



Consumers Health
Forum OF Australia

INITIAL SUBMISSION

Final Review of the National Mental Health and Suicide Prevention Agreement

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Consumers Health Forum of Australia (2025)
*Initial submission to the Final Review of the
National Mental Health and Suicide Prevention Agreement*

P: 02 6273 5444

E: info@chf.org.au

twitter.com/CHFofAustralia

facebook.com/CHFofAustralia

Office Address

7B/17 Napier Close,
Deakin ACT 2600

Postal Address

PO Box 308
Collins Street West VIC 8007

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Introduction

Consumers Health Forum Australia (CHF) is the national peak body representing the interests of all healthcare consumers and those interested in healthcare consumer affairs. CHF works to achieve safe, quality, and timely healthcare for all people living in Australia, supported by accessible health information and systems. At the heart of CHF's policy agenda is consumer-centred care.

CHF welcomes the opportunity to provide a submission to the Productivity Commission's Final Review of the National Mental Health and Suicide Prevention Agreement (the Agreement).

In February 2025, CHF sought feedback from consumers across Australia on their experience with mental health and suicide prevention over the past three years. We also drew upon insights consumers have shared with us in recent years through other consultations related to their current experiences of mental health care in Australia. Their experiences and perspectives are reflected in this submission, including in the form of direct quotes.

CHF supports the existence of a National Agreement and its whole-of-government approach to transforming and improving Australia's mental health and suicide prevention systems. Everyone living in Australia has the right to a universal mental health care system that integrates seamlessly with other parts of the system to give access to essential services in the right place, at the right time, and in the right way.

CHF strongly supports the Agreement Principles, including the focus on a people-centred system; embedding of lived experience into design, planning and delivery of services; reducing overlap, gaps and fragmentation; supporting workforce capability with a focus on rural and remote areas; supporting a stepped care model, early intervention and prevention and service provision across the entire spectrum of care; cooperation across providers, systems and governments; improved transparency and accountability; recognition of social determinants and a focus on vulnerable cohorts.

Our submission focuses on highlighting the key issues and areas that require particular focus and further action through the Agreement, based on what consumers are telling us about their experiences with mental health and suicide prevention services over the past three years. Essentially, while the Agreement may have started progress towards its goal, there is more to be done.

We recognise that there has been positive progress made since the Agreement commenced, including movement toward embedding lived experience into design, delivery and evaluation of services; improved data collection and governance, roll out of more walk-in services (Head to Health Centres – now called Medicare Mental Health Centres¹) and introduction of a Universal Aftercare system for people following a suicidal crisis or attempt. When asked about what has improved recently, consumers have referenced more walk-in services being

¹ Department of Health and Aged Care (2025) *Medicare Mental health Centres*, <https://www.health.gov.au/our-work/medicare-mental-health-centres>

available, hospital in the home services and greater community education and awareness in relation to suicide prevention and mental health and wellbeing.

However, CHF has overwhelmingly heard from consumers that they are still struggling to access mental healthcare and suicide-related support when they need it, that waiting times continue to be a significant issue, that mental health stigma is an ongoing problem and that many aspects of the system – in particular acute mental health and suicide distress treatment in emergency departments – remain inappropriate. We also continue to hear that carers and loved ones are not receiving the support and access to services that they need.

CHF's submission focuses on broader national impact and application of the Agreement, recognising that there are also individual bilateral agreements in place with States and Territories. We agree that services are best planned, coordinated and integrated regionally, and support a continued and expanded role for Primary Health Networks (PHNs) as system integrators. We also support consistency across jurisdictions where appropriate and encourage a process that allows jurisdictions to share and learn from the successes in other locations.

Evaluating the Agreement

CHF notes that the fundamental purpose of this Review, as per the Terms of Reference, is to evaluate the various effects, impacts, consequences, effectiveness, applicability etc of the components of the Agreement.

However, at the time of writing this submission this is not something CHF or any other external party can thoroughly comment on given the slippage in meeting reporting requirements of the Agreement.

As per Part 6 of the Agreement the Parties have agreed to publish Annual National Progress Reports within three months of November 30th for the previous financial year period i.e. by Feb 28th the following year.² At the time of writing this submission the only National Progress Report available publicly is for the period 2022/23 and it was only published in December 2024. This means that it was a full 10 months late and that the report for the 2023/24 period is now additionally late.

Of note, the 2022/23 report concluded at the time that while *"the National Agreement commits to significant reform of the mental health and suicide prevention system in Australia... many commitments are yet to be implemented"*.³ Given the lack of subsequent reporting, we are unable to effectively assess if and how that status quo has changed and

² National Mental Health Commission (2024) *National Mental Health and Suicide Prevention Agreement 2022-2023 – Annual National Progress Report Summary*, <https://www.mentalhealthcommission.gov.au/publications/national-mental-health-and-suicide-prevention-agreement-2022-2023-annual-national-progress-report-summary>

³ National Mental Health Commission (2024) *National Mental Health and Suicide Prevention Agreement 2022-2023 – Annual National Progress Report Summary*, <https://www.mentalhealthcommission.gov.au/publications/national-mental-health-and-suicide-prevention-agreement-2022-2023-annual-national-progress-report-summary>

thus what the impacts of any efforts specifically deriving from this Agreement have been on addressing the matters of mental health and suicide prevention across Australia.

As such, the remainder of this submission will outline our knowledge of issues and consumer experiences on these topics that continue to be an issue for the community. The continued existence of these issues suggests that the Agreement has not yet been effective in making observable progress on resolving them as it sets out to do.

Suicide Prevention and Mental Health

CHF would like to emphasise that mental health and suicide prevention are two distinct issues. While mental health conditions can be associated with increased suicide risk, it is not the only contributor. As recognised in the recently released National Suicide Prevention Strategy, *"Suicidal distress is a human response to overwhelming suffering. It is complex – typically, there are many factors at play rather than a single isolated cause. These factors include social determinants (such as income, education, employment, housing, early childhood development, social inclusion and access to health care) and individual factors, including contextual factors (such as stressful life events, trauma, abuse and discrimination), clinical factors (for example, mental illness, drug and alcohol use, chronic physical illness), personality factors, genetic factors and demographic factors (such as age, gender, sexual orientation, ethnicity, cultural heritage)."*⁴

CHF are concerned that a National Agreement that combines the two issues risks focusing only on the mental health related contributors to suicide risk.

We welcome the very recent release of the National Suicide Prevention Strategy and its clear actions that seek to address the complexity of suicide. Aligning the Agreement with this Strategy and its implementation will be important to ensure long-term, coordinated suicide prevention activity in Australia.

Lived Experience at the centre

The National Agreement aims to work towards mental health and suicide prevention systems that are more sustainable and person-centred. Lived experience insight and leadership is critical to achieving this.

The establishment of two national mental health lived experience peak bodies – one for consumers and one for families, carers and kin - is a particularly important achievement that has occurred over the past three years under the Agreement and is strongly supported by CHF.

Moving forward, it will be critical to closely engage with these peak bodies – including in the Review of the National Agreement - and to ensure that they have the capacity, remit and resources to facilitate lived experience input into and influence over system reform.

⁴ National Mental Health Commission (2025) *National Suicide Prevention Strategy*, <https://www.mentalhealthcommission.gov.au/nspp/publications/national-suicide-prevention-strategy>

Tailored person-centred care

At the point of care consumers need stepped models that give them options for accessing the level of care that meets their needs, ranging from low intensity supports to crisis services that are person-centred and provide wrap-around support.

When asked about what still needs to change to improve the mental health and suicide prevention systems, consumers consistently talk about a need for more tailored person-centred care, including peer-led services and increased emphasis on consumer choice.

"I think there's a lack of options or tailored support for people. We're all different and utilising set services that are inflexible or focus on a narrow range of interventions, can often leave people feeling they can't be helped. Focus on fixing what people ask support for, rather than offering a one size fits all option" – consumer

Many consumers do not feel supported or understood by mainstream services. This can be particularly the case for certain cohorts in society who have specific needs. Targeted services for people in rural and remote areas, First Nations people, young people, the LGBTIQ+ community and other groups with specific needs are critical to reaching vulnerable individuals.

We continue to hear reports of a lack of culturally safe services, particularly in rural locations.

"There is less, or no culturally safe resources and the local health district staff are reluctant to use interpreters and translators. [There is a] lack of translated mental health resources in emerging languages in rural and regional Australia" – consumer

It is well recognised that the specific needs of consumers from particular communities or backgrounds are likely to be better met with initiatives and services that are sensitive to their experiences, culture, and the specific issues they face. This highlights the importance that the Agreement focuses on reform that enables and prioritises person-centred care, including continuing to foster and support the growth of a lived experience (peer) workforce. Lived experience workers are able to draw on their own experiences and recovery journey to support others in a similar situation and build relationships that strengthen connection, resilience, choice, and hope.⁵

Reform under the Agreement has seen some progress in building a well-supported lived experience workforce, however it is still very much in development and will require ongoing, sustained investment to flourish.

Similarly, Aboriginal and Torres Strait Islander organisations should be the preferred providers of mental health, suicide prevention and social and emotional wellbeing programs in their communities.

⁵ Mental Health Commission (2021) *National Lived Experience (Peer) Workforce Development Guidelines*, <https://www.mentalhealthcommission.gov.au/publications/national-lived-experience-peer-workforce-development-guidelines>

Support for carers and loved ones

CHF also continues to hear about a lack of adequate support and services available to carers of people with mental ill-health and/or suicidality, and those bereaved by suicide.

“Support the families who look after the mental health clients. I felt lost and alone about what I should/should not do and had to Google search my own answers” – carer

Further, where these services and supports are available, there can be a lack of awareness about them and/or how to connect with them.

“Services to support carers need more publicity - a government funded tv/online awareness campaign would be a good start” – consumer and carer

There is more emphasis needed on investment in support services for carers and kin, complemented by appropriate publicity and awareness campaigns to ensure all community members are aware of how and where to access the support the need.

Accessibility and Affordability

CHF continues to hear from consumers that mental health services are difficult to access when they need them, primarily due to cost and waiting times.

The increasing cost of living is impacting both peoples' mental health and their ability to access supports. A 2024 representative survey commissioned by Mental Health Australia found that 57% of respondents reported cost of living increases had negatively affected their mental health over the past year.⁶ At the same time, recent ABS figures show that 1 in 5 Australians reported delaying or not seeing a health professional for their mental health when they needed to in 2023-24 due to cost.⁷ Delaying or avoiding treatment due to costs not only results in the person potentially becoming more unwell but it also generally increases future health costs for the individual and for State and Federal governments.

CHF supports expanded funding for community-based mental health services and a focus on ensuring affordable access to therapy and medications.

Consumers continue to call for access to more than 10 subsidised appointments through Mental Health Care Plans, particularly for those with ongoing mental health issues.

“[There needs to be] greater accessibility of affordable clinical care such as psychiatrists and psychologists. More than 10 subsidised psychology appointments per year for people with serious mental illness” – consumer

“Both me and my daughter can only access a private psychiatrist for which I am out of pocket over \$220/session” – consumer

⁶ Mental Health Australia (2024) *Vision Statement: A mentally healthy Australia*, <https://mhaustralia.org/our-work/vision-statement>

⁷ ABS (2024) *Patient Experiences 2023-24*, abs.gov.au/statistics/health/health-services/patient-experiences/2023-24

Mental health workforce issues also remain a significant barrier to care with a lack of available providers, particularly in regional, rural, and remote areas. Some consumers report that this has become worse over the past 3 years, not better.

"It took me over 2 years to get a private psych and my daughter has to see one in NSW via telehealth as there are none available in our region" – consumer

"Waiting times have worsened [over past 3 years]" – consumer

Having to wait prolonged periods for care impacts on a consumer's ability to access early intervention and ultimately may lead to worsened mental health and a need for more acute services.

"Even when someone is fortunate enough to be able to afford to pay for private services, the waiting lists are extensive and leave people struggling, unsupported, for a significant amount of time. This means early intervention isn't accessible" – consumer

"As someone who has lost a child to suicide, I believe that access to services is one of the main issues, as it isn't always possible for families to provide support when someone is suicidal" – carer

CHF recognises that broader social, economic, cultural, environmental, and political factors shape the circumstances of people's lives, including their health and mental health. People experiencing disadvantage often have poorer mental health and are less able to access care. At the same time, mental ill health itself can exacerbate disadvantage and exclusion.

The Agreement will only achieve its goals if the broader factors impacting on mental health and suicide risk are also addressed.

"Greater recognition of some of the broader factors that can lead to mental unwellness and sometimes suicide. Targeting some of the things that are social determinants, such as poverty and homelessness, as well as alcohol and drug disorders, would help, as prevention probably costs a lot less in the long-term than trying to address individual crises and harm" – consumer

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.

Prevention and Early Intervention

CHF has always supported a shift towards prevention, early intervention and coordinated community support through the primary health care setting. We support a stepped model of care, with the capability to step up into higher intensity services where required, but with a focus on providing low intensity care at an early stage to prevent deterioration where possible.

We strongly support the Agreement's commitment to increased investment in prevention and early intervention. We note the ongoing national roll out of Head to Health / Medicare Mental Health centres and Kids Hubs is a positive step towards provision of accessible, free early intervention services and supports.

Further, consumers have noted that there appear to be more free, accessible mental health and suicide prevention awareness and education programs available to the public, including online, which is positive.

However, we believe prevention and early intervention still needs greater focus and investment considering that mental ill-health is increasing amongst the Australian population, particularly younger people.⁸

Acute care

Importantly, an ongoing issue is a lack of access to appropriate services for people in acute mental health or suicidal distress. The Agreement includes a focus on prioritising early intervention and prevention services that aim to reduce future presentations at emergency departments, as well as focusing on reforms in primary care that improve patient outcomes and reduce avoidable hospital admissions – both of which we support. Clearly, however, there is still a need to prioritise provision of appropriate acute care for people in distress that is accessible outside of hospital emergency departments. 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.

"In hospitals the staff are reluctant to admit patients despite being made aware of multiple suicide attempts having been made. Even when it was agreed to (once) they did not keep the patient, allowing him to leave on a promise not to do it again" – carer

"Emergency departments with lots of mental health clients are like being in a zoo - people stare and whisper - not a humane way to treat people and there needs to be dedicated mental health ED areas" – carer

Some existing jurisdictional initiatives are already seeing progress in addressing this issue, such as, for example, mental health co-response models (e.g. the PACER⁹ model in Victoria/Tasmania/ACT) that involve mental health clinicians, paramedics and Police providing support to people experiencing a mental health emergency in the community. CHF has also heard positive reports of Mental Health Hospital in the Home services being more appropriate and effective. Some hospitals also provide 'Safe Haven Cafes' or similar that

⁸ Mental Health Commission (2023) *Monitoring the performance of Australia's mental health system: National Report Card 2023*, https://www.mentalhealthcommission.gov.au/sites/default/files/2024-07/national-report-card-2023_0_0.pdf

⁹ ACT Government (n.d.) *Police Ambulance and Clinician Early Response (PACER)*, <https://www.canberrahealthservices.act.gov.au/services-and-clinics/services/police-ambulance-and-clinician-early-response-pacer>

provide a calm, culturally sensitive and non-clinical place for people experiencing a mental health crisis to access support from peer support workers.¹⁰

Continuing to prioritise the development and implementation of appropriate, person-centred options for people to access in acute suicidal distress – that avoid hospital admittance – should remain a priority.

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.

“Hospital staff should be doing a handover with available services, at the very least they should be handing [the patient] information about who they can contact” – carer

Appropriate and effective aftercare support for people who have attempted suicide can prevent future suicide deaths and attempts, as well as reducing the associated social, emotional, and economic costs of suicide. CHF strongly support further investment in effective aftercare initiatives to achieve universal access for anyone presenting to a health or government service following a suicide attempt, as well as their family, friends, and carers.

Comorbidity

A major issue for CHF’s constituency is physical and mental health comorbidity and the management of multimorbidity, which is becoming increasingly common and is not well managed in the current health system. Research has shown that people living with two or more chronic conditions in Australia have lower levels of physical and mental health, well-being and social functioning compared to those living with only one chronic condition.¹¹ Due to the complexity and mix of services required by these consumers, their experience of the system can be one of fragmented, disconnected services and care. Coordinated, multidisciplinary clinical and non-clinical interventions are required and must be a priority for action under the Agreement if it is to achieve its key outcome to *“improve physical health and life expectancy for people living with mental health conditions and for those experiencing suicidal distress.”*

CHF has also heard reports from consumers with chronic health conditions and/or disability that they continually experience mental health services that are not able to support their physical health needs. For example, mental health wards in hospitals that are not able to cater for the accessibility and pain-related needs of a person with disability.

¹⁰ NSW Government (2024) *Safe Haven*, <https://www.health.nsw.gov.au/towardszerosuicides/Pages/safe-haven.aspx>

¹¹ OECD (2025) *Does Healthcare Deliver? Results from the Patient-Reported Indicator Surveys (PaRIS): Australia*, https://www.oecd.org/en/publications/does-healthcare-deliver-results-from-the-patient-reported-indicator-surveys-paris_748c8b9a-en/australia_6c1248e3-en.html

CHF supports the Equally Well¹² initiative, however it is unclear how much progress has been made to date under this initiative and the ongoing issues faced by consumers suggests a need for greater investment and prioritisation of this work.

Addressing Stigma

Consumers with mental ill health continue to experience stigma and discrimination, which can limit support-seeking and lead to increased isolation and distress. A draft National Stigma Reduction Strategy was developed in 2023, however this process seems to have stalled, and the Strategy is still yet to be publicly released.¹³ The Review of the Agreement should emphasise the need to release the Strategy and an associated implementation plan to progress reform in this area.

"[There is a need to] remove stigma from mental illness and "otherness" in our community (i.e. for queer people). I fear if Australia becomes more right leaning, as seen in other Western countries, that our suicide rate will increase." - consumer

"Less stigma and ignorance of suicide (even amongst the medical professions) would also help." – carer

In previous submissions CHF has called for a multidimensional approach to addressing stigma which includes more education in communities and workplaces about the realities of living with mental ill-health, alongside institutional and structural changes to support real and lasting cultural change.

Addressing the pervading stigma around suicide is also critical and is an identified action are in the National Suicide Prevention Strategy. The Strategy calls for community education campaigns, accurate and balanced media representation, professional development and training programs co-designed with people with lived experience and peer support activities.¹⁴

¹² National Mental Health Commission (2023) *Equally Well*, <https://www.mentalhealthcommission.gov.au/lived-experience/contributing-lives%2C-thriving-communities/equally-well>

¹³ National Mental Health Commission (2024) *National Stigma and Discrimination Reduction Strategy*, <https://www.mentalhealthcommission.gov.au/projects/stigma-and-discrimination-reduction-strategy>

¹⁴ National Mental Health Commission (2025) *National Suicide Prevention Strategy*, <https://www.mentalhealthcommission.gov.au/nspo/publications/national-suicide-prevention-strategy>