

Productivity Commission Final Review of the National Mental Health and Suicide Prevention Agreement Submission

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Community Mental Health Australia (CMHA) is the federated peak body representing the community-managed mental health sector across Australia's states and territories. We advocate for the needs of individuals with mental health challenges, ensuring they receive support at home and in their communities.

CMHA provides a unified voice for over 700 community-based, non-government organisations that work with tens of thousands of mental health consumers, families, and carers. The sector is a vital part of civil society, emphasizing accessibility, prevention, early intervention, and holistic approaches to mental well-being.

These organisations also address the social determinants of health, offering a wide range of practical supports to enhance recovery and resilience.

Community Managed Organisations (CMOs) are a cornerstone of this sector, with many founded by people with lived experience. CMOs play a critical role in expanding the peer workforce and fostering recovery-oriented services. CMHA provides leadership and advocacy to highlight the importance of community mental health and psychosocial support, ensuring its benefits are recognized and valued nationwide.

CMHA sincerely thanks our member state and territory community mental health peaks for their expertise and contribution to this submission. These peak representative bodies comprise state community mental health organisations, lived experience advocates from diverse perspectives-LGBTIQ+, First Nation Peoples and culturally and linguistically diverse groups most affected by the withdrawal of community supports at the intersections of cultural identity and disability.

We thank and acknowledge the custodians of this land, the Aboriginal and Torres Strait Islander people of the many traditional nations and language groups throughout Australia. We acknowledge the wisdom of their Elders past and present and pay our respect to the Aboriginal and Torres Strait Islander communities whose land was never ceded.

CMHA particularly thanks Gaya Dhuwi for generously sharing their thinking and priorities as part of the process of drafting this submission. CMHA notes their messaging and recommendations particularly relating to the Closing the Gap policies and structures and leveraging and reinforcing them through the National Agreement. CMHA's recommendation related to First Nations peoples is guided by Gaya Dhuwi's priorities.

Furthermore, CMHA expects that as the Productivity Commission moves past the Interim review stage, some of the language and conceptualisations framing and introducing the review relating to 'mental illness' is reframed to include distress, rights and Social and Emotional Wellbeing to ensure the next National Agreement does not repeat the grave mistake of the current Agreement of excluding Lived Experience and First Nations participation, perspectives and understandings from the process of consideration, drafting and implementation.

Introduction

CMHA welcomes the opportunity to provide feedback to the Productivity Commission Review of the Mental Health and Suicide Prevention Agreement (Agreement). CMHA notes this is the first time Lived Experience Peak Bodies (National Mental Health Consumer Alliance and Mental Health Australia) have been established to provide long overdue Lived Experience advice into the current Agreement, and CMHA's recommendations should be read in conjunction with both these organisation's submissions. Since the initiation of the Agreement, there has been little progress in achieving the normative objectives of the Agreement in relation to reform. Rather, the Agreement has further entrenched overmedicalized, rights-breaching and social determinants-blind models ill-fitted for mental health in the real world:

Additionally, seven key international Australian and international landmark developments have occurred demanding urgent transformation of outdated system and services models that have proved to be incapable of transforming themselves:

1. 2017-2022: UN Human Rights Council Special Resolutions

Special Resolutions adopted by the UN Human Rights Council following the Special Rapporteur's landmark report on mental health in 2017, including the most recent Human Rights Council resolution on mental health, A/HRC/RES/52/12. These reports explicitly and repeatedly called for a move away from a medical model to a rights-based social model of mental health.

2. 2021: World Health Organisation (WHO) Guidance on Community Mental Health Services: Promoting person-centred and rights-based approaches

3. 2023: World Health Organisation (WHO) / OHCHR Mental health, human rights and legislation: Guidance and Practice

4. 2025: World Health Organization (WHO) Guidance on Mental Health Policy and Strategic Action Plans

These documents collectively call for "urgent transformation of mental health policies" for systems that "fail to meet international human rights standards"

5. 2023: UN General Assembly Resolution

Australia co-sponsored the following resolution to the UN General Assembly 'Mental Health and psychosocial support for sustainable development and peace.'

This is the first resolution to address mental health adopted by the UN General Assembly and several of the Explanation of Position statements are worth including in this introduction to highlight the scale of transformation required if future PHN's are to meet the will and preference of people experiencing psychosocial distress and disability.

"For decades, an insufficient amount of attention has been devoted to mental health and psychosocial support services and systems. Too often, efforts have been centred around a medical model of disability, resulting in the dominance of approaches that favour biomedical intervention, medicalization, and institutionalization."

“We appreciate that this important resolution embraces this (inclusive) approach and rejects an outdated model that sees psychosocial disabilities as a problem that should be clinically defined and treated – a model that we have seen can lead to grave human rights violations.”

“We therefore call on all Member States to take this resolution forward through community-, evidence- and human rights-based services and support that respect, protect, and fulfill the human rights, autonomy, will and preferences of persons with psychosocial disabilities.”

CMHA believes that Australia, as a Member State and as one of the five co-sponsoring countries, should use this review opportunity to ensure alignment in practice with this resolution, as well as the Special Resolutions adopted by the UN HRC calling for alignment with the UN Convention on the Rights of Persons with Disability. We would expect to see demonstrated consideration of these international obligations in any new Agreement, including justifications if these obligations are not met.

6. 2024: National Lived Experience Peak Bodies

Establishment of two national Lived Experience peak bodies, the National Mental Health Consumer Alliance and Mental Health Carers Australia. These peak bodies continue the decades-long lived experience movement call for a move away from a clinically centred system to a social determinants and rights-based system. CMHA supports this call.

7. 2025: Innovations In Mental Health Services Delivery (World Bank, Roberto Mezzina)

Collectively, these seven developments provide substantial evidence that nothing less than transformation of the mental health system, entrenched as it is within a broader medical culture and ecosystem must be invested in. The National Mental Health Commissioned report exploring person-centred systems, identified a ‘stark difference between rhetoric and reality’ and highlighted barriers such as paternal culture, limits of the medical model, and mental health laws and experiences of coercion.

The Agreement has achieved somewhere between little and nothing in addressing these significant barriers, nor begun the process of transitioning systems to psychosocial supports outlined in every one of these documents. Something was lost in translation between the Productivity Commission recommendations and the negotiations for the Agreement.

The exclusion of Lived Experience expertise and leadership in the process of both developing and implementing the Agreement condemned the Agreement activities to BAU. This cannot happen again. Additionally, 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.

The Psychosocial Unmet Needs Project Group in its second stage, continued to exclude both community sector membership and recognise the unmet needs of family/kin, despite informal supports families provide exceeding in value the entire spend of governments on mental health systems.

CMHA provides this background at length because of the persistent failure of governments to implement either contemporary psychosocial supports or the appropriate change management mechanisms to support the transformation of the system.

Additionally, resource constraints mean this brief submission is confined to consultation with member peaks rather than an in-depth and data-supplemented one CMHA would have preferred to be able to provide in order to assess or measure impact of the agreement through the terms of reference of the review.

Recommendations for the next Agreement:

1. Governance: Lived Experience

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. Reporting against it so far, in the limited ways the National Mental Health Commission has been able to access data, is inadequate. Significant work is required to remedy this.

In addition to the usual clarity of scope, roles, purpose together with appropriately funded secretariat support, the development of the next National Agreement must be funded to ensure Lived Experience Peak Bodies, Suicide Prevention Lived Experience and First Nations bodies have much stronger profile and presence in the development and implementation of the next iteration. There must also be significant community mental health sector engagement in its development to enable the development of rights-based psychosocial enabling mechanisms to counter the overwhelming and unsurfaced assumptions that mental health systems are medical systems.

CMHA has not seen efficacy rate data for the current frontline services that justifies these assumptions. Similarly, the National Mental Health Commission's Report Card 2023 identified 'little data is available on the impact and efficacy of the billions of dollars invested by governments across the system each year, or the experiences and outcomes of people who receive support through the system, and their families, carers and kin.' It is imperative that the governance arrangements reflect Australia's international Human Rights obligations – consistently absent until now apart from brief nods to social determinants in Schedule A.

2. Governance: First Nations Social and Emotional Wellbeing

The next Agreement must provide pathways and cross-portfolio structures to facilitate meaningful alignment with the National Agreement on Closing the Gap. Beyond this, CMHA defers to and supports Gaya Dhuwi and the Aboriginal and Torres Strait Islander Lived Experience Centre recommendations.

3. Governance: Transformation Management Office

The current Agreement, aside from stating objectives and a purpose of reform, lacked key contextual structures such as a vision, strategy or a national Human Rights Act. Consequently, together with the structural design constraints of the Bilateral Agreements further embedding states and territories fragmentation, key transformation infrastructure has been absent. If the purpose of the next

Agreement is to genuinely drive reform, an Office must be established to build capability for change management, including training in system reform, form partnerships across portfolios to address social determinants, manage cost-benefit discussions with central agencies and manage the transformation process to allow for flexible responses around the Agreement as it progresses.

4. Interdependencies: Vision and Strategy

The next National Agreement should be linked to both a Vision and a Strategy. Vision 2030, developed by the National Mental Health Commission, provides a solid basis for developing a mental health strategy. This vision and strategy work should be undertaken by the National Mental Health Commission and include articulation of a whole of government approach.

5. Interdependencies: Outcomes Framework. The Measurements that Matter work should be progressed at a national level to provide the outcomes framework against which data is collected.

Data:

There are no current tools, instruments or measurements that are rights-aligned or lived experience designed. There is no national minimum data set. CMHA recommends the development of a mental health and suicide prevention data strategy that addresses the lack of a human rights focus, is family inclusive, lived experience led and enables data sharing inclusive of Indigenous Data Custodianship protocols. It should also support national data linkage. Current approaches to data compliance and management are captured by clinical assumptions and biases and reflect transactional rather than outcomes-focused reporting. The interjurisdictional Data Governance Forum is not inclusive enough of First Nations people, sector membership or Lived Experience representation in a way that enables meaningful co-design. As a key driver for quality improvement, more focus should be given to data and performance reporting through the Transformation-focused working group to develop a contemporary data strategy.

Whilst outside the scope of this Review, it is imperative that the National Mental Health Commission must be given functions and powers as a Statutory Authority located outside of DoHAC to request and be provided with data as required.

6. Human-Rights based National Service Planning Model

The National Agreement should develop a cohesive Mental Health and Suicide Prevention service planning model that is inclusive of Alcohol and other Drugs capabilities and is SEWB complementary. The current National Service Planning Framework needs to be reviewed to reflect contemporary understandings of distress and social and emotional wellbeing, that are informed by social determinants and social responses, genuinely human rights-based, and whole of family and whole of life conceptualised.

7. Human-Rights based Psychosocial Framework: Workforce, Data and Commissioning

Whilst there has been some slow and limited work progressing psychosocial supports through the existing Agreement, the current Agreement has failed to adequately recognise the scale of system transformation away from clinical services towards contemporary community based psychosocial supports.

The next Agreement must develop the three key structural enablers of a psychosocial framework. There must be a Working Group established to oversee the development of a psychosocial data strategy, psychosocial workforce (this was omitted from the National Mental Health Workforce Strategy), and a psychosocial commissioning strategy encompassing PHN's, states and territories and the NDIS, with connections into relevant cross-portfolio policy areas. This investment in the community/psychosocial supports sector must be prioritised in this next Agreement