National Mental Health Consumer & Carer Forum

National Mental Health Consumer and Carer Forum (NMHCCF) Submission to the

Productivity Commission (PC) on the

National Mental Health and Suicide Prevention Agreement Review (the Review of the NMHSPA)

26 March 2025
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The National Mental Health Consumer and Carer Forum (NMHCCF) is pleased to provide the following submission to the Productivity Commission (PC) relating to its Review of the National Mental Health and Suicide Prevention Agreement (NMHSPA).

The NMHCCF is a combined national voice for mental health consumers and carers. We listen, learn, influence and advocate in matters of mental health reform.

The NMHCCF was established in 2002 by the Australian Health Ministers' Advisory Council. It has historically been funded through contributions from each state and territory government, which have now been amalgamated and are afforded by the Australian Government Department of Health and Aged Care. It is currently auspiced by Mental Health Australia.

NMHCCF members represent mental health consumers and carers on many national bodies, such as government committees and advisory groups, professional bodies, and other consultative forums and events.

Members use their lived experience, understanding of the mental health system and communication skills to advocate and promote the issues and concerns of consumers and carers.

The NMHCCF has chosen to respond to this submission opportunity as Australia's national combined voice representing lived and living experience of mental ill-health and their family, supporters, carers, and kin. The NMHCCF is also the Disability Representative and Carer Organisation (DRCO) for psychosocial disability in Australia.

We would be happy to provide any further information to support the issues raised in this submission. Please contact the NMHCCF via the Secretariat at nmhccf@mhaustralia.org or 02 6285 3100.

Yours sincerely,

Peter Heggie
Carer Co-Chair

Jordan Frith
Consumer Co-Chair

National Mental Health Consumer & Carer Forum

Introduction

This submission reflects the insights gathered from two consultations held by the NMHCCF regarding the effectiveness of the NMHSPA in its current form. These consultations identified significant structural and systemic issues, including poor lived experience involvement, funding inequities, service fragmentation, and the neglect of social determinants of mental health and suicide prevention. Furthermore, there are inadequate community-based supports, workforce challenges, system-led divisions creating care gaps, and not enough funding going towards peer-led emergency department alternatives.

To ensure the next iteration of the NMHSPA leads to meaningful improvements, this submission focuses on two key asks:

1. Lived Experience-designed non-clinical supports in the community and the embedding of Lived Experience at all levels:
    a. Lived Experience must be embedded at all levels of mental health and suicide prevention governance, from system design to service evaluation and funding allocation.
    b. The system should move beyond clinical responses and invest in non-clinical, community-led mental health support services.
    c. Governance structures must include Lived Experience Leadership to ensure services reflect the real needs of individuals accessing them.
    d. Current funding models prioritise clinical interventions over preventative and community-based solutions. This must be rectified.
    e. Services are only successful and meaningful if they can address the recovery outcomes identified by Lived Experience, underpinned by a set of principles (please see the following submission for a set of Lived Experience psychosocial service principles: Mental Health Australia and the NMHCCF: Advice to Governments on Evidence-Informed and Good Practice Psychosocial Services (NMHCCF, 2024). Current Commonwealth-led outcomes in the NMHSPA are not fit-for-purpose.

> *"Because of the initial failure to create an appropriate environment for lived experience design and decision-making, what we ended up with was not fit for purpose."* – Consumer Representative

2. Community-identified solutions to community-identified problems:
    a. Mental health and suicide prevention policy must prioritise local, community-driven solutions that reflect the needs of the people they serve.
    b. Addressing social determinants such as housing, employment, and financial security is essential for improving mental health and suicide prevention outcomes (please see the NMHCCF's submission on Foundational Supports for more information on addressing basic needs: NMHCCF Submission on Foundational Supports (NMHCCF, 2025c)).

c. Lived experience governance structures must be integrated into decision-making processes to ensure policies and service outcomes herald lived experience values and principles.
d. The artificial divide between mental health and suicide prevention must be eliminated in favour of a holistic, integrated approach.

> *"Lived experience communities are not involved in a meaningful way in the commissioning cycles for these services, in the evaluation cycles for these services. You might see a Community Advisory Group consulted on one thing or particular people sitting on selection panels, but fundamentally, our communities are under-resourced and not empowered to call out ineffective or poor behaviour on behalf of governing bodies."* – Consumer Representative

Implementing these two requests would require upending the National Agreement in its current form and governments and services taking a radically different approach from what they are used to. Though not simple, if well-implemented these asks would result in a more effective mental health and suicide prevention system that achieves the outlined objectives of the NMHSPA.

Background

The Productivity Commission (PC) has been asked to undertake a final review of the current National Mental Health and Suicide Prevention Agreement by the Australian Government.

The Agreement establishes a reform framework of Australia's mental health and suicide prevention system, through identifying priority action areas, enabling a whole-of-government approach to services, making several data improvements, and promoting consistent evaluation. In addition, the Agreement sets out the differing roles and responsibilities of the Australian, state, and territory governments through a series of bilateral agreements in relation to the mental health and suicide prevention system.

> "*Signed in 2022, the Agreement articulates a national vision for a people-centred, integrated, and sustainable mental health and suicide prevention system. The Agreement outlines how the Australian, state, and territory governments will work together to make sure the mental health and suicide prevention system embeds lived experience in the design, planning, delivery, and evaluation of services, and is able to improve the wellbeing of all Australians and reduce the rate of suicide in Australia"* (Productivity Commission, 2025, p. 4).

The above text, outlined in the Productivity Commission's call for submissions, restates the primary objectives of the Agreement, namely:

- Creating a people-centred, integrated, and sustainable mental health and suicide prevention system.
- All of government working together to embed lived experience in the design, planning, delivery, and evaluation of services.

- Improving the wellbeing of all Australians.
- Reducing the rate of suicide in Australia.

Since the implementation of the Agreement, it is too early to tell if the latter two objectives have been met, as publicly available data is either not yet available or in their preliminary stage. We do know, however, through extensive consultation with lived experience representatives across all states and territories, that the first two objectives have not been met. The Lived Experience community states that it has in no meaningful way been embedded in the design, planning, delivery, and evaluation of services, and the system itself is not people-centred, integrated, or sustainable (NMHCCF, 2025a & b).

> *"The Agreement was never really going to be effective because there was not really sufficient community oversight of the implementation governance of the schemes that were rolled out under the agreement."* – Consumer Representative
>
> *"We weren't involved as the first port of call. We are doing the same old, because how many inquiries and consultations have happened in the past? But in 2025 we're at a point where we still have issues in the sector that are so significantly unresolved, so what can we do differently?"* — Carer Representative
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> *"If we want to get it right, lived experience needs to have actual authority over what is delivered, how it's delivered, where it's delivered, and whether it's meeting outcomes."* — Consumer Representative
>
> *"The main issues with the Agreement are:*
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> - *There is no evidence that the service models that were rapidly established do anything to meet community need.*
> - *There are no consumer- or community-identified measures when evaluating the effectiveness of these types of services.*
> - *And there's no real way to even understand if the Agreement is progressing in any direction that the lived experience community cares about."* – Consumer Representative
>
> *"Right now, we don't have any accountability mechanisms. We are relying on government to self-report on whether or not they're doing a good job, and that's never going to work."* — Consumer Representative

Lived experience groups argue for an overhaul in the Australian Government's top-down approach and traditional ways of thinking. People with lived experience seek to work with the Australian Government in co-producing and co-designing the national mental health and suicide prevention system. This would, however, require sharing power and prioritising the voices of lived experience to identify the principles, values, objectives, outputs, and outcomes of a new Agreement. The NMHCCF refers the Australian Government to its advocacy brief for a better understanding of true co-design and co-production: Co-Design and Co-Production (NMHCCF, 2021).

Themes as Provided by the NMHCCF

1. Limited lived experience leadership and governance:
   - The Agreement was developed without meaningful consultation with lived experience communities, leading to ineffective service models and governance structures.
   - There is a need for lived experience involvement beyond advisory roles, ensuring direct participation in decision-making and funding allocation.
   - Lived experience leadership must be embedded in system governance to prevent policies from being shaped solely through a clinical lens.

> *"The Agreement was designed without adequate consultation from lived experience communities, leading to ineffective service models and governance mechanisms."* – Carer Representative

2. Inequitable access to services:
   - Significant disparities exist across states and territories, particularly in rural and remote communities where access to mental health and suicide prevention care remains severely limited.
   - The current funding model disproportionately benefits urban areas, while regional communities lack adequate resources.
   - Community-led, place-based models should be prioritised to address these disparities.

Spotlight: A Community-Developed Outreach Program

ACDC (Assisting Communities through Direct Connection) is a program which reaches out to households across Australia to have a meaningful conversation about their mental health and wellbeing. Information on mental health support services with tailored information is provided to householders, as well as their friends, families, and the wider community (CMHA, n.d.).

This program goes to the heart of addressing unmet need by "going to the people", rather than waiting for people to arrive at a mental health service further down the line. There are many people who will not walk through the doors of a mental health service for many reasons and crisis response is far too late.

The ACDC program is an example of connecting on the person's terms, where they are.

For more information visit: About The ACDC Project - ACDC

3. Fragmentation of services and system failures:
   - The disconnect between Commonwealth and state-/territory-level responsibilities results in inconsistent service delivery and unmet needs.
   - Jurisdictional siloes contribute to inefficient resource allocation, making it difficult for people to navigate available services.
   - The bilateral agreements must ensure better integration of funding and accountability across all levels of government.

> *"The structure of the current Agreement just beds in all of those gaps and fractures and differences because of the Bilateral Agreements. We need a newly structured agreement that drives transformation and integration, and the current structure doesn't."* – Carer Representative

4. Failure to address social determinants of mental health and suicide:
   - Mental health and suicide prevention services remain siloed, neglecting critical social determinants such as housing, financial insecurity, and community support.
   - Without addressing these factors, mental health and suicide prevention interventions risk being short-term crisis responses rather than sustainable solutions.
   - Greater investment in cross-sector collaboration is necessary to support holistic mental wellbeing.
   - See the NMHCCF's submission on Foundational Supports for more information on defining and addressing basic needs: NMHCCF Submission on Foundational Supports (NMHCCF, 2025c)).

5. Inadequate community-based and preventative supports:
   - The system remains overly focused on crisis and clinical services rather than prevention and early intervention.
   - Certain initiatives, such as free mental health first aid training and emotional CPR, are underfunded despite their demonstrated effectiveness.
   - More flexible, community-driven services are needed to provide preventative and non-clinical support.

> *"Every time they fail to implement real lived experience involvement at the beginning, we end up with service models that do things to people rather than work with them."* — Consumer Representative
>
> *"We don't have any mechanisms for determining on the ground what the needs are — it's always filtered through a clinical gaze."* — Carer Representative

6. Workforce challenges:
   - There is a critical shortage of trained professionals, particularly those with lived experience, within the mental health workforce.
   - GPs and frontline workers often lack adequate training to provide trauma-informed and recovery-oriented care.
   - Increased funding and support are needed for workforce development, including the integration of peer workers in clinical settings.
   - There is inequity in the development of the lived experience workforce, which leads to inequity in service delivery between the states and territories.

7. Concerns about the NDIS and mental health care gaps:
   - Individuals with NDIS packages are frequently discharged from community mental health services, creating additional service gaps.
   - The system must ensure continuity of care rather than shifting responsibility between service providers without accountability.

- Policy clarity is required to prevent people from falling through the cracks of service eligibility criteria.

8. Division between suicide prevention and mental health:
   - The artificial separation of suicide prevention and mental health services leads to inefficiencies and missed opportunities for holistic care.
   - Suicide prevention should not be viewed in isolation, as most cases involve underlying mental health concerns.
   - A more integrated approach is needed to address these overlapping issues effectively.

9. Underfunding of alternatives to emergency departments:
   - Safe Havens and similar crisis alternatives remain underfunded and often operate with limited hours, making them inaccessible when most needed.
   - These initiatives must be adequately funded to ensure 24/7 availability and effective peer-led crisis intervention.
   - Expanding crisis alternatives can reduce pressure on hospital emergency departments and provide a more compassionate response to distress.

Two Key Asks and Recommendations

1. Lived Experience-Designed Non-Clinical Supports in the Community and the Embedding of Lived Experience at All Levels.

Lived Experience-led recommendations for the new NMHSPA:

1. Establish formal mechanisms for lived experience governance at all levels, ensuring direct influence on policy, funding, system and service design, and evaluation.
2. Implement Lived Experience Oversight Bodies to evaluate program effectiveness and accountability.
3. Increase funding for community-based and non-clinical mental health initiatives, including peer-led programs and mental health first aid training.
4. 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.
5. Expand access to preventative supports, ensuring community-based services are designed to intervene before individuals reach crisis points (e.g. see the Alt2Su program: Alt2Su – NSW (Alt2Su, 2025)).
6. Implement national training standards for GPs, emergency services, and mental health professionals, incorporating lived experience insights.
7. Increase funding for the recruitment and retention of peer workers, ensuring they are recognised and valued within the system.
8. Commitment from the states and territories under the new NMHSPA to work with the Lived Experience Workforce Association when it is in future operation, which will require funding through the Agreement.

> *"We should be talking about lived experience governance, not just leadership. We must be involved in governance so that when decisions are made, they are designed from first principles — what actually works for people with lived experience."* — Carer Representative
>
> *"What does good look like? It's lived experience-led systems, not just services, from the conceptualisation stage through to evaluation."* — Carer Representative

2. Call for Community-Identified Solutions to Community-Identified Problems

Lived Experience-led recommendations for the new NMHSPA:

1. Develop targeted funding strategies to improve access to mental health care and suicide prevention in rural and remote areas.
2. Prioritise place-based models that empower communities to design and deliver solutions that meet their specific needs.
3. Establish clear accountability mechanisms for service effectiveness, ensuring transparency in decision-making.
4. Strengthen coordination between Commonwealth and state/territory governments to reduce fragmentation and duplication of services.
5. Integrate the mental health and suicide prevention system with housing, employment, and social support systems to address broader determinants of wellbeing.
6. Prevent individuals from being discharged from community mental health and suicide prevention services solely due to NDIS eligibility.
7. Develop policies ensuring continuity of care for those transitioning between mental health and disability support services.
8. Recognise the significant overlap between suicide prevention and mental health, ensuring funding and services that reflect this reality.
9. Allocate adequate resources to ensure localised crisis alternatives (e.g. NSW Safe Havens) are available 24/7.
10. Expand peer-led crisis services as a compassionate alternative to hospital-based emergency care.

Spotlight: Community-Led Suicide Prevention

CORES (Community Response to Eliminating Suicide) is a community-driven suicide prevention education program developed in a regional part of Tasmania with previously high rates of suicide.

It was started in 2003, developed by the community and people with lived experience. It aims for a "zero suicide rate" by training a cross-section of over 100 community members to increase the chances of early intervention and prevention. In the first two years, there were no suicides and nine known preventions.

CORES is an award-winning program at both a national and state level, and now also deliver courses on Self-care and Mental Wellbeing, LGBTQIA+ Inclusive Practice, and Professional Development programs. CORES networks have now also been established in South Australia, New South Wales, and Victoria (CORES, n.d.).

For more information visit: CORES Program | Kentish Regional Clinic

Conclusion

The NMHSPA, in its current form, does not adequately address the needs of the communities it aims to serve. Without meaningful lived experience leadership, an integrated whole-of-government approach, and a commitment to addressing the social determinants of mental health, the Agreement risks perpetuating the same systemic failures.

This submission calls for a radical shift towards community-driven, flexible, and accountable mental health systems that prioritise prevention, equity, and lived experience expertise. It calls for government to truly embed lived experience in the planning, design, delivery, and evaluation of both systems and services.

We urge the Productivity Commission to implement these recommendations to ensure the next iteration of the NMHSPA delivers real systems change with lasting improvements for individuals, families, and communities across Australia.

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