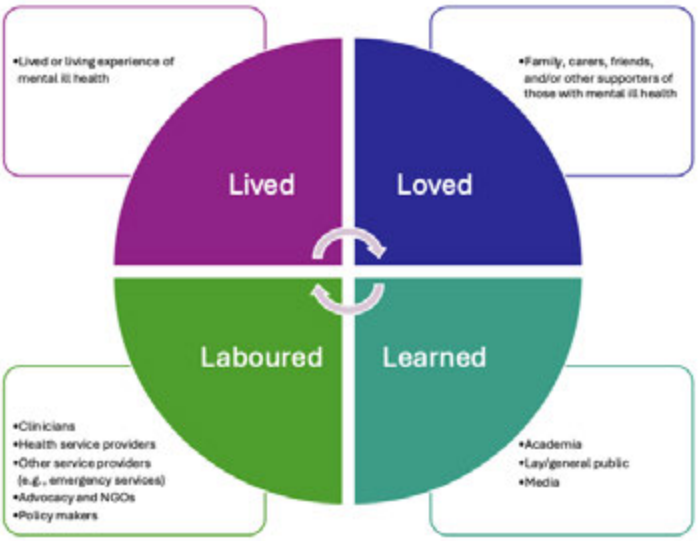
Challenges and Barriers with the Interim Report

Inconsistent use of language around stakeholders. We note that the Interim Report uses multiple terms to represent stakeholders. There is a need to be consistent and have clear inclusive and representative definitions. For example, in the Interim Report 'lived and living experience' is used interchangeably with 'consumers' and seems to also be inclusive of 'carers'. 'Carers' have different experiences and unmet needs which can be lost by grouping them into 'lived and living experience'. Other stakeholder groups are missing from the Interim Report, including universities and peak bodies. Universities for example, are a critical stakeholder, given their central contributions to research, innovation ecosystems, workforce development and the economy.

To assist the Productivity Commission in gaining clarity around stakeholder definitions, we recommend using the 4 L's framework proposed by Killackey et al. (2023). Although the 4 L's framework was initially described in the setting of youth mental health, it can be applied to mental health more broadly and is highly applicable to this submission. The 4 L's categorises stakeholders into four groups: lived, loved, laboured, and learned (see Figure 1). It is important that all stakeholders have a voice in shaping mental health reforms, from those with lived experience through to academics working in this space. We will use these descriptors in this submission. In our view, the use of this inclusive language is a fundamental component of the discussion. We recommend that the Productivity Commission adopts such an inclusive approach.

Figure 1

The 4 L's Framework Adapted from Killackey (2023)



Systems not one system. Individuals experiencing mental ill health rarely engage with just one system. By focusing solely on the 'mental health and suicide prevention system', the Interim Report risks further reinforcing fragmentation of care systems. People with mental health challenges often interact with multiple systems - including primary care, emergency services, alcohol and other drug services, welfare, housing, trauma support, disability services, child protection, education, and the justice system.

Currently, there is little coordination between the mental health system and these other sectors and jurisdictions. Excluding them from the Interim Report represents a significant oversight. This lack of integration perpetuates barriers to care, leads to missed opportunities for early intervention and support, and contributes to poorer long-term outcomes for individuals, as well as increased costs to governments. Including these sectors in the Interim Report is essential for breaking down barriers to care, enabling early intervention and support, and improving long-term outcomes for individuals. This proactive approach also helps reduce future costs for governments by addressing needs before they escalate.

Limiting definition of 'co-design' as defined in the Interim Report. The Interim Report defines co-design as 'the process where governments work in equal partnership with people with lived and living experience to design a service or service improvement.' While this definition signals an intention toward collaboration, it is rooted in a top-down framing, where the government controls the scope, agenda, and decision-making processes. This can result in tokenistic engagement rather than true power-sharing. When co-design is implemented from within rigid bureaucratic structures, it risks reinforcing existing hierarchies and contributing to fragmentation across the service system, particularly when the voices of those with lived experience are incorporated late in the process or only within predefined boundaries. Co-design should be also inclusive of other key stakeholders as we have highlighted in our framework for engagement - lived, loved, laboured, and learned experts (see Figure 1).

We propose an extended and more precise definition of co-design. Co-design should be conceptualised as "a collaborative process in which people with lived experience, service providers, and other stakeholders work together to design policies, services, or programmes It emphasises shared power, inclusion, and mutual respect, ensuring that those most affected play a meaningful role in shaping outcomes. By valuing diverse perspectives and fostering genuine partnerships, co-design leads to "more effective, relevant, and equitable solutions". This definition has been adapted from Killackey's (2023) 4L model but also other work which has involved application of co-design principles (e.g., Owens et al. 2022; Palmer et al. 2021; Walker et al. 2024; Winsper et al. (2023).

'Prevention' and 'early intervention' are not defined. The Interim Report frequently highlights the importance of 'prevention' and 'early intervention' in mental health and positions them as priority areas for investment. While these concepts are often applied in the context of youth mental health, we argue that a lifespan approach is essential. Prevention and early intervention strategies should extend to other vulnerable groups, such as neurodivergent children and their families, where proactive support can foster better mental wellbeing. Similarly, in older adults, emerging mental health issues are often

under-recognised and may be associated with isolation, physical decline, or cognitive impairment, underscoring the need for age-appropriate preventative strategies.

Importance of continuity of care. While prevention and early intervention approaches are admirable, it is important to focus on continuity of care. For example, in the youth mental health space, once young people are discharged from early intervention services, they find it difficult to get the assistance that they need for ongoing mental health issues; they fall through the cracks. Rather than siloing of services, there should be greater focus on how to better support transition through care pathways and ensure continuity of care. We suggest that a framework such as the Institute of Medicine's (IOMs) Continuum of Care, which has been used for substance abuse treatment, be considered.

Psychosocial support. There are three key issues with how 'psychosocial support' is addressed in the Interim Report:
(i) lack of definition;
(ii) limited regulation and weak evidence-base; and
(iii) absence of coordination across sectors and jurisdictions.

While the term 'psychosocial support' is used extensively in the Interim Report (53 times), it is not defined in the glossary. This lack of clarity creates confusion around what constitutes appropriate and effective support.

Currently, a wide range of services offer psychosocial support, regardless of whether an individual with mental illness has NDIS funding. However, many of these services are not underpinned by evidence-based practice, and in some cases, may even cause harm to individuals while also placing financial strain on governments.

Additionally, the Interim Report's narrow focus overlooks the fact that psychosocial supports are often provided by sectors outside of formal mental health services, such as community health, welfare, employment, housing, and others. Failing to acknowledge and coordinate these contributions across sectors and levels of government limits the effectiveness of interventions and reduces opportunities for integrated, person-centred care.

We suggest that the Productivity Commissioner consider using terminology recommended by the Inter-Agency Standing Committee (IASC), which is the highest-level humanitarian coordination forum of the United Nations system. The IASC adopts the composite term 'Mental Health and Psychosocial Support' (MHPSS), which is associated with a formal definition (i.e., any type of support that aims to protect or promote psychosocial wellbeing and/or prevent or treat mental disorder), and also reflects the attempt to unite and encompass diverse and complementary approaches to providing supports. These include health sector agencies (that may tend to reference mental health, while also using terms such as psychosocial intervention or rehabilitation) and agencies outside of the health sector (which may tend to use terminology aligned with supporting psychosocial wellbeing). The term MHPSS is also associated with a conceptual framework for interventions (the IASC Intervention Pyramid) which acknowledges that foundations for (a) specialised mental health services and (b) focused, non-specialised supports are (c) community and family supports

and (d) basic services; which are all important providers of support and should be considered in programmatic approaches to building MHPSS offerings.

Data collection, sharing, and linkage. Because of issues with data collection, sharing and linkage, the true burden of mental ill health in Australia is significantly underestimated.

Routine outcome measures used by governments and service providers, such as the Health of the Nation Outcome Scales (HoNOS), were developed years ago without meaningful input from consumers or clinicians. As a result, many of these tools are no longer fit for purpose, making it difficult to accurately evaluate individual treatment outcomes.

The 2020 Productivity Commission Report highlighted the ongoing underutilisation of administrative data, particularly across sectors and jurisdictions. There remains no infrastructure to support dynamic data linkages that enable routine assessment of individuals' pathways through care. As a result, it is difficult to evaluate service outcomes, identify those who fall through service gaps, or prioritise areas for reform. Investment in data linkage infrastructure and workforce capacity is limited. We have highlighted the barriers and opportunities for data linkage in mental health settings (Cotton et al. 2025); however, greater government investment is urgently required.

The Interim Report recommends ongoing funding for the routine collection of the National Study of Mental Health and Wellbeing (NSMHW) and the National Child and Adolescent Mental Health and Wellbeing Surveys every five years. This is strongly encouraged; however, the outcome measures used in these surveys require updating. For instance, the Kessler Psychological Distress Scale lacks specificity and shows questionable psychometric validity in some population groups. Further, it was not co-designed with the voices of those impacted by mental health issues. What is more relevant to individuals with a lived experience are outcomes such as functioning, social inclusion and quality of life. Consider a new measure of social inclusion that we have developed with those with lived, loved, and laboured experience (Filia et al. 2022). Methodological limitations have also been identified in the NSMHW, including the exclusion of certain high-impact, low-prevalence disorders (schizophrenia and bipolar disorder) and individuals not living in private residences. There needs to be greater discussion, consultation and review of formal evidence around outcome measures as well as with the design of these surveys.

Workforce development. While the Interim Report rightly emphasises the growth of the peer workforce, there is a pressing and parallel need to invest in the future psychology workforce. Engaging professional bodies, universities, and training institutions is essential to ensure a sustainable pipeline of psychologists who are equipped to work within integrative, multidisciplinary models of care. Future psychologists must be trained not only in core therapeutic competencies, but also in trauma-informed practice, cultural responsiveness, and collaborative approaches that position them to work effectively alongside peer workers, social workers, psychiatrists, and other professionals.

Given ongoing psychologist shortages, burnout, and long wait times for services, peer support groups are increasingly being used as a proxy for therapy - an approach that is neither safe nor sustainable. This places undue pressure on peer workers and fails to meet the clinical needs of individuals with complex mental health concerns.

We recommend that there are greater partnerships with universities and accrediting bodies to strengthen psychology training pathways with a focus on integrative care and community-based practice. There should be provision of targeted funding to support supervision and placement opportunities for provisional psychologists, particularly in underserved areas. Clear role definitions and collaborative practice guidelines can promote safe and effective integration of psychologists within multidisciplinary teams. Monitoring and addressing workforce capacity gaps through regular national reporting and targeted investment in high-need regions is also needed. By strengthening the psychology workforce within an integrative care framework, the mental health system will be better positioned to provide timely, appropriate, and effective care for all.

Specific Responses to Draft Recommendations

In Table 1, we highlight the Turner Institute's responses to the Draft Recommendations in the Interim Report. We also reference instances where information is relevant to the Interim Report's Information Requests.

Table 1

Turner Institute's Responses to Draft Recommendations and Information Requests

Draft Recommendations	Turner Institute Response
2.1 Deliver key documents as a priority	No specific comment.
4.1 Developing a renewed National Mental Health Strategy	Our comments for Recommendation 4.1 are covered below under Recommendation 4.2.
4.2 Building the foundations for a successful agreement	There are definitional issues associated with co-design. Other key stakeholders are excluded from the definition (see our Figure 1, page 2). Furthermore, the multiple stakeholders encompassed under 'lived experience' can be limiting as mentioned on page 2 of our submission where we propose the 4 L framework. From pages 9-13 of this submission, we highlight many examples of work that we have done collaborating with multiple stakeholders (Information Request 4.2).
	We support better engagement between all levels of government, across government portfolios and jurisdictions (page 3).

Draft Recommendations	Turner Institute Response
	The AIHW would be an appropriate agency to lead a framework for outcome measures; however, other key stakeholders need to be consulted. This will include the involvement of universities as well as consumers. The current measures are not fit for purpose and are outdated; a new approach is needed incorporating measures that are meaningful to individuals with loved and lived experience (pages 4-5).
	More investment is needed in supporting the infrastructure and use of administrative data across all government portfolios, jurisdictions and sectors; this data can be used for more meaningful assessment of outcomes (pages 4-5). Developing data platforms that could allow for real time tracking of pathways through care both within mental health services and across other sectors would be beneficial for identifying treatment needs, fostering better communications amongst systems and sectors, and reducing the chances of individuals falling through gaps and experiencing poor outcomes.
4.3 The next agreement should have stronger links to the broader policy document	Individuals with mental ill-health are likely to have contacts with services across sectors. There is not only the need to have policy documents aligned between the sectors, including drug and alcohol (Information request 4.1), but also practical approaches to aid individuals through care pathways both within and across sectors (see page 3). This is pertinent for Information Request 4.1.
	A central agency or social prescriber to support individuals navigate the systems and sectors would support better coordinated care and prevent 'the missing middle'.
	As previously mentioned (Recommendation 4.2), there needs to be co-designed and psychometric sound routine outcome measures that could be used across jurisdictions and sectors.
4.4 Immediately address the unmet need for psychosocial supports outside the National Disability Insurance Scheme	As highlighted on page 4, psychosocial support is not well defined, and it is a broad concept. There is no registry or control over services providing psychosocial support. This is regardless of whether they are NDIS funded or not. We need a regulatory regime that incorporates agreed definitions.
	Research is needed to inform an evidence-base for psychosocial support interventions. Universities are essential in developing and evaluating such interventions. Otherwise, individuals are not going to benefit, and some services may be providing ineffectual and harmful (whether intentional or unintentional) interventions. This is also economically burdensome to Government.
	We firmly encourage the Productivity Commission to undertake a broader review of this area rather than just funding psychosocial supports with no evidence-base.

Draft Recommendations	Turner Institute Response
	Consider other models of psychosocial support and better approaches to their integration within services (see page 4).
4.5 Next agreement should clarify responsibility for carer and family supports	There is a lack of evidence-based supports for those with a loved experience.
	Universities play an important role in developing evidence-based resources and interventions for those with a loved experience (e.g., Parenting in Practice Program led by Prof Yap, see pages 10-11).
4.6 Increases transparency and effectiveness of governance arrangements	We agree with recommendation of an independent statutory body; however, it should cover both mental health and suicide prevention.
	The composition of the Committee should be transparent.
4.7 The next agreement should support a greater role for people with lived and living experience in governance	Although greater involvement of individuals with lived experience at all levels of government is commendable, there is no clear plan on how this will be done. Currently it appears tokenistic in its approach (see page 2).
	This is in addition to the definitional issues we have already raised in this submission (see page 2).
4.8 A greater role for the broader sectors in governance	There should be involvement of service providers from other sectors that support those with mental ill health. This includes primary care, emergency services, drug and alcohol, forensic, welfare, etc.
	The Mentally Healthy Workplaces (MHWA) mentioned on page 12 is our example of a coalition of broad sectors including regulators, universities, peak bodies, trade unions, employers and government at state and national levels coming together to solve workplace mental health and wellbeing challenges.
4.9 Share implementation plans and progress reporting publicly	We agree with this recommendation.
4.10 Strengthening the National Mental Health Commission's reporting	A dashboard documenting the progress on the agreement will be valuable. There should be involvement from key stakeholders in decision making about what should be included in the design and content of the dashboard. This dashboard could be housed by the Productivity Commission or by organisations such as AIHW (Information Request 4.3).
	The National Suicide Prevention office should be integral to the reporting.
	Consider other sectors that may inform the selection of outcomes.
4.11 Survey data should be routinely collected	There needs to be consideration of the content and methodologies involved in collection of the National Surveys (see page 5).

Draft Recommendations	Turner Institute Response
4.12 Funding should support primary health networks to meet local needs	Because of the inadequate outcome measures and platforms, it is currently not possible to support PHNs, services, and clinicians in the use of routine outcome data.
	A platform is needed where routine outcome measures can inform PHNs and services in addressing local needs and resource allocation, but also can be used by clinicians working with their clients.
4.13 The next agreement should support the implementation of the National Mental Health Workforce Strategy	As highlighted on page 5, while there should be support for development of a peer workforce, consideration should be given to the training of new clinicians as well as providing better support for those who are currently practicing.
	Our unique work with Roses in the Ocean (page 9) highlights the work of developing a peer workforce with experience in suicide. It is an ideal case study for best practice (Information Request 4.4).
4.14 The next agreement should commit governments to develop a scope of practice for the peer workforce	As highlighted in our previous point, there should be consideration of training and support for clinicians, in addition to a peer workforce.
4.15 The next agreement should build on the evaluation framework and guidelines	We support this Recommendation.
5.1 An Aboriginal and Torres Strait Islander schedule in the next agreement	We support this Recommendation.
6.1 Suicide prevention as a schedule to the next agreement	We acknowledge that suicide is linked but separate from mental health. Again, co-design is not well defined. It is not only important to consider mental health and suicide support services, but it is necessary to consider other supports from other sectors such as housing, employment, drug and alcohol. It is not only important to consider mental health and suicide support services, but it is necessary to consider other supports from other sectors such as housing, employment, drug and alcohol.

Examples of Turner Institute's Innovative Work

The Turner Institute for Brain and Mental Health is deeply committed to improving the health and wellbeing of Australian people. In formulating our responses to the draft recommendations and the requests for information (see Table 1), we have drawn upon our own work in mental health research and implementation and national and international best practice. We highlight seven key areas.

We work across systems, sectors, and disciplines to support people across the lifespan. We work across systems and disciplines to address complex challenges through meaningful collaboration and partnerships. By engaging diverse stakeholder groups - including clinicians, researchers, policymakers, people with lived experience, and community organisations - we integrate multiple perspectives to co-create solutions that are practical, scalable, and grounded in real-world contexts. Our multidisciplinary and cross-sector approach fosters innovation, accelerates impact, and ensures our work is relevant, inclusive, and sustainable.

The NHMRC Centre of Research Excellence in Bipolar Disorder (CORE-BD), led by Prof Sue Cotton, unites an international and multidisciplinary team spanning psychology, psychiatry, biochemistry, cell biology, clinical trials, data science, epidemiology, and health economics. The Centre is dedicated to addressing the significant unmet needs of individuals affected by bipolar disorder. CORE-BD is grounded in meaningful partnerships with people with lived and loved experience, as well as community-based NGOs, to ensure research translates into real-world impact. Key initiatives include the development of a peer psychology network to support clinicians and the establishment of an international student peer support network, both aimed at strengthening the mental health workforce and improving outcomes for those affected by bipolar disorder.

Leading innovation in suicide prevention. Our suicide prevention research, education programs, and community collaborations address multiple drivers within the suicide prevention system and align closely with the draft recommendations and findings of the Interim Report. Led by Dr Kylie King, our suicide prevention research aims to translate knowledge into practice, prioritising the voices of those with lived experience and those who work with those experiencing suicidal distress to inform and evaluate suicide prevention initiatives. Our specialty areas include male suicide prevention, gatekeeper training, program evaluation, youth and school-based interventions, and suicide prevention workforce development.

Our suicide prevention education initiatives translate research and lived experience expertise into knowledge and skills for students and the community. Our researchers and educators collaborated with people with lived experience to develop and launch Australia's first undergraduate course in suicide prevention and support in 2024. Beyond university education, Dr King and her team are partnering with Roses in the Ocean - Australia's peak body for lived experience of suicide - to co-develop the national Future Leaders Program, which aims to build leadership capacity among individuals with lived experience. They are also partnering with the aged care industry to deliver targeted suicide prevention training to aged care workers.

Working with vulnerable and 'at risk' populations. We have teams working with vulnerable and diverse communities with respect to issues such as trauma, family violence and mental health. Research across these areas informs evidence-based education.

The Murrup Bung'Allambee Indigenous Psychology Research Group comprises Indigenous graduate research students researching in the field of Indigenous psychology and wellbeing. They are committed to a self-determined approach to Indigenous social and emotional wellbeing, provide peer support, mentorship and pathways for Indigenous psychology students, developing more Indigenous peoples to become healthcare professionals, educators, and researchers.

Prof Laura Jobson leads the Culture, Trauma and Mental Health Research Group, working with culturally and linguistically diverse populations including developing targeted and culturally sensitive interventions. This work includes extensive collaborations with communities in Australia and with international partners in Malaysia, Iran, Iraq, Afghanistan and China. The mental health needs of migrant and refugee communities is overlooked in the Interim Report.

A/Prof Sean Cowlishaw leads research focused on trauma, with particular emphasis on family violence and veteran mental health. His team has undertaken Australian-first studies addressing family violence in military and veteran families, and enhancing the responsiveness of veteran-centric services to the needs of women veterans. This work is conducted in collaboration with the Commonwealth Department of Veterans' Affairs and the NSW Office for Veterans Affairs.

In partnership with the Department of Health and Aged Care, A/Prof Cowlishaw is also evaluating innovative pilot programs that deliver mental health support for women affected by family, domestic, and sexual violence. Further research, in collaboration with the Victorian state government, focuses on data linkage to map service use and identify care pathways for individuals with mental ill health.

The Turner Trauma Clinic houses a first responder mental health network, which includes representation from major state-based emergency service agencies (including police, fire, and ambulance), and focuses on developing research capacity and evidence across areas of early intervention and treatments in the context of workplace trauma.

Expertise in psychosocial support. While definitions of psychosocial support remain broad our work focuses on identifying and addressing the unmet needs of individuals living with mental ill health. This includes support that extends beyond clinical care - encompassing social connection, functional support, housing, education, employment, and engagement with community and culture - recognising that recovery and wellbeing are shaped by the broader social determinants of health. The National AllPlay Child and Family Centre and the Partners in Parenting Kids (PiP Kids) digital parenting program are perfect examples of this work.

The establishment of National AllPlay holds significant promise to scale up activity and improve the lifelong clinical and community care of Australian children with disability, many of whom experience mental health challenges (co-led by Prof Nicole Rinehart). It is a community-based dance program that aims to boost outcomes for Autistic children with the potential to scale into other areas such as AllPlayFooty. A first of its kind trial is aiming to recruit children aged with a pre-existing formal Autism diagnosis. Researchers will assess whether participation in the community-based dance program, AllPlay Dance, results in significant improvements in motor functioning among autistic children, compared to a treatment-as-usual waitlist control condition, from pre-to post-intervention.

Parents have a pivotal role in child and youth mental health. There is burgeoning evidence demonstrating that parents can modify various risk and protective factors for child and youth mental health, to in turn reduce the risk and impact of mental disorders during these formative years of child development. Since 2014, Monash University's Parenting and Youth Mental Health research team (led by Prof Marie Yap OAM) has translated this body of research evidence into actionable strategies parents can use, via the Partners in Parenting (PiP) program - a multi-level suite of individually-tailored digital parenting interventions. PiP's multi-level approach provides the appropriate level of support for parents across prevention to early intervention for child mental health. Multiple clinical trials have been conducted in Australia to evaluate the effectiveness of the Parenting in Practice (PiP) program. These studies show strong evidence that PiP improves parental and family factors, leading to better mental health outcomes for children and adolescents.

Expertise in prevention and early intervention across the lifespan. Prevention and early intervention for mental health and suicide prevention are not only relevant for children and young people, but they are relevant across the lifespan. Here we highlight case studies of our work.

The Turner Institute's research in neurodevelopmental disorders and youth mental health research aligns directly with the Interim Report which highlights the urgent need for integrated, evidence-driven interventions that improve outcomes for Australian children and youth.

By investigating the mechanisms underlying Autism, ADHD, learning disorders and preterm-born developmental trajectories, our multidisciplinary team - spanning genetics, pharmacology, neuroscience, clinical psychology and psychiatry - develops targeted, scalable interventions grounded in robust biological understanding. Leveraging cutting-edge tools like EEG, oculomotor neurophysiology, TMS, and brain imaging, our work bridges brain and behaviour to translate discoveries into therapies that empower thousands of children to reach their full potential National AllPlay, as highlighted above, is an example of our research making real world differences for young children and their families.

Given the peak age of onset of most mental disorders is in adolescence and young adulthood, work is being done to identify opportunities for earlier diagnosis, design and improve outcome measures, develop more targeted psychosocial treatments, and promote equitable service provision. This work is being conducted in common mental health

disorders (e.g., depression and anxiety, PTSD) as well as less prevalent but high burdensome disorders (e.g., schizophrenia and bipolar disorder). The NHMRC funded Centre of Research Excellence in Bipolar Disorder (CORE-BD), led by Prof Cotton involves international collaborations across stakeholders to reduce the diagnostic delays seen in individuals with bipolar disorder; currently there is approximately a 10-year delay between onset of the disorder and accurate diagnosis and treatment.

There are other settings where prevention and intervention of mental ill health is important. The Mentally Healthy Workplaces Australia (MHWA) is a world-first initiative championing innovation in workplace mental health. Established by a coalition of industry leaders, academic experts, and union representatives, MHWA serves as the national centre for driving scalable, measurable change across the entire workplace ecosystem. Its mission is to develop integrated solutions tailored to the evolving needs of Australian workplaces and workers - now and into the future.

MHWA focuses on pioneering preventive and wellbeing-promoting innovations that deliver tangible benefits to both industry and the workforce. Crucially, the initiative is dedicated to ensuring the effective implementation of these solutions in real-world workplace settings, maximising their utilisation and impact. By doing so, MHWA will generate both social and economic value for workers and organisations.

Also of relevance to the Productivity Commission is that MHWA is committed to rigorous evaluation of the impact on worker wellbeing and workplace performance and will lead the co-design of robust data governance frameworks to ensure the ethical and effective use of technologies and data in workplace environments.

There is an opportunity to expand programs that focus on early identification and intervention, potentially reducing the long-term impact of mental health issues and reducing suicide risk in our community.

The Industrial Transformation Training Centre (ITTC) for Optimal Ageing is training a workforce that is skilled in the development, translation and implementation of digital and robotic systems to optimise cognitive, physical and mental wellbeing in middle-aged and older adults. The Centre is within the Turner Institute and promotes engagement in adaptive behaviours that preserve cognitive function in adults as they age and using the latest technologies to create a sense of community and reduce social isolation.

Outcome measurement and data. Multiple members of the Turner Institute have extensive experience with outcome development and measurement, psychometrics, data linkage and data science. Team members recognise the limitations of current commonly used outcome measures and the need to develop new co-designed measures of mental health and suicidal behaviours. This includes covering areas such as social inclusion.

Recognising that most existing psychosocial supports lack rigorous evaluation, we are working closely with a range of stakeholders to meet the urgent demand for evidence-based, scalable models of care. Prof Sue Cotton leads an NHMRC Partnership Grant titled *“The*

Who, What, When, Where and Why of Youth Mental Health – the 5W Research Program". This initiative brings together partners, including the Victorian Department of Health, *headspace* National, and Ambulance Victoria to examine the mental health needs of Victorians aged 5 to 55 years.

A key innovation of the 5W program is the development of cross-sector and cross-jurisdictional data linkage infrastructure, enabling a comprehensive understanding of pathways through care and outcomes across the health, mental health, and human services systems. This work is crucial in identifying service gaps and improving support for diverse and vulnerable populations, including those who comprise the 'missing middle' - individuals whose needs are often overlooked by current systems.

Strengthening Community Engagement. A strength of the Turner Institute is our extensive partnerships across all 4 L stakeholder groups. They are essential partners guiding research directions and as well as being involved with every aspect of co-design in research implementation. For example, the Turner Institute has a longstanding Community Reference Council comprising individuals with lived and loved experience, as well as individuals from key mental health organisations, including those that represent vulnerable and diverse groups. The Council plays an important role in setting the agenda for the Turner Institute.

Other similar groups have been formed for specific research programs; for example, as already mentioned, the NHMRC Centre of Research Excellence in Bipolar Disorders (CORE-BD) has a Brain Trust comprising those with representatives across the 4 Ls. Our Australian-first projects on veteran mental health have also established community reference and advisory groups organised around national and state-based projects (for example, which have focussed on intersections with family violence and the unique experiences of women veterans).

Conclusion

We have laid out practical, real-world examples that illustrate how the next iteration of the National Mental Health and Suicide Prevention Agreement could be transformed through innovation, real co-design, shifts in language and systems thinking.

While the interim report rightly calls for extending the current Agreement to 2027 to allow for meaningful co-design, our submission offers the blueprint for a next-generation Agreement: one with sharply defined objectives anchored in the National Suicide Prevention Strategy and a renewed national mental health strategy; bold commitments to measurable outcomes; and transparent accountability structures, including independent monitoring.

Ultimately, the next Agreement should not just recommit to past promises - it must enable a system that is proactive, integrated, evidence-based, and truly co-designed. Only then can we move beyond incremental fixes to achieve the systemic reform necessary to improve mental health and suicide prevention outcomes for all Australians.

Contact us

We welcome further consultation on our Submission.

Professor Shantha Rajaratnam, Interim Director, Turner Institute for Brain and Mental Health, Head, School of Psychological Sciences, Monash University

Contributors:

- Professor Sue Cotton, Early intervention in Mental Health and Director, NHMRC Centre of Research Excellence in Bipolar Disorder (CORE-BD), School of Psychological Sciences, Monash University
- Professor Mark Bellgrove, Deputy Head of School (Research), Co-Chair Monash Neuroscience, Monash University
- Professor Judith Gullifer, Deputy Head of School (Education), Senior Director of Education, Monash University
- Professor Laura Jobson, Chair, Athena SWAN Steering group, Deputy Director of Community Engagement, Lead of the Culture, Trauma and Mental Health Research Group, School of Psychological Sciences, Monash University
- Associate Professor Sean Cowlishaw, Senior Lecturer, School of Psychological Sciences, Monash University
- Dr Emma Morton, Senior Lecturer & Deputy Director of Postgraduate Training (Research), School of Psychological Sciences, Monash University
- Dr Kylie King, Senior Lecturer, School of Psychological Sciences, Monash University
- Ms Shannon Checklin, Senior Strategic Project Manager, Turner Institute for Brain and Mental Health, School of Psychological Sciences, Monash University

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Appendix 1. The Turner Institute Drives Innovation in Brain and Mental Health Research

The Turner Institute drives innovation in brain and mental health research across six programmatic areas:

Mental health & wellbeing. Our research groups address pressing issues including child and youth mental health, addictive and eating disorders, mood disorders, suicide prevention, trauma, cultural understandings of mental health and cultural tailoring of interventions, and wellbeing. We collaborate with clinicians, communities, and people with lived experience to conduct relevant, impactful research, including partnerships with underserved and Indigenous communities. Through partnerships with Monash Turner Clinics and BrainPark, we develop interventions that are effective, acceptable and accessible, ensuring our research translates into real-world improvements.

Neurodevelopment. Neurodevelopment involves genetically programmed processes interacting with environmental inputs, particularly in the first 1,000 days of life. Disruption during these crucial windows increases risk for disorders such as autism, ADHD, and intellectual disability, affecting 1 in 6 children globally. Children with neurodevelopmental conditions are also at heightened risk of developing lifetime mental health conditions. Our work bridges neuroscience, developmental science, and implementation research to co-design scalable, evidence-based models of care that support children and families.

Ageing & neurodegeneration. The brain changes as we grow older, yet these changes vary greatly between individuals. We study brain changes across the lifespan and in neurodegenerative conditions like dementia, Huntington's and Parkinson's diseases, developing targeted interventions to support cognitive and neurological functions and mental health.

Brain injury & rehabilitation. Through the Monash-Epworth Rehabilitation Research Centre (MERRC), we investigate intervention programs for individuals with brain injuries or trauma-related injuries. We aim to maximise functional, psychological and social outcomes, including for mental health, helping people rebuild their lives after life-changing injuries.

Brain mapping & modelling. How do our thoughts, experiences, and behaviours arise from the complicated operations of the brain? We tackle this fundamental question by combining sophisticated brain imaging with statistical and mathematical models. Our advanced tools map the brain in unprecedented detail, unlocking the mysteries of how the mind works and identifying novel biomarkers for mental health conditions.

Sleep & circadian rhythms. Sleep is increasingly recognised as the third pillar of good health, alongside diet and exercise. Our program investigates the role of internal biological clocks and sleep in the general population and specific groups such as shift workers, elite athletes and clinical populations, helping people understand and optimise this fundamental aspect of health.

The Turner Institute's Clinical Expertise

In addition to the six programmatic research streams, the Turner Institute also operates the Turner Clinics. As already mentioned, there are four clinic streams: (i) Trauma; (ii) Child, Youth and Family; (iii) Healthy Sleep; and (iv) and Neuropsychology. The Clinics provide psychological services to over 3,000 clients across Victoria each year. Led by registered clinical psychologists and clinical neuropsychologists, the Clinics provide accessible, evidence-based (including trauma-based) care while operating as a translational research hub.

The Clinics also provide a unique environment for workforce development, training the next generation of clinicians who are equipped to address the mental health needs of the Australian population. Clinicians and service providers partner with world-leading experts and student researchers to pilot and rigorously evaluate innovative treatments - from novel sleep interventions to telehealth models for post-traumatic stress disorder (PTSD) and concussion, ensuring real-world validation and continuous improvement.