Inquiry

Final Review of the Mental Health and Suicide Prevention Agreement

An Australian College of Nursing and Australian College of Mental Health Nurses Joint Submission

Tracey Horsfall

Productivity Commission

Australian Government

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Email: mentalhealthreview@pc.gov.au

Dear Ms Horsfall,

Re: Final Review of the Mental Health and Suicide Prevention Agreement [2025]

The Australian College of Nursing (ACN) and the Australian College of Mental Health Nurses (ACMHN) thank the Productivity Commission for the opportunity to comment on the Final Review of the Mental Health and Suicide Prevention Agreement.

ACN and ACMHN are peak nursing bodies, supporting equity for all. Representing the nursing profession, we advocate for social models of healthcare that address the needs of individuals and communities, considering social, economic, and environmental factors. We advocate for access and health equity through evidence-informed, person-centred care across the lifespan.

ACN and ACMHN believe that there must be more accurate data reporting on mental health in Australia. Further, we believe that all healthcare professionals require a baseline level of mental health education to meet the needs of Australians. Mental health services in Australia are heavily burdened and need assistance. Nurse practitioners and credentialed mental health nurses (CMHN) can provide high-quality assistance to alleviate the burden if included in the Medicare Benefits Scheme (MBS). Additionally, we believe the missing middle is still not having their needs met, and a greater focus on social determinants of care and preventive care is necessary to reduce the currently unchanging rate of mental disorders and suicides. Our full submission is attached.

If you would like to discuss any aspect of this response, please contact policy@acn.edu.au

Yours sincerely,

Adjunct Professor Kathryn Zeitz, PhD FACN
Chief Executive Officer
Australian College of Nursing

12 March 2025

Adrian Armitage FGIA
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Australian College of Mental Health Nurses

12 March 2025

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Background

A multitude of biopsychosocial factors, such as adversity, hardship, affluence, nighttime shift work, stress, and social capital can cause mental disorders.[1] Mental disorders are a *"clinically significant disturbance in an individual's cognition, emotional regulation, or behaviour. It is usually associated with distress or impairment in important areas of functioning."*[2] Approximately 44% of Australians have experienced a mental health disorder in their lifetime, with a further 21.5% of people having had a mental disorder lasting at least 12 months.[3] These rates have remained unchanged since 2007, when the previous National Mental Health and Wellbeing Study was conducted in Australia.[4] Mental disorders are closely related to an increased risk of suicide.[5] In 2021, there were 2,398 male and 799 female suicides recorded in Australia.[6] In 2023, there were 2,419 male and 795 female suicides.[7] An increase of 0.008% and a decrease of 0.005%, respectively. First Nations people and 18- to 24-year-olds have the highest rates of suicide in Australia per 100,000 population.[8,9] Additionally, 16- to 24-year-olds experience mental disorders at a significantly higher rate than any other age bracket in Australia (*Appendix 1*).

In 2020-2022, 3.4 million Australians aged 16- to 85-years-old saw a health professional for their mental health.[10] Currently, there is no national definition of a 'mental health worker'; however, the workforce is generally divided into three interrelated sectors: specialists, generalists, and those with lived experience (*Appendix 2*).[11] As of 2023, 26,769 nurses work in mental health settings in Australia.[12] Of these, there are 895 formally recognised specialist CMHN.[13] This does not include post-graduate learning, such as Master's or graduate certificates/diplomas, in mental health, as this is not publicly reported or formally recognised.

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[1] Remes, O., Mendes, J. F., & Templeton, P. (2021). Biological, Psychological and Social Determinants of Depression: A Review of Recent Literature. *Brain Sciences, 11*(12), 1633. doi: 10.3390/brainsci11121633.

[2] World Health Organization. (2022). *Mental disorders*. WHO.

[3] Australian Institute of Health and Welfare. (2024). *Mental health: Overview*. Australian Government, AIHW.

[4] Australian Institute of Health and Welfare. (2024). *Mental health: Prevalence and impact of mental illness.* Australian Government, AIHW.

[5] Bradvik, L. (2018). Suicide Risk and Mental Disorders. *Environmental Research and Public Health, 15*(9). doi: 10.3390/ijerph15092028.

[6] Australian Institute of Health and Welfare. (2023). *Suicide & self-harm monitoring: Deaths by suicide over time*. Australian Government, AIHW.

[7] Ibid

[8] Australian Institute of Health and Welfare. (2022). *Suicide & self-harm monitoring: Deaths by suicide among First Nations people*. Australian Government, AIHW.

[9] Australian Institute of Health and Welfare. (2019). *Suicide & self-harm monitoring: LGBTIQ+ Australians – suicidal thoughts and behaviours and self-harm*. Australian Government, AIHW.

[10] Australian Bureau of Statistics. (2023). *National Study of Mental Health and Wellbeing.* ABS.

[11] Australian Institute of Health and Welfare. (2019). *Mental Health: Workforce*. Australian Government, AIHW.

[12] Department of Health and Aged Care. (2023). *Nurses & Midwives Dashboard.* Australian Government, DHAC.

[13] Australian College of Mental Health Nurses. (2025). *Find a Credentialed Mental Health Nurse.* ACMHN.

Recommendations

ACN and ACMHN recommend:

1. Contemporary reporting of comparable mental health data sets, including a number of nurses with postgraduate education in mental health.
2. Develop and provide a baseline level of mental health education for all healthcare professionals.
3. Grant nurse practitioners and credentialed mental health nurses MBS subsidies for preventive mental health care to improve service accessibility and address social determinants of health.
4. Focus resources on nationwide preventive strategies for the 'missing middle'.

Approach

In undertaking this response, ACN and ACMHN addressed the following terms of reference:

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

We will not be commenting on the other terms of reference as these are outside of our remit. Our submission highlights the unchanging mental disorders and suicide rates in Australia. We are concerned that the *National Mental Health and Suicide Prevention Agreement* (National Agreement) and associated *National Mental Health Workforce Strategy,* whilst being well written with good intentions, have not yet made a profound impact on mental disorder and suicide rates in Australia. We believe there is a need for nationally consistent data collection and approaches to reducing mental disorders. Additionally, we emphasise the underutilisation of nurses and holistic preventive care.

b. the effectiveness of reforms to achieve the objectives and outcomes of the National Agreement including across different communities and populations

The National Agreement set out to nationally, in conjunction with state and territory governments, improve the mental health of all Australians, reduce the rate of suicide towards zero, and improve the Australian mental health and suicide prevention system. All jurisdictions signed and agreed to these goals in 2022. Since 2022, many reforms have been to combat mental health issues in Australia, including addressing workforce shortages, the *Mental Health Reform Advisory Committee, Vision 2030*, and the additions of Medicare Urgent Care Clinics across Australia. However, there has been minimal improvement in mental disorders and suicide rates.

ACN and ACMHN stress that clear data collection and reporting is necessary to understand and implement strategies to reduce mental disorder and suicide rates in Australia. Before 2022, the previous National Mental

Health and Wellbeing Studies were conducted in 2007 and 1997.[14,15] More timely reviews are needed for this large contemporary healthcare issue. The 2022 study was designed to be broadly comparable to the 2007 study, however only mental disorder prevalence can be compared due to variations in data collection:

> *"Many of the non-diagnostic topics and the order in which they were collected in 2020-2022 differs from that in 2007. Some topics collected in 2007 were removed and new topics were added. Other topics changed significantly between 2020-2022 and 2007... Data for non-diagnostic topics may not be comparable between 2020-2022 and 2007."*[16]

ACN and ACMHN believe that workforce data must also be indicative of the level of healthcare services available to Australians and any gaps in the system. Whilst it is currently estimated that there will be an undersupply of 1,918 FTE nurses in the mental health sector by 2035, this figure has been recently reviewed following PHN and sector feedback, and revised estimates note that the figure is closer to 10,000.[17] As of 2023, 26,769 nurses work in mental health settings in Australia.[18] There are estimates of 10,707 Registered Nurses working in the mental health sector with some form of tertiary training; however, these figures are based on unverified surveys conducted across the nursing sector by ACMHN. There are 895 nurses with formally recognised credentials in mental health nursing.[19] It is necessary to collect and report data on how many nurses have postgraduate education in mental health care to inform national strategies better to reduce mental disorders and suicide rates. Additionally, data must be contemporarily reviewed and comparable to ensure that future projections are accurate and that any associated preventive implementations are effective.

c. the opportunities under the National Agreement to adopt best practice approaches across Australia, particularly where productivity improvements could be achieved

ACN and ACMHN believe that promoting mental health nurses and nurse practitioners' roles and responsibilities will greatly reduce costs while significantly improving access to high-quality healthcare services. In late 2025 a new endorsement will allow appropriately educated nurses to prescribe schedule 2, 3, 4 and 8 medicines in partnership with authorised health practitioners.[20] Additionally, the *Unleashing the Potential of our Health Workforce – Scope of Practice Review* has recommended that remote area nurses be granted the ability to refer to medical specialists and nurse practitioners granted the ability to refer directly to psychiatrists.[21]

ACN and ACMHN believe that all nurses should have a baseline level of education in mental health. This includes the ability to identify and escalate concerns about a person's mental health or substance use. The *Mental Health Nurse Incentive Program* (MHNIP), established in 2007, was found to have overwhelmingly positive clinical outcomes and hospital savings of $2,600 per patient per annum.[22] It is noted that the positive outcomes are likely attributable to the fact that the nurses in the program were CMHNs with extensive experience in mental health care. ACN and ACMHN believe that CMHNs are a strong asset in our mental health

[14] Australian Institute of Health and Welfare. (2024). *Mental health: Prevalence and impact of mental illness*. Australian Government, AIHW.
[15] Australian Bureau of Statistics. (2023). *National Study of Mental Health and Wellbeing*. ABS.
[16] Australian Bureau of Statistics. (2023). *National Study of Mental Health and Wellbeing methodology*. ABS.
[17] Department of Health and Aged Care. (2024). *Nursing Supply and Demand Study*. Australian Government, DHAC.
[18] Department of Health and Aged Care. (2023). *Nurses & Midwives Dashboard*. Australian Government, DHAC.
[19] Australian College of Mental Health Nurses. (2025). *Find a Credentialed Mental Health Nurse*. ACMHN.
[20] Ahpra & National Boards. (2024). *Expanded role for registered nurses to improve access to safe and timely healthcare*. Ahpra & National Boards.
[21] Department of Health and Aged Care. (2024). *Unleashing the Potential of our Health Workforce – Scope of Practice Review*. Australian Government, DHAC.
[22] Australian College of Mental Health Nurses. (2016). *Mental Health Nursing Services in Australia: A How to Guide for Primary Health Networks*. ACMHN.

workforce; however, as approximately one in two people in Australia present to healthcare services with a mental health condition, it is vital that all nurses have a baseline education in mental healthcare.[23]

ACN and ACMHN believe that a clear strategy concentrating on holistic care and social determinants of health is needed to reduce mental disorders and suicide rates in Australia. Nurses are uniquely positioned across the healthcare sector to lead the delivery of socialised models of healthcare, particularly in rural and remote areas and through nurse-led services.[24] Psychiatric patients have significantly increased risks of metabolic syndrome and associated premature mortality.[25] Metabolic syndrome is a group of risk factors, such as obesity, insulin resistance, hypertension, and dyslipidaemia, that increase the likelihood of developing cardiovascular diseases, type II diabetes, or having a stroke.[26] Metabolic syndrome in psychiatric patients is often due to a variety of interrelated factors such as an unhealthy lifestyle, psychotropic medication, genetics, and poor health management.[27] Management of metabolic syndrome relies on holistic care that addresses social determinants of health rather than just the presenting medical problem.[28] The 2024-2025 Australian Government budget has started to address holistic care by implementing Urgent Care Clinics and funding for primary health mental health nurses to support patients with complex needs between specialist appointments.[29]

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

The National Agreement does not empower healthcare practitioners working in large institutions to provide high-quality care. Nurses educated in mental health have the capability to provide comprehensive cognitive behavioural therapy (CBT) and dialectical behaviour therapy (DBT), which, in turn, is associated with positive clinical outcomes.[30,31] However, Australian nurses are largely unable to perform these psychological therapies on patients due to institutional restrictions to their scope of practice and the institution's reluctance to support education.[32]

ACN and ACMHN commend the National Agreement for developing and implementing the *Head to Health* program and Medicare Mental Health Centres nationwide. However, to improve access and effectiveness of mental health care in Australia, nurse practitioners and CMHNs must be provided MBS funding for mental health services. Currently, a medical practitioner (with or without mental health skills training) can create a mental health treatment plan for a patient covered by the MBS.[33] A nurse practitioner, even with education and

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[23] Australian Institute of Health and Welfare. (2024). *Mental health: Overview*. Australian Government, AIHW.

[24] Australian College of Nursing. *Achieving a Socialised Model of Healthcare in Australia with Nurse Leadership* [White paper]. ACN.

[25] Penninx, B. W. J. H., & Lange, S. M. M. (2018). Metabolic syndrome in psychiatric patients: overview, mechanisms, and implications. *Dialogues in Clinical Neuroscience, 20*(1), 63-73. doi: 10.31887/DCNS.2018.20.1/bpenninx

[26] Swarup, S., Ahmed, I., Grigorova, Y., & Zeltser, R. (2024). *Metabolic Syndrome*. Statpearls.

[27] Penninx, B. W. J. H., & Lange, S. M. M. (2018). Metabolic syndrome in psychiatric patients: overview, mechanisms, and implications. *Dialogues in Clinical Neuroscience, 20*(1), 63-73. doi: 10.31887/DCNS.2018.20.1/bpenninx

[28] Swarup, S., Ahmed, I., Grigorova, Y., & Zeltser, R. (2024). *Metabolic Syndrome*. Statpearls.

[29] The Hon Mark Butler MP. (2024). *Budget 2024-25: Cheaper medicines, new Medicare Urgent Care Clinics and more free mental health services in a stronger Medicare* [Media release]. DHAC, Minister Butler's media.

[30] Yoshinaga, N., Obara, Y., Kawano, N., Kondo, K., Hayashi, Y., Nakai, M., Takeda, R., & Tanoue, H. (2024). Real-World Effectiveness and Predictors of Nurse-Led Individual Cognitive Behavioural Therapy for Mental Disorders: An Updated Pragmatic Retrospective Cohort Study. *Behavioural Sciences, 14*(7), 604. doi: 10.3390/bs14070604.

[31] May, J. M., Richardi, T. M., & Barth, K. S. (2016). Dialectical behaviour therapy as treatment for borderline personality disorder. *The Mental Health Clinician, 6*(2), 62-67. doi: 10.9740/mhc.2016.03.62.

[32] Fisher, J. E. (2014). The use of psychological therapies by mental health nurses in Australia. *Journal of Psychiatric and Mental Health Nursing, 21*(3), 264-270. doi: 10.1111/jpm.12079.

[33] Department of Health and Aged Care. (2025). *Medicare Benefits Schedule – Item 2715*. Australian Government, DHAC.

experience in mental health, cannot receive MBS funding to create a mental health treatment plan for a patient.[34]

ACN and ACMHN support the following recommendations, which were put forward in previous submissions to Senate Select Committees on Mental Health:

- Enable nurse practitioners (with mental health scope of practice) and CMHN claim under MBS items falling under 'Better Access', which "provides better access to mental health practitioners through Medicare". Better Access item numbers can be claimed by psychiatrists, psychologists, occupational therapists and social workers. However, highly skilled and qualified mental health nurses are currently excluded, which limits consumer access to specialist mental health treatment.
- Reform the fee-for-service funding model to support better the ongoing, multidisciplinary care people with chronic illness and mental illness require.

A recent study has found significant wait times for psychiatric services across Australia despite the introduction of telehealth appointments.[35] Quantity and access to services must be improved to meet the health needs of Australians. Enabling nurse practitioners to receive MBS funding to provide mental health services in person and through telehealth would greatly assist with addressing wait times in Australia. The 2013 Senate Inquiry into ADHD indicated a better care model where nurse practitioners working alongside GPs and Psychiatrists would be able to provide the diagnostic and prescription services, with all three professional groups supported by CMHNs undertaking initial assessments, verifying these with reference to one of the three diagnostic clinicians, and the patient then referring back to ongoing clinical mental health nurse care.[36]

e. whether any unintended consequences have occurred such as cost shifting, inefficiencies or adverse consumer outcomes

ACN and ACMHN believe that support for those who legitimately need it fails to be provided due to gaps in Australia's healthcare system. This was referred to as the 'missing middle' in the 2019 Productivity Commission Inquiry into mental health.[37] The missing middle are people who require specialised care greater than primary health care but who do not meet eligibility for higher-intensity care.[38] The Commonwealth funds national programs such as Headspace and addresses low-level mental health care. State-level funding will often be distributed among acute services such as mental health hospital wards. This results in an unintended cost-shifting on two fronts. The first adversely affects consumers as people in the missing middle can only receive adequate care if they can pay large sums of money for privatised care. The second is a consequence of the people in the missing middle not being able to afford such care. When unable to pay and receive the specialised care that they need, people in the missing middle will deteriorate and be forced to turn to higher-intensity care services such as hospitals. Thus significantly increasing the amount of expenditure required to solve the initial problem and falsely validating the need for large amounts of funding for high-level services.

ACN and ACMHN believe nurses are well positioned throughout Australia with the necessary skills to address the missing middle. Some examples of how nurses can address the missing middle can be found below:

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[34] Department of Health and Aged Care. (2025). *Medicare Benefits Schedule – Item 2715*. Australian Government, DHAC.
[35] Yang, O., & Zhang, Y. (2025). Wait Times for Psychiatric Specialist Services in Australia. *JAMA Network Open, 8*(2), e2461947. doi: 10.1001/jamanetworkopen.2024.61947.
[36] Community Affairs References Committee. (2023). *Assessment and support services for people with ADHD*. Commonwealth of Australia, The Senate, Community Affairs References Committee.
[37] Productivity Commission. (2020). *Mental Health: Productivity Commission Inquiry Report Volume 1*. Australian Government, PC.
[38] Menssink, J. M., Gao, C. X., Zbukvic, I., Prober, S., Kakkos, A., Watson, A., Cotton, S. M., & Filia, K. M. (2024). The missing middle service gap: Obtaining a consensus definition of the 'Missing Middle' in youth mental health. *Australian & New Zealand Journal of Psychiatry, 59*(2), 152-161. doi: 10.1177/00048674241299221.

School youth health nurses – Canberra has a school youth health nurse program promoting positive health outcomes for young people and their families. Employed at ACT Government high schools, these nurses focus on holistic care for the health and social issues that young people and their families face.[39] They often identify and manage young people with challenging mental and sexual health problems.

Maternal and child health nurses – Across Australia, maternal and child health nurses facilitate knowledge sharing and provide insight into infant mental health for parents.[40] These nurses also provide strong psychosocial support to expectant parents and often have education in perinatal depression and anxiety screening.[41]

Another issue is reductions in funding for programs servicing the missing middle. For example, transitional state-based programs such as the *Mental Health Accommodation Pathways at Discharge* (MHAPD) offer short-term accommodation, provide follow-up care, and assist with social supports such as stable work and housing. Without transitional programs, hospitals may unintentionally discharge mental health patients into homelessness, consequently leading to poorer mental health.[42] There is currently national funding for the highly effective *Transition Care Programme,* which helps older people recover after a hospital stay by providing short-term care for up to 12 weeks.[43] Implementing mental health programs similar to the *Transition Care Programme* would greatly improve patient flow and patient outcomes.

ACN and ACMHN advocate for preventive health that addresses a person's holistic health and well-being. Australia spends considerably less on preventive care than similar OECD countries such as Canada, the United Kingdom, and New Zealand.[44] Consequently, as treatment is more expensive than prevention, Australia spends more per person on healthcare than the OECD median expenditure.[45,46] We believe that focusing on funding and interventions for the missing middle will reduce the overall costs of mental health services and promote mental health outcomes for all Australians.

[39] Canberra Health Services. (n.d.). *School Health Service*. ACT Government, CHS.

[40] Stevens, H., Sheeran, L., & Buist, A. (2024). How do maternal and child health nurses incorporate infant mental health promotion into their clinical practice? Experiences of an Australian municipality. *Infant Mental Health Journal, 45*(2), 217-233. doi: 10.1002/imhj.22103.

[41] Centre of Perinatal Excellence. (2025). *Perinatal Mental Health Guideline: Summary for mental health nurses*. COPE.

[42] Australian Housing and Urban Research Institute. (2018). *Housing, homelessness and mental health: towards systems change*. National Mental Health Commission, AHURi.

[43] Department of Health and Aged Care. (2025). *Transition Care Programme*. Australian Government, DHAC.

[44] Jackson, H., & Shiell, A. (2017). *Preventive health: How much does Australia spend and is it enough?* Department of Public Health, La Trobe University and the Australian Prevention Partnership Centre.

[45] Department of Health and Aged Care. (2021). *National Preventive Health Strategy*. Australian Government, DHAC.

[46] Australian Institute of Health and Welfare. (2019). *Australia's health expenditure: an international comparison*. Australian Government, AIHW.

Appendix

Appendix 1 – Mental Disorders by Age Bracket Australia

Age Bracket	Percentage With a Mental Disorder
16-24	**38%**
25-34	**27%**
35-44	**20%**
45-54	**20%**
55-64	**16%**
65-74	**10%**
75-85	**4%**

Data retrieved from [Australian Bureau of Statistics. (2023). *National Study of Mental Health and Wellbeing.* ABS.]

Appendix 2 – Mental Health Worker Sectors

Sector	Included Roles
Specialist Workers	Psychiatrists Credentialed Mental Health Nurses Psychologists Mental Health Occupational Therapists Accredited Mental Health Social Workers
Generalist Workers	Professionals who engage in mental health-related work or with people experiencing mental illness but who may not have specialist training in mental health. This includes administrative and research roles.
Lived Experience Workers	Also called peer workers are people who have experienced mental illness or cared for someone who has and can bring valuable insight into the caring experience.

Data retrieved from [Australian Institute of Health and Welfare. (2024). *Mental Health: Workforce.* Australian Government, AIHW.]

About ACN

The Australian College of Nursing is the peak professional body and leader of the nursing profession. We are a for-purpose organisation committed to our Shaping Health and Advancing Nursing mission.

We support nurses to uphold the highest possible standards of integrity, clinical expertise, ethical conduct, and professionalism through our six pillars of Education, Leadership, Community, Social Impact, Advocacy and Policy.

We are the Australian member of the International Council of Nurses headquartered in Geneva in collaboration with the Australian Nursing and Midwifery Federation (ANMF).

About ACMHN

Australian College of Mental Health Nurses (ACMHN) is the voice of Australia's mental health nursing profession. The College is the peak professional mental health nursing organisation and the recognised credentialing body for Australia's 25,000 mental health nurses. We represent mental health nurses across all levels of government and health service sectors.

ACMHN is the peak advisory body representing nurses on 12 national and State advisory groups, and global advisory councils with ICN, WHO and other European, Asian and North American councils. We are a founding member of the Nursing and Midwifery Health Program (Vic) and also the national body; we helped found the Mental Health Professional Network, a Federal funded body, and we sit as a member of Mental Health Australia and several other State and Territory mental health organisations including Equally Well Australia, Black Dog, and many more.

As an accreditation body, we have 8 of the 10 mental health nursing universities currently accredited with our College on their post-graduate and undergraduate mental health nursing courses.

Working with ACN and ACM, our College has jointly renewed the latest Clinical Supervision code, and recommendations for national implementation.