Australian Government
Productivity Commission

pc.gov.au

Mental Health and Suicide Prevention Agreement Review

Inquiry report overview

No. 108 | 16 October 2025

Acknowledgement of Country

The Productivity Commission acknowledges the Traditional Owners of Country throughout Australia and their continuing connection to land, waters and community. We pay our respects to their Cultures, Country and Elders past and present.

About us

The Productivity Commission (PC) is the Australian Government's independent research and advisory body on a range of economic, social and environmental issues affecting the welfare of Australians. Its role, expressed most simply, is to help governments make better policies, in the long-term interest of the Australian community.

The PC's independence is underpinned by an Act of Parliament. Its processes and outputs are open to public scrutiny and are driven by concern for the wellbeing of the community as a whole.

For more information, visit the PC's website: www.pc.gov.au

ISSN 1447-1337 (online)
ISSN 1447-1329 (print)
ISBN 978-1-74037-819-2 (online)
ISBN 978-1-74037-818-5 (print)

An appropriate reference for this publication is:
Productivity Commission 2025, *Mental Health and Suicide Prevention Agreement Review,* Inquiry report no. 108, Canberra

Publication enquiries:
Phone 03 9653 2244 | Email publications@pc.gov.au

Contents

Full report can be found at www.pc.gov.au/inquiries-and-research/mental-health-review

Overview

Key points

- **The mental health and suicide prevention system is fragmented and out of reach for many people. The National Mental Health and Suicide Prevention Agreement represents the commitment of governments to work together towards a person-centred, integrated mental health and suicide prevention system.**
  - Under the Agreement, the Australian, state and territory governments committed to progress an ambitious set of outcomes through national outputs and specific actions contained in bilateral schedules.
- **The actions in the Agreement do not advance system reform.**
  - Consumers, carers and providers report services remain uncoordinated, unaffordable and difficult to navigate. This is despite some progress in implementing actions under the Agreement and the substantial efforts of many working across mental health and suicide prevention services.
- **Key commitments in the Agreement have not been delivered and should be completed as a priority.**
  - State and territory governments should immediately prioritise addressing the gap in psychosocial supports outside the National Disability Insurance Scheme that is affecting 500,000 people. Ongoing funding arrangements for these services should be included in the next agreement.
  - Governments should publish the completed National Stigma and Discrimination Reduction Strategy and comprehensive guidelines on regional planning and commissioning for primary health networks.
- **A new policy architecture is needed to articulate the collective actions that will deliver changes to the mental health and suicide prevention system and improve outcomes.**
  - To be effective, the new policy architecture should be developed by governments in a process of co-design with people with lived and living experience of mental ill health and suicide, their supporters, family, carers and kin as well as service providers and practitioners.
- **The current Agreement should be extended until June 2027 to allow sufficient time for co-design of the new policy architecture. This architecture should include:**
  - **a Mental Health Declaration, signed by First Ministers, which will set the long-term direction for reform in conjunction with the National Suicide Prevention Strategy**
  - **a five-year national agreement to tackle key priorities in the short term**
  - **new governance, accountability and funding structures to underpin whole-of-government action**
  - **separate schedules on services for Aboriginal and Torres Strait Islander people, services distinctly focused on suicide prevention, and services for people experiencing co-occurring problematic use of alcohol and other drugs and mental ill health and/or suicidal distress.**
- **The next agreement should comprise:**
  - **clear objectives relating to the long-term vision set out in the National Suicide Prevention Strategy and Mental Health Declaration**
  - **specific and measurable outcomes focusing on key priorities for the next five years**
  - **tangible commitments clearly linked to the objectives and outcomes.**
- **The next agreement should formalise the role of the National Mental Health Commission as the independent entity responsible for assessment and reporting on progress.**

Mental health and suicide prevention matter to our wellbeing and productivity. But policies and services meant to improve mental health and prevent deaths by suicide often fall short. The consequences of these failures are well known but still shocking – each year, about 3,000 lives are lost to suicide; and one in five Australians, including one in seven children, experience mental illness. The economic costs are also substantial. The effects of mental ill health and suicide cost Australia over $200 billion a year, through lost productivity and reduced life expectancy, as well as what people and governments spend on mental health and suicide prevention services.

Improving mental health and suicide prevention services is a major challenge for governments, because it requires sustained effort across different areas and levels of government. Governments need to work together with people with lived and living experience of mental ill health and suicide as well as service providers to plan, build and deliver better services centring the needs of consumers. Achieving this can deliver significant gains – better health, higher incomes, improved wellbeing – across the community.

Governments signed the National Mental Health and Suicide Prevention Agreement to strengthen their collaborative efforts towards reform. However, in the three years since the Agreement was signed, little has improved for the people who access mental health and suicide prevention services, and their supporters, family, carers and kin. The consumers, carers and service providers we surveyed spoke of ongoing access and affordability challenges and uncoordinated services not responding to need (box 1).

There are many reasons for this, including external events, such as the COVID-19 pandemic and the Voice referendum, that affected the mental health and wellbeing of Australians over the course of the Agreement. Its four-year timeframe is relatively short to achieve meaningful change.

Nonetheless, the Agreement itself has fundamental flaws and it has not enabled systemic progress towards a person-centred, integrated mental health and suicide prevention system.

Box 1 – ‘Alienating, inadequate, ill-informed, and under-resourced’: consumers, carers and practitioners reflect on the mental health and suicide prevention system

The reflections of consumers, carers and service providers were a central part of assessing progress under the Agreement. The PC asked consumers, carers and mental health and suicide prevention workers and volunteers about their experiences with and views on the system during the period of the Agreement. The responses from consumers reflected four themes.

- Costs and waiting times are a major barrier to accessing services.
- There are gaps and shortages across the system, including general practitioners, specialist providers and acute care.
- Crisis support is inadequate and services are not responsive to people’s needs.
- Experiences of discrimination when accessing services are common.

Carers reflected on a lack of support as well as experiences of exclusion and not being able to access information they needed to support the person they were caring for. Practitioners said the way services are staffed and funded needed to change.

The survey also captured people’s positive experiences of the system and the factors contributing to them. Feeling safe, respected and listened to and having opportunities to meaningfully engage with others (which often came about when interacting with peer workers) contributed to positive experiences.

Box 1 – 'Alienating, inadequate, ill-informed, and under-resourced': consumers, carers and practitioners reflect on the mental health and suicide prevention system

> Intake processes are not trauma informed and have often left myself and my loved ones re-traumatised
>
> **Consumer**

> When I first went to hospital people kept saying 'you will be okay with supports in the community' but no one told me what they were or how to access them
>
> **Consumer**

> There are mental health lines … however these are strictly crisis management, do not provide multiple sessions and are not tailored to early intervention
>
> **Consumer**

> In regional areas the availability, access and affordability has dramatically reduced (and it was poor to begin with)
>
> **Consumer**

> A lot of times you are unable to get support if you don't fit into a certain box. This creates hesitancy to reach out as it becomes too much to try and work through
>
> **Consumer**

> Services are increasingly difficult to access and navigate, hard to get the most vulnerable and individuals in need seen in a timely and appropriate manner without having to share exhausting accounts of why the service is needed
>
> **Practitioner**

> I am consistently excluded from care plan discussions. During the first hospital admission, clinicians refused to share updates, citing confidentiality, even though my involvement is critical to my loved one's recovery
>
> **Carer**

> I think the system is worse than ever and seems to be going backwards. There are mental health service providers in our area who will not refer (or speak to) each other because they are the competition for funding
>
> **Practitioner**

> I live in a cross-border area and there is dispute over whose responsibility services are. I have had to navigate through how to get the right services with the extra pressure of where we can find them and be accepted
>
> **Carer**

> We do not have enough staff, we are underfunded and cannot offer the services people need in our area
>
> **Practitioner**

> I don't feel like we are seen at all
>
> **Carer**

> Inadequate services, wait times too long, couldn't stay on hold any longer
>
> **Consumer**

The Agreement expires in June 2026. This gives governments the opportunity to start again and create a policy architecture, including a new national agreement, enabling collaboration and responding effectively to the needs of people with lived and living experience, and their supporters, family, carers and kin.

The Agreement is not fit for purpose

The National Mental Health and Suicide Prevention Agreement was signed in 2022, replacing the Fifth National Mental Health and Suicide Prevention Plan. The Agreement recognises the role of a whole-of-government approach to system reform rather than having a narrow health focus. It covers the important intersection between the responsibilities of the Australian Government and state and territory governments across the many domains contributing to mental health and suicide prevention and introduces joint funding commitments.

In signing the Agreement, governments agreed to an ambitious set of tasks. The Agreement includes five objectives, five outcomes, 13 outputs, 15 priority populations, 14 policy principles and a plethora of commitments for national and jurisdictional actions – with no obvious links between them (figure 1). Without a clear, evidence-based logic connecting the actions to the Agreement's goals, it is difficult to assess its effectiveness and hold governments to account.

The Agreement contains limited funding commitments, totalling about $360 million per year, or 3% of the $12.6 billion governments spend on mental health and suicide prevention services.[1] Over the past decade, governments' real expenditure on mental health services has grown by 30%. In 2022-23, real expenditure per person was nearly 16% higher than it was in 2013-14.

Funding commitments are included in bilateral schedules to the Agreement, signed by the Australian Government with each state and territory government. The 11 common services funded in the schedules are largely based on initiatives the Australian Government introduced prior to the Agreement's negotiations. In some cases, schedules reflect state or territory governments' priorities, such as the reforms the Victorian Government committed to in response to the Royal Commission into Victoria's Mental Health System.

Many actions in the Agreement are not funded. For example, governments committed to align the implementation of the Agreement with the National Agreement on Closing the Gap and improve services supporting the social and emotional wellbeing of Aboriginal and Torres Strait Islander people. However, the Agreement includes no specific national measures or funding to improve services for Aboriginal and Torres Strait Islander people. Greater investment in prevention and early intervention is one of the Agreement's objectives, but it contains no actions to achieve this. The Agreement also does not allocate funding to enable collaboration between different parts of government and services working to improve mental health and suicide prevention outcomes. This is a core objective of the Agreement, and review participants told the PC collaboration is lacking in many areas. Where it does occur, this is due to the goodwill of staff and their strong commitment to improving consumer outcomes.

The Agreement emphasises the need to incorporate the voices of people with lived and living experience of mental ill health and suicide in all aspects of the system but says little on how this should be achieved. Review participants told the PC the Agreement was developed with limited input from people with lived and living experience, their supporters, family, carers and kin, as well as service providers, and their involvement in governance arrangements is limited.

[1] The bulk of this spending is on clinical services and is managed under the Medicare Benefits Schedule, the Pharmaceutical Benefits Scheme and hospital funding in the National Health Reform Agreement. There are no current national figures on suicide prevention expenditure. The PC estimated total government spending on suicide prevention was $120 million in 2019-20, or 1% of total expenditure on mental health and suicide prevention.

Figure 1 – The National Mental Health and Suicide Prevention Agreement aims to achieve broad objectives and outcomes – while outputs are not clearly linked to systemic reform

Objectives	Outcomes	Outputs
• To work collaboratively to implement systemic, whole-of-government reforms that improve mental health outcomes for all people living in Australia, progress the goal of zero lives lost to suicide, and deliver a mental health and suicide prevention system that is comprehensive, coordinated, consumer-focused and compassionate to benefit all Australians • To work together in partnership to ensure all people living in Australia have equitable access to the appropriate level of mental health and suicide prevention care they need, and are able to access this care when and where they need it • As a priority, to work together to: – reduce system fragmentation – address gaps in the system – prioritise further investment in prevention, early intervention and effective management of severe and enduring mental health conditions	• Improve the mental health and wellbeing of the Australian population, with a focus on priority populations • Reduce suicide, suicidal distress and self-harm through a whole-of-government approach • Provide a balanced and integrated mental health and suicide prevention system • Improve physical health and life expectancy for people living with mental health conditions and for those experiencing suicidal distress • Improve quality, safety and capacity in the Australian mental health and suicide prevention system	• Analysis of psychosocial support services outside of the National Disability Insurance Scheme (NDIS) • Commonwealth-State implementation plans and annual Jurisdiction Progress reports • An annual National Progress Report • Improvements to data collection, sharing and linkage • Development of a National Evaluation Framework • Shared evaluation findings • Consideration and implementation of relevant actions of the National Stigma and Discrimination Reduction Strategy • Establishment of the National Suicide Prevention Office • Development of national guidelines on regional commissioning and planning • Development of the National Mental Health Workforce Strategy and identification of priority areas for action • Report on progress toward increasing the number of mental health professionals per 100,000 people • A submission to the mid-point National Health Reform Agreement review • A final review of this Agreement provided to all Parties

National governance arrangements set up under the Agreement emphasise the perspectives of government agencies and the health system. These arrangements tend to be opaque; there is limited public reporting on the structure and progress of working groups convened under the Agreement.

The governance structures put in place to implement specific initiatives vary significantly at the local level. These structures involve primary health networks (PHNs), funded by the Australian Government, and state- and territory-funded local hospital networks (LHNs). Where these structures are collaborative, PHNs and LHNs plan and commission services suitable to the needs of local communities and incorporate the voices of people with lived and living experience. But where local governance is not effective, there is little collaboration and limited links between community mental health services funded by state and territory governments and those funded by the Australian Government. This hinders integration and collaboration between services and makes it much harder for consumers and carers to find the support they require.

Accountability under the Agreement is limited to annual progress reports published by the National Mental Health Commission (NMHC), with no consequences for stalled progress. These reports reflect governments' own assessment of progress against the initiatives in the bilateral schedules, not the Agreement's objectives and outcomes. The NMHC has only been able to compile two reports due to jurisdictional delays.

Governments have delivered most of the Agreement's outputs – but this has not led to better outcomes

Many of the Agreement's outcomes are not easily measurable, as their scope is broad and they lack specific definitions. Data is not available to measure all aspects of the Agreement's outcomes. Where data is available, it cannot be readily used to assess progress. The most recent data collections are at least two years old and the intended improvements to data collections included in the Agreement are yet to be fully realised.

The latest available data shows measures of mental ill health and suicide have not improved in recent years (figure 2). The suicide rate of Aboriginal and Torres Strait Islander people has worsened. Barriers to accessing mental health services for lower income households have increased in recent years due to rising costs.

Progress in delivering outputs is easier to assess. Governments have delivered nine of the 13 outputs listed in the Agreement, with progress against a further three difficult to determine. They have also progressed initiatives listed in the bilateral schedules.

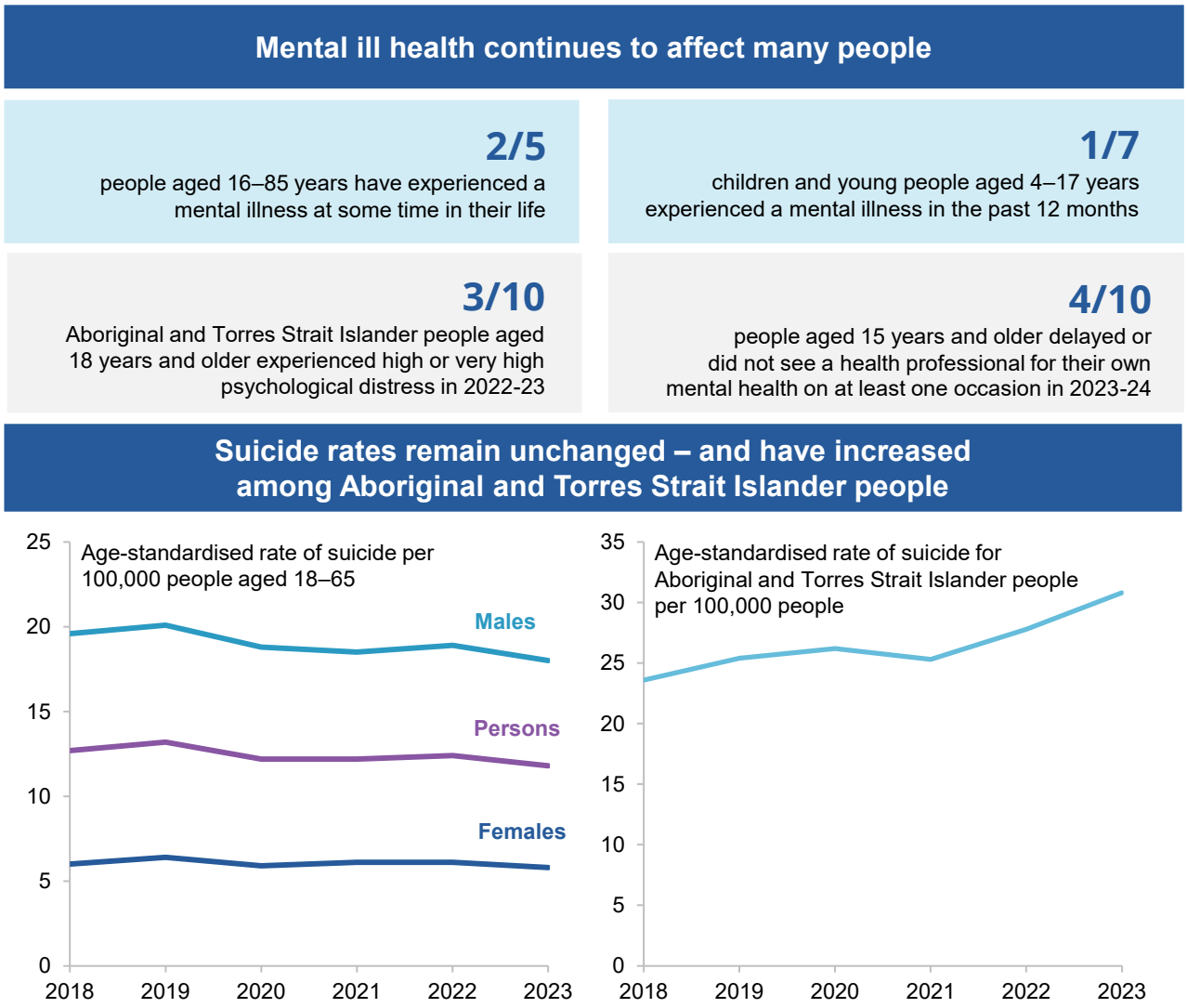
Some of the outputs, such as the establishment of the National Suicide Prevention Office (NSPO), have been well received by people with lived and living experience and service providers. Initiatives in the bilateral schedules, such as the Medicare Mental Health Centres, have improved access to services in their local areas. The Agreement also enabled increased data sharing among government organisations. But there are still significant knowledge gaps about Australia's mental health and the performance of mental health and suicide prevention services. This is despite the substantial volumes of information services need to report to governments to receive funding.

Most outputs have not led to better outcomes nor had a significant effect on policy or planning. For example:

- the analysis of psychosocial support services outside the National Disability Insurance Scheme (NDIS) was done at a high level and does not provide guidance on regional access gaps
- the National Mental Health Workforce Strategy does not contain any ongoing funding commitments or clear accountability structures
- the National Mental Health and Suicide Prevention Evaluation Framework was released in early 2025, and it is too early to tell if it is being used.

Critical outputs remain incomplete and should be addressed within the term of the current Agreement.

Figure 2 – The need for mental health and suicide prevention services remains high



Urgent actions are needed before the Agreement expires

Develop arrangements for psychosocial supports outside the NDIS

In the Agreement, governments agreed to work together to develop arrangements for psychosocial supports for people who do not qualify for the NDIS. This is yet to occur. Governments should use the time remaining in the Agreement to develop solutions for this significant service gap.

Psychosocial supports are non-clinical services for people experiencing mental ill health, enabling them to live independently and safely in the community. Examples include help finding and connecting with services, socialising and maintaining relationships and building daily living skills.

People with psychosocial disability who qualify for the NDIS can access psychosocial supports, but they represent only a small proportion of the people who need these services. An estimated 500,000 people with severe and moderate mental illness are not eligible for the NDIS and had no access to psychosocial supports in 2022-23, according to analysis commissioned under the Agreement.

While the next agreement is being negotiated, state and territory governments should immediately prioritise commissioning services to address identified unmet need. PHNs currently commission psychosocial supports and have experience and existing relationships; they are well placed to work with state and territory governments and providers to support this expansion. Analysis commissioned under the Agreement to estimate the need for psychosocial supports, as well as evaluations of past programs, can offer useful information on efficient service delivery models.

The next agreement should:

- confirm the state and territory governments are responsible for commissioning psychosocial supports outside the NDIS
- confirm the Australian, state and territory governments are jointly responsible for funding these supports and the proportion of funding each will contribute
- include a detailed plan and timeline for the expansion of services, with the aim of fully addressing the unmet need by 2030.

Release the National Stigma and Discrimination Reduction Strategy

Stigma and discrimination limit people's ability to seek support, as well as participate in employment, education and other social and community activities. They create a barrier to person-centred services and continue to have a devastating effect on people with lived and living experience of mental ill health and suicide. This was reflected in the responses to the PC survey (box 1).

The National Stigma and Discrimination Reduction Strategy was developed but never publicly released. In the Agreement, governments committed to the 'consideration and implementation of relevant actions' from the Strategy. While jurisdictions have undertaken initiatives in this space, there is still a need for nationally consistent policy based on a common strategy. As a priority, the Strategy should be made public, alongside specific implementation plans to be included in the next agreement.

Revise and publish guidelines on regional planning and commissioning

Despite commitments in the Agreement, governments have not developed comprehensive national guidelines on regional planning and commissioning. Instead, they have created a set of high level, flexible principles. However, the absence of detailed guidelines makes it harder to address the inconsistencies and inefficiencies in the way PHNs commission mental health and suicide prevention services and work with state and -territory funded- services. This negatively affects the availability of mental health and suicide prevention services and consumer experiences of care.

The Australian Government should revise the current set of principles and develop comprehensive national guidelines to meet the needs of PHNs and LHNs. It should also take additional steps to support PHNs and LHNs in establishing good practice in joint regional mental health and suicide prevention planning. Streamlined procurement and reporting practices can further improve the efficiency of PHNs and LHNs' commissioning.

Reinvigorate the National Mental Health Commission

The NMHC was established to 'provide independent policy advice and evidence on ways to improve Australia's mental health and suicide prevention system'. It was responsible for monitoring progress under the national mental health plans preceding the Agreement and developed a range of national policy documents. Following a review of its culture, capability and efficiency, the NMHC has been operating as a

non-statutory office within the Department of Health, Disability and Ageing and reporting to the Minister since September 2024. In the 2024-25 Budget, the Australian Government announced its intention to 'reset and strengthen' the NMHC.

As a priority, the Australian Government should finalise this process and establish the NMHC and NSPO as a single statutory office, which would reinforce their independence. The NMHC and NSPO should have the necessary resources and legal powers to fulfil their role in keeping governments accountable for progress in mental health and suicide prevention reform.

A new agreement can improve consumer outcomes

As it stands, the Agreement is not an effective tool to achieve cross-government collaboration necessary for mental health and suicide prevention reform. Therefore, a reasonable question is whether the Agreement should be renewed or replaced with a different policy tool.

Incorporating mental health and suicide prevention as a schedule in the National Health Reform Agreement or returning to national plans is unlikely to create the necessary authorising environment for reform. A well-designed, dedicated national agreement for mental health and suicide prevention can resolve outstanding policy gaps and clarify the roles and responsibilities of each level of government in progressing reform. It can build momentum for change and create a policy framework, including dedicated funding, for collaboration and joint commissioning of services.

To achieve this, the next agreement should clearly outline how systems will work together to achieve outcomes and create accountability mechanisms that spur governments to take meaningful action.

Advancing large-scale reform requires an authorising environment that enables collaboration across portfolios and jurisdictions. National Cabinet can create such an environment by recognising mental health and suicide prevention as a national priority. This would create policy momentum and the whole-of-government focus necessary to achieve reform in the mental health and suicide prevention system. First Ministers, alongside Health and Mental Health Ministers, should sign the next agreement and National Cabinet should receive annual updates on progress.

Governments should articulate long-term commitments for reform

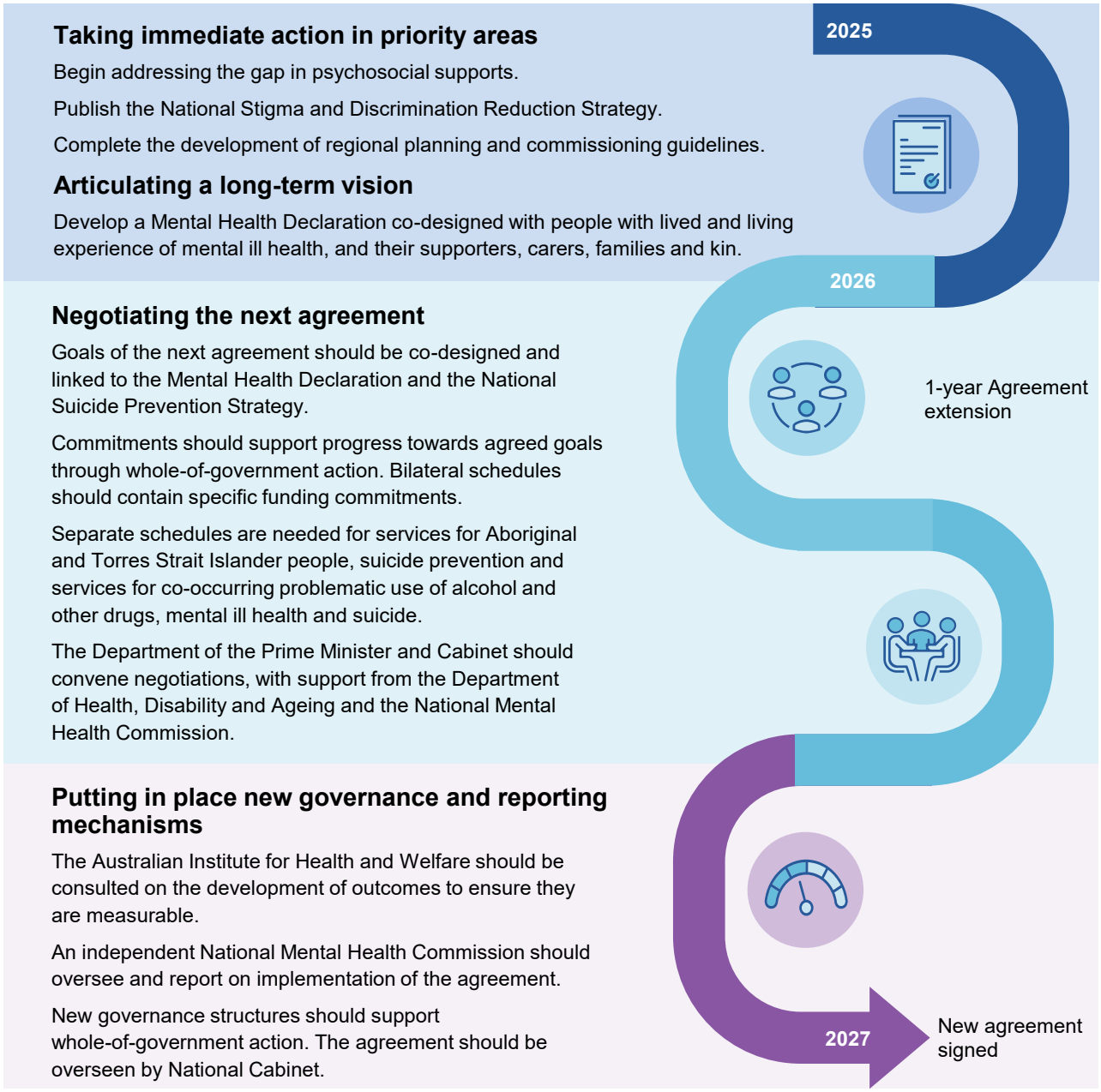
Successful reform in the mental health and suicide prevention system requires a long-term vision beyond the period of one agreement.

As a first step towards improving national policy, governments should articulate their vision and objectives for mental health reform through a joint declaration. The declaration should not be time limited, so it can offer a consistent, enduring and unifying vision for the mental health system for years to come.

The National Mental Health Policy, which was last renewed in 2008, offers a useful starting point for the development of a Mental Health Declaration. The Declaration should be co-designed with people with lived and living experience of mental ill health and suicide, their supporters, family, carers and kin, as well as service providers. It should leverage the substantial body of mental health policy work undertaken by governments and peak bodies over many years. This can significantly shorten the time frames required to agree on the Declaration's content. Similar to the National Suicide Prevention Strategy, the Mental Health Declaration should be endorsed by all states and territories as well as all relevant Australian Government portfolios to enable governments to take joint action.

The Mental Health Declaration, in conjunction with the National Suicide Prevention Strategy, should underpin the next agreement (figure 3). It should articulate the steps governments will take and their contribution towards achieving the objectives of the Declaration and Strategy over the term of the agreement, clearly linking objectives, actions and outcomes.

Figure 3 – A roadmap to national reform in mental health and suicide prevention



Negotiations for the next agreement should commence as soon as the long-term goals for mental health reform are agreed. Given the Department of the Prime Minister and Cabinet's (PM&C) role to coordinate government activities, it should convene negotiations, with support from the Department of Health, Disability and Ageing and the National Mental Health Commission. The Australian Institute of Health and Welfare (AIHW) should have a role in developing a measurement framework for the outcomes of the agreement

(discussed below). The Australian Centre for Evaluation could contribute its expertise on developing coherent, evidence-based policy structures as well as evaluation processes.

At the completion of the final report of this review, less than a year remains until a new agreement needs to be signed. Given the complexity of negotiations and the need for genuine engagement with people with lived and living experience, it is unlikely this timeframe will be sufficient to design an effective Declaration and agreement. The current Agreement, including funding for specific services, should be extended for one year, to enable the negotiation process to run its course.

The next agreement should contain separate schedules (discussed below) on specific policy areas requiring dedicated attention, including services for Aboriginal and Torres Strait Islander people; services for people experiencing co-occurring problematic use of alcohol and other drugs (AOD), mental ill health and/or suicidal distress; and suicide prevention.

Making progress towards genuine co-design

Genuine co-design can lead to better outcomes through the development of inclusive policies and services better suited to the needs and preferences of consumers. It can also reduce stigma and discrimination. Successful co-design needs time and resourcing to enable people with lived and living experience to take part. It requires governments to genuinely share decision making with the community – a significant cultural shift. Review participants were critical of the lack of genuine co-design under the current Agreement, which creates the risk of tokenistic processes undermining community confidence.

The co-design process that should underpin the Mental Health Declaration and the next agreement should avoid the pitfalls of the current approach. There should be balanced representation of people with lived and living experience of mental ill health and suicide, alongside supporters, family, carers and kin. Peak bodies should be sufficiently resourced to take an active role in the process. Through the implementation of the next agreement, governments should realise their commitment to embed the voices of people with lived and living experience and supporters, family, carers and kin across the system. In the survey conducted by the PC, consumers, carers and service providers made valuable suggestions for ways to improve services (box 2).

Box 2 – 'Working together for best outcomes is what works': ideas from consumers, carers and practitioners for a better mental health and suicide prevention system

In the online survey, the PC also asked people for ideas on how to improve the mental health and suicide prevention system, to inform the recommendations in this report. Suggestions included:

- respectful and person-centred engagement with service providers that recognises the agency of consumers and enables them to take an active part in their recovery
- greater involvement of people with lived and living experience and peer workers
- creating more safe spaces for people experiencing crisis or suicidal distress
- focusing on prevention of factors contributing to crisis, such as unstable employment and housing
- providing better information for consumers and support with system navigation.

Carers emphasised the need for more dedicated supports as well as greater recognition of their role in the treatment of the people they care for. Service providers called for sustained funding and greater investment in the workforce, including the peer workforce.

Box 2 – 'Working together for best outcomes is what works': ideas from consumers, carers and practitioners for a better mental health and suicide prevention system

> Services needed to be expanded include: respite care, post-suicide follow-up (to prevent cycle of many attempts), better education of emergency staff of various conditions and how to best treat them, more clinical psychologists & psychiatrists, more access to psychology under Medicare
>
> **Carer**

> All services both government and non government, private and public, charities and places of education should have the ability to have a clear defined path of referral in times of crisis and emergency other than the E.D.
>
> **Consumer**

> We need more buy-in from the government as to the value and importance of the peer-led workforce
>
> **Practitioner**

> You need some sort of advocacy support out here. Like a support coordinator for folks who are really struggling just to eat or whatever let alone figure out which hoops to jump through and actually do it. I needed my hand held
>
> **Consumer**

> We need more non clinical peer led services and peer support. Peer support saved my life
>
> **Consumer**

> I think the service system continues to be far too fragmented and way too reliant on clinical services. The only way I see this changing is by communities being given more say over how supports are delivered locally
>
> **Consumer**

> More funding, long term commitment so these services are sustainable and can provide long term support
>
> **Practitioner**

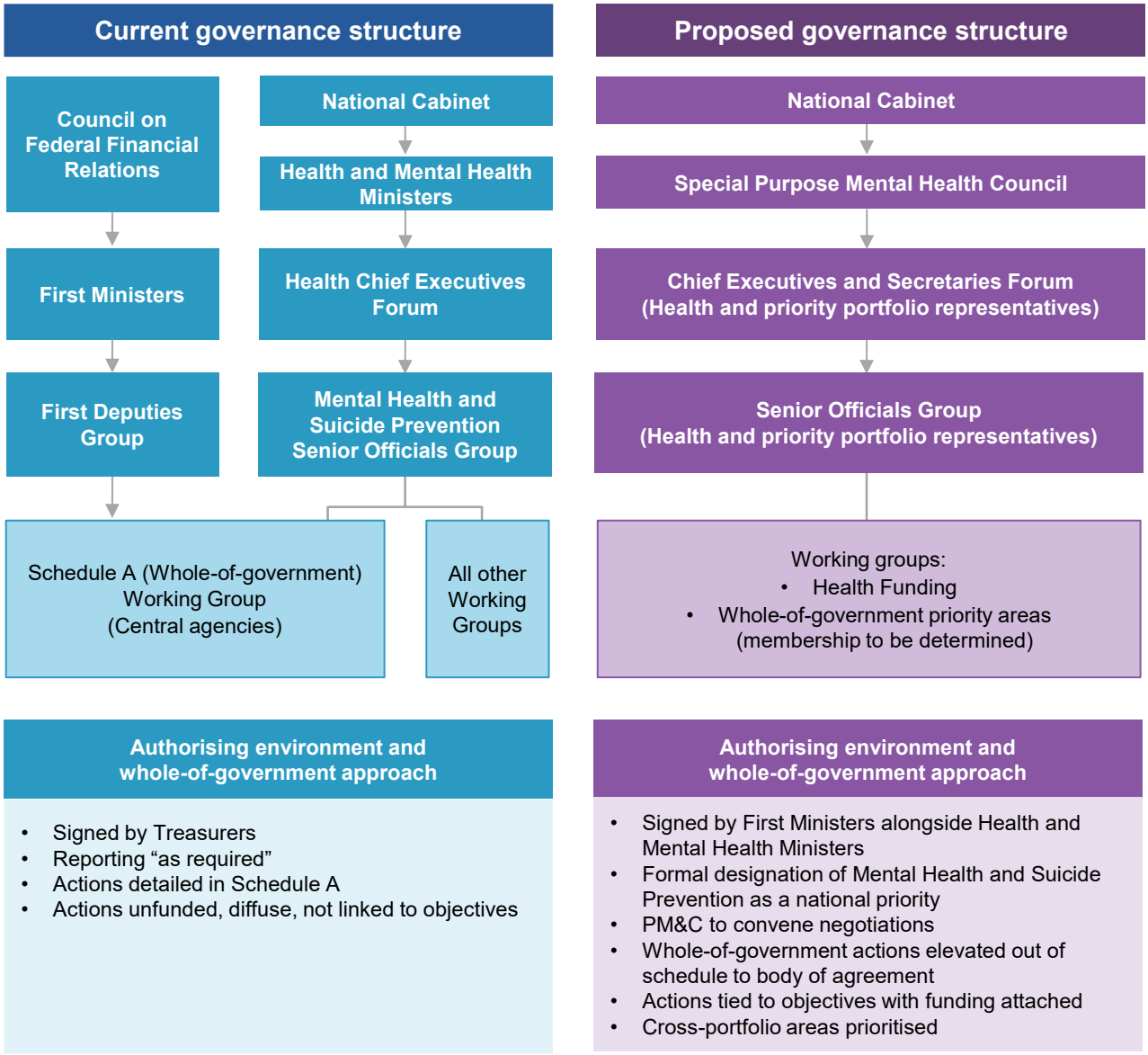
> Let's make more services available for young people before their mental health concerns develop further, and remove the road blocks of having to have a relationship with a GP, and gaining a mental health plan
>
> **Carer**

More effective governance and accountability structures to support whole-of-government action

National Cabinet and the Council on Federal Financial Relations are a part of the current Agreement's governance, but their role has been largely symbolic and progress towards whole-of-government reform has been minimal. The next agreement should retain the emphasis on a whole-of-government integration but with a sharper focus.

A whole-of-government approach needs to flow through all levels of governance (figure 4). National Cabinet should establish a Special Purpose Mental Health Council (SPMHC). This Council should include Australian, state and territory government Health and Mental Health Ministers and Ministers from the portfolios selected as priority whole-of-government reform areas in the next agreement. All relevant portfolios should be represented in senior officials' forums and the working groups that will be responsible for the implementation of specific policies, alongside people with lived and living experience. Carers and service providers should also play a role in the agreement's governance.

Figure 4 – Restructuring governance arrangements in the next agreement



Greater clarity around roles and responsibilities will make the next agreement more effective. For example, the National Mental Health Workforce Strategy was completed under the current Agreement. The next agreement needs to designate roles and responsibilities, including specific funding commitments, for the implementation of actions included in the Strategy.

The greatest areas of focus for governance in the next agreement – and the issues raised most often in consultation for this review – should be stronger accountability and greater transparency.

Several improvements to reporting mechanisms are necessary. As a first step, the NMHC should be established as an independent statutory body, empowered to compel information from jurisdictions and assess progress in annual reports without requiring sign off from jurisdictions. Jurisdictional progress reports, as well as the implementation plans accompanying the next agreement, should be made public.

The next agreement should formalise the role of the NMHC as the entity responsible for ongoing monitoring, reporting and independent assessment of progress against the agreement's outcomes. The NSPO should lead monitoring and reporting on progress against the suicide prevention schedule and contribute to oversight of the next agreement where it is most relevant to suicide prevention.

The focus of reporting and data collection should go beyond fulfilling government requirements, to better meeting the needs of local decision makers, service providers and consumers. Accountability relies on timely and relevant data, which can help consumers to make informed choices and providers to plan better services.

The outcomes the next agreement works towards should be clear and measurable, so progress can be readily tracked. The AIHW, as the custodian of national mental health and suicide prevention data sets, should provide input on how mental health outcomes could be measured using currently available data, as well as continuing to pursue improvements to data collections. Suicide prevention outcomes should align with the National Suicide Prevention Outcomes Framework.

The next agreement can lay the foundations for an outcomes-based approach to funding mental health and suicide prevention services. National agreements based only on delivering specific outputs, without any real focus on outcomes in the community, do little to achieve systemic reform.

New funding arrangements to ensure services respond to community needs

A key objective of the agreement is to address the gaps in the mental health and suicide prevention system, by enabling the provision of services tailored to local need. The agreement is not the only stream of government funding aiming to achieve this. The Australian, state and territory governments each fund community-based mental health and suicide prevention services employing non-clinical staff, including peer workers. These funding streams are opaque and there is limited reporting on objectives and outcomes.

In the next agreement, governments should bring together these funding streams to create a new flexible funding pool. The size of this funding pool would likely be close to $1 billion a year given previous spending amounts in the Agreement, the Australian Government mental health and suicide prevention funding of PHNs and state and territory community-based mental health funding. PHNs and LHNs undertaking joint needs assessments and planning would be able to apply for funding from this pool to implement collaborative community-based mental health and suicide prevention initiatives responding to the needs of their local communities.

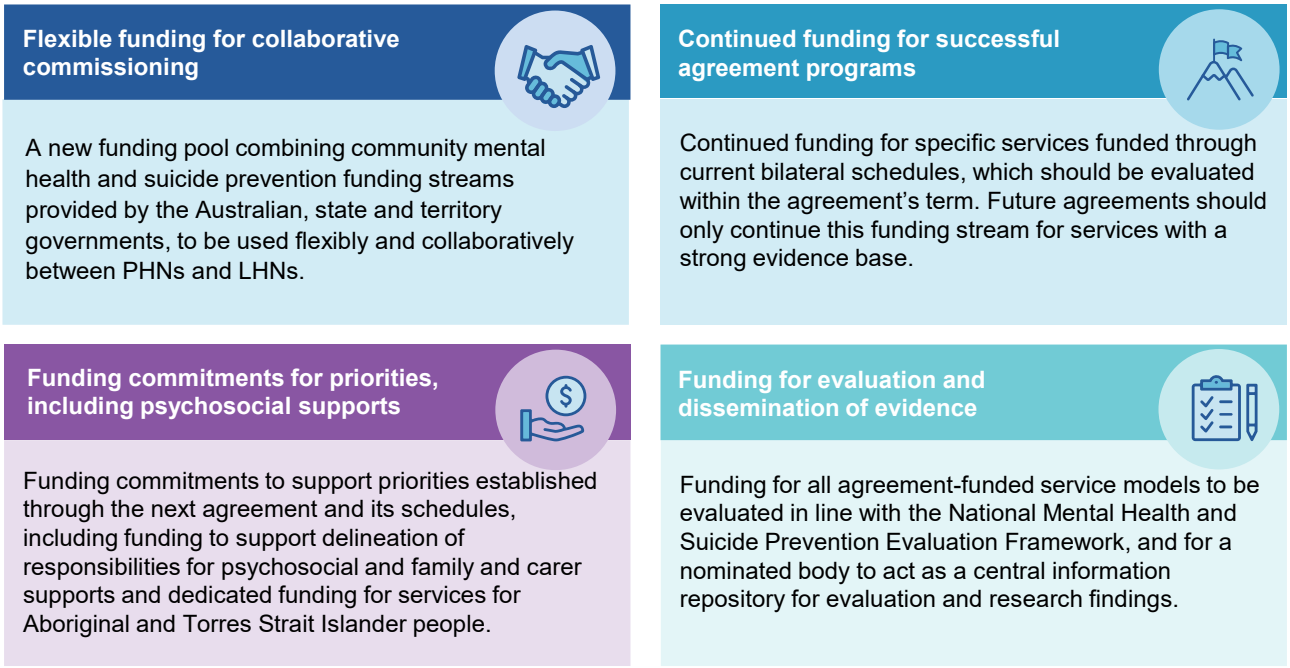
In addition to this flexible funding pool, the next agreement should also include:

- ongoing funding for services commissioned under the current Agreement, where sufficient evidence indicates their effectiveness

- new funding arrangements for commitments in the current Agreement not previously funded, such as psychosocial supports for people who are not eligible for the NDIS
- dedicated funding to ensure all service models commissioned under the agreement are evaluated, and lessons are shared across the system (figure 5).

These funding streams and guiding principles for how they are intended to operate should be established in the core of the next agreement, with detailed funding amounts and local priorities in bilateral schedules.

Figure 5 – The next agreement should include four funding streams



A new schedule to strengthen Aboriginal and Torres Strait Islander social and emotional wellbeing

Improving the services supporting the social and emotional wellbeing (SEWB) of Aboriginal and Torres Strait Islander people requires consideration of their distinct experiences and understanding of SEWB. The current Agreement mentions Aboriginal and Torres Strait Islander people and the National Agreement on Closing the Gap but does not include any specific actions to support them.

The next agreement should include a separate schedule to recognise the factors affecting the SEWB of Aboriginal and Torres Strait Islander people, the contributions of Aboriginal and Torres Strait Islander Community Controlled Health Organisations and the Aboriginal and Torres Strait Islander SEWB workforce, and the need to promote cultural safety in all services. Similar schedules are being developed in other agreements; a First Nations Schedule to the National Health Reform Agreement is under negotiation. The new schedule should be developed through a co-design process, so it addresses the priorities of the community. This reflects the Closing the Gap Priority Reforms (PRs) to build formal partnerships and shared decision making (PR1) and transform government organisations (PR3).

The Social and Emotional Wellbeing Policy Partnership, established under the National Agreement on Closing the Gap, should be designated as the governance mechanism responsible for the schedule. The next agreement should give the policy partnership decision-making power and authority over issues relating

to Aboriginal and Torres Strait Islander SEWB, as well as funding to invest in areas supporting better services, such as the Aboriginal and Torres Strait Islander SEWB workforce.

The schedule should better articulate the agreement's links with the National Agreement on Closing the Gap, and other important documents such as the Gayaa Dhuwi (Proud Spirit) Declaration and the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy. Currently these links are unclear and there is no meaningful direction on how the Agreement can work within the broader policy space to improve outcomes for Aboriginal and Torres Strait Islander people.

The schedule should include dedicated outcome measures co-designed with Aboriginal and Torres Strait Islander people. A community-led evaluation of the schedule at the conclusion of the next agreement would offer important insights for future investment.

A new schedule on suicide prevention to support action under the new National Suicide Prevention Strategy

Many of the factors affecting mental ill health and suicide can be similar, such as trauma and disadvantage. But there are also issues unique to suicide prevention policy, such as the availability of supports for people following a suicide attempt. Suicide prevention services are embedded in the Agreement without due consideration for the aspects setting them apart from mental health services.

The next agreement should include a separate schedule on suicide prevention to enable whole-of-government collaboration focusing on the distinct factors affecting suicide, suicidal distress and self-harm. The schedule should be guided by the National Suicide Prevention Strategy as governments' long-term strategy in suicide prevention.

The Strategy includes a broad list of recommended actions linked to achieving its objectives. In conjunction with people with lived and living experience, supporters, family, carers and kin and relevant peak bodies, governments should select an achievable set of shorter-term objectives and actions from the Strategy for the next agreement. These should form the basis of the schedule, which should include actions that can be completed over the life of the agreement or lay the foundation for long-term reform.

The NSPO should be responsible for monitoring and reporting on the schedule's outcomes, as part of the NMHC annual reporting processes. The outcomes specified in the schedule should align with the National Suicide Prevention Outcomes Framework, which is being developed by the NSPO. The NSPO should be adequately resourced to perform this ongoing monitoring and reporting role on top of their existing work.

A new schedule addressing the co-occurrence of problematic use of alcohol and other drugs, mental ill health and suicidal distress

People experiencing harmful use of alcohol and other drugs (AOD) are one of the priority populations in the current Agreement. But as is the case with other such groups, the Agreement does not include any tangible actions or funding to tackle the challenges they face.

Among service providers, it is often the expectation – not the exception – that people experiencing problematic AOD use will also experience co-occurring mental ill health and/or suicidal distress. However, many people experiencing these co-occurring issues are turned away from treatment; they are unable to

access mental health support until their problematic AOD use is resolved, or unable to access AOD services until their mental ill health or suicidal distress is addressed.

Access barriers stem from the separate administration of these specialist systems and siloed government policies varying across jurisdictions. Since 2020, there has been no national AOD governance to coordinate intergovernmental and cross-sector policy.

The next agreement presents an opportunity to address the intersection of problematic AOD use, mental ill health and suicidal distress. This can be best achieved by including a separate schedule in the next agreement. The schedule should be co-designed with input from people with lived and living experience, their supporters, family, carers and kin, and service providers. Meaningful representation and involvement from consumers and service providers will be key to strong and effective governance of the AOD schedule.

The schedule should:

- set out objectives and actions to improve outcomes for people experiencing co-occurring problematic AOD use, mental ill health and/or suicidal distress, and specify the roles and responsibilities of governments in achieving them
- strengthen coordination and collaboration between the separate but overlapping AOD, mental health and suicide prevention systems
- include new funding to enhance the capacity of the AOD, mental health and suicide prevention workforces to support people experiencing co-occurrence
- introduce clear governance, monitoring and reporting mechanisms, to ensure accountability for actions. Governance arrangements for the schedule should focus on the points of intersection between AOD and mental health and suicide prevention but should align with broader AOD system governance.

A new schedule for co-occurring problematic AOD use, mental ill health and/or suicidal distress should be distinct but closely aligned with broader policy developments in the AOD sector. This includes the review of the Drug and Alcohol Program, which provides most AOD national funding; the expiry of the National Drug Strategy in 2026; and a parliamentary inquiry into the health impacts of AOD. The schedule should avoid adding further complexity and duplication to AOD funding, governance and strategy. Some flexibility in timing and sequencing of development and implementation of the AOD schedule may be appropriate, to allow for issues in the broader AOD system to be resolved.

Besides problematic AOD use, people with lived and living experience of mental ill health and suicide may experience other co-occurring problems, such as physical health conditions and housing insecurity. The process for developing the schedule for co-occurring problematic AOD use, mental ill health and suicidal distress can offer a blueprint for developing schedules in other areas in the future.

Recommendations and findings

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. However, these actions have not led to meaningful improvements across the system for people with lived and living experience of mental ill health and suicide. Some key commitments need urgent action. 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 detailed national guidelines on regional planning and commissioning
- 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.

Recommendation 2.1
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 Child and Adolescent Mental Health and Wellbeing Study, running the surveys at least every five years.

Recommendation 2.2
Governments should immediately address the unmet need for psychosocial supports outside the National Disability Insurance Scheme

State and territory governments, in consultation with primary health networks and the Australian Government, should immediately prioritise commissioning services to address the unmet need for psychosocial supports outside the National Disability Insurance Scheme.

The Psychosocial Project Group, established under the National Mental Health and Suicide Prevention Agreement, should collate and publish data on unmet need and actions taken to address it. The Group should provide progress updates to the Health Ministers Meeting every six months, until the next agreement is signed.

Recommendation 2.3
Deliver key documents as a priority

Before the National Mental Health and Suicide Prevention Agreement expires in June 2026, 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.

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.

Some aspects of the Agreement are commendable, including its ambition and commitments to improve services and address gaps in several important areas. However, a range of problems are limiting its effectiveness.

- People with lived and living experience of mental ill health and suicide, and their supporters, family, 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 Agreement does not set out clear and focused objectives and outcomes, and actions connected to their achievement.
- Roles and responsibilities are unclear.
- The governance structures are not effective, and monitoring and accountability are lacking.
- The Agreement does not address key barriers to reform, including system fragmentation, insufficient collaboration, problems with data use and sharing, a lack of flexibility in funding arrangements and workforce shortages.

Recommendation 4.1
Governments should endorse a Mental Health Declaration that outlines long-term reform goals

An overarching vision is needed for long-term reform in the mental health system.

The National Mental Health Commission should oversee the renewal of the National Mental Health Policy 2008 through a co-design process with people with lived and living experience of mental ill health, their supporters, family, carers and kin, the mental health sector and the Australian, state and territory governments.

The document should be positioned as an enduring Mental Health Declaration, endorsed by all jurisdictions. The Declaration should be refreshed every 10 years to remain up to date.

The next agreement should align with the long-term objectives articulated in the Declaration and the National Suicide Prevention Strategy.

Recommendation 4.2
A new and more effective agreement is needed

A national agreement can be an effective mechanism to facilitate joint actions by governments towards reform in the mental health and suicide prevention system. To achieve this, the Australian, state and territory governments should ensure the next agreement includes:

- clear objectives that align with the long-term visions set out in the National Suicide Prevention Strategy and the Mental Health Declaration (recommendation 4.1)
- specific and measurable outcomes that focus on what is achievable within the scope of a five-year agreement
- commitments that will contribute directly to achieving the objectives and outcomes of the agreement.

Commitments and actions intended to improve collaboration across government portfolios should be included in the main body of the agreement rather than a separate schedule.

Recommendation 4.3
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 the Mental Health Declaration (recommendation 4.1).

This extension should not delay progress on immediate policy priorities, such as addressing the unmet need for psychosocial supports (recommendation 2.2).

To support the next agreement:

- the National Mental Health Commission should run a co-design process with people with lived and living experience of mental ill health and suicide, and their supporters, family, carers and kin to identify relevant and measurable mental health and suicide prevention objectives and outcomes for the next agreement

Recommendation 4.3
Building the foundations for a successful agreement

- the Department of the Prime Minister and Cabinet should convene negotiations with the support of the Department of Health, Disability and Ageing and the National Mental Health Commission, and facilitate engagement between the Australian, state and territory governments on their shared priorities
- 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 six months of the agreement being signed.

The agreement should be signed by First Ministers and Health and Mental Health Ministers to signal the importance of a whole-of-government approach to mental health and suicide prevention.

Recommendation 4.4
The next agreement should clarify responsibility, funding and planning for psychosocial supports

The Australian, state and territory governments should formalise responsibilities for funding and delivery of psychosocial supports outside the National Disability Insurance Scheme (NDIS). The next agreement should:

- confirm the state and territory governments are responsible for commissioning psychosocial supports outside the NDIS
- confirm the Australian, state and territory governments are jointly responsible for funding these supports and the proportion of funding each will contribute (recommendation 6.1)
- include a detailed plan and timeline for the expansion of services, with the aim of fully addressing the unmet need by 2030. The National Mental Health Commission should monitor and report on the implementation of the plan, as part of its accountability role in the next agreement (recommendation 5.6).

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 support services for carers and families of people with lived and living experience of mental ill health and suicide.

Recommendation 4.6
The next agreement should support the implementation of the National Mental Health Workforce Strategy and forthcoming National Suicide Prevention Workforce Strategy

The next agreement should support the implementation of the National Mental Health Workforce Strategy and forthcoming National Suicide Prevention Workforce Strategy. The next agreement should include:

- clear prioritisation, timelines and accountability mechanisms for recommended actions in the Strategies
- an explicit delineation of responsibility and funding for workforce development initiatives.

Governments must also take immediate action on initial priorities under the National Mental Health Workforce Strategy to address pressing workforce issues and relieve acute workforce shortages, prior to the next agreement.

Recommendation 4.7
The next agreement should support the development of a nationally consistent scope of practice for the peer workforce

The next agreement should task the proposed national professional association for peer workers with developing a nationally consistent scope of practice for the peer workforce. The scope of practice should:

- promote safer work practices for peer workers
- contribute to better outcomes for people accessing mental health and suicide prevention peer support
- improve understanding of the profession within the mental health and suicide prevention system and the community.

Recommendation 5.1
Setting cross-portfolio priorities and ensuring cross-portfolio actions are tangible

To ensure cross-portfolio actions are tangible, the next agreement should:

- articulate the social determinants underpinning the need for cross-portfolio collaboration
- present a clear vision of the collective purpose of cross-portfolio actions
- include actions with a clear evidence base, explicitly linking to the improvement of outcomes
- ensure dedicated funding for cross-portfolio actions
- determine relevant actions in collaboration with people with lived and living experience of mental ill health and suicide using evidence and recommendations from recent government inquiries or reviews where appropriate
- prioritise prevention and early intervention.

The next agreement should focus on one or two cross-portfolio priority areas over the five-year period, with the aim of implementing actions to improve how consumers navigate services provided across those portfolios.

Priorities should be in line with the Mental Health Declaration (recommendation 4.1) and determined in conjunction with people with lived and living experience of mental ill health and suicide, and their supporters, family, carers and kin.

Recommendation 5.2
Setting mental health and suicide prevention as a national priority and reorienting agreement governance to support cross-portfolio collaboration

National Cabinet should formally recognise mental health and suicide prevention as a national priority, to motivate the collaborative reform efforts of governments. National Cabinet should have oversight of the next national mental health and suicide prevention agreement and receive annual updates on implementation progress from a new Special Purpose Mental Health Council (SPMHC).

To embed a whole-of-government approach, governance structures for the next agreement should be reoriented to emphasise cross-portfolio collaboration.

- National Cabinet should establish the SPMHC and delegate ministerial oversight of the agreement to it. The SPMHC should comprise Health and Mental Health Ministers and Ministers from priority cross-portfolios.
- A Chief Executive and Secretaries Forum comprising health chief executives and secretaries from relevant cross-portfolios should be established.
- The Mental Health and Suicide Prevention Senior Officials Group (MHSPSO) should remain in place, but membership should be expanded to include senior officials from relevant portfolios. MHSPSO should establish working groups to be directly responsible for the implementation of whole-of-government actions. These groups should comprise members with substantive policy expertise across health and relevant cross-portfolios. Adequate funding should be provided for a coordinated secretariat function and collaboration activities for these working groups.

Recommendation 5.3
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 of mental ill health and suicide in the governance of the next agreement by embedding a governance framework centring people with lived and living experience.

This framework should formalise greater opportunities for representatives with lived and living experience to communicate with the agreement's working groups and the Mental Health and Suicide Prevention Senior Officials Group. The use of confidentiality agreements with lived and living experience representatives should be limited in the governance structures of the next agreement.

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. These bodies should be adequately resourced to fulfill these roles.

Recommendation 5.3
The next agreement should support a greater role for people with lived and living experience in governance

The National Suicide Prevention Office should advise on how governance forums under the next agreement can most effectively incorporate the diverse perspectives of people with lived and living experience of suicide, beyond direct participation.

The successful inclusion of people with lived and living experience in the agreement's governance structures should be measured throughout the life of the agreement. Inclusion indicators should be co-designed with lived and living experience representatives, and results published as part of progress reporting.

Recommendation 5.4
A designated role for service providers in governance

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

Recommendation 5.5
Increase transparency and effectiveness of governance arrangements

The next agreement's governance framework should emphasise transparency and collaboration, and formalise accountability, reporting and evaluation functions.

The Australian Government should:

- 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.

Recommendation 5.6
Establish the National Mental Health Commission (NMHC) as an independent statutory body and strengthen the NMHC and National Suicide Prevention Office's reporting roles

The Australian Government should establish the National Mental Health Commission (NMHC) as an independent statutory authority.

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

The NMHC 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 monitoring and reporting on progress against the suicide prevention schedule (recommendation 8.1).

Recommendation 5.7
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 (NMHC) should be empowered to assess and report on progress independently, using information beyond what is reported by governments. The NMHC should publish national progress reports as they are finalised, without requirements for jurisdictions' sign-off.

Recommendation 5.8
Improving accountability through regional reporting

The next agreement should strengthen regional accountability by requiring primary health networks (PHNs) to publish annual regional reports on progress against the objectives of the agreement.

These reports should be based on information already collected by PHNs through existing processes, such as their needs assessments and regional plans. At a minimum, these reports should cover the local context, services commissioned, service utilisation and consumer experiences.

The Australian Government Department of Health, Disability and Ageing should enable this reporting by providing a common reporting template and addressing barriers to reporting, such as data sharing.

PHNs should be appropriately resourced to undertake this role.

Finding 5.1
Accessibility of reporting for the next agreement can be improved through strengthening existing reporting channels

Accessibility of reporting is critical for transparency, accountability and community engagement.

- A new data dashboard would not be a cost-effective way to improve accessibility, as it risks duplicating existing reporting, confusing users, and imposing unnecessary costs for limited benefit.
- Accessibility can be better improved by strengthening the consumer focus of existing reporting products, such as through plain-language summaries of annual reports, an annual webinar, or targeted publications for specific audiences.

Recommendation 6.1
The next agreement should include four streams of funding

The funding included in the next agreement should be used to enable progress towards an integrated, person-centred mental health and suicide prevention system. The next agreement should include:

- a combined pool of funding comprising current flexible community mental health and suicide prevention funding streams at the Australian, state and territory government levels. This pool should be used to support collaborative commissioning in accordance with joint regional needs assessments and plans
- continued programmatic funding for initiatives delivered under the current National Mental Health and Suicide Prevention Agreement that have a strong evidence base
- funding commitments to support priorities established through the current Agreement, including psychosocial and carer and family supports (recommendations 4.4 and 4.5)
- funding for evaluations of all service models funded under the agreement conducted in line with the National Mental Health and Suicide Prevention Evaluation Framework and associated guidelines.

To inform programmatic funding decisions in future agreements, the Australian Government Department of Health, Disability and Ageing should initiate an independent evaluation of the Medicare Mental Health Centre and Satellite Network model within the first two years of the next agreement.

Governments should nominate and fund a central body to collate and share evaluation and research findings across governments, the sector and the community to support an uplift in the provision of evidence-based care.

Recommendation 6.2
The next agreement should support effective and collaborative commissioning

The next agreement should play a role in effective and collaborative commissioning by primary health networks (PHNs) and local hospital networks (LHNs). The agreement should:

- clarify the roles and responsibilities of PHNs, LHNs and Aboriginal and Torres Strait Islander Community Controlled Health Organisations in achieving their shared objectives and integrating services. This should be done in alignment with the local governance schedule of the National Health Reform Agreement
- clarify the role of joint regional mental health and suicide prevention plans by PHNs and LHNs in establishing a shared local understanding of needs and priorities and detailing ways to jointly address them.

These efforts should be supported by the public release of detailed national guidelines on regional planning and commissioning by the Australian Government (recommendation 2.3).

Recommendation 6.3
Governments should provide practical supports for collaborative commissioning

Primary health networks (PHNs) and local hospital networks (LHNs) need the right guidance, tools and enablers to commission mental health and suicide prevention services effectively and collaboratively. The next agreement should commit governments to:

- produce national guidelines for PHNs for the procurement of mental health and suicide prevention services
- use the National Mental Health Service Planning Framework and forthcoming suicide prevention planning model in regional planning processes
- streamline reporting and data collection requirements for PHNs and LHNs, particularly when undertaking collaborative commissioning
- enable data sharing with and between PHNs and LHNs.

To maintain the relevance of the National Mental Health Service Planning Framework (NMHSPF), the Australian Institute of Health and Welfare should be tasked with consulting with people with lived and living experience of mental ill health in the next review of the NMHSPF and identifying ways to expand non-clinical applications of the framework.

Finding 7.1
Limited improvements in Aboriginal and Torres Strait Islander social and emotional wellbeing over the course of the Agreement

There is no comprehensive data to assess the contribution of the National Mental Health and Suicide Prevention Agreement to Aboriginal and Torres Strait Islander social and emotional wellbeing. The data available shows one in three Aboriginal and Torres Strait Islander people experience high psychological distress and suicide rates are worsening.

While the Agreement is intended to align with the National Agreement on Closing the Gap and improve social and emotional wellbeing outcomes for Aboriginal and Torres Strait Islander people, limited progress has been made in system reform. There is insufficient transparency and clarity in the Agreement about actions, progress, monitoring, reporting and governance.

Recommendation 7.1
An Aboriginal and Torres Strait Islander schedule in the next agreement

The next agreement should include a separate schedule on Aboriginal and Torres Strait Islander social and emotional wellbeing. This schedule should be co-designed with Aboriginal and Torres Strait Islander people.

The schedule should:

- align with the National Agreement on Closing the Gap and other relevant documents and include tangible actions, with commensurate funding, to improve the social and emotional wellbeing of Aboriginal and Torres Strait Islander people, including better mental health and suicide prevention outcomes
- clarify governance for its design and implementation, including 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 relating to Aboriginal and Torres Strait Islander social and emotional wellbeing
- include funding for any social and emotional wellbeing initiatives included in the schedule and the broader agreement, as well as resourcing for the Social and Emotional Wellbeing Policy Partnership to govern the agreement
- measure and report progress in a strengths-based way, with community-led evaluation
- articulate and embed priorities highlighted by community such as cultural safety in all services, greater investment in the community-controlled sector and the Aboriginal and Torres Strait Islander social and emotional wellbeing workforce, and reduced funding fragmentation.

Finding 8.1
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.

Finding 8.2
The Agreement's approach to suicide prevention lacks clarity

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

- The Agreement does not articulate 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.

Recommendation 8.1
Suicide prevention as a schedule to the next agreement

The next agreement should include a separate schedule on suicide prevention. This schedule should be co-designed with people with lived and living experience of suicide, their supporters, family, carers and kin and relevant peak bodies.

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 objectives 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
- contain funding for all suicide prevention services that are distinct from mental health
- include indicators, measures and outcomes for monitoring and reporting that align with the forthcoming National Suicide Prevention Outcomes Framework
- require the National Suicide Prevention Office to be responsible for the monitoring and reporting of the schedule.

The National Suicide Prevention Office should advise governments in the process of negotiating the schedule. It should be adequately resourced to perform its roles in the schedule.

Recommendation 9.1
A schedule to address the intersection of problematic use of alcohol and other drugs with mental ill health and suicidal distress in the next agreement

The next agreement should include a separate schedule on the intersection of alcohol and other drugs (AOD), mental ill health and suicidal distress. This schedule should be co-designed with people with lived and living experience of problematic AOD use, mental ill health and/or suicide.

The schedule should:

- set out objectives and actions to improve outcomes for people with co-occurring needs and specify the roles and responsibilities of governments in achieving these
- facilitate national planning and coordination across jurisdictions and service systems to increase the availability and accessibility of holistic treatment for people with co-occurring needs
- increase and streamline funding for development and implementation of evidence-based, best practice approaches to the treatment and prevention of co-occurring issues
- strengthen workforce capacity in the AOD, mental health and suicide prevention systems to enhance care and support for people with co-occurring needs
- have dedicated governance arrangements involving people with lived and living experience
- include indicators, measures and outcomes for monitoring and reporting
- contribute to implementing the National Stigma and Discrimination Reduction Strategy
- be developed within a flexible timeframe, allowing broader AOD system policy developments to progress in the areas of funding, strategy and governance.