Australian Government
Productivity Commission

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Mental Health and Suicide Prevention Agreement Review

Inquiry report

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.

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16 October 2025

The Hon Dr Jim Chalmers MP
Treasurer
Parliament House
CANBERRA ACT 2600

Dear Treasurer

In accordance with section 11 of the *Productivity Commission Act 1998*, we have pleasure in submitting to you the Commission's final report of the Mental Health and Suicide Prevention Agreement Review.

Yours sincerely

Selwyn Button
Commissioner

Angela Jackson
Commissioner

Terms of reference

I, Jim Chalmers, Treasurer, pursuant to parts 2 and 3 of the *Productivity Commission Act 1998*, hereby request that the Productivity Commission undertake an inquiry into the National Mental Health and Suicide Prevention Agreement.

Background

Mental health is a key component of overall health and wellbeing. In any year in Australia, an estimated 1 in 5 people aged 16–85 will experience a mental disorder, and reported mental wellbeing has declined over the past decade. Poor mental health has broader impacts, as it is associated with poorer social, physical health and economic outcomes for individuals, and can impact workforce participation and productivity. Strengthening the wellbeing and capabilities of Australians is key to underpinning continued growth in Australia's productivity and living standards.

Suicide remains one of the leading causes of death for Australians, with more than 3,000 people dying by suicide every year. Suicide prevention is complex; given the range of factors that can contribute to suicidal distress. In addition to efforts to strengthen the mental health system, effective suicide prevention requires targeted approaches to ensure a range of supports are available to individuals in need.

Australian Governments are making significant investments to improve Australians' mental health and prevent suicide. During 2021-22, national recurrent spending on mental health and suicide prevention related services was estimated to be almost $12.2 billion. Annual average spending has increased by 3% since 2017-18 in real terms, reflecting the priority placed by Australian Governments on investing in Australians' mental wellbeing. The National Mental Health and Suicide Prevention Agreement (National Agreement) sets out the shared intention of Commonwealth, state and territory governments to work in partnership. Australian governments are collaboratively seeking to improve the mental health and reduce the incidence of suicide of all Australians.

A central component of the National Agreement is a shared commitment to transform and improve Australia's mental health and suicide prevention system (Clause 20), including to provide an effective approach to the needs of people at risk of suicide (Clause 122). The Final Review of the National Agreement will assess the objectives, outcomes, and outputs of the National Agreement and its intent to strengthen the evidence base for policy development and identify opportunities for systemic reform. The Final Review will play a key role in identifying opportunities to improve the effectiveness of this significant investment in Australia's human capital.

While the National Agreement sets out the national objectives, outcomes, and outputs for mental health and suicide prevention, individual bilateral agreements (as schedules to the National Agreement) detail the jurisdiction-specific commitments, including funding, which have been adapted to local contexts (Clause 4 and 16). Therefore, the Final Review will assess existing commitments, including those outlined in Schedule A and the bilateral schedules, which support the broader goals of the National Agreement. The Final Review will also provide valuable insights to inform the design of any future arrangements beyond June 2026, ensuring continued progress in mental health and suicide prevention efforts.

The PC is focused on improving understanding of opportunities to improve Australia's national prosperity and economic progress more broadly. Through reporting functions such as the Report on Government Services and Closing the Gap reporting, the PC plays a central role promoting improvements in public service delivery across jurisdictions and over time. The PC's 2023 5-Year Productivity Inquiry also identified that the productivity of Australia's services sector, especially non-market services, will become increasingly important to Australia's productivity going forward. Reflecting this, the Commonwealth Government identified 'Delivering quality care more efficiently' to be one of five pillars of its Productivity Agenda. Commissioning the PC to complete the Final Review of the National Mental Health and Suicide Prevention Agreement is an acknowledgement of the central importance of mental health and suicide prevention to Australia's overall wellbeing and the opportunity for evidence-based policy to support quality and productivity improvements in service delivery.

Scope of the inquiry

The PC is to conduct the Final Review of the National Mental Health and Suicide Prevention Agreement.

In undertaking the review, the PC should holistically consider, assess and make recommendations on the effectiveness and operation of these programs and services in line with the National Agreement, including, but not limited to:

a. the impact of mental health and suicide prevention programs and services delivered under the National Agreement to Australia's wellbeing and productivity
b. the effectiveness of reforms to achieve the objectives and outcomes of the National Agreement including across different communities and populations
c. the opportunities under the National Agreement to adopt best practice approaches across Australia, particularly where productivity improvements could be achieved
d. the extent to which the National Agreement enables the preparedness and effectiveness of the mental health and suicide prevention services to respond to current and emerging priorities
e. whether any unintended consequences have occurred such as cost shifting, inefficiencies or adverse consumer outcomes
f. effectiveness of the administration of the National Agreement, including the integration and implementation of Schedule A and the bilateral schedules that support its broader goals
g. effectiveness of reporting and governance arrangements for the National Agreement
h. applicability of the roles and responsibilities established in the National Agreement
i. without limiting the matters on which the PC may report, in making recommendations the PC should consider the complexity of integrating services across jurisdictions and ensuring that the voices of First Nations people and those with lived and/or living experience of mental ill-health and suicide, including families, carers and kin are heard and acted upon.

In doing so, the scope should include assessment of the integration of social and emotional wellbeing principles, and cultural safety and responsiveness for First Nations people.

The National Agreement is intended to complement other agreements, including the National Health Reform Agreement and the National Agreement on Closing the Gap, and should be examined in this context.

Process

The PC is to undertake an appropriate public consultation process including holding hearings, inviting public submissions and releasing an interim report to the public.

The PC's comprehensive and culturally appropriate consultation should include Commonwealth, state and territory government agencies, commissioning bodies, service providers, peak body organisations, people with lived and/or living experience of mental ill-health and suicide, First Nations communities, priority cohorts and other relevant stakeholders.

In undertaking the review, the PC should have regard to previous inquiries where relevant, including but not limited to the PC's inquiry into Mental Health completed in June 2020 and the final advice of the National Suicide Prevention Advisor in December 2020, as well as other work that may have explored complementary themes. The PC will also consider reports delivered through the National Agreement and Bilateral Schedules.

The PC should make recommendations for the National Agreement that aim to enhance the effectiveness, accessibility, affordability and safety of the mental health and suicide prevention system.

An interim report followed by a final report and recommendations should be provided to the Parties of the National Agreement by 17 October 2025.

The Hon Dr Jim Chalmers MP
Treasurer

[Received 30 January 2025]

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Disclosure of interests

The *Productivity Commission Act 1998* specifies that where Commissioners have or acquire interests, pecuniary or otherwise, that could conflict with the proper performance of their functions they must disclose those interests.

Commissioner Selwyn Button is Chair of the Aboriginal Centre for the Performing Arts, Commissioner for Australian Sports Commission and Director of the Queensland Rugby Union. He was also formerly Chairperson of the Lowitja Institute and Director of the Institute for Urban Indigenous Health (IUIH).

Commissioner Angela Jackson is Chair of the National Committee of the Women in Economics Network, Adjunct Associate Professor at the University of Tasmania and was previously a non-Executive Director of Melbourne Health.

Acknowledgments

The Commissioners express their appreciation to the staff who worked on the review – Assistant Commissioner Miriam Veisman-Apter, who led the review, and other team members including Rachel Burgess, Patrick Chappell, Peter Daniel, Claire Heeps, Anna Law, Erin Massey, Samantha Thomas, Erin Turner, and Brian Vandenberg. Our thanks are also extended to Aditi Das and Pragya Giri for administrative and project support.

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.

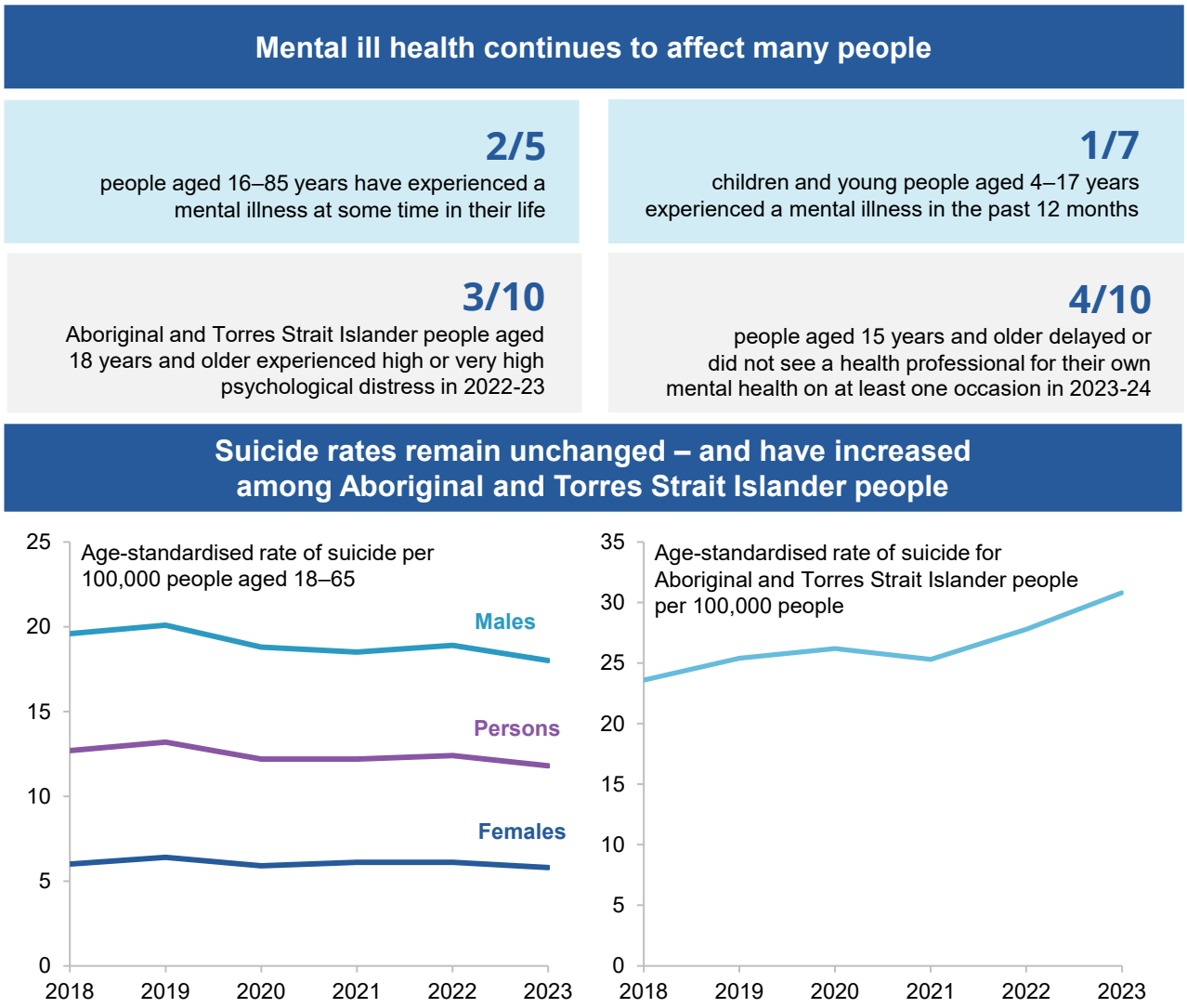
Some of the outputs, such as the establishment of the National Suicide Prevention Office (NSPO), have been well received by people with lived and living experience and service providers. Initiatives in the bilateral schedules, such as the Medicare Mental Health Centres, have improved access to services 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

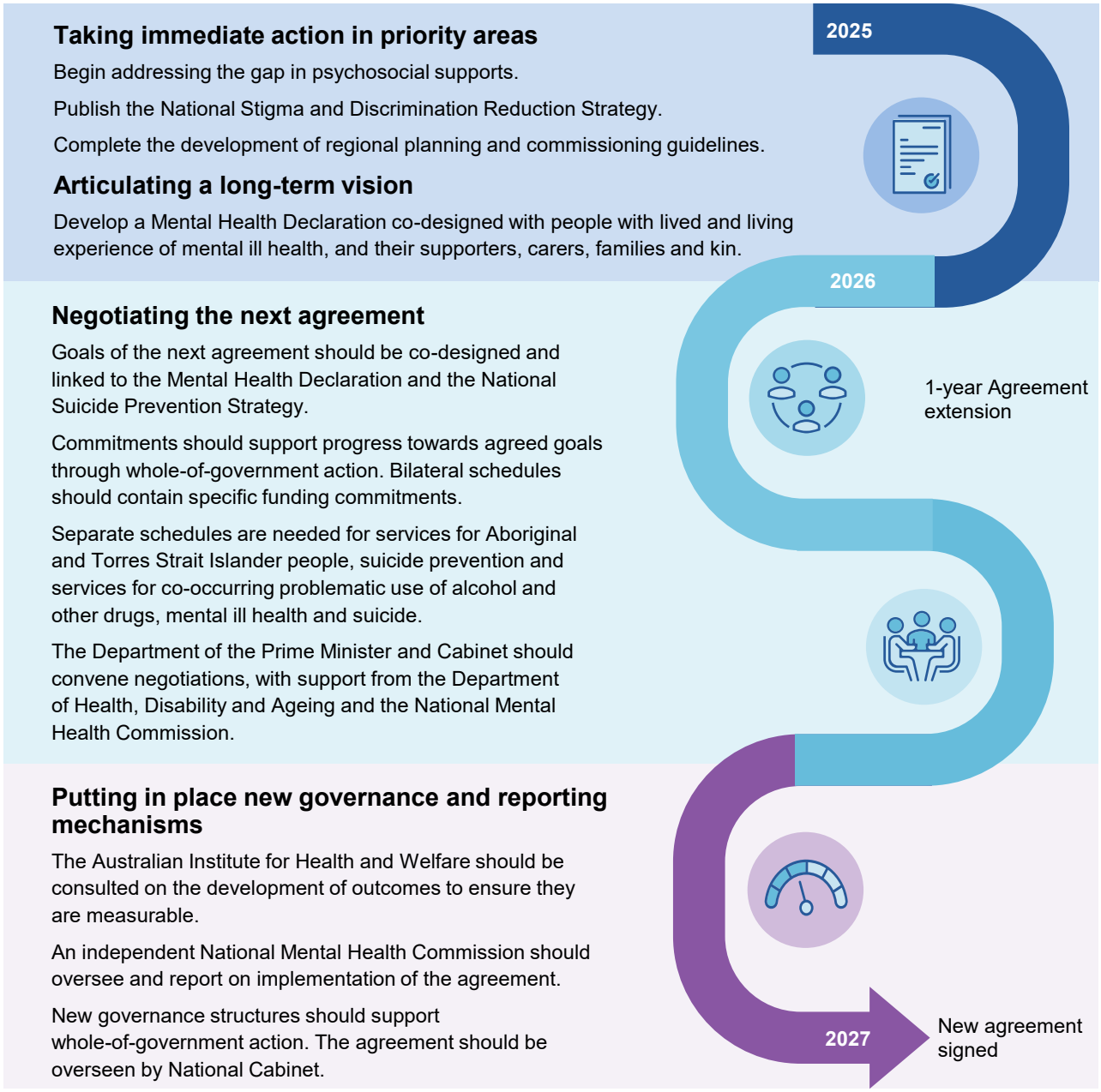
Successful reform in the mental health and suicide prevention system requires a long-term vision beyond the period of one agreement.

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**

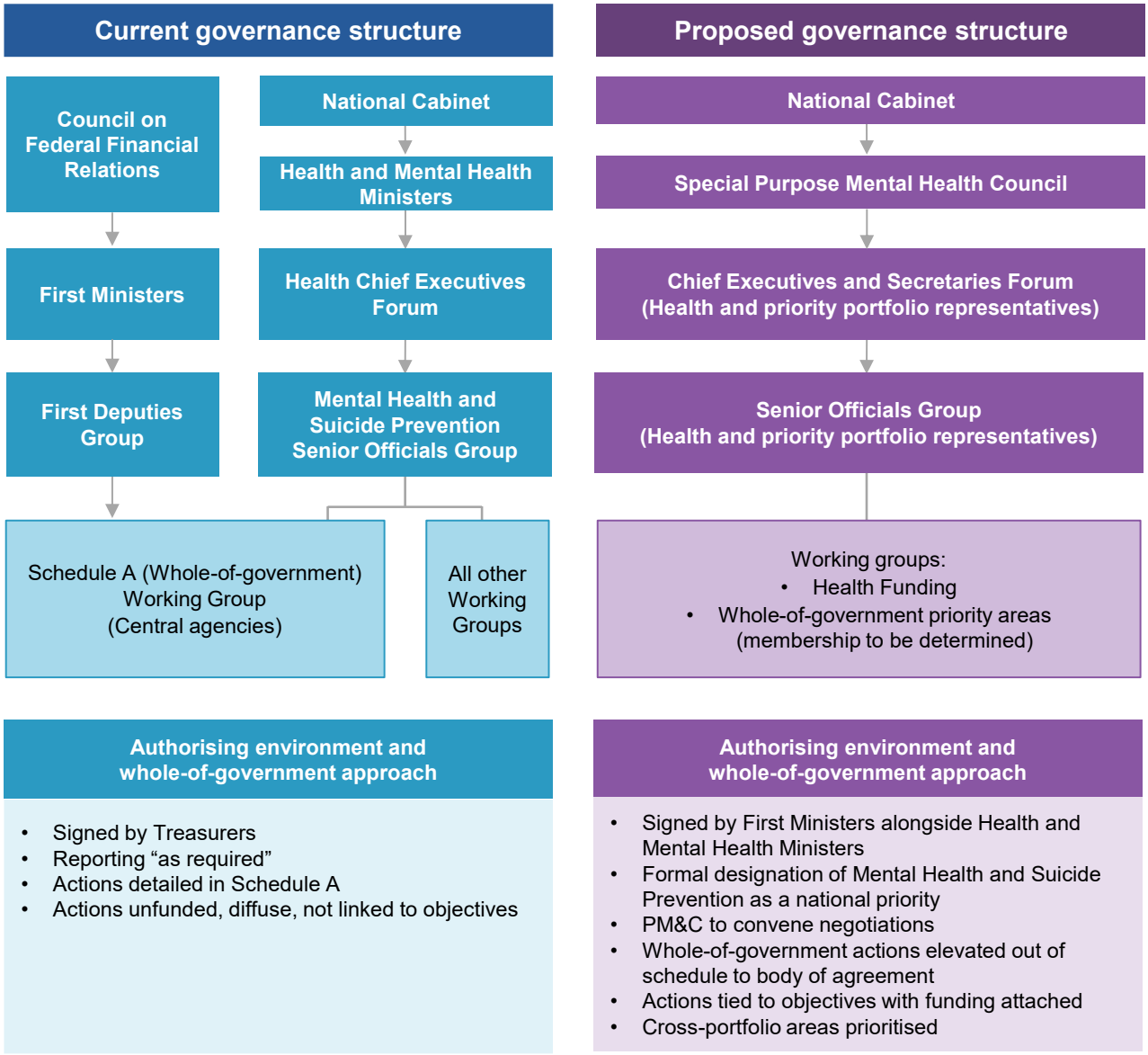
> Let's make more services available for young people before their mental health concerns develop further, and remove the road blocks of having to have a relationship with a GP, and gaining a mental health plan
>
> **Carer**

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.

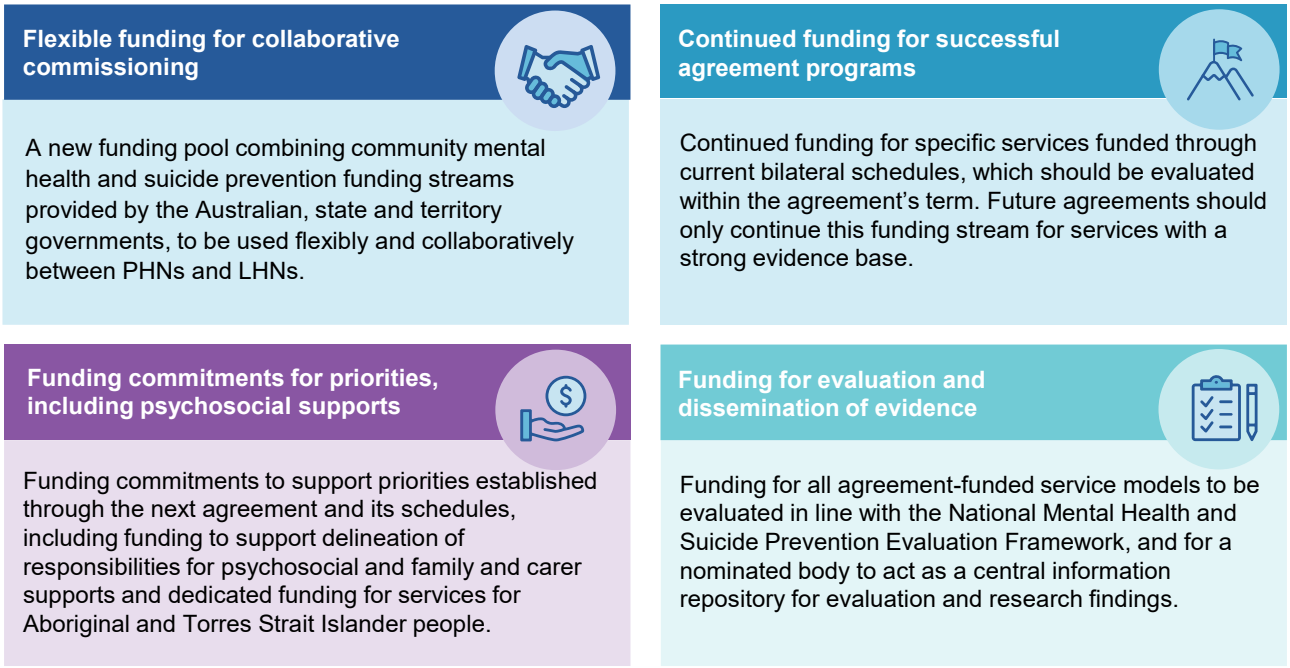
In addition to this flexible funding pool, the next agreement should also include:

- 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.

What we heard

Key points

- **Understanding the experiences of people when they need mental health and suicide prevention services is a key part of reviewing the National Mental Health and Suicide Prevention Agreement. The reflections of consumers, carers and service providers underpin the PC's assessment of progress under the Agreement and the recommendations for future policy directions.**
- **To gather people's perspectives, the PC undertook meetings and site visits, received submissions, conducted an online survey and held public hearings and roundtable discussions. The PC spoke to people with lived and living experience of mental ill health and suicide, supporters, families and carers, peer workers, service providers, practitioners and researchers, peak bodies and associations, primary health networks, hospitals, mental health commissions and government departments in all states and territories.**
- **In meetings, submissions and hearings, people reflected on the lack of progress under the Agreement and the need to develop stronger accountability mechanisms in future. Many spoke about the limited involvement of people with lived and living experience in the development of the Agreement and the urgent need to embed consumers' and carers' perspectives in policy and service delivery.**
- **In the online survey, consumers reflected on four key themes, including:**
  - **costs and waiting times**
  - **gaps and shortages in services**
  - **inadequate crisis support**
  - **experiences of discrimination when accessing services.**
- **Carers reflected on experiences of exclusion and not being able to access information and support. Practitioners spoke about the need for change in the way services are staffed and funded.**
- **Consumers, carers and practitioners also spoke about positive experiences of compassionate, person-centred services and the difference these made to their lives.**

At the core of the mental health and suicide prevention system are the experiences of the people who need it. For some, these experiences are positive and contribute to healing and recovery. But for many, finding the right services at the right time and receiving the support they need for themselves or their loved ones is a very difficult task.

The National Mental Health and Suicide Prevention Agreement aims to create a person-centred system, improving the experiences of people who use mental health and suicide prevention services as well as their supporters, family, carers and kin. To assess progress under the Agreement, the PC undertook extensive engagement with a wide range of people and organisations. This chapter summarises what we heard throughout the process.

To inform this review, the PC spoke to people with lived and living experience, supporters, families and carers, peer workers, service providers, practitioners and researchers, peak bodies and associations, primary health networks, hospitals, mental health commissions and government departments in all states

and territories. We used the principles of the Review of the National Agreement on Closing the Gap (PC 2022b), to ensure engagement was:

- fair and inclusive
- transparent and open
- ongoing
- reciprocal.

The PC thanks all review participants and acknowledges in particular the contributions of the people with lived and living experience of mental ill health and suicide, their supporters, family, carers and kin, and the organisations that represent them. Working towards embedding the voices of people with lived and living experience throughout all aspects of the mental health and suicide prevention system – including this review – ensures reforms contribute to the delivery of comprehensive, compassionate and person-centred services.

The perspectives of people and organisations were gathered through meetings, submissions, public hearings and an online survey. Following the receipt of the review's terms of reference in January 2025, the PC released a call for submissions. In response, the PC received 94 public submissions.[2] We also held 72 meetings and visited services and organisations in Hobart, Launceston, Brisbane and Ipswich. Between 11 February and 21 March 2025 the PC invited people to share their views and experiences of mental health and suicide prevention services via an online survey and received 293 responses. We hosted a webinar on early messages from consultations on 11 April 2025, as part of our commitment to ongoing and reciprocal engagement.

The PC published an interim report on 24 June 2025, which was the foundation for further engagement. In response to the interim report, we received 150 submissions. Public hearings were held from 19 to 21 August 2025, with appearances from 25 individuals and organisations. The PC also met with 23 people and organisations and was involved in eight roundtables, briefings and presentations to seek input on the recommendations included in the interim report. We held a webinar on 23 September 2025, to update participants on messages from consultations undertaken after the interim report.

Reflections from submissions

A wide range of organisations made a total of 244 submissions, including representative bodies for consumers, carers and service providers as well as individual service providers, government agencies and a small number of consumers, carers and researchers (figure 1). There were 94 initial submissions before the interim report and a further 150 submissions in response to the interim report. We received nine submissions from Aboriginal and Torres Strait Islander people or organisations. Public submissions were published on the PC website and are listed in appendix A.

Table 1 lists key themes raised across submissions. These themes have been common to multiple submissions. Some submissions included information and recommendations about specific mental health conditions, groups of people disproportionately impacted by mental ill health or suicide, types of services or professions. While these specific themes are not listed in the table, they have all informed our analysis.

[2] The PC received 95 initial submissions for publication but one was later withdrawn.

Figure 1 – Public submissions by type of organisation or person

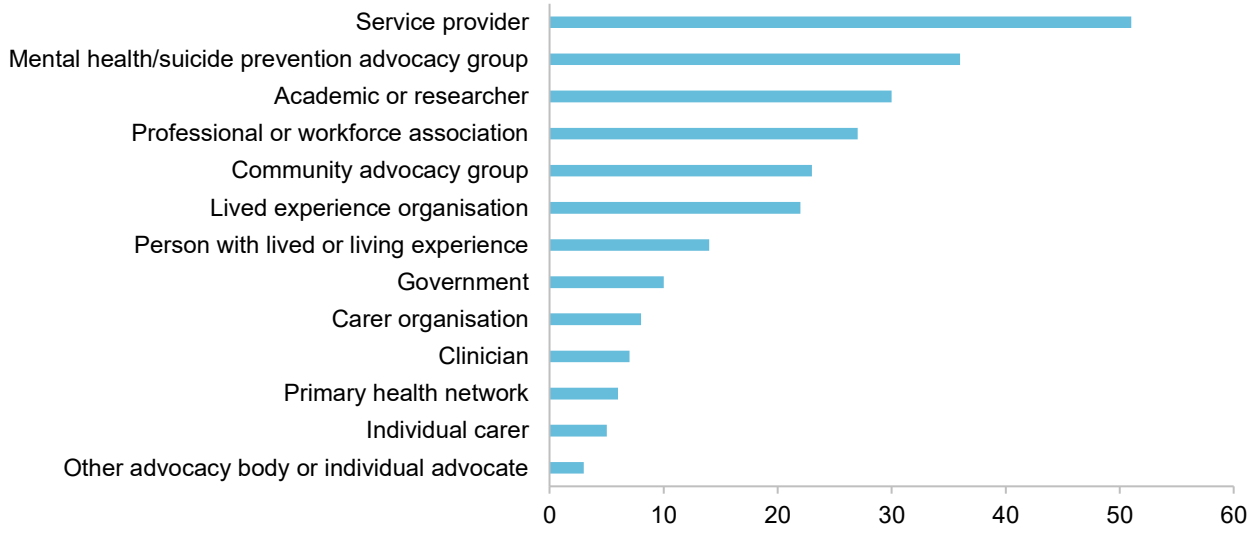


Table 1 – Key themes from submissions

The overall value of the National Agreement	Strong support for having a national mental health and suicide prevention agreement and for the principles within it. Concern the Agreement had failed to achieve many of its objectives and it was not designed to enable transformation of the mental health and suicide prevention system. There were delays and slower progress than planned in developing and implementing services agreed under the bilateral schedules. The creation of new Medicare Mental Health Centres was seen as a success of the Agreement.
The need for a national strategy on mental health and allowing extra time to develop a strategy	There was broad support for the National Suicide Prevention Strategy and some highlighted the absence of a national strategy on mental health. Submissions mostly supported the idea of an extension to the Agreement to allow time for the development of a national mental health strategy but there were some concerns that a delay to the next agreement would defer government action and investment in immediate priorities.
People with lived and living experience should inform the agreement and its governance	Many submissions highlighted the lack of input from people with lived and living experience into the development and ongoing governance of the Agreement. Numerous submissions stated co-design of the next agreement with people of lived and living experience was essential; and recommended people with lived and living experience should be part of ongoing decision making in the implementation and measurement of progress for the Agreement. Many submissions contained specific advice on how to make the participation of people with lived and living experience as effective and meaningful as possible – including the nature of engagement, paying participants for their input, ensuring that people with lived and living experience were not outnumbered by others in co-design processes and that there was representation from a breadth of different lived and living experience perspectives and experiences.

Human rights	Several submissions argued for an ethical human rights-based approach to mental health and suicide prevention, where people with mental ill health were informed and empowered to be decision makers in their own health. Several submissions discussed the need to consider the human rights of those receiving involuntary mental health care.
Cooperation between the Australian, state and territory governments	Views were mixed about the extent to which the Agreement had improved cooperation between the Australian, state and territory governments. • Some examples were provided of improved cooperation and planning in developing and implementing services. • Other submissions highlighted examples of duplication, lack of consistency, poor communication and coordination and competition for qualified staff and resources between the Australian Government and state-funded services.
Contracting and commissioning of services	Many submissions called for improvements in contracting and commissioning of mental health and suicide prevention services. There have been inconsistent contracting, commissioning and reporting processes between different primary health networks (PHNs) and variations in PHN capabilities. Inconsistencies between PHNs increase costs and create challenges for service providers working across multiple PHN regions. There is variation in the degree of communication, cooperation and coordination between PHNs (funded by the Australian Government) and state and territory government local health networks in regional planning, contracting and commissioning.
Gaps and problems in mental health and suicide prevention services	Submissions highlighted numerous gaps and problems in mental health and suicide prevention services, including: • insufficient availability of community-based care. People with lived and living experience of mental ill health and their carers reflected on the unavailability of services, long waits for appointments, no continuity of care and continual changes in staff and clinicians • a lack of coordination and communication between different services for people with mental ill health, including limited information sharing causing consumers to frequently retell their story. Services are often fragmented, which makes it difficult for people with mental ill health and/or with suicidal distress to access integrated person-centred care. • lengthy stays in noisy and overcrowded emergency departments leading to increased distress • the importance of prevention and engaging early in distress (early intervention services), which can reduce the number of people needing acute care • the lack of, or limitations in, digital health services as a supplement to face-to-face services and for consumers in locations where face-to-face services are unavailable • a need for greater investment in psychosocial support services for people not eligible for the National Disability Insurance Scheme • the difficulties people in rural and remote areas have in accessing mental health services • the high cost of private mental health services and suggestions for increasing Medicare rebates for services provided by psychiatrists, general practitioners, psychologists and other mental health professionals • insufficient funding to improve access to mental health and suicide prevention services for all who need them. There were calls for improving the accessibility and appropriateness of mental health services for groups disproportionately impacted by mental ill health and suicide, including:

	• children • young people • people from culturally and linguistically diverse, migrant and refugee backgrounds • LGBTQIASB+ people • women • men • people who have experienced family and domestic violence • veterans • older people • people in occupations with higher rates of mental ill health and suicide • neurodivergent people, including those with autism • people with intellectual disability.
Aboriginal and Torres Strait Islander people	Aboriginal and Torres Strait Islander people should be involved in the co-design and governance of the Agreement. Cultural capability in service provision is essential. The Agreement should deliver on priorities identified in the National Agreement on Closing the Gap. Strong support for the Gayaa Dhuwi (Proud Spirit) Declaration Framework and Implementation Plan and the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy. Support for the work of Aboriginal and Torres Strait Islander Community Controlled Health Organisations.
Carers	The role of carers is vital to improving outcomes for people with mental ill health and/or suicidal distress but there is little support for carers under the Agreement. Carers need greater information, support and resources. Clinicians should ensure carers are informed about the treatment needs of those they are caring for. Submissions included examples of the difficulties carers face when clinicians do not provide them with information.
Addressing social determinants – a whole-of-government approach	Social determinants such as housing and homelessness, education, employment and interactions with the justice system have significant implications for mental health and suicide prevention. Action from agencies across governments is required to improve outcomes for people with mental ill health.
Mental health and suicide prevention workforce	There are workforce shortages across most professions working in mental health and suicide prevention. Peer and lived experience workers were identified as particularly important for improving outcomes. Improved training is needed across the mental health and suicide prevention workforce.
Accountability and evaluation	There has been little accountability for delays or lack of progress against outputs under the Agreement. There is strong support for regular, timely public reporting of progress against key outcomes, with reporting overseen by an independent body. Programs and activities funded under the Agreement should be evaluated to inform policy and practice.

Data	Many submissions called for a national data framework, consistent data standards and a national minimum data set to provide a foundation for measuring performance against the Agreement.
Evidence-based practice	Research and evidence of good practice and what works in services and treatments are readily available but do not always inform mental health and suicide prevention services. Lived and living experience should inform the research and evidence base for mental health and suicide prevention services. Some forms of service and treatment are not supported by research and evidence.
Suicide prevention	There was widespread support for the National Suicide Prevention Strategy. Many submissions called for a greater focus on suicide prevention in the Agreement. Some submissions reported participants' own experience with suicidal distress and their experience with accessing suicide prevention services. Several participants spoke of their own children's death by suicide and the difficulties they and their children had had in accessing mental health and suicide prevention services. They also stated that if appropriate services had been available and if clinicians had better communicated with them as their children's carers, the suicides may have been prevented.
Alcohol and other drugs	Submissions highlighted the overlap between mental ill health and suicide and the misuse of alcohol and other drugs and made recommendations about how it should be reflected in the agreement and in service delivery.

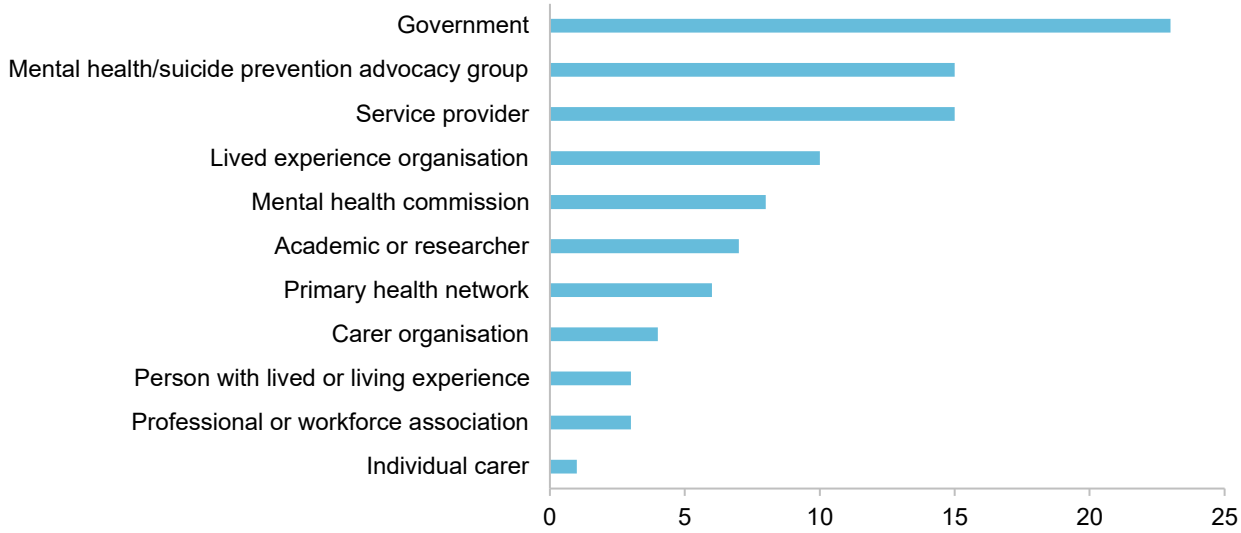
Reflections from meetings and visits

Over the course of the review, the PC met with a range of people and organisations (figure 2) listed in appendix A. The PC held 95 meetings in total, including 18 in-person meetings in Canberra, Brisbane, Ipswich, Hobart and Launceston, and 77 online meetings. Over the course of the review, we had 10 meetings with Aboriginal and/or Torres Strait Islander people or organisations.

There is overlap in the themes identified from meetings and visits and the themes found in submissions. However, each type of engagement highlighted different aspects of these themes. As most of the meetings and visits occurred before publication of the interim report, the themes in table 2 primarily reflect these meetings.

Ten of the meetings held since the release of the interim report relate to the intersection between problematic use of alcohol and other drugs and mental ill health. Key themes are reflected in chapter 9.

Figure 2 – Meetings and visits by type of organisation or person[a,b]



a. This figure uses fewer categories than is used in figure 1 for types of people and organisations providing submissions. Submissions were received from a wider range of people and organisations than the PC was able to meet with.
b. Because of their specific role, mental health commissions have been reported separately from other government agencies in this figure.

Table 2 – Key themes from meetings and visits

The overall value of the Agreement	General support for having an Agreement in principle, but concern the current Agreement has failed to achieve many of its objectives and commitments. The Agreement has resulted in some increase in coordination between Australian, state and territory governments' commissioning of services but with scope for much more improvement. Expansion of Medicare Mental Health Centres has been valuable. There is no clear connection between the Agreement and the bilateral schedules between the Australian, state and territory governments. There was a desire from some participants for greater consistency across jurisdictions and bilateral schedules and funding for national services, such as telephone or digital services. However, some providers, state and territory governments and primary health networks favoured more regional and local flexibility.
The need for a national strategy on mental health	Support for a longer term national mental health strategy to provide a foundation for any future national agreements. A strategy could provide a theory of change that is lacking in the current Agreement.
People with lived and living experience should inform the agreement and its governance	The Agreement was developed with limited input from people with lived and living experience and there is limited lived and living experience input into the ongoing governance and implementation of the Agreement. The next agreement should be co-designed with people with lived and living experience who should also be part of decision-making in the ongoing governance and implementation of the next agreement.

	Input from people with lived and living experience is gradually becoming a more common feature in mental health and suicide prevention services and the creation of new peak bodies for consumer and carer lived experience is valuable.
Cooperation between the Australian, state and territory governments	There is inconsistency in how the Agreement has been implemented between states and territories. Cooperation and coordination between Australian, state and territory government agencies vary, some going well and others problematic.
Contracting and commissioning of services	Inconsistent contracting and commissioning processes across the 31 primary health networks (PHNs) increases administrative burdens and costs for service providers. Some PHNs and state and territory government local hospital networks have good relationships and are working well together to provide co-commissioned, collocated or coordinated services, planning and avoiding duplication, whereas in other regions they are not working well together. PHNs do not always have autonomy to commission services that best meet local needs as they are required to adhere to national policies and guidelines about locations, the nature of the services and who is eligible for them. This makes it difficult for service providers to meet local community needs. Commissioning processes are sometimes rushed. Short term contracts impose uncertainty and create insecurity for service providers, staff and consumers. The Agreement does not provide an opportunity for funding of services that might be better commissioned nationally such as digital or telephone services.
Gaps and problems in mental health and suicide prevention services	Medicare Mental Health Centres are providing services for people who do not require hospitalisation but whose needs are greater than can be met by some other services in the community. The rebranding of Head to Health services to Medicare Mental Health Centres dissuades some people from using them. Restrictions on eligibility to receive services is preventing access for some people but some providers and PHNs are working to make services as accessible as possible. Some Medicare Mental Health Centres have attracted large numbers of consumers and have waiting lists. People in rural and remote areas have significantly less access to services than those in urban areas. Some people need acute care and there is need for additional beds in hospitals but greater focus on prevention and engaging early in distress (early intervention) can reduce the need for hospitalisation.
Aboriginal and Torres Strait Islander people	Separate funding streams for social and emotional wellbeing and mental health services from the National Indigenous Australians Agency and the Australian Government Department of Health, Disability and Ageing create additional administrative burdens for service providers. The transition of funding of services for Aboriginal and Torres Strait Islander people from mainstream to Aboriginal and Torres Strait Islander community-controlled organisations as required under the National Agreement on Closing the Gap is slow or yet to happen. The Aboriginal and Torres Strait Islander peer workforce should be expanded.

	The Social and Emotional Wellbeing Policy Partnership and Aboriginal and Torres Strait Islander people should have a much greater role in shaping and overseeing the next agreement. Governments, PHNs and mainstream service providers talk about the importance of Aboriginal and Torres Strait Islander people but do not genuinely partner with or hand over control to Aboriginal and Torres Strait Islander people and organisations.
Carers	Clinicians do not always recognise carers and include them in conversations about the care of the person they are supporting. Some clinicians make an effort to include carers, but consumer privacy and confidentiality can preclude this, as can restrictions on Medicare and other funding for clinicians to spend time with carers. Carers do not always identify themselves as carers, which creates a barrier to obtaining support and information as well as care for their own physical and mental health. Caring for someone with mental ill health can be very isolating and difficult and increased availability of respite care is important.
Addressing social determinants – a whole-of-government approach	Housing and homelessness, education and interactions with the justice system are important social determinants that affect the outcomes of mental health and suicide prevention services. The Agreement has relatively little effect on agencies across governments that provide services and oversee policies related to these social determinants, despite the inclusion of a whole-of-government schedule (Schedule A) in the agreement (chapter 1). Many participants called for a greater focus on social determinants, particularly housing and homelessness.
Mental health and suicide prevention workforce	Shortages were identified across a range of professions in the mental health and suicide prevention workforce. Addressing workforce needs is an important part of the Agreement and the National Mental Health Workforce Strategy was welcomed but there was concern that it was yet to be implemented. Australian, state and territory government-funded services in local areas were often competing for workers. State and territory health services were also competing against each other for the same workforce. A range of participants suggested extending Medicare funding – increasing the total number of sessions covered, increasing payments to reduce gap fees for clients and extending eligibility to a wider range of clinicians and workers. The peer workforce was identified as important to improved consumer outcomes but required more training and support.
Accountability and evaluation	Many participants noted a lack of accountability mechanisms under the Agreement, which contributed to a lack of progress. Some argued there should be financial consequences if jurisdictions fail to achieve outcomes or to provide data, financial reports or information for reporting. There was strong support for restoring the independence of the National Mental Health Commission and its ability to monitor and report on outcomes and progress against the Agreement. Evaluation is important but the data for evaluation is not always available.

Data	A dashboard publishing data on outcomes from the Agreement would improve accountability and transparency. There is very little transfer of data and information between hospitals and community providers with negative impacts on continuity of care for consumers. Developing new data sets can be slow because of the need to ensure confidentiality, negotiate data linkage with different jurisdictions and data custodians and ethics approval processes. Developing consistent national data sets is difficult, not all jurisdictions have resources to implement new data specifications, and data specifications may not be consistent with clinical practice. Service providers can have contracts with multiple funding sources each with different data requirements. A lot of data collection is focused on outputs and not outcomes. There is a lack of data on suicide and suicide attempts.
Suicide prevention	Aftercare following a suicide attempt is sometimes only available to those who have presented to a hospital emergency department. People should be able to seek aftercare directly and not via a hospital. Many people attending emergency departments following suicide attempts do not receive any ongoing support. There is insufficient suicide prevention support for people in a suicide crisis.

Reflections from public hearings

The PC held online public hearings on 19, 20 and 21 August 2025, with 23 organisations and individuals participating. Many of the participants represented organisations that had made submissions and participants spoke about key points in their submissions and provided feedback on the interim report. Many of these ideas are reflected in the tables above and discussed in more detail in other chapters of the report.

Key themes raised during the hearings included:

- better outcomes can be achieved if people with lived and living experience are influential in co-designing policies and programs and ongoing governance and monitoring. People with lived and living experience need adequate support and resourcing to participate in these processes
- community organisations, often run by people with lived and living experience with little or no government funding, offer valuable support to people with a wide range of needs
- research and evidence are critical to guide policy and service provision
- poor access to service in rural and remote areas.

A full transcript of the public hearings is published on the PC website.

Reflections from roundtable discussions

The PC took part in an online roundtable discussion organised by Equally Well on 8 August 2025, which included a mix of people with lived and living experience of mental ill health, carers, clinicians and service providers. The discussion centred on their experiences with the mental health system, the intersection

between physical and mental health and recommendations for changes to reduce the extent of chronic physical illness and premature death among people with mental ill health.

The PC held an online roundtable discussion on 10 September 2025 with representatives of PHNs and state and territory health services to discuss collaborative commissioning of services. The roundtable was held jointly with the PC's concurrent inquiry into Delivering Quality Care More Efficiently.

Reflections from the online survey

The online survey was designed to explore three broad research questions that map to the terms of reference for the review of the Agreement:

- what gaps and shortcomings in mental health and suicide prevention services have people experienced?
- what changes in service provision have people seen in the past three years?
- what are some examples of good service provision and system improvement that people have experienced or would recommend?

Appendix A provides details of the methods used and sample characteristics. A total of 293 people participated in the survey (table A.5); 10 responses were excluded from analysis because they left the main questions unanswered, and a further nine were excluded from analysis because they did not provide consent.

Respondents could identify as a consumer, carer or worker/volunteer in service provision. We categorised respondents as consumers if they selected 'I have used mental health or suicide prevention services'. This is intended to be inclusive of people who identify as having lived (past) and/or living (current) experience of mental ill health, irrespective of whether they have a formal diagnosis, people who have accessed mental health services and/or received treatment, people who have accessed suicide prevention services and people who have experienced distress, attempted suicide, cared for a person experiencing distress or have been bereaved by suicide.

Of the 283 respondents who answered the main survey questions, nearly 75% identified as consumers. About one third identified as carers and about one quarter as workers/volunteers in service provision. Many respondents identified as belonging to more than one of the three main respondent categories. For example, 39 respondents identified as both a consumer and worker/volunteer in service provision, 38 identified as both a consumer and carer and 17 identified as a consumer, carer and worker/volunteer in service provision. The location that respondents reported as their primary residence broadly reflected the distribution of the Australian population. About 2% of respondents identified as Aboriginal or Torres Strait Islander people.

Care should be taken interpreting the findings of this qualitative study. The study is based on a non-probability sample (convenience sample) and therefore the findings are not generalisable to the population level. The recruitment methods used have meant some potential respondents have been systematically excluded (for example, people who were too unwell to participate and people who could not access the survey online). The open-ended questions we asked meant some individual respondents could share views and experiences from multiple perspectives (consumer, carer and/or volunteer/worker) and raise issues outside the scope of the Agreement or the terms of reference for the review. The subjective interpretation of the data, which may reflect the researchers' positions and perspectives on the issues raised, may have influenced the findings of the thematic analysis.

A description of the main themes in responses from consumers, carers and service providers is presented below, including some illustrative extracts (verbatim quotes). Minimal edits have been made to the verbatim quotes and only where necessary to improve clarity, remove any obvious typographical errors contained in

the original and to preserve anonymity and confidentiality. Labels in brackets after each extract refer to the identification number we assigned to each survey respondent (sr.).

Main themes in the survey responses from consumers

The survey showed many consumers feel unable to access sufficient and appropriate care and support for their mental ill health. Many point to similar obstacles, such as inadequate availability and accessibility of some essential services (for example, shortages of psychiatrists, psychologists, crisis support), long waiting times and high costs for using services as well as experiences of discrimination when using services (figure 3).

Figure 3 – Main themes identified in consumer responses

Positive experiences and feelings towards the mental health and suicide prevention service system were reported by some consumers, but these were less common. Sentiment analysis found 64% of consumer responses to the survey questions were very /moderately negative and 36% were very /moderately positive.

Consumer theme 1: Waiting times and costs

A major theme in what we heard from consumers is that there are significant barriers to accessing services because of the long waiting times and high costs. Many respondents told us about their experiences of long waiting times for accessing treatment and support, in acute settings as well as in primary, specialist and allied care settings. In acute settings such as hospital emergency departments (EDs), the long waiting times before receiving treatment often added to the distress people were experiencing at the time.

> The ED department would have been fine, except i sat there alone for 12 hours only to have a psychiatrist at the end of sitting there for 12 hours telling me i can go home. If anything it made me more distressed. (sr. 226)

> Hospital made me wait 6 hours to be seen for 5 minutes sent me back out to the waiting room so I left without being properly assessed. (sr. 237)

The waiting times for accessing mental health services in community settings can also be substantial.

> It's now almost 12 months since hospital and I still have not been able to access any support for my mental health or my living conditions exacerbating the issues. I am on a 16 week wait list to see a general mental health worker at the local health centre. (sr. 140)

> I was on waiting lists for close to a year. (sr. 246)

Because of the long waiting times, some people felt their mental health and wellbeing was put at risk or declined further.

> The services that are accessible with a mental health care plan are difficult to get into (with long wait times and long times in between appointments) which does not facilitate mental health. (sr. 63)

> I have the highest level of health insurance & have been on a waiting list to be admitted for almost 6 months with no time frame at all … While my condition is getting worse. (sr. 227)

The experience of long waiting times also appears to discourage some people from seeking the help they need.

> Inadequate services, wait times too long, couldn't stay on hold any longer. (sr. 142)

> The waiting lists are getting longer, bulk billing is disappearing, and people are avoiding doctor visits due to financial issues. (sr. 149)

> The services simply ask for consumers to show respect, but it seems that respect isn't always reciprocated. Just take a look at those long waiting times! (sr. 149)

Combined with the long waiting times, the financial costs individuals face for obtaining mental health care and support can put services out of reach for many people.

> Mental health and suicide prevention services are incredibly expensive or time consuming. If you request a mental health plan from non-bulk billing GPS (as bulk billing GPS are incredibly difficult to get appointments), you are already out of pocket. This means these life saving services are inaccessible. (sr. 63)

> I stopped seeing my psychologist because I couldn't afford it. (sr. 37)

People on a fixed and/or low income told us that high costs of services represent a major barrier to them accessing treatment and support.

> when I have needed to most, it's been completely cost prohibitive and I could not access the care I needed. There is almost no support available for the unemployed or underemployed. (sr. 89)

> outpatient services are overbooked and have lengthy delays or are massively expensive. And as someone who is currently unable to work due to the exacerbation of my mental illness during and after covid, it is very difficult to access the appropriate level of support. (sr. 135)

> I am forced to rely on welfare meaning even with a mental health plan, appropriate care is entirely unaffordable. (sr. 137)

Some consumers said they did not have any support navigating through the service system to overcome barriers such as long waiting times and out-of-pocket costs.

> They tell you to see a gp and get a mental health care plan. That's not immediate help and there's a large out of pocket cost also. (sr. 211)

> I took a day off work (unpaid) to see GP for a mental health plan, he did not know who to refer me to and told me to go and find a service myself. when I did the research I found zero services available in Dubbo, only one service had open books with a six month waitlist. (sr. 213)

Regarding the private system, we heard the high costs of such services are prohibitive for many people.

> I cannot afford private mental health admissions so I suffer alone at home. (sr. 122)

> I was referred to residential treatment programs but these were all in the private sector. I had to drop my private insurance due to financial constraints which means I could not access them. (sr. 89)

When asked about any changes in services they've noticed over the past three years, many respondents said they felt waiting times had become longer and costs had increased, making services less accessible and less affordable for them.

> In regional areas the availability, access and affordability has dramatically reduced (and it was poor to begin with). (sr. 126)

> Getting worse, less services available, longer wait times or all have closed books. (sr. 213)

> When we had COVID was allowed 20 sessions covered. This was great. Now back down to 10 that may cover 10 months going once a month. Does not help the long term patients at all. (sr. 248)

Consumers gave a range of suggestions for reducing the barriers to services and improving accessibility (figure 4).

Consumer theme 2: Gaps and shortages in services

Many consumers have experienced service gaps, often in hospital-based services. Consumers told us about experiences of not receiving adequate treatment for their mental health care needs when presenting to hospital emergency departments or when admitted to inpatient facilities.

> I have been taken to hospital numerous times and every time they have said the mental health team isn't here, theres no beds, go home and someone from the mental health team will call you. (sr. 30)

> 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. (sr. 148)

Many also said they did not feel their needs were recognised or respected while in hospital.

> Services at hospital are judgemental, rude, disrespectful and make everything worse. Hospital is not a safe place for someone suicidal due to staff ignorance and restrictive practices. (sr. 256)

> The treatment from the mental health team was not good for the most part in the acute care space. They made me feel like I was not worthy of help. (sr. 265)

However, some respondents also described positive experiences when they've used hospital-based services.

> Psychiatric treatment involving medication and Hospitalisation have saved my life on a number of occasions. (sr. 245)

> The hospital staff were really compassionate and listened to me when I was voluntarily admitted. (sr. 135)

Figure 4 – Suggestions for reducing barriers and improving access to services

Increase information for consumers and support with system navigation

> You need to advertise services and to everyone not just certain age groups. Parents need to know where to take their child and friends need help in helping others. (sr. 48)

> Public awareness campaigns need to continue with open mental health discussions to 'normalise' diagnosis and treatment options. Mental health needs to become a recognised part of health as a whole. (sr. 209)

> 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. (sr. 252)

Provide better resourcing for the mental health service system

> More funding, resources and options in the public system to stop people falling through the cracks. (sr. 19)

> People need greater access to affordable and timely ongoing care and management of mental ill health. This would ultimately lead to less times of reaching "crisis" point. (sr. 43)

> Please provide better fast responses and people focused services in rural and remote places. (sr. 56)

> There needs to be more funding for services outside of the system that has alternative ways of doing things. That don't involve calling police or CATT or sectioning or risk assessments. Fund peer support outside of the system. (sr. 270)

Reduce pressure on the mental health service system by increasing the range and flexibility of services on offer

> 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. (sr. 189)

> There needs to be more help within the community to support families with respite, continuity of care, and options other than going to the ER for 20 hours. (sr. 206)

Increase the supply, quality and capacity of workers to provide mental health and suicide prevention services

> GPs should receive greater training in medication and have the right tools and funding to follow up with patients in an emergency. (sr. 89)

> We need nurse practitioners that make home visits to mentally ill people (public and privately funded) to support outpatient care. (sr. 231)

> Increase the number of psychiatrist trainees annually to reduce the wait times for private psychiatry. (sr. 262)

Beyond hospitals, many respondents told us about experiencing difficulties getting access to key mental health services across the primary, specialist and allied care system in the community. For example, many told us about difficulties accessing psychiatrists.

> I have been unable to find a psychiatrist and psychologist (both public and private) who are accepting new patients in the past 4 years after my old ones retired. (sr. 30)

> During a period of severe mental illness, the only way I was able to get on a psychiatrist's books in under 6 months was to check into hospital privately, at significant expense too (top tier insurance premiums). (sr. 34)

Similarly, many respondents told us about difficulties accessing psychologists, with several highlighting the limited access to publicly subsidised consultations.

> I can only get 12 visits to a psychologist - how is that going to fix years of trauma and clinical major depressive disorder and PTSD? (sr. 25)

> 10 psychologist sessions a year is not enough. (sr. 116)

> There are no bulk-billing psychologists available within reach. (sr. 137)

> No psychologist will treat me as i can only get 10 govt funded mental health sessions per 12 months, I have been told again and again that unless I can afford 40 sessions over a year they cannot help. (sr. 173)

Difficulties accessing general practitioners (GPs) for primary mental health care were also reported by many respondents.

> Can't get a gp that's less than a months wait. (sr. 109)

> Can't get and afford a Gp or psychologist. (sr. 188)

> GPS have closed books in our region also, at least a three week wait for appt it you can get one. (sr. 213)

Experiences of local gaps and shortages in service provision, particularly in rural and remote areas, were reported by many consumers.

> There is a single sub-acute mental health service in the NT that is based in Darwin, and is only available for people who can physically get to the office. (sr. 76)

> Live in regional NSW and people need to travel over 200kms (minimum) for inpatient support where the is rarely adequate support provided and they are released to find their own way home whilst still unwell. (sr. 111)

In addition to concerns about limited availability and accessibility, many people raised concerns about the quality of mental health services.

> Have no confidence in the local services, poorly staffed (attitude, skills, training or experience), too quick to apply medications, no holistic approach. (sr. 126)

> This system is alienating, inadequate, ill-informed, and under-resourced to the point where it is literally costing lives. (sr. 137)

We also heard how the poor quality of some services had sometimes adversely impacted people.

> The reason I haven't used any mental health or suicide prevention services in the past 3 years is because of the large number of very negative experiences I have had in the past when I've tried to reach out for help. (sr. 36)

> Trying so hard to find help for myself drove me even further into suicide because of the trainees in these services. They couldn't care less. (sr. 68)
>
> Intake processes are not trauma informed and have often left myself and my loved ones re-traumatised. (sr. 98)
>
> Feeling invisible when left to wait for hours to be seen. Nurses ignoring my distress. Psychs not respecting identity and questioning my experiences. (sr. 230)

Based on consumer responses, it appears gaps and shortages in service availability and the inconsistent quality of services are sometimes exacerbated by fragmentation in the service system and by a lack of coordination and continuity in care.

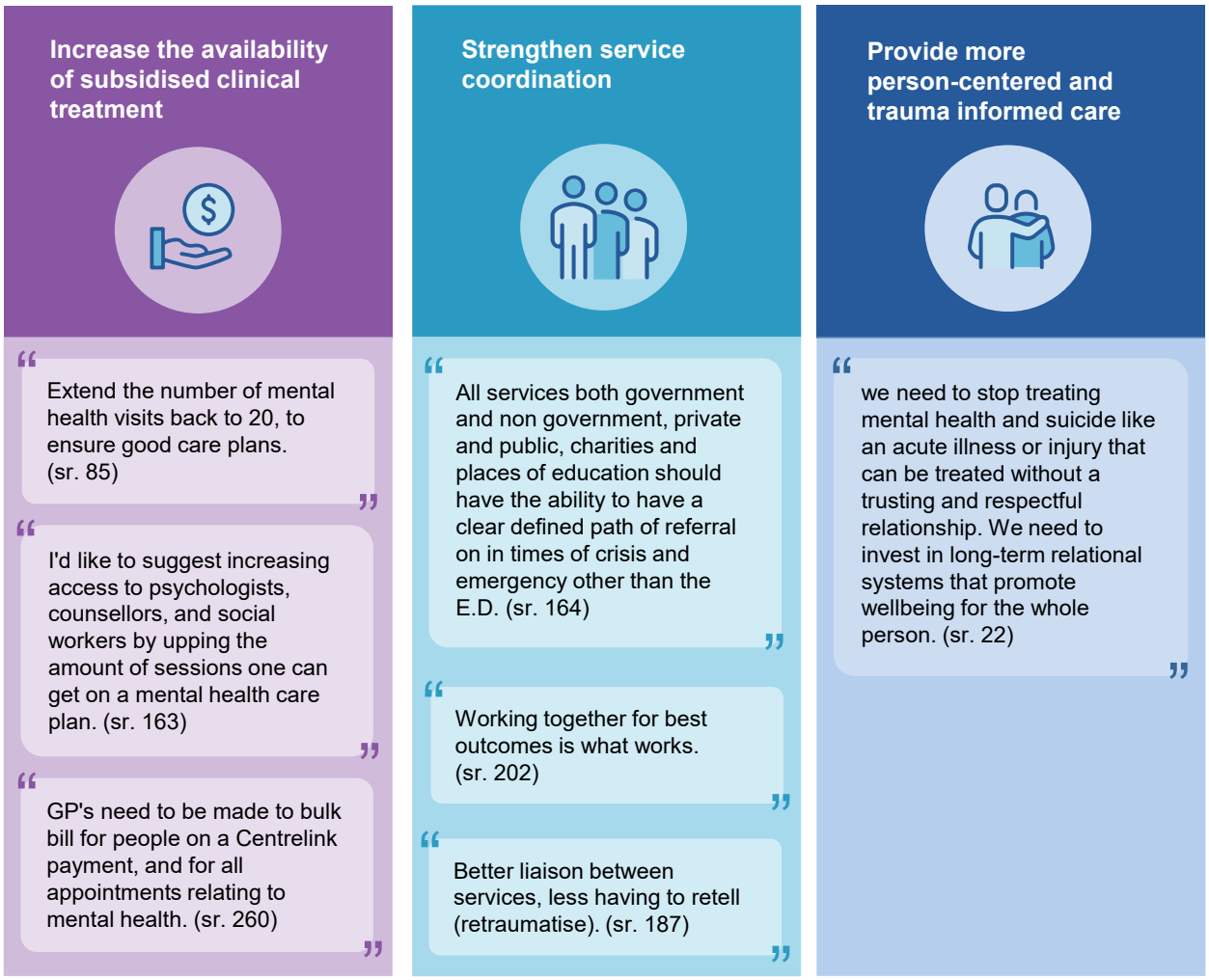
> I've not once had a clinician interact with another, apart from when I was hospitalised for an extended period of time. (sr. 5)
>
> In-patient programs only take us so far. No reintegration and community care/support once discharged. No offer of outpatient programs. (sr. 54)
>
> Emergency services called. Taken to ED - spoke with MH Nurse/Social workers then discharged with no plan, no referral to other services, no safety plan. (sr. 91)

In terms of changes over recent years, some consumers said they had seen some slight improvements, such as a wider range of services becoming available. To some extent, these have addressed gaps in services.

> The existence of more alternatives to ED is a positive change. (sr. 18)
>
> There have been lots of positive introductions into the system over the past few years, like safe spaces and head to health centres. (sr. 22)
>
> as some services are starting to focus on including lived experience people in the workforce, services are becoming kinder. (sr. 76)
>
> There seems to be a few bulk billed organisations that offer services now. (sr. 183)
>
> There seems to be more support available, but the waitlists are longer, prices are higher, and accessibility doesn't seemed to have effectively changed. (sr. 196)

Consumers gave a range of suggestions for improving service accessibility, system integration and service quality (figure 5).

Figure 5 – Suggestions for reducing gaps and shortages in services



Consumer theme 3: Inadequate crisis support

The inadequate availability of appropriate care and preventive supports for people who are experiencing a mental health crisis or suicidal distress is another major theme in consumers' survey responses. Many consumers felt these services are not always as accessible, responsive or appropriate as they need to be.

> emergency departments not equipped for mental health crises. (sr. 6)

> It has been hard to navigate available services. There is a lot of information available online, but sometimes it's not exactly what you need in the moment. (sr. 56)

> at times in the last 3 years I have been suicidal but there are not many services which could have helped me. (sr. 202)

> 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. (sr. 254)

> There are no services to help in a crisis. (sr. 256)

We heard many examples of poor continuity of care following treatment for a crisis and a lack of ongoing suicide prevention support.

> There are mental health lines … however these are strictly crisis management, do not provide multiple sessions and are not tailored to early intervention. (sr. 38)

> Whenever I have a crisis or suicide attempt, they have kept me overnight in ED then send me home the next morning with no follow up usually! (sr. 122)

> There's no continuity of care in the public mental health system, and therefore trauma-informed care is not possible. (sr. 132)

> Only crisis care and then you're thrown to the community with no follow up at all and just hopes that you'll figure it out yourself. (sr. 123)

> Services are still only geared for people in crisis … There is no on-going suicide prevention support for people not in crisis, this hasn't changed and I don't see it even on the radar. (sr. 212)

Safe spaces are drop-in services for people experiencing suicidal crisis that provide welcoming and supportive environments aimed at reducing distress. They are seen by many respondents as valuable and important during a crisis, as clinical services such as hospitals emergency departments are often not suitable or safe for people in distress. However, many told us these are difficult to access.

> The only public service I've interacted with was the local Safe Haven while suicidal. When I could access it, it was incredibly helpful and high quality … but such limited hours. (sr. 34)

> I would like more availability of non-clinical drop in services so they can be accessed 24/7. (sr. 83)

> I desperately needed help, my family were trying everything, but there is nowhere safe to go. (sr. 134)

> When I needed suicide prevention services, alternatives to hospital were not available. It is great to see that now there are more services you can access when feeling suicidal. I think if these services were available when I needed them it would have been a better experience than hospital. (sr. 194)

> There are no services for urgent situations besides going to the ER, which is a terrible place to go when you are in crisis and results in exhaustion and no actual help. (sr. 206)

Many respondents told us about experiencing poor quality care or negative experiences when they had used services during a crisis.

> Clinicians who didn't listen to me, misdiagnosed me or left me in dangerous situations. (sr. 41)

> Let me just remind you that, if you want to seek medical help while your feeling suicidal your going to be forced to pay over 1000$ for an ambulance to come and lock you in a mental ward. (sr. 58)

> In many instances they have been incredibly harmful and damaging, and this has left me with trauma that has had and continues to have a significant negative impact on my life. (sr. 65)

> I have yet to find any public hospital settings to help with a crisis which wouldn't make me more suicidal and depressed. (sr. 89)

> The impatient psychiatric ward was extremely unhelpful. Even though it kept me safe, I experienced a lot of traumatic events there. (sr. 112)

> Presenting to emergency suicidal and being sat in the waiting room 8 plus hours, then spending the night in a hard chair with little to no support. (sr. 184)

Though not common, involuntary services (restrictive practices/interventions) were highlighted by some respondents as a source of distress they have experienced when receiving treatment during a time of crisis.

> The involuntary service made me lose my job, has left me physically worse off and discredited me further. (sr. 57)
>
> Public mental health services and community treatment order made me suicidal. (sr. 118)
>
> When I present to hospital suicidal, they treat me like a prisoner and give me no support. (sr. 122)

Experiences of using phone services during a period of suicidal distress or in a crisis were reported by many respondents. Some people told us about negative experiences when they have used crisis phone services.

> Both services actually increased my suicide risk. Neither informed me at the start they had a 20 minute limit, so conversation was wound up unexpectedly when I was unprepared. I felt vulnerable, foolish, even more worthless than at the start of the call, and more suicidal. (sr. 31)
>
> At times where I've used crisis lines, the hold music has made me more suicidal, and the lack of instant grounding techniques used have been a struggle. (sr. 93)
>
> all called triple 0 when all i needed was someone to talk to in person. Doing this, forced me to go into hospital where i was stuck in the ED for over 12 hours. (sr. 226)

However, some also told us about positive experiences of using phone services.

> The phone lines help you connect to a human who is empathetic to your situation … The human connection is vital for isolated individuals. (sr. 42)
>
> The person on the phone helped. I hear they use volunteers a lot, that's why they are so busy. But very helpful. (sr. 181)
>
> an amazing service, I can tell the responders are better trained. (sr. 231)

And some people told us about having inconsistent experiences.

> I have had a good experience where the person and I talked for an hour, taking me out of a crisis state and calming me down. However, I have had other times where they either do not answer or provide extremely unhelpful comments/advice that further escalated the state I was in. (sr. 112)
>
> it was relief to talk to someone and to make a plan for how I am going to get support/manage the immediate crisis. However, this experience isn't consistent as i have had some people from [service provider] be less helpful (eg. I'm telling them I have thoughts of suicide and she tells me to have a cup of tea). (sr. 162)

Many said they benefited from person-centred and less clinical services, particularly where services employ peer workers or involve people with lived and living experience in service delivery.

> We need more non clinical peer led services and peer support. Peer support saved my life. MH clinical support services were traumatizing and harmful as was the ED experience. (sr. 110)
>
> Thank god for peer support workers liaising with medical professionals to advocate with me (sr. 202)
>
> i wanted to talk to someone who had been through what i had and not give me the pity look which i hate. (sr. 255)

Respondents (including consumers, carers and people working/volunteering in service provision) gave a range of suggestions for addressing suicidal distress and mental health crises and improving the support available for people at risk or experiencing these issues (figure 6).

Figure 6 – Suggestions for preventing and responding to mental health crises and suicide

Consumer theme 4: Discrimination when using services

Another major theme that has come through consumers' responses to the survey is their experience of mental health-related stigma and discrimination when using services. The experiences, feelings and impacts of this included being disapproved of, excluded, devalued, shamed and negatively stereotyped.

Many people feel they have experienced discrimination in the service system related to their mental health issues and their perceived support needs. Some said this impacted the care and support they receive from services.

> In the psych ward and some other instances (like a psychiatrist and a different psychologist) however, I often felt disrespected and invalidated by staff and unsafe even though I was in a locked ward. (sr. 112)

> Mental health is either ignored or blamed for every physical condition! (sr. 240)

> I feel like they didn't really listen to me when making a safety plan and I wasn't respected. I've also made complaints and didn't feel listened to. (sr. 265)

And for some, the experience of mental health-related discrimination from services appears to have contributed to self-stigma (internalising and applying public stigma to oneself).

> Being diagnosed with Borderline Personality Disorder, most health professionals call me a trouble maker or difficult when I'm just struggling and in pain. (sr. 163)

> I feel forgotten about, even when I am with a doctor or other mental health practitioner. Just another pain in the bum with no real problems. (sr. 193)

> Felt stigmatised and judged for suicidal ideation. (sr. 251)

Many consumers who said they had experienced discrimination related to their mental ill health told us this made them feel socially marginalised and the experience of discrimination worsened their mental health and wellbeing.

> As a survivor of domestic violence but having a diagnosis I was discriminated against and left in a worse situation due to this. (sr. 57)

> I have been disrespected, dehumanised and degraded whilst receiving mental health treatment. (sr. 65)

> Psychosis is demonised and misunderstood … and people are terrified. (sr. 134)

> When you're being told you are a liar, with a diagnosis, and they treat us like we're acting, makes us question our own sanity and has us thinking about suicide. (sr. 232)

Some told us that having experienced mental health related discrimination led them to anticipate stigma. It meant they felt excluded from services, had negative feelings towards services and avoided using them.

> The fear of losing work, being deemed unfit for work due to the discrimination of people with lived experience prevented me from trusting services. (sr. 13)

> I have always avoided other mental health services because I know too many people who have been treated poorly and harmed by the system intended to help them. (sr. 70)

We also heard that some people's experiences of mental health related discrimination were related to their gender, sexuality, cultural identity or other personal attributes.

> My Aboriginality was ignored. My own voice was ignored. My cultural situation was ignored. (sr. 25)

> Language barriers, stigma, and a lack of culturally competent professionals make it even harder. I've seen how mental health struggles in CALD communities are often dismissed as 'just stress' or 'family problems,' rather than recognized as serious issues needing proper support. (sr. 67)

> I have been knocked back from 2 private mental health hospitals due to weight discrimination. (sr. 155)

> I do not feel safe to fully disclose my gender identity/sexuality because of the limited knowledge of most of the services I have accessed. (sr. 171)

> Psychiatrists and others judgement on sexualising and gender has impacted my recovery and sent me backwards. Deciding that these issues were the main cause of my MH issues was detrimental and I felt completely unheard! (sr. 230)

Some people told us they felt discriminated against by mental health services because of their neurodivergence and the lack of understanding and awareness of this by mental health services.

> As an autistic person I was not often understood or felt heard. Many of my experiences with crisis services or mental health professionals left me feeling worse. (sr. 100)

> I am autistic and this was ignored when receiving mental health treatment – and I was turned away from some public services for being autistic because they felt they "weren't best suited to help me'. (sr. 119)

> My experience has been that there is a lack of knowledge in drs and mental health professionals regarding women having and seeking a late diagnosis for Autism and ADHD, and the myriad of conditions and difficulties that accompany this. (sr. 172)

Though less common, some people shared experiences where they had felt respected, recognised and protected by services, rather than discriminated against. Some common features to consumers' positive experiences of services include a sense of being sympathetically and non-judgementally heard and treated.

> Clinicians were very caring and supportive. (sr. 66)

> People let me talk, and asked questions. I can't remember anyone telling me what to do. They listened! I also had some great peer worker support when I was in the acute ward. (sr. 168)

> In treatment for more severe mental health issues, I felt seen, heard and supported. (sr. 196)

> Always open honest interactions that were non judgemental, respectful and aimed to work together for my best interest. (sr. 202)

> Everyone was kind and gentle. (sr. 245)

> The psychologist I currently see always makes me feel safe and respected, letting keep control while guiding me through ways to help. (sr. 234)

> Sometimes individual workers provided a sense of recognising and respecting my individual needs. (sr. 269)

Consumers gave a range of suggestions for preventing experiences of discrimination when using mental health and suicide prevention services and in the community more broadly (figure 7).

Figure 7 – Suggestions for preventing discrimination

Main themes in the survey responses from carers

Many carers told us about their continuing struggles to fill gaps in the service system to meet the needs of the people they care for. Many reflected on the pressure and distress they sometimes experience associated with the dual role of being a carer and being a close family member of a person needing care, such as their child, spouse/partner or parent. We also heard about many carers' experiences of feeling excluded and ignored when interacting with services and a lack of support from the service system for their own needs associated with being a carer (figure 8).

Figure 8 – Main themes identified in carer responses

Carer theme 1: Filling gaps in services

Many carers shared experiences of caring for someone with mental ill health spanning several years. They told us how the gaps in the service system often meant services did not meet that person's needs.

> Services often fail to address the complexity of my loved one's needs. For example, crisis support is inconsistent, do not know how to support and help at home, and no follow-up after discharge from hospital care. (sr. 9)

> Navigating mental health services via the ACT mental health system was slow and cumbersome. My son didn't trust the community services agency due to his distrust of frontline workers with poor communication skills. (sr. 78)

> We have been supporting a family member for the last fifteen years and have not seen significant changes required to support Mental health and Suicide Prevention. (sr. 95)

> Need greater crisis support and post-crisis support/care. Our experience is that these services are non-existent. Support for patients and carers to prevent suicide attempts are better than hospital care after. (sr. 16)

Some carers told us how, out of necessity, they had become proficient in understanding and accessing the service system and more assertive in help-seeking for the benefit of the person they care for.

> Getting to the point of service delivery does tend to rely heavily on my own knowledge of the system and ability to speak their language. That earns me more respect than anything else. (sr. 22)

> I introduced myself to my son's clinicians as a mental health consumer representative which seems to have helped with this. (sr. 78)

> In the private sector I managed to set up a good support team. (sr. 85)

> My loved one also lives with a physical disability since birth. I have mostly been my loved one's case manager/advocate even when we lived in Darwin. (sr. 98)

But many carers told us about the ongoing concern and stress they experience when trying to fill service gaps and deal with the complexities of the mental health service system.

> it felt like it was deliberately confusing and impossible to understand and navigate. (sr. 80)

> The system is complicated to navigate and relies on short term bandaid fixes. (sr. 82)

> Coordination between Private Medical (GP and Psychiatrist) and private Therapy services was done by Carer which was stressful and inefficient. (sr. 84)

> As we were having so much trouble getting care from the public system we tried the private sector as well and were turned away by every private provider with the same message - my person was too complex. (sr. 254)

> Psychiatrist waitlist was 12 months, for a vulnerable teen with suicidal ideation, attempts, self-harm. This was completely untenable, and the GP prescribed life-saving medication in this absence. (sr. 263)

Geographic gaps in service accessibility and availability are an issue many carers told us about.

> 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. (sr. 22)

> There is a severe lack of child and adolescent mental health services in my area. (sr. 37)

> No beds available in mental health unit during crisis. The only public non-acute mental health care program available was in Nowra over 2h from Sydney. (sr. 40)

> There are no in-person services locally for psycho-social wellbeing for people without a NDIS plan. (sr. 50)

Where services were available, many carers told us they often faced substantial costs to access them. This could impact significantly on their own financial situation, as well as affect the quality of support and treatment received by the person they care for.

> considerable out of pocket expenses which impacts choice on the number of appointments made and therefore on the quality of care as per given optimum treatment models. (sr. 2)

> Mental health care costs means that I have to work more to pay for treatments. (sr. 42)

> Had to go privately which is costly. He would have benefited from more frequent care, however due to affordability, appointments were spread out and only when really unwell. (sr. 43)

> We need to pay to see a private psychiatrist every 6 months for a medication review to be conducted. The private psychiatrist is excellent but expensive. There is no way my loved one could afford to see a private psychiatrist if they didn't live with me. (sr. 98)

While many carers told us about challenges and negative experiences of using the mental health services system, we also heard some positive experiences.

> Dedicated GPs, holistic experienced psychologists, person centred psychiatrists exist and contribute positively to a persons recovery and support during a MH crisis. (sr. 2)

> Found a good psychologist for my son who saw him via Telehealth. (sr. 37)

> Initial consultations with my son's psychiatrist and psychologist seem to have been the most helpful, including providing the right level of anti depressants and talking therapy. (sr. 78)

> The staff do their best with what little resources they have … a junior psychiatrist went above and beyond for my daughter and was a key player in her transition from 20 months in a mental health unit into the community. (sr. 87)

> took time to understand my son and his family supports, and valued my child as a person rather than a diagnosis. (sr. 262)

> My teen's positive experience came only from a private psychologist who is actively working to learn from neurodivergent advocates/trainers. She is validated, she is seen, she is seen as the expert over her own life, she is empowered to trust her own capacities to navigate her life, and access supports. (sr. 263)

However, we also heard many carers had not seen positive changes in recent years, with many believing there has been a general worsening of the mental health service system.

> core issues (e.g., fragmented care coordination, underfunded rural services) persist. Improvements feel superficial rather than systemic. (sr. 9)

> The system is broken and in total collapse in NSW. (sr. 87)

> There seems to be more options of services that a person can access until you actually try to access one. (sr. 111)

> services in general around mental health are just lacking there is not a lot funding allocated and services are becoming more thin all the time due to not real investment. (sr. 141)

> I would say the system has deteriorated. There is a lot of talk of change but all I see are busier ED's. (sr. 150)

Carer theme 2: Caring for family

While carers have diverse backgrounds and fulfill widely varying roles, we heard carers often have a close family relationship (parent, spouse, partner, or child) to the care recipient experiencing mental ill health. For many carers this underpins their motivations and experiences in providing care.

Many carers in this dual role told us about the heightened concern and distress they experience when trying to access care and support through the mental health and suicide prevention service system for the person they care for.

> My mother is 90 and has mental health issues for the past year - she tends to be disregarded because of her age and overlooked - she has to wait months at a time to see the mental health professional at the hospital. (sr. 14)

> My son attempted suicide. On hospital discharge he was referred to his GP. While developing my son's mental health plan the GP admitted that he wasn't qualified to refer him to any mental health services. (sr. 78)

> Another instance was [when] my daughter was [referred for] an eating disorder. When she went back to the mental health rehab unit the dietician was unable to consult her due to no funding. (sr. 87)

> The public health system failed us and it took months of calling multiple private practices and begging for appointments - then being charged fees for 'intake' sessions and told later they could not help us - before I found someone who can see my son next month. (sr. 206)

Many described the distress they experience as a carer when observing inadequate or poor-quality services being provided to a member of their family.

> Patients, including my partner who was experiencing psychosis and mania [in hospital ward] were treated incredibly disrespectfully by staff. (sr. 52)

> When my wife was experiencing a crisis, we tried to get her supports which ended up with an inappropriate admission to the inpatient unit, and a bungled transition to home which resulted in further and worse SHSI (self-harm screening inventory) that went unaddressed for months. (sr. 76)

> psychologist told my son and I in the waiting room, in front of other waiting clients, that my son was likely too severe for their service … I was emailed a list of private and public services to contact myself to source a psychologist for my son – all of these services had month-long wait lists. This effectively left my son with no psychology services just after an inpatient psychiatric admission. (sr. 262)

Some also told us about wanting to focus on prevention rather than acute treatment, to maintain the health and wellbeing of the person they care for and avoid potential crises.

> My children are not needing services for severe mental illness, but rather ongoing wellbeing matters that could turn into further issues as they get older. With both of them I have had trouble accessing services, to the point where we have still not seen anyone, it has left me managing how their wellbeing is. (sr. 8)

Carer theme 3: Excluded and ignored

Despite often needing to communicate and interact with mental health and suicide prevention services as part of their role in providing care for someone, many carers felt excluded and ignored by services.

> 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. (sr. 9)

> staff ignored me as a primary person providing care. (sr. 25)

> They are less likely to involve me in the planning and delivery of services aspect. Basically services will try to tell you what is going to happen regardless of what my thoughts are. (sr. 98)

> They wouldn't even speak with me. (sr. 103)

> I am often excluded because the person I provide care for is over 18yo. (sr. 187)

> Being excluded from her treatment and care because of delusions and advanced health directives not even looked at made me feel excluded when I was her primary carer and only advocate. (sr. 216)

Many parents, guardians and other adults caring for a child with mental ill health and/or suicidal distress reported feeling dismissed, ignored and negatively impacted by services.

> It is usually more as having any inclusion sidelined or advice not sought – this was especially when my person was younger. (sr. 2)

> Despite considerable advocacy for my daughter I was often dismissed and had to fight tirelessly to get support for her. (sr. 74)

> Myself, my wife, daughter and other children have been traumatised by this system. (sr. 87)

> I think mental health professionals tend to judge you as an over reacting mother without understanding your own education, experience and background. A mother's input is not highly valued. (sr. 124)

In contrast, some carers told us about more positive experiences in recent times where they had a sense of being included and supported by services.

> Carers are generally treated very well by mental health services. This is a valuable part of the mental health system. (sr. 88)

> I am able to contact my son's case manager if I have concerns. (sr. 158)

> I feel privileged that the social worker keeps us connected. Its focused on my child, and they take my lead if I have ideas. (sr. 186)
>
> GP has checked in carefully with myself regarding my service user to be supportive and to provide support for both myself and the service user. (sr. 209)
>
> Private psychiatrist and [clinic name] have provided excellent communication … Our private psychiatrist has always listened to us when we have flagged escalations in my son's depression. (sr. 262)

However, some carers told us they have had mixed experiences across services and had to persevere for some time in order to overcome being excluded and ignored by services.

> While some staff acknowledged my role as a carer, others dismissed my insights. For example, a GP once said, 'You're not the patient; your opinion doesn't matter.' (sr. 9)
>
> After decades of being dismissed and labelled an over-anxious parent, I feel there has been some improvement in some professions of the acceptance of family/parental involvement being crucial in support of the person with mental health conditions. Specifically Therapists and GPs. (sr. 84)
>
> I have had to fight to be involved despite being legally appointed guardian by QCAT and financial administrator. I have received so much push back, including being belittled and ignored until i finally complained to the health ombudsman who accepted the complaint and directed the hospital health service to attend to the complaint. It should never have gotten to that point. (sr. 254)

Carer theme 4: Caring without support

Many carers told us they experience ongoing stress and adverse impacts on their wellbeing from being a carer, especially where they encounter difficulties accessing adequate and quality treatment and support for the person they care for.

Many said they often felt undervalued, unprotected and unsupported by the service system in their role as a carer.

> there was no service capacity to protect my child nor my other children … Let alone myself. (sr. 69)
>
> Being told to go home and someone would follow up and no one ever did. (sr. 176)
>
> I don't feel like we are seen at all. Respected would be meaning we are treated like a somebody and we are not. Protected would be knowing how to help us and protecting us from ourselves when needed and this doesn't happen. (sr. 177).
>
> The person you are caring for has all the rights because to get any service they have to agree to it. Sometimes they don't have the mental capacity to agree and can walk out at any time even if the carers are in danger or the person is suicidal. (sr. 199)
>
> I was never supported in the carers role. (sr. 240)

Some carers felt under considerable pressure because they carry substantial responsibilities and perform major roles in a person's care and support, often filling gaps in the service system that are not properly recognised or supported.

> My person was given new medication without my knowledge or consent and when asking for information around the new medication i was emailed the pamphlet out of the box and told if i needed further information to google it. I have had the psychiatrist sit in a meeting a week ago and try to shift blame onto myself and other supports in front of my person which put our relationship at risk. That entire appointment was psychologically unsafe. (sr. 254)

> At my son's most acute periods of illness (immediately before or after his suicide attempts), the onus of keeping him safe and from preventing him from re-attempting suicide has been placed on my husband and I. In contrast, if my child presented to an emergency department with an acute presentation of asthma that threatened his life, he wouldn't be sent home for us to manage his acute symptoms. A major depressive disorder and suicidal ideation is just as life threatening as other physical conditions. (sr. 262)

Some carers told us about the difficulties they face in navigating the service system and that carers are not well supported with this.

> The lack of centralised official information makes it difficult to know what services exist. For instance, I discovered a local peer support group only by accident after months of searching, highlighting gaps in outreach and communication. (sr. 9)

However, some said they had experiences of receiving help and support with their role as a carer.

> Service has been amazing. Person centred, care tailored to him, Resources provided with strategies to read/review at home and share with me. (sr. 43)

> Roses in the ocean were able to support me across suicide bereavement, carer, and personal distress in an understanding way. They mapped out the services for me, checked wait times and helped me navigate into services that suited me. (sr. 110)

> Carer Gateway are outstanding. (sr. 152)

> The psychologist was thoughtful and kind. Always clear about her plans and kept us informed. (sr. 205)

> [Clinic name] provide a psychologist for my son, and a family liaison for my husband, which has been invaluable in supporting and skilling our whole family. (sr. 262)

Respondents made a range of suggestions for how services could be improved to better meet the needs of carers and the people they care for.

> I think the problem here is that there isn't enough opportunities for carers to be part of service design. (sr. 189)

> Prevention is better than cure. 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. (sr. 8)

> 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. (sr. 16).

Some highlighted the importance of tailored support for carers that recognises their specific needs and circumstances.

> not nearly enough services and or support or support groups for carers. Groups usually that are running are during the day when most people have to work. (sr. 42)

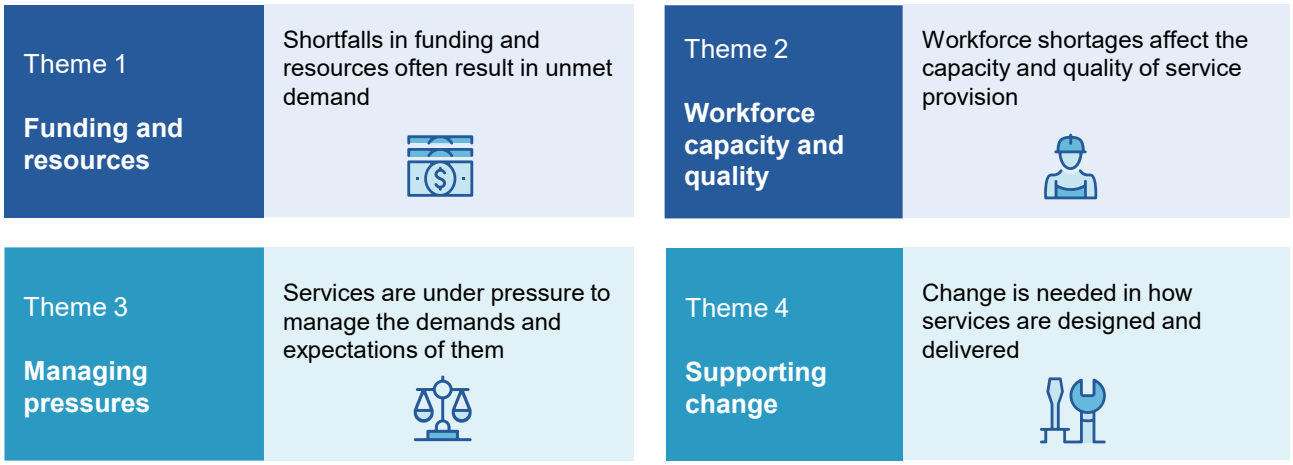
> Because we aren't linked to a government run community based service (even a bad one) it can be quite isolating at times because there is no one responsible for checking in to see how things are going. (sr. 98)

I was asked about my feelings about whether my partner was safe to go home, and whether I was okay with this. What was really good was that they asked this question privately, and asked about how I was coping etc. (sr. 168)

Main themes in responses from workers and volunteers in service provision

In the survey responses from people who work or volunteer in mental health and suicide prevention services, we heard a lack of funding and resources to meet current demands is a major issue. We heard from many about workforce shortages and the impacts of this on service capacity and quality. Many workers told us about the need for the service system to evolve to better meet the needs of consumers and improve the quality of care provided to them. Many offered suggestions for how this could be progressed (figure 9).

Figure 9 – Main themes identified in service provider responses



Service provider theme 1: Funding and resources

Many workers and volunteers told us they believe there are underlying shortfalls in funding and resources for mental health and suicide prevention services, and this is negatively impacting their ability to meet consumers' needs.

There is only so much services can provide without adequate funding. (sr. 63)

closing times/access, infrastructure, lack of funding, outdated models of care and all due to not enough money. (sr. 71)

No positive changes, only negative - less funding across the board particularly for early intervention services. (sr. 147)

lack of resourcing and funding preventing us from being able to adequately reach the people who need us. (sr. 196)

We do not have enough staff, we are underfunded and cannot offer the services people need in our area. (sr. 242)

In this context, many told us more funding is needed for mental health and suicide prevention services.

More funding for more safe spaces. (sr. 18)

> More funding, long term commitment so these services are sustainable and can provide long term support to people bereaved by suicide. It is unacceptable for people to have to wait 8 weeks to access suicide bereavement and peer support services. (sr. 110)

> More funding for community MH - it is too uncertain and not enough staff. (sr. 153)

> More funding being channelled into the most under-resourced teams to ensure our practice is actually sustainable. (sr. 196)

> FUNDING!!! Help us continue to save the lives of the men and women who have or are still serving. (sr. 255)

> Funding for postvention services should be increased, stabilised over the long-term and better integrated with the broader mental health and suicide prevention system. This would ensure services can respond promptly to people who have lost a loved one to suicide. (sr. 266)

Some told us that without more funding to support subsidised access to clinical services, consumers face significant financial barriers to access ongoing care and treatment.

> I would like to see more brokerage funding available so that we are better able to support assessments that may be required to confirm diagnoses to ensure that the support they are receiving is beneficial to them. Unfortunately, there is a large gap in the mental health sector when it comes to people being able to access psychiatry. Psychology is becoming more accessible, but psychiatry is still a large issue. (sr. 1)

> Increase DVA and Medicare fees to private providers of mental health services like mental health social workers and psychologists. (sr. 37)

> The introduction of additional sessions during COVID was a positive move towards addressing the mental health support needs of Australians during times of crisis … Unfortunately there were financial barriers that meant that this increased access to treatment did not reach those with less financial resources. This needs to be addressed by increasing the affordability of psychological treatment services. (sr. 128)

Service Provider Theme 2: Workforce capacity and quality

Many people who work or volunteer in mental health and suicide prevention services told us about significant workforce shortages in the sector, and how this negatively affects the capacity and quality of service provision.

> It is extremely difficult to recruit psychologists and counsellors to deal with the huge demand of clients who need one on one support. (sr. 15)

> Lack of trained mental health professionals. (sr. 42)

> Staff shortages have already emerged as an issue. Short term pilot programs make it hard to recruit staff. (sr. 166)

Many saw retention of existing workers and volunteers in mental health and suicide prevention services as essential to strengthening and stabilising the sector's workforce. Many respondents recommended improving wages, working conditions and career pathways.

> We need funding and more staff. We can train staff but we have no funds for this. (sr. 39)

> The service has real difficulty with turnover of volunteers and resorts to quite amateurish means to try to resolve that. (sr. 53)

> Increase wages, increase staff, fund charities and non profits with sustainable long term funding for confidence in jobs and long term planning and service delivery, empower community groups with such funding, more GPs in regions and rural, train GPs with mental health skills and make sure they know what services are available locally. (sr. 213)

> The workforce also need support to ensure their own mental health is not impacted by significant service demands. (sr. 242)

Many suggested there should be a greater focus on developing workforce capacity and quality.

> We also need to train up and employ a workforce that has a passion for supporting people experiencing suicidality, rather than just using the existing mental health workforce. (sr. 36)

> more funding for services to educate clinicians in contemporary, evidenced based, practices. (sr. 170)

> I would like to see a shift towards a more intentional service delivery model, taking better care of staff and ensuring they have access to safety procedures etc., providing staff with different training opportunities to improve their knowledge and upskill, being more consistent with services delivered to client … When you invest in the workers providing the labour, you will gain more as they will be better trained, more motivated and passionate, and are being paid well for what they do. (sr. 162)

> More access to funding for further education to other health and teaching staff on mental health and mental illness and the importance of early identification of risk and vulnerability to aim to prevent secondary damage/trauma. (sr. 164)

> Continued commitment to learning and growth for all staff with opportunities for training and access to resources … Recruitment strategies and policies that attract and retain a diverse workforce. (sr. 230)

Service provider theme 3: Managing pressures

We heard from many workers and volunteers that as the expectations and demands placed on services have increased in recent years, and as the accessibility and availability of services has been stretched, there is growing unmet need among consumers.

> Again not enough space, resources and staff makes access difficult. People are being turned away even when they are voluntarily reaching out for help. MH has no quick fix a lot of the time and we mustn't assume a few follow up phone calls will be sufficient. Our alternative to emergency departments do NOT have enough environmental space or funding to meet demand. (sr. 47)

> it's now a lot harder to get an appointment with a psychologist or psychiatrist. (sr. 72)

> as we are non-clinical and therefore when someone is in crisis, the hospitals, ambulances, psychologists have been unable to help and therefore we feel we let our members down as are left in suicidal crisis. (sr. 153)

> 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. (sr. 164)

Respondents felt the growing pressure on services and unmet need in recent years can be attributed to increases in demand for mental health care in the community and in the complexity of some people's needs.

> Increase in client complexity, exacerbated by Covid fracturing support systems and increasing individual and family stressors. A lot of services had to just focus on their internal service needs, and a lot of networking and collaboration opportunities went by the wayside during Covid. We are not back to where we were and this has a real impact on both services and clients. (sr. 94)

> Services are overstretched. Secondary services have wait lists that are long. Especially for people that have deteriorated mental health. (sr. 42)

> Homelessness and social issues are driving mental health crisis presentations. (sr. 71)

> Increased service demand and increased reliance on mental health services; lower resilience in the population; conversely the destigmatisation of mental illness has lowered the threshold at which individuals seek help. (sr. 218)

Many told us the co-occurrence of mental ill health and suicide and problematic use of alcohol and other drugs (AOD) is contributing to increased pressure on services.

> in the intersection between co-occurring mental health and alcohol and other drug (AOD) issues. We would often have clients 'stuck' between the 2 - with AOD services saying ''we''ll work with that client once you manage their mental health concerns'', but equally other mental health services saying to AOD services 'we'll work with them once you manage the AOD side of things'. This is not a holistic approach, treating the person as a whole person rather than isolated 'issues'. (sr. 94)

> There needs to be more support for people in active addiction with substance abuse and mental illness. This is something that is falling to the wayside. (sr. 162)

Some also said that while they had seen an increase in the range of service options become available in recent years, they still had concerns about the accessibility and quality of new services.

> There are certainly more services around now to provide the support needed, and it is becoming more accessible for people who may not have previously had access to mental health services prior to COVID. (sr. 1)

> Less wait times for service but less holistic and supportive. (sr. 242)

Many highlighted fragmentation in the service system and believed there needs to more effort made to improve integration, coordination and collaboration between services.

> We are supposed to have "Universal aftercare" funded under the bilateral agreement. However, in our region, "Universal" is limited to one LGA (our region covers 3 LGAs) and the aftercare program (Wayback) can only be accessed via specific pathways. For example, there is no pathway from the intensive care unit or general hospital wards into the Wayback service. Thus if someone made a near-fatal suicide attempt such that they spend time in ICU, they will not be offered the Wayback service. (sr. 36)

> There is a strong desire for state and PHN to work together through the bilateral agreements but it isn't working as well at the frontline. People are still having trouble navigating services and equally frustrating for referrals across services – even within large HHS. (sr. 71)

Some believed competition between services for limited funding is contributing to system fragmentation and lack of collaboration between services.

> 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. (sr. 111)

> it's getting worse with the siloing and division of service funding. (sr. 76)

In contrast, some told us they had seen some improvements in collaboration and coordination between services.

> Suicide prevention networks, Anglicare WA metro postvention response services, StandBy, Roses in the ocean, are all new to the Perth metro area in the past 3 years and this has seen coordinated responses to critical incidents and high impact suicides as well as more suicide specific and peer support service options for communities. (sr. 110)

> Being from another state it has taken time for the local services and GPs to accept my provision of service, but I find that now I am known and GPs refer clients using my name not the service, this is very rewarding. (sr. 209)

Service provider theme 4: Supporting change

We heard from many respondents about the need for changes to the way services are designed and offered to better meet the needs of consumers. Many believed services should continue or begin to involve people with lived and living experience of mental ill health or suicide in planning and delivery of services. This was seen as important for improving the quality of service provided and the experience and outcomes of consumers.

> We need more buy-in from the government as to the value and importance of the peer-led workforce. Lived experience workers are a safe, holistic, unique and sustainable alternative to traditional clinical care, and are especially important now, whilst psychiatrists and clinical care is almost impossible to source. (sr. 21)

> The service puts lived experience at the forefront – it is crucial that those with experience of mental ill-health and/or suicide are the ones volunteering, informing and guiding the delivery of mental health services. (sr.70)

> Peer-to-peer support offers a compassionate space where individuals facing mental health challenges can find understanding and care. It fosters connections that help people feel seen, heard, and empowered on their journey to well-being. (sr. 149)

> Lived experience being added to the mental health system, people are feeling more understood and safe. This has been a great change in the mental health system. (sr. 194)

However, some expressed concern about the inadequate institutional and workplace support provided for peer workers and people with lived and living experience.

> We also need a more genuine focus on the expertise that people with a Lived Experience of suicide bring. Far too often, it is painfully apparent that the Lived Experience representative(s) on a committee are only there to tick a box, rather than because they are seen as bringing something of genuine value to the committee. It is often the case that the LE representatives are the only people in the room who have knowledge of and experience in the suicide prevention sector, yet they are still dismissed by the rest of the committee, which, as I said, is generally made up of mental health clinicians. (sr. 36)

> Erosion of LEW workforce. They are so desperately needed. We need to expand not deplete these colleagues. The issues are not emerging, they are well known and very apparent. Refusal to address them is the problem and that is the priority area to fix. Law breaches, EBA breaches, it's a disgrace. (sr. 249)

We heard from some respondents about the need for services to go beyond the rigidities of a medical approach in how they provide support to people.

> I have seen repeatedly the enormous harm done to patients, patient's families, and clinicians by the medicalisation of suicide. (sr. 20)

> for many people a health response to mental health issues and distress just doesn't work, isn't even needed. (sr. 80)

> all too often, we find ourselves surrounded by medical staff who seem more like automatons, mechanically adhering to heartless regulations. (sr. 149)

Some respondents highlighted service improvements that had been implemented, where providers had adopted more person-centred, holistic and trauma informed approaches to care and support.

> I have seen an increase in commitment from mainstream services to providing an inclusive service for marginalised groups of people. Provision of person centred and trauma informed practices. (sr. 230)

> Services have also improved due to being re-designed with a stronger focus on being person-centred. (sr. 266)

Many positive experiences of working in the service system were highlighted by respondents. Often this was the opportunity to support people to heal and recover from mental ill health or a suicide crisis and see improvements in their wellbeing over time. We heard from many respondents about the satisfaction they gained from helping others and how this underpinned their motivation working or volunteering in the service system.

> Celebrating the small wins with some of my clients and seeing them determined to achieve their goals and continually work on their recovery. (sr. 1)

> Listening to people and validating their experience, sometimes making a difference. (sr. 31)

> It's great to see them when they get well often after many months, sometimes several years, working with them. (sr. 37)

> It is the best experience working with someone's own goals of recovery. (sr. 71)

> Seeing positive relationship changes, engagement, less admissions in crisis, consumer returned to work and living life best they can. (sr. 91)

> Seeing a person who was at their lowest point now working, in a healthy relationship and looking to the future. (sr. 111)

> Getting to meet new people and deliver my lived-experience story to students – something I wish I had when I was in school. It feels incredibly empowering to feel like you are helping contribute to a better mental health system and reducing the stigma around it. (sr. 112)

> We are able to empower young people to normalise talking about mental health in a really meaningful way. Seeing that happen is beautiful. (sr. 196)

> I love working in mental health and being able to speak with service users. Seeing the positive impacts for the people I work with. (sr. 242)

> There are many from over the years, but simply put, when a consumer, their family and carers, are supported, engaged and have agency and informed choice over their mental health care. Watching their journey of recovery and being in the privileged position of sharing their outcomes. (sr. 249)

Respondents made suggestions for how improvements to mental health and suicide prevention services could be achieved by working outside the silos and confines of the mental health system through greater coordination across systems, particularly with the AOD treatment system.

> I had a client die by suicide who I believe would have made it through. He was an alcoholic who had relapsed after 10 years sobriety. He wanted help, and had been successful in managing alcohol and depression previously. The mental health unit declined him due to his alcoholism. Detox declined him due to his suicide risk. He hung himself in his unit. (sr. 31)

> Further work needs to be done to stop the slipping of mental health and alcohol and drug services. They both need a harm reduction approach. They both need to recognise they are interdependent and are serviced poorly through separated provision. (sr. 71)

> Dual diagnosis is a huge issue in rural and regional areas. If a person has a disability they are often told to access NDIS, NDIS will no longer support mental health needs and if the person has a drug and/or alcohol history they are not able to access NDIS or Mental health support. (sr. 111)

We heard a range of suggestions from workers and volunteers in service provision for how the service system could be improved to better meet people's needs. Some highlighted specific parts of the service system they saw as important.

> Bereavement support is a critical component of the mental health and suicide prevention system. Researchers have found that bereaved people are 65% more likely to attempt suicide if they are grieving for loved ones who took their own lives. Beyond the tragic loss of a person to suicide, the impact of suicide deaths are felt by up to 135 people, including family members, friends, work colleagues and first responders at the time of death. (sr. 266)

> There needs to be a huge increase in public campaigns and awareness as to what mental health and suicide prevention orgs do and what services and supports they offer. (sr. 21)

> Given the increasing demand for psychology services and increasing waiting lists to access psychologists, we believe the deployment of provisional psychologists is one of many ideal solutions to swiftly improve the availability of much-needed mental health care support for Australians. (sr. 128)

> Health departments and health service providers need funding incentives to develop seamless care and to take responsibility for the gaps and blockages between systems instead of washing their hands of it. (sr. 166)

1. The role of the Agreement and this review

Key points

- **The National Mental Health and Suicide Prevention Agreement is the first of its kind. Under the Agreement, governments committed to work towards whole-of-government reform to address gaps in the mental health and suicide prevention system and ensure services are responsive to the needs and preferences of people with lived and living experience of mental ill health and suicide and their supporters, family, carers and kin.**
- **The Agreement operates alongside many other policies aiming to improve mental health and suicide prevention outcomes. It contributes about 3% of the annual public funding of mental health and suicide prevention services.**
- **Funding commitments are contained in bilateral schedules signed by the Australian Government with each state and territory government. A range of services are funded through the Agreement, such as peer-led drop-in centres, supports to people following a suicide attempt and perinatal mental health screening.**
- **The Agreement is set to expire in June 2026. This report is the final review of the Agreement, examining what it has achieved and making recommendations for future direction.**

The Australian, state and territory governments signed the National Mental Health and Suicide Prevention Agreement in 2022, to formalise their commitment to work together to improve mental health outcomes and reduce the rate of suicide towards zero.

In January 2025, the Australian Government asked the PC to review the Agreement, ahead of its expiry in June 2026. The PC thanks all individuals and organisations that have taken part in the review and acknowledges the important contributions of people with lived and living experience of mental ill health and suicide, and their supporters, family, carers and kin.

1.1 The National Mental Health and Suicide Prevention Agreement

Mental health and suicide prevention funding and service delivery responsibilities are shared between the Australian, state and territory governments. The way governments work together directly affects the experiences of consumers and the availability of services that suit people's needs.

Governments signed the Agreement to create 'a platform to ensure all parties work together to build a better mental health and suicide prevention system for all Australians against a range of priority areas, including prevention and early intervention, suicide prevention, treatment and support, supporting the vulnerable, workforce and governance, and quality and safety' (clause 8). The Agreement outlines commitments to enable progress towards whole-of-government reform that will 'deliver a comprehensive, coordinated, consumer focused and compassionate mental health and suicide prevention system to benefit all Australians' (clause 3).

The Agreement is the first of its kind, but it follows a series of national mental health plans starting in 1992. The Fifth National Mental Health and Suicide Prevention Plan ended in 2022. The Agreement recognises the Plan's reform directions, emphasising coordinated effort to address system gaps, and adds co-funding commitments agreed between governments (box 1.1). Signing a national agreement was a recommendation of the PC's Mental Health inquiry in 2020.

Box 1.1 – What is the role of a national agreement?

National agreements are an instrument used to support national coordination of policy areas that are primarily state responsibilities (like health) and to govern funding transfers for the delivery of services in these areas. The role of national agreements is established through the Intergovernmental Agreement on Federal Financial Relations (the IGA FFR) (CFFR 2022).

The IGA FFR recognises state and territory governments have primary responsibility for many areas of service delivery, but coordinated national action is necessary to address Australia's economic and social challenges. It outlines how national agreements should perform this role, including stating agreements should reduce the extent to which the Australian Government prescribes the way services are delivered by state and territory governments, clarify roles and responsibilities and enhance accountability to the public (clause 9) (CFFR 2022).

In signing the Agreement, governments jointly agreed to five objectives, five outcomes, 13 outputs, 14 policy principles and a plethora of commitments for national and jurisdictional actions (figure 1.1).

Unlike other national agreements, the National Mental Health and Suicide Prevention Agreement contains only limited funding commitments. In an average year, funding commitments in the Agreement total about $360 million, or 3% of the $12.6 billion governments spent on mental health and suicide prevention in 2022-23 (SCRGSP 2025, tables 13A.1-13A.3). State and territory governments contributed $8 billion and the Australian Government contributed $4.6 billion. The bulk of Australian Government expenditure is through the Medicare Benefits Schedule (including rebates for services from general practitioners, psychiatrists and psychologists) and the Pharmaceutical Benefits Scheme. A large part of state and territory expenditure is for hospital services in the National Health Reform Agreement (SCRGSP 2025, tables 13A.1-13A.3). Suicide prevention services were estimated to comprise 1% of this total expenditure in 2019-20 (PC 2021).

Throughout the Agreement, governments emphasise the need to incorporate the voices of people with lived and living experience in all aspects of the system – although different clauses use different terms to describe their involvement. For example, clause 47 seeks to ensure '[t]he voices of people with lived experience are embedded in the planning, design and evaluation of services', while clause 55 states governments 'will seek advice and provide opportunities for people with lived experience of mental health and/or suicide, other experts including representatives for … priority populations … and community groups to influence matters of service design, planning, implementation, evaluation, data and governance'.

Figure 1.1 – The National Mental Health and Suicide Prevention Agreement

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 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

Source: Adapted from the National Mental Health and Suicide Prevention Agreement.

Aboriginal and Torres Strait Islander people are one of the 15 priority populations identified in the Agreement. Governments committed to align the implementation of the Agreement with the National Agreement on Closing the Gap and other key commitments, such as the Gayaa Dhuwi (Proud Spirit) Declaration, aiming to improve the social and emotional wellbeing of Aboriginal and Torres Strait Islander people. However, there are no specific measures in the Agreement relating to improving services for Aboriginal and Torres Strait Islander people. These issues are discussed in detail in chapter 7.

The Agreement articulates a commitment to whole-of-government collaboration

The Agreement recognises the role of services within and beyond the health system in influencing mental health and suicide prevention outcomes (clause 20m). This whole-of-government approach seeks to address the social determinants of mental health and suicide, rather than being narrowly focused on mental health and suicide prevention services. Schedule A identifies priority areas for whole-of-government collaboration and assigns responsibilities to portfolios outside of mental health and suicide prevention. For example, Health Ministers are to work with Education Ministers on prevention and early intervention, considering approaches to improve school-aged children's social and emotional wellbeing under the National School Reform Agreement (Schedule A, clause 2).[3] Schedule A also contains commitments to integrate and strengthen referral pathways between mental health and suicide prevention supports and services such as homelessness, financial counselling and family, domestic and sexual violence services.

Bilateral schedules contain funding commitments for specific initiatives

The Agreement itself is a high-level document providing broad policy direction for the mental health and suicide prevention system. Specific initiatives and funding commitments are contained in bilateral schedules signed by the Australian Government with each state and territory government. Bilateral schedules allow governments to incorporate a flexible approach to meeting the objectives of the Agreement and recognise the distinct circumstances of each jurisdiction.

There is significant similarity between the commitments in the bilateral schedules (table 1.1). The 11 common initiatives included in the bilateral schedules are based on initiatives the Australian Government introduced prior to the Agreement's negotiations (such as Adult Head to Health Centres – since renamed Medicare Mental Health Centres – and headspace). In some cases, jurisdictions adapted the implementation of initiatives to pre-existing reforms or strategies.

The bilateral schedules outline funding commitments under the Agreement (table 1.2). The Australian Government contributes the bulk of its funding through primary health networks (PHNs), which commission services in line with the commitments in the bilateral schedules. State and territory governments commit funding through the bilateral schedules to co-fund many of these initiatives. The bilateral schedules reflect differences in state and territory governments' contributions (including in-kind contributions) and circumstances; in Victoria's case, for example, the investment undertaken by the Victorian Government to implement the recommendations of the Royal Commission into Victoria's Mental Health System is reflected in its higher financial contributions to the bilateral schedule.

[3] The Better and Fairer Schools Agreement replaced the National School Reform Agreement in January 2025.

Table 1.1 – Initiatives for collaboration under the bilateral schedules reflect similar content[a,b]

	NSW	VIC	QLD	WA	SA	TAS	ACT	NT
Adult Head to Health Centres[c]	✓✓	✓	✓✓	×	✓✓	✓✓	✓✓	✓✓
Head to Health Kids Hubs	✓✓	✓✓	✓✓	✓✓	✓✓	✓✓	✓✓	✓✓
Investment in headspace centres	✓✓	✓	✓✓	✓	✓✓	✓✓	✓✓	✓✓
Universal Aftercare Services	✓✓	✓	✓✓	✓✓	✓	✓	✓✓	✓
Distress Intervention Trial Program	✓✓	✓	✓✓	×	✓✓	×	×	×
Postvention Support	✓✓	✓✓	✓✓	×	✓✓	×	×	✓✓
Perinatal Mental Health Screening	✓✓	✓✓	✓✓	✓✓	✓✓	✓✓	✓✓	✓✓
National Phone/Digital Intake Service	✓	✓✓	✓	×	✓✓	✓✓	✓	✓✓
Initial Assessment and Referral	✓	✓✓	✓	✓	✓✓	✓✓	✓✓	✓✓
Workforce	✓✓	✓	✓✓	✓	✓✓	✓✓	✓	✓✓
Regional Planning and Commissioning	✓	✓✓	✓✓	✓	✓✓	✓✓	✓✓	✓✓
Eating Disorder Services	×	×	×	✓✓	×	✓✓	✓✓	×
Aftercare referral pathways trial	×	✓✓	×	×	×	×	×	×
Aboriginal Mental Health and Wellbeing Centre	×	×	×	×	✓✓	×	×	×
Preventing and reducing suicidal behaviour	×	×	×	×	✓✓	×	×	×
Veterans' Mental Health	×	×	×	×	✓✓	×	×	×

a. ✓✓ indicates a commitment to the initiative; ✓ indicates an altered or partial model for the initiative; × indicates no commitment. **b.** Some of the initiatives have a different title under the bilateral schedule – the name of the program itself has been used above. For example, investment in headspace centres is delivered under Enhancement and Expansion of Youth Mental Health Services. **c.** Adult Head to Health Centres have been renamed Medicare Mental Health Centres.

Source: Adapted from bilateral schedules.

Table 1.2 – Funding provided under the bilateral schedules, April 2022 to June 2026[a]

	Australian Government contribution ($mil)	State/territory government contribution ($mil)	Total funding ($mil)
New South Wales	216.0	167.2	383.2
Victoria	247.9	564.7	812.6
Queensland	150.9	109.5	260.4
Western Australia	35.1	26.5	61.5
South Australia	92.1	61.8	153.9
Tasmania	45.6	9.4	55.0
Australian Capital Territory	25.2	12.9	38.1
Northern Territory	30.6	13.3	43.9
All	**843.3**	**965.2**	**1,808.5**

a. Figures may not add up to totals due to rounding.

Source: Adapted from bilateral schedules.

Governance and reporting requirements

Reflecting its whole-of-government commitment, the Agreement was signed by Treasurers, whereas prior national mental health plans were endorsed by Health Ministers. However, the Council on Federal Financial Relations, which brings together the Australian, state and territory treasurers, does not play a role in the governance of the Agreement beyond its responsibility to oversee the Intergovernmental Agreement on Federal Financial Relations (box 1.1). Governance of the Agreement is handled by departments of health, with other government agencies involved in a working group dedicated to Schedule A.

Health Ministers and Mental Health Ministers from all jurisdictions have collective responsibility for the Agreement through the Health Ministers Meeting. National Cabinet (comprising the Prime Minister and state and territory First Ministers) has oversight of the Agreement (figure 1.2). Implementation of the Agreement is overseen by the Mental Health and Suicide Prevention Senior Officials Group (MHSPSO), which includes senior officials nominated from each jurisdiction who have responsibility for mental health and suicide prevention policy, alongside representatives of people with lived and living experience of mental ill health and suicide and carers. MHSPSO is responsible for reporting on key risks and implementation issues, lessons learned from implementation, and new and emerging policy developments (clause 52).

The Agreement does not provide guidance on the way its governance mechanisms should incorporate the views of Aboriginal and Torres Strait Islander people. The Social and Emotional Wellbeing Policy Partnership was endorsed by MHSPSO and the Closing the Gap Joint Council as the primary governance body advising on Aboriginal and Torres Strait Islander mental health and wellbeing and two representatives were appointed to MHSPSO (chapter 7).

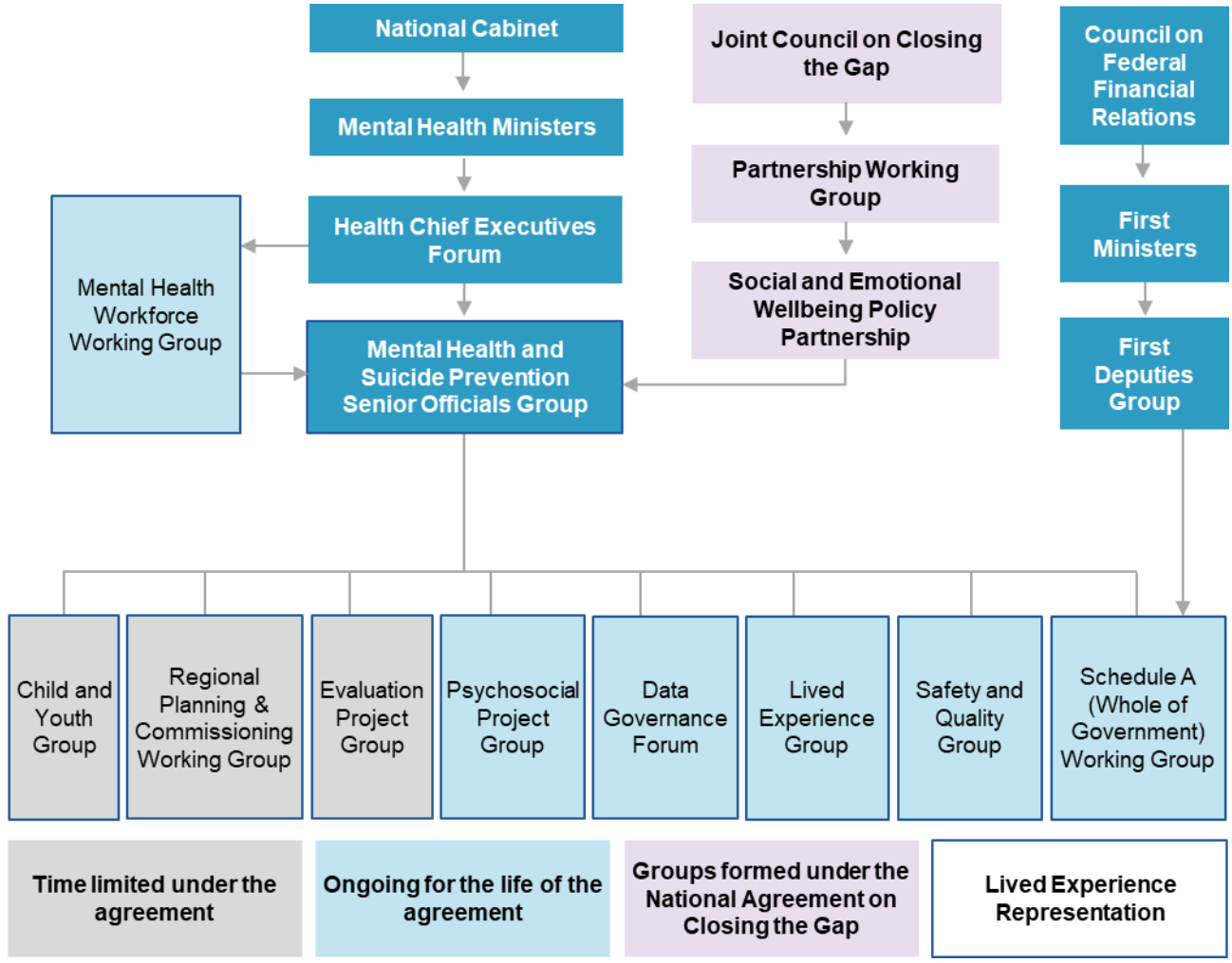
Six ongoing and three time-limited working groups have been established under MHSPSO to advance specific aspects of the Agreement (figure 1.2). The Schedule A working group is led by the Department of the Prime Minister and Cabinet and includes representatives from jurisdictional departments of premier and cabinet and mental health commissions (NMHC 2025, p. 17). This group is responsible for developing a work plan to guide whole-of-government implementation and for providing progress updates to MHSPSO every six months (Schedule A, clause 13). Each bilateral schedule includes a section on governance arrangements and the relevant committees to oversee implementation.

Monitoring of progress under the Agreement occurs through an annual progress report developed by each jurisdiction. The National Mental Health Commission (NMHC) was tasked with consolidating these into an annual national progress report. Two reports have been compiled since the Agreement was signed.[4]

Beyond the implementation of specific commitments, governments also agreed to 'monitor and evaluate the mental health and suicide prevention system' (clause 83a). The Agreement recognises this requires additional data collections as well as greater efforts to share and link data. The Agreement contains significant commitments to improve data collection, sharing and linkages, including a list of priority indicators that need to be developed to assess progress against the Agreement's outcomes (chapter 2).

[4] The 2023-2024 Annual National Progress Report was yet to be publicly released when this inquiry report was submitted to the Australian Government on 16 October 2025.

Figure 1.2 – The governance structure of the Agreement includes many working groups



Source: Adapted from NMHC (2024a, p. 9, 2025, p. 55).

The Agreement is one part of the policy environment

The Agreement overlaps with many other key documents developed by the Australian, state and territory governments, including other national agreements.

The most significant is the National Health Reform Agreement (NHRA). Under the NHRA, governments work together towards 'improving health outcomes for Australians, by providing better coordinated and joined up care in the community, and ensuring the future sustainability of Australia's health system' (DoHAC 2024a). It is the key mechanism for the financing and governance of Australia's public hospital system.

The NHRA establishes roles and responsibilities that apply to mental health and suicide prevention. It includes funding for services delivered through hospitals and community health settings, all of which provide support to people with lived and living experience of mental ill health and suicide.

The mid-term review of the NHRA criticised the NHRA for operating in isolation from other agreements, including the National Agreement on Mental Health and Suicide Prevention (Huxtable 2023, p. 25). It noted the need for the objectives of the National Mental Health and Suicide Prevention Agreement to be reflected in the NHRA's next iteration with 'actions, accountabilities and milestones agreed' (Huxtable 2023, p. 1). It

highlighted the potential to use the NHRA mechanisms, 'including models of care, financing, innovation and performance monitoring to progress … actions in … mental health' (Huxtable 2023, p. 5).

The Agreement also interacts with the National Disability Insurance Scheme (NDIS), which provides funding to eligible people with disability to access services and supports. Some mental health supports are included within the scope of the NDIS, and the transition to the NDIS has had a significant effect on the delivery of community-based mental health services (PC 2020). The 2023 Review of the NDIS noted the need for expanded psychosocial supports outside of the NDIS to be managed and delivered under the Agreement, improved interface between the NDIS and mental health system, and better management of the interdependencies of the NDIS and the mental health system (PM&C 2023).

Many other policy documents, developed by the Australian Government, sit alongside the Agreement (table 1.3 lists examples). State and territory governments have developed their own mental health and suicide prevention strategies, frameworks, plans and policies, which affect the operation of the bilateral schedules.

Table 1.3 – Key mental health policy documents developed by the Australian Government

Key document	Description
National Mental Health Policy (Australian Health Ministers' Conference 2009)	Provides a strategic framework to guide coordinated efforts in mental health reform across all levels and areas of government.
Mental Health Statement of Rights and Responsibilities (Standing Council on Health 2012)	Clarifies the rights and responsibilities of consumers, carers, support persons, service providers and the community, consistent with international obligations and state and territory human rights instruments.
Equally Well Consensus Statement (NMHC 2016)	Statement of commitment, agreed by the Australian, state and territory governments, to improve the quality of life of people with lived and living experience of mental ill health, with the aim of bridging the life expectancy gap between people experiencing mental ill health and the general population.
National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing (PM&C 2017)	Aims to provide a comprehensive and culturally appropriate stepped care model that is equally applicable to Aboriginal and Torres Strait Islander specific and mainstream health services. The National Indigenous Australians Agency is overseeing development of a new National Strategic Framework.
National Mental Health and Wellbeing Pandemic Response Plan (NMHC 2020)	Identifies the specific challenges to mental health and wellbeing associated with the COVID-19 pandemic and outlines measures to address them.
National Children's Mental Health and Wellbeing Strategy (NMHC 2021b)	Long-term vision for supporting the mental health and wellbeing of all children.
National Suicide Prevention Strategy (NSPO 2025)	A comprehensive long-term strategy that aims to coordinate the efforts of governments, communities and service providers to improve suicide prevention outcomes.
National Aboriginal and Torres Strait Islander Suicide Prevention Strategy (DoHAC 2024e)	Aims to achieve a significant and sustained reduction in suicide and self-harm of Aboriginal and Torres Strait Islander people towards zero through Aboriginal and Torres Strait Islander community leadership and governance.

1.2 The PC's approach to reviewing the Agreement

In January 2025, the Australian Government asked the PC to review the Agreement. The terms of reference asked the PC to holistically consider, assess and make recommendations on the effectiveness and operation of the Agreement. The PC was asked to:

- consider the wellbeing and productivity impacts of the mental health and suicide prevention programs and services delivered under the Agreement
- assess the effectiveness of the administration of the Agreement, including reporting and governance
- ensure the voices of Aboriginal and Torres Strait Islander people and people with lived and living experiences are heard.

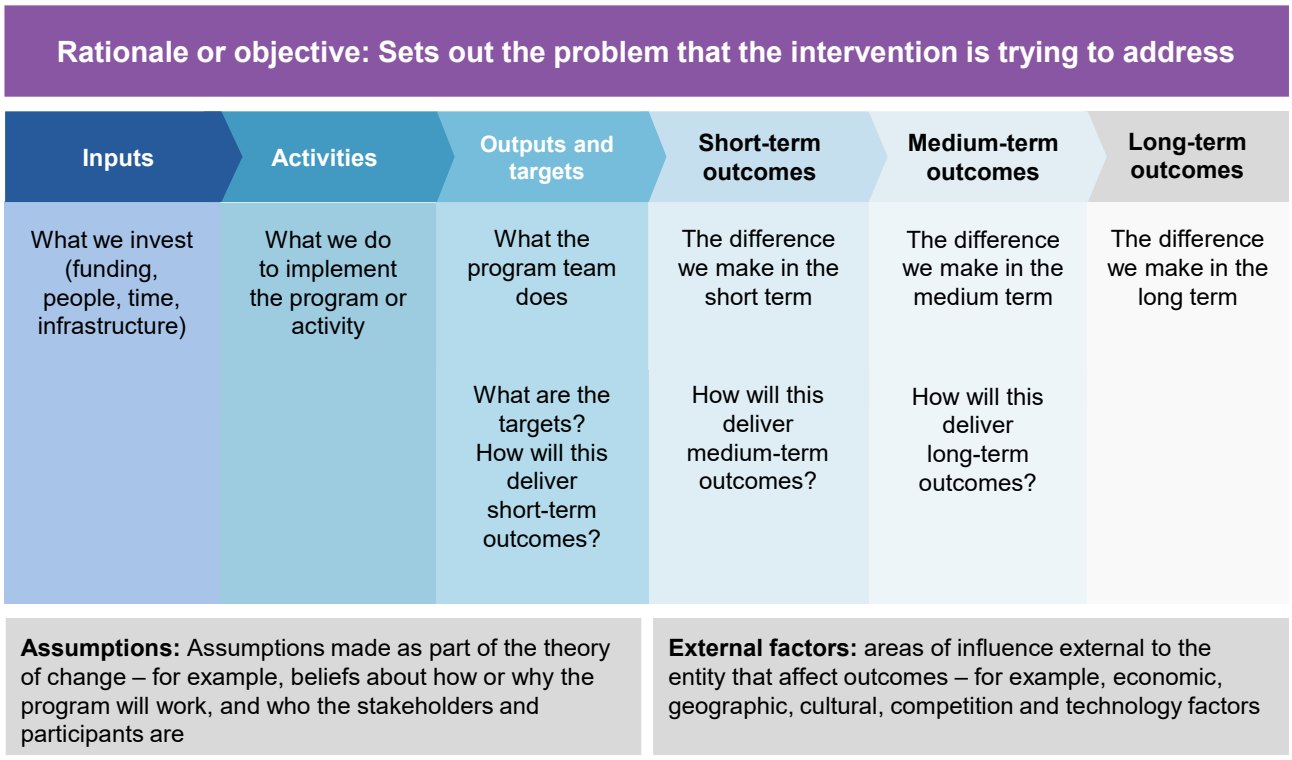
In conducting this review, the PC sought to centre the insights and experiences of people with lived and living experience of mental ill health and suicide, their supporters, family, carers and kin as well as service providers, peer workers and practitioners. These experiences provide a critical reflection on what the Agreement has achieved and how it can be improved. A detailed summary of the engagement undertaken is included in the *What we heard* paper.

In line with the frameworks developed by the Australian Centre for Evaluation and the approach taken by the PC in previous reviews of national agreements, this report uses theory of change and program logic principles to assess the current Agreement and develop recommendations for the future (PC 2022c, 2024b; The Treasury 2025b). A theory of change seeks to 'capture all of the essential elements necessary to understand how a program or activity will achieve the intended outcomes' (The Treasury 2025b). A program logic sets out the pathways through which the inputs and activities of the policy are expected to lead to its outputs and intended outcomes (figure 1.3). A key question for this review is whether these pathways have been articulated clearly in the structure of the current Agreement (chapter 3).

Some of the benefits of using a theory of change include:

- ensuring policy works towards advancing long-term outcomes, and all stakeholders hold similar views about the problem the policy is seeking to address and what success looks like (Goldsworthy 2021)
- creating a policy that is evidence-based, which increases its likelihood of success (Ecorys 2023, p. 15). This process also highlights where there is a need for more evidence
- increasing transparency and accountability. Explicitly mapping how inputs and activities contribute to outcomes provides transparency and holds those designing and implementing the policy to account
- reducing the risk of waste. Articulating how activities and actions contribute to the intended policy outcomes and objectives reduces the risk of resources being used on activities that do not contribute to the outcomes of the policy
- facilitating evaluation and improving the evidence base (BetterEvaluation 2025). By setting out the outcomes and outputs of a policy, data can be collected on those measures and used in an evaluation of the policy. This evaluation also adds to the evidence base.

Figure 1.3 – Linking objectives and outputs in policy development



Source: Adapted from the Commonwealth Evaluation Toolkit (The Treasury 2025a).

This report presents the PC's findings on the progress made in achieving the Agreement's objectives, outcomes and outputs (chapter 2) and the effectiveness of the Agreement in advancing reform (chapter 3). It includes recommendations on necessary changes and areas of focus for the future, including the policy architecture for the next agreement (chapter 4), its governance and accountability structures (chapter 5) and its approach to funding (chapter 6). We have also examined the way the next agreement can support the social and emotional wellbeing of Aboriginal and Torres Strait Islander people (chapter 7), improve suicide prevention services (chapter 8) and address the interactions between problematic use of alcohol and other drug use, mental ill health and suicide (chapter 9).

2. What has the Agreement achieved?

Key points

- **The National Mental Health and Suicide Prevention Agreement set out to achieve an ambitious reform agenda. Assessing progress against this agenda is a complex task.**
  - There is limited publicly available information about actions taken by governments as part of the Agreement.
  - There are still significant data gaps, including a lack of current data on the outcomes achieved under the Agreement.
  - In the three years since the Agreement was signed, significant external factors have also influenced outcomes and services. These effects are difficult to disentangle.
- **While there has been progress in achieving elements of the Agreement, these actions have not led to meaningful improvements across the system for people with lived and living experience of mental ill health and suicide.**
  - Nine of the Agreement's 13 outputs have been delivered. However, some outputs, such as the analysis of gaps in psychosocial supports and the National Mental Health Workforce Strategy, lack sufficient depth and structure to enable progress.
- **Key outputs of the Agreement have not been delivered or need further work. Government action is urgently needed to:**
  - **finalise arrangements for the provision of psychosocial supports outside the National Disability Insurance Scheme**
  - **publish the National Stigma and Discrimination Reduction Strategy to enable the implementation of nationally consistent policies**
  - **publish detailed national guidelines on regional planning and commissioning to improve collaboration between primary health networks and local hospital networks.**
- **Achieving a person-centred system that empowers people to choose services best suited to their clinical and non-clinical needs is the main objective of the Agreement. This will take time to realise but change to date has been minimal and the system remains fragmented.**
  - There is still a high level of need for mental health and suicide prevention services, with little improvement experienced over the past decade. The balance of evidence suggests the mental health and suicide prevention system is not meeting people's needs.

The National Mental Health and Suicide Prevention Agreement represents a commitment from governments to undertake actions to improve the mental health and wellbeing of Australians and reduce the rates of suicide, suicidal distress and self-harm. This chapter assesses the progress achieved to date under the Agreement.

Understanding the mental health and suicide prevention system within which the Agreement operates is important for our assessment of whether the system is meeting people's needs (section 2.1). Assessing progress against the Agreement is not straightforward, due to a lack of relevant data as well as a range of external factors that influence outcomes (section 2.2). This chapter considers progress across two parts of the Agreement:

- specific outputs listed in the main Agreement and bilateral schedules (sections 2.3 and 2.4)
- governments' intent to work together to deliver a coordinated, person-centred mental health and suicide prevention system, which is the core purpose of the Agreement (section 2.5).

This review examines what progress has been made by governments to date in realising the commitments in the Agreement. The Agreement does not expire until 30 June 2026 and therefore further progress may be made in its final months.

2.1 What do we know about the state of the mental health and suicide prevention system?

There is no data available to describe trends in the mental health and suicide prevention system over the term of the Agreement. Most of the data was last collected in 2022 – the year the Agreement was signed. However, this data provides a useful baseline to understand the outcomes of the mental health and suicide prevention system in which the Agreement operates. This will build an understanding of where things are working, where they are not and where more information is needed. The data presented below pertains to the entire population. Changes in outcomes for Aboriginal and Torres Strait Islander people are examined in chapter 7.

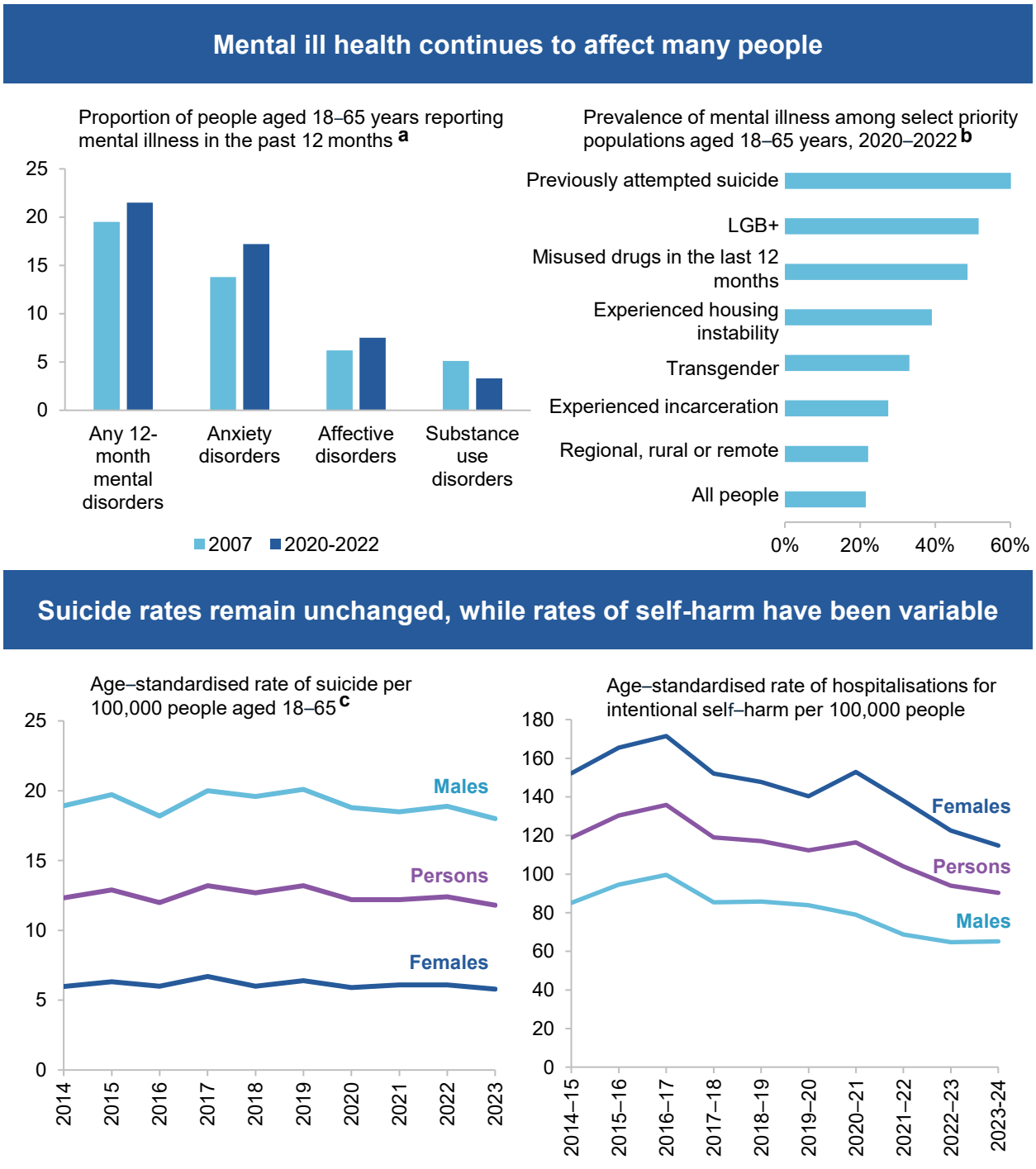
Understanding the demand for mental health and suicide prevention services

Almost half of all Australian adults will experience mental ill health at some stage of their life. The effects of mental ill health are felt not only by the individual but by their supporters, family, carers and kin and Australia as a whole (DoHAC 2024c). Most Australians will also be affected by suicide, suicide attempts or suicidal distress at some point in their lives (NSPO 2025, p. 11). The effects of suicide are devastating not only to friends and family but also to the wider community (NSPO 2025, p. 11).

The economic costs are also substantial. 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 (PC 2020, vol. 2, p. 155).

The most recent data shows that one in five Australian adults, and one in seven children, experienced mental illness in the previous 12 months (AIHW 2025k). The prevalence of mental ill health has increased slightly between 2007 and 2020–2022 (figure 2.1). Anxiety disorders have increased in prevalence and remain the most reported type of disorder (figure 2.1). The effect of mental ill health is not felt uniformly across the population, with many of the priority populations designated in the Agreement reporting a higher prevalence than the general population (figure 2.1).

Figure 2.1 – High level of need for mental health and suicide prevention services



a. People could report more than one disorder and therefore the sum of the three disorders is greater than the proportion of people who reported a mental health disorder in the past 12 months. **b.** Questions on gender orientation were asked separately to questions on sexual orientation in the ABS' survey, and so mental health prevalence has been reported separately for LGB+ and Transgender people to avoid double counting. LGB+ includes Lesbian, Gay, Bisexual and different terms. The ABS notes that different terms people may use to describe their sexual orientation include Asexual, Pansexual and Queer. **c.** Deaths are counted according to the year the death was registered by the Registries of Births, Deaths and Marriages, not necessarily the year in which the death occurred.

Source: ABS (2008, 2023); AIHW (2025n, table Deaths due to suicide 2023 – National Mortality Database, 2025p, table Hospitalisations for intentional self-harm – National Hospital Morbidity Database).

There has been minimal progress in reducing suicide rates, which have remained unchanged over the past decade (figure 2.1). In 2023, there had been a reported 3,214 deaths by suicide, or 11.8 deaths per 100,000 people (AIHW 2023b).[5] Review participants identified changes in trends in suicide rates for particular groups, including concerning increases in the rates for Aboriginal and Torres Strait Islander people (Carers WA, sub. 43, p. 10; Lifeline Australia, sub. 8, p. 3) and people in regional and remote areas (Sidney Allo and Janet Timbert, transcript, 19 August 2025, p. 22). Positively, review participants highlighted falling suicide rates in workers in predominately male blue-collar occupations and industries (Faculty of Health, Deakin University, sub. 174, p. 4; MATES in Construction, sub. 234, p. 17).

Hospitalisations for intentional self-harm have declined from their peak in 2016-17 (figure 2.1). Females and young people were much more likely than the rest of the population to be hospitalised for self-harm.[6]

More recent information suggests there are significant levels of distress in Australia. Lifeline Australia (sub. 8, p. 3) recorded the busiest year in their history in 2024, receiving 1.36 million contacts across their phone, text and chat services. Surveys run by service providers and advocacy groups can provide insights into trends. For example, the March 2025 Community Tracker survey by Suicide Prevention Australia (sub. 59, p. 7) found:

> … 73% of Australians say they're feeling more distress than this time last year due to a range of causes including cost-of-living, social isolation and loneliness, housing affordability and relationship breakdown. In addition, nearly one in five (19%) young Australians (18-34) have experienced suicidal distress in the last 12 months, including having serious thoughts of suicide, making a suicide plan, or attempting to take their life.

The mental health and suicide prevention system is not meeting community need

Both quantitative and qualitative data demonstrates the system is not meeting people's needs in many cases. In 2023-24, four in ten people delayed or did not see a health professional for mental health challenges when they needed to (figure 2.2). One in five people said cost was the reason for delaying or not seeing a health professional (ABS 2024c).

Barriers to accessing mental health and suicide prevention services are not felt uniformly across the population. Children and adults with lower incomes are significantly less likely to access psychotherapy when needed, compared with those with higher incomes. The gap in access between low- and high-income people has worsened overtime, especially for children.[7] The increase in access inequity is likely due to rising out-of-pocket costs and longer waiting times in accessing psychotherapy (Black et al. 2025).

For people in regional and remote areas, access to community-based mental health and suicide prevention services is a significant challenge (Australian Veterinary Association Ltd, sub. 125, p. 3; Manna Institute, sub. 56, p. 2; UnitingSA, sub. 213, p. 1; Youturn Limited, sub. 170, p. 3). The rates of mental health-related

[5] This is the age-standardised rate, which is an incidence rate that enables comparisons to be made between populations that have different age structures.

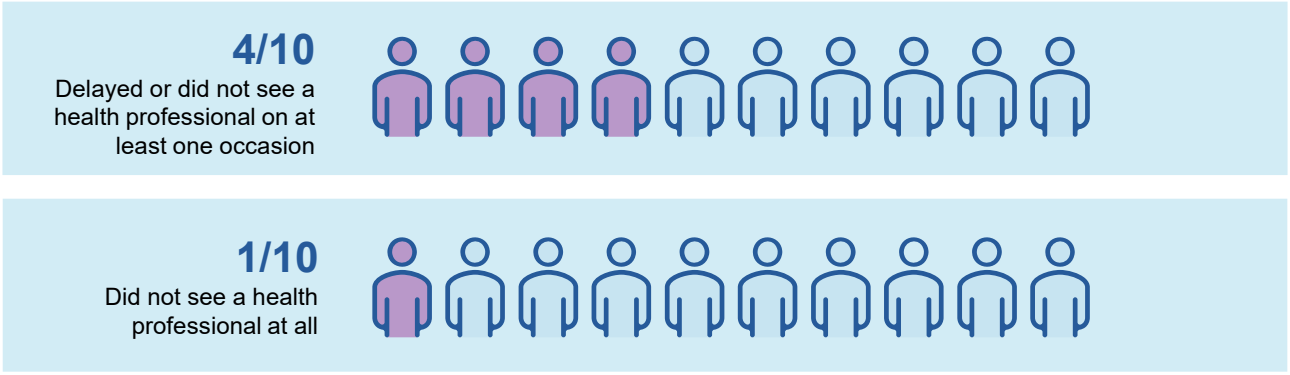
[6] In 2023-24, the rate of hospitalisations was highest for young people, especially young females aged 15–19 years with 405 hospitalisations per 100,000 population (AIHW 2025p). The rate for all females was 115 hospitalisations per 100,000 population compared to all males with the rate of 65 hospitalisations per 100,000 population (AIHW 2025d)

[7] Black et al. (2025) found that in 2014 children from high-income areas were 23% more likely than children from low income areas to access psychotherapy when needed, this grew to 51% in 2023. For adults, the gap was lower but still significant and grew from 18% in 2014 to 31% in 2023.

emergency department visits, hospitalisations for self-harm and suicides were higher in regional and remote areas (Petrie et al. 2025).

Figure 2.2 – People are postponing or not seeking professional help when needed

People aged 15 years and over, who needed to see a professional for their mental health, 2023-24



Source: ABS (2024c).

Waiting times and costs, and their negative effect on people's mental health and wellbeing, were a key theme in the PC's online survey (*What we heard* paper). Survey participants highlighted the personal impact of long wait times on their mental health.

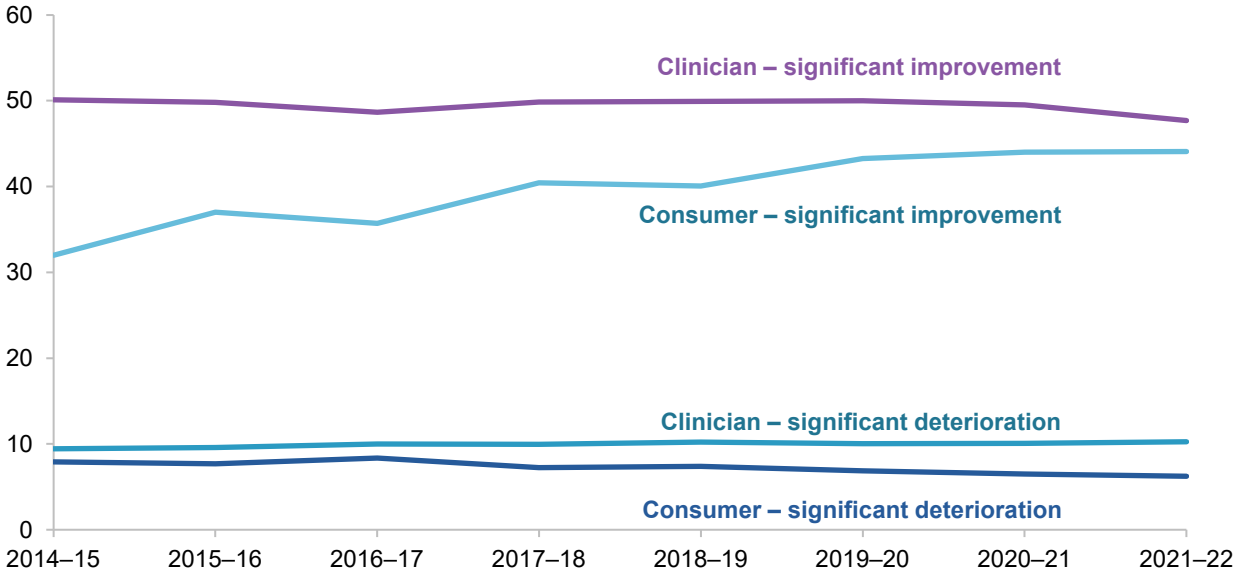
> I won't go to a hospital again. You are left there in the waiting room waiting and waiting. (sr. 48)

> i was diagnosed by the psychiatrist, which i had to wait a year to get an appointment. was then phoned to say to that i had to go back on the waiting list which doesnt get reviewed until july before i had even been given my treatment plan. leaving me still unmedicated and supported indefinitely. (sr. 175)

Survey respondents also reflected on positive experiences in the mental health and suicide prevention system, where they experienced compassionate, holistic care (*What we heard* paper). Since 2014-15, there has been an increase in the proportion of consumers who experience significant improvement following an episode of mental health care (figure 2.3).

Figure 2.3 – Outcomes for episodes of mental health care over time[a]

Proportion of episodes assessed as leading to a significant change in outcomes



a. In the National Outcomes Casemix Collection, data is collected on consumer and clinicians' evaluations of episodes of mental health care, where an episode can either be rated as leading to a significant improvement, no significant change, or a significant deterioration. This includes consumers who experienced inpatient and ambulatory mental health care. The data presented is for consumers aged 18–64 years.

Source: AIHW (2023a).

2.2 Assessing progress is not straightforward

Monitoring and reporting commitments under the Agreement have not been fully adhered to

Monitoring and reporting provide a way to measure governments' progress against their commitments and objectives in the Agreement. It can help the jurisdictions assess whether policies and programs are effective and what changes need to occur. It can also help the community to assess governments' actions and hold them to account.

Not all jurisdictions have met the reporting requirements of the Agreement within the prescribed deadline (figure 2.4). The National Mental Health Commission (NMHC) (2025, p. 53) highlighted the consequences of delayed reporting:

> Delays in the Parties' provision of completed Annual Jurisdiction Performance Reports to the Commission by the specified timeframe has delayed the completion of the Annual National Progress Report and its ultimate release to the Australian community. The final required information to enable completion of this report was provided to the Commission in May 2025. This delay has reduced the report's currency and its utility as a mechanism for highlighting implementation barriers and supporting the Parties to act on them in a timely manner.

The Consumers Health Forum of Australia (sub. 140, p. 9) commented:

> Regular and timely public reporting has not occurred under the current Agreement, which has been highly problematic for the sector.

Figure 2.4 – Unfulfilled reporting requirements

Committed reporting requirements

Annual cycle

Implementation plans	Jurisdictional progress report	National progress report
Commonwealth-state implementation plans (within 12 months, then updated annually)	Annual jurisdiction progress reports (first due 31 August 2023)	National progress report (first due 30 November 2023 and made public within three months of completion)

Reporting delivered

Implementation plans	Jurisdictional progress report	National progress report
Completed Three of the eight plans were delivered after the first 12 months	**2022–2023 progress** Substantial delays	**2022–2023 progress** A summary report was publicly released in December 2024
	2023–2024 progress Substantial delays	**2023–2024 progress** A report was compiled in November 2025[a]

a. The 2023-2024 Annual National Progress Report was not publicly released when this review was submitted to the Australian Government on 16 October 2025.

Source: PC analysis, clauses 75, 76, 78 and 79, NMHC (2024a, 2025, p. 53), NMHC and NSPO (sub. 70, pp. 10–11).

The provisions in the Agreement limit the effectiveness of reporting in two ways. First, there are no clauses to require jurisdictions to provide the data within the specified timeframes, and limited repercussions if they fail to meet reporting requirements (NMHC and NSPO, sub. 70, p. 11). Second, the jurisdictions and working groups provide the primary sources of information for reporting and therefore the extent to which NMHC can provide impartial analysis is limited (NMHC 2025, p. 53).

The NMHC and NSPO (sub. 70, pp. 11–12) criticised the reporting requirements, stating they focused on progress against commitments rather than the effectiveness of the initiatives being implemented. headspace (sub. 23, p. 6) similarly questioned whether the monitoring and reporting requirements under bilateral schedules can capture meaningful data, as the data collected is high level and does not offer sufficient insights into consumer outcomes.

In the Agreement, governments committed to continue building data and systems to improve evaluation, transparency, reporting and accountability (clause 82c) and improving the transparency of mental health and suicide prevention services spending and outcomes delivered (clause 138c). However, their actions do not reflect this intent as neither the implementation plans nor annual jurisdiction progress reports are publicly available. Furthermore, the public release of both the 2022-23 and 2023-24 National Progress Report were significantly delayed and only a summary of the 2022-23 report was released (figure 2.4).

The delay in reporting and lack of public reporting has made it difficult to assess what progress has been made against the Agreement's commitments. Many submissions stated that because of a lack of reporting, it was difficult or infeasible to assess the impact of the Agreement on outcomes in mental health and suicide prevention (Community Mental Health Australia, sub. 84, p. 6; Consumers Health Forum of Australia, sub. 22, pp. 5–6; Mental Health Australia, sub. 76, p. 16; Queensland Nurses and Midwives' Union, sub. 16, p. 5).

Despite some progress, key data challenges remain

In the Agreement, governments state that comprehensive, accurate and accessible information is critical to reform in the mental health and suicide prevention space (clause 80). The Agreement emphasises the need to improve data collection and sharing, to improve data linkage, reporting and transparency, and to use data better to build an evidence base for system improvement (clauses 80–103). Governments agreed they would use the 2020 National Mental Health Performance Framework to monitor and evaluate this system, and they committed to establishing a data governance forum to coordinate the data reforms (clauses 83a, 84).

The Data Governance Forum (DGF) was established by June 2023, and is responsible for overseeing and facilitating the commitments to data and performance measurements within the Agreement (NMHC 2024a, p. 17). There has been substantial progress in data sharing and linkage.

The Agreement helped facilitate the continuation of monthly intergovernmental data sharing meetings, a secure data sharing portal and an agreement to allow increased uses of aggregate data by governments (DGF, pers. comm., 20 May 2025). The data shared includes specialised mental health services (community and admitted), emergency department, other mental health program data and MBS and PBS information (NMHC 2025, p. 49). The Australian Institute of Health and Welfare (AIHW) has established an integrated reporting dashboard to monitor trends in the shared data. A key output from this increased sharing was the development of detailed integrated regional profiles, for public access and use by commissioning organisations (DGF, pers. comm., 20 May 2025).

In response to the priority data linkage commitment (clause 94a), the DGF facilitated a pilot data linkage project to connect state and territory community and residential mental health care data with broader systems data in the National Health Data Hub (DGF, pers. comm., 20 May 2025). Queensland and Victoria are participating in the pilot program, and the remaining jurisdictions are working with AIHW to explore their involvement (NMHC 2025, p. 50). Two indicators in Annex B of the Agreement (life expectancy gap and potentially preventable hospitalisations) are expected to be reported against using this linked data (DGF, pers. comm., 7 October 2025).

The broader commitment to linked data (clause 94b) within 30 months of the Agreement is yet to commence. DGF explained that the project cannot commence until the priority data linkage commitments are completed (NMHC 2025, p. 57).

There are still areas of missing data

Despite the vast collections of data, there are still significant knowledge gaps about Australia's mental health (Black Dog Institute, sub. 61, p. 11; NMHC 2024a, p. 18; Pagliaro et al. 2024, p. 212; Ruah Community Services, sub. 14, p. 8). One reason for this is that the data collected is not always fully utilised (including through sharing and linkages) (PC 2020, pp. 1191–1192). There are also still areas where there is insufficient data (box 2.1), which makes assessing progress under the Agreement difficult.

Annex B to the Agreement contains an ambitious set of data and indicators for development and there is still more work to be done. As at October 2025, ten priority data and indicators for development have been published or reported to the NMHC for inclusion in the Annual National Progress Report (2023-24) under the Agreement and 13 are still in development. Progress of some priority areas is expected to take longer than the life span of the Agreement due to the vast number of indicators, the detailed research, negotiations in determining data definitions and the need for dedicated funding (DGF, pers. comm., 7 October 2025).

Box 2.1 – Gaps identified in data holdings

The development of mental health and suicide prevention data collections at a national level has primarily been based on the Leginski framework. The Leginski framework states that the data collection must be sufficient to answer the question: *who receives what from whom at what cost and with what effect?*

Applying the framework in the PC's 2020 Mental Health inquiry demonstrated there is insufficient data on the following areas:

- outcomes data that measures the outcomes of service users
- mental health services provided by non-government organisations and MBS-rebated providers (psychologists and psychiatrists)
- data on priority population groups
- the prevalence of mental ill health and suicidal distress and services provided in non-health sectors.

Data availability has improved since 2020. The ABS released the 2020–2022 National Study of Mental Health and Wellbeing. New indicators were developed, such as measures of self-harm in an inpatient facility and discharge against medical advice, which were included in the Report on Government Services. However, review participants have reiterated that some major data gaps still exist.

Current data collections focus on measuring service provision rather than measuring the effectiveness of service delivery in improving outcomes (Black Dog Institute, sub. 61, p. 11; Marathon Health, sub. 10, p. 4; Mental Health Carers Australia, transcript, 20 August 2025, p. 40). Specific categories of missing data include:

- mental health outcomes of priority populations (Australasian Institute of Digital Health, sub. 12, p. 5; National Rural Health Alliance, sub. 86, p. 10)
- broader, locally informed suicide data, including behavioural indicators such as GP visits and help-seeking patterns (NACCHO, sub. 245, p. 9)
- all 'late maternal deaths' (43 to 365 days post-birth), perinatal data for expecting and new fathers and non-birthing partners, and for rural parents requiring emergency perinatal psychiatric care (Perinatal Anxiety & Depression Australia, sub. 24, p. 3)
- mental health needs of families, carers and kin supporting individuals with mental ill health or suicidal distress (Mental Health Carers Australia, transcript, 20 August 2025, p. 36; Mental Health Families and Friends Tasmania, sub. 210, p. 6)
- children and young people's mental health and wellbeing (Raise Foundation, sub. 185, p. 3, Centre for Community Child Health, sub. 79, p. 14)
- the social determinants of mental health[8] (Black Dog Institute, sub. 61, p. 11)
- regional mental health workforce data (PHN Cooperative, sub. 69, p. 9)
- coercive practices, especially involuntary medication such as chemical restraint (Justice Action, sub. 150, pp. 6–7)
- family violence-related suicidal ideation, self-harm and suicides (ShantiWorks, sub. 157, p. 7).

Source: Leginski et al. (1989); PC (2020).

[8] Social determinants of mental health are structural conditions that can influences someone's mental health, such as income, employment, socioeconomic status, education, food security, discrimination (Kirkbride et al. 2024).

Important data is collected infrequently

Several population surveys provide detailed information on the state of mental health and suicidal distress in Australia, but they are run too infrequently to provide current information or to track progress.

The National Study of Mental Health and Wellbeing is the main source of population level mental health data, but it has only been run in 1997, 2007 and, most recently, 2020–2022 (ABS 2023). There is no information available on when it will next be run. The PC's previous Mental Health inquiry recommended the survey be run no less than every 10 years (2020, p. 1198). However, given the lack of up-to-date data on prevalence of mental ill health, and concerning trends in recent years, there would be benefit in conducting the survey more frequently. Running the survey every five years would improve the ability to establish and track trends and aid evidence-based and targeted policy.

Survey data on young people's mental health and suicidal distress was last collected in 2014.[9] Given the growing prevalence of mental ill health and lack of understanding about suicidal behaviours in young people, up-to-date data is important for planning and delivering services. Following a recommendation of the National Children's Mental Health and Wellbeing Strategy, funding has been allocated for a National Child and Adolescent Mental Health and Wellbeing Study (DHDA 2025d). There have not been any commitments to run this survey regularly (NMHC 2021b, p. 84), but it should be run at least every five years.

Survey data provides a valuable picture of the population as it can reach those who are not accessing mental health and suicide prevention services and investigate a broad range of questions. It is, however, costly to run population surveys. For example, the National Study of Mental Health and Wellbeing was funded as part of an Intergenerational Health and Mental Health Study comprising four population surveys at a cost of $89.5 million (Hunt 2021).

There was broad support from review participants[10] for the interim recommendation to routinely run both the National Study of Mental Health and Wellbeing and the National Child and Adolescent Mental Health and Wellbeing Study to inform ongoing policy efforts and direct funding in mental health and suicide prevention. Doing so will require providing additional funding to the organisations undertaking the surveys.

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.

[9] The Young Minds Matter survey provides the latest data on children and adolescents aged 4–17 years and was run in 2013-14 (Lawrence et al. 2015, p. 1). The National Study of Mental Health and Wellbeing only collects data for people aged 16–85 years.

[10] Australian Private Hospitals Association, sub. 163, p. 11; Catholic Health Australia, sub. 181, p. 30; Centre for Community Child Health, sub. 183, p. 8; Matilda Centre and PREMISE Next Generation, sub. 220, p. 14; Orygen, sub. 169, p. 4; Size Inclusive Health Australia, sub. 237, p. 4; Suicide Prevention Australia, sub. 214, p. 5.

Given the limited quantitative data, qualitative information has been used throughout this report to strengthen our understanding of what the Agreement has achieved (*What we heard* paper). This includes:

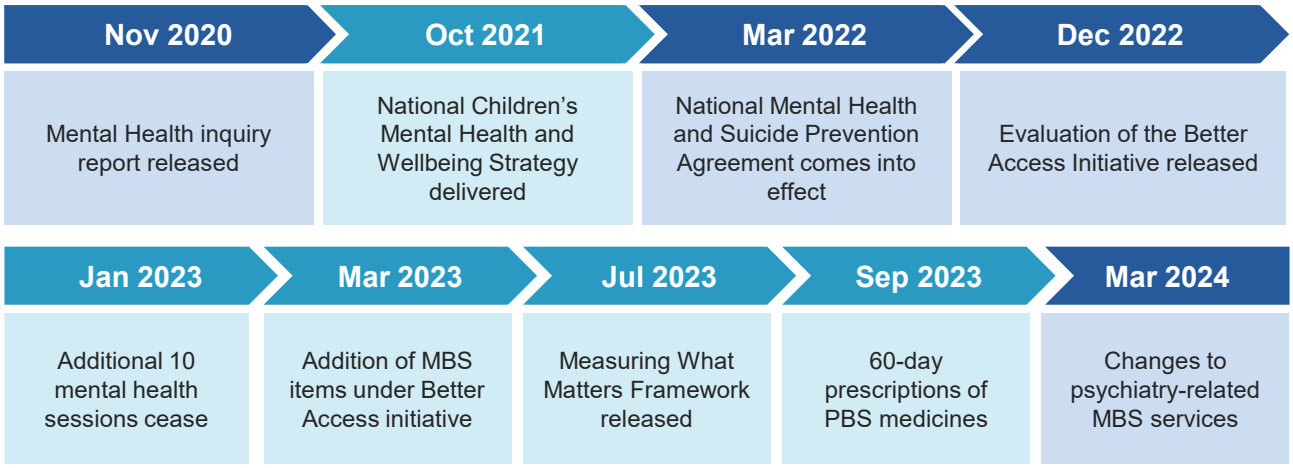
- 293 responses to our online survey, provided by people with lived and living experience of mental ill health and suicide, carers and service providers. The survey asked about their experiences and views of the mental health and suicide prevention system during the period of the Agreement
- 244 public submissions from organisations, including representative bodies for consumers, carers and service providers as well as individual service providers, government agencies and a small number of consumers and carers. Public submissions were published on the PC website and are listed in appendix A
- 95 meetings and site visits. The people and organisations we met with are listed in appendix A
- three days of online public hearings. The people and organisations that presented are listed in appendix A.

Understanding the direct impact of the Agreement is difficult

Even if data were readily available in a timely manner, significant external factors affect our ability to understand the direct impact of the Agreement. The external landscape in which the Agreement operates can have a substantial effect on the progress and impacts of the reform (NMHC 2024a, pp. 6–7).

The Agreement makes up only 3% on average of the annual government expenditure on mental health and suicide prevention, which totalled $12.6 billion in 2022-23 (SCRGSP 2025). Governments' efforts to improve mental health and suicide prevention outcomes encompass a number of other elements (figure 2.5 and chapter 1). For example, the National Children's Mental Health and Wellbeing Strategy was delivered in 2021 and is likely to have an influence on children's mental health and wellbeing outcomes. Separating the impact of the different policies is difficult and beyond the scope of this review.

Figure 2.5 – National policy developments and system reform that influence outcomes



Source: Adapted from AIHW (2024b).

Several significant events occurred during the period of the Agreement and are likely to have affected mental health and suicide prevention outcomes, making it difficult to isolate the impact of the Agreement itself. This includes the COVID-19 pandemic, which resulted in heightened psychological distress and an increase in demand for mental health services (AIHW 2021b). In response to these events, governments significantly increased the rate of expansion in mental health funding. Between 2020-21 and 2022-23, real mental health funding per capita grew by an average of 2.6% a year, compared to 1.5% a year between 2017-18 and 2019-20 (SCRGSP 2025, table 13A.1).

The issues in reporting, data gaps and external factors mean pinpointing the effects of the Agreement on mental health and suicide prevention outcomes is often not possible. The PC has used information gathered from review participants and government sources, alongside the latest available data, to ascertain which of the commitments in the Agreement have been delivered and their effect on progress towards the Agreement's objectives.

2.3 Some progress has been made on the Agreement's commitments

Most national outputs have been delivered

Governments have delivered most of the 13 high level outputs listed in the Agreement (table 2.1). There are three outputs with unclear progress and one that has not yet been completed (section 2.4). This review is also considered an output of the Agreement.

Table 2.1 – National outputs committed to under the Agreement[a]

Output	Delivered?
Analysis of psychosocial support services outside of the National Disability Insurance Scheme	✓
Commonwealth-state implementation plans and annual jurisdiction progress reports	✓
Annual National Progress Report[b]	×
Improved data collection, data sharing and data linkage	?
National Evaluation Framework	✓
Shared evaluation findings using the framework and associated guidelines	?
Consideration/implementation of actions of the National Stigma and Discrimination Reduction Strategy	?
National Suicide Prevention Office	✓
National guidelines on regional commissioning and planning	✓
National Mental Health Workforce Strategy and identification of priority areas for action	✓
Progress reporting on increasing FTE mental health professionals to meet community need	✓
Submission to the mid-term review of the National Health Reform Agreement 2020–25	✓
Final review of the Agreement	✓

a. A tick means the output has been delivered, a question mark means it has commenced but not yet completed or delivered, and a cross means the output has not been delivered or is not on track to be delivered before the deadline. **b**. Two reports have been delivered but did not meet the required timelines due to delays in jurisdictions providing information to the NMHC (NMHC and NSPO, sub. 70, p. 11).

Source: PC analysis.

The outputs delivered have had varying results. For example, the establishment of the National Suicide Prevention Office (NSPO) has been well received by review participants (Black Dog Institute, sub. 61, p .1; Lifeline, sub. 8, p .5; Movember Institute of Men's Health, sub. 80, p. 7). The NSPO has developed a long-term whole-of-government strategy for suicide prevention and is working towards its implementation (chapter 8).

But completion of outputs alone does not tell us if there have been improvements in outcomes. It appears most outputs have not had a significant effect on improving policy or planning. For example:

- the analysis of psychosocial support services outside of the NDIS was done at a very high level and does not provide guidance on regional access gaps (section 2.4)
- the National Mental Health Workforce Strategy has been delivered but does not contain any funding commitments or clear accountability structures (section 2.4)
- the National Evaluation Framework was only released in early 2025, and it is unclear how it is used (Black Dog Institute, sub. 61 p. 1)
- governments had to work together to consider and implement relevant actions of the National Stigma and Discrimination Reduction Strategy (clause 114). The Strategy has not been made public and there has been no publicly available information to assess the impact of any actions that may have been taken (section 2.4).

Most initiatives in the bilateral schedules are underway

Each state or territory has signed a Bilateral Schedule on Mental Health and Suicide Prevention (bilateral schedule) with the Australian Government, set to expire with the Agreement on 30 June 2026. Each bilateral schedule contains details of specific initiatives and funding commitments.

Of the 83 initiatives in the bilateral schedules, ten had been completed, six were yet to commence and 67 were partially or well progressed by June 2024 (figure 2.6). Three of those yet to commence were suicide prevention initiatives renegotiated during the revision of the South Australia bilateral schedule. Of the initiatives that were not considered 'on track', 26 had some issues or delays in achieving milestones and two were facing significant delays or risks to the initiative (NMHC 2025, p. 24).

The establishment of Medicare Mental Health Centres (MMHCs) is a major commitment under the bilateral schedules. Centres aim to provide immediate support to reduce distress, offer care coordination, warm referrals to other services, and assistance with managing stressors such as financial problems and social isolation (DoHAC 2025a, pp. 11–13). As at 2023-24, 14 centres have been established and are operating under the Agreement, with an additional 32 in development (NMHC 2025). An 'implementation co-evaluation'[11] of the MMHC model found that the centres were helping to meet a gap in the mental health system and divert people away from hospitals (Neami National, sub. 63, p. 7).

Although the 2023-24 Annual National Progress Report shows progress, with a significant proportion of the activities being completed or well progressed, review participants have differing views. Some reported delayed and slow progress in developing and implementing services agreed under the bilateral schedules (headspace, sub. 23, p. 3; Northern Territory Mental Health Coalition, sub. 54, pp. 2–3; *What we heard* paper). As assessments of progress are not independently verified, it is difficult to say whether the difference in views is due to high expectations of participants or unambitious milestones set for initiatives in the bilateral schedules. The NMHC and NSPO (sub. 70, p. 11) highlighted this as an issue in assessing implementation.

> The data provided to the Commission to inform reporting is primarily qualitative data, self-assessed by the Parties. While Parties are required to report on key performance indicators under the National Agreement, to date this data has been very limited, with Parties frequently rating KPIs as 'not applicable'. An absence of quantitative data has limited the Commission's ability to draw meaningful and objective insights on implementation progress.

[11] An implementation co-evaluation is a joint evaluation between services and research organisations to encourage two way learning (ALIVE National Centre for Mental Health Research Translation 2024a, p. 1).

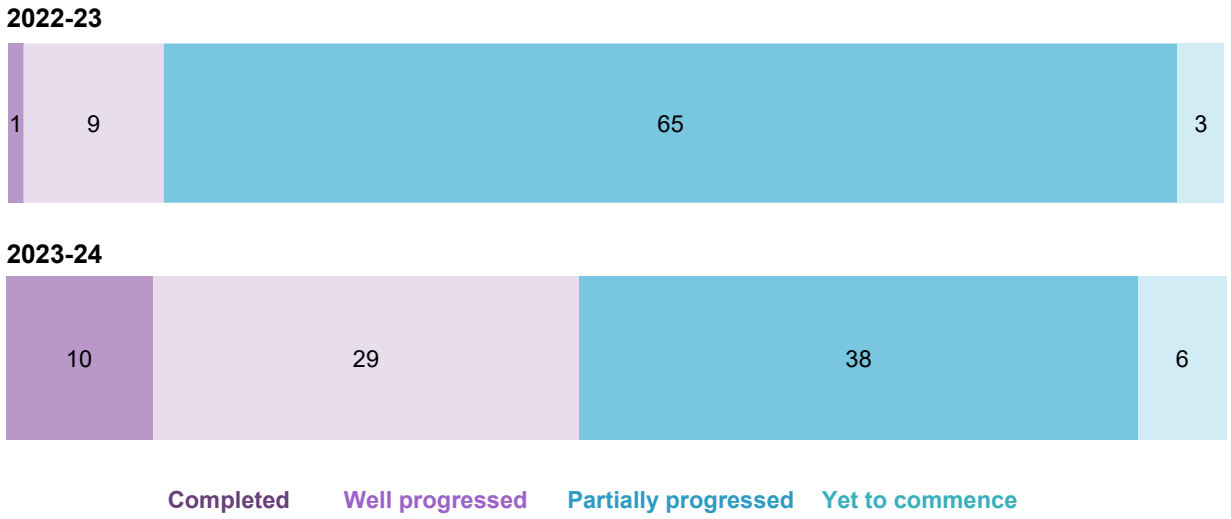
headspace (sub. 23, p. 5) reflected on the way jurisdictions implemented the bilateral schedules, which may further obscure the contribution of the Agreement.

> … the wording of bilateral agreements has allowed jurisdictions to interpret their commitments differently, including re-badging existing work and allocated funding as discharging their bilateral commitments.

Governments are not required to make their bilateral implementation plans or jurisdictional annual reports public, nor have they. These documents are likely to contain more detail on the planned delivery of initiatives, which could be used to clarify progress.

A greater level of independence in reporting, transparency and accountability is needed to accurately measure progress against actions listed in the bilateral schedules (chapter 5).

Figure 2.6 – Progress ratings for the bilateral initiatives[a]



a. The South Australian bilateral schedule was renegotiated in February 2024, one of their initiatives that was 'yet to commence' in 2022-23 was split into three initiatives in 2023-24 and is still 'yet to commence'. This has resulted in an increase in the activities that are 'yet to commence' between the two reporting periods.

Source: NMHC (2025, p. 25).

Insufficient data to assess progress towards the Agreement's outcomes

In signing the Agreement, governments committed to achieving five system-level outcomes (table 2.2). The barriers to assessing progress (section 2.2) make it difficult to measure outcomes and understand what changes have occurred during the period of the Agreement. Since the Agreement did not match outcomes to available indicators, we reviewed national data sets and found there were insufficient relevant and up-to-date indicators to measure progress against the outcomes. In most cases, the data is released infrequently and does not allow measurement during the period of the Agreement. Furthermore, it would not be possible to ascertain what contribution the Agreement made to the changes in outcomes compared to other factors. The Agreement lists a set of priority data and indicators for development for each outcome, but these are not yet available (Annex B).

Table 2.2 – Data reporting on the Agreement's outcomes is limited[a]

Outcome	Indicators of progress and data availability
Improve the mental health and wellbeing of the Australian population, with a focus on improving outcomes for priority populations	There is no current data to assess whether improvements have occurred during the period of the Agreement. The latest national data for adults is from 2020–2022.[b] Data on the mental health of young people was last collected in 2013–2014, but a new survey is underway.[c] There are no plans to run another survey for adults at this stage.
Reduce suicide, suicidal distress and self-harm through a whole-of-government approach to coordinated prevention, early intervention, treatment, aftercare and postvention supports	The latest data on deaths by suicide and rates of hospitalisations for intentional self-harm is from 2023 and 2023–2024 respectively,[d] and data on suicidal behaviours is from 2020–2022.[b] There is limited information to assess the effect of a whole-of-government approach on suicide rates.
Provide a balanced and integrated mental health and suicide prevention system for all communities and groups	There are no indicators available for this outcome. The indicators listed for development to measure this outcome focus on regional planning and commissioning, but they are yet to be developed.
Improve physical health and life expectancy for people living with mental health conditions and for those experiencing suicidal distress	There is no current data to assess whether improvements have occurred in physical health during the period of the Agreement. The latest data is from 2022.[e] There is no measure of life expectancy for people living with mental health conditions or experiencing suicidal distress.
Improve quality, safety and capacity in the Australian mental health and suicide prevention system	There is no current data to assess whether improvements have occurred during the period of the Agreement. This outcome encompasses many facets of the system; data is either not available or not able to be used to assess progress.

a. No current data means there is no national data set that reports regularly within the period of the Agreement and would allow the tracking of an outcome. **b.** National Study of Mental Health and Wellbeing 2020–2022. **c.** Australian Child and Adolescent Survey of Mental Health and Wellbeing 2013–2014. This survey has been funded to occur again between 2024–2027 (Curtin University 2025). **d**. Suicide and Self-harm Monitoring, National Mortality Database. **e.** Suicide and Self-harm Monitoring, National Hospital Morbidity Database.

2.4 Key commitments have not been fulfilled

Psychosocial supports outside the NDIS remain in limbo

Many people experiencing mental ill health benefit from psychosocial supports to improve their wellbeing and engage with their communities (PC 2020). Psychosocial supports refer to 'non-clinical and recovery-oriented services, delivered in the community and tailored to individual needs, which support people experiencing mental illness to live independently and safely in the community' (Psychosocial Project Group 2023c, p. 1). They include services assisting people with mental ill health to acquire daily living skills, obtain and maintain housing, access other services (such as clinical care), socialise, build and maintain relationships, and engage with education and employment (HPA 2024, p. 13).

However, many people who should receive and would benefit from such services do not receive sufficient – or any – support. In 2022-23, about 230,000 people with severe mental illness and 263,100 people with moderate mental illness aged 12–64 years who required psychosocial supports were not receiving them

through the NDIS or other government-funded programs (HPA 2024, p. 76). Participants in the PC's survey commented on the difficulty in finding psychosocial supports and the effect this has had on them:

> My condition is a psychosocial disorder and the lack of groups makes it very hard to find people I can connect and interact with (sr. 202)

> There are no community groups funded by local government or free/cheap programs for those with mental health issues or past suicidal ideation. Leading to isolation and less awareness of other services that might help (sr. 116)

> There are no in-person services locally for psycho-social wellbeing for people without a NDIS plan (sr. 50)

While the Australian and some state and territory governments continue to fund psychosocial supports (MIFA, sub. 88, p. 7), service provision has long been hampered by inefficient and duplicative funding arrangements. In addition, the introduction of the NDIS led to a significant shift in how psychosocial supports are funded, exacerbating the long-term issues. Many people with psychosocial disability who should be eligible for the NDIS have had trouble accessing support. At the same time, governments withdrew much of the funding for psychosocial supports outside of the NDIS (PC 2020).

In 2020, the PC (2020, pp. 826, 1134) recommended governments 'ensure all people who have psychosocial needs arising from mental illness receive adequate psychosocial support', and to achieve this:

- the shortfall in psychosocial supports outside the NDIS should be estimated at a regional and state and territory level
- state and territory governments, with support from the Australian Government, should be responsible for commissioning psychosocial supports and should increase funding to address the shortfall
- the proposed national agreement should clarify psychosocial support responsibilities.

The 2023 NDIS review of psychosocial supports made similar findings.

- National Cabinet agree to jointly invest in psychosocial supports external to the NDIS as a targeted foundational support, including expanding Australian, state and territory government services to address unmet need.
- National Cabinet agree to jointly design, fund and commission an expanded set of foundational disability supports outside individualised NDIS budgets.
- The expansion of services for people with severe and persistent mental ill health be managed and delivered under the Agreement (PM&C 2023, pp. 60–64).

The Agreement has made minimal progress in improving psychosocial arrangements

In the Agreement, governments committed to working together to 'develop and agree future psychosocial support arrangements (including roles and responsibilities) for people who are not supported through the NDIS' (clause 127). To achieve this, governments committed to:

- developing and agreeing to a common definition for psychosocial supports (clause 128a)
- estimating demand for psychosocial supports outside the NDIS, to be completed as soon as possible within the first two years of the Agreement (clause 128b)
- once demand has been estimated, developing clauses related to future arrangements and attaching them to the current Agreement as a schedule (clause 129)
- maintaining current investments in psychosocial supports outside the NDIS while the analysis was undertaken (clause 130).

While some progress has been made, governments have not fully met their commitments.

The Psychosocial Project Group[12] agreed to a common definition of psychosocial supports and engaged a consultant to estimate unmet need (Psychosocial Project Group 2023a, 2023b). The resulting report was provided to governments in August 2024 and has since been publicly released (HPA 2024). The report provides estimates of the number of people who require psychosocial supports and those receiving services at the jurisdiction level, which does not enable planning of local services. It is difficult to assess whether governments maintained their investments in psychosocial supports while the analysis of demand was undertaken, as there is incomplete public information on governments' investments (MIFA, sub. 88, p. 7).

In December 2023, National Cabinet agreed that the Australian, state and territory governments should jointly commission foundational supports, and consultation has begun the design and implementation of foundational supports (Albanese 2023; DSS 2025).

In August 2024, Health and Mental Health Ministers agreed the Psychosocial Project Group would develop the plan for future arrangements. Publicly available information indicated further information on consultations on this plan would be available in 2025 (DoHAC 2025b). In June 2025, the Health and Mental Health Ministers again highlighted the importance of investing in psychosocial supports. The Ministers agreed addressing unmet need should be a priority of the next agreement and planned to consult with people with lived and living experience and sector representatives in their jurisdictions to inform the negotiations of the next agreement and determine shared priorities and investment plans. The Psychosocial Project Group has been tasked with working with lived experience and sector representatives to inform negotiations on the next agreement (DoHAC 2025b). There was also a consensus to at least maintain existing Australian, state and territory governments funding to ensure continuity of delivery (DHDA 2025c).

As at early October 2025, governments have not developed and agreed to future psychosocial support arrangements, including roles and responsibilities, delaying access to much needed support for nearly 500,000 people with moderate and severe mental illness. Review participants were critical of the lack of progress (for example, Australian Psychosocial Alliance, sub. 55, p. 5). Community Mental Health Australia (sub. 84, p. 4) stated:

> The Agreement has achieved somewhere between little and nothing in addressing these significant barriers, nor begun the process of transitioning systems …

Review participants strongly argued that a resolution is needed.[13] The Queensland Alliance for Mental Health (sub. 83, p. 5) stated:

> without urgent clarification, people will continue to be excluded from services, falling through the cracks.

There was overwhelming support from review participants[14] for the interim recommendation that governments need to finalise arrangements for the funding and commissioning of psychosocial supports

[12] This group was set up by the then Department of Health and Aged Care, and state and territory governments to progress psychosocial commitments under the Agreement (DoHAC 2025b). This group is intended to meet quarterly, however, it is unclear if this has occurred as there was no publicly available information on meetings released between November 2023 and July 2025 (Psychosocial Project Group 2023c, 2025).

[13] Australian Psychosocial Alliance, sub. 55, pp. 9–10; Community Mental Health Australia, sub. 84, p. 7; Mental Health Australia, sub. 76, pp. 24–25; NSW Health, sub. 90, p. 3; Skylight Mental Health, sub. 91, pp. 1–3; Western Australian Association for Mental Health, sub. 82, p. 5.

[14] Allied Health Professions Australia, sub. 178, p. 5; Australian Association of Psychologists Incorporated, sub. 109, p. 5; Australian Multicultural Action Network, sub. 124, p. 2; Australian Private Hospitals Association, sub. 163, p. 8; Catholic Health Australia, sub. 181, p. 20; Consumers Health Forum of Australia, sub. 140, pp. 5–6; Faculty of Health, Deakin University, sub. 174, p. 2; Health Consumers Council WA, sub. 139, p. 4; Jesuit Social Services, sub. 131, p. 10;

immediately, within the life of the Agreement. These arrangements need to be clearly defined. To achieve this, states and territories should be responsible for commissioning psychosocial supports. The Australian, state and territory governments should jointly fund psychosocial supports, with the Australian Government providing funding to the state and territory governments to help cover the shortfall in support.

However, the Tasmanian Government (sub. 239, p. 3) warns that:

> immediately commission[ing] services does not sufficiently account for the complex interconnection between current health and disability reform processes that are still being negotiated. There are significant risks in advancing commissioning of these services ahead of completing these reform and negotiation processes, including potentially undermining broader system cohesion and risking unforeseen consequences for service delivery and consumer experiences.

While governments should be mindful of the processes for determining how foundational supports are designed and funded and the interaction with existing reviews, this should not delay decisions about how psychosocial supports are commissioned and funded outside the NDIS.

While the next agreement is being negotiated, state and territory governments should immediately prioritise commissioning services to address unmet need. Primary health networks (PHNs) should work with state and territory governments and providers to support this expansion and transition. PHNs have experience commissioning psychosocial supports and existing relationships. For example, Partners in Recovery was a long-standing service commissioned across PHNs from 2012 until 2019 to support people with mental ill health to access services and supports in partnership with local organisations (Mental Health Coordinating Council 2019; Trankle and Reath 2019). 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.

As an interim measure until the next agreement is signed, the Psychosocial Project Group is well placed to regularly collate and publish data on unmet need and publicly report on actions taken by governments. Progress updates should be provided to the Health Ministers Meeting every six months.

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.

Mental Health Association of Central Australia, sub. 166, p. 1; Mental Health Australia, sub. 153, p. 10; Mind Australia, sub. 187, p. 6; Orygen, sub. 169, p. 2; Ruah Community Services, sub. 177, p. 2; Stroke Foundation, sub. 168, p. 2; Suicide Prevention Australia, sub. 214, p. 5; Western Australian Association for Mental Health, sub. 172, pp. 3–4.

The National Stigma and Discrimination Reduction Strategy has been developed – but not released

Many of the participants in the PC's survey commented on the devastating effects of stigma and discrimination (*What we heard* paper).

Stigma and discrimination pose barriers to help-seeking and affect people's ability to participate in employment, education and other social and community activities. batyr (sub. 27, p. 1) identified stigma as a major barrier deterring young people from seeking support. Stigma and discrimination can also lead to adverse outcomes in care settings and in interactions with police, justice and social services. As social and cultural phenomena, stigma and discrimination are hard to shift; they require a long-term, comprehensive and coordinated approach. As such, a national strategy is necessary and has been met with support from review participants.

The National Stigma and Discrimination Reduction Strategy was agreed to prior to the Agreement in 2020. In the Agreement, governments committed to the 'consideration and implementation of relevant actions' of the strategy once finalised (clause 27g).

The draft strategy was delivered to government in June 2023 following a consultation process. The then Minister for Health and Aged Care asked the Department of Health and Aged Care to consider actions from the strategy and to share the strategy across governments to support joint action (NMHC 2024b).

The current status of the National Stigma and Discrimination Reduction Strategy and whether there has been any action taken under the Strategy is unclear. The Strategy has been finalised and 'considered by the Australian Government and provided to Mental Health and Suicide Prevention Senior Officials Group (MHSPSO) to inform joint action' (NMHC 2025, pp. 13–14). Jurisdictions have been implementing various initiatives[15] to tackle stigma and discrimination but it is unclear whether these align with the Strategy. To improve transparency and accountability as well as foster a nationally consistent approach to stigma and discrimination reduction, the Strategy should be publicly released as a priority.

There was resounding support from review participants[16] for the interim recommendation to release the Strategy by the end of 2025 to prevent any further delays to action. Some participants also called for dedicating resources for the Strategy (Consumers Health Forum of Australia, sub. 140, p. 5; Jesuit Social Services, sub. 131, p. 8).

Comprehensive national guidelines on regional planning and commissioning are needed

Effective commissioning is essential to addressing service gaps, duplication and fragmentation in the mental health and suicide prevention system, and to providing integrated and coordinated care. In the Agreement, governments committed to develop national guidelines on regional planning and commissioning (clauses 27i and 133).

MHSPSO granted two separate extensions to the Australian Government to enable it to complete the national guidelines. MHSPSO first approved a six-month extension for the guidelines to be delivered by

[15] For example, the Australian Government funds the National Communications Charter that guides how organisations talk about mental ill health and suicide to reduce stigma (DHDA 2025g).

[16] Beyond Blue, sub. 156, pp. 3–4; Catholic Health Australia, sub. 181, pp. 9–10; Centre for Community Child Health, sub. 183, p. 4; Consumers Health Forum of Australia, sub. 140, p. 5; Consumers of Mental Health WA, sub. 148, p. 7; Faculty of Health, Deakin University, sub. 174, p. 4; Jesuit Social Services, sub. 131, p. 7; Mental Health Australia, sub. 153, p. 5; Mental Health Association of Central Australia, sub. 166, p. 1; Mental Health First Aid International, sub. 147, p. 3; Stroke Foundation, sub. 168, p. 2.

December 2023. This was to allow additional time to develop meaningful guidance and undertake sufficient consultation (NMHC 2024a, p. 10). The second extension was to allow consideration of the role of the proposed guidelines within the national context (NMHC 2025, p. 14).

The delay in releasing national guidelines has hindered the ability of health services to engage in local and regional planning (Catholic Health Australia, sub. 181, p. 10) and has likely contributed to other issues observed by review participants, including:

- uncertainty at the regional level (PHN Cooperative, sub. 69, p. 7; WQPHN, sub. 45, p. 7)
- variations in commissioning practices between PHNs and local hospital networks (LHNs), with little national or state and territory coordination (Australian Psychosocial Alliance, sub. 55, p. 10; Mental Health Australia, sub. 76, p. 27; PHN Cooperative, sub. 69, p. 7)
- different approaches to commissioning and joint commissioning across PHNs (Mental Health Carers Australia, sub. 73, p. 12), with some PHNs being very effective and others not.

Despite the extension for consultation, the PHN Cooperative, whose core function is regional planning, were never formally engaged as partners in the development of the guidelines (PHN Cooperative, pers. comm., 8 October 2025).

In their initial submissions to this review, the PHN Cooperative (sub. 69, p. 7) and Western Queensland PHN (sub. 45, p. 7) referred to a one-page National Principles for Regional Planning and Commissioning of Mental Health and Suicide Prevention Services (Principles) that they have been provided. Both described the document as shallow and lacking useful guidance.

The Principles were endorsed by MHSPSO in April 2025 and are the national guidelines on regional commissioning and planning identified in the Agreement. The Principles have not been publicly released but have been provided to all PHNs and to jurisdictions to provide to their LHNs (DHDA, pers. comms, 10 October 2025). DHDA (pers. comm., 10 October 2025) stated:

> The Principles are intended to guide the development of Joint Regional Plans, and strengthen ongoing regional planning and commissioning arrangements to help inform effective practices across Australia. The principles are designed to be high-level and flexible, and work alongside the relevant state or territory government and PHNs' guidance documents.

The PHN Cooperative (sub. 69, p. 7) called for the guidelines to have a similar level of guidance and practical advice to that included in the now outdated resources released in 2018. The previous guidance outlined the expectations of and roles of PHNs and LHNs, the process for developing a joint regional plan and how to plan for integration. It was supported by a compendium of detailed resources, data and tools to assist in regional planning (Integrated Regional Planning Working Group 2018).

Review participants[17] strongly supported the interim recommendation to publicly release detailed national guidelines on regional planning and commissioning that meet the needs of PHNs and LHNs before the end of 2025. Given that the Principles are high level and may not fully meet these needs, governments will need more time to work with PHNs and LHNs to revise the Principles into appropriately detailed guidelines. The detailed guidelines should be publicly released before the Agreement expires in June 2026.

Better utilisation of the National Mental Health Service Planning Framework (NMHSPF) would also improve regional planning and commissioning. The NMHSPF is 'an evidence based framework designed to support

[17] Beyond Blue, sub. 156, pp. 3–4; Catholic Health Australia, sub. 181, p. 10; Centre for Community Child Health, sub. 183, p. 4; Consumers Health Forum of Australia, sub. 140, p. 5; Consumers of Mental Health WA, sub. 148, p. 7; Mental Health Australia, sub. 153, p. 19; Victorian and Tasmanian PHN Alliance, sub. 154, p. 1.

coordinated planning across Australia's mental health system' (AIHW 2024e). The NMHSPF appears to be used on an ad hoc basis and a greater capacity among PHNs to use this tool could assist planning for local commissioning (chapter 6).

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.

Actions have failed to address chronic workforce issues

Governments delivered the required National Mental Health Workforce Strategy and some states and territories have reported progress on bilateral workforce initiatives under the Agreement (NMHC 2025). But more work is needed to reduce chronic shortages in the mental health and suicide prevention workforces.

In the Agreement, governments committed to addressing workforce challenges by:

- supporting workforce development and sustainability across sectors, especially in areas of thin markets (clause 149)
- developing the National Mental Health Workforce Strategy (clauses 150–151) and supporting the development of the National Suicide Prevention Workforce Strategy (clause 156)
- working together to take action to increase the number of full-time equivalent (FTE) mental health professionals per 100,000 people over the life of the Agreement for professional groups identified, including psychiatry, psychology, mental health nursing, Aboriginal and Torres Strait Islander mental health and suicide prevention workers, lived experience (peer) workforce and other relevant allied health professionals (clauses 154 and 159)
- supporting the governance and use of the NMHSPF and sharing program level and other data to achieve optimal workforce planning at the regional level (clause 153).

Published in 2023, the National Mental Health Workforce Strategy presents a vision and actions to build a sustainable mental health workforce (box 2.2). It is too early to tell if the Strategy has been effective, as many of its actions have not yet been delivered and others take time to affect the workforce. The Victorian Government (sub. 228, p. 17) highlighted:

> Governance structures authorised through the National Agreement have facilitated work under the strategy to progress and provide a platform for cross-jurisdictional collaboration on workforce challenges.

However, there are no funding commitments or clear accountability structures included in the Strategy (Vocational Mental Health Practitioners Association of Australia, sub. 115, p. 2). The Royal Australian and New Zealand College of Psychiatrists (sub. 7, p. 4) stated:

> Immediate and sustained funding commitments are essential to support the National Mental Health Workforce Strategy (the Strategy), including the expansion of training programs and incentives for professionals in underserved regions. Clear definitions of governmental

responsibility for funding and workforce development are necessary to ensure accountability and the successful implementation of the Strategy.

The National Suicide Prevention Workforce Strategy is yet to be developed (chapter 8).

Box 2.2 – The National Mental Health Workforce Strategy

The National Mental Health Workforce Strategy provides 'a vision and roadmap to build a sustainable workforce that is skilled, distributed and supported to deliver mental health treatment, care and support that meets the current and future population needs' (DoHAC 2023a, p. 23).

The Strategy has four strategic pillars that focus on:

- attracting capability and capacity to meet future demand and address thin markets, supported by a training and education system that equips the workforce to meet the needs of the community
- maximising and connecting the workforce to ensure there is coordination of care, workforce distribution and opportunities to best use the skills and strengths of all workers
- supporting workplaces and addressing issues that impact retention
- better use of data, planning, evaluation and technology.

The Strategy contains a detailed list of actions to support these pillars, as well as implementation plans.

The Strategy also outlines roles and responsibilities. The Australian, state and territory governments have joint responsibility to ensure equitable access to effective mental health and suicide prevention services. Education providers, the Australian Health Practitioner Regulation Agency and National Boards, and professional peak bodies and colleges are responsible for different aspects of registration, training and education and continuing professional development requirements. Health and community service providers are responsible for supervision and support to attract and retain the mental health workforce. Consumer and carer organisations ensure the needs and preferences of people with lived and living experience, and their supporters, family, carers and kin are reflected in governments' actions to grow and support the mental health workforce.

Source: DoHAC (2023a).

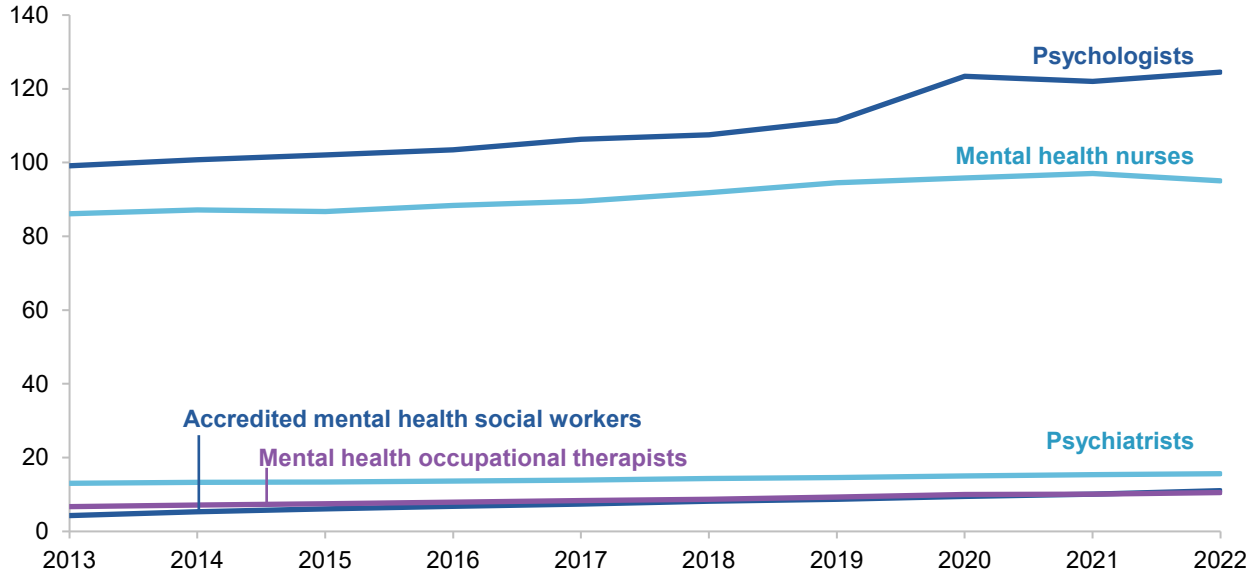
Despite the commitments in the Agreement, shortages in the workforce have continued. Since 2013, there has been minimal growth in the number of mental health professionals per 100,000 people, except for psychologists (figure 2.7). This growth has not been at the rate required to meet need, given lengthy wait times (section 2.1 and *What we heard* paper).

The Occupation Shortage List continues to show shortages across the mental health workforce nationally and across jurisdictions (table 2.3).[18] The number of mental health professionals would need to grow by at least 42% by 2030 to fully respond to community demand (DoHAC 2023a).

[18] A shortage is defined as when employers are unable to fill, or have considerable difficulty filling, vacancies for an occupation or cannot meet significant specialised skill needs within that occupation, at current remuneration, employment conditions and in reasonably accessible locations.

Figure 2.7 – Minimal growth in the mental health workforce

Number of workers per 100,000 people



Source: PC analysis using ABS (2024b) and AIHW (2024g).

Table 2.3 – Shortages in the Australian mental health workforce, 2024[a,b]

Occupation	Aus	NSW	VIC	QLD	WA	SA	TAS	ACT	NT
Psychologist	S	NS	S	S	S	S	S	S	S
Psychiatrist	S	NS	S	S	S	S	S	S	S
Registered Nurse (Mental Health)	S	NS	S	S	S	S	S	S	NS
General Practitioner	S	S	S	S	S	S	S	S	S
Indigenous Health Worker	S	NS	S	S	S	S	NS	NS	S
Occupational Therapist	S	S	S	S	S	S	S	S	S
Psychotherapist	NS	NS	S	NS	NS	NS	NS	NS	NS

a. This analysis covers the Australian labour market and therefore includes both the public and private system. **b.** NS indicates no shortage and S indicates shortage.

Source: Jobs and Skills Australia (2024).

The analysis in the National Mental Health Workforce Strategy found workforce shortages were more pronounced in rural areas (DoHAC 2023a, p. 16). This conclusion has been supported through participants' input to this review, with several noting the continued critical shortages in rural, regional and remote workforces (Australian Association of Psychologists Incorporated, sub. 13, p. 5; Consumers Health Forum of

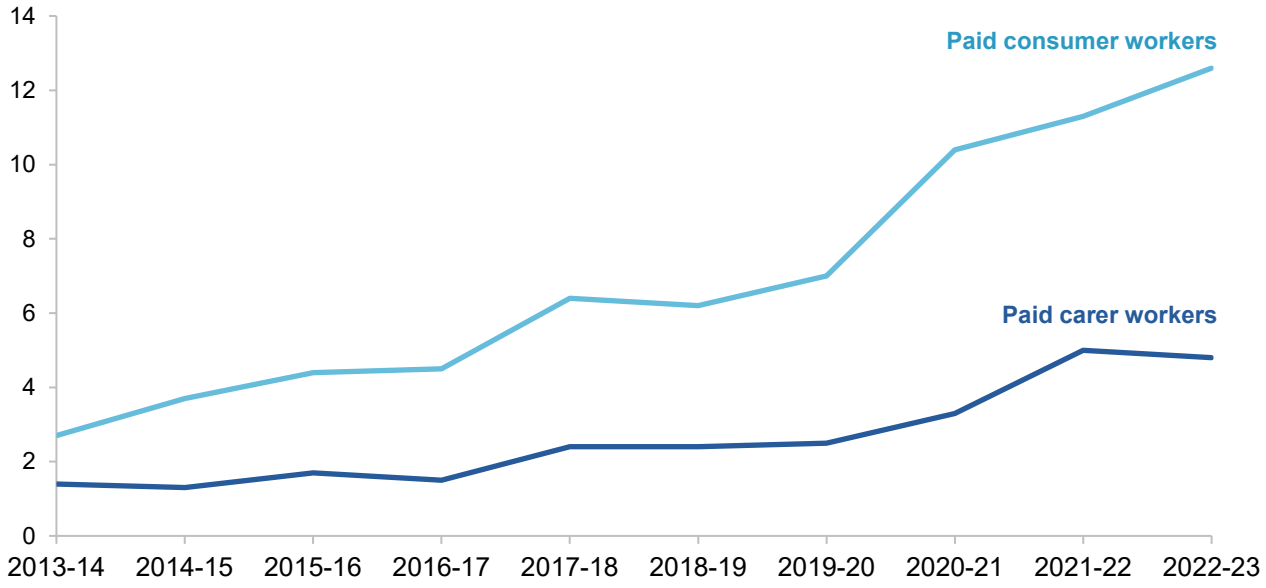
Australia, sub. 22, p. 9; Marathon Health, sub. 10, p. 3; National Rural Health Alliance, sub. 86, p. 5, Sidney Allo and Janet Timbert, transcript, 19 August 2025, p. 22).

One area of progress is an expansion of the peer workforce. Peer workers are people employed in paid positions that require lived and living experience as an essential employment criterion, regardless of position type or setting (Byrne et al. 2021, p. 4). In 2022-23, there were 12.6 paid consumer peer workers per 1000 paid direct care staff, up from 2.7 per 1000 in 2013-14 (figure 2.8). During this same period, the number of paid carer peer workers grew from 1.4 to 4.8 per 1000 paid direct care staff (SCRGSP 2025).[19] This disparity between consumer and carer peer workers was supported by anecdotal evidence in submissions, for example:

> There remains a concerning lack of carer peer workers across government, government-funded, and PHN-funded mental health and suicide prevention services. Consultations with our members also indicate a significant disparity between the number of carer peer workers and consumer peer workers. (Mental Health Carers Australia, sub. 73, p. 23)

Figure 2.8 – The rate of consumer and carer peer workers has been steadily increasing[a,b]

Workers per 1,000 paid direct care staff



a. Full time equivalent of direct care staff employed in specialised public mental health services. Direct care staff include 'salaried medical officers, nurses, diagnostic and allied health professionals and other personal care' (AIHW 2011, p. 11).
b. The ACT data is not available for 2013-14 to 2015-16 or 2021-22 and 2022-23, as such it is not included in the Australian total.

Source: SCRGSP (2025).

The workforce strategy and the development of the peer workforce are discussed further in chapter 4.

[19] A consumer peer worker is someone who has lived experience of a mental health issue and is employed to use that experience, working with others who are recovering from a mental health issue. A carer peer worker is someone with lived experience of caring for someone with a mental health issue and uses their experience to support other carers (AIHW 2024d).

2.5 Progress towards a coordinated, person-centred system is very slow

Under the Agreement, governments committed to working together to implement a mental health and suicide prevention system that is comprehensive, coordinated and person-centred (clause 23). Such a system would offer the full range of services and supports, including prevention, early intervention, treatments and recovery supports for people with lived and living experience of mental ill health and suicide, as well as their supporters, family, carers and kin. It also incorporates coordination with services beyond health, such as housing and employment, which are known be important for improving mental health and reducing suicide rates (National Mental Health Consumer Alliance, sub. 66, p. 10). A person-centred system focuses on the needs and preferences of service users, rather than service providers and funders, and enables people to access the services and supports best suited to their needs.

At the core of such a system is better integration. In the health system, integration means governments, organisations and individuals collaborating and aligning their practices and policies to efficiently deliver high quality, person-centred, outcome-focused healthcare (Bywood et al. 2015, p. 1).

Integration commitments can be found throughout the Agreement

Integration appears throughout the Agreement and plays a pivotal role in its establishment, purpose, principles and objectives (box 2.3). The Agreement embeds commitments to three types of integration:

- cross-jurisdictional integration, bringing together services funded by different levels of government
- whole-of-government integration, including areas beyond the health system
- integration of lived and living experience. The Agreement commits governments to embedding the voices of people with lived and living experience in the design, planning, delivery and evaluation of services.

Box 2.3 – Integration plays a pivotal role in the Agreement

Integration is central to the very idea of a national agreement. The Agreement, which is a commitment between the Australian, state and territory governments to work together, is in and of itself, an example of integration.

Integration also implicitly or explicitly appears in:

- eight of the 14 principles that guide the implementation of the Agreement
- four of the five objectives, with the first objective being the aim 'of moving towards a unified and integrated mental health and suicide prevention system' (clause 21), and three other objectives discuss the requirement to work together and work collaboratively to improve the system and reduce fragmentation
- the overarching outcome to 'implement arrangements for a unified and integrated mental health and suicide prevention system' (clause 26).

Cross-jurisdictional integration commitments

This approach is primarily embedded in the governance mechanisms of the Agreement. Health and Mental Health Ministers from all jurisdictions are responsible for implementation of the Agreement. Additional commitments were made to:

Box 2.3 – Integration plays a pivotal role in the Agreement

- support PHNs and LHNs and other commissioning bodies to develop and/or strengthen joint regional plans (clause 134)
- assess and share evidence about the effectiveness of different models through testing and evaluating innovative planning and commissioning arrangements (clause 136)
- use the National Mental Health Service Planning Framework and/or other tools appropriate for their local population to support regional planning and commissioning (clause 139).

Whole-of-government integration commitments

The vision of a whole-of-government approach to mental health is explicitly mentioned in the purpose, principles, objectives and outcomes of the Agreement and set out in Schedule A.

Schedule A to the Agreement provides an outline of the activities to be undertaken to implement the commitment to a whole-of-government approach. It identifies priority areas for integration with education, work environments, homelessness, alcohol and other drugs, financial counselling, family, domestic and sexual violence, child maltreatment and justice.

Lived and living experience integration commitments

The Agreement includes commitments to centre the voices of people with lived and living experience in the Agreement itself, and in services and system reform, including:

- ensuring people with lived and living experience and their families and carers are consulted throughout the implementation of the Agreement, including seeking advice and providing opportunities for people with lived and living experience 'to influence matters of service design, planning, implementation, evaluation, data and governance' (clause 55)
- people with lived and living experience having input into the Agreement's governance (clause 84)
- co-designing place-based approaches while ensuring 'the voices of people with lived and living experience are embedded in the planning, design and evaluation of services' (clause 47h(i))
- developing suicide prevention services and programs in collaboration with communities and people with lived and living experience (clause 124c).

The importance of integration flows through to the bilateral schedules, which include commitments by the Australian, state and territory governments to improve coordinated care, such as through the Medicare Mental Health Centres.

Limited progress towards an integrated system

The Australian, state and territory governments have made limited progress implementing integration initiatives. Fragmentation remains across the system, with consumers seeing no meaningful change at the service level. These experiences were shared by many participants in the PC's survey (*What we heard* paper).

Unclear progress in cross-jurisdiction integration

Six permanent and three time-limited working groups have been established under MHSPSO. These working groups promote cross-jurisdictional integration by including representatives from all jurisdictions, holding regular meetings and overseeing policy development and implementation (chapter 1).

Due to the lack of public reporting on actions from the various working groups, we are unable to assess what impact they have made on cross-jurisdiction integration. However, the NMHC and NSPO (sub. 70, p. 13) found there was variable momentum across the groups.

There have been examples of improved cross-jurisdictional integration in the alignment between Australian Government-funded services and state-funded services. Reflecting on their experiences of services implemented under the Agreement, headspace (sub. 23, pp. 10–11) pointed to mixed progress, with:

> … some shift at the structural and relational level, where unprecedented levels of State government funding in service integration have improved policy alignment between headspace and State-funded services and prompted the establishment of new relationships at the strategic and service delivery level. … However, there is little indication that this has translated to aligning deeply held beliefs relating to service integration across the system, noting that this is a complex system change initiative that is at a relatively early stage of implementation.

At the local level, the failure to deliver detailed national guidelines on regional planning and commissioning has led to ad hoc progress in collaboration between PHNs and LHNs (section 2.4).

Minimal progress in whole-of-government integration

The primary mechanism in the Agreement to encourage whole-of-government integration is Schedule A. The Schedule A Working Group is responsible for coordinating efforts across government areas and jurisdictions (chapter 1).

The focus of the group has been on sharing examples of best practice across jurisdictions, including mental health and suicide prevention support in school settings, mental health and suicide prevention literacy and capability of public sector workforces, and legislative reform for work-related psychological health (NMHC 2024a, p. 16). The Tasmanian Government (sub. 78, p. 5) said information sharing and lessons from other jurisdictions had been a key achievement that allowed other states to refine their own approaches.

However, the NMHC and NSPO (sub. 70, p. 8) stated:

> … there has been minimal evidence of targeted progress with the [Schedule A] working group primarily focused on information sharing as opposed to reporting against tangible actions … The information provided did not articulate concrete evidence of how actions translated to outcomes aligned with the objectives of Schedule A.

Failing to turn information sharing into tangible actions reduces the impact on whole-of-government integration. The NMHC (2025, p. 17) found that the Schedule A Working Group:

> … was still unresolved as to whether, and how, it should extend its impact beyond information sharing and seek to deliver tangible products and/or actions against Schedule A commitments.

There has been some evidence of better whole-of-government integration and coordination between services within the mental health and suicide prevention system, however this appears to be on an ad hoc basis (*What we heard* paper). For example, the Medicare Mental Health Centres the PC visited (as well as other community-based mental health services) supported people to access a broad range of supports beyond health. The Australian Psychosocial Alliance (sub. 55, p. 6) noted:

> … in the case of Medicare Mental Health services there are some that provide predominantly clinical therapeutic care while others are providing a holistic approach which incorporates psychosocial support, including peer led support.

The Victorian Government (sub. 228, p. 4) also noted:

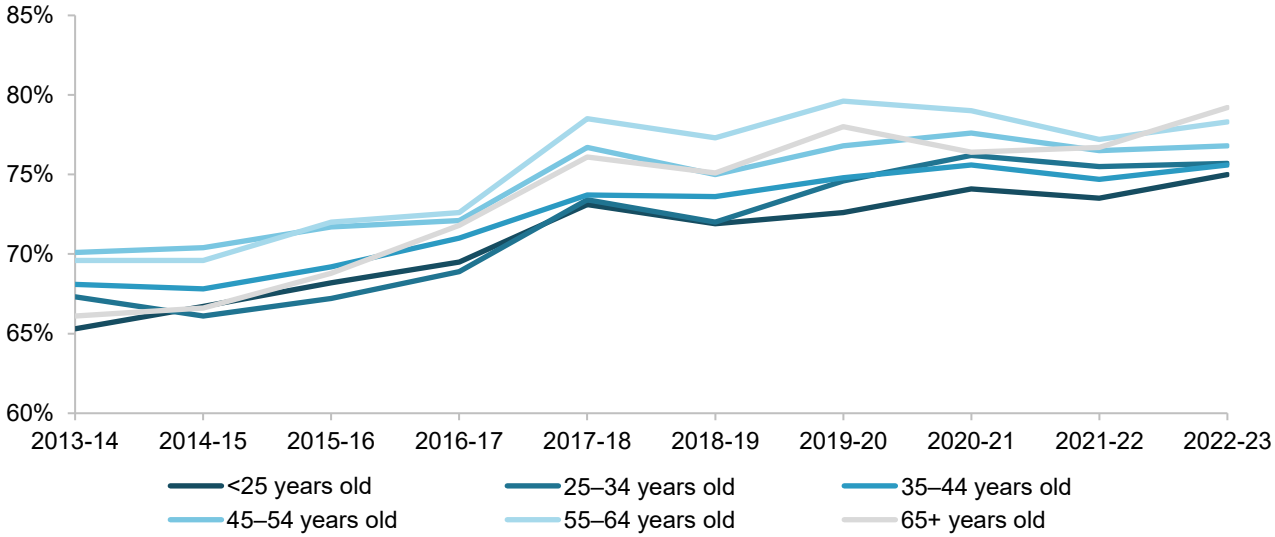
> We are beginning to see progress on the ground, for example, the delivery of more equitable and integrated community-based mental health care for Victorians through collaboratively funded initiatives under our bilateral schedule, such as the Mental Health and Wellbeing Locals.

Participants in this review criticised the renaming of Head to Health Centres to Medicare Mental Health Centres, stating it 'is seen as reducing accessibility and desirability of the services by invoking the stigma associated with clinical mental health services' (Roses in the Ocean, sub. 19, p. 6, *What we heard* paper).

Further evidence of better coordination between services is the steady improvements in the proportion of people receiving community follow-ups within seven days of discharge from psychiatric admission (figure 2.9). This suggests there has been an improvement in coordination and continuity of care between hospitals and the community sector.

Figure 2.9 – Rates of community follow up have been steadily rising

Proportion of people who received community follow ups within seven days of discharge from psychiatric admission or hospitalisation[a]



a. 'Community follow-up after psychiatric admission/hospitalisation' is defined as the proportion of state and territory governments' specialised public admitted patient overnight acute separations from psychiatric units for which a community-based ambulatory contact was recorded in the seven days following separation.

Source: SCRGSP (2025).

Integrating lived and living experience is improving in parts of the system

There has been progress in integrating the voices of people with lived and living experience in the Agreement's governance. The Australian Psychosocial Alliance (sub. 55, p. 14) noted 'the Governance arrangements have improved over the life of the National Agreement, including better representation of, and participation by, people with lived experience'.

Five lived experience representatives sit on MHSPSO (DoHAC 2024d). A separate National Mental Health and Suicide Prevention Lived Experience Group (LEG) was established in February 2024. Mental Health Australia (sub. 76, p. 21) welcomed the establishment of the LEG to inform MHSPSO and encouraged governments to ensure lived experience informs tangible actions.

However, members of LEG had mixed thoughts as to whether people with lived and living experience had been heard and understood by MHSPSO and the working groups. The Psychosocial Project Group reported that people with lived and living experience had raised concerns regarding lived experience engagement in pieces of their work while the Safety and Quality Group noted significant delays with appointing a carer representative (NMHC 2025, p. 23).

Some participants in this review felt the inclusion of people with lived and living experience in governance has been tokenistic (Consumers of Mental Health WA, sub. 49, p. 8; National Mental Health Consumer and Carer Forum, sub. 68, p. 6).

> Lived experience representatives refer to an imbalance of power being evident and a high turnover of lived experience representatives further contributing to dysfunction in the Agreement's governance. There is little flow of information from the various working groups' back to the lived experience advisory group, which was developed substantially later than the signing of the Agreement and has struggled to be integrated into the Agreement's broader governance arrangements. (Roses in the Ocean, sub. 19, p. 2)

> The rollout of the bilateral agreement has not been informed by the lived experience of consumer or carers. (Northern Territory Mental Health Coalition, sub. 54, p. 3)

Several review participants called for improved balance in lived and living experience representation, to address insufficient representation of lived and living experience of suicide (NMHC and NSPO, sub. 70, p. 15; NSW Health, sub. 90, p. 3; Roses in the Ocean, sub. 19, p. 2).

The 2022-23 National Progress Report noted several examples of good practice in incorporating the voices of people with lived and living experience, including collaborating with the National Mental Health Consumer and Carer Forum and nationwide co-design to develop aftercare best practice guidelines (NMHC 2024a, p. 18). These issues are discussed further in chapters 3 and 5.

Another example of the greater role people with lived and living experience have in some mental health services is a rise in the number of consumer and carer peer workers (figure 2.8).[20] This measure reflects the representation and active participation of those with lived and living experience of mental ill health within the mental health system.

The system remains fragmented

The Agreement's focus and commitment to integration is commendable; however, review participants overwhelmingly argued the system remains fragmented (box 2.4).

While initial advancements have laid some of the groundwork for integration, their impact on service delivery is limited. Consumers who find the system easy to navigate and receive comprehensive, coordinated care to address their needs remain the exception rather than the norm.

[20] A consumer peer worker is someone who has lived experience of a mental ill health and is employed to use that experience, working with others who are recovering from a mental health issue (AIHW 2024d). A carer peer worker is someone with lived experience of caring for someone with a mental health issue and uses their experience to support other carers (AIHW 2024d).

Box 2.4 – Review participants' views on fragmentation within the mental health and suicide prevention system

Overall, consumers are still experiencing an expensive, fragmented mental health system, and while the Agreement has had some positive impact, more needs to be done. (Consumers Health Forum of Australia, sub. 22, p. 9)

Over the last three years, the mental health and suicide prevention service system has become increasing[ly] fragmented and at the same time Australia's mental health has worsened. (Australian Psychosocial Alliance, sub. 55, p. 8)

There are significant challenges facing the mental health and suicide prevention sector, including … a fragmented and complex network of services that is difficult to navigate. (Lifeline Australia, sub. 8, p. 10)

Mental health and suicide prevention services remain fragmented across prevention, primary care, and specialist settings. Many individuals fall through the gaps, particularly those with severe and enduring conditions. (Australian Association of Psychologists Incorporated, sub. 13, p. 5)

Despite these well-documented recommendations, systemic fragmentation has hindered real change, leaving a persistent gap between policy aspirations and actual service delivery on the ground. (Ruah Community Services, sub. 14, p. 1)

Duplication and ambiguity of responsibilities in mental health and suicide prevention systems continues to result in inefficiently targeted resources, services and associated system gaps. (PHN Cooperative, sub. 69, p. 6)

Current policy, funding and models of care too often divide young people's needs into rigid categories of 'mental health', 'suicide prevention', 'alcohol and other drug use (AOD)' as if these issues exist and can be addressed in isolation. This uncoordinated and siloed approach fails to reflect the reality of adolescents, whose distress is rarely confined to a single diagnosis or service stream. Instead, young people experience complex, overlapping needs compounded by the nature of normative adolescent development. (Name withheld, sub. 106, pp. 3–4)

We agree with the Commission's finding that progress towards the Agreement's intent to create an integrated, person-centred mental health and suicide prevention system has been piecemeal, and that services remain unaffordable, difficult to access for many people and do not always respond to need. (Jesuit Social Services, sub. 131, p. 6)

The combination of a lack of a national vision, coupled with underwhelming funding commitments and differences across bilateral agreements, have continued to perpetuate fragmentation and failed to adequately and efficiently address service system gaps. (Mental Health Australia, sub. 153, p. 19)

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.

3. Is the Agreement effective?

Key points

- **The National Mental Health and Suicide Prevention Agreement has not enabled the systemic reform needed to improve mental health and suicide prevention outcomes.**
- **The Agreement's top-down approach and inflexible funding are restricting the ability of services to respond to local need. The initiatives implemented under the Agreement have limited scope and reach, affecting only a small proportion of the people who need support.**
- **The Agreement has ambitious objectives and outcomes, but it is not clear how the commitments in the Agreement and the bilateral schedules are helping achieve these.**
  - Some objectives, such as greater investment in prevention and early intervention, are not well reflected in the actions governments have committed to.
  - Many of the commitments do not have allocated funding.
  - The Australian, state and territory governments share responsibility for the Agreement's major outcomes, but there are no clear accountability mechanisms.
  - Unclear responsibilities affect the availability of services. For example, governments are yet to determine responsibilities for psychosocial supports outside the National Disability Insurance Scheme – leaving 500,000 people without the services they need.
- **The Agreement does not adequately embed the voices of people with lived and living experience of mental ill health and suicide, or their supporters, family, carers and kin. They were not involved in the design and negotiation of the Agreement and are not meaningfully included in its governance and implementation.**
- **The Agreement's governance arrangements mostly serve as mechanisms for information sharing across governments. The governance arrangements do not reflect the need for whole-of-government action, are slow to make progress and lacking in transparency and accountability.**

The National Mental Health and Suicide Prevention Agreement sets out governments' intention to work together to 'improve the mental health of all Australians and ensure the sustainability and enhance the services of the Australian mental health and suicide prevention system' (clause 1).

It includes commitments in several important areas, including:

- establishing a National Suicide Prevention Office (NSPO) (clause 125)
- addressing the gap in psychosocial supports (clauses 127–130)
- undertaking regional planning and commissioning (clauses 131–141)

- developing important frameworks and strategies, including a National Evaluation Framework, National Stigma and Discrimination Reduction Strategy and a National Mental Health Workforce Strategy (clauses 102a, 114 and 150)
- working with Aboriginal and Torres Strait Islander people, communities, organisations and businesses to improve social and emotional wellbeing and make progress under the National Agreement on Closing the Gap (clauses 47i, 110, 159d and 82d).

The Agreement's Schedule A reflects a whole-of-government approach to improving mental health and suicide prevention in the priority areas of education, work environments, homelessness, alcohol and other drugs, financial counselling, family, domestic and sexual violence, including sexual harassment, child maltreatment and justice. The bilateral schedules, signed by the Australian Government and each state and territory government, include funding for specific services, such as adult and child mental health services and supports for people after a suicide attempt.

However, there is broad consensus among review participants that, despite the importance of the commitments and the progress made towards achieving some of them, the Agreement has not been an effective mechanism for achieving the shared intentions of governments to improve the mental health and suicide prevention system (*What we heard* paper).[21]

> … while the National Agreement has made a good start in establishing system architecture and has facilitated much-needed investment in mental health services, it falls short of delivering a truly national mental health and suicide prevention system. (Mental Health Australia, sub. 76, p. 3)

> … consumers are still experiencing an expensive, fragmented mental health system, and while the Agreement has had some positive impact, more needs to be done. (Consumers Health Forum of Australia, sub. 22, p. 9)

> … the National Mental Health and Suicide Prevention Agreement … has delivered little systemic change, has not progressed system reform and is not effective. (National Mental Health Consumer Alliance, sub. 149, p. 5)

This chapter discusses why the Agreement is not effective.

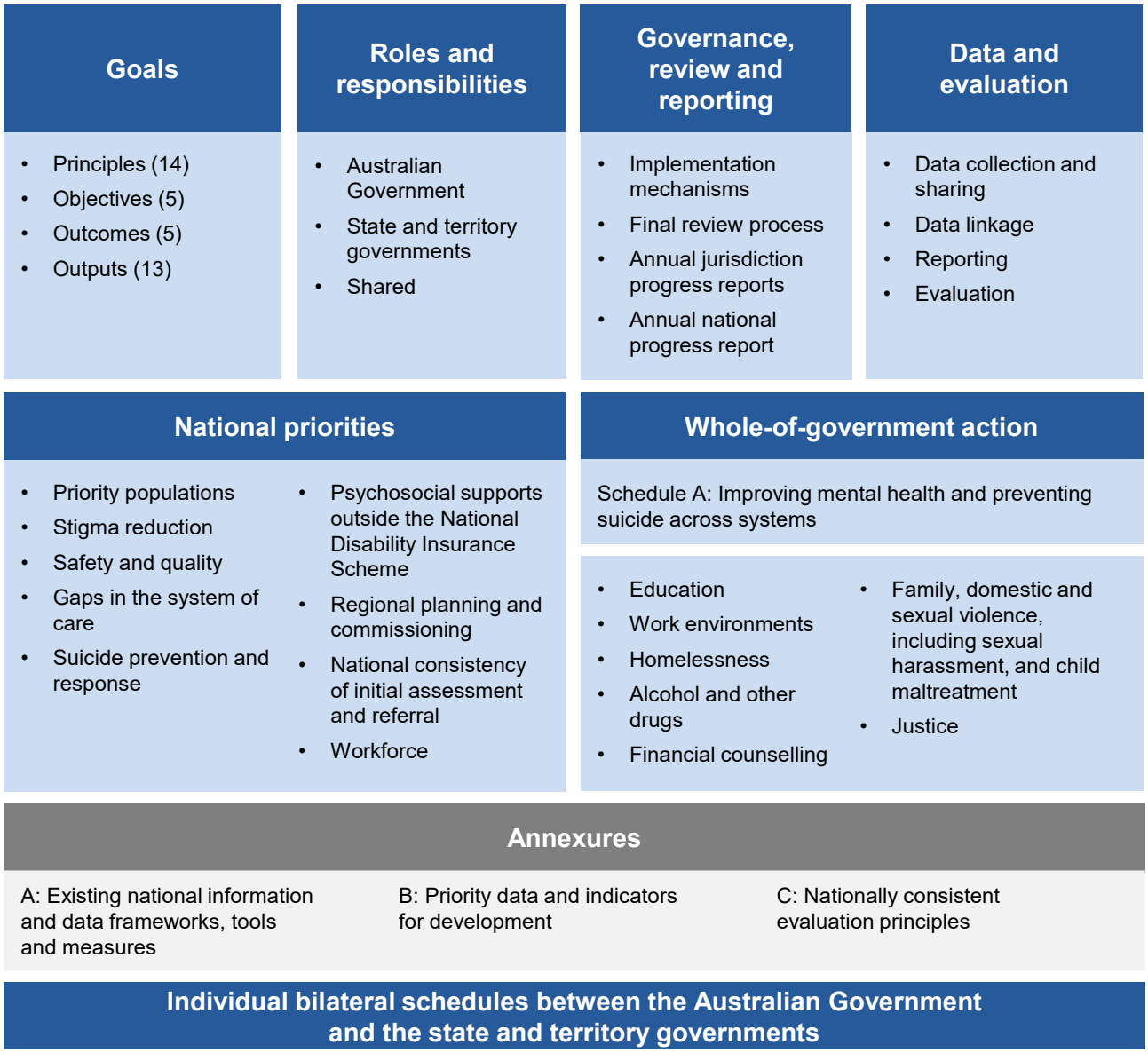
- There is insufficient clarity around many of the Agreement's components, including the objectives, intended outcomes, priority populations, roles and responsibilities, performance monitoring and reporting and funding. There is also no clear link between these components (section 3.1).
- The Agreement does not adequately embed the voices of people with lived and living experience of mental ill health and suicide and their supporters, family, carers and kin (section 3.2).
- The governance arrangements are ineffective and there is insufficient accountability (section 3.3).
- The Agreement does not include many of the elements needed to progress system reform (section 3.4).

[21] For example: AAPi, sub. 13, p. 4; ACT Mental Health Consumer Network, sub. 114, p. 1; AMA, sub. 235, p. 1; BDI, sub. 151, p. 1, transcript, 19 August 2025, p. 4; Gayaa Dhuwi (Proud Spirit) Australia, sub. 230, p. 4; HER Centre Australia, sub. 122, p. 2; Mental Health Australia, transcript, 20 August 2025, p. 64; MHCC, sub. 120, p. 5; MHLEPQ, sub. 144, p. 5; MHNS, sub. 202, p. 2; MHV, sub. 95, p. 4; Michael Thorn, sub. 6, p. 2; Mind Australia, sub. 187, p. 3; Movember, sub. 80, p. 1; NACCHO, sub. 245, p. 5; NMHC and NSPO, sub. 70, p. 4; NMHCCF, sub. 68, p. 5; Open Dialogue Centre, sub. 135, p. 1; PHN Cooperative, sub. 69, p. 6, sub. 208, p. 6; QNMU, sub. 136, p. 3; Ruah Community Services, sub. 14, p. 1; Stephen Carbone, sub. 201, p. 1; VMHPAA, sub. 115, p. 1; yourtown, sub. 126, p. 5.

3.1 The Agreement has not been set up for success

The Agreement is an aspirational document that includes principles and priorities, objectives, outcomes and outputs, roles and responsibilities, governance arrangements, reporting, data and evaluation, and financial arrangements. It describes agreed national priorities for reform and separate bilateral schedules contain commitments for each state and territory (figure 3.1).

Figure 3.1 – Main components of the Agreement



For the Agreement to be effective, each individual component needs to be well defined and functioning. All components need to be clearly linked and work together through a program logic and theory of change (chapter 1). For example, specific activities in the Agreement and in the bilateral schedules, such as establishing new services, should clearly link and contribute to improving outcomes.

However, many key components lack sufficient specificity. The objectives and national priorities are too broad to constitute clear reform direction, the outcomes are not easily measurable, and roles and

responsibilities are not well defined. Many of the commitments in the Agreement do not have funding attached to them. Where funding is allocated, it is unclear how the specific commitments will achieve the agreed objectives and outcomes.

The goalposts are not clear and measurable

Objectives and outcomes are typically used within national agreements to set goalposts. Objectives speak to the vision of the agreement (what is the agreement trying to achieve?) (Ramia et al. 2021). Outcomes are tangible measures that illustrate the intended effect of the agreement (how will we know when we have made progress?) (WYCA 2023, pp. 16–17).

The objectives are too vague to articulate a direction for reform

The objectives should clearly articulate what change the Agreement is aiming to achieve. Objectives should provide a long-term goal that is supported by governments as well as people with lived and living experience of mental ill health and suicide, their supporters, family, carers and kin and the broader mental health and suicide prevention sector. Without shared goals, it is harder to achieve change and hold governments to account for lack of progress.

The Agreement's objectives are described in five clauses, reflecting governments' commitment to working together to improve mental health and suicide prevention outcomes (box 3.1). Some review participants were supportive of the objectives (for example, Australian Psychosocial Alliance, sub. 55, p. 3). Mental Health Australia (sub. 76, p. 2) stated 'the National Agreement articulates sound principles and objectives for interjurisdictional collaboration to progress mental health and suicide prevention system reform'.

Box 3.1 – Objectives of the Agreement

- The Commonwealth and the States recognise that this Agreement provides an opportunity to work together to lay the foundations for delivering landmark mental health and suicide prevention reform, with the aim of moving towards a unified and integrated mental health and suicide prevention system (clause 21).
- This Agreement acknowledges the significant, and often cumulative, challenges for people living in Australia including drought, bushfires and COVID-19. These challenges have amplified the need to improve our mental health and suicide prevention system to address the increased impact on mental health, increased levels of mental illness, and increased levels of suicidal risk, self-harm and distress (clause 22).
- The Parties agree on their shared objective to work collaboratively together 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 (clause 23).
- The Parties will work together in partnership to ensure that 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 (clause 24).
- As a priority in the first instance, the Parties agree to work together to address areas identified for immediate reform as informed by the PC's Inquiry Report on Mental Health (PC Report), the National Suicide Prevention Adviser's Final Advice (NSPA Final Advice) and other relevant inquiries including to:

Box 3.1 – Objectives of the Agreement

- reduce system fragmentation through improved integration between Commonwealth and State-funded services (clause 25a)
- address gaps in the system by ensuring community-based mental health and suicide prevention services, and in particular ambulatory services, are effective, accessible and affordable (clause 25b)
- prioritise further investment in prevention, early intervention and effective management of severe and enduring mental health conditions (clause 25c).

While the objectives describe positive aspirations, they are not sufficiently clear (Consumers Health Forum of Australia, sub. 140, p. 4; Mental Health Victoria, sub. 95, p. 4). The Western Australian Association for Mental Health (sub. 82, p. 8) said 'these stated objectives are very bold, broad and not particularly well-defined'.

Some of the objectives are not objectives at all. Instead, they provide contextual information or statements about how the objectives will be achieved. For example, acknowledging the effect of recent, cumulative challenges, such as natural disasters and COVID-19, is essential to building a better system that meets people's needs, but it is not an objective.

The way objectives are articulated makes it difficult to determine whether they have been met. The National Mental Health Consumer Alliance (sub. 66, p. 9) said consumers felt the objectives were not measurable, which made it difficult to assess progress, and 'this lack of clarity undermines the transparency of the agreement and makes it seem superficial'.

Not all the outcomes are measurable

Under the Agreement, governments seek to achieve five outcomes across a wide range of mental health and suicide prevention domains. Outcomes should describe the desired change resulting from the Agreement. To be effective, they should be specific, measurable, achievable, relevant and time-bound (ANAO 2007, p. 57). Not all the outcomes in the Agreement meet these criteria (Community Mental Health Australia, sub. 216, p. 8; Consumers Health Forum of Australia, sub. 140, p. 4).

The outcomes are highly ambitious given the Agreement's term is only four years. Some outcomes are also hard to measure. For example, existing data is insufficient to measure improvements in mental health and wellbeing of all 15 'priority populations' listed in the Agreement (chapter 2). Mental Health Australia (sub. 76, p. 13) argued:

> It is inherently difficult to ascertain whether these outcomes have been achieved. First, there is little timely, public data reported against these outcomes. Second, even where there is data available, it is difficult to ascertain whether any changes identified are attributable to the reforms outlined in the National Agreement.

Measurement of other outcomes is complicated by ambiguity over what they are trying to achieve or how they would be measured. For example, it is not clear what a 'balanced' mental health system means, or how 'balanced and integrated' would be measured. While the Agreement contains commitments to develop indicators for this outcome, these indicators are not clearly linked to balance and integration (Annex B). This lack of specificity leaves the perceived progress on the outcome up to the discretion of the evaluators, who can pick and choose between indicators to evaluate progress.

Priority populations are listed – but their needs are not addressed

The Agreement lists 15 'priority populations' disproportionately impacted by mental ill health and suicide. Implementation of initiatives under the Agreement needs to consider and support the mental health and wellbeing of these groups (clause 111).

The Agreement does not articulate why these 15 groups were chosen. Many of these groups have a higher prevalence of mental ill health than the general population, but other groups who also experience mental ill health and suicide at high rates are not included (Name withheld, sub. 101, pp. 16–17). For example, review participants argued carers, supporters, family and kin (particularly young carers and Aboriginal and Torres Strait Islander carers), people with autism, emergency services personnel and their families, and people seeking asylum should be added to the list or more fully recognised in the Agreement.[22]

Despite the requirement that initiatives under the Agreement consider these groups, there is minimal reference to the listed priority populations in other parts of the Agreement or in the bilateral schedules.

> … it is difficult to find a link between the priority populations identified, and tangible actions or funding allocated through the National Agreement and Bilateral Agreements. (Mental Health Australia, sub. 76, p. 13)

Gayaa Dhuwi (Proud Spirit) Australia (sub. 75, p. 6) and Mental Health Australia (sub. 76, pp. 13–15) noted commitments related to Aboriginal and Torres Strait Islander people, culturally and linguistically diverse communities and refugees, and LGBTQIASB+ people are not reflected in the bilateral schedules. The National Mental Health Consumer Alliance (sub. 66, p. 16) added:

> The National Agreement includes commitments to mental health consumer involvement and the inclusion of specific marginalised groups including people who identify as LGBTIQA+, Aboriginal and Torres Strait Islander, and culturally and linguistically diverse communities. However, there is no clear accountability mechanism to ensure these commitments have led to meaningful action.

Roderick McKay (sub. 17, p. 2) stated:

> Despite being listed as a priority population, no actions are focused on improving services to older Australians in any Commonwealth-State Agreements beyond continuation of existing state mental health services for this population …

Some review participants argued the next agreement should continue to list priority populations (for example, FASSTT, sub. 223, p. 4; JFA Purple Orange, sub. 226, p. 16), so people receive support meeting their needs. However, it is questionable whether a long list of groups disproportionately impacted will lead to better targeting of support. As the PC (2022a, p. 113) has previously noted when reviewing the National Housing and Homeless Agreement, 'if everyone is a priority, no one is a priority'.

Roles and responsibilities are not well defined

In 2020, the PC found the roles and responsibilities of the Australian, state and territory governments for mental health and suicide prevention are often unclear and overlapping (PC 2020, p. 1135). The Mental Health inquiry recommended a national agreement to help clarify 'the responsibilities of each level of government for providing mental healthcare, psychosocial supports, mental health carer supports and suicide prevention services' (PC 2020, p. 1149).

[22] Carers ACT, sub. 60, p. 6; Carers WA, sub. 43, p. 6; Everymind, sub. 32, pp. 3–4; FASSTT, sub. 223, p. 4; MESHA, sub. 175, p. 3; MHCA, sub. 73, pp. 16–17; OTARC, sub. 108, p. 1; QNMU, sub. 136, p. 7.

The Agreement describes the broad roles and responsibilities of the Australian, state and territory governments, which align with other policies, legislation and constitutional responsibilities. However, review participants noted the roles and responsibilities for implementing the Agreement remain unclear.[23]

Much of the lack of clarity is due to the inclusion of a substantial number of 'shared responsibilities' (clauses 41–46). All governments share responsibility for the Agreement's major commitments, including an overarching shared responsibility 'to ensure equitable access to effective mental health and suicide prevention services for all people living in Australia' (clause 41).

> Articulation of joint responsibilities in the National Agreement introduces potential unintended consequences through lack of clear lines of accountability, and opportunity for cost shifting and lack of transparency. (Mental Health Australia, sub. 76, p. 19)

> There is not enough clarity around the roles and responsibilities, and too many shared responsibilities without consideration of how these roles will be shared. (Australian Psychosocial Alliance, sub. 55, p. 14)

The lack of clarity has significant consequences. As discussed in chapter 2, governments have not fully met their commitments in the Agreement regarding psychosocial supports outside the National Disability Insurance Scheme (NDIS). This is partly due to how the commitments in the Agreement were designed – addressing gaps in psychosocial supports is a shared responsibility of the Australian, state and territory governments.

Governments took a conservative approach, committing to agreeing to a definition of psychosocial supports and estimating the level of unmet need, before working out roles and responsibilities. As review participants noted, this approach has delayed progress (Mental Illness Fellowship of Australia, sub. 88, p. 13).

> Critically, the National Agreement has (perhaps inadvertently) stalled action in addressing the growing gap in the provision of psychosocial support ("unmet need"). In part this is because it prioritised the re-visiting of the Productivity Commission analysis of need in this area over action, while simultaneously failing to provide a pathway or framework for addressing the gap or addressing the interface issues between the NDIS and the mental health service system. (Australian Psychosocial Alliance, sub. 55, p. 3)

As a result, people are not receiving the support they need, which was reflected in the survey conducted by the PC. One respondent stated:

> There are no in-person services locally for psycho-social wellbeing for people without a NDIS plan. (sr. 50)

There is a pressing need to determine responsibilities for funding and commissioning psychosocial supports, given almost 500,000 people with mental illness are missing out (HPA 2024, p. 77). This is discussed further in chapters 2 and 4.

Monitoring and reporting requirements are insufficient

Jurisdictions have failed to adhere to their reporting requirements under the Agreement (chapter 2). However, even if the commitments had been met, it is unlikely they would have provided sufficient information, transparency and accountability.

[23] AAPi, sub. 13, pp. 9–10; LELAN, sub. 190, p. 9; Mental Health Australia, sub. 76, pp. 24–25, sub. 153, p. 5; Orygen, sub. 26, p. 4; PHN Cooperative, sub. 208, p. 6; RANZCP, sub. 7, pp. 3–4; WAAMH, sub. 82, pp. 14–16; WQPHN, sub. 45, p. 4.

Performance monitoring

Strong performance monitoring is crucial to improving outcomes. The Agreement recognises this through several commitments to data collection, sharing and linkage (chapter 2), as well as plans to develop specific indicators included in Annex B. The Data Governance Forum (DGF) and Evaluation Project Group, established under the Agreement, have facilitated notable progress, particularly in the areas of data sharing and linkage, indicator development, and the development of a National Evaluation Framework and Sharing Guidelines (chapter 2; NMHC 2025, p. 6). This will help to improve aspects of performance monitoring. However, this progress is limited relative to the Agreement's targets, as many commitments were too ambitious and vague, and the requisite resources were not provided to achieve them.

Annex B set out indicators for data development, some of which are already being internally reported to the National Mental Health Commission (NMHC) (DGF, pers. comm., 20 May 2025), and some of which will take time to develop. However, once developed, the indicators may not effectively measure progress in meeting this Agreement's outcomes. In some cases, the indicators flagged for development are too narrow relative to the broad outcome they are tied to. For example, under 'improving the mental health and wellbeing of the population', while indicators are being developed for Aboriginal and Torres Strait Islander mental health and wellbeing, measurement gaps for other priority populations are not addressed (Annex B). Some of the indicators will only be finalised and publishable after the Agreement ends, meaning they will not be used at all over the life of the Agreement (DGF, pers. comm., 20 May 2025).

While some commitments to improving performance monitoring are clear and specific, such as the goal to establish an appropriate governance forum (clause 84), others are too broad, making it difficult to determine how they could be achieved, such as the goal to '[s]treamline the collection and management of existing datasets to minimise collection burden, reduce duplication and improve national consistency' (clause 88d). No clear roadmap was provided on how to complete these commitments, and there was no clear mechanism to motivate governments to act on them, outside of tasking the DGF to coordinate them.

Despite the progress the DGF has facilitated, it lacks the necessary powers to motivate governments to act on commitments such as increasing data sharing and linkage, which require high levels of interjurisdictional collaboration between levels of government.

Performance reporting

The Agreement requires each state and territory government to develop an annual progress report by 31 August each year. These progress reports must be consolidated into an annual national progress report, which is to be finalised and endorsed by Health Chief Executives and Mental Health CEOs where relevant and provided to Health Ministers and Mental Health Ministers by 30 November each year. The national progress report is required to be made public within three months of its completion, unless it is not reasonable, appropriate or practical to do so at the time. Jurisdiction progress reports should include both qualitative and quantitative elements, incorporating key performance indicators as relevant and appropriate (clauses 76–79).

The way these reporting requirements were implemented does not support transparency. Jurisdictional progress reports are based on self-assessment, include limited quantitative data and focus too heavily on qualitative and descriptive commentary on progress made (Community Mental Health Australia, sub. 216, p. 8; LELAN, sub. 190, p. 16; NMHC 2025, p. 53; NMHC and NSPO, sub. 70, p. 11). Reports are not required to be made public, limiting their effectiveness as an accountability tool and preventing public scrutiny on their assessment of progress.

> Without this public reporting and monitoring across jurisdictions, the community, the mental health sector and government will not be able to compare performance, highlight success and identify areas for future effort. (Equally Well Australia, sub. 53, p. 18)

The NMHC has been tasked with preparing the national progress report. However, it is required to consolidate the information provided by the state and territory governments and it has no powers to compel governments to provide information (clauses 76, 78; NMHC 2024a, p. 4). This substantially limits the NMHC's effectiveness as an oversight body, as the reports are not an independent assessment of progress. This is discussed in section 3.3.

While reporting is meant to include monitoring of progress against the Agreement's objectives and outcomes, for the most part, the data reported publicly focuses on activities and whether outputs have been delivered (NMHC 2024a).

> … clear and consistent monitoring and reporting, not just on outputs but also on outcomes, are essential in determining the impact of the agreement. (Lifeline Australia, sub. 8, p. 3)

There are also no consequences if performance reporting requirements are not met. As discussed in chapter 2, not all jurisdictions have met the reporting requirements of the Agreement within the prescribed deadline.

Many of the commitments have no funding or deadlines

While the Australian, state and territory governments contribute funding for initiatives in the bilateral schedules, many important commitments in the Agreement itself are not funded (LELAN, sub. 190, p. 12; Mental Health Australia, sub. 153, p. 5). This includes commitments such as addressing gaps in the system of care, supporting the workforce and improving referral pathways between mental health and suicide prevention services and other services, such as housing.

Not funding these activities means there is a risk they will not be completed. The little publicly available information to date suggests this is the case. For example, the NMHC and NSPO (sub. 70, p. 8) stated:

> … there has been minimal evidence of targeted progress with the [Schedule A] working group primarily focused on information sharing as opposed to reporting against tangible actions. In the Annual National Progress Report 2022-23, it was reported that the working group had shared best practice examples and/or case studies concerning a range of topics (e.g. mental health supports in school settings, legislative reform for work-related psychological health) and discussed a broad range of common issues or ideas. The information provided did not articulate concrete evidence of how actions translated to outcomes aligned with the objectives of Schedule A.

There is also no funding allocated to enable collaboration between different parts of government 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 still lacking in many areas. Where it does occur, this is due to the goodwill of staff and their strong commitment to improving outcomes for people with lived and living experience (*What we heard* paper).

Many review participants also reflected on the lack of clear accountability for actions governments committed to carrying out under the Agreement (*What we heard* paper).[24] The majority of the Agreement's commitments do not

[24] AAPi, sub. 13, p. 10; AMA, sub. 72, p. 5; LELAN, sub. 190, p. 16; Mental Health Australia, sub. 76, p. 2; MHNS, sub. 202, pp. 8–9; MIFA, sub. 88, pp. 10–11; NMHCA, sub. 66, p. 9; Northern Territory Mental Health Coalition, sub. 54, pp. 1–2; Orygen, sub. 26, p. 5; RANZCP, sub. 7, p. 4; Roses in the Ocean, sub. 19, p. 2; Skylight Mental Health, sub. 91, p. 2; WAAMH, sub. 172, p. 4.

have defined deadlines and funding transfers are not linked to outcomes being achieved. In effect, even when actions are not completed as intended or not completed at all, this carries no consequences for governments.

> Without enforceable accountability measures, governments can shift responsibility without ensuring services are delivered effectively. (Australian Association of Psychologists Incorporated, sub. 13, p. 10)

> While there are commitments from the federal, state and territory governments to work together, clear definitions of governmental responsibility for funding and workforce development are necessary to ensure accountability and the successful implementation of the National Agreement. (Australian Medical Association, sub. 72, p. 3)

It is not clear how the Agreement's components are connected

The Agreement's objectives and outcomes are highly ambitious, aiming for system reform and improved outcomes. But it is unclear how the outputs, priorities and actions in the Agreement, even if achieved, will meet these ambitions (MHLEPQ, sub. 144, p. 6; SUPERCRO, sub. 111, p. 1).

> The National Agreement specifies priority indicators for development (Annex B), which are categorised against the five high-level outcomes specified in the Agreement (Clause 26). Beyond this, it is difficult to discern a clear overarching logic for these indicators and how they map to the outputs or initiatives underpinning the National Agreement. (NMHC and NSPO, sub. 70, p. 11)

> There is no clear or measurable connection between the Agreement's goals, the initiatives being funded, the outcomes being pursued, and the people and communities they are intended to support. (LELAN, sub. 190, p. 11)

The Agreement's outputs are generally focused on providing or improving information about progress, improving evaluation processes and developing strategies and guidelines (clause 27). While they are all worthwhile activities, and some contribute to the building blocks for reform, on their own they are unlikely to improve outcomes.

Review participants talked about a lack of theory of change or program logic to explain how activities funded under the Agreement will lead to the expected outcomes (*What we heard* paper).[25] Some of the outcomes appear to have few or no commitments linked to them. For example, while the need to 'improve physical health and life expectancy for people living with mental health conditions and for those experiencing suicidal distress' is identified as an outcome of the Agreement (clause 26d), there do not seem to be any actions or initiatives within the Agreement or the bilateral schedules to achieve this outcome.

The Agreement states governments will prioritise further investment in prevention and early intervention (clause 25c). This is a key priority for consumers, carers and service providers, but beyond the initial objective, there is no further mention of how these investments will occur (Beyond Blue, sub. 156, p. 5; OurFutures Institute, sub. 182, p. 7).

> While the Agreement currently mentions prevention as an area for joint action across Commonwealth and State governments, there are no current prevention priorities included, meaning that collaborative evidence-based action on prevention is missing from the Agreement. (Wellbeing and Prevention Coalition in Mental Health, sub. 31, p. 3)

Some commitments do not flow through to the bilateral schedules. For example, Gayaa Dhuwi (Proud Spirit) Australia (sub. 75, p. 6) and the Victorian Aboriginal Legal Service (sub. 200, p. 13) noted the commitments

[25] MHNS, sub. 202, p. 13; Mindgardens Neuroscience Network, sub. 195, p. 2; QAIHC, sub. 221, p. 1; VMHPAA, sub. 115, p. 1.

related to Aboriginal and Torres Strait Islander people's social and emotional wellbeing in the Agreement are not included in the bilateral schedules (chapter 7). Turning Point and the Monash Addiction Research Centre (sub. 137, p. 4) noted Schedule A commits governments to improving integration of mental ill health and alcohol and other drugs services, but only Victoria and Western Australia's bilateral schedules include any alcohol and other drugs-related commitments (chapter 9).

The activities in the bilateral schedules, where implemented, can have positive effects on their local communities but they are limited in their reach. An early evaluation of the Medicare Mental Health Centres (MMHCs), one of the main initiatives under the Agreement, showed positive results. The people who attended the centres felt welcomed and they valued the expertise of peer workers working alongside clinicians (Neami National 2024). However, in 2023-24, the five centres evaluated supported about 1,450 consumers a month on average (ALIVE National Centre for Mental Health Research Translation 2024b). While the experience of each consumer is important and increasing the reach of mental health and suicide prevention services is a critical goal of the Agreement, there would need to be a significantly larger investment in MMHCs to achieve the Agreement's objectives.

3.2 The Agreement does not embed the voices of people with lived and living experience

Including people with lived and living experience of mental ill health and suicide, and their supporters, family, carers and kin, in the design and governance of policy and services is essential for achieving system reform (Beyond Blue, sub. 37, p. 5; Consumers of Mental Health WA, sub. 49, p. 8; LELAN, sub. 190, p. 5; National Mental Health Consumer Alliance, sub. 66, p. 7). It can improve the quality of planning and decision making in governance, enhance the mental health and suicide prevention system's performance, and ultimately improve outcomes. As noted in the Agreement:

> Achieving [reform] requires collaboration from all governments, as critical players in policy and service delivery, as well as meaningful engagement with key stakeholders, particularly those with lived experience. (clause 29)

The Agreement includes several commitments to centre the voices of people with lived and living experience, although it says little about how this should be achieved (Mental Health Lived Experience Peak Queensland, sub. 144, p. 5; Roses in the Ocean, sub. 133, p. 3). Commitments include:

- ensuring people with lived and living experience and their supporters, family, carers and kin are consulted throughout the implementation of the Agreement, including seeking advice and providing opportunities for people with lived and living experience 'to influence matters of service design, planning, implementation, evaluation, data and governance' (clause 55)
- people with lived and living experience having input into the Agreement's governance (clause 84)
- co-designing place-based approaches while ensuring 'the voices of people with lived and living experience are embedded in the planning, design and evaluation of services' (clause 47h(i))
- developing suicide prevention services and programs in collaboration with communities and people with lived and living experience (clause 124c).

Since the Agreement was signed, there has been progress in including people with lived and living experience, not just in the governance and actions covered by the Agreement (chapter 2), but in policy and service design and delivery in the wider mental health and suicide prevention system. For example, in 2024, the Australian Government funded the National Mental Health Consumer Alliance and Mental Health Carers Australia to be the national peak bodies representing consumers and carers. This was seen as a positive

step by review participants (Beyond Blue, sub. 37, p. 5; Consumers Health Forum of Australia, sub. 22, p. 6; Tasmanian Government, sub. 78, p. 4).

However, we heard these peaks have limited resourcing. The effectiveness of these bodies and the level to which they can engage will be constrained unless they are adequately resourced.

> Funding for Peak bodies provides an informed and ready voice to provide thought leadership, high-level committee representation and deep policy advice to Governments. They should be funded adequately to perform this important role, noting that most mental health consumer peaks receive core funding covering wages for 3-4 staff plus funds for paid participation and general operating expenses. This is inadequate to cover the breadth of tasks required of them (which extends beyond health into areas such as NDIS and social services) and therefore does not indicate a commitment to lived experience leadership by governments despite their placations. (National Mental Health Consumer Alliance, sub. 66, p. 23)

People with lived and living experience were not involved in the negotiation and design of the Agreement

Review participants stated people with lived and living experience were not involved in the negotiation and design of the Agreement. Mental Health Australia (sub. 76, p. 2) reflected 'lived experience and sector engagement in development of the National Agreement was very poor'. And Community Mental Health Australia (sub. 84, p. 5) said:

> The existing Agreement was developed by a small group of non-sector and non-Lived Experience actors without consultation with the broader sector or transparency. This Review is the only opportunity Lived Experience has had to be consulted for feedback on the suitability of the Agreement or its implementation.

It is highly unlikely governments are meeting their commitments in the Agreement to centre the voices of people with lived and living experience when they were not sufficiently involved in its design.

> The Agreement was developed without meaningful consultation with lived experience communities, leading to ineffective service models and governance structures. (National Mental Health Consumer and Carer Forum, sub. 68, p. 6)

> Significantly, the National Agreement itself was not developed in consultation with those with a lived or living experience of mental ill-health or suicide, nor families, kin and carers. This represents a critical missed opportunity to harness this wisdom and experience in shaping the direction of this important reform from the outset. (NMHC and NSPO, sub. 70, pp. 16–17)

In addition, there is only minimal recognition of carers in the Agreement:

> Carers remain largely invisible in the mental health system, and this agreement's failure to adequately include carers has likely contributed to this reality. The Agreement does not align with the *Carer Recognition Act 2010* (Cwth) as it does not recognise carers or acknowledge their needs, neither as individuals or as carers, nor does it commit to providing them with meaningful support. (Carers ACT, sub. 60, p. 3)

The Agreement uses a range of terms, including co-design, when referring to the commitments to embed the voices of people with lived and living experience. Across many parts of the mental health and suicide prevention system, co-design has been used to develop effective, community-based solutions that address the needs of consumers and carers (CERIPH 2024). Genuine co-design takes time and resources. But it has substantial benefits and is essential to improving outcomes (box 3.2).

Box 3.2 – Co-design brings substantial benefits if done well

Co-design occurs when decision-making power is shared and when consumer voices are heard, valued, debated and acted upon (Slay and Stephens 2013, p. 4). Valuing and supporting the unique contributions consumers and carers have to offer, alongside those of policymakers, funders, providers and workers, makes the most of people's skills, experiences and capabilities (NMHCCF 2021, p. 1). The benefits of lived and living experience engagement have become increasingly evident as the practice has grown. Projects engaging people with lived and living experience through co-design have reported:

- increasing relevance of their information and services
- improved social networks and inclusion
- reduced stigma
- better attitudes, interactions and understanding between service users and providers
- improved outcomes such as improved wellbeing, reduced mental health needs, and improved skills and employability (Hawke et al. 2024; Slay and Stephens 2013).

Genuine co-design requires several conditions to be met. People with lived and living experience and the peak bodies representing them must be adequately resourced to participate in any co-design process. They should have the information, agency and support to actively participate, and their knowledge and expertise should be valued and respected (Roper et al. 2018).

> Genuinely engaging and co-designing with community takes time. Funding and contract terms must allow time to establish trust and credibility with communities, for people to meaningfully contribute, and for organisations to learn from the people we serve. (Beyond Blue, sub. 37, p. 5)

Review participants highlighted there may be some way to go in ensuring these conditions are met. Policy design and service commissioning often do not allow sufficient time for genuine co-design:

> Very short time frames make important aspects of service development such as co-design and evaluation unviable, particularly in terms of meaningfully embedding the views of people with lived experience as per the Agreement's commitments, which risks reducing these commitments to tokenism.
>
> The rushed approach to co-design diminishes these activities to merely consultative exercises and makes the needed time to develop trust and effective engagement with key populations, such as culturally and linguistically diverse communities or people in rural and remote areas largely impossible. When there is also no requirement for co-design results to be utilised by the service, this risks undermining community confidence further. (Roses in the Ocean, sub. 19, p. 4)

Achieving effective co-design in the mental health and suicide prevention system faces substantial barriers beyond insufficient funding and time. Shifting the organisational culture underpinning these processes and addressing power imbalances and stigma take time and significant effort from all participants in the process (CERIPH 2024, pp. 22–24). If these barriers are not addressed, this can significantly diminish the effectiveness of co-design.

> Tokenistic co-design and misuse of the participatory label, when a project has not involved equitable decision-making of people with lived experience, will likely perpetuate marginalisation (CERIPH 2024, p. 21).

People with lived and living experience are not sufficiently involved in the Agreement's governance and delivery of commitments

People with lived and living experience are included in the memberships of the Mental Health and Suicide Prevention Senior Officials group (MHSPSO) and some project and working groups. However, many review participants were critical of how this is working in practice. Some described efforts as tokenistic and the involvement of people with lived and living experience as mostly limited to being consulted and providing advice, rather than participating fully in the design, planning, delivery and evaluation of services under the Agreement.[26]

> … whilst there was some Lived Experience on the implementation structures of the Mental Health and Suicide Prevention Senior Officials Group, it was largely tokenistic – for example the Psychosocial Unmet Needs Project Group had one person with personal lived experience included, and despite repeated requests, denied family member inclusion in the group. (Community Mental Health Australia, sub. 84, p. 4)

> Unfortunately, the National Agreement has not succeeded in embedding ongoing, curated co-design and co-development, limiting the amplification of the voice of, or providing appropriate services for, people with lived experience. (National Mental Health Consumer Alliance, sub. 66, p. 7)

The introduction of a Lived Experience Group (LEG) is a positive step. However, it was established late and only met for the first time in February 2024. Members of the LEG said this resulted in a lack of momentum (Mental Health Australia, sub. 76, p. 21; NMHC 2025, pp. 5, 22; Roses in the Ocean, sub. 19, p. 2). Mental Health Australia (sub. 153, p. 12) noted confusion about the LEG's role:

> With different government agencies and teams providing the secretariat function for various working groups under the Agreement, there appears to be confusion around the role of the MHSPSO LEG and engagement of lived experience representatives.

A lack of clarity across the Agreement's governance structures about the role of the LEG may mean other working groups may be uncertain about how to draw on its expertise, when to involve its members, or what weight to give its advice, underutilising the substantial breadth of lived experience knowledge represented in the LEG and diminishing its potential contribution.

Review participants also noted the LEG does not receive sufficient information from other parts of the Agreement's governance.

> There is little flow of information from the various working groups back to the lived experience advisory group, which was developed substantially later than the signing of the Agreement and has struggled to be integrated into the Agreement's broader governance arrangements. (Roses in the Ocean, sub. 19, p. 2)

> There have been other issues reported to the [National Mental Health] Commission concerning the effective engagement of lived experience in the implementation of the National Agreement, such as:
>
> - irregularity/ infrequency of meetings limiting opportunities for meaningful input
> - limited communication between groups leading to a lack of visibility, effectiveness and consistency
> - varied engagement in the co-design of individual initiatives. (NMHC and NSPO, sub. 70, p. 17)

[26] For example: BDI, sub. 151, p. 3; LELAN, sub. 190, p. 9; Mental Health Australia, sub. 76, p. 19, sub. 153, p. 12, transcript, 20 August 2025, p. 69; MHNS, sub. 202, p. 14; NMHC and NSPO, sub. 70, pp. 16–17; NMHCA, sub. 149, p. 11; Stroke Foundation, sub. 168, p. 8.

Information flows can also be hindered by confidentiality agreements. Review participants reported the usage of confidentiality clauses in some working groups limits communication between LEG members and other groups (Mental Health Australia, sub. 153, p. 12). LEG members are meant to be representatives of people with lived and living experience, who may have more diverse experiences and perspectives. But confidentiality agreements can make this role more difficult. Being able to seek feedback on issues raised in governance forums from the people they represent is essential to the role people with lived and living experience are expected to play in governance (LELAN, sub. 190, pp. 26–27).

> Over-reliance on confidentiality and legalistic approaches can hinder transparency, diminish trust, and isolate representatives from the very networks they are meant to reflect. (Catholic Health Australia, sub. 181, p. 25)

LEG members reported mixed experiences and progress when asked how their contributions had been heard and understood by other governance groups. Some felt they had been heard and respected, while others reported progress was slow, with little evidence their contributions had been incorporated into ongoing work. Members noted the lack of feedback made it difficult to see what influence they were having (NMHC 2025, p. 22).

Review participants also raised the reticence of governments to share power with people with lived and living experience.[27] Although many forums have lived and living experience representation, outcomes will not improve if their participation is seen as supplementary and decision making still sits wholly with government leadership.

The PC has heard where people with lived and living experience are included, this often does not reflect the diversity of experiences. For example, some review participants stated the voices of people with lived and living experience of suicide need to be heard as much as those with lived and living experience of mental ill health (NMHC and NSPO, sub. 70, p. 17; NSW Health, sub. 90, p. 3; Roses in the Ocean, sub. 19, p. 2). In addition, we heard about insufficient inclusion of Aboriginal and Torres Strait Islander people (chapter 7), as well as supporters, family, carers and kin (Community Mental Health Australia, sub. 84, p. 5).

> The failure to incorporate carers into governance structures prevents the system from addressing the full scope of mental health needs and undermines the overall effectiveness of the Agreement. (Carers ACT, sub. 60, p. 5)

3.3 The Agreement's governance lacks effectiveness and accountability

Good governance is an essential enabler of reform. Governance arrangements and mechanisms have been established to oversee the implementation of the Agreement (chapters 1 and 5). These arrangements have evolved out of a structure that was in place under the Fifth National Mental Health and Suicide Prevention Plan during 2017 to 2022 (COAG Health Council 2017) and in response to the abolition of the Council of Australian Governments (COAG).

The Agreement partly addresses deficiencies in governance of the mental health system the PC observed in its previous Mental Health inquiry (PC 2020). The Agreement incorporates, in part, governance reforms recommended in the Final Advice of the National Suicide Prevention Adviser (National Suicide Prevention Adviser 2020b), and builds on some of the important steps taken to strengthen governance under the Fifth

[27] LELAN, sub. 190; Medibank, sub. 198, p. 6; MIFA, sub. 233, p. 23; Mind Australia, sub. 187, p. 18; VACCHO and BDDC, sub. 162, p. 14; Victorian Government, sub. 228, p. 26

National Mental Health and Suicide Prevention Plan. It also reflects recent national commitments and agreements to strengthen Aboriginal and Torres Strait Islander social and emotional wellbeing (chapter 7).

The Agreement's governance arrangements:

- bring together representatives across jurisdictions, through National Cabinet, the Health and Mental Health Ministers, the Health Chief Executives Forum and MHSPSO
- include working groups focused on key gaps and areas for reform, such as workforce and psychosocial supports. The Schedule A Working Group, with oversight by National Cabinet, First Ministers and the First Deputies Group, aims to facilitate a whole-of-government approach to reform
- incorporate people with lived and living experience, through representation in MHSPSO and its working groups, and a lived experience advisory group with consumer, carer and Aboriginal and Torres Strait Islander representatives (section 3.2)
- link to the Closing the Gap Social and Emotional Wellbeing Policy Partnership, which is involved in overseeing progress on improving Aboriginal and Torres Strait Islander social and emotional wellbeing.

Some review participants noted the governance arrangements provide a solid foundation to build upon (for example, Beyond Blue, sub. 37, p. 1; Mental Health Australia, sub. 76, p. 21; Mental Health Victoria, sub. 95, p. 4; NSW Health, sub. 90, p. 3; Tasmanian Government, sub. 78, p. 6; Victorian Government, sub. 228, p. 16). The 2023-24 Annual National Progress Report stated working groups had reported working well together to progress key deliverables and share information (NMHC 2025, p. 16).

However, the governance arrangements lack effectiveness and accountability, and have not enabled a whole-of-government approach.

There were delays in establishing governance and arrangements are still unclear

Ideally, the Agreement's governance arrangements would have been established as the Agreement was being finalised, allowing for the various groups and forums to 'hit the ground running' on the much-needed reform. However, some working groups took time to establish, including the LEG and Evaluation Project Group (NMHC 2025, pp. 5, 16; section 3.2). There were also delays in making key appointments to some groups, including appointing members of the Social and Emotional Wellbeing Policy Partnership to MHSPSO (chapter 7). This limited the groups' influence on the design and early activities under the Agreement, contributing to delays in achieving some of the Agreement's outputs.

In addition, there appears to still be a lack of clarity regarding some arrangements. For example:

- while the Social and Emotional Wellbeing Policy Partnership was endorsed as the primary governance body advising on Aboriginal and Torres Strait Islander mental health and wellbeing, it is unclear how the policy partnership is intended to interact with MHSPSO beyond its representatives on MHSPSO (chapter 7)
- channels between the LEG and other working groups to allow the dissemination of lived experience perspectives remain unclear (section 3.2)
- secretariat responsibilities are spread across different agencies and teams, creating silos and contributing to confusion across governance forums (Mental Health Australia, sub. 153, p. 12).

Governance does not centre whole-of-government reform

Through the Agreement, governments acknowledged that achieving significant improvements in mental health and suicide prevention requires a more holistic and person-centred service system and a stronger focus on addressing the social determinants of health, facilitated through a whole-of-government approach.

In recognition of this, National Cabinet is included in the Agreement's governance (clause 52a). However, this appears to be insufficient to achieve a whole-of-government approach. This is because the governance below National Cabinet is health-centric.

National Cabinet has delegated oversight to the Health Ministers Ministerial Council, which in turn is supported by the Health Chief Executives. Implementation responsibility is delegated to MHSPSO. Government representatives in MHSPSO are drawn from Australian, state and territory health departments (chapter 1). There are no requirements under the Agreement that governance must involve others outside of MHSPSO in decision making or consultation (clauses 53–55). For example, where there are governance commitments to engage and collaborate with mental health commissions or Aboriginal and Torres Strait Islander bodies, the Agreement requires this only be done 'where required' (clause 54).

Schedule A and the Schedule A Working Group are intended to achieve the Agreement's whole-of-government ambition. However, the ambition was too broad from the outset. Schedule A includes a wide-array of actions spanning many areas and portfolios – education, work environments, homelessness, alcohol and other drugs, financial counselling, family, domestic and sexual violence, including sexual harassment, child maltreatment, and justice. Substantial reform in four years was never possible.

While the establishment of the Schedule A Working Group is a welcome development, it is highly unlikely one working group responsible for improvements across that many areas could facilitate the necessary reform in these areas. Further, working group representatives are from First Ministers departments, health departments and mental health commissions (NMHC 2025, p. 17). Involvement of First Ministers department officials is key for coordination across portfolios. However, it is essential working group members have deep policy matter expertise and understanding of how to implement coordinated action, and representation from relevant portfolios is notably absent.

Achieving whole-of-government reform was further constrained by the lack of dedicated funding for many of the commitments and activities. The 2023-24 Annual National Progress Report noted the Schedule A work has not progressed beyond information sharing, and next steps are unclear (NMHC 2025, pp. 5, 17, 18). Review participants noted the lack of funding for cross-portfolio initiatives under the Agreement.

> Commonwealth and state governments have failed to adequately fund and integrate mental health and suicide prevention services across critical sectors such as justice, education, disability services, and housing. (Australian Association of Psychologists Incorporated, sub. 13, p. 9)

> … the commitments outlined in Schedule A largely focus on broad collaboration rather than tangible action. Concerningly, the Schedule has no associated funding for initiatives or services. (Mental Health Australia, sub. 76, p. 20)

Engagement with the sector is insufficient

Review participants commented there has been limited engagement with providers of mental health and suicide prevention services in the design and implementation of the Agreement (Australian Psychosocial Alliance, sub. 55, p. 13; Mental Health Australia, sub. 153, p. 5; Western Australian Association for Mental Health, sub. 82, p. 6).

> The lack of broader mental health sector representation on governance groups under the National Agreement has hampered progress. Mental Health Australia is pleased to provide representation for the mental health sector on the Data Governance Forum and Safety and Quality Group, but such limited sector representation to only two subgroups is unacceptable. (Mental Health Australia, sub. 76, p. 22)

From a primary health network (PHN) perspective, Western Queensland Primary Health Network (sub. 45, p. 5) argued governance shortcomings affected its ability to support the community. The NMHC and NSPO (sub. 70, p. 13) stated lack of sector engagement has implications for the effectiveness of services:

> There are some key limitations within the current governance arrangements for the National Agreement, including … [l]ack of broader sector involvement: an absence of actors outside the government sector in the governance process has hampered capacity to ensure interoperability of service arrangements and limited the efficiency of monitoring.

Governance emphasises a clinical approach to mental health

The Agreement, its activities and the services it funds focus primarily on clinical services. Delegated responsibility for implementation of the Agreement sits largely with government officials who have a focus on clinical services rather than other areas of the system such as community support (DoHAC 2024d). The predominant focus on the clinical areas of mental health and suicide prevention was questioned by some groups (for example, Australian Psychosocial Alliance, sub. 155, p. 4; Vocational Mental Health Practitioners Association of Australia, sub. 115, p. 5).

> Our members see deep flaws in the National Mental Health and Suicide Prevention Agreement … in its reliance on the medical model of understanding mental health and suicidal distress. Some mental health consumers understand their mental health through this lens and seek more access to treatment through this model. However, this approach does not benefit all consumers and may cause harm, perpetuate stigma and limit a person's ability to drive their own recovery. The dominance of the medical model through the prioritisation of funding the fields of psychiatry, psychology, and epidemiology, does not serve all mental health consumers. (Consumers of Mental Health WA, sub. 49, p. 6)

The main governance arrangements are heavily focused on mental health, and there needs to be a stronger focus on suicide prevention (chapter 5).

> The current arrangements for the National Agreement do not reflect the full range of suicide prevention expertise required for effective governance. This imbalance reflects the limited consideration of suicide prevention within the National Agreement and that governance structures have been established through existing mechanisms dominated by mental health expertise. (NMHC and NSPO, sub. 70, p. 14)

Governance lacks transparency

There is limited public information on the way the Agreement's governance operates, including working group membership, meetings, decision making, work plans and the outcomes of their work.

For example, there is no requirement for MHSPSO to report to any other forum or group outside of government. The group has only released two sets of meeting minutes in the three years since the Agreement has been signed, and these documents are too generic to allow any meaningful assessment of progress (DoHAC 2024d). There is no public reporting from some of the Agreement's working groups.

Another area lacking transparency is the bilateral schedules. Much of the progress on the Agreement's objectives is covered by actions in the bilateral schedules, where governance arrangements are unclear and separate to the national Agreement (Mental Health Families and Friends Tasmania, sub. 210, p. 4). Jurisdictional implementation plans have never been publicly released. Progress reports have been

significantly delayed and contain little detail to support an independent assessment of progress (chapter 2). Mental Health Lived Experience Tasmania (sub. 15, p. 2) stated:

> … despite the Tasmanian Bilateral Agreement stating that implementation of the Schedule will be "informed by the lived experience of consumers and carers", aside from a generalised summary in the 2022-2023 Annual National Progress Report, any specific data relating to any consultations undertaken is not available and/or accessible.

Governments are not being held to account

As outlined in section 3.1, monitoring and reporting arrangements are not enabling accountability. Monitoring and reporting on progress are key mechanisms for accountability, and are a shared responsibility of governments. While governments agreed to produce annual progress reports, there is no commitment to independent assessment of progress, other than a final review (clause 65).

Governments have asked the NMHC to play a role in the reporting progress through the compilation of national annual progress reports based on jurisdictions' self-assessment. These reports are not an effective accountability tool (section 3.1).

The NMHC was established to 'provide independent policy advice and evidence on ways to improve Australia's mental health and suicide prevention system' (NMHC 2024c). It was responsible for monitoring progress under the national mental health plans preceding the Agreement and developed a range of national policy documents. In 2020, the PC recommended the NMHC become an independent statutory authority with interjurisdictional responsibilities for strategic national evaluation, monitoring and reporting on government-funded mental health and suicide prevention programs (PC 2020, pp. 81, 1131). This recommended role has only been noted as a consideration in the Agreement (clause 102h).

Since September 2024, the NMHC has operated as a non-statutory office within the Department of Health, Disability and Ageing, following a review of the NMHC's culture, capability and efficiency. In the 2024-25 Budget, the Australian Government announced its intention to 'reset and strengthen' the NMHC, starting with a consultation process in late 2024, seeking views on the NMHC's function and structure (DoHAC 2024g). As of September 2025, there is no public information about when the NMHC will be independent or what form its independence will take.

Several review participants raised concerns about the NMHC's independence, roles and its position in the Department.[28]

> … there are a range of issues related to a fundamental lack of transparency on progress made under the National Agreement. This includes … the current temporary position of the National Mental Health Commission within the Department of Health and Aged Care, rather than sitting as a truly independent entity … (Mental Health Australia, sub. 76, p. 19)

> This failure of 'accountability and transparency' may be traced back to the disruption within the NMHC, which in 2024 was folded back into the Department of Health and Aged Care (DoHAC). Its future – as [an] internal element of the Department, an independent agency, or a Statutory Authority - remains unknown. (Mental Illness Fellowship Australia, sub. 88, p. 10)

[28] For example: LELAN, sub. 190, p. 16; Maria Katsonis, sub. 117; Mental Health Australia, sub. 153, p. 14; MHLEPQ, sub. 144, p. 8.

3.4 The Agreement is not enabling reform

Many of the Agreement's objectives, such as clauses 21, 23 and 25 (box 3.1), align with what people have told us about their aspirations for mental health and suicide prevention services. In the online survey undertaken for this review, people with lived and living experience of mental ill health and suicide, carers and practitioners shared with the PC ideas on how to improve the mental health and suicide prevention system, including through:

- reducing the pressure on mental health services by increasing the flexibility of services and strengthening their capacity through better training and more peer work
- improving the coordination between services
- focusing more on prevention and the underlying causes of mental ill health and suicide (*What we heard* paper).

However, the Agreement does not enable the scale of reform needed to achieve these improvements. In its 2020 Mental Health inquiry, the PC identified key enablers of reform in the mental health and suicide prevention system, including:

- better use of data to plan, monitor and evaluate services
- workforce policy that alleviates shortages and supports the peer workforce
- planning and funding approaches that are responsive to local needs
- effective governance mechanisms that underpin greater collaboration (PC 2020).

The Agreement has made limited progress in creating the necessary governance mechanisms (sections 3.2 and 3.3). There is also much room for improvement in the way data is used. While the Agreement has led to the creation of the National Mental Health Workforce Strategy, there is little else supporting progress towards the creation of a person-centred mental health and suicide prevention system.

Better data use and sharing remains an elusive goal

The Agreement contains many commitments to improve the availability and sharing of data about the effectiveness of mental health and suicide prevention programs and the system itself. There are provisions for increased and improved reporting and evaluation, improved data collection, linkage and sharing, and the creation of forums to support diffusion of best practice (clauses 80–103).

The roll-out of these commitments has been slow. For example, the National Evaluation Framework and Sharing Guidelines were only publicly released in February 2025. While there are evaluations of jointly funded programs, it is difficult to say if their findings are supporting better practice.

Data gaps across the mental health and suicide prevention system persist (chapter 2). The PHN Cooperative (sub. 69, p. 12) argued there are still significant shortcomings in data use:

> … PHNs have been disappointed that the Agreement has not enabled the development of fit for purpose regional data and tools to inform mental health service planning:
>
> - The National Mental Health Service Planning Framework is an evidence based and comprehensive planning tool but remains more geared towards the state public mental health sector than the primary mental health sector where PHNs are commissioning community managed organisations for service delivery.
> - PHNs play a valuable role in collecting regional workforce data, as identified elsewhere in this submission, however there is a lack of easy access to regional mental health workforce data on a regional basis. For example, it's difficult for PHNs or LHNs to reliably know how many allied health professionals there may be available to work in mental health in a region.

There is no specific funding allocated to the extensive commitments to data improvements. In some cases, such as evaluation of funded programs, the Agreement specifies they be co-funded, but the funding amount is not set out in the Agreement or the bilateral schedules. The Data Governance Forum established under the Agreement has made some headway, but substantial challenges remain (chapter 2; section 3.1).

The Agreement could do more to alleviate workforce shortages

Despite commitments in the Agreement to expand and strengthen the workforce, it remains a critical issue. The Agreement and the bilateral schedules include commitments to address workforce challenges, including through developing the National Mental Health Workforce Strategy, increasing the size of the workforce and improving workforce data and planning (chapter 2).

While some of these commitments have been achieved (chapter 2), many appear to have not been meaningfully progressed, or there is no sufficient publicly available information to assess progress. The National Mental Health Workforce Strategy has been developed, but the Agreement did not set aside funding to progress its implementation.

> The National Agreement rightly acknowledges the importance of joint action on mental health workforce priorities. However, a lack of funding, delays in delivery and implementation of the National Mental Health Workforce Strategy (the Workforce Strategy), absence of clear prioritisation and lack of accountability for delivery has meant little meaningful action. (Mental Health Australia, sub. 76, p. 17)

The lack of progress on workforce commitments appears to be at least partly due to a lack of detail on how commitments will be met and unclear roles and responsibilities. This lack of progress is mirrored in the workforce initiatives under the bilateral schedules.

The Agreement prioritises national approaches over place-based solutions

In its 2020 Mental Health inquiry, the PC (2020) found place-based and regional approaches were essential to ensuring people had access to the support they need. However, the approach taken in the Agreement prioritises nationally consistent models of care, such as headspace and Medicare Mental Health Centres. This imposes rigidities on state and territory governments and PHNs in how they commission services. It limits their ability to tailor services to local needs and engage with people with lived and living experience, local communities and others in designing and implementing the models of care.

> Very little funding is available in most mental health programs to provide the services that people are asking for – limiting the connection we can build in communities. For example, some models specify delivery of mental health services by psychologists, when social workers could be engaged more easily. (Marathon Health sub. 10, p. 3)

Review participants repeatedly highlighted the need for greater flexibility in funding and care models as being key to providing effective care (Marathon Health, sub. 10, pp. 3–4; Orygen, sub. 26, pp. 3–5; Ruah Community Services, sub. 14, p. 9; Western Queensland PHN, sub. 45, pp. 5–9). The PC heard of cases where deviations from rigid models of care had been negotiated, but these seemed to be exceptions rather than the standard practice and added to the administrative burden (for example, Institute for Urban Indigenous Health, sub. 81, pp. 9–10).

The bilateral schedules include funding for initiatives in line with nationally consistent models of care, without much acknowledgement of existing services (or lack thereof). The minimal variation between the bilateral

schedules also suggests they may not be based on the needs of local communities, such as those identified by PHNs and local hospital networks in regional planning.

Funding standardised services entrenches existing programs and continues the approach whereby 'governments continue to fund what they know' (Simon Tatz, sub. 1, p. 2). While national consistency can be a positive, funding has not always been directed to services with high efficacy (Kisely and Looi 2022; KPMG 2022) and nationally consistent models of care can lack local relevance and trust. Submissions identified programs that had proven successful locally but had not been able to continue or scale up due to a lack of funding (Institute for Urban Indigenous Health, sub. 81, pp. 9–10; Ruah Community Services, sub. 14, pp. 4–5). This recurring issue was noted by Occupational Therapy Australia (sub. 9, p. 6), who suggested:

> A key priority in the design [of a new agreement] will be ensuring that commissioning processes enable and strengthen existing local service capacity rather than overlaying new services with no local footprint.

The focus on national models of care may be particularly problematic for consumers who 'do not feel supported or understood by mainstream services' (Consumers Health Forum of Australia, sub. 22, p. 7) or who are not well served by them (for example, there is evidence headspace has struggled to reach several priority populations (KPMG 2022, pp. 224–241). Some populations may be better served by targeted services that do not fit with the national model of care.

> Targeted services for people in rural and remote areas, First Nations people, young people, the LGBTIQA+ community and other groups with specific needs are critical to reaching vulnerable individuals. (Consumers Health Forum of Australia, sub. 22, p. 7)

The Agreement has not enabled systemic collaboration across the mental health and suicide prevention services

The Agreement's main function within the mental health and suicide prevention policy space is to enable greater collaboration and overcome the fragmented nature of the system. This critical component of reform is not funded in other agreements, but it is the 'glue' that brings together people with lived and living experience, supporters, family, carers and kin, service providers and governments.

But as discussed above and in chapter 2, the Agreement has not done enough to enable collaboration and reduce fragmentation. It contains many commitments to 'work together' but no practical guidance on how this will be achieved. Collaboration activities are not funded under the Agreement, and they are not included in bilateral schedules.

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.

Finding 3.1
The National Mental Health and Suicide Prevention Agreement is not effective

- 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.

4. Laying the groundwork for a better agreement

Key points

- **A new national mental health and suicide prevention agreement is needed to enable progress towards a person-centred mental health and suicide prevention system. Governments should also articulate their overarching and enduring policy vision and set long-term goals for reform in the mental health system.**
- **A Mental Health Declaration, endorsed by all jurisdictions, should underpin the next agreement. The Declaration should be based on the National Mental Health Policy 2008 and developed in 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.**
- **Clarity on the goals and purpose of the next agreement, co-designed with people with lived and living experience, is necessary for it to deliver improvements in outcomes.**

  The next agreement must also set out clear objectives and outcomes linked to the commitments needed to achieve them. Objectives should align with those of the Mental Health Declaration and the National Suicide Prevention Strategy 2025–2035.
- **Extending the current Agreement for one year would allow sufficient time to build strong foundations for the next agreement. This time should be used to develop the Mental Health Declaration, co-design the next agreement's objectives and outcomes and improve outcome measurement.**
- **A whole-of-government approach remains critical and should be elevated to the main body of the agreement. Reflecting this approach, negotiations of the agreement should be convened by the Department of the Prime Minister and Cabinet with advice from Department of Health, Disability and Ageing and the National Mental Health Commission.**
- **Additional schedules to the agreement should be developed where a distinct approach is needed, including for services for Aboriginal and Torres Strait Islander people and suicide prevention, and to elevate underserved policy areas, such as problematic alcohol and other drug use.**
- **Governments must clarify in the next agreement:**
  - **arrangements for the funding and commissioning of psychosocial supports outside the National Disability Insurance Scheme**
  - **responsibilities for carer and family supports**
  - **implementation plans and priorities for mental health and suicide prevention workforce strategies.**

The current National Mental Health and Suicide Prevention Agreement has not enabled significant progress towards reform, despite most outputs being completed (chapter 2). This raises questions about the need for a new agreement, or whether reform efforts could more effectively be guided by, for example, a mental health and suicide prevention schedule to the National Health Reform Agreement (NHRA), or a Sixth National Mental Health and Suicide Prevention Plan (chapter 1).

Advancing reform in the mental health and suicide prevention system relies on policy that sets out clear and relevant roles and responsibilities, adequate funding commitments, mechanisms for system integration and coordination and targeted accountability and performance measures. A national agreement is a suitable mechanism to articulate these. If incorporated into an existing agreement, such as the NHRA, mental health and suicide prevention reform would likely not receive adequate attention. A separate agreement on mental health and suicide prevention has the potential to create a stronger authorising environment than a national plan and elevate reform efforts to a whole-of-government agenda (chapter 5).

A national agreement on mental health and suicide prevention, signed by Australian, state and territory governments, can be a helpful piece of the policy infrastructure for collaboration and a whole-of-government approach to reform (Mental Health Australia, sub. 76, p. 2). Collaboration and a whole-of-government approach are essential to achieving an integrated and person-centred mental health and suicide prevention system. Review participants affirmed the need for a mental health and suicide prevention agreement.[29]

A national agreement is not the only policy tool necessary. Participants highlighted the need for a strategy.[30] For example, yourtown (sub. 126, p. 5) argued:

> The numerous isolated initiatives and outputs in the Agreement fail to form a functional system due to the absence of a cohesive strategy and coordinated implementation framework.

Setting the long-term goals of the system enables focused policy work and avoids ongoing short-termism that undermines investment in longer-term objectives such as prevention. National strategies in mental health and suicide prevention have the capacity to align the collective efforts of health and non-health sectors for a whole-of-government approach (NMHC and NSPO, sub. 70, pp. 4–5; PC 2020, p. 1078).

A new agreement is needed to improve mental health and suicide prevention outcomes and overcome persistent policy gaps. This chapter discusses the groundwork for a more effective agreement – namely the surrounding policy infrastructure and processes to get to a better agreement. Chapters 5 and 6 follow this discussion by recommending governance, accountability, funding and commissioning structures needed within the next agreement to affect change and ensure successful reform.

4.1 Governments should articulate national directions

The current Agreement sets many objectives, some of which speak to the long-term goals of the mental health and suicide prevention system (chapter 1). However, these do not provide clear strategic direction, and the term of the agreement does not allow adequate time for these goals to be achieved (chapter 3).

[29] For example, Carers WA, sub. 43, p. 4; Consumers Health Forum of Australia, sub. 22, p. 4; Jesuit Social Services, sub. 131, p. 15; Mental Health Coordinating Council, sub. 120, p. 2; Neami National, sub. 63, p. 4; Queensland Nurses and Midwives' Union, sub. 136, p. 3; Roses in the Ocean, sub. 19, p. 2; VACCHO and BDDC, sub. 162, p. 5.
[30] Community Mental Health Australia, sub. 84, p. 6; Health Justice Australia, sub. 65, p. 3; Jesuit Social Services, sub. 131, p. 15; Mental Health Australia, sub. 76, p. 2; Mental Health Lived Experience Peak Queensland, sub. 144, p. 6; Michael Thorn, sub. 6, p. 2; NMHC and NSPO, sub. 70, p. 2.

Prior to the Agreement, the National Mental Health Strategy set the direction for mental health policy in Australia. The National Mental Health Strategy included the National Mental Health Policy (established in 1992 and updated in 2008), the Mental Health Statement of Rights and Responsibilities and five successive National Mental Health and Suicide Prevention Plans, which were superseded by the Agreement. This system was developed in the context of a transition away from institutional mental health services towards care in community settings (AHMC 2009, p. 20; Rosen 2006, p. 19).

In 2020, the PC found the National Mental Health Strategy no longer met consumer and carer expectations. The PC (2020, p. 1086) recommended the Australian, state and territory governments develop a new national strategy to guide long-term resource allocation and align efforts of relevant sectors across jurisdictions, but this has not occurred. The Agreement has instead functioned in isolation.

The National Suicide Prevention Strategy, developed under the Agreement and agreed by Australian, state and territory governments, sets the direction for suicide prevention policy (chapter 8). But it is difficult to identify a current, unified guiding objective for the mental health system, akin to the National Suicide Prevention Strategy. In addition to the National Mental Health Policy 2008, there are multiple documents identifying objectives for the mental health system, but there is little coherence. For example:

- the Vision 2030: Blueprint for Mental Health and Suicide Prevention document, developed by the National Mental Health Commission (NMHC), aims for 'a connected, effective, person-centred and sustainable mental health and suicide prevention system designed to meet the needs of all individuals and their communities' (NMHC 2022, p. 8)
- state and territory governments operate their own mental health legislation, strategies, plans and frameworks, many of which establish goals independent from national policy
- specific objectives sit within targeted strategies such as the National Children's Mental Health and Wellbeing Strategy.

There is a clear need to develop and articulate shared goals for the mental health and suicide prevention system to underpin future agreements and reform efforts. The interim report for this review recommended a National Mental Health Strategy be developed through a co-design process and operate alongside the National Suicide Prevention Strategy. Participants in this review were broadly supportive of the recommendation for a strategy,[31] with particular emphasis on the need for co-design of the strategy.[32] However, some noted concerns with timing, including not wanting to further delay the next agreement with a lengthy strategy development process.[33] Other participants recommended the strategy be a deliverable of the next agreement rather than an input for the next agreement (Black Dog Institute, sub. 151, p. 4; Beyond Blue, sub. 156, p. 1; Mental Health Australia, sub. 153, p. 3).

Participants also expressed a desire to recognise and consolidate the insights of previous reviews, inquiries and consultations that have been undertaken in the mental health sector in recent years, rather than beginning new ones (Beyond Blue, sub. 156, p. 2; Simon Tatz, sub. 1, pp. 1–2). This can reduce the length of consultation processes and risk of delays to the next agreement.

[31] Australian Private Hospital Association, sub. 163, p. 7; Community Mental Health Australia, sub. 216, pp. 3–4; Melbourne Children's Campus Mental Health Strategy, sub. 196, p. 1; MESHA, sub. 151, p. 2; MHLEPQ, sub. 144, p. 6; Orygen, sub. 169, p. 1; Relationships Australia Victoria, sub. 193, p. 1; Youturn Limited, sub. 170, p. 2.
[32] Catholic Health Australia, sub. 181, p. 11; Consumers Health Forum of Australia, sub. 140, p. 6; COTA Australia, sub. 218, p. 1; Health Consumers' Council WA, sub. 139, p. 3; Jesuit Social Services, sub. 131, pp. 12; Name withheld, sub. 188, p. 4; Stroke Foundation, sub. 168, pp. 1–2.
[33] Health Consumers' Council WA, sub. 139, p. 3; Mind Australia, sub. 187, p. 6; PHN Cooperative, sub. 208, p. 7; WAAMH, sub. 172, p. 3.

A Mental Health Declaration as a way forward

To articulate the long-term direction of reform, governments should develop and endorse a Mental Health Declaration. The Declaration should be based on a renewed National Mental Health Policy 2008, to make the most of existing policy work while providing opportunity for co-design of future goals.

The National Mental Health Policy 2008 positions itself as a whole-of-government document, acknowledging a range of sectors 'have an important role to play in promoting the mental health and well-being of the general population' (Australian Health Ministers' Conference 2009, p. 8). It was endorsed by First Ministers through the Council of Australian Governments.

The Policy's role is described as 'a broad agenda to guide coordinated efforts in mental health reform' (Australian Health Ministers' Conference 2009, p. 7). The goals established in the Policy remain relevant and align with those suggested by participants in this review (box 4.1).

The Policy should be renewed in a genuine co-design process with people with lived and living experience of mental ill health, their supporters, family, carers and kin and the mental health sector. Genuine co-design requires adequate representation and resourcing for people with lived and living experience to be able to contribute their expertise (box 3.2). This would enable the resulting document to provide a consistent, enduring and unifying vision for the mental health system. This process should also be viewed as an opportunity to ensure states and territories are able to meaningfully contribute to a shared vision.

The Mental Health Declaration should align with existing strategies and reform efforts. For example, the National Suicide Prevention Strategy and National Aboriginal and Torres Strait Islander Suicide Prevention Strategy will be key inputs to the development of the next agreement and aligning the Declaration with them will be important. Review participants noted the need for this alignment.[34]

There is also a need to align the Declaration with the National Agreement on Closing the Gap, the Gayaa Dhuwi (Proud Spirit) Declaration and Implementation Plan and the forthcoming National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing. Other policy areas relevant to the social determinants of mental ill health should also be considered, including the National Plan to End Violence against Women and Children. Coherence with state-based reform efforts was also raised, such as the implementation of the recommendations made by the Royal Commission into Victoria's Mental Health System (Mental Health Victoria, sub. 95, pp. 7–8; National Mental Health Consumer Alliance, sub. 66, p. 6).

There are benefits to reinvigorating the National Mental Health Policy 2008 as a Mental Health Declaration rather than as a strategy. A declaration is not time-limited, instead aiming to create enduring goals that can be periodically updated. Examples of similar declarations already exist, such as the Gayaa Dhuwi (Proud Spirit) Declaration and Alice Springs (Mparntwe) Education Declaration. The Declaration will need to be renewed on a 10-yearly cycle to reflect progress and remain relevant to a changing system.

The NMHC is well placed to lead the process of developing the Declaration, given their ability to work across government and expertise extending beyond health (Catholic Health Australia, sub. 181, p. 11; Community Mental Health Australia, sub. 84, p. 6). To strengthen the whole-of-government approach required for reform, the Declaration should be endorsed by First Ministers in addition to sign-off by Health and Mental Health

[34] BEING – Mental Health Consumers, sub. 141, p. 14; Catholic Health Australia, sub. 181, p. 17; Centre for Community Child Health, sub. 79, p. 7–8; Gayaa Dhuwi (Proud Spirit) Australia, sub. 75, pp. 4–5; Jesuit Social Services, sub. 131, p. 16; National Mental Health Consumer Alliance, sub. 149, p. 26; Psychotherapy and Counselling Federation of Australia, sub. 180, pp. 4–5; RANZCP, sub. 7, p. 3; Roses in the Ocean, sub. 19, p. 6; ShantiWorks, sub. 157, p. 5; TWB Consulting, sub. 98, pp. 1–2; Women's Health NSW, sub. 236, p. 2.

Ministers. This process would be similar to the process undertaken in the development of the National Mental Health Policy 2008 and the recently released National Suicide Prevention Strategy.

The next agreement should be designed as a five-year plan to achieve progress towards the long-term objectives set out in the National Suicide Prevention Strategy and new Mental Health Declaration. Explicit links to long-term goals would focus actions across successive agreements, even where short-term priorities shift and new challenges emerge (NMHC and NSPO, sub. 70, pp. 4–6).

Box 4.1 – The National Mental Health Policy 2008

The National Mental Health Policy 2008 sets out an enduring vision for a mental health system that 'enables recovery, prevents and detects mental illness early, [and] ensures that all Australians with a mental illness can access effective and appropriate treatment and community support to enable them to participate fully in the community' (Australian Health Ministers' Conference 2009, p. 2).

While the Policy has not been updated in some time, this vision provides a sound starting point to inform the next agreement. Its four aims are to:

- promote the mental health and well-being of the Australian community and, where possible, prevent the development of mental health problems and mental illness
- reduce the impact of mental health problems and mental illness, including the effects of stigma, on individuals, families and the community
- promote recovery from mental health problems and mental illness
- assure the rights of people with mental health problems and mental illness, and to enable them to participate meaningfully in society. (Australian Health Ministers' Conference 2009, p. 2)

These aims align with review participants' suggestions for future objectives of the mental health system, particularly regarding prevention, engagement early in distress and mental health and wellbeing promotion,[35] reduction of stigma and discrimination,[36] and human rights and accessibility.[37]

[35] Beyond Blue, sub. 156, pp. 2, 5–6; Everymind, sub. 32, p. 3; Mental Health First Aid International, sub. 147, pp. 2–3; Municipal Association of Victoria, sub. 152, pp. 4–5; National Rural Health Alliance, sub. 86, p. 5; Relationships Australia Victoria, sub. 193, pp. 2–3; Dr Stephen Carbone, sub. 201, pp. 2–3; Wellbeing and Prevention Coalition in Mental Health, sub. 31, p. 4; yourtown, sub. 126, pp. 7–8.

[36] Australian Multicultural Action Network, sub. 124, p. 3; Australian Veterinary Association, sub. 125, p. 4; batyr, sub. 27, pp. 1–2; FASSTT, sub. 64, pp. 12–13; Kevin Bell, Tim Heffernan, Maria Katsonis, Mark Orr, sub. 11, p. 5; Mental Health First Aid International, sub. 147, p. 3.

[37] Community Mental Health Australia, sub. 216, pp. 9–10; Consumers Health Forum of Australia, sub. 22, pp. 8–9; Mental Health Australia, sub. 76, p. 3; Mental Health Lived Experience Peak Queensland, sub. 144, pp. 9–10; RANZCP, sub. 7, p. 3; Simon Katterl Consulting, sub. 204, pp. 9–10.

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.

4.2 The next agreement should have clear goals

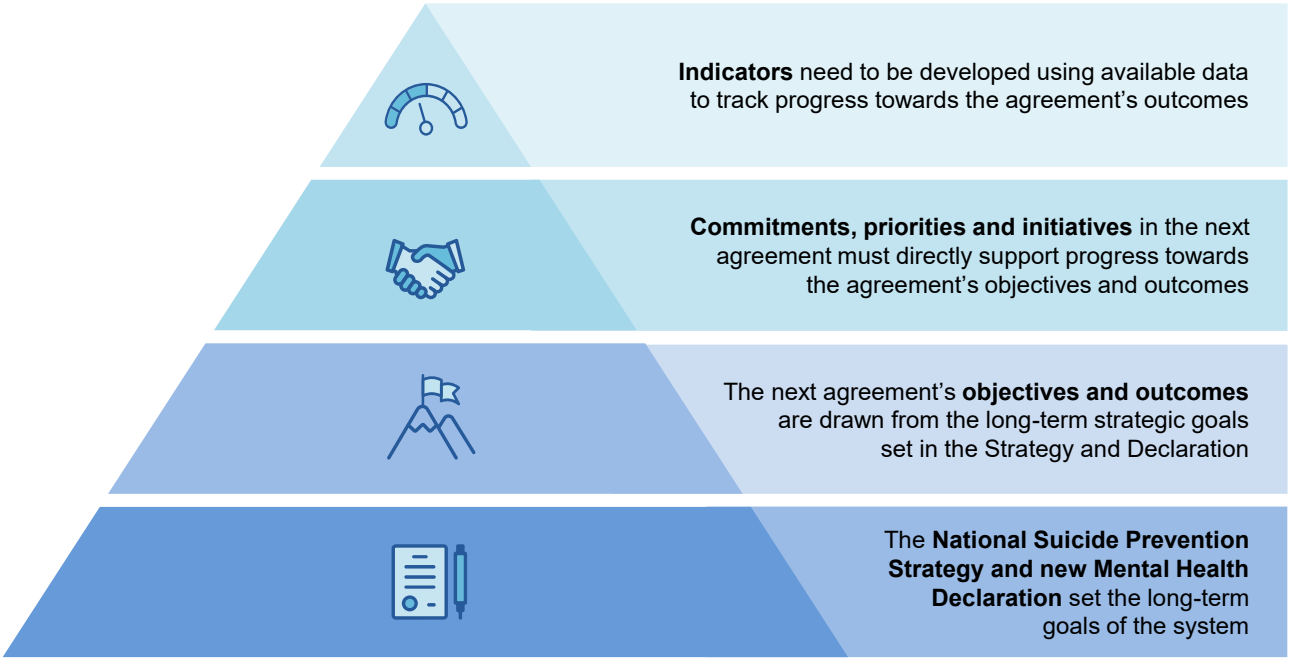
For reform efforts to be effective, the objectives and outcomes of the next agreement must set clear and well-defined goalposts (chapter 1). These should be aligned with the direction set in a new Mental Health Declaration and the National Suicide Prevention Strategy (recommendation 4.1). Co-design of these elements can ensure the goalposts are meaningful and relevant to people with lived and living experience, their supporters, family, carers and kin, as well as service providers. Outcomes should be measurable; indicators used for measurement should be methodically chosen and developed.

In line with theory of change principles (chapter 1), agreed priorities, commitments and initiatives should be informed by the objectives and outcomes. Creating logical, evidence-based connections throughout the agreement can increase the likelihood actions taken under the agreement will lead to tangible improvements in consumer and carer outcomes and experiences.

Setting clear and measurable goalposts

The National Suicide Prevention Strategy and a new Mental Health Declaration (recommendation 4.1) should set the long-term direction of the system (figure 4.1). The next agreement should then identify a clear and achievable set of objectives and outcomes to progress reform within the agreement's five-year term towards that direction.

Figure 4.1 – A cohesive approach to mental health and suicide prevention reform



Objectives are high-level system goals that speak to what governments intend to achieve through the agreement. Participants suggested a range of possible objectives (yourtown, sub. 126, p. 7; Consumers Health Forum of Australia, sub. 140, pp. 5, 12–13.). For example:

> Prevention of mental ill-health to be included as a national priority, with the opportunity to use the next National Mental Health and Suicide Prevention Agreement to set, coordinate and monitor progress on two to five national priorities. (Everymind, sub. 32, p. 3)
>
> The Agreement should prioritise the delivery of connected services that allow a smooth transition and a clear referral pathway for people seeking help. (Lifeline Australia, sub. 8, p. 11)
>
> The RANZCP has previously highlighted in its Position Statement: Principles for a mental health system, which include equitable access, culturally safe, and person-centred. (RANZCP, sub. 7, p. 3)

Similar aspirations were mentioned by participants in the PC's survey and public hearings. Survey respondents, particularly people with lived and living experience, emphasised the need for a more accessible and responsive system that provides seamless and comprehensive support and works to prevent crises before they arise (*What we heard* paper). In public hearings, peak bodies spoke of the need to emphasise harm reduction and human rights.[38]

Outcomes are more tangible goals, grounded in the reality of consumer and carer experiences. The SMART framework is useful for designing outcomes. It requires outcomes are:

- specific: the outcome should be clear, detailed and well defined
- measurable: progress should be easy to demonstrate and evaluate
- achievable: the outcome should be challenging but realistic and achievable
- relevant: the outcome should relate to overarching objectives
- timed: the outcome should have a clear timeline (ANAO 2007, p. 57).

[38] Community Mental Health Australia, transcript, 19 August 2025, pp. 94–95; Mental Health Coalition of South Australia, transcript, 20 August 2025, pp. 25–27; National Mental Health Consumer Alliance, transcript, 19 August 2025, pp. 52–53.

Objectives and outcomes should be clearly aligned to long-term strategies

Objectives and outcomes should be directly drawn from the National Suicide Prevention Strategy and new Mental Health Declaration and tailored to the context and timeline of the agreement. This would be akin to the process taken in the development of the Better and Fairer Schools Agreement (BFSA). The BFSA specifies:

> … this Agreement will support the Mparntwe Education Declaration's 2 interrelated goals - that the Australian education system promotes excellence and equity and that all young Australians become confident and creative individuals, successful lifelong learners, and active and informed members of the community. (clause 7)

This BFSA seeks to achieve this through three national priority areas – equity and excellence, wellbeing for learning and engagement, and a strong and sustainable workforce – that are consistent with the goals of the declaration. These are made tangible and measurable through the detailed objectives and outcomes of the BFSA.

Meaningful objectives and outcomes must identify what is most relevant to people with lived and living experience of mental ill health and suicide, their supporters, family, carers and kin and service providers. Co-design of the next agreement's outcomes and objectives would allow people with lived and living experience to be a part of defining the problem and setting the reform direction. NSW Health (sub. 90, p. 3) welcomed the input of people with lived and living experience in this process:

> People with a lived and living experience of mental health issues and suicidality need to have a clear voice and opportunity to input into the scoping, development and decision making associated with the next Agreement.

This is a first step in the engagement of people with lived and living experience that should continue throughout the execution of the next agreement in service planning, design, implementation and evaluation.

This co-design process should be facilitated by the NMHC as an independent body. This is similar to the process undertaken by the National Suicide Prevention Office (NSPO) to develop the National Suicide Prevention Strategy. The objectives and outcomes identified in this process should inform the rest of the negotiations.

Outcomes should be measurable and linked to effective indicators

Progress monitoring and accountability in the next agreement will require outcomes that are person-centred (rather than system-centred), tangible and measurable. Prioritising measurable outcomes will rely on the availability of indicators and data to support measurement.

Individual indicators should be useful, understandable and feasible. The selection process will involve balancing trade-offs across these criteria (box 4.2).

The next agreement should include a complementary set of indicators that collectively satisfy the criteria. Such a set of indicators can provide a picture of progress that is both balanced and more comprehensive than the sum of its parts, as illustrated by Suicide Prevention Australia (sub. 214, p. 11):

> … an increase in service usage accompanying an increase in distress levels shows the support system responding to a crisis, an increase in service usage with distress levels going up shows that more people are willing to reach out for help. Likewise a decrease in service use may be a positive indicator if distress is falling, but a concerning sign if distress is stable or increasing.

Box 4.2 – Choosing effective indicators of progress

Different approaches, such as the ABS Data Quality Framework, can be used to select effective indicators. The following criteria draws on the PC's Review of the National Disability Agreement (PC 2019, p. 140), the AIHW's Key Performance Indicators for Australian Public Mental Health Services (2013, p. 4), and Annex B of the Agreement. They offer a practical checklist when choosing specific indicators.

Indicators should be useful …

An indicator is useful if it helps demonstrate progress towards the next agreement's goals. Useful indicators are:

- aligned with a theory of change: the indicator relates to an agreed outcome, objective or output, and meaningfully measures progress
- attributable: the indicator measured can be influenced by government policy and will likely show change within a reasonable timeframe
- able to avoid unintended consequences: the indicator will not create perverse incentives that give rise to undesirable or unwanted actions.

… understandable …

An indicator is understandable if it can be clearly interpreted and provides an unambiguous signal about performance. Understandable indicators should be:

- interpretable: the indicator is clear and understandable to a broad audience
- clearly directed: an increase or decrease in the indicator represents a clear improvement or decline in performance
- credible: the indicator is meaningful to people with lived and living experience of mental ill health and suicide, their supporters, family, carers and kin and service providers.

… and feasible

An indicator is feasible if it is viable to track. Feasibility requires consideration of:

- data availability: data is currently available or will be within a reasonable timeframe and the benefits of additional data collection outweigh the costs
- timeliness: data is available and updated at an appropriate frequency to be relevant for decision-making
- comparability: data collection methods are consistent, allowing indicator data to be broadly comparable across jurisdictions and over time.

The relative importance of these criteria will shift depending on the context, and there may be other relevant considerations not listed. For instance, indicators reflecting outcomes for Aboriginal and Torres Strait Islander people should be strengths-based and consistent with the principles of Indigenous data sovereignty and Indigenous data governance (box 7.3).

Source: AIHW (2013, p. 4); Annex B; PC (2019, p. 140).

The chosen set of indicators should have coverage, minimal sufficiency and multidimensionality.

- Coverage means indicators collectively describe the whole system and each part of the system with appropriate detail (Schang et al. 2021, p. 3).
- Minimal sufficiency means the number of indicators is limited to the smallest set while still providing a comprehensive measure of progress (PC 2017, p. 21).
- Multidimensionality refers to a set of indicators that measure the system from multiple perspectives, including person-centred measures such as self-reported consumer and carer experiences and system-centred measures, such as service provision and government expenditure (PC 2017, p. 18).

Engaging with the expertise of people with lived and living experience of mental ill health and suicide can help embed these principles into the selection of indicators, particularly ensuring coverage of different areas of the system, and the balance between system and person-centred indicators. The National Suicide Prevention Outcomes Framework is a recent example of how clear planning, in partnership with people with lived and living experience, can help match indicators to outcomes to track progress, in this case against the National Suicide Prevention Strategy (box 4.3).

Ongoing data development efforts may also feed into what outcomes can be measured and how. Data developments under the Agreement are improving data holdings (chapter 2) and the development of a National Suicide Prevention Outcomes Framework will support further measurement of outcomes (box 4.3). Existing data can also be better used (chapter 2). For example, sharing and linkage of minimum dataset collections at the primary health network (PHN) level would provide substantial information about the outcomes achieved through mental health and suicide prevention services (PHN Cooperative, sub. 69, pp. 16–17).

The AIHW is a central repository for health data with existing expertise and relationships within the mental health and suicide prevention sector and with state and territory governments. Partnering with the AIHW can help refine proposed outcomes and indicators, think through how existing data can be better used to support the next agreement, and determine the feasibility of new indicators.

As part of the development of the next agreement, the AIHW should be tasked with identifying a set of mental health related indicators to support the measurement of progress towards agreement outcomes. The suicide prevention indicators and outcomes should be selected from those identified in the National Suicide Prevention Outcomes Framework (chapter 8). Any implementation plans to develop new indicators should be in place within six months of the agreement being signed.

Box 4.3 – Establishment of the National Suicide Prevention Outcomes Framework

The National Suicide Prevention Office (NSPO) is establishing a National Suicide Prevention Outcomes Framework in partnership with people with lived and living experience of suicide and key stakeholders from academia, government, suicide prevention services and other relevant sectors. The Outcomes Framework:

> … will draw on qualitative and quantitative data to identify and measure progress against outcomes that we know contribute to the emergence of suicidal distress (such as personal safety, housing security, employment, and social connection); the accessibility and effectiveness of supports for people who do experience suicidal distress; and the key system reforms required to enable these improvements. (NSPO 2024b, p. 3)

The Outcomes Framework has four components.

- The Overview outlines the purpose, the components and operation of the Outcomes Framework.
- The Outcomes Map translates the National Suicide Prevention Strategy into a quantifiable set of goals, outcomes, indicators and data measures, showing the underlying logic that connects them and identifying gaps in what we can currently measure.
- The Data Quality and Improvement Plan provides data standards for fit-for-purpose data and identifies priority data gaps. It proposes plans to address gaps either through improving existing data collections, establishing new ones, or increasing data sharing and linkage.
- The Monitoring and Reporting Plan outlines how progress will be reported, by whom and in what formats to serve both public and technical audiences.

The NSPO engaged the expertise of the AIHW and senior researchers from the University of New South Wales to contribute to quantitative and qualitative aspects of the Outcomes Map. Over 200 potential data measures were reviewed and considered for inclusion in the Outcomes Framework. Through the quantitative and qualitative data measures, it is estimated that most of the indicators will be measurable and the remainder will be put forward as data gaps for inclusion in the Data Quality and Improvement Plan. Ultimately, the Outcomes Map will include five goals and 16 outcomes for suicide prevention.

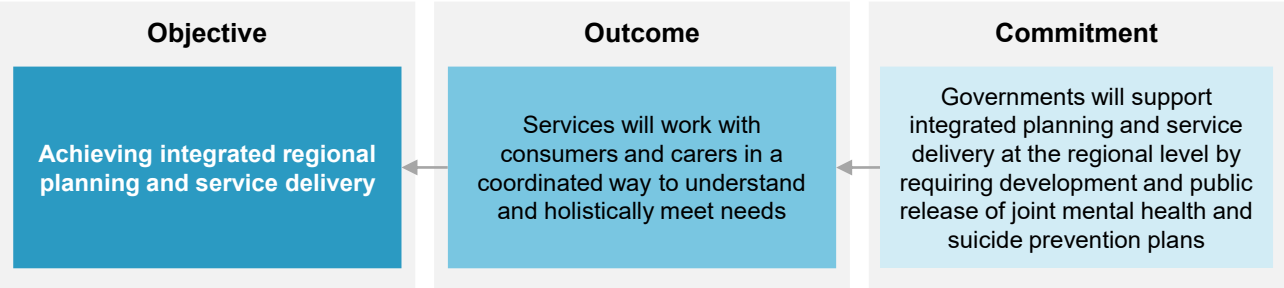
Leadership from the NSPO's Lived Experience Partnership Group and inclusion of people with lived and living experience of suicide helped ensure the inclusion and phrasing of goals, outcomes and indicators that are meaningful and accessible to the people they most affect. The NSPO also worked closely with Gayaa Dhuwi (Proud Spirit) Australia to consider alignment of the Outcomes Framework with the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy 2025–2035.

Source: NSPO (2024b, pers. comm., 7 October 2025).

Actions must contribute to agreed objectives and outcomes

Articulating links between the agreement's objectives, outcomes and actions (such as commitments, outputs and initiatives) helps ensure actions are evidence-based and effective at shifting outcomes. For example, the Fifth National Mental Health and Suicide Prevention Plan (Fifth Plan) created links by identifying eight priority areas for reform, specifying a set of actions within each priority area, followed by descriptions of how change will be measured, including the direct impact on consumers and carers (figure 4.2).

Figure 4.2 – Example of program logic applied throughout the Fifth Plan



Source: COAG Health Council (2017, pp. 18–22).

For consumers, carers and the broader sector, an agreement with clear links throughout provides transparency, demonstrating how it intends to affect change. This is a departure from the current approach, which makes various commitments without explicitly linking them back to intended outcomes (chapter 3).

There may be a role for the Australian Centre for Evaluation to support the development of a program logic within the next agreement and link it to the Mental Health Declaration and National Suicide Prevention Strategy. The Centre has expertise to support the use of best practice in developing a program logic. It also works across portfolios to uplift evaluation practices and use of evidence in policy design and decision making, which can further contribute to embedding a whole-of-government approach in the next agreement.

Careful sequencing is required for this approach to be embedded in the next agreement. Objectives and outcomes must be agreed before governments are able to negotiate priorities and commitments for the next agreement; otherwise, they risk being disconnected. Governments have begun discussing some priorities for the next agreement, including psychosocial supports and youth mental health (DHDA 2025c, pp. 1–2).

Whole-of-government actions in the body of the next agreement

The current Agreement acknowledges the need to work across systems and identifies eight priority areas to progress a whole-of-government approach through its Schedule A. While whole-of-government action remains crucial, the current approach has proved ineffective at achieving whole-of-government reform (chapter 3).

In the next agreement, commitments to improve collaboration across government portfolios should be included in the main body of the agreement rather than a separate schedule. Review participants were supportive of this approach (AAPi, sub. 109, p. 4; Beyond Blue, sub. 156, p. 4; Mental Health Australia, sub. 153, p. 9). The next agreement needs to strike a balance between breadth and depth of cross-portfolio actions through prioritising action in one or two areas determined in conjunction with people with lived and living experience, and their supporters, family, carers and kin (chapter 5 discusses this approach in detail).

The next agreement should include meaningful links to the broader policy environment influencing the social determinants of mental ill health and suicide. These links can take the form of alignment with existing national strategies, policies or agreements or stronger measures like embedding shared reporting requirements and financial incentives (box 4.4). Review participants agreed that a clearer articulation of how the agreement interacts with the broader policy environment is vital.[39]

[39] AHPA, sub. 178, pp. 5–6; Beyond Blue, sub. 156, p. 4; Cancer Council Australia, sub. 207, p. 2; Catholic Health Australia, sub. 181, p. 16; Centre for Community Child Health, sub. 183, pp. 7–8; Jesuit Social Services, sub. 131, p. 16; Mental Health Australia, sub. 153, p. 7; NMHCA, sub. 149, p. 17; Orygen, sub. 169, p. 2; QNMU, sub. 136, p. 4; Suicide Prevention Australia, sub. 214, p. 5.

Box 4.4 – Alignment with the National Agreement on Closing the Gap in the National Skills Agreement

The National Skills Agreement (NSA) provides a useful example of how national agreements can be aligned to achieve common objectives. The NSA supports coordinated action with reforms under the National Agreement on Closing the Gap by establishing financial incentives for jurisdictions to work with Aboriginal and Torres Strait Islander people. These incentives are provided through two funding avenues.

- To access additional flexible funding from the Australian Government through the NSA, state and territory governments are required to publish a jurisdictional action plan that sets out actions and targets to give effect to agreed national priorities, including Closing the Gap.
- The NSA includes Closing the Gap as a policy initiative, with $47.4 million retained by the Australian Government to progress its own Closing the Gap activities and $166.4 million available to state and territory governments as matched funding to deliver initiatives that demonstrably contribute to the achievement of Closing the Gap targets. Jurisdictions must develop their application for matched funding under this stream in partnership with Aboriginal and Torres Strait Islander communities and organisations.

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.

4.3 Developing the next agreement

Governments should take the time to get the next agreement right

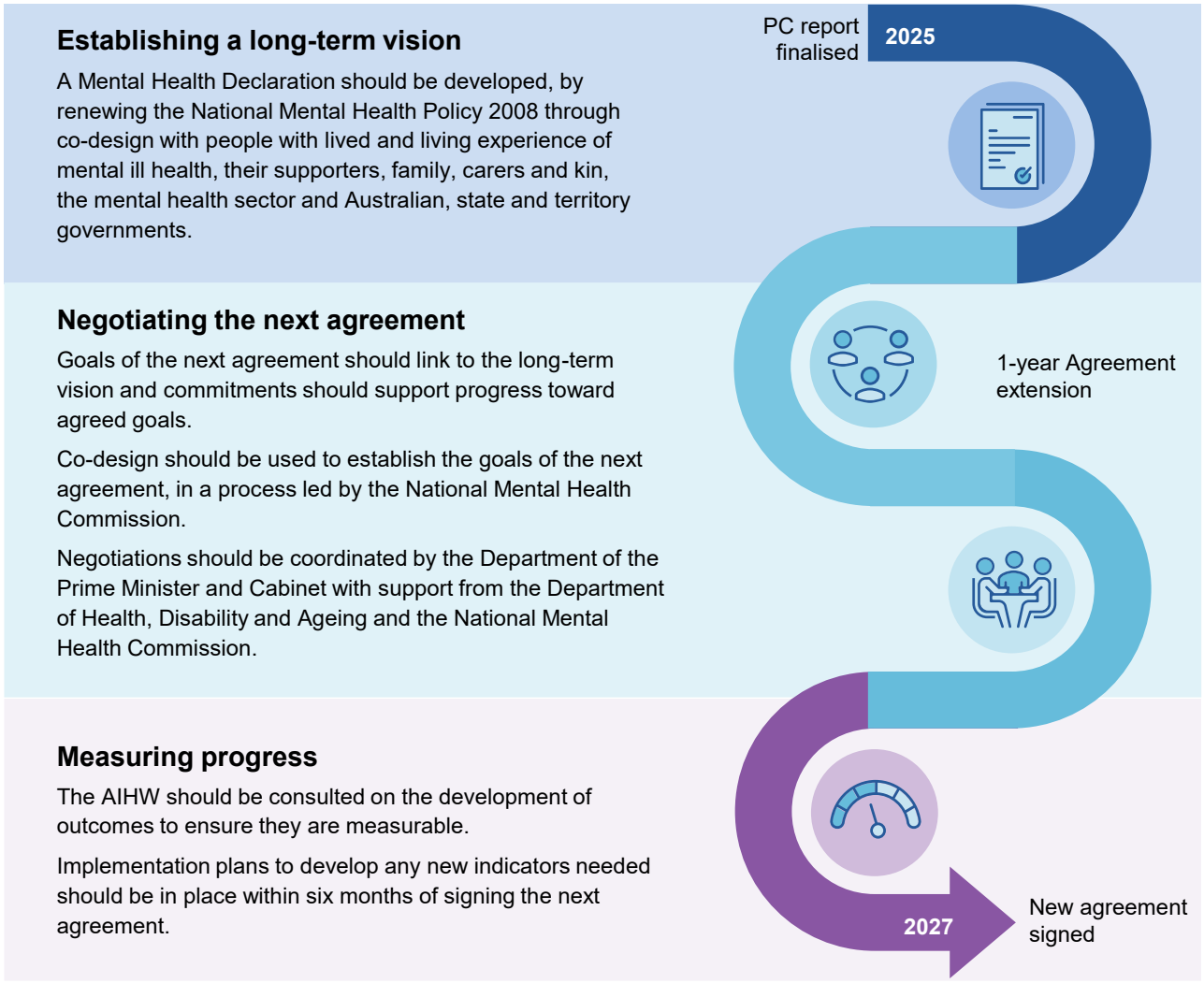
Getting the next agreement right will require the co-design of a new Mental Health Declaration and a set of objectives and outcomes for the agreement to pursue in the next five years; both processes will take time. The development of a Declaration (including a co-design process) is likely to require time for consultation, development and governmental endorsement.

The time left between the completion of this review and the expiry of the current Agreement in June 2026 is insufficient for these processes to be done well. Rushing the development of the next agreement risks creating a document that has limited buy-in and relevance for consumers and the sector, and no effect on outcomes.

The current Agreement, including funding arrangements, should be extended for one year and the next agreement should be in place by June 2027. An extension would allow co-design processes to be undertaken and effective sequencing of these processes prior to negotiations taking place (figure 4.3).

This extension should not delay progress on immediate policy priorities, such as addressing the unmet need for psychosocial supports and workforce development (chapter 2).

Figure 4.3 – A roadmap for renegotiating the next agreement



Negotiating and signing a whole-of-government agreement

Effective reform in mental health and suicide prevention requires a whole-of-government approach (chapter 5). The primacy of a whole-of-government approach should be reflected through the new Mental Health Declaration and made tangible through the next agreement. Doing so will require the whole-of-government approach to be embedded throughout the next agreement (section 4.2), supported by governance and accountability mechanisms (chapter 5) and enabled through the negotiation process.

Reflecting the need for cross-agency involvement in the next agreement, negotiations should be convened by the Department of the Prime Minister and Cabinet (PM&C), with advice from the Department of Health, Disability and Ageing (DHDA) and the NMHC. PM&C has a mandate for coordinating the policy approach to

cross-cutting issues and ensuring the alignment of policies, programs and actions across the care and support economy (PM&C 2024a).

Review participants expressed mixed views on the proposal for negotiations to be convened by PM&C. While some acknowledged that PM&C leading negotiations would support improved cross-government collaboration (CHA, sub. 181, p. 15; CHF, sub. 140, p. 7; NMHCA, sub. 149, p. 25), there was concern this approach would lead to a loss of important federal- and state-level health subject matter expertise and stakeholder relationships in negotiations (Mental Health Australia, sub. 153, pp. 8–9; MHV, sub. 215, p. 6; MHCC, sub. 120, p. 2).

PM&C has the convening authority to ensure the right mix of expertise is at the table. This would allow health expertise to remain central while compelling the inclusion of other social policy portfolios responsible for the broader social determinants of mental ill health and suicide. PM&C has the authority and responsibility to progress systemic change, while DHDA and the NMHC have subject matter expertise and established cross-sectoral relationships. Having PM&C convene negotiations may help overcome the siloed approach to mental health and suicide prevention reform, enabling integration and collaboration across portfolios, and promoting a community approach to the mental health and suicide prevention system rather than the current focus on clinical services.

To further support a whole-of-government approach, the next agreement should be signed by First Ministers and Health and Mental Health Ministers. Having the agreement signed by First Ministers rather than Treasurers supports a stronger whole-of-government commitment and broad accountability across portfolios. The addition of Health and Mental Health Ministers recognises the central role of health in the agreement.

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
- 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.

Schedules should be used to address specific policy areas

Agreement schedules can be used to give separate attention to specific issues. This is particularly useful where aspects of these issues are distinct from the broader mental health and suicide prevention system. Separating out specific areas can also elevate their importance to ensure specific reform efforts and actions continue to attract the attention of policy makers. The next agreement should therefore include separate schedules on services for Aboriginal and Torres Strait Islander people, suicide prevention, and co-occurrence of problematic alcohol and other drug (AOD) use and mental ill health and suicide.

Aboriginal and Torres Strait Islander people have distinct and diverse concepts and experiences of wellbeing, often described through the framework of social and emotional wellbeing. A separate, co-designed schedule for Aboriginal and Torres Strait Islander services would locate commitments to improving social and emotional wellbeing together, recognising the need for specific actions and increased visibility and accountability. While broader reforms will be relevant to Aboriginal and Torres Strait Islander services and consumers, a separate schedule allows a focus on their distinct needs (chapter 7).

The suicide prevention system has some areas that are distinct from the mental health system, such as the management of suicidal behaviours, means restriction, universal aftercare and postvention support services. The National Suicide Prevention Strategy, the forthcoming National Suicide Prevention Outcomes Framework and the NSPO form a policy environment that should be drawn on to support suicide prevention activities within the agreement. Areas that are unique to suicide prevention should be included in a separate schedule to ensure they receive sufficient attention (chapter 8).

There is significant co-occurrence of mental ill health, suicide and problematic AOD use as well as a lack of coordinated effort to address these intersecting policy areas. A schedule to the next agreement dedicated to the intersection of mental ill health, suicide and problematic AOD use would help fill a gap in national policy, enable increased investment and action and support holistic care (chapter 9). AOD is just one of the areas that intersect with the mental health and suicide prevention system; future agreements should consider the effectiveness of schedules to improve outcomes for other priority groups, such as people who are affected by mental and physical health issues or those experiencing homelessness.

4.4 Addressing policy gaps in the next agreement

The next agreement should outline ongoing responsibilities for psychosocial supports

As discussed in chapter 2, governments need to take urgent action before the end of the current Agreement to agree to responsibilities for psychosocial support outside the NDIS. State and territory governments should be responsible for commissioning services and commence work immediately to address unmet need (recommendation 2.2).

In addition to this immediate action, the next agreement should provide greater accountability and clarity over the future of psychosocial supports. Participants in this review noted the need to establish agreed government responsibilities for the funding and commissioning of psychosocial supports.[40]

[40] Jesuit Social Services, sub. 131, p. 10; Mental Health Coordinating Council, sub. 120, p. 2; SUPER CRO, sub. 111, p. 1; Victorian Government, sub. 228, p. 19.

The Mental Illness Fellowship of Australia (sub. 88, p. 15) suggested under the next agreement:

> The Commonwealth, States and Territories unilaterally commit to addressing the psychosocial support gap for individuals and family carers and chosen supporters within four years based on the proportion of the need they currently address while system improvements are underway.

The Queensland Alliance for Mental Health (sub. 130, p. 6) suggested a similar, joint funding model:

> QAMH also reiterates its longstanding position that psychosocial supports should be jointly funded through a 50:50 contribution from state and federal governments. A shared investment model would improve consistency and sustainability while encouraging closer collaboration in planning, delivery and accountability across jurisdictions.

While a funding split will need to be negotiated between Australian, state and territory governments, sole state and territory government responsibility for managing psychosocial supports would improve efficiency, resolve ambiguity and create better links with the clinical services needed by consumers (PC 2020, pp. 861–862). Governments have already committed to prioritising addressing unmet psychosocial needs in the next agreement and at least maintaining funding for psychosocial support services (DHDA 2025c, p. 2).

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.

The National Mental Health Commission should monitor and report on the implementation of the plan to address unmet need for psychosocial supports, as the entity responsible for ongoing monitoring, public reporting and assessment of progress under the next agreement (recommendation 5.6).

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).

Responsibility for carer and family supports should be clarified in the next agreement

Nearly one million Australians cared for someone with mental illness and about 273,000 were the primary carer for a person with mental illness in 2018 (PC 2020, pp. 872–873). Carers play a vital role in the mental health and suicide prevention system, often at the expense of their own wellbeing, employment prospects and financial security. Family and kin can also be affected by mental ill health and suicide even when not regularly providing care or support.

The issues carers face are many and complex (*What we heard* paper; Mental Health Carers Australia, transcript, 20 August 2025). Caring for someone with mental ill health or supporting someone through suicidal distress can have a negative impact on the carer's own physical and mental health (Phillips et al. 2021, p. 2). The wellbeing of carers and consumers is interdependent. An individual case study provided by one participant said:

> If I were to stop helping, the consequences for my daughter would be catastrophic - more hospitalisations, homelessness, or worse. My wellbeing is directly tied to my daughter's survival. This is the reality for many of us, caught in a system that expects everything but offers little in return. (Mental Health Carers Australia, sub. 73, p. 7)

Mental ill health and suicide can significantly affect family dynamics (Robinson et al. 2008, p. 1) and different family members are likely to be affected in different ways (SANE 2025). Review participants reflected on some of these impacts.

> Despite considerable advocacy for my daughter I was often dismissed and had to fight tirelessly to get support for her. (sr. 74)

The roles of the Australian, state and territory governments in providing carer and family supports are unclear. Many crucial supports for carers and families, such as income supports and the Carer Gateway, are funded by the Australian Government outside of the Agreement. State and territory governments also fund supports, such as the NSW Family and Carer Mental Health Program and Mental Health and Wellbeing Connect centres in Victoria (Mental Health Carers Australia, sub. 205, p. 12; Victorian Department of Health 2025b). The PC's Mental Health inquiry recommended the Agreement require the state and territory governments be responsible for the planning and funding of carer support services for mental health carers, as well as family support services for families affected by mental illness (2020, p. 868). However, the Agreement makes no mention of responsibilities for carer or family supports.

The lack of clarity in roles and responsibilities has resulted in adverse outcomes for consumers and carers, inconsistencies in service provision and insufficient support for carers (Carers ACT, sub. 60, p. 5). A lack of carer and family support was also reflected by survey participants.

> Supports for Carers and family members of people with mental health has been incredibly difficult to access and availability of needed help has decreased (sr. 84)

The Mental Health Statement of Rights and Responsibilities highlights carers' rights to 'comprehensive information, education, training and support to facilitate their care and support roles' and, with the consent of the consumer and where appropriate, 'participate in treatment decisions and decisions about ongoing care'

(Standing Council on Health 2012, pp. 19–20). Mental Health Carers Australia (sub. 205, p. 5) noted the benefits of carer inclusion on recovery:

> In truth, recovery is profoundly relational. Most people heal through connection with families, carers, kin, friends, professionals, and community. Hope, identity, and empowerment are not simply private achievements but are built and sustained through the quality of our social relationships.

Some of the policy gaps that affect carers should be pursued outside of the agreement, for example, by amending the Medicare Benefits Schedule to include rebates for carer and family consultations (PC 2020, p. 868).

Nonetheless, to create accountability and reduce service gaps, the next agreement should clarify which level of government is responsible for providing carer and family supports. Carer involvement in the design and implementation of the next agreement will go some way to recognising the rights, contributions and challenges faced by carers. It will also ensure the next agreement is informed by carers, their perspectives and their needs. Their involvement should encompass co-design processes and governance working groups established under the agreement (recommendation 4.2; chapter 5).

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.

Workforce development remains a priority

A well-supported and skilled workforce is crucial to high-quality mental health and suicide prevention services. Workforce development is needed to ensure sustainability of the system over the coming years (chapter 2) and was identified by participants as a priority for the next agreement (Australian Private Hospitals Association, sub. 163, p. 12; Mental Health Australia, sub. 153, p. 15; Transforming Australia's Mental Health Service System, sub. 191, p. 2).

> Action through the next National Agreement to grow, strengthen and appropriately distribute the mental health workforce must be proportionate to the urgency and significance of this issue. (Mental Health Australia, sub. 76, p. 18)

Under the current Agreement, the Australian, state and territory governments collaborated to develop the National Mental Health Workforce Strategy and committed to supporting the NSPO to develop a National Suicide Prevention Workforce Strategy (clause 156). But the plan for implementing these strategies is not yet clear.

The National Mental Health Workforce Strategy includes a framework for action, a vision for a sustainable mental health workforce and 74 actions for workforce development. The goals of the strategy are to attract, train, support and retain an appropriately skilled, motivated and coordinated mental health workforce to meet the evolving needs of the mental health system into the future (box 2.2).

The National Suicide Prevention Workforce Strategy is yet to be developed (chapter 8). The suicide prevention workforce encompasses a wide range of disciplines and occupations, including people and roles outside those usually associated with suicide prevention (NSPO 2025, pp. 83–84). While this workforce often works collaboratively with the mental health sector, it is a discrete workforce and therefore requires tailored supports and policies (StandBy Support After Suicide, sub. 167, p. 11).

Workforce shortages are acute and threaten to worsen without immediate, coordinated action. Governments must act on pressing workforce issues during the term of the current Agreement. Immediate action to relieve workforce pressures should include implementing priorities specified within the National Mental Health Workforce Strategy and the National Suicide Prevention Strategy, while the National Suicide Prevention Workforce Strategy is being progressed (chapter 2). Some participants argued retention should also be a priority in the short-term, including addressing practitioner burnout and moral injury (Australian Medical Association, sub. 72, p. 3; Australian Psychological Society, sub. 85, p. 8; RANZCP, sub. 7, p. 2; TWB Consulting, sub. 98, p. 1).

Investment in initiatives under the National Mental Health Workforce Strategy has been inconsistent. For example, the 2023-24 Budget included almost $600 million to progress some priority initiatives, such as resolving bottlenecks in the psychology training pipeline and upskilling of the broader health workforce (Butler 2023). However, the following 2024-25 Budget included less than $80 million including funding for PHNs to commission the services of mental health nurses, counsellors, social workers and peer workers and the establishment of a national peer workforce association (DoHAC 2024b, p. 20). Ongoing investment will be needed to continue implementing priorities over the term of the next agreement.

It is difficult to hold governments to account for progress on workforce development given the lack of clarity around the implementation of the National Mental Health Workforce Strategy. The next agreement should include specific commitments to support prioritised actions, particularly by formalising accountability, timelines and funding. Review participants strongly supported this recommendation in the interim report.[41]

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.

The status of peer work should be uplifted

Peer work stands out as a highly valued part of the mental health and suicide prevention system. Survey respondents and submissions pointed to peer workers as being an important part of effective service delivery (*What we heard* paper), working both autonomously in specialised services and within multidisciplinary

[41] Beyond Blue, sub. 156, pp. 3, 6–7; Black Dog Institute, sub. 151, p. 9; Catholic Health Australia, sub. 181, p. 33; Consumers Health Forum of Australia, sub. 140, p. 11; Consumers of Mental Health WA, sub. 148, p. 11; Queensland Nurses and Midwives' Union, sub. 136, p. 5; SUPER CRO, sub. 111, p. 1.

teams.[42] Peer workers have positive relational and role modelling impacts on consumers. They play a unique role in assisting consumers and carers to navigate the system and provide organisations a consumer perspective to help make services more person-centred (Davidson et al. 2012, p. 124; PC 2020 p. 725).

> Peer-to-peer support offers a compassionate space where individuals facing mental health challenges can find understanding and care. It fosters connections that help people feel seen, heard, and empowered on their journey to well-being. (sr. 149)

> Lived experience workers are a safe, holistic, unique and sustainable alternative to traditional clinical care, and are especially important now, whist psychiatrists and clinical care is almost impossible to source. (sr. 21)

> If we are serious about reform, the lived experience workforce must be a key lever—not an afterthought. (Ruah Community Services, sub. 177, p. 3)

Peer workers have in many instances been effectively and meaningfully integrated into mental health and suicide prevention settings that deliver both clinical and non-clinical services. Medicare Mental Health Centres – a recent addition to the mental health and suicide prevention system – are staffed with multidisciplinary teams including peer workers and clinicians who offer people in distress immediate support and assistance with system navigation (DoHAC 2025a, pp. 4–5). Participants raised other examples of peer workers being effectively integrated into mental health and suicide prevention settings (box 4.5).

Box 4.5 – Peer workers in mental health and suicide prevention settings

There are many promising examples of peer workers operating effectively and safely in clinical and non-clinical mental health and suicide prevention settings.

One example is Hobart's Peacock Centre, which brings together integrated community mental health and suicide prevention services for anyone wanting support for mental ill health or suicidal distress. The Centre is a drop-in service designed to be an alternative to emergency departments as well as a support system for people experiencing low to medium severity mental ill health. All services are free for the community and aim to provide a welcoming, calm environment focussed on recovery and personal choice (Tasmanian Government Department of Health 2023a).

The Centre hosts the Mental Health Integration Hub (offering short term practical mental health support, information and advice), Recovery College (a dedicated space providing education for mental health and wellbeing and personal recovery) and Safe Haven (support for people in suicidal or situational distress and their families, friends or support networks). The Centre also supports those with a formal referral from Tasmania's Statewide Mental Health Services through Peacock House, a 12-bedroom home-like unit for intensive mental health support oriented towards respect, recovery and personal choice. Services include psychosocial supports, psychological and medication-based interventions, safety planning and assistance with self-management and autonomy (Tasmanian Government Department of Health 2023a).

The Centre's model of care emphasises a relational approach to wellbeing and recovery, which requires and supports the genuine integration of peer workers. Each of the services delivered by the Centre

[42] Consumers of Mental Health WA, sub. 49, pp. 10–11; Mental Health Carers Australia, sub. 73, pp. 28, 32; Mental Health Lived Experience Tasmania, sub. 116, pp. 6–7; National Mental Health Consumer Alliance, sub. 66, p. 15; National Mental Health Consumer and Carer Forum, sub. 68, p. 8; Standby Support After Suicide, sub. 167, p. 7.

Box 4.5 – Peer workers in mental health and suicide prevention settings

brings together senior mental health clinicians with peer workers who have lived experience of mental ill health and/or suicidal distress (Tasmanian Government Department of Health 2020, pp. 8, 10). Peer workers are supported to excel in this environment through clearly delineated roles within the Centre and an emphasis on team-based approaches to recovery where peer workers operate interdependently with clinical staff (Tasmanian Government Department of Health 2023b).

Another example raised by review participants are Safe Havens, also known as Safe Spaces, which are non-clinical, peer-led services that provide support for people experiencing suicidal distress and their supporters, family, carers and kin. They are designed to be an alternative to clinical and hospital services, offering a calm and culturally sensitive environment for people in distress (Consumers Health Forum of Australia, sub. 140, p. 13). Safe Havens exist in some form in all states and territories, with variation in models of care in response to local contexts (Life in Mind 2025). For example, Roses in the Ocean run a network of community-led Safe Spaces that prioritise a trauma-informed 'no wrong door' approach delivered by a compassionate and capable peer-led, volunteer workforce (Roses in the Ocean 2022, pp. 12–13).

Despite their aptitude in providing effective supports to consumers, peer workers face many barriers to contribute their full scale of expertise and knowledge. Participants spoke of varying levels of organisational readiness to integrate the peer workforce, and peer workers being asked to operate in environments that are not yet fully equipped to support them.[43] For example, many peer workers are not well supported due to a lack of understanding of their contribution to mental health and suicide prevention services and care models (Lived Experience Australia, sub. 42, pp. 5–6). Cultural inertia within the clinical system has limited many peer workers to working within existing medical models, meaning they are sometimes not able to take full advantage of their capabilities and learnings from their lived and living experience. This can lead to peer workers operating outside of their scope, heightening the risk of unsafe work practices and unsafe outcomes for consumers (Consumers of Mental Health WA, sub. 49, pp. 10–11).

The 2024-25 Federal Budget committed $7.1 million over four years to establish a national professional association for peer workers in mental health and suicide prevention, deliver a workforce census and explore further training pathways (DoHAC 2024b, pp. 9, 20). The next agreement should look to build on this momentum by supporting the development of a national scope of practice designed by this national professional association. Developing a consistent understanding of peer workers' scope of practice would help clinicians and other practitioners understand their value and would help peer workers to reinforce the boundaries of their work. It could also lay the foundation for further supports for the workforce, such as consistent supervision and on-the-job training requirements (Allied Health Professions Australia, sub. 178, p. 6). This recommendation was strongly supported by participants responding to the interim report, who emphasised the importance of enabling support systems for peer workers.[44]

[43] Australian Psychosocial Alliance, sub. 55, p. 10; Mental Health Carers Australia, sub. 73, p. 23; Queensland Alliance for Mental Health, sub. 83, p. 7.

[44] Allied Health Professions Australia, sub. 178, p. 6; Faculty of Medicine, Nursing and Health Sciences, Monash University, sub. 202, p. 29; LELAN, sub. 190, p. 23; Mental Health Lived Experience Peak Queensland, sub. 144, p. 14; Medibank Private Limited, sub. 198, pp. 7–8; National Mental Health Consumer Alliance, sub. 149, p. 8; Occupational Therapy Society for Invisible and Hidden Disabilities, sub. 146, p. 5; Standby Support After Suicide, sub. 167, p. 11.

Participants also raised the importance of maintaining the integrity of peer work.[45] Creating a scope of practice would contribute to some standardisation of the profession by formalising the capabilities peer workers can be expected and supported to demonstrate. This must be managed sensitively so as not to risk the relational, adaptable nature of their work being co-opted into more rigid ways of working (Byrne et al. 2017, p. 79). Standardisation, which might involve introducing consistent entry requirements to the profession such as formal qualifications in mental health and peer support, could increase barriers to entry. This may have adverse implications for the composition of the workforce or for organic, issue-focused peer support (Faulkner and Kalathil 2012, p. 48).

In light of these concerns, the professionalisation of the Aboriginal and Torres Strait Islander Health Workforce can be seen as setting a precedent for the clarification of community-based, clinical and non-clinical roles without compromising the culturally safe and responsive nature of the work. A scope of practice was developed to address the underutilisation and undervaluation of the Aboriginal and Torres Strait Islander Health Workforce and establish a shared understanding of capabilities and standards of practice (NAATSIHWP 2024, p. 9). This puts guardrails around the context-responsive work of Aboriginal and Torres Strait Islander Health Workers and Practitioners, allowing them to continue to meet the needs of their communities in a safe and holistic way. A scope of practice for the peer workforce in mental health and suicide prevention could have similar protective effects.

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.

[45] BEING – Mental Health Consumers, sub. 141, p. 12; National Mental Health Consumer Alliance, sub. 149, p. 8; Suicide Prevention Australia, sub. 214, p. 7.

5. Effective governance and accountability

Key points

- **The next national mental health and suicide prevention agreement requires a stronger authorising environment to enable genuine cross-portfolio collaboration and integration. To create this environment, National Cabinet should include mental health and suicide prevention as a national priority and receive annual updates on implementation of the agreement.**
- **The next agreement should focus on one or two cross-portfolio priorities over its five-year term. Governance arrangements should be reoriented to support these priorities, aligned with the Mental Health Declaration and National Suicide Prevention Strategy, and co-designed with people with lived and living experience and their supporters, family, carers and kin.**
- **National Cabinet should establish a Special Purpose Mental Health Council to provide cross-portfolio ministerial oversight of the agreement, supported by a Senior Officials Group including participants from all relevant priority portfolios.**
- **Governance of the next agreement should be more transparent and involve greater participation of people with lived and living experience of mental ill health and suicide, carers and service providers. The next agreement should embed a lived experience governance framework to clarify roles, address power imbalances and ensure meaningful participation.**
- **The National Mental Health Commission should be established as an independent statutory body and have greater powers to monitor and report on progress. Improving the effectiveness and accessibility of national reporting and implementing regional-level reporting will enable greater accountability.**
- **The next agreement can progress whole-of-government reform, but building a truly person-centred system also depends on vertical integration across jurisdictions, coordination at the regional and local levels, and embedding lived and living experience perspectives in service delivery and evaluation. Examples from existing governance models and innovative services show integration is achievable and requires sustained effort beyond a national agreement.**

The National Mental Health and Suicide Prevention Agreement took important steps to recognise mental ill health and suicide are affected by many aspects of government policy and committed to the concept of whole-of-government integration (chapter 1). However, it was not successful in delivering cross-portfolio action beyond information sharing (NMHC 2025, p. 4). In the next agreement, governments should renew

their commitment to whole-of-government collaboration and create governance and accountability structures that enable integration.

The next agreement should focus on cross-portfolio integration that can be achieved within its term, while aligning with national strategies (including a Mental Health Declaration) (chapter 4). Making mental health and suicide prevention a formal priority of National Cabinet would provide a stronger authorising environment for reform (section 5.1). Governance forums should be restructured to emphasise and encourage cross-portfolio collaboration (section 5.2).

The next agreement should centre the voices of people with lived and living experience, and their supporters, family, carers and kin. The experience of the past three years, under the current Agreement, offers many lessons for improvement (section 5.3).

Embedding transparency and strengthening the role of the National Mental Health Commission (NMHC) are positive steps the next agreement can take. Monitoring and reporting could be improved through regular, timely publication of progress reports and implementation plans, focusing reporting on outcomes rather than activities and supporting primary health networks (PHNs) to publish regional-level reports on progress towards the agreement. Publishing the underlying data used to support reporting and enhancing the accessibility of reporting for consumers and communities will further improve accountability (section 5.4).

The next agreement should also include dedicated schedules to improve services for Aboriginal and Torres Strait Islander people (chapter 7), suicide prevention (chapter 8) and the co-occurrence of problematic alcohol and other drug (AOD) use, mental ill health and suicide (chapter 9). These schedules will require dedicated governance arrangements, discussed in detail in later chapters.

A truly person-centred mental health and suicide prevention system requires coordination and collaboration across all levels. While the next agreement is a major lever to progress a whole-of-government approach at a national and interjurisdictional level, it is part of a longer journey towards a truly integrated system. The focus should be on the steps governments can reasonably take in the next five years, without losing sight of the longer-term vision of reform. This chapter showcases examples of what good regional and local-level governance structures and integrated service delivery look like but are not yet common practice (section 5.5). Planning and commissioning, which are important enablers of integration, are discussed in chapter 6.

5.1 Progressing whole-of-government action

Years of research have demonstrated the significant and reciprocal relationships between mental health, suicide and a wide range of social and economic factors, as well as the value of prevention and early intervention (Alegría et al. 2018, pp. 2–6). While many areas of social policy are shaped by social determinants, mental health is unique in its effects across all domains of society (Kirkbride et al. 2024, pp. 58–67), and this sets it apart in a policy context.

Governments, non-government organisations, people with lived and living experience, service providers, clinicians and researchers agree a whole-of-government response is essential to address the complexity of mental health and suicide (National Suicide Prevention Adviser 2020a, pp. 1–2; WHO 2013, pp. 6–7). Working across jurisdictions and portfolios is the only way to achieve a system that puts people first, intervenes early and actively prevents mental ill health and suicide. Review participants overwhelmingly

emphasised the need for a whole-of-government approach and the prioritisation of prevention and early intervention measures (box 5.1).[46]

Box 5.1 – Review participants' views on the imperative of a whole-of-government approach and prioritisation of prevention and early intervention

> We … agree that seamless strategic cooperation across all levels of government is essential to achieving lasting change. A whole-of-government approach supported by dedicated effort and appropriate resourcing will be foundational in achieving national reform. (Victorian Government, sub. 228, p. 4)

> Addressing … social determinants requires investment in early intervention and a whole-of-government approach, identifying and integrating population level risk factors, including health, job and housing insecurity, education, justice, disability, and social services. (Faculty of Health, Deakin University, sub. 174, p. 3)

> We endorse the need for the next agreement to include funding commitments for prevention and early intervention initiatives, as well as clearly designated responsibility for action outside of the health and mental health portfolio. (WAAMH, sub. 172, p. 7)

> Mental health is not the sole responsibility of health portfolios. Disaster recovery, housing, education, immigration, and community services all play roles in influencing and addressing risk and protective factors related to mental health and suicide risk. (Australian Red Cross and Phoenix Australia, sub. 159, p. 9)

> As investment in upstream prevention strategies is far more cost effective than providing mental health services downstream, the QNMU asserts that governments must also fund strategies that address the broader structural determinants of mental health such as access to adequate housing, education and employment. (QNMU, sub. 136, p. 4)

> We also need to shift towards a whole-of-government, cross-portfolio approach where every Minister, every government department, and every level of government plays its role in promoting, protecting, and restoring mental health. (Dr. Stephen Carbone, sub. 201, p. 3)

> Prevention and early intervention are essential: the earlier the intervention, the less likely small problems will escalate into crises, easing pressure on emergency services. Early intervention initiatives are also highly cost-effective; for example, research on workplace mental health initiatives indicates an average 4:1 return on investment. (MHFAI, sub. 147, p. 2)

> It is necessary for governments to foster a new era of acceptance of cross departmental funding and program development that understands and accepts that costs expended in one portfolio area will impact savings in other areas and vice versa. (MHCC, sub. 120, p. 2)

[46] AAPi, sub. 109, p. 4; Catholic Health Australia, sub. 181, p. 4; CMHA, sub. 216, p. 7; Jesuit Social Services, sub. 131, p. 16; Liptember Foundation, sub. 164, p. 8; Manna Institute, sub. 194, p. 7; MATES in Construction, sub. 234, p. 8; MAV, sub. 152, p. 4, MHV, sub. 215, p. 9; RANZCP, sub. 222, p. 3; Stroke Foundation, sub. 168, p. 6; Uniting-SA, sub. 213, pp. 1–2; yourtown, sub. 126, pp. 9–11.

Review participants noted the case for a whole-of-government approach has been a recurring theme in multiple reviews, inquiries and strategies (Homelessness Australia, sub. 112, p. 5; Name withheld, sub. 101, p. 1; Open Dialogue Centre, sub. 135, p. 1). For example, in recent years, the challenges and opportunities of a siloed approach across service systems and governments have been:

> … starkly reflected in evidence presented to the [National Disability Insurance Scheme] Review (2023), the Disability Royal Commission (2023), the NDIS Quality and Safeguard Commission's Inquiry into Support Accommodation (2022), the Productivity Commission's Inquiries into Mental Health (2020) and the National Housing and Homelessness Agreement (2022), Victoria's Mental Health Royal Commission (2021), the Aged Care Royal Commission (2021) and various Parliamentary Inquiries into homelessness. (Homelessness Australia, sub. 112, p. 5)

Yet, as the Western Australian Association for Mental Health (sub. 172, p. 5) noted:

> … whilst such rhetoric [addressing social determinants of mental health] is common in government policy documents and strategies, including the national agreement, we have not seen sustained effort or funding by governments to address these issues through cross-sectoral policy and action.

Achieving whole-of-government reform requires more than rhetorical commitment. It requires deliberate prioritisation, resourcing, leadership, governance and joint accountability embedded across portfolios. These are not features that emerge organically, they must be built into the governance and accountability of the system. The Agreement currently lacks the supporting architecture to enable this. But while the Agreement has fallen short, we cannot recommend an alternative, more siloed direction, simply because it may be easier to achieve; to do so would be tantamount to recommending failure.

Transforming the mental health and suicide prevention system will require time and substantial resources. The next agreement is an opportunity to create authorising environments and governance structures to commence the process of transformation.

Prioritising and funding cross-portfolio reform areas

The current Agreement set unrealistic goals for progress towards an integrated system (chapter 3). Schedule A listed eight priority areas for whole-of-government approaches to mental health and suicide prevention. These included education, work environments, homelessness, AOD, financial counselling, domestic and sexual violence, child maltreatment and justice, with one to six actions for each (Schedule A, clauses 1–8). Deep cross-sectoral integration cannot be achieved between every relevant sector at once. Attempting to 'boil the ocean' risks diluting focus and ending up with shallow actions that fail to change how people with lived and living experience and their supporters, family, carers and kin experience the system.

The next agreement should renew the focus on advancing cross-portfolio integration. However, focusing on a smaller number of initiatives improves prospects of success (Daley 2020, p. 5). Mental Health Australia (sub. 153, p. 9) suggested:

> … specific, funded commitments in the next agreement to address discrete priority areas of social determinants and cross-portfolio collaboration. For example, one suggestion from Mental Health Australia members was for jurisdictions to nominate a particular area to focus on (such as housing, justice or family violence) in their bilateral agreement, and demonstrate progress in this determinant, before then moving to address other drivers of distress.

The next agreement should focus on one or two cross-portfolio priority areas over the five-year period, for example, the interaction of mental health and suicide prevention with the education system and the housing

system. The specific priority areas should be determined in a process of co-design with people with lived and living experience, and their supporters, family, carers and kin.

Progress in achieving whole-of-government reform in the last agreement was limited by a lack of dedicated funding for whole-of-government activities, resulting in high-level actions requiring minimal resources (chapter 3). The next agreement should focus on implementing whole-of-government actions that provide adequate funding and aim to make a noticeable difference in how consumers experience the intersection of services. Creating logical, evidence-based connections between the outcomes and actions can lead to real improvements in consumer and carer experiences (chapter 4).

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

- articulate the social determinants underpinning the need for cross-portfolio action
- 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 using evidence and recommendations from recent government inquiries or reviews where appropriate
- prioritise prevention and early intervention in cross-portfolio actions.

The NSW Housing and Mental Health Agreement (HMHA) provides a practical, albeit still evolving, example of how cross-portfolio collaboration can be embedded into a governmental agreement. It demonstrates the possibility of developing a strong authorising environment and a clear framework for collaboration, with implementation devolved to local levels. This stands in contrast to the current Agreement, which sets out detailed whole-of-government actions but a less explicit overarching framework. The HMHA highlights collaboration can be structured around broad elements supporting local adaptation while promoting a shared vision (box 5.2).

This example is not intended as a recommendation for which objectives, outcomes or commitments should be in the next agreement, or an endorsement of the approach taken to develop the HMHA. Rather it is intended to show it is possible to establish a targeted approach to cross-portfolio collaboration.

Where nationally consistent actions are required, there is a substantial foundation to draw from as a result of many years of advocacy from people with lived and living experience, peak bodies, service providers and academics. Numerous action plans and policy statements have been developed by the sector, often synthesising findings from recent government inquiries and reviews (for example: Australia's Mental Health Think Tank et al. 2022; Brackertz et al. 2021; Homelessness Australia, sub. 112; Mental Health Australia 2022). These plans often provide evidence-based proposals across specific intersections of mental ill health, suicide and social determinants. For example, Homelessness Australia (sub. 112) sets out an action plan for improving housing outcomes for people with psychosocial disability and other complex needs.

Box 5.2 – Cross-portfolio collaboration in practice: NSW Housing and Mental Health Agreement

The NSW Housing and Mental Health Agreement (HMHA), effective from 2022, is an agreement between NSW Health and the Department of Communities and Justice, to work together and with key stakeholders to achieve a shared vision that 'people who live with mental illness have housing security and support to sustain housing in the community'. It is underpinned by three frameworks on governance, service delivery, and monitoring and reporting (NSW Health 2022a, pp. 3, 11). The approach to district and local-level governance is discussed further in section 5.5.

The HMHA illustrates how cross-portfolio collaboration can be embedded in a government agreement. Although implementation is still evolving, the HMHA establishes an authorising environment that sets integration as a clear expectation and provides escalation pathways where collaboration has stalled at a local or district level. Each level works together by sharing information, communicating regularly and using structures within the signatory agencies to support collaboration (NSW Health, pers. comm, 9 September 2025).

Key strengths of the HMHA include:

- a targeted vision – people living with mental health conditions have timely access to safe, secure and appropriate housing
- clear articulation of the two-way relationship between housing and mental health
- balancing state-wide consistency with local flexibility by outlining minimum governance standards and a common agenda while allowing districts to adapt governance structures and implementation to local needs
- formal incorporation of people with lived and living experience with representatives funded to participate in state and district-level governance (NSW Health, pers. comm, 9 September 2025).
- co-design embedded in the development of district plans, which are signed off at the state level including by a state-level lived experience advisory group.

The HMHA has faced some criticism for its comprehensive, three-tiered governance model (state, district and local), but district-level practitioners report the level of detail provides a useful foundation for accountability when implementation issues arise (NSW Health, pers. comm, 9 September 2025). As anticipated, implementation has progressed at varying rates across districts due to differences in geography, local challenges, available services and whether districts are adapting existing structures or establishing new ones. However, uptake has recently expanded, and more tangible outcomes are expected in the coming year (NSW Health, pers. comm, 9 September 2025).

Source: NSW Health (2022a).

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.

5.2 A new governance approach is needed

The governance of the next agreement should be structured to enable whole-of-government action. The elevation of mental health and suicide prevention to a National Cabinet priority, including direct reporting on agreement progress to National Cabinet, would provide a stronger authorising environment across jurisdictions. Governance arrangements should be reconfigured, including reorienting senior governance forums to emphasise cross-portfolio collaboration and establishing working groups responsible for the implementation of specific cross-portfolio actions (figure 5.1).

Setting a stronger authorising environment

Good governance includes having a strong authorising environment to undertake reform and implement policy (APSC 2021). An authorising environment refers to the institutional arrangements such as leadership signals, mandates and accountabilities giving cross-portfolio action its legitimacy and support (Winkworth and White 2010, p. 11). The absence of effective authorising environments has been identified as a key barrier to cross-portfolio collaboration (PM&C 2019, p. 233). The authorising environment for the next agreement should be strengthened.

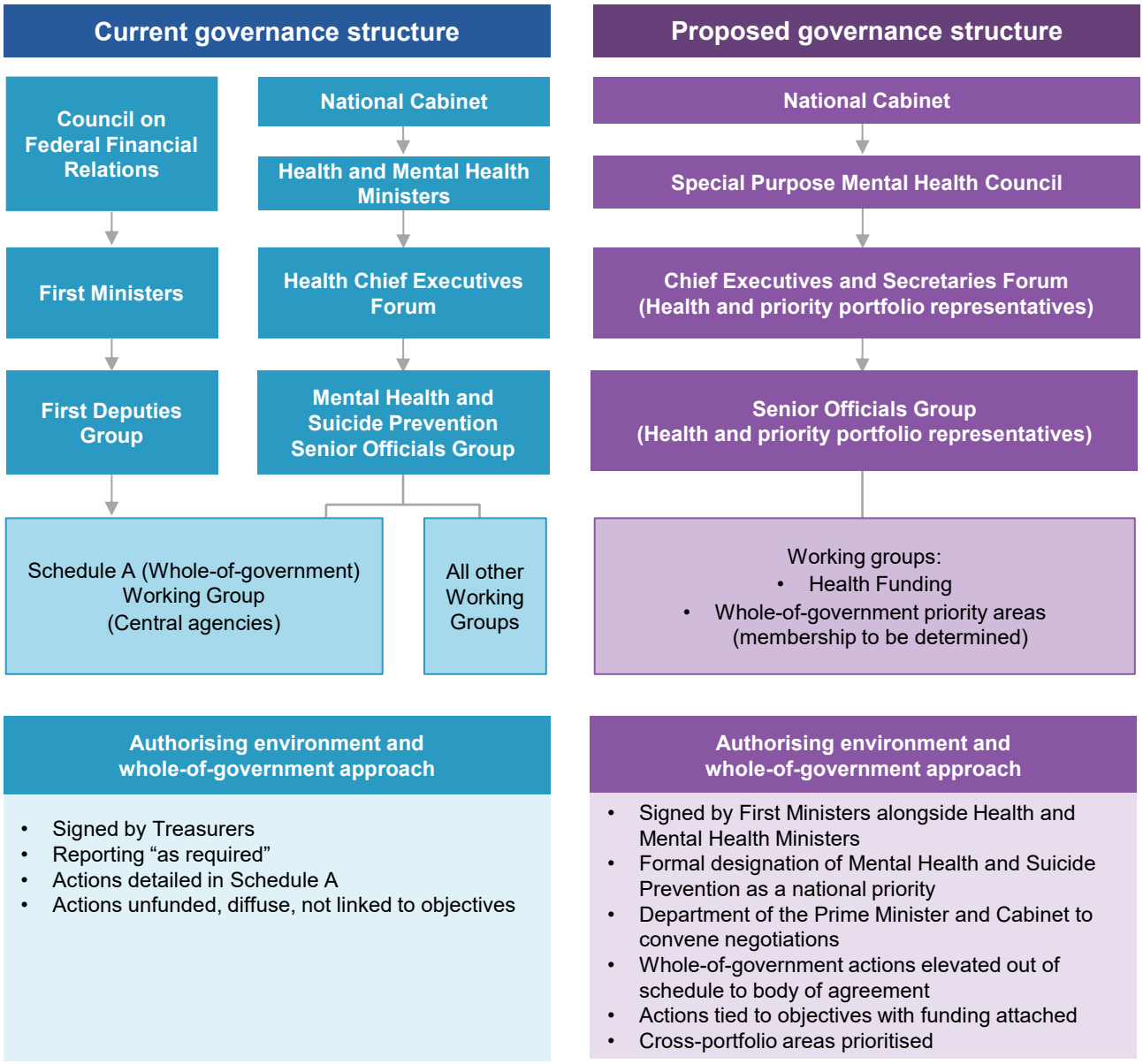
Mental health and suicide prevention as a national priority

Whole-of-government reforms are difficult and require the authorising environment to be initiated at the top, with senior decision-makers setting the mandate and expectations for action (Gaukroger et al. 2025, p. 31). In Australia, National Cabinet is the peak intergovernmental body able to set priorities of national significance. It enables interjurisdictional collaboration, and the involvement of First Ministers ensures the necessary cross-portfolio coordination. National Cabinet has six current priorities, which intersect with mental health and suicide prevention in different ways. Priorities include implementing long-term health reform, as well as addressing gender-based violence, disability reform and housing reform, which are social

determinants of mental health. National Cabinet's involvement is reserved for issues considered nationally significant, requiring continued attention across Australian, state and territory governments and potentially from more than one portfolio (PM&C 2024b, p. 1).

Mental health and suicide prevention meet these criteria. Almost half of all Australian adults will experience mental ill health at some point (DoHAC 2024c) and Australian governments spent $12.6 billion on mental health related services in 2022-23 (chapter 2). Further, the causes, consequences, and solutions of mental ill health and suicide cut across jurisdictions and social policy portfolios including education, employment, housing and justice. This combination of scale and multi-dimensionality makes mental health and suicide prevention a strong candidate for national priority status.

Figure 5.1 – Comparison of current and proposed governance structure and approach to whole-of-government integration



Source: Current governance structure adapted from NMHC (2024a, p. 9), PC analysis.

National Cabinet is in the current Agreement's governance structure, as the forum overseeing all national agreements. However, this has not been sufficient to enable a sustained, whole-of-government focus on the Agreement or mental health and suicide prevention more broadly (chapter 3).

Recognising mental health and suicide prevention as a national priority would enable National Cabinet to advance an effective whole-of-government focus. Elevating mental health and suicide prevention as a priority acknowledges its foundational role across reform agendas, elevates its visibility beyond the broader health portfolio and strengthens the authorising environment required to support meaningful whole-of-government action.

An alternative option is to recognise mental health and suicide prevention within the current health priority, alongside a new National Health Reform Agreement (NHRA). This is not the PC's preferred option as it risks narrowing the focus to health rather than more broadly across portfolios.

Including mental health and suicide prevention in the national priorities would also support stronger reporting to National Cabinet (PM&C 2024c, clause 16). As part of the current Agreement, National Cabinet may receive implementation updates as required and request additional oversight of the Agreement (clause 52a). A review of meeting outcomes suggests National Cabinet has not received an implementation update on the Agreement.[47] For the next agreement, National Cabinet should receive annual implementation updates. Increasing the frequency of reporting and the involvement of First Ministers would reinforce the agreement's authorising environment and support sustained attention on the need for a whole-of-government approach to mental health and suicide prevention.

Reorienting governance forums to emphasise cross-portfolio collaboration

The effectiveness of whole-of-government collaboration under the agreement will depend not only on national prioritisation but also on the governance structures supporting a genuine cross-portfolio approach. The Agreement's current governance architecture and the structure of Ministerial Councils more generally present challenges. The APSC (2007, p. 23) noted:

> There is some inevitable tension between the horizontal responsibilities in working across organisational boundaries and the vertical accountabilities embedded in the Westminster system of Cabinet Government, in which the existence of separate portfolio agencies reflects an underlying accountability of individual Ministers to Parliament.

Vertical structures are well-suited to managing delivery within their own domain but poorly designed for addressing cross-cutting challenges. Ministerial Councils reporting into National Cabinet are largely structured with a singular portfolio focus. Despite clear acknowledgement of the need for a cross-portfolio approach to mental health and suicide prevention in the Agreement, its governance positions it as the responsibility of a single portfolio, assigning primary responsibility to Health and Mental Health Ministers and senior officials.

Embedding a whole-of-government approach for the next agreement requires new governance arrangements that move beyond vertical, portfolio-based structures towards more horizontal, cross-portfolio collaboration.

Restructuring senior oversight of the agreement

Enabling joint responsibility across portfolios requires an authorising environment at the ministerial level that supports systematic consideration of policy interactions (PC 2020, p. 1097). Yet, unless National Cabinet takes on

[47] National Cabinet meeting outcomes and media statements released between 11 March 2022 and 21 January 2025 (PM&C 2025).

primary oversight of cross-portfolio issues itself, the scale and complexity of the factors affecting mental health and suicide exceed the current capacity of Australia's intergovernmental ministerial structures (PC 2020, p. 1098).

To create the required authorising environment, National Cabinet should establish a Special Purpose Mental Health Council (SPMHC). The PC's Mental Health inquiry recommended such a council, proposing its membership comprise Australian, state and territory government Health/Mental Health Ministers as permanent members with 'partnering' Ministers from selected social policy portfolios (PC 2020, p. 1098).

The SPMHC should include Australian, state and territory government Health and Mental Health Ministers and Ministers from the social policy portfolio/s selected as priority whole-of-government reform areas in the next agreement. Health and Mental Health Ministers should retain primary responsibility for overseeing actions related to health funding. However, collaboration with Ministers from relevant social policy portfolios on actions cutting across portfolios is crucial. Representatives from relevant social policy portfolios should have a role on the SPMHC for the life of the agreement.

Revised senior officials group and working groups

The commitment to cross-portfolio collaboration should extend throughout the governance structure, while also recognising health departments have deep expertise in the mental health and suicide prevention space and contribute much of the agreement's funding.

The Health Chief Executives Forum (HCEF) is accountable for implementing the current Agreement. The HCEF delegated responsibility to the Mental Health and Suicide Prevention Senior Officials group (MHSPSO). The next agreement should establish a Chief Executives and Secretaries Forum comprising health chief executives and secretaries from relevant social policy portfolios. MHSPSO should remain in place, but membership should be broadened to include relevant senior officials from priority cross-portfolios.

Expanding governance forums to include additional members carries the risk of forums becoming unwieldly. With careful design, governance can remain effective and streamlined while still reflecting joint responsibility where necessary.

Under the current Agreement, the Schedule A Working Group was established to lead whole-of-government actions outlined in Schedule A. However, it was not set up for success (chapter 3). Rather than relying on a single overarching whole-of-government working group, multiple working groups are needed to support the range of whole-of-government actions in the agreement. MHSPSO should establish working groups to be directly responsible for the implementation of specific priorities. They should comprise members with substantive policy expertise across health and relevant cross-portfolios. Given the importance of coordination for these groups, adequate funding should be provided for a coordinated secretariat function and for collaboration activities such as cross-portfolio workshops.

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.

5.3 Giving consumers, carers and service providers a voice in the next agreement

The current Agreement commits to including the voices of people with lived and living experience, but this inclusion has been far from meaningful (NMHC and NSPO, sub. 70, pp. 16–17). Supporters, family, carers and kin as well as service providers are not adequately included in the Agreement's governance arrangements (chapter 3).

The perspectives of those with lived and living experience of mental ill health and suicide are grounded in the realities of navigating the mental health and suicide prevention system. These perspectives bring a depth of understanding distinct from clinical, academic or bureaucratic viewpoints and are essential to building an equitable, effective and person-centred system (Sartor 2023; WHO 2022, pp. 92–94). Embedding perspectives of people with lived and living experience can improve public trust, legitimacy and the relevance of policies (Lumby 2024, p. 16). Inclusion of empowered and diverse people with lived and living experience in the agreement's governance structures can help ensure the next agreement is responsive and connected to the people it is intended to serve.

People with lived and living experience should be supported to take part in decision-making

The next agreement's governance should enable greater partnership between government and people with lived and living experience of mental ill health and suicide. Although the inclusion of people with lived and living experience in the Agreement's governance arrangements was a welcome step, several barriers

prevented genuine participation (chapter 3). The engagement and influence of people with lived and living experience in the next agreement's governance forums can be supported by embedding a governance framework centring lived experience.

A lived experience governance framework can clarify expectations, accountabilities and decision-making power of people with lived and living experience (Hodges et al. 2023, p. 8). Many engagement frameworks have been developed to guide the public sector in including people with lived and living experience (Lumby 2024, p. 5). Review participants identified the Lived Experience Governance Framework (LEGF), co-designed by the National Mental Health Consumer Carer Forum and the Mental Health Lived Experience Engagement Network, as a suitable Australian-specific framework to embed within the national agreement.[48] Participants noted embedding this framework will address current barriers to genuine participation (CHF, sub. 140, p. 8; LELAN, sub. 190, pp. 30–31).

Embedding a framework alone is not enough; lived and living experience representatives need structural supports to be effective in these roles (Youturn, sub. 170, p. 5). Capacity building supports representatives to bring their full value to governance processes and effectively exercise the roles and responsibilities defined by the framework. In setting up governance arrangements for the next agreement, MHSPSO should work with the Lived Experience Group (LEG) to identify the development opportunities most valuable to representatives. Opportunities could include induction programs, tailored training programs or mentoring (Roses in the Ocean, sub. 133, p. 8; Tasmanian Government, sub. 239, p. 5; Victorian Government, sub. 228, p. 26). Orygen (sub. 169, p. 4) identified the Victorian Mental Illness Awareness Council's 'Consumer Leading in Governance Program' as an example of a training program specifically designed to support people with lived and living experience to contribute meaningfully to mental health governance. Funding should be provided to build the capacity of lived and living experience representatives.

Unnecessary barriers to the engagement of people with lived and living experience should also be removed in the next agreement. For example, the use of confidentiality agreements in some working groups has hindered information flows (chapter 3) and should be limited under the next agreement.

Taking steps to strengthen the role of people with lived and living experience in governance arrangements is an opportunity to demonstrate, at the highest level, the value of the perspectives they bring to policymaking. It would normalise meaningful inclusion and set expectations that can be mirrored across state, local and service-level governance.

Incorporating diverse perspectives and experiences

The benefits of involving people with lived and living experience of mental ill health and suicide in governance are greater where diverse perspectives are captured (CHF, sub. 140, p. 9; FASSTT, sub. 223, p. 12; Manna Institute, sub. 194, p. 5; Youturn, sub. 170, p. 5). There are gaps in representation of certain groups in governance forums (chapter 3). Addressing these gaps and ensuring relevant perspectives are effectively incorporated will require changing the current composition of lived and living experience representation in governance forums.

Review participants voiced support for reconsidering the representation of carers and people with lived and living experience of suicide in the agreement's governance arrangements (Jesuit Social Services, sub. 131, p. 12; Manna Institute, sub. 194, p. 5; MHA, sub. 153, p. 13; Roses in the Ocean, sub. 133, p. 3). However,

[48] CHF, sub. 140, p. 8; LELAN, sub. 190, pp. 30–31; MHLEPQ, sub. 144, p. 9; Mind Australia, sub. 187, p. 17; NMHCA, sub. 149, p. 28

there are different views about the way diversity should be acknowledged and the appropriate balance in representation (CoMHWA, sub. 148, pp. 9–10; LELAN, sub. 190, pp. 25–26).[49]

Equity in governance does not necessarily mean every group must be represented in equal numbers. Rather, it requires recognising people with lived and living experience of mental ill health and suicide and their carers, family, supporters and kin each bring distinct and valuable insights. When these perspectives are incorporated together, they can lead to a better mental health and suicide prevention system.

Review participants argued for representation of specific cohorts of lived and living experience of mental ill health and suicide (FASSTT, sub. 223, p. 13; Raise Foundation, sub. 185, p. 3; SIHA, sub. 237, p. 3; Youturn, sub. 170, p. 5). However, no arrangement can capture the full diversity of lived and living experience but this does not diminish the value of representation within governance structures. Inclusivity and diversity can be embedded not only through who sits at the table, but through the way governance forums draw on wider networks and processes. As Youturn (sub. 170, p. 5) highlighted:

> Meaningful inclusion of lived experience in governance must reflect collective insight, not just individual stories … Effective representation requires … skill-building to effectively synthesise diverse perspectives into a unified voice.

Since the signing of the Agreement, the Australian Government has funded two national peak bodies – the National Mental Health Consumer Alliance and Mental Health Carers Australia. With appropriate and ongoing funding, these peaks are well placed to capture a greater breadth of lived and living experience perspectives in relation to the implementation of the agreement. For example, peaks could convene remunerated workshops and structured consultations drawing in and synthesising diverse voices, including from jurisdictional peaks, on specific issues related to the agreement. These peak bodies are well positioned to play an expanded role in the governance of the next agreement alongside the direct involvement of people with lived and living experience of mental ill health and of suicide. Review participants were supportive of a formalised governance role for these peak bodies.[50]

Review participants also highlighted the current peak bodies are focused on lived and living experience of mental ill health rather than suicide (Roses in the Ocean, sub. 133, p. 5; Suicide Prevention Australia, sub. 214, p. 7). To ensure these perspectives are not overlooked, the National Suicide Prevention Office (NSPO) should advise on how governance forums under the next agreement can most effectively incorporate diverse perspectives of lived and living experience of suicide.

Measuring successful inclusion of people with lived and living experience

Measuring how effectively governance forums incorporate the perspectives of people with lived and living experience is essential. It supports people providing these perspectives to shape decision-making in ways that deliver benefits, rather than it being a tokenistic exercise. As Roses in the Ocean (sub. 133, p. 9) noted:

[49] For example, CoMHWA (sub. 149, pp. 9–10) argued against proportional representation of lived and living experience of mental ill health and suicide because of concerns that in the cohort of people with lived and living experience of suicide there is a predominance of carer and family perspectives and there is a tendency for these perspectives to preference clinical or risk averse approaches to suicide prevention. LELAN (sub. 190, p. 26) argued against equal representation of consumers and carers in governance forums on the basis this could result in 'dilution, overshadowing or silencing of consumer voices.'

[50] BEING – Mental Health Consumers, sub. 141, p. 8; MHA, sub. 153, pp. 12–13; MHLET, sub. 116, p. 6; NMHCA, sub. 149, p. 7; Simon Katterl Consulting, sub. 204, p. 5; Suicide Prevention Australia, sub. 214, p. 7.

> … without clear indicators or shared definitions of what constitutes meaningful participation, it becomes difficult to evaluate the effectiveness of lived experience roles and to demonstrate their value beyond anecdotal feedback.

Measuring the inclusion of people with lived and living experience commonly requires consideration of two dimensions: how decisions were informed by people with lived and living experience and the experience of those representatives in governance processes (Beyond Blue, sub. 156, pp. 8–9). Existing frameworks provide useful starting points for embedding measurement into governance arrangements. While many are designed for the service level, elements can be adapted to a national context. For example, the National Mental Health and Suicide Prevention Evaluation Framework offers a principles-based approach to the measurement of successful engagement with people with lived and living experience of suicide in governance (Roses in the Ocean, sub. 133, p. 11). The Mental Health Commission of NSW has also published a series of qualitative and quantitative indicators to evaluate inclusion of people with lived and living experience in governance forums (box 5.3). Beyond Blue (sub. 156, p. 9) noted measurement will 'likely require regular reporting that describes what outputs or processes have changed due to lived and living experience input, and an ongoing evaluation with lived and living experience representatives'. JFA Purple Orange (sub. 226, p. 19), encouraged regular feedback to be sought from people with lived and living experience and others on the governance forums.

Box 5.3 – Examples of qualitative and quantitative indicators to measure inclusion of people with lived and living experience in governance forums

Quantitative measures may include the:

- number of people with lived and living experience on governance bodies
- length of time on governance bodies and frequency of participation for people with lived and living experience
- number of groups and committees available
- number of recommendations and actions taken resulting from action items raised by, or related to, people with lived and living experience.

Qualitative measures may include asking lived and living experience representatives whether they:

- have positive or negative experiences as a member
- experience any issues with attending
- feel included and able to contribute to meetings
- have power to contribute to decision-making in the group.

Source: Mental Health Commission of NSW (2024, p. 30).

Embedding measurement of the inclusion of people with lived and living experience from the outset of the next agreement is critical. Agreeing upfront which dimensions of inclusion will be assessed and how, and incorporating these into terms of reference, can safeguard against tokenism and create genuine accountability. Inclusion indicators should be co-designed with lived and living experience representatives, and results published as part of progress reporting, to strengthen transparency and reinforce the agreement's commitment to meaningful inclusion.

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.

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.

Community-based service providers should play a greater role in governance

Australia has a diverse and engaged mental health and suicide prevention sector yet review participants noted a lack of engagement with service providers in governance arrangements (chapter 3). There was broad support for a stronger role for the sector in the governance arrangements of the next agreement.[51] Catholic Health Australia (sub. 181, p. 4) argued this will ensure the next national agreement 'is grounded in the realities of service delivery and better positioned to deliver integrated, timely and effective care'. At the same time, the National Mental Health Consumer Alliance (sub. 149, p. 11) raised concerns a greater role for the sector in governance could embed a

[51] APA, sub. 155, p. 4; APHA, sub. 163, p. 10; CHA, sub. 181, p. 7; CHF, sub. 140, p. 9; MHA, sub. 153, p. 13; Mind Australia, sub. 187, p. 12; QAMH, sub. 130, p. 8; ShantiWorks, sub. 157, p. 7; Suicide Prevention Australia, sub. 214, p. 5; VMPHAA, sub. 115, p. 5; WAAMH, sub. 172, p. 5.

preference for clinical approaches, and review participants underscored the value of incorporating the community-managed mental health sector (APA, sub. 155, p. 4; CHF, sub. 140, p. 9, QAMH, sub. 130, p. 8).

> The mental health sector is broad and dominated by clinical (hospital) services. It is vital that the next agreement gives a stronger voice to community-based and managed services and the people, their families, carers, kin and other supporters who use these services (APA, sub. 155, p. 4)

Involving the broader sector more systematically in governance would provide opportunities to bring together diverse clinical and non-clinical perspectives, including the expertise of peer workers, and ensure that the implementation of the agreement is informed by the full spectrum of service delivery.

Review participants acknowledged challenges related to conflict of interests (MHLEPQ, sub. 144, pp. 13–14; Suicide Prevention Australia, sub. 214, p. 6) and concerns that including the broader sector in governance could dilute input from lived experience expertise into governance processes (CoMHWA, sub. 148, p. 10; MHLEPQ, sub. 144, pp. 13–14). Practical approaches were suggested to manage these risks, such as drawing on sector peak bodies, requiring declarations of interest, or establishing a sector advisory group to provide high-level advice to MHSPSO rather than direct involvement in agreement development (Suicide Prevention Australia, sub. 214, p. 6).

The goal should not be to balance representation equally between service providers and people with lived and living experience, but to recognise the distinct and complementary contributions of each. Including the perspectives of service providers will strengthen the governance of the next agreement and support the development of a more effective system. This can be achieved in different ways, such as including designated roles for service provider representatives, including peer workers, in the agreement's working groups, enriching them with a more practical perspective on the implementation of the agreement. Alternatively, a sector reference group could be established to inform decision-making of senior officials.

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.

Governance forums should be transparent

Openness and transparency of government decisions are key drivers of public trust (APSC 2018) and can motivate governments to take effective action. Greater transparency of the agreement's governance forums would enable public accountability and trust.

Most ongoing decisions under the current Agreement are made in governance forums such as working groups and MHSPSO. These forums, and the decisions made in them, tend to be opaque. Public reporting of the work plans and outcomes delivered by MHSPSO and working groups is inadequate. The communication channels between working groups and MHSPSO are unspecified and decentralised secretariat responsibilities across working groups contribute to confusion (chapter 3).

Review participants agreed transparency of these governance forums would allow public scrutiny of the agreement's implementation and they could be more collaborative and effective[52] The next agreement should include actions to enable greater transparency.

- The roles of the different governance forums should be clearly articulated.
- Information on the participants and represented organisations on each working group should be publicly available.
- Public reporting on working group activities should include meeting frequency, detail on who is carrying responsibility for deliverables and progress of working groups (akin to the Implementation Plan Action Status Report published as part of the National Agreement on Closing the Gap reforms).
- A dedicated, well-resourced administrative function should be established to coordinate secretariats and streamline communication to provide more coherence across governance forums.

These steps will also contribute to more effective governance arrangements. Additional public reporting on working group composition and activities will contribute to greater accountability of those responsible for implementing the agreement. Clarity on the roles of governance forums and a dedicated administrative function will improve coordination and communication, making governance forums more efficient.

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.

5.4 Accountability mechanisms must be bolstered

Accountability is a key aspect of any national agreement – and one lacking in the current Agreement (chapter 3). The next agreement should include actions to improve accountability, including giving the NMHC greater authority and making data more accessible to the community.

Oversight bodies should be empowered through the next agreement

The current Agreement states governments will consider a role for the NMHC in monitoring (clause 102h). The NMHC has an oversight and reporting role in the Agreement, compiling two National Progress Reports; however, these reports were limited in their scope and their publication was significantly delayed due to jurisdictional approvals processes (chapters 2 and 3).

[52] APA, sub. 155, p. 4; MHA, sub. 153, p. 13; MHCC, sub. 120, p. 6; Suicide Prevention Australia, sub. 214, p. 5; ZSIA, sub. 238, p. 5

The next agreement should designate the NMHC as the body responsible for national monitoring and reporting against the agreement's objectives and empower it to fulfill its reporting role. Review participants agreed the NMHC, as an independent statutory body with expert knowledge of the mental health and suicide prevention system, would be the right body to continue in this role.[53] This aligns with one of the NMHC's core functions to report on the mental health and suicide prevention system more broadly (NMHC 2024c).

The ability to effectively monitor the system and the agreement depends on the capacity and authority of the NMHC. Since October 2024, the NMHC has been operating within the Department of Health, Disability and Ageing (DHDA) as a non-statutory body reporting to the Minister of Health, Disability and Ageing in relation to its core functions (DoHAC 2024g, p. 3). The Australian Government is currently undertaking a review of the future operating arrangements of the NMHC. As part of this review, several reform options have been proposed, including the possibility of establishing the NMHC and NSPO as a single statutory office within the DHDA, reporting to the Department on administrative matters only. In the interim report of this review, as well as in previous inquiries, the PC recommended establishing the NMHC as an independent statutory body (2020, p. 1131). Review participants likewise stressed only statutory independence would enable the Commission to credibly fulfil its role.[54]

> The NMHC must be re-established as an independent standalone statutory agency to deliver this function effectively. Such independence is integral to enabling the NMHC to monitor delivery of the National Agreement commitments appropriately, and provide the frank and fearless advice to governments and the public necessary on implementation and outcomes achieved. (MHA, sub. 76, p. 23)

Statutory powers are the norm for bodies tasked with scrutinising public sector performance (DoF 2021). For the NMHC to carry out its monitoring role effectively and instil confidence in its oversight, it should be established as an independent statutory body.

This recommendation assumes the NSPO would transition alongside the NMHC, with statutory independence applied to both. If, however, the NSPO were separated from the NMHC, it should have the same level of independence. In either case, statutory independence for both oversight bodies is the foundation of public accountability in the next agreement.

Given the importance of the NMHC's monitoring and reporting role in maintaining accountability within the Agreement, the NMHC should be given legislative powers to make reasonable requests for information in the course of its monitoring and reporting responsibilities. Allowing the NMHC to report independently will also reduce delays to public reporting, currently held up by jurisdictional reporting (chapter 2). If jurisdictions are tardy in reporting under the next agreement, the NMHC would be able to independently assess the jurisdictions' progress and clearly identify the limitations caused by the lack of jurisdictional input. The NMHC should not delay their reporting to accommodate jurisdictional delays as this has been detrimental to both accountability and transparency of progress in the current Agreement. The requirement jurisdictions approve publication of the report should be removed for the next agreement.

The PC has previously recommended legislative powers for the NMHC to compel information from Australian, state and territory government agencies when required to fulfil its statutory functions (2020, p. 1127). Review participants noted the importance of these powers to enable the NMHC to undertake

[53] Beyond Blue, sub. 156, p. 1; LELAN, sub. 190, p. 16; Lifeline, sub. 128, p. 2; MHCC, sub. 120, p. 3; MHV, sub. 215, p. 6; Orygen, sub. 169, p. 4; PHN Cooperative, sub. 208, p. 19; SIHA, sub. 227, p. 4; Suicide Prevention Australia, sub. 214, p. 5; ZSIA, sub. 238, p. 5.

[54] LELAN, sub. 190, p. 16; Maria Katsonis, sub. 117, p. 4; MHCA, sub. 205, p. 10; MHV, sub. 215, p. 6; Neami National, sub. 63, p. 5; NMHCA, sub. 149, p. 15; PHN Cooperative, sub. 208, p. 14; Simon Katterl Consulting, sub. 204, pp. 5–6.

effective monitoring and reporting (APHA, sub. 163, p. 10; Brain and Mind Centre, sub. 227, p. 3; LELAN, sub. 190, p. 16; MHA, sub. 153, p. 14; MHLEPQ, sub. 144, p. 8; SIHA, sub. 237, p. 4). Te Hiringa Mahara, New Zealand's Mental Health and Wellbeing Commission, as an independent monitor, has legislative power to request data from organisations that hold or collect information and data needed for monitoring. This power has been exercised regularly, its existence has lent authority to the Commission and encouraged organisations to provide data promptly, particularly in the early years of reporting (Te Hiringa Mahara, pers. comm., 19 August 2025).

The NSPO should also play a role in overseeing the next agreement and assessing its impact. The NSPO's subject matter expertise, stakeholder relationships and work on the National Suicide Prevention Outcomes Framework will be beneficial in this process. Review participants were supportive of the NSPO being tasked with monitoring and reporting on progress against the suicide prevention schedule (chapter 8) (APHA, sub. 163, p. 10; Lifeline, sub. 128, p. 2; PHN Cooperative, sub. 208, p. 19; Turner Institute for Brain and Mental Health, sub. 242, p. 8). However, they noted the importance of it being given requisite independence to effectively undertake this role (PHN Cooperative, sub. 208, p. 19). The NSPO should also be given an advisory role in the monitoring and reporting requirements of the core agreement, enabling them to contribute to assessing progress where it is most relevant to suicide prevention, as well as its role in monitoring progress in the implementation of the suicide prevention schedule (chapter 8).

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).

Public reporting on progress of the agreement should be improved

The publication of governments' performance information is important for accountability, transparency and continuous improvement (ANAO 2025). It facilitates monitoring of what is working and what needs improvement and helps hold governments accountable for the timely implementation of their commitments. While the current Agreement includes commitments to ongoing monitoring and public reporting, in practice this reporting has been ineffective (chapter 2).

Enhancing national reporting

In developing the national progress reports, the NMHC is confined to using information provided by the jurisdictions and is required to seek approval from the jurisdictions before publication (chapter 2). As

discussed above, the NMHC should be empowered to act as an independent assessor of progress. This should extend to reporting on progress using information gathered from service providers, consumers, carers, lived and living experience groups and commissioning agencies. This would allow the NMHC to validate the jurisdictions' assessments and enable reporting on progress from a range of perspectives beyond governments. The jurisdictions have a possible conflict of interest if they are both responsible for the successful implementation and judging the success of the Agreement.

Review participants have also suggested improvements to what is reported. For example, participants argued to include carer outcomes (Mental Health Carers Australia, sub. 73, p. 13), and cover whole-of-government commitments (Lifeline Australia, sub. 8, p. 6), including reporting requirements for non-health departments (Ruah Community Services, sub. 14, p. 11). Focusing on outcomes rather than service throughputs and activities can better measure the scale of the problem and the agreement's effectiveness (Lifeline Australia, sub. 8, p. 3; Marathon Health, sub. 10, p. 4; Ruah Community Services, sub. 14, p. 8). However, additional reporting should align with other efforts to improve data availability.

> The next Bilateral Schedule should avoid data collection or reporting requirements which are inconsistent with national agreements and systems … Joint performance and reporting arrangements need to be established for co-funded initiatives to reduce fragmentation and duplication of effort. (NSW Health, sub. 90, p. 4)

The current Agreement reflects an intent to report on progress towards objectives and outcomes. However, measures and indicators are yet to be developed and therefore are missing from reporting (chapter 2) (NMHC 2024a, p. 17).

Progress reports under the next agreement should include consumer and carer outcome measures, based on improvements to data collections (chapters 2, 4). Reporting should also include information gathered from non-health departments related to whole-of-government reform and the social determinants of mental ill health and suicide.

Beyond national progress reporting, there is limited transparency over how the Agreement is being implemented, as annual jurisdictional performance reports and implementation plans are not made public. Publishing these would improve understanding of progress, help hold governments to account for delayed commitments, and may help motivate regional action.

> Visibility of implementation plans including good practice examples, and progress reports are a valuable tool for PHNs and LHNs to engage local stakeholders and are essential for reviewing implementation progress and ensuring plans remain responsive to evolving local needs. Seeing regional-level activity in the context of a national program provides further impetus for local stakeholder participation. (PHN Cooperative, sub. 208, p. 18)

The Fifth National Mental Health and Suicide Prevention Plan and the Gayaa Dhuwi (Proud Spirit) Declaration set a precedent for this practice by publishing implementation plans (Gayaa Dhuwi (Proud Spirit) Australia 2025a; NMHC 2021a).

Review participants were supportive of improving transparency by requiring state and territory governments to publish annual jurisdictional performance reports as well as implementation plans developed under the next agreement.[55]

[55] APHA, sub. 163, p. 10; CHF, sub. 140, p. 9; MHA, sub. 153, p. 14; Orygen, sub. 169, p. 4; PHN Cooperative, sub. 208, p. 18; Suicide Prevention Australia, sub. 214, p. 5.

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.

Enhancing regional reporting

While the Agreement includes commitments to ongoing monitoring and public reporting at the national, state and territory level, transparency at the regional level is limited. Review participants identified the following issues due to the lack of regional reporting:

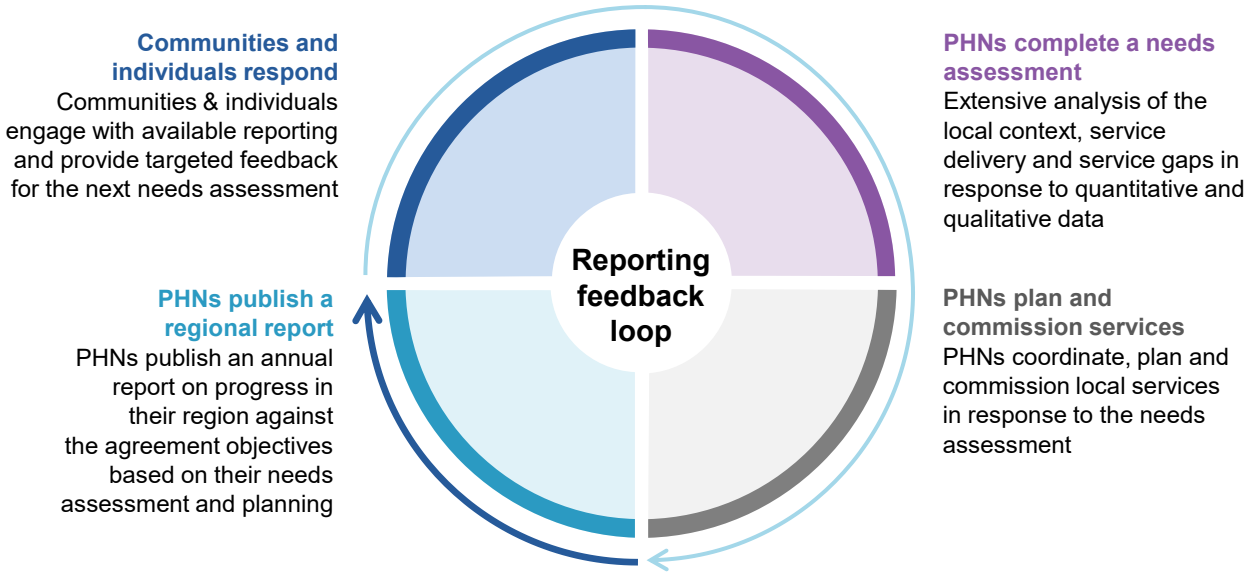
- difficulty in understanding what services are available in each region (Suicide Prevention Australia, sub. 59, p. 9)
- difficulty for service providers and PHNs in seeing whether needs are being met (PHN Cooperative, sub. 208, p. 15)
- limited visibility of funding per region (Suicide Prevention Australia, sub. 59, pp. 9–10) or how effectively investments translate into outcomes (PHN Cooperative, sub. 208, p. 20)
- lack of consistent measures (Suicide Prevention Australia, sub. 59, p. 9) and inability to compare outcomes between regions (Sidney Allo and Janet Timbert, transcript, 19 August 2025, pp. 22–23)
- lack of effective feedback loops for commissioning and planning (PHN Cooperative, transcript, 21 August 2025, p. 20).

These issues could become more pronounced with the recommended shift towards collaborative commissioning of services by PHNs and local hospital networks (LHNs) (recommendation 6.3). Since responsibility for commissioning a greater proportion of services will sit with PHNs and LHNs, accountability also needs to operate at that level.

Government has prioritised the visibility of regional-level outcomes data in other domains, acknowledging its importance and feasibility. For example, the Regional Insights for Indigenous Communities report (RIFIC) provides local-level statistics about the health and wellbeing of Aboriginal and Torres Strait Islander people to support joint planning and track progress towards Closing the Gap targets (AIHW 2025l). Similarly, the Data Governance Forum (DGF) helped progress some of the Agreement's commitments to data sharing through coordinating the publication of detailed regional profiles of mental health service activity (chapter 2).

The next agreement should task PHNs with publishing reports on progress towards the next agreement's objectives at a regional level. This would provide a clearer line of accountability for regional bodies to demonstrate how they are addressing service gaps, not only upwards to governments but also outwards to the communities they serve (PC 2020, p. 1224). These reports could help service providers better identify unmet need and allow PHNs to compare their activities and performance with similar regions. They would also provide a shared framework of understanding to help communities and consumers provide clear, constructive critiques on how effectively their needs are being met, contributing to a positive feedback loop (figure 5.2).

Figure 5.2 – Regional reporting will help close the feedback loop between communities and PHNs[a]



a. The light arrows indicate existing processes, while the dark arrows indicate process gaps.

Publishing regional reports on agreement progress would not constitute a whole new reporting system, but rather a practical extension of what PHNs already do. Most necessary information can be sourced from administrative reporting, pre-existing needs assessments that bring together data from a range of sources[56] (DoH 2021; DoHAC 2025d) and regional plans that summarise local priorities and commissioned services.

Collating this material into a regional report in a consistent, structured format would make it accessible and more easily comparable across regions; figure 5.3 presents a possible structure.

Figure 5.3 – A consistent structure for regional reports can ensure that they are accessible and comparable

[56] Data sources that support needs assessments include national (ABS, AIHW, MBS/PBS, etc), state and local jurisdiction datasets, service provider and workforce data, local hospital and government sources, survey data, and reporting from commissioned services (DoH 2021, pp. 9–11).

DHDA should develop a regional report template, or list of minimum requirements for regional reporting, promoting comparability between reports while leaving space for PHNs to adjust the format and content of their regional reports based on local context. DHDA should also collaborate with PHNs to identify and address barriers to regional reporting such as limited access to regional health workforce data or jurisdictional and national databases (PHN Cooperative, sub. 69, p. 9). PHNs should publish regional reports annually and they must be appropriately resourced to take on this additional reporting requirement. These reforms would ensure regional reporting under the next agreement is not only feasible but also credible, consistent and impactful.

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.

Improving the accessibility of reporting

To promote transparency, reporting on the next agreement needs to be carried out in ways that consumers, carers, service providers and the community can easily understand and engage with. This will help build trust in the system (JFA Purple Orange, sub. 226, p. 12).

When reporting is not designed for a broad audience, it risks serving only government and technical users rather than the consumers and communities most affected by mental health and suicide prevention reforms. Improving the ease with which consumers, carers, service providers and organisations can understand actions and achievements related to the agreement will improve the feedback loop between governments and the community (figure 5.2). This will support continuous improvements in mental health policy and service provision (Cobb et al. 2018, p. ii; NMHCA, sub. 149, p. 23).

Better accessibility requires a range of actions – not just a data dashboard

One option to improve accessibility is the creation of a public-facing data dashboard. Data dashboards generally consist of a set of summary graphs paired with contextual information to provide a clear, at-a-glance view of a system. They allow users to compare performance between indicators and over time, and provide a central place for the measurement, monitoring and reporting of progress. Government agencies often use dashboards to provide an overview of system performance or progress against a set of commitments and goals.

Submissions to this review were generally supportive[57] or conditionally supportive[58] of the development of a dashboard to track and report on progress of the next agreement. Reasons for support included the potential for dashboards to improve the transparency, accountability and accessibility of public reporting of progress[59] and to motivate system change (Medibank, sub. 198, p. 6; PHN Cooperative, sub. 208, p. 20). Review participants also hoped the dashboard could help inform consumer choice of services (BEING – Mental Health Consumers, sub. 141, p. 12; NMHCA, sub. 149, p. 23), as well as lead to more detailed data collection and publication.[60]

There are risks and costs associated with establishing a new dashboard. A dashboard to track agreement progress would likely duplicate reporting from the national annual progress reports and existing AIHW dashboards, which already provide extensive public reporting on mental health and suicide prevention.[61] Reporting duplication can create additional administrative burden on data providers (Beyond Blue, sub. 156, p. 9; PHN Cooperative, sub. 208, p. 20), and risk confusing users through multiple presentations of the same data, potentially leading to inconsistency in interpretation. Creating a dashboard requires significant investment to employ an appropriate team of data visualisation specialists, and continual employment of a smaller maintenance team. Review participants raised other concerns, including that a poorly designed dashboard could perpetuate deficit framings of Aboriginal and Torres Strait Islander people (VACCHO BDDC, sub. 162, pp. 15–16) or entrench existing data gaps (Centre for Community Child Health, sub. 183, p. 1).

While the format of reporting – whether a dashboard, statistical document or another product – can influence accessibility, it is only one part of a wider system. Most submissions framed their support for a dashboard as an effective way to achieve stronger accountability and transparency. A well-designed dashboard alone cannot overcome fundamental barriers such as delays in reporting, unclear communication, or poorly specified goals (chapter 2), and would likely risk duplicating existing reporting while diverting resources away from more cost-effective solutions to improve accessibility.

Accessible reporting requires timely data, clear communication and relevance to consumers and communities. A number of recommendations made across this review will contribute towards creating a reporting system that offers timely, clear and meaningful information to the community – without the additional cost of creating a new dashboard (figure 5.4).

[57] AHPA, sub. 178, p. 7; APHA, sub. 163, p. 10; BEING – Mental Health Consumers, sub. 141, p. 12; CHA, sub. 181, p. 28; CHF, sub. 140, p. 9; Medibank, sub. 198, p. 6; MHCA, sub. 205, pp. 16–17; MHLEPQ, sub. 144, p. 13; Relationships Australia Victoria, sub. 193, p. 6; Suicide Prevention Australia, sub. 214, p. 10; Victorian and Tasmanian PHN Alliance, sub. 154, p. 2; Youturn, sub. 170, p. 4.

[58] APA, sub. 155, p. 5; Beyond Blue, sub. 156, p. 9; FASSTT, sub. 223, p. 8; LELAN, sub. 190, p. 17; MHA, sub. 153, p. 14; NMHCA, sub. 149, p. 23; PHN Cooperative, sub. 208, p. 20.

[59] LELAN, sub. 190, p. 17; MHA, sub. 153, p. 14; NMHCA, sub. 149, p. 23; Suicide Prevention Australia, sub. 214, p. 10.

[60] AAPi, sub. 109, p. 7; Medibank, sub. 198, pp. 9–10; MHCA, sub. 205, pp. 16–17, PHN Cooperative, sub. 208, p. 20; Suicide Prevention Australia, sub. 214, p. 11.

[61] These include AIHW dashboards in the mental health monitoring and performance report (2025g), and the suicide and self-harm monitoring system (2025o). These include AIHW dashboards in the mental health monitoring and performance report (2025g), and the suicide and self-harm monitoring system (2025o).

Figure 5.4 – A suite of reforms to enable more accessible reporting

Goal		
People have access to information about mental health and suicide prevention reforms that is easy to understand and use		
Enhancements to improve reporting		
Timely	**Clear**	**Meaningful**
• Routinely collecting survey data (rec 2.1) • NMHC should be able to compel information to fulfil its reporting requirements (rec 5.6) and publish reports as they are finalised without requiring parties' sign-off (rec 5.7)	• Setting clear, measurable objectives and outcomes that link to the long-term vision (rec 4.2) • AIHW should lead the development of a nationally consistent set of outcome measures (rec 4.3) • Governments should publish all implementation plans and jurisdictional progress reports (rec 5.7) • PHNs should publish annual regional reports on progress against the objectives (rec 5.8)	• Using a co-design process to identify relevant and measurable objectives and outcomes (rec 4.3) • Strengthen consumer-focused reporting (finding 5.1) • Measure and report on progress in a strengths-based way for Aboriginal and Torres Strait Islander people (rec 7.1) • Dedicated reporting on the schedules (recs 7.1, 8.1 and 9.1)

Promoting accessibility through improvements to existing reporting

Enhancing existing reporting products can further improve accessibility. Submissions suggested several practical ways to make annual national progress reports more consumer-focused, including the use of plain-language summaries and accessible formats (CHF, sub. 140, p. 9; JFA Purple Orange, sub. 226, p. 12).

Consultation done for the NMHC's monitoring and reporting framework emphasised that lower literacy levels should be accommodated through plain-language writing (Nous Group 2018), while the Disability Royal Commission stressed the importance of formats such as Easy English, audio, video and accessible websites for people with disability (JFA Purple Orange, sub. 226, p. 12). Consideration of accessibility when choosing reporting type, writing style, visual aid design and the dissemination of the final product will elevate the national annual progress reports beyond compliance documents for government. Instead, they would become practical tools for accountability, transparency, community engagement and improved decision-making.

Complementary reporting products can also broaden accessibility. For example, the Australian Early Development Census (AEDC) produces a national report, short research snapshots on specific areas, key findings fact sheet, best practice examples, data deep dives and a webinar discussing the results (AEDC 2025). While the PC is not recommending that the NMHC publish all equivalent products, the AEDC is an example of how additional reporting can support and promote accessibility by tailoring publications to specific audiences and needs without duplicating information.

Another area for improvement is publication of underlying datasets. Where possible, releasing data disaggregated by geographic and demographic factors that is used to inform annual national progress

reports would support accountability at all levels and allow stakeholders to interrogate the data directly (Rock & Cross, 2020). This could strengthen transparency while avoiding duplication of reporting.

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.

5.5 Moving from fragmentation to integrated services

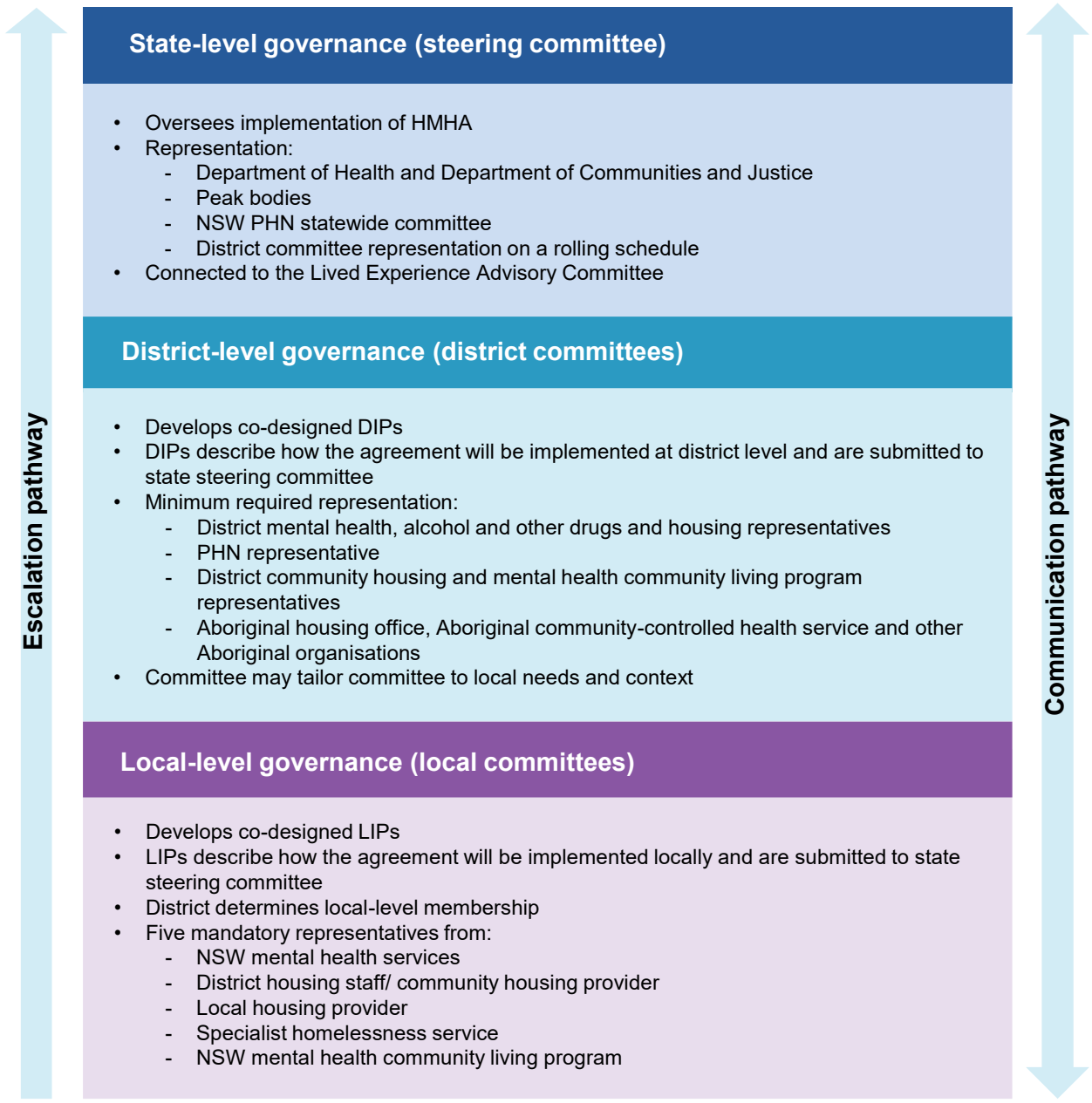
This chapter focuses primarily on national-level governance and better accountability to support whole-of-government integration in the next agreement. But the success of reform depends on more than cross-portfolio collaboration between senior officials. Real system integration requires coordination across portfolios (horizontal integration) and across the health sector (vertical integration), from the top levels through to service delivery where people experience the system as either fragmented or joined up. Participants in the PC's online survey reflected on the challenges of getting support from disjointed and siloed services (*What we heard* paper).

National whole-of-government reforms are therefore necessary, but not sufficient. A person-centred system also depends on collaboration at the regional and local levels across the health system and between health and social policy portfolios. Review participants suggested mechanisms to increase collaboration, including the development of regional governance mechanisms (Brisbane North PHN, transcript, 20 August 2025, pp. 48–50; Victorian and Tasmanian PHN Alliance, sub. 154, p. 2) and multidisciplinary team arrangements. The examples below, drawn from submissions and hearings, show governance and service models exemplifying a more person-centred, joined-up system. They highlight what is achievable but not yet common practice. Other enablers, such as planning and commissioning, are also critical to integration and are discussed further in chapter 6.

Regional and district level governance

The HMHA demonstrates how cross-portfolio collaboration can be operationalised through regional and local governance forums (figure 5.5). Alongside a state-level steering committee, co-chaired by health and housing officials, the HMHA guides the establishment of district and, over time, local committees. These committees enable collaborative service planning and delivery through the development of District and Local Implementation Plans (DIPs and LIPs). They are supported by formal requirements for lived-experience participation in governance and co-design of DIPs and LIPs (NSW Health 2022b).

Figure 5.5 – What is possible: District and local governance structures under the HMHA



Source: Adapted from NSW Health (2022b).

District committees have been established, and all DIPs are expected to be finalised by the end of 2025. Local committees and LIPs are at different stages of development and will become a key focus next year following finalisation of DIPs in the coming year (NSW Health, pers. comm., 9 September 2025). While the HMHA sets out a detailed governance framework, translation to consistent local practice will take time to emerge.

While it may not be feasible or desirable for the next national agreement to mandate governance structures across all jurisdictions, this example shows building integrated district and local governance structures is not only important but also possible. To move towards this model while also providing states and territories necessary flexibility, the next agreement could encourage state and territory governments to pilot and evaluate multi-layered governance models similar to the approach taken by the HMHA.

Integrated service delivery through cross-sectoral approaches and multi-disciplinary teams

Review participants offered many examples of mental health and suicide prevention services co-designed with people with lived and living experience with a cross-sectoral approach (for example, box 5.4). These initiatives demonstrate the breadth of opportunities for cross-sectoral approaches to service delivery and embedding lived experience in the design, governance and evaluation of services. With more flexible funding arrangements and stronger links between regional planning and commissioning, such models could be supported, tested and scaled to provide more integrated and person-centred care.

Review participants also raised multi-disciplinary care teams as a key mechanism to improve the consumer experience of the system.[62] Unlike clinical models, which participants noted tend to promote siloed care,[63] multidisciplinary team arrangements bring together multiple practitioners from varied occupational backgrounds to work collaboratively. Such arrangements have proven successful in achieving person-centred, integrated care (DoHAC 2023a; Mental Health Commission (Ireland) 2006, pp. 11–12).

> Integrated care models offer a critical opportunity to address persistent fragmentation across the mental health, health and human and welfare services. By bringing together multidisciplinary expertise … these models can support seamless transitions between community-based and acute care settings (Faculty of Medicine, Nursing and Health Sciences, Monash University, sub. 202, p. 9)

Box 5.4 – Review participant examples of co-designed, cross-sectoral approaches to service delivery

Housing and Accommodation Support Initiative (HASI) and Community Living Supports (CLS)

HASI and CLS are NSW-based programs to support people with complex mental health conditions to live and participate in the community. The programs offer tenancy support and support to access secure housing, clinical mental health supports and psychosocial supports. An evaluation of HASI and CSL showed most participants experienced positive outcomes, including improved wellbeing, being able to better manage their mental health, and increased opportunities for social inclusion.

The programs had a net cost saving of about $86,000 per person over five years. Over 90% of cost savings were due to less time spent in hospital (Homelessness Australia, sub. 112, p. 22; Mental Health Coordinating Council, sub. 120, p. 4; Purcal et al. 2022). The main factors identified for HASI and CLS's success were strong local partnerships between community organisations and local health districts, the person-centred approach and increasing focus on consumer choice, and the focus on early intervention (Purcal et al. 2022).

A review participant (Name withheld, sub. 119, p. 2) reflected:

> I had a very good experience during my time with the HASI program … The flexibility of outreach, friendliness of staff and assertive engagement within HASI met my needs, they even ensured that I got NDIS funding.

[62] Black Dog Institute, sub. 151, p. 10; ESSA, sub. 132, p. 3; Name withheld, sub. 123, p. 2; National Rural Health Alliance, transcript, 19 August 2025, p. 46; OTSi, sub. 146, p. 5; VMHPAA, sub. 115, p. 1.
[63] AHPC, sub. 206, p. 1; LELAN, sub. 190, p. 5; TAMHSS, sub. 191, p. 1.

Box 5.4 – Review participant examples of co-designed, cross-sectoral approaches to service delivery

The Gender Centre

The Gender Centre, established in NSW in 1984, is a multidisciplinary centre providing a broad range of services supporting transgender and gender expressive people to explore gender identity and assist with alleviating gender dysphoria. It offers a wide range of support services, from housing and employment support, counselling, mental health and allied health and outreach clinics. These services support people in regional and rural New South Wales and those who might otherwise not be able to access services, such as people in correctional facilities. It has established support groups, including for young people, adult transgender men, transgender women and non-binary people, partners and parents (Transgender Victoria, sub. 179, p. 19).

Jacaranda Place

Jacaranda Place provides integrated and multidisciplinary educational, vocational and mental health treatment services to young people with complex mental health conditions, aged 13–18 years (and up to 21 years in some situations). It is a partnership between the Queensland Department of Education and Children's Health Queensland, and is the only service of its kind in Australia (Children's Health Queensland 2023; Queensland Children's Hospital School 2025).

Jacaranda Place offers a day program for young people who require more support than a community service can provide and inpatient care to young people who require more intensive mental health care. Services are provided by psychologists, nurses, doctors, dieticians, exercise physiologists, occupational therapists, art and music therapists, speech pathologists, social workers, Aboriginal and Torres Strait Islander health workers, carer consultants and a peer workforce (Children's Health Queensland 2023).

Health Consumers Queensland was commissioned to support consumer and carer engagement in the co-design of Jacaranda Place. Over four years, more than 70 consumers and carers helped co-design the facility through face-to-face consultation, engagement and presentations by young people and carers about their journeys (Health Consumers Queensland 2025).

MATES in Construction

MATES in Construction was established in Queensland in 2008 to address the high levels of suicide in the construction industry. MATES provides mental health and suicide prevention support outside the health system and in employment settings, including training for workers and supervisors, a 24/7 helpline, an app for peer-to-peer volunteers, and a hub with mental health and suicide prevention tools (MATES in Construction, sub. 33, p. 2).

The Faculty of Health, Deakin University (sub. 174, p. 4) highlighted the effectiveness of MATES:

> MATES has shown a significant national decline in suicide rates among male construction workers—greater than that of other working males—highlighting the impact of sector-specific interventions. MATES combines peer support, mental health literacy, and stigma reduction within the workplace, supported by ongoing population-level surveillance and both non-experimental and experimental evaluations. This model illustrates the value of embedding suicide prevention in everyday work environments.

6. Funding and commissioning

Key points

- **The National Mental Health and Suicide Prevention Agreement contributes to the rigid and opaque funding of the community-based mental health and suicide prevention sector. Creating more flexible streams of funding through the next agreement will help rebalance the system towards non-clinical and innovative care that is responsive to local needs.**

- **The next agreement should implement four distinct streams of funding to support system integration and address service gaps. The funding streams 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 by primary health networks (PHNs) and local hospital networks (LHNs) in accordance with their joint regional needs assessments and plans**
  - **continued programmatic funding for initiatives funded under the current Agreement that have a strong evidence base**
  - **funding to support agreed priorities, including psychosocial and carer and family supports**
  - **funding for evaluations of service models delivered under the agreement and for a nominated body to act as a central information repository of evaluation and research findings.**

- **The next agreement should clarify the roles and responsibilities of PHNs, LHNs and Aboriginal and Torres Strait Islander Community Controlled Health Organisations. The agreement should enable greater collaboration and joint planning among these organisations.**

- **Further guidance, tools and supports for PHNs and LHNs to undertake effective and collaborative commissioning are needed. Governments can jointly deliver these through the next agreement.**
  - The Australian Government Department of Health, Disability and Ageing should commit to developing detailed guidance for PHN procurement, including guidance on joint procurement between PHNs and LHNs.
  - Australian, state and territory governments should streamline and align reporting and data collection for PHNs and LHNs engaging in collaborative commissioning.
  - Australian, state and territory governments should commit to using the National Mental Health and Suicide Prevention Planning Framework and task the Australian Institute of Health and Welfare with ensuring people with lived and living experience are consulted in its next update.
  - Australian, state and territory governments should jointly commit to data sharing, including sharing with and between PHNs and LHNs.

Building on the foundations recommended for a more effective mental health and suicide prevention agreement (chapters 4 and 5), this chapter looks at the ways in which agreement funding can be used to support an integrated and efficient mental health and suicide prevention system and how commissioning practices can be improved to enable best practice.

6.1 Agreement funding can be directed more effectively

Funding provided through the agreement influences the type of care and support people with lived and living experience and their supporters, family, carers and kin experience. Making the best use of this funding can lift productivity and have a material effect on outcomes. While the National Mental Health and Suicide Prevention Agreement funds initiatives that have had positive effects on consumers' lives, elements of the way this funding has been provided have been inefficient (chapter 3).

Some of the issues experienced within the Agreement's funding approach are present beyond the Agreement. Fragmentation of the mental health and suicide prevention system occurs in part because funding differs based on the type of care being provided, the level of government responsible and the funding mechanism being used (box 6.1). Few resources and incentives exist for collaboration and integration of care across these funding silos.

Box 6.1 – Expenditure on mental health and suicide prevention services, 2022-23

Several funding streams and mechanisms contribute to the mental health and suicide prevention system; funding provided through the Agreement is a small piece of the overall pie. In 2022-23, there was an estimated $12.6 billion of recurrent government expenditure on the mental health and suicide prevention system; $8 billion was spent by state and territory governments and $4.6 billion by the Australian Government. 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.

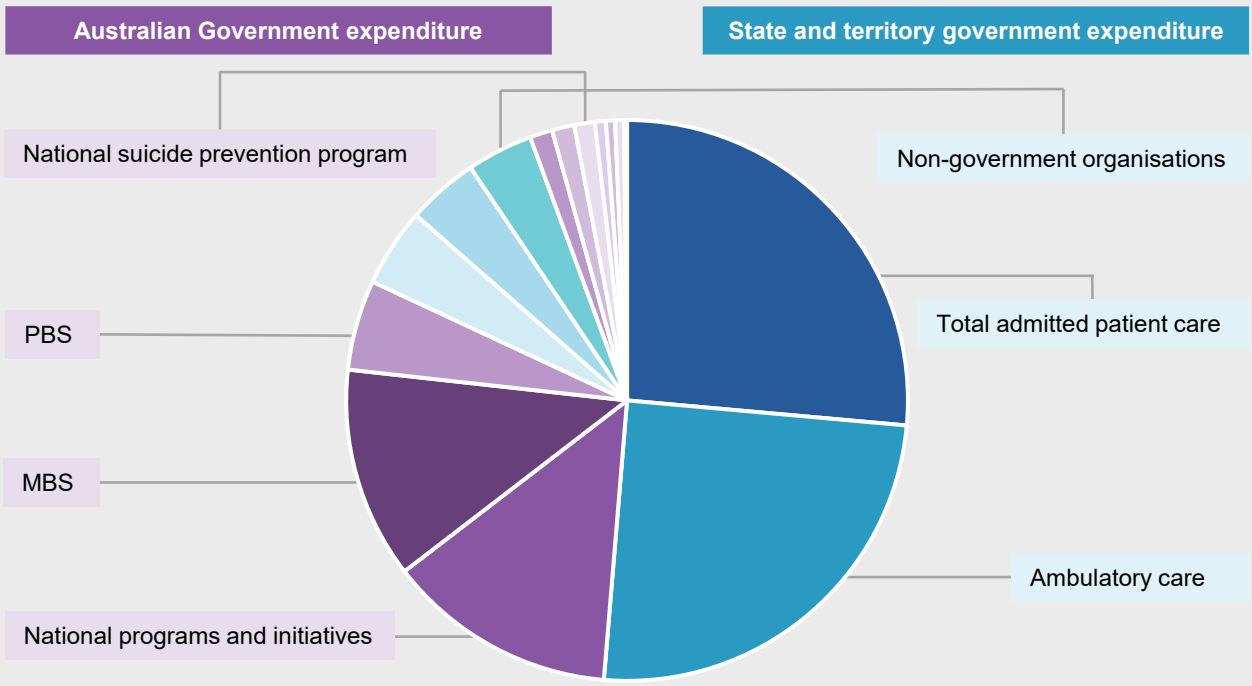
The National Health Reform Agreement (NHRA) governs $6.5 billion in mental health and suicide prevention funding (51%), including funding for admitted patient (tertiary care) and ambulatory care. The Australian Government provides funding under the NHRA to states and territories. State and territory governments co-contribute funding and manage service planning and provision through local hospital networks (LHNs). Most NHRA funding goes to hospital-based mental health care and suicide prevention. It also funds outpatient care and some community-based care. Typically, this funding is provided as activity-based funding. NHRA-funded community mental healthcare is transitioning to activity-based funding.

The Australian Government subsidises primary mental health and suicide prevention services through the Medicare Benefits Schedule (MBS) and pharmaceuticals through the Pharmaceutical Benefits Scheme (PBS), spending $1.5 billion and $659 million respectively. This funding includes general practitioner consultations, the Better Access initiative and prescription medications (primary care). The National Indigenous Australians Agency contributes a further $39 million in funding for mental health and suicide prevention services provided by Aboriginal and Torres Strait Islander organisations (NIAA, pers. comm., 14 October 2025).

Community-based and non-clinical mental health and suicide prevention services are funded through several streams, and the total amount is not clear in expenditure data. Funding provided by state and

Box 6.1 – Expenditure on mental health and suicide prevention services, 2022-23

territory governments to non-government organisations ($481 million), the Australian Government's funding of the National Suicide Prevention Program ($150 million) and social and emotional wellbeing ($65 million) gives an indication of the potential relative size of this funding. This is generally delivered through grants.



$317 million was provided under the Agreement in 2022-23, making up less than 3% of total mental health and suicide prevention funding. Funding is contributed by the Australian, state and territory governments, with 53% coming from state and territory governments over the life of the Agreement. The Agreement mostly funds community-based mental health and suicide prevention services.

Source: SCRGSP (2025); IHACPA (2023, pp. 14–15).

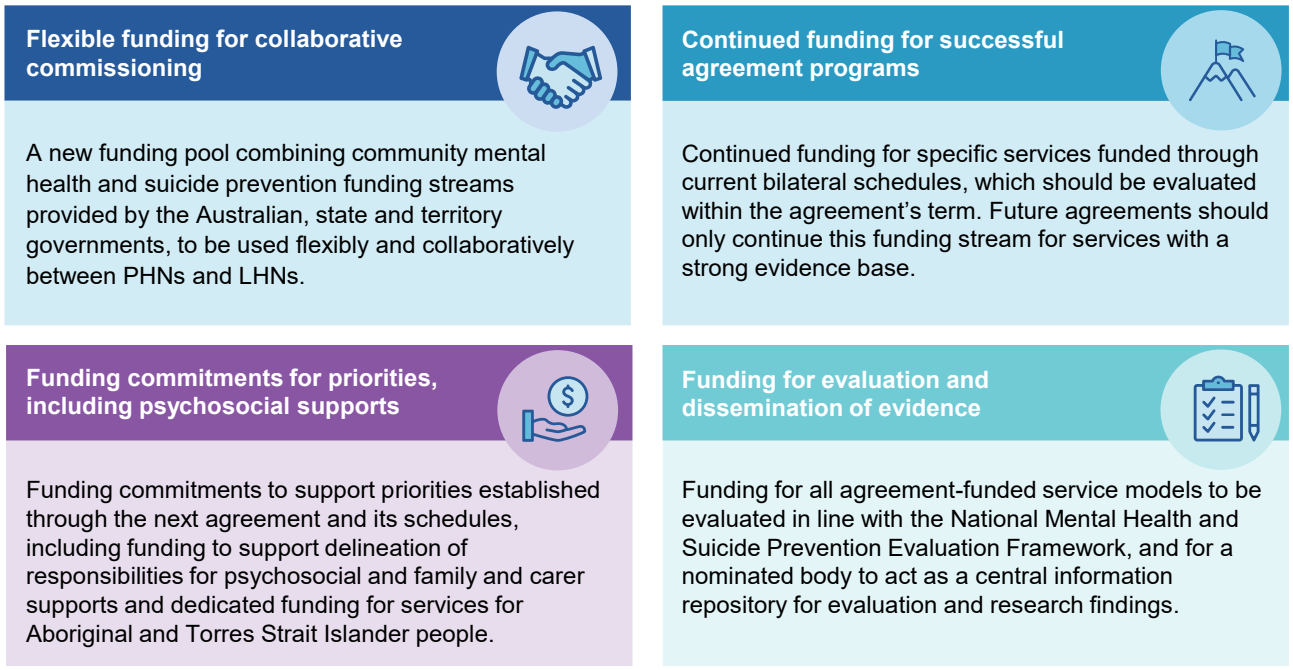
Given existing and well-established funding streams for tertiary and primary mental health care and suicide prevention (box 6.1), the next agreement would be well-positioned to continue focusing on funding community-based care. Review participants have reflected on the value of community-based care and the need for its expansion.[64]

However, the next agreement must work to overcome the impact of current funding fragmentation as it affects consumers' and carers' access to services (chapters 2 and 3). The way funding is provided must support the integration of care and direct funding towards evidence-based practice. The next agreement should also include funding arrangements for initiatives left unfunded in the current Agreement or funded ad hoc outside of the Agreement. This will ensure transparency and accountability and reduce service gaps.

The next agreement should include four funding streams to meet these goals (figure 6.1).

[64] Australian Psychosocial Alliance, sub. 155, p. 3; LELAN, sub. 190, p. 12; Mental Health Carers Australia, sub. 205, p. 6; Mind Australia, sub. 187, p. 11; Relationships Australia Victoria, sub. 193, p. 7.

Figure 6.1 – Four funding streams are needed in the next agreement



Given the Agreement represents a small share of expenditure in the mental health and suicide prevention system, restructuring its funding streams alone will not be sufficient to achieve broader goals of system reform and improvements to wellbeing. For example, review participants suggested changes to the Medicare Benefits Schedule (MBS) to increase access to and affordability of care (box 6.2). Such changes are outside the scope of this review, but are important context for the development of funding mechanisms for the next agreement.

Box 6.2 – Review participants argued for changes to MBS funding for mental health

The Better Access initiative gives Medicare Benefits Schedule (MBS) rebates to eligible people for mental health sessions. MBS rebates are available for up to 10 individual and 10 group allied mental health services per year. Many survey respondents said the number of sessions subsidised through the initiative is inadequate to support recovery.

> Ten sessions per annum is not enough for people with complex mental health disorders, and it does nothing but get peoples hopes up, gives them high amounts of anxiety when their sessions are "up". For people with complex trauma disorders and psychotic disorders, this is not good enough. (sr. 163)

> Severely sick people are not magically better after 10 weeks of treatment and cannot afford a $240 psychology appointment each week. (sr. 89)

> The current arbitrary cap of 10 sessions per year is inadequate and inconsistent with evidence-based recommendations. (sr. 128)

Participants also called for an expansion of services subsidised under the MBS and the inclusion of a broader range of mental health and suicide prevention professions in MBS-subsidised services. For example, participants called for the use of the Better Access initiative or other MBS item numbers to allow mental health nurses and nurse practitioners to provide services (Australian College of Nursing and

Box 6.2 – Review participants argued for changes to MBS funding for mental health

Australian College of Mental Health Nurses, sub. 30, pp. 6–7; sr. 164; Stephen Goldsmith, sub. 96, pp. 1–2), recognition of the role of care coordinators through MBS or other payment mechanisms (IUIH, sub. 81, p. 12) and direct access to MBS-subsidised psychologist sessions in specific situations like family and domestic violence (Australian Psychological Society, sub. 85, p. 3) and during and following natural disasters (sr. 128).

Source: DHDA (2025b).

Flexible funding is needed to enable effective local commissioning

Rigid and prescriptive funding undercuts the potential of local commissioning bodies (Bates et al. 2022, p. 14). The current Agreement funds primary health networks (PHNs) and local hospital networks (LHNs) to commission specific services or service areas listed in the state or territory's bilateral schedule. Some adaptation and co-design of these service models occurs, but it varies depending on the PHN. In some instances, contract negotiation with PHNs has allowed for the tailoring of agreed services to emerging local needs, but the need for negotiation has created delays in service delivery (Neami National, sub. 63, p. 15).

The Agreement's prescriptive funding approach can result in funded services not meeting local needs. For example, some prescribed services have been difficult to establish in regional areas given requirements about which professions can deliver which services (Marathon Health, sub. 10, pp. 3–4).

Rigid funding can also restrict the ways in which commissioning bodies operate, for example by not resourcing important commissioning processes like co-design and collaboration (Brisbane North PHN, transcript, 20 August 2025, pp. 47, 49). A prescriptive approach may also reduce incentives and opportunities for PHNs and LHNs to work together to respond to local needs.

Opportunities for flexible funding

Allowing PHNs and LHNs to make decisions about what services are needed and how they should be provided ensures commissioning is based on an understanding of local needs, done in partnership with stakeholders, and focuses on the outcomes that matter to consumers and communities (DoH 2019a). Flexible funding would support more innovative and effective commissioning, including commissioning more collaboratively within the health system and with local communities and providers (Koff et al. 2021, p. 297). Review participants noted the need for greater flexibility to enable commissioning that is locally relevant and collaborative.

> Allow for funding flexibility that is not attached to Commonwealth-prescribed services and outcomes, but the values, principles, and needs identified by Lived Experience at the community level. (National Mental Health Consumer and Carer Forum, sub. 68, p. 8)

> … Tasmania considers there is an opportunity during the development of a new National Agreement to allow Parties more flexibility in commissioning approaches, such as enabling flexible funding and shared working arrangements between government and community-sector organisations, which would ultimately enhance collaboration and innovation. (Tasmanian Government, sub. 78, p. 7)

Existing community-based mental health and suicide prevention funding could be used for this purpose, including the Mental Health Flexible Funding Pool provided by the Australian Government and other state and territory funding (box 6.3).

Box 6.3 – Funding streams for community-based mental health and suicide prevention services

In the Agreement, community-based mental health and suicide prevention is a shared responsibility across levels of government. In principle, state and territory governments are responsible for specialist community mental health (clause 40d) and the Australian Government is responsible for clinical and non-clinical community mental health (clause 34). Suicide prevention is a joint responsibility (clause 47e). In practice, governments fund similar services in the community.

The Australian Government provides funding to primary health networks (PHNs) for community mental healthcare and suicide prevention through three streams. These include:

- a quarantined portion of funding to commission headspace, Medicare Mental Health Centres and other select services, in addition to the current Agreement's funding for these services ($358 million in 2024-25)
- a flexible portion of funding to commission services for a select set of needs including suicide prevention, also known as the Mental Health Flexible Funding Pool ($344 million in 2024-25)
- a pool of funding for Aboriginal and Torres Strait Islander mental health services ($33 million in 2024-25) (DHDA, personal communication, 7 October 2025).

States and territories fund their own community-based mental healthcare and suicide prevention initiatives outside of the Agreement. In 2022-23, state and territory governments provided $481 million to non-government organisations for mental health and suicide prevention services. Funding to non-government organisations is for personalised support, residential mental health services, counselling, care coordination and other supports (AIHW 2025i). The amount of funding for non-government organisations as a proportion of total state and territory recurrent expenditure has decreased between 2013-14 and 2022-23 from 7.4% to 6% (SCRGSP 2025).

In some instances, this funding is used to provide similar services as those delivered through the Agreement and the Australian Government's Mental Health Flexible Funding Pool. For example, the Victorian Government's 2025-26 budget includes $34.5 million for Mental Health and Wellbeing Locals (akin to Medicare Mental Health Centres), $7.5 million for suicide prevention initiatives and $44 million for alcohol and other drug services – both service areas funded through the Mental Health Flexible Funding Pool (Victorian Department of Health 2025a).

There may be other streams of community-based mental health and suicide prevention funding that are not captured in this figure, such as funding that does not go to non-government organisations. For example, the NSW Government committed $30.4 million for local hospital networks (LHNs) (called local health districts in NSW) to employ community mental health teams to improve outreach, accessibility of services and coordination of care (NSW Government 2024). Some community-based mental health care is also funded under the NHRA as activity-based funding. However, this funding should not be brought into the next agreement as it relates to services delivered by public hospitals and is clinical in nature.

Both levels of government fund community-based mental health and suicide prevention services, reflecting their shared responsibilities in this area (box 6.3). This funding is somewhat opaque; it is often reported with other mental health and suicide prevention expenditure such as hospital spending, and there is no clarity about what is funded and how much is spent. However, this funding is intended to support community-based services that emphasise recovery and wellbeing promotion in community through non-clinical care

(QAMH 2025). These are the type of services the next agreement is likely to focus on, and which review participants have called for.[65]

Integrating the Mental Health Flexible Funding Pool and state and territory community-based mental health and suicide prevention funding into the next agreement would provide a pool of funding to support more effective and collaborative commissioning of mental health and suicide prevention services. There is currently insufficient detail in mental health and suicide prevention expenditure data to project the size of the flexible funding pool created if these funding amounts were combined under the next agreement. However, the size of select funding streams can give an indication of the potential size. In 2022-23, the Agreement included about $145 million in flexible funding,[66] the Australian Government provided $344 million to PHNs through the Mental Health Flexible Funding Pool and state and territory governments provided $481 million to non-government organisations for mental health and suicide prevention initiatives (DHDA, pers. comms., 25 September 2025; SCRGSP 2025). Pooling existing funding streams would likely provide close to $1 billion a year in community-based mental health and suicide prevention funding.

The agreement should play a role in identifying priorities to be funded through this flexible funding pool. For example, levels of funding for suicide prevention established through the current Agreement should be at least maintained by hypothecating a set amount of the flexible funding pool for suicide prevention (chapter 8). However, ensuring commissioned services meet local needs requires flexibility and not prescribing a service model to be commissioned.

Drawing together these streams of funding would increase transparency and accountability over funding for community-based mental health and suicide prevention services. Review participants noted the current lack of visibility and recognition of the community-based sector (Australian Psychosocial Alliance, sub. 155, p. 3; LELAN, sub. 190, p. 12; Ruah Community Services, sub. 177, p. 2). This is despite the sector 'providing more than 25% of services nationally' (Mind Australia, sub. 187, p. 11). The amount of funding available for community-based mental health and suicide prevention and the way it is used would come under the reporting and accountability requirements recommended for the next agreement (chapter 5).

Flexible funding should support greater collaboration

To achieve progress towards an integrated and person-centred mental health and suicide prevention system, flexible funding should enable collaboration. Collaboration reduces fragmentation and service gaps for consumers as well as administrative burden for service providers and offers efficiency gains for taxpayers (Bates et al. 2023, pp. 471–472). A range of participants emphasised the importance of collaboration in providing person-centred care (chapter 5).

> Services must interact with each other, breaking down the silos that currently fragment a person's care experience, often re-traumatising them as they continually repeat their story. (Open Dialogue Centre, sub. 135, p. 1)

> Integration of mental health and suicide prevention services is urgently warranted to overcome existing fragmentation, which hampers effective communication, collaboration, and continuity of

[65] Australian Psychosocial Alliance, sub. 155, p. 3; LELAN, sub. 190, p. 12; Mental Health Carers Australia, sub. 205, p. 6; Mind Australia, sub. 187, p. 11; Relationships Australia Victoria, sub. 193, p. 7.

[66] Flexible funding includes funding that was not earmarked for a specific model of service. However, the vast majority of this funding was hypothecated for a service area such as perinatal mental health screening, aftercare and eating disorder programs. Only3 million in 2022-23 was not hypothecated; made up of $1 million for PHN regional commissioning and governance in the bilateral schedule with the Victorian Government and $2 million for gaps in the system of care in the bilateral schedule with the South Australian Government.

> care. A unified and interoperable service system would foster timely information sharing among providers, ensuring individuals receive coordinated, person-centred support across their recovery journey. (Faculty of Health, Deakin University, sub. 174, p. 3)

Collaboration is not well supported by episodic funding mechanisms such as activity-based funding or rebates. Likewise, funding tied to a specific service model limits the scope for collaboration and does not allow funding to be used for enablers of collaboration. The current Agreement uses co-funding and co-location of services to encourage collaboration. Participants have warned co-location of existing services is not synonymous with integrated care (Movember, sub. 80, p. 5). While fragmentation has remained pervasive (*What we heard* paper), there is some suggestion that the approach has increased communication between funders. For example, PHN Cooperative (sub. 208, p. 4) explained:

> Some PHNs have been successful using the bi-lateral relationships to open new discussions on system issues, however other PHNs have found resistance at the regional level due to a lack of clear expectations and accountability mechanisms.

Flexible funding through the next agreement is an opportunity to directly fund collaboration. Joint needs assessments, plans and governance arrangements provide some of the structures needed for collaborative commissioning to occur between PHNs and LHNs. However, LHNs have relatively little incentive to engage with PHNs in commissioning community-based mental health and suicide prevention services. LHNs can have budgets 100–200 times the size of PHNs' (Bates et al. 2023, pp. 475–476) and are incentivised to focus primarily on hospital care for which they receive activity-based funding. Collaborating with PHNs to commission community-based mental health and suicide prevention services currently does not attract any additional funding for LHNs and, where doing so reduces hospital presentations, may reduce their activity-based funding. The use of financial mechanisms to adjust activity-based funding creates some incentive to reduce avoidable hospital readmissions (IHACPA 2025), including by engaging with the community-based sector.

Flexible funding for PHN-LHN partnerships would enhance incentives for the collaborative commissioning of community-based mental health care and suicide prevention. A shared pool of funding will enable PHNs and LHNs to overcome challenges navigating funding allocations and work towards providing integrated pathways of care for consumers and carers (Bates et al. 2023). Flexible funding should be disbursed to state and territory governments to create a pool of money available to PHN-LHN partnerships where they have completed joint regional mental health and suicide prevention needs assessments and plans. To maintain flexibility, this funding should not be ascribed to a specific service model. Quarantining funding for specific service areas, such as suicide prevention, may be necessary to ensure funding does not flow solely to service areas that are easiest to fund and manage (chapter 8).

Funding should also be made available for enablers of collaboration, not just for services and initiatives. For example, data and information sharing systems and performance monitoring systems are key drivers of successful integration but may require initial investment to establish (Koff et al. 2021, p. 299; Peiris et al. 2024, p. 9). This funding approach was supported by the Consumers Health Forum of Australia (sub. 140, p. 7):

> We strongly support the call for commitments and actions intended to improve collaboration across all government portfolios being included in the main body of the agreement and for the allocation of dedicated funding for collaborative initiatives and enablers of collaboration.

A set of guiding principles in the core agreement should establish these expectations for how the new funding pool should be used.

Longer funding cycles would support service continuity, development and evaluation

Short-term, insecure funding undermines effective mental health and suicide prevention service delivery (chapter 3). Some state and territory governments have made recent efforts to extend the funding cycles of service providers; for example, the Queensland Government has transitioned to 5-year contracts for social services organisations wherever possible (Queensland Government 2024). But this has not been a uniform change across all states and territories, nor has it been matched by the Australian Government.

> … Queensland Government's move to longer term (5 year) contracts has contributed to increased stability for services. However, delays at a national level in Commonwealth funding flowing to PHNs and then decision making by individual PHNs has had a negative impact on service provision. (QNADA, sub. 18, pp. 5–6)

Longer-term funding cycles would help establish trust with consumers, attract and retain skilled workers and support service development, innovation and evaluation while accountability can be retained through regular monitoring and reporting (chapter 3). These benefits will be especially important for services funded through the flexible funding pool, which may be delivered by smaller providers with a lesser ability to take on financial risk or liabilities, and newer service models requiring time to demonstrate their value.

The next agreement's flexible funding pool should embed a default funding cycle of five years with notice of renewal, cessation or alteration of funding at least six months prior to the end of the contract. This shift would align with recommendations made in the PC's Mental Health inquiry (2020, p. 843) and the House of Representatives Select Committee on Mental Health and Suicide Prevention's inquiry into mental health and suicide prevention (SCMHSP 2021, p. 216).

Funding should continue for services and initiatives under the Agreement that improve consumer outcomes

The Agreement funds important services and initiatives that provide substantial benefit to consumers. These existing services and initiatives should continue to be funded alongside new streams of funding in the next agreement. In some cases, such as universal aftercare and perinatal mental health, funding will be available through the flexible funding pool (discussed above). Funding for specific programs, including headspace, the Medicare Mental Health Centres and Satellite Network, StandBy Support After Suicide, Distress Intervention Trial Program, Initial Assessment and Referral Decision Support Tool (IAR Tool) and National Phone Digital Intake Service, requires more consideration.

Programmatic funding should be used strategically

There are circumstances where programmatic funding – where the agreement specifies the type of service to be provided – can have benefits, such as continuity of services or cost savings. Programmatic funding may be appropriate where:

- a service model has a strong evidence base and is the best possible value for money, thereby negating the benefits of local decision making
- there are economies of scale that could be achieved by centralised provision of that service.

Current mental health and suicide prevention funding, including funding provided through the current Agreement, does not explicitly take this strategic approach to programmatic funding. The share of funding that is provided to PHNs for specific programs has grown significantly over recent years, far outpacing growth in flexible funding. Between 2018-19 and 2024-25, the proportion of PHN mental health funding

quarantined for specific services like headspace increased from 32% to 47% (DoH 2018b, p. 5; DHDA, pers. comm., 1 October 2025). The Agreement added to this programmatic funding, with the bilateral schedules mostly funding headspace and Medicare Mental Health Centres and Satellite Networks (chapter 3).

As centre-based models of care, economies of scale are unlikely, but it is possible these services provide the best value for money available. There is insufficient evidence for governments to decide whether these services provide value for money. headspace has been evaluated but there has not yet been robust evaluation of the Medicare Mental Health Centre model (box 6.4). The lack of evaluation of comparable services further hinders governments' ability to decide whether these service models constitute the best value for money.

Other programmatic funding, such as that provided for the IAR Tool and National Phone Digital Intake Service, may be justified on the basis that centralised funding for digital tools and services can offer cost savings and a national roll out produces economies of scale compared to local development of individual digital tools and services.

Box 6.4 – Insufficient evaluation of services receiving programmatic funding

headspace was last evaluated in 2022. The evaluation found the headspace model was effective at improving mental health literacy, early help seeking and access to services, but it had mixed success with supporting 'hard to reach' groups and providing culturally appropriate and inclusive supports. It found psychosocial outcomes improved for headspace users but not at clinically significant levels and not for all users. External barriers to headspace's effectiveness were identified, including limited referral pathways, workforce shortages, high demand and complexity of presenting need.

The evaluation estimated headspace cost $44,722 per quality-adjusted life year gained, which is cost-effective compared to other similar healthcare services. It also recommended changes to the headspace model to improve its effectiveness, including enhancing workforce diversity to better represent 'hard to reach' groups, better using PHNs' local needs analysis to inform headspace service commissioning and improved outcome monitoring.

The Medicare Mental Health Centre and Satellite Network model has not been thoroughly evaluated. There has been an early implementation co-evaluation of five Medicare Mental Health Centres, but given the small sample size and early stage of the centres' implementation, the findings are not robust enough to establish a strong evidence base for the service model. The evaluation did however make promising early findings of positive consumer experiences and extended reach to consumers who may not have otherwise accessed support.

Source: KPMG (2022); Neami National (2024).

Overall, the next agreement should take a more strategic approach to programmatic funding that measures the benefits of funding specific programs against the costs. Without a sufficient evidence base to make these decisions, the next agreement can take steps towards this approach by continuing programmatic funding for existing services and prioritising evaluation of these services as part of a broader effort to expand evaluation (section 6.2). Future agreements should then fund specific programs only when governments can be assured they are providing the best value for money or where there are economies of scale.

Priority areas will require funding commitments

Many of the current Agreement's commitments lacked funding (chapter 3). In particular, funding was not included in the Agreement for psychosocial supports, carer and family supports, workforce initiatives or services for Aboriginal and Torres Strait Islander people. These represent ongoing priorities that require committed and ongoing funding.

Governments must clarify responsibilities for psychosocial supports and carer and family supports within the next agreement (chapters 2 and 4). Specifying both Australian and state and territory government contributions to funding psychosocial supports and carer and family supports would ensure existing funding contributions continue. However, this must be done in tandem with intergovernmental funding transfers where state and territory governments are expected to provide large amounts of additional funding to the mental health and suicide prevention system.

In 2020, the PC estimated state and territory government expenditure would have to grow by $373–1,085 million per year to meet the existing gaps in the provision of psychosocial supports (2020, p. 1147). Given state and territory governments' limited capacity for revenue raising, it is likely Australian Government funding will be needed to support this expenditure growth.

The next agreement will also need to clarify responsibilities for carer and family supports. Additional funding transfers may be necessary as a result. It is difficult to estimate the required expenditure without sufficient data on the unmet needs of supporters, family, carers and kin of people experiencing mental ill health and suicide. However, anecdotal evidence from our survey suggests there are substantial gaps in services (*What we heard* paper).

Other priorities established through the next agreement and its schedules will require funding commitments to enable reform. For example, workforce initiatives are currently funded through ad hoc budget commitments, limiting transparency and accountability for funding and longer-term actions (chapter 4). Likewise, funding for services for Aboriginal and Torres Strait Islander people comes from multiple government departments and with different priorities and governance structures. Including funding in a schedule for services for Aboriginal and Torres Strait Islander people enables oversight by its own governance structure and reduces fragmentation (chapter 7).

An evaluation uplift is needed to inform funding decisions

Evaluations help direct funding towards best practice services, but they can be costly. Review participants emphasised their importance (APHA, sub. 163, p. 14; Manna Institute, sub. 194, p. 6; MESHA, sub. 175, p. 5; Mental Health Australia, sub. 153, p. 15).

> Robust monitoring and evaluation are essential to understanding what works, for whom, and in what context. They provide the evidence base needed to inform continuous improvement, guide investment decisions, and ensure that mental health reforms outlined in the next Agreement delivers meaningful outcomes for the sector. (Catholic Health Australia, sub. 181, p. 36)

> [Research, evaluation and data collection] are crucial for informing best practices and guiding policy improvements. Embedding research within mental health reforms is vital to driving meaningful change. (Youturn Limited, sub. 170, p. 4)

Evaluation of mental health and suicide prevention service models are ad hoc. Only some initiatives funded under the bilateral schedules were evaluated in recent years (although mostly prior to the Agreement's signing). For example, there have been recent evaluations of headspace (KPMG 2022), the Head to Health Digital Mental Health Gateway (Bassilios et al. 2022) and The Way Back Support Service (Nous

Group 2022), all commissioned by the then Department of Health (DoH). There has also been a self-initiated early implementation co-evaluation of five Medicare Mental Health Centres (Neami National 2024).

Evaluation plays an important role in developing effective models of care (Faculty of Medicine, Nursing and Health Sciences, Monash University, sub. 202, p. 10). But it can be costly and smaller organisations often lack adequate resourcing to undertake evaluation (Mental Health Association of Central Australia, sub. 166, p. 2). The evaluation clause in the bilateral schedules suggests evaluation is a shared responsibility of Australian, state and territory governments. The clause commits both levels of government to require evaluations to be conducted for services funded through the bilateral schedule; however, it does not commit any funding for evaluations. Funding for evaluation should be embedded in the next agreement to ensure all models of care can be evaluated.

High-quality and comparable evaluations are crucial for governments and commissioning bodies to achieve value for money. The National Mental Health and Suicide Prevention Evaluation Framework and associated guidelines developed under the current Agreement could uplift the quality of evaluations and create greater consistency across evaluation practices to allow comparison of programs. The next agreement should require evaluations to be conducted for all funded service models in line with the Framework.

Review participants also detailed the benefits of broader research, including improving access to emerging and effective treatments and equipping policy makers with the best available evidence (Black Dog Institute, sub. 151, p. 8). They also noted the need for greater funding (Black Dog Institute, sub. 151, pp. 7–8; MESHA, sub. 175, p. 3; Youturn Limited, sub. 170, p. 4). Mental health and suicide prevention research is a shared responsibility of Australian, state and territory governments (clauses 37i and 40i); universities and the private sector also play a substantial role (Medibank Private Limited, sub. 198, p. 3; Faculty of Medicine, Nursing and Health Sciences, Monash University, sub. 202, p. 10).

Dissemination of evidence and knowledge translation are crucial to enable evaluation and research to improve consumer outcomes. There is room for improvement in the use of evidence and evaluation to direct mental health and suicide prevention expenditure (Cutler et al. 2023, p. 21). In addition, not all ongoing monitoring and evaluation of programs is made public. One evaluation of headspace suggested there is an ongoing process of evaluation occurring internally but only select findings from this process were made public (KPMG 2022, p. 81).

A central information repository for research and evaluation findings would support governments and commissioning bodies to draw from current evidence of best practice when designing or choosing services for their communities, and to benchmark the performance of individual services against evaluated service models. Publishing findings would support consumers to exercise choice when accessing services and strengthen accountability for public expenditure and service delivery.

Several existing bodies could contribute to such a repository. The ALIVE National Centre for Mental Health Research Translation would be well placed to take on this responsibility as it has existing links with PHNs, LHNs and research organisations. However, it was only funded for five years beginning in 2021 (NHMRC 2021). Ongoing funding in the next agreement will be needed for a central information repository.

The Australian Commission on Safety and Quality in Health Care (ACSQHC) also plays a role in promoting best practice through national safety and quality standards.

> Standards provide an existing mechanism to incentivise improvement in the system by providing a framework for how safe and high-quality care can be achieved … Standards can also help with the commissioning of services by providing a structured framework for guiding and monitoring quality improvement that funders and providers can use in negotiating consistent funding agreements. (Australian Commission on Safety and Quality in Health Care, sub. 176, p. 2)

PHN Cooperative (sub. 208, p. 5) suggested the use of 'what works networks', currently operating in the UK:

> These Networks collate existing evidence on the effectiveness of programs and practices and would support PHN and LHN commissioners and policymakers to use these findings to implement the next Agreement.

The next agreement should include funding for evaluations to be conducted of all funded service models in line with the Framework and prioritise an evaluation of the Medicare Mental Health Centre and Satellite Network model to inform decisions about the appropriateness of programmatic funding. It should also delegate roles and responsibilities to the appropriate bodies for the dissemination of evidence and knowledge translation. Funding should be provided for a central information repository to collate and share evidence of best practice in mental health care and suicide prevention.

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.

Funding arrangements should be part of the core agreement

Funding in the current Agreement is solely provided through bilateral schedules, without connection to the objectives and outcomes of the Agreement or any centralised principles for mental health and suicide prevention funding. Outlining funding arrangements in the core agreement would support transparency and consistency, while detail on funding amounts and local arrangements can be maintained in bilateral schedules.

The core agreement should be used to establish the funding streams detailed above. Guiding principles can explain the purpose of each funding stream and give broad direction as to how funding should be used. For example, the core agreement should reaffirm the commitment to flexibility in funding and the use of funding by PHN-LHN partnerships.

Detailed funding amounts and arrangements will depend on the contributions made by each state and territory government and their priorities and needs. As such, bilateral schedules remain a necessary part of the next agreement. Bilateral schedules should acknowledge and build on the guiding principles within the core agreement, adding exact funding commitments and establishing the high-level priorities shared between the Australian Government and each state and territory government. This structure would be similar to that of other national agreements, such as the National Skills Agreement.

Issue-specific schedules to the next agreement, such as those recommended for services for Aboriginal and Torres Strait Islander people, suicide prevention and co-occurrence of problematic alcohol and other drug use and mental ill health and suicide (recommendations 7.1, 8.1 and 9.1), can help inform funding priorities and establish broad funding commitments, such as minimum funding commitments through maintenance-of-effort clauses. Funding for specific initiatives necessary to improve consumer outcomes (such as investment in workforce capability to support people with co-occurrence of problematic alcohol and other drug use, mental ill health and suicide) should be included in the designated schedules.

6.2 Commissioning integrated and locally relevant services

The balance between flexibility and consistency is a core tension in the local commissioning model of health care. The National Health Reform Agreement (NHRA) reflects this balance in the aspiration for a 'nationally unified and locally controlled' health system (clause 7).

A responsive health system relies on PHNs, LHNs and Aboriginal and Torres Strait Islander Community Controlled Health Organisations (ACCHOs) to ensure health care services meet the needs of their communities and create integration at the service level. Local commissioning bodies are well-placed to understand the characteristics of their communities, design tailored responses with a range of local stakeholders, including consumers and providers, and make use of their existing relationships and social capital to improve service integration and connectedness (OECD 2025, p. 37) (box 6.5).

Some level of consistency is necessary to avoid fragmentation and service gaps, ensure evidence-based practice and create a national standard of accessibility. Participants in this review raised concerns about variable commissioning practices across PHNs leading to poor outcomes and inefficiencies, and a lack of PHN-LHN partnerships.[67] PHN management and capability has been examined beyond this review and a broad uplift in these areas will contribute to better commissioning.[68]

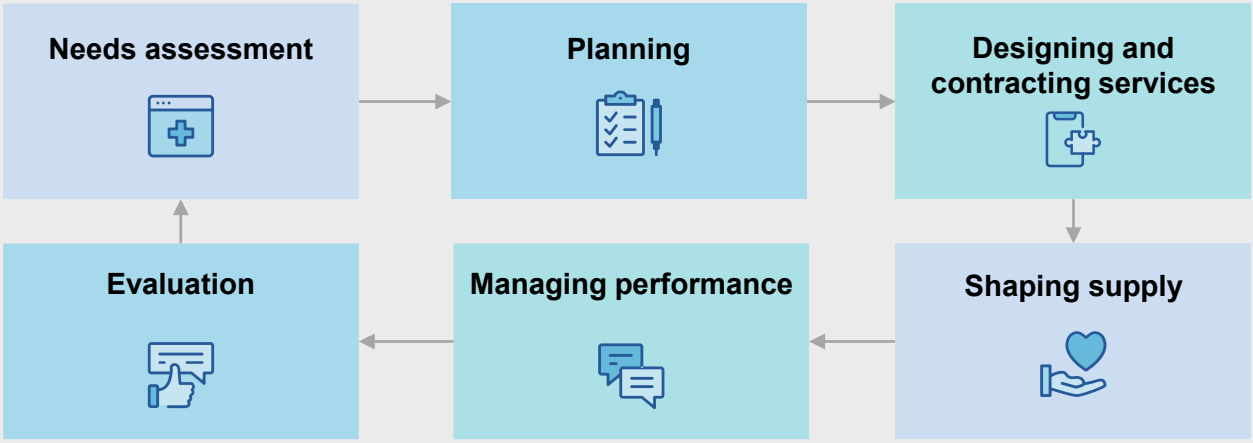
Engagement, collaboration and joint governance arrangements exist in varying ways across PHNs and LHNs (box 6.6). These are critical enablers of collaborative commissioning that should be reaffirmed as core responsibilities for PHNs and LHNs in the next agreement.

[67] LELAN, sub. 190, p. 17; National Mental Health Consumer Alliance, sub. 66, p. 22; Ruah Community Services, sub. 177, p. 3; VACCHO and BDDC, sub. 162, p. 8; *What we heard* paper.

[68] In 2024, the Australian National Audit Office reviewed the effectiveness of DoHAC's performance management of PHNs finding several areas for improvement including in performance measurement and reporting (ANAO 2024). The PHN business model and mental health flexible funding model are also currently under review (DoHAC 2025c).

Box 6.5 – The potential benefits of local and collaborative commissioning

Commissioning in the context of primary health networks (PHNs) refers to a continual cycle of assessing need, planning, designing and procuring services and monitoring and evaluating performance. Local commissioning recognises the needs of individuals and communities, and the regional differences in resources (such as workforce, infrastructure and other services) and commissions services accordingly. Undertaking this process at the local level should result in more relevant, responsive and targeted health care.



Source: Adapted from DoH (2019a).

LHNs do not commission in the same way as PHNs but they do provide public hospital services in line with their community's needs and the resources afforded to them, mostly through the NHRA.

PHNs and LHNs decide, based on the needs of their local communities and any requirements attached to their funding, what services to provide or commission and how they should be provided. These decisions can often involve dialogue with consumers (including through co-design) and providers to ensure services commissioned are appropriate and viable.

Collaborative commissioning is the commissioning of services to address community health needs through a partnership approach between PHNs, LHNs and other relevant organisations such as ACCHOs and service providers. It can overcome the silos created by different funding streams and mechanisms and different jurisdictional responsibilities to move towards a unified health system.

The partnerships formed to undertake collaborative commissioning vary by organisation and circumstance. For example, Brisbane North PHN described their collaborative approach to commissioning as varying from informing their LHN counterpart about their activities to sharing membership on commissioning panels or pooling funding to commission jointly. They noted the need to underpin collaborative activities with joint needs assessment, planning and priorities reporting.

Review participants pointed to co-commissioning and collaborative commissioning as essential drivers of an integrated mental health and suicide prevention system.[69] Collaborative commissioning can also produce efficiencies by streamlining care pathways and minimising duplication, both of effort and services.

Source: Brisbane North PHN (transcript, 20 August 2025, p. 49); Catholic Health Australia (sub. 181, p. 31); DoH (2019a); NHFB (2025); NSW Health (2024a); PC (2025b).

[69] Catholic Health Australia, sub. 181, pp. 31–32; Centre for Community Child Health, sub. 183, p. 6; Mental Health Coordinating Council, sub. 120, p. 3; PHN Cooperative, sub. 208, p. 8; StandBy Support After Suicide, sub. 167, p. 10.

Box 6.6 – Examples of joint governance arrangements between PHNs and LHNs

Individual PHN-LHN groupings have taken different approaches to shared governance arrangements. Brisbane North PHN, for example, spoke at the review's public hearings about the 'one-system approach' (transcript, 20 August 2025, p. 48) driving their collaboration with Metro North Hospital and Health Service (their LHN counterpart). This approach is enabled by a co-funded team sitting across the PHN and LHN, working on shared priorities. A joint board committee meets quarterly to oversee collaborative activities, including the Chairs, CEOs and Directors of both the PHN and LHN.

Northern Sydney LHN and Sydney North Health Network have an annual joint board meeting to discuss priorities for the year. Bi-monthly meetings are held between key members of each organisation's executive to oversee progress of these priorities. This joint governance arrangement has facilitated reductions in avoidable hospitalisations, development of localised care pathways and information sharing.

The NSW Government has taken a more systematic approach to creating shared governance arrangements across the state by establishing Patient Centred Co-commissioning Groups (PCCGs). PCCGs comprise PHNs and LHNs taking on joint responsibility for improving care for their regions. They develop care pathways and distribute resources according to local need. This approach allows PCCGs to bring together regional partners to create a person-centred health system and support greater efficiency.

Source: Brisbane North PHN (transcript, 20 August 2025, pp. 48–50); Northern Sydney Local Health District (2023, p. 22); NSW Health (2024b).

The next agreement should play a role in embedding collaboration between PHNs, LHNs and ACCHOs and ensuring these commissioning bodies are supported to undertake effective and collaborative local commissioning. The next agreement should:

- clarify the roles and responsibilities of PHNs and LHNs, specifically regarding their responsibilities for integration and shared governance arrangements
- clarify the role of joint regional mental health and suicide prevention plans
- commit governments to developing detailed guidance materials for procurement, including for joint procurement between PHNs and LHNs
- commit governments to streamlining reporting and data collection requirements and data sharing, including with and between PHNs and LHNs.

The roles and responsibilities of commissioning bodies should be clarified

Achieving integration of care and collaboration between commissioning bodies has long been a challenge for Australia's health system (Peiris et al. 2024, pp. 1–2). PHNs and LHNs play an important role in building an effective system of care and achieving system integration. The next agreement must set expectations for PHNs and LHNs and create an authorising environment for collaborative local commissioning.

Services funded under the current Agreement are mostly commissioned by PHNs.[70] Concerns were raised about variable approaches to commissioning by PHNs and the impacts on consumers and supporters, family, carers and kin.[71] Mental Health Carers Australia (sub. 73, p. 22) for example, noted:

> While PHNs' regional focus allows them to tailor services to local needs, this flexibility has resulted in significant variability and fragmentation across the 31 PHNs.

Several factors contribute to variability in PHN commissioning approaches and effectiveness.

- Participants noted a lack of role clarity for PHNs under the Agreement.[72]
- Performance management of PHNs by DHDA has been only 'partly effective' (ANAO 2024, p. 8).
- Commissioning guidance for PHNs has been delayed or insufficient (chapter 2). The PHN Cooperative (sub. 69, pp. 7–8) also noted a lack of guidance and training for PHN staff on using the National Mental Health Service Planning Framework for joint planning.

The PC also heard that collaboration between PHNs and LHNs was not routinely occurring across all PHNs and LHNs.

> Service coordination is a nightmare in our region. Our PHN and LHD just plain don't like each other and consequently, meaningful collaboration between them is virtually non-existent. (sr. 36)

This lack of collaboration may be a result of poor incentives for collaboration or other barriers, such as misaligned funding cycles and mismatched geographical borders. Review participants noted even where LHNs and PHNs have developed joint needs assessments and plans, the current Agreement has not sufficiently empowered them to commission services based on these joint efforts (PHN Cooperative, sub. 69, p. 6; WQPHN, sub. 45, p. 7).

To some extent, barriers and enablers of effective and collaborative commissioning sit outside of the agreement. Recommendations made in the PC's *Delivering quality care more efficiently* interim report would support a broad uplift of collaborative and local commissioning practices to enable more effective commissioning, including under the next agreement (PC 2025b).

Nonetheless, the next agreement should play a role in facilitating effective and collaborative commissioning. The role of PHNs and LHNs should be clarified in the next agreement to outline the role they are intended to play in local commissioning and their responsibilities for collaboration. This should be done in alignment with the local governance schedule of the NHRA. The current local governance schedule (Schedule E) of the Addendum to the NHRA 2020–25 provides the basis for local governance, including the shared objectives of PHNs and LHNs to meet the health needs of their communities and integrate services, and reciprocal responsibilities for engagement, collaboration and shared governance arrangements. Clarity about the role of PHNs and LHNs in relation to ACCHOs and their responsibilities to engage with ACCHOs would also be beneficial. Regional reporting would provide accountability for commissioning and outcomes achieved by regional commissioning bodies (chapter 5).

PHNs and LHNs share responsibility for the creation and maintenance of joint regional mental health and suicide prevention plans. All PHN and LHN groupings report having developed a foundational plan

[70] For example, PHNs commissioned providers to establish Medicare Mental Health Centres, which are one of the key commitments of the Agreement. Some funding through the Agreement does flow through LHNs to encourage collaborative commissioning of services. For example, a portion of the Queensland Government's funding for universal aftercare services is provided to LHNs to support clinical components of the program (Queensland Bilateral Schedule, clauses 52–54).
[71] headspace National Youth Mental Health Forum, sub. 23, p. 5; Neami National, sub. 63, p. 11; Orygen, sub. 26, p. 3.
[72] Adelaide PHN, sub. 62, p. 1; Northern Territory Mental Health Coalition, sub. 54, p. 2; PHN Cooperative, sub. 69, p. 5; WQPHN, sub. 45, p. 4.

(DoHAC 2024f, p. 61) but review participants noted that progress of this planning has been uneven (LELAN, sub. 190, p. 18) and had not translated to implementation (WQPHN, sub. 45, p. 7). Rigid funding arrangements may have stood in the way of these plans being implemented. The PHN Cooperative (sub. 69, p. 5) argued commitments to joint planning were one-sided:

> While PHNs had contractual deliverables to the Commonwealth for joint planning and commissioning, this was not consistently reciprocated in LHN arrangements.

Joint needs assessments and plans provide a holistic view of population needs, including social determinants, and allow for place-based models of care to develop as a response (Quigley et al. 2023, p. 2). Robust joint plans can also create transparency and accountability around PHNs and LHNs. A review of PHN performance management noted PHN accountability has been lacking (ANAO 2024).

Establishing good practice in joint regional mental health and suicide prevention planning, including the use of joint plans in ongoing decision-making and performance monitoring requires, commitment from governments in the next agreement, supporting guidance and an enabling environment. The next agreement should commit PHNs and LHNs to maintaining joint regional mental health and suicide prevention plans and highlight the role of PHNs and LHNs in establishing a local understanding of need and mapping services. Such plans will underpin the flexible funding approach of the next agreement (recommendation 6.1). As recommended in chapter 2, the Australian Government should develop comprehensive planning and commissioning guidelines. Good guidance will enable a maturation of PHN-LHN planning and facilitate greater collaborative commissioning (PHN Cooperative, sub. 208, p. 5).

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).

Better supports are needed to uplift quality throughout the commissioning cycle

Providing PHNs, LHNs and ACCHOs with the tools and supports they need to perform their role will facilitate more effective and collaborative commissioning in the next agreement. Tools and supports should not constrain commissioning bodies to a single way of operating; rather, they should provide guidance and build commissioning capabilities. Enabling greater consistency and capability in key areas can reduce the risk that flexibility results in poor outcomes for consumers, system inefficiencies and administrative burden for providers.

Some tools needed to support the commissioning process have been developed already. For example, the National Mental Health Service Planning Framework (NMHSPF) provides some of the information necessary

for the needs assessment and planning processes. Likewise, the National Mental Health and Suicide Prevention Evaluation Framework and associated guidelines developed under the current Agreement can support consistent and comparable evaluation practices (section 6.2). Other areas – namely procurement, reporting and data collection – would benefit from further clarity within the next agreement.

Guidance on procurement can enable quality commissioning

Procurement plays a crucial role in PHNs developing local markets and services and achieving value for money. Procurement processes can also affect transparency and administrative burden for providers (APHA, sub. 163, pp. 11–12; LELAN, sub. 190, p. 17). Despite some existing guidance from governments on procurement, approaches can vary across regions (Ruah Community Services, sub. 177, p. 3). Detailed and instructive guidance on effective procurement of mental health and suicide prevention services would create greater consistency across regions and uplift the quality of procurement processes.

Guidance should include detail on best practice processes. For example, review participants emphasised the value of including people with lived and living experience of mental ill health and suicide in procurement processes. An example of this approach was provided by LELAN (transcript, 21 August 2025, p. 37):

> Normally there's a panel for commissioning and they may have a single person with lived experience on it. We set up a whole separate panel of people with lived experience to come up with scenarios and questions that preferred providers were asked in a tender process and had to respond to, and a person from that panel sat on the main panel.

Good procurement practices may also vary depending on the market. For example, procurement in thin markets, such as regional and rural areas, may require a less competitive process, including bringing providers together to scale up their operations (PHN Cooperative, transcript, 21 August 2025, p. 14; WAAMH, sub. 172, p. 8). A relational approach to commissioning, in which outcomes and performance measurement can be tailored to the relevant service and community, may also be appropriate in some cases (PHN Cooperative, sub. 208, p. 21). This approach relies on strong relationships between commissioning bodies, providers and other stakeholders, alongside commissioning flexibility.

Guidance on procurement should look to establish default procurement practices for mental health and suicide prevention services, allowing PHNs to build on these processes and vary them where needed. Doing so would create consistency across regions, simplify commissioning processes for providers and improve overall transparency of PHN operations (APHA, sub. 163, pp. 11–12). Simplified procurement processes, coupled with longer-term funding (section 6.1), would allow providers to focus resources on consumer needs.

This guidance should be developed by DHDA, in consultation with PHNs, providers and people with lived and living experience of mental ill health and suicide. DHDA should look to align their guidance with similar procurement guidance provided to LHNs by state and territory governments to enable greater collaborative commissioning efforts. This guidance should be an agreed output of the next agreement.

Planning tools can help match services to community demand

Service planning tools and frameworks can help establish shared planning approaches and understandings of community needs between PHNs and LHNs. Several service planning tools assist governments, PHNs and LHNs in mental health and suicide prevention service planning.

- The National Mental Health Service Planning Framework (NMHSPF) is a comprehensive model designed to help plan and coordinate mental health services to meet population demands (AIHW 2024e).
- A needs-based planning model for suicide prevention services is being developed by The University of Melbourne, funded by DHDA. The model will be similar to the NMHSPF, with potential for integration, and

is being developed in consultation with a national expert advisory group and other relevant stakeholders. The project is expected to be completed in 2025 (Queensland Centre for Mental Health Research 2023).
- UNSW has developed a Drug and Alcohol Services Planning Model (DASPM), originally funded by the NSW Ministry of Health and the Intergovernmental Committee on Drugs (DPMP 2024).

Governments committed to using the NMHSPF and other appropriate tools to support regional planning and commissioning through the current Agreement (clause 139). But the value of these tools relies on the capability of users to understand their limitations and interpret their outputs (Western Australian Primary Health Alliance, transcript, 19 August 2025, pp. 107–108).

Criticisms have been made of the NMHSPF itself. Participants criticised the framework for being highly clinical and lacking in its ability to consider and respond to social determinants, its use of broad concepts of distress and social and emotional wellbeing, and inadequate consideration of the needs of people experiencing co-occurrence of issues or those of supporters, family, carers and kin (Community Mental Health Australia, transcript, 19 August 2025, pp. 96–97; Mental Health Carers Australia, transcript, 20 August 2025, p. 40).

> It's a profoundly flawed structurally tool – because you're always starting with an assumption that people need this many psychiatrists, this many psychologists. And the people that model these systems and deliver these services are all acculturated in that way of thinking. (Community Mental Health Australia, transcript, 19 August 2025, p. 96)

Despite limitations, the NMHSPF and similar tools are useful resources for PHNs and LHNs and the next agreement should continue governments' commitments to their use. However, the next agreement should task the Australian Institute of Health and Welfare (AIHW) 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. The AIHW should ensure PHNs and LHNs are aware of ongoing limitations of the framework that must be factored into its outputs.

Improving consistency in reporting and data collection

Duplicative or complex reporting and data collection requirements can hinder collaborative commissioning efforts. PHNs and LHNs often operate with different outcome measures, data sets and performance management frameworks that create barriers. Western NSW Local Hospital District (2023, p. 32) argued:

> Reliable, shared information is the bedrock of co-design and co-commissioning … What is vital is that there is conscious macro-system support of the need to plan and commission services together and that both the Commonwealth and State level agencies respect and work through, rather than act in competition with or parallel to, these more regional models of collaboration if they are to succeed.

Reporting and data collection requirements can also be burdensome for providers, particularly when working with both PHNs and LHNs or across different regions, and can prevent benchmarking and system-wide learning (APHA, sub. 163, p. 14). Jesuit Social Services (sub. 131, p. 10) noted:

> … programs that are commissioned by multiple PHNs face an onerous reporting environment involving a high number of reports, with inconsistent reporting requirements and templates … We support standardisation of reporting requirements across PHNs to reduce the administrative burden on service providers.

There would be clear benefit in both updating and streamlining data and reporting frameworks for PHNs and LHNs working together in the mental health and suicide prevention space. Doing so would free up resources for the provision of care, reduce barriers to collaborative commissioning and enable more purposeful data

collection. The size of these benefits can be significant. For example, one PHN was able to reduce reporting requirements by up to 58% for commissioned services by streamlining reporting processes and using third party data sources to assist with data collection (HNECC PHN 2024).

Data sharing between governments as well as PHNs and LHNs would also support streamlined reporting and data collection and lower barriers to collaboration. Mental Health Carers Australia (sub. 73, p. 22) argued:

> Establishing comprehensive data-sharing agreements between PHNs and jurisdictional health systems would facilitate better resource allocation, addressing service gaps and improving care coordination. Collaborative frameworks supported by robust data-sharing mechanisms would enhance service alignment and integration.

Progress on this front has been occurring at different levels.

- The current Agreement has facilitated data sharing between governments through a Data Governance Forum (chapter 2).
- The mid-term review of the NHRA recommended an additional schedule committing to progressing digital health for the next NHRA, including priorities, roles and responsibilities, and actions to progress data sharing and linkage as a foundation for co-commissioning (Huxtable 2023, pp. 12–13).
- Individual jurisdictions have created their own data sharing systems across parts of the health system, such as Lumos in NSW, which shares data across the consumer journey including with PHNs and LHNs (NSW Health 2025).
- PHNs have begun pooling their data for joint analysis and benchmarking on service delivery, cost and outcomes in the PMHC-MDS Collaboration project (PHN Cooperative, sub. 69, pp. 16–17).

Data sharing commitments in the next agreement (chapter 5) should include consideration of broader sharing of administrative data with and between PHNs and LHNs in addition to governments.

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.

7. Services for Aboriginal and Torres Strait Islander people

Key points

- The National Mental Health and Suicide Prevention Agreement includes several commitments to improve Aboriginal and Torres Strait Islander social and emotional wellbeing, including:
  - aligning with the National Agreement on Closing the Gap and other relevant documents
  - boosting the Aboriginal and Torres Strait Islander social and emotional wellbeing workforce
  - state- and territory-specific commitments outlined in the bilateral schedules.
- There is no funding attached to the commitments relating to Aboriginal and Torres Strait Islander people.
- Some commitments in the Agreement have been achieved, including a number of commitments within the bilateral schedules that have been implemented or are on track to be delivered. Governance arrangements aim to include Aboriginal and Torres Strait Islander perspectives.
- Aboriginal and Torres Strait Islander social and emotional wellbeing does not appear to have improved since the Agreement was signed, with Aboriginal and Torres Strait Islander suicide rates worsening. However, there is limited up-to-date data available to monitor progress achieved under the Agreement.
- The Agreement has not enabled the improvement in services necessary to support better outcomes.
  - Governance is not fit for purpose and there is a lack of detail on how commitments are to be implemented.
  - Addressing barriers to access and cultural safety in mental health and suicide prevention services remains a priority for Aboriginal and Torres Strait Islander people. While the Agreement contains commitments to address these issues, it does not include any tangible actions governments agreed to undertake.
- The next agreement should include a separate schedule that outlines substantive commitments to improve Aboriginal and Torres Strait Islander social and emotional wellbeing. This schedule should:
  - align with the National Agreement on Closing the Gap, including target 14 (significant and sustained reduction in suicide of Aboriginal and Torres Strait Islander people towards zero) and the Priority Reforms, as well as other key documents such as the Gayaa Dhuwi (Proud Spirit) Declaration and implementation plan
  - address key priorities including cultural safety, funding and workforce
  - improve and clarify governance for the design and implementation of the agreement, which should be overseen by the Social and Emotional Wellbeing Policy Partnership
  - measure progress in a strengths-based way, with community-led evaluation.

The National Mental Health and Suicide Prevention Agreement sets out a shared commitment for governments to contribute to the objectives of the National Agreement on Closing the Gap. This includes improving social and emotional wellbeing (SEWB), mental health and suicide prevention outcomes for Aboriginal and Torres Strait Islander people, with a focus on delivering culturally and locally appropriate services.

Some progress has been made in implementing specific actions related to improving SEWB. However, outcomes for Aboriginal and Torres Strait Islander SEWB have not improved over the term of the Agreement.

The next agreement needs a stronger approach to addressing Aboriginal and Torres Strait Islander SEWB to ensure Aboriginal and Torres Strait Islander priorities are acted upon and progress is made. This chapter:

- provides an overview of Aboriginal and Torres Strait Islander SEWB (section 7.1)
- discusses how Aboriginal and Torres Strait Islander SEWB is incorporated into the Agreement and its commitments (section 7.2)
- discusses whether the Agreement has improved Aboriginal and Torres Strait Islander SEWB (section 7.3)
- includes recommendations for the next agreement, including a separate schedule dedicated to services for Aboriginal and Torres Strait Islander people (section 7.4).

7.1 Aboriginal and Torres Strait Islander social and emotional wellbeing

Understanding the Agreement's effectiveness requires an understanding of Aboriginal and Torres Strait Islander SEWB, the services available to support SEWB and what governments are doing to improve SEWB.

The social and emotional wellbeing of Aboriginal and Torres Strait Islander people

Aboriginal and Torres Strait Islander SEWB is a holistic concept acknowledging the multiple and interrelated social, cultural, historical and political determinants of mental health and wellbeing for Aboriginal and Torres Strait Islander people (Dudgeon et al. 2020). This concept encompasses a broad range of interconnected factors, including: autonomy, empowerment and recognition; family and community; culture, spirituality and identity; Country; basic needs; work roles and responsibilities; education; physical health; and mental health (Butler et al. 2019). SEWB also recognises Aboriginal and Torres Strait Islander people come from diverse nations, cultures and language groups with many perspectives and experiences, meaning not all communities will share the exact same concepts and experiences of wellbeing.

Aboriginal and Torres Strait Islander people are more likely to experience poor SEWB and higher levels of psychological distress and suicide relative to non-Indigenous people (discussed below). Many of the negative effects on Aboriginal and Torres Strait Islander people's SEWB arise from their experience of historic, enduring and interrelated stressors. These factors include intergenerational trauma originating from colonisation, institutional racism, inherent biases and discrimination in mainstream services and inequality across social determinants of mental health such as access to adequate housing, education and employment (PC 2024a).

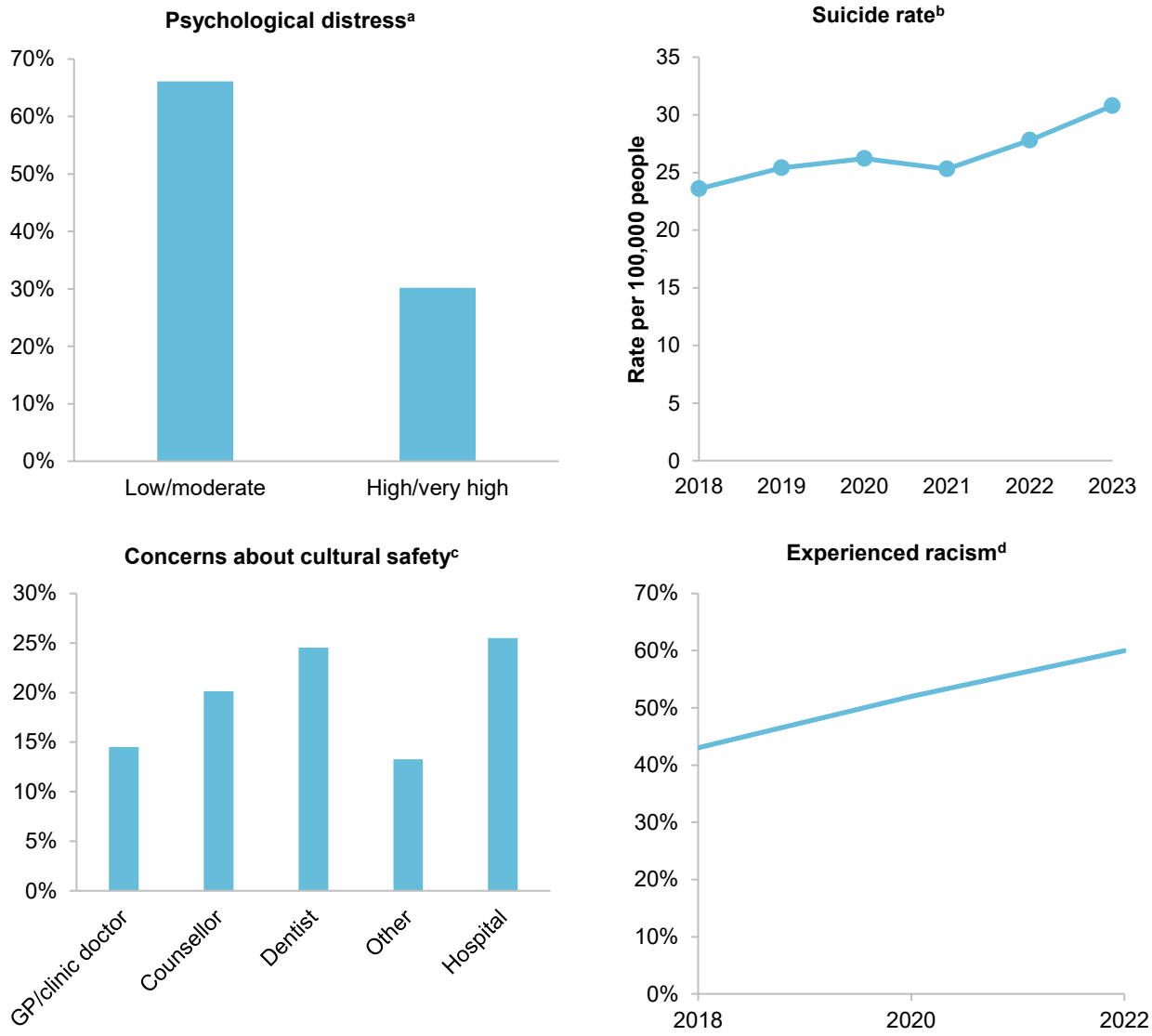
The presence of these factors underscores the need for cultural safety in the delivery of services. The National Agreement on Closing the Gap (2020b, p. 52) defined cultural safety as:

> … overcoming the power imbalances of places, people and policies that occur between the majority non-Indigenous position and the minority Aboriginal and Torres Strait Islander person so that there is no assault, challenge or denial of the Aboriginal and Torres Strait Islander person's identity, of who they are and what they need.

Many Aboriginal and Torres Strait Islander people experience distress

In 2022-23, one in three (30.2%) Aboriginal and Torres Strait Islander people experienced high or very high levels of psychological distress (figure 7.1). This represents a slight increase compared to 2004-05 (ABS 2024a, table 1.3).

Figure 7.1 – Indicators of Aboriginal and Torres Strait Islander social and emotional wellbeing



a. Proportion of Aboriginal and Torres Strait Islander people aged 18 years and older who had low/moderate or high/very higher psychological distress in 2022-23. **b.** Age-standardised rate of suicide for Aboriginal and Torres Strait Islander people, 2018–2023. **c.** Proportion of Aboriginal and Torres Strait Islander people who did not visit a health service due to concerns about cultural safety in 2018-19. **d.** Proportion of Aboriginal and Torres Strait Islander people aged 18 years or older who reported they experienced at least one form of racial prejudice in the past six months in 2018, 2020 and 2022.

Source: ABS (2024a, table 1.3); PC (2025a, tables CtG14A.1, SE14e.1-5 and CtGSE14g.1).

Aboriginal and Torres Strait Islander people experience higher levels of psychological distress than the general population. In 2020-22, 16.7% of people aged 16–85 years had experienced high or very high levels of psychological distress in the four weeks prior (ABS 2023, table 16).

There are groups within the Aboriginal and Torres Strait Islander population who are more likely to experience poor SEWB. For example, experiencing high or very high psychological distress was more likely among Aboriginal and Torres Strait Islander people who were younger, female or living in non-remote areas (ABS 2024a, table 6.3). In 2018-19 survivors of the Stolen Generations aged 50 years and older were 1.4 times more likely to have poor mental health and 1.3 times more likely to have been diagnosed with a mental health condition than other Aboriginal and Torres Strait Islander people of the same age (AIHW 2021a). Aboriginal and Torres Strait Islander people in the criminal justice system are also at high risk of experiencing poor mental health outcomes. In 2022, about two in five (42.6%) Aboriginal and Torres Strait Islander prison entrants reported having been told they had a mental health condition (AIHW 2023d, table S31).

Aboriginal and Torres Strait Islander LGBTQIASB+ youth also experience high levels of psychological distress. A survey found 91.9% of participants aged 14–25 years scored in the high/very high range for psychological distress. Nearly half (45.4%) of participants had attempted suicide in their lifetime and 19% had attempted suicide in the 12 months before the survey (Liddelow-Hunt et al. 2023).

The Closing the Gap target for a significant and sustained reduction in suicide is not on track to be met

A decline in SEWB is associated with an increased risk of self-harm and death by suicide (Dudgeon et al. 2014, p. 13). In 2023, 265 Aboriginal and Torres Strait Islander people died by suicide in New South Wales, Victoria, Queensland, Western Australia, South Australia and the Northern Territory, compared with 196 in 2018. This is a rate of 30.8 per 100,000 people, up from 23.6 in 2018 (figure 7.1) – and much higher than the suicide rate for non-Indigenous people. In 2023, the suicide rate for non-Indigenous people was 11.1 per 100,000 people, down from 12.0 in 2018 (PC 2025a, table CtG14A.1).

There are barriers to accessing services

Many Aboriginal and Torres Strait Islander people experience barriers to accessing health services. This is due to a range of factors, including services not being available in their area (especially for those living in remote areas), lack of transport, cost, waiting times, and the availability of culturally safe and responsive health services (AIHW 2024c).

In 2022-23, 26.1% of Aboriginal and Torres Strait Islander people reported they would have liked to seek support for their mental health but did not do so in the past 12 months. Reasons for not seeking support included being too busy, transport factors, cost, discrimination and the service not being culturally appropriate (ABS 2024a, table 10.3).

Cultural safety is a key reason Aboriginal and Torres Strait Islander people do not seek support. One in four of the Aboriginal and Torres Strait Islander people who avoided going to hospital in 2018-19 reported that this was at least in part due to cultural safety concerns (figure 7.1).

Discrimination and racism affect social and emotional wellbeing

Discrimination and racism have established long-term effects on Aboriginal and Torres Strait Islander people's SEWB. Experiences of racism affect SEWB long after direct exposure has ended (ANU 2021; Ferdinand et al. 2012).

A growing number of Aboriginal and Torres Strait Islander people report experiences of racism. In 2022, 60% of Aboriginal and Torres Strait Islander people reported experiencing racism in the past six months, an increase from 43% in 2018 (figure 7.1). This proportion is significantly higher than the general community, with about 25% of all Australians reporting experiences of racism in 2022 (PC 2025a, table SE14g.1).

Significant events that push Aboriginal and Torres Strait Islander people to the forefront of public discussions can also exacerbate their experiences of racism and affect SEWB. For example, the Aboriginal and Torres Strait Islander crisis support line 13YARN experienced a 40% increase in calls during the Voice to Parliament Referendum in 2023 (Lifeline Australia 2024).

Aboriginal and Torres Strait Islander people report experiencing racism in health settings. In 2022-23, 5.1% of Aboriginal and Torres Strait Islander people reported GPs rarely or never respected culture, traditions, customs and beliefs, and 10.8% reported staff at their most recent hospital admission did not respect culture, traditions, customs and beliefs (ABS 2024a, table 9.3). One of the respondents to the survey undertaken by the PC for this review shared their experience:

> My Aboriginality was ignored. My own voice was ignored. My cultural situation was ignored (sr. 25)

Services for Aboriginal and Torres Strait Islander people

SEWB services for Aboriginal and Torres Strait Islander people are delivered through a variety of providers. Some providers are Aboriginal and Torres Strait Islander specific such as Aboriginal and Torres Strait Islander Community Controlled Health Organisations (ACCHOs) and Aboriginal Medical Services (AMSs). These services are committed to delivering culturally safe, integrated and holistic care to support SEWB. They can provide tailored care to meet the needs of the local population, including, but not limited to:

- cultural healing activities
- psychological therapies
- complex mental health support
- suicide prevention services
- drug and alcohol services
- case management and care coordination, such as referrals to employment and housing services (DHDA 2025a; IUIH, sub. 81 p. 5).

Funding for ACCHOs comes from a variety of sources, including funding for primary care through the Medicare Benefits Schedule and grant funding provided by different Australian Government departments, including the Department of Health, Disability and Ageing (DHDA), the National Indigenous Australians Agency (NIAA) and primary health networks (PHNs) (chapter 6).

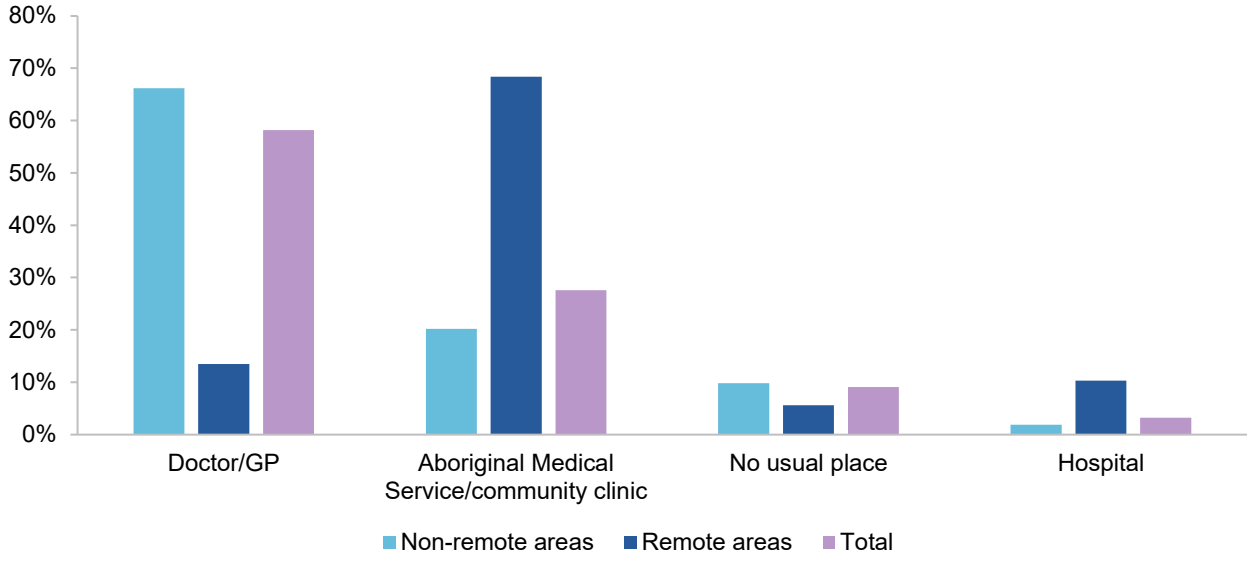
Funding tends to be fragmented, with ACCHOs funded from more sources than most other healthcare organisations of their size (DoH 2020a, p. 19; Lowitja Institute 2010). Funding is often delivered through specific purpose grants that usually last for only 12 months before the recipient needs to reapply. The various agencies issuing these grants, including DHDA and NIAA, often have different policy and program priorities. This funding and policy fragmentation puts strain on ACCHOs, challenging the continuation and long-term nature of many of their programs (VACCHO 2025), and creating broader barriers for ACCHOs to provide the comprehensive care they are designed for (Lowitja Institute 2010; PC 2024b, p. 52).

PHNs administer many of the funding sources for Aboriginal and Torres Strait Islander mental health and suicide prevention services. This type of funding arrangement can create further structural barriers to effective service delivery. PHNs generally lack the cultural expertise and community connections of ACCHOs, and some have not built the necessary relationships with ACCHOs to help overcome this barrier. It can also create unnecessary layers of complexity that limit the ability of ACCHOs to design and implement services (IUIH, sub. 81, p. 12).

Depending on where they live, many Aboriginal and Torres Strait Islander people access mainstream services in addition to, or instead of, Aboriginal and Torres Strait Islander specific services (figure 7.2).

Figure 7.2 – Aboriginal and Torres Strait Islander people access ACCHOs, AMSs and mainstream services

Type of health service Aboriginal and Torres Strait Islander people usually access if they have a problem with their health, 2022-23



Source: ABS (2024a, table 9.3).

The policy landscape includes many documents and organisations

There are multiple agreements and strategies connected to the Aboriginal and Torres Strait Islander mental health and suicide prevention system. The Agreement aims to align with some of these national commitments.

The National Agreement on Closing the Gap

The National Agreement on Closing the Gap is an agreement between all Australian governments and the Coalition of Peaks. It is the first agreement of its kind to be developed in genuine partnership and seeks to change the way governments work with Aboriginal and Torres Strait Islander people.

This agreement sets out a strategy to close the gap underpinned by Aboriginal and Torres Strait Islander people's priorities, with targets and socio-economic outcome indicators reported on as an accountability measure (Coalition of Peaks and Australian Governments 2020b).

The Agreement highlights four Priority Reforms:

- Formal partnerships and shared decision-making
- Building the community-controlled sector
- Transforming government organisations
- Shared access to data and information at a regional level.

These Priority Reforms should be reflected in all policies and activities the Australian, state, and territory governments implement in relation to Aboriginal and Torres Strait Islander people, including agreements such as the National Mental Health and Suicide Prevention Agreement.

The National Agreement on Closing the Gap provides a framework for governments to enact changes across all levels, jurisdictions and outcome areas. However, it leaves space for funding arrangements and implementation

processes required to achieve improvements in the socio-economic outcome areas. It does not contain any funding commitments or direct the implementation processes of any specific policies to improve SEWB.

The Social and Emotional Wellbeing Policy Partnership

The Social and Emotional Wellbeing Policy Partnership (SEWB PP) was established under the National Agreement on Closing the Gap. Its focus is to improve SEWB and mental health and reduce suicide rates among Aboriginal and Torres Strait Islander people (box 7.1).

Box 7.1 – Social and Emotional Wellbeing Policy Partnership objectives

- Establish a 'joined-up' approach between all governments and Aboriginal and Torres Strait Islander representatives.
- Improve social and emotional wellbeing and mental health outcomes and reduce suicide rates.
- Give a focus to the Priority Reforms in the National Agreement on Closing the Gap (national agreement), and how they can make the changes needed to accelerate improved levels of social and emotional wellbeing in the lives of Aboriginal and Torres Strait Islander people.
- Identify specific measures to accelerate improved levels of social and emotional wellbeing and mental health outcomes and reduce suicide rates.
- Identify opportunities to work more effectively across governments, reduce service gaps and duplication and improve outcomes under the national agreement.
- Support efforts to implement the national agreement. This includes meeting targets for the Priority Reform areas and socioeconomic outcomes.
- Enable Aboriginal and Torres Strait Islander community-led outcomes on Closing the Gap, and support community-led development initiatives.
- Enable Aboriginal and Torres Strait Islander representatives, communities and organisations to negotiate and implement agreements with governments to address all Priority Reforms and policy strategies to support the national agreement.

Source: DHDA (2025f).

The partnership has 20 members, and representation is split equally between Aboriginal and Torres Strait Islander and government parties. The partnership is co-chaired by an Aboriginal and Torres Strait Islander senior representative of Gayaa Dhuwi (Proud Spirit) Australia and an Australian Government deputy secretary from the Department of Health, Disability and Ageing. There is also a deputy Aboriginal and Torres Strait Islander co-chair, who is the Chief Executive Officer of Gayaa Dhuwi (Proud Spirit) Australia. The Aboriginal and Torres Strait Islander members include five representatives from the Coalition of Peaks and five independent representatives (DHDA 2025f). The majority of the government representatives are from their jurisdiction's respective health department (Joint Council on Closing the Gap 2023, p. 13).

The Australian Government committed $8.6 million from 2022-23 to set up the partnership. This included funding for Gayaa Dhuwi (Proud Spirit) Australia to provide joint administrative support with the Department of Health, Disability and Ageing. In 2024-25, the SEWB PP received an additional $2.25 million over one year to continue its work until June 2026 (DHDA 2025f).

Gayaa Dhuwi (Proud Spirit)

Gayaa Dhuwi (Proud Spirit) Australia is the national peak body for Aboriginal and Torres Strait Islander SEWB, mental health and suicide prevention. The Agreement includes a specific commitment to support the implementation of the Gayaa Dhuwi (Proud Spirit) Declaration. This Declaration focuses on Aboriginal and Torres Strait Islander leadership across all parts of the Australian mental health system to achieve the highest attainable standard of mental health and suicide prevention outcomes for Aboriginal and Torres Strait Islander people (box 7.2).

Box 7.2 – Gayaa Dhuwi (Proud Spirit) Declaration

The Declaration focuses on a 'best of both worlds approach', highlighting five themes.

1. Aboriginal and Torres Strait Islander concepts of social and emotional wellbeing, mental health and healing should be recognised across all parts of the Australian mental health system, and in some circumstances support specialised areas of practice.
2. Aboriginal and Torres Strait Islander concepts of social and emotional wellbeing, mental health and healing combined with clinical perspectives will make the greatest contribution to the achievement of the highest attainable standard of mental health and suicide prevention outcomes for Aboriginal and Torres Strait Islander peoples.
3. Aboriginal and Torres Strait Islander values-based social and emotional wellbeing and mental health outcome measures in combination with clinical outcome measures should guide the assessment of mental health and suicide prevention services and programs for Aboriginal and Torres Strait Islander peoples.
4. Aboriginal and Torres Strait Islander presence and leadership is required across all parts of the Australian mental health system for it to adapt to, and be accountable to, Aboriginal and Torres Strait Islander peoples for the achievement of the highest attainable standard of mental health and suicide prevention outcomes.
5. Aboriginal and Torres Strait Islander leaders should be supported and valued to be visible and influential across all parts of the Australian mental health system.

Source: Gayaa Dhuwi (Proud Spirit) Australia (2015).

The Gayaa Dhuwi (Proud Spirit) Declaration Framework and Implementation Plan, launched in early 2025, sets out a 10-year plan to implement the Declaration. The framework describes the goals and strategies and the implementation plan describes the priority actions, strategies and goals for the themes identified in the Declaration (Gayaa Dhuwi (Proud Spirit) Australia 2025a). This plan aligns with key documents, including the National Agreement on Closing the Gap, and was developed in partnership with Aboriginal and Torres Strait Islander leaders, mental health professionals and community stakeholders (Gayaa Dhuwi (Proud Spirit) Australia, sub. 75, p. 4).

Priority actions to complete within Phase One (2025–2026) include promoting concepts of SEWB, identifying funding streams that enable Aboriginal and Torres Strait Islander people to access culturally safe services, and developing guidance on how governments and services can work with Aboriginal and Torres Strait Islander communities and organisations to develop policies, services and programs.

The National Aboriginal and Torres Strait Islander Suicide Prevention Strategy

The National Aboriginal and Torres Strait Islander Suicide Prevention Strategy was recently renewed by Gayaa Dhuwi (Proud Spirit) Australia, providing an updated Strategy for 2025–2035. The Strategy's purpose is to 'achieve a significant and sustained reduction in suicide and self-harm of Aboriginal and Torres Strait Islander people towards zero through Aboriginal and Torres Strait Islander community leadership and governance' (DoHAC 2024e, p. 10). To achieve this, the Strategy draws on key elements of the Gayaa Dhuwi (Proud Spirit) Declaration, incorporating Aboriginal and Torres Strait Islander cultural concepts with clinical approaches.

The Strategy is centred around the core principles of: being Aboriginal and Torres Strait Islander led; underpinned by culture; lived experience informed; holistic and integrated systems and services; and place-based responses (DoHAC 2024e, p. 10).

The National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing

The NIAA is overseeing the development of a new National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing. The previous framework concluded in 2023, just after the Agreement was signed. Once released, the refreshed framework will provide practical guidelines on how governments and services can embed Aboriginal and Torres Strait Islander SEWB (Gayaa Dhuwi (Proud Spirit) Australia, sub. 75, p. 4).

7.2 The Agreement includes commitments to improve social and emotional wellbeing

The Agreement aims to improve SEWB for Aboriginal and Torres Strait Islander people, though most commitments are high level. The commitments include:

- contributing to the National Agreement on Closing the Gap (clause 47i)
- working in partnership with Aboriginal and Torres Strait Islander people through formal partnership arrangements (clause 110)
- strengthening the Aboriginal and Torres Strait Islander workforce (clause 159d)
- improving monitoring and evaluation of the National Agreement on Closing the Gap commitments (clause 82d).

The Agreement provides little detail on how these commitments will be implemented, how success will be measured and how governments will be held accountable if objectives are not met. This is discussed in more detail in section 7.3. Similarly, the Agreement lists Aboriginal and Torres Strait Islander people as one of 15 priority populations, though there is minimal detail on how these groups are to be prioritised (chapter 3).

Alignment with the National Agreement on Closing the Gap

All governments have a shared commitment to implement the National Agreement on Closing the Gap. The National Mental Health and Suicide Prevention Agreement seeks to ensure alignment with the National Agreement on Closing the Gap and highlights a commitment to the target of significantly and sustainably reducing suicide rates towards zero (target 14).

Commitments in the Agreement to action the National Agreement on Closing the Gap include:

- empowering Aboriginal and Torres Strait Islander people to share decision-making authority with governments through formal partnership arrangements (clause 47i(ii))
- building a strong, sustainable community-controlled sector to meet the needs of Aboriginal and Torres Strait Islander people across the country (clause 47i(iii))
- ensuring all services funded by governments are culturally safe and responsive to the needs of Aboriginal and Torres Strait Islander people (clause 47i(iv))
- ensuring Aboriginal and Torres Strait Islander people have access to, and training and support to use, locally relevant data and information to set and monitor the implementation of efforts to close the gap, their priorities, and drive their own development (clause 47i(v))
- continued collaboration to build the data and systems needed to understand and improve progress under the National Agreement on Closing the Gap, including outcome 14 (Aboriginal and Torres Strait Islander people enjoying high levels of social and emotional wellbeing) and target 14 (significant and sustained reduction in suicide of Aboriginal and Torres Strait Islander people towards zero) (clause 82d).

There is limited direction and transparency in how governments intend to implement these commitments. The bilateral schedules outline some specific actions, though there is a lack of consistency between the Agreement and the bilateral schedules (section 7.3).

Co-design and collaboration

Under the Agreement, the Australian, state and territory governments agree to be jointly responsible for co-designing place-based approaches with community at a local level. This includes ensuring the voices of people with lived and living experience, experts and non-government organisations are included in the planning and implementation of these approaches (clauses 47h(i), 54, and 55).

The Agreement outlines a series of commitments to work in partnership with Aboriginal and Torres Strait Islander people, their communities, organisations and businesses to improve social and emotional wellbeing, and access to and experience with mental health and wellbeing services (clauses 110a–e). These commitments include:

- supporting the implementation of the Gayaa Dhuwi (Proud Spirit) Declaration
- ensuring alignment with the National Agreement on Closing the Gap and associated Implementation Plans
- ensuring alignment with other relevant national commitments and agreements for Aboriginal and Torres Strait Islander mental health and suicide prevention, including the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy and the National Strategic Framework for Aboriginal and Torres Strait Islander Peoples Mental Health and Social and Emotional Wellbeing
- recognising and enabling leadership of Aboriginal and Torres Strait Islander people throughout the mental health, wellbeing and suicide prevention system
- collaborating with ACCHOs and other service providers wherever possible to improve Aboriginal and Torres Strait Islander people's access to mental health, wellbeing and suicide prevention services and deliver services in a culturally and locally appropriate manner.

Similar to the Agreement's commitments related to Closing the Gap, actions related to co-design are high level and details on how they will be undertaken are not included.

Other commitments

The Agreement outlines several other commitments related to Aboriginal and Torres Strait Islander SEWB (table 7.1). These commitments are scattered throughout, and like previous commitments outlined, there is little detail on how they will be implemented or how success will be measured.

Table 7.1 – Other commitments in the Agreement

Topic	Commitment
Bilateral schedules	**Victoria** committed to working with the Australian Government to increase the representation of Aboriginal and Torres Strait Islander people in the mental health workforce and upskill the mental health workforce in culturally appropriate care (VIC Bilateral Schedule, clause 85e). **Western Australia** committed to working with the Australian Government on Aboriginal and Torres Strait Islander-specific aftercare arrangements in partnership with Aboriginal and Torres Strait Islander stakeholders (WA Bilateral Schedule, clause 48). **The ACT** committed to continuing to implement a culturally safe Aboriginal and Torres Strait Islander integrated suicide prevention, intervention, aftercare and postvention service (ACT Bilateral Schedule, clause 47). **South Australia** committed to: • establishing an Aboriginal Mental Health and Wellbeing Centre to improve access to culturally appropriate, multidisciplinary mental health and wellbeing services for Aboriginal and Torres Strait Islander people and improve service integration (SA Bilateral Schedule, clauses 11h, 13d, 48). • focusing on supporting the mental health and social and emotional wellbeing of Aboriginal and Torres Strait Islander people in the implementation of joint regional mental health and suicide prevention plans between the SA Government and primary health networks (PHNs) (SA Bilateral Schedule, clause 13l).
Workforce	Governments agreed to: • seek opportunities to grow and support the representation of Aboriginal and Torres Strait Islander people in the mental health and suicide prevention workforce, in effort to achieve population parity, through training, recruitment and retention strategies and through supporting culturally safe workplaces (clause 161) • allocate a minimum number of scholarships, traineeships, clinical placements and employment placements that reflect the Aboriginal and Torres Strait Islander population in each jurisdiction, for allocation to Aboriginal and Torres Strait Islander people as first priority, over the life of the Agreement (clause 161a) • build on and leverage existing efforts to build the capability of the mental health and suicide prevention workforce, including the peer and Aboriginal and Torres Strait Islander workforces, to provide support and appropriate clinical treatment to people with co-occurring alcohol and other drug use and mental ill health and suicidality (schedule A, clause 8f).
Monitoring and evaluation	Governments agreed to build the data and systems needed to improve progress against the National Agreement on Closing the Gap commitments (clause 82d). Under the Agreement's priority data indicators for development (Annex B), the first focus area is 'Improving health and wellbeing for Aboriginal and Torres Strait Islander Australians'. The Agreement sets out its priority data and indicators for development as: • specific prevalence estimates for Aboriginal and Torres Strait Islander health status • growth in Aboriginal and Torres Strait Islander mental health workforce • social and emotional wellbeing measures for Aboriginal and Torres Strait Islander Australians.

Topic	Commitment
	Furthering commitments to the National Agreement on Closing the Gap, the Agreement continues the commitment for all Australian governments to ensure Aboriginal and Torres Strait Islander people have access to, and support to use, locally relevant data and information to set and monitor the implementation of efforts to close the gap, their priorities, and drive their own development (clause 47i(v)).

7.3 What progress has been made?

Governments have made some progress implementing the Agreement and actions aimed at improving Aboriginal and Torres Strait Islander SEWB. However, the overall ineffectiveness of the Agreement means it is unlikely to have led to improved mental health and suicide prevention outcomes (chapter 3). Assessing the contribution of the Agreement is hampered by a lack of current data (chapter 2). Significant external events, such as the Voice to Parliament Referendum, have influenced outcomes, but these effects are difficult to disentangle (NMHC 2024a).

Some commitments have been actioned ...

Co-design and collaboration

One key area of progress is the establishment of an Aboriginal and Torres Strait Islander governance mechanism to aid the Agreement and its implementation.

The Mental Health and Suicide Prevention Senior Officials Group (MHSPSO) and the Closing the Gap Joint Council endorsed the SEWB PP as the primary governance body advising on Aboriginal and Torres Strait Islander mental health and wellbeing. Two SEWB PP representatives and two Aboriginal and/or Torres Strait Islander members with lived experience were appointed to MHSPSO in May 2023 (NMHC 2024a).

These governance arrangements were formalised after the Agreement was signed. This meant some decisions were made without adequate consultation with Aboriginal and Torres Strait Islander people, and decisions on implementation were delayed (NMHC 2024a).

Workforce

Some state and territories have made progress against workforce commitments within the Agreement. There is not enough publicly available information to assess whether this progress has improved Aboriginal and Torres Strait Islander workforce numbers and retention, though Black Dog Institute indicates there has been little improvement.

> Regarding workforce retention and turnover, accurate figures on these issues are limited but high turnover is well recognised within [the mental health sector] and noted as a significant issue within a workforce that is already in high demand. (Black Dog Institute, sub. 61, p. 6)

Bilateral schedules

Only four jurisdictions included specific commitments that relate to Aboriginal and Torres Strait Islander SEWB in their bilateral schedules. These appear to be mostly on track, with Victoria, South Australia and the ACT all having delivered or being on track to deliver their commitments (table 7.2). However, there is no publicly available information on progress made by South Australia on their commitment to focus on supporting SEWB in the development and implementation of their joint regional mental health and suicide

prevention plans (SA Bilateral Schedule, clause 13l). New South Wales, Queensland, Tasmania and the Northern Territory's bilateral schedules did not include any specific commitments to improve Aboriginal and Torres Strait Islander SEWB.

Table 7.2 – Bilateral schedules progress

Jurisdiction	Commitment	On track?
Victoria	Increase workforce representation	✓
Western Australia	Aboriginal and Torres Strait Islander-specific Aftercare arrangements	?
South Australia	Aboriginal Mental Health and Wellbeing Centre	✓
	Focusing on supporting SEWB in the implementation of joint regional mental health and suicide prevention plans	?
ACT	Continuing to implement a culturally safe Aboriginal and Torres Strait Islander integrated suicide prevention, intervention, aftercare and postvention service	✓

Source: ACT Government (2022); SA Health (2025); Victorian Department of Health (2024a).

Where state and territory governments have made progress, it is not always connected explicitly to the Agreement. For example, Victoria committed to increasing Aboriginal and Torres Strait Islander SEWB workforce representation in its bilateral schedule. It appears it has been successful in progressing this commitment, but it aligns this progress with the Royal Commission into Victoria's Mental Health System, not the National Mental Health and Suicide Prevention Agreement (Victorian Department of Health 2024a).

… but the Agreement has not been an effective mechanism to improve Aboriginal and Torres Strait Islander SEWB

While it is hard to measure the effect of the Agreement on Aboriginal and Torres Strait Islander SEWB, the most recently available data shows a lack of improvement. Among other concerning trends, while the Agreement commits to Closing the Gap target 14, Aboriginal and Torres Strait Islander suicide rates are worsening (section 7.1).

Beyond its stated intent to contribute towards the Closing the Gap targets, the Agreement includes commitments to improve access to culturally safe services. But submissions to this review show Aboriginal and Torres Strait Islander people continue to experience barriers to access.

> Negative and harmful experiences at services remains a barrier for Aboriginal and Torres Strait Islander peoples accessing suitable services and failure to address these in the current National Agreement is a catastrophic gap. (Suicide Prevention Australia, sub. 59, p. 11)

> Despite the National Agreement's recognition of First Nations peoples as a priority group, there are still significant gaps in mental health care for Aboriginal and Torres Strait Islander peoples. The role of governments in the delivery and design of mental health services for First Nations communities must be more comprehensively addressed in the National Agreement. (RANZCP, sub. 7, p. 3)

The Agreement has not been set up effectively to improve outcomes. Some of the contributing factors are discussed below.

Lack of detail on how commitments should be implemented

The Agreement provides little detail on how commitments for Aboriginal and Torres Strait Islander SEWB will be implemented. For example, the commitment to implementing the Gayaa Dhuwi (Proud Spirit) Declaration,

which is included in the Agreement, is absent from the state and territory bilateral schedules (Gayaa Dhuwi (Proud Spirit) Australia, sub. 75, p. 6). This inconsistency means there are no details on how states and territories, as well as the services funded in the Agreement, will implement the Declaration.

There are other key documents referenced within the Agreement without clear guidance on appropriate outcomes, principles and initiatives.

> The National Agreement commits governments to support implementation of the Gayaa Dhuwi (Proud Spirit) Declaration, and in implementing activities of the National Agreement to ensure alignment with the National Agreement on Closing the Gap, the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy and the National Strategic Framework for Aboriginal and Torres Strait Islander Peoples Mental Health and Social and Emotional Wellbeing. However, this has not flowed through to tangible actions being funded through the bilateral agreements to deliver practical reform. (Mental Health Australia, sub. 76, p. 13)

The Agreement lacks detail on how to implement and measure progress against commitments. This can be seen in key areas such as commitments to cultural safety and increasing access to services, where detail is necessary but missing.

> A gap in the National Agreement is its failure to mention or commit governments to enhancing cultural safety in the mental health system. Some of the bilateral agreements include a measure around the proportion of services delivered to the Aboriginal and Torres Strait Islander population that are culturally appropriate, however there are no initiatives on how appropriate services will be delivered or measured. (Gayaa Dhuwi (Proud Spirit) Australia, sub. 75, p. 5)

The governance arrangements are not fit for purpose

Review participants reflected on the limited involvement of Aboriginal and Torres Strait Islander people and communities in the development and implementation of the Agreement.

> Priority Reform One of the Closing the Gap agreement committed governments to work collaboratively and in genuine, formal partnership with Aboriginal and Torres Strait Islander peoples. This level of partnership and influence was not present in the development of the National Agreement, the bilateral agreements or in the governance mechanisms that monitored progress. (Gayaa Dhuwi (Proud Spirit) Australia, sub. 75, p. 6)

The Agreement does not provide guidance on the way its governance mechanisms should incorporate the views of Aboriginal and Torres Strait Islander people to ensure their perspectives are heard and acted upon throughout the Agreement's implementation.

The SEWB PP was eventually endorsed by MHSPSO and the Closing the Gap Joint Council as the primary governance body advising on Aboriginal and Torres Strait Islander mental health and wellbeing and two representatives were appointed to MHSPSO in May 2023. However, it is unclear how these governance bodies are intended to interact and how decisions are expected to be made. This means there is little accountability for these governance mechanisms to ensure they adequately embed Aboriginal and Torres Strait Islander voices. Overall, governance arrangements do not appear fit for purpose.

In the 2023-24 Agreement Annual Progress Report, the SEWB PP representatives to MHSPSO highlight how issues of inefficient governance and clearance processes and not working in genuine partnership have hindered effective utilisation of SEWB PP's expertise (NMHC 2025, p. 20). Gayaa Dhuwi (Proud Spirit) Australia (2025b, p. 6) stated:

> At present, the SEWB Policy Partnership functions more as a symbolic advisory body than a governing mechanism, lacking the autonomy, authority, and decision-making power required to influence system reform.

This is consistent with the findings of the Aboriginal and Torres Strait Islander-led review of the National Agreement on Closing the Gap. The review found that while the Policy Partnerships established under the Agreement were created to have shared-decision making, many partnerships still operate with government retaining ultimate decision-making authority (Lavarch et al. 2025, p. 73).

The Aboriginal and Torres Strait Islander-led review noted a mismatch in how different parties in the policy partnerships approach the Closing the Gap commitments and their implementation. For example, there is a non-Indigenous worldview informing who is, and is not, included in policy discussions. When a Western lens is applied to SEWB, the interconnected factors that affect and shape the health and wellbeing of Aboriginal and Torres Strait Islander people are overlooked. The government representation on the SEWB PP mostly covers health departments, which does not allow consideration of the multiple factors that influence SEWB such as housing and employment (Lavarch et al. 2025, pp. 73–74).

Support and funding for the community-controlled sector is inadequate

In the Agreement, governments commit to collaborating with ACCHOs to improve Aboriginal and Torres Strait Islander mental health, wellbeing and suicide prevention services. However, the Institute for Urban Indigenous Health argues the Agreement fails to recognise the capability and expertise of ACCHOs and these resource-constrained organisations must undertake uncompensated engagement to make their voices heard.

> There is no formal recognition of ACCHSs leadership, expertise, or the demonstrated effectiveness of our models within the NMHSPA. Instead, we are often required to participate in regional planning committees and working groups without appropriate resourcing, placing significant strain on our capacity. While we value participation, this unfunded engagement leaves ACCHSs at a structural disadvantage, perpetuating power imbalances where government agencies and mainstream providers retain disproportionate control over mental health policy, funding, and service design affecting Aboriginal and Torres Strait Islander peoples. (IUIH, sub. 81, p. 8)

The only funding commitment in the Agreement designated to Aboriginal and Torres Strait Islander SEWB services is to establish an Aboriginal mental health and wellbeing centre in South Australia (section 7.2). This means where funding may apply for ACCHOs, there are no mechanisms or requirements for directly funding ACCHOs delivering SEWB services. This is particularly problematic as ACCHOs are left finding ways to fit into mainstream funding processes, which creates significant challenges. This fragmented system restricts the holistic and culturally informed approaches that make ACCHOs best placed to deliver effective SEWB services.

> Despite consistent evidence that community-controlled, preventative models deliver better outcomes, funding continues to flow predominantly to mainstream-designed, acute services. This reflects the same systemic issues described above: ACCHSs are expected to deliver services within inflexible, mainstream frameworks or as subcontractors, rather than being resourced and trusted to design culturally safe, community-led prevention approaches from the start. (IUIH, sub. 81, p. 10)

A lack of suitable funding mechanisms for services can have significant effects for consumers.

> The failure to distribute funds efficiently means that First Nations communities are left waiting for essential mental health care, often until crises escalate to hospitalisation, incarceration, or tragic loss of life. These delays contradict the commitments under the Closing the Gap Agreement, which calls for timely, equitable, and needs-based investment in Aboriginal and Torres Strait Islander-led services. (IUIH, sub. 81, p. 11)

Insufficient reporting and accountability

The data indicators in the Agreement should enable measurement of progress against its intended outcomes. However, review participants noted data is not available to determine if the Agreement and bilateral schedules have had any impact on outcomes for Aboriginal and Torres Strait Isander SEWB (Northern Territory Mental Health Coalition, sub. 54, pp. 1–2).

> Data and performance information between the National Agreement and the bilateral agreements is similarly misaligned. For example, the National Agreement includes a priority performance indicator as social and emotional wellbeing (SEWB) measures for Aboriginal and Torres Strait Islander peoples, however none of the bilateral agreements include such measures. Similarly, the National Agreement includes an indicator related to growth in Aboriginal and Torres Strait Islander mental health workforce that is not represented in the bilateral agreements. (Gayaa Dhuwi (Proud Spirit) Australia, sub. 75, p. 6)

The insufficient and misaligned data results in a lack of transparency and accountability for commitments within the Agreement. More information on monitoring and accountability commitments can be found in chapter 2. Monitoring commitments in the Agreement specific to Aboriginal and Torres Strait Islander SEWB face mostly the same challenges highlighted more broadly.

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.

7.4 The next agreement

The next agreement provides an opportunity to make meaningful and tangible commitments that contribute to better outcomes for Aboriginal and Torres Strait Islander SEWB. To achieve this, the next agreement should:

- ensure meaningful alignment with the Closing the Gap targets, Priority Reforms and other key documents
- include a separate Aboriginal and Torres Strait Islander schedule
- address key priorities including cultural safety, funding and workforce
- improve and clarify governance arrangements
- enable co-designed monitoring of the agreement and Aboriginal and Torres Strait Islander SEWB outcomes, including a community-led evaluation of the schedule.

The next agreement should articulate the ways it will support Closing the Gap and other important policy documents

The National Agreement on Closing the Gap is an important platform for cross-government reform. However, it does not provide the required detail on how parties will improve Aboriginal and Torres Strait Islander SEWB. Therefore, the National Agreement on Closing the Gap does not replace the need for a comprehensive, informed and co-designed national mental health and suicide prevention agreement.

While the current Agreement outlines a commitment to align with the National Agreement on Closing the Gap, the next agreement should clarify how it aims to work alongside the National Agreement on Closing the Gap and contribute to the Priority Reforms. Providing clarity on how the two agreements interact would ensure governance arrangements and accountability enable progress against national goals.

> A clear articulation of the relationship between governance of the National Agreement and Closing the Gap is essential given the overlap in purpose to improve social and emotional wellbeing and mental health and reduce suicide rates for First Nations people. A key area requiring clarification is the intention for the governance and activity of the National Agreement to embed Closing the Gap reforms, such as 'building the community-controlled sector' and 'formal partnerships and shared decision-making'. (National Mental Health Commission and National Suicide Prevention Office, sub. 70, p. 15)

The next agreement needs to demonstrate genuine commitment to other key documents in the Aboriginal and Torres Strait Islander SEWB space. The agreement needs to commit to the implementation of the Gayaa Dhuwi (Proud Spirit) Declaration and Implementation Plan and the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy as well as the forthcoming National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing.

The next agreement should not just commit to aligning with these documents but should include tangible actions to progress their implementation. These actions need to be consistent between the agreement and the bilateral schedules to ensure meaningful, coordinated and adequately funded implementation.

The agreement should include an Aboriginal and Torres Strait Islander schedule

Commitments to Aboriginal and Torres Strait Islander outcomes are scattered throughout the National Mental Health and Suicide Prevention Agreement and there is no coordinated approach to their implementation.

The next mental health and suicide prevention agreement should include a separate schedule outlining ways to improve the services supporting Aboriginal and Torres Strait Islander people's SEWB. Aboriginal and Torres Strait Islander people should be involved in a co-design process with governments to develop the new schedule and ensure it reflects the community's SEWB needs. This is in line with governments' commitments under Closing the Gap to work in partnership with Aboriginal and Torres Strait Islander people, their communities, organisations and businesses to improve SEWB. The PC recommends the current Agreement be extended for 12 months to allow time for the co-design process, including for a schedule to improve services for Aboriginal and Torres Strait Islander people (recommendation 4.2).

Review participants who commented on this issue agreed that a separate Aboriginal and Torres Strait Islander schedule is necessary (Gayaa Dhuwi (Proud Spirit) Australia, sub. 230, p. 4; Queensland Aboriginal

and Islander Health Council, sub. 221, p. 2; TWB Consulting, sub. 98, p. 2; Victorian Aboriginal Legal Service, sub. 200, p. 4). Many non-Indigenous organisations also voiced their support.[73]

The Victorian Aboriginal Community Controlled Health Organisation and Balit Durn Durn Centre of Excellence for Aboriginal Social and Emotional Wellbeing (sub. 162, p. 7) highlighted the importance of a separate schedule that seeks to improve SEWB.

> The Interim Report [of this review] notes the importance of Aboriginal SEWB and recommends the incorporation of a separate schedule in the next Agreement to outline actions to improve Aboriginal SEWB. We welcome this and uphold that inclusion of SEWB within a new iteration of the Agreement would not only benefit Aboriginal communities but Australians more broadly.

The Indigenous Australian Lived Experience Centre (IALEC) also endorsed a schedule through the National Mental Health Consumer Alliance's submission (sub. 149, p. 17).

> IALEC endorses the inclusion of a dedicated Schedule for Aboriginal and Torres Strait Islander peoples within the new Agreement. IALEC advocates for the equitable and transparent distribution of resources, the genuine inclusion of lived experience at all levels of decision-making, and the prioritisation of co-design, leadership, and decision-making power held by Aboriginal and Torres Strait Islander peoples – not just rhetorical commitment, but meaningful structural change.

The schedule should be framed around the Closing the Gap Priority Reforms for joint national action, namely: formal partnerships and shared decision-making; building the community-controlled sector; transforming government organisations; and shared access to data and information at a regional level (Coalition of Peaks and Australian Governments 2020b).

The development of the Aboriginal and Torres Strait Islander schedule in the next agreement should be informed by the process undertaken to negotiate the First Nations Schedule of the new National Health Reform Agreement (NHRA) (Butler 2024). This schedule in the NHRA was co-designed with Aboriginal and Torres Strait Islander people. It creates policy focus on commitments specific to Aboriginal and Torres Strait Islander people, while also influencing the overall agreement to better meet the needs of Aboriginal and Torres Strait Islander people. This supports transparency and enables consideration of the unique factors Aboriginal and Torres Strait Islander communities experience, which are important to an effective agreement.

The schedule should address several priorities

While the next agreement should be co-designed with Aboriginal and Torres Strait Islander people, review participants consistently raised key areas that should be prioritised. These priorities are key to an agreement that improves outcomes for Aboriginal and Torres Strait Islander SEWB. Addressing funding fragmentation could also be a priority for the next agreement – this is discussed in more detail below.

[73] For example: AHPA, sub. 178, p. 7; AMAN, sub. 124, p. 2; Anglicare WA, sub. 225, p. 3; APHA, sub. 163, p. 14; BDI, sub. 151, p. 14; Beyond Blue, sub. 156, pp. 7–8; CHF, sub. 140, p. 11; CMHA, sub. 216, p. 7; CoMHWA, sub. 148, pp. 12, 17; LELAN, sub. 190, p. 13; Lifeline Australia, sub. 128, p. 2; Manna Institute, sub. 194, p. 5; Matilda Centre and PREMISE Next Generation, sub. 220, p. 6; Medibank, sub. 198, p. 4; Mental Health Australia, sub. 153, p. 17; MHCC, sub. 120, p. 2; MHFAI, sub. 147, p. 5; MHLEPQ, sub. 144, pp. 5–6; MHNS, sub. 202, p. 6; Mind Australia, sub. 187, p. 8; Orygen, sub. 169, p. 6; PACFA, sub. 180, p. 10; PHN Cooperative, sub. 208, p. 27; QAMH, sub. 130, p. 8; QNADA, sub. 173, p. 4; QNMU, sub. 136, p. 7; SIHA, sub. 237, p. 5; Simon Katterl Consulting, sub. 204, p. 5; Suicide Prevention Australia, sub. 214, p. 8; Turner Institute for Brain and Mental Health, sub. 242, p. 9; Victorian Government, sub. 228, p. 5; WAAMH, sub. 172, p. 9; ZSIA, sub. 238, p. 5.

Cultural safety

Review participants raised the need to meaningfully embed a focus on culturally safe services in the next agreement (Carers WA sub. 43, p. 11; Ruah Community Services, sub. 14, p. 9; Suicide Prevention Australia, sub. 59, p. 11). While cultural safety was mentioned in the current Agreement, there needs to be clear and implementable commitments in the next agreement reflected in the bilateral schedules to ensure that outcomes are achieved. Gayaa Dhuwi (Proud Spirit) Australia (sub. 75, p. 5) outlines some of the principles and actions required to establish culturally safe services:

> … services and their workforce must recognize the inherent aspects of delivery of care that may prevent culturally safe care from occurring, including the impact of intergenerational trauma, the historical impact of colonisation, the inherent biases of westernized models of healthcare and unconscious individual bias.

These actions must be seen as priority, ensuring Aboriginal and Torres Strait Islander people can access the same quality of culturally safe care in mainstream services as they would when attending ACCHOs. The Mental Health Lived Experience Peak Queensland (transcript, 20 August 2025, p. 78) highlighted the importance of cultural safety in mainstream services:

> … our people must walk into mainstream systems every day, including emergency departments, child protection and the police, and feel safe and know that the spaces where our people are at most at risk will remain safe and accountable.

Funding for improvements in cultural safety should not impinge on funding allocated to ACCHOs. The Victorian Aboriginal Legal Service (sub. 200, p. 16) highlighted this in the context of eliminating institutional racism:

> The institutional racism that exists in mainstream health services is harmful and must be eradicated. Aboriginal people have a right to choose where they access care, be it through mainstream or ACCHO delivered services. A new Agreement must increase the cultural safety of mainstream services to ensure that Aboriginal people accessing care through those mainstream services are receiving the same quality and culturally safe care they would through an ACCHO delivered service. Improving the cultural competency and safety of mainstream services should not limit the funding allocated to ACCHOs. ACCHOS must be adequately funded to service all people who wish to access their service.

Workforce investment

Greater investment in the Aboriginal and Torres Strait Islander SEWB workforce is another issue review participants noted as a key focus. There have been calls to increase investment in this workforce (for example, Beyond Blue, sub. 37, p. 5, NACCHO, sub. 245, p. 8). This refers not only to an increase in the size of the workforce, but also dedicated funding for professional development and support.

> The lack of dedicated funding for professional development, clinical supervision, and mental health workforce support further exacerbates workforce fatigue and turnover, limiting the capacity of ACCHSs to meet increasing demand and the critical and rising levels of poor mental health discussed earlier. (IUIH, sub. 81, p. 11)

The Black Dog Institute (sub. 61, p. 6) highlighted a need to include specific measures to invest in the SEWB of Aboriginal and Torres Strait Islander Healthcare Workers in the future bilateral schedules:

> Provide expanded SEWB Support to First Nations healthcare workforce: First Nations health workers face heavy workloads, racism, and the ongoing impact of colonial load – contributing to high turnover.

Suicide Prevention

Aboriginal and Torres Strait Islander people have distinct experiences and understandings of SEWB and require culturally informed approaches to suicide prevention. The next agreement should therefore include specific commitments and funding of suicide prevention for Aboriginal and Torres Strait Islander people. These commitments should be outlined within the Aboriginal and Torres Strait Islander schedule.

Aboriginal and Torres Strait Islander suicide prevention within the schedule should focus on Aboriginal and Torres Strait Islander-led solutions, including the implementation of the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy, integrating the SEWB model of care into suicide prevention, aftercare and postvention, and uplifting the Aboriginal and Torres Strait Islander suicide prevention workforce (eMHPrac, sub. 47, p. 4; Gayaa Dhuwi (Proud Spirit) Australia, sub. 75, p. 4; Suicide Prevention Australia, sub. 59, p. 12). Gayaa Dhuwi (Proud Spirit) Australia (2025b, p. 10) outlines the need for these approaches:

> A more sustained and culturally responsive postvention approach is needed, one that supports not only families and individuals, but entire communities over time … Likewise, self-harm requires targeted, trauma-informed responses that reflect cultural understandings of distress, identity, and belonging.

While suicide prevention policies aiming to support Aboriginal and Torres Strait Islander people should be covered in the Aboriginal and Torres Strait Islander schedule, the suicide prevention schedule should ensure cultural safety is a priority in all mainstream initiatives and commitments (chapter 8).

Stronger governance mechanisms are needed

The agreement should designate a specific Aboriginal and Torres Strait Islander governance mechanism to lead the schedule design and implementation. Review participants noted the importance of Aboriginal and Torres Strait Islander governance:

> Future agreements, bilateral agreements and governance mechanisms must be developed in partnership with Aboriginal and Torres Strait Islander peoples. (Gayaa Dhuwi (Proud Spirit) Australia, sub. 75, p. 6)

Aboriginal and Torres Strait Islander governance is necessary to improving SEWB outcomes. Aboriginal and Torres Strait Islander governance structures hold an understanding of lived and living experience, community needs and cultural safety, and have greater capacity for meaningful engagement. Effective governance arrangements are also required to fulfil governments' commitments to the Closing the Gap Priority Reforms, as part of Priority Reform 1 (formal partnerships and shared decision-making) and Priority Reform 3 (transforming government organisations).

While it is not referenced in the current Agreement, the SEWB PP has acted as the primary governance body under the Agreement for Aboriginal and Torres Strait Islander SEWB. This is an appropriate and effective governance mechanism for this agreement as the group brings together the experiences and voices of community and government, to act in collaboration and ensure communities' voices are heard and acted upon.

The next agreement should further strengthen this governance mechanism. The SEWB PP should play an explicit governance role in the process of designing and implementing the next agreement.

> The government should look to the example of the five policy partnerships established under the Closing the Gap Agreement that exemplify how self-determination and shared governance can work in practice (Gayaa Dhuwi (Proud Spirit) Australia, sub. 75, p. 6)

The SEWB PP highlighted the need to strengthen governance in the Agreement's Annual National Progress Report for 2023-24 with suggestions to:

> [b]etter utilise the policy expertise and strengths of the SEWB Policy Partnership – for instance, solidifying the authorising environment and endorsement processes for key policy documents such as the Gayaa Dhuwi Declaration Framework and Implementation Plan and the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy. (NMHC 2025)

To enact these changes and fully implement the Closing the Gap Priority Reforms, the governance arrangements in the next agreement need to give the SEWB PP decision-making power and authority over issues relating to Aboriginal and Torres Strait Islander SEWB. These arrangements should be formally set out within the next agreement to ensure commitment and transparency.

Due to the potential for an increased workload, the SEWB PP should receive sufficient funding and compensation for their additional time and work. The National Aboriginal Community Controlled Organisation (NACCHO, sub. 245, p. 7) raised the need for ongoing funding for the SEWB PP, and other key initiatives:

> There also needs to be committed, long-term and sustainable funding to support strategic policy work led by the ACCHO and ACCO sector. Key initiatives such as the Culture Care Connect program and the SEWB Policy Partnership are only funded until mid-2026. This creates uncertainty and risks disruption to vital community-led efforts. Without long-term investment, these initiatives cannot deliver the continuity and impact they are designed for. Another critical example is the Gayaa Dhuwi (Proud Spirit) Declaration Framework and Implementation Plan, which was launched in February with activity set to begin on 1 July. However, it currently lacks any committed funding to support its rollout.

Once key priorities for the schedule have been set, the SEWB PP should consider if governance arrangements have adequate representation in key areas identified, such as representation of the workforce and its peak bodies. It may also be beneficial to consider the breadth of government representatives and portfolios on the SEWB PP due to the interconnected nature of SEWB.

Designated funding for Aboriginal and Torres Strait Islander commitments should be included in the next agreement

Review participants called out the importance of dedicated funding for the Aboriginal and Torres Strait Islander schedule (for example, Beyond Blue, sub. 156, p. 8). Black Dog Institute (sub. 151, p. 15) explained:

> A purposeful, outcomes-driven First Nations Schedule must be backed by appropriate and dedicated funding mechanisms. This funding should sit alongside – rather than be carved out of – the broader Agreement and be delivered through bilateral agreements between States and the Commonwealth to ensure jurisdictions are held accountable for improving SEWB outcomes.

The next agreement should designate specific funding towards the schedule and Aboriginal and Torres Strait Islander commitments. This funding should not add to the disjointed funding environment for ACCHOs; funding under the schedule should focus on initiatives that enable reform, such as the key priorities identified above. In the 2023-24 Agreement Annual Progress Report, the SEWB PP highlighted actions needing investment, including to:

- strengthen the investment in community-led programs, including greater investment into outreach services and workforce training to improve access to services in remote and regional areas, and move to longer-term resourcing

- allocate additional resources to remote and regional areas to ensure more equitable access to services and improve digital infrastructure in remote areas to allow an effective expansion of telehealth (NMHC 2025, p. 21)

In determining funding mechanisms to support improved SEWB outcomes, the agreement should take a similar funding approach to the National Skills Agreement (NSA). The NSA includes direct funding commitments to achieve improvements in Aboriginal and Torres Strait Islander outcomes. The Australian Government provides part of these funding commitments as transfers to state and territory governments, with the requirement that states and territories match the federal funding contribution (DEWR 2024, pp. 17-18). This allows for a minimum amount of long-term funding for commitments and ensures coordination and cost sharing between governments. Adopting this approach would help embed specific funding for priorities such as cultural safety throughout both the agreement and its bilateral schedules.

The next agreement should also include funding for evidence-based initiatives to expand community mental health services responding to local need (chapter 6). Funding for SEWB services in the agreement should prioritise ACCHOs. The NSA (DEWR 2024) sets out a specific clause (A103) for Closing the Gap implementation plans:

> In agreeing implementation plans, the Commonwealth will favour proposals that include a strong focus on and investment in the ACC [Aboriginal Community Controlled] and FNO [First Nations owned] sectors, unless there is a robust rationale (including the views of First Nations communities) that alternative investments will better achieve progress against Closing the Gap targets.

The next agreement should adopt a similar clause in the proposed Aboriginal and Torres Strait Islander schedule that prioritises funding for ACCHOs to deliver SEWB services, aligning with Closing the Gap Priority Reform 2 (Building the community-controlled sector).

Many review participants spoke of the need to strengthen the capacity and boost funding to the Aboriginal and Torres Strait Islander community-controlled sector to deliver SEWB services. This includes consolidating the various funding streams for SEWB and mental health programs, and transferring the commissioning of SEWB funding from PHNs to ACCHOs, while prioritising flexibility and sustainability (Black Dog Institute, sub. 61; Institute for Urban Indigenous Health, sub. 81). The Institute for Urban Indigenous Health (sub. 81, p. 12) suggested this would:

- reduce delays and inefficiencies associated with PHN-led commissioning
- ensure funds are allocated according to community-identified needs, rather than external funding priorities
- strengthen the role of ACCHSs as the primary providers of culturally safe mental health care
- align with the Closing the Gap Priority Reforms, particularly formal partnerships and shared decision-making.

Consolidating funding streams and addressing fragmentation could be a priority for the next agreement. The SEWB PP is best placed to lead such an initiative.

How the agreement is monitored and evaluated needs to be co-designed

The current Agreement includes plans to develop specific indicators for Aboriginal and Torres Strait Islander SEWB but as discussed in section 7.3, monitoring of progress has been insufficient.

The next agreement should reconsider how success is measured and introduce consistent indicators in the agreement and its bilateral schedules. This should be done in partnership with Aboriginal and Torres Strait

Islander people, creating an opportunity to move away from deficit-based narratives to a strengths-based framework. This shift would align with key documents such as the Gayaa Dhuwi (Proud Spirit) Declaration.

> Future agreements provide an opportunity to shift towards a strength-based framework for measuring progress in recognition of the complex and interrelated factors that underpin the social and emotional wellbeing and mental health of Aboriginal and Torres Strait Islander peoples. This aligns with the Gayaa Dhuwi (Proud Spirit) Declaration and the National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing which emphasise how strength in culture, community and connection support outcomes … This shift is essential in moving away from deficit-based narratives and creating policies and programs that genuinely promote systemic and lasting change. Outcomes measurement in future Agreements should be designed in partnership with Aboriginal and Torres Strait Islander organisations and be committed to in bilateral agreements. (Gayaa Dhuwi (Proud Spirit) Australia, sub. 75, p. 6)

AIHW is establishing a First Nations Health System Metrics Expert Committee, as part of the development of measures to assess the effectiveness of health system reforms for Aboriginal and Torres Strait Islander people under the new NHRA First Nations schedule. This work will ensure that measures under the NHRA are co-designed with Aboriginal and Torres Strait Islander people, allowing for strengths-based reporting (AIHW 2025e). The next agreement should either leverage this committee and its work or create a similar process.

The way data is collected, held and presented should align with key principles and policies relating to Aboriginal and Torres Strait Islander data (box 7.3). This includes ensuring that data and measurements are relevant to Aboriginal and Torres Strait Islander communities and align with their priorities. The National Aboriginal Community Controlled Organisation (sub. 245, p. 9) noted the:

> … limitations of current national suicide data, which focus only on high-level mortality figures. Broader, locally informed data, including behavioural indicators such as GP visits and help-seeking patterns, are essential for effective planning and funding. A localised register, guided by Aboriginal and Torres Strait Islander governance structures such as the Data Policy Partnership, would provide culturally relevant insights. All measurement must align with the SEWB framework, incorporating indicators such as connection to family and kin.

Any data in the next agreement collected and used to measure Aboriginal and Torres Strait Islander SEWB should be transparent and accessible to communities. The Victorian Aboriginal Legal Service (sub. 200, p. 18) outlines the importance of transparency in data:

> This lack of transparency enables government to avoid public scrutiny and accountability for the impacts of its policymaking. If ACCOs and ACCHOs are to provide adequate services, access sufficient resources, advocate for change and hold the government accountable, Aboriginal people and communities must be able to:
>
> - Exercise control over the manner in which data concerning Aboriginal individuals and communities is gathered, managed, interpreted, utilised and published; and
> - Access and collect data obtained about Aboriginal individuals and communities.

Box 7.3 – Reporting on Aboriginal and Torres Strait Islander data

The way data is presented and reported can determine the narrative about the people at the centre of the data – it is not neutral. This is particularly important when developing and reporting on Aboriginal and Torres Strait Islander data, which has historically been deficit focused, influencing policy decisions that have at times led to harmful and undesirable outcomes (Lowitja Institute 2023b).

There are three key principles to ensure that data on Aboriginal and Torres Strait Islander people is presented in an accurate, respectful and meaningful way.

Strengths-based data

Strengths-based data focuses on collecting and reporting information in a self-determined way that highlights the strengths of Aboriginal and Torres Strait Islander communities. It does this by emphasising the resources, capabilities and resilience that individuals, families and communities possess even in the face of adversity.

In order for data to be strengths-based, it should not fall into the categories of BADDR data – Blaming, Aggregate, Decontextualised, Deficit and Restricted data (Walter et al. 2020, p. 3).

There are multiple data frameworks that can help shift data from BADDR to be strengths-based. One of these frameworks is CARE principles (Collective benefit, Authority to control, Responsibility, and Ethics), developed by the Global Indigenous Data Alliance. These principles ensure that the governance and use of data are respectful and beneficial to Indigenous communities (Carroll et al. 2021, p. 2).

An example of strengths-based data in practice is Mayi Kuwayu, a longitudinal study exploring the connections of Aboriginal and Torres Strait Islander wellbeing to Country, cultural practices, spirituality and language use. The Mayi Kuwayu Study was created by and for Aboriginal and Torres Strait Islander people with a majority Aboriginal and Torres Strait Islander team. The study has strong Aboriginal and Torres Strait Islander governance and guidance in place and adheres to Indigenous Data Sovereignty principles (Mayi Kuwayu 2025).

Indigenous data sovereignty and Indigenous data governance

Indigenous data sovereignty (IDS) and Indigenous data governance (IDG) shift the way research has historically been done ‘on’ Aboriginal and Torres Strait Islander people, to research ‘for’ and ‘by’ Aboriginal and Torres Strait Islander people (Lowitja Institute 2023a, p. 2). They are important principles when working with data, as they ensure that data is strengths-based and useful to the communities at the centre of the data.

The Lowitja Institute describes IDS as ‘the right of Aboriginal and Torres Strait Islander peoples, communities and organisations to maintain, control, protect, develop, and use data as it relates to us’. IDG is ‘Aboriginal and Torres Strait Islander people and communities right to govern, retain control over, manage the collection, usage, and application of data in ways that align with their self-determined priorities, aspirations and practices’ (Lowitja Institute 2023a, p. 2). Strong governance ensures that data collection:

- supports the priorities of Aboriginal and Torres Strait Islander peoples, communities or organisations
- implements agreed standards for quality control
- helps ensure data is available in a timely way (Lowitja Institute 2023a, p. 2).

Box 7.3 – Reporting on Aboriginal and Torres Strait Islander data

Closing the Gap Priority Reform 4 – shared access to data and information at a regional level

Governments commit through the National Agreement on Closing the Gap to share data and change how they collect and use data to better meet the needs of Aboriginal and Torres Strait Islander people, and to enable Aboriginal and Torres Strait Islander people to use data to serve self-determined purposes. IDS and IDG are currently not explicitly included under Priority Reform 4. The PC has previously recommended to amend Priority Reform 4 to include IDS and IDG (PC 2024b, p. 68).

The final review of the next agreement must have a community-led evaluation of the Aboriginal and Torres Strait Islander schedule. This would allow community to provide their own insight and perspectives on areas of achievement and how the schedule can continue to improve. A community-led evaluation for the schedule should be undertaken by an appropriate group as decided by the Aboriginal and Torres Strait Islander governance mechanism. The evaluation would need to be appropriately resourced in order to not create extra burden for those who are already delivering outcomes within community.

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.

8. Suicide prevention

Key points

- **Suicide prevention in Australia is in a period of transition. There has been a shift in suicide prevention policy towards an integrated, whole-of-government approach addressing the social and emotional drivers of suicide. This shift recognises the suicide prevention system sits alongside the mental health system, not within it.**
- **The National Mental Health and Suicide Prevention Agreement reflects this shift. It includes ambitious priorities and commitments to improving Australia's suicide prevention services and reducing the rate of suicide, suicidal distress and self-harm through a whole-of-government approach.**
- **The establishment of the National Suicide Prevention Office (NSPO) is the only national output in the Agreement specifically for suicide prevention.**
  - The NSPO was established by the Australian Government and is working to implement a national whole-of-government approach to suicide prevention. It published the National Suicide Prevention Strategy 2025–2035 and is developing an outcomes framework for suicide prevention.
- **Governments also committed to invest in specific suicide prevention services through the bilateral schedules. While some progress has been achieved, significant gaps remain, which affect the availability of supports to people who need them.**
- **Since the Agreement was signed, there has been no change in the suicide rate and anecdotal evidence points to an increase in rates of distress.**
  - The contribution of the Agreement to any changes in suicide, suicidal distress and self-harm is difficult to assess. Governments share responsibility for key commitments, leading to ineffective accountability mechanisms. Reporting of progress has been significantly delayed.
- **Suicide prevention in the next agreement should be guided by the National Suicide Prevention Strategy. Areas where mental health and suicide prevention policy overlap should be included in the main agreement. A separate schedule to the agreement should enable progress in areas where policy intervention is relevant specifically to suicide prevention. This schedule should:**
  - **articulate short-term objectives, outcomes and actions clearly linked to the Strategy**
  - **list the funding commitments for suicide prevention services distinct from mental health**
  - **include outcomes selected from the forthcoming National Suicide Prevention Outcomes Framework**
  - **require the NSPO to be responsible for the monitoring and reporting of the schedule.**

Suicide, self-harm and suicidal distress are a significant issue in Australia. On average, every day nine people die by suicide and more than 150 people attempt to take their own life (NSPO 2025, p. 7). Since 2015, about 3,000 people have died by suicide every year (AIHW 2023b).

The distress of the people who have died by suicide and those people who have lost someone to suicide is immeasurable. However, trying to contextualise the impact in numbers helps to mobilise efforts and hold government accountable for the lack of progress (PC 2020, p. 409). Each death of a person by suicide is estimated to impact 135 people (Cerel et al. 2019, p. 529), which means approximately 1,215 people are affected by suicide each and every day in Australia. At some point in their lives, one in six Australians aged 16–85 years had serious thoughts of attempting suicide (AIHW 2024f). In 2020, the PC estimated suicide and suicidal distress cost $30.5 billion each year as a result of the healthy years of life lost due to disability or premature death and other direct and indirect costs such as medical costs (PC 2020, vol. 2, p. 416).

Information on government expenditure on suicide prevention services is not regularly reported. In 2019-20, only 1% ($120 million) of Australian, state and territory government expenditure on mental health and suicide prevention programs was spent directly on suicide prevention (PC 2021, p. 19).[74] While there are no current figures on total government funding for suicide prevention services, the Australian Government spent $150 million in 2022-23 on the National Suicide Prevention Program (SCRGSP 2025, table 13A.2) as well as their expenditure through the Agreement of approximately $78.5 million a year.[75]

The approach to suicide prevention in Australia is in a period of transition (Bassilios et al. 2024, p. 1). Australia's previous response to suicide prevention relied on the person in distress seeking help, primarily through the health or hospital system (National Suicide Prevention Adviser 2020a, p. 5). But this approach is not effective, as one in ten people who died by suicide did not access any health services in their last year of life (AIHW 2025j).[76] It also misses engaging early when people experience distress to reduce the factors contributing to suicide. There has been a shift towards an integrated, whole-of-government approach that seeks to address the social and emotional factors affecting suicidal distress and recognises the suicide prevention system as sitting alongside the mental health system, not within it (Lifeline Australia 2021; National Suicide Prevention Adviser 2020a, pp. 5–6; NSPO 2025, pp. 13, 68).

Assessing progress in suicide prevention through the National Mental Health and Suicide Prevention Agreement is not straight forward for the same reasons as assessing progress against the Agreement as a whole (chapter 2).

- Monitoring and reporting commitments under the Agreement have not been adhered to.
- Key data gaps remain.
- Understanding the specific impact of the Agreement is difficult due to external factors, such as the COVID-19 pandemic occurring during the period of the Agreement and other government policies impacting the suicide prevention system.
- The Agreement has only been in operation for three years, which is a relatively short period to realise change across the system.

[74] Suicide prevention programs were categorised as those aimed at interrupting an individual's movement towards suicide and to reduce suicidal thoughts, plans, attempts and deaths (PC 2021, p. 10).
[75] The exact figure of government expenditure is unclear. The annual expenditure on suicide prevention programs in the Agreement is approximately $132 million, with the Australian Government committing $78.5 million a year. The Australian, state and territory governments also fund suicide prevention services outside of the Agreement (box 8.8).
[76] This study looked at access to hospitals, services covered under the Medicare Benefits Schedule and the Pharmaceutical Benefits Scheme for people who died by suicide between 1 July 2010 and 31 December 2017.

This chapter considers the progress the Agreement has made in implementing an integrated, whole-of-government suicide prevention system that contributes to reducing suicides to zero (section 8.1). It examines the commitments made in the Agreement that affect suicide prevention (section 8.2) and outlines a new way of incorporating suicide prevention in the next agreement (section 8.3).

8.1 What progress has been made?

There has been mixed progress under the Agreement

The Agreement addresses suicide prevention largely in combination with mental health services. Only a limited number of elements are directly related to suicide prevention (box 8.1).

Box 8.1 – Suicide prevention in the Agreement

Objective

Governments agree on their shared objective to work collaboratively together to implement systemic, whole-of-government reforms … progress the goal of zero lives lost to suicide, and deliver a … suicide prevention system that is comprehensive, coordinated, consumer-focussed and compassionate.

Outcomes

Reduce suicide, suicidal distress and self-harm through a whole-of-government approach to coordinated prevention, early intervention, treatment, aftercare and postvention supports.

Outputs

Establishment of the National Suicide Prevention Office (NSPO). A related commitment is that governments support the NSPO to develop a National Suicide Prevention Workforce Strategy.

Commitments to specific suicide prevention services are contained in the bilateral schedules (table 8.1).

National priorities

Governments agree, in collaboration, to:

- seek to reduce suicide deaths, suicide attempts, and self-harm towards zero
- progressively meet the different needs of identified priority population groups and increase accessibility to services through evidence informed care and targeted approaches
- develop suicide prevention services and programs in collaboration with communities and people with lived experience to identify gaps in service provision and to gain insights into individual experiences
- improve joint regional planning for suicide prevention to drive development of evidence-based services in areas of identified need to address gaps in service provision nationally
- improve the quality of suicide prevention services by establishing standards either developed specifically for the program or by an external organisation to improve outcomes of service provision
- incorporate suicide prevention training into service modelling to develop skills for building capacity and fostering suitably skilled workers who are empathetic to the needs of people in suicidal distress
- build competency within the suicide prevention workforce, including the peer workforce, through evidence-informed training

Box 8.1 – Suicide prevention in the Agreement

- seek to avoid or minimise service gaps, fragmentation, duplication, and inefficiencies in joint suicide prevention activities.

Schedule A

Governments commit to working together to pursue whole-of-government approaches to mental health and suicide prevention in priority areas, such as education, work environments and homelessness.

Source: Clauses 23, 26b, 27h, 124 and 156; Schedule A, clause 1.

A sound objective lacking progress

The Agreement sets out an overarching objective to 'progress the goal of zero lives lost to suicide' (clause 23). The objective provides a clear and simple, long-term unifying purpose for all governments.

The objective is in line with previous government initiatives, such as the National Suicide Prevention Advisor and the National Suicide Prevention Taskforce commencing in 2019 (National Suicide Prevention Adviser 2020b), and present-day strategies such as the National Agreement on Closing the Gap (Coalition of Peaks and Australian Governments 2020a).

There has been minimal progress in reducing suicide rates, which have remained almost unchanged over the past decade (chapter 2). In 2023, there had been a reported 3,214 deaths by suicide, or 11.8 deaths per 100,000 people (AIHW 2023b). Preliminary data has indicated a decline in the age-standardised rate of suicide of young people (aged up to 25 years) since 2020 (AIHW 2025p). However, caution should be used in interpreting this data as it is subject to change and comes following a decade of rising rates of suicide deaths in young people.[77] Anecdotal evidence from review participants indicated concerning trends in rising suicide rates among groups disproportionately impacted by suicide, in particular Aboriginal and Torres Strait Islander people (Carers WA, sub. 43, p. 10; Lifeline Australia, sub. 8, p. 3) and people living in remote areas (Sidney Allo and Janet Timbert, transcript, 19 August 2025, p. 22). Suicide prevention for Aboriginal and Torres Strait Islander people is discussed further in chapter 7.

There is mixed evidence on the rates of suicidal distress and self-harm (chapter 2). Hospitalisations from self-harm have declined from their peak of 136 hospitalisations in 2016-17 to 90 hospitalisations per 100,000 people in 2023-24 (AIHW 2025q, table S2). However, evidence from service providers and advocacy groups suggests there has been no change, or in some cases a worsening of incidents of self-harm and suicidal ideation, particularly in young people (chapter 2). For example, yourtown (sub. 71, p. 12) stated:

> Over the past five years, there has been a 48% rise in the number of young people from [rural and remote] areas presenting to the service with suicidal ideation. Suicide-related concerns have increased from affecting one-in-six of these young people to one-in-four over the same five-year period.

The Agreement contains commitments to improve suicide-related data, led through the Data Governance Forum (DGF) (Annex B). The DGF have assisted to progress initiatives, such as by supporting data development and technical discussions on the development of a priority indicator for emergency department self-harm presentations (DGF, pers. comm., 20 May 2025). Improvements in data sharing supported by the

[77] As death by suicide is a statistically rare event, relatively small changes in numbers can result in large fluctuations in the rate (AIHW 2023b).

DGF (chapter 2) have led to regular reporting of data on suicide and self-harm monitoring for smaller geographic areas (DGF, pers. comm., 20 May 2025). However, our understanding of suicide and suicidal distress is still restricted by infrequent collection of national surveys of mental health and remaining data gaps (chapter 2).

It remains difficult to understand from data and reporting whether the whole-of-government approach to suicide prevention activities has been embedded in practice, as outlined in the Agreement (box 8.1). Advocacy groups and service providers stated there is limited evidence of a whole-of-government approach on the ground.

> Effective whole-of-government reforms seeking to drive a reduction in social determinants of suicide would expect to be paired with a reduction in Lifeline's contact data. However, this is not what is being witnessed on the ground at Lifeline. We are seeing more people than ever reach out to Lifeline's crisis support offerings. (Lifeline Australia, sub. 8, p. 6)

> … despite repeated commitments to integration, mental health and suicide prevention are still treated as the responsibility of the health system alone, rather than a whole-of-government priority. (Ruah Community Services, sub. 14, p. 10)

> A whole of government approach to suicide prevention is key. Still, an investment in building capabilities across government agencies and clear mechanisms to monitor and support cross-jurisdictional and cross-portfolio action is needed. (Everymind, sub. 32, p. 3)

> Australia still lacks a whole-of-system approach and a shared understanding of the drivers of suicidality … Whole-of-government collaboration is weak, as suicide prevention efforts remain fragmented across portfolios, and while the National Agreement commits governments to cooperation, practical implementation and funding alignment are inconsistent. (National Mental Health Consumer Alliance, sub. 66, pp. 15, 22)

One possible explanation for the lack of progress is the scale of the task governments have signed up to. The Agreement was only signed in 2022 and achieving ambitious commitments such as whole-of-government integration in a four-year time frame is unlikely to be feasible. It is also plausible some of the changes in policy and service delivery arising from the Agreement have not yet had time to flow through to the system.

The National Suicide Prevention Office is a key output of the Agreement

As part of its commitments under the Agreement, the Australian Government established the National Suicide Prevention Office (NSPO). The creation of the NSPO was announced in May 2021, and it operates as a non-statutory office within the Department of Health, Disability and Ageing (NSPO 2024a). The NSPO has been set up to lead a whole-of-government approach to suicide prevention (box 8.2).

The establishment of the NSPO has been well received by people with lived and living experience as well as service providers.

> The development of the National Suicide Prevention Office … represent[s] [a] significant step forward in enhancing the sustainability and services provided by the Australian mental health and suicide prevention system. (Lifeline Australia, sub. 8, p. 5)

> The National Suicide Prevention Office is a good step towards coordinated suicide prevention. (Movember Institute of Men's Health, sub. 80, p. 7)

Box 8.2 – About the National Suicide Prevention Office

The Agreement tasked the National Suicide Prevention Office (NSPO) with leading a national whole-of-government approach to suicide prevention (clause 125). Significant progress has been made in achieving this task.

- The NSPO worked with people with lived and living experience, service providers, peak bodies and governments to develop and release the National Suicide Prevention Strategy 2025–2035. The Strategy outlines 'a comprehensive approach to suicide prevention, aligning national efforts with the latest evidence and insights about what works' (NSPO 2025, p. 17).
- The NSPO is developing a national outcomes framework for suicide prevention. It is also responsible for working with all jurisdictions to set priorities for suicide prevention research and knowledge sharing (NSPO 2024a).

On establishment, the NSPO was tasked with the development of a National Suicide Prevention Workforce Strategy. This is reflected in the Agreement. This work was placed on hold so the NSPO could develop the National Suicide Prevention Strategy. In the National Suicide Prevention Strategy, the suicide prevention workforce is acknowledged as a critical enabler to an effective suicide prevention system, and there are specific actions to strengthen the general practitioner and peer workforce. With the Strategy now being in its delivery phase, the NSPO will begin scoping work to ensure suicide prevention has a capable and integrated workforce (NSPO, pers. comm., 7 October 2025).

Lack of accountability for national priorities

There are eight national priorities governments agreed to progress collaboratively in relation to suicide prevention (box 8.1). These priorities are not well-defined, and this makes it challenging to assess whether there has been any progress in achieving them. It is also difficult to tell which actions in the Agreement or the bilateral schedules are linked to which priorities.

As part of the national priorities, governments committed to 'develop suicide prevention services and programs in collaboration with communities and people with lived experience to identify gaps in service provision and to gain insights into individual experiences' (box 8.1). One example of progress towards this priority has been the development of the Lived Experience of Suicide Service Guidelines by Roses in the Ocean (box 8.3). The Guidelines are not stated as an output of the Agreement but arose from the Agreement and were funded by the then Department of Health and Aged Care (Roses in the Ocean and Folk 2024). They align with the types of services funded under the Agreement and are likely to improve the quality of suicide prevention services. Roses in the Ocean have heard through their engagement with primary health networks (PHNs) and service providers that many organisations have used the Guidelines to help establish or deliver suicide prevention support services (Roses in the Ocean, pers. comm., 21 May 2025).

Box 8.3 – Lived Experience of Suicide Services Guidelines

In 2023, Roses in the Ocean collaborated with 260 people with lived and living experience of suicide, to develop a set of Lived Experience service guidelines. These guidelines provide practical ideas and recommendations for the design and delivery of aftercare services for people following a suicide attempt or caring for a loved one who has made a suicide attempt, postvention for people with lived and living experience of suicide bereavement, and distress brief support services.

The documents provide guidance from people with lived and living experience on what is required from the different service types to best meet the needs of their users. For example, the 'Lived Experience of Suicide Service Guidelines: Distress Brief Support' advocated that:

- support should be individually responsive and holistic
- anyone in distress is eligible
- referral into the service should be widely available
- peer workers have a primary role
- support should be practical, not just emotional
- flexible access is required
- communicate the briefness of support early
- no one leaves a clinical setting without support or to a waitlist
- provision for 24-hour support is required
- follow up is an essential component of the service.

Source: Roses in the Ocean and Folk (2024).

Other priority areas have shown little improvement. For example, review participants identified continued fragmentation and gaps in suicide prevention service provision. Ruah Community Services (sub. 14, p. 2) stated there are many people 'at risk of suicide [who] are falling through the cracks of a fragmented, clinical-centric mental health system'. In the survey conducted by the PC, respondents provided many examples of poor continuity of care following treatment for crisis, lack of engagement early in distress and limited ongoing suicide prevention support.

> I have yet to find any public hospital settings to help with a crisis which wouldn't make me more suicidal and depressed. (sr. 89)

> Whenever I have a crisis or suicide attempt, they have kept me overnight in ED then send me home the next morning with no follow up usually! (sr. 122)

> At times in the last 3 years I have been suicidal but there are not many services which could have helped me. (sr. 202).

> Services are still only geared for people in crisis … There is no on-going suicide prevention support for people not in crisis, this hasn't changed and I don't see it even on the radar. (sr. 212)

Overall, in the suicide prevention space as in the mental health system, the Agreement has not enabled reform.

> The current Agreement has not delivered effective reform in suicide prevention. It lacks resourcing, research, and service design focused on reducing suicide and suicidality. (Black Dog Institute Australia, sub. 151, p. 16)

> We continue to hear stories of people's only option being to attend emergency departments – where they often receive inadequate care in an inappropriate environment. For example, a carer shared the story of taking her suicidal daughter to the emergency department, where they waited for 7 hours before seeing an ED doctor, only to be told to wait in the public waiting room overnight before eventually seeing a mental health nurse. In total they waited 36 hours before being seen by an appropriate person. We also hear stories of staff being reluctant to admit suicidal consumers due to a lack of beds. … We also continue to hear reports of a lack of follow up or connection to aftercare services for people who have had a suicidal crisis or acute mental health episode, and those caring for them. (Consumer Health Forum of Australia, sub. 22, pp. 10–11)

> In my volunteer role as suicide support with Roses in the Ocean, I speak with people from all across the country at a loss for where to turn because the clinical and emergency spaces we have and are encouraged to access are not capable of care for a variety of reasons. People are turned away from hospital emergency rooms across the country because they present knowing the danger they are to themselves. (Name withheld, sub. 161, p. 2)

Some progress through the bilateral schedules

The bilateral schedules provide a greater level of information on the initiatives co-funded by the Australian Government and the state or territory governments to fulfil their commitments under the Agreement (table 8.1).

Table 8.1 – Suicide prevention initiatives in bilateral schedules

Initiative	Jurisdiction	Description	Progress[a]
Universal Aftercare Services	All (VIC, TAS and NT altered)	Commitment to a two-part approach to universal aftercare services. • Implement services to support those who have been discharged from hospital following a suicide attempt. • Implement a pilot to expand referral and entry pathways to aftercare services from other health settings to capture those who have experienced a suicidal crisis without being admitted to hospital. Aftercare services transitioned to the bilateral schedules on 30 June 2023.	Three jurisdictions are well progressed, three are partially progressed and one is yet to commence.
Distress Intervention Trial Program	NSW, VIC, QLD, SA (VIC altered)	Establish Distress Intervention Trial sites with the objective of preventing and reducing suicidal behaviour through early intervention in non-mental health settings. Bilateral schedules provide very little further information on this initiative.	Three jurisdictions are partially progressed and one is yet to commence.
Postvention Support	NSW, VIC, QLD, SA, NT	Co-funding Youturn Ltd to deliver postvention support, so all people who are bereaved or impacted by suicide can access postvention services.	Two jurisdictions have completed, two are well progressed and one has yet to commence.

a. Progress as self-assessed by jurisdictions in the 2023-2024 Annual National Progress Report.

Source: PC analysis of bilateral schedules and NMHC (2025).

The 2023-2024 Annual National Progress Report compiled by the National Mental Health Commission provides a snapshot of progress in suicide prevention activities contained in the bilateral schedules. Almost all the commitments for suicide prevention services had commenced, with the majority being ranked 'on track' or 'ongoing' (table 8.1). South Australia revised its bilateral schedule in February 2024, which resulted in a change to suicide prevention initiatives. Therefore, the suicide prevention commitments are 'yet to commence' (NMHC 2025, p. 37).

The Victorian Government (sub. 228, p. 17) stated the Agreement and its bilateral schedule:

> … have been pivotal in facilitating and strengthening effective partnerships and collaboration between governments and with Primary Health Networks (PHNs) – particularly in suicide prevention and response.

All funding in the Agreement is specified through the bilateral schedules. Only three types of services distinct to suicide prevention are funded, with most funding allocated to universal aftercare services (table 8.2).

Table 8.2 – Funding contributions by activity and government level[a]
2021-22 to 2025-26, $m

	States and territories	Australian Government	Total
Universal aftercare services	185.5	288.5	**474.0**
Distress intervention trial program	9.8	8.2	**18.0**
Postvention support	20.3	17.1	**37.4**
Total	**215.5**	**313.9**	**529.4**

a. Row and column totals do not add up due to rounding.

Source: PC analysis of bilateral schedules.

Lack of transparency around commitments and progress

The design of the Agreement and bilateral schedules increases the difficulty in tracking progress against suicide prevention commitments. Separating the overall objectives, outcomes and commitments from the funding schedules makes it difficult to identify which elements of the Agreement have been funded. For example, the Agreement states that governments will seek to 'reduce suicide, suicidal distress and self-harm through a whole-of-government approach to coordinated prevention, early intervention, treatment, aftercare and postvention supports' (clause 26b). But the bilateral schedules only include funding for specific services and do not outline their link to these broader commitments.

The reporting issues affecting the entire agreement are also present for suicide prevention activities. There have been significant delays to releasing national annual progress reports (chapter 2). There are also limitations on the National Mental Health Commission (NMHC) and the PC's ability to verify progress in completing activities included in the bilateral schedules.

- There is no independent validation of the jurisdictions' progress assessments. The way the reporting process has been structured has resulted in jurisdictions self-assessing progress, and their reports are collated and presented by the NMHC in the national annual progress report. The NMHC does not verify the assessments (NMHC 2025, p. 54). This introduces the risk that jurisdictions may not accurately assess progress and there may be inconsistent assessments across jurisdictions in how they classify progress.
- Independent validation is not possible by a third party with the public information available. To validate progress, the PC would require information about the implementation plan, service provider and operational reporting, which are not currently available.

Suicide Prevention Australia (transcript, 19 August 2025, p. 82) raised concerns about the lack of transparency in funding for suicide prevention services.

> Critical issue around funding is transparency. It's hard enough, even over the sort of mental health and suicide prevention space, to see what money is allocated where. But when you're looking specifically at suicide prevention, it's never accounted separately. We really don't know how much money is going into aftercare services, how much money is going into postvention services.

Review participants raised concerns about gaps in services persisting despite commitments in the bilateral schedules.

> The approach to suicide aftercare varies significantly across jurisdictions and levels of care, including primary and secondary services. This variability has resulted in gaps in the transfer of care, particularly in the absence of functional integration and interoperable information-sharing systems. (PHN Cooperative, sub. 208, p. 28)

> Even with a narrow definition of universal aftercare that applies only to hospital admissions, we have not yet reached the point where 100% of people presenting to Emergency Departments (ED) for suicide attempts or distress are being referred to aftercare. Additionally, delays in funding for some aftercare services further hinder the development of universal aftercare. Insights from Suicide Prevention Australia's members, and publicly available information, both indicate that significantly greater action is required in moving towards genuinely universal aftercare and postvention. (Suicide Prevention Australia, sub. 59, p. 5)

> … there are areas of the country where there is no feasible access to aftercare and postvention, with some postvention services having closed their books to new clients due to excessive waiting lists having accrued. It remains the case that people in regional, rural and remote areas are especially disadvantaged in this regard. If services are available, they will be limited to telehealth, which brings access issues dependent on communications infrastructure, and can present problems for privacy and confidentiality. (Roses in the Ocean, sub. 19, p. 4)

There is insufficient data to determine whether the jurisdictions have met their commitments through the bilateral schedules. However, anecdotal evidence suggests more work is needed so people who require suicide prevention services can access the support they need.

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.

8.2 Suicide prevention is not well set up in the Agreement

Components are not clearly linked or well defined

While there are numerous commitments to improve suicide prevention policy and services in the Agreement (box 8.1), it lacks a coordinated and holistic approach outlining how specific actions are linked to outcomes.

Without an articulation of the linkages between the objective and the outputs, there is a risk the actions in the Agreement will not be evidence-based and long-term outcomes will not be achieved (chapter 1).

> Suicide prevention initiatives funded under the first Agreement, whilst valuable, significantly underrepresent what is considered evidence-based and best-practice suicide prevention support for Australian communities. Black Dog Institute has highlighted nine strategies—of which aftercare and crisis care represent only one element—that, when implemented together in a defined community, are likely to reduce the rate of suicide. (Neami National, sub. 63, p. 14)

The outcome the Agreement is working towards is not specific and measuring progress against it is a complex task (box 8.4).

Box 8.4 – Applying the SMART Framework to the suicide prevention outcome

To provide effective guidance for policy design and for the actions funded under the Agreement, its outcome needs to be clearly defined. The SMART framework is a useful tool for designing functional outcomes that will guide behaviour in a way that is specific, measurable, achievable, relevant and time-bound (chapter 4).

There is only one outcome in the Agreement related to suicide prevention. Through the Agreement, governments aim to 'reduce suicide, suicidal distress and self-harm through a whole-of-government approach to coordinated prevention, early intervention, treatment, aftercare and postvention supports' (clause 26b).

- **Specific**: The outcome is not specific. It seeks to address a broad range of issues (suicide, suicidal distress and self-harm), which are closely connected but may also require separate government actions. It is also not clear what scale of reduction would constitute progress in achieving this outcome.
- **Measurable**: It is difficult to measure progress due data limitations. For example, understanding whether the prevalence of self-harm has changed is difficult as there is underrepresentation in the data. Similarly, understanding whether the reduction is through a whole-of-government approach is currently not assessable as there is no way to measure a whole-of-government approach.
- **Achievable**: The outcome is achievable in the sense it is possible to reduce suicide, suicidal distress and self-harm through a whole-of-government approach. Furthermore, a whole-of-government approach is within the control and influence of governments. However, it is difficult to achieve the outcome within the short period of the Agreement.
- **Relevant**: The outcomes are in line with the objectives of the Agreement, especially in relation to the creation of an integrated system that provides comprehensive, timely, consumer-focused and equitable access to suicide prevention and support services (clauses 23–25).
- **Time-bound**: There is no consideration of the time required to achieve the outcome.

There is only one output in the Agreement directly related to suicide prevention (clause 27h). Establishing the NSPO is an important starting point but completing this output alone will not enable governments to achieve progress towards the agreed outcome within the term of the Agreement. The bilateral schedules contain additional actions, but there is insufficient information to assess their impact. Similarly, Schedule A of the Agreement contains several statements about cross-agency action to support suicide prevention. There is no funding attached to these commitments and limited information about progress is publicly available (NMHC 2024a, p. 16).

The national priorities within the Agreement overlap and are duplicative (box 8.1). For example, there are three separate national priorities to identify or address gaps in service provision and two priorities to upskill the workforce.

There is continued confusion around roles and responsibilities

Under the Agreement, the role of the Australian Government is described as a 'national leadership role'. In addition, 'it is responsible for funding and delivering whole-of-population suicide prevention activities in a nationally consistent way' (clause 35).

The Australian, state and territory governments have joint responsibility in the Agreement (clause 47d–f) for:

> Improving system capacity to respond to people who are at risk of suicide, experiencing suicidal distress or crisis or following a suicide attempt. This includes working together to focus on prevention and early intervention, improving leadership to increase integration, prioritising lived experience knowledge, using data and evidence to drive outcomes and increasing the workforce and community capability.
>
> Providing and/or funding of suicide prevention, early intervention, aftercare and postvention programs which reflect and respond to local needs and circumstances.
>
> Contributing to closing the gap in Aboriginal and Torres Strait Islander peoples' disadvantage and life expectancy and achieving the Closing the Gap targets, including a significant and sustained reduction in suicide of Aboriginal and Torres Strait Islander peoples towards zero (Target 14).

The bilateral schedules provide additional detail on the roles and responsibilities relating to the initiatives included within them. Similar to the national priorities, responsibility for those initiatives relating to suicide prevention is largely shared between levels of government. The exception to this is where three states and territories take on sole responsibility for certain aspects of universal aftercare services.[78]

Having joint responsibilities over major issues in the suicide prevention system has resulted in a lack of clarity and ownership about what joint responsibility means or how it is operationalised. The NMHC (2024a, p. 19) called for:

> … consistent and ongoing communication and engagement between the various governance groups (coordinated by MHSPSO) and the jurisdictions to ensure roles and responsibilities for the

[78] The Victorian Government has the responsibility for oversight of the services; the Queensland Government has responsibility for co-commissioning arrangements and the ACT Government has responsibility for services for Aboriginal and Torres Strait Islander people.

> implementation of commitments are clearly identified and stakeholders are aligned in their views on governance, responsibilities, timeframes and milestones.

Aspects of this call have been echoed in the National Suicide Prevention Strategy (NSPO 2025, pp. 68–69) and in submissions to this review (Australian Association of Psychologists Incorporated, sub. 13, p. 10; Roses in the Ocean, sub. 19, p. 5; Suicide Prevention Australia, sub. 59, pp. 10–11).

Having unclear roles and responsibilities can act as a barrier to progress on joint initiatives as neither party is clearly responsible for the task. This contributes to a lack of accountability and transparency for the community. Suicide Prevention Australia (sub. 59, p. 10) reflected:

> There is a lack of transparency around roles established in the National Agreement, which meant that it was often unclear how decisions were being made about funding allocations or the location of services. This means that it can be difficult to establish where delays are occurring when funding is late, giv[ing] services that are impacted no recourse, and increasing uncertainty by making it difficult to predict how significant delays to funding will be.

Furthermore, unclear roles and responsibilities can create an environment where gaps in services can emerge and persist, as each level of government can plausibly claim support should have been delivered by the other (PC 2019, p. 82). This can make it difficult for the community to hold the different levels of government to account for service provision and outcomes as they cannot tell who the responsible party is (Suicide Prevention Australia, sub. 59, p. 10, Roses in the Ocean, sub. 19, p. 5).

In 2020, the PC recommended the Agreement include 'precise detail about the responsibility of each tier of government to fund and deliver mental health services and suicide prevention activities' (2020, p. 441). Providing clarity regarding roles and responsibilities is fundamental for achieving accountability and ensuring adequate supports are available to the people who need them (PC 2019, p. 70).

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.

8.3 Suicide prevention in the next agreement

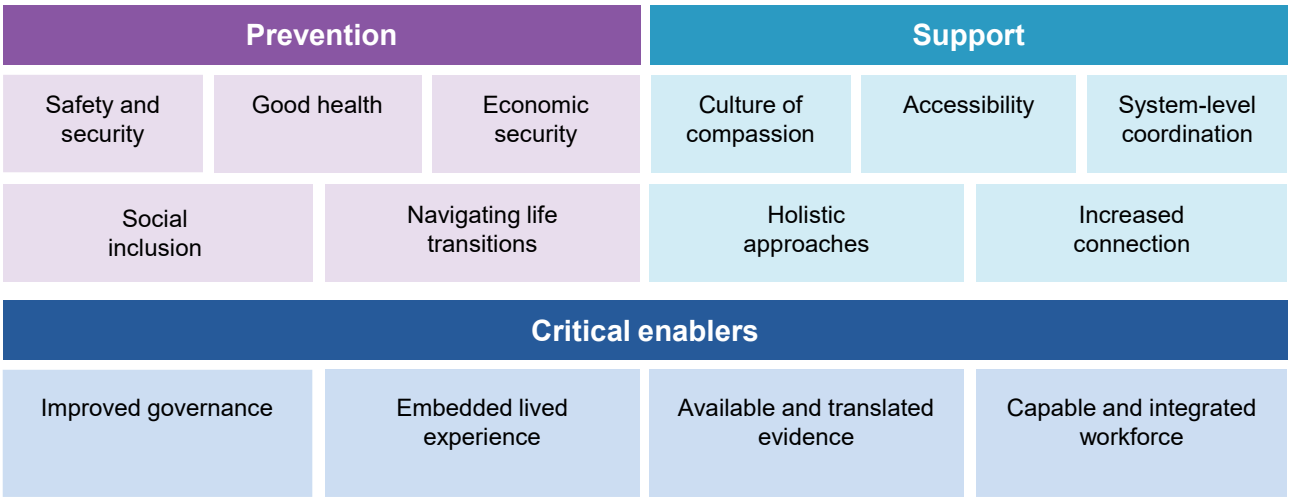
The agreement should contribute to the implementation of the National Suicide Prevention Strategy

Progressing the goal of zero lives lost to suicide will take time. The short duration of the Agreement limits its ability to guide the long-term structural changes required for a whole-of-government approach to suicide prevention (chapter 3). An overarching long-term strategy can provide a clear vision for what Australia's

suicide prevention system should look like in the medium to long term. It can help coordinate not only a whole-of-government response but a whole-of-system response to suicide prevention (chapter 4).

The National Suicide Prevention Strategy 2025–2035 sets out the pathway to achieve a comprehensive approach to suicide prevention, with the aim of aligning expenditure and activity with evidence and insights about what works (NSPO 2024c, p. 17). It does this by adopting a model focusing on the prevention of suicidal distress and supports for people experiencing distress and those who care for them, and by identifying the critical enablers of an effective suicide prevention system (figure 8.1).

Figure 8.1 – A national model for suicide prevention in Australia



Source: Adapted from NSPO (2024c, p. 17)

The Strategy was developed by the NSPO in collaboration and consultation with people with lived and living experience, the suicide prevention sector, academia and all governments (NSPO 2024c).

> … [the Strategy] was formally endorsed by all states and territories as well as all relevant Commonwealth portfolios, ensuring critical buy-in from all jurisdictions and portfolios. It represents a clear commitment to coordinated, consistent and evidence-based suicide prevention reform and aligns with other relevant strategies, including the *National Aboriginal and Torres Strait Islander Suicide Prevention Strategy 2025 - 2035*. (NMHC and NSPO, sub. 70, p. 5)

There was strong support from review participants for the Strategy to set the overarching direction for suicide prevention in the next agreement (Consumers Health Forum of Australia, sub. 22, p. 6; Everymind, sub. 32, p. 3; Lifeline Australia, sub. 128, p. 2; Jesuit Social Services, sub. 131, pp. 18–19, NMHC and NSPO, sub. 70, p. 5; PHN Cooperative, sub. 69, p. 13; Roses in the Ocean, sub. 19, p. 6).

The PC agrees the Strategy should provide the long-term direction for suicide prevention in the next agreement. The Strategy outlines a broad list of recommended actions linked to achieving its overarching objectives. In conjunction with people with lived and living experience, supporters, family, carers and kin and relevant peak bodies, governments should select a clear and achievable set of shorter-term objectives and actions for the next agreement from the Strategy. These objectives and actions should address the most pressing priorities in suicide prevention requiring collaboration between the Australian, state and territory governments. They should also focus on actions that can be completed over the life of the agreement or lay the foundation for long-term reform. There should be a clear link between the objectives, inputs, activities and outputs for suicide prevention (chapter 4).

Until the National Suicide Prevention Workforce Strategy is released, the actions contained in the National Suicide Prevention Strategy for building a capable and integrated workforce should guide decisions on workforce development (chapter 4).

Where suicide prevention services are specifically intended to support Aboriginal and Torres Strait Islander people and communities, the next agreement should be guided by the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy 2025–2035 (chapter 7).

Suicide prevention as a separate schedule to the agreement

The need for a suicide prevention schedule

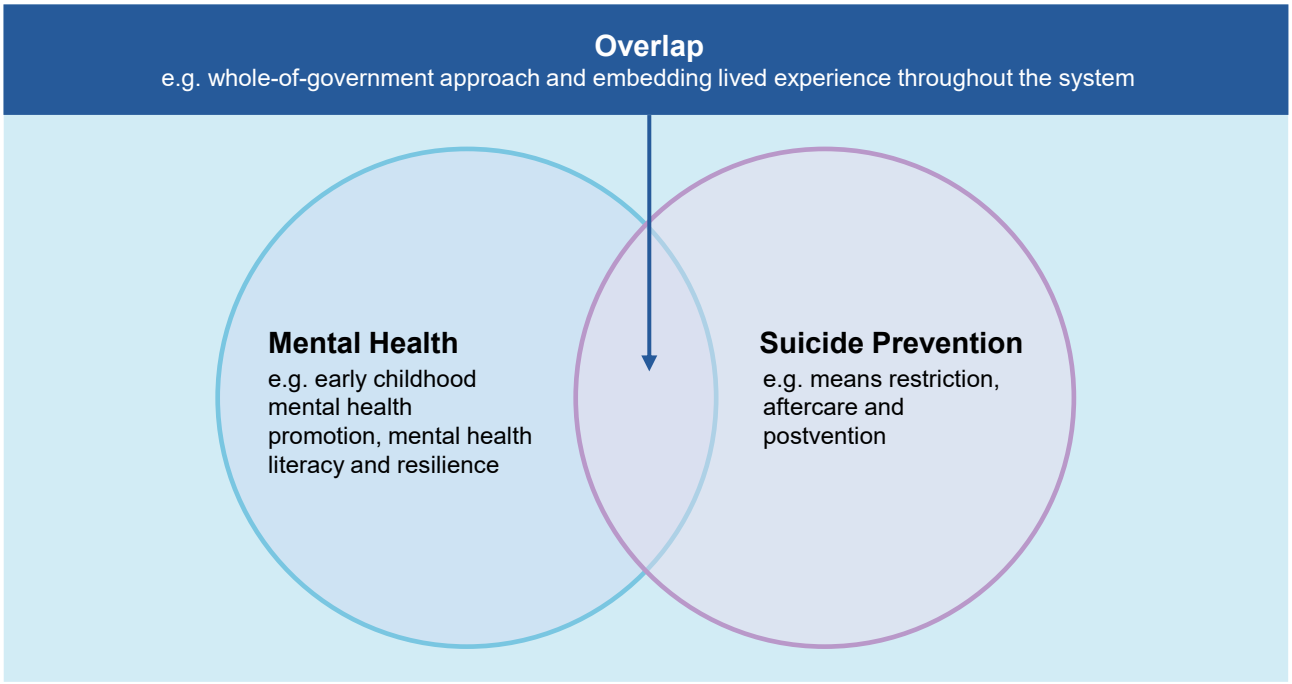
Mental health and suicide prevention are often discussed simultaneously because there are many elements of each domain that affect the other. However, there are many people with mental ill health not affected by suicidal thoughts, and there are many people who have suicidal thoughts or die by suicide who do not have mental ill health (Lifeline Australia 2021). This means there are parts of each service system distinct from the other. The areas of the suicide prevention system distinct from mental health include assessment and management of suicidal behaviours, means restriction and aftercare and postvention services (PC 2020).

Submitters were divided on whether suicide prevention should be considered in the same agreement as mental health. The Consumer Health Forum of Australia (sub. 22, p. 6) argued mental health and suicide prevention were two distinct issues and combining them in the Agreement risked focusing only on mental health. The National Mental Health Consumer and Carer Forum (sub. 68, p. 8) argued the 'artificial separation of suicide prevention and mental health services leads to inefficiencies and missed opportunities for holistic care'. The PHN Cooperative (sub. 69, p. 13) argued for a joint approach:

> Future agreements should reflect the emerging suicide prevention system, particularly in prevention which is distinct from the mental health system, as well as the areas in which mental health and suicide prevention are united.

On balance, the PC considers where mental health and suicide prevention policy overlaps, it should be contained in the body of the next agreement and bilateral schedules. This will help to promote integration and avoid duplication (figure 8.2). However, areas unique to suicide prevention should be included in a separate suicide prevention schedule.

Figure 8.2 – The relationship between mental health and suicide prevention



Developing a separate schedule for suicide prevention was a recommendation in the interim report of this review. This proposed approach was supported by all review participants who reflected on it.[79]

Jesuit Social Services (sub. 131, p. 19) and Orygen (sub. 169, p. 6) were supportive but warned the approach could deepen the segregation of suicide prevention from the mental health system and result in sidelining of suicide prevention. Having people with lived and living experience of suicide, both distinct and in combination with mental ill health, co-designing the agreement and taking part in the overarching governance mechanism (chapter 5) will help to safeguard against these risks.

Review participants suggested areas of focus for the suicide prevention schedule in the next agreement (box 8.5). These ideas should be considered in the co-design process and assessed for their alignment with the Strategy.

[79] Anglicare WA, sub. 225, p. 3; Australian Private Hospitals Association, sub. 163, p. 15; Black Dog Institute, transcript, 19 August 2025, p. 6; Catholic Health Australia, sub. 181, p. 37; Consumers Health Forum Australia, sub. 140, p. 12; Faculty of Health, Deakin University, sub. 174, p. 4; Jesuit Social Services, sub. 131, p. 18; MATES in Construction, sub. 234, p. 17; Medibank Private Limited, sub. 198, p. 5; Mental Health Association of Central Australia, sub. 166, p. 3; Mental Health Australia, sub. 153, p. 17; Orygen, sub. 169, p. 6; Primary Health Network (PHN) Cooperative, sub. 208, p. 29; Size Inclusive Health Australia, sub. 237, p. 5; Standby Support After Suicide, sub. 167, p. 6; Suicide Prevention Australia, sub. 214, p. 5; Victorian Government, sub. 228, p. 3; Youturn Limited, sub. 170; Zero Suicide Institute of Australasia, sub. 238, p. 4.

Box 8.5 – Possible areas of focus for the suicide prevention schedule

Some of the areas participants identified as priorities for suicide prevention are:

- Universal access to aftercare (LELAN, sub. 190, p. 14; Name withheld, sub. 106, p. 2; Roses in the Ocean, sub. 19, p. 4). Access to aftercare should not require hospital referrals (Lifeline Australia, sub. 8, p. 8; NMHCA, sub. 66, p. 19) and should be available to people who have self-harmed or experience suicidal risk (PHN Cooperative, sub. 69, p. 14).
- Universal access to postvention support (Anglicare WA, sub. 225, p. 5; MESHA, sub. 175, p. 4; StandBy Support After Suicide, sub. 167).
- Development and implementation of national best practice guidance for crisis support services to assist people in suicidal crisis (Jesuit Social Services, sub. 131, p. 7).
- Funding for research into models of suicide prevention, care models, ways to reduce stigma, and research implementation to ensure organisations, programs and government are using best practice models in suicide prevention (Suicide Prevention Australia, transcript, 19 August 2025, pp. 82–83).
- Consideration and investment in the suicide prevention workforce (Roses in the Ocean, sub. 133, p. 16; Suicide Prevention Australia, transcript, 19 August 2025, p. 82) and the suicide prevention peer workforce (Roses in the Ocean, sub. 133, pp. 13–14; StandBy Support After Suicide, sub. 167, p. 7; Suicide Prevention Australia, sub. 214, p. 7).

Participants also highlighted groups disproportionately impacted by suicide, who should be prioritised.

- People in regional and remote areas (Jesuit Social Services, sub. 131, p. 19; Sidney Allo and Janet Timbert, 19 August 2025, pp. 21–24)
- Adolescents (Name withheld, sub. 106, p. 1) and young people (Orygen, sub. 169, p. 6)
- People with autism (Olga Tennison Autism Research Centre, sub. 108, p. 1)
- Serving and former military and emergency services personnel (MESHA, sub. 175, p. 3).

Developing the schedule

Like the agreement, the schedule needs to be co-designed with people who access suicide prevention services, people with lived and living experience, supporters, family, carers and kin and service providers. The co-design process should emphasise lived and living experience of suicide rather than solely mental ill health to address concerns about unbalanced representation in the Agreement. In line with best practice frameworks for co-design, people and organisations with lived and living experience representatives need to be adequately resourced and supported to enable true participation in the development of the schedule. Co-design processes should also include the voices of service providers (chapter 5). Given the expertise and remit of the NSPO, it should be responsible for advising governments in the negotiations and coordinating the development of the schedule. This can help to ensure alignment with the National Suicide Prevention Strategy and related documents.

In the development of the schedule, governments should provide further clarification regarding areas of joint responsibility. At a minimum, the next agreement should establish which government agency at either the Australian or state/territory level is responsible for planning, implementing, monitoring and reporting on each commitment. Given the necessity of a whole-of-government response to suicide prevention, the roles and responsibilities should extend to agencies outside of health where appropriate (chapter 5).

The PC considers the current Agreement should be extended for 12 months, to give sufficient time for the negotiation of the next agreement (recommendation 4.3). The development of the schedule should allow

PHNs (commissioning services funded under the Agreement) enough time to ensure services are in place for those who need them, and prevent delays experienced previously.

> The delays in the South Australian Bi-lateral agreement have resulted in schedules for service not having made their way to PHNs e.g. AfterCare. This limits the level and type of commissioning (unable to co-design and do large approaches to market) the PHNs can undertake due to timeframes and duration of the agreement e.g. Bilateral agreement is ending 30 June 2026, PHN does not have the schedule at the time of writing this document. (Adelaide PHN, sub. 62, p. 1)

Funding the activities in the schedule

Activities identified within the schedule need to be adequately funded. Suicide Prevention Australia (sub. 214, p. 6) highlighted 'the need for the suicide prevention schedule to have dedicated additional funding to address its commitments'.

To improve transparency and accountability, the funding commitments for activities distinct to suicide prevention should be listed within the schedule itself, rather than in the body of the Agreement or bilateral schedules (chapter 6). Listing the objectives, activities and funding commitments within the schedule will help to improve the transparency and accountability (chapter 5).

The level of funding for suicide prevention services should remain at or above the existing level for the next agreement. The existing funding should be absorbed into the flexible funding stream but earmarked for suicide prevention services. This would allow PHNs and local hospital networks to respond to local needs, based on joint planning and commissioning (chapter 6). As StandBy Support After Suicide (sub. 167, p. 3) stated:

> … the next agreement must support increased collaboration to ensure flexible, community-led postvention services tailored to groups disproportionately impacted by suicide.

The funding provided outside of the agreement for community-based suicide prevention activities (box 8.6) should be combined into the flexible funding pool. This is similar to the funding approach recommended for community mental health services (recommendation 6.1).

Box 8.6 – Examples of funding for community-based suicide prevention activities outside the Agreement

The Australian, state and territory governments fund a range of community-based suicide prevention activities outside of the Agreement, Medicare Benefits Schedule and hospitals. The key Australian Government initiatives are:

- National Suicide Prevention Leadership and Support Program, which has a particular focus on groups disproportionately impacted by suicide across seven activity streams. The program delivered $114 million to 31 organisations over three years (2022-23 to 2024-25 financial years). The groups determined to be disproportionately impacted by suicide are Aboriginal and Torres Strait Islander people, men, LGBTQIASB+ people, people from culturally and linguistically diverse backgrounds, regional and remote communities, veterans and young people. The seven activity streams are national leadership in suicide prevention, national leadership in suicide prevention research and translation, Centre of Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention, national support for lived experience of suicide, national media and communications strategies, national suicide prevention training and national suicide prevention support for at risk populations and communities

Box 8.6 – Examples of funding for community-based suicide prevention activities outside the Agreement

- Targeted Regional Initiatives for Suicide Prevention program, which funds suicide prevention in all primary health networks (PHNs). The program provided $63.3 million across the 31 PHNs over two years (2022-23 to 2024-25 financial years). The funding targets local needs and builds on the National Suicide Prevention Trial. It also establishes a Suicide Prevention Regional Response Leader or Coordinator in each PHN region.

In addition, state and territory governments have grant programs for community-based suicide prevention services.

Source: DHDA (2025e); DoHAC (2024h); Bassilios et al. (2024).

Monitoring and reporting mechanisms for the schedule

Measuring the right things means selecting outcomes that describe the desired change resulting from the schedule. Outcomes should be measurable, well-defined and achievable within the period of the schedule (chapter 4).

The NSPO is developing the National Suicide Prevention Outcomes Framework (box 4.4) to measure progress towards the National Suicide Prevention Strategy (NSPO 2024b, p. 4). The Framework is intended to translate the Strategy into person-centred outcomes defining the desired impact and measurement methodology to allow monitoring of progress. It is expected to be finalised by mid-2026 (NSPO 2024b, p. 9). As part of the Framework's development, the NSPO is creating an outcomes map depicting outcomes, indicators and measures, as well as the logic connecting them. The measures for these outcomes can be both qualitative and quantitative data to ensure full coverage of the indicator and outcomes (NSPO 2024b, p. 3). The NSPO (2024b, p. 8) considers the intended users of the Outcomes Framework to be:

- All levels of government to help gauge the impact of their activities, improve coordination, guide investment towards activities that are most impactful, and track progress against outcomes;
- The suicide prevention sector to link activities to population wide outcomes and to utilise data in their own planning and evaluation of suicide prevention programs and services;
- Researchers to identify areas of suicide prevention where evidence needs to be strengthened;
- Data custodians to better understand what data is needed, identify gaps in data collection and integration, and to guide prioritisation of efforts to address these gaps; and
- Communities and workforces with an interest in suicide prevention to deepen their understanding of the suicide prevention system, and of the ways in which they can contribute to suicide prevention efforts.

The outcomes selected for the schedule should be from the list of short-term outcomes in the Framework. The outcomes need to align with the priorities and logic established in the schedule. Given the time it takes for data to be developed, only outcomes with indicators and measures that currently exist, or can be developed within the first six months of the next agreement, should be chosen to ensure reporting can be completed.

Having an independent authority appropriately resourced to undertake monitoring and reporting is important for improving transparency and community trust (Neami National, sub. 63, p. 5). The NMHC should be established as an independent statutory authority and undertake monitoring and reporting in the next agreement, with a strengthening of its legislative powers to collect information (recommendation 5.6).

Review participants agreed given the expertise of the NSPO, it should support the NMHC by being responsible for monitoring and reporting on the suicide prevention schedule (Jesuit Social Services, sub. 131, pp. 18–19; Lifeline Australia, sub. 128, p. 2; Mental Health Australia, sub. 153, p. 18; Suicide Prevention Australia, sub. 214, p. 3). Progress reporting in relation to the schedule should form part of annual reporting but be clearly signposted as reporting for the suicide prevention schedule.

Information used to report progress should not be limited to that provided by governments. The NMHC should be empowered to report on progress using information gathered from service providers, people who access suicide prevention services, lived and living experience groups and commissioning agencies (recommendation 5.7). The NSPO should be similarly supported to report on progress using information gathered from a broad range of stakeholders. The NSPO should be adequately resourced to perform this ongoing monitoring and reporting role on top of its existing work.

The NSPO should also publish evaluations of programs and services funded through the schedule. Having the evaluations published in one spot will assist commissioning bodies to compare the effectiveness of different services. This can also be especially helpful for people who access suicide prevention services in selecting the service that can best meet their needs. Enabling individuals to make more informed decisions is aligned with the desired person-centred approach to suicide prevention (chapter 2).

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.

9. The intersection of alcohol and other drugs with mental ill health and suicidal distress

Key points

- Many people experience co-occurring problematic use of alcohol and other drugs (AOD), mental ill health and/or suicidal distress. One in five Australians have experienced a substance use disorder (SUD) in their lifetime and half of all Australians with a recent SUD have one or more other mental health conditions. The co-occurrence of these conditions magnifies the harm from each and worsens health outcomes.
- People experiencing these co-occurring conditions face systemic barriers to treatment and support and a fragmented and siloed service system. Mental health and suicide prevention services are often inaccessible or unprepared for treating people with co-occurring problematic AOD use.
- AOD services dedicate substantial resources to treat and support people with co-occurring mental ill health and suicidal distress, but the sector is chronically underfunded. Since 2020, there have been no national governance arrangements to coordinate AOD policy.
- The National Mental Health and Suicide Prevention Agreement identifies co-occurring problematic AOD use, mental ill health and suicidal distress as a priority but lacks specific actions, funding and governance for system reform, and as a result has achieved little. There is no national strategy or capacity to address the intersection of AOD, mental health and suicide prevention.
- The next agreement should include a separate schedule focused on the intersection of problematic AOD use, mental ill health and suicidal distress. The schedule should:
  - be co-designed with people with lived and living experience
  - 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 funding for evidence-based approaches in treatment and prevention of co-occurrence
  - strengthen workforce capacity in AOD, mental health and suicide prevention services to support people with co-occurring needs, with a focus on building and supporting the peer workforce
  - have dedicated governance arrangements involving people with lived and living experience
  - 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.

Many people experience problematic use of alcohol and other drugs (AOD) as well as mental ill health and/or suicidal distress. Among service providers, it is the expectation, rather than the exception, that problematic AOD use and mental ill health co-occur. Co-occurrence often brings with it stigma and discrimination (box 9.1) and leads to much poorer health outcomes (section 9.1). But for several reasons, people experiencing these issues often go without professional help for years (section 9.3).

The high frequency of this co-occurrence and the need for dedicated policy responses and service system improvements was highlighted by many review participants.

> [There is] a high co-occurrence of mental health conditions and AOD use disorders, with at least 47% of people seeking AOD treatment having a current mental health concern, and at least a third having multiple co-occurring conditions. (Turning Point and the Monash Addiction Research Centre, sub. 137, p. 8)

> The need for greater connection across mental health and AOD policy, planning, and service delivery is an ongoing challenge that is well documented. (Mental Health Australia, sub. 153, p. 9)

> There is substantial evidence that the harms from alcohol and other drugs are a significant driver of suicide risk, and so recognising the need to address these issues in the national agreement is welcome. (Suicide Prevention Australia, sub. 214, p. 10)

But while the National Mental Health and Suicide Prevention Agreement mentions the need to address these concerns, it contains few specific commitments and no funding (section 9.2).

Box 9.1 – Language used when communicating about AOD issues

The language used when communicating about AOD-related issues, as well as mental ill health and suicidal distress, can have far reaching impacts. Labelling a person by their AOD use or pathologising a person's AOD behaviour can be stigmatising. Using person-first language and avoiding stereotyping, labelling and alarmist language can help reduce stigma and discrimination and encourage help-seeking behaviour by people who need support.

This report follows the guidance of Mindframe, which recommends using terminology that accurately describes a person's AOD use, such as the term 'problematic AOD use' (rather than 'drug habit') (Everymind 2019, p. 17). The term 'problematic AOD use' is intended to capture all harmful use of AOD including harmful, hazardous, risky, misuse, dependence and substance use disorders (Marel et al. 2025). In general, we limit using the term 'substance use disorder' to instances where we refer to the specific clinical condition.

The term 'co-occurring' problematic AOD and mental ill health and suicidal distress is used because this makes it clearer which health issues are included. Suicidal distress is used instead of suicidality or suicide to align with the language used in the National Suicide Prevention Strategy when discussing the areas of connection between AOD and suicide. Terms such as 'comorbidity' and 'dual diagnosis' are generally avoided because these do not apply exclusively to AOD/substance use, mental ill health and suicidal distress (for example, they can also refer to the co-occurrence of other illnesses or disabilities).

Source: Everymind (2019); Hamilton Centre (2025b); NSPO (2025); Turning Point (2025).

A key challenge in addressing the needs of people with co-occurring AOD and mental ill health and/or suicidal distress is the fragmented treatment and support across separate and siloed specialist service systems (section 9.3).

> This presents many challenges in service provision, particularly for people in distress, with [substance use disorders], and/or mental illness who are required to navigate multiple systems, continually retelling their story (Victorian Aboriginal Community Controlled Health Organisation (VACCHO) and Balit Durn Durn Centre of Excellence for Aboriginal Social and Emotional Wellbeing (BDDC), sub. 162, pp. 11–12).

The capacity of AOD services to provide care and support for people with co-occurring needs is stretched (NSW Ministry of Health 2023, p. 7; Ritter and O'Reilly 2025, p. 778). There has been long-term insecure funding (van de Ven et al. 2022, p. 2) and falling government investment in AOD services (Ritter et al. 2024, pp. 12–13).

> … the AOD sector frequently provides mental health interventions for high – and sometimes low – prevalence mental health disorders. Conversely, the mental health service sector also sees people with co-occurring problematic substance use but is not similarly prepared to provide appropriate treatment or intervention. As such, higher demands are placed on the AOD sector, which remains chronically underfunded and insufficient in supply, resulting in longer access wait times and increased pressure on the workforce (Queensland Network of Alcohol and other Drug Agencies (QNADA), sub. 173, p. 5)

Previous reviews, reports and inquiries have highlighted the need to address barriers and fragmentation in the service system for people with co-occurring needs (Design Health Collab 2023, pp. 28–36; Lee and Allsop 2020, p. 36; NSW Ministry of Health 2015, pp. 9–10; PC 2020, pp. 645–648; RCVMHS 2021, p. 311; SCHACS 2025, pp. 45–46). Several current national strategies call for the AOD, mental health and suicide prevention systems to work more closely and collaboratively (DoH 2017, p. 27, 2019c, p. 12; NSPO 2025, p. 28). Yet holistic, collaborative and integrated care continues to be rare and there is a general lack of person-centred treatment (Marel and Mills 2022, p. 12).

Siloed government policy making processes and the separate administration of these systems reinforce service barriers and fragmentation (Butt et al. 2024, p. 32). There is no cross-sector consensus or nationally consistent policy guiding the provision of care for people with co-occurring problematic AOD use and mental ill health (Deady et al. 2024, p. 10), despite evidence-based approaches being available (Matilda Centre and PREMISE Next Generation, sub. 220, p. 10). Both systems lack a shared recognition of 'what good looks like' in service provision for people with co-occurring needs (Design Health Collab 2023, pp. 10–15). Further, there is no national approach to preventing these issues from co-occurring in the first place, despite the significant potential benefits and cost savings from greater investment in prevention (OurFutures Institute, sub. 182, pp. 5–8).

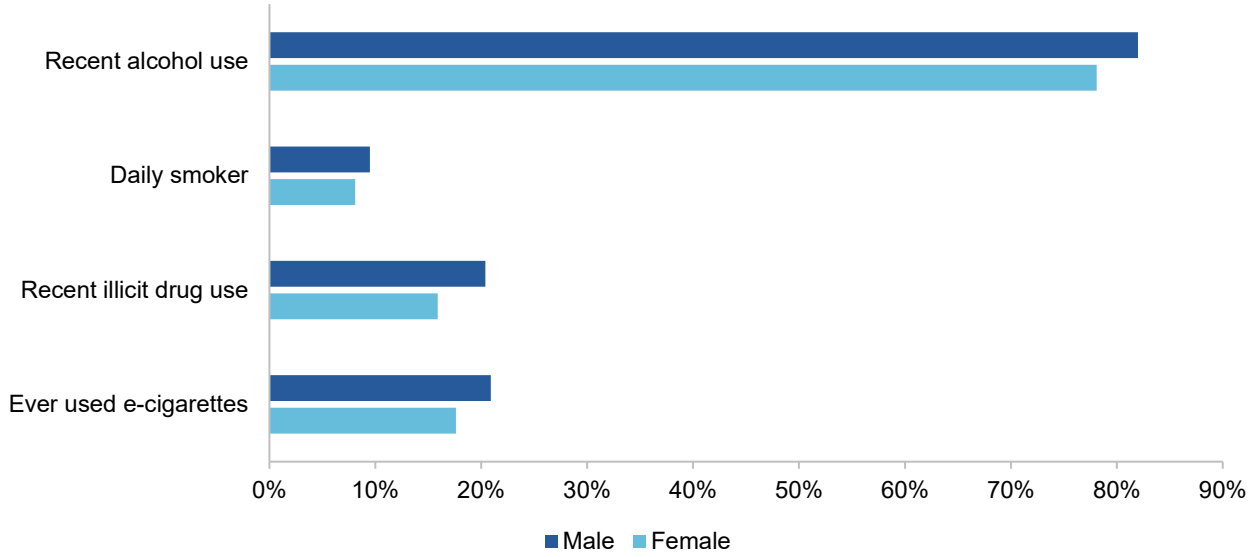
The next agreement presents an opportunity to address the intersection of problematic AOD use, mental ill health and suicidal distress. The agreement can fill a critical gap in policy, where there is currently no national strategy focused on addressing these co-occurring issues. This can best be achieved by including a separate AOD schedule in the next agreement (section 9.4).

9.1 Co-occurring problematic AOD use, mental ill health and suicidal distress

AOD use in Australia

Most Australian adults use alcohol or other drugs. In 2022-23, about four in five adults reported consuming alcohol during the past year. About one in five males and one in six females reported using illicit drugs (figure 9.1).

Figure 9.1 – Prevalence of AOD use in the Australian adult population, 2022-23[a]



a. 'Recent' includes any use within the previous 12 months.

Source: AIHW (2025h, tables 2.4, 3.9, 4.4 and 5.8).

AOD use occurs along a continuum of severity; from no use, occasional use (ranging from low- to high-risk patterns) to problematic use (which can include dependence) (DoH 2017, p. 6). For many people, their AOD use is not considered problematic and will not transition into a disorder (Marel et al. 2019, p. 138). But the risk of experiencing AOD-related harm tends to rise as severity of use increases. Further, for many drug types, such as alcohol for example, there is no completely risk-free level of use; even moderate occasional use poses some risk of harm and any health benefits are far outweighed by the detrimental effects (Anderson et al. 2023, p. 6; WHO 2024, p. 47).

At the severe end of the continuum, a person's use may meet the criteria for a substance use disorder (SUD)[80], which is a clinically diagnosed mental health condition (APA 2024). SUDs are among the top three most prevalent classes of mental health disorders in the Australian population (ABS 2023). Almost one in five Australians aged 16–85 years have experienced a SUD some time in their life and 3% have experienced a SUD during the past year (ABS 2023). SUDs are more prevalent in males, young adults (aged 16–24), unemployed persons, current

[80] A SUD is a complex condition in which there is uncontrolled use of a substance despite harmful consequences. Symptoms include impaired control (for example, unable to cut down), social problems (for example, negative impacts on work, school or home), dangerous use (for example, use in unsafe settings) and drug effects (for example, tolerance or withdrawal symptoms) (APA 2024).

smokers and people who have ever been without a permanent place to live (ABS 2023; Slade et al. 2025, p. 516). Alcohol is the drug type most frequently involved in SUDs (ABS 2023).

People experiencing SUDs are often viewed more negatively than people with other conditions by health services for reasons such as stigma, stereotyping and criminalisation (Cazalis et al. 2023, pp. 12–13; El Hayek et al. 2024, p. 2; Hamilton Centre 2025b, p. 1). This adversely affects people's access to treatment and support for SUDs and their willingness to seek help (Rethink Addiction and KPMG 2022, p. 17; Turning Point and the MARC, sub. 137, p. 9) (section 9.3).

In addition to impacts on mental health and suicidal distress, AOD use can result in a range of physical harms (AIHW 2024a, pp. 17–18) and contribute to social and economic problems for the user and the people around them (WHO 2024, p. 9). Alcohol, tobacco and illicit drug use accounted for 14% of the total burden of disease in Australia in 2024 (AIHW 2025c). The physical health harms of AOD use are wide ranging and can include injuries, cancers, cardiovascular diseases, hepatitis C and HIV/AIDS (AIHW 2024a, pp. 71–78). The risk of harm from AOD use is higher among people who have experienced trauma, marginalisation and socio-economic disadvantage, and these can be further worsened by harmful patterns of AOD use (Social Ventures Australia 2024, p. 12). The costs associated with AOD use in Australia are substantial, estimated to be almost $60 billion in 2022-23 (Gadsden et al. 2023, p. 4).

Patterns of AOD use and harm in Australia are ever-changing and require close monitoring to guide timely and well targeted policy responses (ACIC 2025, pp. 18–19; Sutherland et al. 2024, pp. 11–15). The shifting trends and patterns in substance use can impact how AOD use, mental ill health and suicidal distress co-occur and interact (Carlyle et al. 2021, p. 2; Centre for Population 2024, p. 6). While population rates of alcohol consumption and daily tobacco smoking have been falling over time, some amphetamine and other stimulant use and e-cigarette use have increased (AIHW 2025b). In recent years, there has also been an increase in the use of substances such as novel synthetic opioids (NSOs) and ketamine, posing new risks of harm (Mammoliti et al. 2025, pp. 9–12; Stewart et al. 2021).

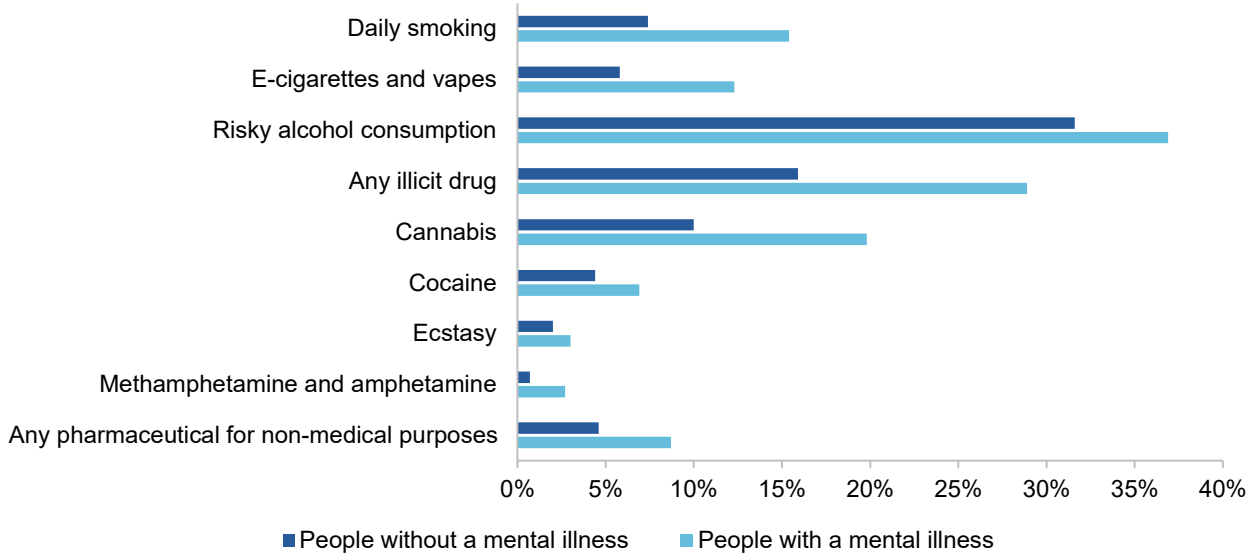
The relationship between AOD use, mental ill health and suicide

Not everyone who experiences problematic AOD use will also experience mental ill health and/or suicidal distress, or vice versa. In 2022-23, about one in two people with alcohol use disorders and one in four people with drug use disorders did not have any other co-occurring mental health conditions (Sunderland et al. 2025, p. 525). The National Mental Health Consumer Alliance (sub. 149, p. 21) emphasised 'many individuals who use AOD do not experience co-occurring mental health challenges or suicidality and should not be systematically framed within a deficit-based or clinical lens'.

However, there is a substantial body of evidence showing a large proportion of people experiencing problematic AOD use have co-occurring mental health conditions (Jane-Llopis and Matytsina 2006, p. 521; Kingston et al. 2017). There is also considerable evidence of the reverse, with research showing people who experience mental ill health are more likely to concurrently experience problematic AOD use (Marel et al. 2025; Puddephatt et al. 2022).

In Australia, population survey data from 2022-23 shows high rates of problematic AOD use among people experiencing mental ill health (AIHW 2025f). Compared to people without a mental illness, a greater proportion of people with a mental illness consume alcohol at risky levels and smoke daily (figure 9.2). People with a mental illness are almost twice as likely to have recently used illicit drugs compared to people without a mental health illness (figure 9.2).

Figure 9.2 – Prevalence of past-year AOD use in the Australian adult population according to mental health status, 2022-23



Source: AIHW (2025f).

The reverse of the relationship is also evident. Analysis of the most recent national population survey finds in 2020-22 almost one in two of the 622,000 Australians with a SUD (49%) have at least one other mental health condition (Sunderland et al. 2025, p. 526). In 2007, about one in six people with a SUD (16%) had two or more other mental health conditions (Prior et al. 2017, p. 319). Within this co-occurrence there are a range of possible combinations of conditions and varying levels of severity, highlighting the diversity of individual treatment needs and different patterns in treatment attendance behaviour (Harris et al. 2025, pp. 814–815; Sunderland et al. 2025, pp. 526–527).

The overall prevalence of co-occurring SUDs and at least one other mental health condition in the Australian population has not fallen in two decades and in younger cohorts (aged 16–24) it has increased (Sunderland et al. 2025, p. 530). Young people and people experiencing homelessness are recognised as groups at particular risk of experiencing co-occurring problematic AOD use and mental ill health (Deady et al. 2024, p. 2). There is also evidence of co-occurrence disproportionately affecting gender and sexuality diverse young people in Australia (Bailey et al. 2024).

There are high rates of co-occurring problematic AOD use and mental ill health among Aboriginal and Torres Strait Islander people. The 2018-19 National Aboriginal and Torres Strait Islander Health Survey found about one in five people have experienced co-occurring psychological distress, risky alcohol use and/or substance use (Hobden et al. 2024, p. 671). VACCHO and BDDC (sub. 162, p. 10) highlighted this as a concern:

> The prevalence of comorbidity for Aboriginal and Torres Strait Islander people is even more pronounced. An investigation by the Victorian Coroner revealed that 87.5% of Aboriginal people who passed by suicide between 2018–2022 had substance abuse as a contextual stressor; a further 71.6% had been diagnosed with co-occurring mental illness and substance abuse disorders prior to their death.

In AOD treatment settings, co-occurrence is endemic. Australian studies find at least half – and in some cases all – people presenting for SUD treatment have other co-occurring mental health conditions (Kingston et al. 2017). Further, large numbers of people accessing AOD treatment have symptoms of a mental health condition, though not a formal diagnosis, which impacts significantly on their health and treatment outcomes (Marel et al. 2022, p. 10). A recent survey of AOD treatment services in Victoria found most service users

(83%) experience mental ill health. This places substantial demands on AOD services, with about three-quarters of clinical time spent providing mental health interventions, much of which is unfunded (VAADA 2025, p. 4).

Co-occurring problematic AOD use is also highly prevalent in mental health treatment settings. A recent meta-analysis of Australian studies found more than a third of people attending mental health treatment services (37%) had co-occurring past-year problematic AOD use. Prevalence rates of problematic AOD use in Australian mental health settings are significantly higher compared to the general population for several substances, including past-year problematic use of tobacco (53%), cannabis (37%) and amphetamines and other stimulants (12%) (Marel et al. 2025, pp. 367, 369–370).

There is no universal explanation for why problematic AOD use and mental ill health frequently co-occur (box 9.2). The link can vary between individuals depending on their AOD use, their specific mental health conditions and other individual and contextual factors (Volkow and Blanco 2023, p. 210). From a treatment perspective, the direction of the causal link may not necessarily matter because effective treatment should involve similar holistic and person-centred care (Marel et al. 2022, p. 14).

Box 9.2 – Why do problematic AOD use and mental ill health co-occur?

Intermediary or shared risk factors

There is no single explanation for the link between problematic AOD use and mental ill health. In some cases, the link may be indirect and established through intermediary factors that trigger the primary issue and, in turn, the secondary issues. For example, problematic AOD use can increase the likelihood of school non-completion and subsequent unemployment, which, in turn, can increase the risk of experiencing depression (Kingston et al. 2017, p. 528).

Another explanation is the presence of shared risk factors that contribute to an increased likelihood of experiencing both problematic AOD use and mental ill health. This includes underlying vulnerabilities such as past trauma, stress, certain personality traits, childhood experiences and genetic predispositions (Deady et al. 2013, pp. 525–526; UNODC 2022, p. 10).

Research finds exposure to past trauma (for example, witnessing serious injury or death, being threatened with violence) is near universal among people who access AOD services and contributes to both the development and maintenance of SUDs (Marel et al. 2022, p. 28).

Bi-directional relationships

There is also evidence of a direct cause-and-effect relationship between a person's problematic AOD use and their mental ill health. But this relationship can be bi-directional (two-way) and can change over time (Deady et al. 2024, p. 9; Volkow and Blanco 2023, p. 210).

In some cases, certain patterns and types of substance use can induce mental ill health symptoms, distress and disorders. Alcohol use, for example, is a causal factor in depression (Jane-Llopis and Matytsina 2006, p. 531). In other cases, AOD use can commence and become more severe because of a person's existing mental ill health (sometimes referred to as self-medicating behaviour) (Hawn et al. 2020, pp. 701–703; Marel et al. 2019, p. 140). There is longitudinal survey evidence of this cause-and-effect relationship occurring in the Australian population (Mitrou et al. 2024).

AOD use can play a significant part in suicide and many review participants highlighted this link (Australian Alcohol and other Drugs Council (AADC), sub. 171, p. 2; Matilda Centre and PREMISE Next Generation, sub. 220, p. 9; OurFutures Institute, sub. 182, p. 5; Suicide Prevention Australia, sub. 214, p. 10). Acute alcohol use, for example, is recognised as a contributing factor to suicide deaths in Australia (AIHW 2023c). Analysis of coronial cases shows acute alcohol use is present in more than a quarter of suicide deaths (Chong et al. 2020). Problems related to psychoactive substance use, such as harmful use and dependence, are the second most common associated cause of death due to suicide (29%), and are particularly prevalent in suicide deaths among males (31%) (ABS 2020).

But the relationship between AOD use and suicide is complex and multidimensional (Fisher et al. 2020, p. 16). Participants told us AOD use is often one of many individual and environmental factors that can interact and contribute to suicide (Faculty of Health, Deakin University, sub. 174, p. 5; Roses in the Ocean, sub. 133, p. 5).

Impacts of co-occurring problematic AOD use, mental ill health and suicidal distress

When people experience co-occurring problematic AOD use, mental ill health and/or suicidal distress, the conditions can become mutually reinforcing and can maintain or exacerbate each other. The harm from each is often magnified compared to when they occur in isolation (Deady et al. 2024, pp. 5, 9). This can include a worsening of psychiatric symptoms and AOD use, increased suicidal ideation, poorer short- and long-term health outcomes and reduced life expectancy (Leung et al. 2017, p. 6; Plana-Ripoll et al. 2020, p. 347).

For people experiencing co-occurring problematic AOD use and mental ill health, often there are other accompanying social issues present that can worsen their AOD use, mental health and general wellbeing, including an increased risk of relationship breakdowns, homelessness and violence (Marel et al. 2022, p. 20). Similar factors are associated with higher risk of suicide for people experiencing problematic AOD use (Everymind 2025). Problematic AOD use and mental ill health also place considerable strain on families and carers (ADF 2022, p. 2; Marel et al. 2022, p. 20; Phillips et al. 2021, p. 18).

Many people living with co-occurring problematic AOD use and mental ill health and/or suicidal distress experience ‘double stigma’ and frequent discrimination in service settings and in the community (Everymind 2025; Hamilton Centre 2025b, p. 1). They often face being denied support and turned away from treatment until their problematic AOD use and/or mental ill health improve (Bryant et al. 2020, p. 41; VDDI 2019, p. 8).

Co-occurring issues can be successfully treated. But the intersection of problematic AOD use and mental ill health can be challenging for clinical assessment and diagnoses (Marel et al. 2022, p. 21). This can contribute to poorer treatment compliance and outcomes, including a greater risk of relapse (Deady et al. 2024, p. 7). Australian adults who smoke and have co-occurring mental ill health, for example, are more likely to experience multiple unsuccessful attempts to quit smoking (Greenhalgh et al. 2022, p. 226).

For service providers, co-occurring problematic AOD use and mental ill health often contribute to increased case volumes and complexity in individual presentations. In hospital emergency departments, there are reports of growing safety risks for health workers because of increases in problematic AOD use and mental ill health among consumers (ACEM 2025, p. 14). The Australian Medical Association (sub. 235, pp. 1–2) told us that ‘a serious concern for healthcare professionals working in Australian emergency departments (EDs) is the rise in violence and aggression’ because of co-occurring problematic AOD use and mental ill health.

9.2 Government policy does little to tackle the challenge of co-occurrence

National strategies for AOD, mental health and suicide prevention are not connected

There is no national strategy addressing the intersection of problematic AOD use, mental ill health and suicidal distress. And like the different service systems (section 9.3), the key national strategies tend to be siloed and only loosely connected to one another.

Through the National Drug Strategy 2017–2026, Australian, state and territory governments have a long-standing commitment to the harm minimisation approach for addressing the health and social impacts of AOD use (DoH 2017, p. 6) (box 9.3). This approach, which brings together the justice/law enforcement and health portfolios, is one of the features of AOD policy that distinguishes it from mental health policy.

Review participants expressed support for a harm minimisation approach to the intersection of AOD, mental ill health and suicidal distress (MATES in Construction, sub. 234, p. 8; VACCHO and BDDC, sub. 162, pp. 10–13). However, there are concerns the current distribution of 'investment across the three pillars of supply, demand and harm reduction is unbalanced' because the majority of the drug budget is spent on law enforcement (that is, supply reduction) (Turning Point and the MARC, sub. 137, p. 6). We also heard from review participants there are gaps in governance, reporting and accountability for the National Drug Strategy (AADC, sub. 171, p. 3; QNADA, sub. 18, p. 8; Turning Point and the MARC, sub. 137, p. 7).

Box 9.3 – The National Drug Strategy

Australia has a 10-year National Drug Strategy aiming to reduce and prevent the harmful effects of alcohol, tobacco and other drugs. There are six sub-strategies under the current National Drug Strategy, which expires in 2026. Discussions recently commenced regarding the next iteration of the National Drug Strategy.

Cooperation between the justice/law enforcement and health portfolios across the Australian, state and territory governments underpins the Strategy's development and implementation. A foundation of the Strategy is a shared commitment by governments to the principle of harm minimisation and its three complementary pillars, including:

- demand reduction (for example, preventing uptake and harmful use)
- supply reduction (for example, reducing the availability of alcohol and other drugs)
- harm reduction (for example, reducing unsafe behaviours).

Governance of the Strategy was previously led by the Ministerial Drug and Alcohol Forum (MDAF), which reported directly to the Council of Australian Governments (COAG). It comprised ministers with responsibility for AOD policy from the justice/law enforcement and health portfolios in each jurisdiction. MDAF was supported by the National Drug Strategy Committee (NDSC), consisting of senior officials responsible for AOD policy from the justice/law enforcement and health portfolios of each jurisdiction. However, since the dissolution of COAG in 2020, there have been no dedicated governance arrangements for the National Drug Strategy. And despite a commitment in the Strategy to regular progress reporting, this has not occurred since the 2018 annual report.

Source: ANACAD (2025); DoH (2017, 2018a, 2019b, 2020b); QNADA (sub. 18, p. 8).

Review participants voiced concern about the lack of integration across the sub-strategies that sit under the National Drug Strategy, as each has a discrete focus (box 9.3). We heard there is 'little coherence between or coordination across them' (Turning Point and the MARC, sub. 137, p. 7).

The National Drug Strategy identifies 'people with co-morbid mental health conditions' as one of seven priority populations. But it does not include any specific actions in this regard (DoH 2017, p. 27). Sub-strategies such as the National Alcohol Strategy 2019–2028 and the National Tobacco Strategy 2023–2030 acknowledge the high prevalence of co-occurring alcohol use and smoking among people with mental ill health (DoH 2019b, p. 9; DoHAC 2023b, p. 19). But neither sub-strategy includes a comprehensive plan to address this. And despite the significant role alcohol use plays in a large proportion of suicide deaths, the National Alcohol Strategy lacks any specific actions in this area.

Outside of the National Drug Strategy and its sub-strategies, there is some focus on co-occurring problematic AOD use, mental ill health and suicidal distress in the National Suicide Prevention Strategy 2025–2035 (NSPO 2025). This strategy acknowledges AOD use is one of the most common risk factors in suicide deaths in Australia. It highlights 'the critical role a well-functioning alcohol and other drug system plays in effective suicide prevention efforts' and includes several broad actions in this regard (NSPO 2025, p. 27).

But overall, as one review participant told us, the policy inaction on co-occurring problematic AOD use and mental ill health 'demonstrates that Australian governments are not yet ready to have difficult conversations about the two-way role these factors play in the mental health of the population' (Movember Institute of Men's Health, sub. 80, p. 5).

The AOD system lacks national governance to coordinate planning and action

Compounding the AOD system's long-term funding challenges (section 9.3) is the lack of formalised national governance arrangements. The previous governance arrangements for setting national AOD policy and coordinating actions were disbanded in 2020, following the abolition of the Council of Australian Governments (COAG). Review participants told us the lack of overarching governance is destabilising for the AOD sector. It means there is no appropriate forum for addressing systemwide issues, undertaking collaborative strategic planning, or cross jurisdiction and cross sector coordination on key AOD policy matters (AADC, sub. 171, p. 3; QNADA, sub. 173, p. 3; Turning Point and the MARC, sub. 137, p. 7).

During this governance vacuum, the planned mid-term review of the National Drug Strategy 2017–2026 was abandoned and the National Aboriginal and Torres Strait Islander Peoples' Drug Strategy has lapsed (QNADA, sub. 18, p. 8). As Turning Point and the MARC (sub. 137, p. 7) told us, the situation 'has resulted in a fragmented approach to AOD policy with limited opportunities for federal, state and territory information sharing, collaboration, and learning'.

There are commitments to AOD in the current Agreement, but little has been achieved

The Agreement identifies people experiencing problematic AOD use as one of 15 'priority population groups' (clause 111) and Schedule A includes several whole-of-government commitments to improve services for people with co-occurring problematic AOD use and mental ill health and/or suicidal distress (box 9.4). But no meaningful progress on this has been made under the Agreement, as it lacks specific actions, outputs, outcomes, funding and effective governance to hold governments to account.

The Agreement's annual progress report for 2023-24 notes the Schedule A working group met three times in the reporting period and rated the status of all Schedule A commitments as 'commenced - on track'. However, it also reported little impact has been made beyond information sharing and there has not been any delivery of tangible products or actions against Schedule A commitments (NMHC 2025, pp. 5, 17).

Little appears to have been achieved in relation to the AOD commitments in the state and territory bilateral schedules (Anglicare WA, sub. 225, p. 3). As Turning Point and the Monash Addiction Research Centre (sub. 137, p. 4) told us, 'only Victoria and Western Australia's bilateral agreements include any AOD commitments, and even these are limited, inconsistently linked to national strategies, and poorly integrated with broader mental health reforms'.

Box 9.4 – AOD related commitments in the Agreement

As drug use and other substance use disorders and mental illness or suicidal distress can co-occur frequently, governments agree to:

a. Improve communication, collaboration and coordination between Commonwealth, state and territory government-funded health services, including through trialling and evaluating joint planning and regional commissioning of alcohol and other drug services, in line with the *National Framework for Alcohol, Tobacco and Other Drug Treatment 2019–29* (DoH 2019c).
b. Implement clear and consistent care pathways for people with co-occurring alcohol and other drug use and mental illness, and ensure warm referrals across alcohol and other drug services, and mental health and suicide prevention services irrespective of funding source.
c. Integrate (and trial where appropriate) alcohol and other drug services and mental health and suicide prevention services, regardless of the level of government delivering the service, with co-location being one option to facilitate integration.
d. Develop a nationally consistent approach to data collection to understand the prevalence of co-occurring alcohol and other drug use and mental illness and suicide.
e. All levels of government will work collaboratively to appropriately share findings from research and data analysis with relevant stakeholders, to assist in identifying gaps, improving supports provided.
f. Build on and leverage existing efforts to build the capability of the mental health and suicide prevention workforce, including the peer and Aboriginal and Torres Strait Islander workforces, to provide support and appropriate clinical treatment to people with co-occurring alcohol and other drug use and mental health and suicidality.

Source: Schedule A, clause 8.

9.3 Service providers are hampered by a lack of funding and policy action

Important work has been undertaken outside the Agreement

Outside the Agreement, a patchwork of initiatives to address the co-occurrence of problematic AOD use, mental ill health and suicidal distress has been introduced in different parts of Australia for more than two decades (box 9.5) (Deady et al. 2024, p. 10; RCVMHS 2021, pp. 306–309; Sax Institute 2015; VAADA 2023). However, these are not nationally coordinated.

The predominant model of care offered to people with co-occurring problematic AOD use and/or mental ill health and suicidal distress continues to be single disorder focused, usually provided in a sequential order according to what is assessed as the person's primary issue (Deady et al. 2024, p. 10; Fisher et. al. 2020, p 31). Only piecemeal progress has been made towards providing more integrated and holistic clinical treatment in Australia, despite almost three quarters of people with co-occurring needs reporting a preference for having the same worker treat both their AOD and mental health issues (Barrett et al. 2019, p. 41). Evidence suggests where integrated care includes co-located AOD and mental health services, this improves treatment engagement and reduces problematic AOD use and mental ill health symptom severity (Glover-Wright et al. 2023). There is growing interest among policy makers in integrated care but more research is needed to evaluate this approach and alternative models (Deady et al. 2024, p. 11; Hunt et al. 2019, p. 2).

Box 9.5 – Examples of state-level initiatives to address the co-occurrence of problematic AOD use, mental ill health and suicidal distress

Queensland

For the past decade, the Queensland Government has promoted more integrated care in AOD and mental health service provision (QMHC 2018, p. 33). The aim of the reform strategy for state-funded AOD and mental health services is to support 'integration and co-ordination, maximising available resources and minimising duplication between different funders and providers to better support streamlined treatment, care and support' (Queensland Health 2022, p. 23). However, we heard from QNADA (sub. 18, p. 4) that AOD services in Queensland continue to be chronically underfunded and there is a 'need to resolve issues within the current funding, contracting and commissioning environment which hamstring the ability of AOD services to operate effectively'.

Victoria

The Victorian Government has funded a 'dual diagnosis' initiative since 2002, with workers trained specifically to support people experiencing co-occurring problematic AOD use and mental ill health. However, evaluations have found limited progress in broadening access to integrated care over the life of this initiative (Cheetham et al. 2024, p. 8). More recently, Victoria has established the Hamilton Centre to improve statewide access to integrated treatment and support for people who are experiencing co-occurring AOD and mental health issues (Victorian Department of Health 2024b). The establishment of the centre addresses decades-long obstacles to providing integrated care, including philosophical differences between the mental health and AOD workforce and little shared understanding of integrated care (Cheetham et al. 2024, pp. 3–4; Design Health Collab 2023, p. 2). Key services provided by the

Box 9.5 – Examples of state-level initiatives to address the co-occurrence of problematic AOD use, mental ill health and suicidal distress

centre include in-person and telehealth appointments and service navigation to assist clinicians in delivering integrated care (Hamilton Centre 2025a).

Western Australia

A decade ago the Western Australian Government adopted a plan to integrate mental health, suicide prevention and AOD services and has pursued this by merging the Drug and Alcohol Office into the West Australian Mental Health Commission (WAMHC) (WAMHC 2015, p. 154). Responsibility for promoting service integration now sits with WAMHC as the State Government's primary commissioning agency for mental health and AOD services.

However, a recent capability review of the WAMHC found it 'has not effectively executed its leadership role of the sectors to achieve integrated service delivery, resulting in inefficiencies, gaps in services and vulnerable people not always receiving services when and where they need them' (WAPSC 2024, p. 5). The review also found 'structural fragmentation in the agency is evident in the distinct silos separating service and treatment teams as well as the internal divide between mental health and AOD' (WAPSC 2024, p. 6). Further, we heard from the Western Australian Network of Alcohol and other Drug Agencies (WANADA) (sub. 41, p. 1) that while the state's AOD sector 'has long been actively working to build their capability and responsiveness to co-occurring issues' they have found 'in the mental health service sector [this] is not reciprocated'.

Australia is world recognised in developing and evaluating clinical treatments for people experiencing co-occurring problematic AOD use and mental ill health. But access to these treatments remains limited (Matilda Centre and PREMISE Next Generation, sub. 220, p. 10). This includes, for example, treatment for co-occurring post-traumatic stress disorder (PTSD) and SUDs, developed in a world first clinical trial by Australian researchers (Mills et al. 2012). This is the only integrated treatment recognised by the American Psychological Association for these co-occurring conditions. However, at this stage, such treatment is not available in routine clinical practice in Australia, largely because of insufficient national policy support and resourcing for implementation (Matilda Centre and PREMISE Next Generation, sub. 220, p. 10).

Australia has also developed guidelines for how AOD services should aim to treat co-occurring mental ill health, consolidating the advances in treatment made over the past 15 years (Marel et al. 2022) (box 9.6). These are the only such guidelines worldwide. While there has been Australian Government funding support to promote the use of these guidelines in the AOD sector, there is a need for more funding to support similar translational work in mental health and suicide prevention services (Matilda Centre and PREMISE Next Generation, sub. 220, pp. 10–11). There is considerable evidence showing compared with treatment as usual, people who are cared for with guideline-adherent treatments improve faster and experience better outcomes (Setkowski et al. 2021).

Box 9.6 – Guidelines for the management of co-occurring AOD and mental health conditions in AOD treatment settings

In 2007, the Australian Government funded the development of 'Guidelines on the management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings'. The guidelines were developed by the Matilda Centre for Research in Mental Health and Substance Use and aim to improve the capacity of the AOD workforce in responding to co-occurring mental health conditions. The guidelines have been revised and updated in 2016 and 2022 (Marel et al. 2022).

The guidelines include principles for how AOD workers should provide treatment and support for people with co-occurring mental ill health, such as embracing a 'no wrong door' policy, routinely screening for co-occurring conditions, adopting a person-centred, trauma informed and holistic approach and facilitating a collaborative approach to treatment that enables shared decision making (Marel et al. 2022, p. 23).

More than 45,000 hard copies of the guidelines have been distributed to practitioners, services and students nationally. Since 2018, more than 15,000 people have undertaken the training, which is also embedded into more than 200 vocational and educational training (VET) courses nationally (Matilda Centre and PREMISE Next Generation, sub. 220, p. 11).

In a survey of AOD workers who completed the online training, the majority said they found it useful (94%) and most reported having gained knowledge that would enable them to work more effectively with people experiencing co-occurring issues (95%) (Marel et al. 2023).

But substantial unmet need and delays in treatment remain

Many people experiencing co-occurring problematic AOD use and mental ill health do not access treatment. Only 10% of people experiencing SUDs report accessing any professional AOD treatment in the past year (Ritter and O'Reilly 2025, p. 773). A survey of people who inject drugs found among those with self-reported mental health problems, there was a decline in attendance at mental health treatment (from 31% in 2019 to 27% in 2023) (Thomas et al. 2024, p. 3). In a survey of the general population, one in three people with a SUD co-occurring with another mental health condition reported not seeing any health professional for their mental health during the past year (Harris et al. 2025, p. 815).

Fewer than a third of people with a SUD (27%) will eventually seek treatment over their lifetime (Birrell et al. 2025, p. 3). By comparison, most people with a mood disorder (94%) or an anxiety disorder (85%) eventually seek treatment in their lifetime. Delaying treatment can result in problematic AOD use or mental ill health becoming harder to treat and lead to single issues progressing into multiple issues (Birrell et al. 2025, p. 1).

Many people delay seeking AOD treatment for a long period; 'the median time to first treatment for alcohol dependence, for example, is an astonishing 18 years' (Turning Point and the MARC, sub. 137, p. 8). If left untreated, during this period 'a person may develop secondary physical and mental health disorders, or … existing co-occurring conditions may worsen' (Matilda Centre and PREMISE Next Generation, sub. 220, p. 10). And as more problems escalate, 'the more costly treatment becomes' (Turning Point and the MARC, sub. 137, p. 8). In the worst-case scenario, a 'delay may prove fatal' (Matilda Centre and PREMISE Next Generation, sub. 220, p. 10).

> This gap [in meeting people's need for treatment] represents a significant cost to society—not just in economic terms (where the burden of untreated substance use disorders is substantial), but also in terms

> of the physical and psychological effects (pain and suffering) that could be alleviated with the provision of treatment (QNADA, sub. 18, p. 3)

There are multiple reasons why people with problematic AOD use and mental ill health, in isolation or co-occurring, do not access treatment (box 9.7). For many people, co-occurrence itself can be a major barrier to access (Jesuit Social Services, sub. 131, p. 17). People with co-occurring problematic AOD use and mental ill health are often unable to access treatment in mental health services or the broader health system because of experiences of discrimination or because of restrictive entry points. Some can find themselves in a 'comorbidity roundabout' moving from one service to another to meet their treatment needs (Barrett et al. 2019, p. 41).

> We would often have clients 'stuck' between the 2 - with AOD services saying 'we'll work with that client once you manage their mental health concerns', but equally other mental health services saying to AOD services 'we'll work with them once you manage the AOD side of things'. This is not a holistic approach, treating the person as a whole person rather than isolated 'issues'. (sr. 94)

Most people with co-occurring needs (64%) report they would prefer to work on their issues in an integrated way (Barrett et al. 2019, p. 40). But evidence indicates uneven use of AOD and mental health services. Most people who attend treatment usually present at AOD services (RCVMHS 2021, p. 298). Only a small proportion (16%) of people with co-occurring needs report receiving some support for their AOD issues in mental health services, whereas most (60%) report receiving some support for their mental health problems in AOD services (Barrett et al. 2019, p. 40). Often, mental health services are either unwilling to treat people with co-occurring problematic AOD use or are not sufficiently prepared with the appropriate skills and supports in place (Matilda Centre, sub. 220, p. 11; RCVMHS 2021, p. 310). Most of the AOD workforce report also report being ill-prepared, with 62% saying they are concerned about gaps in their training to effectively support people experiencing co-occurring problematic AOD use and mental ill health (Skinner et al. 2020, p. 17).

Box 9.7 – Individual and system level reasons for not accessing treatment

People with co-occurring conditions often present in distress and with complex symptoms that can interfere or compromise assessment and treatment for their conditions (Marel et al. 2022, pp. 20–21). They are more likely to represent a severe clinical case compared to people with AOD or mental health conditions in isolation, including poorer general health, more severe AOD use and interpersonal difficulties (for example, homeless, no social supports) (Kingston et al. 2017, p. 528). They are also at greater risk of experiencing relapse following treatment, particularly if their co-occurring needs are not properly assessed, supported and treated (Deady et al. 2024, p. 7). Further, many people with problematic AOD use will not desire treatment and/or will not ever seek treatment (for example, because of low problem recognition) and instead will experience untreated remission (Grigg et al. 2023, pp. 70–71; Ritter and O'Reilly 2025, p. 774).

People with co-occurring conditions often experience difficulties finding and accessing appropriate care and support in a siloed and segregated system with different eligibility criteria, multiple entry points and 'wrong doors' (Deady et al. 2024, pp. 6, 10). Many experience stigma and discrimination when presenting to services (Barrett et al. 2019, p. 40; RCVMHS 2021, pp. 317–318). They also face geographic barriers (especially for people in rural and remote locations) (Marel et al. 2022, pp. 319–320) and financial barriers when care is not fully funded by the public system (Birrell et al. 2025, p. 2). Many experience logistical problems when services do not coordinate care or when there is poor integration across services (Marel et al. 2022, p. 147). The lack of nationally agreed and funded models of care for people with co-occurring problematic AOD use and mental ill health contributes to unmet need (PC 2020, pp. 648–651).

Funding arrangements for AOD services exacerbate the shortfalls in services

For AOD services, funding shortages continue to be the major obstacle to enhancing service responses for people with co-occurring needs (Jesuit Social Services, sub. 131, p. 18; Matilda Centre and PREMISE Next Generation, sub. 220, p. 10; QNADA, sub. 173, pp. 3–5). One of the state peak bodies submitted that 'the AOD sector, while chronically underfunded, uses its limited existing resources to continually build capability to provide care for people who present with co-occurring problematic substance use and mental ill health' (QNADA, sub. 173, p. 5).

Funding shortages have accrued over time, and 'have been exacerbated by the lack of indexation on Commonwealth contracts with AOD services for the better part of a decade' (QNADA, sub. 18, p. 4). An analysis of AOD system funding reported the total 'drug budget' of all Australian governments combined in 2021-22 was $5.5 billion, representing a 160% increase in real terms since 2002-03 (Ritter et al. 2024, p. 12). But as a proportion of total government expenditure, the drug budget has fallen over time and represents only 0.6% of total government spending (Ritter et al. 2024, p. 13).

Most of the drug budget in Australia is allocated to law enforcement (64%), with considerably less dedicated to treatment (27%), prevention (7%) and harm reduction (2%). These budget shares have remained virtually unchanged for the past two decades (Ritter et al. 2024, p. 13) despite a 15% increase in the number of people receiving AOD treatment between 2013-14 and 2023-24 (AIHW 2025a) and increased complexity in presentations to AOD treatment services (van de Ven et al. 2021, p. 52).

AOD system funding arrangements are fragmented, irregular and lack transparency. There are several 'highly siloed' government funding sources that AOD services are dependent upon (PHN Cooperative, sub. 208, p. 11). This includes grants from state and territory governments, the National Indigenous Australians Agency (NIAA), and the Australian Department of Health, Disability and Ageing's (DHDA) Drug and Alcohol Program (DAP). The latter has been the Australian Government's main AOD funding scheme since 2015; as at October 2025, it is under review (AADC, sub. 171, p. 3).

Regional commissioning of DAP-funded services is administered by PHNs. Some review participants argued PHNs have 'limited' understanding of the AOD and mental health system, which 'constrains their ability to plan and commission such services effectively' (Jesuit Social Services, sub. 131, p. 9). QNADA (sub. 18, pp. 6–7) said PHNs 'commissioning of AOD services is focussed on outputs rather than outcomes at the detriment of on-the-ground service delivery' and this is 'an ineffective approach and counterproductive to increasing system stability and service quality'.

There are overarching concerns about AOD system funding, including the fragmentation and inefficiencies created by short-term grants with high administrative burden, the disconnect from other federal funding agreements, data gaps and poor outcome tracking and the failure to address unmet needs in several priority populations (QNADA, sub. 18, pp. 4–6; Turning Point and the MARC, sub. 137, p. 6).

Service providers funded to deliver services to people with co-occurring problematic AOD use and mental ill health and/or suicidal distress can face significant administrative burden. For example, a non-government organisation delivering integrated AOD and mental health care said they are faced with 'duplication of reporting' and 'misaligned funding periods' (Jesuit Social Services, sub. 131, p. 18). VACCHO and BDDC (sub. 162, p. 12) told us multiple funding bodies 'are largely working in siloes' with 'each requiring their own reporting streams, systems and processes'.

9.4 AOD in the next agreement

The next agreement is an opportunity to address the intersection of problematic AOD use, mental ill health and suicidal distress. It can fill a critical gap in policy and deliver a strategic, national approach to addressing these co-occurring issues. To best achieve this, the next agreement should include a separate AOD schedule. This schedule should be co-designed by people with lived and living experience, include new funding to invest in service system enhancements and should be overseen by dedicated governance arrangements.

The PC also recommends the next agreement include a separate schedule to support services for Aboriginal and Torres Strait Islander people (recommendation 7.1) and to address suicide prevention (recommendation 8.1), recognising the factors affecting these areas that are distinct from the mental health system and the need for coordinated action. The need for an AOD schedule stems from the fact that this is a major issue *within* the mental health and suicide prevention system requiring a dedicated response – but is not appropriately considered in any other policy environment.

Including a dedicated schedule for AOD in the next agreement is not the only potential means for addressing co-occurrence at a national level. Possible alternatives to a schedule include addressing the intersection of problematic AOD use, mental ill health and suicidal distress within the main body of the next agreement or addressing these issues outside the agreement, such as within the next iteration of the National Drug Strategy. But compared to a separate schedule, these alternatives do not provide the necessary dedicated focus on coordinating action and funding, or the intergovernmental and cross sector accountability required for achieving reform.

Including a separate AOD schedule in the next agreement was supported by many review participants.[81] Several stated a dedicated schedule for the intersection of problematic AOD use, mental ill health and suicide would be valuable for improving cross jurisdiction and cross system coordination to enhance service provision for people with co-occurring needs.

> At present, the approach to AOD is different across jurisdictions … National leadership is required and best practices need to be shared between jurisdictions. Hence, to see improved coordination between AOD and Mental Health treatment services across Australia, a new schedule in the next agreement is recommended (Australian Medical Association, sub. 235, p. 2).

> Co-occurring conditions are prevalent and complex, often requiring coordinated responses across service systems. A dedicated schedule would provide a structured mechanism to support joint planning and service integration across jurisdictions (Victorian Government, sub. 228, p. 26).

To be effective, there should be adequate funding provided for implementing actions included in the schedule and for providing oversight and governance of the schedule. The scope of the schedule should be tightly focused on addressing the intersection of problematic AOD use, mental ill health and suicidal distress. This recognises the specific challenges for policy making and for service planning and commissioning where these issues co-occur (Matilda Centre and PREMISE Next Generation, sub. 220, p. 9).

External to the schedule there are imminent policy developments occurring across the broader AOD system. This includes the current departmental review of the DAP funding arrangements, the expected update of the National Drug Strategy and the potential re-establishment of a national AOD governance forum for

[81] For example, Australian Association for Psychologists Incorporated (AAPi), sub. 109, p. 6; Matilda Centre and PREMISE Next Generation, sub. 220, p. 4; Medibank Private Limited, sub. 198, p. 6; Queensland Nurses and Midwives' Union (QNMU), sub. 136, p. 6; Royal Australian and New Zealand College of Psychiatrists (RANZCP), sub. 222, p. 3; Turning Point and the MARC, sub. 137, p. 3; Zero Suicide Institute of Australia (ZSIA), sub. 238, p. 6.

intergovernmental and cross-sector policy decision making and coordination. There is also a current parliamentary inquiry into the health impacts of AOD (SCHACD 2025). There is no certainty about the outcomes of these processes. But inaction on co-occurring problematic AOD use, mental ill health and suicidal distress in the meantime could potentially be more harmful than planning some steps forward through an AOD schedule in the next agreement.

Some review participants told us of concerns an AOD schedule would potentially add more complexity, duplication and confusion to a system where there is already some uncertainty and instability (AADC, sub. 171, pp. 3–4; Catholic Health Australia, sub. 181, p. 18; Mental Health Australia, sub. 153, pp. 9–10; PHN Cooperative, sub. 208, p. 11; Suicide Prevention Australia, sub. 214, p. 10). Recognising these concerns, it is recommended the AOD schedule be developed after substantive progress has been made on broader AOD policy developments outside the remit of the schedule. This includes completion of the current review of DAP funding, and progress towards updating the National Drug Strategy and re-establishing national AOD system governance.

As much as practicable, the timeframe for developing the schedule should accommodate these developments in the external AOD environment to ensure there is policy consistency, capacity for cross-sector collaboration and a nationally integrated strategy for the intersection of problematic AOD use, mental ill health and suicidal distress (PHN Cooperative, sub. 208, p. 11). Providing flexibility in the timeframe for developing the AOD schedule aligns with the recommendation to extend the current Agreement until June 2027 to give sufficient time to develop the foundations of the next agreement (recommendation 4.3).

A dedicated AOD schedule has several potential benefits

A dedicated AOD schedule in the next agreement has the potential to deliver several benefits. This includes strengthened intergovernmental and cross sector planning and coordination and more funding for targeted investment in service improvements where gaps exist. Other potential benefits include enhanced capacity of the care workforce, increased accessibility to high quality treatment, action to reduce stigma and discrimination and a stronger focus on prevention.

A mechanism for national planning

A key benefit of an AOD schedule is providing a mechanism for national planning and resourcing of system improvements for preventing and treating co-occurring problematic AOD use, mental ill health and suicidal distress. To enable this, the schedule should set out strategic objectives, priority actions, roles, responsibilities, deliverables, outcomes and timeframes (Tasmanian Government, sub. 239, p. 4).

The AOD schedule should act as a tool for strengthening communication, coordination and collaboration across jurisdictions and between the separate but overlapping AOD, mental health and suicide prevention systems. The schedule should recognise and accommodate, where appropriate, the different approaches taken across jurisdictions and sectors to address co-occurrence. But it should work towards national consistency and best practice in addressing these issues (Anglicare WA. sub. 225, p. 4; Faculty of Medicine, Nursing and Health Sciences, Monash University, sub. 202, p. 27; Municipal Association of Victoria, sub. 152, p. 5).

Funding for implementation

The schedule should include new funding to support implementation of evidence-based and best practice approaches in the AOD, mental health and suicide prevention systems for preventing and treating co-occurring issues. The schedule should help guide investment priorities, which may first include scaling-up approaches shown to be effective, followed by developing, trialling and evaluating promising new approaches to prevention and treatment.

There should also be a focus on streamlining and simplifying the funding of AOD, mental health and suicide prevention services that deliver programs to people who are experiencing or are at risk of co-occurrence. For example, consideration should be given to better coordinating or integrating the currently siloed funding arrangements of Australian, state and territory governments (chapter 6). The schedule should aim to reduce inefficient and insecure short-term program funding, administrative burden and duplication in reporting requirements for services (PHN Cooperative, sub. 208, pp. 11–12; QNADA, sub. 173, p. 5; VACCHO and BDDC, sub. 162, p. 12). Funding and commissioning processes under the AOD schedule should align with broader improvements recommended for the next agreement. This includes simplifying and integrating funding streams and supporting collaborative commissioning (recommendations 6.1, 6.3 and 6.4).

Building workforce capacity

A key aim of the schedule should be strengthening workforce capacity to better support people with co-occurring needs in the AOD, mental health and suicide prevention systems. Attracting, retaining and building the skills of these workforces is key to delivering better treatment and support for people with co-occurring needs (QNADA, sub. 173, p. 5).

We heard from review participants about the need to strengthen the AOD workforce to enable improvements in the capacity, quality and availability of services (AADC, sub. 171, p. 4; Jesuit Social Services, sub. 131, p. 18; PHN Cooperative, sub. 208, p. 12). Any strengthening of the capacity of AOD services is also likely to benefit mental health and suicide prevention services by offsetting some of the demand pressures they face.

Peer workers should be an integral part of any workforce capacity building across services for people with co-occurring needs (chapter 4). Peer workers can help make AOD, mental health and suicide prevention services more welcoming and accessible for people with co-occurring needs by reducing stigma (Emery et al. 2024, pp. 4–7; Matthews et al. 2023, p. 5). Preliminary evidence has shown peer worker involvement can reduce the likelihood of relapse and improve satisfaction with treatment (Eddie et al. 2019; Marel et al. 2022, p. 30). As VACCHO and BDDC (sub. 162, pp. 16–17) stated:

> peer workers are an essential part of multidisciplinary teams and should be adequately supported to excel in their roles' because they 'have unique knowledge and are able to draw on their own experience, service use and journey of recovery to support other people currently experiencing similar circumstances.

The AOD schedule should support the development of a nationally consistent scope of practice for the peer workforce in AOD, mental health and suicide prevention services (recommendation 4.7). To achieve this, the schedule should build on and leverage available guidance that has been developed by lived experience peak bodies for organisations employing peer workers.[82]

Increasing the availability and accessibility of care

For people experiencing co-occurring problematic AOD use and mental ill health and/or suicidal distress, there is significant unmet need for treatment. A lack of access to appropriate support services was highlighted by review participants as a contributing factor in individuals' problematic AOD use (QNMU, sub. 136, p. 6). Accordingly, the schedule should coordinate a nationwide expansion of service models that

[82] Examples of guidance include 'Peer workforce: a practical national framework for employing people with lived-living experience of using drugs as health, harm reduction and alcohol and other drug (AOD) workers' (AIVL 2025) and 'The alcohol and other drugs (AOD) lived experience workforce discipline framework' (SHARC 2025).

provide holistic, trauma informed, person-centred, coordinated and collaborative treatment and support for people experiencing co-occurring problematic AOD use and mental ill health and/or suicidal distress.

Australian researchers have developed evidence-based clinical treatment practices and guidelines for the intersection of problematic AOD use, mental ill health and suicidal distress. But these currently lack application and accessibility on a national scale (Matilda Centre and PREMISE Next Generation, sub. 220, p. 10). A new AOD schedule should support national adoption and uptake of these.

The AOD schedule should support models of service offering more flexible access (for example, outreach and afterhours support), which is often key to helping people overcome barriers to treatment and support (Jesuit Social Services, sub. 131, p. 18). Developing and implementing digital options should also be explored for increasing access to information, support and treatment (Matilda Centre and PREMISE Next Generation, sub. 220, p. 11).

The schedule should recognise the importance of cultural safety as a factor in treatment seeking among Aboriginal and Torres Strait Islander people (chapter 7). The AOD schedule should contribute to ensuring AOD, mental health and suicide prevention services are culturally safe.

While some believe an integrated approach to problematic AOD use, mental ill health and suicidal distress is critical (for example, Matilda Centre and PREMISE Next Generation, sub. 220, p. 5), evidence on the effectiveness of service and treatment integration remains mixed (Chetty et al. 2023, p. 9; Glover-Wright et al. 2023, pp. 1212–1214; Hunt et al. 2019, p. 2). As noted in a recent parliamentary inquiry, ‘a cautious approach to service integration’ may be prudent given the complexities and uncertainties involved (SCHACS 2025, p. 59). As part of implementing the AOD schedule, the benefits and feasibility of integrated treatment models should therefore be rigorously evaluated alongside alternatives.

Reducing stigma and discrimination

Experiencing stigma and discrimination can be a major barrier faced by people with co-occurring problematic AOD use and mental ill health when attempting to access treatment and support services (Jesuit Social Services, sub. 131, pp. 7–8). A new AOD schedule should align with the implementation of the National Stigma and Discrimination Reduction Strategy. The Strategy is yet to be released but should be made public as a matter of priority (recommendation 2.2). Government actions should focus especially on reducing the ‘double stigma’ often experienced by people with co-occurring needs. Key to this will be upskilling the AOD, mental health and suicide prevention workforces and building greater awareness and understanding of co-occurring needs, with the aim of reducing stigma and discrimination (Barrett et al. 2019; Hamilton Centre 2025b).

The schedule should contribute to breaking down system-generated barriers to treatment faced by people with co-occurring problematic AOD use, mental ill health and/or suicidal distress, such as the different entry criteria depending on an individual’s range of needs and each service’s funding sources (Allied Health Professions Australia, sub. 178, p. 7). It should coordinate national initiatives to enable easier system navigation and improved access to treatment and support (that is, a ‘no wrong door’ approach) (Mental Health Coordinating Council, sub. 120, p. 2).

A stronger focus on prevention

Given the evidence of a strong association between problematic AOD use, mental ill health and suicidal distress, implementing policies that prevent problematic AOD use are likely to help reduce some incidence of co-occurring mental health conditions and suicide (Jane-Llopis and Matytsina 2006, p. 533; Plana-Ripoll et al. 2020, p. 348; Volkow and Blanco 2023, p. 211). Effective prevention and early intervention strategies should be expanded under the AOD schedule. This should be aimed towards groups most at risk of

co-occurring problematic AOD use, mental ill health and/or suicidal distress and focused on addressing the root causes of co-occurring conditions. In particular, prevention and early intervention strategies focussed on young people should be prioritised (OurFutures Institute, sub. 182, p. 5).

Intervening early and preventing problems from worsening, or occurring in the first place, can help reduce the likelihood of downstream pressure on treatment and support services in the AOD, mental health and suicide prevention systems. Prevention of co-occurring issues not only has health benefits, it also produces substantial cost savings (OurFutures Institute, sub. 182, p. 4; Turning Point and the MARC, sub. 137, p. 6).

Schedule co-design, governance and accountability

The schedule should be co-designed and align with other recommendations to increase the involvement of people with lived and living experience in developing and implementing the next agreement (recommendations 4.3 and 5.3). Review participants recommended a meaningful co-design approach be adopted for developing and implementing the AOD schedule. This approach should be strengths-based and empowering for consumers, supporters, family, carers and kin and the peer workforce (Matilda Centre and PREMISE Next Generation, sub. 220, pp. 8–9; Mental Health Lived Experience Peak Queensland, sub. 144, p. 11; National Mental Health Consumer Alliance, sub. 149, p. 22).

Separate governance arrangements should be established to oversee implementation of the schedule and to ensure there is transparent reporting and accountability for progress. Governance arrangements for the schedule should focus primarily on the points of intersection between problematic AOD use and mental ill health and suicidal distress and therefore aim to avoid creating duplication with other governance arrangements in the next agreement or elsewhere. The Mental Health and Suicide Prevention Senior Officials group (MHSPSO) should establish a working group with responsibility for implementation of the AOD schedule. This working group should have a formal reporting line to the recommended Special Purpose Mental Health Council via MHSPSO and the Chief Executives and Secretaries Forum (recommendation 5.2).

Membership of the AOD schedule working group should include people with lived and living experience, supporters, family, carers and kin, services providers, peak bodies and relevant government agencies across portfolios and jurisdictions. At minimum, this should include senior officer representation from both the justice/law enforcement and health portfolios in each jurisdiction, as per Australia's longstanding approach to governance of the National Drug Strategy (DoH 2017, p. 35).

This dedicated governance for the AOD schedule will help ensure there is the necessary intergovernmental and cross-sector coordination for planning, implementing and progress reporting on initiatives, which has been lacking since 2020 following the disbandment of national AOD governance arrangements. Given the inconsistencies across jurisdictions in addressing co-occurring problematic AOD use, mental ill health and suicidal distress, a goal of governance arrangements for the AOD schedule should be to develop national consensus and consistency in approaches to treatment and prevention, as much as practicable.

Also important is ensuring implementation of the AOD schedule is monitored and evaluated. The next agreement should adopt a dedicated set of indicators to monitor progress under the AOD schedule (Turning Point and the MARC, sub. 137, p. 10). This can help track the trends in demand and the outcomes of service delivery to people with co-occurring needs. This should align with other reforms recommended to strengthen monitoring and reporting under the next agreement, such as formalising the role of the National Mental Health Commission as the entity responsible for assessment of progress against the agreement's outcomes (recommendation 5.6), including the outcomes specified in the AOD 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.

A. Public consultation

This appendix provides information about the consultation process undertaken for the review of the National Mental Health and Suicide Prevention Agreement. It lists the organisations and individuals who participated in consultation, submissions received, as well as the organisations and individuals who participated in the public hearings and roundtable that were held following the release of the interim report (section A.1). It also provides information about the online survey undertaken by the PC (section A.2).

The PC would like to thank everyone who participated in this review.

A.1 Engagement

Table A.1– Consultation

Participants
Aboriginal Drug and Alcohol Council, South Australia
Alcohol and Drug Foundation
Arafmi
Australian Association of Psychologists Incorporated (AAPi)
Australian Capital Territory Health Directorate
Australian Government Department of Health, Disability and Ageing
Australian Government Department of the Prime Minister and Cabinet
Australian Government Department of the Treasury
Australian Injecting & Illicit Drug Users League (AIVL)
Australian Institute of Health and Welfare (AIHW)
Australian Psychological Society
Australian Psychosocial Alliance
Bayliss, Dean
Black Dog Institute – Aboriginal and Torres Strait Islander Lived Experience Centre
Brisbane North Primary Health Network
Carers Australia
Coalition of Peaks
Darling Downs West Moreton HHS – Mental Health Service Wacol
Darling Downs West Moreton Primary Health Network

Participants

Data Governance Forum (under the National Mental Health and Suicide Prevention Agreement) (DGF)
Davison, Dr Sophie, Chief Psychiatrist
Diminic, Sandra and Rutherford, Zoe
Eastern Health, Hamilton Centre
Eastern Melbourne Primary Health Network
Equally Well
Frith, Jordan
Gayaa Dhuwi (Proud Spirit) Australia
headspace
Healing Foundation
Health Consumers Queensland
Heggie, Peter
Holdsworth, Graeme
Institute for Urban Indigenous Health (IUIH)
Ipswich Medicare Mental Health Service, Open Minds
LGBTIQ+ Health Australia
Lifeline Australia
Lived Experience Australia
Matilda Centre for Research in Mental Health and Substance Use
Medicare Mental Health Centre Launceston, Stride
Mental Health and Suicide Prevention Senior Officials Group
Mental Health Australia
Mental Health Carers Australia
Mental Health Commission of New South Wales
Mental Health Council Tasmania
Mental Health Families and Friends Tasmania
Mental Health Lived Experience Peak Queensland
Mental Health Lived Experience Tasmania
Mental Health and Wellbeing Commission Victoria
Mental Illness Fellowship of Australia
Micah Projects
Mind Australia
New South Wales Mental Health Commission
New South Wales Ministry of Health
National Aboriginal Community Controlled Health Organisation

Participants
National Mental Health and Suicide Prevention Lived Experience Group
National Mental Health Commission
National Mental Health Consumer Alliance
National Rural Health Alliance
National Suicide Prevention Office
Northern Territory Health
Peacock Centre
Primary Health Network (PHN) Cooperative
Primary Health Tasmania
Queensland Alliance for Mental Health
Queensland Department of Health
Queensland Mental Health Commission
Queensland Network of Alcohol and Other Drug Agencies (QNADA)
Ritter, Alison
Robotham, Julie
Roses in the Ocean
Royal Australian and New Zealand College of Psychiatrists (RANZCP)
SANE
Self Help Addiction Resource Centre (SHARC)
South Australian Department of Health and Wellbeing
South Australian Mental Health Commissioner
Staying Deadly Hub, IUIH
Suicide Prevention Australia
Tasmanian Department of Health
Te Hiringa Mahara (Mental Health and Wellbeing Commission) New Zealand
Thirrili
Victorian and Tasmanian PHN Alliance
Victorian Department of Health
Western Australian Department of Health
Western Australian Mental Health Commission
Western Australian Primary Health Alliance

Table A.2 Submissions received

Participants	Submission no.
ACT Mental Health Consumer Network	114
Actuaries Institute	189
Adelaide PHN	62
Advanced Pharmacy Australia (AdPha)	48
Allied Health Professions Australia (AHPA)	178
Anglicare WA	225
Australasian Institute of Digital Health (AIDH)	12
Australian Alcohol and other Drugs Council (AADC)	20, 171
Australian Association of Psychologists Incorporated (AAPi)	13, 109
Australian Association of Social Workers (AASW)	231
Australian BPD Foundation	39
Australian College of Nursing (ACN) and Australian College of Mental Health Nurses (ACMHN)	30
Australian Commission on Safety and Quality in Health Care (ACSQHC)	67, 176
Australian Health Policy Collaboration (AHPC)	206
Australian Medical Association (AMA)	72, 235
Australian Multicultural Action Network (AMAN)	124
Australian Private Hospitals Association (APHA)	163
Australian Psychological Society (APS)	85
Australian Psychosocial Alliance (APA)	55, 155
Australian Red Cross and Phoenix Australia	159
Australian Suicide Prevention Foundation (ASPF)	52
Australian Veterinary Association (AVA)	25, 125
Basic Rights Queensland (BRQ)	77
batyr	27, 203
BEING – Mental Health Consumers	141
Bell, Kevin, Heffernan, Tim, Katsonis, Maria and Orr, Mark	11
Beyond Blue	37, 156
Birth Trauma Australia (BTA)	28
Black Dog Institute (BDI)	61, 151
Brain and Mind Centre	227
Breen, Dr Lauren	113
Cancer Council Australia	207
Catts, Stanley	240

Participants	Submission no.
Carbone, Dr Stephen	201
Carers ACT	60
Carers Australia	74
Carers NSW	57
Carers WA	43
Catholic Health Australia (CHA)	181
Centre for Community Child Health (CCCH)	79, 183
Centre for Muslim Wellbeing (CMW)	224
Commissioner for Children and Young People	158
Community Mental Health Australia (CMHA)	84, 216
Consumers Health Forum of Australia (CHF)	22, 140
Consumers of Mental Health WA (CoMHWA)	49, 148
COTA Australia	218
DeepEnd	107
e-Mental Health in Practice (eMHPrac)	47
Emerging Minds	40
Equally Well Australia	53, 243
Ethnic Communities Council of Queensland (ECCQ)	3
Everymind	32
Exercise and Sports Science Australia (ESSA)	132
Faculty of Health, Deakin University	174
Faculty of Medicine, Nursing and Health Sciences, Monash University (MHNS)	202
Federation of Ethnic Communities' Councils of Australia (FECCA)	58
Footprints Community Limited (FCL)	217
Forum of Australian Services for Survivors of Torture and Trauma (FASSTT)	64, 223
Gayaa Dhuwi (Proud Spirit) Australia	75, 230
Genspect Australia	92
Goldsmith, Stephen	96
Growing Minds Australia (GMA)	165
headspace National Youth Mental Health Foundation (headspace)	23
Health Consumers' Council WA (HCC)	139
Health Justice Australia (HJA)	65
Hensing, Nicholas	244
HER Centre Australia	122
Highway Foundation	211

Participants	Submission no.
Homelessness Australia	112
Institute for Urban Indigenous Health (IUIH)	81
Jesuit Social Services	131
JFA Purple Orange	226
Justice Action (JA)	94, 150
Katsonis, Maria	117
Kindred Clubhouse	105
LELAN	190
Lifeline Australia	8, 128
Liptember Foundation	164
Lived Experience Australia	42
M, Monica	93
Manna Institute	56, 194
Marathon Health	10
Massa, Jane	229
Massage & Myotherapy Australia	5
MATES in Construction (MATES)	33, 234
Matilda Centre and PREMISE Next Generation	220
McKay, Roderick	17
Medibank Private Limited (Medibank)	198
Melbourne Children's Campus Mental Health Strategy	35, 196
Mental Health Association of Central Australia (MHACA)	166
Mental Health Australia	76, 153
Mental Health Carers Australia (MHCA)	73, 205
Mental Health Coalition of South Australia (MHCSA)	142
Mental Health Coordinating Council (MHCC)	120
Mental Health Families and Friends Tasmania (MHFFTas)	210
Mental Health First Aid International (MHFAI)	147
Mental Health Lived Experience Peak Queensland (MHLEPQ)	144
Mental Health Lived Experience Tasmania (MHLET)	15, 116
Mental Health Victoria (MHV)	95, 215
Mental Illness Fellowship of Australia (MIFA)	88, 233
Mentor and Support Ltd	121
Middlewood, James	143
Military and Emergency Services Health Australia (MESHA)	175

Participants	Submission no.
Mind Australia	187
Mindgardens Neuroscience Network	195
Morris, Wes	209
Movember Institute of Men's Health (Movember)	80
Multicultural Communities Council of South Australia (MCCSA)	34
Municipal Association of Victoria (MAV)	152
Name withheld	2
Name withheld	50
Name withheld	97
Name withheld	99
Name withheld	100
Name withheld	101
Name withheld	106
Name withheld	119
Name withheld	123
Name withheld	129
Name withheld	160
Name withheld	161
Name withheld	186
Name withheld	188
Name withheld	199
Name withheld	212
Name withheld	232
National Aboriginal Community Controlled Health Organisation (NACCHO)	245
National Centre of Excellence in Intellectual Disability Health (NCEIDH)	145
National Eating Disorders Collaboration (NEDC)	44, 134
National Emergency Management Agency (NEMA)	184
National Mental Health Commission (NMHC) and National Suicide Prevention Office (NSPO)	70
National Mental Health Consumer Alliance (NMHCA)	66, 149
National Mental Health Consumer and Carer Forum (NMHCCF)	68
National Rural Health Alliance	86
Neami National	63
Neuro Balance	118
Northern Territory Mental Health Coalition	54
NSW Advocate for Children and Young People (acyp)	127

Participants	Submission no.
NSW Health	90
Occupational Therapy Australia (OTA)	9, 197
Occupational Therapy Society for Invisible and Hidden Disabilities (OTSi)	51, 146
Olga Tennison Autism Research Centre (OTARC)	108
Open Dialogue Centre	135
Orygen	26, 169
OurFutures Institute	182
Page, Melissa Lizzy	241
Perinatal Anxiety & Depression Australia (PANDA)	24
Primary Health Network (PHN) Cooperative	69, 208
Psychotherapy and Counselling Federation of Australia (PACFA)	180
Queensland Aboriginal and Islander Health Council (QAIHC)	221
Queensland Alliance for Mental Health (QAMH)	83, 130
Queensland Network of Alcohol and other Drug Agencies (QNADA)	18, 173
Queensland Nurses and Midwives' Union (QNMU)	16, 136
Raise Foundation	29, 185
Rayner, Ailsa and Arro, Paula	4
Red Rose Foundation	219
Relationships Australia Victoria (RAV)	193
Revill, Jessica	102, 103, 104
Roses in the Ocean	19, 133
Royal Australian and New Zealand College of Psychiatrists (RANZCP)	7, 222
Ruah Community Services	14, 177
Rural Health Research Institute	38
Service Users Participating, Educating and Researching, Consumer-run Organisations (SUPER CRO)	111
ShantiWorks	157
Simon Katterl Consulting (SKC)	204
Simpson, Bruce	138
Size Inclusive Health Australia (SIHA)	237
Skylight Mental Health	91
Stephen Goldsmith	96
St Vincent's Health Network Sydney and THIS WAY UP	36
StandBy Support After Suicide	167
Stroke Foundation	168

Participants	Submission no.
Suicide Prevention Australia	59, 214
Tasmanian Government	78, 239
Tatz, Simon	1
The Royal Australian College of General Practitioners (RACGP)	89
Thorn, Michael	6
Transforming Australia's Mental Health Service Systems (TAMHSS)	191
Transgender Victoria (TGV)	179
Turner Institute for Brain and Mental Health	242
Turning Point and the Monash Addiction Research Centre (MARC)	137
TWB Consulting	98
UnitingSA	213
Victorian Aboriginal Community Controlled Health Organisation (VACCHO) and Balit Durn Durn Centre of Excellence for Aboriginal Social and Emotional Wellbeing (BDDC)	162
Victorian Aboriginal Legal Service (VALS)	200
Victorian and Tasmanian PHN Alliance (VTPHNA)	154
Victorian Government	228
Victorian Women Lawyers (VWL)	87
Vocational Mental Health Practitioners Association of Australia (VMHPAA)	115
Wellbeing and Prevention Coalition in Mental Health	31
Western Australian Association for Mental Health (WAAMH)	82, 172
Western Australian Network of Alcohol and Other Drug Agencies (WANADA)	41
Western Queensland Primary Health Network (WQPHN)	45
Women's Health NSW (WHNSW)	236
yourtown	71, 126
Youth Climate Policy Centre (YCPC)	21, 192
Youturn Limited	170
Zero Suicide Institute of Australasia (ZSIA)	238

Table A.3– Public hearings

Participants
19 August 2025
Allo, Sidney and Timbert, Janet
Black Dog Institute
Community Mental Health Australia
Faculty of Medicine, Nursing and Health Sciences, Monash University (MNHS)
Kindred Clubhouse

Participants
National Mental Health Consumer Alliance
National Rural Health Alliance
Queensland Alliance for Mental Health
Roses in the Ocean
Suicide Prevention Australia
Western Australian Primary Health Alliance
20 August 2025
Brisbane North Primary Health Network
Equally Well Australia
Howald, Stephen
Jervis, Jane
Mental Health Australia
Mental Health Carers Australia
Mental Health Coalition of South Australia
Mental Health Lived Experience Peak Queensland
Turner Institute for Brain and Mental Health
21 August 2025
Highway Foundation
LELAN
Liptember Foundation
Page, Melissa Lizzy
Primary Health Network (PHN) Cooperative

Table A.4 – Collaborative commissioning roundtable

Participants
Adelaide Primary Health Network
Brisbane North Primary Health Network
Gold Coast Health
Hunter New England Local Health District
Metro North Hospital and Health Service
North Western Melbourne Primary Health Network
Northern Adelaide Local Health Network
Northern Sydney Local Health District
Northern Sydney Primary Health Network
Northern Territory Health

A.2 Online survey methods and sample

Study design

Including a qualitative research component in this review was considered important given the limited available data to understand people's experiences and views of initiatives introduced under the Agreement. As highlighted in the National Mental Health and Suicide Prevention Evaluation Framework (artd Consultants 2025, p. 68), collecting qualitative data has the advantage of not only helping to fill gaps where quantitative data is lacking, it also provides a more in-depth understanding of issues.

> Standard outcomes measures and administrative data alone are likely to be insufficient to capture the full value of a program to the people accessing it. Qualitative data can help to understand what matters to people accessing the program and its value to them, as well as help interpret the administrative data. It can also help to understand the experiences of people who had trouble accessing the program or service, and who did not feel safe to do so although it can be difficult to reach these groups in evaluation.

The PC conducted an online survey of consumer, carer and service provider experiences and views of the Agreement and the mental health and suicide prevention system. A qualitative descriptive research study design was adopted for data collection, analysis and reporting of the findings (Doyle et al. 2020; Sandelowski 2000). This is a well-established approach for qualitative research and evaluation of mental health services (Palinkas 2014). Some advantages of qualitative descriptive research include that it is relatively simple and flexible, useful for exploring new, poorly understood or hard-to-measure issues in detail and it provides a comprehensive description of different individuals' experiences and views in context (Ayton 2023). In a qualitative descriptive study design, the focus is on understanding the 'who', 'what, 'where' and 'when' of the phenomenon or situation being investigated.

Research questions and assumptions

The online survey was designed to explore three research questions that map onto the terms of reference for the review of the Agreement:

- What gaps and shortcomings in mental health services have people experienced?
- What changes in service provision have people seen in the past three years?
- What are some examples of good service provision and system improvement that people have experienced or would recommend?

Data collection

The survey was administered entirely online through the District Engage platform. A convenience sample was recruited by disseminating a web link to the survey via:

- a call for submissions on the PC's home page
- an email to people and organisations who registered their interest in the review or made submissions to the PC's previous Mental Health inquiry (PC 2020) as well as stakeholders, such as lived experience peak bodies in all jurisdictions
- advertising (paid and unpaid) about the survey on social media platforms (Facebook, Instagram, LinkedIn) and through newsletters of peak bodies.

This wide dissemination strategy aimed to recruit respondents who could provide detailed and in-depth information from a diverse range of perspectives. The survey was open to the public for about six weeks

(11 February to 21 March 2025). Recruitment extended further than the point of data saturation (i.e. beyond where no new information was emerging) to allow time for as many people as possible to submit responses and include these in the analysis (Guest et al. 2006).

The online survey environment and the survey questions were refined through consultation with experts in the sector (e.g. Aboriginal and Torres Strait Islander engagement consultants, peak bodies representing carers) and user testing before going into the field. We also followed guidance in the National Mental Health and Suicide Prevention Evaluation Framework, by including open questions (artd Consultants 2025, p. 69):

> Open text questions in surveys are useful for allowing people to explain their responses to closed questions and describe their experiences and outcomes of a service in their own words. However, questions should be focused on the respondent's experiences and outcomes from the service to avoid the risk of distress and re-traumatisation … Online forums (i.e. a webpage where participants respond to prompts, questions and material) allow people to participate at times that suit them without being publicly identified …

All questions could be left unanswered, and responses could be submitted anonymously. We aimed to collect only relevant information that we could use to inform the review. Therefore, each set of survey questions was closely framed around the review terms of reference. One broad, open-ended question was also asked to allow respondents to submit any views or experiences not captured in the main set of questions ('Is there anything else about your experiences of services that you think we should know that could be helpful for our review?').

We did not apply any exclusion criteria for participation. However, respondents were asked to identify as either (i) a consumer (ii) a carer or (iii) a worker/volunteer in mental health or suicide prevention services, or some combination of these three categories. Self-selection into one or more of these categories determined conditional branching of respondents into the relevant path of survey questions. Where a respondent identified as an Aboriginal or Torries Strait Islander person, they were asked three additional questions (box A.1).

Respondents were asked to consent to their responses being analysed (96.8% consented) and for extracts (quotes) from their responses to be included in the PC's reporting (93.3% consented).

Box A.1 – Online survey questions

Consumer: has used mental health or suicide prevention services

- Do you feel that mental health and suicide prevention services have met your needs? (Tell us more)
- Have you ever been unable to find a service or unable to use a service you needed? (Tell us more)
- Can you tell us about some positive experiences of services?
- Did you feel recognised, respected and protected while using a service? (Tell us more)
- Have you noticed any changes in services over the past three years (e.g. improvements in service coordination)? (Tell us more)

Carer: has been a carer for someone with mental ill health

- Do you feel that services are meeting the needs of the person/s you provide care to and support? (Tell us more)
- Have you ever been unable to find a service or unable to access services for the person/s you provide care to and support? (Tell us more)

Box A.1 – Online survey questions

- As a carer, were you ever asked by services whether you needed any support, including for your own mental health? (Tell us more)
- Are you involved by services in the planning and delivery of services to the person you care for? (Tell us more)
- Can you tell us about some positive experiences of services?
- Did you feel recognised, respected and protected while using a service? (Tell us more)
- Have you noticed any changes in the services over the past three years (e.g. improvements in service coordination)? (Tell us more)

Service provider: has worked or volunteered with a mental health or suicide prevention service

- Do you feel that your service is meeting people's needs?
- Has your service ever been unable to meet somebody's needs?
- Can you tell us about some of your best experiences working or volunteering in mental health service provision?
- Are there any changes you have noticed over the past 3 years? (e.g. improvements in service coordination). And any improvements you've seen in the wider service system?
- Thinking about the service where you work, what improvements would you like to see? What is needed to make these improvements possible?
- What do you see as the emerging issues and priorities for services like yours?

Respondents who identified as an Aboriginal or Torres Strait Islander person

The same questions as above, plus:

- What has been your experience in accessing Aboriginal and Torres Strait Islander specific services?
- What has your experience been in accessing mainstream services?
- How much say does your community have in planning and management of the services you use?

All respondents: additional questions

- Is there anything else about your experiences of using/working in services that you think we should know that could be helpful for our review?
- Location of your primary residence (select from list of States/Territories)
- Which of the 15 priority population groups listed apply to you (select from a list of 15 priority populations as per clause 111 of the Agreement)

Sample description

A total of 293 people participated in the survey (table A.5). Ten of these were excluded from analysis because they left the main questions unanswered, and a further nine were excluded from analysis because they did not provide consent.

The location that respondents reported as their primary residence broadly reflected the distribution of the Australian population, with most respondents based in either New South Wales (28.3%), Victoria (19.1%) or Queensland (18.4%). Around two percent (n=5) of respondents identified as Aboriginal or Torres Strait Islander.

Of the 283 respondents who answered the main survey questions, most self-identified as consumers (n=210, 74.2%). About one third identified as carers (n=88, 31.1%) and about one-quarter as workers/volunteers in

service provision (n=70, 24.7%). Some respondents identified as belonging to more than one category. For example, 39 respondents identified as both a consumer and worker/volunteer in service provision, 38 identified as both a consumer and carer and 17 identified as a consumer, carer and worker/volunteer in service provision.

Table A.5 – Description of survey respondents

	Number of respondents	Percentage of the total complete survey responses (%)
Total survey responses submitted	293	–
Complete survey responses	283	100.0
Respondent category[a]		
Consumer	210	74.2
Carer	88	31.1
Worker/Volunteer in service provision	70	24.7
Location of primary residence:		
New South Wales	80	28.3
Victoria	54	19.1
Queensland	52	18.4
Western Australia	18	6.4
South Australia	23	8.1
Tasmania	9	3.2
Australian Capital Territory	20	7.1
Northern Territory	2	0.7
Prefer not to say	1	0.4
Not stated	24	8.5
Identified as		
Aboriginal person	5	1.8
Torres Strait Islander person	0	0.0
Aboriginal and Torres Strait Islander person	0	0.0
Non-Indigenous person	176	62.2
Prefer not to say	17	6.0
Not stated	85	30.0
Consent		
Consented for responses to be analysed	274	96.8
Consented for responses to be reported anonymously	261	92.2

a. Respondents could select more than one category.

Respondents were also asked to indicate whether they identified as one or more of the priority populations listed in the Agreement (table A.6). Most respondents (n=195, 71.2%) provided a response to this question.

On average, respondents provided free-text responses to about seven survey questions. However, many respondents answered more questions. For example, 16.4% (n=45) answered 8–12 questions and 8.8% (n=24) answered 13–19 questions. In total, the survey yielded 1,254 free-text responses for analysis.

Analytic method

Thematic analysis and thick description were used to interpret, understand and report on the data collected from the survey. Thematic analysis involves an iterative process of data familiarisation, data visualisation, coding, theme development, theme refinement and reporting of themes with illustrative extracts (verbatim quotes) (Braun et al. 2022, pp. 27–28). Thick description involves providing a detailed account and interpretation of people's views and experiences in context (Patton 2002, pp. 437–438).

For the thematic analysis, we used a combination of deductive coding (i.e. we organised the raw data into broad categories according to the topics explored in each survey question and undertook the initial coding) and inductive coding (i.e. we iteratively read, visualised, and interpreted meanings in the data and refined the initial codes, renaming or combining some as required). A key advantage of deductive coding is ensuring that *a priori* issues of interest are explored, while a key advantage of inductive coding is revealing themes that become apparent in the data. Themes were constructed by grouping together codes that have similar or related meanings. We used NVIVO 15 software to help organise, code and visualise the data during the thematic analysis (Lumivero Pty Ltd 2024).

We applied several strategies to increase the reliability and robustness of the analysis, including: a systematic coding process; documentation of coding decisions; checks of data interpretations (multiple coders); standardised reporting; presentation of supporting extracts for each theme and adopting some reflective practices.

Table A.6 – Survey respondents who identfied as a priority population[a]

	Number of respondents	Percentage of survey responses included in analysis (%)
People who have made a previous suicide attempt or who have been bereaved by suicide	125	45.6
People with complex mental health needs, including people with co-occurring mental health and cognitive disability and/or autism	118	43.1
People with disability	108	39.4
People experiencing socioeconomic disadvantage	66	24.1
People living in regional, rural and remote areas of Australia	59	21.5
LGBTQIASB+ people	56	20.4
People experiencing or at risk of abuse and violence, including sexual abuse, neglect and family and domestic violence	34	12.4
People with harmful use of alcohol or other drugs, or people with substance use disorders	31	11.3
People experiencing homelessness or housing instability	30	11.0
Older Australians (over 65, or over 50 for Aboriginal and Torres Strait Islander people)	17	6.2

	Number of respondents	Percentage of survey responses included in analysis (%)
Culturally and linguistically diverse communities and refugees	15	5.5
Children and young people, including those in out-of-home care	10	3.7
Aboriginal and/or Torres Strait Islander	9	3.2
People who are (or were previously) in contact with the criminal justice system	9	3.3
Australian Defence Force members and veterans	5	1.8
Prefer not to say	4	1.5
Not stated	79	28.8
Survey responses included in analysis	274	100.0

a. Respondents could select more than one priority population group.

Glossary and abbreviations

A note on language

The PC has used a range of resources and consulted with sector experts to develop this glossary, which contains the key terms used throughout the report. The terms chosen aim to reflect inclusive language and recognise the variety of ways people engage with mental health and suicide prevention services.

Glossary

Term	Description
Aboriginal and Torres Strait Islander Community Controlled Health Organisations (ACCHOs)	Community-run primary healthcare services that provide comprehensive, culturally informed care for Aboriginal and Torres Strait Islander people. These services address not only physical health but also the social, emotional, and cultural wellbeing of individuals, families, and communities.
aftercare	Services that provide support to people following a suicide attempt with the aim of preventing repeated self-harm by increasing access to and engagement with care.
Agreement	When written with the capital letter 'A' refers to the current National Mental Health and Suicide Prevention Agreement.
agreement	When written in lowercase letter 'a' refers to future national agreement/s relating to mental health and/or suicide prevention.
Annex	A supplementary document that forms part of the Agreement and contains specific details about a program of work, project or other information relevant to the Agreement. Annexes in the current Agreement include Annex A (existing national information and data frameworks, tool and measures), Annex B (priority data and indicators for development), Annex C (nationally consistent evaluation principles) and Annex D (glossary).
ambulatory services	Non-admitted, community-based mental health care, including services provided to individuals who are not staying in a hospital or inpatient facility, but still require ongoing mental health support and treatment.
bilateral schedules	Agreements made between the Australian Government and an individual state or territory government that set out the details of funding arrangements for particular initiatives.
co-design	The process where governments work in equal partnership with people with lived and living experience to design a service or service improvement.
comorbidity	The presence of two or more diseases or medical conditions in a person.
community managed sector	Non-government, not-for-profit organisations that provide a range of community-based mental health supports and services.
community mental health care	A range of specialised, non-admitted mental health services that are provided in community settings (not in hospitals) and are usually the responsibility of state and territory governments.
engaging early in distress	Identifying and responding to early signs of mental or emotional distress before it escalates into more serious mental health conditions. This term is generally preferred over 'early intervention' by people with lived and living experience.
Local hospital networks	Geographically defined organisations that deliver public hospital services jointly funded by the Australian, state and territory governments under the National Health Reform

Term	Description
	Agreement. Each LHN can include one or more hospitals and may also manage community-based health services.
mental ill health	Overarching term that includes both (i) mental health challenges/concerns and (ii) diagnosed mental health conditions. Mental health challenges include reduced cognitive, emotional or social abilities, but not to the extent that it meets the criteria for a mental health condition diagnosis. These challenges can result from life stressors and often resolve with time or when the person's situation changes. A mental health challenge may develop into a diagnosed mental health condition if it persists or increases in severity.
participants	People and organisations who have engaged with the PC during this review through meetings (online and in-person), visits, submissions, surveys and webinars.
person-centred	Refers to a model of care and support that places the person at the centre of their own care and considers the needs of the person's supporters, family, carers and kin.
Parties	The signatories to the current Agreement including the Australian, state and territory governments.
peer worker	Professionals with expertise gained from their own lived and living experience of mental ill health or suicide who are employed in clinical and non-clinical settings to provide peer support and advocacy to people experiencing mental ill health and/or suicidal distress and/or their supporters, family, carers and kin.
people with lived and living experience	People who have experienced (in the past) and/or are experiencing (at present) mental ill health or suicidal distress, and/or who care for a person experiencing mental ill health or suicidal distress and/or who have been bereaved by suicide.
people with lived and living experience of suicide	People who have experienced (in the past) and/or are experiencing (at present) suicide, suicidal thoughts or a suicide attempt, and/or who care for someone during a suicidal crisis, bereavement by suicide or being impacted by suicide in another way.
Primary health networks (PHNs)	Independent organisations funded by the Australian Government to manage health regions with the goals of improving the efficiency and effectiveness of health services, improving the coordination of health services, and increasing access and quality.
psychosocial supports	Non-clinical services that help individuals with mental ill health manage their daily lives, build skills, and participate more fully in their communities.
respondents	People who submitted responses to the PC's online survey during the review. Also referred to as survey respondents (sr.).
schedule	The detailed part of a Federation Funding Agreement (discussed above) that sets out the specific terms, funding amounts, objectives, performance measures, and reporting requirements for particular programs or initiatives under the Agreement.
social determinants	Social, economic, and environmental conditions that influence an individual's mental health and risk of suicide, which can include socio-economic status, cultural and historical factors, education, employment, housing, social inclusion and community connectedness.
social and emotional wellbeing (SEWB)	A community led framework that encompasses the mental, emotional, cultural and spiritual health of Aboriginal and Torres Strait Islander people.
suicidal distress	The experience of unbearable emotional and psychological pain, which can be associated with thoughts or plans to end one's life as a means of escaping that unbearable pain. This experience is also referred to as suicidal crisis.
suicidality	Encompasses suicidal ideation (thinking about ending one's own life), making suicide plans and making suicide attempts (intentional and voluntary action taken to end one's own life that does not result in death).
trauma-informed care	Institutional or practice approaches to care and support directed by an understanding of the neurological, biological, psychological and social effects of trauma and its prevalence in society. Includes a strengths-based framework that emphasises physical, psychological and emotional safety for consumers, and their supporters, family, carers and kin.

Abbreviations

ABS	Australian Bureau of Statistics
ACCHOs	Aboriginal and Torres Strait Islander Community Controlled Health Organisations
AEDC	Australian Early Development Census
AIHW	Australian Institute of Health and Welfare
AOD	Alcohol and other drugs
CLS	Community Living Supports
COAG	Council of Australian Governments
DGF	Data Governance Forum
DIP	District Implementation Plan
DHDA	Department of Health, Disability and Ageing
ED	Emergency department
FTE	Full-time equivalent
GP	General practitioner
HASI	Housing and Accommodation Support Initiative
HCEF	Health Chief Executives Forum
HMHA	Housing and Mental Health Agreement
IDG	Indigenous data governance
IDS	Indigenous data sovereignty
IGA FFR	Intergovernmental Agreement on Federal Financial Relations
LEG	Lived Experience Group
LGBTQIASB+	Lesbian, gay, bisexual, trans and/or gender diverse, queer, intersex, asexual, sistergirl, brotherboy plus other identities not explicitly listed
LHN	Local hospital network
LIP	Local Implementation Plan
MBS	Medicare Benefits Schedule
MHSPSO	Mental Health and Suicide Preventions Senior Officials Group
MMHC	Medicare mental health centre
NDIS	National Disability Insurance Scheme
NHRA	National Health Reform Agreement
NMHC	National Mental Health Commission
NMHSPF	National Mental Health Service Planning Framework

NSPA	National Suicide Prevention Adviser
NSPO	National Suicide Prevention Office
PBS	Pharmaceutical Benefits Scheme
PC	Productivity Commission
pers. comm.	Personal communication
PHN	Primary health network
PM&C	Department of the Prime Minister and Cabinet
PR	Priority Reform
SEWB	Social and emotional wellbeing
SEWB PP	Social and Emotional Wellbeing Policy Partnership
SPMHC	Special Purpose Mental Health Council
sr.	Survey respondent
sub.	Submission

References

ABS (Australian Bureau of Statistics) 2020, *Associated causes of death in mortality: Associated causes for suicides*, https://www.abs.gov.au/articles/associated-causes-death-mortality#associated-causes-for-suicides (accessed 10 October 2025).

—— 2023, *National study of mental health and wellbeing, 2020–2022*, https://www.abs.gov.au/statistics/health/mental-health/national-study-mental-health-and-wellbeing/latest-release (accessed 10 October 2025).

—— 2008, *National survey of mental health and wellbeing: summary of results*, https://www.abs.gov.au/statistics/health/mental-health/national-study-mental-health-and-wellbeing/2007 (accessed 8 May 2025).

—— 2024a, *National Aboriginal and Torres Strait Islander health survey*, https://www.abs.gov.au/statistics/people/aboriginal-and-torres-strait-islander-peoples/national-aboriginal-and-torres-strait-islander-health-survey/latest-release (accessed 7 May 2025).

—— 2024b, *National, state and territory population*, https://www.abs.gov.au/statistics/people/population/national-state-and-territory-population/sep-2024#data-downloads (accessed 4 January 2025).

—— 2024c, *Patient experiences*, https://www.abs.gov.au/statistics/health/health-services/patient-experiences/latest-release (accessed 8 May 2025).

ACEM (Australasian College for Emergency Medicine) 2025, *Breaking point: an urgent call to action on emergency department safety*.

ACIC (Australian Criminal Intelligence Commission) 2025, *National wastewater drug monitoring program: Report 24*.

ACT Government 2022, *New ACT Aboriginal and Torres Strait Islander suicide prevention, intervention, postvention and aftercare program*, Media Release, 31 May, Chief Minister, Treasury and Economic Development Directorate, https://www.cmtedd.act.gov.au/open_government/inform/act_government_media_releases/davidson/2022/new-act-aboriginal-and-torres-strait-islander-suicide-prevention,-intervention,-postvention-and-aftercare-program (accessed 15 May 2025).

ADF (Australian Drug Foundation) 2022, *Family and friends of people with substance use issues: survey report*.

AEDC (Australian Early Development Census) 2025, *Resources*, https://www.aedc.gov.au/resources/all (accessed 18 September 2025).

AHMC (Australian Health Ministers' Conference) 2009, *Fourth National Mental Health Plan*.

AIHW (Australian Institute of Health and Welfare) 2011, *Profile of specialised mental health care facilities*.

—— 2013, *Key performance indicators for Australian public mental health services*, Third Edition.

—— 2021a, *Aboriginal and Torres Strait Islander stolen generations aged 50 and over: updated analyses for 2018-19*.

—— 2021b, *Mental health impact of COVID-19*.

—— 2023a, *Consumer outcomes in mental health care*.

—— 2023b, *Deaths by suicide in Australia*, https://www.aihw.gov.au/suicide-self-harm-monitoring/data/deaths-by-suicide-in-australia/suicide-deaths-over-time (accessed 20 February 2025).

—— 2023c, *Suicide & self-harm monitoring: Alcohol and other drug users*, https://www.aihw.gov.au/suicide-self-harm-monitoring/population-groups/aod-users (accessed 10 October 2025).

—— 2023d, *The health of people in Australia's prisons 2022*, https://www.aihw.gov.au/reports/prisoners/the-health-of-people-in-australias-prisons-2022/contents/summary (accessed 11 May 2025).

—— 2024a, *Australian burden of disease study 2024*.

—— 2024b, *Australia's mental health system*, https://www.aihw.gov.au/mental-health/overview/australias-mental-health-system (accessed 19 November 2024).

—— 2024c, *First Nations people and the health system*, https://www.aihw.gov.au/reports/australias-health/indigenous-australians-use-of-health-services (accessed 22 May 2025).

—— 2024d, *Glossary terms*, https://www.aihw.gov.au/mental-health/resources/glossary-terms (accessed 13 May 2025).

—— 2024e, *National mental health service planning framework*, https://www.aihw.gov.au/nmhspf/overview/introduction (accessed 29 May 2025).

—— 2024f, *Thoughts, ideation and suicide attempts*, https://www.aihw.gov.au/suicide-self-harm-monitoring/overview/summary (accessed 16 May 2025).

—— 2024g, *Workforce*, https://www.aihw.gov.au/mental-health/topic-areas/workforce (accessed 7 May 2025).

—— 2025a, *Alcohol and other drug treatment services in Australia annual report 2023–2024*.

—— 2025b, *Alcohol, tobacco & other drugs in Australia*, https://www.aihw.gov.au/reports/alcohol/alcohol-tobacco-other-drugs-australia/contents/ (accessed 10 October 2025).

—— 2025c, *Alcohol, tobacco & other drugs in Australia: health impacts*, https://www.aihw.gov.au/reports/alcohol/alcohol-tobacco-other-drugs-australia/contents/impacts/health-impacts (accessed 10 October 2025).

—— 2025d, *Intentional self-harm hospitalisations*, https://www.aihw.gov.au/suicide-self-harm-monitoring/overview/self-harm-hospitalisations (accessed 28 August 2025).

—— 2025e, *Members for First Nations expert committee on health system metrics*, https://www.apsjobs.gov.au/s/job-details?Id=a05OY00000FbwFiYAJ (accessed 25 September 2025).

—— 2025f, *Mental health and substance use - mental health*, https://www.aihw.gov.au/mental-health/topic-areas/health-wellbeing/mental-illness-and-substance-use (accessed 10 October 2025).

—— 2025g, *Mental health: monitoring & performance*.

—— 2025h, *National Drug Strategy Household Survey 2022–2023*.

—— 2025i, *National mental health establishments database*, https://www.aihw.gov.au/mental-health/topic-areas/facilities-resources/expenditure (accessed 25 August 2025).

—— 2025j, *Patterns of health service use in the last year of life among those who died by suicide*, https://www.aihw.gov.au/suicide-self-harm-monitoring/service-use/use-of-health-services-preceding-suicide (accessed 17 May 2025).

—— 2025k, *Prevalence and impact of mental illness*, https://www.aihw.gov.au/mental-health/overview/prevalence-and-impact-of-mental-illness (accessed 9 October 2025).

—— 2025l, *Regional insights for Indigenous communities*.

—— 2025m, *Regional profiles of mental health service activity*.

—— 2025n, *Suicide & self-harm monitoring*, https://www.aihw.gov.au/suicide-self-harm-monitoring (accessed 13 February 2025).

—— 2025o, *Suicide & self-harm monitoring*, 24 March, Summary.

—— 2025p, *Suicide and self-harm among young people*, https://www.aihw.gov.au/suicide-self-harm-monitoring/population-groups/young-people/suicide-self-harm-young-people (accessed 29 May 2025).

—— 2025q, *Suicide and self-harm monitoring*, https://www.aihw.gov.au/suicide-self-harm-monitoring/resources/download-data-tables (accessed 13 August 2025).

AIVL (Australian Injecting and Illicit Drug Users League) 2025, *Peer workforce: a practical national framework for employing people with lived-living experience of using drugs as health, harm reduction and alcohol and other drug (AOD) workers*.

Albanese, A (Prime Minister) 2023, *Meeting of National Cabinet – the Federation working for Australia*, Media release, 6 December.

Alegría, M, NeMoyer, A, Falgas, I, Wang, Y and Alvarez, K 2018, 'Social determinants of mental health: where we are and where we need to go', *Current Psychiatry Reports*, vol. 20, no. 11, p. 95.

ALIVE National Centre for Mental Health Research Translation 2024a, *What is an implementation co-evaluation? A snapshot on the framework and its application in Medicare Mental Health Centres*.

—— 2024b, *Who accesses Neami National Medicare Mental Health Centres? An Implementation Co-Evaluation Snapshot # 1*.

ANACAD (Australian National Advisory Council on Alcohol and Other Drugs) 2025, *Meeting Communique 3–4 June 2025*.

ANAO (Australian National Audit Office) 2007, *Application of the outcomes and outputs framework*, 2006-07 Performance Audit, Audit Report No.23.

—— 2024, *Effectiveness of the Department of Health and Aged Care's performance management of Primary Health Networks*, Auditor-General Report 19.

—— 2025, *Performance statements auditing in the Commonwealth — Outcomes from the 2023–24 audit program*, Auditor-General Report 25.

Anderson, BO, Berdzuli, N, Ilbawi, A, Kestel, D, Kluge, HP, Krech, R, Mikkelsen, B, Neufeld, M, Poznyak, V, Rekve, D, Slama, S, Tello, J and Ferreira-Borges, C 2023, 'Health and cancer risks associated with low levels of alcohol consumption', *The Lancet Public Health*, vol. 8, no. 1, pp. e6–e7.

ANU (Australian National University) 2021, *Racism linked to poor health among Indigenous Australians*, https://www.anu.edu.au/news/all-news/racism-linked-to-poor-health-among-indigenous-australians (accessed 21 May 2025).

APA (American Psychiatric Association) 2024, *What is a substance use disorder?*, https://www.psychiatry.org/patients-families/addiction-substance-use-disorders/what-is-a-substance-use-disorder#:~:text=Substance%20use%20disorder%20(SUD)%20is,abnormal%20movements%2C%20and%20other%20behaviors. (accessed 10 October 2025).

APSC (Australian Public Service Commission) 2007, *Tackling wicked problems: a public policy perspective*.

—— 2018, *Chapter 2: transparency and integrity*, State of the service report 2017-18, https://www.apsc.gov.au/state-service/state-service-report-2017-18/chapter-2-transparency-and-integrity (accessed 13 May 2025).

—— 2021, *Governance*, https://www.apsc.gov.au/initiatives-and-programs/aps-mobility-framework/taskforce-toolkit/governance (accessed 1 September 2025).

artd Consultants 2025, *National mental health and suicide prevention evaluation framework*, Department of Health, Disability and Ageing.

Australian Health Ministers' Conference 2009, *National Mental Health Policy 2008*.

Australia's Mental Health Think Tank, Bower, M, Smout, S and Donohoe-Bales, A 2022, *Building mentally healthy futures: Australian youth recovery plan*.

Ayton, D 2023, 'Chapter 5: Qualitative descriptive research', *Qualitative research – a practical guide for health and social care researchers and practitioners*, Open Educational Resources Collective, Monash University.

Bailey, S, Newton, N, Perry, Y, Davies, C, Lin, A, Marino, JL, Skinner, SR, Garlick-Bock, S, Nguyen, H, Mitrou, F and Barrett, E 2024, 'Prevalence, distribution, and inequitable co-occurrence of mental ill-health and substance use among gender and sexuality diverse young people in Australia: epidemiological findings from a population-based cohort study', *Social Psychiatry and Psychiatric Epidemiology*, vol. 59, no. 12, pp. 2323–2337.

Barrett, E, Mills, K, Dudley, L, Conroy, C, Teesson, M and Kay-Lambkin, F 2019, 'Lived experiences of Australians with mental health and AOD comorbidity and their perspectives on integrated treatment', *new paradigm*, vol. Summer 2018-2019, pp. 38–42.

Bassilios, B, Currier, D, Krysinska, K, Dunt, D, Machlin, A, Newton, D, Williamson, M and Pirkis, J 2024, 'Government funded suicide prevention in Australia – an environmental scan', *BMC Public Health*, vol. 24, no. 1, pp. 1–26.

——, Ftanou, M, Machlin, A, Mangelsdorf, S, Banfield, M, Tan, A, Roberts, L, Scurrah, K, Le, L, Spittal, M, Mihalopoulos, C and Pirkis, J 2022, *Independent evaluation of the head to health digital mental health gateway - final report*, University of Melbourne.

Bates, S, Harris-Roxas, B and Wright, M 2023, 'Understanding the costs of co-commissioning: Early experiences with co-commissioning in Australia', *Australian Journal of Public Administration*, vol. 82, no. 4, pp. 462–487.

Bates, S, Wright, M and Harris-Roxas, B 2022, 'Strengths and risks of the Primary Health Network commissioning model', CSIRO Publishing, vol. 46, no. 5, pp. 586–594.

BetterEvaluation 2025, *Describe the theory of change - manager's guide to evaluation*, https://www.betterevaluation.org/frameworks-guides/managers-guide-

evaluation/scope-evaluation/describe-theory-change (accessed 5 March 2025).

Birrell, L, Prior, K, Vescovi, J, Sunderland, M, Slade, T and Chapman, C 2025, 'Treatment rates and delays for mental and substance use disorders: results from the Australian National Survey of Mental Health and Wellbeing', Cambridge University Press, *Epidemiology and Psychiatric Sciences*, vol. 34, p. e8.

Black, N, Jayawardana, D, Johnston, DW and Trinh, T-A 2025, *The growing divide: Income inequities in access to mental healthcare in Australia*, Working Paper, 2025–13.

Brackertz, N, Davidson, J and Wilkinson, A 2021, *Trajectories: the interplay between mental health and housing pathways - policy priorities for better access to housing and mental health support for people with lived experience of mental ill health and housing insecurity*, report prepared by AHURI Professional Services for Mind Australia, Australian Housing and Urban Research Institute.

Braun, V, Clarke, V, Hayfield, N, Davey, L and Jenkinson, E 2022, 'Doing reflexive thematic analysis', in Bager-Charleson, S and McBeath, A (eds), *Supporting research in counselling and psychotherapy: qualitative, quantitative, and mixed methods research*, Palgrave Macmillan, Cham, pp. 19–38.

Bryant, J, Horwitz, R, Gray, R, Lafferty, L, Jops, P, Blunden, H and Brener, L 2020, *Barriers and enablers associated with access and equity in alcohol and other drug treatment in NSW*, Network of Alcohol and other Drugs Agencies.

Butler, M (Australian Government Minister for Health and Ageing and the National Disability Insurance Scheme) 2023, *Building the workforce to make mental health care more available and equitable*, Media Release, 10 October.

Butler, M (Australian Government Minister for Health and Ageing) 2024, *First Nations health leaders and Health Ministers gather to progress Close the Gap reform agenda*, Media Release, 22 March.

Butler, TL, Anderson, K, Garvey, G, Cunningham, J, Ratcliffe, J, Tong, A, Whop, LJ, Cass, A, Dickson, M and Howard, K 2019, 'Aboriginal and Torres Strait Islander people's domains of wellbeing: a comprehensive literature review', *Social Science & Medicine*, vol. 233, pp. 138–157.

Butt, J, Wilkes, E, Jones, J and Stearne, A 2024, *Harmful use of alcohol and other drugs and its relationship with the mental health and wellbeing of First Nations people: a review of the key issues, policy and practice approaches*, AIHW Indigenous Mental Health and Suicide Prevention Clearinghouse.

Byrne, L, Roennfeldt, H and O'Shea, P 2017, *Identifying barriers to change: The lived experience worker as a valued member of the mental health team: Final report*, Queensland Government.

——, Wang, L, Roennfeldt, H, Chapman, M, Darwin, L, Castles, C, Craze, L and Saunders, M 2021, *National lived experience (peer) workforce development guidelines*, National Mental Health Commission.

Bywood, P, Brown, L and Raven, M 2015, *Improving the integration of mental health services in primary health care at the macro level*, Primary Health Care Research and Information Services.

Carlyle, M, Leung, J, Walter, ZC, Juckel, J, Salom, C, Quinn, CA, Davidson, L, Ellem, R, Newland, G and Hides, L 2021, 'Changes in substance use among people seeking alcohol and other drug treatment during the COVID-19 pandemic: evaluating mental health outcomes and resilience', *Substance Abuse: Research and Treatment*, vol. 15, pp. 1–8.

Carroll, SR, Herczog, E and Hudson, M 2021, 'Operationalizing the CARE and FAIR principles for Indigenous data futures', *Sci Data*, vol. 8, no. 108, pp. 1–6.

Cazalis, A, Lambert, L and Auriacombe, M 2023, 'Stigmatization of people with addiction by health professionals: current knowledge, a scoping review', *Drug and Alcohol Dependence Reports*, vol. 9, pp. 1–15.

Centre for Population 2024, *Mortality trends - deaths of despair*, The Treasury.

Cerel, J, Brown, MM, Maple, M, Singleton, M, Venne, J van de, Moore, M and Flaherty, C 2019, 'How many people are exposed to suicide? Not six', *Suicide and Life-Threatening Behaviour*, vol. 49, no. 2, pp. 529–534.

CERIPH (Collaboration for Evidence, Research and Impact in Public Health) 2024, *Co-design and mental health: a rapid review*, Curtin School of Population Health.

CFFR (Council on Federal Financial Relations) 2022, *Intergovernmental agreement on federal financial relations*.

Cheetham, A, Arunogiri, S and Lubman, D 2024, 'Integrated care - panacea or white elephant? A review of integrated care approaches in Australia over the past two decades', *Advances in dual diagnosis*, vol. 16, no. 1, pp. 3–16.

Chetty, A, Guse, T and Malema, A 2023, 'Integrated vs non-integrated treatment outcomes in dual diagnosis disorders: A systematic review', *Health SA Gesondheid*, vol. 28, no. a2094, pp. 1–10.

Children's Health Queensland 2023, *Welcome to Jacaranda Place*, https://www.childrens.health.qld.gov.au/resources/health-services/welcome-to-jacaranda-place (accessed 11 September 2025).

Chong, DG, Buckley, NA, Schumann, JL and Chitty, KM 2020, 'Acute alcohol use in Australian coronial suicide cases, 2010–2015', *Drug and Alcohol Dependence*, vol. 212, pp. 1–7.

COAG Health Council (Council of Australian Governments Health Council) 2017, *The fifth national mental health and suicide prevention plan*.

Coalition of Peaks and Australian Governments 2020a, *Closing the Gap targets and outcomes*, https://www.closingthegap.gov.au/national-agreement/targets (accessed 26 March 2025).

—— and —— 2020b, *National Agreement on closing the gap*.

Cobb, L, Driver, C and Tabac, L 2018, *Communicating with data: a guide to writing public health data reports*, Vital Strategies.

Curtin University 2025, *Young minds: our future*, https://research.curtin.edu.au/young-minds-our-future/ (accessed 10 June 2025).

Cutler, PH, Norman, A, Aghdee, M, Bilgrami, DA and Abiona, DO 2023, *Getting more value from mental healthcare funding and investment*, Consultation paper, August, Macquarie University Centre for the Health Economy.

Daley, J 2020, *Prioritising a government's agenda*, Grattan Institute.

Davidson, L, Bellamy, C, Guy, K and Miller, R 2012, 'Peer support among persons with severe mental illnesses: a review of evidence and experience', *World Psychiatry*, vol. 11, no. 2, pp. 123–128.

Deady, M, Teesson, M and Brady, KT 2013, 'Chapter 55 - Impact of substance use on the course of serious mental disorders', in Miller, PM (ed), *Principles of Addiction*, Academic Press, pp. 525–532.

——, Teesson, M, Mills, K, Kay-Lambkin, F and Baker, A 2024, *One person, diverse needs: living with mental health and alcohol and drug difficulties*, National Mental Health Commission.

Design Health Collab 2023, *Statewide centre for addiction and mental health consultation*, Monash University.

DEWR (Australian Government Department of Employment and Workplace Relations) 2024, *National Skills Agreement*.

DHDA (Australian Government Department of Health, Disability and Ageing) 2025a, *Aboriginal and Torres Strait Islander mental health program*, https://www.health.gov.au/our-work/aboriginal-and-torres-strait-islander-mental-health-program (accessed 14 April 2025).

—— 2025b, *Better access initiative*, Australian Government Department of Health, Disability and Ageing, https://www.health.gov.au/our-work/better-access-initiative (accessed 25 September 2025).

—— 2025c, *Health Ministers Meeting (HMM) – Communique*, 13 June.

—— 2025d, *National child and adolescent mental health and wellbeing study*, https://www.health.gov.au/our-work/national-child-and-adolescent-mental-health-and-wellbeing-study (accessed 5 May 2025).

—— 2025e, *National suicide prevention leadership and support program*, https://www.health.gov.au/our-work/national-suicide-prevention-leadership-and-support-program (accessed 11 September 2025).

—— 2025f, *Social and Emotional Wellbeing Policy Partnership*, https://www.health.gov.au/committees-and-groups/social-and-emotional-wellbeing-policy-partnership (accessed 14 April 2025).

—— 2025g, *What we're doing about mental health*, https://www.health.gov.au/topics/mental-health-and-suicide-prevention/what-were-doing-about-mental-health (accessed 2 October 2025).

DoF (Australian Government Department of Finance) 2021, *Types of Australian government bodies*, https://www.finance.gov.au/government/managing-commonwealth-resources/structure-australian-government-public-sector/types-australian-government-bodies (accessed 5 September 2025).

DoH (Australian Government Department of Health) 2017, *National drug strategy 2017–2026*.

—— 2018a, *National fetal alcohol spectrum disorder (FASD) strategic action plan 2018–2028*.

—— 2018b, *Submission to the Senate Community Affairs References Committee inquiry and report into the accessibility and quality of mental health services in rural and remote Australia*.

—— 2019a, *A commissioning overview in the PHN context*.

—— 2019b, *National alcohol strategy 2019–2028*.

—— 2019c, *National framework for alcohol, tobacco and other drug treatment 2019–2029*.

—— 2020a, *Available funding sources and resources for the Aboriginal Community Controlled Health Services (ACCHS) sector*.

—— 2020b, *National drug strategy 2017–2026, 2018 annual report*.

—— 2021, *PHN program needs assessment policy guide*.

DoHAC (Australian Government Department of Health and Aged Care) 2023a, *National mental health workforce strategy 2022–2032*.

—— 2023b, *National tobacco strategy 2023–2030*.

—— 2024a, *2020–25 national health reform agreement (NHRA)*, https://www.health.gov.au/our-work/2020-25-national-health-reform-agreement-nhra (accessed 23 April 2025).

—— 2024b, *2024–25 Budget communication pack*, 14 May.

—— 2024c, *About mental health*, https://www.health.gov.au/topics/mental-health-and-suicide-prevention/about-mental-health (accessed 29 May 2025).

—— 2024d, *Mental Health and Suicide Prevention Senior Officials Group (MHSPSO)*, https://www.health.gov.au/resources/collections/mental-health-and-suicide-prevention-senior-officials-group-communiques?language=en (accessed 10 May 2025).

—— 2024e, *National Aboriginal and Torres Strait Islander suicide prevention strategy*.

—— 2024f, *Primary health network program annual performance report 2021-22*.

—— 2024g, *Reforms to strengthen the National Mental Health Commission and National Suicide Prevention Office*, https://consultations.health.gov.au/primary-care-mental-health-division/nmhc-nspo-reforms/ (accessed 2 June 2025).

—— 2024h, *Targeted regional initiatives for suicide prevention*, https://www.health.gov.au/our-work/targeted-regional-initiatives-for-suicide-prevention (accessed 27 February 2025).

—— 2025a, *Medicare mental health centres: national service model*.

—— 2025b, *Psychosocial project group*, https://www.health.gov.au/committees-and-groups/psychosocial-project-group (accessed 2 May 2025).

—— 2025c, *Review of primary health network business model & mental health flexible funding model*.

—— 2025d, *What primary health networks do*, https://www.health.gov.au/our-work/phn/what-PHNs-do (accessed 10 April 2025).

Doyle, L, McCabe, C, Keogh, B, Brady, A and McCann, M 2020, 'An overview of the qualitative descriptive design within nursing research', *Journal of Research in Nursing*, vol. 25, no. 5, pp. 443–455.

DPMP (Drug Policy Modelling Program) 2024, *Drug and Alcohol Services Planning Model (DASPM)*, https://www.unsw.edu.au/research/sprc/our-projects/drug-and-alcohol-services-planning-model-daspm (accessed 29 August 2025).

DSS (Australian Government Department of Social Services) 2025, *Foundational supports*, https://www.dss.gov.au/foundational-supports (accessed 9 May 2025).

Dudgeon, P, Bray, A, Darlaston-Jones, D and Walker, R 2020, *Aboriginal participatory action research: An Indigenous research methodology strengthening decolonisation and social and emotional wellbeing*.

——, Milroy, H and Walker, R 2014, *Working together, Aboriginal and Torres Strait Islander mental health and wellbeing principles and practice*, Attorney-General's Department.

Ecorys 2023, *Theories of change: understanding your project*, West Yorkshire Combined Authority.

Eddie, D, Hoffman, L, Vilsaint, C, Abry, A, Bergman, B, Hoeppner, B, Weinstein, C and Kelly, JF 2019, 'Lived

experience in new models of care for substance use disorder: a systematic review of peer recovery support services and recovery coaching', *Frontiers in Psychology*, vol. 10, no. 1052, pp. 1–12.

El Hayek, S, Foad, W, de Filippis, R, Ghosh, A, Koukach, N, Mahgoub Mohammed Khier, A, Pant, SB, Padilla, V, Ramalho, R, Tolba, H and Shalbafan, M 2024, 'Stigma toward substance use disorders: a multinational perspective and call for action', *Frontiers in Psychiatry*, vol. 15, pp. 1–5.

Emery, H, Matthews, A and Duggan, M 2024, '"A little bit of hope goes a long way": Exploring the role of peer workers in alcohol and other drug rehabilitation services', *Journal of Substance Use and Addiction Treatment*, vol. 163, pp. 1–10.

Everymind 2019, *Mindframe for alcohol and other drugs: guidelines for communicating about alcohol and other drugs*.

—— 2025, *People with harmful use of alcohol and other drugs (AOD)*, https://lifeinmind.org.au/suicide-prevention/priority-populations/people-with-harmful-use-of-alcohol-and-other-drugs-aod (accessed 14 October 2025).

Faulkner, A and Kalathil, J 2012, *The freedom to be, the chance to dream: Preserving user-led peer support in mental health*, Together UK.

Ferdinand, A, Paradies, Y and Kelaher, M 2012, *Mental health impacts of racial discrimination in Victorian Aboriginal communities*, Lowitja Institute.

Fisher, A, Marel, C, Morley, K, Teesson, M and Mills, K 2020, *The role of alcohol and other drugs in suicidal behaviour and effective interventions to reduce suicidal thoughts and behaviours*, Matilda Centre for Research in Mental Health and Substance Use.

Gadsden, T, Craig, M, Jan, S, Henderson, A and Edwards, B 2023, *Updated social and economic costs of alcohol, tobacco, and drug use in Australia, 2022/23*, The George Institute for Global Health.

Gaukroger, C, Koh, E and Phillips, T 2025, *Embedding progress: how to align public institutions with a better future*, Centre for Policy Development.

Gayaa Dhuwi (Proud Spirit) Australia 2015, *Gayaa Dhuwi (Proud Spirit) Declaration*.

—— 2025a, *Gayaa Dhuwi (Proud Spirit) declaration framework and implementation plan*.

—— 2025b, *System-wide approach to Aboriginal and Torres Strait Islander social and emotional wellbeing, mental health, and suicide Prevention*.

Glover-Wright, C, Coupe, K, Campbell, AC, Keen, C, Lawrence, P, Kinner, SA and Young, JT 2023, 'Health outcomes and service use patterns associated with co-located outpatient mental health care and alcohol and other drug specialist treatment: A systematic review', *Drug and Alcohol Review*, vol. 42, no. 5, pp. 1195–1219.

Goldsworthy, K 2021, *What is theory of change*, Australian Institute of Family Studies.

Greenhalgh, EM, Brennan, E, Segan, C and Scollo, M 2022, 'Monitoring changes in smoking and quitting behaviours among Australians with and without mental illness over 15 years', *Australian and New Zealand Journal of Public Health*, vol. 46, no. 2, pp. 223–229.

Grigg, J, Manning, V, Cheetham, A, Youssef, G, Hall, K, Baker, AL, Staiger, PK, Volpe, I, Stragalinos, P and Lubman, DI 2023, 'A latent class analysis of perceived barriers to help-seeking among people with alcohol use problems presenting for telephone-delivered treatment', *Alcohol and Alcoholism*, vol. 58, no. 1, pp. 68–75.

Guest, G, Bunce, A and Johnson, L 2006, 'How many interviews are enough?: An experiment with data saturation and variability', *Field Methods*, vol. 18, no. 1, pp. 59–82.

Hamilton Centre 2025a, *Our services*, https://www.hamiltoncentre.org.au/help/service-providers (accessed 10 October 2025).

—— 2025b, *Stigma towards co-occurring disorders: Challenges and opportunities in mental health and alcohol and other drug (AOD) settings*, Turning Point.

Harris, MG, Tapp, C, Vescovi, JJ, Sunderland, M, Diminic, S, Chapman, C, Slade, TN, Teesson, M, Pirkis, J and Burgess, PM 2025, 'Consultation with health professionals for mental health in Australia in 2020–2022 and changes since 2007: findings from the 2020–2022 national study of mental health and wellbeing', *Australian & New Zealand Journal of Psychiatry*, vol. 59, no. 9, pp. 810–823.

Hawke, LD, Sheikhan, NY, Bastidas-Bilbao, H and Rodak, T 2024, 'Experience-based co-design of mental health services and interventions: A scoping review', *SSM - Mental Health*, vol. 5, pp. 1–12.

Hawn, SE, Cusack, SE and Amstadter, AB 2020, 'A systematic review of the self-medication hypothesis in the context of posttraumatic stress disorder and comorbid problematic alcohol use', *Journal of Traumatic Stress*, vol. 33, no. 5, pp. 699–708.

Health Consumers Queensland 2025, *Youth mental health reform: Jacaranda Place*, https://www.hcq.org.au/youthmentalhealth/ (accessed 11 September 2025).

HNECC PHN (Hunter New England and Central Coast Primary Health Network) 2024, *Fine tuning project identifies measures that have reduced burden of reporting for commissioned services*, https://thephn.com.au/news/fine-tuning-project-identifies-measures-that-have-reduced-burden-of-reporting-for-commissioned-services (accessed 8 July 2025).

Hobden, B, Bryant, J, Davis, R, Heard, T, Rumbel, J, Newman, J, Rose, B, Lambkin, D, Sanson-Fisher, R and Freund, M 2024, 'Co-occurring psychological distress and alcohol or other drug use among Indigenous Australians: Data from the national Aboriginal and Torres Strait Islander health survey', *Australian & New Zealand Journal of Psychiatry*, vol. 58, no. 8, pp. 668–677.

Hodges, E, Leditschke, A and Solonsch, L 2023, *The lived experience governance framework: centring people, identity and human rights for the benefit of all*, Prepared by LELAN (SA Lived Experience Leadership & Advocacy Network) for the National Mental Health Consumer and Carer Forum and the National PHN Mental Health Lived Experience Engagement Network.

HPA (Health Policy Analysis) 2024, *Analysis of unmet need for psychosocial supports outside of the National Disability Insurance Scheme*.

Hunt, G (Australian Government Minister for Health and Aged Care) 2021, *National study of mental health and wellbeing gets underway*, Media Release, 10 February.

Hunt, G, Siegfried, N, Morley, K, Brooke-Sumner, C and Cleary, M 2019, 'Psychosocial interventions for people with both severe mental illness and substance misuse', *Cochrane Database of Systematic Reviews*, no. 12.

Huxtable, R 2023, *Mid-term review of the national health reform agreement addendum 2020–2025*.

IHACPA (Independent Health and Aged Care Pricing Authority) 2023, *Pricing framework for Australian public hospital services 2024-25*.

—— (2025, *Safety and quality*, https://www.ihacpa.gov.au/health-care/pricing/safety-and-quality (accessed 10 September 2025).

Integrated Regional Planning Working Group 2018, *Joint regional planning for integrated mental health and suicide prevention services*.

Jane-Llopis, E and Matytsina, I 2006, 'Mental health and alcohol, drugs and tobacco: a review of the comorbidity between mental disorders and the use of alcohol, tobacco and illicit drugs', *Drug and Alcohol Review*, vol. 25, no. 6, pp. 515–536.

Jobs and Skills Australia 2024, *Occupation shortage list*, https://www.jobsandskills.gov.au/data/occupation-shortages-analysis/occupation-shortage-list (accessed 7 May 2025).

Joint Council on Closing the Gap 2023, *Agreement to implement the Social and Emotional Wellbeing Policy Partnership*.

Kingston, R, Marel, C and Mills, K 2017, 'A systematic review of the prevalence of comorbid mental health disorders in people presenting for substance use treatment in Australia', *Drug and Alcohol Review*, vol. 36, no. 4, pp. 527–539.

Kirkbride, JB, Anglin, DM, Colman, I, Dykxhoorn, J, Jones, PB, Patalay, P, Pitman, A, Soneson, E, Steare, T, Wright, T and Griffiths, SL 2024, 'The social determinants of mental health and disorder: evidence, prevention and recommendations', *World Psychiatry*, vol. 23, no. 1, pp. 58–90.

Kisely, S and Looi, JC 2022, 'Latest evidence casts further doubt on the effectiveness of headspace', *Medical Journal of Australia*, vol. 217, no. 8, pp. 388–390.

Koff, E, Pearce, S and Peiris, DP 2021, 'Collaborative commissioning: Regional funding models to support value-based care in New South Wales', *Medical Journal of Australia*, vol. 215, no. 7.

KPMG 2022, *Evaluation of the national headspace program*.

Lavarch, L, Coombes, L, Gray, K, Anthony, C and Nolan-Smith, S 2025, *Closing the Gap independent Aboriginal and Torres Strait Islander-led review*, Jumbunna Institute for Indigenous Education and Research.

Lawrence, D, Johnson, S, Hafekost, J, Boterhoven de Haan, K, Sawyer, M, Ainley, J and Zubrick, S 2015, *The mental health of Australian children and adolescents: report on the second Australian child and adolescent survey of mental health and wellbeing*, Department of Health.

Lee, N and Allsop, S 2020, *Exploring the place of alcohol and other drug services in the mental health system*, 360Edge.

Leginski, WA, Croze, C, Driggers, J, Dumpman, S, Geertson, D, Kamis-Gould, E, Namerow, MJ, Patton, RE, Wilson, NZ and Wurster, CR 1989, *Data standards for mental health decision support systems: a report of the task force to revise the data content and system guidelines of the mental health statistics improvement program*, United States Department of Health and Human Services.

Leung, J, Stockings, E, Wong, I, Galasyuk, N and Diminic, S 2017, *Co-morbid mental and substance use disorders – a meta-review of treatment effectiveness*, National Drug and Alcohol Research Centre.

Liddelow-Hunt, S, Uink, B, Daglas, K, Hill, JHL, Hayward, L, Stretton, N, Perry, Y, Hill, B and Lin, A 2023, *Walkern Katatdjin phase 2 national survey community report*, Telethon Kids Institute.

Life in Mind 2025, *Safe spaces*, https://lifeinmind.org.au/suicide-prevention/approaches/intervention/safe-spaces (accessed 10 October 2025).

Lifeline Australia 2021, *Mental health and suicide: connected but not the same*, *Linkedin*, 6 October, https://www.linkedin.com/pulse/mental-health-suicide-connected-same-lifeline-australia/ (accessed 17 May 2025).

—— 2024, *13YARN marks 50,000 calls supporting Aboriginal and Torres Strait Islander people in crisis*, Media Release, 16 May.

Lowitja Institute 2010, *The overburden project*, https://www.lowitja.org.au/projects/overburden-project/ (accessed 11 May 2025).

—— 2023a, *Indigenous data governance and sovereignty*.

—— 2023b, *Indigenous data sovereignty policy brief*.

Lumby, C 2024, *Lived experience engagement and participation: current approaches and emerging practice developments in the public sector*, National Mental Health Commission.

Lumivero Pty Ltd 2024, *NVIVO (Version 15)*.

Mammoliti, E, Nielsen, S and Roxburgh, A 2025, 'A scoping review of the emergence of novel synthetic opioids in Australian drug markets: what does this mean for harm reduction responses?', *Drug and Alcohol Review*, pp. 1–16.

Marel, C, Madden, E, Wilson, J, Teesson, M and Mills, KL 2023, 'Effectiveness of online training for improving knowledge, attitudes, and confidence of alcohol and other drug workers in relation to co-occurring mental health conditions', *Drugs: Education, Prevention and Policy*, vol. 30, no. 2, pp. 115–123.

—— and Mills, K 2022, *Current practices and support needs of healthcare providers in CESPHN in relation to addressing patients' co-occurring mental health and alcohol and other drug issues*, Central and Eastern Sydney Primary Health Network (PHN).

——, Siedlecka, E, Fisher, A, Gournay, K, Deady, M, Baker, A, Kay-Lambkin, F, Teesson, M, Baillie, A and Mills, K 2022, *Guidelines on the management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings*, Matilda Centre for Research in Mental Health and Substance Use.

——, Siedlecka, E, Wilson, J, Rochesson, S, Chu, D, Fisher, A and Mills, KL 2025, 'A systematic review and meta-analysis of the prevalence of alcohol and other drug use and problematic use among people accessing mental health treatment in Australia', *Australian & New Zealand Journal of Psychiatry*, vol. 59, no. 4, pp. 361–377.

——, Sunderland, M, Mills, KL, Slade, T, Teesson, M and Chapman, C 2019, 'Conditional probabilities of substance use disorders and associated risk factors: progression from first use to use disorder on alcohol, cannabis, stimulants, sedatives and opioids', *Drug and Alcohol Dependence*, vol. 194, pp. 136–142.

Matthews, EB, Rahman, R, Schiefelbein, F, Galis, D, Clark, C and Patel, R 2023, 'Identifying key roles and responsibilities of peer workers in behavioural health services: a scoping review', *Patient Education and Counseling*, vol. 114, p. 107858.

Mayi Kuwayu 2025, *Mayi Kuwayu national study of Aboriginal and Torres Strait Islander wellbeing*, https://mkstudy.com.au/ (accessed 25 September 2025).

Mental Health Australia 2022, *Employment and mental health position statement*.

Mental Health Commission (Ireland) 2006, *Multidisciplinary team working: from theory to practice*.

Mental Health Commission of NSW 2024, *Leading the change: a toolkit to evaluate lived experience inclusion and leadership*.

Mental Health Coordinating Council 2019, *Partners in recovery*, https://mhcc.org.au/publication/partners-in-recovery (accessed 30 May 2025).

Mills, KL, Teesson, M, Back, SE, Brady, KT, Baker, AL, Hopwood, S, Sannibale, C, Barrett, EL, Merz, S, Rosenfeld, J and Ewer, PL 2012, 'Integrated exposure-based therapy for co-occurring posttraumatic stress disorder and substance dependence: a randomized controlled trial', *Journal of the American Medical Association*, vol. 308, no. 7, pp. 690–699.

Mitrou, F, Nguyen, HT, Le, HT and Zubrick, SR 2024, 'The causal impact of mental health on tobacco and alcohol consumption: an instrumental variables approach', *Empirical Economics*, vol. 66, no. 3, pp. 1287–1310.

NAATSIHWP (National Association of Aboriginal and/or Torres Strait Islander Health Workers and Health Practitioners) 2024, *Professional scopes of practice for Aboriginal and/or Torres Strait Islander health workers and health practitioners*.

National Suicide Prevention Adviser 2020a, *Final advice: connected and compassionate*.

—— 2020b, *Final advice: executive summary*.

Neami National 2024, *Early implementation findings from co-evaluation research of Medicare Mental Health Centres delivered by Neami*, https://www.neaminational.org.au/news-and-stories/early-implementation-findings-from-co-evaluation-research-of-medicare-mental-health-centres-delivered-by-neami/ (accessed 6 February 2025).

NHFB (National Health Funding Body) 2025, *Local hospital networks*, https://www.publichospitalfunding.gov.au/local-hospital-networks (accessed 19 May 2025).

NHMRC (National Health and Medical Research Council) 2021, *NHMRC special initiative in mental health (SIMH)*, https://www.nhmrc.gov.au/research-policy/research-priorities/nhmrc-special-initiative-mental-health (accessed 19 August 2025).

NMHC (National Mental Health Commission) 2016, *Equally Well Consensus Statement: Improving the physical health and wellbeing of people living with mental illness in Australia*.

—— 2020, *National mental health and wellbeing pandemic response plan*.

—— 2021a, *The fifth national mental health and suicide prevention plan: implementation plan*.

—— 2021b, *The national children's mental health and wellbeing strategy*.

—— 2022, *Vision 2030 for mental health and suicide prevention in Australia*.

—— 2024a, *National mental health and suicide prevention agreement 2022–2023: annual national progress report*.

—— 2024b, *National stigma and discrimination reduction strategy*, https://www.mentalhealthcommission.gov.au/projects/stigma-and-discrimination-reduction-strategy (accessed 10 October 2025).

—— 2024c, *Our role*, https://www.mentalhealthcommission.gov.au/about/our-role (accessed 5 June 2025).

—— 2025, *National mental health and suicide prevention agreement 2023–2024 (year 2): annual national progress report*.

NMHCCF (National Mental Health Consumer and Carer Forum) 2021, *Co-design and co-production*.

Northern Sydney Local Health District 2023, *Submission to the special commission of inquiry into healthcare funding*.

Nous Group 2018, *Mental health and suicide prevention monitoring and reporting framework*.

—— 2022, *The Way Back support services evaluation - final evaluation report*.

NSPO (National Suicide Prevention Office) 2024a, *About the National Suicide Prevention Office*, https://www.mentalhealthcommission.gov.au/nspo/about-national-suicide-prevention-office (accessed 25 March 2025).

—— 2024b, *Development of the national suicide prevention outcomes framework*, https://www.mentalhealthcommission.gov.au/nspo/projects/development-national-suicide-prevention-outcomes-framework (accessed 13 February 2025).

—— 2024c, *Development of the national suicide prevention strategy*.

—— 2025, *National Suicide Prevention Strategy 2025–2035*.

NSW Government 2024, *$111.8 million to support community mental health*, Media release, https://www.nsw.gov.au/media-releases/1118-million-to-support-community-mental-health (accessed 18 August 2025).

NSW Health 2022a, *Housing and mental health agreement 2022*.

—— 2022b, *Housing and mental health agreement 2022 governance framework*.

—— 2024a, *Collaborative commissioning*, https://www.health.nsw.gov.au:443/Value/Pages/collaborative-commissioning.aspx (accessed 16 September 2025).

—— 2024b, *Role of Patient Centred Co-commissioning Groups (PCCGs)*, https://www.health.nsw.gov.au:443/Value/Pages/collab-commissioning-pccgs.aspx (accessed 29 August 2025).

—— 2025, *Lumos: shining a light on the patient journey in NSW*, https://www.health.nsw.gov.au:443/lumos/Pages/default.aspx (accessed 21 August 2025).

NSW Ministry of Health 2015, *Effective models of care for comorbid mental illness and illicit substance use*.

—— 2023, *NSW Alcohol and Other Drugs Workforce Census Report*.

OECD 2025, *Place-based policies for the future*, OECD Regional Development Studies, OECD Publishing.

Pagliaro, C, Mundie, A, Whiteford, H and Diminic, S 2024, 'Analysis of data items and gaps in Australia's national mental health services activity and capacity data collections for integrated regional service planning', *Health Information Management Journal*, vol. 53, no. 3, pp. 206–216.

Palinkas, LA 2014, 'Qualitative methods in mental health services research', *Journal of Clinical Child and Adolescent Psychology*, vol. 43, no. 6, pp. 851–861.

Patton 2002, *Qualitative research and evaluation methods*, 3rd Edition, Sage Publications, Inc, Thousand Oaks, CA.

PC (Productivity Commission) 2017, *Comparative Performance Indicators*, Shifting the Dial: 5 year Productivity Review, Supporting Paper no. 3.

—— 2019, *Review of the National Disability Agreement*, Study Report, Canberra.

—— 2020, *Mental Health*, Report no. 95, Canberra.

—— 2021, *Mental health and suicide prevention stocktake*.

—— 2022a, *In need of repair: the National Housing and Homelessness Agreement*, Study Report, Canberra.

—— 2022b, *Review of the National Agreement on Closing the Gap - Review paper 1: Engagement approach*.

—— 2022c, *Review of the National School Reform Agreement*, Study Report, Canberra, December.

—— 2024a, *Closing the Gap Annual Data Compilation Report*, July.

—— 2024b, *Review of the National Agreement on Closing the Gap*, Study report, Vol. 1, Canberra.

—— 2025a, *Closing the Gap information repository, socio-economic outcome area 14 data tables*, https://www.pc.gov.au/closing-the-gap-data/dashboard/se/outcome-area14/ (accessed 7 May 2025).

—— 2025b, *Delivering quality care more efficiently*, Interim report, August.

Peiris, D, Feyer, A-M, Barnard, J, Billot, L, Bouckley, T, Campain, A, Cordery, D, Souza, A de, Downey, L, Elshaug, AG, Ford, B, Hanfy, H, Hales, L, Khalaj, BH, Schneider, CH, Inglis, J, Jan, S, Jorm, L, Landon, B, Lujic, S, Mulley, J, Pearson, S-A, Schierhout, G, Sivaprakash, P, Stanton, C, Stephens, A and Willcox, D 2024, 'Overcoming silos in health care systems through meso-level organisations – a case study of health reforms in New South Wales, Australia', *The Lancet Regional Health – Western Pacific*, vol. 44, pp. 1–10.

Petrie, D, Saxby, K and de New, S 2025, 'Just $7 extra per person could prevent 300 suicides a year. Here's exactly where to spend it', *The Conversation*, 7 July, http://theconversation.com/just-7-extra-per-person-could-prevent-300-suicides-a-year-heres-exactly-where-to-spend-it-259890 (accessed 3 September 2025).

Phillips, R, Durkin, M, Engward, H, Cable, G and Iancu, M 2021, 'The impact of caring for family members with mental illnesses on the caregiver: a scoping review', *Health Promotion International*, vol. 38, no. 3, pp. 1–23.

Plana-Ripoll, O, Musliner, KL, Dalsgaard, S, Momen, NC, Weye, N, Christensen, MK, Agerbo, E, Iburg, KM, Laursen, TM, Mortensen, PB, Pedersen, CB, Petersen, LV, Santomauro, DF, Vilhjálmsson, BJ, Whiteford, HA and McGrath, JJ 2020, 'Nature and prevalence of combinations of mental disorders and their association with excess mortality in a population-based cohort study', *World Psychiatry*, vol. 19, no. 3, pp. 339–349.

PM&C (Department of the Prime Minister and Cabinet) 2017, *National strategic framework for Aboriginal and Torres Strait Islander peoples' mental health and Social and Emotional Wellbeing 2017–2023*.

—— 2019, *Our public service our future - independent review of the Australian public service*.

—— 2023, *Working together to deliver the NDIS - independent review into the National Disability Insurance Scheme: final report*.

—— 2024a, *Care and support economy*, https://www.pmc.gov.au/domestic-policy/care-and-support-economy (accessed 16 May 2025).

—— 2024b, *National Cabinet priorities*.

—— 2024c, *National Cabinet terms of reference*, https://federation.gov.au/national-cabinet/terms-of-reference (accessed 20 August 2025).

—— 2025, *Meeting outcomes*, https://federation.gov.au/national-cabinet/meeting-outcomes (accessed 10 October 2025).

Prior, K, Mills, K, Ross, J and Teesson, M 2017, 'Substance use disorders comorbid with mood and anxiety disorders in the Australian general population', *Drug and Alcohol Review*, vol. 36, no. 3, pp. 317–324.

Psychosocial Project Group 2023a, *Psychosocial project group: project update #1 March 2023*.

—— 2023b, *Psychosocial project group: project update #2 July 2023*.

—— 2023c, *Psychosocial project group: project update #3 November 2023*.

—— 2025, *Psychosocial project group: meeting summary, meeting 19 (17 July 2025)*.

Puddephatt, J-A, Irizar, P, Jones, A, Gage, SH and Goodwin, L 2022, 'Associations of common mental disorder with alcohol use in the adult general population: a systematic review and meta-analysis', *Addiction*, vol. 117, no. 6, pp. 1543–1572.

Purcal, C, O'Shea, P, Giuntoli, G, Zmudzki, F and Fisher, KR 2022, *Evaluation of NSW community-based mental health programs: community living supports and housing and accommodation support initiative*, UNSW Social Policy Research Centre.

QAMH (Queensland Alliance for Mental Health) 2025, *Our sector*, https://www.qamh.org.au/about/our-sector/ (accessed 28 August 2025).

QMHC (Queensland Mental Health Commission) 2018, *Queensland mental health, alcohol and other drugs strategic plan 2018–2023*.

Queensland Centre for Mental Health Research 2023, *Developing a national needs-based planning model for suicide prevention services (LIFEWAYS)*, https://qcmhr.org/uncategorised/developing-a-national-needs-based-planning-model-for-suicide-prevention-services-lifeways (accessed 29 August 2025).

Queensland Children's Hospital School 2025, *Jacaranda Place - Chermside*, https://qchschool.eq.edu.au/facilities/campuses/jacaranda-place-chermside (accessed 9 November 2025).

Queensland Government 2024, *Best practice industry conditions for social service procurement*.

Queensland Health 2022, *Better care together: a plan for Queensland's state-funded mental health, alcohol and other drug services to 2027*.

Quigley, E, Arnold, L, Rebbeck, J and Goodwin, N 2023, 'Central coast joint strategic needs assessment - A collaborative approach to improving health and social care outcomes at a local level', *International Journal of Integrated Care*, vol. 24, no. 1.

Ramia, I, Powell, A, Stratton, K, Stokes, C, Meltzer, A and Muir, K 2021, *Roadmap to social impact: your step-by-step guide to planning, measuring and communicating social impact*, Centre for Social Impact.

RCVMHS (Royal Commission into Victoria's Mental Health System) 2021, *Volume 3: promoting Inclusion and Addressing Inequities*.

Rethink Addiction and KPMG 2022, *Understanding the cost of addiction in Australia*.

Ritter, A, Grealy, M, Kelaita, P and Kowalski, M 2024, *The Australian 'drug budget': government drug policy expenditure*

2021/22, Social Policy Research Centre, University of New South Wales.

—— and O'Reilly, K 2025, 'Unmet treatment need: The size of the gap for alcohol and other drugs in Australia', *Drug and Alcohol Review*, vol. 44, no. 3, pp. 772–782.

Robinson, E, Rodgers, B and Butterworth, P 2008, *Family relationships and mental illness: impacts and service responses*, 4, Resource Sheet, Australian Family Relationships Clearinghouse.

Roper, C, Grey, F and Cadogan, E 2018, *Co-production: putting principles into practice in mental health contexts*, University of Melbourne.

Rosen, A 2006, 'Australia's national mental health strategy in historical perspective: beyond the frontier', *International Psychiatry*, vol. 3, no. 4, pp. 19–21.

Roses in the Ocean 2022, *A Safe Spaces narrative: emerging outcomes of Safe Spaces co-design*.

—— and Folk 2024, *Lived experience of suicide service guidelines: distress brief support*, https://rosesintheocean.com.au/lived-experience-of-suicide-service-guidelines/ (accessed 16 May 2025).

SA Health 2025, *Aboriginal Social and Emotional Wellbeing Centre*, https://www.sahealth.sa.gov.au/wps/wcm/connect/Public+Content/SA+Health+Internet/Services/Mental+Health+and+Drug+and+Alcohol+Services/mental+health+services/statewide+specialist+services/aboriginal+mental+health+services/Aboriginal+Social+and+Emotional+Wellbeing+Centre (accessed 16 April 2025).

Sandelowski, M 2000, 'Whatever happened to qualitative description?', *Research in Nursing & Health*, vol. 23, no. 4, pp. 334–340.

SANE 2025, *Families, friends & carers*, https://www.sane.org/information-and-resources/facts-and-guides/families-friends-carers (accessed 10 October 2025).

Sartor, C 2023, 'Mental health and lived experience: The value of lived experience expertise in global mental health', *Cambridge Prisms: Global Mental Health*, vol. 10, no. e38.

Sax Institute 2015, *Effective models of care for comorbid mental illness and illicit substance use: an evidence check*.

SCHACD (Standing Committee on Health, Aged Care and Disability) 2025, *Health impacts of alcohol and other drugs in Australia*, https://www.aph.gov.au/Parliamentary_Business/Committees/House/Health_Aged_Care_and_Disability/Healthimpactsofalcohol (accessed 10 October 2025).

SCHACS (Standing Committee on Health, Aged Care and Sport) 2025, *Issues paper relating to the health impacts of alcohol and other drugs in Australia*.

Schang, L, Blotenberg, I and Boywitt, D 2021, 'What makes a good quality indicator set? A systematic review of criteria', *International Journal for Quality in Health Care*, vol. 33, no. 3.

SCMHSP (House of Representatives Select Committee on Mental Health and Suicide Prevention) 2021, *Inquiry into mental health and suicide prevention - Final report*.

SCRGSP (Steering Committee for the Review of Government Service Provision) 2025, *Report on Government Services 2025 - Health (part E)*, Productivity Commission, Canberra.

Setkowski, K, Boogert, K, Hoogendoorn, AW, Gilissen, R and van Balkom, AJLM 2021, 'Guidelines improve patient outcomes in specialised mental health care: A systematic review and meta-analysis', *Acta Psychiatrica Scandinavica*, vol. 144, no. 3, pp. 246–258.

SHARC (Self Help Addiction Resource Centre) 2025, *Alcohol and other drug (AOD) lived experience workforce discipline framework*.

Skinner, N, McEntee, A and Roche, A 2020, *Australia's alcohol and other drug workforce: national survey results 2019–2020*, National Centre for Education and Training on Addiction.

Slade, T, Vescovi, J, Chapman, C, Teesson, M, Arya, V, Pirkis, J, Harris, MG, Burgess, PM, Santomauro, D, O'Dean, S, Tapp, C and Sunderland, M 2025, 'The epidemiology of mental and substance use disorders in Australia 2020–22: Prevalence, socio-demographic correlates, severity, impairment and changes over time', *Australian & New Zealand Journal of Psychiatry*, vol. 59, no. 6, pp. 510–521.

Slay, J and Stephens, L 2013, *Co-production in mental health: a literature review*, New Economics Foundation.

Social Ventures Australia 2024, *AOD use and the risk of entrenched disadvantage in Australia*.

Standing Council on Health 2012, *Mental health statement of rights and responsibilities*.

Stewart, AC, Djordjevic, F, Cossar, R, Lenton, S, Salom, C, Peacock, A and Dietze, P 2021, *Ketamine use among people who regularly use ecstasy and other illicit stimulants in Australia: trends and characteristics of use, 2009–2019. Drug Trends Bulletin Series*, National Drug and Alcohol Research Centre.

Sunderland, M, Vescovi, J, Chapman, C, Arya, V, Harris, M, Burgess, P, Marel, C, Mills, K, Baillie, A, Teesson, M and Slade, T 2025, 'Co-occurring mental and substance use disorders in Australia 2020–2022: Prevalence, patterns, conditional probabilities and correlates in the general population', *Australian & New Zealand Journal of Psychiatry*, vol. 59, no. 6, pp. 522–532.

Sutherland, R, Karlsson, A, Uporova, J, Chandrasena, A, Tayeb, H, Price, O, Bruno, R, Dietze, P, Lenton, S and Farrell, M 2024, *Australian Drug Trends 2024: Key Findings from the National Illicit Drug Reporting System (IDRS) Interviews*, National Drug and Alcohol Research Centre.

Tasmanian Government Department of Health 2020, *Peacock centre redevelopment: submission to the parliamentary standing committee on public works*.

—— 2023a, *Peacock Centre*, Tasmanian Government Department of Health, https://www.health.tas.gov.au/health-topics/mental-health/tasmanias-mental-health-system/adult-mental-health-service/peacock-centre (accessed 10 October 2025).

—— 2023b, *Safe Haven*, https://www.health.tas.gov.au/health-topics/mental-health/tasmanias-mental-health-system/adult-mental-health-service/peacock-centre/safe-haven (accessed 30 September 2025).

The Treasury 2025a, *Commonwealth evaluation toolkit, template 2: program logic*, https://evaluation.treasury.gov.au/sites/evaluation.treasury.gov.au/files/2023-09/template-2-program-logic.docx (accessed 27 May 2025).

—— 2025b, *Commonwealth evaluation toolkit, templates, tools and resources*, https://evaluation.treasury.gov.au/toolkit/templates-tools-and-resources (accessed 14 May 2025).

Thomas, N, McLachlan, J, Juckel, J, Daly, C and Salom, C 2024, *Trends in mental health problems and mental health treatment attendance among a sample of people who regularly inject drugs in Australia, 2019–2023*, Institute for Social Science Research, University of Queensland.

Trankle, SA and Reath, J 2019, 'Partners in recovery: an early phase evaluation of an Australian mental health initiative using program logic and thematic analysis', *BMC Health Services Research*, vol. 19, no. 1, p. 524.

Turning Point 2025, *Framing addiction and dependence: building support and reducing stigma*.

UNODC (United Nations Office on Drugs and Crime) 2022, *Comorbidities in drug use disorders: No wrong door*.

VAADA (Victorian Alcohol and Drug Association) 2023, *Integration of care in practice: Examples of models of care, tools and activities that promote integrated treatment, care and support for people experiencing mental illness and substance use or addiction*.

—— (2025, *Mental health presentations in the AOD sector: Highlighting the challenge and working towards solutions*.

VACCHO (Victorian Aboriginal Community Controlled Health Organisation) 2025, *The Victorian ACCO model*, https://www.vaccho.org.au/vicaccomodel/ (accessed 14 April 2025).

VDDI (Victorian Dual Diagnosis Initiative) 2019, *Victorian dual diagnosis initiative submission to the Royal Commission into Victoria's mental health system*, St Vincent's Hospital Melbourne.

van de Ven, K, Ritter, A and Stirling, R 2021, *The impact of the COVID-19 pandemic on the non-government alcohol and other drug sector: future implications*, Monograph No. 34, Drug Policy Modelling Program.

——, Ritter, A, Vuong, T, Livingston, M, Berends, L, Chalmers, J and Dobbins, T 2022, 'A comparison of structural features and vulnerability between government and nongovernment alcohol and other drug (AOD) treatment providers', *Journal of Substance Abuse Treatment*, vol. 132, p. 108467.

Victorian Department of Health 2024a, *A shared vision for Aboriginal social and emotional wellbeing in Victoria*, https://www.health.vic.gov.au/mental-health-wellbeing-reform/a-shared-vision-for-aboriginal-social-and-emotional-wellbeing-in (accessed 10 October 2025).

—— 2024b, *The Hamilton Centre*, https://www.health.vic.gov.au/mental-health-services/the-hamilton-centre (accessed 10 October 2025).

—— 2025a, *Budget delivers record boost for frontline service delivery: Health highlights from the Victorian Budget 2025-26*, https://www.health.vic.gov.au/news/budget-delivers-record-boost-for-frontline-service-delivery (accessed 21 August 2025).

—— 2025b, *Mental health and wellbeing connect*, https://www.betterhealth.vic.gov.au/mental-health-and-wellbeing-connect#about-mental-health-and-wellbeing-connect (accessed 25 September 2025).

Volkow, ND and Blanco, C 2023, 'Substance use disorders: a comprehensive update of classification, epidemiology, neurobiology, clinical aspects, treatment and prevention', *World Psychiatry*, vol. 22, no. 2, pp. 203–229.

Walter, M, Lovett, R, Maher, B, Williamson, B, Prehn, J, Bodkin-Andrews, G and Lee, V 2020, 'Indigenous data sovereignty in the era of big data and open data', *Australian Journal of Social Issues*, vol. 56, no. 2, pp. 143–156.

WAMHC (Western Australian Mental Health Commission) 2015, *Better Choices. Better Lives. Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015–2025.*

WAPSC (Western Australia Public Sector Commission) 2024, *Agency capability: mental health commission*.

Western NSW Local Health District 2023, *Submission to the special commission of inquiry into healthcare funding*.

WHO (World Health Organization) 2013, *Mental health action plan 2013–2020*.

—— 2024, *Global status report on alcohol and health and treatment of substance use disorders*.

—— 2022, *World mental health report: transforming mental health for all*.

Winkworth, G and White, M 2010, 'May do, should do, can do: collaboration between Commonwealth and state service systems for vulnerable children', *Communities, Children and Families Australia*, vol. 5, no. 1, pp. 5–20.

WYCA (West Yorkshire Combined Authority) 2023, *Theory of change, monitoring, and evaluation: a toolkit for developing a culture of evaluation and learning*.